



AGEING AND IMPRISONMENT

**Workshop on ageing and imprisonment:
identifying and meeting the needs
of older prisoners**

Summary Report



ICRC



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INTRODUCTION

On 1 and 2 December 2016, the International Committee of the Red Cross (ICRC) organised, in Paris, France, a workshop entitled “Ageing and Imprisonment: Identifying and Meeting the Needs of Older Prisoners”. Participants came from 11 European countries, Japan and the US, the Council of Europe Committee for the Prevention of Torture (CPT), the International Criminal Court (ICC), the International Criminal Tribunal for the former Yugoslavia (ICTY), the Mechanism for International Criminal Tribunals (MICT) and the World Health Organization Health in Prison Project (Europe).

The workshop was co-organised by Elisa Querci of the ICRC Paris Regional Delegation and Mary Murphy of the Deprived of Liberty Unit at ICRC’s HQ in Geneva in response to needs identified during ICRC detention visits in Europe, and trends observed more globally. There is a growing focus on ageing in inter-governmental fora. The ICRC’s aim was to provide an opportunity for itself and those present to explore concepts surrounding ageing and detention, particularly, in this case, criminal justice detention, and to discuss related challenges, experiences, practice and plans.

This report summarises the proceedings of the two-day meeting, including a number of recommendations that emerged. The ICRC has in addition produced a short public briefing entitled Ageing in Detention, while an article by one of the meeting experts, Brie Williams, can be found in the International Review of the Red Cross (<https://bit.ly/2KoBK6p>).

The workshop was held in plenary, and was structured around four presentations by experts, each followed by questions, answers and discussion (for the Agenda and speakers’ biographies, see Annexes I and II):

- I. The (European) Legal and Ethical Implications of Custodial Measures for Older Prisoners
Sonja Snacken, Professor of Criminology, Penology and the Sociology of Law at the Vrije Universiteit Brussels, Belgium, with Diète Humblet, doctoral researcher of the same University;
- II. Addressing the Ageing Dilemma in Criminal Justice Healthcare: Using Medical Evidence to Motivate Policy Change
Brie Williams, Professor of Medicine at the University of California San Francisco, US, Director of the Criminal Justice & Health Program at UCSF, practising geriatrician and specialist in palliative medicine;
- III. Creating a Suitable Environment and Regime for Older Prisoners During and After Custody
Lynn Saunders, Governor of Her Majesty’s Prison Whatton, England;
- IV. Developing an Integrated Policy Response to Ageing in Prison
Éamonn O’Moore, National Lead for Health & Justice, Public Health England and Director of the UK Collaborating Centre for WHO Health in Prisons (Europe Region).

Additional examples of national practice were presented by Harold Egerer, Head of the Personnel Department of the Ministry of Justice of Baden-Württemberg and Deputy Head of the Prison Service of Baden-Württemberg, Germany; and, from the French Prison Administration, Olivier Sannier, National Health Focal Point in the Office for Policy on Social, Reinsertion and Legal Rights, and Bénédicte Riocreux, Head of the Office for Professional Practices in Detention and Security.

The structure of this report mirrors the order in which the discussions were conducted. A brief summary of the presentations is followed by a summary of the relevant discussions.

The last chapter of the report “Conclusions and Recommendations” summarizes the main recommendations and reflections that emerged from discussions among participants during the workshop.

SESSION ONE - THE LEGAL AND ETHICAL IMPLICATIONS OF CUSTODIAL MEASURES FOR OLDER PRISONERS



Prof. Sonja Snacken

Professor of Criminology, Penology and the Sociology of Law at the Vrije Universiteit Brussels, Belgium

Diete Humblet

Doctoral researcher at the Vrije Universiteit Brussels, Belgium



(This presentation refers to the European framework.)

Different dimensions of age

It is complex to define who the older prisoner is. Correctional facilities and research studies use ages that range from 50 to 65. This is partly linked to the phenomenon of “accelerated ageing” in prison; people tend to age more rapidly in prison than outside. However, it is unclear the extent to which prison itself creates the conditions for accelerated ageing. Often, older adults enter detention with existing vulnerabilities which prison then exacerbates.

Gerontology is the scientific study of old age and the ageing process. It is a discipline that is becoming increasingly important in societies where the proportion of older people is growing and where they are living longer, with all the associated needs. It speaks of the following different dimensions of ageing:

- ▶ **Chronological age:** this is the dimension most commonly referred to, but it only gives information as to the number of years a person has lived, not his/her individual condition.
- ▶ **Biological age:** this is based on the individual’s physical condition and potential life span. This aspect is relevant also with regard to sentencing, as it influences the experience and significance of the number of years they have to spend in prison (e.g., can a non-prison future be foreseen? How long might they be expected to live?) This is spoken of as the “pain quotient”, the ratio between “time to be served” and “time to be lived”, the impact of the sentence on the prisoner (with the quotient greater for the prisoner whose life expectancy is shorter than the time to be served).
- ▶ **Functional age:** this indicates the comparative level at which the person can function. Functional limitations impact on the capacity to participate in life. In the outside society this includes: bathing, eating, going to the toilet, dressing, and getting in/out of bed. In some prison administrations one might need to add: standing for a head count, dropping to the floor for alarms, climbing on/off a high bunk, hearing and responding quickly to spoken orders, walking while wearing handcuffs, standing in line for medication or to use a phone.
- ▶ **Psychological age:** this is based on behavioural and perceptual aspects. The subjective feeling and perception of age can be different from chronological age (“how you feel”, “how you see it”). Similarly, the ability to adapt to biological and environmental changes varies from individual to

individual. These all have implications for the individual's detention (how they perceive it) and also for their regime. Prisons were never built with a focus on care for the wellbeing of prisoners; they are among the "Total Institutions" not so designed (ref: Goffman et al).

► **Social age:** this relates to society's expectations. This is important from a human rights perspective given that older people are often victims of stereotypes ("ageism"). Expectations of them in prison can be low to non-existent (leading, for example, to exclusion from education and vocational training). Expectations can also be too high; for example, when an older prisoner who has reached the age of retirement has to respond to the same criteria for parole in terms of finding employment.

In prison, there is a growing population of ageing prisoners and they can be divided roughly into four categories:

- People apprehended for the first time at an old age and serving long sentences;
- People incarcerated at a younger age and serving life and long-term sentences;
- Prisoners who have been in and out of prison over a long time span but for short periods;
- Older short-term prisoners.

Legal and ethical issues

Human dignity and imposing a custodial sentence in later life

Is imposing a custodial sentence in old age incompatible with human dignity and therefore a violation of Article 3 (Prevention of Torture) of the European Convention on Human Rights (ECHR)? The European Court of Human Rights (ECtHR) has found that there is no prohibition on such a practice. In law and practice in Council of Europe Member States, advanced age is neither a bar to prosecution, nor to pre-trial detention or a prison sentence. However, age may be taken into account, along with other factors, such as the individual's state of physical or mental health, when sentences are being determined (*Papon v France 7 June 2001*). As to implementation of sentences: age is rarely taken into account per se, but rather in conjunction with the state of health (*Papon v France 7 June 2001*). In some countries prison sentences for minor offences are not implemented if the convicted person is over a certain age, and in others age is taken into account when considering parole.

Findings in cases before the ECtHR have included the following: "Detention of an elderly person over a lengthy period **may** violate human dignity, but regard is to be had to the **particular circumstances** of each specific case" (*Papon v France 7 June 2001, Priebke v Italy 5 April 2001, Sawoniuk v UK 29 May 2001*). "A sentence of life imprisonment for war crimes imposed on an 80-year-old is not disproportionate due to the **seriousness** of the crime and the fact that there is still a **prospect of release**" (*Sawoniuk v UK 29 May 2001*). In this case the ECtHR drew upon the biological dimension of age.



Credits: Her Majesty's Prison and Probation Service

Human dignity and continued detention in older age

When is continued detention of older prisoners (in)compatible with human dignity? It appears that advanced age and health problems in themselves are not sufficient to bar continued detention if they cannot be considered as critical for detention purposes and if the prisoner receives adequate medical care (*Papon v France* 7 June 2001; *Haidn v Germany* 13 January 2011). The ECtHR systematically looks into three elements:

- ▶ the situation of the prisoner;
- ▶ the quality of medical care;
- ▶ the continued appropriateness of detention given the person's health status.

In cases before the ECtHR no violation was found in the case of an 83-year-old prisoner on the grounds that “his overall condition was found to be good by the prison doctor” (*Patsos v Greece* 25 September 2012). In *Papon v France* 7 June 2001 no violation was found, as “While he had heart problems, his overall condition had been described as ‘good’ by an expert report” (Medical reports constitute an important element in the Court decision-making process). In *Farbtuhs v Latvia* 2004 the Court ruled that it took the authorities much too long to decide to transfer from detention a paraplegic, disabled 85-year-old. In *Contrada v Italy* 2014 the Court found that the 9 months it took the authorities to take action after a medical report stated that detention was no longer a suitable option constituted a violation. In *Mouisel v France* 2002, a violation of Article 3 was found in the case of a 52-year-old suffering from leukaemia when he was held in a cell without sanitary precautions at a time when his immune system was severely weakened, and no special measures were taken when his health situation deteriorated.

The Council of Europe Committee for the Prevention of Torture (CPT) referred, in its 3rd General Report, to “those who are the subject of a short-term fatal prognosis, who are suffering from a serious disease which cannot be properly treated in prison conditions, who are severely handicapped or of advanced age.”



Credits: G. Korganow for the CGLPL

It stated “The continued detention of such persons in a prison environment can create an intolerable situation. In cases of this type, it lies with the prison doctor to draw up a report for the responsible authority, with a view to suitable alternative arrangements being made” (3rd General Report, CPT/Inf (93) 12 §70).

Human dignity and equivalence of care

Lack of appropriate medical care can violate Article 3 of the ECHR, both in the eyes of the ECtHR and the CPT.

In *Sawoniuk v UK* 29 May 2001 it was found that failure to provide the necessary medical care to prisoners may constitute inhuman treatment and there is an obligation on States to adopt measures to safeguard the wellbeing of persons deprived of their liberty. In *Farbtuhs v Latvia* 2 December 2004 a violation was found when a prisoner suffering from a physical disability was assisted during working hours by the prison medical staff but outside working hours by unqualified prisoners working on a voluntary basis, even though this was for a limited period.

Human dignity and use of restraints

Prison officers typically use force/restraints (shackles, handcuffs) during transfers of older prisoners to another prison or to an outside hospital to receive treatment. In this case it should be recalled that restraining prisoners who present no serious risk of escape constitutes humiliating treatment within the meaning of Article 3 of the ECHR (*Henaf v France* 2003, *Mouisel v France* 2002, *Mouisel v France* 2012).

Human dignity and end of life in prison

The presence of persons of advanced age in prison raises the very real chance of their dying there. While hospice programmes exist in some prison systems, in other facilities prison staff and other inmates are often not trained or prepared for the complexities related to the medical and mental healthcare required in the setting of serious and terminal illness. Often proper arrangements are not in place for assisting prisoners in final moments that may be characterised by feelings of hopelessness, solitude and failure. It may be difficult for families to be present as the end approaches.

However, release may be a very remote option when people have been sentenced for serious offences. In some countries, it is difficult for public opinion to accept, for example, release of people with convictions for sexual offences, and this affects the law and decision making.

End of life requires care and palliative care, which can be incompatible with a punitive prison environment. Accessing appropriate medication can be difficult in a context where security considerations surrounding possible exploitation of vulnerable prisoners are allowed to predominate.

Prison staff try to transfer inmates to hospital in what appear to be their final days. However, obtaining the necessary resources in the form of escorting staff and transport can be challenging, and hospital doctors may not be well briefed. There have been cases where staff have made great efforts to transfer ailing prisoners to hospital but doctors, once the immediate medical emergency is over, have returned them, not understanding that an appropriate environment was not available in the prison.

The CPT standards state that “terminally ill or dying prisoners would normally no longer be a threat to society and should have the possibility to die outside of prison if they so wish.” (CPT 3rd General Report, CPT/ Inf(93) 12 §70).

Voluntary recourse to euthanasia

This is only allowed in certain countries and under very strict regulations. Belgium is one such country. The Belgian Prison Act prescribes the same medical care as for a patient in society outside for prisoners, who are also eligible for euthanasia if fulfilling all legal criteria. Euthanasia has already been performed for two detained patients with terminal cancer. Prisoners suffering from psychiatric diseases and other mental health problems have so far not been considered to fulfil the criteria.

Human dignity, release and the right to hope

The ECtHR, in *Vinter v UK 2013*, has stated that life with no possibility of parole is a life without human dignity. Everyone has the “right to hope”. Conditional release should be a prospect for all, including life sentenced prisoners. Compassionate release does not fit with the goal of rehabilitation, as it usually only applies when a prisoner is terminally ill and has no prospect of life. In the case of older prisoners the question arises: should the minimum proportion of a sentence to be served before the person can be considered for release be the same as for a younger person?

Human dignity and “institutional thoughtlessness”

“Institutional thoughtlessness” refers to a common notion that every prisoner should be treated in the same way. It can significantly disadvantage older prisoners, in light of the different dimensions of age, as discussed above.

The principle of “normalization” of prison life, however, requires adaptation of **prison infrastructure and accommodation** (for example, in the case of stairs and small cells), and additional facilities to meet their needs (*Papon v France, 2001*).

Prison regimes, services and balanced programmes of **activities** are essential to guarantee humane treatment of older prisoners. The CPT suggests that all prisoners should have access to at least “8 hours or more outside their cells, engaged in purposeful activity of a varied nature” (2nd General Report, CPT/Inf (92) 3 §47). Sometimes, unfortunately, there is little understanding of what “purposeful activities” might mean for older prisoners, or how preparation for their reintegration should differ. In reality, older prisoners in many places remain in their cells most of the time.

Prison staff culture often adheres to the “sameness principle”; in the interests of good order and security, no or very few individual exceptions are made. This can prevent adaptations being made to the prison routine to accommodate the needs of older prisoners. Negative impacts from this can go unnoticed when older prisoners who are weaker and less resistant just disappear from the sphere of attention of staff, staying in their cells. The fact that they cause few problems in terms of order and security can contribute to the perception that they do not require attention. In some countries a significant number of older prisoners are people with convictions for sexual offences. These prisoners are particularly likely not to leave their cells and not to participate in activities, in order to avoid the negative attitude of other detainees. In addition to that, “care” may not be seen by prison staff as an appropriate role, with resulting failure to adapt adequately to physical and/or mental deterioration in those for whom they are responsible.

The “sameness principle” may lead to discrimination when older prisoners remain in the general population (**integration**). They may be left vulnerable to social isolation, violence and victimisation, and exclusion from a range of services. **Segregation** on grounds of age/condition can offer an infrastructure and regime that are more adapted in terms of mental and physical health care, safety, staff relations, and reintegration activities. However, segregation by age may also be discriminatory, leading to another form of isolation, greater distance from any family and friends and premature consignment to a “home for the elderly” for individuals who are psychologically and physically youthful. Council of Europe Recommendation R (98)7 on ethical and organizational aspects of health care in prison (§50) promotes the concept of normalization in relation to those with a disability: “Prisoners with serious physical handicaps and those of advanced age should be accommodated in such a way as to allow as normal a life as possible and should not be segregated from the general prison population. Structural alterations should be effected to assist the wheelchair-bound and handicapped on lines similar to those in the outside environment.” The decision over integration or segregation should take into account the individual choice of the prisoner.

Points arising from discussion

- ▶ **Staffing:** There is a need for more staff training, to recruit the right profile of persons and to have appropriate prisoners–staff ratios. While motivated staff are important, this does not necessarily translate into quality of care, and even motivated staff can become disillusioned. They deal with a multiplicity of challenges and problems, and those arising from an ageing detainee population are just part of the picture. The complexity of meeting the particular needs associated with older prisoners is sometimes underestimated, insufficiently emphasised during recruitment/assignment, and under-recognised when awarding performance. Each prison presents a different reality, including its own culture, and a culture change towards a greater emphasis on care cannot simply be forced. Particularly important is common training for healthcare and custodial staff, and for healthcare staff working with older people inside and outside the prison. A common language is needed, whether the Ministry of Health is in charge of healthcare in prisons or not.

- ▶ **Financing healthcare:** A variety of national systems exist for financing healthcare in prison and outside. However, the State retains a legal obligation to safeguard the lives and well-being of the people in its custody, and poor prison health has clear implications for overall public health. In prison, the health problems are sometimes greater and more complex than outside, for a variety of reasons, and providing a standard of prison healthcare that is merely equivalent to that in the community (and even bearing in mind the low standard of some healthcare in the community) would in some cases fall short of human rights obligations and public health needs. There is a need, therefore, to promote not equal standards of care, but standards of care that achieve equivalent objectives. In some circumstances, meeting these objectives will require that the scope and accessibility of prison health services be greater than those outside prisons.

- ▶ **Care of prisoners by prisoners:** There are positive aspects of more able bodied prisoners caring for those suffering from age-related conditions. This mirrors the care by family and friends which is a significant coping mechanism in any community. Both caring and cared for prisoners have spoken of this relationship as giving meaning to their detention. However, it can also be a burden, has the potential to render vulnerable detainees even more vulnerable, and should not be imposed. Fellow prisoners providing care should be carefully selected, trained and given the necessary psychological support.

- ▶ **The role of prison healthcare personnel in making decisions on transfer and release on age-related grounds:** Decision-making on transfer and release on age-related grounds is one of the many ethical challenges which healthcare personnel face. Both the World Medical Association and World Health Organization have addressed similar challenges in written guidance, and these should be consulted. Healthcare staff should not be expected to pronounce on issues for which they were not trained and should therefore have the possibility to refer to peers/their national medical association for additional support. They should not be expected to practice outside the scope of their competence. They should be consulted at drafting stage on policies that require a healthcare input (for example, the use of restricted regimes/solitary confinement with regard to older prisoners).

SESSION TWO - ADDRESSING THE AGEING DILEMMA IN CRIMINAL JUSTICE HEALTHCARE: USING MEDICAL EVIDENCE TO MOTIVATE POLICY CHANGE



Brie Williams

Professor of Medicine at the University of California San Francisco, US, Director of the Criminal Justice & Health Program at UCSF, practising geriatrician and specialist in palliative medicine

(This presentation refers largely to US experience.)

The ageing prison population

In the US, over 2 million citizens are incarcerated, 11 million pass through US jails each year, and the US prisoner population is ageing at a significantly more rapid rate than the overall US population. While the US is an outlier in terms of the sheer number of its citizens that it incarcerates, most nations are experiencing a similar ageing of their incarcerated populations. While there is no global consensus on the age at which a prisoner becomes “older” or “geriatric,” several research studies define older prisoners beginning at age 50 or 55 years. The population of adults aged 55 or older in US prisons has more than tripled since 1990.

Although empirical evidence that incarcerated older adults experience “accelerated ageing” is in its infancy, many criminal justice systems estimate that, on average, many prisoners experience a physiological age that is 10 to 15 years older than their chronological age. This difference is attributed to the high prevalence of risk factors for poor health that are common among many prisoners, arising both prior to and during incarceration (such as substance use disorder, Traumatic Brain Injury, limited education, low socio-economic status, homelessness). Studies that describe **evidence of accelerated ageing** observe a big burden at younger ages of common afflictions that occur with advancing age and which affect overall health including **activities of daily living (ADL, difficulty bathing, dressing, feeding, using the toilet or transferring)**, mobility impairment, hearing or vision impairment and incontinence. Evidence suggests that the prevalence of these types of geriatric conditions are present in a group of prisoners with an average age of 60 in rates similar to what would be found in community-dwelling older adults in their 80s.

In the US in 1976, a landmark Supreme Court case *Estelle v Gamble* decided that prisoners have a constitutional right to “adequate” healthcare, generally considered the same standard of healthcare as in the community. **For older adults, geriatrics is the community standard of care, and palliative care is the community standard for the seriously ill.** However, few geriatricians or palliative care clinicians work in correctional facilities. Geriatrics and palliative care are fundamentally multi-disciplinary (as is criminal justice health care).

In general, **older prisoners have chronic medical conditions and a considerably higher burden of chronic conditions** like hypertension, diabetes and pulmonary disease than both younger prisoners and older non-prisoners. When they return to the community following release from prison, older former prisoners

are vulnerable to serious and costly social and medical challenges such as housing instability, poor employability, management of multiple chronic health conditions, and health-related mortality. Rates of emergency department use appear to be similar to those among individuals in the last year of life.

Mental health issues and substance use in older prisoners are also a problem. Studies suggest that psychiatric conditions are commonly underdiagnosed and undertreated in older prisoners. Notably, the prevalence of co-occurring mental and physical health conditions among older prisoners has not been comprehensively studied. Older prisoners have unique unmet, distressing psychosocial needs, including fear of dying while incarcerated, victimization, estrangement from outside family and friends and social isolation, and, particularly for long-term prisoners, institutionalization.

Most systems are unprepared to address the unique problems of this population, and prison often presents a profound mismatch between function (e.g. the physical ability of residents) and the environment (e.g. the physical demands that their living environment places on them). For example, even for the middle aged it may be very difficult to climb on and off of a top bunk bed assigned to them. The rapid ageing of the criminal justice population has created major management dilemmas. For example, common age-related conditions (such as hearing impairment and urinary incontinence) can pose special challenges for the management of older prisoners. If older adults do not hear other residents speaking to them they could risk arguments or physical confrontation. If they don't hear officer commands they could risk rule violation charges. In terms of solutions, some prisons have introduced a yellow vest for such prisoners so staff can be aware and modify behaviour accordingly, but prisoners may not want to wear it, for fear that the vest will brand them an "easy target". Similarly, urinary incontinence can represent a safety risk when a prisoner is housed in small cells at close quarters with cellmates. Meanwhile, dementia is also a growing phenomenon that prisons are not prepared to handle. Older adults are also contributing to a cost crisis in US correctional facilities. At the time of speaking, annual prison spending has reached \$77 billion, around 10% of which is for healthcare. Per capita prison healthcare spending has tripled in the last decade (in the 37 states that publicly report these numbers). Older prisoners are the most expensive subset of prisoners and per capita healthcare costs for older prisoners are 3.8 to 9 times those for younger prisoners.

Applying geriatric care models to the prison context

Geriatric disability and functional independence are assessed by measuring ADLs. These are bathing, dressing, eating, using the toilet and transferring (for example, between chair and bed). Inability to perform ADLs generally requires that the patient have 24-hour care. Instrumental ADLs (IADLs) are activities which are not necessary for fundamental functioning, but which permit individuals to live independently in their community. Here moderate impairment might require intermittent help, for example with managing medication and money, preparing meals, shopping for groceries or clothing, transportation within the community, use of the telephone or other forms of communication. The risk of losing any ADL or IADL ability increases with age and is a harbinger of major medical/psychological problems. It is associated with more use of health care services and higher health care costs, further decline and greater morbidity. While ADL are generally similar in the prison context, the IADL assessment can have limited application for incarcerated individuals. This can impede functional assessment and accommodation for older prisoners. Given that optimal care for functionally impaired older adults includes adapting the environment to meet their functional abilities, it is essential to think about unique

activities that affect independence in prison. These “**Activities of Daily Living for Prison**” (ADL-P) differ according to the facility but may include dropping to the floor for alarms, climbing on/off the assigned bed, hearing orders, walking while wearing handcuffs, standing in line for medications, getting to the dining hall on time for meals and standing for a head count. Because of these unique physical activities, a person who would be independent in the community could be functionally impaired when confronted with unique physical tasks required for independence in prison. However, activities that are necessary for independence may differ by institution and level of security. To be most effective, it is recommended that a list be drawn up of the physical activities necessary for independence in each housing unit or institution. These lists should be used in housing considerations for older adults and to risk stratify those in need of additional assistance or supervision.

Acknowledging and enhancing the role of informal caregivers. Informal caregivers form the core of geriatric care, often recognizing changes in behaviour and health decline before a person comes to the attention of medical personnel. Outside prison these informal caregivers are generally family, friends and neighbours. In prison, correctional officers often end up being the individuals who interact most with older adults. They also often have an informal liaison-role between older adults and correctional health services. Correctional officers require training to identify warning signs of health deterioration in older adults (e.g. falls, confusion, memory problems). Optimizing older prisoner health also requires a good system of communication between correctional officers and medical staff such that correctional officers are encouraged and empowered to convey any health-related concerns that they have to healthcare staff. Identification of health-related problems and communication about these concerns to medical staff are impeded when prisons are overcrowded, and lower staff to prisoner ratios lead to lack of familiarity with prisoners and their health and safety needs.

Recognising and adapting policies to the limitations of prognostication. Death rates in prison are expected to increase with population ageing. In the US, prisoners ≥ 55 yrs. account for a disproportionate number of deaths (in 2013, 56.5% of all state prison deaths). Early or “compassionate” release policies allow some eligible, seriously ill prisoners to die outside prison. These policies should be comprised of two distinct elements: medical eligibility (determined by doctors, based on medical evidence) and approval (determined by the correctional and legal authorities based on consideration of public safety). Despite its availability, in the US compassionate release is rarely used. For example, from 2013 to 2017, the Federal Bureau of Prisons approved 6 percent of the 5,400 applications received, while 266 inmates who requested compassionate release died in custody*. Some applicants died during the final review process. One problem is that compassionate release eligibility guidelines often do not reflect the way people die. To meet most guidelines, prisoners must have a predictable end of life course, i.e. be expected to die quickly ($< 6-18$ months). Prognosis is difficult to establish for several conditions (except in the last hours to days before death). Some conditions where the prognosis is longer (dementia, coma, end-stage organ disease) can be excluded (i.e., a 50 year-old man in a persistent vegetative state may live far more than 6 to 18 months and therefore would not be eligible under many early release policies that are driven by prognosis). Other barriers may prevent medically-eligible prisoners from obtaining compassionate release. For example, many guidelines require a written petition (most patients with advanced illness have profound cognitive incapacity; prisoners may have poor literacy, are distanced from family and/or friends, and may have no advocate) and foresee a lengthy process (many prisoners die while awaiting

*Data was updated using information published in the New York Times article “Frail, Old and Dying, but Their Only Way Out of Prison Is a Coffin” by Christie Thompson, March 7, 2018; <https://www.nytimes.com/2018/03/07/us/prisons-compassionate-release-.html>



Credits: Noah Berger

a case hearing). To improve these policies, we should incorporate the **medical evidence developed by the fields of geriatrics and palliative care**. For example, **uniform medical eligibility criteria** could be established for the different ways that people experience serious illness (terminal illness with an easy-to-predict life expectancy; Alzheimer's and related dementias; serious, progressive, non-reversible illness; profound functional impairment). Moreover, procedural barriers could be overcome by assigning a **prisoner advocate** and introducing a **fast-track option for short life expectancies**.

Palliative care: Palliative care has many overlaps with geriatrics; it is specialized medical care for patients with serious illness. It focuses on relief from symptoms, and quality of life and it is appropriate at any stage of illness. It can be provided alongside curative treatment from the moment of diagnosis of a life-limiting, serious illness. Palliative care decreases costs and may, at times, prolong life. A well-known component of palliative care is the hospice. Hospice care can be considered a stage of palliative care for patients near the end of their lives. Hospice care replaces curative treatment in favour of continuous palliative care. Prison hospice programmes have emerged over the last several decades and are providing a critical service to patients (for example, relaxed family visitation policies, ensuring a hospice inmate is never left to die alone, support of inmate volunteers for company etc.). However, there is more to palliative care than the hospice. Palliative care programmes focused on symptom relief and quality of life throughout the course of a serious illness are far less common in prison.

The transdisciplinary approach: geriatric care is transdisciplinary, and addressing the ageing crisis in prison will need a multidisciplinary approach that includes the person concerned.

Older prisoners pose a unique challenge for the criminal justice system, not only throughout detention and reintegration (for example, where do we house medically frail patients when all we have left in the prison are top bunks? How do we optimize post-release planning for patients with dementia?) but also during arrest and adjudication. Ensuring detection and proper management of "older" detainees' vulnerabilities requires **adapting policies and practices across criminal justice systems**. Because older adults pose a challenge for many criminal justice professionals, it is important to develop and deliver

targeted geriatrics training (a mix of lectures and hands-on exercises to learn geriatric-focused care and to identify warning signs in older adults) **for several professional groups**, including police officers, attorneys, judges, correctional staff and probation officers, as well as jail and prison clinicians (one example of such training is the San Francisco Police Officer Geriatric Training Workshop). For example, during an arrest, certain age-related medical conditions, such as sensory impairments or dementia, may make it difficult for an older person to comply with police officers' orders. Similarly, for busy police officers, it may be difficult to tell when the problem is criminal or health related (for example, an older person arrested for public urination may have cognitive impairment and incontinence). Training can help police officers to think proactively about the best way to manage an older person and to seek medical attention for them when needed. Medical conditions may also make it difficult for older adults to participate in their own defence and adjudication. It is therefore essential for legal professionals to recognize cognitive impairment and dementia. This could even help interrupt the cycle of repeated arrests (for example, an older prisoner with dementia released without proper preparation and accompaniment may risk mandatory return to prison on grounds of a parole breach) and could favour diversion via treatment-based alternatives to incarceration. **Partnerships between healthcare professionals and with other professionals and community members** are also essential.

Examples of steps to help forge a way forward: **A geriatric healthcare policy agenda**

EXAMPLE PRIORITY AREAS	ACTION ITEMS
Geriatrics informed programmes	<ul style="list-style-type: none"> ▶ Develop and assess programmes to address geriatric needs ▶ Train criminal justice professionals in geriatric care
Functional Assessment	<ul style="list-style-type: none"> ▶ Define and assess functional tasks needed for independence, and use to assign housing
Dementia screening	<ul style="list-style-type: none"> ▶ Institute a system of screening for and responding to dementia
Long Term Care (LTC) protocols	<ul style="list-style-type: none"> ▶ Create a classification and care plan for Long Term Care
Enhance Palliative Care	<ul style="list-style-type: none"> ▶ Train clinicians in advance care planning, communication and symptom management for patients with serious illness ▶ Make early medical/compassionate release policies based more on medical evidence
Address Re-entry	<ul style="list-style-type: none"> ▶ Analyse programmes for how they meet the needs of older adults

Examples of geriatrics informed programmes and programmes to address re-entry

Within the Gold Coats Programme fellow detainees provide support in several Californian (US) prisons to inmates with age-related impairments. They assist with ADLs, escort to the dining hall, act as companions, lead exercise classes and activities.

The 60 West Nursing Home in Connecticut (US.) is a skilled nursing facility run by a private nursing operator outside prison walls. Patients with serious chronic medical conditions such as dementia, paralysis and cancer are referred by the Connecticut Department of Corrections.

Older adults may face unique challenges upon release linked to medical conditions, low literacy rates, difficulties in finding employment and suitable housing, and in navigating the system, etc.

The Patient Centred Care for Chronically-Ill Returning Prisoners - Transitions Clinic Network receives direct referrals from prisons. Appointments are made within 2 weeks of release. Care is coordinated for medical and re-entry needs by specially-trained formerly incarcerated Community Health Workers. This approach improves primary care use and decreases Emergency Department use by 50%. This is a national network in the US.

An older persons' ex-offender programme in California (Bayview Senior Service) is the first community-based programme in the US to focus on formerly incarcerated older adults (>50 years). It was developed and is run by former detainees and provides counselling, social support and transitional housing to give older adults the opportunity of a new start.

Points arising from discussion

- ▶ **Common problems:** These include infrastructure and staff training that are not adapted to older prisoners, a lack of focus on the latter's specific needs, and consequently their invisibility and under-treatment.
- ▶ **Re-offending and re-imprisonment of older people:** The reasons behind older people's return to prison are multiple. In at least one context, people with dementia were particularly represented in the returning prisoner population, and behaviour associated with their condition made breach of conditions for release highly likely. Another reason for return is lack of social support following release; prison may be for some the only sure source of "three meals and a bed". Mental health problems associated with traumas such as war are also present in returning prisoners. However, returning to prison depends on a number of factors. For example, while the majority of those involved in criminal behaviour tend to be young, individual older people may have had long and repeated exposure to the criminal justice system, which increases the likelihood of a custodial sentence. The stigma of a criminal record is also a major barrier to successful reintegration. Additionally, attitudes to age and to offences change with time, for example among sentencing judges.
- ▶ **Creating a solid research base:** Detaining authorities have the opportunity to commission research from independent providers, posing questions to which they need answers, and this facilitates collaboration with relevant actors, access to data and remedial action. However, it is also possible to collect data and design action-oriented research independently.

- ▶ **Challenges in bringing about change:** Financial investment is usually needed but there are different costs to be considered. For example, staff training can be inexpensive but the staff time (including replacement time) needs to be budgeted for. The key challenge is to make the case for change and bring all the necessary actors to the table.
- ▶ **Data collection and chronological age:** Current disparities in defining a threshold for including detainees in the group of “older prisoners” prevent us from having a common model for collecting data and a common base for discussion of and provision for likely needs. Setting the threshold at 65 only allows for basic planning on the assumption of increased likelihood of vulnerability and higher health costs. Planning on this basis risks failure to identify in time, and to provide appropriate care and support for younger detainees suffering from dementia and other severe conditions that change life expectancy. More generally, adopting a high chronological age threshold can result in failure to take preventive action that promotes health and facilitates independence. The discussion has thus far been too simplistic.
- ▶ **Community based care for older prisoners:** Placing offenders in the community is always challenging in terms of public and media perception. Community based care for older prisoners who do not present a risk to the public, in the form of a specialised old age home for prisoners, is unlikely to be any different in that regard. It is up to all concerned to make appropriate arrangements and sustain convincing arguments.
- ▶ **Private prisons:** Where private prisons can select those they accept, there is a risk that they will avoid the responsibility for the complex and expensive care which older prisoners may require, placing an undue burden on the publicly managed system. Planning in both systems needs to take into account the cost of providing appropriate care and conditions for older prisoners, including with regard to escorts when visits to external health providers are frequent.
- ▶ **Access for prisoners to specialist in-patient care:** Accessing geriatric expertise is essential in the care of older prisoners and may involve in-patient care. Creating a few centres of expertise that permit older prisoners to access appropriate specialist care has proved to be both positive and challenging. A positive aspect has been that prison staff have easy access to centres where they can receive appropriate training. One challenge can be distance (a concentration of geriatric specialists on a small number of sites). Another can be that when patients display difficult behaviour they are transferred back, sometimes on the pretext that they no longer need specialist care, to prisons that no longer have access to the necessary expertise.

SESSION THREE – CREATING A SUITABLE ENVIRONMENT AND REGIME FOR OLDER PRISONERS DURING AND AFTER CUSTODY



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(This session refers to experience in England and Germany)

An Example of Practice in England, Whatton Prison

Her Majesty's Prison Whatton opened as a detention centre in the 1960s and since May 1990 has held people with convictions for sexual offences. A major expansion of Whatton started in 2006, increasing the capacity of the prison, which currently has a capacity of 841.

The prison is a specialist treatment site (medium security) for people convicted of sexual offences. It delivers six accredited cognitive behavioural programmes including two programmes for people with intellectual disability (30%). There is also a specialist programme for deaf people (interpretation in British Sign Language).

The prison hosts adult prisoners (this means, over 21 years old), 70% of whom have committed offences against children. The majority of Whatton's population are serving long sentences of in excess of four years, with around three quarters serving indeterminate or life sentences (120). Some 158 of them are over 60 (since 2008, there have been 53 natural deaths, mainly because of ageing, and one murder.) There are a minority of foreign national prisoners who do not speak English as their first language.

There are 58 prisoners needing social care support: basic living support such as help to wash, keep themselves and the cells clean, making sure they can get to other parts of the prison.

Environment and Regime: The problems

Whatton was not purpose built for the elderly. It was built for young people initially, and 40% of the cells were very small and not wide enough for adaptation. Some 440 additional cells were built in 2006 but cell doors were still not wide enough for wheelchair access or hospital beds. Whatton is a very large site, it takes 20 minutes to walk from one end to the other, and therefore there are mobility issues. There is no full time health care cover. Prison rules require prisoners under 65 to work. Prisoners are responsible for collecting food and personal hygiene. Prisoners with long sentences whose family have died, those who never had a family, or who have been disowned by them lack family support. Deaths in prison custody, natural or not, must be investigated by the Prisons and Probation Ombudsman.

Environment and Regime: The solution

Adaptation of infrastructure to peoples' needs

The prison had to do something because the services provided were not good enough. The physical infrastructure needed to be appropriate for the needs of older prisoners. It was decided to adapt and staff the downstairs level of one unit for social care patients. The majority needed to have a hospital bed, and these had to be dismantled and reassembled inside the cell. All equipment is provided for the detainee in the cell in order to allow them to be as independent as possible (for example, a paraplegic detainee has a hospital bed and motorized chair). One of the end cells was adapted to be a first stage end-of-life suite.

Addressing social isolation and providing intellectual stimulation

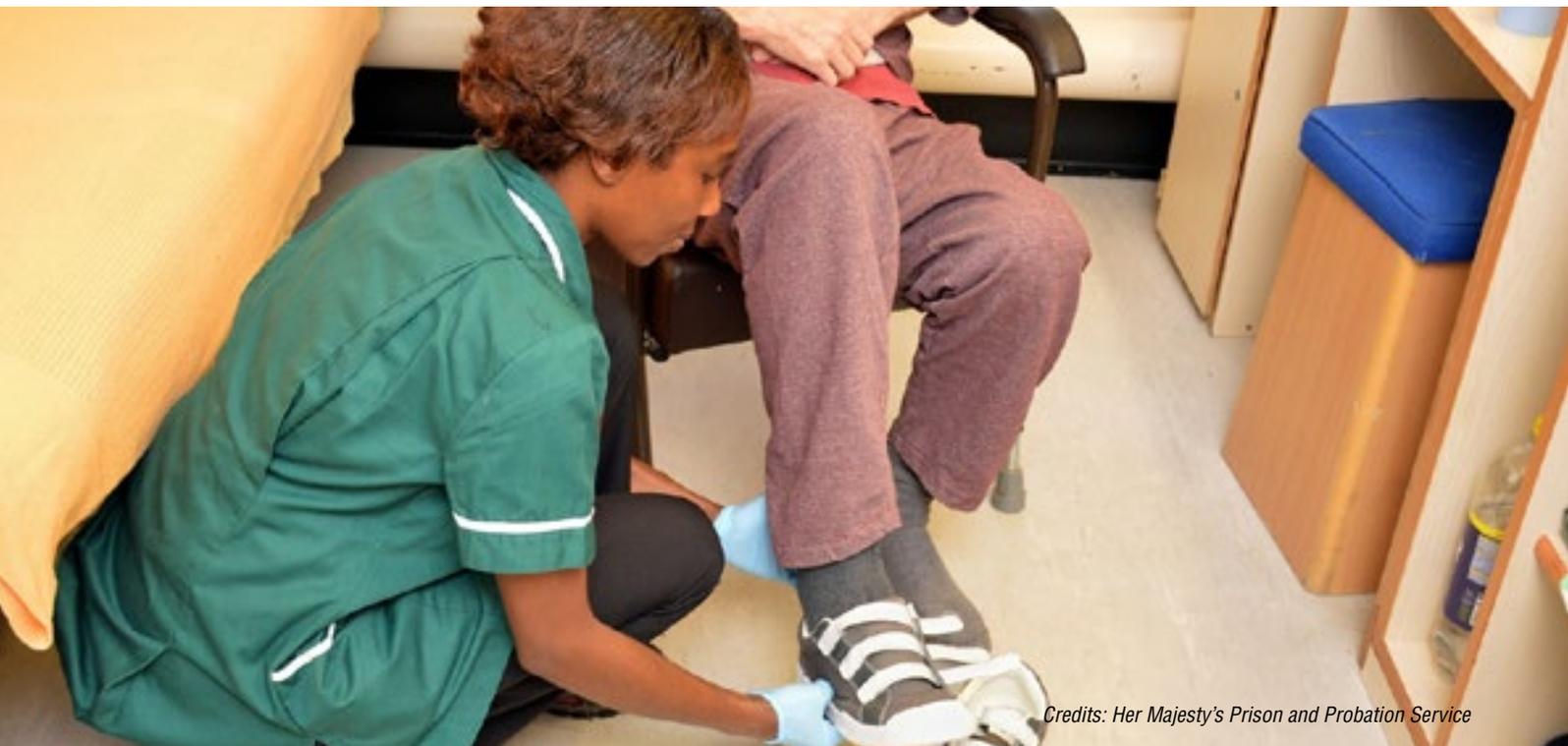
The prison decided to develop opportunities to enable prisoners to leave their cells, socialize and engage in activities. The “Older Prisoners Active Living Group” (OPAL) was initiated in conjunction with voluntary sector organizations, such as Age UK, Carers Federations, armed forces association SAFFA. The aim was to set up the kind of project that would exist in the community. The OPAL groups provide a number of activities for older prisoners: advice on a range of matters (healthcare, resettlement, debt, housing advice, finance planning, etc.) and activities promoting the constructive use of leisure time (quizzes, board games, community singing, veterans family support group, etc.). Also, modified exercise programmes and activities suitable for the over 50s (walking groups, bowls, gym sessions, badminton and modified cardiovascular sessions) were developed by the gymnasium team. The prison provides educational opportunities, such as history, music, art and crafts, etc. This is important in encouraging the elderly prisoners to develop skills for using their leisure time constructively once released. The prisoners can also have a piece of land to garden and compete for a gardening prize. It is really beneficial for prisoners to develop skills that they can also use outside.

Social Care advocates – Peer Support Project

A paid peer support scheme has been developed. Peer supporters have been risk-assessed (psychological test, offending history) and trained to work with other prisoners to assist them with their basic social care needs. They are supported and supervised. These prisoners work with prisoners needing extra support with day-to-day social care such as carrying meals, laundry and assisting with mobility. A team of paid prisoner wheelchair “pushers” are also selected and trained by gym staff in manual handling. They operate a human “taxi” service enabling movement around the prison and it is working very well.

Palliative care services and suite, the “Retreat”

A palliative care suite for the final few days of a prisoner’s life was opened in 2011. It was developed on a hospice model viewed in the community. The idea is that prisoners can remain in their residential wing as long as possible in order to maintain the contact and support of peers, and they will be moved to the specialist suite for the final days. The decision to open the suite was justified because of the impact that seeing another prisoner declining and dying was having on fellow prisoners and also because of



Credits: Her Majesty's Prison and Probation Service

the need to keep the deceased person's body on the wing until the police arrive (in accordance with the law regarding death in custody). The Retreat provides for families to stay with a prisoner for longer (not dependent on prison routine). Other prisoners can also visit. Compassionate release is initiated for any person needing hospice care. It is not always recommended for people who are still judged to pose a risk; some people have nothing to lose if they are still physically capable. Whatton has had only two compassionate releases since 2008. Furthermore, many people prefer to stay because they would be looked after better in prison than outside as they do not have family support, and their friends and support are in prison.

Paid carers for social care and end-of-life care (24 hours)

Paid carers are deployed when there is a need for intimate care to be provided (going to the toilet and bathing).

Other services

The prison established a dementia care suite designed especially for dementia sufferers. Relevant courses on dementia are also provided to staff and prisoners.

Resettlement

Pre-release services include advice on benefits and provision of services. Liaison is established with community resources for post-release planning and follow-up (for example support for housing, debt issues and opening bank accounts). When appropriate, public protection arrangements will be put in place.

The conclusion is that when there is imagination, enthusiasm and compassion it is possible to provide suitable care and support for older people in prison.



Credits: Her Majesty's Prison and Probation Service

An Example of Practice in Germany, Singen prison

The German Prison Act establishes that reintegration in society should be the objective of sentencing. To this end, facilities are to be made available in different institutions or units, guaranteeing treatment to meet the different needs of prisoners (section 141 of the Federal Prison Act). Singen prison in Baden-Württemberg was established in 1970 as a specialized prison for older prisoners, in order to promote social contact and medical care and prepare those prisoners for release. It is intended to cater for those needs of older adults that cannot be met in regular prisons, e.g., certain treatment measures, age appropriate activities and other measures necessary to prepare prisoners for release.

In 2015, there were 5,000 prisoners serving prison sentences in Baden-Württemberg. Singen prison has a capacity of 54 and is designed for male prisoners who are at least 62 years old at the time of conviction, must serve a prison sentence of at least 15 months, have the ability to integrate into the community, will most likely not abscond and are in good health. In 2015 the offence profile of the detainees was as follows: 30% sex offences (child abuse), 30% fraud (investment fraud), 20% violent offences (mainly within the family), and 20% other offences (eg, theft, drug crimes, tax offences). Seventy per cent of prisoners in Singen are first time offenders. The average age is 70.5 years. In 2016, there were 44 prisoners in the prison, 15 of them between 70 and 75 years old and three older than 80.

Regular staff consist of a governor, a social worker, one head of correctional officers and 16 prison officers, a doctor (surgery at least 2 hours per week; the infirmary is open for 5 hours every working day), a psychologist (6 hours a week), an administrative officer.

Prisoners enjoy **maximum freedom of movement**. Cells open from 7 am to 10 pm and prisoners can move around within the prison building. From 8 am until 8 pm (in winter until dusk) prisoners may use the courtyard, where there are benches, a sports field and a fishpond. Prisoners can lock their cells when they are absent.

Many prisoners have had a long working career and want to work in prison too. We recognise that it is essential that they keep mentally and physically fit. In Baden-Württemberg prisoners are obliged to work until the age of retirement (65 years). In Singen, they can continue working after that on a voluntary basis, and currently about 70 percent of prisoners work, although only five are obliged to do so. Many prisoners get a pension, in which case they are obliged to contribute to detention costs. A contribution to detention costs is not levied if a prisoner works.

The prison has **working space** for up to 40 prisoners in an industrial workshop, the kitchen (4 spaces), laundry (2.5) and housekeeping (3). Prisoners who are unfit to work are offered occupational therapy with the aim of providing a daily routine and promoting social contacts with other prisoners and staff. The therapy helps to maintain skills and offers the possibility of learning new skills, which can promote self-confidence in the elderly prisoners.

Occupational therapy is offered from Monday to Friday from 10 am to 2 pm and is delivered by trained staff and people from outside. The therapy includes: doing handicrafts, cooking, cleaning, care and maintenance of the courtyard, gardening, gymnastics, relaxation exercises, memory training, collective games and health talks. The decision to refer a person to occupational therapy is taken collectively by the persons responsible for the treatment of prisoners (head of the institution, social worker, warden, doctor and psychologist). If this group finds that the therapy could be helpful for the treatment of the elderly prisoner, he is obliged to take part. In Germany, there is a strict regime regarding money to guarantee a comparable level of wealth/standard of living for all prisoners within the prison. Prisoners who are taking part in the therapy can spend an extra 50 Euros a month of their own money in the prison.

Every prisoner can receive visits for at least 6 hours a month. Social contacts and visits are judged to be important for the treatment programme, potential relaxation of conditions of imprisonment and preparation for release. Elderly inmates who do not have social contacts (wife, other family) outside the prison can receive visits from trained volunteers arranged by the social workers in the prison. Volunteers play an important role in preparations for release and sometimes support former prisoners after release. Telephone calls are also an important means of maintaining contact and are allowed between 5 pm and 10.30 pm.

Singen prison has two recreation rooms (one for smokers and one for non-smokers). An officer and volunteers organize a considerable number of leisure activities, such as sports groups (competitions outside the prison are also organized), table tennis, cookery classes (they prepare healthy, good and cheap food; a training kitchen was installed in 1999), memory training, discussion groups, meditation groups. Inmates may use the fitness rooms, which have equipment suitable for older persons. There is also a small library with CDs, audiobooks, newspapers and books and it is frequently used.

Relaxation of conditions of imprisonment: Such measures are essential in preparing a prisoner for release and helping keep in touch with everyday life outside the prison. The prison has a progressive scheme which consists of three consecutive phases. Phase 1 consists of short leaves under escort during a period of nine months (up to a maximum of 8 prisoners go hiking for one or two days, out for lunch, shopping, to exhibitions, etc). For prisoners with no social contacts outside, this leave under escort is often the only relaxation of the conditions of imprisonment available. Phase 2 involves short leaves without an escort, once a month for 3 to 12 hours which the prisoners can spend with a family member or other attachment figure in Singen or the surrounding area and/or at home. Phase 3 permits 21 days a year leave from custody which the prisoner must spend with his family or other attachment figure (a friend or volunteer).

Medical care: 70% of Singen prisoners are first time offenders and their health is quite good. They have neither drug nor withdrawal related problems. A doctor holds a surgery at least two hours a week. The infirmary is on duty five hours every working day. A psychotherapist offers one-to-one conversations for people convicted of sexual offences (offending behaviour programme, Wischka et al, 2002). This may lead to the transfer of a prisoner to the Hohenasperg socio-therapeutic institution close to Stuttgart. No group therapy is offered in Singen Prison itself. An offending behaviour programme (sex offender treatment programme) must be continued after release if necessary. This is a precondition for release on probation.

Obstacles to successful reintegration into society: Because older prisoners are often not fit enough to live alone after their release, finding appropriate accommodation is often the main task for the prison's social worker and, after release, the probation service. Often not only the family, but nursing homes, old people's homes and institutions offering sheltered housing reject former prisoners due to the nature of the crimes they have committed. Many of them therefore live for a long period in dormitories for released prisoners. These are not suitable for the old people as they are not intended for long-term stays; they concentrate on finding jobs for released younger prisoners and do not offer a daily routine.

Points arising from discussion

► **Intimate care of prisoners by prisoners:** In the national system under discussion (England and Wales), peer supporters do not provide intimate care for safeguarding reasons (the older prisoners are considered vulnerable). An external social worker, employed by and paid for by the local government authority, in line with national legislation (The Care Act), makes an assessment and gives advice on what needs to be done in terms of adapting the cell, and the specific personal help required, and provides that help. To facilitate security arrangements in the prison, those receiving this external support are concentrated in one particular area. An example of organised peer to peer support was given (it was not specified how it is deployed in relation to vulnerable older prisoners): the Irish Red Cross has created a community health, hygiene awareness and first aid programme adapted to the prison. Prisoners are trained and made temporary volunteers of the Irish Red Cross. Theirs is not a position of power over their peers, but of peer-to-peer support. <http://bit.ly/1Y4ckLO>

► **Prison staff, role, motivation and medical confidentiality:** The majority of staff in this prison find caring for older prisoners an extremely rewarding job, very multidisciplinary, very busy and very demanding. It is not a problem to get staff to work on the age-related projects which have been developed, and indeed they come with many ideas for improvements. However, their job remains that of a prison officer, with a key objective of protecting society. Many of the older prisoners have been convicted of sexual offences, and officers are required to monitor for access to pornography, for example. If a staff member needs to be aware of certain information related to a detainee's medical condition in order to carry out his/her job, and it is in the prisoner's best interest, then the required, and only the required, information is shared.

► **Secure facilities that are not prisons:** Prisons are not always suitable for older prisoners and consideration should be given to creating alternative, secure facilities for those who still represent a danger to society.

- ▶ **Education:** Older prisoners are diverse and should have access to a range of educational opportunities. Some may come from a professional background which makes access to higher levels of education particularly important. Distance learning is therefore likely to be essential as prison-based education tends to concentrate on basic skills.
- ▶ **Preparation for release:** Probation and release conditions should take into account mental and physical needs and disabilities. Older prisoners may be in particular need of help upon release. They may need help before release in finding accommodation that is appropriate to age-related needs, mobility, mental health, risk of social isolation, etc. Offence-related restrictions (for example on people convicted of sexual offences) may be an added complication in resettling older prisoners and preventing social isolation.
- ▶ **Support following the death of a prisoner:** Family members, staff and volunteer prisoner carers may need support after the death of a prisoner.
- ▶ **Cost of a prison dedicated to older people:** It is not easy to compare the cost of accommodating older prisoners in a dedicated prison and in a unit for the elderly within a non-dedicated prison, or to say which is better. It depends on many factors. A positive point is that a dedicated prison is not influenced by being situated in a non-dedicated prison. When there is a specialist unit for the elderly within a prison, the older prisoners and the staff are obliged to fit in with the wider prison routine and security measures. A prison dedicated to older prisoners can develop and implement its own concept of treatment and management without these constraints. On the other hand, a unit within a bigger institution may offer the older prisoner the opportunity to participate in a wider range of activities, and offers the possibility of mixing with people of all ages.
- ▶ **Suicide:** In the particular context under discussion (Germany) there is no indication that older prisoners are more likely to commit suicide than younger ones. This may be because of efforts to provide treatment and conditions suitable for older prisoners. Suicide prevention is the same for all ages.
- ▶ **Older staff:** In neither of the two contexts under discussion (England/Wales and Germany) is there a policy preference for employing older staff in the care of older prisoners. It is not necessarily the case that older staff perform better than young staff with older prisoners. Many younger staff have experience of older relatives, for example, and gain useful knowledge and insight this way.
- ▶ **Dietary supplements:** A participant experienced that providing older prisoners with appropriate multivitamin supplements is economical, can compensate for inadequate time in the open air, and may have beneficial effects on mental health. Vitamin D has several important functions, plays a role in the immune system, and makes older people healthier.



SESSION FOUR – DEVELOPING AN INTEGRATED POLICY RESPONSE TO AGEING IN PRISON



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Effective management of older prisoners' health and social care needs

There can be “no health without justice and no justice without health”. Public Health England (PHE) is an executive agency of the Department of Health, and is a distinct operational organization. PHE works alongside the Ministry of Justice, the Department of Health and the National Health Service in England to ensure that health is at the heart of prison reform. The PHE mission statement on health and justice includes: a) to understand and meet the health and social care needs of people in contact with the criminal justice system (in the community and in custody); b) to improve health, to tackle health inequalities, to reduce offending and reoffending behaviour; c) to take account of the movement of people along justice, as well as health & social care pathways; d) to work in partnership with health and justice policy makers, commissioners, service providers and service users.

The oldest public health service in the UK is the prison medical service, established because of fear that infectious diseases in the community came from the prisons. In 1948, the National Health Service was founded. It continues to exist. At that time, it did not include the prison medical services, which remained separate, and the doctors were employed by the Home Office. There was increasing criticism of the difference between the two regimes, and in 2006 the prison healthcare regime was integrated in the general regime.

One of PHE's roles is to reduce inequalities in quality and access for prisoners. This group suffers from inequalities; it experiences a higher burden of chronic illness, mental health and substance misuse (drugs, alcohol and tobacco) problems than the general public. Prisoners often come from already marginalized and underserved populations in the wider community. “Prisoners are the community. They come from the community, they return to it. Protection of prisoners is protection of our communities” (Joint United Nations Programme on HIV/AIDS (UNAIDS) Statement on HIV/AIDS in Prisons). Also, “Prison Health is Public Health” (Declaration on “Prison Health as part of Public Health”, adopted in Moscow on 24 October 2003).

The public health model for health and justice should address the upstream and downstream determinants. This includes thinking of the factors that drive behaviour (e.g. troubled families, unemployment, drug and alcohol dependence, mental health problems, access to primary care, etc.) and that we can mitigate to help reduce offending and reoffending.

When we think about this model it is important to think about action and activities. In England a **strategic direction** (2016 – 2020) **for the health services in the justice system** was established consisting of three main elements:

- ▶ **Care not Custody:** This promotes the idea of early intervention and of diversion, when appropriate, to community-based care. If the primary need concerns health (mental health issues, disabilities, dementia, substance abuse and so on) then the person should be diverted to community-based care. Through identifying vulnerability at the earliest possible opportunity and making sure people have access to the right care, there is an opportunity to reduce the number of entrants into the criminal justice system and this is surely more cost effective and prevents further exacerbation of vulnerabilities.
- ▶ **Care in custody:** The NHS delivers a high care service according to need. Detention can impact positively on the health care needs of many people, and health care in custody is central to rehabilitation and to a consequent reduction in offending and re-offending behaviour; it is an opportunity to address health inequalities.
- ▶ **Care after custody:** This aims to ensure that ex-prisoners are supported and have continued health care. The effect of leaving prison is similar to a cleavage. Structure simply disappears. We need to ensure that benefits of health care accessed in prison are still effective (including cost effective). In this light, reoffending can be seen not necessarily as a failure, but in some cases may offer a further opportunity to address important issues.

At the centre of this strategic direction there should be a decisive shift toward **person-centred care** (“No decision about me without me”) that provides the right treatment and support. Paternalistic approaches ignore the patients. Patients know their needs and what is best for them at that moment in time. Getting the patient engaged is fundamental to a high quality and efficient health care service.

A public health approach also includes the following **factors to be considered in controlling and preventing diseases in prison:** population, environment, prevalence of disease and the interrelation between them.

The UK has the highest prison population rate in Western Europe. In 2014, England and Wales had 146 prisoners per 100,000 of the population. In 2013 the proportion of older prisoners (50+) was 12.2% in England and Wales. The number of such prisoners grew by 150% between 2005 and 2016, and older prisoners are the fastest growing group within a prison population in England that is projected to continue to rise. There will be an increase in the associated complex health and social care needs.

To give more detail on the statistics, in December 2015 there were 12,335 prisoners aged 50 years or older in English and Welsh prisons (14% of the total prison population). 95% of them were male and 134 prisoners were aged 80 and over. The main categories of offence committed by prisoners aged 50+ were sex offences (42%), violence against the person (24%) and drug offences (11 %).



Credits: Her Majesty's Prison and Probation Service

The Criminal Justice Estate in England & Wales is one of the largest prison estates in Western Europe and the government has made a £1.3 billion commitment to build eight new prisons, including five during this Parliament. However there are still many older Victorian **prisons completely unsuited to the social care, mobility and other needs of older prisoners** (these prisons were built with young men in mind).

People in prison have multiple complex needs, including a high prevalence of infectious diseases (HIV/AIDS, BBVs, TB and other respiratory infections, poor vaccine coverage); high prevalence of chronic illnesses (including epilepsy, asthma, coronary heart disease and poorer access to treatment and care); poor mental health or learning disabilities (49% have an identifiable mental health problem such as depression and anxiety); poly-substance misuse (higher rates of substance abuse including alcohol, drugs and tobacco smoking); homelessness, joblessness, poor education (24% of those in prisons have been in care as a child, with a high rate of homelessness and insecure accommodation).

Older prisoners may have multiple and complex medical and social care needs including: impaired/reduced mobility; need for assistance with personal care; impaired sensory function (including loss of hearing, visual impairment); chronic illness (including cardio vascular and pulmonary disease, dementia, arthritis, diabetes); care may be complicated by stroke, heart attack, falls and injury, as well as dietary and medication needs (complex medication regimes/drug interactions); mental health including depression and anxiety; poor dental health; substance use (alcohol abuse and tobacco smoking have also been identified as a widespread problem among this group). These issues are complicated by the need for specialist care, pain management, palliative/end of life care, the risk of diversion of medicines and risk associated with the reason for incarceration (e.g. people with convictions for sexual offences).

Alternatives to imprisonment should be considered wherever possible, taking into account the probable harmful impact of imprisonment on older prisoners and the costs associated with catering for their multiple health care needs. Certain types of offence, however, for example many “historic” sex cases, pose challenges in offering non-custodial measures to some older prisoners in the UK.

As older prisoners are also likely to include a high proportion of prisoners with physical disabilities, **structural alterations may need to be made to their accommodation to facilitate their mobility in the prison and protect them from accidents.** The determination of suitable accommodation should be based on a **careful assessment of individual needs.**

In England and Wales there has been a rise in the number of prisoners **dying in custody.** In 2016, compared to the previous year, there was an increase in all causes of death in custody of 21% (324 deaths). The greatest proportion of deaths in custody is due to an increase in natural deaths (17%) and it is attributable to the age of the population, but this is not straightforward. The leading cause of death is, for example, cardio vascular disease.

Since April 2015 in England (2016 in Wales), local authorities are responsible for assessing and meeting the **social care needs of adult prisoners,** not just on discharge from prison but also while they are in custody. This change affects 58 local authorities in England which have prisons within their boundaries. All prisoners within those prisons will be treated as if they are resident in that local area for the purposes of the Care Act for as long as they reside in that prison.

Partnerships are essential and there is a need to find ways for everyone to work together, national and local government (policy makers), health providers (commissioners of care, healthcare providers, Public Health) and justice partners (commissioners and providers, including custodial and community). PHE and NHS England have concluded three partnerships, respectively with the National Offender Management Service (NOMS), the Home Office Immigration Enforcement (HOIE) and the Youth Justice Board (YJB).

The other partners are the prisoners. If we ignore the prisoner's role we will not deliver a good service. **Prisoners can be partners in public health** with the prison system and the health system. Health needs assessments and health service evaluations need to take account of the prisoners' voices if they are to be truly useful. **Prisoners can be part of the solution in designing and delivering health promotion and health improvement programmes** (peer educators are a much more effective means of engagement, and peer-modelling can promote more effective uptake of positive health behaviours, e.g., stopping smoking). Sustaining change beyond the prison gate is also possible and positive change can be driven by the actions of ex-prisoners.

The Prison Reform White Paper adopts a **whole system approach to delivering reforms.** The key health issues are: joint commissioning of health services (prison governors and NHS England); enshrining the principle of equivalence; recognition of the link between improving health and reducing offending; data intelligence and evidence based practice; wider determinants of health such as work, housing, education, time out of cell in purposeful activity, all of which are highly protective for mental health.

WHO Health in Prisons Programme (WHO HIPP). In 1995, WHO (European Region) and the UK established a network for the exchange of experience in tackling health problems in prisons. From this network emerged the WHO Health in Prisons Programme (WHO HIPP), which at this time includes 47 Member States of the 53 from the WHO EURO region. WHO Europe is the only WHO Region to have a prisons programme and so in many ways provides global leadership in the area of health and justice. Its main activity is to give technical advice to Member States on: a) the development of prison health systems and their links with public health systems; b) technical issues related to communicable diseases (especially HIV/AIDS, hepatitis and tuberculosis), illicit drug use (including substitution therapy and harm reduction)

and mental health. (For more information, see: <http://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/who-health-in-prisons-programme-hipp>)

WHO advocate for the Ministry of Health to deliver care in prison and not the Ministry of Justice/Interior. The **WHO guidance on “Good Prison Healthcare Services”** advocates for prison healthcare services and their staff to be integrated with the wider healthcare system, allowing for continued professional development and training of staff, and continuity of care on reception and on discharge.

Older prisoner populations are growing in most jurisdictions in Western Europe. These prisoners have complex social and healthcare needs before incarceration, while in prison and in the community (if released). Meeting their complex needs requires more rigorous assessment, improved data quality and better partnerships. Better partnerships also improve the continuity of care. Another fundamental question is whether there is now a need to think of “secure nursing homes”, special older offenders institutions, mirroring the young offenders’ institutions that have been around for a long time.

One way to bring about significant change in prison health care generally and also for older prisoners is to join the **WHO Minimum Public Health Dataset for Prisons**. Data collection started among Member States in 2016 and as a minimum dataset covers the main areas of prison health, including prison health systems (such as financing and governance); the prison environment; risk factors for diseases; and the screening, prevention, treatment and prevalence of communicable and non-communicable diseases. The findings will enhance understanding of the health needs of the prison population and will help identify emerging themes to be considered to ensure that prison healthcare continues to improve, not only for the benefit of people in prison, but for the wider population. Prison health can contribute directly to addressing wider health inequalities, as well as tackling health-related drivers of criminogenic behaviour which can reduce re-offending and costs and improve community safety. It is important to **improve the quality of data and information sharing**.

The WHO European Prison Health Research & Engagement Network - WEPHREN was also presented during the session. The Network will focus on providing a forum for all stakeholders interested in prison health to exchange ideas and to work together across the **WHO European Region**, for example by **developing collaborative multi-centre research proposals**. Capacity building for prison health will also be a key feature of WEPHREN; the network will provide the opportunity for supported professional development of researchers, healthcare professionals and other stakeholders conducting research and disseminating findings, improving the health of prisoners and prison services across Europe. WEPHREN is currently funded and supported by the UK Collaborating Centre for WHO Health in Prisons (European Region). WEPHREN is not intended to replace existing and established networks, rather it will embrace them, acting as a resource/signpost to them.

An Experience from France

A Law of January 1994 established the transition of the prison health service in France from the Ministry of Justice to the Ministry of Health, and the latter has been working for over 20 years to implement specific programmes concerning the health of detainees.

In France older people constitute more than 10% of the overall prison population. In and out of detention the national population is ageing. No projections are available, but the proportion of older detainees

will probably increase. However, the main reason for current numbers lies in penal policy, in particular regarding sexual offences.

In France, prisons have not generally offered specific cells for detainees with special needs (this includes older prisoners, prisoners with disabilities, and those serving long sentences). The need to provide **accommodation adapted to particularly acute needs** is now being addressed in all new prisons, and modifications have been or are being made in many others, although much remains to be done. Effort has also been made to offer appropriate activities to older prisoners.

In recognition of the risk to human dignity that potentially arises when older people are incarcerated, **legislation has been adopted that offers scope for sentence adjustment:**

- ▶ Article 82 of the Penitentiary Law of 2009 provides that **prisoners older than 70 years are eligible for conditional release without any time requirement** (safety period, minimum term to be served) if there are assurances for his/her reinsertion (for example, accommodation, appropriate care) and if he/she doesn't pose a threat to public order. However, it appears that many detainees and professionals are unaware of this legal provision or do not know the conditions required to invoke it (many wrongly believe that there is a temporal requirement).
- ▶ In 2002, via the Loi Kouchner of 4 March, the possibility of **suspending a sentence on medical grounds** was introduced (some provisions of the law were subsequently relaxed and extended by the Law of 15 August 2014 on individualization in sentencing). The law concerns detainees who have mental or physical conditions that are life-threatening or permanently incompatible with detention. The law does not foresee any age requirement. After 3 years' suspension of a sentence on medical grounds, conditional release can be granted. Problems in interpreting and implementing this law have included: a) deciding when to initiate the suspension process (for example, is it appropriate when it occurs only days before the detainee's death?); b) finding an outside structure that is prepared to accept sick, older prisoners; c) obtaining a consensus among medical experts (it is only since 2014 that one expert opinion is deemed sufficient); evaluating incompatibility with detention (which has to include consideration both of the appropriateness of the physical conditions and the availability or otherwise of adequate health care); addressing the needs of detainees who still represent a danger to the community.

The French colleagues presented a real life story to illustrate the potential complexity of cases intended to lead to suspended sentences for old and sick detainees. Multiple hurdles required the involvement of many actors, and the human cost for the detainee and staff was considerable when aspirations and reality repeatedly did not match. In this particular case challenges included:

- ▶ To **find an outside institution adapted to the case**, both in terms of care and security.
- ▶ **Interpretation of the notions of consent and confidentiality, admission criteria for psychiatric and other institutions** (long-term/short-term patients, physical/mental health needs, match of expertise/mandate/available services with need, capacity, etc.).
- ▶ **Ongoing communication and collaboration ; balancing the care, security and other roles of the different authorities involved in the process.**

- ▶ **Complexity and length of procedures; challenges for detainees, particularly long-term detainees, in adapting to a new and very different** (including mixed-sex, geriatric) **environment** (support work was needed).

Colleagues from the French prison administration saw additional opportunities for improved implementation of what they considered to be a good legal framework in areas such as screening (systematic assessment of older detainees), **resource mobilization, housing models, and staffing ratios**. They spoke also of ongoing work to elaborate comprehensive guidelines on suspending sentences for medical reasons, and that these should apply to all stakeholders, regardless of their institutional allegiance.

They saw a **role for all staff in health promotion**, in order to take advantage of the opportunity detention can sometimes offer for encouraging a healthier lifestyle and preventing conditions associated with old age. Such **initiatives should not be addressed only to older detainees**. For example, prisoners encouraged to engage in exercise at an earlier age are less likely to experience certain health problems as they grow older.

Points arising from discussion

- ▶ **Preventive healthcare:** Prison can offer the opportunity to implement a healthy lifestyle and prevent certain diseases, including some that are associated with ageing. This means addressing old age at a younger age, promoting exercise, etc. There are varying practices and experiences with regard to smoking in prison. Where prisoners are expected to give up smoking they should have access to support in doing so.
- ▶ **Changing older prisoners' perspective on life:** Instilling a sense of self-worth in older prisoners, and supporting them in changing their perspective on life is important. Encouraging older prisoners to engage with education and other activities, rather than seeing them as at the end of life, can lead to a culture shift and improvement in the overall environment, without necessarily requiring large financial investment.

CONCLUSIONS AND RECOMMENDATIONS

In Europe and on other continents the number of older prisoners has increased over recent decades. In some countries this is the fastest growing age group in detention. The reasons are multiple and cannot be exclusively ascribed to demographic changes in broader society. They include shifts in the areas of prosecution, sentencing and release, for example, the increased prosecution of certain infractions, prosecution of historic cases with the aid of developments in forensic science, long sentences past and present, and longer stays in prison. The need to address the issue of ageing in prison has variously been recognized by prison administrations, agencies responsible for health care provision to prisoners and by special interest groups (old age, disability, etc.), but not yet by everyone who should be concerned. It appears that there is still work to do on designing an appropriate, consistent and integrated response.

Multiple and inter-related economic, health and social issues associated with an ageing community constitute a significant and growing concern for many States. The same issues are often aggravated in prison. Many people entering detention are already suffering from a range of health problems. They are then at risk of more rapid deterioration. Their social marginalisation is likely to be even greater than that experienced by their counterparts in the broader community, with potentially serious consequences for reintegration.

The participants in the workshop acknowledged the challenges posed by a growing number of prisoners ageing in criminal detention, and/or arriving there at an advanced age. They identified various causes of this phenomenon, which included sentencing practices, technological and policy developments, demographics, etc.

Significant suffering was sometimes caused in older detainees because authorities lacked the capacity (including budget) to respect their dignity and humanity.

Problems could arise throughout the detention trajectory, from arrest to preparations for release and post release, due to a mismatch between the needs of this population of older prisoners, and the facilities/services available at almost all stages.

Detained persons' vulnerability in detention was observed to increase over time when there was an accumulation of often poorly visible and poorly managed physical, mental and social disabilities.

As older people were acknowledged to be diverse in their needs and conditions, and sometimes to age at an accelerated rate in detention, it was emphasised that services needed to be provided according to identified needs and not only chronological age. Conditions that affect life expectancy and quality of life needed to be identified much earlier.

During the workshop, participants tried to define and give shape to the above-mentioned multifaceted challenges. Most importantly, they looked at the various approaches which have already been developed, and tried to identify good practice guidance and opportunities for improvements in practice, in normative frameworks, information-sharing and collaboration, training and resourcing.

Closing the proceedings, the ICRC thanked the presenters and other participants. It encouraged them to explore the possibility of implementing interesting practices they had heard described and overcoming the challenges identified. The ICRC requested that participants continue to share developments with the

ICRC and colleagues around the world in whatever way they found most appropriate. In this way the workshop would have met its aim of assisting countries in improving their ability to respond to the needs of older people deprived of their liberty.

Below is a summary of the recommendations that emerged from the workshop.

1. Priority issues at different points in the criminal justice journey

1.1 Early stages of detention

1.1.1 Arrest

Police authorities should ensure that their staff are appropriately trained in identifying and managing persons with physical and/or mental impairments; all older arrestees should be screened for cognitive impairment.

Adequately trained medical staff must be present on arrest, and prompt contact with social services should be assured. Health personnel working in police stations must have basic training in geriatrics.

1.1.2 Trial

Older people's "fitness for trial" should be assessed at a very early stage in the criminal justice process, in order to identify physical or mental disability, and particularly serious/terminal illness and cognitive impairment. Appropriate alternative options (e.g., house arrest, electronic tracking devices, diversion to secure nursing homes, hospices, etc.) should be considered.

Lawyers, police, prosecutors, judges, etc., should be adequately prepared to identify and manage older prisoners. They should have timely access to the necessary specialist advice.

1.1.3 Sentencing

In sentencing, the judiciary should consider the appropriateness of imprisonment, in view of issues such as "remaining life upon release" and the "pain quotient", when contemplating a custodial sentence. They should systematically evaluate and consider effective alternatives to incarceration for older adults, especially for those with cognitive impairment or dementia.

Qualified doctors should be involved, always in line with medical ethics, in certifying "fitness for incarceration".

1.2 During implementation of a custodial measure or sentence

1.2.1 Staff training and mission

Care should be part of a detention officer's training, daily routine and mission.

1.2.2 On admission

Screening

Assessment of social/personal care and health needs on arrival should be systematic, with screening in particular for dementia/cognitive impairment.

The assessment process should be adapted to the older person being interviewed (e.g., volume, speed, legibility), and performed by trained staff with support from specialist personnel if needed (healthcare staff, disability liaison, etc.).

The assessment should include the detainee's capacity to perform "Prison Activities of Daily Living" so as to identify vulnerabilities specific to a prison setting.

Diversion, allocation, transfer

The assessment should be linked to prompt provision of appropriate support: from diversion, to allocation to adapted accommodation/bed, provision of mobility and sensory aids, etc.

Allocation or transfer should be determined according to the needs identified and the facilities and services available, and should take into account elements of choice available to the prisoner.

Separate and integrated facilities

Allocation to separate, dedicated units or to parts of facilities set aside for older people can present advantages in terms of targeting the necessary services and resources, ensuring an adapted regime and infrastructure, and protecting more vulnerable prisoners from the general population. However, segregation can exacerbate isolation from family/community/other age groups. Intermediate solutions (for example, where older prisoners have their own dedicated spaces but can still have the option/choice to socialize and interact with other age groups) have also proved effective.

1.2.3 During incarceration

Regime

Applying the "sameness principle" to older people can lead to discrimination. Regulations and practices must therefore reflect the needs and capabilities of older prisoners.

Adaptations (for example to the obligation to stand for head counts, crouch or lie on the floor for alarm exercises etc.) should be included as options in the regulations and should be predictable and transparent, permitting older detainees to lead as normal a life as possible.

Infirmities should be identified early so as to avoid conflicts and possibly unmerited disciplinary action (e.g., deafness or poor memory may lead to an unwitting rule violation, or to arguments and confrontations among fellow prisoners).

Staff should have time and space to get to know the older prisoners, their capabilities and



Credits: Noah Berger

needs, free from the constraints caused by overcrowding/understaffing/inappropriate job emphasis or focus.

Where restraints are used (e.g., during transfer) this should be proportionate to the risk the older person poses of effecting an escape.

Awareness should be raised among staff of the potential invisibility of older people, including if they withdraw from posting written complaints and requests, and if they do not compete for the space to make oral interventions, including via telephone hotlines.

Infrastructure and facilities

To encourage independence while still ensuring safety, prison design and planning should anticipate the needs of older prisoners (and others with specific needs). Premises should be adapted to physical challenges common in older prisoners, which could mean considering: use of ground floor premises, sound proofing, adapted lighting, distances between facilities, the challenges that may be posed by stairs, steps and walkways, doors and gates, space needs for mobility aids, the type of bed, furniture height, grips and rails for entering and exiting, location of furniture, bathroom facilities, gym facilities, etc. Mobility could be facilitated by creating posts with responsibility for disability liaison. Wheelchair “taxi drivers” (prisoners whose job it is to push the wheelchair) could be used to mitigate the effect of distant facilities. In addition, sticks, wheelchairs, walking frames, hearing aids, glasses, etc. should be made available.

In contexts where prisoners cannot be released, and in the existing prison environment they cannot get access to the necessary treatment and dignified and compassionate conditions that their health situation demands, secure care facilities must be created, including dementia and terminal care suites.

Services and support programmes

Health, functional and social assessments are needed not only on arrival of the detainee in a new place of detention but at regular intervals, at appropriate life stages, and in relation to follow-up care.

Legal services: Older prisoners may need access to tailored legal (or paralegal) advice and representation. Release applications may be more problematic for them, while end of life brings many other issues, including, for example, wills and testaments. Older prisoners may need additional help to access such advice, because of mobility (e.g., access to lawyers’ visiting rooms), and impairment (e.g., deafness when trying to use the phone), etc.

Health services: Clinical facilities (surgeries/dispensaries) should be adapted to the needs of older prisoners, while training in geriatrics should be provided for all prison health professionals. Palliative care programmes may be needed, and should focus on symptom relief and quality of life throughout the course of a serious illness rather than just end-of-life care. In addition, nursing and occupational therapy services should be provided where required.

Where a detainee lacks functional independence in the areas of eating, bathing, dressing, going to the toilet, walking around etc., 24 hour care should be available to him/her, including, if necessary, professional intimate care. Intermittent care should be provided in case of lack of functional independence in areas such as taking medication, handling money/expenditure, shopping, cooking, housekeeping, telephone, etc.

Socialization and leisure: Barriers (physical, sensory, psychological, e.g., fear) to participation and socialization should be identified and removed. A range of activities should be provided to meet different capabilities as defined by older prisoners' needs, aspirations and assessments of their capacity. Relevant resources include: drop-in day centres, discussion groups, singing, board games, external speakers, theatre groups, memory training, life skills courses such as cooking and budgeting, gardening, adapted sports and gym exercise.

Peer care

Involvement of fellow prisoners in the care of and support for older prisoners seems natural and obvious as it can tap into friendships, common experience and understanding, but this must be carefully designed and monitored. Moreover, the prisoners providing support may also need support. They also need to be supervised, trained (including in manual handling if they will be involved in lifting their fellow detainee) and risk assessed. In contexts where work is remunerated, this care and support role should also be paid. In many contexts it will be inappropriate for a fellow prisoner to give intimate care. Appropriate support given by peers includes: assistance with activities of daily living, e.g., escorting the detainee to the dining area, acting as a companion, and leading exercise classes and other activities.

Contact with the family

Contact and communication with the family of older prisoners should be facilitated to the maximum degree possible. Family members age too and may need help for visits, while long-term prisoners and those sentenced for certain offences (e.g., people with convictions for sexual offences) may lose touch with the family and need access to a community substitute (e.g., volunteer visitors, chaplaincy). The prisoner and their visitors may need help with communications technology (e.g., visit booking services) because of poor hearing, sight or understanding. Video/skype visits may need to be considered in cases where the visitor has severe mobility problems or live far away from the prison (e.g. family overseas).

Sentence management

Older detainees should have access to rehabilitation services, and have the right to hope and a plan for release. Closeness to death is not the only appropriate reason to favour an older person's request for early release/pardon, and programmes that it is essential to complete before release should be genuinely available to older prisoners. So should professional training, and all types of education, including higher education, even if the detainee will not be of employable age by the anticipated time of release.

Specific considerations regarding the end of life

Medical eligibility criteria should reflect the fact that people age and experience serious illness in diverse ways. A fast-track procedure should be available where life expectancy is likely to be short, a procedure that recognises that predicting the moment of death is, however, not an exact science.

Applications for release should be made in a timely fashion, and specialist decision-making procedures should be in place concerning release. Automatic application for release at a certain age could be considered and the application should not necessarily depend on the independent initiative of the detainee, although consent could be needed if release is granted. Policies and procedures should facilitate access to palliative (or other necessary health) care and hospice services through compassionate release whenever imprisonment is not consistent with human dignity.

These policies and procedures should be designed with input from medical specialists in prognostication, geriatrics and end-of-life care. (The end-of-life course can be unpredictable, but severe dementia, coma, and end-stage organ disease should be acknowledged as just a sample of conditions that would seriously compromise dignity in detention, while not necessarily leading to a quick death; indeed the patient may linger for months or years.)

Care should be taken to preserve the role of treating doctor, when medical personnel are asked to pronounce on the patient's "fitness" to remain in detention or be released. Consideration should be given to involving at least two doctors in such decisions, doctors with the necessary specialist knowledge.

When considering how best to meet the prisoner's needs, care options explored should include those both in and outside prison.

The wishes of the prisoner concerning end of life care should be sought and considered. The desire of a prison to avoid the complications of a death in custody (in some contexts, for example, this involves treating the scene of death as a crime scene) should not influence decisions to transfer the prisoner out. The prisoner's best interests should be considered.

The dignity of the patient, with provision of appropriate care and pain relief, should be safeguarded, whatever the location of the detainee. Preparation should be made in good time where admission to an appropriate hospice is a possible option, and arrangements for access to appropriate palliative care must be put in place in a timely fashion. There should be constant follow-up on decisions taken and actions planned and undertaken.

Where an end-of-life suite exists in the place of detention, protocols should be in place for its utilization, including protocols concerning the use and security of medication, and the safety of care staff. 24-hour healthcare will need to be in place. Risk assessments should be undertaken where healthcare staff will access patients during night hours. The surroundings in the suite should be appropriate to its purpose. Access should be possible for family members and others familiar to the patient, including other prisoners. These,

and staff should receive a range of support appropriate to the fact that someone's life is coming to an end. The prisoner and family should have access to help in relation to relevant administrative preparations, while healthcare staff and the prisoner should also be given the conditions (privacy, time, etc.) which difficult conversations and decisions require.

1.2.4 Pre-release

There is a need for recognition that older prisoners have different opportunities, needs for and likelihood of release, and different needs upon release. Preparation for release should be tailored to the realities of release at an older age, and informed by regular determination of the prisoner's mental and physical abilities and needs. Special care should be taken in preparing for the release of an Alzheimer sufferer, who is likely to have other, additional impairments. It may be necessary to assign such prisoners a personal advocate.

Preparation for release should be seen not only in terms of linking the right people and services, but also in establishing and continuing hobbies, education, etc. Relevant services for assuring continuity of care include health and social welfare agencies.

1.3 Post-detention

Continuity of care should be assured, with particular support put in place for those who have lost contact with their family/community while incarcerated. They should be helped with finding age-, mobility- and socially appropriate accommodation in preparation for release.

For those identified as being at risk of re-offending, and particularly those released under conditions that restrict their opportunities for socializing and integrating (e.g., prohibitions on accessing certain people, buildings or infrastructures, etc.) multi-disciplinary post-release social care networks (prison, probation, police, healthcare, community groups, etc.) should be activated well in advance.

2. Prerequisites

2.1 Definition of "older prisoners"

A common definition of "older prisoners" should be agreed in order to facilitate early identification of the most vulnerable, and provision to them of adequate and timely services and facilities. Such a definition, accompanied by common, agreed methods of data gathering, should also facilitate "geriatric informed" research and decision making, identifying trends, and measuring the impact and cost-effectiveness of different services. A threshold of 50 years and above would seem desirable, in view of the fact that some detainees age particularly fast in detention. However, this should not obscure the detainees who at an earlier age acquire conditions associated with ageing (e.g. dementia), and it should not result in independent and healthy elders being treated inappropriately.



Credits: Her Majesty's Prison and Probation Service

2.2 Equity of care

Standards for care available to older prisoners should be at least equal to those available to their peers in the community, in light of their, often, more complex needs (“equity of care”).

2.3 Research, data collection and health information systems

More research is required to assess health needs, to evaluate health service effectiveness and cost effectiveness, to develop adapted responses, plan resources, encourage funding, adjust/define policies, and promote reforms in favour of older prisoners. Longitudinal studies in particular are lacking and needed, as well as policy-oriented research projects. Research results need to be packaged (made understandable to a variety of actors) and disseminated to stakeholders.

Reliable data for research, collected and analysed consistently and accurately, is required, as is the creation of communities of researchers. WHO WEPHREN is one relevant new international initiative.

Computerised health information systems allowing age-disaggregation, and sharing of data across the prison estate and between prison and community health services are also needed: prison health must be included in national health statistics to inform national health policies.

2.4 Strategy, policies

Development of a national strategy concerning older people in detention is recommended, based on a public health model. This should embrace, for healthcare and other services in the criminal justice system, data concerning ageing, and involve a working partnership among government/policy makers, health providers, justice commissioners and providers,

including both custodial and community providers at national and local levels. The health and justice care pathway “Care not custody. Care in custody. Care after custody” is a useful guide when considering an appropriate response to older people.

A review of existing policies, systems and available services, and of their effectiveness is needed as a basis for establishing an integrated policy response to ageing in prison. Where gaps are apparent, decision makers should explore whether policy review, closer coordination between existing systems and/or more efficient service-delivery can address them, or if innovations are required. Inter-professional partnerships should be formed to identify best practices and consider what innovative approaches can overcome the challenges inherent in detaining older people. Partnerships should be encouraged among, for example, correctional leaders, academic and public health researchers, community agencies, neighbourhood associations, former detainees, their families and law enforcement.

2.5 Costs and funding

Appropriate State health and social care funding should be ensured, supplemented where necessary from charitable sources. It should not be assumed that every adaptation and innovation requires a large budget allocation.

2.6 Civil society involvement

Involvement of civil society should be encouraged. Specialist organizations can provide advice to staff, prisoners and their families. They can also provide activities adapted to the needs and interests of older prisoners, including education. Investment should be made in coordination and liaison with them over how to facilitate their work (access, provision of appropriate spaces, etc.).

2.7 Public and other awareness

While respecting legitimate needs and concerns of victims, effort should be made to raise awareness of the problems facing older detainees in detention. One aim in improving research and data gathering should be to use it to better inform the public of the plight of some older people in detention and of the need for action.

2.8 Inspection and monitoring

Standards should be developed against which to monitor and inspect places of detention in light of the specific needs of older prisoners. Those carrying out the monitoring should receive specific training and have access to specialist advice.



ANNEX I: WORKSHOP AGENDA

Ageing and imprisonment: Identifying and Meeting the Needs of Older Prisoners 1 - 2 December 2016 - Hotel la Villa Modigliani - Paris

DAY 1, Thursday 1st December 2016

8h30 – 9h00 Opening

Mr Régis Savioz, *Head of ICRC Regional Delegation, Paris*

9h05 – 10h30 Legal and Ethical Implications of Custodial Measures for Older Prisoners

Chair: Ms Janet Foyle, Secretariat of the European Committee for the Prevention of Torture (CPT), Council of Europe/Conseil de l'Europe

Rapporteur: Ms Katharina Schwarzl, Department for Enforcement and Supervision in prison, Austrian Prison Service

► **Prof Sonja Snacken** – *Professor of Criminology, Penology and Sociology of Law at the Vrije Universiteit Brussel (Belgium)*, **Ms Diete Humblet** – *Doctoral researcher of the Crime and Society Research Group (CRiS)*: discussion on the complexity of the ageing process from a legal and penological perspective; presentation on how human rights standards developed by the European Court of Human Rights (ECtHR) and other institutions, address specific issues related to the sentencing, imprisonment and release of older adults. (45 minutes)

► Q&A, Plenary discussion

10h35 - 11h00 Coffee Break

11h05 - 13h00 Addressing the Ageing Dilemma in Criminal Justice Healthcare: Using Medical Evidence to Motivate Policy Change

Chair: Dr Paul Falke, General Practitioner, Palliative Healthcare Consultant, Judicial Physician Penitentiary Institution Haaglanden, Medical Officer ICTY-UNDU & ICC-DC

Rapporteur: Dr José-Manuel Arroyo Cobo, *General Subdirector of Sanitary Coordination, Ministry of Interior, Spain*

► **Dr Brie Williams** – *Professor of Medicine in the University California San Francisco (UCSF) Division of Geriatrics, Founding Director of the University of California Criminal Justice & Health Consortium, and Director of the Criminal Justice and Health Project at UCSF*: a review of some of the unique healthcare needs of older prisoners; discussion on the implications of a growing ageing prison population for health-related policy and practice, prison management and staff training; consideration also of how to promote a better response to older persons in conflict with the law by other criminal justice professionals, including police, lawyers, judges, clinicians. (60 minutes)

► Q&A, Plenary discussion

13h00 - 14h00 Lunch break**14h05 – 16h00 Creating a Suitable Environment and Regime for Older Prisoners During and After Custody**

Chair: Mr Paddy Craig, Chief Custody Officer ICC- Detention Centre

Rapporteur: Mr Mark Brailsford, Protection Delegate, ICRC London

- ▶ **Ms Lynn Saunders**, *Governor HMP Whatton, Nottinghamshire, England*: discussion about practical innovations and adaptations that can anticipate and respond to the needs of older adults in prison, taking into account their diversity (nationality, culture, religion, etc.) and challenges for staff. Needs include accommodation, health and social care, age-appropriate activities, family links, “end of life” arrangements, support for released prisoners.(40 mins)
- ▶ **Mr Harald Egerer**, *Head of the Personnel Department of the Ministry of Justice of Baden-Württemberg and Deputy Head Prison Service of Baden-Württemberg, Germany*: Germany established a special prison for elderly prisoners in Singen, Baden-Württemberg in 1970: why was it created and how are the needs of older prisoners met there? What evaluation can be made after several decades of functioning? (20 mins)
- ▶ Q & A, Plenary Discussion

16h00 – 16h30 Lunch Break**DAY 2, Friday 2nd December 2016****8h30 – 10h30 Developing an Integrated Policy Response to Ageing in Prison**

Chair: Dr Emma Plugge, Honorary Senior Research Fellow with the UK Collaborating Centre of the World Health Organization (WHO) Health in Prisons Programme (WHO HIP, European Region) and the University of Oxford

Rapporteur: Mr Austin Treacey, Governor of HMP Magilligan, Northern Ireland Prison Service

- ▶ **Dr Éamonn O’Moore** – *National Lead for Health & Justice, Public Health England & Director of the UK Collaborating Centre for WHO Health in Prisons (European Region)*: A joint WHO and UK perspective on prisons as opportunities for effective management of older prisoners’ health and social care needs, both during incarceration and post release, through appropriate service planning and delivery, closely integrated with the wider public health and social care systems. Are new policies towards incarceration of older people required to effectively manage an ageing prison population with complex health & social care needs and to ensure continuity of care? (40 mins)
- ▶ Q & A (20 mins)

► **Dr Olivier Sannier**, *National Health Focal Point, Office for Social, Reinsertion and Legal Rights Policy*; **Mme Bénédicte Riocreux**, *Head of the Office of professional practices in prison and security, Penitentiary Administration Department, Ministry of Justice, France*: For more than a year, the French central prison administration has been conducting a global project about loss of autonomy in prison. In order to improve the detention management of inmates, particularly those with disabilities, the French prison administration intends to use new tools to enable prison officers to identify physical and psychological disability. It is developing a new shared platform (with the social services and civil society organizations) to enhance its ability to offer adapted housing for inmates with disabilities facing release. Discussion on the project and its implications with special focus on older prisoners (20 mins).

► Q & A and Plenary discussion (40 mins)

10h35 - 11h00 Coffee Break

11h00 – 13h00 Conclusions & Recommendations

Chair: Mr Régis Savioz, *Head of ICRC Regional Delegation, Paris*

- Concluding remarks from each session by rapporteurs (15 mins per session)
- Plenary discussion following each presentation (10 minutes per session)
- Concluding remarks by ICRC and proposal for follow-up (20 minutes)

ANNEX II: SPEAKERS BIOGRAPHIES



Prof. Sonja Snacken

Sonja Snacken is Professor of Criminology, Penology and Sociology of Law at the Vrije Universiteit Brussel (Belgium), where she holds a 'Research Fellowship' (2006-2016). Her research focuses on penalty in Belgium and Europe, including sentencing and implementation of custodial and non-custodial sanctions and measures. She has been involved in over 40 research projects, at a European, national and local level, with a special emphasis on the integration of an empirical social scientist approach with human rights concerns. Her interest has recently broadened to other forms of (extreme) institutional dependency. She is currently supervising PhDs on the changing position of prison governors, on open reception centres for asylum seekers, on elderly prisoners, on euthanasia requests by prisoners, on community reintegration of former prisoners, on the impact of legislation on relations of extreme dependency in prisons and health care institutions, on the impact of European norms on prison reform in Russia, on the pathways of prisoners without legal permit of residence.

She is member of the Editorial Board of Punishment and Society and Déviance et Société. She was president of the European Society of Criminology (2004-2005). She has been closely involved in the drafting and monitoring of the Council of Europe standards relating to prisons and community sanctions (2006 European Prison Rules, 2010 Council of Europe Probation Rules, expert to the European Committee for the Prevention of Torture). She was actively involved in the drafting of the Belgian Prison Act (2005) and the Act on the External Legal Position of Prisoners and Victims's Rights (2006). More information on Prof. Snacken and on her publication can be found here: <http://www.crisresearchgroup.be/index.php/members/prof-dr-snacken>



Ms Diete Humblet

Prof. Sonja Snacken will be participating to the workshop together with Ms Diete Humblet. Ms Humblet is a doctoral researcher and member of the Department of Criminology, the Research Group Crime & Society (CRiS) – Research Area Penalty and Society, at the Vrije Universiteit Brussel. She is also part of the project Human Rights in Situations of (Extreme) Dependency' (HOA), and is a member of the ESC Working Group on Prison Life and the Effects of Imprisonment. Under the supervision of Prof. Snacken Sonja, she is currently preparing a PhD on older adults in prison. Diete's paper "Older prisoners" was the winning entry in the Perrie Lectures Essay Competition 2015, Howard League for Penal Reform (see ECAN bulletin issue 27, September 2015).



Dr Brie Williams

Dr. Brie Williams, Professor of Medicine at University of California San Francisco, is a practicing geriatrician and palliative medicine specialist. Dr. Williams works with collaborators from the criminal justice, public safety and legal fields to apply geriatrics and palliative medicine paradigms to transform criminal justice healthcare.

Dr. Williams has published work calling for a more scientific development of compassionate release policies; broader inclusion of prisoners in national health datasets and in NIH-funded health research; and improved systems for defining, recognizing, and responding to disability, cognitive impairment, and multimorbidity in incarcerated older adults. Dr. Williams also directs the Criminal Justice Aging Project, which develops and delivers geriatrics training to professionals throughout the criminal justice system including police, judges, attorneys, and healthcare providers. In 2015, Dr. Williams founded the University of California Criminal Justice & Health Consortium to bring evidence-based healthcare solutions to criminal justice reform.

The Consortium now includes over 130 faculty and graduate students spanning all 10 campuses of the University of California and more than 20 academic departments. Dr. Williams also directs the European-US Criminal Justice Innovation Program, an immersion program funded by the Prison Law Office for U.S. criminal justice leaders and government officials that introduces them to innovative criminal justice policies and systems in Europe and delivers targeted planning, technical assistance, and evaluation support to achieve transformative change in their home jurisdictions.



Ms Lynn Saunders

Lynn Saunders is the Governor of Whatton Prison. She has worked for the Prison Service for 23 years and has previously been the Governor of Lincoln and Morton Hall prisons.

She qualified as a Probation Officer in 1986 and has a degree in Applied Social Sciences and an MA in Criminology. She was a Mental Health Act commissioner from 2002-2004 and is a Trustee of the humanitarian charity, Prisoners Abroad.

She set up, along with other colleagues, the Safer Living Foundation, a charity to help prevent sexual (re) offending, in 2014. She is currently Chair of the organization and is engaged in a part-time PhD at Nottingham University studying the transition of people convicted of sexual offences from custody to the community.

She has worked with people convicted of sexual offences for most of her career and is considered to be one of the more knowledgeable and compassionate prison Governors in this difficult and controversial area. She developed a holistic approach to manage and care for those prisoners with complex and diverse needs such as elderly prisoners, those with personality disorder or intellectual disability. This includes pioneering an anti-libidinal drug treatment programme to support the cognitive behaviour programmes based in the prison and the treatment of prisoners at the end of life. This programme is considered to be an exemplar for the wider prison estate.

Lynn was awarded an Honorary doctorate from Nottingham Trent University in 2015 in recognition of her work with this group of offenders.



Dr Éamonn O'Moore

Dr Éamonn O'Moore, Consultant in Public Health, graduated in medicine from University College Dublin in 1991. He was appointed National Lead for Health & Justice in the newly formed Public Health England (PHE) and Director of the UK Collaborating Centre for the WHO Health in Prisons Programme (European Region) in April 2013. He is an international expert on prison health, has written national and international guidelines on managing health issues in prisons, contributed to research in this area, and supported the development of national surveillance systems for infectious diseases in prisons in England and the WHO Europe Region. He is member of the Health & Justice Partnership Board, chaired by the Department of Health, and NHS England's Health & Justice Clinical Reference Group as well as the Prison Healthcare Board for England. He has advised expert groups, including NICE, WHO, national governments and the European Centre for Disease Surveillance and Control (ECDC). Throughout his career, he has worked to understand and meet the health and social care needs of vulnerable, marginalised or excluded people and communities. His research interests include prison health, migrant health, sexual health, HIV & blood-borne viruses (BBVs), and health inequalities.



Mr Herald Egerer

Mr Herald Egerer studied law in Mannheim, Bonn and Aberdeen in Scotland. At the beginning of 1997, he joined Baden –Württemberg judiciary (Germany). He worked at the district court and regional court in Mannheim, and at the public prosecutor’s office in Heidelberg. He was subsequently seconded to the Federal Ministry of Justice in Berlin. After a good three years in Berlin, Mr Egerer returned to the regional court in Mannheim.

From 2007 to 2010, he worked at the Ministry of Justice of Baden-Württemberg, where he worked, among other things, on the draft of the Länder Prison Rules. In April 2010, he became deputy head of the correctional institution in Stuttgart and afterwards head of the Karlsruhe correctional institute. After an assignment at the Oberlandesgericht (Higher Regional Court) in Stuttgart, Mr Egerer became, in July 2013, Head of the Personnel Department of the Ministry of Justice of Baden-Württemberg and Deputy Head Prison Service of Baden-Württemberg.



Dr Olivier Sannier

Dr Olivier Sannier is the national medical referent to the French penitentiary administration, office of social and insertion policies and access to rights, Ministry of Justice. He graduated in medicine (general practice) from University of Amiens in 2006 and integrated the direction of the French penitentiary administration in August 2014.

He worked in the prison of Liancourt as a general practitioner, and head of the medical unit, from 2007 to 2013. He has conducted several studies in prison on drug consumption, non-communicable disease management, ageing and disabilities. He has written numerous articles on ethics, drugs, juveniles and the elderly in French prisons.

Since graduation, he has always been involved in the healthcare of people confronted by the justice system whether victims or offenders.



Ms Bénédicte Riocreux

Ms Bénédicte Riocreux is presently working as Head of the Office for professional practices in prison and security, French Prison Service. After obtaining a post-graduate degree in penal law and Criminal Science, Ms Riocreux integrated the French Prison Service and worked in a number of penitentiary institutions. From 2003 to 2011, she was Assistant Director at Rouen, Rennes and Rennes-Vezin prisons and in 2011 she was nominated prison Governor at Chateau-Thierry prison.



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