

Article Title:

The nature and extent of prisoners' social care needs: Do older prisoners require a different service response?

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The nature and extent of prisoners' social care needs

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Abstract

Summary: In light of longstanding concern about the lack of social care in prisons, the 2014 Care Act made local authorities in England responsible for identifying, assessing and meeting prisoners' social care needs. However, service planning is difficult, for little is known about the level of demand or the extent to which the needs of older and younger prisoners differ. Against this background, face-to-face interviews (including screens for social care needs, substance misuse and mental health problems) were undertaken with a sample of male prisoners in North-West England.

Findings: 399 participants were aged 18-49 and 80 aged 50 plus. Overall, more than a tenth of participants had problems maintaining personal hygiene, dressing and/or getting around the prison safely; a significant minority lacked meaningful occupation; and approaching a sixth acknowledged problems forming/maintaining relationships. Older prisoners were significantly more likely than younger prisoners to need help with personal hygiene, dressing and moving around safely and to identify problems with their physical health and memory.

Applications: The findings highlight the substantial number of older prisoners who could potentially benefit from some form of social care and support if they are to maintain their safety and dignity and make best use of their time in prison. They also underline the need to develop suitable screening and assessment tools for older prisoners, and for further research on the best service models for prisoners requiring intimate personal care.

Keywords: Social care; social work; prison social work; prisons; prisoners; older prisoners

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Introduction

Against a background of ongoing growth in the total prison population, the expanding number of older prisoners and longer prison sentences, the level of social care needs in prisons in England is increasing (HM Inspectorate of Prisons and Care Quality Commission, 2018; Parker, McArthur, & Poxton, 2007; Stürup-Toft, O'Moore & Plugge, 2018). Around the world, more than 10.35 million people are held in penal institutions, and prisoner numbers are rising in all five continents (Charles, 2015; Walmsley, 2015). The situation in England and Wales is no exception. Since the turn of the 20th century, the number of prisoners has quadrupled to around 85,000, representing 179 people per 100,000 of the population - the highest imprisonment rate in Western Europe (International Centre for Prison Studies, 2017; Sturge, 2018; Walmsley, 2015). Older prisoners are the fastest growing subgroup; in the last 15 years the number of prisoners aged 50 or over has nearly trebled with one in six prisoners now in this age group, and the number over 70 has grown still faster (Prisons and Probation Ombudsman, 2017; Prison Reform Trust, 2018). This ageing profile is partly due to wider demographic changes (Omolade, 2014). However, increasing sentence

lengths and a surge in retrospective prosecutions for historic crimes (including sex offences) have also played a role (Moll, 2013; Omolade, 2014; Prisons and Probation Ombudsman, 2017).

Internationally, research indicates that the majority of prisoners come from socioeconomically disadvantaged and marginalised sections of society. Several of the factors that make these groups more likely to offend also raise the chance that they will adopt unhealthy behaviours / develop chronic ill health (Marmot, 2017; Stürup-Toft, O'Moore & Plugge, 2018; World Health Organization, 2014). Further, their typically chaotic lifestyles preclude access to regular health care. It is thus not surprising that high levels of mental health problems, substance abuse disorders and communicable diseases are found in this population (Charles, 2015; Moll, 2013; Møller, Stöver, Jürgens, Gatherer & Nikogosian, 2007; Prison Reform Trust, 2018; Senior et al., 2013a), and following sustained concern about the standard and cost of the previous 'in house' Prison Medical Services (HM Prison Service & NHS Executive, 1999), responsibility for prisoners' health care was transferred to the wider NHS in 2006, with services now commissioned by NHS England. This resulted in a long overdue improvement in standards of health care for people in prison (Cooney & Braggins, 2010) and subsequent calls for the similar development of social care (Parker et al., 2007).

In contrast to what is known about prisoners' health, relatively little is understood about prisoners' social care needs. Although it is recognised that some younger prisoners with mental health problems, physical or learning disabilities, autistic spectrum disorders or long-term health conditions will have social care needs, it is commonly assumed that the majority of prisoners with social care needs will be older people (Local Government Association & National Offender Management Service, 2014; Skills for Care, National Skills Academy for Social Care & College of Occupational Therapists, 2015). Indeed, one study that looked solely at the needs of older prisoners, typically defined as 50 and over (Prisons and Probation Ombudsman, 2017), found that over a third of older prisoners had a functional need for help with activities of daily living (ADLs) and an eighth had difficulty mobilising (Hayes, Burns & Shaw, 2010; Hayes, Burns, Turnbull & Shaw, 2013). In light of this it is important to ask whether the prison system is able to support not only those younger, predominantly physically fit adults for whom most prisons were originally designed (HM Inspectorate of Prisons & Care Quality Commission, 2018), but also whether there are adequate opportunities for those older people whose capacities lie outside 'the norm'.

In addressing this question, this paper concerns itself not only with identifying whether older and younger prisoners have different social care needs, but also whether existing institutional arrangements afford different degrees of opportunities for older and younger prisoners to achieve wellbeing. As such it is interested in what Young has termed 'structural inequality', where 'structures' refer to "the relation of basic social conditions that fundamentally condition the opportunities and life prospects of the persons located in those positions" (Young, 2001 p14), and structural inequality refers to the relative constraints some people encounter in their choices and wellbeing as the cumulative effect of the possibilities of their social positions in comparison with others whose social position offers more options or easier access to benefits (Young 1990, 2001, 2005). To the extent that structural injustices exist, social professions are then challenged "to work towards greater justice for differently located social groups, and the individuals within them, at both micro and macro levels of society" (Clifford, 2013, p40).

That said, prior to the introduction of the 2014 Care Act, it was not clear who was responsible for meeting prisoners' social care needs. Although the 2011 Law Commission report on adult social care had stated that the legal framework did not explicitly exclude prisoners from social services provided by local authorities, in practice they were often excluded on the basis of other legislative provisions, such as

residency rules. Indeed, as recently as 2014, local authority social work staff were engaged in assessing/meeting prisoners' needs in just a quarter of establishments, a situation generally agreed to have contributed to a profound lack of social care in prisons, as evidenced in a series of reports containing multiple examples of prisoners with poor or no access to shower, workshop, education, chapel and recreational facilities (Anderson and Cairns, 2011; Cooney and Braggins, 2010; HM Inspectorate of Prisons, 2004, 2008, 2009; Local Government Association & National Offender Management Service, 2014; Parker et al., 2007). Older people's needs were, in particular, described as neither planned nor provided for (Cooney and Braggins, 2010; HM Inspectorate of Prisons, 2004, 2008, House of Commons Justice Committee, 2013; Moll, 2013), whilst the potential consequences for prisoners' day-to-day functioning, dignity, health and well-being, and preparation for release, including their ability to rebuild their lives and their risk of re-offending, were perceived to be profound. The dearth of social care in prisons was thus acknowledged to impact not just on prisoners' themselves, but the public at large and the public purse (Cooney & Braggins, 2010; Department of Health, 2014a, 2014b; HM Inspectorate of Prisons, 2004, 2008; Parker et al., 2007; Prisons and Probation Ombudsman, 2017; O'Hara et al., 2016; Senior et al., 2013b).

In view of these long-standing and growing concerns about the failure to address prisoners' social care needs, the clarification provided by the 2014 Care Act (Section 76) was widely welcomed. This made it clear that as of April 2015 the local authority within whose area a prison was located was responsible for assessing and meeting the eligible social care and support needs of any prisoners detained therein, regardless of the geographical area they came from or where they would live on release. Further, eligible needs included not only assistance with ADLs, but help to achieve the much broader range of outcomes set out in the national eligibility criteria (e.g. access to work and training) so long as these arose from a physical or mental impairment or illness, affected the individual's ability to achieve at least two desired outcomes, and had a significant impact on their wellbeing. As such, the Act signified a shift from the duty of local authorities to provide particular services, to the concept of 'meeting needs', whilst highlighting their responsibility to promote wellbeing in all cases where they have a care and support function. Section 76 of the Act detailed the manifestation of this principle for prisoners, and states that even where prisoners' needs do not meet the eligibility criteria, the local authority is charged with looking at how their general wellbeing could be improved to prevent, delay or reduce deterioration by (at a minimum) providing advice and information at an individual level (Social Care Institute for Excellence, 2015). The Act thus clearly states that the promotion of wellbeing is the key principle around which care

and support should be built at both a local and national level (Department of Health, 2014a, Section 1.3).

Although all local authorities have responsibility for social care provision for people who are released from prison into their area, this new statutory framework has particularly significant implications for the 58 authorities with prisons within their boundaries. However, service planning has proved difficult since the extent of likely demand was unknown. Against this background, the study reported in this paper aimed to identify the social care needs of male prisoners in one area of North-West England and to explore the extent to which the needs of older and younger prisoners' differ – information with important implications for providing and commissioning care and support.

Method

Participants and procedures

The study was conducted in five prisons:

- a category B (closed, high security) local prison receiving remand and convicted prisoners directly from court (Prison 1);

- a category B training prison for medium to long-term prisoners (Prison 2);
- a category C (closed, but with less internal security) training prison with four sex offender wings and an older prisoners wing (Prison 3);
- a category C resettlement prison for long-term prisoners (Prison 4); and
- a category D (open) training prison (Prison 5) in which prisoners spend much of their day away from the prison on licence undertaking work or education in preparation for release.

All housed adult men.

Data was collected in each prison in turn between May 2015 and July 2016.

Recruitment followed a three-stage process. First, a 20 per cent cross-sectional sample of prisoners aged 18 or over was randomly generated from each prison's roll call and all identified individuals were sent study information sheets. Second, those prisoners who returned a brief reply slip expressing an interest in taking part in the research and who prison healthcare staff deemed to have the capacity to consent and not to pose a threat to researchers were approached by a researcher to talk about the study and answer questions. Third, after a minimum of 24 hours to consider their involvement, prisoners were re-approached by a researcher, and if they still wished to take part in the study, written consent was taken and the research assessments completed. Interviews were

conducted in private locations within the prisons by researchers who had received training in the use of the measures administered and took an average of an hour.

Measures

The data collection schedule focused mainly on the needs of prisoners in custody (as opposed to on release) and contained seven items:

- i. A short bespoke questionnaire capturing information about the individual's demographic, social and criminal history, current offence, status and sentence;
- ii. The Michigan Alcoholism Screening Test (MAST), a 25-item alcoholism screen to determine likely lifetime alcohol-related problems and alcoholism (Selzer, 1971; Selzer, Vinokur & Van Rooijen, 1975); and
- iii. The Drug Abuse Screening Test (DAST), a 20-item drugs screen to identify misuse of psychoactive substances (Gavin, Ross & Skinner, 1989; Skinner, 1982), both of which have been found to be reliable in detecting substance dependence disorders in prisoners (Peters et al., 2000);
- iv. The Prison Screening Questionnaire (PriSnQuest), an 8-item mental health screen with good weighted sensitivity and specificity in this population (Shaw, Tomenson & Creed, 2003);

- v. The Revolving Doors Prisoner Social Care Screen Questionnaire, a 45-item tool that was specifically developed to identify prisoners' social care needs, including their employment, learning, accommodation, finance, thinking and behaviour, family social support and well-being needs (Anderson & Cairns, 2011);
- vi. A modified version of the FACE Social Care Screen Assessment, a broader social care needs schedule which captures information on individuals' needs for help with daily and instrumental activities of living and current social care support (Imosphere) that is widely used with community care clients and
- vii. The 6 Item Cognitive Impairment Test, a short, simple cognitive functioning screen (Katzman et al., 1983) that has been shown to correlate well with the Mini Mental State Examination (MMSE) (Brooke & Bullock, 1999) and to show promise in a variety of settings (O'Sullivan, O'Regan & Timmons, 2016) was administered to participants aged 55 plus.

Data analysis

The data were entered into SPSS version 23 and checked for errors. Information on physical health problems was initially recorded as free text but later categorised into nine broad groups relating to different body systems plus an 'other' category. Frequency

distributions were used to describe the sample and Chi-squared tests were used to identify any differences in the characteristics of younger and older prisoners. Where expected cells for two dichotomous variables contained less than five members, Fisher's exact test was used. All tests were conducted at the 5% level of significance. In order to maintain consistency with other reported findings, 'older' prisoners were defined as aged 50 and over (Prisons and Probation Ombudsman, 2017).

Findings

Information was collected about 482 prisoners, representing approximately 12.5 per cent of the local prison population. This included more than 10 per cent of prisoners in Prisons 2, 3, 4 and 5 respectively, and 9.6 per cent in Prison 1. Of those prisoners that provided this information, 399 (83.3%) were aged 18-49 and 80 (16.7%) were aged 50 plus (maximum 91 years).

Table 1 details the sample's sociodemographic characteristics and shows that 85 per cent of prisoners described their ethnicity as 'White British', 'White Irish' or 'any other White background'. Of the remainder, the majority identified as 'Mixed' or 'Asian or Asian British'. Overall, approaching a quarter of the sample reported having been

placed in care as a child, whilst almost a third had attended a special school and over half had been excluded from school at some point. The majority (60%) had lived in rented accommodation prior to prison entry, and over half were unemployed or in part-time/casual employment. Compared with the younger prisoners, the older prisoners were less ethnically diverse. They were also less likely to have been excluded from school, to have attended a special school or to have been unemployed/ long-term sick prior to prison entry and more likely to have owned their own house/flat.

Turning to their offence histories, just under five per cent of the full sample (4.6%) were on remand whilst the remainder had been convicted (2.7% un-sentenced, 92.7% sentenced). Approaching two-thirds had had a previous stay in custody, of whom approximately half (50.8%) had had three or more stays (Table 2). Over half the sample had been convicted of violence, robbery or burglary or theft and handling and more than two-thirds were serving a sentence of four or more years, with almost a third sentenced to ten years plus. The older prisoners were significantly less likely than the younger prisoners to have been in prison before. They were also less likely to have been convicted of a drug-related crime and more likely to have been convicted of a sexual offence.

Looking at their health profile, more than a third of the full sample (39.4%) said that they had been in contact with mental health services in the past year, and almost a quarter scored three or more on the PriSnQuest, indicating a need for specialist assessment for potential mental illness. Approximately half the sample (51.3%) reported a disturbance of their mood/anxiety (emotional wellbeing), and approaching a quarter (23.7%) said that this had a noticeable impact on their behaviour, activities or interaction most or every day. Memory problems were more common in older than in younger prisoners, and 15 (20.0%) of the 75 older prisoners who completed the 6CIT scored 8 or more indicating the need for specialist assessment for possible dementia. That said, over a fifth of younger prisoners also reported problems with their memory, which may be linked to acquired brain injury, learning disabilities, limited education or substance misuse. Indeed, more than two-thirds of prisoners (66.9%) screened positive for substance misuse, with younger prisoners more likely than older prisoners to report the misuse of both drugs and alcohol. In contrast, older prisoners were significantly more likely than younger prisoners to report physical health problems, with musculoskeletal disorders and injuries (e.g. arthritis and back pain) most common (Table 3).

Whilst, as above, more than two-fifths of the full sample reported a physical health problem, only 7.7 per cent (including 20.3% of the over 50s) considered themselves to

have a physical impairment or disability that limited their involvement in day-to-day activities, and still fewer detailed problems undertaking ADLs such as washing, dressing and showering that often required assistance, supervision or prompting from another person, or caused considerable pain or difficulty. That said, approximately a tenth of the full sample identified problems with making use of the prison safely (with most of these having difficulties mobilising), whilst just over a tenth (10.1%) of younger prisoners and a fifth (20.8%) of older prisoners reported problems maintaining their personal hygiene, dressing/undressing, toileting, making use of the prison safely and/or eating and drinking (see Table 4). Further, although the small numbers in some of these categories made it hard to detect differences between age groups, older prisoners were significantly more likely than younger ones to report a need for help maintaining their personal hygiene, getting dressed and moving around safely, with almost a third (31.3%) of older prisoners reporting a recent fall and 16.3 per cent using a mobility aid. No significant differences were found in the proportion of younger and older prisoners who were not engaged in any work, education or training, or who had problems maintaining and developing relationships (17.8% and 14.3 % of the full sample respectively).

Finally, when asked about the support they received, just under half of prisoners (47.7%) said that they received a high level of support from family and friends (31.6%),

staff (22.2%) or other prisoners (6.5%). However, a little over a quarter identified no source of support and only 3.5 per cent reported any social care input in the last 6 months (which typically related to the care of the prisoner's child or to their accommodation and finances in preparation for release).

Discussion

Further to the introduction of the Care Act in April 2015, the findings presented in this paper provide some of the most detailed information to date on prisoners' social care needs and compare the profiles of older and younger prisoners, an area about which evidence is scarce. In line with previous research, the results confirm that this is a population with multiple and complex needs (Fazel, Hayes, Bartellas, Clerici & Trestman, 2016; Hayes et al., 2013); the sample as a whole had high levels of physical and mental health problems as well as substance misuse issues. In comparison, the proportion of prisoners requiring help with ADLs appeared relatively low. Nonetheless, in contrast to the very small proportion (0.9%) of the total prison population estimated to have one or more personal care needs in a survey of the prison estate prior to the Care Act (Local Government Association and National Offender Management Service, 2014), more than a tenth of this sample (including approximately a fifth of older

prisoners), had problems maintaining their personal hygiene, dressing and/or getting around the prison safely; a significant minority lacked meaningful occupation; and approaching a sixth acknowledged problems forming/maintaining relationships. Moreover, notwithstanding the considerable diversity found within both the older and younger and subgroups, the results confirm and extend existing research to suggest that older and younger prisoners' needs differ (HM Inspectorate of Prisons, 2010; Omolade, 2014). Whereas both subgroups had high levels of mental health problems (most commonly anxiety and depression), the proportion of younger prisoners who screened positive for drug misuse was five times greater than that of older prisoners, whilst older prisoners were more likely to identify problems with their physical health and memory and to need help with personal care and mobility. In addition, whilst for ease of analysis individual needs have been presented independently, there is of course considerable interplay between them. For example, those prisoners whose mobility difficulties prevented them moving freely around the prison were often unable to access work or training or engage in social activities, with the resultant increased isolation putting them at greater risk of developing mental health problems.

Clearly not all of these individuals will have met the national eligibility criteria for the provision of social care and support; no information was collected on the underlying aetiology of people's needs and the research interviews followed a structured format

including multiple standardised measures, quite unlike the more discursive, strengths-based social care and support needs assessments undertaken by social care practitioners (Social Care Institute for Excellence, 2017). Nevertheless, the findings highlight the substantial number of prisoners (particularly older prisoners) whose social care needs impact upon their day-to-day functioning, and who could potentially benefit from some form of advice, care and support if they are to make the best use of their time in prison, maintain their safety and dignity and leave prison equipped to manage in the wider society. In an environment in which resources in all quarters are increasingly rationed, this is the challenge faced by local authorities working with colleagues from prison, education and healthcare services. The remainder of the discussion will explore some of the implications of these findings for social care commissioners, providers and prison social workers and, in particular, the need for a different service response for older prisoners (HM Inspectorate of Prisons, 2004; House of Commons Justice Committee, 2013; Howse, 2003).

Although there is some evidence to suggest that prisons are gradually developing more age-specific services (Cooney & Braggins, 2010; Lee et al., 2016), it seems unlikely that the complex and multiple needs of the older prisoners interviewed in this study can be addressed by current service approaches. To start with, it is by no means clear that adequate systems are in place to *identify* older prisoners with social care needs. In a

survey of the early arrangements local authorities had put in place to identify, assess and meet the social care needs of adult prisoners in custody undertaken in 2015/16, the authors found that the content of the screening tools used to identify prisoners who may be in need of social care and support on their receipt to custody varied hugely; in one authority, for example, prisoners were simply asked if they had social care needs (Tucker et al., 2017). Moreover, systematic attempts to identify *existing* prisoners with social care needs were lacking. Admittedly, the survey was undertaken in the first year after the introduction of the Care Act and did not specifically explore whether the same tools were used for older and younger prisoners. However, the responses contained no reference to age-specific arrangements, and it is easy to see how in comparison with the acute substance misuse and mental health needs presented by many of the younger prisoners in this study, the less obvious social care needs of older prisoners could be missed (Hayes et al., 2012; HM Inspectorate of Prisons, 2004). As is well documented, prisoners are often reluctant to expose any vulnerability within the prison environment (Anderson & Cairns, 2011), and older prisoners in particular may not ask for help, having been raised with a more stoic attitude to life's hardships (Moll, 2013). A specialist screening and assessment tool such as the Older Prisoner Health and Social Care Assessment and Plan (OHSCAP) may thus be required (Senior et al., 2013b).

If different approaches are required for assessment and screening, they may also be required for the environment. For example, the current poor condition of much of the prison estate (much of which dates from the Victorian era, with long corridors and narrow staircases) is likely to disproportionately affect older prisoners, one in five of whom reported mobility difficulties and a third a recent fall. As Lee and colleagues (2016) noted, one way the prison system could accommodate older prisoners more successfully would be to adapt the built environment, enabling individuals to remain more independent and access the prison's facilities without need for additional support. However, it is likely that in order to facilitate access to the full range of education, employment, religious, leisure, shower and canteen facilities, large areas would need to be redeveloped, at prohibitive cost. In recognition of this, some commentators have advocated the development of dedicated older prisoner units (Hayes et al., 2012), although others have cautioned that the resultant segregation of older and younger prisoners could encourage dependency and accelerate ageing (Lee et al., 2016). Less costly responses include the provision of aids and equipment as well as low-cost adaptations, and guidance now requires local authorities to provide equipment and personal aids for prisoners up to the value of £1,000, whilst prisons themselves are responsible for minor adaptations and fixings (National Offender Management Service, 2016). In the long-term, however, this will not be sufficient, and at the very least it

would seem imperative that all future prison builds/adaptations are required to accommodate the needs of older prisoners.

Although they represent a significantly smaller proportion of the prison population, careful consideration should also be given to the best way to meet the needs of those older prisoners who require assistance with intimate personal care, such as showering and dressing. In the aforementioned survey of local authorities' early care arrangements to meet prisoners social care needs, the majority of respondents stated that prison healthcare staff (usually health care assistants) provided this support (Tucker et al., 2017). The advantages of this arrangement include the onsite presence of such staff and their ability to respond to changing levels of demand. However, some authorities expressed concerns that, when under pressure, healthcare staff prioritised health over social care, and did things 'for' as opposed to 'with' prisoners. Other local authorities had therefore made arrangements for local domiciliary care providers to deliver social care in prisons through a mixture of spot and block contracts, but this too had its problems, including reduced flexibility (particularly availability at night) and the time taken to gain security vetting. As yet it is too early to draw any robust conclusions as to the optimal service model, and future research is needed to assess the relative strengths and weaknesses of the different options. Interestingly, a recent exploration of the need for a dedicated social care unit for prisoners in the West Midlands (comparable to a care

home in the community) did not fully support this. Whilst a case could be made for around ten places for men requiring ongoing 24-hour supervision or a reablement/intermediate care short stay facility (out of over 9,000 surveyed), the audit rather highlighted the need to improve provision on the main wings and to consider the establishment of a more 'sheltered' unit for (mostly) older prisoners, offering a high level of accessibility alongside peer-to-peer support and a quieter environment (I Anderson, personal communication, August 13, 2018).

Although this study found older prisoners were more likely than younger prisoners to present with mobility and personal care needs, it is important to note that a significant minority of younger prisoners also required such assistance, whilst similar proportions of both groups acknowledged problems achieving other desired outcomes. Asked about their main concerns or difficulties, both younger and older prisoners voiced concerns about finding accommodation and employment on release, saying they had not had sufficient help and information about these issues, whilst others spoke of the need for help to participate in education or training because of mental health and learning difficulties. Indeed, previous research has found that approaching a third of people in prison have learning disabilities or difficulties that interfere with their ability to cope within the criminal justice system, including filling in forms and accessing facilities (Prison Reform Trust, 2018), and it is thought that a number of older people in prison

with mild cognitive impairment currently go ‘under the radar’ (House of Commons Justice Committee, 2013).

Given that engagement in education and training can promote wellbeing, reduce reoffending and increase prisoners’ prospects of securing employment upon release (Hopkins & Brunton-Smith, 2014; Ministry of Justice, 2015), the finding that almost one in five prisoners across both age groups reported a lack of engagement in meaningful activity is also of concern. Although this study was not able to differentiate those individuals who wanted to access work or training from those who did not, several interviewees expressed frustration about the dearth of education and job opportunities and, nationally, just 43 per cent of inspected prisons received a positive rating for the provision of purposeful activity in 2017/18 (HM Chief Inspector of Prisons for England and Wales, 2018). Further, given that prison education and work services are generally geared towards working age adults, older prisoners are often effectively excluded (Lee et al., 2016), and even where places are available, a combination of staff shortages and poor allocation processes can prevent their best use. Indeed, echoing a past report by the Chief Inspector of Prisons, it would appear that one of the main issues facing prisons today is not how many prisoners the system can hold, but whether there are sufficient resources to do anything useful whilst they are there (HM Chief Inspector of Prisons for England and Wales, 2012). In this context, the development of activities

aimed at promoting the physical, mental and emotional wellbeing of older prisoners and maintaining/developing their independent living skills as well as confidence in approaching community based support services could be a sound investment.

Finally, in light of past research to suggest that prisoner contact with families is important for their wellbeing, as well as helping facilitate their return to the community and decrease re-offending (May, Sharma & Stewart, 2008; Williams, Papadopoulou & Booth, 2012), it is noted that a significant minority of the sample, both younger and older prisoners, expressed the need for help to maintain family relationships. It is thus important that these needs are also addressed, with consideration given to the adequacy of systems to facilitate family contact and involvement (Williams et al., 2012).

Methodological considerations

Whilst this study had a number of strengths, including its large random sample, a number of factors should be considered when interpreting its findings. First, the absence of women's prisons in the study means that the results cannot be generalised to this population. The study was confined to male prisoners largely because the number of female prisoners aged 50 plus in England and Wales is very small (less than 500 in September 2016, Ministry of Justice, National Offender Management Service and HM

Prison Service, 2016). A separate national study is required to investigate this group. Second, it is recognised that in relying on prisoners' responding to a recruitment letter and giving informed consent, the study will have excluded some prisoners who by virtue of severe physical or mental health problems are particularly likely to have high social care needs, including people with progressive neurological disorders, strokes, profound dementia and learning difficulties. Discussion with frontline practitioners in another strand of the study suggested that the number of such cases most authorities had seen were low. Not surprisingly, however, they often required considerable levels of care and support. Third, as no data were available on non-participants, it was not possible to compare the characteristics of those prisoners who had participated in the research with non-participants. Nevertheless, in the main, the participants' basic demographic and offence characteristics closely reflected contemporaneous national figures (Prison Reform Trust, 2017), albeit with less ethnic diversity, which may be due to the geographical area of the prisons concerned. Fourth, it is considered likely that in general prisoners will have played down rather than talked up their needs for fear of appearing vulnerable/being reported to prison authorities (if, say, acknowledging drug use) which, in combination with the factors above, suggests that the study will have underestimated the full extent of prisoners' social care needs. Fifth, although this research was undertaken at the start of local authorities' new responsibility for prisoners (2015/16), there is no reason to think that the prison population today have less social care needs.

Indeed, the ongoing aging of this population might rather suggest that the extent of social care needs experienced by prisoners will increase over time.

Conclusions

Notwithstanding the above concerns, which should be considered in the context of the well-documented difficulties of conducting research in prison (Wakai, Shelton, Trestman & Kesten, 2009; Walker, Shaw, Turpin, Reid & Abel, 2017), this study provides an important insight into the social care needs of prisoners and suggests that local authorities face a major challenge in managing the increasing level of social care need in this population, including promoting wellbeing and independence. It also raises critical issues about the organisation of social care provision, and reinforces calls for a range of different service response for older prisoners, whereby, to the return to the work of Young (2001), the goal is strong equality of opportunity.

Whilst there has previously been some evidence that government may be willing to address the specific needs of this growing population (DH, 2007), almost fifteen years on from the publication of the seminal report *No Problems – Old and Quiet* (HM Inspectorate of Prisons, 2004), there remains no national strategy for their care and

support, despite concerted calls for this (Criminal Justice Alliance, 2013; HM Inspectorate of Prisons, 2004; House of Commons Justice Committee, 2013; Prisons and Probation Ombudsman, 2017). Neither is there a comprehensive national strategy for the provision of social care in prisons (HM Inspectorate of Prisons and Care Quality Commission, 2018). As noted at the start of this paper, older prisoners are the fastest growing subgroup in the prison estate and in order to meet their needs, attention must be paid to this group. As the recently published thematic report on the provision of social care in prisons states, the failure to address this situation represents a serious and obvious defect in strategic planning (HM Inspectorate of Prisons and Care Quality Commission, 2018).

Ethical approval

The study received ethical approval from a National Research Ethics Committee (reference 14/NW/1425) and was approved by the National Offender Management Service (reference 2014-367), the host NHS Trust and all relevant research governance departments and prisons. All participants gave written informed consent before taking part.

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There are no conflicting interests

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Table 1. Prisoner profile: Sociodemographic characteristics by age group

		Full sample		18-49		50 plus		p-value
		%	(n)	%	(n)	%	(n)	
Ethnicity	White Caucasian	85.0	(409)	83.0	(331)	96.2	(76)	0.002
	Other	15.0	(72)	17.0	(68)	3.8	(3)	
Adverse childhood events	In local authority care	23.4	(112)	25.1	(99)	15.0	(12)	0.052
	Attended special school	30.1	(143)	34.4	(135)	8.9	(7)	<0.001
	Excluded from school	54.1	(259)	62.6	(248)	12.5	(10)	<0.001
Accommodation prior to prison entry	Own house or flat	26.7	(128)	23.8	(95)	41.3	(33)	0.001
	Rented house or flat	60.5	(290)	62.9	(251)	48.8	(39)	
	Homeless/hostel/temporary accommodation	9.4	(45)	10.5	(42)	3.8	(3)	
	Other	3.3	(16)	2.8	(11)	6.3	(5)	
Living situation prior to prison entry	Alone	29.4	(141)	29.6	(118)	28.8	(23)	0.883
	With others	70.6	(338)	70.4	(281)	71.3	(57)	
Employment status prior to prison entry	Employed full time	35.7	(171)	34.1	(136)	43.8	(35)	<0.001
	Part time/casual employment	9.8	(47)	10.5	(42)	6.3	(5)	
	Retired	1.9	(9)	0.0	(0)	11.3	(9)	
	Unemployed/long-term sick/other	52.6	(252)	55.4	(221)	38.8	(31)	

Table 2. Prisoner profile: Offence history by age group

		Full sample		18-49		50 plus		p-value
		%	(n)	%	(n)	%	(n)	
Previous stay in custody	Yes	63.5	(305)	68.0	(270)	42.5	(34)	<0.001
	No	36.5	(175)	32.0	(127)	57.5	(46)	
Index offence ^a	Violence	28.4	(135)	30.2	(120)	19.0	(15)	<0.001
	Robbery/burglary/theft & handling	24.2	(115)	26.4	(105)	12.7	(10)	
	Drugs	17.0	(81)	19.1	(76)	6.3	(5)	
	Sexual	15.1	(72)	10.3	(41)	39.2	(31)	
	Other	15.3	(73)	13.9	55	22.8	18	
Sentence length	< 1 year	3.3	(15)	3.0	(11)	5.1	(4)	0.152
	1 to 4 years	22.7	(102)	24.0	(89)	16.7	(13)	
	4 to 10 years	41.9	(188)	42.9	(159)	37.2	(29)	
	10 years plus	32.1	(144)	30.2	(112)	41.0	(32)	

^a Only the four most common categories of offence shown

Table 3. Prisoner profile: Health profile by age group

		Full sample		18-49		50 plus		p-value
		%	(n)	%	(n)	%	(n)	
Mental health problems ^a	Yes	23.5	(112)	23.4	(92)	25.0	(20)	0.760
	No	76.5	(364)	76.6	(301)	75.0	(60)	
Lack of emotional wellbeing	Yes	51.3	(243)	52.5	(207)	45.0	(36)	0.219
	No	48.7	(231)	47.5	(187)	55.0	(44)	
Problems with memory/orientation	Yes	25.7	(122)	22.8	(90)	40.0	(32)	0.001
	No	74.3	(353)	77.2	(305)	60.0	(48)	
Problems planning/ decision making	Yes	10.7	(51)	10.9	(43)	10.0	(8)	0.815
	No	89.3	(424)	89.1	(352)	90.0	(72)	
Drug misuse ^b	Yes	29.6	(138)	34.1	(132)	6.6	(5)	<0.001
	No	70.4	(328)	65.9	(255)	93.4	(71)	
Alcohol misuse ^c	Yes	62.1	(279)	66.8	(249)	39.2	(29)	<0.001
	No	37.9	(170)	33.2	(124)	60.8	(45)	
Physical health problems	Yes	41.9	(199)	38.0	(150)	61.3	(49)	<0.001
	No	58.1	(276)	62.0	(245)	38.8	(31)	

^a Indicated by a score of at least 2 on the General Health Questions (GHQ) from the Prison Mental Health Screening Questionnaire (PriSnQuest) or a score of at least 1 on the Psychosis Screening Questions (PSQ) from PriSnQuest or answered yes to having previously seen a psychiatrist on PriSnQuest as per Author's own, 2003

^b Indicated by a score of 6 or more on the Drug Abuse Screening Test (DAST)

^c Indicated by a score of 5 or more on Michigan Alcoholism Screening Test (MAST)

Table 4. Prisoner profile: Presence of social care needs by age group

	Full sample		18-49		50 plus		p-value
	%	(n)	%	(n)	%	(n)	
Maintaining personal hygiene	2.7	(13)	1.3	(5)	10.0	(8)	<0.001
Being appropriately clothed	2.5	(12)	1.3	(5)	8.8	(7)	0.001
Managing toilet needs	1.5	(7)	1.0	(4)	3.8	(3)	0.097
Making use of the prison safely (including getting around safely)	10.9	(50)	8.9	(34)	20.8	(16)	0.002
Managing & maintaining nutrition	0.4	(2)	0.3	(1)	1.3	(1)	0.308
Accessing work/education/training	17.8	(80)	18.0	(67)	17.6	(13)	0.935
Maintaining and developing relationships	14.3	(68)	13.7	(54)	16.3	(13)	0.551