Psychiatric needs of elderly prisoners

The number of elderly prisoners is increasing and evidence suggests that there is significant unidentified psychiatric morbidity in this group. Currently, elderly prisoners who have psychiatric needs are managed either by the generic forensic psychiatric services or generic old age psychiatry services. **Drs Arghya Sarkhel, Carlo Thomas and Ajit Shah** discuss the extent of the problem and how these patients can be better identified.

The number of elderly prisoners in England and Wales is increasing. In 1990, the number of elderly male prisoners (those who have been tried and found guilty) was 472. This rose to 808 in 2000 and then to 1,496 in 2002. Several studies have demonstrated that there is significant unidentified psychiatric morbidity within this group of sentenced prisoners as well as those on remand.

Taylor and Parrot found that 50 per cent of male remand prisoners over the age of 55 years had hidden active symptoms of mental illness on entering the prison. This rate was twice that of remand prisoners under the age of 55 years. Alcohol-related disorders, including withdrawal features and functional psychosis, were the most prevalent psychiatric diagnoses. In the vast majority of cases, psychiatric morbidity had not been previously identified. In the same sample about half the subjects had significant physical morbidity and this rate was again twice that of those under the age of 55 years. An Israeli study reported similar findings.

In addition, a study of sentenced male prisoners over the age of 60 years across 15 prisons revealed that 32 per cent had a psychiatric illness. The most common problems were personality disorders and depressive illness. However, only 12 per cent of the depressed group received antidepressants and only 40 per cent had a documented history of depression.

Out of all the study’s sample group, 75 per cent were receiving medication. Those with cardiovascular, respiratory and endocrine health problems were prescribed medication that was appropriately targeted. However, only 18 per cent of subjects with recorded psychiatric morbidity were treated with psychotropic drugs. Also, it was found that substance misuse or dependence was rarely recorded in the patients’ notes.

But it is not only elderly prisoners who have unidentified mental illnesses. A community study from Essex reported that 28 per cent of elderly people apprehended by the police had a mental illness, which was higher than those apprehended from the general population. The most common psychiatric diagnoses were ‘organic’ and depressive illness; this was particularly the case among shoplifters.

**Identifying psychiatric morbidity**

This psychiatric morbidity in this group is likely to increase as the number of elderly prisoners is growing. Therefore, there is a need to identify and treat these individuals and this is important from
the primary care perspective as the responsibility for prison medical services has been with Primary Care Trusts (PCTs) since 1st April 2005.

There is some evidence that elderly prisoners are receiving appropriate treatment for their physical health problems and are in contact with prison doctors. This contact provides an opportunity to identify and treat mental illnesses. Another way these illnesses could be identified is to make the PCT that provides services to a prison aware of the significant psychiatric morbidity among elderly prisoners.

In addition, as such prisoners have high levels of physical morbidity, they are likely to come in contact with a geriatrician. This provides another opportunity for psychiatric morbidity to be identified. These approaches would also be consistent with Standard 7 of the National Service Framework for Older People. However, both the primary care and secondary care general medical systems may need support (including advice on treatment and management) from more specialist psychiatric services within secondary care settings or even at a tertiary care level.

**Improvements for the future**

Efforts should be made to identify cases of psychiatric morbidity much earlier in the Criminal Justice System (CJS) than imprisonment (i.e. identification of psychiatric morbidity at the time of arrest and/or trial). It has been suggested that efforts to service the hidden psychiatric morbidity amongst the elderly (at whatever stage) within the CJS requires multi-agency collaboration involving the public, the CJS department, mental health services and the prison service. Improving the awareness of the importance of recognising mental illness in elderly people within the CJS, among the police and lawyers, has also been advocated.

As well as these measures, it has been proposed that a court diversion scheme would be a useful interface between the judicial system and mental health services. In a court diversion scheme, individuals with suspected mental illnesses are assessed before the trial (often on court premises) to see if they can be diverted to receive treatment in the mental health system.

As elderly prisoners with psychiatric illnesses fall between prison, forensic psychiatry and old age psychiatry services, it has been suggested that there should be an integrated approach between these groups. This is because alone, these three groups may be ill equipped to manage this group of patients. This integrated approach should include joint training initiatives and development of specialist old age psychiatry liaison services to prisons and forensic psychiatric units.

Regional forensic psychiatric services may also be helpful in offering advice, but they may be reluctant to admit elderly patients into their units because their wards may not be suitable for frail, physically ill and vulnerable elderly. This may result in elderly mentally ill prisoners remaining in the prison system.

As a solution, the development of a small number of tertiary specialist forensic old age psychiatry services at a regional or supra-regional level has been proposed. Such a service could include secure beds on a dedicated ward, the ability to deliver services to prisons and the probation service, the ability to deliver sex offender programmes as well as a liaison service to prisons, and both generic old age and forensic psychiatry services. Unfortunately there is no consensus about the most appropriate model and there are some organisations already offering some components of the services described above.
Conclusion

There is significant hidden psychiatric morbidity among elderly prisoners so it is important to develop services to recognise and treat this morbidity.

Conflict of interest: none declared

Key points

- The number of elderly prisoners in England and Wales is increasing.
- Psychiatric morbidity within this population is significant, but is often unidentified and untreated.
- Existing generic services appear unable to meet their needs.
- Efforts should be made to identify cases of psychiatric morbidity much earlier in the CJS than imprisonment.

References

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