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Older women in the criminal justice system: a brief report from a nominal group

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ABSTRACT

There are increasing numbers of older women in prison in England and Wales. The needs of older women in prison have been under researched and are often unmet. This paper explores staff and expert perspectives on the needs of older women in prison through a nominal group attended by six participants, including a consultant at the UK Health Security Agency; a General Practitioner; a postgraduate student completing a project on older women in prison; an academic researcher with expertise on older women in prison; a National Women's Health, Social Care, and Environment Review Group lead; and a HMMPS Diversity and Inclusion Lead. Six key themes were identified: 1) health screening; 2) health services and unmet health needs; 3) emotional wellbeing; 4) social and family connections; 5) the need for a professional's forum; and 6) limited data and research. Participants agreed that this population's needs are not adequately met. Moving forward, structures must be put in place to ensure that older women's needs are understood and met, and their voices heard.

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Background

At the end of March 2024, there were 3,635 women in prison in England and Wales, making up 4.1% of the overall prison population (Ministry of Justice and HMPPS, 2024). Between 2003 and 2023 the number of women aged 50 or above in these prisons increased by 179.5%, from 184 to 514, and the proportion increased from 4% to 15% (Ministry of Justice, 2023a).

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Women in prison have different health needs to men (Plugge & Fitzpatrick, 2005). They have higher rates of self-harm (Kottler et al., 2012), high rates of adverse childhood experiences (Friestad et al., 2014), and are more likely to be primary caregivers (Mignon & Ransford, 2012). Although their needs should be considered separately (McCann et al., 2020), they live in a justice system primarily designed for men (Jewkes et al., 2019), and what few women's prisons there are in England and Wales are widely dispersed (Ginn, 2013).

Within the prison population, older adults are typically defined as those 50 years of age and over (Merkt et al., 2020), in contrast to the cut-off which is commonly used across community health and care settings of 65 (AgeUK, 2023). This difference derives from evidence which suggests prison populations have a biological age that is comparable to the age of community populations who are 10–15 years older, described by 'greater burden of illness, disability, functional impairment, chronic conditions and comorbid conditions' (Merkt et al., 2020, p. 105). Causes are complex, though are believed to be based on factors including previous socioeconomic disadvantage; potential past substance misuse; poor nutrition; previous limited engagement with or access to medical care; as well as the effects of imprisonment itself, including distress, social and/or familial isolation, and healthcare systems functioning less well than those in the community (Merkt et al., 2020).

Older women have different offence and sentence length profiles to younger women (Centre for Policy on Ageing, 2016). They have lower rates of substance misuse (Haesen et al., 2019), but high rates of past physical and mental abuse, mental illness, and functional impairment (Aday & Farney, 2014). Older men in prison have greater health and social care needs than younger prisoners or peers in the community (Hayes et al., 2012; Tucker et al., 2021). While the poor health of older women in prison is worse than that of older men (Kottler et al., 2012), less is known about their needs (Haesen et al., 2019). What evidence exists indicates that there are difficulties with access to and provision of health and social care, living conditions, access to suitable activities, and the social and physical environment (Aday & Farney, 2014; Handtke et al., 2015; Plugge et al., 2008; Woodall et al., 2021).

The 2021 ministry of Justice (MoJ) Women's Policy Framework does not consider the needs of older women specifically (Ministry of Justice and HMPPS, 2021). A recent review on health and social care in women's prisons in England recognised that women in prison have disproportionately higher levels of health and social care needs than their male counterparts in prison and women in the general population, and that current prison environments are unfit for the women they house (NHS England and HMPPS, 2023). The report also found that health and social care services across women's prisons in England are inconsistent, not always gender specific, and commonly

insensitive to women with protected characteristics (NHS England and HMPPS, 2023).

The current paper aims to explore the opinions and accounts of staff working within the prison environment or with expertise in the provision of healthcare for women in prison. Through a nominal group discussion (Harvey & Holmes, 2012; Manera et al., 2019), this paper specifically aims to identify current practice, areas of difficulty, and potential improvements to support the health and social care needs of older women in prison.

Method

A nominal group was conducted to explore the views of experts with experience of and expertise in supporting older women in prison. Data were analysed thematically (Braun & Clarke, 2006, 2012). A detailed description of rationale and methods used is presented in an accompanying paper of this journal edition (O'Neill et al., 2024). For this group, there were six participants, including: a consultant at the UK Health Security Agency; a General Practitioner; a postgraduate completing a project on older women in prison; an academic researcher with expertise on older women in prison; a National Women's Health, Social Care, and Environment Review Group lead; and a HMMPSDiversity and Inclusion Lead.

Findings

Six main themes were identified: 1) screening; 2) health services and unmet health needs; 3) emotional wellbeing; 4) social and family connections; 5) need for a professionals' forum; and 6) limited data and research. The group acknowledged that they considered a large age range (50 and above) and therefore the needs of within this group would not be uniform.

Health screening

Participants noted that health screening was not well developed for older women in prison. Poor uptake in cervical screening was identified as a missed opportunity to provide screening to a population at increased risk of cervical cancer who may have been previously underserved in this aspect. One participant suggested that older women needed more information about screening for uptake to increase. Additionally, the importance of offering older female to male transitioners screening based on their birth-registered sex was also raised. One group member, serving at the time on the National Women's Health and Social Care Review, explained that screening templates were currently being evaluated. However, identification of screening eligibility was limited:

> It's not very easy to always identify who's eligible. You have to go on self-report data because we don't have that data coming through routinely from national screening databases.

Availability of breast screening was also considered to be poor, with coverage estimated by the group at 20%. Screening was not offered in many cases:

> It doesn't happen everywhere because the community services may not offer it, or for example in one of the prisons there's a bridge, so the [mobile] breast screening . . . can't come in under the bridge.

While some community services have begun to improve access for women in prison, they were not thought to be offering an adequate service as a whole:

> One prison . . . for example, their local hospital ring fences Friday afternoon for women from prison and they said that works really well and they can get a few people out because they know that slot is held for them and equally where the vans can go in. [In theory that's] great, but they'll go . . . what twice a year? And women go in and out (of prison) quite quickly.

Health services and unmet health needs

Participants reported many older women living in prison do not access services when living in the community and rely on prison services to meet their health needs. Cervical and breast cancers, heart disease, hypertension, musculoskeletal disorders, osteoporosis, mood disorders, and menopause, were all considered by the group as conditions for which detection and treatment should be prioritised in this population.

Education and support around menopause were described as lacking. In particular, the group suggested that there was minimal allowance for the impact of being in custody and the accompanying loss of control over environment and routine, which can exacerbate menopause symptoms:

> If you are in an environment where you don't have much autonomy, being able to manage your temperature, that sort of thing is quite difficult.

Participants suggested menopause services could be included in 'well women' clinics; however, the group observed that existing prison menopause services are not always accessed, potentially due to a lack of awareness or accessibility:

> Often . . . they (prison healthcare) have run menopause clinics and have the facility there for the older women, but I don't know why this is just an information issue or whether it's that it's just there's difficulties accessing health care. Most of the women that I would speak to would have no idea that there was any sort of clinic that was available for them to go to.

The group explained that women with complex needs were not receiving specialist care because their numbers in any one locality were

relatively small. They suggested that women requiring enhanced care, for example, with terminal illness or complex long-term conditions, should be housed in small, specialised units where staff understood their needs, and with more accessible medical care and medication. There are also women with social care needs who might not need such intensive support but cannot be appropriately cared for on a standard wing. The group gave the example of women with mobility difficulties needing accessible spaces:

> Some of our patients that are older [have] struggled on the wings because of the hustle and bustle with stairs and access to rooms [and] to some corridors.

However, one downside discussed around sending women to specialist locations was that that they might be moved further from their local area and from families and support networks.

Emotional wellbeing

Participants thought that emotional wellbeing is overlooked and noted a lack of research on self-harm in older women. Data from Assessment, Care in Custody and Teamwork (ACCT) documents, the care planning process for prisoners identified as being at risk of suicide or self-harm was used to suggest that few older women self-harm in prison:

> There's a really low number on ACCT documents aged over 50.

Reasons for less self-harm amongst the older women in prison in comparison to their younger counterparts were thought to be complex. One participant noted that older women in prison may have a history of self-harm but stop this behaviour over time. However, older adults are known to participate in self-harming behaviours, and these behaviours need to be better understood to provide appropriate support.

Additionally, the lack of privacy inherent in prison systems appeared to hamper discussion with older women around issues of wellbeing. It was felt by the group that older women may not wish to discuss wellbeing needs, particularly those which can arise from ageing, to access the support they need:

> [Some] feel quite embarrassed having to discuss lots of … intimate personal female issues, often with a range of officers either male or female of any age to actually get their needs met and accessed … There are certain aspects of ageing which you wouldn't necessarily want to discuss with a wide range of people. And obviously then the necessity in prison means that you have to do that.

Social and family connections

Difficulties in maintaining family links were considered important for older women by the group. Loss of contact with elderly parents and dependent children was a particular concern:

> There's this dual worry about losing your parents and losing your children and how . . . the children can't get to the prison because they're not physically able to and the parents are too elderly to get there so you end up having less visits. So, it's about being able to maintain that family contact. You know things like using the telephones if you don't have a phone in your room.

It was also suggested that women would value the quieter environment and opportunity to socialise with women of their own age if they were housed together:

> If you put women together within a similar age, what you end up with is it will reduce anxiety because they're living in a quieter environment, but it would also allow them to try and form . . . small social cohesive groups which are really supportive.

This was considered more difficult than in the male prison estate because the smaller numbers of older women increase the likelihood of being far from home, risking relationships. It also makes communication with local agencies to arrange care on release challenging. Additionally, prison managers value maintaining mixed age groups because of the perceived calming influence of older people across the estate. It was also emphasised that where older women are housed with younger women, they should be allowed to use the gym and socialise separately.

Women's forum for professionals

The group highlighted that communication around older women across prisons was lacking. They suggested that a dedicated forum or network for social care professionals would help:

> [There is] a real appetite for health and social care colleagues in the women's estate to kind of come together and support each other and work together collectively.

The current, very limited duplication of work and ideas based on men's prison health services was thought to reflect a lack of overall structure and ownership, due to the commissioning structure:

> Different commissioners doing different bits and pieces do it slightly different.

Limited data and research

Participants highlighted that there is very limited data to inform service development for older women. This includes a lack of data on trans women living in prison, women aged over 50, and women who are foreign nationals:

> We don't necessarily know what the different needs are because we don't collect [data] at the moment.

There is also a lack of research, largely due to the small number of older women in each establishment.

Discussion

Summary of findings

Six key themes were identified from this research. Firstly, health screening was considered to be significantly underdeveloped for women in prison, with poor uptake and availability in, for example, cervical screening and breast screening. Overall, health services were thought to be inadequate owing to a lack of gender-specific provision and education on women's health conditions, such as menopause. In particular, there were concerns around older women with complex needs and the lack of capacity on a typical prison wing to support these individuals. Suggestions to address wider women's healthcare limitations included training, awareness raising, targeted services and service promotion; and, for women with more complex needs, specialist facilities to meet these needs. However, concerns arose around the small number of women's prisons and how specialist facilities might lead to individuals being moved large distances from their support networks outside of prison.

Emotional wellbeing was thought by the group to be an overlooked aspect of older women's health in prisons given the low number of women currently supported through the ACCT process. Hypothesised barriers to the engagement of women on wellbeing included the lack of privacy afforded to individuals and older women being reluctant to seek help. In addition, social and family connections were seen as a vital aspect of maintaining positive wellbeing for older women in prison. It was thought that this might also be positively affected by housing older women with other older women so that they could enjoy a calmer living environment. Nonetheless, the group acknowledged that limited data is currently collected on the needs of older women in English and Welsh prisons, in particular, older women, foreign nationals, and trans women. Similarly, academic research, particularly on older women in prison is lacking. However, amongst those who provide services and support for women in prison, there is a real appetite to cultivate

and exchange knowledge such that uniform and appropriate services might be developed via a forum of relevant professionals.

Comparison with published literature

Findings from this study are in keeping with other research. In England and Wales, evidence suggests there are serious shortcomings in health and care provision for women in prison (Davies et al., 2023; NHS England and HMPPS, 2023; Wahidin, 2011), with health and care needs inadequately or poorly met. Internationally, a US study of prison healthcare staff (Barry et al., 2020) highlighted challenges in care delivery and unmet health needs as key themes. A study of women in prisons in Switzerland also found similar themes and additionally identified loss of autonomy and excess security in prisons (Handtke et al., 2015); it highlighted a lack of adaptation of prison workplaces, poor nutrition, and problematic officers' attitudes.

The United Nations (2011) recommend that screening is offered to women in prison on an equal basis with women of the same age in the community. However, participants in this study identified significant systemic difficulties preventing uptake, which is in keeping with accounts from women in prison (Handtke et al., 2015). Despite defined standards for older women's access to healthcare (Public Health England, 2018), participants in this paper identified deficits in service quality. Accessing menopause services is difficult for women in prison internationally (Van Hout et al., 2022), as are challenges with community services bringing healthcare into prisons (Aday & Farney, 2014), or bringing prisoners to community healthcare; between 2019 and 2020, older women in prison in England and Wales were recorded as missing 45% of their outpatient appointments overall, and more than 57% of their gynaecology and ophthalmology outpatient appointments (Davies et al., 2023).

Furthermore, the groups' focus on emotional wellbeing appears appropriate, given recent data from England and Wales, which demonstrates that a significantly higher percentage of older women accessing hospital services have a diagnosis of depression (21%) compared to older men in prison (8%) (Davies et al., 2023); in addition, the proportion of hospitalised older women prisoners with a diagnosis of depression was also much higher than the older women in the general population ('98 per 1,000, compared with 34 per 1,000') (Davies et al., 2023, p. 24). Qualitative research also emphasises the psychological and emotional burden experienced by older women in prison, especially in situations of ill health (Prison Reform Trust, 2023; Wahidin, 2005). Older women have reported feeling fearful of becoming ill and losing their autonomy within a system which already limits autonomy, as well as how the inadequacy of healthcare provision re-emphasises their situation as

incarcerated individuals, and imposes on them a 'double punishment' (Prison Reform Trust, 2023; Wahidin, 2005).

Despite the groups' discussion around self-harm in this population, little is known about self-harm in imprisoned older women. Data from England and Wales reflect participants' views that numbers of self-harm incidents and women who self-harm in prison are lower in women over 50 (Ministry of Justice, 2023b). However, this may reflect the smaller number of women being sampled, and self-harm in this group should not be dismissed. It is known that older adults in community settings do self-harm; moreover, the distinct characteristics of self-harm found in this group (Troya, Babatunde, et al., 2019), including the differing functions self-harm appears to hold for older adults (Troya, Dikomitis, et al., 2019), may not be as easily detected by the Assessment, Care in Custody and Teamwork (ACCT) document legally used to manage those at risk of self-harm or suicide in prisons (Humber et al., 2011). Given that data indicate the risk of suicide is significantly higher in older adults who have self-harmed (Murphy et al., 2012), further evidence is required on older women and self-harming behaviours in prison settings.

Reflecting the findings of this paper, the value of maintaining community and social connections for women in prison is recognised internationally (United Nations, 2011). The importance of older women being housed near others is emphasised in prison standards (Public Health England, 2018) and has also been recommended by health providers in the US (Barry et al., 2020). Finally, the limited data and research on older women in prison remains evident despite having been highlighted for several years (Kottler et al., 2012).

Implications for policy and practice

Findings from this nominal group suggest that the needs of older women in prison in England and Wales are not adequately met. As the numbers of older women in prison increase, many more will experience poor health and social outcomes. It is important that information about services is shared with staff and women, and that professionals share understanding and good practice. However, change at an organisational level is required, particularly regarding service provision and how women are accommodated. Promise in this direction has recently appeared in the eight strategic recommendations of the recent report reviewing health and social care in women's prisons (NHS England and HMPPS, 2023), which endorses an appropriately tailored approach that is gender specific, gender compliant, considerate of protected characteristics, personalised, accessible, equitable, and consistent. We suggest these recommendations should be enacted as a priority.

Additionally, screening processes should be improved for women with specific conditions and awareness-raising efforts should be undertaken to reach this typically underserved group (Plugge & Fitzpatrick, 2004). Health

and social care services should be developed to meet the currently unmet needs of women in prison, and staff should be educated on women-specific health challenges. Adaptations should be made for the wellbeing of older women in prison, such as situating them with other older women, or allowing them opportunity for exercise and activity with their older peers, and specialist facilities should be developed for those whose health and social care requirements are more serious. The facilitation of strong family and social connections should also be enacted wherever possible, by locating women closely to their support networks or facilitating regular, meaningful contact.

A forum for professionals providing health and social care in women's prisons should be formed which facilitates knowledge exchange and examples of good practice. Robust data collection procedures on this group should also be in place so that their needs and how to meet them can be effectively captured.

Future research

In this paper, professionals identified key issues regarding the needs of older women in prison. However, little research has heard from older women in prisons themselves. Empirical evidence is desperately needed on the prevalence of health and social care need in women's prisons, and models for how these needs should be addressed require rapid development.

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Ethical approval

Ethical approval was not sought for this study as by Research Ethics Service guidance standards it was classified as 'service evaluation', specifically, it was 'designed and

conducted solely to define or judge current care or service, or to deliver and measure improvements in quality of the current service' (https://www.hra-decisiontools.org.uk/research/). Therefore, NHS Research Ethics Committee review was not required. This was verified by the project team using the Health Research Authority's decision tool.

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