

Behind bars: the challenge of an ageing prison population

Dementia in prison is an under-reported and quickly developing problem in correctional facilities around the world. As a result of mandatory prison sentences for offences and longer incarceration periods for inmates, a larger sector of the prison population is ageing behind bars and many have, or are developing, dementia. This article discusses the way in which dementia is treated and handled in prisons, and will address some of the ethical and moral questions surrounding this growing issue.

Research and literature on people with dementia in prisons

In 2010 there were 527 prisoners in Australia over the age of 65, a rise of 142 per cent since 2001. New South Wales (NSW) accounted for 161 of these older prisoners; there were 118 in Victoria and 109 in Queensland. There are 2799 prisoners in Australian jails who were between 50 and 64 in 2010. The past decade has seen the prison population of older Australians expand by approximately 84 per cent, with 11.2 per cent of all inmates being over 50 years of age (Australian Bureau of Statistics 2010). This figure is expected to increase over the next decade in line with the rest of Australia's ageing population.

While there is little literature on older prisoners and prisoners with dementia in Australia, international literature provides some clues as to what is likely to be happening in our prisons. 'Psychiatric morbidity in older prisoners: unrecognized and undertreated' (2011) by Kingston *et al* studied 120 older prisoners across four prisons in the UK and found that 15 per cent of the surveyed inmates showed signs of cognitive impairment, suggesting that there may be many as-yet unnoticed cases of dementia in prisons.

In 2011, an Australian Institute of Criminology study led by Ms Susan

James Baldwin is contributing editor of the AJDC. Jasmin Leete is a graduate criminologist based in Queensland. Contact Jasmin at jasmin.leete@griffithuni.edu.au

With the number of older people with dementia in correctional facilities surging, complex ethical, legal and medical issues have arisen. **James Baldwin** and **Jasmin Leete** discuss the challenges and solutions for people with dementia in Australian prisons



Nurses' station at Long Bay Hospital. The nurses work inside, while prison officers supervise from behind the counter

Baidawi at Monash University found that prison staff often perceive older prisoners as being 'compliant', and therefore do not require particular attention. However, older prisoners have been found to be at high risk of depression and other psychological difficulties, which suggests that there is less satisfactory adjustment than is often assumed. The research that does exist indicates that older inmates are at a considerably higher risk of developing mental illnesses and cognitive impairment than the general population.

The current situation

Changes in sentencing procedures, such as mandatory and fixed term (non-parole) sentences mean that prisoners are often serving longer sentences without chance of early release (Judicial

Commission of New South Wales 2011). Furthermore, older prisoners tend to be incarcerated as a result of offences which necessitate longer sentences, such as homicide, drug, and sex offences which were committed during their younger years or which have only recently come to light due to DNA technology (Baidawi *et al* 2011).

Prisons are not generally equipped to deal with infirm or disabled people. According to a report in *The Age*, existing prison health systems are experiencing difficulties with their ability to prioritise beds, which are primarily intended for prisoners with acute medical needs (Elder 2011). There is also strain on staff, as corrections officers are generally trained to manage inmate behaviour, not to recognise and attend to the symptoms of dementia.

Consequently, prisoners experiencing milder dementia symptoms are often treated much the same as other inmates, with no specialised care (Hancl 2008). This may cause problems in cases where a person with dementia may have a limited ability to comply with prison rules, procedures, and routines. An inability to comply with orders or routines may be misunderstood as defiance, which may lead to penalties. There is a risk of a vicious cycle where lack of training and staff awareness contribute to dementia in inmates not being recognised or treated, and the symptoms of dementia worsening from the methods used to obtain compliance.

Further misconceptions can occur within the context of the prison social setting. Inmates with dementia may experience confusion regarding social hierarchies and prison etiquette. They may wander into restricted locations or into the cells of other inmates.

These misunderstandings can put the person with dementia into a conflict situation. In a survey taken by the Prison Reform Trust (PRT) in the UK, 60 per cent of older inmates reported feeling unsafe as a result of experiencing severe harassment or bullying in prison (PRT 2008).

Aggressive behaviour against people with dementia has been observed, and has been reported as ranging from mild to moderate 'school yard' style bullying, where a person with dementia is verbally or physically provoked in order to illicit a self-defence response, all the way through to serious assault and sexual victimisation (Kerbs & Jolley 2007). Similarly, older prisoners may have to 'buy off' other inmates for assistance or protection, and are forced to forgo any personal items that are permitted in exchange for assistance.

The physical environment in prison generally caters poorly for older inmates in general and inmates with dementia in particular, with some writers referring to it as a 'double punishment' for inmates who cannot reach upper bunks, use bathroom or toilet facilities, or become involved in social or exercise programs (Baidawi *et al* 2011).

Lack of stimulation, depression and loneliness all increase the impact of dementia. At a forum hosted at Fordham University in New York, Maschi *et al* (2012) reported that: "Older adults involved in the criminal justice system are a highly vulnerable and neglected population. Currently, there are few professions and communities that can solely and adequately address the needs of this population."

The comparative age problem

One of the primary concerns expressed by aged-care advocates is the experience of ageing in the older prison population in comparison to the equivalent general population. Studies have revealed that the prison population experiences age-related health issues at a rate equivalent to people a decade older, with 50 year olds displaying the same tendencies to age-related infirmity and cognitive decline as 60 year olds in the general population (Baidawi *et al* 2011, Heckenberg 2006). This disparity between chronological and biological age is thought to be due both to the general issues preceding imprisonment – low socioeconomic status, substance and alcohol abuse, poor health practices and other harmful behaviours – as well as the emotional and social deprivation, stress, and health disadvantages associated with imprisonment. As noted by Yun-Hee Jeon *et al* from Southern Cross University, these conditions are particularly severe in minority prison groups, such as Indigenous prisoners and female prisoners (Jeon *et al* 2007).

Not only do prisoners show a higher propensity for accelerated mental decline and intellectual disability while incarcerated, but the mentally declining and intellectually disabled are also more likely to be convicted in the first place (Mullen 2001). This is reflected in the number of older prisoners with such conditions. In one British study, people with measurable cognitive decline could comprise up to 55 per cent of all prisoners in the UK, versus 10-20 per cent

in the general population of older people (Fazel *et al* 2001).

Moral problems

The moral problems surrounding the continued imprisonment of people with dementia are primarily concerned with the application of compassionate early release policies. There are compassionate release policies in all states and territories of Australia, however, the process is often long and drawn-out. According to a study completed at the University of Tasmania in 2006, prisoners with dementia often die before being granted respite (Heckenberg 2006).

The debate surrounding compassionate release of terminally ill patients throws light on the plight of the prisoners with dementia. It revolves around four primary issues: the chance of recidivism (reoffending); the rights of the victim of the person's crime; the costs involved in continued incarceration versus the cost of external health care; and the continued welfare of the prisoner with dementia.

As the majority of older prisoners are imprisoned due to serious crimes, such as rape, homicide, organised criminal activities and serious drug offences, it is extremely important to ensure accuracy in the prediction of recidivism where compassionate release is concerned. When prisoners are experiencing advanced signs of dementia, recidivism becomes less of an issue due to their impaired physical and mental functioning. The amount of time it can take to enact compassionate release for



Bed at the Long Bay Hospital unit

Aged care service provision for older offenders in New South Wales

By Claire Newman, Gary Forrest & Katherine Doona

The healthcare needs of older offenders in NSW are addressed by Justice Health & Forensic Mental Health Network (JH & FMHN). The Aged Care and Rehabilitation Unit, based at Long Bay Hospital and operated by JH & FMHN, is an inpatient facility for older offenders requiring long-term supported care. This 15-bed unit provides for both male and female offenders, forensic mental health patients, and patients requiring palliative care.

Comprehensive assessment and treatment planning is provided to patients in addition to a range of daily rehabilitation-based activities that include gardening, bingo, table tennis, air hockey, and Wii computer games. Aged-care patients who do not require inpatient-based supportive care are transferred to the Kevin Waller Unit, operated by Correctional Services NSW (CSNSW). This 15-bed unit offers aged-care offenders independent living in segregation from the mainstream prison population with support from a disability service provided by CSNSW.

In order to accommodate for the increasing aged-care prison population, CSNSW and JH & FMHN have been working in collaboration to both increase and improve service provision. Future facilities include an 8-bed unit based at Long Bay Correctional Centre opening later

this year for the assessment of patients who do not require inpatient management. It is expected in 2013 that specific areas allocated for older offenders will be available in three rural correctional centres, totalling 48 beds plus a further 10 beds for female older offenders within a mainstream correctional centre for women.

JH & FMHN are also committed to ongoing service development and research in this area. Forthcoming research initiatives include the development of an aged-care health service model to ensure appropriate placement of and care provision for older offenders in the correctional environment, and working in collaboration with the Dementia Training Study Centre at the University of Wollongong to develop educational materials designed to assist nursing staff to identify and assess offenders with dementia in the correctional system. Future direction for research and service development will also relate to the placement and care of older forensic mental health patients who require long-term aged-care support.

Claire Newman is a Research Officer with the Practice Development Unit of the Justice Health & Forensic Mental Health Network. Gary Forrest is Service Director of Long Bay Hospital, and Katherine Doona is Nursing Unit Manager of the Aged Care & Rehabilitation Unit.

someone with advanced dementia means that they may not survive the duration of the decision-making process.

Closely related to the issue of recidivism are the rights of the victims of crime and their families. The rights of the victim in the case of a released dementia prisoner are primarily concerned with the principles of justice, rather than about any fears of recidivism and consequent re-victimisation.

This is an issue which brings many moral questions to the table. Is it unethical to incarcerate a prisoner whose physical and psychological needs cannot be met in the available conditions? Is it moral to punish a prisoner for a crime they may not even remember committing? If so, which principles of justice – incarceration, rehabilitation, deterrence, or retribution – does the imprisonment of a person with dementia address?

Incarceration, rehabilitation, deterrence and retribution

Incarceration is used primarily as a means to protect the public from offenders who may cause further harm if released. Whilst there is a possibility that a prisoner who has dementia may re-offend upon release,

and the risk of recidivism should, of course, be judged on a case-by-case basis, the chances of recidivism are reported to be slim in cases of advanced dementia (Fazel *et al* 2002).

Attempts at rehabilitation are very likely to be both ineffective in the case of prisoners unable to grasp the concept, due to lack of cognitive functioning and counterproductive in people with advanced dementia due to their inability to recover. However, before giving up on rehabilitation the possibility that the prisoner has 'pseudo-dementia', where treatment of depression, for example, can reverse the 'dementia-like' symptoms must be investigated (McNamara 2011). Furthermore, thorough evaluation needs to occur to ensure that reported cases of dementia are genuine, as well as to ascertain the level of disability in each individual case.

In one study from the USA, there are cited incidents where inmates feign symptoms of dementia. Their ruses were effective enough to fool authorities into issuing them premature release: Vincent 'The Chin' Gigante, the convicted New York mafia leader, feigned incompetence to stand trial for seven years before

confessing to the gambit as part of a plea agreement. He feigned both dementia (both Alzheimer's type and vascular were diagnosed) and psychosis for many years and was found incompetent to stand trial in 1969 (Soliman & Resnick 2010).

Deterrence is assumed to have a dual role, it deters the public from committing crime by showing that punishment occurs for offenders, whilst also deterring each individual offender from reoffending through fear of further punishment. Whilst continued incarceration of people with dementia may seem like a 'tough on crime' deterrent which would make potential offenders reconsider committing a crime, numerous studies have shown that it is, in fact, the possibility of arrest, rather than the severity of punishment, which has the greater influence on the incentive to commit a crime or not (Fazel *et al* 2002).

It could be argued that incarcerating someone with moderate to advanced dementia serves no purpose for deterrence, as the punishment ceases to mean much to the person with dementia, but also has little impact deterring future criminals from committing crimes.

Of the principles of punishment, the principle of retribution is the most controversial in regards to prisoners with dementia. Many people now reject the old fashioned 'eye for an eye' rationale for punishment, which is one facet of retributive justice. However, society nevertheless calls for some atonement for crimes: punishment equating to the damage that the crime has caused, as well as an expectation that the offender will feel regret for committing the crime. The moral dilemma associated with dementia-affected prisoners occurs when we consider the judgement of *mens rea* ('knowledge of wrongdoing') at trial in relation to the state of mind of an incarcerated person with dementia. In doing so, we can see that, in an offender with advanced dementia, the *mens rea* is absent, therefore, our laws would deem them not sufficiently culpable to be punished (Capeheart & Milovanovic 2007, Fazel *et al* 2002).

The question is, do we extend that standard to incarcerated prisoners who were originally culpable, but are no longer cognisant of their surroundings? Some argue that once the functions of deterrence and rehabilitation have been fulfilled or unobtainable – as in the case of a person with dementia – the threat to the public is ameliorated and there is no longer any reason to detain an individual. Others argue that it is unjust to release a prisoner, particularly those who have committed atrocious crimes, into the hands of health or aged care facilities whose resources

would be better spent on law-abiding citizens who are more deserving of those facilities (Heckenberg 2006).

Contemporary Australian policy surrounding compassionate release for people with dementia is primarily based around cost and availability of beds, unless an individual case reveals a violation of human rights.

This raises the issue surrounding continued cost of caring for people with dementia within the corrections setting. The cost for maintaining an older prisoner is estimated to be three times that of a younger inmate (Baidawi *et al* 2011). The Department of Justice (DJV) in Victoria reports that the cost of housing an inmate (no age specified) in a correctional facility is \$257.35 per day, or \$93,932 per year. The cost of caring for a person with dementia outside of the corrections setting in a residential care home is far less than care costs within a prison because of the design and resources of specialised facilities, as well as the reduced security measures and lower insurance. However, this solution puts other residents in the company of a convicted felon, which may not be acceptable in the case of some criminal histories. The supply of nursing home beds is limited, and alongside the valid public safety issues, allowing prisoners access to this resource may be frowned upon by the general public who may wish to see nursing homes reserved for their law-abiding family members.

This then brings to the fore the issue of the continued welfare of a released prisoner with dementia and whether or not their needs are going to be catered for post-release. These concerns seem justified due to the fact that many older prisoners tend to lack support from family and others who may be willing to care for them after release. This, combined with documented cases of economic and social disadvantage suffered by released prisoners, a return to impoverished pre-incarceration conditions and likely lack of income during incarceration, means that their post-release needs may not be met under current conditions (Heckenberg 2006).

Innovations and future directions

Due to the difficulty in balancing prisoners' rights with victims' rights and financial constraints, there is no clear, single direction for the care of prisoners who have dementia. There have been innovative steps taken in Australia, and internationally, to address the accommodation and medical needs of these prisoners, with specialised prisons being constructed and alterations to existing facilities being made (Jeon *et al* 2007). There are several examples of

specialised prisons designed to accommodate older prisoners with chronic health needs, including Laurel Highlands, a geriatric and special needs facility in Central Pennsylvania, and a 50-bed prison in Singen, Germany.

In Australia, older inmates in NSW can be admitted to the 15-bed Aged Care & Rehabilitation Unit (ACRU) in the Long Bay (Prison) Hospital for assessment and management (see box on p18). Upon discharge from the ACRU back to the prison environment, a discharge plan is developed for suitable patients to assist ongoing placement and management. This can include placement in the 15-bed Kevin Waller Unit at Long Bay Correctional Complex for aged inmates who are not healthy enough to endure mainstream prison life and may require some assistance with personal care or daily living tasks.

Megan Stoyles of Aged Care Insight reported in May 2012 that a partnership between Justice Health NSW and Calvary Health Kogurah has resulted in over 60 older people being treated and cared for at a hospital outside of prison, some of whom have dementia, as well as consultants who enter the prison environment to advise on ways to provide more effective care for older inmates (Stoyles 2012). This form of established partnership between corrections authorities and healthcare providers is still very new in Australia and presents an opportunity for research into the effectiveness of such programs.

There is still a general lack of programs in Australia designed to better meet the needs of people with dementia in prisons. Programs internationally, such as the Alzheimer's Association-sponsored 'Gold Coats' inmate-inmate care program in the USA signal increasing international awareness and attention to this problem in some countries. In Australia, there remains great need for further research into the circumstances of prisoners who have dementia, development of training programmes for prison staff, improvement in the physical design of the facilities and, perhaps most importantly, a wider debate on how we should respond to these issues at home and abroad. ■

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