ARK Policy Brief

Ageing in Northern Ireland Prisons

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Demographic change in prisons

Older men are the fastest growing cohort in prison within the UK. In 2008, 11% of the adult male prison population in Northern Ireland was aged 50 years and over, and by 2015, this figure had risen to 16%[1] . Reflecting this, the number of older men has grown from 134 in 2008 to 236 in 2015, which is an increase of 76%. A review of the adult prison population in England and Wales between 2004 and 2014 showed that the largest percentage increase across the prison estate was for those aged 60 and over (125%) followed closely by prisoners aged 50-59 (104%) (Omolade, 2014). In 2019, there were 13,620 prisoners aged 50 and over in English and Welsh prisons, representing 16% of the total prison population. This compares to 2002 when this age group constituted just 7% of the prison population.

The increase in the number of older prisoners is largely due to wider demographic changes and increasing life expectancy, as well as reforms in sentencing resulting in longer sentences (Fazel et al, 2001). Penal policy and sentencing have been subject to extensive ideological and political debate resulting in electoral candidates offering a 'tough on crime' approach in exchange for votes. In the 1990's, England and Wales saw an expansion of prison building programmes, which had the intention of showing the general public that the government were taking crime seriously, despite the cost (Piper and Easton, 2006). In addition, the increased eagerness of courts to pursue historical offences, alongside changes in societal attitudes towards sexual abuse, has led to an increase in the perpetrators of these crimes being sent to prison later in life (Crawley, 2005).

Health and social care needs

Research shows that older people in prison often experience worse health than their community dwelling peers, and have distinct differences in their health and wellbeing needs in comparison to younger prisoners (Fazel, 2001). Scholars have argued that addressing these needs is not only a human right entitlement and thus beneficial for the person, but also beneficial for wider society (Williams, 2013). This is because the majority of those who come to prison will eventually be released, and thus such unmet needs may require expensive treatment within hospital facilities upon release from prison. In addition, and particularly for older people, unmet needs may limit a person's ability to function independently within the community thus creating a difficulty for reintegration after prison (ibid).

The higher prevalence of poor health among the prison population often creates a difficulty for prison healthcare providers who inherit many of the unmet needs within the community upon a person's admission to prison (House of Commons, 2018). Whilst some have argued that prison presents an opportunity to address such unmet needs, many healthcare providers are not sufficiently resourced to provide specialist services for the specific health needs of the population including mental health, self-harm, suicide, problematic drug-use and alcohol dependency (Ross, 2013). The prison environment is also important, as prisons are built with the purpose of containing prisoners, not treating their health needs.

Health and social care provision

Healthcare provision within Northern Ireland prisons has undergone significant reform during the past decade. Responsibility for healthcare transferred from the Northern Ireland Prison Service (NIPS) to the South Eastern Health and Social Care Trust (SEHSCT) in 2012, although this process formally began in 2008. The aim of this reform was to enable greater alignment between prison and community healthcare standards and practice. This reform also aimed to address issues around professional isolation for healthcare professionals working in prison. A

1. Source: Prison population data provided by Northern Ireland Prison Service as part of PhD study conducted by the author of this publication.

Partnership Agreement was signed by NIPS and the Department of Health, Social Services and Public Safety (DHSSPS) in 2009 (DOJ, 2009). This stipulated that whilst the Agreement was not legally binding, it represented the intention of the stakeholders in relation to the future arrangements of healthcare in prison, noting that the Health and Social Care commissioner ....:

> *"shall commission health and social care services equivalent to those the general public receive in the community. For the purposes of this agreement, the scope of commissioned services included the appropriate range of primary care (general medical, dental, optometry and pharmacy), secondary care (various disciplines) and other specialist services (e.g. forensic psychiatry and other specialist mental health services)." (2009:5)*

Whilst the Partnership Agreement identified that the Health and Social Care Board (HSCB) would commission both health and social care services equivalent to those provided within the community, some have argued that there has been reluctance to do so based on the financial arrangements relating to the healthcare transfer. The Prison Review Team (PRT) highlighted that funds were only transferred over to the SEHSCT from the NIPS budget for health and not social care. Furthermore, in the absence of a health needs assessment, the transfer of funds did not take into account the level of 'unmet needs which a professionally delivered service was likely to expose' (PRT, 2011: 42). In 2016, a report by the Independent Monitoring Board (IMB) in HMP Maghaberry identified that the SEHSCT had outsourced domiciliary care for one prisoner in HMP Maghaberry and orderlies were tasked as carers to severely disabled or disorientated prisoners (IMB, 2016). The IMB highlighted the need for clarity on where the responsibility should lie for future provision of social care (IMB, 2016). Furthermore, IMB's annual report recommended that the issue of social care provision prison be included in the joint Healthcare Justice Strategy (IMB, 2016).

In June 2019, *Improving Health with Criminal Justice* was published (DHSSPS/DOJ, 2019). This strategy and action plan noted the particular concerns around the provision of social care in custodial environments in Northern Ireland and therefore specific action plans had been identified relating to this area. This included a commitment to collate available evidence in relation to social care needs and provision available in prison and to review this within the first year of the three year action plan. It also highlighted the role that the NIPS, Probation Board of Northern Ireland (PBNI) and third sector partners had upon aspects of social care. Additionally, the Strategy pinpointed that on individual cases the SEHSCT would provide personal healthcare support for individuals with complex needs. However, it fell short of identifying where financial responsibility for social care in prisons should lie in the future, nor did it identify the possibility of a new Partnership Agreement which would explicitly address social care within the agreement.

What next?

To date, no such update to the Partnership Agreement has taken place, nor have the arrangements for social care provision in prison for older people or other vulnerable groups of people been formalised. As the population of older people held in prisons continues to grow this remains an area of concern. Whilst the *Improving Health within Justice* Strategy made a commitment to review evidence on social care in prison, there is a need to take action on long standing issues experienced by older prisoners and staff who coordinate services for their needs. For example, the need to appoint a suitably qualified individual similar to the role of a social care manager within the community, who could appropriately assess social care needs in prison and coordinate services to meet these needs. There is also a need for clarity on where responsibility lies for specific services both in prison and particularly upon retry back into the community. This would require a joint approach between the key stakeholder organisations (NIPS, SEHSCT, PBNI) and the other Health and Social Care Trusts that exist in Northern Ireland.

Furthermore, a policy framework relating to the management of older prisoners in prison in Northern Ireland is needed, which should address areas which are contentious among the older men and sometimes among staff. These include the difficulties

transporting older men to healthcare appointments outside of prison and the use of restraints during such appointments. Additionally, such a policy should provide clear guidelines on the expectations of care for those requiring palliative care. This should not only include guidelines for the care that should be provided in prison but also a framework for release of those who are dying in prison.

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