

## MEN'S HEALTH ACROSS THE LIFESPAN: HEALTH AND WELLBEING OF OLDER MALE PRISONERS

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<sup>1</sup>Health and Wellbeing Needs of Older Men Held in Northern Ireland Prisons

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### Abstract

**Introduction:** Older men aged 50 years and over are the fastest-growing cohort in the prisons of the United States (US) and the United Kingdom (UK). This reflects wider demographic change, such as increased life expectancy, as well as harsher sentencing policies, and an increased eagerness of courts to pursue historical offenses particularly relating to sexual crimes. Research has shown that older men in prison often experience poorer physical health than younger prisoners and those with similar age in the general public. However, to date, no such study has explored the health-related needs of older men held in Northern Ireland prisons. The aim of this research was to explore the health and wellbeing needs of older men held in custody in Northern Ireland.

**Method:** A questionnaire was completed by 83 men aged 50 years or over, who were in prison in Northern Ireland in 2016. Comparisons were made with similar community-based surveys.

**Results:** The data showed that on many indicators, older prisoners experience worse health than their peers living in the community.

**Conclusion:** These findings suggest that there is a need for appropriate healthcare planning for older men in prison which recognizes how their health may differ from other age cohorts within prison, as well as from those living outside a custodial establishment.

**Keywords:** ageing; health; older men; prisoners; wellbeing

### INTRODUCTION

Older men aged 50 years and over are the fastest-growing cohort in the prisons of the United States (US) and the United Kingdom (UK).<sup>1,2</sup> This increase partly reflects increasing life expectancy and wider demographic changes. However, reforms in sentencing have resulted in serving longer time.<sup>3,4</sup> Additionally, the increased eagerness of courts to

pursue historical offenses, as well as changes in societal attitudes toward sexual abuse have led to an increase in the number of perpetrators of these crimes being sent to prison later in life.<sup>5,6</sup> Older men in prison often experience poorer physical health than younger prisoners and those with similar age in the general public.<sup>3</sup> Thus, there is a need for appropriate healthcare planning for older men in prison that recognizes the needs of this particular group.

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The prison population is a “hidden” population and there is a dearth in research pertaining to the current health status specifically of older prisoners in Northern Ireland (NI). Relevant Health Needs Assessments have focused on all prisoners,<sup>7</sup> or specific issues (such as mental health), without addressing the needs of older men explicitly. Furthermore, a recent review of healthcare services in NI prisons highlighted the absence of a robust system for data collection and monitoring.<sup>8</sup> As well as hindering research, this lack of knowledge limits the ability of statutory agencies and prison authorities to diagnose and meet the healthcare needs of older men in prison. This is exacerbated by a complicated Partnership Agreement between the Northern Ireland Prison Service and the South Eastern Health and Social Services Trust relating to healthcare service provision.<sup>9</sup>

This article is based on data collected as part of PhD research by Sarah Lawrence. The study took place in Northern Ireland, a small region within the United Kingdom (UK) and it has a prison population of approximately 1565 sentenced and remanded prisoners. The prison population in Northern Ireland is smaller compared to other UK regions (England & Wales,  $n = 79,744$ ; Scotland,  $n = 7479$ ) and the Republic of Ireland ( $n = 3970$ ). In addition, the prison population rate in Northern Ireland (82 per 100,000) is lower than other regions of the UK (England & Wales 132; Scotland 137) and higher than that of the Republic of Ireland (78 per 100,000 national population).<sup>10</sup>

The aim of this research was to explore the health and wellbeing needs of older men held in custody in Northern Ireland. Furthermore, this study explored health care provision available to this cohort of older men as well as opportunities for health improvement. By utilizing data from this PhD research, this article provides a baseline assessment of health and wellbeing needs of the older male prison population within the region. It is hoped that this provides robust evidence to assist in future policy development that promotes better practice and the improved health and wellbeing of older men in prison.

### **Older men**

The ageing of a population is evident in statistics on the variation in the number and relative distribution of different age groups, as well as by increased life expectancy. For example, in Northern Ireland between 1994 and 2019, the percentage of the population aged 65 and over increased from 12.9% to 16.6%. Significantly, demographic change among men has taken place at a different rate than among women. Between 2009 and 2019, the population of males in Northern Ireland aged 85 and over has increased by 51.8%, compared with 21.1% for females.<sup>11</sup> Explanations for the faster improvement in male mortality include a reduction of smoking levels for men, as well as advances in health treatments for circulatory illnesses.<sup>12</sup> In addition, agricultural and manufacturing jobs, within which males have traditionally been the majority, have become safer and less physical.<sup>13</sup>

These changes mean that older men are becoming more visible statistically and so later life has become less numerically dominated by women.<sup>14</sup> However, academic literature and research has been slow to acknowledge and respond to the increasing visibility of older men.<sup>15</sup> Furthermore, social and community services often fail to consider how to engage specifically with older men, and to tailor their activities for this cohort.<sup>16</sup> Older age can be associated with decreasing health and worsening health outcomes, such as the increasing risk of cancer with age.<sup>12</sup> There is also concern about suicide rates among middle-aged<sup>17</sup> and older men.<sup>18</sup> Nevertheless, there has been a paucity of health-related research among men beyond early adulthood, particularly in the context of mental health.<sup>19</sup>

### **Older men's health in prison**

It has been argued that the prison population experience accelerated ageing of 10 to 15 years compared with those living outside a custodial establishment, and this is manifested in poorer physical health.<sup>3</sup> This may be a result of prisoners' increased likelihood of living a chaotic or unhealthy lifestyle prior to imprisonment, the detrimental effects of

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living in a prison environment, or perhaps a combination of both.<sup>20–22</sup> Common health issues include angina or ischemic heart disease, osteoarthritis, hypertension, diabetes mellitus, chronic obstructive pulmonary disease, and asthma.<sup>3</sup> Age-related physical changes and the conditions specific to confinement are likely to impact the physical and mental wellbeing of ageing inmates.<sup>23</sup> One UK study of male prisoners aged 60 and over ( $n = 203$ ), found that 28% self-reported that their health is as bad or very bad compared to 3% of their younger peers in prison (aged 18–49) and 10% of community-dwelling men who were aged on average 10 years older (65–74).<sup>3</sup>

Another study<sup>24</sup> examined the prevalence of both psychiatric and physical disorders, including dementia, for sentenced prisoners in the UK aged 50 and over ( $n = 121$ ). Nearly half (49.6%) ( $n = 60$ ) were identified as having a diagnosable psychiatric illness, the most prevalent being depressive disorder (80% of diagnoses). Only two participants had a diagnosable score indicating the prevalence of dementia; however, 15 men (12%) indicated signs of cognitive impairment. Depression was more likely to be found if the respondent had self-reported a previous mental illness, or among those who were serving sentences for violent offenses (66.7%). Those over the age of 65 were significantly more likely to report depression (75%) than those aged 50–64 (50.5%). Despite the high prevalence of depressive disorders, only 21 participants (17.8%) reported that they were prescribed psychiatric medication. This is in contrast with a research finding that older prisoners with psychiatric illness mostly went undetected and untreated, although the needs of older men in prison experiencing physical illness mostly had their needs met.<sup>25</sup> Elsewhere, over half of older prisoners who had identified a need for personal care were not having this need met.<sup>26</sup> These unmet needs will have implications for prison authorities and community resettlement agencies as the older population in prison continues to grow.<sup>24</sup>

Individuals in prison have been described as the most neglected population in relation to the

increased efforts to improve the quality of life of those with dementia.<sup>27</sup> This is despite the fact that their poor physical and mental health as detailed above may make them more susceptible to developing that condition. Moreover, developing dementia in prison may reduce the likelihood of obtaining early interventions which could slow its progression and enable support to the individual affected.<sup>28</sup> For those experiencing dementia in prison, difficulties may arise in meeting the basic demands associated with the regime including long periods of locked time in cells, cell sharing with younger prisoners, and the noise associated with prison accommodation. Furthermore, there is a higher chance of experiencing victimization and bullying from other prisoners.<sup>27</sup> Despite varying accounts from region to region on the prevalence of dementia in prison, there have been calls for prisons to respond to such needs through the development of staff training in relation to identifying, recognizing, and responding to symptoms, physical adaptations to cells, increased provision of programs for those with dementia, and greater consideration of release options for these individuals. For example, a lack of awareness of dementia and mild cognitive impairment among staff and prisoners may mean that problematic behavior is viewed as a disciplinary issue rather than a health issue.<sup>29</sup> A review in NI noted the lack of specialist provision for prisoners, such as memory clinics or social care support, meaning that prisoners requiring specialist input were referred to external memory clinics.<sup>8</sup>

A criticism of historical research on health and wellbeing in prison is that it tends to take a short-term view and focus on primary health problems whilst neglecting prevention.<sup>30</sup> Thus, there is an almost complete absence of research relating to health promotion in prison for older prisoners. This may be because health promotion in prison more broadly is an under resourced and a poorly understood area.<sup>31</sup> Therefore, such research has tended to focus on ways to reduce communicable diseases such as tuberculous and hepatitis A, B, and D.<sup>32</sup> Significantly, the underlying principles of modern

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health promotion, (i.e., personal responsibility and choice), can be particularly problematic in a place such as prison which constrains personal autonomy.<sup>33</sup> While research is emerging in the area of health promotion for the wider prison population,<sup>34,35</sup> little work has focused on the relevant needs of older prisoners who may differ considerably from their younger peers. Nevertheless, one quantitative study undertaken in the US found that older prisoners possess high levels of self-efficacy,<sup>36</sup> meaning that they were likely to benefit from participation in health promotion programs in prison. A qualitative study also undertaken in the US found that older men have particular concerns about their diet in prison and their ability to remain active.<sup>37</sup> Opportunities for exercise in prison has been shown as particularly problematic for older men, with many feeling that there is little value from the activities which are typically offered.<sup>38</sup> However, it has been argued that the public health agenda needs to tackle the structural determinants of poor health before focusing on the promotion of healthy lifestyles, given that the majority of men in prison come from the poorest and most socially excluded parts of society with the greatest health needs.<sup>30</sup> Whilst a few examples of specific initiatives designed with the needs of older people are beginning to emerge (horticultural sessions, 50+ gym sessions, chair-based exercise training), significant work is still required to better understand the health-related lifestyles, including the exercise needs, of older people in prison.<sup>39</sup> This sits in contrast to the extensive work that has been undertaken to explore the benefits of sporting initiatives for younger people within prison and to develop and evaluate specific programs.<sup>40,41</sup>

## METHODS

Primary data was collected in the Well Man Survey (WMS) via a paper self-completion questionnaire. This focused on general health, mental wellbeing (Warwick-Edinburgh Mental Wellbeing Scale: WEMWBS),<sup>42</sup> attitudes relating to male roles (Males Roles Norms Scale),<sup>43</sup> attitudes to

mental health, access to health services in prison, and improving health and lifestyle, as well as demographic, socio-economic, and custodial information. The survey drew on questions used in other research to enable comparison to be drawn and also to promote the reliability and validity of the responses. However, a small number of questions were adapted to reflect the specific prison context.

All older men held in prison in Northern Ireland between January and April 2016 were invited to take part, with the exception of “separated” prisoners who are placed in a separate wing because of paramilitary status. The lower age threshold was 50 years, in line with other studies which explored health and ageing.<sup>1,44</sup> Older men are held in two prison locations in NI (HMP Maghaberry and HMP Magilligan), depending on the type of offense, security classification, sentence length, and the amount of time served. HMP Maghaberry, which is the larger of the sites, has an extremely diverse population which includes prisoners who are on remand or newly sentenced. HMP Magilligan is used for prisoners having a lower security classification and nearing the end of their sentence, and also has a designated wing for older and disabled sentenced prisoners. The research was conducted in both sites to reflect the heterogeneous population residing in different locations and also subject to different regimes.

A participant information sheet and an invitation were circulated to older men, and information sessions were held so that potential participants could meet the researcher and find out more about the study. The researcher obtained signed consent from all participants prior to taking part in the study. It was envisaged that participants would complete the survey with the researcher present in an educational room within the prison houses.

To enable those with disabilities or literacy issues to take part, participants were offered the opportunity to complete the survey on a one-to-one basis with the researcher rather than within a group session. This meant that the researcher could assist prisoners who experienced difficulty reading

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or writing. Whilst this mechanism was offered primarily as a means to minimize the difficulties that such prisoners had, nearly all participants wished to complete the survey in this way. This was because many participants wanted to talk about their experiences with the researcher whilst completing the survey and doing this on a one-to-one basis also promoted confidentiality (but not anonymity). On average, the survey took around 20 min to complete. Upon completion, participants placed the questionnaire in a blank envelope. No names or prison numbers were recorded anywhere on the survey or the envelope to ensure anonymity and confidentiality during analysis.

Further, elements of the research included qualitative interviews with older men and relevant stakeholders (e.g., prison staff, health staff). However, the focus of this article is on the quantitative survey.

Two secondary data sources provide useful comparators with the Well Man Survey. First, Surveying Prisoner Crime Reduction Survey (SPCR) is a longitudinal study which began in 2006 and is administered in prisons in England and Wales.<sup>45</sup> This allows comparisons to be made between the older prisoners in NI and prisoners in England and Wales. The 2013 SPCR survey incorporated 2171 adult prisoners serving sentences during 2013, of which 2056 were aged 18–49 years and 115 were aged 50 and over.<sup>46</sup>

The Health Survey Northern Ireland (HSNI) is an annual random sample survey of the general population aged 16 years and over, with approximately 4000 respondents each year.<sup>47</sup> The questionnaire changes each year, and so data was accessed from a number of years in order to make appropriate comparisons. This survey allows comparisons to be drawn between the health needs of the older prisoners and older men living in the community.

The primary and secondary data were collected before the COVID-19 pandemic, which had, and continues to have an impact on physical, mental, and social wellbeing,<sup>12</sup> including those in prison.<sup>48</sup> Thus, if this research was repeated, the impact of the pandemic would be evident among prison and community-dwelling cohorts.

### ***Access and ethical requirements***

Research with older prisoners requires significant consideration of potential ethical issues. Older prisoners may be viewed as a vulnerable population due to their status as incarcerated individuals, as well as heightened likelihood of experiencing literacy issues, mental health difficulties, and a history of substance misuse and addictions. The process of gaining both permission to access the prisons as a research site and the appropriate level of ethical review was very lengthy (approximately 9 months), as approval was needed from a number of organizations. The Northern Ireland Prison Service (NIPS) approved this study and put in place arrangements for access and liaison. Queens University Belfast, Research Governance undertook a review of the study and provided sponsorship and indemnity insurance. The procedural ethics of the study were then favorably reviewed by the The Office of Research Ethics Committees Northern Ireland (ORECNI).

## **RESULTS**

### ***Prison population***

There has been a gradual increase in the proportion of men aged 50 and over in Northern Ireland prisons since 2008 (Table 1), rising from 11% in 2008 to 16% in 2015. Over the same period, the number of prisoners of all ages has also increased. In particular, the number of older men has grown from 134 in 2008 to 236 in 2015, which is an increase of 76%.

At the time of fieldwork (January 2016–April 2016) there were over 200 men aged 50 years and over held in Northern Ireland prisons. This number fluctuated on a day-to-day basis due to commitments, bails, and releases. A small proportion of the older men were not eligible to take part in the Well Man Survey due to security or safety concerns, or because staff advised they were extremely vulnerable and participation risked causing possible harm. This included a small number of men ( $n = 3$ ) whose poor mental health made them extremely vulnerable or their health conditions created uncertainty

**TABLE 1.** Northern Ireland Prison Population 50 Years and Over

Year	Percentage of Total Adult Male	Yearly Average (N)	Min	Max
2008	11%	134	121	146
2009	12%	134	119	150
2010	13%	148	130	168
2011	13%	167	143	187
2012	13%	183	153	207
2013	14%	209	182	237
2014	15%	230	206	248
2015	16%	236	218	252

Source: Prison population data provided by Northern Ireland Prison Service as part of this study.

around their ability to provide consent for the study. The researcher engaged with prison staff and health professionals in such cases to ensure that as many people as possible were given the opportunity to take part in the study while the risk of harm by doing so was reduced. Of those who were eligible to take part, 83 participated, which represents a response rate of 49%. Of these, 45 participants were held in HMP Magilligan and 38 in HMP Maghaberry. The age of participants ranged from 50 to 77; this large age range meant that their needs, expectations, life experiences, and ability to cope with the carceral environment differed substantially.

The majority of participants had come to prison in the later period of life, with more than two-thirds (69%) beginning their current sentence at age 50 years and over (53% at age 50–59 and 16% at age 60 and over). Only 1% began their sentence aged 20–29, 5% at age 30–39, and 25% at age 40–49. Nearly half (48%) had limited experience of prison and were serving their first custodial sentence. In contrast, 20% were serving their second sentence, 24% had been in prison three to five times, and 9% had been in prison at least six times.

Most participants were in prison because they had either been accused or found guilty of a serious offense. These tended to be of a violent (42%) or sexual nature (32%), or a combination of both.

Other offences included robbery/burglary (10%), drug (4%), or fraud (1%). However, whilst many of the participants were serving long sentences for serious offences, a small number of participants described their experience of the “revolving door.”<sup>49,50</sup> They had served a large number of short sentences across their lifetime, which often equated to a large amount of time spent in custody for relatively minor crimes. These individuals tended to cite challenging personal circumstances such as addictions and poor mental health as contributing factors in their offending pattern. In this study the majority of those who had spent a long time in prison tended to have been found guilty of a serious offense when they were younger and thus had aged in prison with hope for release in the future. Those who had come to prison later in life tended to be sentenced for historic offences, which mainly were of a sexual nature.

A comparison of SPCR and Well Man data shows that a lower proportion of older men in prison in Northern Ireland were sentenced for drug offences compared with the sample of older men in England and Wales (4% compared with 23%). This may reflect the historically lower levels of drug-related offending in NI compared to the UK as a whole.<sup>51</sup> However, the normalization of society in NI as a result of the Peace Process has led to an increased prevalence in illicit drug-use within the region, particularly amongst younger people.<sup>52</sup> This is an important point to note as many of the Well Man participants held strong views against drug use in prison, and experienced alienation as a result of normalized drug use amongst younger men in prison.

For Well Man participants, violence against the person was the most frequent primary offense (42%), which is more than twice the proportion of older men within the SPCR study who were charged with this (20%). This may reflect differences in the whole prison population within the jurisdictions. For example statistics published in 2018 based on the total adult prison population suggest a 9 percentage point (35%) higher prevalence in violence against the

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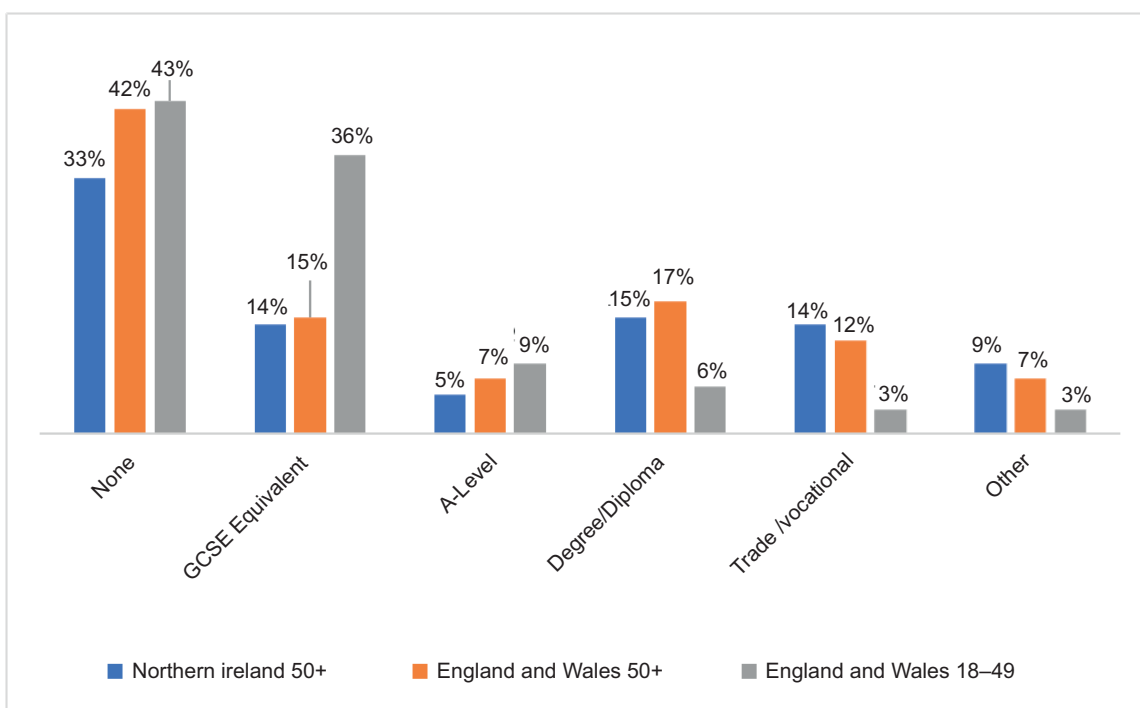
person offenses in Northern Ireland when compared with England and Wales (26%).<sup>22</sup> However whilst this may explain some of the disparity between the two older prisoner samples, it is also plausible to assert that the violent time period through which the study participants lived through, i.e., the troubles, may have led to an overrepresentation of violent offenses among this age cohort of men in NI.

The second most frequent offense identified by the Well Man participants were sexual (32%) which is similar to the proportion of older men taking part in the SPCR study (31%). The high proportion of sexual offenses is likely to have impacted upon how participants experienced prison, given that these offenses often attract significant shame within the prison environment<sup>53</sup> Furthermore, individuals who have been incarcerated for such an offense are at an increased risk of bullying and victimization from other prisoners.

### Education

Previous research has described the prison population as mostly comprising people who experience social and economic deprivation prior to prison, defined in sociological terms as the underclass.<sup>3,54</sup> The Well Man Survey elicited information about educational attainment, as this is often used as a proxy for social class. However, this approach does not fully capture the dynamics of social class, and education alone is not a sufficient measurement of social class for this age cohort.<sup>46</sup> Figure 1 shows that that one-third of the NI sample had no qualifications compared with 43% of their SPCR peers.

Whilst some participants outlined such challenging personal circumstances throughout their lifetime, this was not the case for others: several had run successful businesses or held positions of significant responsibility in their employment prior to imprisonment.



**FIGURE 1.** Highest level of educational attainment (%).

Source: Well Man Survey (2016) and SPCR (2013).

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**Self-reported health**

Note that 3 in 10 WMS participants self-reported that their general health as being bad or very bad (30%), which is almost twice that reported by men aged 50 years and over taking part in HSNI (17%). In contrast, 42% of WMS respondents said that their health was very good (15%) or good (27%), compared with 21% and 37% of older men taking part in HSNI.

There was also disparity between the two prison locations, with participants in HMP Magilligan prison self-reporting their health more positively than those in Maghaberry prison. This may be unexpected given the higher average age in HMP Magilligan (59 years) compared with HMP Maghaberry (54 years). It is possible that the relaxed regime present within HMP Magilligan prison may have a mediating effect on poor health, or that those coming to the end of their prison sentence (as is the case with HMP Magilligan prisoners) may have a more positive outlook than those with a longer term still to serve.

Well Man Survey participants were more likely than the community dwelling respondents to report their health as being somewhat or much worse than a year previously: 41% and 25% respectively (Table 2). This suggests that prison may have a negative impact upon health and undetected health issues are being identified only when someone came to prison, or perhaps a combination of these. However, a small proportion of prison participants

reported their health as being much better than a year ago (5 percentage points higher than their community dwelling peers). This may suggest that specific needs (such as addictions or poor mental health) were not being met within the community or were exacerbated by the environments that participants were living within, and were now addressed within the prison. This is an important finding that demonstrates the heterogeneity of the older prisoner population. Furthermore, this has implication for other healthcare providers and prison authorities who may overlook this group as needing particular services in prisons often not associated with the older prisoner population.

Three quarters (69%) of WMS participants reported that they had one or more health issues, including one-third having three or more. The most frequently identified issues related to mental health, angina and heart conditions, diabetes, arthritis, and back problems. Other less common health issues included addictions, historic fractures, mobility issues, high cholesterol, difficulty sleeping, and pain. The majority of participants (83%) said that they were currently receiving treatment for health needs.

To give an indication of participants' current subjective wellbeing and psychological functioning, the Well Man Survey included the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). The 14 items of this standardized scale are positively worded and address aspects of positive mental health. Respondents score the way they have

**TABLE 2.** Current Health Compared with a Year Previously

<b>Compared to one year ago, how would you say your health is now?</b>	<b>Men aged 50+ living in the community</b>	<b>Men aged 50+ held in prison</b>
Much better now than a year ago	3%	8%
Somewhat better now (than a year ago)	7%	7%
About the same as a year ago	65%	43%
Somewhat worse now (than a year ago)	18%	31%
Much worse now than a year ago	7%	10%
Total	100%	100%
unweighted count	919	83

Source: Health Survey Northern Ireland 2015/16 and Well Man Survey (2016).

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been feeling over the previous 2 weeks across the 14 items (e.g., good about self, close to other people, optimistic about the future, etc.), on a five-point scale ranging from 1 “all of the time” to 5 “none of the time.” Scores are added together, and the total ranges from 14 to 70, with a high score reflecting a high level of subjective wellbeing, and a low score reflecting lower subjective wellbeing. WEMWBS has been administered in both the NI general population within the 2016/17 Health Survey Northern Ireland,<sup>47</sup> and a sample of older prisoners held in prisons in Scotland.<sup>54</sup> The results from Health Survey Northern Ireland (2016/17) found a mean score of 51.19 among men aged 50 years or more living in the community, whilst the mean score among older prisoners taking part in the Well Man Survey was 42.34—see Table 3. This suggests lower subjective wellbeing among the older men in prison.

As with the questions on self-reported general health, there was disparity in the mean WEMWBS scores between the two prisons. Table 4 shows that participants in Maghaberry prison had a score four points lower than their peers in HMP Magilligan, and a score 11 points lower than community dwelling older men. This may suggest that mental wellbeing is adversely affected during the beginning of a person’s sentence and that individuals report their subjective wellbeing more positively toward the end of their sentence. Studies on adjustment to prison propose that individual and environmental factors, and the interaction between the two are strong predictors for how well an individual copes with incarceration.<sup>55</sup> Thus, attributes including age, health status, and

past experience with prison can all impact an individual’s ability to cope with the regime. Almost half of WMS participants (49%) were in prison for the first time in their life and this inexperience may have had a negative impact upon coping for those initially sent to the HMP Maghaberry which receives new committals to prison.

Environmental factors such as physical characteristics of the prison estate and disruptions caused by policy changes can have a major impact on how individuals cope.<sup>55</sup> The majority of those held in HMP Maghaberry were residing within prison houses that mostly held younger prisoners. In contrast, HMP Magilligan offered an accommodation block to people aged 50 and over that reduced the isolation often described by older prisoners held in units with a younger population, and also provided additional supports relating to health care access. At the time of fieldwork, in HMP Maghaberry Her Majesty’s Inspector for Prison (HMIP) reported significant administrative challenges which were having a detrimental impact upon the regime.<sup>56</sup> At this time HMIP considered the prison to be both unsafe and unstable, and cautioned that if these issues were not resolved, serious disorder and loss of life could occur. These environmental impacts are likely to have had a negative impact upon many people held at that time in HMP Maghaberry, including those who were older.

The majority of Well Man participants (60%) indicated that they were receiving medication for stress, anxiety, or depression (see Table 5). This is more than five times higher than the figure for older men living in the community (11%).

**TABLE 3.** Warwick-Edinburgh Mental Wellbeing Scale Community and Prison Comparison

WEMWBS	Men aged 50+ living in the community	Men aged 50+ being held in prison
Mean	51.19	42.34
Standard deviation	9.483	10.54
Unweighted Count	457	82

Source: Health Survey Northern Ireland 2016/17 and Well Man Survey (2016).

**TABLE 4.** Warwick-Edinburgh Mental Wellbeing Scale Comparison by Prison

WEMWBS	N	Mean	STD.DEV	Min	Max
Magilligan prison	44	44.14	10.71	15	63
Maghaberry prison	38	40.26	10.09	22	63
Total prison sample	82	42.34	10.54	15	63

Source: Well Man Survey (2016).

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**TABLE 5.** Taking Medication for Stress, Anxiety, or Depression

Are you taking an medication for stress, anxiety or depression	Men aged 50+ living in the community	Men aged 50+ held in prison
Yes	11%	60%
No	89%	40%
Total	100%	100%
Unweighted Count	546	83

Source: Health Survey Northern Ireland 2016/17 and Well Man Survey (2016).

**Activities of daily living**

Two survey questions explored participants’ ability to carry out basic activities of daily living such as walking, or dressing and feeding oneself. Participants were asked to tick as many activities that applied to them personally. The two multiple response questions consisted of 7 and 11 items respectively, and they also included an option to tick *none of these*. One in three (31%) participants are experiencing difficulty with at least one activity of daily living, 18% identified difficulty with at least two activities of daily living and 2% with three or more activities of daily living (see Table 6).

Comparison of Well Man Survey responses with HSNi data indicate a similar incidence of needs in respect of the activities. For both samples, the most common difficulties identified centered around mobility, eyesight, and hearing. However, given that the environment in prison can pose specific challenges, a number of activities were added to the questions. These related to getting access to other areas of the prison.<sup>1</sup> However, these questions were excluded from the comparison with the community sample.

<sup>1</sup>Additional prison-based questions were as follows; (1) Cannot get access to the toilet when you need it, (2) Cannot walk the distance to the toilet without difficulty, (3) Cannot use the toilet on my own without difficulty, (4) Cannot collect my own food at meal times without difficulty, (5) Cannot get to other areas of the prison without help.

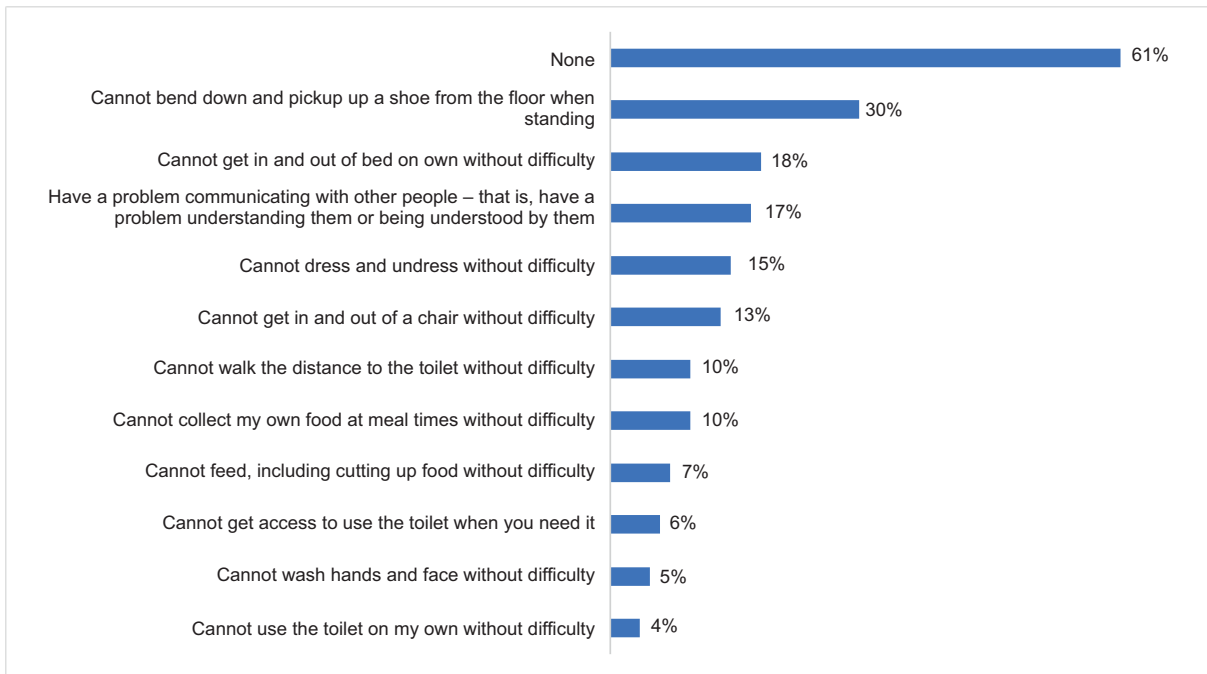
**TABLE 6.** Number of Activities of Daily Living Identified by Participants (Question 1)

Do any of the things on this card apply to you?	Men aged 50+ living in the community	Men aged 50+ held in prison
0	70%	69%
1	11%	13%
2	15%	16%
3+	4%	2%
Total	100%	2%
Unweighted count	965	68

Source: Health Survey Northern Ireland 2014/15 and Well Man Survey (2016).

The second question relating to activities of daily living again focused on mobility as well as more specific tasks such as personal care needs. The responses to the second question indicated that 32% (N = 25) experienced difficulty with at least one activity of daily living, 20% (N = 16) with two or more activities of daily living and 10% (N = 8) with three or more activities of daily living. Prevalence of these needs was 10 percentage points higher among the Well Man participants than the community-based sample. However, this differential could be reflective of the small sample size who participated in the study.

Again, a number of specific items were added to this question to reflect some of the potential difficulties that the prison environment may present to older people. These related to accessing toilet facilities and they aimed to reflect the distinct challenges experienced by older prisoners,<sup>57</sup> in particular, being allowed to access a toilet during a locked regime. These items were excluded from comparison with the community-based sample; however, they are included in Figure 2 to identify particular challenges for a prison-based sample. Despite the inclusion of these questions, the most common activities identified as difficult for participants related to mobility and communication with others. All of the items can be seen Figure 2.



**FIGURE 2.** Activities of daily living (Question 2).

*Source:* Well Man Survey (2016).

The percentage for “none” does not correspond with the figure stated in Table 6 because additional activities added as part of the Well Man Survey are removed from Table 6 to enable comparison.

The participants who identified at least one activity from either of the two questions as being difficult, were asked to indicate what help they received with these needs. The most common response of those who answered this question was “none.” This was followed by “transport,” “ground floor cell,” “carer,” “medication,” “treatment,” and “mobility scooter.”

**Healthy lifestyles**

The final section of the Well Man Survey explored healthy lifestyles in prison and perceptions of health improvement, and comparative data was available from HSNI. Almost 40% of the older men in prison identified living an unhealthy life compared to 15% of HSNI respondents (see Table 7). This disparity may be reflective of lifestyle factors imported from the community when individuals entered prison such as addictions and poor mental

health.<sup>58</sup> However, it may also reflect some of the challenges of maintaining a healthy lifestyle while in prison.

Similar proportions of respondents in each survey felt that they could do something to make their own life healthier: 67% for 2015/16 HSNI and 70% for Well Man Survey (see Table 8). Both samples were asked about the types of things that they could do to make their life healthier, and the modal response was to eat more healthily: 57% in WMS and 43% for HSNI. Diet in prison was a strong theme within the qualitative interviews with the older men, who generally perceived the options they had as unhealthy. The second most frequent response for the prison-based sample was to reduce the stress in their life, which was identified by more than half of participants (55%)—34 percentage points higher than those residing in the community. This is not surprising, given the lower levels of

**TABLE 7.** Healthy Lifestyles Comparison

Which of the following best describes the life you lead?	Men aged 50+ living in the community	Men aged 50+ held in prison
Very healthy	14%	10%
Fairly healthy	71%	51%
Fairly unhealthy	11%	33%
Very unhealthy	4%	7%
Total	100%	100%
Unweighted Count	918	83

Source: Health Survey Northern Ireland 2015/16 and Well Man Survey (2016).

subjective wellbeing and higher rates of medication for stress, anxiety, and depression among those held in prison.

Finally, participants were asked about how much influence they felt they have on their own health by the way they choose to live their life. There was a significant disparity between the two samples. More than 4 in 10 (43%) of those held in prison felt they

**TABLE 8.** Lifestyle Changes Which Would Make Participants Life Healthier

Which, if any, of the things on this card do you feel you can do to make your life healthier?	Men aged 50+ living in the community	Men aged 50+ held in prison
Cut down smoking	9%	20%
Stop smoking	17%	34%
Cut down the amount Of alcohol I drink	15%	10%
Stop drinking alcohol	4%	17%
Be more physically active	49%	43%
Control weight	36%	48%
Eat more healthily	43%	57%
Reduce the amount of stress in my life	21%	55%
None Of these	7%	7%
Unweighted Count	585	83

Source: Health Survey Northern Ireland 2015/16 and Well Man Survey data (2016).

**TABLE 9.** Perceptions of Influence on Own Health

How much influence do you think you have on your own health, by the way you choose to live your life?	Men aged 50+ living in the community	Men aged 50+ held in prison
A great deal	45%	32%
Quite a lot	41%	26%
A little	12%	26%
None at all	3%	17%
Total	100%	100%
Unweighted Count	917	82

Source: Health Survey Northern Ireland 2015/16 and Well Man Survey (2016).

had little or no influence over their health, whereas only 15% of community dwelling older men had this perception (see Table 9). This may reflect the challenges prison places upon autonomy and thus the difficulties the men perceived in relation to the choices they could make in respect of health.

## DISCUSSION

The Well Man Study provides the first major exploration of the experiences and needs of older prisoners in NI. The WMS was specifically designed to allow comparisons with other data sources, including those based in prison and community-based samples. There are distinct differences between WMS participants and the older men held in prison elsewhere in the United Kingdom. For example, whilst violence against the person was the most common primary offense within both samples, the proportion was higher for those in NI. In contrast, a lower proportion of WMS participants were in prison for drug offenses. This reflects NI’s historical low levels of drug offending and also provides some context to the hostility that the older men felt toward younger prisoners who experienced drug dependence whilst in prison.

Comparison of the Well Man data with community health surveys also enabled an



understanding of the needs of the older men. Older prisoners experienced similar prevalence of ill-health as older people within the community, and in some instances, worse health. The data suggest that prison may have a worsening effect on older men's health, and that this cohort reported lower subjective wellbeing than community peers. However, whilst older prisoners self-reported their lifestyles as unhealthy, they feel less autonomy to improve their health compared to peers within the community.

### LIMITATIONS OF STUDY

One limitation of the study is the small number of participants, although this reflects the small number of older men in prison in NI. Furthermore, there was a small number of foreign national prisoners and individuals from the Irish Traveller community. In NI prisons, the foreign national prisoner population represents 11% of the total population and Irish Travellers make up 1%,<sup>59</sup> although no breakdown of age was available. Specific challenges for foreign national prisoners in NI include language barriers, difficulty accessing information, and the potential threat of deportation, all of which may be detrimental to health and wellbeing and to accessing healthcare while in prison.<sup>60</sup> Outside of NI, research has highlighted the substantial hardship experienced by Irish Traveller prisoners, which is linked to racism and discrimination.<sup>61</sup> Irish Travellers experience higher rates of addiction, mental distress, and suicide in the community than the general population, which undoubtedly has important implications for healthcare provision for this group of people in prisons. Although the research design attempted to overcome difficulties recruiting a diverse sample, only one foreign national person and no one from the Irish Traveller community took part. The already minority status of the older prisoner population coupled with the small population of foreign national and Traveller population made sampling particularly difficult.

Other hindrances to participation include the positionality and biography of the researcher,

which may have important implications on how the research is conducted.<sup>62</sup> For example, participants may be less likely to describe negative experiences of their treatment in prison with a person who does not have a similar demographic background.<sup>63</sup> For this current research, data was collected by a white female, aged in her 30's, born in Northern Ireland and not from an Irish Traveller community background. Some participants expressed paternalistic sentiment and the desire to help a younger person to achieve their educational goals. However for both Irish Traveller and foreign national potential participants these attributes may have been interpreted as making the researcher less likely to understand the nuance of their experiences in prison.

Finally, an additional limitation specific to NI is the exclusion of 'separated' prisoners within the study, due to risk to researcher safety. However, such prisoners often move from HMP Maghaberry to HMP Magilligan towards the end of their sentence. Thus, some participants were able to reflect on their previous experiences of 'separated' status.

### CONCLUSION/IMPLICATIONS

These data provide vital evidence of the health and wellbeing of older men in prison. In recent times it has been argued that addressing the health and wellbeing needs of people held in prison is both a human right entitlement and of benefit to wider society.<sup>64</sup> In particular, untreated health and wellbeing needs which are left to worsen often require more extensive and costly treatment within hospital facilities when the person is eventually released back into the community. Furthermore, for older people held in prison, unmet health and wellbeing needs which negatively impede a person's ability to function independently may impact reintegration back into the community.<sup>64</sup>

Healthcare providers in prison face additional challenges compared to community providers due to a higher prevalence of poor health in prison. Furthermore, healthcare providers in prison are often faced with existing unmet needs which were

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neither identified nor treated within the community.<sup>65</sup> Whilst there have been calls to use prison as an opportunity to address such needs, many prison providers have not been sufficiently resourced to meet such needs. To do so requires special facilities for specific health conditions including mental health, suicide, self-harm, problematic drug-use, and alcohol dependency, many of which are arguably more pertinent than in wider society.<sup>32</sup> Providing such therapeutic interventions is particularly challenging in an environment which was built for the purpose of containing prisoners, not treating their health and wellbeing needs.

Whilst acknowledging that healthcare provision in NI prisons has undergone significant reform in recent years, challenges remain in respect of service provision for older prisoners.<sup>9</sup> Qualitative research undertaken as part of this current project found substantial difficulties with social care provision, often due to ambiguity around where responsibility lies for such services. Thus, developing a new partnership agreement between the two main stakeholders (the Northern Ireland Prison Service and the South Eastern Health and Social Care Trust) would offer an opportunity to address some of the problems with the current agreement. For example, the appointment of an individual to coordinate social care services in prison—not just for older people but for other vulnerable groups who require such support—would allow coordination of services which promote health and wellbeing, as well as equivalency with the community.

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