Growing Old in Prison
A scoping study on older prisoners

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The last decade has seen a steady increase in the number of older prisoners. Some have grown old in prison, having received lengthy sentences while still relatively young. Others are serving a first sentence, having been convicted late in life. Many are recidivists whose lives have been punctuated with frequent returns to prison.

Each of these types of older prisoner can be expected to increase in the years ahead. By the end of February 2003, the prison population in England and Wales exceeded 72,000. Home Office predictions suggest that the population will be between 91,000 and 110,000 by the end of the decade. This ignores the effect of the proposals in the Criminal Justice Bill currently before Parliament, which includes a number of potentially inflationary measures, such as indefinite prison sentences for dangerous offenders.

This report does not detail the damaging effects of the chronic overcrowding that already affects every aspect of prison regimes. An earlier Prison Reform Trust publication, ‘Prison Overcrowding: The Inside Story’ (September 2002), describes the negative impact on safety, stability, purposeful activity, rehabilitation and maintenance of family and community ties. The wear and tear of a system approaching its ‘bust limit’ can be most acutely felt among the more vulnerable prisoners. Many older prisoners will, therefore, be suffering not just the effects of incarceration, but the unintended consequences of institutions that are unable to provide for their particular needs.

This report is the result of a collaborative exercise between a charity with expertise in work with the elderly and one whose remit is penal reform. We are grateful to the Prison Service and the many other individuals and organisations, which have assisted in this scoping study.

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INTRODUCTION

This report, supported by the Nuffield Foundation, documents the findings of a scoping study conducted by the Centre for Policy on Ageing and the Prison Reform Trust on the needs of older prisoners in England and Wales. The number of older people in our prisons has increased considerably in recent years and the trend is likely to continue.

There is a growing awareness in the Prison Service, the National Health Service, the National Probation Service, Social Services Departments and the voluntary sector that at least some older prisoners have special needs which require special provision. The presence of a growing number of older people in our prisons led us to question whether there are policy issues that remain unresolved.

This scoping study gathers together available information on the growth in the older prison population. Its aim is to decide, firstly, whether it raises issues of policy or practice that require further analysis or consideration, and secondly, how any unresolved issues might be best explored in subsequent research. It is the first stage in a wider piece of research that should take full and proper account of the views that older prisoners themselves hold about their own situation and needs.

The scoping exercise set out with two main objectives:

• to use information from statistics and published research to compile a profile of the older prison population in England and Wales; and
• to gather information from various sources – including published research, policy documents and expert opinion – which might help to identify whether the older prison population has special needs;

It looked at five main sources of information:

• official statistics on prisons and the criminal justice system;
• responses to a survey of prisons conducted by the National Advisory Council of Boards of Visitors;
• a literature review;
• contacts with relevant organisations and agencies
• an expert seminar;

Most of the statistical information collected for this report is presented in chapters two and three. Chapter two gives a profile of the older prisoner population. Chapter three presents the contextual information about offending by older people and their involvement with the criminal justice system. Nearly all the information presented in chapters two and three comes from published sources. One of our aims was to identify (i) what information is readily available from published sources; (ii) to find out what can be obtained by negotiation through official sources; and (iii) what is missing because it is not collected.

Since the time allocated to the completion of the study was fairly short – three months in all – there was not much leeway for negotiation with the Home Office on the supply of unpublished data. With more time – including more time for analysis – more data could be extracted from unpublished official sources. This profile of the older prison population cannot therefore lay claim to completeness. There are data sources that remain untapped and there are questions that cannot yet be answered because the data has not been collected – either locally by individual prisons, or centrally by the Prison Service.
The National Advisory Council of Boards of Visitors allowed us to use information from a small-scale survey it carried out amongst Boards of Visitors into older prisoners. Although some of the conclusions based on the data from this survey have been included in the body of the report, a full report of the analysis is at Appendix 3.

It was known at the very outset of the scoping exercise that older prisoners had not attracted much interest in the research community in this country (see Phillips 1996; Brogden et al 2001), though there are one or two notable exceptions. However, older offenders had attracted a good deal of interest in the US. No literature review can avoid the large amount of North American research and comment on these topics. For our purposes, the US literature matters mainly because it is here that we find the most detailed and informed discussion of the needs of older prisoners – in particular whether older prisoners have special needs. And, if they do, are they different from younger prisoners?

In order to reach even tentative conclusions about policy and practice in this country, it is necessary to combine the research literature with the kind of expert commentary that can only be provided by the various organisations and agencies which work with older prisoners in this country. Insofar as we are looking for evidence that the older prison population has special needs, in the absence of research evidence from this country, US research will probably serve just as well. What it cannot supply is evidence regarding the problems experienced by the agencies that have to meet the needs of older prisoners in this country. It was essential therefore that the scoping exercise should approach key organisations and agencies in England and Wales for their views on the needs of older prisoners. These organisations and agencies were invited to an expert seminar. A list of participants is contained in Appendix 4. The opinions expressed in this seminar form an important part of the conclusions to this report.
Chapter 1

THE PROBLEM AND THE POLICY BACKGROUND

1.1 The problem

In 2000 in England and Wales there were around three times as many prisoners aged 60 or over as there were in 1990. The prison population as a whole is growing, and so are the numbers of older people in prison, somewhat faster indeed than the total prison population (see chapter 2). These changes are occurring not only in the UK, but also in the US, in Canada and in Australia – and government agencies in all three of these countries have published reports on the policy implications of the growth in the older prisoner population.

Most of the research comes from the US, where the number of older prisoners is much larger than in any of the other countries – around 50,000 prisoners 55 or over in 1998. The weight of numbers of older prisoners accounts for the note of urgency in much of the US commentary on the issue. Even 10 years ago when numbers were smaller than they are now, the “graying of the prison population” was being presented as an impending crisis (Flynn 1992). The US is of course different from the UK, not only in respect of its larger overall population, but also because it imprisons a larger proportion of its population, and tends to impose longer sentences.

What makes the imprisonment of older offenders in the UK or anywhere else an issue is that the typical prison has been designed to hold and control offenders who are young and energetic. Older prisoners with even moderate levels of physical infirmity find it very hard, sometimes impossible, to move around the prison; those with chronic health problems may find it difficult to get adequate care; and those who have neither of these difficulties may still find that the programmes and services provided by the prison are poorly adapted to their needs. This mismatch between the environment and services that the prison provides and the needs of the older prisoner will be most striking in cases of ‘gross’ physical or mental infirmity – prisoners, say, who are in their late 70s or 80s, and have degenerative conditions such as dementia, Parkinson’s Disease, or congestive heart failure.

1.2 What are the causes of the problem?

• demographic change

People are living longer, so there are more older people around to commit crimes. If more older people are offending and being convicted of criminal offences – including the sorts of offences that usually receive custodial sentences – then we should expect more older people to be sent to prison.

• changes in sentencing practices

A general increase in the use of custodial sentences together with increased length of sentences and greater use of mandatory sentences has led to an increase in the numbers of older people in prison. As more people receive longer custodial sentences, then more people will grow old in prison. This second factor has been the centre of much of the debate in the US and elsewhere. The ‘three strikes and you’re out’ laws passed by many US states, together with ‘truth in sentencing policies’, inevitably mean that increasing numbers of people will grow old in prison and die there.
• an overall increase in levels of reported crime
One final factor that might lead us to expect an increase in the numbers of offences committed by older people would be an overall increase in offending behaviour. If more crimes are being committed and a fairly constant proportion of these are attributable to older people, then we should expect increasing numbers of older people to be convicted of criminal offences.

1.3 How do we define older prisoners?
The age at which a prisoner is deemed to be an ‘older prisoner’ is inevitably arbitrary. Prisoners in England and Wales are not required to work once they reach the age of sixty, as opposed to sixty-five for those living in the community. The survey by the National Advisory Council of Boards of Visitors asked about prisoners aged 65 years or more because of its interest in pensions (see Appendix 3). The age limit could be fixed rather higher than this, say at 70 years, because of the greatly increased likelihood that prisoners in this age group will have special health and social care needs arising out of physical and/or mental infirmity. Most US research on older prisoners prefers, however, a much younger age threshold than this, and usually cites statistics for all prisoners aged 50 years or more (and there are individual studies which take 45 years of age as a cut-off), and for this also there may be good reasons. Perhaps it is around this age that prisoners start to think of themselves as ‘old’, as belonging to a class apart because of their age, and perhaps this is how they are regarded by younger prisoners. Nowadays, for people living in the community, this will no doubt seem rather strange, but then prison is itself an unrepresentative environment, with a predominantly young population. Another argument for choosing such a low threshold is that prisoners tend to have a biological age about 10 years in advance of their contemporaries in the community, due to chronic health problems.

This report will use an age threshold of 60 years to define an older prisoner. This is convenient for the presentation of statistics (60+ is the oldest age band used in the published UK statistics), and it corresponds to a ‘natural’ administrative division because of the relaxation of the requirement to work. It is high enough to include a group of prisoners of which the majority have chronic health problems. It is, on the other hand, low enough to cover a substantial number of prisoners. There is, however, one significant drawback to choosing 60 rather than 50, namely that it excludes virtually all females prisoners. There are simply too few women prisoners aged 60 years or more to warrant their separate consideration in a report of this kind – which is not to say that their position has not attracted some research interest (see Wahidin 2000).

1.4 The policy background in England and Wales
Only over the last couple of years has the growth in the numbers of older prisoners become an issue for the Prison Service. There are several reasons for this. The Chief Inspector of Prisons has recently urged the Government to develop a national strategy for elderly prisoners. From April 2003 the Prison Health Service will be transformed by its new partnership with the National Health Service, which will be expected to review provision for all prisoners with special needs. There is also pressure for change coming from disability legislation.

1.5 HMP Kingston and the Chief Inspector of Prison’s recommendation for a national strategy for elderly prisoners
In 2001 Her Majesty’s Chief Inspector of Prisons (HMCIP) took the opportunity presented by an inspection report on HMP Kingston to recommend that “the Prison Service draw up a national strategy for elderly prisoners, indicating the type of regime required and how this is
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The Chief Inspector believed that the Prison Service should have “a fully developed strategy for the growing number of elderly prisoners” following a visit to Winchester, where he had met two prisoners with dementia and one with advanced Parkinson’s Disease. They had previously been at Kingston and were moved because Winchester – a larger local prison – could provide 24 hour health care. The Prison Service is obliged to respond to this call for a national strategy. In the same report, the Chief Inspector recommended that the Prison Health Policy Unit should initiate a review of the needs of older prisoners and how these may best be met.

HMP Kingston is one of two Category B closed training prisons which hold only life sentence prisoners. It is the only prison in England and Wales which has a specialist unit for older prisoners, which is why the Chief Inspector chose that particular inspection report to air his views. The Elderly Prisoners’ Unit was established in 1997 for life sentence prisoners over 60, who may have health problems, but are mobile and do not require full-time nursing care. Referrals are accepted from other prisons subject to assessments by unit staff. A previous inspection report from 1997 notes that the “clientele was similar to that which might be found in a residential care home; many had served extremely long sentences and had been subject to several recalls. The unit was staffed by a mixture of discipline and health care staff”.

The Chief Inspector took the view that the unit “was a sensible and humane way to accommodate a group of prisoners who were vulnerable both on account of their age and their impaired health”. It brought “very real benefits both to individual prisoners and to the wider Prison Service”.

The 2001 inspection is more critical, however, and doubts whether Kingston “offers a clear model” to the rest of the Prison Service. There are two reasons for this: the nature of the accommodation and a lack of clarity about the unit’s purpose.

• Although accommodation in the rest of the prison was provided in single rooms/cells, most of the prisoners in the specialist unit were housed in two, three or four-bedded cells with free-standing partitions. Since lifers usually have single cells, the arrangement is not popular. Even though the unit had a less strict security regime than the main prison (category C rather than category B), older prisoners in the main prison preferred to stay in category B conditions awaiting transfer to another prison than move to the unit. At the time of the inspection one fifth of the places on the unit were unoccupied, despite the fact that the admission age had been lowered in an attempt to attract more prisoners (the youngest prisoner in the unit was 54 years old).

• “The role of E wing was unclear. Staff as well as prisoners were confused as to its purpose. It seemed to be a combination of general support, sheltered accommodation, specialist care for the elderly and a nursing home. Many of its prisoners could easily manage on normal location at Kingston and in other Category C prisons. The less mobile found it difficult to get around a wing on three floors (though there is a chair lift). There was little that distinguished this wing from other wings in terms of daily routines and regimes”.

Other recent inspection reports which have commented on the needs of older prisoners include those for Littlehey (January 1997) and Wymott (February 1999). In both these cases the Chief Inspector highlighted problems with the provision of health care to chronically ill, disabled, or infirm older prisoners. Kingston, unlike either Wymott or Littlehey, was already well-known inside and outside the Prison Service as the only establishment of its kind in England and Wales. The Guardian newspaper, for example, had carried an article on Kingston as early as 1994, when it publicised its plans to set up a “special pensioners’ unit” (18 October 1994). More recently the same newspaper published an extended feature article on the
In 1999 a joint thematic review on lifers – ‘Lifers: A Joint Thematic Review by HM’s Inspectorate of Prisons and Probation’ had drawn attention to the needs of disabled and infirm life sentence prisoners. During the review, several doctors expressed concern about physically disabled and infirm lifers who required high levels of medical care not available in less secure prisons. It is a feature of prisons that the most comprehensive healthcare services are available in more secure establishments. For lifers to progress and achieve release, special arrangements had to be made to deliver the healthcare they needed in less secure prisons and in the community after release. The postal survey of lifer centres revealed that only one Category C prison out of 19 holding lifers had 24 hour medical cover and full-time nursing provision. Such lifers should not be disadvantaged by their physical condition and it is important that the Prison Service plans for their needs.

The Prison Service, in response to this report, approved new money for the development of another (besides Kingston) specialist unit for older lifers.

1.6 Prison Health Care

The Prison Health Service, which had been established as the Prison Service’s own separate medical service in 1877, was not incorporated into the National Health Service when the NHS was founded in 1948. Since this time, the Prison Health Service has come under considerable criticism from professional medical organisations on the grounds that it provides second class health care to prisoners (e.g. Smith 1984; BMA 2001). Two recent studies, based on prison inspections, concluded that, although in some prisons the quality of care was broadly equivalent to what is available in the NHS, for the most part the quality of services fell below the standards of the NHS (Reed & Lyne 1997; Reed & Lyne 2000).

Both the Royal College of Physicians and the Royal of Psychiatrists have argued that the NHS should take over the Prison Medical Service (as it was then known), and in 1996 the Chief Inspector of Prisons echoed these views in recommendations for a new health care strategy for prisons (‘Patient or Prisoners? A New Strategy for Health Care in Prison’). In 1999, a joint report from the NHS and the Prison Service (The Future organisation of Prison Health Care) recommended “a formal partnership” between the two services to improve the health and health care of prisoners. The report also recommended that the health needs of all prisoners should be assessed with the help of health authorities, and care provided to match standards of care elsewhere in the NHS. By 2004, each prison in the UK should have a health improvement plan based on assessed needs.

In 2002 the Department of Health and the Home Office announced that, as from April 2003, the NHS would begin to take responsibility for prison healthcare and hold full operational responsibility for it from 2008.

Some of the implications of the proposed changes for older prisoners (as well as the recently published National Service Framework for Older People) were made explicit in the joint Prison Service and Department of Health ‘Report of a Working Group on Doctors Working in Prisons’, which recommended that:

“As part of the health needs assessment process, prisons, health authorities and primary care groups/trusts review the needs of older prisoners and those with a disability and take steps to ensure that they have access to the same range of professionals and services that are available to these groups in the community. There needs to be a greater emphasis placed on providing both groups with a healthy and suitable regime”. 
The report pointed out that the health needs of older prisoners are often long-term and chronic in nature. Social care and support – similar in some respects to that provided in the community by social services – may be required.

“Referral to health care is not sufficient and long-term placements in health care are inappropriate. Doctors will only be able to work effectively with these groups if they are supported by the other professionals and services which would be available in the community. Older prisoners and those with a disability should have access to the relevant self-help groups and services”.

1.6 Disability and anti-discrimination legislation

The Disability Discrimination Act 1995 makes it unlawful to discriminate against disabled people by:

i) refusing to provide (or deliberately not providing) any goods, facility or service;

i) providing service of a lower standard or in a worse manner;

iii) failing to comply with a duty to make reasonable adjustments if that failure has the effect of making it impossible or unreasonably difficult for the disabled person to make use of any such goods, facility or service.

Different parts of the Act have different start dates. In 2000 it became unlawful for service providers to fail in their duty to provide auxiliary aids and services. In 2005 service providers will be required to remove physical barriers in premises.

Although the Prison Service is exempt from many pieces of legislation, it has accepted that it is a ‘service provider’ in the terms of the Act and has issued a Prison Service Order (PSO 2855 1999) on this topic outlining their requirements to comply with the law:

“In accordance with the Statement of Purpose (of the Prison Service) and the commitment to equality of opportunity, the Prison Service will ensure that prisoners with physical, sensory and mental disabilities are able, as far as is practicable, to participate equally in prison life”.

Policies for disabled prisons were to be implemented in three stages:

1. During 1999, to ensure that adequate policies, practices and procedures are in place to prevent discrimination against prisoners and visitors on grounds of disability;

2. By October 1999, to provide extra help, in the form of aids and services, to allow disabled prisoners to use available services and facilities;

3. By 2004, to remove or alter physical barriers that prevent a disabled prisoner from gaining access to facilities and services, or to provide the service in a different way.

What makes the legislation important is that prisons have traditionally been designed for able-bodied people. The older Victorian prisons in particular present difficulties to anyone with mobility problems, and many older people have mobility problems. Attempts to rectify lack of provision for people with impairments are often ad hoc and inadequate (Parry 2002).
Chapter 2

A PROFILE OF OLDER PRISONERS IN ENGLAND & WALES

2.1 The growth in the older prisoner population

The prison population as a whole is growing, and so are the numbers of older people in prison. Between 1990 and 2000 the number of people held in prisons in England and Wales increased by 42 per cent, from 45,636 to 64,602 (increasing again to 72,256 by 28 February 2003). These figures refer to the total population in prison, which includes prisoners who are convicted and 'under sentence', prisoners who are convicted and awaiting sentence, and prisoners who are untried. It includes adult males and females (21 yrs old and over), and also young offenders and juveniles (15-20 yrs), the majority of whom are held in separate establishments.

Home Office Prison Statistics 2001 show that there were 1,206 (2.4 per cent) of the male prison population and 19 (0.7 per cent) of the female population under sentence in prison aged 60 or over. Older people in this age group are of course much more common in the general population, making up 21 per cent of the total general population, and 25 per cent of the general population excluding children under 15 years (which brings the comparison in line with the prison population).

The prison population has an age-sex distribution quite different from that of the general population – being overwhelmingly male (95 per cent) and relatively young (79 per cent are aged 15-39 yrs compared to 35 per cent in the general population). As fig 2A shows, the number of older people under sentence in prison has risen more than twofold over the last 10 years – with the 60 and over population growing even faster than the 50-59 years olds. In 1990 there were 355 sentenced prisoners aged 60 or more, and 1,341 aged 50-59 yrs. What has also grown is the proportion of older prisoners in the prison population. Between 1990 and 2000 the proportion of prisoners under sentence who were aged 60 or over increased from one per cent to 2.3 per cent.

Figure 2A  Rise in numbers of older people in prison population (under sentence) over past 10 years

In 1990 (see fig 2B) 412 men and women aged 60 or more were received into English and Welsh prisons (0.8 per cent of the total number of adult receptions). By 2000 this had increased almost twofold to 808 (1.1 per cent of the total). Most of these new prisoners are
male, 97 per cent in 1990 and 96 per cent in 2000. Of the 71,265 adults discharged from
prison in 2000, 917 were aged 60 or more (1.3 per cent).

Figure 2B Receptions of prisoners under immediate sentence aged 60+ 1990-2000

The only published information available on older prisoners held on remand is now 20 years
out of date. Taylor & Parrott (1988) collected information on a large sample (n=1241) of
men remanded on criminal charges to Brixton Prison between June 1979 and May 1980, and
at that time Brixton received most male custodial remands from the Greater London area.
Just under two per cent were aged 65 years or more.

2.2 Age, sex and ethnicity

Data supplied by the Home Office for the prison population in November 2001 (see table
2C) show that most of the prisoners aged 60 and over are in their sixties (81 per cent). The
‘older old’ therefore are under-represented among older prisoners just as the older
population is under-represented in the prison population. Five per cent of older prisoners
(n=75) were aged 75 years or more. In the general population 36 per cent of people aged
60 or over are 75 or more.

In 2000 about five per cent of the prison population under sentence were female. The
difference between the sexes is, if anything, even more marked in older prisoners. Only 16 of
the 1,154 sentenced prisoners aged 60 or more were female – less than two per cent – and
in 1990 there had been 10 women prisoners in this age group (with 48 women aged 50-59
years in 1990 and 102 in 2000). The ratio of male to female in the prison population aged 60
or over has changed hardly at all in the last 10 years. In other words, nearly all the increase in
the older prison population charted in fig. 2A is accounted for by older men. The 34 women
aged 60 yrs or more who were received into prison ‘under immediate sentence’ in 2000
accounted for only 0.6 per cent of all female adult receptions.

Ethnic minority groups make up 20-25 per cent of the prison population (Prison Statistics
2000). In the year 2000, 19 per cent of the male prison population (under sentence and on
remand) and 25 per cent of the female prison population were known to belong to ethnic
minority groups (including a substantial number of foreign nationals). Ethnic minority groups
are over-represented in the prison population. In England and Wales in 2000, six per cent of
the general male population aged 15-64 years were classified as ‘non-white’, compared to 14
per cent of male British nationals in prisons.

In the older prisoner population, it appears that ethnic minority groups are, if anything, even
more heavily over-represented. In November 2001, 146 (11 per cent) of 1,379 prisoners
aged 60 or over being held in English and Welsh prisons were known to belong to minority ethnic groups (see fig. 2C). 11.8 per cent of the older prisoners under sentence in Fazel et al (2001) are from ethnic minorities. Even though this figure includes an unknown number of foreign nationals, it is still much higher than estimates of the proportion of older people aged 60 or over from minority ethnic groups — at around two per cent in the general population (Schuman 1999).

These figures on ethnicity can be supplemented by data on the religious affiliations of prisoners from a 1999 Prison Service report on religion in prisons (Religion in Prisons 1999/2000, Home Office Research Bulletin 15/01). It is perhaps unsurprising to find that the proportion of prisoners with a declared religious affiliation increases in line with age. Eighty five per cent of the 60 or over prison population declared a religious affiliation compared with 45 per cent of the young offenders. The majority of the older prisoners with a religious affiliation belonged to one of the Christian churches (93 per cent). Muslims were the largest group of prisoners with a non-Christian faith (four per cent of the older prisoners with a religious affiliation).

2.3 Length of sentence

Most of the people imprisoned in any given year have been given relatively short sentences by the courts. Seventy two per cent of the adults (of all ages) received into prison in the year 2000 had sentences of twelve months or less (see fig 2D). Less than one per cent (n = 465) of the 69,873 adults sent to prison in that year had been given life sentences. Most of the adults in prison under sentence, on the other hand, are serving relatively long sentences. In 2000 just under half of the adult prison population under sentence were serving sentences of four years or more (see fig 2C). Ten per cent were serving life sentences (n = 4,442). The ‘lifer’ population has been increasingly steadily since 1990. By the end of November 2001 there were almost twice as many prisoners serving life sentences (n = 4,960) as there had been in 1990.

The main source of annually updated and published information on the sentences served by older people is the data on discharges from prison. There is no detailed age breakdown in the statistics published annually on (i) length of sentence of people received into prison and (ii) length of sentence of the prison population under sentence. Eighteen per cent of the prisoners aged 60 or over who were discharged in 2000 had been serving sentences of over four years — compared to just six per cent of the discharged prisoners aged 21-40 years. And a somewhat higher proportion of the younger discharged prisoners (56 per cent compared to 40 per cent ) had been serving relatively short sentences of six months or less. These figures aggregate the data for men and women, which disguise the fact that older women are
much more likely than older men to be serving short sentences. Just over one half of all the older prisoners discharged in 2000 had been serving sentences of three months or less.

It would seem, therefore, that older prisoners are more likely to be serving long sentences than younger prisoners. This view is confirmed by data from the 1991 National Prison Survey (OPCS 1992). Slightly more than one per cent of the sample of 3,844 prisoners who responded to this survey were aged 60 or over (n=48), and four per cent of all the ‘lifers’ in the sample were in this age group.

About five per cent of the prisoners currently serving life sentences (n=229) are aged 60 or over (data supplied on request by the Home Office). This means that one fifth of all older prisoners under sentence are lifers – compared to nine per cent in the prison population as a whole.

In England & Wales the average time served by life sentence prisoners before release on licence is just over 13 years, and about two fifths of prisoners currently serving life sentences have been in prison for 10 years or more. This compares with 16 per cent of the older prisoners in the sample examined by Fazel et al (2001a) who had already served at least ten years. What the published data do not tell us are the proportions of prisoners who (i) have ‘grown old in prison’ (e.g. imprisoned in their forties or fifties) or (ii) have been imprisoned for a first offence when already in their sixties or seventies (ii) or have been in prison several times in their adult life. A high proportion (72.5 per cent) of older prisoners in a Canadian study had been imprisoned for the first time ‘late in life’ (Uzoaba 1998).
2.4 Types of offence

Since the length of a prison sentence tends to reflect the seriousness of the crime, it is not surprising to find that a relatively high proportion of the older prisoners in the National Prison Survey had been convicted of serious violent crimes such as murder, attempted murder, manslaughter or rape (29 per cent). In the annual statistics on the types of offences committed by older people in prison what really stands out is the disproportionately high number of sex offenders. Detailed age breakdowns of prisoners by type of offence are published each year only for receptions into prison, and not for prisoners under sentence. In 2000 one third of the adults aged 60 or more received into prison under immediate sentence had been convicted of a sexual offence, compared with approximately three per cent of all the adults received into prison that year. This proportion has remained fairly constant since 1990. About half of older male prisoners under sentence are sex offenders (Fazel et al 2002).

As figures 2G and 2H show, increasing age marks big changes in the pattern of offences for which people are sent to prison. The proportion of sexual offenders in the prison population increases with age and the proportion of offences against property (which includes burglary, robbery and theft & handling) decreases with age. Very few older people are sent to prison for robbery or burglary; theft being the most common of the offences against property committed by older people (12 per cent of all receptions in this age group). The category 'other' in figs 2G and 2H includes (i) a small proportion of cases in which the offence is not recorded (about 2-3 per cent of the total) and (ii) a miscellany of other offences including arson, criminal damage, drunk driving, affray, threatening or disorderly behaviour etc. The largest category of ‘other’ offences among adult receptions of all ages are motoring offences. Seventeen per cent of the adults received into prison in 2000 had been convicted of a motoring offence. Among adults aged 60 or over, the figure is somewhat lower, at eight per cent. It is perhaps surprising to see that as many as six per cent of the older adults sent to prison in 2000 were convicted of drug offences, though Fazel et al (2001a) put the figure even higher – with 14 per cent of their sample of older prisoners under sentence having been convicted of drug offences.

Of the 34 women aged 60 or over who were sent to prison in 2000, only one of them had been convicted of a sexual offence. The most common offences for which older women are imprisoned in England and Wales are fraud and drug offences (though it must be remembered that the numbers here are very small).

2.5 Previous criminal career

Most of the adults in prison have previous convictions. In 2000, the last year for which full data are available, only 14 per cent of the adult males in prison were known to have no...
previous convictions, though the proportion is higher among female prisoners (32%). A substantial proportion of the prison population (one third of all males in 1999) have received more than 10 previous convictions. Persistent offending increases the likelihood of a custodial sentence.

Although the published annual statistics do not provide a detailed age breakdown of data on previous convictions, there is some evidence to suggest that older prisoners are not much different in this respect from younger ones. In Taylor & Parrott’s 1988 study of prisoners in Brixton, the older prisoners were just as likely to have previous convictions as the younger ones. The figures for previous imprisonment (not the same as previous convictions) from the 1991 National Prison Survey paint a slightly different picture – with some suggestion of a slight age difference. Just under half of prisoners aged 60 or over had been in prison before. This is somewhat lower than the modal figure of 64 per cent for men in their late twenties (see below).

2.6 Location
Older prisoners are found in most of the prisons in England and Wales which hold adult prisoners (109/121) (data supplied on request by the Home Office). These prisons vary considerably in type, and in 2001 older prisoners were to be found in all types of prison, except remand centres and young offender institutions. At the end of 1998, the majority of older prisoners (58 per cent) were being held in ‘closed training’ prisons (including the maximum security prisons). Ten per cent were in ‘open training’ prisons, and 32 per cent in local prisons (Marshall et al 2000). Figures for August 2001 show hardly any change in the distribution of older prisoners across different types of prison (see table 2D).

The category ‘closed training prisons’ include several ‘dispersal’ prisons, which hold prisoners – generally those serving the longest sentences – in high security conditions. These five dispersal prisons hold about 10 per cent of all older prisoners. HMP Wakefield, which holds mainly serious sex offenders, has more older prisoners than the other dispersal prisons.

Other closed training prisons may receive prisoners from only one particular security category (B or C), or they may fulfil some other kind of special role within the prison system. There are, for example, closed prisons with a lower security classification than Wakefield – such as HMP Kingston or Gartree – which accept only prisoners serving a life sentence. There are other prisons, such as HMPP Whatton, which accept only serious sex offenders. Some prisons, such as HMP Wymott, have special units or wings – ‘vulnerable prisoner units’ – which hold mostly sex offenders separate from the rest of the prison population. HMP Risley and HMP Albany, on the other hand, have ‘integrated vulnerable
prisoner regimes’. Some of these closed training prisons are fairly large, like HMP Acklington. Some, like HMP Usk, are fairly small. They may be purpose-built and fairly new, like HMP Littlehey, or purpose-built and Victorian, like Dartmoor (with 26 older prisoners in Aug 2001). Or they may have been converted from another use, like an army camp. Half of all older prisoners are in prisons of this type.

‘Open’ prisons, such as HMP Leyhill, are prisons with the most relaxed security regime. Some of these establishments serve as specialist resettlement prisons, others describe themselves as ‘working’ prisons. In 2001 all open prisons met the Prison Service targets for the time spent by prisoners engaged in ‘purposeful activity’ (Prison Reform Trust 2001). Less than 10 per cent of older prisoners are held in open prisons.

Local prisons are distinguished in various ways from both closed training and open training prisons. They tend to have more ‘impoverished regimes’ than the closed training prisons (Prison Reform Trust 2001). The primary criterion for assignment to a local prison is geographical – rather than sentence length or type of offence. That is to say, they take prisoners from a catchment area, and usually hold remand prisoners as well as prisoners under sentence. Unlike many closed prisons there will be no lower limit on sentence length, and there tends to be a relatively high turnover.

Some of the local prisons are among the largest prisons in the system. HMP Wandsworth, for example, which has over 30 older prisoners, holds around 1,400 prisoners. There are therefore various factors which go some way to explaining why it is that conditions in local prisons are often worse than in closed training prisons – with less opportunity for work or other forms of ‘purposeful activity’, and more time spent in cells. A disproportionate number of the prisoners who commit suicide are being held on remand in local prisons.

A relatively small number of prisons holds a relatively high number of older prisoners (see table 2F). Almost 40 per cent of all older prisoners being held in 2001 were in just 11 prisons. Most prisons have fewer than 10 older prisoners.

2.7 Physical and mental health

Information on the health and disability status of prisoners in England and Wales is not routinely collected by the Home Office. Parliamentary questions about the number of prisoners using wheelchairs or the numbers of prisoners with serious impairments are regularly met with the answer that this information is not collected centrally. There are, however, enough published research studies available to confirm that the health of prisoners of all ages is worse than that of the general population, and that their use of medical services is correspondingly higher (Tarbuck 2001). This certainly was the conclusion of two large, government-sponsored studies conducted in the 1990s, one on physical health (Office of Population Censuses & Surveys 1995), and one on psychiatric morbidity (Office for National Statistics 1998), though neither sample included older prisoners as the numbers would have been too small to permit meaningful analysis by age group.

The differences between the prison population and the general population are (see table 2G) more marked for mental disorders than for physical health problems. In the 1998 ONS study the prevalence rates for personality disorders, psychoses and depressive illnesses were all much higher than in the general population – and were also considerably higher than the estimates of the proportion of prisoners with “some degree of mental disorder requiring intervention” reported in a series of ‘snapshot surveys’ undertaken by the Prison Health Service in 1995/6 (five per cent in 1995 and 3.8 per cent in 1996) (HMP Prison Service, Report of the Director of Health Care 1995-1996). The ONS view is backed up by two
other recent UK studies of mental disorders among prisoners on remand (Birmingham et al 1996; Brooke et al 1996). Although both studies included older prisoners, neither of them include a separate analysis by age group. What is notable about the results of Birmingham et al is the high proportion of prisoners with mental health problems on reception which the initial prison health screen failed to identify.

All three recent major studies of psychiatric morbidity among prisoners in the UK – together with another study conducted by the Prison Service and the Public Health Laboratory Service in the latter half of the 1990s (Prevalence of HIV in England and Wales in 1997: Annual Report of the Unlinked Anonymous Prevalence Monitoring Programme) – confirm the widely held view that substance abuse or dependency is very common in the prison population (and is often closely associated with the nature of the offending behaviour). It is arguable that illicit drug use, especially injecting drug use, and connected with this, HIV and Hepatitis B infection, have been the major health problems facing the Prison Service during the 1990s.

Given what is known about the health of the prison population in general and the health of older people in the general population, we would expect to find (a) that older prisoners tend to have more health problems – certainly more physical health problems – than younger prisoners and (b) that older prisoners tend to have more health problems – physical health problems and mental health problems – than older people in the general population. This certainly was the conclusion drawn by Taylor and Parrott (1988) in a study which looked at a fairly small sample of older remand prisoners. They found that the prevalence of physical illness and psychiatric disorder increased with age.

A slightly more complex picture emerges from a comparison of the findings of a more recent UK study of the physical and mental health of prisoners aged 60 years or over (Fazel et al 2001a) with the results of the OPCS and ONS studies of prisoner health, as well as those by Birmingham and Brooke. The study by Fazel et al has a larger sample of older prisoners (203 men aged 60 or over) than the earlier study by Taylor and Parrott (63 men aged 55 or over), and looks exclusively at older prisoners under sentence. A higher proportion of older prisoners in this study reported longstanding illness or disability (83 per cent) than is found among older people in the community (65 per cent); and there were more health problems reported by this sample of prisoners than the younger sample in the 1994 OPCS survey. What these older prisoners say about their health is very similar in fact to the rates of self-reported chronic illness among elderly patients with depressive illnesses (Burvill et al 1990). The most common major illnesses recorded in the prisoners’ medical notes were psychiatric problems (45 per cent), cardiovascular disease (35 per cent), and musculo-skeletal disease (24 per cent).

The prevalence of mental disorder among older prisoners – on the showing of this sample – is also significantly higher than among the general population (Fazel et al 2001a). The relationship between age and mental disorder within the prison population is, however, less straightforward. Five per cent of the sample had psychotic illness, more or less the same rate as reported by both Birmingham and Brooke for remand prisoners of all ages, and slightly less than the seven per cent reported by the 1998 ONS survey of male prisoners under sentence aged 18-55 yrs. Depression was diagnosed in 30 per cent of the older prisoners, and, as Fazel et al point out, this is considerably higher than the 6 per cent found in a sub-analysis of the data for 45-55 yr olds in the ONS sample (1998), who were also the heaviest users of antidepressants. It is however about the same as the rate reported by Brooke (1996) for remand prisoners aged 15-61 years.

The difference between older and younger prisoners in respect of mental health problems is most apparent in the prevalence of personality disorders – especially antisocial personality.
disorder – and substance abuse. These problems are not so common among prisoners aged 60 and over as in prisoners aged 18-55, many of whom have a dual diagnosis. Only eight per cent of Fazel’s sample were diagnosed as having anti-social personality disorder (see table 2G), and five per cent were current substance abusers. This association between age, on the one hand, and drug dependence and personality disorders, on the other, extends and confirms the conclusion of the ONS study – namely that these problems are most common in prisoners in their teens or their twenties (though the older prisoners in the Taylor & Parrott sample had a very high rate of alcoholism). In all, 53 per cent of the sample had a psychiatric diagnosis (including substance abuse) – somewhat less than the 60 per cent and 63 per cent reported by Birmingham and Brooke respectively (when substance abuse is included). Two of the older prisoners (one per cent) had dementia. The Director of the Prison Service recently suggested that as many as 90 per cent of prisoners may have a psychiatric diagnosis.

Closely associated with the high prevalence of mental health problems among prisoners is the problem of suicide. In the year 2002 there were 94 self-inflicted deaths in prisons in England and Wales, and 85 of these were men (source: HM Prison Service Safer Custody Group 2003). This is a 29 per cent increase on the previous year and reflects the pressures of chronic overcrowding across the prison system. The suicide rate for prisoners is more than ten times the rate for the general population.

Suicide in the community is most common among males aged 25-34 years. Among prisoners the age distribution of suicides closely follows the age distribution of the population. None of the self-inflicted deaths in prison in 2000 involved prisoners aged 61 or over. Two were of prisoners aged 51-55 years and two aged 56-60. The risk of deliberate self-harm is also high in prisons (about 1.6 per cent per prisoner per year), and in this case there are marked age differences in risk. Older prisoners – those in the 60-69 age group – are less likely than those in any other age group to harm themselves deliberately (Marshall et al 2000).

A detailed Home Office study of causes of death among prisoners and offenders under community supervision for the years 1996 and 1997 (Sattar 2001) shows that older prisoners (55 and over) are more likely to die of natural causes and less likely to die from a self-inflicted injury, an accident, or a drug overdose than younger prisoners. Thirty nine per cent of the deaths that occurred over this period were due to natural causes, and the older prisoners in the sample accounted for the largest proportion of these (51 per cent). Rather more deaths (47 per cent) were due to suicide or self-inflicted injury, and the 25-34 age group accounted for the largest proportion of these (39 per cent).

If self-harm is a problem that mainly affects younger prisoners, the same cannot be said of disability. In the general population, the prevalence of disability increases with age, and although the majority of older people aged 60 and over are without disabilities, a sizeable minority (increasing to a large majority among people aged 80 and over) have some form of functional limitation (Martin et al 1988). Mobility problems tend to be the most common form of disability in the older population, as they are in the general population. In a recent London-based study 22 per cent of community-dwelling people aged 65 yrs or more had mild to moderate locomotor disability (at worst unable to walk 50 yards without stopping), and another 18 per cent were more severely restricted. About 10 per cent had difficulties getting dressed or getting round the house without help (Harwood et al 1998).

There is no reason to expect older prisoners to be less susceptible than their community-dwelling peers to chronic disabling disease. Indeed the evidence provided by Fazel et al (2001) would suggest that disabilities associated with chronic disease are more common in older prisoners than in older people of the same age living in the community. This does not mean,
however, that we should expect the overall prevalence of disability (and the need for help with activities of daily living) among older prisoners to be at least as high as it is among older people living in the community. The incidence of disability rises steeply as people move into their late seventies and eighties, and this age group is heavily under-represented among older prisoners.

A Home Office internal report on disabled prisoners (cited in Marshall et al 2000) estimated that 324 prisoners of all ages (in 118 prisons) were known to have a disability, with 212 prisoners having mobility problems. At 0.6 per cent. of the prison population this seems rather low, even if allowance is made for the unusual age structure of the prison population (i.e. young) and the use of a relatively high threshold for the identification of disability; the 1988 OPCS survey estimated that about 13 per cent of the adult population living in private households (i.e. excluding residential and nursing care) have some degree of disability.

Marshall et al (2000) suggests that the report almost certainly under-estimates sensory impairments (about one fifth of people aged 65 or over have hearing impairments). The study by Fazel et al (2001) found that nine per cent of older prisoners had Barthel scores of <20, and most of these were unable to climb stairs. A few of them had additional disabilities, such as the inability to wash themselves without help. The most common problem identified in an internal Home Office survey of elderly and disabled lifers was shortness of breath after walking a short distance or climbing stairs (22 per cent). Most of the prisons who reported having elderly lifers (26/46) did not identify any prisoners with problems in performing basic functions / activities of daily living.
Chapter 3

OLDER OFFENDERS IN THE CRIMINAL JUSTICE SYSTEM: ARRESTS, CONVICTIONS AND PROBATION

Probably the most important aspect of offending by older people is that there is so little of it. Older people are under-represented in prison because they are much less likely than teenagers or younger adults to be arrested, convicted or cautioned for a criminal offence – any criminal offence, and not only those offences which usually attract custodial sentences. All the data on recorded crime support this conclusion – and most criminal offences are in fact committed by young males aged between 18 and 25 years. Children start to make a significant impact on crime rates around the age of nine or ten, and thereafter criminal activity rises steeply through adolescence to peak in the late teenage years.

In 1999 the peak ages for offending were between 17 and 19, with about eight in every 100 males in this age group being convicted or cautioned for an indictable offence. The crime rate then gradually drops off for each succeeding age group, until among males aged 60 years or more it is only about one in every 1,000 who is convicted or cautioned for a criminal offence. Although the published data do not permit a finer age breakdown of offending among older people, there is little reason to doubt that this downward trend in criminal activity continues as people advance into their seventies and eighties. The age pattern of offending is similar among females, though at all ages females are much less likely than males to commit a criminal offence.

Table 3A Convictions, cautions and receptions into prison of people aged 60 or over

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<tbody>
<tr>
<td><strong>Males aged 60+</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>– Convictions</td>
<td>2478</td>
<td>1994</td>
<td>2170</td>
<td>2163</td>
</tr>
<tr>
<td>– Cautions</td>
<td>3754</td>
<td>2157</td>
<td>1861</td>
<td>–</td>
</tr>
<tr>
<td>– Convictions + cautions per 100,000 population</td>
<td>140</td>
<td>91</td>
<td>88</td>
<td>–</td>
</tr>
<tr>
<td>– Receptions into prison</td>
<td>398</td>
<td>463</td>
<td>642</td>
<td>774</td>
</tr>
<tr>
<td><strong>Females aged 60+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Convictions</td>
<td>393</td>
<td>245</td>
<td>256</td>
<td>279</td>
</tr>
<tr>
<td>– Cautions</td>
<td>2301</td>
<td>1064</td>
<td>879</td>
<td>–</td>
</tr>
<tr>
<td>– Convictions + cautions per 100,000 population</td>
<td>44</td>
<td>21</td>
<td>19</td>
<td>–</td>
</tr>
<tr>
<td>– Receptions into prison</td>
<td>14</td>
<td>14</td>
<td>19</td>
<td>34</td>
</tr>
</tbody>
</table>

That older people are found in small numbers in other parts of the criminal justice system is clear from the annual crime statistics. In 1990 less than one per cent of people found guilty of indictable crimes were aged 60 or over (n=2871). This proportion has changed very little over the last 10 years. The data on cautions tell the same story – in 1999 2,528 people aged 60 or over were cautioned by the police in England & Wales – 1.5 per cent of the total. Although there has been a big drop in the numbers of older people receiving cautions (from over 6,000 in 1990), there is an increase in the numbers being prosecuted and convicted.

Data from Phillips & Brown (1998) and Codd & Bramhall (2002) on arrests and probation flesh out the picture that emerges from the annual crime statistics. Only 2 per cent of a sample of 3,682 people arrested on suspicion of having committed a criminal offence were
aged 60 or over (Phillips and Brown 1998). Codd and Bramhall report that 494 people aged 50 or more appeared in the records of a large urban probation service – holding information on 13,000 offenders. This is just four per cent of the total – rather less than the proportion of prisoners under sentence in the same age group (8 per cent).

As fig. 3A shows, the rate of offending among older people has declined since 1989. Offending has declined both in absolute terms – there were fewer older people convicted or cautioned for an indictable offence in 2000 than in 1989 – and in relation to the population in this age group. The fact that more older people are being sent to prison is not to be explained therefore by an increase in the amount of criminal activity by older people. Rather it reflects the increased use of custody by the courts.

3.1 The nature of offending by older people

Much of the published research which has looked at older people in other parts of the criminal justice system in England and Wales or at older offenders in other countries supports the conclusion drawn from the annual prison statistics (see chapter 2), that older people tend to commit or be convicted for (as well as imprisoned for) different kinds of offences than younger people. What is most striking in these data is the disproportionately high number of sex offenders in the older age groups. One of the first studies of older offenders to be conducted in the UK looked at a sample of prisoners of all ages (n = 1241) remanded in custody in Brixton Prison in London at the end of the 1980s (Taylor & Parrott 1988). Three per cent of the sample were aged 55 years or more, and one-fifth of the men in this age group were charged with sexual offences, a significantly higher proportion than in the younger population. Fifty three per cent of the males in Codd & Bramhall’s study of older offenders on probation were sex offenders – and the majority of these (62 per cent) had been released from prison under supervision orders.

Table 3B: Persons found guilty of indictable offences – 1990

<table>
<thead>
<tr>
<th></th>
<th>Males all ages</th>
<th>Males 60+</th>
<th>Females all ages</th>
<th>Females 60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>All offences exc. motoring offences</td>
<td>285046</td>
<td>2478 (0.9%)</td>
<td>43578</td>
<td>393 (0.1%)</td>
</tr>
<tr>
<td>Sex offences</td>
<td>6564</td>
<td>434 (7%)</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Theft from shops</td>
<td>33612</td>
<td>828 (2.5%)</td>
<td>16406</td>
<td>296 (1.8%)</td>
</tr>
</tbody>
</table>

Table 3B gives figures from 1990 for convictions of older people for selected offences (in both Magistrates’ Courts and Crown Courts, and irrespective of the nature of the sentence). Older people in this year – 2,478 men and 393 women – were responsible for less than one
per cent of indictable offences. Seventeen per cent of the men in the 60 and over age group were convicted of sexual offences — compared with two per cent for males of all ages — and older males accounted for seven per cent of all sexual offences. Theft from shops was, however, the most common offence in the age group — 40 per cent of the convictions — and over a quarter of these were committed by women. Two per cent of all shop theft — on the basis of these figures — was committed by older people.

The data for 1998 are very similar: 21 per cent of convicted older males had committed a sexual offence — and this accounted for 10 per cent of all sexual offences (Fazel & Jacoby 2002). Once again theft was the most common offence among older people, but older people accounted for a much smaller proportion of convictions for theft (0.6 per cent) than for sexual offences. Although more older people are convicted of theft than of indictable motoring offences, older people do in fact account for a larger proportion of convictions for motoring offences (1.7 per cent) than convictions for theft.

None of this means of course that older men are more likely than younger men to commit a sexual offence. Given the much lower levels of overall offending in the older population, the rate of sexual offending in the older male population will be lower than it is in the younger male population. Nor is it by any means certain that the high proportion of convictions for sexual offences among older offenders tells us much about the kinds of offence committed by older males. It is possible that many of these offences — especially if they involved children — were committed several years before the actual conviction. In other words, the charge is brought against an older man, but the offence was not committed by an older man. However, as Clark & Mezey (1997) make clear, persistent offending is not an uncommon pattern among older sex offenders.

In samples of older people arrested on suspicion of having committed an offence, the proportion of sex offences is lower — and the proportion of thefts higher — than among convicted older offenders. Although a disproportionate number of older people in the sample studied by Phillips & Brown were detained on suspicion of sexual or public order offences, it is theft, and especially theft from shops, that is the main type of offence committed by older offenders in two studies of the Community Services Branch (CSB) of the Essex Police Force. Between May 1979 and July 1980 the CSB assessed the cases of 412 people aged 60 or over (Markham 1981). Seventy-four per cent had committed a shoplifting offence. Only eight per cent had committed some form of assault, which included indecent assault. Nearly half of the prosecutions were for theft from shops, and 12 per cent were for drunkenness.

A second study of 153 alleged offenders reported to the CSB in over a 7 month period in 1990 (Needham-Bennett et al 1996) also found that shop theft was the most prevalent crime in this age group (63 per cent). Ten per cent were reported for sexual offences. The data on cautions paints a similar picture — in 1990 77 per cent of all the cautions given to older people in England & Wales were for theft from shops (n = 4653).

Studies of older offenders or older prisoners conducted in countries other than England and Wales reinforce the conclusion that their contribution to criminal activity is relatively small. The rumours of an impending ‘geriatric crime wave’ which appeared in early US research on this topic have now been scotched (Flynn 1992). Theft, drunkenness, drunk driving, and fraud tend to be the most common kinds of offence for which convictions are secured (e.g. Feinberg 1984; Schichor 1984). ‘Victimless crimes’ such as vagrancy and gambling feature high on the lists of offences for which older people tend to be arrested.
As in the UK, studies of older prisoners or older offenders on probation tend however to show a relatively high proportion of male sex offenders (e.g. Shichor 1988; Ellsworth & Helle 1994). Barak et al (1995), in a study of first-time criminal offenders aged 65 yrs or more in Israel, found that almost one-fifth had been convicted of sexual offences, all performed against minors. These were by no means the most common kind of offence, however. Financial offences, usually fraud, and driving offences, were both more common than sexual offences.

A retrospective study of all offenders aged 65 years or more who had been referred to the National Forensic Psychiatric Service in Ireland between 1972 and 1992 found that one-fifth of the older people referred for court reports were charged with sex offences (Farragher & O’Connor 1995).

### 3.2 Mental health problems

The very fact that criminal behaviour is so unusual among older people should lead us to question whether mental health problems have contributed to their offending. When the Superintendent in charge of the diversionary scheme run for older people by the Community Service Branch of the Essex Constabulary argues that “a person’s behaviour at this time of life may be more easily explained in medical rather than legal terms” (Markham 1980), it seems that what he has in mind here is the possibility of an association between petty theft or public order offences and mild dementia.

It is important at this point to distinguish between older people who might be described as ‘career criminals’ and older people who offend for the first time late in life. The suggestion that mental health problems are behind the offending behaviour which is relatively rare in older people, carries considerably less weight if the people concerned have been engaging in this sort of behaviour – on and off – most of their adult lives. They may still have a longstanding mental health problem of course, and this may go some way to explaining their behaviour; but this is quite different from the situation of the previously law-abiding older person whose offending may perhaps be explained by the emergence of previously non-existent mental health problems. It is for this reason that studies by Needham-Bennett et al (1996) in England and Barak et al (1995) in Israel have tried to look at the association between first time offending in late life and mental health problems.

Needham-Bennett, whose study takes a second look at the special diversionary scheme run by Essex Constabulary, reports that 28 per cent of referrals to the scheme had a psychiatric diagnosis. When they divided the sample into early onset offenders (criminal record < 60 yrs) and late onset offenders, they found that there was no association between late onset offending and mental disorder. This finding was so unexpected that the authors have pointed to methodological problems in the study rather than rush to conclusions about the absence of a link between late onset offending and mental disorder. Barak’s study in Israel is rather different – no hypothesis-testing, just description of a sample of first time offenders (not prisoners) aged 65 years or more, and results which tend to support the notion of an association between late onset offending and mental disorder. Over half the sample had a ‘neuropsychiatric disorder’, with half of these having either dementia or a personality disorder.

The results from most of the other published studies which look at the prevalence of mental health problems in older offenders seem sufficiently diverse in their implications to throw little additional light on the question aired by Needham-Bennett. Parrott & Taylor, in their 1988 study of prisoners on remand, found that 55 per cent of the older prisoners in their sample had ‘active symptoms of psychiatric disorder’ – mostly psychosis and alcoholism, which certainly suggests that mental health problems played a part in their offending. The prevalence of mental disorders in the English and Welsh sample of older prisoners under
20 Growing Old in Prison

sentence examined by Fazel et al (2002) is similarly high at 53 per cent, but in this case the pattern of disorders is quite different. Although one third of the sample have personality disorders, what really stands out in these results and pushes up the level of mental health problems is the prevalence of depression – and the suggestion here is that these problems have emerged as a result of imprisonment rather than being a contributory factor in the offending.

Is it perhaps the case that evidence for the connection between mental disorders and offending in later life is more commonly found with some types of offences rather than others? The obvious candidate for enquiry in this matter is sexual offending. It is interesting to note therefore that the sex offenders in Fazel’s (2002) sample, although they show a relatively high rate of personality disorders, are no more likely to suffer from mental disorders, including personality problems, than other kinds of offenders. On the face of it, Fazel’s findings run counter to other research on older sex offenders which has reported either relatively low levels of psychiatric illness (Clark & Mezey 1997) or fairly high levels of psychiatric diagnoses – but with very few personality disorders (Hucker & Ben-Aron 1984).

3.3 Age and differential treatment

Evidence to suggest that older offenders are treated more leniently by the police than younger adults can be found in various data sources and studies looking at the criminal justice system in England and Wales. Certainly age makes a difference to the likelihood of receiving an official caution from the police instead of being prosecuted in the courts.

This is clear from the regularly published national data on cautions. The ratio of cautions to convictions is higher for older males and females than for offenders as a whole. The difference, as fig. 3B shows, is especially apparent with older women. A considerably larger number of older women receive police cautions than are prosecuted and convicted. The proportion is rather smaller for older men, and since 1997, convictions have outnumbered cautions. What fig. 3B also shows of course is that police use of cautions with older people has declined since 1989.

The administering of a caution is not the only alternative to prosecution that is available to the police when dealing with an older offender. They have the discretion to drop the case altogether, to take no further action. This may happen for various reasons that have nothing to do with a tendency to take a more lenient view of offending behaviour in older people – such as lack of evidence. No further action was taken by the police with more than one fifth of all the people arrested in the Phillips and Brown (1998) sample.

Fig 3B Ratio of cautions to convictions 1989 to 1999
The use of this option shows, however, little difference with age. It is in the use of cautions that age differences really show themselves. The police handling of cases involving older people (aged 60 or more) was in fact remarkably similar in this respect to their handling of cases involving juveniles (i.e. under 17 yrs old). Only 40 per cent of the older people in the sample were charged – the same as with juveniles – and 34 per cent were cautioned. Sixty five per cent of the people in the 20-29 age group were charged and only 12 per cent were cautioned, with figures not much different from this for the 30-59 age group (60 per cent and 16 per cent respectively). As with the national data on cautions, it has to be born in mind however that the differential use of cautions may reflect the nature of the offence as much as – or more than – the age of the offender. In other words, these data only suggest, rather than confirm, that the police are not strictly ‘age neutral’.

It is not surprising perhaps, given the special nature of the scheme run by the Essex Constabulary, that cautioning rates cited in two studies of older offenders referred to the scheme are higher than those reported by Phillips & Brown (and cautioning rates for older people were higher across the country as a whole at the time when these studies were conducted). Between May 1978 and July 1979, 412 elderly offenders were reported to the Community Service Branch in Essex, and only 16 per cent of these prosecuted, as against 77 per cent who were cautioned. In 1990 even fewer of the older offenders reported to the scheme were prosecuted – seven per cent. What makes the scheme special is that the charge procedure is actively discouraged for older people, so as to allow for maximum discretion in police action. Age (rather than mental or physical ill health) was cited as a reason for using a caution in 15 per cent of the cases looked at by Needham-Bennett (1996). The most common reasons for not proceeding with charges (and remember these are all older people) were the offender’s attitude to the offence and the lack of a criminal record.

Table 3C Police reasons for administering cautions or taking no further action with older people (from Needham-Bennett)

<table>
<thead>
<tr>
<th>Reasons for administering caution (97 individuals – more than one reason may be cited in each case)</th>
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<tr>
<td>Mental illness / impairment</td>
<td>7</td>
</tr>
<tr>
<td>Severe physical illness</td>
<td>5</td>
</tr>
<tr>
<td>Emotionally disturbed / other distress</td>
<td>13</td>
</tr>
<tr>
<td>Age</td>
<td>14</td>
</tr>
<tr>
<td>Attitude to offence / expression of regret</td>
<td>36</td>
</tr>
<tr>
<td>No previous criminal history</td>
<td>33</td>
</tr>
<tr>
<td>Offence explicable given circumstances</td>
<td>3</td>
</tr>
<tr>
<td>Aggrieved party does not wish to prosecute</td>
<td>3</td>
</tr>
<tr>
<td>Public interest considerations</td>
<td>26</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reasons for no further action (42 cases)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health</td>
<td>6</td>
</tr>
<tr>
<td>Cautioning might exacerbate mental health problems</td>
<td>8</td>
</tr>
<tr>
<td>Age</td>
<td>1</td>
</tr>
<tr>
<td>Previous good character / no record</td>
<td>3</td>
</tr>
<tr>
<td>Lack of clear &amp; reliable admission of offence</td>
<td>15</td>
</tr>
<tr>
<td>Intent denied</td>
<td>18</td>
</tr>
<tr>
<td>Lack of evidence of guilt</td>
<td>6</td>
</tr>
<tr>
<td>Minor nature of offence/complaint withdrawn</td>
<td>3</td>
</tr>
<tr>
<td>Aggrieved party does not wish to take matters further</td>
<td>2</td>
</tr>
<tr>
<td>Probability of nominal sentencing</td>
<td>4</td>
</tr>
</tbody>
</table>
Prosecutions and the Crown Prosecution Service

That the CPS may legitimately regard the age of an offender as a reason for not proceeding with prosecution is clear from the Code for Crown Prosecutors. Age, as well as “significant mental or physical ill health”, is cited as a possible “public interest factor against prosecution”, though this has to be balanced against the seriousness of the offence and the risk of re-offending. Although there appears to be no regularly published data on the frequency of CPS decisions not to prosecute on grounds of age, there is some information on the relationship between age and CPS decisions to terminate proceedings in the 1998 study of arrests by Phillips and Brown. Decisions to terminate proceedings were made in the cases of seven per cent of the older (60 and over) offenders. Although this is a smaller proportion of terminations than for any other age group, it does not emerge as significant.

Sentencing and the Courts

Imprisonment is only one of the sentences available to the courts for someone convicted of a criminal offence. Over a quarter of a million people were sentenced in Magistrate’s Courts in the year 2000, and 86 per cent of these received non-custodial sentences. Crown Courts, dealing with more serious offences, impose a higher proportion of custodial sentences – 64 per cent in 2000. Even so, it is still a minority of people convicted of a criminal offence by the courts (about 321,000 in 2000) that are given a custodial sentence.

Over the last ten years, there has been a substantial increase in

Table 3D  Sentences imposed on people aged 60+ in 1995 and 2000 (from Frazer 2002)

<table>
<thead>
<tr>
<th>Sentence Type</th>
<th>1995 n</th>
<th>1995 (%)</th>
<th>2000 n</th>
<th>2000 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imprisonment</td>
<td>452</td>
<td>(20)</td>
<td>711</td>
<td>(29)</td>
</tr>
<tr>
<td>Suspended sentence</td>
<td>129</td>
<td>(6)</td>
<td>185</td>
<td>(8)</td>
</tr>
<tr>
<td>Conditional discharge</td>
<td>520</td>
<td>(23)</td>
<td>404</td>
<td>(16)</td>
</tr>
<tr>
<td>Fine</td>
<td>711</td>
<td>(32)</td>
<td>585</td>
<td>(24)</td>
</tr>
<tr>
<td>Probation order</td>
<td>207</td>
<td>(9)</td>
<td>216</td>
<td>(9)</td>
</tr>
<tr>
<td>Community service</td>
<td>103</td>
<td>(5)</td>
<td>121</td>
<td>(5)</td>
</tr>
<tr>
<td>Combination order</td>
<td>17</td>
<td>(&lt;1)</td>
<td>18</td>
<td>(&lt;1)</td>
</tr>
<tr>
<td>Absolute discharge</td>
<td>34</td>
<td>(2)</td>
<td>23</td>
<td>(1)</td>
</tr>
<tr>
<td>Curfew order</td>
<td>0</td>
<td></td>
<td>3</td>
<td>(&lt;1)</td>
</tr>
<tr>
<td>Drug treatment</td>
<td>0</td>
<td></td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Other outcome</td>
<td>66</td>
<td>(3)</td>
<td>103</td>
<td>(4)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2239</td>
<td>(100)</td>
<td>2459</td>
<td>(100)</td>
</tr>
</tbody>
</table>

the proportion of convicted adults who receive custodial sentences, from 16 per cent in 1990 to 28 per cent in the year 2000, which is of course one of the main reasons for the increase in the overall prison population. As table 3D shows, this trend is mirrored in the increasing use of custodial sentences for older offenders.

However, sentencing for older offenders seems to differ most markedly from the adult population generally in the use of community sentences (probation orders, community service or combination orders). Twenty four per cent of all adult males convicted in the year 2000 received community sentences compared to 14 per cent of older males.

There is now quite of lot of published US research on the sentencing of older offenders, and in particular on the question of whether they are treated more leniently by the courts than younger people. Several studies of older shoplifters and older sex offenders have concluded
that they do tend to receive lighter sentences (e.g. Champion 1987; Wilbanks 1988; Curran 1984; Cutsall & Adams 1983), though it is not always easy in studies like these to take into account all the various factors (apart from age) that will affect sentencing decisions, such as the seriousness of the offence and previous criminal record. One recent attempt to plug these various methodological loopholes, and with a large sample, has however come to more or less the same conclusion (Steffensmeier & Motivans 2000). Older offenders are less likely to be imprisoned than younger offenders; and if they are imprisoned receive somewhat shorter sentences. The one exception to the general conclusion that offenders aged 60 years or more receive sentences that are “especially lenient relative to other age groups” is older drug traffickers.

Comparison between the use of custodial sentences for adult offenders with the data in table 3D – even though this says nothing about the nature of the offence – certainly gives us no reason to suppose that magistrates and judges in England and Wales might be inclined to regard a defendant’s age (that is to say, whether they are over sixty or not) as a significant factor in their sentencing decisions. The situation is not made much clearer by the data on the sentences received by that part of the Phillips & Brown (1998) sample of arrests whose cases were heard in Magistrates’ Courts. The proportion of older adults who received custodial sentences is indeed larger than for other adult offenders, and there is less use of community sentences. The difference, however, appears not to be statistically significant, and once again the data is hard to interpret in the absence of information about the nature of the offence and the previous history of the offender.

What the data most definitely does not suggest is that older people are treated more leniently than younger people – though there does seem to be a problem with the availability of community sentences for older people, which in this sample may well be the reason for an increased use of custody. Nevertheless, and in spite of the absence of firm statistical evidence one way or the other; Samuels (2001), who does have first hand experience of the English courts (as a JP), voices what is probably a common view when he says that “there is a natural judicial tendency to treat the older person with mercy and leniency”.

<table>
<thead>
<tr>
<th></th>
<th>Juvenile</th>
<th>17-20 yrs</th>
<th>21-29</th>
<th>30-59</th>
<th>60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custody</td>
<td>10</td>
<td>14</td>
<td>9</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Community sentence</td>
<td>49</td>
<td>23</td>
<td>19</td>
<td>20</td>
<td>14</td>
</tr>
<tr>
<td>Fine/compensation</td>
<td>3</td>
<td>36</td>
<td>47</td>
<td>36</td>
<td>43</td>
</tr>
<tr>
<td>Other</td>
<td>37</td>
<td>28</td>
<td>26</td>
<td>36</td>
<td>29</td>
</tr>
</tbody>
</table>
Chapter 4

SPECIAL TREATMENT, NEEDS AND PROVISION

Debate over the treatment of older offenders has centred on two main policy issues. Should older offenders – by virtue of their age – receive special consideration by those parts of the criminal justice system, (the police, the Crown Prosecution Service, the courts and the Parole Board), which decide if offenders are to be prosecuted, and what kind of sentence should they receive if found guilty? It is widely accepted that young offenders are entitled to special consideration because of their age – which is taken as grounds for mitigating the severity of the law. Should the same apply to older offenders? It has even been suggested in the US that special judicial procedures might be developed for the elderly similar to those that apply to young people (Cavan 1987).

The second issue – and a crucial one for this report – concerns the needs of older prisoners. To what extent and in what ways are their needs different from those of younger adults in prison? And what kind of special provision, if any, should be made by the Prison Service (and allied health and welfare services) to meet these needs? The two issues are of course connected: if older people do have special needs which the Prison Service is unable to meet, then this itself argues for special consideration in sentencing.

4.1 Age as grounds for differential treatment: prosecuting, sentencing and early release

Prosecutions and cautions

That the police sometimes choose not to pursue charges against older offenders is apparent from the data presented in chapter 2. In so far as this reflects an explicit policy decision on the part of the police, it seems to be based largely on the belief that a certain class of mental health problems (e.g. dementia rather than anti-social personality disorder) is often an important contributory factor in the offending. If this is indeed the case, then presumably age per se should not constitute grounds for special treatment – though this is in fact what seems to have happened with some of the offenders in the study by Needham-Bennett (1996). It seems likely also that the grounds for special treatment would only apply to certain classes of offence (e.g. theft from shops).

Age neutrality in sentencing

Only one of the various arguments which have been used in the (mainly US) literature to justify the favourable treatment of older offenders in the Courts regards age per se as grounds for leniency in sentencing. Objections to age neutrality in sentencing which insist that chronological age should count for something are based on the notion that a relatively long prison sentence is a more severe punishment for someone who is already in their 60s or 70s than for someone in their 20s or 30s (James 1992). Quite a high proportion of older offenders in this age group may reasonably expect to die before completing their sentence, whereas the younger offenders may reasonably look forward to release. For older offenders a sentence of 15 or 20 years often means life, which is not the case for younger offenders. Therefore, given two offenders who are just as likely to reoffend and two offences of the same degree of seriousness, age (or rather, life expectancy) should make a difference.

Other arguments in favour of differential treatment for older people generally turn on the presence and consequences of infirmity or disability, characteristics which are associated with
age, and yet may justify a different approach in sentencing, quite independently of age. What matters therefore is not so much age as physical or mental condition. It has been suggested, for example, that the association between advanced age and ‘mental infirmity’ (which here means deteriorating cognitive abilities) provides grounds for a presumption of diminished responsibility. If older people do indeed descend into a ‘second childhood’, then the courts would do well to treat them in similar fashion to those who are not yet adults.

The kind of physical infirmity that is associated with advanced age also presents a case for differential treatment, firstly, on the grounds that physically infirm older offenders do not represent a very serious threat to society, and secondly, on the grounds that imprisonment is worse for someone in poor health (or with a severe disability) than for someone in good health (and with no disabilities). Arguments about infirmity provide no grounds for regarding age per se as a reason for differential treatment. They merely apply to the case of older people the general rule that sentencing decisions should be informed by medical and psychiatric assessments. A similar argument may of course be applied to disabled people irrespective of age. If disabled people in prison cannot be given equal care and treatment with non-disabled people, then they should not receive custodial sentences.

Arguments for early release

The context for US debate on the justifiability of using age as a criterion for early release is crisis. The prison system is under massive pressure, and the situation appears to many commentators as unsustainable. From this point of view, it is no longer enough to press for the repeal of ‘three strikes and you’re out!’ legislation or the abandonment of ‘truth in sentencing’ policies. What is needed to avert the crisis is the release of large numbers of prisoners, even though they have not served their full sentence(s). Accept the premise, and the question arises – which groups of prisoners have the best case for early release (Kerbs 2001b)? It is a moot point whether Kerbs’ arguments have any relevance to policy in the UK. It may, even so, be of some interest to compare the two systems in the light of the case advanced by Kerbs for giving priority to older prisoners as candidates for early release.

There may, firstly, be a strong cost benefit argument for selecting older prisoners for early release. The annual cost (in the USA) of keeping older prisoners is on average three times more than younger prisoners. What makes the difference is the cost of health care provision for older prisoners. One Michigan-based study found that 69 per cent of prisoners aged 65 and over used off-site medical facilities during a one year period. To keep an older person in prison is also about 50 per cent more expensive than the provision of nursing home care. Furthermore, older offenders released from prison are less likely to reoffend than younger offenders. Recidivism rates among adults tend to be lower in each succeeding age group, and the older someone is at his or her first offence, the less likely that person is to commit repeat offences. However, this needs to be seen in the context of the disproportionately high number of sex offenders in the older age group in the UK.

The second part of Kerbs’ argument rests on the view that older prisoners tend to suffer unfair discrimination at the hands of the prison system. The essential point is that prisons neglect and discriminate against older people by failing to provide them with access to relevant services and programmes. Prisons are not designed for older people with disabilities and chronic health problems, and this undermines the ability of the prison system to afford them equal treatment with younger prisoners.

The main factors that make the position of older prisoners worse than that of younger prisoners are (i) problems of physical access, (ii) the lack of availability of appropriate health care (i.e., for chronic problems), and (iii) the inadequate provision of rehabilitation programmes.
structured to their specific needs. The deficiencies of the prison system in these respects are such that prisons are vulnerable to individual and class action litigation by prisoners alleging infringement of rights; and in support of his views, Kerbs cites a 1986 paper which claims that “older prisoners have been systematically denied access to existing programs and not given access to programs specific to their needs…”

4.2 The welfare of older prisoners – special provision for special needs?
The general burden of virtually all the US research on older prisoners finds that they really do have special needs. They are different in all sorts of important respects from younger prisoners – and should therefore have special provision. The forms which this special provision might take include:

• specialist facilities (or “nursing home prisons”)
• separate or segregated facilities
• special programmes and provision for psychosocial needs.

Nursing home prisons and the need for health and social care
Those who develop separate facilities for housing older prisoners have to decide what criteria to use for admission – and the facilities themselves may be distinguished accordingly. Where admission is based mainly on an assessment of the need for special care – the prisoner’s state of health/degree of infirmity is sufficient to warrant this kind of placement – it seems common practice (in the US) to describe the facility as a ‘nursing home prison’ or a ‘geriatric prison’.

Some US states, generally those with large numbers of older prisoners, have developed specialist facilities for older infirm prisoners who require considerable help with activities of daily living (ADLs) or have chronic health problems requiring frequent medical and/or nursing attention (Morton 1992; Flynn 1992; Aday 1994). It may be that only a fraction of these prisoners have levels of need comparable to those which would argue a strong case for placement in residential care or nursing home care for an older person in the community.

Even so these facilities are intended for prisoners who need more intensive social, medical, or nursing care that is usually provided in a regular prison. Kentucky, for example, has a special unit which requires prisoners to be “suffering from chronic or other disabling diseases”, and North Carolina has a minimum-security institution for prisoners “with geniatric or other special needs”. In South Carolina there is an entirely separate state prison for the elderly, and Mississippi has a facility “specifically designed as a nursing home in a correctional setting”. Both these latter states have fairly harsh sentencing practices with the expectation that a substantial number of prisoners will stay in prison for the whole of their natural life.

This same issue of the need for nursing home-type provision has been aired in Australia largely because of the growing number of prisoners sentenced to natural life terms (Grant 1999). If the number of older prisoners continues to increase as it has been doing over the last decade, and especially if it increases to include large numbers of prisoners in their seventies or eighties, there will be a growing demand for facilities analogous to those provided for infirm older people living in the community.

Concern over the development of this kind of facility has been fuelled by the suggestion that older prisoners have a ‘biological age’ about ten years in advance of their age peers in the community (Rosefield 1995). In other words, substantial numbers of prisoners in their sixties or early seventies – perhaps even younger – may require the kind of special residential facility that, in the community, is used mostly by people who are in their late seventies or older. Some commentators attribute this phenomenon to the adverse effects of being in prison,
though it seems likely that many of these prisoners would have had a very unhealthy lifestyle before imprisonment – heavy smoking, heavy drinking and poor diet.

However this may be, and there is good evidence to suggest that the physical health of older prisoners is worse than that of their age peers in the community (Fazel 2001), it is clear that the prison health care system is not really geared up to meet the long term care needs which are associated with the kinds of chronic health problem and disabling disease that tend to develop in later life. This certainly is the conclusion to be drawn from some of the comments in the Board of Visitors’ survey as well as some recent inspection reports from HM Inspectorate of Prisons.

Given that the nursing home prison responds to the growing numbers of older prisoners with chronic health problems and physical disabilities by housing them together in special facilities that can provide for their needs (which would include access to specialist medical care), this still leaves open the question of where exactly to set the threshold level of need for admission (and hence what kind of facilities to provide). How wide should the system cast the net? It would be possible, for example, to take a quite restricted view of the facilities to be provided, and admit only those prisoners who have the same (relatively high) level of need that would normally secure admission to residential or nursing home care in the community. A more inclusive approach would also admit older prisoners with the kind of chronic medical conditions (e.g. cardiovascular disease and arthritis) that would not normally require placement in special facilities if they were living in the community. As things stand, and even in the US with its high numbers of older prisoners, it seems likely that considerations of efficiency will incline the system towards the more inclusive model of provision (Aday 1994). There are simply not enough older prisoners with high levels of dependency to justify the development of the more specialised kind of facility for their use alone (or at least not in every state).

It is important not to forget, however, that the health status of a substantial minority of older prisoners – those who are reasonably fit and healthy, especially if they are mobile and able to work – would not warrant admission to a facility of this kind which operated even the most relaxed admission criterion – say, the presence of any chronic condition requiring regular medical attention (such as mild hypertension). Seventeen per cent of the older prisoners in Fazel et al 2001 had no longstanding illness or disability. Furthermore, a substantial proportion of the remainder – those with long-standing illness or disability – would be unlikely to have levels of need that would meet the current threshold for the provision of social care that prevailed in the community.

Nursing home prisons, where they exist in the US, tend to admit prisoners in the expectation that they will stay there for the rest of their sentence (especially if this extends to the end of their natural life). This kind of long-term care function, however, is not the only possible model of provision for facilities which admit older prisoners on the basis of need.

The Prison Service plans to develop a specialist unit for elderly and infirm lifers in Norwich Prison, and it is intended that this unit will have a rehabilitative role, and hence a higher turnover of prisoners than would be expected in the US geriatric facilities. One consequence of the US approach – together with the use of relatively long custodial sentences – is that prisons are being forced to consider the development of hospice care for the growing numbers of older prisoners who are likely to die in prison. The position in the UK is slightly different. In exceptional circumstances it is Prison Service policy to use mechanisms for compassionate release to cover this kind of situation.
Once prisons in England and Wales have carried out the health care needs assessments that are now required of them (see chapter 1), the problem for the Prison Service will be to translate what is known about the need for health care into concrete plans for the development of facilities and forms of provision. We should expect that the proposed health care assessments will at least raise the question of the need for ‘nursing home prisons’ (apart from what is being proposed at Norwich). The main policy question to answer here is the size of the ‘critical mass’ of older prisoners required to justify the development of this kind of facility. Even in the absence of large numbers of prisoners sentenced to natural life terms, such a facility would eventually be required if the numbers of prisoners in their seventies or eighties continued to grow (quite apart from the argument about the advanced ‘biological age’ of older prisoners).

If it is assumed that prison health care assessments will follow standard practice and make some sort of distinction between need for health care and need for social care (i.e. kind of help with Activities of Daily Living that is usually organised for older people in the community by social services), then health care assessments alone will not form the basis for the provision of social care for older prisoners – both in prison and on release.

Given that there is a well-recognised system for assessing need and arranging provision for older people living in the community, it is important to decide how this system should relate to what might happen in prison. In the context of discussion about nursing home prisons, this must include deciding how the Prison Service should respond to prisoners with fairly high levels of need – i.e. they need the kind of regular and frequent social support or nursing care that would tend to lead to residential care/nursing home placements among older people living in the community. It is important, however, to think more comprehensively than this about social care needs, and consider how the Prison Service should respond to prisoners with more moderate levels of need (i.e. they need the kind of help with ADLs that would be met by some form of home care provision in the community). More generally, we should ask how the different kinds and levels of provision for older people living in the community might map onto the needs of older prisoners.

In the survey carried out in England and Wales by the National Advisory Council of Boards of Visitors, one third of prisons with older prisoners had at least one prisoner who had problems with mobility or needed help with basic activities of daily living, and some prisons said that they would not be able to accept prisoners who needed help with ADLs (July 2001). Although nine per cent of the older prisoners in the Fazel (2001) sample had significant levels of functional disability (e.g. unable to climb stairs), there were only six prisoners (2.5 per cent) who were unable to perform some basic function of personal care (e.g. washing or dressing) without help. Colsher (1992) found “gross physical functional disability” in over 40 per cent of a US sample of older prisoners – and a quarter of these had “routine self-care dependency”.

Separate facilities: segregation vs integration

If admission according to need determines one model for the provision of specialist facilities for older prisoners, age is the other main criterion which can be used to determine admission. An increasing number of US states routinely house older prisoners – irrespective of health and disability status – apart from the general prison population (i.e. in separate wings or units with adult prisoners) and offer them different ‘programs and services’. Most of these units also mix older prisoners with younger disabled prisoners – though if cells are shared (and they usually are) they are shared by same age prisoners. Whether or not prisoners have to request or consent to be sent to these units is not always clear (Aday 1994), and most of them use other criteria for admission besides age (Flynn 1992), such as a record of good
behaviour (because of the privileges associated with the unit) or the requirement that the prisoner is “ambulatory” and needs no help with ADLs.

The only UK facility which explicitly follows this model of age-segregated facilities – at Kingston Prison – operates a thoroughly voluntary policy and does not include younger disabled prisoners. The age threshold at Kingston is 50 years (as in many of the US units) and prisoners must be mobile. It seems likely that “most [UK] prisons which have a substantial number of elderly prisoners probably already run an informal system which groups them together rather than mixing them with the general prison population” (prison governor quoted in Eastman 2002). The main reasons that researchers and commentators have offered for providing age-segregated facilities (apart from the relatively high prevalence of chronic health and disability problems among older prisoners) are that:

• age diminishes the prisoner’s ability to cope with the hostility and aggression that characterises much of the behaviour of younger prisoners – and to the extent that they feel themselves to be more vulnerable to hostility and aggression, they need more protection from it;
• age segregated facilities make it easier for the authorities to provide different programmes for a group which tends to have different psychosocial needs from younger prisoners – such as, for example, a preference for peace and quiet and privacy;
• older prisoners want age-segregated facilities – several US studies have reported that older prisoners express a preference for being housed with people of their own age (for reasons which no doubt include their sense of personal safety and the desire for peace and quiet and privacy etc).

And against the establishment of separate facilities, it has been argued that:

• age per se is not a sufficient reason for special treatment (with regard to a prisoner’s sense of vulnerability to aggression);
• older prisoners provide a sense of stability to the general prison population;
• segregation may lead to ‘ghetto-isation’ and neglect (analogous to arguments in the 1980s and 1990s about acute hospital care for older people);
• those held on separate specialist facilities are more likely to be held far from home, making maintaining links with family and friends difficult;
• there may be a problem with lack of social stimulation and participation in mainstream prison activities;
• prisoners do not want them – “All of the older prisoners are happy to be here and prefer to mix with the younger population rather than be segregated in their own discrete areas”.

In the Board of Visitors’ survey, most of the prisons which had older prisoners housed them ‘on normal location’. Some of these prisons – a minority – said that they had placed these prisoners on a ground floor or flat location because of actual or possible mobility problems. Twenty per cent of the prisons with older prisoners housed some or all of them in a separate or designated area, either a Vulnerable Prisoners’ Unit or the healthcare facility.

Special programmes & provision for psycho-social needs

• Coping with prison and psychological adjustment

One of the main arguments for age-segregated facilities for older prisoners is that they do not cope well with certain aspects of the typical prison social environment. How, in fact, do older
prisoners cope with prison? Better or worse than younger prisoners? Do they have more or less of the various kinds of resources that might enable people to cope with prison? Or is it rather that they have different kinds of psychological problems than younger prisoners?

In order to answer questions like these it is useful to distinguish between different categories of older prisoner. US researchers have used various typologies of older prisoners (see e.g. Flynn 1992), and most prisoners seem to fall into two main categories: older first time offenders, and ‘career criminals’ – individuals with a previous history of crime and/or previous episodes of imprisonment. Over the next few years in the US, however, this may change, as the impact of the ‘three strikes’ legislation makes itself felt, and increasing numbers of prisoners sentenced to very long prison terms start to reach their seventies and eighties i.e. they will have ‘grown old in prison’. In the UK National Prison Survey (OPCS 1991), 52 per cent of the older prisoners had no previous experience of imprisonment – but it is not stated whether they were sent to prison relatively late in life or had already been there a long time.

Distinctions like these help us to distinguish between different problems of psychological adjustment. The situation of the older prisoner who has already served several years of a long sentence and has ‘grown old in prison’ is different in many ways from that of the first time offender who finds himself imprisoned at the age of sixty five.

It has even been argued by some US researchers that ‘growing old in prison’ may have something to be said for it. Prison may be experienced as a kind of haven from the stresses of ageing in a social world which is generally hostile to older people – especially older males with low incomes from relatively disadvantaged circumstances (Reed & Glamser 1979). The point is that imprisonment is a peculiar sort of ‘levelling experience’ which exempts the older prisoner from some of the status transitions that make ageing so difficult in the wider society. Older prisoners may find themselves accorded a degree of prestige and deference (as ‘old hands’), which would be altogether absent in the outside world (Wiltz 1982). Results like these – which are perhaps atypical and rather dated – seem more plausible if we apply them to the kind of prisoner who is imprisoned in middle life to serve a very long sentence (say more than 20 years) and grows old in prison.

Against this has to be set research which suggests that the stresses and demands of the prison social environment (quite apart from the physical environment) make it even more difficult to grow old in prison than to grow old in the community (Wilson & Vito 1986). The values of the prisoners’ social world set a premium on physical strength and endurance – so physical decline matters more in prison than outside (hence a heightened sense of vulnerability). Older prisoners, like older people in the outside world, are no longer respected in the way they once were (Hunt 1993).
If we ask about the problems of being old in prison rather than growing old in prison, there is some evidence to suggest that older prisoners may be more vulnerable than younger prisoners to all that is unpleasant or depersonalizing in prison life — and hence are more likely to suffer rapid deterioration of mental health (Silverman & Vega 1990).

There are studies, for example, which highlight their relative lack of social support — both inside and outside of prison — as well as the importance of external family support for coping with prison (Rubenstein 1984). There are studies which highlight their vulnerability to victimisation and anxiety over physical dependency and weakness (Krajick 1979; Vito & Wilson 1985). And finally there are studies which have found psychological illness or distress to be more prevalent in older prisoners than younger prisoners. This would seem to be the conclusion of the major study of the psychological health of older prisoners in the UK by Fazel et al — especially if personality disorders are excluded from consideration as being forms of mental disorder rather than treatable illness.

By no means all the North American studies support this conclusion, however (see Gallagher 1990; Teller & Howell 1981), and it should also be borne in mind that there is a relatively low incidence of self-harm and suicide among older prisoners. One factor that may contribute to depression among older prisoners — certainly in the US where many prisoners have very long sentences — is the sense of hopelessness about the prospect of release.

Another aspect of prison life which has attracted the attention of quite a few US researchers is the relative lack of disciplinary problems among older prisoners. If this is construed as an indicator of psychological adjustment, then to this extent at least, older prisoners would seem to adjust better to prison life than younger prisoners. The consensus is that older prisoners tend to be more stable, more readily institutionalised, more cooperative with prison staff, and less troublesome than younger prisoners (Kerbs 2001a). As ever, generalisations of this kind invite qualification (and it is, besides, questionable whether conformity to rules should be taken as an indicator of psychological adjustment). One study of old prisoners found that 10 per cent of the sample presented serious disciplinary problems and a further 32 per cent presented minor problems — whereas the remainder had no kind of prison disciplinary record (McShane & Williams 1990).

Whether or not the problems of psychological adjustment to prison are worse for older prisoners than for younger prisoners (and the evidence does seem rather inconclusive), there is certainly evidence enough to suggest that these problems are both common and severe, especially perhaps for first time older offenders. One recent US study found that first reactions to prison were characterized by depression, family conflict, fear of dying in prison and thoughts of suicide (Aday 1994b). What also emerges quite strongly from the US research is the preference of older prisoners for a social environment and regime different from what is desired by younger prisoners. As we have seen, interview studies with older prisoners have led researchers to the conclusion that they want to be “insulated from the noise, rabble and intrusion of younger, aggressive inmates” (Walsh 1992). They do not relish social stimulation and activity to the extent of younger prisoners; and prefer more structured and predictable prison regimes (Toch 1977). What little UK evidence there is on this matter (see above on age segregation) seems, however, to point to a quite different conclusion.

**Prison regimes: education, recreation, work and rehabilitation**

If prisons are to have some function besides the punishment of the offender (and the protection of society through the deterrent effect of punishment), then they must provide various programmes aimed at the prevention of reoffending and the reintegration of offenders into mainstream society. They will want to provide prisoners with opportunities for
continuing education, for vocational training and for recreational activities, as well as participation in programmes intended to tackle some of the root causes of their offending behaviour. As a general rule, prisons also require prisoners to engage in some form of paid employment. Furthermore, willing participation in these various programmes, certainly in the UK, is an important determinant of the level of privileges allowed to the individual prisoner.

It is often – and perhaps inevitably – the case, however, that the content of these different programmes should be geared towards the younger prisoners who make up the majority of the prison population. This is most evident in education provision, which often tends to concentrate on the basic literacy and numeracy skills which so many younger prisoners lack, and physical exercise programmes, which are almost certain to be too demanding for many older prisoners, even in the absence of chronic health problems. It is understandable, then, that US research studies should report low participation in prison educational programmes – or lack of motivation to participate in ‘meaningful activities’ (a term now used in the key indicators for the Prison Service).

More generally, it has been argued that prison programmes that aim at “returning the offender to mainstream society” may have little relevance for older prisoners. The point is that ‘reintegration into mainstream society’ will tend to have rather different meanings for a prisoner of working age than a prisoner who is past retirement age. If the prison system is to help younger prisoners achieve this goal, then it makes sense to provide them with the skills that are needed to obtain legitimate and remunerative employment. Vocational training has to be a central plank of the programme. For older prisoners, those anyway who will be past retirement age on release, reintegration into mainstream society, if it is to have any meaning at all, will have to be something different from this.

What can be said about the situation in the UK? The information available is limited. Data from the 1991 National Prison Survey would suggest that the proportion of older prisoners who are actually working is not much different from that of other adults. In the Board of Visitors’ study (see appendix 3), work for older prisoners was described as voluntary in nearly all prisons (the exceptions being working prisons), and most older prisoners wanted to work. There is, however, a substantial minority who do not work either out of choice or because of their health. Under present prison rules, prisoners aged 60 years or more are not required to work, whereas the pensionable age in the community is of course 65 years. Educational programmes are pursued by only a small minority of prisoners. What this suggests is that older prisoners who are no longer required to work may drift into the kind of inactivity that a great many community-based programmes for older people are designed to prevent.

**Resettlement**

In 1978 the British Journal of Criminology published a study of psychological change in life sentence prisoners. Prisoners older than 49 years at the time of their conviction were excluded from the study on the grounds that “men who have only a pension to go out to have problems untypical of life sentences prisoners as a whole” (Sapsford 1978). What makes the resettlement problems of older men untypical, therefore, is the absence of both the difficulties and the opportunities that are associated with finding paid employment after release from prison. This clearly reflects back on the kind of educational and rehabilitation programme that might be considered appropriate for prisoners who will be past retirement age on release (see above).

Apart from the problems of income and employment highlighted by Sapsford, another circumstance that may well compound the difficulties experienced by older prisoners on release is the lack of social support that they will find. It is well-known that prison often
undermines family ties – especially marital ties – in adult prisoners of all ages. Prisoners are less likely to be married than adults in the general population (OPCS 1991), and this is as true of prisoners aged 60 and over as it is of prisoners aged 30-39. Thirty eight per cent of the National Prison Survey sample of older prisoners were married – compared to 59 per cent of the general population in this age group. It is not surprising then, given the likely marital status of older prisoners, that so many of the NPS sample – 39 per cent – lived alone before imprisonment (39 per cent). There are, furthermore, many older prisoners whose offence (say a sexual offence) will have contributed to the break-up of family ties. It seems likely therefore, on the evidence available, that older prisoners tend to have less social support on release than younger prisoners. One US study found that a majority of the older prisoners in the sample received no family visitors and only 10 per cent had regular visits from friends. As many as 42 per cent of the UK sample interviewed by Fazel et al were divorced or separated.

The absence of ties with family or friends in the community may be gauged by the relatively high proportion of older prisoners in the NPS sample who had received no letter in the previous three months. Among adult prisoners, this kind of isolation from the community seems to increase more or less in line with age, from nine per cent in men aged 21-24 yrs to 30 per cent in men aged 60 and over.

One question that has been asked by a handful of US studies is whether older prisoners who have served long sentences are more difficult to resettle than younger prisoners because they are more likely to become institutionalised (Fattah & Sacco 1989). This is of course the other side of the coin to the idea that prison might serve as a haven for some older prisoners.

Rehabilitation and the maintenance or development of family and community ties can be especially problematic when prisoners are located at a distance from their home area. In October 2002, in England and Wales, 27,500 prisoners were held more than 50 miles and 12,500 more than 100 miles, from their committal court town. Where relationships are already strained or limited in number the impact of such distances, together with the likelihood of moves, often unplanned, within an overcrowded prison system, can be hugely problematic.
Chapter 5

CONCLUSIONS AND KEY FINDINGS

- **Key findings**
  - Prisoners aged 60 years and over make up just over two per cent of the prison population. In 1990 only one per cent of prisoners were in this age group. Between 1990 and 2000 the number of older prisoners trebled.
  - More than one in ten older prisoners belongs to a minority ethnic group.
  - Older prisoners are more likely to be serving long sentences than younger prisoners. One fifth of all older prisoners under sentence are lifers — compared to about 10 per cent in the prison population as a whole. The situation of the older prisoner who has already served several years of a long sentence and has ‘grown old in prison’ is different in many ways from that of the first time offender who finds himself imprisoned at the age of sixty five.
  - Research suggests that the stresses and demands of the prison social environment (quite apart from the physical environment) make it even more difficult to grow old in prison than to grow old in the community. The values of the prisoners’ social world set a premium on physical strength and endurance – so physical decline matters more in prison than outside (hence a heightened sense of vulnerability). There is some evidence to suggest that older prisoners may be more vulnerable than young prisoners to all that is unpleasant or depersonalising in prison life.
  - Three-quarters of older prisoners under sentence have been convicted of a violent or sexual offence. About 50 per cent have been in prison before.
  - More than 80 per cent of older prisoners report longstanding illness or disability. Thirty per cent have a diagnosis of depression. There are studies which have found psychological illness or distress to be more prevalent in older prisoners than younger prisoners.
  - There is good evidence to suggest that the physical health of older prisoners is worse than that of their age peers in the community. It is clear that the prison health care system is not really geared up to meet the long term care needs which are associated with the kinds of chronic health problems and disabling disease that tend to develop in later life. Disabilities associated with chronic disease are more common in older prisoners than in older people living in the community.
  - Older prisoners present very few disciplinary problems. This would suggest that they better adjust to prison life than younger prisoners and become more easily institutionalised. However, it is also more likely that they will be more difficult to resettle because they are more likely to become institutionalised.
  - Many older prisoners have no family or community support. Thirty per cent did not receive a letter during the period of a three month survey.
  - Prison programmes are not geared to the needs of older prisoners, but to those of the younger prisoner who make up the bulk of the prison population. This is particularly evident in educational provision, vocational programmes and physical exercise.
  - Reintegration into mainstream society is very different for a prisoner of working age than a prisoner who is past retirement age.
Because most of the older prison population is concentrated in a relatively small number of prisons, there are several establishments in which the presence of older prisoners is not seen as a problem. The fact that a prisoner has crossed a given age threshold does not of itself create a new set of problems for prison governors. Their presence tends to make itself felt as an issue in the day-to-day management of prison life only if they have disability problems which impair their ability to look after themselves or chronic health problems which require regular medical or nursing attention.

**Growth in the older prison population**

Increasing numbers of offenders are receiving relatively long prison sentences, which means that more people will ‘grow old’ in prison. The lifer population has been increasing steadily since 1990. At the end of 2001 there were almost twice as many prisoners serving life sentences as there had been in 1990. The increase in the older prison population is not to be explained, however, simply by the fact that more people are receiving longer sentences and hence more people are growing old in prison. The number of older people being sent to prison each year doubled between 1990 and 2000. An increasing proportion of all offenders – including older offenders – are receiving custodial sentences.

**Diversity in the older prison population**

The older prisoner population is in many ways less heterogeneous than the general older population. Older prisoners, for example, resemble the prison population as a whole in being overwhelmingly male. Also there are very few among their number who have reached their late seventies or eighties (five per cent of all prisoners aged 60 years or more). If they are old, then they tend to belong to the category sometimes given the label ‘younger old’.

Despite this relative homogeneity however, there is enough diversity among older prisoners to undermine the theory that there is any such thing as a ‘typical’ older prisoner with a fairly predictable set of needs. This is apparent, for example, in differences in health status, and in their criminal histories, and in the kind of informal social support which they might expect on release. If the older prisoner population includes every prisoner aged 60 years or more, then it will include substantial numbers of prisoners who are reasonably fit and healthy as well as substantial numbers with what the General Household Survey calls ‘limiting long-standing illness’.

Although many of these older prisoners will be serving fairly long sentences for violent crimes or persistent sexual offending, there will be many also who are serving relatively short sentences (say six months or less) for what are presumably judged to be less serious offences. Some will be first time offenders; others will have a long history of offending and previous experience of prison. And finally, it is undoubtedly the case that many older prisoners, perhaps the majority, will receive little or no family support on their release from prison, but there will be a substantial number who will find themselves in a more fortunate position.

**Commitment to change**

The Prison Service is committed to action that will improve provision for older prisoners, firstly in respect of the health care they receive, and secondly in respect of needs that arise as a result of disabilities. The new partnership with the NHS should lead to improvements in health care for prisoners of all ages, and the medical profession has already underlined some of the implications of this commitment for older prisoners with chronic health problems. The full benefits of these developments still lie in the future, of course, as does the fulfilment of the Prison Service’s intention to comply with disability discrimination legislation.

The Board of Visitors’ survey strongly suggests that most prisons have quite a long way to go if
they are to be able to provide for the health and social care needs of infirm older prisoners. It has yet to be determined, for example, how these commitments will be squared with the kind of security considerations that normally determine a prisoner’s placement within the prison system. The system has still to demonstrate its ability to deliver appropriate care to older prisoners who need it.

Unresolved issues around provision for special needs

Although the Prison Service has recognised that (a) prison health care must be improved in order to meet the needs of older prisoners, and (b) prisons as physical environments must be better adapted to the needs of older prisoners with physical disabilities, there are still a number of important policy issues that remain unresolved. What is not yet clear is:

• the nature of the ‘social care’ provision that should be made for older prisoners with the kinds of functional disability that make them dependent on the help of other people for essential activities of daily living;

• the need for other kinds of special provision besides (a) health care and (b) the kind of social care that is intended to help with activities of daily living (ADLs).

There is evidence to suggest that the Prison Service and other service providers (social services, probation services and the voluntary sector) should be doing more for older prisoners than is contained in their current proposals for improving prison health care and complying with disability legislation.

The Chief Inspector of Prisons has recommended that the Prison Service develop a strategy for older prisoners. There are several issues – besides the improvement of health care and compliance with disability legislation – which any such strategy will have to address. These relate to special provision, and all merit further investigation.

• To what extent should the Prison Service favour the development of age-based/disability-based segregation of facilities?

• Are older prisoners who need help with ADLs getting the help they need? How do the assessment procedures and aims of social services in providing care in the community compare with the provision of social care in prisons?

• Are discharged older prisoners getting the kind of help they need on release? What should be the role of social services, probation services and the voluntary sector in providing help with the resettlement of older prisoners?

• What, if any, special provision, should be made for older prisoners who choose not to work in prison, or are unable to work in prison? What might be done for older prisoners to promote social participation and participation in meaningful activities during their period of imprisonment?

Areas for further research

– Sentencing of older offenders

Evidence on the treatment of older offenders by the criminal justice system in England and Wales is thin on the ground. What evidence there is suggests that older people do receive special consideration from the police and the Crown Prosecution Service. It would also be useful to have some more data on the sentencing of older offenders.

– Reoffending rates for older prisoners

A second question which has an important bearing on policy for older offenders concerns the rate of reoffending. This is known to be very high in younger adults who receive custodial sentences. US data suggests that the rate of reoffending is significantly
lower among older offenders. It seems likely that England and Wales will be similar. If this was the case it would add considerable weight to the argument that older people should receive differential treatment in the criminal justice system.

- **Views and experiences of older prisoners**
  Relatively little is known about the perception of older prisoners and their experiences in prison and on release. Such a study would inform a strategy to improve prison regimes and plans for resettlement.

- **Integration of support and supervision in prison and in the community**
  Effective resettlement depends on the active involvement of all parties: prisoners and their families, prison staff and those on probation, health, social services, housing and voluntary agencies. It would be helpful to determine where such co-ordinated plans are made and what are the outcomes, with a view to improving national policy and practice.
### Appendix I

**SUPPLEMENTARY TABLES**

#### Table 2A  
Prisoners aged 60 or over in English and Welsh Prisons

<table>
<thead>
<tr>
<th>Number</th>
<th>No. aged 60+</th>
<th>% aged 60+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total prison population on 30/11/01</td>
<td>68,450</td>
<td>1,379</td>
</tr>
<tr>
<td>Receptions into prison in 2000 – adult males</td>
<td>64,103</td>
<td>774</td>
</tr>
<tr>
<td>Receptions into prison in 2000 – adult females</td>
<td>5,770</td>
<td>34</td>
</tr>
<tr>
<td>Male prison population under sentence on 30/06/2000</td>
<td>50,514</td>
<td>1,138</td>
</tr>
<tr>
<td>Female prison population under sentence on 30/06/2000</td>
<td>2,666</td>
<td>16</td>
</tr>
</tbody>
</table>

#### Table 2B  
Change in prison population and older prisoner population 1990-2000

<table>
<thead>
<tr>
<th>1990 (average daily pop.)</th>
<th>2000 (average daily pop.)</th>
<th>% change</th>
</tr>
</thead>
<tbody>
<tr>
<td>total prison population</td>
<td>456,36</td>
<td>646,02</td>
</tr>
<tr>
<td>all adult receptions</td>
<td>364,71</td>
<td>698,73</td>
</tr>
<tr>
<td>prisoners under sentence (on 30 June 2000)</td>
<td>352,20</td>
<td>531,80</td>
</tr>
<tr>
<td>50-59 yrs</td>
<td>1,425</td>
<td>2,486</td>
</tr>
<tr>
<td>– receptions</td>
<td>1,390</td>
<td>2,852</td>
</tr>
<tr>
<td>60+ yrs</td>
<td>412</td>
<td>808</td>
</tr>
<tr>
<td>– under sentence</td>
<td>365</td>
<td>1,154</td>
</tr>
</tbody>
</table>

#### Table 2C  
Age and ethnicity of all prisoners (under sentence and remand) aged 60+ yrs on 30/11/01

<table>
<thead>
<tr>
<th>60-69 yrs (%)</th>
<th>70-74 yrs (%)</th>
<th>75+ (%)</th>
<th>All 60+ (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>991 (89)</td>
<td>169 (91)</td>
<td>72 (96)</td>
</tr>
<tr>
<td>Black – Caribbean / African/Other</td>
<td>70 (6)</td>
<td>9 (5)</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Asian – Pakistani/ Bangladeshi/Indian/Other</td>
<td>44 (4)</td>
<td>6 (3)</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Chinese</td>
<td>3 (&lt;0.5)</td>
<td>0 –</td>
<td>0 –</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>11 (1)</td>
<td>1 (&lt;0.5)</td>
<td>0 –</td>
</tr>
<tr>
<td>Total</td>
<td>1,119 (100)</td>
<td>185 (100)</td>
<td>75 (100)</td>
</tr>
</tbody>
</table>
### Table 2D  Location of prisoners aged 60+ on 31/08/01

<table>
<thead>
<tr>
<th>Type of prison</th>
<th>Prisons with older prisoners</th>
<th>Number of prisoners</th>
<th>% of all older prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>local</td>
<td>40</td>
<td>404</td>
<td>31</td>
</tr>
<tr>
<td>open</td>
<td>9</td>
<td>94</td>
<td>7</td>
</tr>
<tr>
<td>closed – b/c</td>
<td>41</td>
<td>672</td>
<td>50</td>
</tr>
<tr>
<td>dispersal</td>
<td>5</td>
<td>133</td>
<td>10</td>
</tr>
<tr>
<td>Female</td>
<td>12</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>1345</td>
<td>100</td>
</tr>
</tbody>
</table>

### Table 2E  The ‘top ten’ prisons with most older prisoners

<table>
<thead>
<tr>
<th>Type of prison</th>
<th>no. of older prisoners</th>
<th>% older prisoners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acklington</td>
<td>63</td>
<td>8</td>
</tr>
<tr>
<td>Albany</td>
<td>62</td>
<td>14</td>
</tr>
<tr>
<td>Littlehey</td>
<td>56</td>
<td>9</td>
</tr>
<tr>
<td>Wymott</td>
<td>56</td>
<td>7</td>
</tr>
<tr>
<td>Whatton</td>
<td>43</td>
<td>16</td>
</tr>
<tr>
<td>Wandsworth</td>
<td>42</td>
<td>5</td>
</tr>
<tr>
<td>Wakefield</td>
<td>36</td>
<td>5</td>
</tr>
<tr>
<td>Frankland</td>
<td>35</td>
<td>5</td>
</tr>
<tr>
<td>Usk/Prescoed</td>
<td>34</td>
<td>27</td>
</tr>
<tr>
<td>Sidley</td>
<td>33</td>
<td>4</td>
</tr>
</tbody>
</table>

### Table 2F  Concentration and dispersal of older prisoners

<table>
<thead>
<tr>
<th>Number of older prisoners</th>
<th>Prisons with this no. of older prisoners</th>
<th>Total no. of older prisoners in these prisons</th>
<th>% of older prisoners in these prisons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-4</td>
<td>35</td>
<td>81</td>
<td>6</td>
</tr>
<tr>
<td>5-9</td>
<td>22</td>
<td>134</td>
<td>10</td>
</tr>
<tr>
<td>10-19</td>
<td>29</td>
<td>390</td>
<td>29</td>
</tr>
<tr>
<td>20-29</td>
<td>10</td>
<td>248</td>
<td>18</td>
</tr>
<tr>
<td>30-49</td>
<td>7</td>
<td>255</td>
<td>19</td>
</tr>
<tr>
<td>50+</td>
<td>4</td>
<td>237</td>
<td>18</td>
</tr>
<tr>
<td>all ages</td>
<td>107</td>
<td>1345</td>
<td>100</td>
</tr>
<tr>
<td>Problem</td>
<td>Study</td>
<td>Age of sample</td>
<td>Prevalence rate in prison %</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------</td>
<td>---------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Longstanding illness or disability</td>
<td>OPCS 1994 Fazel 2001</td>
<td>18 – 50 60+</td>
<td>46% 83%</td>
</tr>
<tr>
<td></td>
<td>Fazel 2001</td>
<td></td>
<td>3% 36%</td>
</tr>
<tr>
<td>- cardiovascular disease</td>
<td>OPCS 1994 Fazel 2001</td>
<td>18-50 60+</td>
<td>15% 21%</td>
</tr>
<tr>
<td>- respiratory disease</td>
<td>OPCS 1994 Fazel 2001</td>
<td>18-50 60+</td>
<td>16% 43%</td>
</tr>
<tr>
<td></td>
<td>Fazel 2001</td>
<td></td>
<td>3% 36%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1% 7%</td>
</tr>
<tr>
<td>Substance abuse or dependency</td>
<td>ONS 1998</td>
<td>18 – 55</td>
<td>43% male sentenced 41% female sentenced</td>
</tr>
<tr>
<td></td>
<td>Brooke 1996 Birmingham 1996 Fazel 2001a</td>
<td>15-61 18-70 60+</td>
<td>38% male remand 38% male remand 5%</td>
</tr>
<tr>
<td>- opiate dependency</td>
<td>ONS 1998</td>
<td></td>
<td>18% male sentenced 23% female sentenced</td>
</tr>
<tr>
<td>- injecting drug use</td>
<td>PHLS 1997</td>
<td></td>
<td>14% male 21% female</td>
</tr>
<tr>
<td>- current smokers</td>
<td>OPCS 1994 Fazel 2001</td>
<td>18 – 50 60+</td>
<td>81% 54%</td>
</tr>
<tr>
<td></td>
<td>Fazel 2001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental disorders (inc substance abuse)</td>
<td>Brooke 1996 Taylor &amp; Parrott Fazel 2001a</td>
<td>15 – 61 18 – 70 65+ 60+</td>
<td>60% 63% 55% 53%</td>
</tr>
<tr>
<td>- antisocial personality disorder</td>
<td>ONS 1998 Fazel 2001a</td>
<td>18 – 55 60+</td>
<td>51% 10%</td>
</tr>
<tr>
<td>- psychosis</td>
<td>ONS 1998</td>
<td>18-55</td>
<td>7% 5%</td>
</tr>
<tr>
<td></td>
<td>Brooke 1996 Birmingham 1996 Fazel 2001a</td>
<td>15-61 18-70 60+</td>
<td>5% 4% 5%</td>
</tr>
<tr>
<td>- depression</td>
<td>ONS 1998</td>
<td>18-55</td>
<td>13% male 51% female 30%</td>
</tr>
<tr>
<td></td>
<td>Fazel 2001a</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 2

REFERENCES


42  Growing Old in Prison

HM Chief Inspector of Prisons and Probation (1999). Suicide is everyone’s concern: a thematic review.


Appendix 3

SUMMARY REPORT ON BOARD OF VISITORS SURVEY OF TREATMENT OF PRISONERS OF PENSIONABLE AGE

Questionnaires were sent to Boards of Visitors at all prisons in England and Wales holding adult prisoners. Completed questionnaires were returned for 79 prisons. The respondents included all types of prison – closed and open training prisons, local prisons and female prisons. The original aim of the survey was to gather information on financial payments to prisoners of pensionable age, who lose their entitlement to a state pension during custody. The National Advisory Council of the Boards of Visitors took the opportunity presented by the survey to gather other information about older prisoners and their treatment in prison. The information collected in the questionnaire relates to prisons rather than individual prisoners.

- The majority of prisons (90 per cent) have at least one prisoner of pensionable age, though in most cases the numbers are small – between one and five prisoners. There is a handful of prisons with 20 or more older prisoners.
- Work for older prisoners is described as voluntary in nearly all prisons, and most older prisoners want to work. Educational programmes are pursued by only a small minority of prisoners.
- Rates of pay vary. Some prisons seem to have a single rate for every working prisoner; other prisons pay according to the job. If older prisoners work, they seem as a general rule to be paid at the same rates as younger prisoners. The only clear deviation from this rule occurs in one prison which tops up wages with a small prison pension. There is no evidence that they are paid less than younger prisoners.
- Most – but not all – prisons make some kind of regular payment to non-working prisoners as an equivalent of unemployment benefit or retirement pension (3/71 prisons with older prisoners made no payments to those who chose not to work). Payments vary between prisons. Some prisons clearly regard these payments as a kind of prison pension – which suggest that entitlement is based solely on age. Others see the payments as a form of unemployment benefit – and it is possible that medical certification is required in order to receive the payment.
- Eighty per cent of prisons with older prisoners housed them ‘on normal location’. In some prisons (14 per cent) the older prisoners had been placed on a ground floor location as a way of dealing with actual or potential mobility problems. A handful of prisons (n=6) housed some of their older prisoners in a healthcare facility.
- Regime concessions (apart from the relaxation of work requirements) are granted only in a minority (23 per cent) of prisons. It is not clear to what extent this is a matter of general prison policy or is based on assessments of individual prisoners. Concessions included less strenuous exercise classes, delivery of meals to cell, free association with other prisoners after roll call (if not working), availability of TV in cell (if not working), availability of ‘light work’, baths in the healthcare unit and “recognition of mobility constraints”. Some prisons stated that they would not grant concessions on the basis of age alone (rather than ill-health or disability). Whether or not there are any prisons which do have a policy of age-based concessions is not known.
- Two thirds of prisons with older prisoners reported that all their older prisoners
were mobile and could climb stairs/get to areas of activity and needed no regular help
with activities of daily living. Seven prisons had at least one older prisoners who
needed regular help (though in some cases this was only help with mobility). Where
help was required it might be provided by staff from the healthcare centre or other
inmates.

- Just under one half of prisons with older prisoners stated that at least one of them
  had special needs for equipment or treatment.
- It is not easy to get a clear picture of policies and provision for older prisoners with
  special needs as a result of chronic illness or disability. A few prisons say that they
  would not accept prisoners who needed regular help. Others say that prisoners with
  relatively high levels of need would have to be permanently housed in health care
  facilities. There is clearly concern about the ability of health care facilities to cope
  with the needs of older people with chronic disabling disease – and concern also
  about the access problems that arise for disabled older people in old-style prison
  accommodation.