

Commentary: Older Offenders—No Place to Go?

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For offender groups, difficulties in definition of 'elderly' and 'older' are considerable. Adoption of chronological age cutoffs gives little indication of service need. Contrary to popular belief, there has been no upsurge of offending among people of 60 and over, but there has been an increase in their representation in the prison population. Older prisoners tend to have more mental and physical health care needs than younger prisoners and than their similarly aged peers in the community. Their needs may be more appropriately met in health care rather than criminal justice services. Neither health care nor criminal justice services, however, have yet made adequate specific provision for this group. Our commentary reviews current evidence for more appropriate and safer service responses.

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Who are the violent “elderly”? What defines a “geriatric forensic evaluatee”? Lewis and colleagues¹ include people of 60 years and over in that “age category beyond maturity,” but later point out that other researchers have considered age 45 as elderly for offenders. We first became supersensitive to the choice of adjective in this field when a research ethics committee, median age perhaps nearing 55, required a new title for our research proposal to study people of 60 and over as “elderly offenders,” on grounds that some might find the title demeaning. Political correctness aside, there is a value judgment in the term “elderly.” Simple description is perhaps best covered by a dispassionate reference to the age in years in the title, but chronological age *per se* may offer little guidance when people are first encountered by professionals. Use of terms such as older and elderly imply hypotheses about differences from younger offenders, about frailty or other special needs or perhaps about gaps in service.

Pioneering papers² referred to this group as being unjustly overlooked and even went so far as to suggest that subjective judgment underpinned the neglect: “Old criminals offer an ugly picture and it

seems as if even scientists do not like to look at it for any considerable amount of time” (Ref. 2, p 213).

In the 1970s, except for a few isolated papers in the psychiatric literature, the main advances came from several qualitative studies performed mainly in the U.S. prison system and informed by gerontological or criminological perspectives. The key finding that emerged was that older prisoners, generally, though not always, preferred being in special units away from the noise and aggression of younger inmates.³ Small-scale studies of referrals to forensic psychiatric services in the United States,^{4–6} United Kingdom,⁷ and Israel,^{8,9} were published, and one of us identified an older subgroup in a survey of pretrial men in one large U.K. prison,¹⁰ using standardized diagnostic instruments for assessment. Fazel and colleagues¹¹ conducted a similar, systematic study of sentenced prisoners over the age of 59, but from 15 prisons in England and Wales. At around the same time, there were calls for greater collaboration between forensic and old age psychiatrists in the United Kingdom, and specialist low- and medium-security psychiatric inpatient services for older men were established.¹²

Increasing Numbers

Alarmist media headlines refer to soaring rates of “senile delinquency,”¹³ as the balance of populations in developing countries shifts toward older age bands. In fact, statistical data both in the United

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Kingdom and United States show the number of convictions of people over the age of 60 have been remarkably stable over the past 10 years.^{14,15} The number of older people within the prison system has risen sharply, however. In the United States, the number of older inmates in state and federal prisons tripled between 1990 and 2001, and their proportion in the total prison population doubled (from 4.0% to 8.2%).³ In England and Wales, there were 365 sentenced prisoners aged 60 and over in 1990.¹⁶ By 2002, the number sentenced had almost quadrupled to 1,359, with older prisoners making up 2.6 percent of the total prison population in the United Kingdom. Of these, 80 percent were serving sentences of longer than 4 years and around 20 percent were serving life sentences.¹⁷ These increases may have been because of a change in the way older offenders were dealt with by the courts. There is evidence to suggest that, in the past, the elderly were treated with a degree of leniency at all stages of the criminal justice process, and older people were able to plea bargain substantially smaller sentences than younger offenders.¹⁸ Indeed, in Imperial China, the emperor's amnesty could even excuse capital crimes for the oldest of the old.¹⁹ In 1967 Whiskin²⁰ described the elderly sex offender as "the most benign and impotent of individuals" and concluded his paper with a paragraph explaining how the child victims were not always the innocent parties. Our understanding of child sex abuse has moved on since then and, in some U.S. states at least, there is evidence that the elderly are now dealt with more harshly than younger offenders for certain offenses.^{21,22} The biggest reason for the graying of the prisons in the United States, however, is almost certainly the changes in mandatory sentencing practice. "Three strikes and you're out" sentences were introduced in Washington in 1993 and in 1995 in South Carolina, where the study by Lewis *et al.*,¹ in this edition of *The Journal*, was conducted. They do not say whether this made any difference in the referral rate over time (1991–1998) in their large sample of individuals over 60, from the whole of South Carolina.

Prisoners' Rights

With the increase in the number of older prisoners came the development of special units for them. In the 1970s, the U.S. correctional system started to

develop specialist units for elderly infirm inmates, and by the end of the century there were over 15 such units in 13 different states.²³ By 2002, over half of the U.S. states had introduced age-segregated accommodation for older inmates, many adopting the age of 40 as the cutoff for defining an older prisoner.³ Units for older prisoners are more expensive to run, however. Despite the cost savings of having fewer security and disciplinary incidents, the costs of providing health care are much higher, estimated at over three times as much for an inmate over 60 compared with a typical adult inmate.²⁴ The Estelle ruling in 1976, which placed a duty on prison authorities to meet the health care needs of prisoners, means that health care costs are likely to remain high. Several studies, reviewed by Rubinstein,²⁵ describe the benefits to the prison system of having well-behaved older men mixed in with younger inmates, helping to maintain order and social control. Older inmates are seen by some prison authorities as being less prone to violate rules or to try to escape, thereby exerting a stabilizing or deflating force in the high-tension institutional environment where violence and riot are ever-present threats. It has been suggested that awareness of the importance of this stabilizing influence has discouraged some prison authorities from setting up age-segregated units for the elderly. In the United Kingdom, there are as yet no specialist units for older prisoners, although there have been small initiatives for frail and older-life sentenced prisoners within health care facilities at two prisons in England (Norwich and Portsmouth). The British view has generally been that those individuals with more complex physical and mental health needs are better looked after outside the prison system.

Health Care Needs

Most research on elderly offenders has drawn attention to the higher prevalence of physical ill health in this group. It is known that younger offender patients have worse health than age-matched control subjects. There is also evidence that such ill health continues into old age, with the elderly having more physical health problems than younger inmates and age-matched, community-living elders.²⁶ In their study, Lewis *et al.*¹ report some new and important findings in this area. First, they showed the importance of thorough neurological histories and examinations. There is now much secondary preventive treatment that can be offered to people with cerebro-

vascular disease and stroke. It is important, therefore, that older prisoners have access to primary- and secondary-care physicians who are familiar with the latest research and guidance on health promotion in this age group. Second, they showed that sexually transmitted disease is common among older prisoners. Clinicians unfamiliar with working with the elderly often assume that older people are sexually inactive, but a 1990s U.S. community survey, with a 79 percent cooperation rate, found that 45 percent of men between 80 and 84 years of age reported still having sex with a partner.²⁷ These findings were consistent with those in other studies of non-institutionalized men²⁸⁻³⁰ and a study of physically healthy men aged 80 to 102, living in residential retirement facilities.³¹

Mental Health Needs

A finding of a high prevalence of mental health problems is common ground in research with older patients referred for specialist forensic mental health assessments. In most of these studies, however, few cases of affective disorder were found, perhaps reflecting the way the study samples were selected, as in people identified by the court for psychiatric evaluation. Depression in elderly men can easily be missed, as elderly men tend not to complain of mood symptoms, even when asked, and often adopt a somewhat stoic demeanor in the face of life difficulties.³² In the study by Fazel *et al.*,¹¹ by contrast, affective disorders were the most common mental health problem. These authors estimated that as many as 50 older men in the U.K. prison system at any one time during the late 1990s were suffering from a depressive illness with psychotic symptoms severe enough to be in need of urgent transfer to a treatment center, but the number would be much higher in 2006. While many studies of older offenders identify cases of dementia, in a study of referrals to a regional medium secure unit in England it was found that forensic psychiatrists did not routinely use standardized rating scales for the assessment of cognitive functioning.⁷ It was suggested that mild cases of dementia may therefore not have been identified. It is also the case that individuals in the very early stages of dementia, especially frontotemporal dementia, are not easily identified by clinicians unfamiliar with diagnosing dementia, and it is possible that many cases are missed.

One problem in the past, particularly in the United Kingdom, was that it was very difficult for older patients to access specialist secure psychiatric services. Only one percent of those newly admitted

to high- and medium-security beds in England and Wales between 1988 and 1994 were over 60.³³ The conclusion drawn was that this was because people of such age were not regarded as suitable for existing U.K. forensic services, mainly because of concerns about their potential vulnerability to aggression from younger patients. The obverse of this conclusion, however, is that forensic mental health services were not able to meet the needs of older patients! Why did services develop without any specific provision to meet the needs of a significant section of society? In the past, there was a widely held view that the elderly were rarely responsible for violence other than an occasional kick on the shin or swing at a passer-by with a handbag. There is perhaps now something of a shift in the other direction, as research has consistently shown that people of 60 years of age or older do commit offenses that are no less serious than those of their younger counterparts. Lewis and colleagues¹ provide further evidence for this, with most of the 99 evaluatees in their series having been charged with serious offenses: 58 with serious violence, 18 with sex offenses, and 7 with arson. Although other studies of referrals of older patients to forensic mental health services have shown that, if anything, their offenses are more serious than those of their younger counterparts, it is important to be reminded that we still have only studies of highly selected populations. In a contrasting setting, a study of a special police project in one region in England in 1990³⁴ showed that of 367 consecutive referrals of those aged 60 or over, less than 10 percent were prosecuted. The remainder were cautioned if they admitted guilt or were subject to no further action. Nearly two-thirds of the arrests had been for shoplifting, in most cases of grocery items of small value. There were 15 arrests for violence, some minor, and 11 arrests for indecent assault. Police referred the arrestees to their primary care physician or to the police doctor more often than to any other agency. Only 50 arrestees had research interviews but nearly one-third of these were identified as "psychiatric cases."

Security Needs

Given that older people do occasionally commit the most serious of crimes, what do we know about their placement in secure hospitals? There have been several descriptive studies of the elderly in high security settings, but these mainly focused on diagnostic issues.³⁵⁻³⁸ In 2004, one of us (GY), in a study at

Broadmoor high-security hospital in England,³⁹ highlighted the heterogeneity of older mentally disordered offenders in terms of diagnosis, assessed needs, and expressed preferences. Despite the availability of a ward specifically for older vulnerable patients, the 16 patients over the age of 65 identified in the study were spread across nine different wards in the hospital. Lewis *et al.*¹ discuss “streamlining” older offenders, to make their care more cost effective, but if the findings of the Broadmoor study are replicated, then it would appear that streamlining will be very difficult. Older patients have some similarities because of their age, but the range of problems they present and their needs appear to be just as diverse as those of younger patients. It would be wrong to confine them together solely on grounds of chronological age. This important issue emerged in some of the earlier qualitative work in prisons, when it was found that not all older inmates wanted to be housed together. Some liked the hustle and bustle and felt they enjoyed a high status in mixed-age units because of their age and life experience.⁴⁰

Prevention

Lewis *et al.*¹ point out that the elderly, being less physically able, make greater use of firearms than younger violent offenders. Access to guns is much more restricted in the United Kingdom, yet older homicide offenders still manage to find weapons of sufficient lethality without too much difficulty. There has been no systematic research on older homicides in the United Kingdom, but a forensic pathologist, Knight,⁴¹ coined the term “Darby and Joan syndrome” for homicides committed by older men. These men are perceived by family and friends as being in a very close and loving relationship with their partners, but then suddenly, and often for no apparent reason, they kill, often with extreme brutality. In the United Kingdom the weapon of choice for such incidents is usually a blunt object; and, between us, we have seen homicides by men of 60 and over involving repeated blows to the head with a ceramic fruit bowl, a club hammer, a walking stick, a pair of long-handled garden loppers, a fence-post rammer, and an antique flat iron and decapitation with a saw. Restricting access to conventional weapons is unlikely to affect the rate of these domestic homicides because the victims are generally of similar age and may be quite frail, and almost any household implement can be made into a lethal weapon given suffi-

cient will and a little physical strength. One of us was involved in assessing a man who, in an extended suicide, had merely reached for the kitchen towel. A far better preventive strategy would be to focus efforts on delivering good-quality psychiatric care to all older people with mental health problems and on increasing the skills of primary care physicians for early identification of depression. Other priorities include persisting with efforts to help those with alcohol problems and routinely asking patients and caregivers about physical aggression and sexually inappropriate behavior.

Placement Problems

Care and treatment of mental health problems seem to go in cycles. It was long expected that families would generally care for their sick relatives at home, but then people with advanced dementia were admitted to psychiatric hospitals when their families could no longer look after them.⁴² Now, again, old age psychiatrists try to avoid admitting people with dementia to hospitals and most care is delivered at home or in residential and nursing homes. Care homes for older adults often cope with high levels of minor physical aggression and sexually disinhibited behavior.⁴³ However, they are not equipped to deal with more serious aggression or predatory sexual behavior. The understanding of risk factors and how to assess and manage them is often highly sophisticated for the common behavioral problems of dementia, but for behavior driven by antisocial personality traits it is usually lacking. The latter means there is a lack of suitable facilities for older offenders who have been assessed and require ongoing nursing care in an environment that is also able to manage their risky behavior. In the United Kingdom, specialist hospital units have been set up for those who require inpatient assessment and treatment, but a lack of suitable places for discharged patients once they have been stabilized, though not necessarily to a state where the risks they pose to others have been substantially reduced, means that many remain in the hospital for longer periods than would otherwise be necessary. Most offenders with established dementia will be unfit to plead or stand trial, and, if violence has been serious, will require further care and supervision in a hospital unit specially designed to meet their mental and physical health care needs with just sufficient security to ensure public protection. Good procedural and relational security are likely to be more

important than physical security measures for most older mentally disordered offenders. A range of facilities in both criminal justice and health services must be developed if older mentally disordered offenders are not to be stuck in inappropriate facilities with nowhere else to go.

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