Losing track of time

Dementia and the ageing prison population: treatment challenges and examples of good practice

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Executive Summary

Dementia presents a looming problem for prisons responsible for a rapidly growing population of older people, yet to date it remains largely overlooked. The last decade has seen increasing academic interest in the impact of this demographic shift on a criminal justice systems designed to house younger people, however the issue of dementia has attracted little attention.

The aims of this report are to scope existing research on treating and managing male offenders with cognitive impairment to identify and share examples of good practice employed by a handful of prisons around the globe. Each establishment identified was invited to complete a comprehensive survey detailing their policies and provisions in the following areas:

- Screening, diagnosing and referral processes
- Specialist staff training
- Collaboration with specialist external agencies and voluntary sector organisations
- Prisoner carer or 'buddy' programmes
- Alternative activities and services for the cognitively impaired
- Older prisoner forums and centres
- Desired additional resources to better manage prisoners with dementia

Surveys were completed by 14 prisons in seven justice jurisdictions across four countries. Several themes were prevalent in the responses, which have steered the following recommendations:

1. Routine screenings for older prisoners
2. Staff training
    a. Dementia awareness training for security officers
    b. Appointment of a designated lead for older prisoners in the health care team
3. Utilise the expertise of specialist external agencies
4. Promote information sharing and adopt clear procedures
    a. Clear referral processes
    b. Establish an online forum to facilitate dissemination of good practice
5. Low cost modifications to prison living environments

Introduction

Across much of the developed world, the number of older men serving prison sentences has risen to unprecedented levels. This swelling population is accompanied by an abundance of healthcare needs unfamiliar to prisons primarily designed to manage younger people. In recent years there has been an increase in research focusing on both the physical and mental health needs of older prisoners, but as yet very little attention has been given to the management and treatment of inmates with dementia.

This study will begin by offering a review of existing research, examining the dramatic increase in the number of ageing men in custody and why prisons are ill-equipped to manage this demographic transformation. Focus will then shift to the growing sub-section of ageing male prisoners with dementia, investigating the significant challenges of diagnosis and treatment within a correctional environment, where the punitive and rehabilitative ideals of the prison regime are often of little significance to largely incurable, degenerative conditions destroying cognitive capacity. Finally, this paper will identify examples of good practice employed by a minority of establishments around the globe, ranging from specialist units to coordinating with external service providers, with a particular focus on the United States and the United Kingdom.

A number of limitations to this research should be noted. This study will not discuss the ideological debate surrounding the incarceration of mentally incapacitated individuals, for which Fazel's 'Dementia in Prison: Ethical and Legal Implications' offers an interesting introduction (Fazel et al. 2002). The aim of this paper is not to dispute increasingly draconian sentencing policy, but rather to explore its implications from a prison management perspective. The differing needs of older prisoners by gender is also beyond the scope of this paper, although research conducted to date suggests that, as with younger offenders, older females present a distinct range of risks and issues to establishments, particularly in relation to self-harm (Reviere and Young 2003; Williams et al. 2006). Lastly, due to linguistic limitations the overwhelming majority of research reviewed and facilities examined are based in English-speaking nations.

The rise of the older prisoner population

There remains some discrepancy within government and academic circles regarding the definition of an 'older' prisoner. Research in the UK tends to use an age threshold of 60 years for qualification, reflecting the 'sixty plus' category used in most official statistical publications as well as the age at which prisoners are no longer required to work (Howse 2003). In the US, however, a base of 50 years is more commonplace and there are strong arguments for adopting the latter.

Research to date suggests that older prisoners possess a physiological age approximately ten years in excess of their chronological age (Nacro 2009), which can be explained by a number of factors. Many offenders experience chronic health problems prior to or during incarceration as a result of poverty, diet, inadequate access to healthcare, alcoholism, smoking and other substance abuse (Anno et al. 2004). The psychological strains of prison life, including separation from family, fear of victimisation and the prospect of spending a long period behind bars, further accelerate the ageing process and affect older prisoners disproportionately (Sterns et al. 2008). Additionally it is argued that the predominance of young adults in custody encourages inmates to view themselves as 'elderly' at a younger age as they begin to feel distinct and disconnected from the majority of their neighbours (Howse 2003).

Regardless of threshold specifics, the number of older prisoners has increased dramatically in recent years, representing the fastest growing age group in Britain and most states in the US (Prison Reform Trust 2008; Cox and Lawrence 2010). In England and Wales the number of sentenced prisoners aged fifty or above has risen by 74 per cent in the past decade to number almost 10,000, with the over 60 population increasing eight-fold since 1990 (Ministry of Justice 2012a; Ministry of Justice 2010c). A similar pattern can be observed in the US where inmates 55 years and older held in local, state and federal correctional facilities now number over 170,000, treble the total in 1990 (Sabol and West 2010). At the end of 2009, prisoners over the age of 50 comprised 11 per cent of the total sentenced populations in both the US and England and Wales. Moreover, comparable growth in older prisoner populations is evident in Japan, Australia, Canada and Scotland [1] (Yamaguchi 2011; Grant 1999; Uzoaba 1998; Scottish Government 2010).

The explanations for such a drastic increase are multiple and extend far beyond increased life expectancy and the demographic impact of the 'baby-boom' generation (Howse 2003). Tougher sentencing policies are undoubtedly a major cause, enacted by governments mortified at the prospect of appearing 'soft' on crime. This is particularly pertinent in the US, where the passage of 'three strikes' legislation has led to an explosion of middle-aged offenders serving mandatory long-term sentences. California, one of the first states to enact the laws, now holds twenty-six thousand prisoners over the age of fifty, making up 18.5 per cent of the total population in custody, compared to 3.9 per cent in 1990 (CDCR 2012).

1 The Scottish Prison Service is an agency of the Scottish Government and is managed and operated independently of Her Majesty's Prison Service in England and Wales.

Draconian measures to combat the war on drugs since the 1980s has also contributed, as has 'truth in sentencing' legislation, forcing offenders to serve at least 85 per cent of their sentences before being eligible for parole (Anno et al. 2004). In the UK, the last decade has witnessed courts more willing to order custodial outcomes for breaches of bail and supervision orders, as well as impose indeterminate sentences, which have more than doubled since 2002 (MoJ 2010c). Furthermore, improvements in forensics have assisted a surge in retrospective prosecutions for more serious crimes in recent years (Recoop 2011). The latest prison population figures for the US and England and Wales detail slowing growth rates in the past two years, however it is difficult to ascertain whether this portends the beginning of a trend of stabilisation (Sabol and West 2010; Ministry of Justice 2012a).

Older offenders can be divided into four broad categories; individuals over the age of fifty being incarcerated for the first time, younger inmates serving sentences less than 20 years but long enough to remain in prison beyond the age of fifty, career criminals returning to prison after multiple sentences and offenders given a life sentence as a young adult who are now older than fifty (Sterns et al 2008). A disproportionately high number of older offenders are admitted for sexual offences. This is particularly noticeable for inmates over fifty when convicted. In England and Wales, 40 per cent of offenders over 50 have been sentenced for a sexual offence compared with 9 per cent of the remaining prison population (MoJ 2012b). In Australia and the United States the figures are 41 and 25 per cent for over 55s respectively (ABS 2011; Human Rights Watch 2012).

The nature of these crimes, particularly those committed against children, further encourages lengthy custodial sentences and creates a 'stacking effect' as new entrants join ageing long-term prisoners and lifers (Le Mesurier et al 2010). While 15 states, as well as the District of Columbia, have attempted to combat this effect by implementing geriatric early release provisions, public perception towards sex offenders tends to dictate such measures are seldom utilised (Chiu 2010).

Unsurprisingly older prisoners are more costly to accommodate. Most existing research evidences per-prisoner expenditure on older inmates as roughly three times higher than the general population (Anno et al. 2004; Mitka 2004; Ware 2009; Williams et al. 2010). This ratio is largely the result of healthcare costs driven by high rates of chronic disease among older offenders. Healthcare expenditure in Texas in fiscal 2010 was $545 million, with $4,853 spent per inmate over 55, compared with just $795 for younger inmates. Hospitalisation costs for the state were also six times higher (Correctional Managed Health Care Committee 2010). Alarmingly this group has grown by almost 8% in the past year alone (Correctional Managed Health Care Committee 2012).

In the UK, where prison healthcare jurisdiction has been transferred to the National Health Service (NHS), research suggest that over 80 per cent of older prisoners have a serious illness or disability, with cardiovascular and respiratory diseases the most common. Disabilities associated with chronic disease are more common in incarcerated older people than those living in the community. Mental health disorder rates are also significantly higher among older offenders, with thirty per cent diagnosed with depression (Howse 2003). Research in the US has returned rates of mental illness ranging from 16 to 52 per cent, with depression also listed as the most prevalent followed by dementia, anxiety and late life schizophrenia (James and Glaze 2006; Sterns et al. 2008).

The dearth of provisions for older prisoners

'No problems – old and quiet' was an entry discovered in an older prisoner's wing sheet during the inspection of an English prison. It summarised the widespread neglect of older inmates, who pose little security threat, and became the title of a damning report from the Inspectorate of Prisons highlighting the lack of care provisions for the older prison population (HMCIP 2004). In England and Wales, the National Offender Management Service (NOMS) continues to operate without a national strategy for older prisoners, contending they should be managed on the basis of individual need rather than age (Wahidin and Aday 2005). In 2008 just three of 29 inspected establishments possessed guidelines to cover this population's needs (HMCIP 2008).

This scarcity of management strategies reflects the Prison Service's emphasis on security, ensuring public protection and reducing reoffending within the younger population (Davies 2011). On both sides of the Atlantic, research has uncovered a lack of sensitivity towards older inmates' physical, social and emotional needs (Aday 1994b). Many older prisoners were unable to cope with the standardised regimes and timetables they were expected to adhere to, for example numerous interviewees complained of missing exercise periods because they could not reach the gate in time (Crawley and Sparks 2005). Some gave up participating in activities and described themselves as 'vegetating' (HMCIP 2003). The release and resettlement process caused particular anxiety, with prisoners feeling clueless as to what they were supposed to do or if anything was being arranged for them after release (Crawley 2004).

Moreover basic staff training to manage older offenders appears fundamentally absent. A former assistant commissioner in New Jersey was quoted as saying; 'I know how to run prisons, not old-age homes' (Malcolm 1988). Indeed it has been argued that the culture of prison officers is largely resistant to developing the required skills, because the tasks involved are often dishonourable, domestic and viewed as emasculating (Crawley and Sparks 2004). Yet other research has illuminated knowledgeable prison staff with strong proposals for improving conditions for older detainees, but lacking the influence required for implementation. In a UK study focusing on education, officers bemoaned the emphasis on filling quotas and meeting targets at the expense of offering relevant courses or avoiding duplicating qualifications attained prior to imprisonment (Mann 2010).

With the highest incarceration rate in the world, the United States has had to take steps to confront the challenges posed by the volume of older people in prison, although the issue remains low on the agenda for most states. The Federal Bureau of Prisons has been considering the benefits of accommodating older inmates separately from the younger population since the 1970s (Davies 2011), while a recent survey, completed by 41 states, reported that 13 states (32 per cent) operated units dedicated to older prisoners, nine states provided specialist medical facilities including a hospice, and six states managed entire correctional facilities specifically for older offenders (Sterns et al. 2008). Ohio has six separate prisons housing solely older prisoners, the largest of which holds 450 inmates and will be discussed later in this report (Davies 2011).

'At some point correctional systems will have to decide if it is better to house ageing inmates in separate units that can provide for their special needs, including deteriorating health, memory impairment, mobility problems, and psychiatric and psychological problems' – *Chief Psychologist, California Men's Colony, 2012*

The merits of age-based segregation are much debated. Undoubtedly it can help to prevent isolation issues for some prisoners, by both alleviating the fear of victimisation by younger inmates, and facilitating social interaction with peers of a similar age (Davies 2011). It is also argued that separate facilities are cheaper to run since fewer security personnel are required (Stojkovic 2007) although this claim appears a lot more contentious once healthcare and programme costs are considered. However, concerns have been raised that segregation purely on the basis of age will prevent healthier older prisoners from taking part in general population activities, stigmatise them as 'elderly', and potentially accelerate any deterioration in physical or mental health. Furthermore, many establishments insist the presence of older people among the general population is primarily beneficial as they can help maintain stability on the wing by acting as a calming influence on younger, more volatile prisoners (Uzoaba 1998).

Dementia in prison – a hidden problem

Dementia is an umbrella term for a range of different conditions that affects mainly older people. It includes a range of symptoms including the erosion of mental capacity (decision-making ability), impacting memory, concentration, problem solving, perception, communication and, in later stages, personality and motor skills (Mental Health Foundation n.d.). About 800,000 people in the UK have dementia and the risk increases significantly with age. Although dementia affects each individual differently (and can vary depending on the type of dementia), it is generally divided into three stages. Early stage dementia includes concentration and minor memory issues, the second stage typically features greater forgetfulness, such as names or the time of day, difficulties understanding conversations and becoming angry or upset, while in the final stage the person will be unable to recognise familiar faces or remember what they have just said or heard, and will be incapable of managing daily tasks, including personal hygiene (Nacro 2009).

Dementia is a consequence of damaged brain tissue, causes of which are still relatively unknown although for some, less common forms of dementia, can include brain injury, pressure from a brain tumour or long-term alcoholism (Nacro 2009). The most common form is Alzheimer's disease, accounting for roughly 65 per cent of cases. With the exception of dementias caused by vitamin deficiency or some head injuries, the disease is incurable, although there are a range of treatments and interventions to slow the rate of degeneration (Mental Health Foundation n.d.). On average, people live for six years after being diagnosed with dementia, with 90 per cent of cases eventually requiring full-time nursing care (Wilson and Barboza 2010).

Approximately 30 per cent of people with dementia suffer symptoms of depression, while anxiety and aggression issues are also associated with its onset (Calleo and Stanley 2008). A minority of patients will also exhibit sexually inappropriate behaviour, with research to date suggesting this occurs in between three and 15 per cent of cases (Light and Holroyd 2006).

Dementia is acknowledged as one of the most pressing problems facing health and social care systems (Henley 2012). It is estimated that there are 35.6 million people living with dementia around the globe, including 5.4 million people in the US and 800,000 in Britain, where one in three people over the age of 65 will die with some form of the condition (Wimo and Prince 2010; Alzheimer's Society 2012a). The World Health Organisation estimates that incidences will double by 2030 and more than triple by 2050 (World Health Organisation; 2012).

Currently it affects roughly one in 20 people over the age of 65 and one fifth of people over 80 (Mental Health Foundation n.d.). In 2010, the worldwide cost of the disease was estimated at $604 billion (Wimo and Prince 2010). In the UK, 40 per cent of people in general hospitals and two thirds of people in care homes have dementia, however diagnosis rates are poor; two thirds are never diagnosed and just one third of GPs believe they have been sufficiently trained to identify the conditions (Department of Health 2010b). A recent audit of hospitals in England and Wales discovered that only six per cent of facilities had a dementia care pathway in place (Royal College of Psychiatrists 2011).

'The sad thing is that there are many inmates with mild dementia who go unnoticed in the prison system. They develop coping mechanisms which provide the correct answers to people exposed to them for a short time. It usually isn't until they can no longer cope that we realize the problem exists. The prison systems are just too large to devote the time necessary to diagnose early dementia effectively' – *Corrections Health Care Administrator, SCI Waymart, 2012*

The prevalence of dementia among older prisoners remains largely undetermined. Combining rates in the community with the theory of accelerated ageing in prison would suggest it affects approximately five per cent of detainees over 55. An article in an American correctional healthcare magazine, taking this phenomenon into account, estimated there are currently 40,000 inmates with dementia in the U.S. and forecasted this figure could increase to a quarter of a million by 2050 (Wilson and Barboza 2010).

Previous mental health research conducted in England and Wales has returned lower rates, ranging from one to four per cent, although the cases identified were severe; prisoners who knew neither how long they had been in custody nor why they were there (Crawley and Sparks 2006; Fazel et al. 2001; Fazel et al. 2002; Le Mesurier et al. 2010). Fazel et al. (2001) attribute these reduced instances to two factors; the successful diversion of those offenders displaying symptoms and that people with cognitive impairment lack the capacity to commit more serious crimes for which people are incarcerated.

The latter reason is challenged by research in other countries suggesting offences committed in old age are often expressions of the onset of dementia, and that pathological shifts can weaken inhibitions and result in instances of violence and deviant sexual behaviour (Aday 2003). An Israeli study of first-time offenders over the age of 65 reported a dementia rate of 25 per cent (Barak et al. 1995), while a second paper from Israel studying men over 60 referred by court for psychiatric assessment found that 30 per cent had dementia and that sexual offences were far more prevalent in this population than the remaining subjects (Heinik et al. 1994). Studies in Sweden and New York State examining detainees aged 60 or above on psychiatric units returned dissimilar rates of seven per cent and 33 per cent respectively (Fazel and Grann 2002; Paradis et al 2000).

Furthermore, it is highly likely that lower instances of dementia in custody are illusionary, masking the challenges of diagnosis within a prison environment. The highly regimented nature of life in prison determines that mental health issues are easily missed or ignored if they do not pose a threat to the security of the establishment. This is a particular problem for older prisoners, who not only present few disciplinary issues but are also less likely to self-harm than any other age group (Howse 2003). Older offenders are often reluctant to seek attention or report changes in mood, even when questioned, as many have been raised with a more stoic attitude to the hardships of life (Yorston and Taylor 2006; Le Mesurier et al. 2010). Depressive symptoms or early-stage dementia will instead likely manifest themselves in less sociable, 'quieter' behaviour with the result that available mental health services are directed towards more vocal, younger prisoners (Sterns et al 2008; CSIP 2010).

This is reflected in two studies of older prisoners' mental health needs in England and Wales, with both uncovering serious deficiencies in diagnosis and treatment rates. Fazel et al. (2004) discovered that just 18 per cent of older people with a recorded mental illness were being treated, and that of the sixty men they diagnosed with depression, only seven were receiving medication. The second study produced similar results, with 24 per cent of diagnosed prisoners receiving healthcare of any kind. This research also discovered several prisoners with cognitive impairment using the Mini Mental State Examination (MMSE), a common assessment tool for dementia diagnosis (Le Mesurier et al. 2010). The lead author of this study argues that without a comprehensive screening policy

for older prisoners, cognition issues are unlikely to be recognised, particularly considering that the symptoms of early stage dementia can easily be mistaken for mild depression (Le Mesurier 2012). Indeed there is a case to be made that the exceedingly structured format of prisons not only obstructs diagnosis but also enables people to better cope with the onset of dementia, thereby concealing the difficulties they are likely to face upon release.

However, the challenges of identifying detainees with dementia are exacerbated by deficiencies in staff training and prison healthcare. While all custodial establishments conduct a medical screening of new arrivals, most assessments are not designed to detect issues associated with ageing, including cognitive impairment. As in the community, few healthcare practitioners possess the familiarity or diagnostic tools required to recognise symptoms of dementia and disregard standardised scoring scales for assessing cognitive functioning (Yorston and Taylor 2006).

Mental health problems, particularly forgetfulness and disinterest, are often viewed merely as an inevitable result of the ageing process. One prisoner in England reported he was laughed at when informing the psychologist of his difficulty remembering things (PRT 2008). Indeed, a number of reports have documented a lack of awareness of the need to conduct mental health checks on older prisoners at regular intervals to detect symptoms that may fluctuate over time (CSIP 2007; Stojkovic 2007; Calleo and Stanley 2008). Repeated calls for healthcare units to train and appoint a manager or lead nurse to be responsible for overseeing the delivery of care for older detainees have gone largely unheeded (HMCIP 2008).

Moreover, while wing officers develop relationships with prisoners and are therefore best positioned to notice changes in mood or behaviour, most lack the required skills to look for specific conditions and refer the individual to healthcare for further assessment (Sterns et al. 2008). Improved communication between security and mental health staff members, through regular case management meetings or including officer observations in functional evaluations, is a need highlighted on both sides of the Atlantic (HMCIP 2008; Cox and Lawrence 2010).

The aims of incarceration, whether punitive or rehabilitative, hold little meaning to prisoners with dementia. Existing research on the experiences of older people in prison is replete with examples of detainees oblivious to their surroundings, those mentally incapable of participating in the courses required for release, and those whom officers knew would pose a risk to themselves and the public without intensive supervision in the community (Fazel et al. 2002; Edgar and Rickford 2009; Le Mesurier et al. 2010). While it is difficult to ascertain how many people in custody currently have dementia, the projected increases in life expectancy and older prisoners indicate the figure will rise substantially in the coming decades (Administration on Ageing 2006). This will have major operational implications for facilities lacking the knowledge, tools and resources to effectively manage this population, ensuring more and more older inmates will be left ‘vegetating’.

Surveying examples of good practice

While the challenges associated with this demographic shift appear to be creeping up on most prisons, some facilities have already implemented reforms to manage older prisoners, including provisions for those with dementia. Although such innovations have been acknowledged in existing research, few reports go into great depth on programmes, policies and regimes designed specifically for prisoners with cognitive impairment.

To try to develop a greater understanding of these practices, a survey was developed and those establishments identified in existing research as potential models of good practice were invited to participate. The limited research available on this subject strongly suggested that most prisons proactively seeking to manage this limited but growing population were acting as silos, and therefore a comprehensive survey could not only compare and contrast innovations from around the globe but also, critically, share this work with a wider audience of interested parties.

This section of the paper will examine existing models of good practice and identify common themes in effective management and interventions, including specialist units, staff training, older prisoner clinics, forums and day centres, alternative regimes and activities, carer schemes and links with external service providers. Survey responses and any relevant existing research have been incorporated within these themes.

Survey methodology

Available studies on older prisoners, many of which are referenced in the previous sections, offered a useful starting point for establishing which prisons warranted further investigation. Ten establishments were initially identified; four in England and Wales, four across separate states in the US, one in Japan and one in Belgium. During the consent-seeking process, a further nine were recommended for inclusion by relevant governing bodies and academics. National and State-level research committees were approached for approval, before the prisons themselves were invited to participate. In total 14 of the 19 establishments approached completed the surveys; eight from England, four from the United States, one from Japan and one from Belgium.

This disproportionate representation of English establishments can largely be explained by the publication of several detailed reports on older prisoners in the UK in the past few years offering case studies and thereby potential leads (PRT 2008; Cooney and Braggins 2010; Le Mesurier et al. 2010). The National Offender Management Service, in approving the research, also recommended an additional four establishments to approach, further skewing the figures. Only one other governing body, the Pennsylvania Department of Corrections, suggested an additional establishment to investigate.

The survey consisted of 22 questions and was designed to encourage participants to share examples of good practice in the following areas:

- Screening, diagnosing and referral processes
- Specialist staff training
- Collaboration with specialist external agencies and voluntary sector organisations
- Prisoner carer or 'buddy' programmes
- Alternative activities and services for the cognitively impaired
- Older prisoner forums and centres
- Desired additional resources to better manage prisoners with dementia

The questions were answered by a combination of Officers, Senior Officers, Offender Managers, Voluntary Sector workers and, in two cases, central government employees. All but three surveys included input from health care professionals working in the establishment. Responses were generally comprehensive and thoughtful, offering a detailed insight into different prisons' strategies and interventions.

Participating prisons

Surveys were completed by the following establishments:

- California Men's Colony (California, USA)
- HMP Dartmoor (England)
- HMP Exeter (England)
- Fishkill Correctional Facility (New York, USA)
- HMP Isle of Wight (England)
- SCI Laurel Highlands (Pennsylvania, USA)
- HMP Leyhill (England)
- Penitentiary Institution Merksplas (Belgium)
- HMP Northumberland (England)
- Onomichi Prison (Japan)
- HMP Stafford (England)
- HMP Wakefield (England)
- SCI Waymart (Pennsylvania, USA)
- HMP Whatton (England)

This sample contains a diverse range of establishments, in terms of structure, regime and facilities as well as location. Just one prison, Wakefield, is classified as maximum security or 'Category A'. Of the remaining 13, seven are categorised as medium security and six listed as low security. Just four prisons, California Men's Colony, Fishkill, Merksplas and Onomichi, operate wings or units solely housing older prisoners and only two, California Men's Colony and Fishkill, possessed a unit designed specifically for offenders with dementia.

Opened in 2006 and housed on one floor of the facility's medical centre, Fishkill's Unit for the Cognitively Impaired receives referrals from other facilities across New York State. All occupants suffered with some form of dementia, although some patients suffer from additional conditions including Parkinson's disease, Huntington's and AIDS. California Men's Colony also contains a specialist unit which houses prisoners with moderate to severe dementia. Previously it did not

offer therapeutic interventions but it has recently been piloting programmes which are tailored for those with cognitive impairment. The preliminary results indicate that the prisoners who participated significantly improved in terms of social skills, depression and attention (Human Rights Watch, 2012). California Men's Colony has also received considerable attention for its prisoner buddy scheme for occupants with dementia.

Like Fishkill, both Pennsylvanian participants, SCIs Laurel Highlands and Waymart, manage a high proportion of their state's older prisoners within their healthcare units. Laurel Highlands serves as the primary medical care provider for the Pennsylvania Department of Corrections and receives transfers from the other 26 facilities in the system, while Waymart operates two 45-bed personal care units, on which the average age is 62. Waymart's plans to add a unit for the cognitively impaired had been postponed due to budget constraints. Exeter is in the process of altering the social care unit to enable it to have a dementia area, with a specially adapted walk ways and lighting. There are also plans to open an end of life unit in early 2013, which will include rooms for families to stay overnight.

Onomichi prison's specialist unit does not cater solely for detainees with dementia, but over half its occupants have some form of cognitive impairment. Accommodating 61 prisoners, it employs two certified nurses around the clock and has a small clinic, with more serious medical cases transferred to the nearest hospital in Hiroshima. The layout of the unit was designed for less mobile prisoners, with customised washrooms, handrails and ramps instead of stairways. Padded walls were installed in several cells after one inmate with dementia began repeatedly banging his head against them. In response to the doubling of the over-60 prison population in the last decade, the Japanese government had planned to build three larger units, at a cost of over $100 million, which will accommodate one thousand older inmates (Yamaguchi 2011), although these projects are currently under threat due to economic conditions and local opposition.

Penitentiary Institution Merksplas in Antwerp also houses its oldest and most infirm inmates on a separate wing, although the building's listed status prevents radical overhauls like Onomichi and has determined that the layout hasn't changed a great deal since it was opened as a homeless colony in 1825. In fact criteria for admission to 'zaal 1', the specialist unit, include good behaviour as it is not deemed safe to manage violent offenders of any age. Specialist accommodation for older prisoners is a rarity and a luxury not afforded to most facilities. The remainder of respondents have undertaken a range of other initiatives to adapt to rising numbers of older inmates with cognitive impairment, which will be explored in the next section of this paper.

Of the establishments who did not return surveys, a couple are particularly worthy of attention. Hocking Correctional Facility in Ohio has a population solely consisting of older offenders and also operated a successful buddy programme. The Ohio Department of Rehabilitation and Correction (ODRC) declined to take part in the research, although they did state that their buddy programme had recently been disbanded due to budgetary issues. In England, Norwich opened the first elderly lifers' unit in the United Kingdom, housing 15 men with serious conditions including dementia. In the interests of sharing good practice, information acquired from existing research on establishments who did not respond will also be included in this section.

Survey findings

Assessing older prisoners

Establishments were asked if any specific age threshold was used to define an 'older' prisoner. Interestingly nine of the 14 surveyed prisons (64 per cent) used 'over 50' to categorise, citing the accelerating ageing process and health risks associated with time in prison and a pro-criminal lifestyle, as discussed earlier in this paper. One establishment used over 55, one over 60 and another over 65, while the remaining two preferred a case by case approach.

Respondents were asked how often older prisoners' health needs were reassessed. Six establishments did not periodically examine older offenders, conducting health checks as and when required by the individual or referred by a member of staff. Of the remaining eight prisons, half reassessed needs at least once every three months and only one, Fishkill, had an official policy of assessing less than once per year, although in practice most of its occupants were evaluated far more frequently. The healthcare lead at Merksplas in Belgium, where prisoners are assessed on a case-by-case basis, expressed a wish to be able to conduct more regular checks but stated staff capacity prevented this. They also stressed the importance of older offenders, when mentally capable, being able to take charge of their health and remain independent.

SCI Laurel Highlands provides the most regular routine checks, with skilled care patients assessed every 30 days during their first six months and then every 60 days thereafter. A critical rounding meeting for more severe cases is conducted weekly. The institution's Long–Term Care Programme houses 73 personal care inmates, the majority of whom have dementia. Referrals are received from Correctional Facilities across the State, after which a senior specialist nurse travels to the originating prison to assist with functional assessments. A second screening incorporating both medical and cognitive issues is conducted upon arrival at Laurel Highlands. The establishment also accommodates over one hundred older inmates who are bedridden, dependent on a respirator or have a terminal illness (Anno et al. 2004).

Eight of the surveyed prisons had implemented, or were in the process of developing, assessment tools specific to older offenders. Seven used some form of dementia screening tool within their assessment, with a further two outsourcing this procedure. The Mini Mental State Examination (MMSE) was the most commonly applied, by six establishments across four jurisdictions, but a further three types of test were also utilised; the Addenbrooke's Cognitive Examination, the Wellman Clinic's 'Test Your Memory' and the Six Item Cognitive Impairment Test (6CIT).

Fishkill Correctional Facility utilised an additional two screening modules; 'Early Warning Signs', a 10-question tool assessing the presence of cognitive impairment by either self-report or observation and 'Dementia Symptoms and Behaviour Triggers', a 14-question assessment to identify symptoms through observation of the patient. Similarly, Stafford had developed their own bespoke tools, drawing on existing tests for anxiety and depression and the Kingshill Cognitive Impairment Test for dementia (Le Mesurier et al. 2010).

Coordinating service provision

Common to most of the programmes and treatments examined in this report are working partnerships forged between different departments within each establishment, and between prisons and external agencies, whether charities, healthcare providers or social services in the community. This multi-disciplinary approach offers facilities access to resources and expertise that would otherwise be unavailable, allowing them to develop comprehensive assessments and sentence plans not only spanning an older offender's time in custody but also ensuring risks and needs continue to be addressed after release. Participants were asked about the levels and methods of coordination between health care and prison officers, as well as with offender managers and relevant service providers in the community in preparation for resettlement.

Establishments reported mixed experiences of information sharing between different internal departments. Several, including Laurel Highlands, Fishkill and Whatton, hold weekly or monthly meetings to discuss specific older prisoners and men with mental health issues, which are attended by security staff, psychologists and internal social workers as well as health care. At Fishkill, quarterly meetings also include input from education staff, dieticians and the prison's clergy.

Two establishments, Leyhill and Merksplas, reported the use of treatment plans with multi-agency input, which focus on behavioural rather than medical interventions and therefore are easier to understand for staff on the wing. At Leyhill, these plans are managed by a voluntary sector organisation, Recoop (Resettlement and Care of Older ex-Offenders and Prisoners), rather than prison staff. Recoop attend parole board meetings and case reviews and routinely communicate with the Offender Management Unit, while ensuring that each older prisoner's Personal Support Plan offers multidisciplinary support, including from health care. At Merksplas, handelingsplannen are designed for every detainee with mental health issues, with the health care team taking the lead but routinely consulting with security staff. At California Men's Colony, officers working on the wing receive documentation regarding any inmate who needs prompting or reminders due to memory impairment, as well as information on any required modifications to their rooms, such as a lower bed.

HMP Isle of Wight, an amalgamation of three sites housing a high proportion of older lifers and sex offenders, has set up a 'Memory Services Prison Pathway', offering a clear referral process for security staff who may be concerned about a prisoner's memory. The officer can refer them either to the mental health team or to the over-50's Wellman Clinic, both of which will routinely evaluate each person referred with a Test Your Memory assessment. Scores of 42 or below are then referred on to a GP, who will conduct further tests including a blood dementia screen. This Memory Services model can be viewed in Annex A.

Dartmoor reported the need for better integration between Healthcare and the Social Inclusion department, but felt this was due to extreme staffing shortages rather than a lack of enthusiasm within the establishment. At the time of writing, a nurse had been identified to bridge this gap, who would be based permanently in the prison's over-50's club and assist with the development of referral pathways with a view to expanding them to incorporate other marginalised groups within the establishment, including men with learning difficulties and those who speak little English.

Prior to an older offenders' release, eight of the 14 participants reported routinely sending full health assessment histories to Offender Managers and relevant agencies. Those that did not cited patient confidentiality issues as the major barrier, noting that securing consent could be problematic. Three establishments responded that health care information was only forwarded to the Offender Management Unit if it was specifically requested, which, one prison stated, was a rare occurrence.

As well as offering diagnoses and care in prison, the older prisoners' clinic at Stafford provides an assessment for care services in the community. This screening is conducted in the two months prior to the offender's release before being forwarded to any applicable agencies with the aim of combating resettlement problems and prisoner anxieties about returning to the community. Both California Men's Colony and Laurel Highlands had set up a system for medical and psychology staff to provide continuity of care information to receiving personal care facilities, mental health or Department of Public Welfare (DPW) sites. Laurel Highlands employ a Social Worker responsible for coordinating scheduling and destination details.

At Dartmoor, such referrals are often made face-to-face through weekly Multidisciplinary Team (MDT) meetings held in the prison's healthcare department. These meetings are used to discuss complex mental health cases and, in instances where an individual is nearing release, external agencies, including community teams and probation, are invited to attend. Age UK, the country's largest charity for older people, play an integral role in the release and resettlement of older prisoners at Norwich, providing an advice and support service on finance and accommodation and following up these issues after release (HMCIP 2012).

The Older Prisoners Action Group (OPAG) are working at the Isle of Wight prisons, bringing together professionals from the Department of Health, prison and probation services, the NHS, Birmingham University and a number of charities to offer a continuum of care for ageing prisoners. A key objective of the alliance is to advocate for the adoption of a multi-stage common assessment procedure for older inmates, which would create a single appraisal process integrating health and social care needs bridging the transition from prison to resettlement (HMCIP 2008). This project is on-going with monthly meetings working towards the new assessment framework.

Staff training

To navigate the complexities of multidisciplinary approaches, the majority of participating prisons had appointed a lead on older offenders to oversee these working relationships and coordinate service delivery.

Eight establishments had an identified lead within the healthcare team in a range of roles, including doctors, primary care managers, matrons and nurses. At Fishkill, the head physician is supported by a management team including a psychologist, a social worker and a psychiatrist, while Northumberland have recruited two nurses with a background in older people's care to lead on older prisoners.

At Leyhill, a lead officer is responsible for completing assessments for new arrivals on reception, offering advice and guidance and acting as a liaison between departments, other prisons and the wider community (Nacro 2009), while at Wakefield, the elderly and disabled offender team encourage ageing inmates to join a register where their needs can be catered for on an individual basis. Working with Age UK, the prison has also implemented a 'dignity tool', which examines the social concerns of older detainees (Prison Service News 2009). At Whatton, which houses exclusively sex offenders, one fifth of the prisoners are over 60 and over one third have no fixed release date. A senior nurse leads on the care of older offenders and has made arrangements with the local primary care trust store for assessment for and provision of mobility and daily living equipment (HMCIP 2012b).

Six leads had received training specific to the role, often from external organisations, with one more to deliver imminently. The Modern Matron for Prison Healthcare at Isle of Wight has been involved in part of the CAF (Common Assessment Framework) project and attended a week's course on communication and care-giving in dementia delivered by Dementia UK, which includes design considerations on care giving environments, stage specific

activities and interpersonal approaches. At Exeter, the Primary Care Manager had spent time with the older adult team at the Royal Devon and Exeter Hospital and attended additional training on Parkinson's, while the healthcare lead at Waymart had received Americans with Disabilities Act (ADA) training and had attended a number of conferences on dementia care.

Age-specific training had also been extended to security officers and other staff in a number of those establishments identified as models of good practice. The Prison Reform Trust's report on staff views of the ageing population noted that employees in prisons that had invested in awareness training were much more confident in identifying and referring age-related ailments (Cooney and Braggins 2010). Security staff occupy a critical position in ensuring mental health services are directed towards detainees incapable of requesting support, and in the US and the UK, dementia and Alzheimer's charities have played a prominent role in training wing officers to identify symptoms of cognitive impairment.

Security staff had received some form of specialist training to work with older offenders in eight of the prisons surveyed. In six establishments this covered mental health issues with a further three specific to dementia. In all eight of these cases external agencies and charities had been involved in the design or delivery of this guidance.

Perhaps unsurprisingly, given its unit for cognitively impaired prisoners, Fishkill offers the most comprehensive training package. All positions on the unit, including security officers, are filled on a bidding basis that only includes individuals who have expressed an interest in working there. Every employee completes a 40-hour training programme, designed by a local branch of the Alzheimer's Association in partnership with doctors, mental health workers, nurses and prison officers, to equip staff with a thorough understanding of the impact of dementia on behaviour and enable them to manage each prisoner appropriately. The regime aims to minimise situations conducive to confrontation than may confuse and upset inmates. Personnel meet with inmates in their rooms and in recreational areas, rather than in the more formalised setting of staff offices. Wing officers are also required to complete a report following most incidents involving physical contact with an inmate. While this may appear laborious, the process is intended to increase awareness that seemingly hostile outbursts are usually a symptom of dementia and can be managed without the use of force (Hill 2007).

At Exeter and Dartmoor, dementia awareness training is available to staff, organised by Recoop, who operate in a cluster of three prisons in the south west of England. Uniquely, this training session, delivered by a Dementia Support Worker from the Alzheimer's Society, is offered to both prisoners and staff. Stafford is set to be a pilot site for a memory clinic pathway in early 2013. This will include training for healthcare and wing staff on dementia, as well as further assessment tools for those who may have dementia and a visiting geriatrician, and a pathway for further diagnostics. In California, the Alzheimer's Association were involved in designing and delivering training to security officers on identifying, referring and caring for occupants with cognitive impairment. Custodial staff are required to attend refresher training annually.

Age UK will be delivering training to staff at Wakefield and Whatton in the next six months. The charity has recently produced an older prisoner assessment tool as well as a monitoring guide for Independent Monitoring Boards in each prison (IMBs), while at Shepton Mallet they have distributed self-help booklets and preliminary self-assessment tools for older prisoners, to help alleviate the burden on staff (Cooney and Braggins 2010). Both Age UK and the Alzheimer's Society were present at a community engagement event hosted by Leyhill, where staff and older prisoners had received falls prevention training.

Three establishments are currently partnering with academic institutions to improve conditions for older prisoners. At Merksplas, students from the University of Ghent had worked on a project scoping the needs of older

prisoners, including those with dementia. Next year a professor from the Artesis Hogeschool in Antwerp will be conducting further research on this population. SCIs Laurel Highlands and Waymart are working on a research project with Penn State University to develop an End of Life toolkit and procedures with a view to establishing a hospice. Laurel Highlands had also recently piloted Adaptive Inmate Management (AIM) training.

While many of the establishments surveyed had taken the initiative in coordinating service delivery and staff training, it is much rarer for such reforms to be instigated at a higher level of government. One such exception is the Missouri Department of Corrections, which has developed specific policies to ensure staff work towards shared goals and to clearly defined standards. An Ageing Offender Management Team has been formed to establish and implement reform in facilities across the state. This has included training and 'cultural awareness' courses and equipping officers with fact cards to help them identify symptoms of dementia and depression. The team is also charged with building a support network of relevant service providers in the community (Missouri DOC 2009).

Similar initiative was evident within the Ohio State government. The Department of Ageing had helped facilities construct a 40-hour training course for corrections personnel incorporating age sensitivity, issues around death such as writing a will, nutritional advice and helping offenders due for release access Medicare and senior citizen discount cards (ODRC 1997). ODRC declined to take part in this research and it is not known whether this course is still in operation.

Prisoner carer schemes

Whilst training helps to ensure that staff have the appropriate skills for working with older prisoners, often they do not have the resources to meet their needs, with the provision of care for older and infirm inmates representing a major drain on staff time.

Ten of the surveyed establishments operate prisoner carer and buddy schemes, employing younger inmates to help provide care for those struggling with physical or cognitive impairments. These schemes can benefit both officers and prisoners as they offer additional, often one-to-one, support that staff lack the capacity to provide. Roles vary by establishment and range from to palliative and medical support to meal collection and cleaning assistance.

The scheme at California Men's Colony is particularly demanding, with Social Service Aides expected to work at least 36 hours per week, in return for a monthly salary of $50. The 'Gold Coats', named after the gold-colour jacket they wear to identify themselves, receive training from a local chapter of the Alzheimer's Association and assist those with cognitive impairments and mental health issues by walking them to their appointments, coaching them through their daily routine and reminding them of their scheduled activities and appointments, as well as helping them to read or fill out forms. Buddies are allowed to cover each other's shifts and also to swap their patients to encourage better personality matches. The programme has been lauded as extremely successful, with aides building strong relationships and demonstrating protective behaviour over their charges (Ubelacker 2011).

There can be other benefits with enlisting the support of the other prisoners to care for older inmates and those with dementia. At California Men's Colony, the programme was implemented specifically to provide care and protection for occupants with dementia, after numerous cases of victimisation emerged involving younger prisoners tricking them into giving away their possessions (Ubelacker 2011).

SCI Waymart has established an extensive buddy programme where inmates are employed as porters and wheelchair assistants. They use approximately

nine porters per unit per shift, with five offering care to those housed on each of the personal care units. The porters housed on the personal care units receive specific training and can assist the visually handicapped to walk throughout the establishment. These porters offer additional support and are willing to be called on at night if needed. The prison has also recently started a forensic peer programme where inmates with a history of mental illness, but who have been stable for a prolonged period, act as a support system for other prisoners with similar conditions.

SCI Waymart also runs a volunteer programme that was originally started to provide comfort from a peer during a death vigil. The programme has expanded to offer more general support, including with writing letters and reading, as well as playing games with older prisoners. Staff at the establishment reported that this has helped the volunteers build a personal relationship with the older prisoners that may provide additional comfort during any death vigil. Volunteers receive 40 hours of training on diseases, infection control principles, comfort measures, and death and dying. Many of the porters are also volunteers or have at least participated in the volunteer training. Volunteers are scheduled for approximately two hours per night and each is on duty one or two nights per week. SCI Laurel Highlands also runs a volunteering programme where, once approved, the selected prisoners assist in the medical setting with personal care and daily living activities.

Wakefield and Leyhill prisons operate similar schemes employing a small number of prisoners, four and six respectively, as paid carers who are responsible for tasks such as cell cleaning, collecting items including meals, laundry and mail and offering other assistance specific to the needs of the individual who requires support, including pushing wheelchairs. HMP Isle of White utilises approximately 14 buddies to work three hours each day in the morning or afternoon to offer assistance to older or less able prisoners on each wing. The buddies are designed to encourage independence and the re-enabling of personal care. Three additional English prisons were working together to develop a buddy training programme that will provide participants with a formally recognised National Vocational Qualification in social care (HMCIP 2008).

HMP Whatton uses Disability Awareness Coordinators to offer additional care to older or less able prisoners. These are prisoners who are identified, trained and risk assessed as being appropriate for the role. Two are employed full time and involved in palliative care with an additional 12 offering support such as wheelchair pushing, collecting meals, assisting with canteen lists and cleaning and making beds.

Some establishments use buddies to monitor the older inmates and can feed back to staff if there any changes in the recipient's behaviour or health needs. At Hull prison, buddies are trained to carry out basic assessments and they promote the scheme to other prisoners who would benefit from the assistance but may be reluctant to ask for help. At Hocking Correctional Facility in Ohio, aides were utilised to help the cognitively impaired create a sentence plan and participate in activities.

The schemes all have a rigorous application process and regular monitoring to ensure aides pose no risk of predatory behaviour. At Hull and Dartmoor prisons this includes a formal, job description, application form, two rounds of interviews and periodic evaluations (Le Mesurier et al. 2010). California Men's Colony demands at least ten years of exemplary behaviour (Ubelacker 2011). Some establishments prohibit personal care but it is allowed in others with some, such as SCI Waymart, requiring direct staff observation when there is physical contact, for example if a volunteer helping another inmate button his shirt (ODRC n.d.; Le Mesurier et al. 2010).

Alternative employment and recreational activities

Many older prisoners find participating in a normal prison regime overly strenuous, which can in turn increase the potential for isolation and the risk of mental health issues. Recognising this, all but one of the surveyed prisons had tailored their regimes to encourage greater participation from older offenders. Alternative employment roles, leisure activities and exercise options were all evident in the responses.

Day centres
A number of establishments have set up day care centres offering less arduous activities and providing older inmates with a place to socialise. Staff working in these settings generally reported that this assisted in improving mental wellbeing, social engagement and physical health.

At Leyhill a day care centre is provided for older prisoners open six mornings and four evenings a week, offering activities such as poetry, creative writing, crafts, gardening and nature walks, as well as documentary screenings. The centre can accommodate those with dementia and offers reminiscing and discussion sessions that are aimed at helping improve memory. Similarly, within the Isle of Wight prisons, an older prisoners group is run four afternoons per week which offers age appropriate activities, including playing board games, musical instruments, arts and crafts as well as teaching practical skills. Whilst not specifically designed to benefit those with dementia, staff reported positive benefits from this type of activity from prisoners who were symptomatic of the condition.

Onomichi prison hosts an arts and calligraphy club and karaoke sessions, as well as organising visits from comedians and musicians. Unusually, the facility also has a bale of turtles which detainees with cognitive impairment are responsible for looking after, to encourage a sense of routine and responsibility (Yamaguchi 2011). Both Laurel Highlands and Fishkill offer a range of recreational activities for older prisoners including bingo, cards, dominoes, draughts and puzzles. Fishkill have also collaborated with a charity called 'Rehabilitation Through the Arts' to organise theatrical performances, as well as running a facility band consisting of offenders.

At California Men's Colony, a number of activities have been specifically designed for those with cognitive impairment, including psycho-educational groups that focus on daily planning and discussing current events and the prison also offers reminiscing sessions. Prisoners with dementia are given the opportunity to engage in recreational pursuits according to their interests and abilities including reading, play card games, dominoes and with jigsaw puzzles and watching films.

A number of establishments utilise the assistance and expertise of the voluntary sector to run their day centres and alternative activities. At Dartmoor, Exeter, Leyhill and Shepton Mallet, Recoop deliver over 50s 'wellbeing clubs' which allow older prisoners to socialise with each other in a less intimidating environment. They provide entertainment including quizzes, games, discussions and interest groups, plus speakers who talk on various health and resettlement related issues. They also run sessions to aid relaxation and meditation to reduced stress and improve energy, vitality and emotional well-being.

Aimed specifically at offsetting dementia and to accommodate those with early signs of the disease, Recoop deliver 'brain gyms' which include a range of cognitive exercises to help promote optimal storage and retrieval of information which helps improve memory and concentration. A 'memory café' runs once per week at Shepton Mallet, an adapted version of the initiative run in communities across the UK by the Alzheimer's Society. As well as offering relaxation exercises

and a brain gym, the café hosts 'Singing for the Brain', an innovative programme conceived to help people with dementia socialise and express themselves, based on the concept that music and song are easier for the brain to recall (Alzheimer's Society n.d.).

Staff at Whatton work with the charity Age UK to provide the Older Persons Activities and Learning group which offers activities and support to older prisoners. The prison has also implemented a more relaxed regime on the older prisoners' wing, where volunteers run reminiscing sessions. Similarly, Age UK has opened a day care centre at Stafford, running seven half-day sessions per week. It provides a relaxed, social setting for inmates who previously had no facility or occupation during the day. Most of its users are residents on the vulnerable person wings. Recreational activities include cookery classes, play readings, creative writing and gardening. They have also offered older prisoners additional in-cell activities such as painting and one prisoner with mild cognitive impairment had received permission to take up knitting. The centre is used as a platform for Age UK to run a Senior Citizen Group to provide individually tailored advice on benefits, resettlement support and what to do in the event of the death of a family member. Its coordinator had prior experience as a senior mental health nurse and as a prison governor. Merksplas also utilises volunteers, from JWT - a judicial welfare group, who attend the establishment every two weeks to offer relaxing activities designed for older inmates including walking and home cycling. Moreover, the prison has a nurse who plays specialised games with older prisoners designed to benefit those with memory problems.

Exercise
Regular exercise is often cited as effective in combating both early dementia and depression and ten of the surveyed prisons offer exercise aimed specifically at those less able.

Five establishments offered chair-based work out classes and six run alternative physical activities such as yoga, martial arts and tai-chi. Dartmoor and Exeter provide Shibashi Qigong classes, which is a form of tai chi adapted for the older person and for those with reduced mobility. This form of exercise has been shown to have beneficial effects for a range of physical and psychological conditions, as well as helping to improve balance, flexibility and to reduce anxiety. Similarly, Onomichi offers martial arts classes modified for older prisoners, as well as including 40 minutes of light exercise in their daily regime.

A number of prisons allow older inmates to access standard gym equipment but either at times separate to the general population to allow them to exercise in a non-threatening environment, as at Stafford (Le Mesurier et al. 2010) or with their own specific facilities, such as at SCI Waymart where they have a treadmill and exercise bike on the personal care unit and offer an over 40s weight lifting programme. Wakefield also has a gym facility called the ‘Pair Suite’ which is an adapted form of ‘multi-gym equipment’ which allows older prisoners to undertake appropriate exercise. In addition, PE staff attend the healthcare unit twice per week to assist older prisoners with exercising and a physiotherapist attends on a weekly basis to work with older prisoners on a one-to-one basis and they can also offer acupuncture.

Stafford hosts a senior leisure activities afternoon on a Saturday for up to 30 prisoners to undertake light exercise such as badminton or bowls, two sports that are also offered at Whatton and the Isle of Wight. Coldingley has introduced a programme in association with Age UK's ‘fit as a fiddle’ scheme and this offers age appropriate prison exercise such as curling and bowls (Le Mesurier 2011). At Merksplas, they use their volunteers from JWT to assist with exercises on the wings and staff have reported that this has had a very positive effect on the inhabitants.

Employment
Despite prisons generally classifying prisoners as 'older' at age 50, most detainees are encouraged to participate in prison employment until the standard retirement age. In Stafford and Whatton, prisoners are required to work up to the age of 65, however staff at Stafford reported that even when inmates are eligible to retire many opt to continue working, particularly in the prison gardens. Inmates at Onomichi are required to work six hours per day, compared to the eight hours expected of other Japanese prisoners, but are given lighter jobs including laundry folding, paper crafts, beadwork and shoe-making for external clients (Yamaguchi 2011).

At the majority of prisons surveyed, older adults can apply for employment opportunities in the same way as other offenders and roles are assigned on the basis of an individual assessment. However, six establishments have created specific employment roles suitable for older prisoners. At Merksplas, they have tasks such as cleaning the paths in the yards, feeding their fish and watering the plants, although they report that in reality little gets done. SCI Waymart assigns occupants of their personal care units tasks such as wiping down windowsills and wrapping silverware in napkins. Dartmoor and the Isle of Wight prisons both have over 50s groups offering employment activities for older and less able inmates, including stamp-sorting, ornament painting and box and rug making. Out of the establishments surveyed, only Onomichi and California Men's Colony had roles specifically designed as being productive for prisoners with dementia that involve repetitive simple tasks. Onomichi commented in their survey that using the fingertips assists with brain activity and so roles had been created to reflect this, including separating plastic beads, putting small products into bags and inserting manual instructions into products.

Prisoner forums
Five prisons (Dartmoor, Isle of White, Exeter, Stafford and Wakefield) have established older adult/ over 50 forums where prisoners can meet with their peers and raise issues relevant to them. The forums also provide an opportunity for older prisoners to be consulted on social, economic and community issues that affect them.

At Dartmoor and Exeter, these forums are run by Recoop, with an elected Executive Committee managing their affairs. They hold monthly meetings and all members of the Committee are full voting members. The forum also provides a means for consultation for those prisoners and is designed to raise issues relevant specifically to the over 50 population, with the chair meeting with the governor on a monthly basis. Recoop also work at Leyhill, where until 2010 an older prisoners' forum was operated to ensure that inmates' views were heard and their needs met. Run democratically, the forum offered a range of activities, including an allotment and computer training, but also provided a platform for members to express any worries over peers who were struggling with the regime or had become reclusive. This had proved especially effective in identifying inmates with depression and early-stage dementia, who were then referred to healthcare for a full assessment.

Additionally, the forum recruits outside speakers to discuss policy issues of relevance to older people, and subjects have included the government's National Dementia Strategy and changes to social care funding. The programme has proved extremely popular to date, with over ninety per cent of eligible prisoners joining the forum (Cooney and Braggins 2010). Whatton is currently developing a similar patient involvement group specifically for older prisoners.

Recognising that older prisoners may be isolated and their views not heard, a number of establishments have an over 50s representative attending other forums at the prison. At Dartmoor and Exeter an older prisoner attends the Equality Action Team meetings, Disability Forums and Prisoner Consultation Forums. At Leyhill, staff from Recoop represent over 50s on other prison

forums. Other establishments have more general forums where prisoners meet as a whole, regardless of age such as at Merksplas. However, Merksplas did comment that, to ensure that older prisoners' views are heard, they plan to develop their prisoner forums to have an elected representative from each of the units attending, including from the wings holding older prisoners.

Additional resources

Each of the establishments surveyed were asked what additional resources, if any, did they believe would enable them to better manage prisoners with dementia.

The most common provision listed was training for staff, requested both by establishments where none had been delivered and in those who had received some form of staff training but felt a more comprehensive package was needed.

Awareness and signpost training for officers was particularly in demand, as a number of participants expressed concern that deteriorating memory was likely to go unnoticed until older occupants were assessed for, possibly connected, physical injuries or psychological conditions. SCI Waymart stressed the importance of consistency from all staff in contact with cognitively impaired offenders to minimise confusion as much as possible, as well as the need for thorough assessment training, citing the issue that prisoners with dementia often do not or cannot say what is wrong. Exeter requested that this training was extended to prisoners, noting that it was often the friends of an offender suspected of developing dementia who were the first to highlight the issue.

Unsurprisingly, an increase in the number of personnel was also a popular request, with a range of specific roles listed. Wakefield was seeking funding for a full time member of staff to be their identified lead as an older prisoners' champion. This would allow for routine screening of prisoners in the 'at risk' age group, as well as for more targeted training to be delivered to a wider staff group.

Both Merksplas and Dartmoor required greater nursing capacity; for the former this was a position to cover for the psychiatric nurse, for Dartmoor this meant the full integration of a social inclusion nurse, who could assist in healthcare provision but also provide advice to prisoners in the over-50's club. Fishkill sought an additional recreational therapist, dedicated to the Unit for the Cognitively Impaired, while Isle of Wight requested details of external support agencies and resources that could assist in the management of prisoners with dementia and help them develop a broader social care model.

Several establishments called for adaptations to their regime, ranging from infrastructure and physical layout to designated areas to better care for prisoners with cognitive impairment. In Merksplas, where the older inhabitants in zaal 1 sleep in a collective area, the issue of privacy was raised. This was a particular issue for personal hygiene, with detainees all sharing one bathroom that is ill-equipped for less mobile occupants. Bathing and showering facilities that offer more privacy and are designed with mobility issues in mind were requested. SCI Waymart emphasised the importance of a living environment in which older prisoners would feel safe and comfortable to wander to help reduce levels of anxiety. At the time of writing, Exeter was in the process of making changes to this effect by providing an area with specially adapted walkways and lighting.

Dartmoor sought better physical access to services and departments but admitted this was challenging due to the age of the buildings and the restrictions of the regime. A Social Inclusion residential wing that could compliment the provisions offered at the over-50's club was a desired outcome. Merksplas and Whatton requested a space where activities could be conducted comfortably with older men, with the Belgian establishment seeking a day care centre where a nurse could deliver memory activities and a redesign of the garden so that ageing occupants could tend to it. Exeter had submitted an application for funding to finance a beekeeping scheme on their site for older prisoners.

Finally, two respondents hoped for the issue of dementia, and older prisoners generally, to be placed higher on the criminal justice agenda, arguing it was a problem that was likely to grow and one that individual prisons were unlikely to continue managing effectively without sufficient political and financial support.

Conclusions and recommendations

'The current service provision is solely needs based and relies on a referral being completed by either the prisoner or a member of staff. This may result in prisoners with dementia not being identified in the early onset stage of the illness' – *Service Lead, Prison Mental Health Services, HMP Isle of Wight, 2012*

The older male offender population presents a vast array of challenges to prisons in the delivery of health and social care. Inmates with dementia pose added difficulties as the early symptoms are often difficult to identify, even to the trained eye. With the exception of a tiny minority of costly specialist units, establishments lack the resources to meet these challenges alone. While the number of older inmates continues to rise, prisons around the globe are bearing the brunt of government cuts in the wake of the financial crisis. Provisions for prisoners will always be low on the list of electorates' demands, so the disproportionate reductions in rehabilitation spending over the past few years are unsurprising. However, the impact of these cuts on personnel, regimes and staff morale undoubtedly portends correctional systems less and less able to prepare for a growing problem.

In Dartmoor, the over-50's club was having increasing difficulties finding space for their activities. The British government's focus on employment meant that some workshops set up by Recoop (including Red Cross wheelchair repair) had survived but 'softer' programmes were seen as less of a priority. In Ohio, fiscal restraints have seen the state's prisoner buddy programme disbanded, while the Japanese government's plans for much needed additional units for older prisoners are on hold.

In contrast, dementia continues to climb the political agenda. In 2012, the respective leaders of the United States and the United Kingdom have both announced programmes to deliver major improvements in dementia diagnosis, care and research by 2015 (USHHS 2012b; Department of Health 2012a). The Obama administration has pledged a further $156 million to combat Alzheimer's in their proposed 2013 budget, while the British Health Secretary has announced £50 million of funding will made available to support NHS Trusts, local authorities and care providers to create care environments to help reduce anxiety and distress (USHHS 2012a; Department of Health 2012b). The extent to which this funding will be accessible to prisons remains to be seen, although it will likely be limited, yet there may well be some capacity for individual establishments to benefit, particularly where strong relationships have been forged with local government, care providers and voluntary sector agencies.

There are also some signs that dementia is beginning to gain recognition as a growing issue for prison health care. In 2010, the cover story of the National Commission on Correctional Health Care's quarterly magazine was titled "the looming challenge of dementia in corrections". The short article outlined some of the steps prison health teams could take to begin addressing the issue including; improving early detection, informing the prisoner and their family where appropriate, environmental changes, staff training and non-

pharmacological interventions to encourage a high level of functioning for as long as possible. The authors stressed the need for urgent action, warning that the correctional system would likely become the largest provider of skilled nursing and dementia services in the U.S. within decades (Wilson and Barboza 2010).

The surveys received from sites of good practice provide an interesting insight into a wide range of steps being taken to combat the challenges of managing male prisoners with dementia. A number of themes were prevalent, both in participants' responses and in the limited existing research on the area and have informed the recommended improvements in the following areas:

1. Routine screenings for older prisoners
2. Staff training
3. Utilise the expertise of specialist external agencies
4. Promote information sharing and adopt clear procedures
5. Low cost modifications to prison living environments

The extent to which each prison will be able to implement each recommended reform will naturally vary, depending on specific factors, including building design, budget, regime, population, staff-prisoner ratio and security level. Nevertheless, even minor progression in each area could impact greatly on ensuring prisoners with dementia are treated in a humane environment, conducive to prolonging functionality.

Confronting the wider challenge of the ageing prison population will require governments to face up to and begin reversing decades of populist sentencing policy. Given this will likely remain politically unpalatable, prisons will continue to shoulder the burden of an unsustainable model.

Recommendation 1: Routine screenings for older prisoners

As this paper has discussed, diagnosing dementia in prison is a major challenge. A highly structured regime with an emphasis on maintaining order can easily mask issues of cognition among an 'old and quiet' population that pose little risk to security. Despite the increase in older prisoners, the majority of prison healthcare departments are largely unfamiliar with the risks and needs associated with this age group, ensuring that many mental health issues, including dementia, are likely to go unnoticed unless accompanied by extrovert behaviour.

Over half of the establishments surveyed routinely used some form of dementia screening tool when assessing older prisoners' health. This is an example of good practice that should be adopted by other prisons as a low-cost method of signalling which offenders are likely to experience difficulties comprehending prison instructions and will require further support. There are a number of quick and easy assessment tools that can offer an initial indication of a prisoner's cognitive abilities and highlight those cases that will require a more thorough assessment. The Montreal Cognitive Assessment takes ten minutes to administer and can be accessed, with instructions, on the internet (Nasreddine 2010). The DemTect also takes 10 minutes to administer and score and has demonstrated a high level of accuracy in identifying cognitive impairment, outperforming MMSE in independent tests (Kalbe et al. 2004).

A basic cognitive screening should be conducted on all new arrivals over the age of 50 as part of their initial health assessment, with individuals attaining low scores undergoing more comprehensive tests. Serving prisoners over this age threshold should be reassessed at least once per year and screenings should also be conducted within the three-month period prior to release so that the impact of any issues on the resettlement process can be assessed and referrals can be made to relevant agencies in the community.

Recommendation 2: Staff training

'Staff need to remember that, for an inmate with dementia, life is always like coming into the middle of a movie' - *Wilson and Barboza (2010)*

While routine screenings will help to detect cognitive issues, it is imperative that staff are equipped with the knowledge and confidence to manage prisoners with dementia, treating them humanely, helping them to preserve their dignity and independence and ensuring they are protected as much as possible from the risks of prison life. Living with dementia can prove a highly stressful experience, provoking anxiety, depression and aggression, therefore it is crucial to build an empathetic support system to help put prisoners at ease (Maschi et al. 2012).

All of the surveyed models of good practice had adopted some form of training provision to better prepare staff, whether in health care or the on the wing, to identify and work with offenders with dementia. However, additional training remained the most popular request from these prisons when asked what additional resources were required. Penal institutions were not designed with older people in mind and prison officers are rarely recruited on the basis of an interest in social care. Yet security officers hold a pivotal position in identifying older prisoners who may be struggling, observing their behaviour on a daily basis and often building trusting relationships over time.

Basic training around working with older prisoners should be provided to all officers. This should incorporate early warning signs of dementia, which can include indecisiveness, confusion around time or place, mood changes, wandering and developing problems with handwriting (Wilson & Barboza, 2010). While officers on the wing cannot and should not be expected to diagnose residents, their unique role as the face of the regime offers a far greater level of contact with prisoners and therefore the ability to recognise potential symptoms and make relevant mental health referrals would be invaluable to ensuring better diagnosis rates and earlier intervention.

Training would also serve to benefit security officers and the wider regime by increasing awareness of the impact of dementia on a prisoner's ability to function, thereby reducing the potential for conflict arising from misunderstandings and giving staff the tools to better manage their movements. As Fishkill's staff training stresses, bad behaviour may often be a result of the confusion and anxiety provoked by dementia and can be addressed far more effectively with calming, reassuring communication than by steadfast orders and discipline. Similarly offenders with cognitive impairment may require more time than their peers to process instructions. Giving prisoners praise for positive behaviour can increase the chances of repeat good behaviour, as can developing methods to communicate without sounding belittling or patronising. This can include respectful ways to ask a prisoner to perform a task, such as taking medication, and, for occupants with more advanced impairment, introducing oneself at the beginning of each exchange to help out them at ease (Maschi et al. 2012).

Away from the wing, it is essential that prison health care teams possess the knowledge required to manage and treat occupants with dementia as best as possible. A member of staff from the department, where possible with experience in geriatric care, should be appointed to lead on older prisoner health care and provided with the relevant training if needed. As well as conducting assessments and producing individual care plans, this lead should disseminate good working practice among other health care staff and liaise with providers in the community to support continuity of care in release and resettlement.

Recommendation 3: Utilising expertise of specialist external agencies

The combination of growing prison populations and demands for financial efficiencies will render many criminal justice systems increasingly dependent on external agencies and the voluntary sector to cope with the additional strain and deliver education, training and other purposeful activities to prisoners. Yet the involvement of outside organisations has other benefits, most notably their experience and expertise of working with particular segments of the prison population.

The value of outside agencies was borne out in the survey responses received. Over 75% of participants were working alongside external service providers, who were administering staff awareness training, delivering alternative activities and designing referral processes. A number of voluntary sector organisations with specialist knowledge around later life and dementia, including the Alzheimer's Association, Age UK and Recoop, had been involved in more than one of the surveyed establishments and had played an integral role in transforming attitudes and environments and enhancing the experiences of older offenders.

Dementia charities are obvious candidates to deliver training to security officers, given their remit to educate the public and communicate in layman's terms how to identify symptoms and effective practice for providing care. These organisations had been involved in designing or delivering training packages in six of the surveyed establishments. In several cases, they were raising awareness and developing skills among the prisoners themselves, by designing training packages for buddies, offering basic self-assessment tools and providing advice on identifying possible symptoms among their peers.

For health care teams, strong working relationships should be forged with local hospitals and health care providers. This is particularly pertinent for establishments without in-house knowledge of pharmacological treatment options for the cognitively impaired.

The voluntary sector had also made a significant contribution to establishments offering alternative physical exercise, employment and recreational activities for older prisoners. In Britain, charities such as Recoop combine expertise of issues around ageing with experience of overcoming the challenges of operating in a prison environment. In the United States, both Fishkill and Waymart had established links with local community organisations, who delivered activities and musical performances. Charities tackling issues around ageing should also be encouraged to participate in older offenders' resettlement plans, since these organisations will usually have better awareness of the age-specific challenges likely to be faced, as well as the links with agencies that can help released offenders overcome these obstacles.

In some cases, charities may be able to provide services under existing statutory or foundation funding, allowing delivery at little or no cost to the prison while helping the organisation to meet its key performance targets for funders. Generally voluntary sector organisations offer a relatively inexpensive means of varying recreational provisions, disseminating awareness among staff and encouraging a cultural shift in attitude towards older prisoners.

Recommendation 4: Promote information sharing and adopt clear procedures

The surveys revealed communication deficiencies in some establishments, with coordination between security and health care staff insufficient or absent. This is understandable given the demands of working in prison, particularly as budgets are being cut, and the largely distinct remits of the two departments. Moreover, as the surveys revealed, the patient confidentiality is a highly sensitive issue with

legal implications, particularly in cases where the offender may not want their declining cognitive ability shared with staff on the wing.

Nonetheless a clear referral process, particularly if combined with the staff training recommended, could considerably improve a prison's ability to diagnose dementia and intervene early. HMP Isle of Wight offers an example of a clear, effective referral process, a copy of which is provided in Annex A. Security officers should be encouraged to refer prisoners exhibiting suspicious behaviour at the earliest possible juncture. Swift diagnoses could at the very least provide officers on the wing with context for why an occupant becomes easily agitated or is at risk of victimisation. Where staffing levels allow, a wing officer should participate in the health care planning process for offenders with dementia, as they will be able to report the effects on the block or landing while disseminating appropriate responses to colleagues working in the same unit.

There is also scope for far greater information sharing between prisons. When asked if aware of any other establishments engaging in similar work with older prisoners, only one of the eight English survey participants responded positively. Two prisons proposed networking opportunities to share best practice around treatment and activities.

Given the geographical spread of the survey sample, a secure online forum would offer the best platform for information sharing. This and other research has unveiled a plethora of good practice and innovative interventions, yet the vast majority of prisons are acting as silos. The forum would allow establishments around the globe to disseminate real examples of effective treatment strategies, utilise experience of working with cognitively impaired prisoners and seek guidance on how to identify possible symptoms and manage associated behavioural issues. Encouraging contributions from security staff and management grades, as well as healthcare teams, could enable the sharing of good practice covering all areas of the regime.

If sufficient levels of buy-in and participation were realised, a forum could offer efficiencies around responding to the risks and needs of offenders with dementia, particularly for prisons finding these issues a new or unfamiliar experience. An obvious example would be sharing guidelines and resources on training staff or employing prisoner-carers, which could save individual establishment the time and resources required to develop their own packages. Such a platform would also be ideal for disseminating information on specialist external agencies that prison staff may be unaware of.

The set up and management of a forum would incur some, albeit fairly limited, costs. Commitment from several governing bodies, i.e. NOMS in England or corrections departments in the U.S., would likely render these costs negligible and could help encourage participation from member prisons to maximise its potential.

Recommendation 5: Low cost modifications to prison living environments

People with dementia are highly sensitive to their surroundings. Adaptations to their physical environment can reduce anxiety and help them to maintain their independence. Alterations range from mobility enablers, such as grab rails, wider door frames and specially designed bathroom facilities, to 'dementia friendly' design changes that make it easier for the individual to find their way around. These adaptations include extra lighting, signposting, labelling each cupboard with pictures of the contents and using contrasting colours to make everyday items easier to identify (Alzheimer's Society 2012b).

Many of the alterations advised by dementia specialists could prove difficult to implement within a prison environment for security reasons. An obvious example is the Alzheimer's Association's recommendation that carers 'encourage, support, and maintain a resident's mobility and choice, enabling him

or her to move about safely and independently' (Alzheimer's Association 2009). Of the five recommended areas for change, living environment adaptations may also prove the costliest for establishments to implement.

However there are a number of inexpensive changes that can assist in supporting independence and alleviating confusion and anxiety in an often stressful environment. As Wilson and Barboza note, prisons are in many ways ahead of the curve in providing a suitable dementia care environment, with a consistent daily routine, locked units and a lack of rugs with edges (Wilson & Barboza, 2010).

A number of survey participants have already discovered the importance of good lighting and handrails in equipping cognitively impaired offenders with the confidence to navigate the landings unassisted. Where possible, placing activity areas and exercise facilities on the same floor as older prisoners' living area can also assist those with mobility issues. Hearing and vision is essential to minimising memory problems as reduced perceptive senses force the brain to try to piece together the puzzle, causing agitation and risking misinterpretations (Wilson & Barboza, 2010). Regular sight and hearing tests for older prisoners could ensure each is equipped with the required aids to support independence.

Additional changes that can be made with little effort include the removal of any mirrors and clear signposts with relevant pictures as well as large font lettering. Incontinence issues can arise from forgetting where the bathroom is or being unable to remove clothing, as well as from diminishing control of bodily functions. The first two can be combated by using contrasting coloured walls (alongside signs) to highlight toilet facilities, while providing easy to remove clothing incorporating elastic and Velcro. Onomichi prison also provides incontinence pads and lay rubber flooring for prisoners with severe bladder problems (Japan Probe 2010).

Conclusion

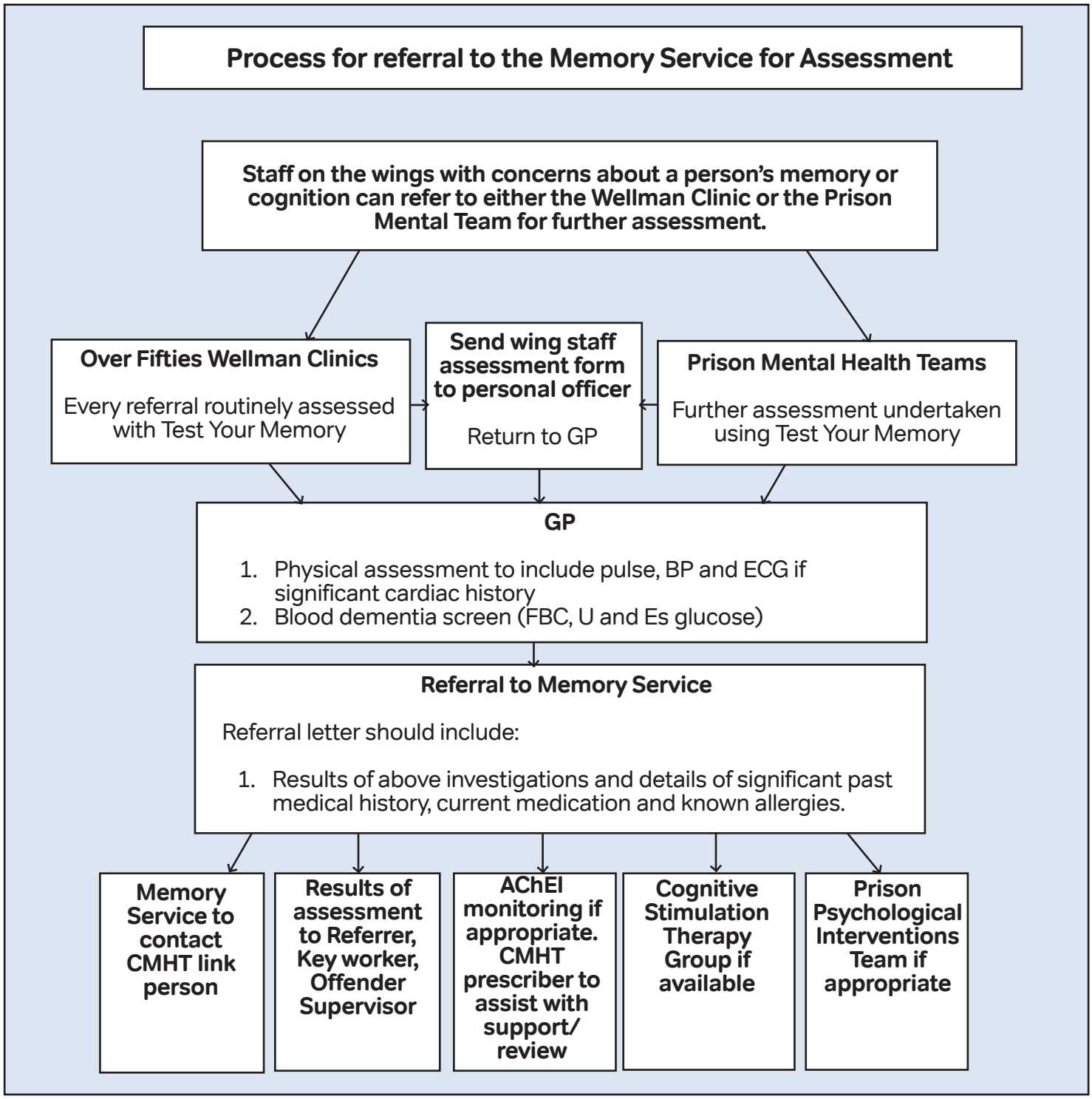
'Until now we are dealing with it the best we can. Each step is a step forward. But it is the government who needs to be aware of the specific needs of those prisoners' – *Social Service Policy Officer, Penitentiary Institution Merksplas, 2012*

Prisoners with dementia represent a sub-section of the most rapidly growing age group in prison. Given diagnosis challenges and the fact this population pose few threats to security, it is unsurprising that they have attracted little attention to date from policymakers, governing bodies or academics. There is growing recognition of the increasing strains being placed on prison health care and budgets by a greying clientele, yet cognitive impairment remains a largely hidden problem.

However a condition affecting 40% of patients in general hospitals and one in 20 over the age of 65 in the community is unlikely to remain hidden for much longer (Department of Health 2010b). Forecasted increases in dementia rates, swelling older prisoner populations and the accelerated ageing process associated with pro-criminal lifestyles and time in prison together point towards a looming crisis for criminal justice systems built on populist, punitive foundations. There can be little question that national and state governments will eventually have to confront public opinion and reform sentencing policies if they are to prevent prisons from becoming the biggest providers of dementia care in their jurisdictions.

This report has highlighted some of the innovative frontline responses, which have inspired some hopefully useful recommendations for establishments to better manage prisoners with cognitive impairment. Yet in the absence of change at the highest levels, individual prisons will continue to face a reality not dissimilar from the older offenders in their care: quietly coping as best they can, while their capacity to do so continues to diminish.

Annex A: HMP Isle of Wight memory service referral process



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