The rising health, social and economic costs of Australia’s ageing prisoner population

Australia needs a more systematic and nationally coordinated approach to manage the escalating health burden arising from incarcerated older people.

Based on figures from the Australian Bureau of Statistics, the number of prisoners aged 65 years and over has increased by 348% (805 people) over the past 16 years (Box 1). Troublingly, rates for older women, many of whom are Indigenous, have increased markedly (from 3 to 26 female prisoners; a 767% increase). While the younger prisoner population has stabilised, the older cohort has risen rapidly, with 5212 men and women aged 50 years and older currently in full-time custody in Australia (Box 2). Changes to laws in the 1990s, such as mandatory sentencing and standard non-parole periods, as well as better forensic techniques resulting in successful cold case prosecutions, have led to increased numbers of older offenders (aged 50 years and older), who now constitute over 13% of the total Australian prisoner population. Notably, the Royal Commission into Institutional Responses to Child Sexual Abuse resulted in many convictions of older men relating to historical sexual abuse offences. Additionally, population ageing has led to increased rates of people with dementia, for which criminal behaviour can be a presentation. Indeed, criminal cases have emerged where the offender’s cognitive status has been examined as part of the judicial process to determine whether cognitive impairment played a role in their actions. Older offenders are therefore a mixed group. Some are older first time offenders who are diverted because of cognitive impairment, some are career recidivists. Others are prosecuted for historical offences and, although they may have been of sound mind at the time of the crime, are now frail. These groups require specific medico-legal care arrangements that the justice system is still developing.

The literature on older prisoners suggests that many experience accelerated ageing because of poor health, mental illness and lifestyle factors, including drug and alcohol misuse, and other social determinants such as trauma, homelessness and victimisation. Accordingly, a prisoner aged 50 years and older is considered aged; for Indigenous people, the age threshold is lower at 45 years. Population ageing has led to increased rates of people with dementia, for which criminal behaviour can be a presentation. Indeed, criminal cases have emerged where the offender’s cognitive status has been examined as part of the judicial process to determine whether cognitive impairment played a role in their actions. Older offenders are therefore a mixed group. Some are older first time offenders who are diverted because of cognitive impairment, some are career recidivists. Others are prosecuted for historical offences and, although they may have been of sound mind at the time of the crime, are now frail. These groups require specific medico-legal care arrangements that the justice system is still developing.

Challenges among the ageing prisoner cohort include high levels of mental health problems as well as multiple physical health issues, which can be exacerbated by limited resources and lack of specialist aged care within the prison setting. The serious nature of many older offenders’ crimes often precludes diversion into the community or compassionate release. At the end of their prison sentence, aged care facilities are often reluctant or unable to accommodate ex-offenders, who may have prominent behavioural disturbance, which in turn places this group at an increased risk of homelessness. Multisectoral collaboration is required to devise feasible solutions.

Incarceration costs in Australia rank fourth highest among Organisation for Economic Co-operation and Development countries, at $109 500 per prisoner per year. While separate data are not available for the older prisoner cohort, it is known that health costs increase with age in the general population, and costsings on the impact of older prisoner health care in the United States show an unsustainable upward budgetary pressure on prisons. So much so that the US Federal Bureau of Prisons is exploring how to redefine “older prisoners” to enable more prisoners to meet the compassionate release criteria. The escalating costs of housing older prisoners sit alongside the human rights issue of not providing age-appropriate care to meet the needs of this vulnerable group.

The World Health Organization has recommended restructuring prisons to accommodate the environmental needs of elderly prisoners. Recommended provisions include grip rails, seats in showers, bunk bed ladders, ramps and widened doorways to accommodate wheelchairs, and better access to bathroom facilities. The WHO has also urged institutions to adopt appropriate screening for conditions associated with ageing, such as sensory impairment, mobility problems and arthritis. A report by the NSW Inspector of Custodial Services also highlights the high prevalence of geriatric syndromes such as dementia, incontinence, and sensory impairment. These conditions significantly increase morbidity and in older inmates increase the risk for adverse health events. A recent Australian prisoner health survey shows that inmates aged over 45 years are more than four times more likely than younger prisoners to be diagnosed with cardiovascular disease. In addition, comparative studies of prisoners and the general community show that prisoners manifest cardiovascular disease risk factors at a relatively young age, with a significantly higher prevalence of hypertension. Aside from the difficulty of managing cardiovascular disease in older prisoners (eg, extended waiting times for specialist care), vascular risk factors further increase the risk of dementia. Poor health before incarceration (eg, chronic alcohol misuse) is also related to accelerated dementia onset, as are in-prison factors such as obesity and lack of exercise. Traumatic brain injury and chronic depression, both common among prisoners, have also been associated with an increased risk of dementia.

Few screening and care protocols are in place for the detection and treatment of dementia in the prison setting. Tailored tools are required to detect changes in function.
and behaviour within prison. Dementia literacy training, as well as education on ageing, would benefit custodial staff, who are arguably the first line of contact with prisoners.\(^8\) The acceptability and suitability of this carer role for custodial officers is currently unknown. The WHO multimorbidity care model uses care coordination between clinicians, the patient, nurses, social workers and pharmacists, although this is yet to be trialled.\(^{12}\) Palliative, including end of life, care is challenging in most health settings but magnified in the prison setting.\(^{19}\) Continuity of care programs for older prisoners following release are rare. More research is required to determine how to improve service delivery to older prisoners as well as post-release care.\(^{8,9}\)

Corrections Victoria and Justice Health have jointly established the Corrections Ageing Prisoner and Offender Policy Framework 2015–20. There is an emphasis on promoting rehabilitation and reintegration into the community as well as access to appropriate health care. In addition, the policy framework aims to strengthen workforce capacity to recognise and respond to common health conditions of prisoners and offenders, and to monitor how programs and services can be more responsive to the needs of this group. Given the large demographic shift across all Australian prisons, a nationally coordinated, best practice approach to screening for and managing age-related conditions is needed.\(^{20}\)

Older prisoners are a particularly vulnerable and marginalised group who are at risk of poor health and social isolation before, during and on release from prison. Although at some point almost all prisoners are released back into the community, a growing number will die in prison.\(^{19}\) Apart from the increased burden on health services in prison, social support networks are lost due to incarceration.\(^{20}\) This becomes apparent on release from prison and can result in homelessness. A recent study of over 2000 patients attending psychiatric clinics at several inner Sydney homeless hostels reported that 28% of patients had recently been released from prison.\(^9\) Notwithstanding human rights and ethical questions about health and ageing within prison, there is an economic cost of incarcerating older offenders who may be frail and cognitively impaired.\(^{21}\) The current reported health care cost for inmates in public prisons in Australia represents about one-tenth of the entire budget for prisons. However, if the aggregate health care costs by age for the general population are applied to the rates of change in the age structure of the prisoner population, health costs could increase by as much as 70–90% (over $330 million) in the coming decade.\(^{21}\) Assessment and management plans are needed before these costs become unsustainable. Investment in continuity of care programs (and their evaluation) that are initiated pre-release and continue in the community with stable accommodation could potentially have an impact on re-offending, as recidivism rates are reportedly higher in homeless former prisoners.\(^{9,22}\)

**Conclusion**

Sentencing changes combined with a gradual increase in the numbers of older offenders over the past decade have
led to a unique set of challenges within Australian prisons. Recent reports have highlighted the many challenges associated with housing older inmates, and a more systematic approach to the health screening and care of ageing offenders on reception to prisons pre-release and after release is warranted. Prison health services and custodial authorities are mindful of the ageing prisoner population as demonstrated by recent reports in NSW and Victoria. Clearly, training of key personnel in the justice system such as custodial staff will be required. A significant challenge to overcome will be how the prison environment can be adapted to incorporate elements of best practice to meet the mobility and cognitive needs of older, frail inmates. Revealing the economic models that underpin these population ageing issues brings to light the full magnitude and cost of inaction. The literature shows major gaps in the care of older prisoners, requiring policy reform and the development of multidisciplinary interventions to ameliorate the costs and provide more humane and appropriate management of older offenders both inside and outside of custodial settings.

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