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The impact of the custodial setting on the mental health of older prisoners:

a biopsychosocial perspective

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Introduction

Much literature and research exists around the issue of mental health within the prison setting. It is an accepted fact that incidences of mental health problems, personality problems and drug and alcohol use are substantially higher within the prison walls than in the community which lies outwith them[1]. However, little acknowledgement is made of the variety of sub-groups within the prison population and the particular effects that imprisonment has on their mental health. One such group is older prisoners.

This paper will highlight those biopsychosocial factors which impact on the mental health of older male prisoners in particular. Considering this issue from a biopsychosocial perspective also raises opportunities within such a framework to promote positive mental wellbeing amongst this group of prisoners.

The Elderly Prison Population

For the purposes of this paper, older prisoners shall be taken to refer to those members of the prison population who are aged 50 and over. There is some disparity within the literature as to what constitutes an 'older' prisoner. However, in terms of the prison population, those over the age of 50 are relatively elderly in comparison with the overwhelming majority of younger prisoners[2].

A search of the literature has shown that surprisingly little is written about this group of prisoners and their unique needs, and that no local or nationwide policy exists that relates to any mandatory requirement to meet these needs within the prison environment. This is the case despite the fact that since 2004, the Disability Discrimination Act (DDA) has applied within prisons[(2)], and has obvious repercussions for the treatment and management of elderly prisoners who may be less mobile or able than the general prison population.

The DDA carries the requirement that all public authorities will proactively promote equal opportunities for disabled people, eliminate discrimination, actively encourage participation in public life of disabled people, and to account for individual's disabilities – including positive discrimination if necessary[3].

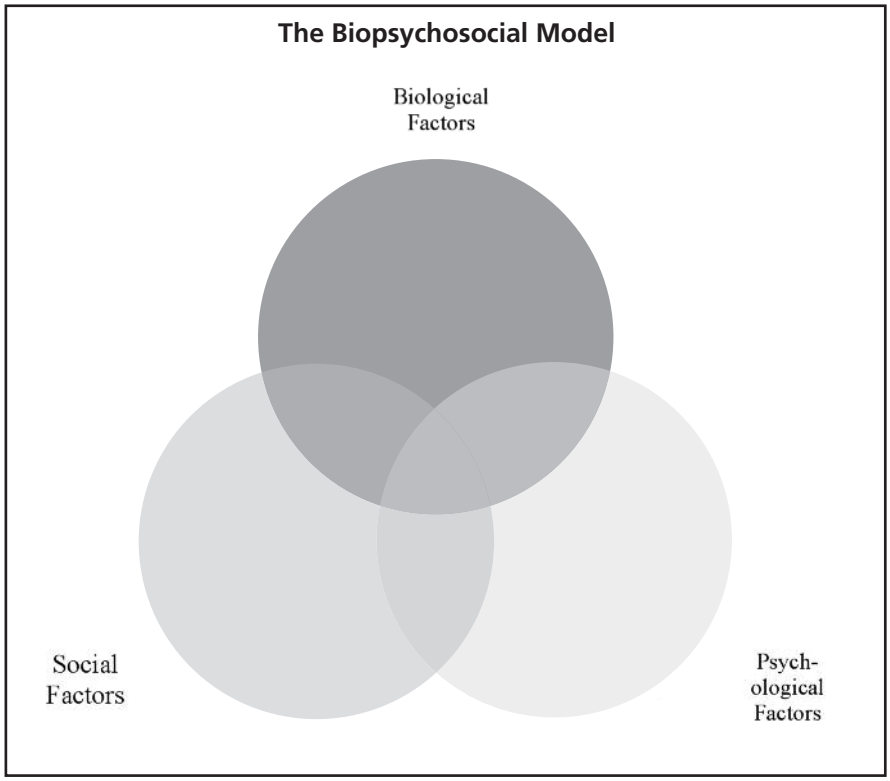
The application of such legislation within the prison setting is challenging. As we shall explore, the regimen is often rigid and inflexible, allowing little leeway for allowances to be made in order to accommodate such stipulations.

No Problems: Old and Quiet

This is the title of a thematic review produced in 2004 by HM Inspectorate of Prisons[4] which aimed to look at the specific issues, including the mental health, of older prisoners in England and Wales. The report highlighted the specific needs of the 1700 older prisoners in the system at that time as a neglected area, with specific areas of good practice being few and far between. Major problems for older prisoners were highlighted in the areas of the physical environment of the prison, limitations and restrictions created by the regimen, appropriate assessment of health and social care needs and preparation for release and resettlement.

Of the 83 000 people incarcerated within England and Wales in 2009[5], 7358 were aged 50 and over, and 518 were aged 70 and over. This represents around 9 per cent of the total prison population and the number is continuing to increase. In actual fact older prisoners are the fastest growing group within the prison population[6]. This statistic reflects both a large number of prisoners convicted of lengthy sentences who are growing old within the prison walls, as well as a number of prisoners convicted (often of sexual offences) later in life and who may reasonably expect to

1. Singleton N, Meltzer H, Gatward R, Coid J, Deasy D. (1997). *Psychiatric Morbidity Among Prisoners.* ONS; London.
2. Kakoullis A, Le Mesurier N, Kingston P. (2010). The Mental Health of Older Prisoners. *International Psychogeriatrics;* 22, 5, pp693-701.
3. Disability Rights Commission. (2006). *Statutory Code of Practice for England and Wales on the New Disability Discrimination Act 2005*.
4. HMIP. (2004). *No Problems – Old and Quiet: Older Prisoners in England and Wales*. HMIP; London.
5. MoJ. (2009).
6. Prison Reform Trust. (2010). *Doing Time: Good Practice with Older People in Prison – the Views of Prison Staff*. Prison Reform Trust; London; ISBN: 0946209944.



end their lives in prison. The latter may well have committed their crimes earlier in life, and have been convicted now, years or decades later[7].

The Biopsychosocial Approach

Based on the work of George Engel[8], this framework for looking at the health and mental health of individuals can also provide us with a means of examining those custodial factors which may impact either positively or negatively upon the mental health of older prisoners.

In investigating the primary mental health of older male prisoners, it is appropriate therefore to frame this within the parameters of biological factors, psychological factors and social factors. Only by taking account of the interconnectedness of these factors on the wellbeing of the person as a whole can we hope to gain a truly holistic understanding of the issues which affect the mental health of this prisoner group.

Biological Factors — Physical Health and Wellbeing in Custody and Beyond

Standard one of the National Service Framework for older people[9] (a set of standards set out by the Department of Health to provide clear quality standards in health and social care) states that *'NHS services will be provided, regardless of age, on the basis of clinical need alone.'* This has obvious implications for elderly people in the prison setting for who issues of both provision and access might stand in the way of them receiving the healthcare interventions they require. Furthermore, standard two of the same document advocates the individual being able to make choices about the care they are receiving. Again, within the prison walls, choice may be very limited or even non-existent.

Older prisoners with physical health problems may find that there are significant difficulties in accessing facilities within the prison. The Prison Reform Trust's paper *Doing Time*[10] highlights that of the 92 prisons they sampled in England, two had no access to the healthcare department. This has obvious implications for the ability for healthcare needs to be assessed and met in a timely and equitable manner.

Nacro and the Department of Health[11] rightly point out that *'growing older is inevitable, but being in poor health as one grows older is not'*. However, some studies[12] suggest that there is a direct correlation between coming into custody and deterioration in physical health.

7. Kakoullis, Le Mesurier, Kingston (2010) see n.2.
8. ngel GL. (1977). The Need for a New Medical Model: A Challenge for Biomedicine. *Science*. 196; 4286; pp129-136.
9. DoH. (2001). *National Service Framework for Older People*. DoH; London.
10. See n.6.
11. NACRO, DoH. (2009). *A Resource Pack for Working with Older Prisoners*. NACRO; London.
12. Colsher PL, Wallace RB, Loeffelholz PL, Sales M. (1992). Health status of older male prisoners: A comprehensive survey. *American Journal of Public Health*. 82; 6; pp881-84 and Aday RH. (1994). Aging in prison: A case study of new elderly offenders. *International Journal of Offender Therapy and Comparative Criminology*. 38; 1; pp79-91.

There is evidence that the physical health of older prisoners is worse than that of their counterparts outwith the prison walls. It has been suggested that the average older prisoner has the physical health and condition of someone ten years older than them in the community, giving the average 60 year old prisoner the same state of health as someone aged 70 in the community[13]. The relationship between poor physical health and poor mental health is well evidenced[14].

It can reasonably be expected that due to lack of choice and opportunity in terms of diet exercise and other lifestyle choices, the physical health of older inmates will deteriorate more rapidly than a younger person or someone of a similar age in the community, and this is likely to lead to decreased mental wellbeing or mental illness such as anxiety and depression.

Furthermore from a healthcare perspective arrangements around the provision of palliative care may be an important consideration in the treatment and management of those who will end their lives in the prison environment. In addition to this there is also an issue around the management of organic mental health problems such as dementia amongst an aging prison population, although exploration of this is beyond the limited scope of this work.

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It might be fair to draw the following conclusions. Firstly, there is a marked difference between the elderly prison population and the elderly general population in terms of physical health condition, namely that the elderly people in custody experience poorer physical health than their peers in the community.

Secondly, this factor raises issues for the delivery of healthcare interventions and treatments for the elderly in custody. Opportunities for timely treatment of physical healthcare needs and for health promotion activities are available in the prison setting and need to follow prisoners out into the community on release to enable a successful outcome in their resettlement[15]. However, as the HMIP report of 2008[16] states, often effective management and treatment of chronic physical health problems can be disrupted by prisoners being moved from one establishment to another.

Thirdly the issue of end of life treatment choices and palliative care options within the prison system warrants further exploration and debate.

Fourthly, deterioration in physical health is very likely to have implications for the emotional and mental health and wellbeing of this population group within the prison setting. It is this which this author will now attempt to explore further.

Psychological Factors — Psychiatric Morbidity, Suicidality and Risk

The HMIP Thematic Review of 2008(14) highlights a lack of training amongst staff to spot the signs of mental health difficulties amongst older prisoners, and cites this as an area of concern *'especially in light of the elevated levels of depression among the older age group'*. It goes on to point out that *'of those with mental health problems, 78 per cent were experiencing depression, or reactive depression as a result of imprisonment'*.

The report suggests that the NSF standards for the care of older people are not uniformly implemented within the prison system, with only pockets of good practice being identified. This may be due to the lack of a national prison service policy or protocol on the treatment of mental health problems in older prisoners. The report goes on to highlight the gap that exists within prisons in the treatment of mild to moderate primary mental health problems due to the role and criteria of Mental Health Inreach Teams (MHIT) to treat severe and enduring mental health problems[17]. However, this report dates from 2008, and this author would suggest from practical experience, that this gap is rapidly closing.

Standard seven of the NSF for older people clearly states that *'older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and*

13. Kakoullis, Le Mesurier, Kingston (2010) see n.2.
14. CSIP. (2006). *Improving Primary Care Mental Health Services: A Practical Guide*. DoH; London.
15. Crawley E. (2004). *Release and resettlement: the perspectives of older prisoners. CJM.* 56; summer 2004; pp32-33.
16. HMIP. (2008). *Older Prisoners in England and Wales: A Follow-up to the 2004 Thematic Review by HM Chief Inspector of Prisons*. HMIP; London.
17. DoH/HMPS. (2001ii). *Changing the Outlook: A strategy for developing and modernising mental health services in prisons*. London; Department of Health & HM Prison Service.

their carers.'[18] It points to the fact that mental health problems in the elderly population commonly go undetected, or are simply attributed to the natural ageing process and are untreatable. The document highlights three key interventions, namely the promotion of mental health, early recognition and management of mental health problems and access to specialist care. HMIP[19] reports very little indication that any of these guidelines are being applied in a widespread and consistent manner across the prison estate.

It is far more likely for older prisoners to suffer from depression than any severe or enduring mental health problem, or drug-related problem[20]. It is clear from this fact, and those presented above, that primary mental health care plays a central role in meeting the health and social care needs of this particular prisoner group.

Social Factors — Isolation, Social Exclusion and Reduced Social Capital:

On entering prison in later life, many people are leaving behind families, jobs, friends and hobbies, often with little prospect of ever returning to them, and due to the mobility of the prison population may be held in prisons far away from home, reducing the likelihood of continuity of important and significant relationships and support networks. This has implications in terms of adjustment, affect, anxiety, stress, social isolation and suicidality.

The Department of Health's *A Pathway to Care for Older Offenders*[21] raises a number of key questions and recommendations relating to the NSF for Older People standard two. It indicates the frequent lack of compatibility between the prison regimen and the health and social needs of older prisoners. The often rigid and inflexible nature of the prison regimen and the negative impact this can have on older prisoners is described in detail elsewhere[22].

The document highlights three key interventions, namely the promotion of mental health, early recognition and management of mental health problems and access to specialist care.

The prison environment itself is likely to have an impact on the mental health and wellbeing of older prisoners. An HMCIP report made in 2004[(4)] states that *'Prisons are, in the main, built for young, able-bodied prisoners'*, with very few prisons having purpose-built or specially adapted facilities for elderly or disabled prisoners. Similarly the regimen within prisons tends to be biased towards younger men of working age and good physical health.

A combination of inaccessibility within the fabric of the environment and the restrictions, limitations and inflexibility of the regimen contribute to what Crawley[23] describes as 'institutional thoughtlessness.' An example to highlight what this means in reality might be that older prisoners may have to negotiate stairs to access medication, meals or educational and work opportunities. It may also mean that older prisoners find it hard to utilise facilities within the wing setting such as showers, either because they cannot reach them or because they are intimidated or put off by younger, more boisterous inmates accessing them at the same time. Exercise periods might become impossible for older prisoners to manage due to lack of access to toilet facilities or seating in the exercise yard, and the fact that they are unable to re-enter the building for the duration of the exercise period (usually one hour).

It is clear then that institutional thoughtlessness can have a significant impact on the mental health and wellbeing of older prisoners, contributing to low mood, stress and anxiety.

By its nature and purpose, prison is an excluding experience[24]. Statistics show that many elderly prisoners have been convicted late in life for an offence committed years or even decades earlier, and find themselves entering custody for the first time at this late stage in their lives[25]. This has been described as 'prison shock.'[26] It describes the experience of older

18. DoH. (2001) see n.9.
19. See n.16.
20. Le Mesurier N, Kingston P, Heath L, Wardle S. (2010). *A Critical Analysis of the Mental Health of Older Prisoners: Final Report*. Centre for Age and Ageing, South Staffs NHS PCT, Staffs University.
21. DoH. (2007). *A pathway to care for older offenders: A toolkit for good practice*. DoH; London.
22. Crawley E. (2005). Institutional thoughtlessness in prisons and its impacts on the day-to-day prison lives of elderly men. *Journal of Contemporary Criminal Justice*. 21; 4; pp350-63 and Crawley E, Sparks R. (2005). Hidden Injuries? Researching the experiences of older men in English prisons. *The Howard Journal*. 44; 4; pp345-56.
23. Ibid.
24. Caie J. (2011). Social inclusion and the prison population. *Mental Health Practice*. 14; 6; pp24-27.
25. Prison Reform Trust. (2003). *Growing Old in Prison: A Scoping Survey on Older Prisoners*. Prison Reform Trust.
26. Aday (1994) see n.12.

prisoners as they try to come to terms not just with the prison environment, but also with their crimes, and points to *'depression, guilt and psychological stress'* as being prevalent in this study group.

It might be argued that one of the characteristics of the prison population is its transient nature. As well as endangering family and existing social ties on entering custody, the older person becomes part of a system where they and others are moved from one establishment to another on a reasonably regular basis.

Friendships and ties formed in one prison are likely to be short-lived as people move on or are released. On top of this comes the fact that amongst the older prison population, as is the case outside prison, death is a natural variant in the changing and shifting of social networks.

Social networks are then unstable and temporary within the prison walls. This author is not aware of any studies in existence which look at the likely impact that this would have on the emotional and mental wellbeing of older prisoners, however based on what this review has already discussed, it might be a fair assumption that it would be highly unsettling and unhelpful.

A Sure Start to Later Life, a document produced jointly by the Department of Health, the Department of Work and Pensions and the Social Exclusion Unit[27] states that *'Many older people find it very difficult to access intermediate care services as they do not have an appropriate discharge address'*. It goes on to highlight the fact that *'older homeless people are likely to have a greater need for care than younger people.'*

Clearly there is a link between entering prison and a worsening of physical health complaints. Often on admission to custody older males are already experiencing poor physical health and the conditions within prison worsen this.

Biopsychosocial Opportunities

In summary, the review of the literature has showed the interconnectedness of biological, psychological and social factors in the onset or worsening of primary mental health problems amongst older male prisoners.

Clearly there is a link between entering prison and a worsening of physical health complaints. Often on admission to custody older males are already experiencing poor physical health and the conditions within prison worsen this. This however provides an opportunity for commissioners and providers of prison healthcare to offer both health promotion activities and to effectively diagnose and treat physical health problems which the individual are in essence a 'captive audience'. There are also opportunities arising to ensure that the interfaces between prison and community healthcare provision and between healthcare departments of individual

prison establishments is smooth, atuned to the needs of the individuals accessing it and equitable in order to provide continuity of care and treatment.

Psychologically, the research has shown that the standards set out under the NSF for older people are not uniformly met within the prison service, and that there is a lack of access to specialist services. In addition, diagnosis and risk assessment are not always accurately carried out in a timely manner. This again highlights an opportunity for prison health services to improve and develop specialist services for older people within the prison setting and to effectively diagnose, treat and monitor the mental health of older people.

Difficulties arising out of the social aspect of the biopsychosocial model are harder to address in custody, but their impact on older people in prison is easy to see.

There are compelling arguments for the timely and effective treatment of physical and mental health problems amongst the elderly prison population, not least of all financial considerations. Whilst no accurate figures are available for the treatment of older people within the UK prison system, data from the United States suggests that medical costs associated with older prisoners are around three times higher than those of their younger counterparts[28].

There are clearly a number of effective biopsychosocial interventions ranging from work and education to exercise, access to psychological interventions and medication which could be utilised to

27. Social Exclusion Unit. (2006). *A Sure Start to Later Life: Ending Inequalities for Older People*. Office of the Deputy Prime Minister; London.
28. Wahidin A, Aday R. (2005). The Needs of Older Men and Women in the Criminal Justice System: An International Perspective. *Prison Service Journal*. 160; pp13-22.

a greater extent within the prison environment. This too provides both prison managers and healthcare commissioners with an opportunity to look at flexible, cost-effective and creative ways of improving the treatment choices available to older people in prisons.

The introduction of the Improving Access to Psychological Therapies (IAPT) programme in 2006[29] brought about a shift in the healthcare economy. With the aim of reducing the benefits bill and getting people back to work, IAPT is widely available in communities across the UK. It is not so widely available within prison communities however, and must surely be considered as a means of reducing spending on healthcare within prisons, as well as a means of empowering elderly prisoners to engage in some kind of meaningful occupation and activity which will improve their quality of life.

Practice, Policy and Research Implications

Surprisingly, and perhaps shockingly, there is no national policy within the Prison Service as to how elderly prisoners should be treated and dealt with. This appears to have led to inconsistency in approach and in the provision of facilities and appropriate regimen across prisons in England and Wales. Effectively this author sees this as meaning something of a 'postcode lottery' for older prisoners, and can surely only lead to an unsettling experience, the effects of which may lead to the onset of mental health problems as well as inconsistent treatment and exacerbation of existing physical and mental health difficulties. Without such a policy it is doubtful as to whether both the prisons and their healthcare commissioners and providers will be able to grasp the opportunities highlighted in the section above.

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Further research into the experience of older prisoners and the treatment of their mental health needs may raise the profile of this group and spur the prison service on to provide a policy which will ensure consistency, consideration and fair treatment of the elderly prison population. Such research will surely also be of significant value to healthcare professionals responsible for the provision of care and support to older prisoners, and may also highlight the need for NHS Trusts to ensure the input of specialist practitioners to work with this client group.

There is a clear need for staff within the prison walls to receive training so that they can be aware of the problems and distress caused to older prisoners by a fixed and rigid application of the standard regimen. Staff working within the prison service also need to find a way of ensuring that the prison population is not viewed homogenously, but as a diverse group. Whilst this is perhaps beginning to happen in the case of ethnic, cultural and religious groups, the issue of older age as a separate group under the diversity banner is perhaps not so readily recognised. Again, a specific policy would help to bring this to the fore and identify the elderly as a specialist group within the population.

In the face of the evidence, it can be argued that such an overarching policy ought to include guidance to staff on the nature of the difficulties likely to be experienced by older prisoners, and the impact these factors may have on their mental health and ability to cope with their incarceration.

Training on mental health and the management of challenging behaviour already exists, and is in actual fact mandatory for staff working in some areas of the prison estate such as in Discrete Units (Segregation Units, Category A units, Closed Supervision Centres etc) where prisoners held present with complex, dangerous and challenging behaviours and difficulties[30]. However this mandatory training need has not been identified, and does not extend to other groups of prisoners with unique needs, such as older prisoners. It could be argued that as a prisoner group with unique and often complex biopsychosocial needs, specialist training should also be available to, and mandatory for, prison staff working with older prisoners in order to better understand and meet the needs which these prisoners have.

A national policy could also allow for flexibility in the regimen which establishments could tailor to their own needs, or preferably recommend a completely separate regimen, perhaps in separate accommodation, for the elderly population of the prison. Such a policy should take into account the different needs of elderly prisoners, such as the need for meaningful occupation and activity after retirement age; the longer length of

29. Layard R. (2006). *The Depression Report: A New Deal for Depression and Anxiety Disorders*. London; London School of Economics and Political Science, Centre for Economic Performance.
30. Wellbeing Strategy. (2011). *Working With Challenging Behaviour Training*. High Security Prisons Group; HMPS

time which older people may need in order to carry out their daily living activities; the need for more integrated working between prison staff and healthcare and mental health staff; and the accessibility of the accommodation and other facilities provided. In addition to these more abstract needs should be addressed in policy. Needs such as the rights of the elderly to feel safe on the wing and not to be intimidated and bullied by younger prisoners, and the need for dignity and at times privacy, which the main regimen seldom affords.

Some establishments such as HMP Wymott offers facilities especially for the over 50s within its population which is run according to the NSF for the Elderly, and on a biopsychosocial model[31]. Other prisons such as HMP Gartree and HMP Hull have strong links with Age Concern in order to provide advocacy and support to elderly prisoners[32].

Pockets of good practice therefore do exist, and the intentions behind setting such projects up are positive and beneficial to the elderly prisoners housed at these establishments. However, for those elderly prisoners not fortunate enough to be housed at one of these prisons, or who have been and have subsequently moved to another establishment where their needs are not so robustly met, there is still much room for development and improvement. We have seen in this paper the impact which incarceration can potentially have on the mental health of elderly prisoners, and it is surely within the power of the prison service to introduce national measures to benefit this group both from the perspectives of their physical and mental health.

As such this must represent some financial benefit in terms of preventing the onset of chronic conditions and the treatment costs associated with these. Prevention is surely better than cure, both in terms of individual quality of life and in financial implications.

Conclusions

The prevention and treatment of primary mental health problems in older male prisoners, is a subject worthy of further investigation and investment. We have seen that the elderly are the fastest growing group within the prison population, and as such there is a need for both researchers and clinicians to address this growing issue within the walls of our prison establishments.

There is a clear need for further research to be carried out in this area to examine the effectiveness of a variety of biopsychosocial interventions in the care and treatment of primary mental health problems in the elderly prison population. The effectiveness of such interventions has been studied within the general elderly population. However this author would suggest that the prison environment is quite alien to the community setting, and presents those elderly people living within it with a different set of challenges and obstacles in having their needs accurately identified and treated. In addition, the day to day difficulties of living in such a setting, and being party to a restrictive regimen, may call for a more innovative approach to the provision of mental healthcare, and further research may assist in informing practitioners in how best to deliver interventions of an equally high standard as those delivered in community settings. In this instance, equity does not perhaps mean equivalence in terms of what is delivered and how, but rather equivalence in terms of outcome, accessibility and acceptability.

In short, further research and investigation is required in order to ensure that the elderly in prison do not become a forgotten group, but that their voices are heard and their mental healthcare needs are effectively met. This will require not only research and study, but a concerted will from both the prison service and healthcare providers to improve how health and social care services are delivered to older prisoners. This finds us standing on the edge of not only a huge challenge but also a great opportunity. It is entirely possible to ensure specialist training to staff, timely detection and treatment of physical and mental health problems, and creative and effective biopsychosocial interventions to older people with primary mental health needs in prisons. Only then can we positively say that older people in prison are 'no problems, old and quiet'.

31. Fry D, Howe D. (2010). Managing Older Prisoners at HMP Wymott. *Prison Service Journal*.
32. Evans C. (2010). Age Concern Leicestershire and Rutland — HMP Gartree Older Prisoners Advocacy and Support Project. *Prison Service Journal*.