OCCASIONAL PAPER

The Penitentiary visit—a new role for geriatricians?

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Abstract

The number of older prisoners is increasing and, with reforms in the prison health service, there is a requirement to provide equity of access to standard healthcare services. The health of older prisoners is often poor, with high levels of psychiatric and physical illnesses, compounded by poor access to appropriate rehabilitation and resettlement services. A recent case presenting to our department highlighted these deficits and illustrated how specialist input from a geriatrician could be useful to older prisoners (see Appendix 1, available at www.ageing.oxfordjournals.org). We propose that regular penitentiary visits may be an important new role for geriatricians at a supra-regional level.

Keywords: Prison, stroke, geriatrician, older prisoner, elderly

Introduction

Geriatricians have infrequent contact with the prison system, although this is likely to change with changes in prison demographics, changes in prison medical services and increasing recognition of medical problems in older prisoners. A recent case presenting to our department highlighted many of the issues that affect older prisoners and clarified that input from a geriatrician could be useful. (see Appendix 1 available at www.ageing.oxfordjournals.org)

The older prisoner population

Older people are more often portrayed as victims rather than perpetrators of crime and are known to make up only a small proportion of those involved in criminal activity. Nevertheless, the number of older prison inmates in the United Kingdom is increasing. From 1992 to 2002, prisoners aged 50 and above almost doubled, from 1,538 to 2,955, and the number of prisoners aged above 60 tripled, from 454 to 1,376, while the actual percentage of inmates older than 60 rose from 1.3 to 2.4% over the same period [1]. Trends are similar in the United States, where the number of prisoners aged 55 and above rose by 55% among males and 50% among females from 1996 to 1998. Prisons in the United States now hold 43,000 (4% of the total prison population) sentenced men over the age of 55 years, 2,834 of whom are older than 75 [2]. Factors that include ageing of ‘lifers’, a commitment to mandatory custodial sentences for serious offences irrespective of age, technology-aided retrospective prosecutions, particularly based on DNA evidence, and a general ageing of the population are all partly responsible for this trend. In addition, there is a genuine increased recognition of in older persons committing crimes.

Older prisoners, however, should not be looked upon as a homogenous group. The criminological concept of ‘punitive bifurcation’ results in a mix of those growing old as ‘inmates’ while serving long sentences and ‘new inmates’ imprisoned in the later years of their life, which may influence health status differently. Theft and handling of stolen goods (31%) and sexual offences (21%) are the commonest reasons for custodial sentences in older offenders, although violence is not uncommon. There are also some unexpected modern trends, including drug trafficking by older females [3]. Why people actually commit crimes in their later years is a matter of research; it may partly relate to loss of esteem and social milieu, poverty due to lack of income on retirement, or a presumption of leniency if caught, so called ‘ageist courtesy’. There are also many reported incidents of dementia and affective psychosis among select groups of older prisoners who are referred for psychiatric review [4].
The health of older prisoners

Prisoners aged 55 and above are often considered ‘older’ for the purposes of healthcare management. Reports of ‘accelerated biological ageing’ of inmates are well documented; this is reflected by the high prevalence of health problems that are more common in those ten years their senior in the community [5–7]. This, combined with the general ageing of the prison population, poses great challenges in terms of health, social care, rehabilitation and resettlement.

Psychiatric illness is the most commonly recorded major illness in older prisoners and a prevalence of 45% has been reported, which is almost twice the rate recorded among younger men. The occurrence of depressive illnesses is three times higher than in younger inmates or those of similar age in the community [6]. Older prisoners also have a higher incidence of physical illnesses, with the reported frequency of cardiovascular (35%), musculoskeletal (24%) and respiratory (15%) illnesses being higher than that in a similar age-matched population in the community [7]. In addition, though most older prisoners are on medication, there is some evidence that this may not meet their actual requirements and that many cases of psychiatric illnesses are left untreated [8].

In April 2000, the health strategy of prisons was changed from a ‘stand alone’ system to joint responsibility between the NHS and the Prison Health Policy Unit, making the assessment of the healthcare needs of older prisoners a joint responsibility of the two agencies, and in theory, at least, the National Service Framework would apply. This reform has created many challenges for prisons and primary care trusts (PCTs), with high levels of undetected and under-recognised health problems, inequalities in healthcare and access due to poor prison environment and infrastructure and a lack of vocational training and rehabilitation programmes for older prisoners. In one study of 203 prisoners older than 60 years, 10% were, to some degree, functionally disabled in activities of daily living, most of whom were unable to climb stairs [7]. Some prisons have recognised this emerging predicament of aged prisoners and ‘older prisoner units’ are being created.

Little is currently known about the health needs of older prisoners, particularly because morbidity in older prisoners cannot be compared to estimates of morbidity in younger inmates or in community-based older people. Ideally, there is a requirement for providing appropriate care equal to the care available in the community, but this need not necessarily mean admission to healthcare centres, which is often problematic and expensive for the prison service. A penitentiary visit by geriatricians could be an important step for ‘bridging this gap’ in the standards of care. Advocacy for the provision of a similar specialist service in forensic old age psychiatry at a supra-regional level has been made elsewhere [9]. While the overall number of older prisoners is small, the number is growing steadily and they are likely to have significant healthcare needs in the areas of mental health, cardiovascular risk and chronic illness management.

A regional liaison service to existing jails could provide a comprehensive health assessment for older prisoners, including modification of risk factors, assessment of mental health, cognition and capacity, evaluation of older inmates’ life inside with an opportunity to provide advice regarding activities of daily living, aids and adaptations. Prison medical and nursing staff also need ongoing support, training and education with regard to managing older prisoners. The importance of such education in understanding the social needs, life cycle roles and age related changes of older prisoners has been recognised and discussed elsewhere [10].

In addition, many prison pharmacy formularies are in need of updation. Furthermore, views of geriatricians may be helpful for considering the downgrading of prisoners who are too ill to be of any threat or harm. Thus, they can contribute to a structured process of judgement in decisions regarding whether a hospital transfer, compassionate release or a review of prison resuscitation (mandatory by law at present) would be appropriate in cases of terminal illness. Sir David Ramsbotham, former chief inspector of prisons, previously noted ‘when I discover an 87-year-old on a zimmer frame with Alzheimer’s in a high-security prison, I’m sorry, but I think that is a nonsense’ (Her Majesty’s Chief Inspector of Prisons ‘Report on a fully announced inspection on HM Prison Kingston: 12–16 February 2001).

Up to 56% of older male remand prisoners and 47% of older female remand prisoners are homeless [11]. Lack of family and community links (owing to length of sentence or estrangement due to the nature of crimes committed) in ageing prisoners is likely to result in similar rates, and this, together with institutionalisation and reluctance to leave the prison environment, is a challenge for resettlement. Healthcare issues, including functional ability, cognitive decline, medical and psychiatric needs, are also likely to dictate a range of different housing needs and merits multidisciplinary planning. Additionally, the nature of crimes committed by the individual and the risk of re-offending have to be considered. Preparing older prisoners for release and ‘rehabilitation’ is often a neglected and poorly planned process (Wentworth-James S. Personal communication at Ageing, Crime and Society Conference, London, March 2004), making their re-integration into mainstream society a potentially daunting task on release and more likely to fail, as the case reported by us has illustrated. Suicide rates are high among recently released older prisoners [12] and appropriate preparation, planning, re-integration and follow up after release may impact on this burden.

The number of older prisoners has increased and there is a requirement to provide them equity in access to healthcare and rehabilitation. Providing integrated specialist geriatric medicine and psychogeriatric services has a number of potential benefits. A liaison ‘penitentiary visit’ service may be a useful investment for the prison medical service and PCTs that have large prisons in their catchment area. This is a new challenge for geriatric medicine and training and requires a focused response.
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Key points
• The number of older people in prisons is increasing, and this trend is set to continue.
• Older people in prisons exhibit ‘accelerated ageing’, and have high levels of psychiatric and physical morbidities that are often undetected or inadequately treated.
• The Prison Health Service is now an integral part of the NHS and older prisoners are entitled to the same standards of care. There is a need for integrated geriatric medicine and forensic psychogeriatric services for older prisoners.
• Geriatricians may have an important role in assessing older prisoner’s health needs and educating prison medical and nursing staff. This will require focus and training.
• A penitentiary visit should become part of geriatric medicine at a supra-regional level, at least where such visits are needed.

Conflicts of interest

There are no conflicts of interest to declare.

References

Received 19 July 2005; accepted in revised form 24 October 2006