

WHAT IS CURRENTLY KNOWN ABOUT OLDER MENTALLY ILL OFFENDERS IN FORENSIC CONTEXTS: RESULTS FROM A LITERATURE REVIEW

Stefaan De SMET

University College Ghent, Faculty of Health Care Vesalius / Free University of Brussels, Faculty of Psychology and Education
Hogeschool Gent, Departement Gezondheidszorg Vesalius
Keramiekstraat 80, B-9000 Gent Belgium
E-mail: Stefaan.desmet@hogent.be

Stijn VANDEVELDE

University College Ghent, Faculty of Social Work and Welfare Studies/
Ghent University, Faculty of Orthopedagogics
Voskenslaan 362, B-9000 Ghent Belgium
E-mail: stijn.vandevelde@hogent.be

Dominique VERTÉ

Free University of Brussel, Faculty of Psychology and Education
Pleinlaan 2, 1050 Brussel Belgium
E-mail: dverte@vub.ac.be

Eric BROEKAERT

Ghent University, Faculty of Orthopedagogics
Henri Dunantlaan 1, 9000 Gent Belgium
E-mail: Eric.Broeckaert@UGent.be

Abstract

As in most Western countries, Belgium is confronted with a growth of the older offender population. There is currently a dearth in research on the living conditions and needs of older offenders being judged as irresponsible for their offences because of mental illness.

Therefore, from a gerontological perspective an explorative literature review has been carried out to investigate which features characterize the subpopulation of older mentally ill offenders.

This paper presents and discusses the findings about following themes: definition of an age threshold in forensic contexts, the nature of offences committed by older mentally ill offenders, psychopathology, physical health and victimization and vulnerability.

Key Words: *older, elderly, mentally ill offenders, forensic*

JEL Classification: I00

1. INTRODUCTION

As in most Western countries, the Belgian population of older offenders is increasing in correctional institutions (Fazel & Grann, 2002; Belgian Ministry for Justice, 2009). There is currently a dearth in research on the living conditions and needs of older offenders being judged as irresponsible for their offences because of mental illness. Older offenders tend to have more mental and physical health care needs than younger offenders and than their similarly aged peers in the community (Yorston & Taylor, 2006). Older mentally ill offenders have complex needs and fall within the expertise of old age and forensic psychiatry and they have characteristics beyond age that distinguish them from general forensic populations (Lewis, Fields, & Rainey, 2006; Nnatu, 2005).

The focus of this study is on older offenders suffering from mental illness and who are patients in the general psychiatric or the forensic psychiatric system. Mentally ill offenders taken care of in the psychiatric system, differ from prison inmates with mental health problems because during their trial they were considered as not being criminally responsible for their offences (Salize & Dressing, 2007). In Belgium the lack of a consistent multidisciplinary psychiatric expertise often leads to an arbitrary judgment of criminal responsibility (Heimans, 2010). In addition, the deficiency in psychiatric facilities, is a contributing factor to the incarceration of a substantial number of mentally ill offenders in Belgian prisons instead of the care in the psychiatric system (Heimans, 2010; Goorden & Oei, 2007). Wiersma (2006) argues that for persons with severe mental illnesses the prevalence of unmet needs is related to the system of mental health care: "the less integrated and continuous care and the poorer the life situation, the more unmet needs." Needs in relation to the care system can be understood in four distinct ways: Normative needs, felt needs, expressed needs and comparative needs, whereby Thompson (2009) referring to Bradshaw, (1972) and Van Bilzen, (2007) indicates that comparative needs are obtained by studying the characteristics of a population in receipt of a particular service. If there are people with the same characteristics not receiving service, they are "in need" of that service. Wiersma et al.(2006), indicate that unmet needs are a strong predictor of less favorable health perceptions and a lower quality of life. Despite as far as mentally ill offenders are concerned, quality of life is little researched (Van Nieuwenhuizen, Schene, & Koeter, 2002). The concept of quality of life however, is an important outcome measurement for treatment and distinguishes eight domains: personal relationships, social inclusion, personal development, self-determination, rights, emotional well-being, material well-being and physical well-being (Schalock, 2002).

Taking into account that in the Belgian situation, older mentally ill offenders are staying in the psychiatric system as well as in prisons, the identification of the most striking features of the population is the subject of this explorative literature research. The results are meant as a first step towards a future investigation of the quality of life of older mentally ill offenders.

2. METHODS

In order to demarcate the population of older mentally ill offenders, the electronic databases Web of Science, Pubmed, CINAHL, Wiley Cohrane Library, Medline, Psychinfo and Google scholar were searched. The search strategy included all aspects of older offenders with special attention to mental health problems. Except from psychinfo, whereby the 'subject headings' were used

(“aging”, “mentally ill”, “offenders” “criminals” “forensic” and “psychiatry”), the Boolean search strategy was utilized by a combination of the search terms: older, elderly, geriatric, mentally ill, aging, mentally disordered, criminals, forensic psychiatry, offenders, prisoners and inmates.

Based on the abstracts initially only publications about older mentally ill offenders already judged as not being criminal responsible for their offences, were taken into consideration. Strictly maintaining these criteria, just five publications could be included: Coid et al. (2002), Curtice et al. (2003), Farragher & O’Connor (1995), McLeod et al.(2008) and O’Sullivan & Chesterman (2007). Five other publications deal with the characteristics of older offenders from prison referred by court to a forensic psychiatric setting in order to assess their mental health condition. Nevertheless the referrals discussed in these reports were not necessarily judged as criminally irresponsible for their offences because of mental illness, the results are still valuable.

Most publications however deal with health related research on the general population of older imprisoned offenders. In order to explore important characteristics applicable to the intended subpopulation of the older mentally ill offenders, only publications from Web of science referring in the abstracts to mental health problems of older offenders were included (N=21). In addition two often cited policy making research documents from the U.S. were included, one from Virginia (2008) and one of the Southern states (2006).

3. RESULTS

3.1. Age threshold

As for the general population, defining an age threshold in order to label people as “old”, “geriatric” or “elderly”, is an arbitrary matter for older offenders as well (Fazel & Grann, 2002; Loeb & AbuDagga, 2006).

Particularly in American literature, the age threshold of 50 years is commonly used, substantiated by the idea of “early aging” or “accelerated aging”(Aday, 1994; E. H. Johnson, 1988). Referring to the consequences of a harsher lifestyle, several argumentations are brought up to support this assertion: Risky behaviours in earlier lifetime (e.g. drug and alcohol abuse), a lack of preventive health care, limited health care prior to incarceration, poor diets, the stressors of life in prison. With reference to the living conditions in penal institutions, Williams (2006), mentions the basic stress of prison life of older offenders as follows: anxiety associated with a change in environment, isolation and often ostracism from friends and family, the prospect of living a large portion or even an entire life in confinement and the threat of victimization. In their entirety these factors tend to an emotionally and psychically aging that is more common in persons ten to fifteen years older in the general population (Gal, 2002) .

Although the idea of accelerated aging seems to be generally accepted in the U.S., Gallagher (2001) notices the lack of empirical evidence to support this assertion. Above more variations are used to define the lower age boundary of older offenders, sometimes even starting from 45 years. (Gallagher, 2001; Loeb & AbuDagga, 2006; Rayel, 2000; B. Williams & Abraldes, 2007; J. L. Williams, 2006; Yorston & Taylor, 2006). European researchers apply in general 60 years as an age threshold (Fazel & Grann, 2002; Fazel, Hope, O’Donnell, Piper, & Jacoby, 2001; Wong,

Lumsden, Fenton, & Fenwick, 1995; Yorston & Taylor, 2006). In some cases even a lower limit of 65 years is used (Curtice e.a., 2003; Tomar, Treasaden, & Shah, 2005) .

Both referring to Uzoaba, Curtice (2003) and Gallagher (2001) indicate a distinction can be made between “older offenders”, classified as those 50-64 years and “elderly offenders” that are considered to be aged 65 or older. However Yorston et al. (2006), report that some may find the title “elderly offenders” demeaning, this doesn’t hinder the use of the adjective in the literature. In practice, “Elderly” as a keyword to indicate older offenders is still commonly used.

3.2. Offences of older mentally ill offenders

As for the younger offender population, many variables influence the classification of older offenders to such a degree, they neither may be considered as a homogeneous group. Grant (1999) distinguishes 3 types of older offenders in the Australian prison population from 50 years and older: first time offenders imprisoned at an older age (66,5%), repeat offenders who return to prison at a later age (37% was imprisoned before) and offenders who grow old in prison due to long sentences (26%).

Results about the nature of offences among older mentally ill offenders demonstrate substantial variations which must be interpreted with caution because of limited numbers of the researched cases in most of the reports. Nevertheless, violent offences and sexual offences appear to be the most occurring types of offence. Yorston & Taylor (2006) suggest that in existing research such seriousness in the nature of crimes among the older mentally offenders could be due to a selection of ‘highly selected populations’. O’Sullivan & Chesterman (2007) found 37,5% of the older mentally offenders in a forensic psychiatric setting had commit homicide, 25% attempted murder and 7,1% sexual offences, with no significant differences between offenders who commit their crime earlier in lifetime and the first time older offenders.

Tomar et al.(2001) found prevalence rates of 47% concerning sexual offences as the most occurring type of offence and 37% for violent offences as secondly most occurring. Also, Curtice et al. (2003), found sexual offences are the most common offences (56%) and above exclusively commit towards minors. They found 25% as a level of violent offending. Rayel (2000), found that 77% of the older offenders in a maximum-security forensic hospital are involved in violent crimes and 27% have a sexual assault arrest history. Compared to younger mentally ill offenders, Fazel & Grann (2002) found the proportion of violent offences and sexual offences to be higher among the older population. Coid et al. (2002) on the other hand found no differences in the rates of sexual offences between the younger and older mentally ill offenders’ population and mention hereby, this in contrast to older sentenced prisoners. Wong et al. (1995), found that sex offending among older mentally ill offenders of 60 years and more was common among male first time offenders, if they had committed their crime after 50 years. However still not confirmed for the group of older offenders in particular, there is consensus that sexual aggression decreases with age because of the decreasing bio available testosterone and the decrease of sexual arousal and libido (Barbaree, 2003).

3.3. Psychopathology

However older mentally ill offenders who are considered to be irresponsible for their criminal offences should be treated as patients in forensic psychiatric settings, the number of older offenders referred to forensic psychiatry services is low (Tomar, 2005). Coid et al (2002) reported less than 1% of all admissions to secure forensic psychiatric services were older offenders.

Loeb et al. (2006), indicate that in prison psychiatric conditions is the most occurring health variable among older offenders next to physical illnesses and substance abuse. Watson et al. (2004) pose that it is unknown whether or not being in prison exacerbates the mental health problems, but they pose besides that having mental health problems is a causative factor in imprisonment.

Prevalence rates of mental health problems in the literature are not unanimous. Some studies indicate a higher prevalence of mental health problems among the older offenders compared to younger offenders, while to the results of others, fewer mental health problems are shown (Gal, 2002).

O'Sullivan & Chesterman (2007), indicate that in a forensic psychiatric setting, among the older mentally ill offenders 72% have a mental illness of which psychotic disorders are predominant with 50% suffering from schizophrenia, 12% have a psychopathic disorder and 9,4% have a mental impairment. 59% percent of the older offenders in a forensic psychiatric setting had a history of psychiatric hospitalization, 32% had a history of self-injurious behavior and 86% had a history of alcohol abuse (Rayel, 2000).

O'Sullivan & Chesterman (2007), initially found low rates of cognitive disorders 2,8% (mainly dementia). The lack of using systematically standardized rating scales for the assessment of cognitive disorders is suggested to be an explanation for this kind of underreporting (Curtice e.a., 2003). The same authors found dementia as the most common diagnosis (19%) among older offenders in a forensic psychiatric service. Accordingly, O'Sullivan & Chesterman (2007) suspected much higher true rates for cognitive impairment because symptoms became more visible in the course of hospitalization.

3.4. Physical health

Since research on older mentally ill offenders in forensic psychiatric settings is focussing more on mental health issues rather than on physical health problems, the findings below are mainly derived from reports based on the older offenders' population in prison. Nevertheless, Rayel (2000) indicates that the cardiovascular and endocrinologic problems are most common among older mentally ill offenders in a forensic psychiatric setting. Moreover, the physical health conditions of older offenders in prison seem to be of the same kind as those of the aging population in the community. Cardiovascular diseases, arthritis and/or back problems, endocrine disorders e.g. diabetes and sensory deficits such as vision and hearing problems are most common among older offenders in prison as well (Loeb & AbuDagga, 2006). However the rates of morbidity are high: Fazel et al. (2001) found that 85% of the older offenders in prison had major illness recorded in their medical notes and 83% reported a chronic illness at interview. The same authors indicate that these figures are significantly worse compared to those of younger prisoners

and older people living in the community. (Fazel e.a., 2001; Gallagher, 2001), showed that apart from more hearing and visual difficulties, the physical health of older male offenders did not differ significantly from those of the younger ones.

Colsher, (1992) found, although 42% of the older offenders report limitations in their physical functioning, only 11% have limitations in routine self-care activities. Besides, they are more likely to experience incontinence.

In addition to the normal aging process, many offenders prematurely deteriorate as a result of substance abuse and poor dental hygiene (Gal, 2002).

Findings based on self-reporting indicate that 41% of the older offenders perceived a worse degree of physical health status since incarceration, 33 % reported no change and 26% perceived an improvement (Loeb, Steffensmeier, & Myco, 2007). Accordingly, figures from correctional medical professionals indicate that after some time incarceration can improve the offenders' health status in prison because of better lifestyle and food. (Kratcoski & Babb, 1990).

3.5. Victimization and vulnerability

Although not age-specifically described, the physical victimization of male mentally ill offenders is found to be much higher compared to offenders with no mental disorders (Blitz, Wolff, & Shi, 2008).

Older offenders in prison are presumed to have a disproportionately higher risk of being victimized by younger offenders. Older offenders become targets of prison violence and abuse by younger offenders due to their physical frailty and lack of ability to defend themselves. Especially first-time older offenders are more vulnerable towards victimization (Williams & Abraldes, 2007). Furthermore, to avoid sanctions from staff, extra vigilant supervision is needed to ensure that officer's instructions are heard, understood and obeyed (G. M. Johnson, 2008). Kerbs & Jolley (2007), indicate that psychological- and property victimization towards older offenders were most reported, whereas physical and sexual victimization were rather uncommon. Nevertheless, results about inmate-on-inmate victimization towards older offenders, demonstrates conflicting and contradictory results. Some suggest that older offenders are relatively less likely to be victimized compared to younger offenders, because they have more experience in avoiding victimization (Kerbs & Jolley, 2007).

4. CONCLUSION

International variations in prison policies, programs and facilities influence the composition of older mentally ill offenders in forensic psychiatric settings. Consequently the variety in search results complexes the understanding of the characteristics and needs of the older mentally ill offenders. (Loeb & AbuDagga, 2006; Van Nieuwenhuizen e.a., 2002).

Adopting 50 years as common lower limit age (age threshold) could lead to better comparison across studies (Loeb & AbuDagga, 2006a). Watson et al.(2004), advocate a better health screening with an emphasis on mental health of mentally ill offenders by using validated instruments on arrival in the penal system. In addition, offenders with mental illness who have been victims of physical violence in prison before should be screened as well in order to prevent

revictimisation (Blitz e.a., 2008). Staff should made cognizant of the potential for victimization and should especially be encouraged towards a heightened awareness of victimization of older mentally ill offenders (J. L. Williams, 2006).

Seen the high prevalence of psychiatric morbidity in older offenders, Tomar et al. (2005), suggest an appropriate forensic psychiatry service for older mentally ill offenders is needed. Corrections departments may need to modify the physical environment of prisons that house large numbers of older inmates and provide special programming (Colsher e.a., 1992). On the other hand, Yorston & Taylor, (2006) are warning for housing the older mentally ill offenders together exclusively on grounds of chronological age: "some like of them like the hustle and bustle and feel they enjoy a high status in mixed-age units."

Further research on the characteristics featuring the population of older mentally ill offenders is needed to investigate their needs in order to measure and thus improve the quality of life of each individual. Consequently, a critical discussion leading to future research topics for the Belgian forensic context seems obvious.

BIBLIOGRAPHY

Aday, R. H. (1994). Golden years behind bars: Special programs and facilities for elderly inmates. *Federal Probation*, 58(2), 47.

Barbaree, H. E. (2003). The Development of Sexual Aggression through the Life Span. *Annals of the New York Academy of Sciences*, 989(SEXUALLY COERCIVE BEHAVIOR: Understanding and Management), 59-71.

Blitz, C. L., Wolff, N., & Shi, J. (2008). Physical victimization in prison: The role of mental illness. *International Journal of Law and Psychiatry*, 31(5), 385-

Coid, J., Fazel, S., & Kahtan, N. (2002). Elderly patients admitted to secure forensic psychiatry services. *Journal of Forensic Psychiatry*, 13(2), 416-

Colsher, P. L., Wallace, R. B., Loeffelholz, P. L., & Sales, M. (1992). Health status of older male prisoners: a comprehensive survey. *Am J Public Health*, 82(6), 881-884.

Curtice, M., Parker, J., Wismayer, F. S., & Tomison, A. (2003). The elderly offender: an 11-year survey of referrals to a regional forensic psychiatric service. *Journal of Forensic Psychiatry & Psychology*, 14(2), 253.

Farragher, B. B. .. O. (1995). Forensic psychiatry and elderly people--a retrospective review. *Medicine, science, and the law*, 35(3), 269-73.

Fazel, S., & Grann, M. (2002). Older criminals: a descriptive study of psychiatrically examined offenders in Sweden. *International Journal of Geriatric Psychiatry*, 17(10), 907-913.

Fazel, S., Hope, T., O'Donnell, I., Piper, M., & Jacoby, R. (2001). Health of elderly male prisoners: worse than the general population, worse than younger prisoners. *Age Ageing*, 30(5), 403-407.

Gal, M. (2002). The physical and mental health of older offenders. *The physical and mental health*

of older offenders, Mountain Institution, Correctional Service of Canada.

Gallagher, E. M. (2001). Elders in prison. Health and well-being of older inmates. *International Journal of Law and Psychiatry*, 24(2-3), 325-333.

Grant, A. (1999). Elderly inmates: issues for Australia.

Heimans, H. (2010) Kerkers in de geest, Knack, 17 maart 2010.

Johnson, E. H. (1988). Care for Elderly Inmates: Conflicting Concerns and Purposes in Prisons (From Older Offenders: Perspectives in Criminology and Criminal Justice, P 157-163, 1988, Belinda McCarthy and Robert Langworthy,

Johnson, G. M. (2008). *Assisted Living facilities for Geriatric Inmates* (No. act chapter 879-B).

Kerbs, J., & Jolley, J. (2007). Inmate-on-Inmate Victimization Among Older Male Prisoners. *Crime & Delinquency*, 53(2), 187-218.

Kratcoski, P. C., & Babb, S. (1990). Adjustment of Older Inmates: An Analysis by Institutional Structure and Gender. *Journal of Contemporary Criminal Justice*, 6(4), 264-281.

Lewis, C. F., Fields, C., & Rainey, E. (2006). A Study of Geriatric Forensic Evaluatees: Who Are the Violent Elderly? *J Am Acad Psychiatry Law*, 34(3), 324-332.

Loeb, S. J., & AbuDagga, A. (2006). Health-related research on older inmates: An integrative review. *Research in Nursing & Health*, 29(6), 556-565.

Loeb, S. J., Steffensmeier, D., & Myco, P. M. (2007). In Their Own Words: Older Male Prisoners' Health Beliefs and Concerns for the Future. *Geriatric Nursing*, 28(5), 319-329.

McLeod, C., Yorston, G., & Gibb, R. (2008). Referrals of older adults to forensic and psychiatric intensive care services: a retrospective case-note study in Scotland. *The British Journal of Forensic Practice*, 10(1), 36-43.

Nnatu, I. O. I. .. M. (2005). Is there a need for elderly forensic psychiatric services? *Medicine, science, and the law*, 45(2), 154-60.

Schalock, R., & Verdugo Alonso, M. A. (2002). Handbook on quality of life for human service practitioners. Washington: American Association on Mental Retardation.

O'Sullivan, P. C. J., & Chesterman, L. P. (2007). Older adult patients subject to restriction orders in England and Wales: A cross-sectional survey. *Journal of Forensic Psychiatry & Psychology*, 18(2), 204.

Rayel, M. G. M. .. (2000). Clinical and demographic characteristics of elderly offenders at a maximum-security forensic hospital. *Journal of forensic sciences*, 45(6), 1193-6.

Salize, H., & Dressing, H. (2007). Admission of mentally disordered offenders to specialized forensic care in fifteen European Union member states. *Social Psychiatry and Psychiatric Epidemiology*, 42(4), 336-342.

Thompson, J. R., Bradley, V. J., Buntinx, W. H., Schalock, R. L., Shogren, K. A., Snell, M. E.,

- Wehmeyer, M. L., e.a. (2009). Conceptualizing supports and the support needs of people with intellectual disability. *Journal Information*, 47(2).
- Tomar, R. (2005). Is there a case for a specialist forensic psychiatry service for the elderly? *International Journal of Geriatric Psychiatry*, 20(1), 51-56.
- Tomar, R., Treasaden, I. H., & Shah, A. K. (2005). Is there a case for a specialist forensic psychiatry service for the elderly? *International Journal of Geriatric Psychiatry*, 20(1), 51-56.
- Van Nieuwenhuizen, C., Schene, A. H., & Koeter, M. W. J. (2002). Quality of life in forensic psychiatry: an unreclaimed territory? *International Review of Psychiatry*, 14(3), 198-202.
- Watson, R., Stimpson, A., & Hostick, T. (2004). Prison health care: a review of the literature. *International Journal of Nursing Studies*, 41(2), 119-128.
- Wiersma, D. (2006). Needs of people with severe mental illness. *Acta Psychiatrica Scandinavica*, 113(s429), 115-119.
- Williams, B., & Abraldes, R. (2007). Growing Older: Challenges of Prison and Reentry for the Aging Population. In *Public Health Behind Bars* (pp. 56-72).
- Williams, J. L. (2006). The aging inmate population: Southern states outlook. In *Atlanta, GA: Southern Legislative Conference of the Council of State Governments*.
- Wong, M. T. H., Lumsden, J., Fenton, G. W., & Fenwick, P. B. C. (1995). Elderly offenders in a maximum security mental hospital. *Aggressive Behavior*,
- Yorston, G. A., & Taylor, P. J. (2006). Commentary: Older Offenders--No Place to Go? *J Am Acad Psychiatry Law*, 34(3), 333-337.