ASSESSMENT AND MANAGEMENT OF OLDER PRISONERS

The growing ageing population is being reflected in our prisons. Amanda Sumner describes the health and welfare issues that healthcare and prison staff need to address.

Abstract

People over 60 make up the fastest growing age group in prison, but their specialist health and social needs may be difficult to accommodate on general wings. The author discusses the development of an assessment she has devised for prisoners aged over 65 at Jurby Prison on the Isle of Man to gather information on physical, social and mental health needs. Agreed plans of care covering continence, mental health, mobility, nutrition, sensory impairment and communication difficulties are also explored.

Keywords

Assessment, criminal justice system, older prisoners, vulnerable adults

It is predicted that in the next ten years the number of people aged over 80 is likely to increase by 29 per cent and that by 2050 there will be about 250,000 people aged over 100 compared with only 10,000 in 2008 (Nursing and Midwifery Council 2009). This forecast places pressure on UK prisons to ensure they have the facilities to cope with an influx of potentially infirm prisoners. Home Office figures show that the number of male prisoners aged over 60 increased from 699 in 1996 to 2,242 in 2008 and that this age group is the fastest growing in the prison population (Prison Reform Trust 2008).

Jurby Prison on the Isle of Man is a purpose-built secure establishment that became operational in 2008. Although not part of Her Majesty’s Prison Service, it equates to Category B, that is, for those prisoners who do not require maximum security but for whom escape needs to be made very difficult. It can hold 138 inmates and more than 90 per cent of the prisoners are male. Convicted and remand prisoners are held, with the latter making up 80 per cent of the population. Ten per cent are young offenders aged between 18 and 21 and 4 per cent are aged over 65.

Facilities

All wings, except the young offenders’, have two landings with stairs leading up to the first floor. The education department and visits hall are based on the first floor and can be accessed by stairs or a small lift. Each wing has one cell specifically designed for wheelchair users and a shower for prisoners who have disabilities.

The healthcare department runs as an independent GP surgery and provides nursing cover from 7.30am to 8.30pm weekdays and 8.30am to 5.30pm at weekends. Local doctors attend for three surgeries a week. There are no inpatient facilities.

In preparation for the trend towards an older prison population, staff in the healthcare department at Jurby Prison have developed a protocol, which is still in its infancy, to ensure they can meet the needs of this group.
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Its objectives are to:
■ Ensure the fundamental needs of all prisoners are met irrespective of age or ability.
■ Ensure that older prisoners remain free from discrimination in prison.
■ Maintain the dignity of all prisoners.

Assessment
All prisoners, regardless of age or condition, are interviewed by a member of the healthcare department when they arrive at the prison to start their sentence.

The initial assessment includes:
■ Baseline observations, including blood pressure, weight, blood glucose levels for prisoners with diabetes and peak expiry flow rate for those with asthma or chronic obstructive pulmonary disease.
■ Any medical conditions.
■ Medical and surgical history.
■ Use of addictive substances, for example, nicotine, alcohol and illicit drugs.
■ Prescribed and non-prescribed medication. This information is entered onto the prisoner’s computerised medical record.

As an aid to a more comprehensive evaluation for prisoners aged over 65, the author has devised an elderly and disabled assessment (EDA). The EDA is a series of six brief computerised evaluations to gather further information on the physical, mental and social needs of prisoners.

Template one: Continence
Up to 24 per cent of women and 15 per cent of men aged over 65 have some degree of incontinence. Although there is evidence that older people respond to treatment just as well as younger patients, older people are often undertreated because geriatricians do not consider incontinence a priority (Wagg 2007). Constipation is also a common feature among older people predominantly due to poor diet, lack of exercise, polypharmacy and co-existing medical conditions (Bharucha 2007). It is, therefore, essential that prisoners’ continence status and usual bowel pattern are assessed and documented.

Template two: Mental Health
The second template addresses the offender’s mental state and completion relies on the practitioner’s observation skills. The information gathered here serves as a good basis for comparison at a later date, should the prisoner’s mental state deteriorate.

Research shows that more than half of older prisoners have some form of mental disorder – the most common being depression (Prison Reform Trust 2008). This may be exacerbated while in prison, especially if the person has received a lengthy sentence or becomes isolated because of hearing or visual impairment. It is crucial, therefore, that prison staff are aware of the insidious nature of depression and are familiar with its signs and symptoms, which may include (Clinical Knowledge Summaries 2010):
■ Persistent sadness or low mood.
■ Loss of interest in activities.
■ Altered eating habits.
■ Insomnia or hypersomnia.

Template three: condition of skin
This template gives practitioners the opportunity to document any abnormalities of the skin, such as lacerations, contusions or open wounds. Any obvious skeletal deformities, as well as details of previous orthopaedic or replacement surgery, are also noted.

Template four: Mobility and respiration
Falls are the commonest cause of accidental injury in older people and 6 per cent of falls result in a fracture (Martin 2010). A fall not only results in loss of dignity, it also impedes confidence, which often results in lack of activity. This template is used to identify any mobility or respiratory restrictions that may impair the prisoner’s ability to function in the prison environment.

Mobility and respiration are linked because the main problem on the wings with anyone who is breathless is mobility. They are located on the ground floor and use the lift when they need to attend the visits hall or education classes.

Template five: Nutrition
Among older people living in the community, an estimated 10 per cent are undernourished (Age UK 2010). Factors influencing this include swallowing difficulties, ill-fitting dentures, arthritis of the hands and general health problems (Collier 2009). These individuals require close monitoring while in prison and are assessed using the Malnutrition Universal Screening Tool (British Association for Parenteral and Enteral Nutrition 2003).

Conversely, close attention should also be paid to those who are overweight. Special diets, and eating patterns or difficulties, as well as any fluctuations in the individual’s weight, are documented.

Each prisoner is allocated two personal officers, who ensure that the transition into prison life is as smooth as possible.
Template six: vision/hearing/speech
Senescence (the process of ageing) often creates communication problems that can hinder a person’s ability to adapt to prison life by reducing the likelihood of involvement in activities such as education and interaction with fellow prisoners. Steps should be taken to resolve any highlighted problems as soon as possible. These can include referral to the optician, hearing aid clinic or speech and language therapist.

On completion of the EDA and with the prisoner’s consent, the information obtained will:
1. Form the basis of a comprehensive chronic health management plan specific to the prisoner’s needs.
2. Be discussed with the allocated personal officer should any health problems or limitations have the potential to prove problematic on the wings.

Further health considerations
Investigations Laboratory tests for the following are considered for all prisoners over the age of 65 during their first week in prison:
- Full blood count/vitamin B<sub>12</sub>.
- Fasting lipids.
- Urea and electrolytes.
- Liver function.
- Thyroid function.
- HbA<sub>1c</sub> for prisoners with diabetes.
- Serum drug levels for any prisoner prescribed medication with a narrow therapeutic/toxic ratio, such as lithium and antiepileptic therapy.

Diabetes affects 1.8 million people in the UK and up to a further one million are undiagnosed (Gostling 2006). A fasting blood sugar test is offered to all new prisoners aged over 65. Mammogram appointments are arranged for all female prisoners over the age of 50 if they have not been screened within the past two years.

Medication Older people often take several drugs for different diseases, which increases the risk of drug interactions as well as adverse reactions (Joint Formulary Committee 2011). Furthermore, because of the reduction in the percentage of body water and altered fat storage associated with ageing, the pharmacokinetic properties of many drugs are altered (Beckwith and Franklin 2011), which often results in unwanted side effects. Medication is, therefore, reviewed regularly to ensure that prisoners take only tablets they require.

Practitioners should also take into consideration the fact that prisoners may experience difficulty in swallowing tablets. In this instance, medication is prescribed in liquid form whenever possible.

Being older or disabled does not automatically disqualify prisoners from holding their own medication as each case is individually assessed to determine competency for self-administration. This is determined by taking into consideration the type of medication prescribed; whether, for example, it is a sedative open to misuse or a drug that may prove fatal if taken in excess, such as warfarin or amitriptyline; prisoners’ history, for example, whether they have taken an overdose, stored medication or have been bullied; and their understanding of their medication. Tablets for older prisoners are, however, dispensed in weekly dosette packs instead of original boxes, especially where there is polypharmacy.

All older prisoners are encouraged to have an annual influenza vaccine. Studies show that it is cost effective and that in England it saves up to 5,000 additional lives each year (Department of Health 2001). There are also invitations to well-person clinics for cardiovascular disease monitoring.

As recommended by the Health Protection Agency (2012), all prisoners beginning a new prison sentence are offered hepatitis B immunisation. The mortality risks associated with hepatitis B infection are much higher in older people, thus underscoring the need for vaccination as soon as possible (Keefe et al 2011).

Care plans
Prisons are functional buildings and discipline is maintained through implementation of strict regimens. Unlocking time is 7.30am for breakfast and collection of medication, followed by education or work. Visit sessions are held in the afternoon. At Jurby Prison, all older prisoners are considered vulnerable and whenever possible are housed in an appropriate wing. Although the prison has been designed to accommodate prisoners with disabilities, the housing of any individual with special needs will place added pressure on the service by requiring a more tailored regimen.

Each prisoner is allocated two personal officers, who are responsible for ensuring that the detainee’s transition into prison life is as smooth as possible. The officer’s role involves providing support and encouragement at a more in-depth level than that given by other staff. Their fundamental duty is to encourage prisoners to make positive changes during their incarceration. These officers can prove a valuable source of information for the healthcare department and regular liaison with them is imperative if older prisoners are to be cared for appropriately.

Given the lack of 24-hour healthcare cover and inpatient facilities at Jurby Prison, it is unlikely...
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Offenders with impaired hearing require special consideration at visiting time because sessions can be noisy

it would accommodate immobile individuals or those whose disabilities are so severe that they cannot feed, wash or dress themselves. For those who may require extra assistance, however, the author has devised a series of multidisciplinary interventions covering five problem areas that might arise as a result of having older prisoners on general wings: continence, mental health, mobility, nutrition, and sensory impairment/communication difficulties. They are care plans to ensure individuals’ needs are met while detained in prison and are agreed after consultation between the prisoner, his or her personal officers and the healthcare team. Plans are under way to provide officers with in-house training on common conditions affecting older people such as incontinence, dementia, cerebrovascular accident and Parkinson’s disease. The aim is to help improve their ability to empathise with prisoners.

Continence Prisoners who have urinary or faecal incontinence are allowed extra access to laundry facilities and fresh linen and can shower more often if required. A small clinical waste bin, along with yellow bags, is positioned in the prisoner’s cell for disposal of incontinence pads or bags for those with stomas or catheters. Non-aerosol air fresheners are provided for use in the cells.

Mental health Personal officers are adept at noticing changes in prisoners’ behaviour, such as altered eating habits or withdrawal from activities, which can be helpful in the early detection of depression or other mental disorders. If depression is suspected, officers are responsible for making further discreet observations and conveying their findings to the healthcare department.

If the prisoner’s mental state causes serious concern, a more formal monitoring process, often referred to by the layperson as ‘suicide watch’, may be required. This is initiated after a multidisciplinary assessment involving the healthcare department, one or both personal officers and a senior ranking officer. Prisoners can request visits from voluntary agencies, such as Samaritans or Cruse Bereavement Care or speak to them by telephone.

Acute confusion must also be monitored. Obvious causes such as urinary tract infection, hypoxia, transient ischaemic attack, head injury or adverse reaction to medication should be considered first. Personal officers can help inmates with non-acute memory problems by regularly orientating them to time and place, and providing them with written reminders about wing routines and the names of staff involved in their care, for example, the personal officer, solicitor and probation officer.

Mobility Although activities in the prison are curtailed by time constraints, detainees with mobility restrictions should not be rushed. They should, instead, be given extra time to carry out their activities. Wing staff should encourage unsteady prisoners to make use of any walking aids, if issued and to ensure appropriate footwear is worn rather than the use of flip-flops and loose-fitting slippers. It is equally important that the officer ensures that communal areas remain free from obstruction, to reduce the risk of falls.

Nutrition Many potential problems may prevent individuals from achieving optimal nutritional intake. These include poorly fitting dentures; difficulty in holding cutlery because of arthritis; difficulty in cutting food or controlling the plate; and dysphagia. If any of these problems arise, a joint effort should be made by the healthcare department and the personal officer to ensure that prisoners are referred to appropriate professionals, that is, a dentist or speech and language therapist, and that the necessary eating aids such as plate guards and foam cutlery handles are available.

Meals are served at 7.45am, 11.45am and 4.45pm and approximately 30 minutes are allocated for each session. This may be too little for older prisoners to collect and consume their meals. Priority is given to older prisoners at mealtimes and permission given for them to finish eating in their cells if necessary. The catering department provides a varied diet using three menus in weekly rotation. Low fat and vegetarian options are available every day, and special requests such as for soft diets or halal food can be met. Prisoners must complete their menu forms one week in advance.

Sensory impairment/communication difficulties If an inmate is visually impaired, the prison must provide large print versions of information leaflets and the forms used to apply for permission to speak with the prison governor, probation officer or doctor, or to arrange for a family member or friend to visit. The education department supplies low-vision aids such as magnifying sheets if required and large-print books can be obtained.
Assistance is offered when completing menus, documentation to arrange for visits, and ‘canteen’ requisition forms for the purchase of items from the prison shop. Assistance applies not only to those with visual impairment, but also to people with literacy problems, who comprise up to 60 per cent of the UK prison population (Clark and Dugdale 2008).

Offenders with impaired hearing require special consideration at visiting time because sessions can be noisy, especially if children visit. The supervising senior officer should ensure that, if possible, those with impaired hearing sit as far away from other prisoners as possible to make it easier for them to communicate with their visitors. Similar considerations should be made on the wing and officers should make sure prisoners have heard announcements about attending for medication, education classes, meals and physical exercise. The healthcare department’s role in the management of prisoners with sensory impairment is assessment, monitoring and referral to the appropriate agency, for example, the optician, the hearing aid clinic or the speech and language therapist.

Pre-release
There is regular liaison between the prison’s resettlement officer, probation officer and the healthcare department in the months before release to ensure that prisoners are being released into an environment that is compatible with their needs. Detainees who are particularly vulnerable are those:

- Who have lost contact with family and friends because of the nature of their offence.
- Whose physical or mental state has deteriorated while in prison.
- Who have served a long sentence.
- It may be considered necessary for occupational therapists to assess their accommodation, and home care might be arranged in some cases.

Conclusion
Caring for older prisoners is complex and may require subtle changes being made to a regimen that is dominated by strict time limits and where security is paramount. Responsibility for their welfare is held jointly by the healthcare department and its affiliates, wing officers, probation and prison management. Holistic care can be achieved only if there is ongoing communication between these agencies and prisoners, to give everyone involved the opportunity to air concerns, review care management plans and develop objectives.

However, a prison sentence is not just about punishment and loss of liberty; it is about changing individuals’ mental, physical and social wellbeing in a way that ultimately proves beneficial to them, and the community, when they are released. There should be no disparity between the provisions for younger and older prisoners. Both have been placed into the care of the prison authority by the courts and prisons are obliged to meet their needs, regardless of age.

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References


