Chapter 55

Older people as victims and perpetrators of crime

Claudio Di Lorito and Birgit Völlm

Abstract

Older people are at a higher risk of becoming the victims of crime than of being the perpetrators of it, given the added vulnerability that comes with aging. This chapter examines crime in relation to old age. The first section presents data around older people as victims of crime, and further discusses different types of abuse against older people, which, in the presence of intensive care needs and carer burden, may be perpetrated within the family or in residential and institutional settings. The second section of the chapter examines older people as the perpetrators of crime. In particular, it describes how older offenders are dealt within the justice system, it presents data on the growing population of older offenders in prisons and in forensic psychiatric services and report on whether the unique needs of older offenders are being met in these settings.

Keywords: elder violence, elder abuse, elder crime, older prisoners, older forensic psychiatric patients

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1. Older people as victims

Crime against ageing individuals is recognised as a worldwide phenomenon, which transcends cultural values and societal attitudes (Ryan, 2009). It is predicted that by 2050 the global population of individuals over 60 years old will reach two billion, from the current 900 million (WHO, 2017). At the current prevalence rates, 320 million older people will be the victims of crime (WHO, 2017). A large proportion of these will be located in low and middle-income countries, where resources to deal with these issues are often inadequate (WHO, 2017).

This section of the chapter will focus on older people as victims. We do not want to restrict our discussion solely to those actions that are identified as crime as these constitute only a small part of all the types of harmful acts against older people, such as abuse, which are not necessarily detected and pursued through the criminal justice system. This section is in three parts. The first focuses on older people as victims of actions which are regarded as crime; the second on abuse of older people, which may not necessarily be reported as crime. The final section reports on issues of identification, reporting, prevention and intervention, which apply to all types of victimisation of older people.

1.1. Older people as victims of crime

This section focuses on the existing evidence around criminal acts against older people by reporting on criminological data and by making comparisons with offences against younger victims. Data regarding violence in residential and institutional care settings are also discussed. Most research data concerns violent crimes (i.e. murder, robbery and assault), sexual violence and financial fraud.

1.1.1. Violent crime

Statistics show that violent crime perpetrated against older individuals, aged 50 years old or above, occurs 20 times less frequently than violent crime against younger people (Bachman & Meloy, 2008). However, this may be a considerable underestimate, given that prevalence data rely on police reports and adult protection services and these crimes may often be undisclosed to the authorities (Bachman, Dillaway, & Lachs, 1998). However, it may also be the case that older people make fewer interactions outside their home and are therefore less at risk of some types of violence. Despite the lower rates of falling victim to violent crime, it should be borne in mind that older people may be disproportionately fearful of such crimes and, if they are attacked, may find it more difficult to recover from the aftermath than younger people.

The risk of being murdered is lower among older people than at any age and its incidence has remained stable in the last few years (Klaus, 2005). Compared to violence against younger victims, there are differences in relation to the method and context of killing as well as the perpetrators' characteristics. In the UK, while the prevalence of murder among the over 50s is similar to that in younger people, there are some gender differences. In 2015, 13% of female victims of homicide were aged 75 and over, 9% of the UK female population being in this age group. Conversely, 4% of male victims were over 75 years old, 7% of the UK male population being in this age group (ONS, 2016). Older victims are more frequently killed during robbery, while younger ones more often following interpersonal conflicts (Bachman, & Meloy, 2008). While overall homicide statistics report that perpetrators are more likely to be known to the victim, for elder homicide strangers account for a large proportion of the perpetrators (Bachman, & Meloy, 2008).

As with homicide, the risk of falling victim of robbery decreases with age (Bachman, & Meloy, 2008), except for street robbery and handbag snatching (Klaus, 2005). While younger victims of robbery are more likely to be male, victims in the older group are equally shared in terms of gender (Bachman, Dillaway, & Lachs, 1998).

The prevalence of assault is lower for older victims compared to younger ones (Klaus, 2005). The perpetrators are more frequently known to the victims than not (Bachman, & Meloy, 2008), often being their spouse or family members (Bachman, & Meloy, 2008). Therefore, compared to assault against younger victims, elder assault is more likely to occur at home than in public places (Bachman, & Meloy, 2008).

The physical consequences of falling victim of violent crime can be particularly serious for older individuals, especially if they are frail. Several studies on older female victims have reported that they more frequently require medical attention for physical injuries, in comparison with younger female victims (Bachman, Dillaway, & Lachs, 1998; Bachman, Lachs, & Meloy, 2004). Research also confirms that the risk of death following assault is higher among older victims than among younger ones (Chu & Kraus, 2004).

The evidence relating to violent crime in care homes and institutional settings is very limited, particularly around resident-to-resident violence, which is remains the most common type of violence in these settings (Lachs, Bachman, Williams, & O'Leary, 2007). In terms of staff-to-resident violence, research studies tend to include violent acts within the overall category of elder abuse, which also includes emotional and psychological abuse, making it difficult to derive specific data specifically for violence (Bachman, & Meloy, 2008). Moreover, the few studies available are based on reports of members of staff, which limits the accuracy of reporting, given their obvious conflict of interest in reporting malpractice. In one US study (Pillemer & Hudson, 1993), 17% of the nursing staff admitted to having used excessive physical restraint against residents and 10% to having pushed, grabbed, or shoved a resident in the last month. However, in another US sample of nurses working in home facilities, only 3% admitted to having used any type of violence in the last year (Pillemer & Bachman, 1991).

Several risk factors for staff-to-resident violence have been identified. They include: residents' characteristics (dementia and high-dependency needs) (Talerico, Evans,& Strumpf, 2002; National Center on Elder Abuse, 2000, 2005); staff characteristics (young age, poor education, little experience of work with older residents) (Pillemer & Bachman, 1991; Pillemer & Moore, 1990); staffing issues (inadequate training, low staffing, high turnover, work-related stress and "burn-out" (National Center on Elder Abuse, 2000), (Pillemer & Bachman,1991; Pillemer & Moore,1990; Shaw,1998); and infrastructural issues (i.e. accessibility issues) (National Center of Elder Abuse, 2000).

1.1.2. Sexual violence

There is no consensus across different jurisdictions on what constitutes sexual violence, and in some instances the term sexual abuse is used interchangeably. Sexual violence can encompass actions perpetrated by individuals known or unknown to the victim (Johannesen and LoGiudice, 2013). The matter is further complicated by the fact that for sexual offences, unlike for other offences, the issue of consent is central to determining whether an offence has been committed or not. Therefore, the same action could either be consensual sex or rape. In the case of older people, their ability to consent may be affected by mental disorders and cognitive decline to a larger extent than is the case in younger individuals. Therefore, it may well be that what was previously consensual sex with a long-term partner is later technically a crime as one of the two partners has lost their capacity to consent. Such issues pose significant challenges to providers of services for older people who have to strike a balance between protecting individuals from unwanted sexual activities while not depriving them of pleasurable activities in the context of a loving relationship (Williams, 2015). Here, we only present data around sexual violence.

Contrary common assumptions, research evidence suggests that the risk of sexual victimisation does not decrease with age, particularly among women (European Union Agency for Fundamental Rights, 2014; Stockl, Watts, & Penhale, 2012). The prevalence of self-reported elder sexual violence ranges from between 0.2% (O'Keefe et al., 2007) and 17% (Lisboa, Patrick, Barroso, Leandro, & Santana, 2009). Risk factors include being a

woman of white ethnicity (though this perhaps reflects the likelihood of reporting rather than a true increase in prevalence), being aged between 60 and 70 years old (Baker, Sugar, & Eckert, 2009; Ball & Fowler, 2008; Bows and Westmarland, 2017; Jeary, 2005; Lea, Hunt, & Shaw, 2011; Naughton et al., 2010; O'Keefe et al., 2007), having poor physical and psychological health, cognitive impairment (i.e. intellectual disability, dementia), and poor communication skills (Pinto, Rodrigues, Dinis-Oliveira, & Magalhaes, 2014). As with homicide, elder sexual assault most often occurs in the victim's home and in care homes / institutional settings, rather than in public places (Ball & Fowler, 2008; Jeary, 2005; Teaster, Roberto, Duke, & Kim, 2001).

Perpetrators tend to be male, often much younger than the victim, and often with previous convictions (Bows, 2017). Research has also evidenced that, in contrast with younger victims, sexual violence committed by strangers is more common (Bows, 2017). In care homes and institutional settings, while some studies have found that members of staff are the most likely perpetrators (Baker, Sugar, & Eckert, 2009), others have reported that peer-to-peer sexual violence is more common (Roberto & Teaster, 2005).

The impact of sexual assaults on older victims can be both physical and emotional. While the risk of HIV and other sexually transmitted diseases is in line with younger female victims of sexual assault (Sormanti & Shibusawa, 2008; Sormanti, Wu, & El-Bassel, 2004), older victims are more likely to experience genital trauma (Jones, Rossman, Diegel, Van Order, & Wynn, 2009; Morgan, Dill, & Welch, 2011; Muram, Miller, & Cutler, 1992; Ramin, 1997; Templeton, 2005). High mortality rates have also been reported, with over half of the sexually assaulted older women dying within one year (Burgess, Dowdell, & Prentky, 2000). As in younger victims, emotional consequences of sexual violence include low self-esteem, hopelessness, numbness, social withdrawal, sleeping problems, flashbacks and nightmares, though these effects might be more severe in older people (Burgess, 2006; Jeary, 2007).

1.1.3. Financial fraud

A necessary distinction is to be made between financial abuse and financial fraud, the first being perpetrated by people known to the victim, the latter not necessarily occurring in the

context of victim-perpetrator acquaintance. Financial fraud includes doorstep crime (selling goods or services at extortionate prices), bank account theft, mass marketing fraud (e.g. asking for upfront payment for goods or services), pension fraud, investment fraud, and cybercrime (Age UK, 2015). These crimes may be perpetrated through the web, mail, phone and texts (Age UK, 2015) through various expedients, such as befriending or coercing the victim, using false credentials or credible documentation (Button, Lewis, & Tapley, 2009), selling dreams at a low price, and taking relatively small amounts of money (Age UK, 2015). The victims are often included in "sucker lists", making them susceptible to further victimisation (Age UK, 2015).

Prevalence studies report high prevalences of financial fraud of older people: 53% of people over 65 years old believe they have been the victim of this crime and 70% of those responding to the financial requests of scammers having lost money. This percentage amounts to 500,000 people in the UK alone (Age UK, 2015). Older people are much more likely to be targeted than younger people, as more than half the cases of financial fraud are perpetrated against people over 55 years old, who also experience twofold financial losses, the mean loss per scam being £684 for victims below 55 years old, and £1,261 for those aged above 55 (Age UK, 2015).

The commonest type of financial fraud among older people is doorstep crime, with 85% of the victims above 65 years old being a victim of this type of crime (Andrews, 2014). The victims are more likely to live alone (62%), and have a physical impairment (63%) (Andrews, 2014). Social isolation (40%), depression in the last six months (36%) and bereavement in the past two years (33%) are also common, and cognitive impairment occurs in 14% of the older victims (Andrews, 2014).

As for other types of crimes, prevalence estimates of elder financial fraud may be conservative, as the phenomenon may be largely underreported due to several factors, including a sense of shame on the part of the victims (Age UK, 2015). Risk factors include social isolation, cognitive impairment as well as victims' overconfidence in their capability to make financial investments (Lea, Fisher, & Evans, 2009).

The impact of financial fraud is both practical and psychological. Financial losses can take a higher toll on older people, who may have to live on limited fixed income. Research has identified that 46% of older victims experience financial difficulties (Andrews, 2014). Deteriorating psychological health is also common among the victims of financial fraud, who may be exposed to stress, anger and loss of self-esteem (Age UK, 2015). 40% of victims report a sense of shame and 28% symptoms of depression (Andrews, 2014).

1.2. Older people as victims of abuse

Abuse or acquaintance violence is defined as 'a single or repeated act, or lack of appropriate action, occurring within any relationship, where there is an expectation of trust which causes harm or distress to an older person' (Wood, Bellis, Penhale, & Passman, 2010). Abuse can be intentional, but sometimes the perpetrator may be unaware of the harm being caused to the older person (Wood, Bellis, Penhale, & Passman, 2010). Either way, the concept of abuse implies an existing relationship between the perpetrator and the victim.

While abuse against children and women has been the focus of research, policy and prevention/intervention strategies since the 1960s (Kleinschmidt, 1997), elder abuse was neglected until the mid-1970s, when the phenomenon was first identified as 'granny battering' (Baker, 1975; Burston, 1975). Since then, the understanding of elder abuse, how it is perpetrated, experienced, prevented and dealt with has grown. This development notwithstanding, abuse of older people has not yet been comprehensively addressed in international health policy documents (Yon, Mikton, Gassoumis, & Wilber, 2017). The recently established 17 Sustainable Development Goals of the United Nations mention abuse against women (target 5.2) and children (target 16.2), but there is no reference to abuse against older people (United Nations, 2017). In addition, progress has been hindered by governmental underfunding of campaigns, programmes and interventions. In 2009, in the US, the annual spending for all activities related to elder abuse was $11.9 million, compared with $649 million for women and $7 billion for children (Dong, 2015). To raise awareness among policy makers, professionals and the public, the International Network for the Prevention of Elder Abuse (INPEA) designated 15 June as World Elder Abuse Awareness day for the first time in 2006, ratified by the United Nations in 2010 (United Nations, 2013).

Elder abuse includes:

- Physical abuse, causing physical harm, pain or injury, through restraining, hitting, grabbing, pushing, slapping and bruising the older person (Wyandt, 2004).
- Psychological or verbal abuse, which may cause emotional harm or pain to the older person through humiliation, insults, infantilisation, yelling and threats (Wyandt, 2004; Kleinschmidt, 1997).
- Sexual abuse, engaging in any non-consensual sexual act with an older person.
- Financial abuse, the illegal or improper exploitation or use of funds or other resources of the older person (WHO, 2002b), which may include misappropriation or mismanagement of financial assets, account takeover, investment fraud, pension fraud and inheritance fraud (Age UK, 2015).
- Neglect, failing to fulfil the care needs of the older person or provide assistance in activities of daily living (Kleinschmidt, 1997).

A culture-sensitive approach to considering these five categories is crucial, as marked variations exist across cultures as to what constitutes elder abuse (Pillemer, Burnes, Riffin, & Lachs, 2016). Caution is required when comparing prevalence data across different countries. Sooryanarayana, Choo and Hairi (2013) found that prevalence rates in high-income countries are higher than those reported in low-income countries, due to the cultural variations on how the phenomenon is perceived and reported (Kleinschmidt, 1997). As an example, in parts of India and Africa it is customary that widows are forced into finding a new husband, they may be banished and their financial assets (e.g. property) may be seized by family members (Kumari, 2014; McFerson, 2013). While this would be classed as abuse in other countries, it is unlikely to be reported as such in countries where such behaviour is the cultural norm.

How elder abuse is defined also depends on different concepts of who is regarded an ‘older person’. Some countries, such as Ireland, consider a retired individual over the age of 65 to be ‘older’, while others use 60 years old as criterion for inclusion in the older age category (Ryan, 2009). In Australia, Aborigines are considered older at age 50 (Wainer, Darzins, &

Owada, 2010) and the cut-off is as low as 45 years old for indigenous women, given their lower life expectancy (McFerran, 2008).

The perception of elder abuse also varies with age and gender. Young people tend to identify abuse only in more serious cases, while older people are more likely to acknowledge the subtleties of emotional abuse (Daskalopoulos, Kakouros, & Stathopoulou, 2007; Childs, Hayslip, Radika, & Reinberg, 2000). In addition, a UK study found that women are more knowledgeable of elder abuse and aware of its extent, compared to men (Hussein, Manthorpe and Penhale, 2007).

How serious the abusive behaviour is perceived to be also depends on the victim's characteristics. In those not considered of 'sound mind', such as in dementia or in the presence of other mental health issues, the abuse may be less likely to be acknowledged by others (Werner, Eisikovits, & Buchbinder, 2006; Mills, Vermette, & Malley-Morrison, 1998).

1.2.1. Prevalence of elder abuse

A recent review by Yon, Mikton, Gassoumis, & Wilber (2017), based on 52 studies in 28 countries, presents the most up to date pooled prevalence data on elder abuse. The authors report a 15.7% prevalence for "any form of abuse", equal to one in six (141 millions) older adults worldwide.

In relation to single countries, in the United Kingdom, 2.6% of older people aged 66 and above residing in private accommodation report any type of abuse on the part of family, friends or caregivers each year (Biggs, Manthorpe, Tinker, Doyle, & Erens, 2009). In the United States of America, 10% of respondents to a phone survey reported being abused (Peterson et al., 2014; Burnes et al., 2015). A similar prevalence (9%) was found in a population-based nationally representative study in the USA, involving 3,000 community-residing participants aged 57 to 85 (Laumann, Leitsch, & Waite, 2008). Prevalence data range from 1% to 4% in Australia; in Norway, Finland and the Netherlands the estimate is around 5%, in Sweden and France 17% and 20% respectively (Fallon, 2006) and in Spain over 40% (Sooryanarayana, Choo, & Hairi, 2013).

High prevalences were also found in some Asian countries, where a review synthesising results from 18 studies, using one-year prevalence rates, found that India had a higher aggregate rate for all types of abuse (14%), compared to Europe (6%) and Canada (4%) (Pillemer, Burnes, Riffin, & Lachs, 2016). The marked differences across countries can be explained by the lack of a standardised tests to detect abuse, with a range of assessments and methods adopted employed in the existing literature, paired with different age cut-offs for inclusion in the older age category (Sooryanarayana, Choo, & Hairi, 2013).

In relation to specific types of abuse, Cooper, Selwood, & Livingston (2008) found that one in four older people experienced significant levels of psychological abuse, which was identified as the most prevalent type of abuse. This was followed by neglect, financial abuse and physical abuse. The least reported form of abuse was sexual abuse, with prevalences varying from 0.04% in Nigeria (Pillemer, Burnes, Riffin, & Lachs, 2016) to 1.3% in Spain (Sooryanarayana, Choo, & Hairi, 2013). It is relevant to note, however, that these data probably underestimate the problem, as identification and reporting elder abuse is affected by several factors, including how visible the signs of abuse are, the victims' expectation of outcome following disclosure (e.g. will they be believed or stigmatised), and being able to report the abuse (e.g. if there are physical and other restrictions preventing access to the police) (Fealy, Donnelly, Bergin, Treacy, & Phelan, 2013).

Abuse against older people occurs most frequently within the person's home (67%), followed by nursing homes (12%), residential care facilities (10%), hospitals (5%) and sheltered accommodation (4%) (Ogg & Bennett, 1992). The presence of abuse within care homes was confirmed in a study based on self-reports by nurses, 88% of whom had witnessed elder abuse in the workplace at least once and 12% of these on a frequent basis (House of Commons, 2004). Cooper, Selwood and Livingston (2008) reported that 16% of members of staff in residential care facilities admitted to having engaged in some form of psychological abuse.

All these figures are likely to be underestimates given the low reporting rates by the victims. For instance, Pillemer and Finkelhor (1988), in a US study, found that only one in 14 cases of abuse was reported, while a UK found that one among seven victims of physical abuse and

half of the victims of verbal abuse disclosed their experiences (Homer & Gilleard, 1990). In a Canadian study, just one in 20 older people who had been financially abused reported it (Podnieks, 1993). While, therefore, prevalence rates vary, partly due to methodological challenges and differences, it is clear that elder abuse constitutes a significant problem worldwide.

1.2.2. Risk factors for elder abuse

A number of victim characteristics have been associated with elder abuse. These can be divided into six broad categories: (i). Mental health; (ii). Physical health; (iii). Ethnicity; (iv). Gender; (v). Age; (vi). Living arrangements.

1.2.2.1. Mental Health

Both psychological distress and the presence of a mental disorder increase the risk of victimisation (Dong, Simon, Odwazny, & Gorbien, 2008; Dong & Simon, 2008); for example, clinical symptoms of depression have been found to increase the risk of becoming the victim of abuse (Lachs, Williams, O'Brien, Hurst, & Horowitz, 1997).

Those with dementia are at particular risk of abuse with prevalence rates ranging from 28% to 52%; severity of symptoms of psychosis, aggression, depression and anxiety (Cooper & Livingston, 2014; Conner, Prokhorov, Page, Fang, Xiao, & Post, 2011) and higher care and dependency needs appear to be correlated to higher risk of victimisation (Pillemer, Burnes, Riffin, & Lachs, 2016; Lachs & Pillemer, 2015; Dong, 2015; Murphy, Waa, Jaffer, Sauter, & Chan, 2013). There are some distinctive characteristics of abuse of people with dementia. More than one third of victims were found to be the victims of multiple forms of abuse simultaneously (Wiglesworth, Mosqueda, Mulnard, Liao, Gibbs, & Fitzgerald, 2010). In addition to being victims, older people with dementia may also be perpetrators of abuse, either against their carers (Cooney, Howard, & Lawlor, 2006) or against peers in residential care settings (Shinoda-Tagawa, Leonard, Pontikas, McDonough, Allen, & Dreyer, 2004).

Following abuse, victims with dementia present with more frequent behavioural symptoms of distress, compared to older people without dementia (Burgess, 2006). In addition,

mortality is higher (Dong et al., 2009) and may be partly accounted for by the over-prescription of antipsychotics to contain behavioural symptoms (House of Commons, 2004).

The identification of abuse can be extremely challenging. Many behavioural symptoms and physical signs (e.g. social withdrawal, communication difficulties) can be misinterpreted as caused by the underlying disorder (Dong, Chen, & Simon, 2014). Interview screening protocols may not be easily administered to people with deteriorating cognition, and, in fact, most existing screening tools have not been validated with this population (Wiglesworth, Mosqueda, Mulnard, Liao, Gibbs, & Fitzgerald, 2010). Even when identified, the perpetrators of abuse against older people with dementia are less likely to be prosecuted than those of victims who do not have dementia (Burgess, 2006).

Given the challenges of dealing with abuse against older people with dementia, efforts have focused on prevention strategies. The STrAteies for RelaTives (START), for example, is a psychological intervention to help with the stress and emotional burden experienced by family carers, and has proven effective in reducing abusive behaviours (Cooper, Barber, Griffin, Rapaport, & Livingston, 2016; Livingston et al., 2013).

1.2.2.2. Physical health

Declining physical health is also associated with elder abuse (Biggs, Manthorpe, Tinker, Doyle, & Erens, 2009). Kamavarapu, Ferriter, Morton and Völlm (2017) reported that 49% to 70% of older individuals who were the victims of abuse had physical impairments such as mobility issues, sensory impairment (loss or sight) and incontinence. Physical ill health was associated with increased financial abuse in the USA, UK and Canada (Laumann, Leitsch & Waite, 2008; O'Keeffe et al., 2007; Podnieks, 1993), with physical abuse, sexual and emotional abuse in Israel (Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009) and with neglect in the USA, Canada and Israel (Acierno et al., 2010; Amstadter, Zajac, Strachan, Hernandez, Kilpatrick, & Acierno, 2011; Burnes et al., 2015; Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009; Pillemer & Finkelhor, 1988; Podnieks, 1993).

1.2.2.3. Ethnicity

Studies investigating ethnicity and elder abuse suggest that prevalence differences between groups relate more to help-seeking attitudes (i.e. how acceptable it is within the culture to seek help following abuse), rather than ethnicity per se. Proneness to help-seeking was found to be less common among Korean-Americans, compared to black people and white people, and this was explained in terms of the value attributed to behaviours which preserve family unity ahead of personal independence typical of Korean culture (Moon & Williams, 1993).

1.2.2.4. Gender

As with women of all age groups, older women are exposed to a high risk of abuse. Although some researchers, including from Australia, Canada, Norway, Sweden and the USA, have carried out pioneering work in the field, gender-related issues in elder abuse have been often neglected (Penhale, 2003). In relation to older women populations with refugee status living in conflict zones, research and practice is even less advanced (United Nations, 2013).

The largest prevalence study around abuse of older women is the European Union prevalence study of Abuse and Violence against Older Women (AVOW) (Luoma et al., 2011), which found that 28.1% of women had suffered from any type of abuse, 23.6% from emotional abuse, 8.8% from financial abuse, 5.4% from neglect, 3.1% from sexual abuse, and 2.5% from physical abuse. Results from a study in China on older community dwellers found higher rates for physical (6.3%) and emotional abuse (28.4%) and neglect (13.8%) but a lower prevalence for financial abuse (1.9%) (Wu et al., 2012). A high prevalence of emotional abuse (33.7%) was confirmed in a Hong Kong study on intimate partner abuse (Yan & Chan, 2012). Women were also found to be more exposed than men to any type of elder abuse in studies carried out in the USA (Laumann, Leitsch, & Waite, 2008), the UK (Wood, Bellis, Penhale, & Passman, 2010), Portugal (Gil, Kislaya, Santos, Nunes, Nicolau, & Fernandes, 2015), India (Chokkanathan & Lee, 2006), Ireland (Naughton et al., 2010), Israel (Lowenstein, Eisikovits, Band-Winterstein, & Enosh, 2009) and Mexico (Giraldo-Rodríguez & Rosas-Carrasco, 2013).

Being lonely and retired were the most relevant predictors of the victimisation of older women (United Nations, 2013), and the most frequent perpetrators were their spouses and partners (Luoma et al., 2011). The most commonly reported consequences of abuse were found to be low quality of life, increased anxiety symptoms, and feelings of hopelessness, anger, and low self-esteem (Luoma et al., 2011).

Significant challenges in identifying abuse against older women are related to poor reporting rates. Barriers to disclosing abuse have been divided into internal (i.e. inherent to the individual) and external (i.e. inherent to the environment). Internal factors which can override the victim's need for safety and disclosure include self-blame, the need to protect the family unit and the children, feelings of powerlessness and the fear of not being believed (United Nations, 2013). External variables comprise threatening attitudes and behaviour from the perpetrator, rejection from the family, and a lack of trust that law enforcement agencies can end the abuse (United Nations, 2013).

It has long been acknowledged that the impact of internal and external barriers, and indeed the abuse of older women as a phenomenon, can be better understood within a feminist gender-sensitive framework. This perspective asserts that abuse is mediated by the inequity and power imbalance which sees women in a disadvantaged position compared to men in all societies and cultures (Neremberg, 2002). Therefore, any prevention and intervention campaign, as well as promoting legislative change, should promote equal rights in society for older women (Neremberg, 2002).

1.2.2.5. Age

A lack of consistency is found in relation to victim age. Several international studies reported a higher risk of abuse for the older age category (85 years old and above) compared to the younger group (65 to 85 years old) (Biggs, Manthorpe, Tinker, Doyle, & Erens, 2009; Giraldo-Rodríguez & Rosas-Carrasco, 2013; Gil, Kislaya, Santos, Nunes, Nicolau, & Fernandes, 2015; Naughton et al., 2010). However, research in the United States found an association between younger age and increased risk for physical, emotional and financial abuse and neglect (Acierno et al., 2010; Burnes et al., 2015; Laumann, Leitsch, & Waite, 2008). Once

again, these apparently conflicting findings are likely to be influenced by reporting and ascertainment issues in the various studies.

1.2.2.6. Living arrangements

Findings from the literature around living arrangements as a risk factor are also discordant. Some studies indicate that being married is a precursor for abuse in general (Pillemer & Finkelhor, 1988), and for emotional and physical abuse in particular (Podniecks, 1993; Soares et al., 2010). This can be explained in terms of the shared living environment with the potential perpetrator (Wood, Bellis, Penhale, & Passman, 2010). In line with this, Lachs and Pillemer (2015) reported that a higher number of household members increased the risk for elder abuse, in particular in the presence of poor income or financial difficulties and when the family members were depending on the older person for housing and finance (Wood, Bellis, Penhale, & Passman, 2010)

Other studies, however, found a correlation between being unmarried and being the victim of abuse, both for aggregated abuse (Giraldo-Rodríguez & Rosas-Carrasco, 2013; Naughton et al., 2010; O'Keeffe et al., 2007) and for any single type of abuse (Burnes et al., 2015; Laumann, Leitsch, & Waite, 2008; O'Keeffe et al., 2007; Podnieks, 1993; Wu et al., 2012). Higher risk for victimisation was also reported among older people who are lonely (Dong, Simon, Gorbien, Percak, & Golden, 2007) and who lack social support (Amstadter, Cisler, McCauley, Hernandez, Muzzy, & Acierno, 2010).

Even less is known in relation to institutional settings (Lachs & Pillemer, 2015). In these settings, abuse may be perpetrated by a range of people, including members of staff and visitors (e.g. family, friends). Increasing interest has also been given to the phenomenon of elder abuse perpetrated by fellow residents, which seems to be more prevalent than abuse from staff (Pillemer et al., 2011).

Although for various reasons, including fear of retribution, abuse in institutional settings may pass unreported and unidentified (Kleinschmidt, 1997), the evidence suggests that abuse may be more prevalent than in the community (Pillemer, Burnes, Riffin, & Lachs, 2016) and increased by: (i). Organisational issues, including understaffing, inadequate

training, and stress; (ii). Problems in staff-resident relationships, such as poor communication; (iii). Environmental factors, including poor health and safety; and (iv). Policy and regulations, such as an overly strict regime (Bennet, Kingston, & Penhale, 1997). Therefore, adequate strategies (regulation, policies, management of the workforce) are crucial to ensure good practice in the workplace.

Several specific tools have been developed to investigate abuse in institutional settings. The Elders' Psychological Abuse Scale (EPAS) (Wang, Tseng, & Chen, 2007) detects psychological abuse in long-term facilities, the Caregiver Psychological Elder Abuse Behavior Scale (CPEAB) (Hsieh, Wang, Yen, & Liu, 2009) investigates violent behaviour as reported by staff of nursing homes, while the 24-item list of maltreatment/abuse acts (Cohen, Halevy-Levin, Gagin, Priltuzky, & Friedman, 2010) is administered to the older residents. These context-specific tools may contribute to service improvement, as they represent an invaluable support for providers to identify when abuse is occurring.

1.2.3. Perpetrators of elder abuse

The explanatory model for elder abuse contends that risk is mainly affected by the perpetrator's rather than the victim's characteristics (Anetzberger, 2000). Ramsey-Klawsnick (2000) divided perpetrators of elder abuse into five typologies:

(i). The "Overwhelmed", who may experience such high levels of emotional burden and stress in providing care to the older person (the caregiver stress hypothesis) that it can result in violent behaviour.

(ii). The "Impaired", who present with health issues that make them more prone to violent behaviour. These include individuals with a history of mental or physical health problems, substance dependence, a history of serious psychiatric conditions such as personality disorder, or a history of offending (Laumann, Leitsch & Waite, 2008; Amstadter, Zajac, Strachan, Hernandez, Kilpatrick, & Acierno, 2011; Chokkanathan & Lee, 2006; Oh, Kim, Martins, & Kim, 2006; Soares et al., 2010; O'Keeffe et al., 2007).

(iii). The “Narcissistic”, who are driven by personal gains to be derived from the abuse. The classic example is of individuals who are unemployed and/or in financial difficulties and who depend financially on the victim (Wood, Bellis, Penhale, & Passman, 2010).

(iv). The “Bullying”, who justify their abusive behaviour in terms of the victim not fulfilling their expectations. For example, health care staff may become perpetrators of violent behaviour against older residents who repeatedly fail to abide by the rules and regime of the residential home.

(v). The “Sadistic”, who have proneness to criminal behaviour and may have a history of serious offending (Mark & Pillemer, 2015).

Overall, the perpetrators are more likely to be family members of the victims than not (Lachs & Pillemer, 2015). In institutional settings, however, Benbow and Haddad (1993) found that a large proportion of the perpetrators of sexual abuse were fellow residents. Differences in terms of gender are minimal. Ryan (2009) reported that 56% of perpetrators of abuse are male and 44% females. Wood, Bellis, Penhale, & Passman (2010) found no difference in the proportion of male and female financial abusers.

1.2.4. The impact of elder abuse

Although very limited research has looked into the consequences of elder abuse, its negative impact in several spheres of the victim’s life is undisputed.

In relation to physical health, the consequences of abuse can be very serious for older people, given their frailty. A systematic review synthesising data around the types of injuries following elder abuse, reported injuries to the arms and shoulders (44%), face, teeth and neck (23%), head (12%), legs and hips (11%), and torso (10%) (Murphy, Waa, Jaffer, Sauter, & Chan, 2013). There is evidence of higher emergency department use (Dong, Chang, Wong, Wong, & Simon, 2011) and hospitalisation (Dong & Simon, 2013), and an increased mortality risk associated with elder abuse (Dong, Chen, Chang, & Simon, 2013).

Serious consequences are also reported for mental health with increased symptoms of depression, anxiety and post-traumatic stress (Dong, Chen, Chang, & Simon, 2013; Mouton, Rodabough, Rovi, Brzyski, & Katerndahl, 2010; Gibbs & Mosqueda, 2010). These are often triggered by overall psychological distress, which is accompanied by feelings of shame, fear, guilt, denial, helplessness and alienation (Booth, Bruno, & Marin, 1996; Goldstein, 1996). The severity of symptoms is associated with the type of abuse. Emotional and verbal abuse are more positively correlated with increased psychological distress, compared with physical abuse (Begle, Strachan, Cisler, Amstadter, Hernandez, & Acierno, 2011; Coker et al., 2002; Pico-Alfonso, Garcia-Linares, Celda-Navarro, Blasco-Ros, Echeburúa, & Martinez, 2006).

A negative impact on financial stability and quality of life can be the result of financial abuse among those who have limited income and for whom the loss of any amount of money leads to a failure to fulfil their basic needs (WHO/IPNEA, 2002; Alves & Wilson, 2008; Al-Baho, 2004).

1.3. Identifying elder victimisation

Given their frequent contact with older people in a variety of settings, including general practices, emergency departments, hospitals and surgeries, health care professionals play a central role in identifying elder abuse and violence (Wood, Bellis, Penhale, & Passman, 2010). It is therefore crucial for these professionals to receive adequate training to raise their awareness of the issue, be educated on the identification of signs of violence, become aware of the resources available to intervene, and manage suspected cases effectively, by liaising with the relevant agencies (Lachs & Pillemer, 2015; Shefet et al., 2007). Training should also be focussed on encouraging sympathetic views and attitudes toward older people and on sensitising staff to age-related issues (Pillemer, Burnes, Riffin, & Lachs, 2016).

The two main strategies for improved identification of elder abuse, which ideally should be combined for increased accuracy, are a clinical interview and a physical examination (Cohen, Levin, Gagin, Friedman, 2007). Before any of these assessments are undertaken, however, the health professional should assess the mental capacity of the older person. Where the person is deemed to be fully capable, the investigation can proceed, the older person becoming directly responsible for any choice made during and following the investigation

(Wang, Brisbin, Loo, & Straus, 2015). Where the person lacks capacity, a suitable person should be identified to help them – for instance, there may be a person, often a relative, with an enduring power of attorney. If it is suspected that the identified person is the perpetrator of the violence, the case should be referred to social services (Wang, Brisbin, Loo, & Straus, 2015; see also Chapter 54 for further information about safeguarding).

The interview should ideally be undertaken with the older person separately from any potential perpetrator (Lachs & Pillemer, 2015) and should include an investigation of their personal context (e.g. culture, living arrangements, family characteristics) (Dong, 2015). The health professional undertaking the interview should adopt a sympathetic attitude and avoid being confrontational or drawing any conclusions before the facts have been ascertained (Lachs & Pillemer, 2015; Kleinschmidt, 1997).

A physical inspection of the older person can detect evidence of possible violence. There are typical signs that can indicate some form of violence, including scars, lacerations, bruising, burns, fractures, injuries, sexually transmitted diseases, decubitus ulcers, poor hygiene, dehydration and malnutrition (Wyandt, 2004). Although none of these signs is unequivocally associated with violence, as they may be symptoms of a range of age-related conditions, they nonetheless provide visible evidence which may be relevant in future proceedings and should therefore be adequately recorded (Lachs & Pillemer, 2015). Where abuse occurs, physical signs are often accompanied by frequent medical appointments or visits to emergency departments and by some behavioural symptoms, which may include but are not limited to appearing fearful, withdrawn, nervous, and helpless (Wyandt, 2004).

In addition to clinical experience, health professionals can rely on several screening tools for violence. These include the self-report Vulnerability to Abuse Screening Scale (VASS) (Schofield, Reynolds, Mishra, Powers, & Dobson, 2002), the 10-item tool for disclosure of abuse by Cohen, Levin, Gagin, and Friedman (2007), the Elder Abuse Suspicion Index (EASI) (Yaffe, Wolfson, Lithwick, & Weiss, 2008), the Elder Assessment Instrument (EAI) (Fulmer, Guadagno, & Connolly, 2004; Fulmer & Wetle, 1986; Fulmer, Street, & Carr, 1983) and the evident signs of abuse inventory (Cohen, Halevi-Levin, Gagin, & Friedman, 2006; Fulmer,

Guadagno, & Connolly, 2004; Cohen, Levin, Gagin, & Friedman, 2007; Cohen, Halevy-Levin, Gagin, Priltuzky, & Friedman, 2010).

1.4. Reporting elder victimisation

Several barriers may hinder the process of reporting violence towards older people. The older person may be reluctant to disclose violence or even to collaborate in the investigation, because they may feel guilty, embarrassed, ashamed, fearful of reprisal, afraid they may be relocated or institutionalised or that they may not be believed (Burgess, 2006; Kleinschmidt, 1997). Language and cultural barriers may also play a part (Lachs & Pillemer, 2015). In addition, the criminal justice system might be unwilling to get involved due to uncertainties regarding the reliability of the older person as witness. It is therefore essential that support is available to the potential victim in this process.

Secondly, the consequences of violence, physical or emotional, can easily be misinterpreted as linked to normal age-related maladies, but false positives can also occur (Wyandt, 2004; Lachs & Pillemer, 2015). Some types of violence, namely sexual abuse, may pass undiagnosed, as they are not typically expected to occur in old age and might therefore be overlooked (Falk, Hasselt, & Hersen, 1997; Gray & Acierno, 2002).

Thirdly, health professionals might conceal abuse, because of the sensitivity of the topic, their unawareness of resources available to help or simply to avoid detection for their own wrongdoing (Lachs & Pillemer, 2015). Even when reported, an investigation can take several weeks or even months, during which the health professional is required to make decisions in the face of ongoing uncertainties (Lachs & Pillemer, 2015).

1.5. Preventing elder victimisation

As elder abuse and violence towards older people have become a global health concern, the World Health Assembly recently published a strategy aimed to reduce elder violence worldwide, through a collaborative action plan and joint initiatives (WHO, 2017). These include: (i). Increasing the evidence base and understanding of elder abuse, its types and its extent, particularly in low and middle-income countries; (ii). Developing guidance on how to

respond to elder abuse; (iii). Sharing good practice across countries on how to prevent elder abuse; (iv). Implementing collaborating networks worldwide to fight elder abuse.

Several strategies have potential to prevent elder violence and abuse, although consistent evidence in relation to their effectiveness is still limited (Ploeg, Fear, Hutchison, MacMillan, & Bolan, 2009; Sethi et al., 2011; Stolee, Hiller, Etkin, & McLeod, 2012). Strategies can be divided into: (i). Interventions focused on single individuals (i.e. at-risk individuals or any potential perpetrator); (ii). Interventions focused on the community/society and in the workplace, especially care home settings.

Among the most common strategies in the first group are caregiver interventions, which aim to reduce carer burden, manage stress and increase social connection (Wood, Bellis, Penhale, & Passman, 2010; Pillemer, Burnes, Riffin, & Lachs, 2016). Such interventions include peer and professionally-led support groups, psychological treatment (e.g. anger management), training on providing care (e.g. preparing meals), education on age-related issues, and respite care (finding temporary alternative care arrangements so that the primary caregivers can take time off their caring duties) (Wood, Bellis, Penhale, & Passman, 2010; Pillemer, Burnes, Riffin, & Lachs, 2016).

Prevention strategies for potential victims can be non-specific (i.e. targeted to all types of violence or abuse) or specific (i.e. depending on the type of violence or abuse they aim to tackle). In the first group, telephone helplines represent a valuable resource to provide emotional and practical advice to potential victims. Phone helplines can also function as intervention (i.e. post-violence) strategies. They are usually staffed by volunteers or professionals and often work around the clock (Pillemer, Burnes, Riffin, & Lachs, 2016). In contrast with web-based chats, which require IT literacy, telephones are widely accessible even in low income countries. In relation to specific prevention interventions, money management training, catering to older individuals who may be at risk of financial abuse, is a commonly employed strategy for older people to receive external support and assistance in carrying out financial routines, such as paying bills, manage shopping money and banking (Pillemer, Burnes, Riffin, & Lachs, 2016).

Prevention strategies in the community and in society, such as mass media (television, radio, printed materials and the web) campaigns, aim to promote a more positive image of older people as valuable members of the community, in order to stigmatise elder abuse. These initiatives include educating the younger generations (in schools, universities and community settings) about the value of older people in society (Baker, Francis, Hairi, Othman, & Choo, 2016).

Prevention strategies in care homes include: (i). Identifying especially vulnerable individuals and implementing strategies to reduce their risk of becoming the victims (e.g. offering low stimulation environments to decrease challenging behaviours and aggression). (ii). Increasing the knowledge and skills of members of staff to identify and deal with challenging behaviours (e.g. de-escalation training) to prevent violent responses against older individuals; (iii). Creating a safe environment and culture of openness/support (e.g. through regular community meetings) to increase the confidence of staff and service users to discuss issues of violence and abuse; (iv). Carrying out pre-employment background checks and closely monitoring members of staff, perhaps especially those at higher risk of becoming perpetrators (i.e. male, non-trained, frontline care staff) (Kamavarapu, Ferriter, Morton, & Völlm, 2017).

1.6. Intervening in cases of elder victimisation

In order to tackle elder abuse, appropriate policies and laws are required, including local, national and international strategies to report and deal with violence affecting older people (Baker, Francis, Hairi, Othman, & Choo, 2016). The US has the most comprehensive advanced national system for the reporting and management of elder violence, which operates at the single-state level, and is supported by the National Centre on Elder Abuse at the federal level (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). Specific legislation to protect older victims is also in place in Canada, Japan, South Korea, Israel and Slovenia.

In the UK, notification of suspected abuse to the relevant local authority, which is legally bound to make an enquiry, theoretically requires the consent of the victim. In most circumstances, however, this can be and is bypassed (e.g. lack of mental capacity, ongoing risk to the victim, potential risk of the perpetrator to other members of the public,

suspected violence within the NHS or professional care contexts) (Age UK, 2017), thus raising ethical dilemmas around the rights and autonomy of the individual. In Japan, Israel and some states and provinces in the USA, Canada and Australia, the law mandates the reporting of elder abuse without the victim's consent (Wood, Bellis, Penhale, & Passman, 2010).

Following identification of violence, the primary goal of an intervention strategy is to ensure the victim's safety. This can be obtained through hospitalisation, in case the victim is in immediate need of health assistance, emergency shelters, when the victim needs immediate transfer to a temporary safe setting (Pillemer, Burnes, Riffin, & Lachs, 2016), and support groups. The secondary goal is to arrange support according to the person's needs, which usually is by means of multidisciplinary teams, given the multidimensional needs of older victims (Lachs & Pillemer, 2015). Multidisciplinary teams comprise a range of professionals with different fields of expertise, including the criminal justice system, primary physical, mental and social health care, the legal system, financial services, and social and adult protective services. Such teams have been found to improve outcomes in addressing issues related to elder violence in a number of studies (Blowers, Davis, Shenk, Kalaw, Smith, & Jackson, 2012; Navarro, Gassoumis, & Wilber, 2016; Rizzo, Burnes, & Chalfy, 2015; Teaster, Nerenberg, & Stansbury, 2003; Ulrey & Brandl, 2012).

1.7. Conclusion

The existing knowledge gap around elder crime requires further research at various levels. Given the increasing diversity of the ageing population, this includes considering how cultural factors impact on elder violence. Community-based participatory research and research partnerships with stakeholders would enable researchers to better capture the cultural dimensions of the phenomenon (Dong, 2015). Collaboration between academic researchers and members of the public would also deepen the understanding of how extensively societal ageism impacts on the perpetration of violence and abuse against older people.

Another area requiring further research is that of effective interventions to prevent violence and abuse. A recent review of the evidence around prevention strategies found that only 10

intervention studies had been carried out to assess the effectiveness of interventions for elder abuse, obtaining equivocal results (Pillemer, Burnes, Riffin, & Lachs, 2016). In addition, there is virtually no comparative international literature or cost-effectiveness analysis looking at the sustainability of existing interventions (Pillemer, Burnes, Riffin, & Lachs, 2016). In order to fill this gap and to determine which interventions (or elements of them) are really effective and financially sustainable, there is a need for high-quality randomised controlled trials carried out in both high, middle and low-income countries (Baker, Francis, Hairi, Othman, & Choo, 2016).

2. Older people as perpetrators of crime

This section focuses on the existing evidence around older people as perpetrators of crime. The section opens with overall data around prevalence and types of crime, clinical characteristics of older offenders and how elder crime is dealt with within different legal systems. A differentiation is then made between older prisoners and older patients in forensic psychiatric settings. Epidemiological data about each population are presented and compared against those of younger offenders. Relevant issues around ageing in forensic settings are also discussed.

2.1. Operational definition: who is an ageing offender?

Before delving into what is known about ageing offenders and about their experience of the justice system, an operational definition of *"ageing offender"* is necessary.

Despite an ongoing debate around an appropriate age cut-off, given the highly subjective experience of the ageing process, old age forensic psychiatric and social health care researchers and practitioners generally set age 50 as criterion for inclusion in the older offender age group. This is based on evidence that ageing offenders experience poorer health and a quicker ageing process compared to people living in the community, for whom the United Nations set 60 years as criterion for older age (Natarajan & Mulvana, 2017; Cooney & Braggins, 2010). This is therefore also the cut-off we will apply in this chapter.

2.2. Prevalence of crime and type of offending in older people

It is generally accepted that offending peaks in younger age, adolescence and early adulthood, though the gap between convictions in younger and older people might decrease. While most authors (e.g. Yorston, 2013; Natarajan & Mulvana, 2017) report that crime rates in older people appear to be stable over time with people over the age of 60 contributing approximately 1% to overall crime statistics, several countries have reported an increase in both newly convicted older people and older prisoners. For example, the number of prisoners over 60 years old in the Netherlands increased from 60 to 234 in the period 1994-2006 (van Alphen & Oei, 2010).

In England and Wales in 2003, sexual offences, theft and handling stolen goods, and violence (including homicide) were the three largest categories of indictable offences in those aged 60 and over while amongst prisoners over 60 years of age nearly 60% were serving their sentence for a sexual offence (Fazel, 2016).

Rates of homicide committed by older people vary and should be interpreted with caution, given that they might be underreported in certain settings (e.g. assaults between residents in care homes that result in death) (Yorston, 2013). In the UK context, where homicide rates are among the lowest worldwide, the ONS (2018) reported that in 2006, people over 55 years old were responsible for 26 homicides, accounting for 4% of the total number of homicide in the UK; in 2016, they were responsible for 11 homicides, accounting for 5% of the total. In contrast, in 2016, adults aged 45-54 responsible for 23 homicides (10% of total); the percentage was even higher in the group 35-44 (50 homicides; 22% of total) (ONS, 2018).

Compared to younger perpetrators, older individuals more frequently commit homicide against family members, particularly female spouses (Fazel, Bond, Gulati, & O'Donnell, 2007). They are more likely to kill their victims through strangulation/suffocation (Hunt et al., 2010), and they have a higher prevalence of active psychiatric conditions affecting judgment and impulse control, including dementia and affective psychosis (Fazel & Grann,

2002). However, older perpetrators are less likely to be acting under the influence of substances (Hunt et al., 2010). The phenomenon of 'dyadic death' (i.e. suicide occurring after the homicide of the spouse) is more common among older than younger offenders (Fazel, Bond, Gulati, & O'Donnell, 2007; Cohen, Llorente, & Eisdorfer, 1998). Motivations often include a fear of not being able to care of the other person anymore in the face of illness and frailty, or a misguided view that a disabled spouse may be better off dead.

Within forensic psychiatric settings, homicide is the commonest offence that has led to admission (Yorston & Taylor, 2009; Shah, 2006; Lightbody, Gow, & Gibb, 2010; Coid, Fazel, & Kahtan, 2002). In fact, older patients in secure settings (60 years old and above) have an index offence of murder significantly more frequently than younger patients (16-59 years old), the ratio between the two groups being 5.71 (Coid, Fazel, & Khatan, 2002). This might be explained by the fact that those with such offences stay longer and therefore they will eventually be part of the older group.

The UK Office for National Statistics reported that in 2017, in 14% of the cases of rape or assault by penetration (including attempts), the offender was 40 years old and above; in 1% of the cases, the offender was 60 years old and over (ONS, 2018). This figure is aligned to those of other countries. Despite the prosecution and convictions of older sex offenders having increased over time, such crimes might still be underreported, because sexuality in old age is still a sensitive topic among many professionals working in hospitals and care homes (Yorston, 2013). Nonetheless, some studies in old age forensic psychiatry reported that sexual offences surpassed homicide as the primary offence leading to admission (Curtice, Parker, Wismayer, & Tomison, 2003).

The perpetrators of sexual offences are more likely to be males and the victims female (Curtice, Parker, Wismayer, & Tomison, 2003; Tomar, Treasden, & Shah, 2005). Compared to younger sex offenders, child sexual abuse was found to be much more prevalent in the older group (Yorston, 2013), but recidivism rates were lower (Fazel, Sjöstedt, Långström, & Grann, 2006; Barbaree, Blanchard, & Langton, 2003). The sexual offence most likely occurs at home (72%) and in the presence of a psychiatric condition (33%) (Curtice, Parker, Wismayer, & Tomison, 2003). Hypersexuality and sexual disinhibition, which occur in about one in five

people with dementia' which have a 17% prevalence in neurodegenerative condition such as dementia (Series & Degano, 2005), are also linked to an increased risk for sexual offences. Curtice, Parker, Wismayer, and Tomison (2003) found that in 17% of sexual offences the perpetrator had a diagnosis of dementia.

Acquisitive offences have been reported as one of the commonest types of offences among older individuals and the most frequent reason for arrest in older people (Yorston, 2013). In a large study on ageing offenders, Needham-Bennett, Parrott and Macdonald (1996) found that theft accounted for 63% of all offences among people aged 60 years old and above, compared to 22% for all types of assaults, 10% for firearm, drug and public order offences, and 4% for criminal damage. Shoplifting is the most prevalent among the acquisitive offences (58%) (Needham-Bennett, Parrott, & Macdonald, 1996). Offenders are as likely to be men as women, most likely to be single, poor and unemployed, though perhaps surprisingly people with higher levels of education are also over-represented (Lamontagne, Boyer, Hétu, & Lacerte-Lamontagne, 2000).

Despite the high prevalence, most cases of acquisitive offences are not considered serious enough to be prosecuted and most older offenders (58%) are only cautioned (Needham-Bennett, Parrott, & Macdonald, 1996). As a result, less than one in three offenders (28%) were referred to welfare agencies (e.g. for psychiatric evaluation) in one study (Needham-Bennett, Parrott, & Macdonald, 1996). Given that engaging in shoplifting has been found to be associated with depression and fulfilment of psychological needs (Lamontagne, Boyer, Hétu, & Lacerte-Lamontagne, 2000), failure to offer offenders mental health treatment may result in an exacerbation of their symptoms (Yorston, 2013).

2.3. Clinical characteristics of older offenders

Older offenders can be divided into three distinct types (Natarajan & Mulvana, 2017): Those who start offending early and continue into old age, those who committed an offence earlier in their life and remain incarcerated into older age as a result, and those who commit their first offence at an older age. Only limited data is available about the numbers of offenders in each of these groups, though one US study (Steffensmeier & Motivans, 2000)

suggested that, in prison, the second group was the smallest, with each of the other two groups accounting for over two fifth of prisoners over 55 years each.

We will report on the prevalence of disorders in prison and secure forensic settings later in this chapter. Here, we briefly outline psychopathological characteristics of particular relevance to older offenders. Psychotic and mood disorders most frequently lead to the involvement of psychiatric services and, depending on the seriousness of the illness, to a transfer from prison to a hospital setting in all age groups.

Cognitive decline is a particularly important issue for older offenders, whether or not it occurs in the context of a formally diagnosed dementia. In addition to impairments in memory, typical in dementia, other symptoms may make the individual more prone to behavioural difficulties, including offending, such as disinhibited behaviour, lack of judgement and impairment in executive function (e.g. a lack of planning and impulse control). These symptoms may result in reactive (as opposed to instrumental, i.e. planned) aggression (Yorston, 2013). On the other hand, personality disorder symptoms, which may also include impulsivity, are generally regarded to decrease in severity with age, though changes in life circumstances as may occur in older people might lead to an exacerbation of symptoms. While of importance in all ages, an interview with an older person's relative or carer to identify any changes in behaviour is especially crucial.

When assessing and managing risk in the context of these disorders, practitioners need to consider the potential limitations of risk assessment tools, which have been standardised with younger populations. This is particularly so with actuarial risk assessment tools, which predict risk according to percentages of those who go on to reoffend or allocate offenders to high, medium or low risk bands. The presence of cognitive impairment/dementia could both increase (e.g. through an increase in impulsivity) and decrease (e.g. through apathy, lack of opportunity) risk (Natarajan & Mulvana, 2017). A detailed, individualised assessment using a structured professional judgement approach, including a formulation of the risks (type and severity of risk, triggers, motivators, inhibitors, protective factors) and their management, is required in each case.

2.4. The route to prison and forensic psychiatric services

Although different countries adopt different legal systems and procedures, the general principles around the detention and care of offenders are similar (Edworthy, Sampson, & Völlm, 2016; Lepping, & Dressing, 2005). Once an individual is charged with an offence, three options are available: acquittal, punishment or diversion into a treatment setting, including hospital admission (Völlm et al., 2017). A pre-requisite for punishment is criminal responsibility for the offence, the criteria for which may vary across jurisdictions (Völlm et al., 2017). If criminal responsibility is present, the offender can be sentenced, including to imprisonment.

If not deemed fully responsible for the criminal act, the offender is either acquitted or required to undergo some type of forensic psychiatric treatment (Völlm et al., 2017). In order for the offender to have access to treatment, in most European countries a degree of reduced responsibility is a pre-requisite (Völlm et al., 2017). There are some exceptions, however, as in the United Kingdom, for example, where admission to forensic psychiatric care can occur regardless of criminal responsibility and can be ordered based solely on the person's mental condition at the time of assessment (Konrad & Völlm, 2010). In addition, some countries allow transfer from prison to forensic psychiatric settings, if the detainee develops a psychiatric illness which requires specialist care. The mentally disordered offender (MDO) may then later move back to prison though more frequently remains in the treatment setting.

Psychiatric treatment for MDOs can be offered as in-patient services, out-patient (i.e. community) services or within the prison system. In most jurisdictions, excluding countries such as Italy, Croatia and Portugal, offenders in in-patient forensic psychiatric units can be detained beyond the length of the prison sentence they would have been given for the same crime, had they not been mentally disordered (Völlm, Bartlett, & McDonald, 2016).

However, the majority of mentally disordered offenders are found within the prison system, even in jurisdictions where specialist services exist (Völlm et al., 2017). Provision equivalent

to care in the community is the guiding principle of prison care, as per the United Nations Standard Minimum Rules for the Treatment of Prisoners and the UN Convention on the Rights of Persons with Disabilities. It is questionable, however, to what extent different countries operate in full compliance with the standards prescribed (Gee, & Bertrand-Godfrey, 2014).

In-patient forensic psychiatric services are offered in most countries at different levels of security, based on the risk the patient poses to themselves or others (Salize, Lepping, & Dressing, 2005), but there are notable exceptions. In Italy, in-patient forensic psychiatric services are offered in residential units at one single (low) level of security (Di Lorito, Castelletti, Lega, Gualco, Scarpa, & Völlm, 2017). In addition to a degree of security, other common elements of in-patient forensic psychiatric services are medical, psychological and social interventions offered by multidisciplinary teams (Tapp, Warren, Fife-Schaw, Perkins, & Moore, 2016).

Out-patient services offered in the community are available in a limited number of countries, including Austria, Belgium, Germany, the Netherlands, the UK and Poland (Heitzman & Markiewicz, 2017; Sugarman & Oakley, 2012; Salize, Dreßing, & Kief, 2005). These provide treatment to offenders equivalent to that offered to non-offending community citizens, one important difference being that it can have elements which are mandated by the courts (Völlm et al., 2017).

2.4.1. Issues relating to arrest, interviewing and trial in older offenders

Several authors have suggested that older offenders might previously have been dealt with differently by the criminal justice system, in particular that they were less likely to be arrested and charged due to issues around fitness to plead and an assumption that older people pose less of a risk to society compared to younger offenders (Yorston, 2013). However, given the increase in older offenders as outlined in this chapter, this appears to have changed in recent years. Older people who appear to have a mental health problem affecting their ability to participate in proceedings, like vulnerable younger offenders,

should have the right to be accompanied by an 'appropriate adult' when interviewed the police, to ensure that they understand what is happening to them and why (e.g. Police and Criminal Evidence Act, 1984 for England and Wales).

When standing trial, the first requirement, before criminal responsibility can be considered, is to determine whether the defendant is fit to plead and stand trial (i.e. 'fitness to plead' in the context of UK law or 'competence to stand trial' in US law). This is to ensure that the defendant has a fair trial (i.e. he/she is able to participate effectively in the proceedings). In UK law, as an example, criteria for fitness to plead are (Rogers, Blackwood, Farnham, Pickup, & Watts, 2008):

- ability to plead
- ability to understand the evidence
- ability to understand the court proceedings
- ability to instruct a lawyer
- knowing that a juror can be challenged

Fitness to plead can be affected by both mental and physical abilities. Examples of the former include cognitive functioning or delusional thinking, while sensory impairment can also affect someone's capacity to follow proceedings. It is important that arrangements are made to achieve fitness to plead where possible, for example through adjustments of the proceedings (e.g. shorter sessions) or visual/hearing aids. When fitness to plead is in question, the defendant is likely to be assessed by a psychiatrist, who will be able to comment on possible adjustments. The assessment is the same for older and younger individuals, but issues like cognitive functioning, including memory and executive function, as well as physical impairments, are likely to play a more important role in older defendants.

2.5. Ageing Prisoners

2.5.1. Prevalence

Since 2000, the general prison population worldwide has grown by about 6% (Walmsley, 2016). In some countries, such as Spain, offenders are released from prison at age 80 and in Azerbaijan and Russia life sentences cannot be given to people over 65 years old (Penal Reform International, 2015). However, in most countries worldwide the number of ageing prisoners has a markedly increased, representing the fastest growing group (Joyce & Maschi, 2016; Davoren et al., 2015; Cornish et al., 2016).

In the period 2000-2010, for instance, the number of ageing inmates in Australia increased by 36% (Baidawi et al., 2011) and in Canada by 50% (Penal Reform International, 2015). In the period 2002-2011, Japan experienced an increase of around 100%, while in the United States of America, the number of ageing prisoners increased by a record 300% (Williams, Goodwin, Baillargeon, Ahalt, & Walter, 2012). In the United Kingdom, a 169% increase in the population of prisoners over 50 years old was reported in the period 2002-2016, while the percentage of prisoners below 20 years old decreased from 13% to 6% between 2005 and 2016 (Allen & Watson, 2017).

Ageing prisoners now constitute 10% of the total prison population in Ireland (Joyce & Maschi, 2016), 15% in the United Kingdom (Allen & Watson, 2017), 19% in the Unites States of America (Carson, 2015), and 25% in Italy (ISTAT, 2015). At the end of 2016, the UK prison system even had one prisoner over the age of 100 (Allen & Watson, 2017).

The phenomenon of an increasing ageing prison population is caused by several factors (Frazer, 2003). Longer life expectancy and fewer releases by parole boards have reduced the turnover and led to an accumulation of ageing detainees (Senior et al., 2013). Societal attitudes toward ageing offenders have become less lenient. Crimes that were seldom reported to the authorities in the past, such as sexual offences, are now more frequently prosecuted (Frazer, 2003, Yorston, 2015b). Advances in forensic evidence have caused a 95% increase between 1995 and 2005 in the charge and incarceration in old age of people who have committed historical offences (RECOOP, 2015). At the same time, in some countries, tougher sentencing policies have been adopted to discourage crime, and ageing offenders are receiving life sentences more often than in the past (Frazer, 2003; Moll, 2013).

2.5.2. Psychiatric morbidity

While prisoners of all age groups experience poor mental health (Baldwin & Leete, 2012; Cooney & Braggins, 2010; Moll, 2013), the added challenges of ageing in restrictive settings and the poor physical, mental and social health care provision may further expose ageing prisoners to deteriorating mental health. Although limited epidemiological research exists, a recent systematic review and meta-analysis synthesising the existing international evidence found that almost 40% of ageing prisoners experience at least one psychiatric disorder, including depression (28.3%), alcohol abuse (15.9%) and psychoses (5.5%) (Di Lorito, Völlm, & Dening, 2018). The prevalence reported in the overall prison population (i.e. all ages), based on 109 studies including 33,588 prisoners in 24 countries, was 11.4% for depression and 3.7% for psychosis (Fazel & Seewald, 2012). In relation to alcohol abuse, an international systematic review based on 13 studies on the overall prison population reported an 18-to-30% prevalence for male prisoners and a 10-to-24% prevalence for female prisoners (Fazel, Bains, & Doll, 2006). We can therefore conclude that, compared to prisoners of all ages, in the older prisoners' group depression and psychoses are more prevalent and alcohol abuse is less prevalent.

When comparing data from the older prison population against the prevalence found among ageing people in the community, a greater Relative Risk (RR) was found for most psychiatric disorders, including depression, schizophrenia/psychoses, bipolar disorder, cognitive impairment, personality disorder, anxiety disorders and PTSD (Di Lorito, Völlm, & Dening, 2018). The RR was highest for schizophrenia/psychoses, evidencing that ageing prisoners may potentially experience more severe psychiatric conditions (Di Lorito, Völlm, & Dening, 2018).

Conversely, the RR was not statistically significantly higher for dementia (Di Lorito, Völlm, & Dening, 2018). This may be due to several factors: 1. lack of systematic cognitive assessment within the prison system (Moll, 2013); 2. a prison culture which is typically oriented towards principles of punishment rather than care, and which, in the absence of geriatric training among prison staff, may hinder the identification and diagnosis of the condition (Moll,

2013); and 3. lower incarceration rates or diversion from prison for offenders with dementia (Natarajan & Mulvana, 2017).

Suicide rates are also markedly high among ageing prisoners. Handtke and Wangmo (2014) found that 50% of ageing prisoners engage in suicidal thinking, as they may come to such a level of despair and alienation from life that they view death as the only possible escape from their misery. Although younger age has been identified as a risk factor for self-harm in the general population (Hawton, Linsell, Adeniji, Sariaslan, & Fazel, 2014), a large UK study reported that 'only' 30% of male prisoners aged 16-20 years old had engaged in suicidal thoughts in the previous year (Lader, Singleton, & Meltzer, 2000).

2.5.3. The challenges of ageing in prison

A recent systematic review of 25 international studies around the individual experience of ageing prisoners (Di Lorito, Völlm, & Dening, 2017) reported that despite emerging examples of good practice, the inadequacy of the prison system to respond to the unique physical and social health care needs of ageing prisoners has a detrimental impact on their overall experience of imprisonment (Aday, 1994; Lemieux, Dyeson, & Castigione, 2002; Smyer, Gragert, & LaMere, 1997). In the UK context, these findings confirmed previous evidence gathered by the prison inspectorate (HM Inspectorate of Prisons, 2013). This report commented that, although prison services are becoming a key accommodation and care provider for ageing offenders, little emphasis is placed on the rehabilitation and needs of ageing prisoners (HM Inspectorate of Prisons, 2013).

Currently, most prison institutions across the world are affected by common barriers that hinder adequate care provision. Among these is what has been defined by Crawley (2005) *"institutional thoughtlessness",* the widespread neglect of mental and social care health needs of ageing prisoners. Institutional thoughtlessness is partly explained in terms of untrained prison staff. Although some initiatives, such as the Community Ageing Health Project in the United States of America, have delivered geriatric training to all professionals working in the justice system (Ahalt & Williams, 2015), most prison staff are unable to

appreciate the difficulties which the prison regime presents to ageing prisoners or, if they do perceive the problems, they may feel powerless to act.

The neglect of ageing prisoners' needs is further caused by a macho prison culture, which views care duties as feminine and makes staff reluctant to undertake them (Moll, 2013). In addition, compared to the younger inmates who are often more assertive self-advocates, ageing prisoners appear more reserved and often reluctant to disclose their needs, which may therefore pass unnoticed (Doron, 2007).

Further challenges are presented by declining physical health. Ageing prisoners have been evidenced to present with greater mobility needs compared to both younger prisoners and ageing individuals in the community, as more than 80% suffer from chronic conditions or disability (Natarajan & Mulvana, 2017). Prison institutions do not seem able to respond adequately to the ageing prisoners' accessibility needs, often providing inaccessible prison cells and bathrooms, narrow doors, and key facilities (i.e. healthcare offices) accommodated on the upper floors of century-old buildings (Senior et al., 2013; Crawley, 2005; Joyce & Maschi, 2016). This is in contravention of the UK Disability Discrimination Act 2005.

Some examples of good practice, however, are emerging. For example, Her Majesty's Prison in Norwich in the UK offers an in-patient healthcare facility for ageing prisoners, and HMPs Frankland, Kingston and Whymott have dedicated wings for ageing prisoners (Natarajan & Mulvana, 2017). In the US, specialist services for ageing prisoners are common, including the creation of specialised units or wards for people living with dementia or the implementation of peer-support programmes to promote the inclusion and independence of prisoners in need (Moll, 2013). However, much remains to be done for current prison services to be considered dementia-friendly (Joyce & Maschi, 2016).

In relation to the activities offered in the prison system, Senior et al. (2013) reported that, in England and Wales, only half of the recreational programmes were suitable for ageing prisoners, while 67% were not accessible for anyone with mobility issues. Because of these barriers to taking part in activities, ageing prisoners may become reluctant to venture out of their cells and thus may develop feelings of social isolation and disengagement, which may

negatively impact on their process of rehabilitation (Crawley, 2005). The frequent loss of family contact experienced by ageing prisoners, and the death of partners or spouses, only add to the risk of alienation from life (Moll, 2013; Crawley, 2005).

The process of release into the community may also be more of a problem for older prisoners. One study found that 50% of ageing ex-prisoners ended up in homelessness and destitution (Senior et al., 2013; Joyce & Maschi, 2013), compared to 30% for the overall (i.e. all ages) prisoner population (Niven & Stewart, 2005). The lack of systematic pre-release courses tailored to the unique needs of ageing prisoners and the poor liaison strategies between prisons, probation services and offender managers often leave them unprepared to face the challenges of life in the community (Senior et al., 2013).

2.6. Ageing forensic psychiatric patients

Ageing forensic psychiatric patients represent a minority of the patients living in secure institutions. Nonetheless, as for ageing prisoners, given the recent changes in cultural attitudes toward ageing offenders (Yorston, 2015b; Frazer, 2003), the ageing trends in the population (Senior et al., 2013) and a tougher approach to crime (HM Inspectorate of Prisons, 2008), their number is on the rise.

In a UK study, over 20 years ago at Broadmoor Hospital (one of the three UK high secure services), 8% of patients were aged 50 years old and above (Wong et al., 1995). At the present time, in Rampton Hospital (another UK high secure service), one patient in five falls within this age category (Data provided by the Applied Information Team to the authors). This trend, however, is not specific to the UK context as similar prevalence rates have been reported elsewhere. In Italy, for example, in a single-site case study on the experience of ageing forensic psychiatric patients, Di Lorito et al. (2017c) reported that 20% of the patients were over the age of 50. In Germany, 20% of all patients in forensic-psychiatric hospitals and substance misuse units (in Germany different sections apply to those with offending related to substance misuse) are over 50 years old (Dönisch-Seidlel, personal communication).

Despite this increasing prevalence, research around older forensic psychiatric patients remains scant.

2.6.1. Demographic data

Available data suggest that in terms of gender composition, the overwhelming majority of the older patients in secure care - at least 85% -are males. In our study at Rampton Hospital, one of the three high security units in the UK, 89% of the patients were male, a male to female ratio of over 8:1 (Di Lorito, Dening, & Völlm, 2018). This is not greatly different from the proportion among younger patients: Coid et al. (2002) found that around 85% of patients aged below 60 years old in secure settings were male (Coid, Fazel, & Khatan, 2002).

In relation to marital status, a significantly smaller percentage of patients over 60 years old were single (31%), compared to patients below 60 years old (73%) (Coid, Fazel, & Khatan, 2002). In relation to ethnic composition, Whites were found to be most prevalent, making up to 100% of the sample in the UK studies (Curtice, Parker, Wismayer, & Tomison, 2003; Lightbody, Gow, & Gibb, 2010; Yorston & Taylor, 2009). The proportion of White ethnicity was higher among older patients (88%) than younger patients (75%) (Coid, Fazel, & Khatan, 2002).

2.6.2. Contact with services

Older patients typically have long admissions, ranging from an average of 14 years in Lightbody, Gow, & Gibb (2010) to 26 years in Shah (2006). This is longer than for either a prisoner sentenced for the same offence or for patients in general psychiatric services with a similar mental disorder (Völlm, Bartlett & McDonald, 2016). A recent study on long-term patients in medium/high security hospitals found a positive correlation between age and length of stay (Völlm et al., 2017).

Coid, Fazel, & Kahtan (2002) reported that 11% of 61 patients over 60 years old in medium and high secure forensic psychiatry services in the UK over a 7-year period were admitted following non-criminalised behavioural disorder, compared to 28% of younger patients. The same authors found a statistically significant lower percentage of older patients admitted to high security (3%), compared with the younger patients (15%) (Coid, Fazel, & Khatan, 2002).

The majority of older patients (65%) had previous psychiatric admission (Paradis, Broner, Maher, and O'Rourke, 2000; Lightbody, Gow, and Gibb, 2010), whose number averaged two (range 0-10) (Yorston & Taylor, 2009). However, previous psychiatric admission of older offenders was significantly lower than younger offenders (Coid, Fazel, & Khatan, 2002). Coid, Fazel and Khatan (2002) found that 23% of older patients had been in prison, the percentage being lower than among the younger offenders (Coid, Fazel, & Khatan, 2002). Prison transfers amounted to up to 60% in a UK study on long-stay patients (Völlm et al., 2016).

2.5.3. Mental health

Yorston and Taylor (2009) found that 36% of patients over 60 years old in a UK high secure service had schizophrenia, 27% delusional disorder and 9% schizoaffective disorder. High prevalence of psychotic illness was also found in a retrospective study of older patients in secure psychiatric care in Scotland from 1998 to 2007 by, with an aggregated prevalence of 64% for schizophrenia, schizotypal and delusional disorders (Lightbody, Gow, and Gibb, 2010). However, the prevalence of schizophrenia was found to be significantly lower in older patients (33%), compared to younger patients (58%) in one study (Coid, Fazel, & Khatan, 2002). Conversely, the older patients had a significantly higher prevalence of delusional disorder.

Personality disorder was found to be the most prevalent psychiatric disorder among older patients in a cross sectional study carried out in three secure settings in the UK (61%) (Di Lorito, Dening, & Völlm, 2018) The older patients had significantly higher prevalence of schizoid personality disorder, as opposed to the younger patients, who were more frequently diagnosed with antisocial and borderline personality disorder (Coid, Fazel, & Khatan, 2002). Lifetime prevalence of depression was 42% for older patients, compared to 18% for younger patients, the difference being statistically significant (Coid, Fazel, & Kahtan, 2002). The difference may indicate that the added challenges of ageing in secure settings may expose the older patients to added vulnerability of psychiatric disorder.

Paradis, Broner, Maher, and O'Rourke (2000) found that 33% of the older patients were affected by some type of dementia (2% with Alzheimer's disease). Similar findings were reported by Shah (2006) who found a dementia prevalence of 27%. One study reported a

prevalence of below 10% (Tomar, Treasden, & Shah). Organic brain syndrome was statistically significantly more prevalent in the older patients (33%) compared to the younger ones (12%) (Coid, Fazel, & Khatan, 2002). However, only a small proportion (less than 20%) of older patients had undergone any formal cognitive testing (Curtice, Parker, Wismayer, and Tomison, 2003; Lightbody, Gow, and Gibb, 2010). Thus, the rates reported could underestimate the extent of the problem. At any rate, the higher rates of dementia in forensic secure settings compared to prison samples might indicate that diversion into psychiatric care might be more appropriate for some of this patient group.

A formal diagnosis of alcohol abuse appears to be relatively uncommon, around 3% to 6% of older patients (Curtice, Parker, Wismayer, & Tomison, 2003; Paradis, Broner, Maher, & O'Rourke, 2000). However, the rates were much higher if regular consumption was considered (41%) (Curtice, Parker, Wismayer, & Tomison, 2003). No significant differences were found compared to the younger patients (Coid, Fazel, & Khatan, 2002). However, in the study of Coid et al. (2002), the prevalence of drug abuse and dependence among older patients was much lower than among younger patients (0% and 52%, respectively, though these figures are likely to have changed since the time of that study).

2.6.4. Physical health

Forensic psychiatric patients of all ages experience poorer physical health and have a shorter life expectancy (10–20 years less) compared to people living in the community (Davies, 2013). In addition, older patients may be affected by age-related conditions, which exacerbate their overall physical wellbeing.

Curtice, Parker, Wismayer, and Tomison (2003) found that 44% of older patients had one health problem and 16% had two or more. On average, each patient had one to two diagnoses of physical illness upon admission, which increased to more than two upon discharge (Shah, 2006; Lightbody, Gow, & Gibb, 2010). Mobility problems were prevalent, affecting up to 61% of the ageing patients in one study (Lightbody, Gow, & Gibb, 2010). One-fifth of the sample suffered from sensory impairment, including hearing (16%) and eyesight problems (6%) (Curtice, Parker, Wismayer, & Tomison, 2003). Cardiac disease, hypertension and diabetes were also widespread, with prevalences of 23%, 15%, and 13% respectively (Paradis, Broner, Maher, & O'Rourke, 2000).

2.6.5. Qualitative studies

Very limited data exist around the individual experience of ageing patients in forensic settings at the international level. One common theme emerging from studies carried out in the United Kingdom and Italy (Yorston & Taylor, 2009; Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017) is about the challenges of life in confinement and how the limitations to freedom have a negative impact on the experience of ageing patients. For example, patients complain about the rigidity of policies around gender separation, which do not reflect the reality of life in the community and are therefore believed to hinder successful reintegration into life outside the institution (Yorston & Taylor, 2009; Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017).

Given the challenges of life in secure settings, ageing patients adopt a variety of coping mechanisms, the most reported of which is relying on strong support networks (Yorston & Taylor, 2009; Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017). In this sense, the clinical team on the ward plays a central role in promoting the emotional wellbeing of the patients, given the extended time they spend with the patients on a daily basis (Dutta, Majid, & Völlm, 2016). In fact, several patients reported how, in times of difficulty, they preferred to talk to the staff on the ward (e.g. nurses), rather than wait for psychology consultation (Yorston & Taylor, 2009). Older patients generally appreciated the effort of the members of staff on the ward to go beyond traditional work duties and develop genuine relationships with them, which enhances both clinical rapport and the therapeutic journey of the patients (Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017).

Peers may also represent a source of support. Although most patients reported having a special friend or a small group of friends to confide in, they acknowledged that the common mental health symptoms may hinder good rapport at times (Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017). Similar mixed feelings apply to their relationships with younger patients. While several older patients appreciated the balance and diversity of mixed (i.e. younger and ageing) wards, others reported irreconcilable differences and called for the creation of separate wards for ageing patients (Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017). Another argument in support of the creation of aging patients' wards is related to the unique care needs of this population, treatment and security, and

the barriers to addressing these in mixed ward environments. For example, some occupational therapists raised concerns about fitting handrails to aid ageing patients' mobility, as they thought these would present security issues in relation to the younger patients (Yorston & Taylor, 2009).

In relation to personal resources to deal with the difficulties of life in confinement, older patients frequently reported a strong sense of spirituality, which provides them with inner peace and comfort (Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017). This was in contrast to younger patients who may be reluctant to voice a religious dimension to their life. In order to find the emotional strength to deal with their present difficulties, older patients also resort to positive thinking, by reminiscing happy memories or imagining a future life outside the institution (Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017).

Ageing patients also emphasised the importance of getting off the ward to boost their recovery. Although the existing programmes of vocational, educational and cultural activities were generally found to be satisfactory, some patients wished to be more involved in the development and design of age-friendly activities (Di Lorito, Castelletti, Tripi, Gandellini, Dening, & Völlm, 2017; Yorston & Taylor, 2009). Pressures on budgets and staffing levels, experienced by most forensic psychiatric systems worldwide, are therefore likely to be a significant barrier to improved services for older patients. Issues of security may also represent a challenge to implementing recovery-oriented activities in more restrictive settings.

Discharge from the service is also a challenge for the mental wellbeing for older patients, many of whom may have spent a long time in the service. Several patients reported developing emotional attachment to the institution, and anxiety at the uncertainty of future prospects (Yorston & Taylor, 2009). This may be particularly so in legal systems, such as the UK, where some patients may be transferred back to prison after their discharge from the mental health service. These challenges may be difficult to overcome and require extra effort on the part of the multidisciplinary team to encourage the patients to move along their pathway (Yorston & Taylor, 2009). Therefore, older patients who have been in the service for a long time need careful attention and tailored individual discharge plans (Yorston & Taylor, 2009).

2.7. Conclusion

The United Nations has identified ageing offenders as a special need population, owing to their unique physical, mental health and social care needs (Atabay, 2009). This requires the development of adequate strategies to ensure improvement of forensic service provision for this population.

One option which could address the unique needs of older offenders is the development or further implementation of services specifically catering for older offenders, both within the prison system and in the forensic psychiatric sector (Tomar, Treasden & Shah, 2005; Nnatu, Mahomed, & Shah, 2005). Some argue that separate services for older offenders are not ethically acceptable, as these may present segregation and have unsustainable costs; they advocate in favour of mixed-age services, which may have added benefits (e.g. a calming effect of older individuals on younger ones, locality rather than distance of services from home area). Others instead emphasise the benefits of specialist care provided by adequately trained professionals and view dedicated services as safer environments, with reduced risk for bullying and victimisation (Natarajan & Mulvana, 2017). Super-specialisation of forensic services with minority populations, such as women, people with learning disabilities and deaf people, has so far proved effective in boosting service users' experience, and represents a further argument in favour of dedicated services for older offenders (Natarajan & Mulvana, 2017). Furthermore, these services might offer end-of-life and palliative care to address the intensive care needs of offenders with progressive conditions, who cannot be released in the community on compassionate grounds, given their risk.

In the ongoing debate around specialist care provision, some implications for service improvement in the current mixed-age units can be derived. In order to boost opportunities for recovery of older offenders, services should further develop: (i). Specialist expertise through staff training; (ii). age-relevant treatment and activities; and (iii). age-friendly environments. Expertise in forensic mental health and in geriatric issues are a key requirement for staff dealing with older offenders (Natarajan & Mulvana, 2017). Sensitising

all members of the multidisciplinary team to age-related needs requires a change of culture, with a greater balance between duties of restrictiveness and care. The emphasis on rehabilitation through care is typical of strength-based frameworks such as the Good Lives Model (Robertson, Barnao, & Ward, 2011) and the Recovery model (Drennan et al., 2014), which are recommended to be widely implemented across all forensic settings. Forensic services need to offer treatment and activities which better respond to the unique rehabilitation/recovery needs of older offenders, such as Cognitive Stimulation Therapy (CST), reminiscing, speech and language therapy, physiotherapy and mobility work (Natarajan & Mulvana, 2017). Finally, to promote independence in the presence of deteriorating physical and mental abilities, modifications to the environment and the daily routine may be necessary. These include orientation aids/cues to facilitate navigation within the premises, more frequent daily planning meetings and special furniture (e.g. shower chairs, handrails) (Natarajan & Mulvana, 2017).

Service improvement should be supported/informed by dedicated policy on older offenders, which has only been developed in few countries thus far. In Ireland, for example, the Prison Service Strategic Plan 2016–2018 includes the development and implementation of the first national strategy on older prisoners (Joyce & Maschi, 2016). In other countries, standards of health care provision for ageing offenders are aligned to principles and guidelines established in international human rights documents, such as the European Convention of Human Rights (ECHR), or based on general national policies. In the United Kingdom, equality in the treatment and care for ageing offenders is granted through the National Institute for Health and Care Excellence (NICE) guidelines on mental wellbeing and independence in ageing people (NICE, 2015) and the Care Act 2015. The latter document, for example, establishes the responsibility for local authorities to provide equal social heath care to all older individuals.

In the absence of dedicated strategies, however, these general policies do not seem sufficient to ensure consistent levels of quality in service provision across different institutions. At present, the existing examples of good practice are largely dependent on the commitment of individual institutions and the enthusiasm of staff (Yorston, 2015a). In order to ensure uniformity in quality standards and promote good practice, accumulating

evidence suggests that policy makers should take initiatives at the governmental level and develop specific national strategies to address the unique needs of older offenders.

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