

# British Society of Criminology

Dr Azrini Wahidin  
British Society of Criminology on-line journal.

## **‘We are a significant minority’: Old Women in English Prisons**

I do think that they [The Home Office] should have a plan of action for what they *are going to do with older women*.

No specific thought is given to people who are in this age category. It is given to sort of other categories - *they don't really think about people of our age group or the needs of our families*. I appreciate we are *a minority* but I think a number of people you have to interview would say we are a *significant minority!* (emphasis in original)

PETRA PUDDEPHA<sup>1</sup>  
AGE: 55

As a society, we are unaccustomed to thinking about elderly people as criminal offenders. Usually, when the elderly receive publicity they are represented as the victims of crime, not its perpetrators. Common portrayals of the elderly offender in the media have been that of driving under the influence, engaging in disorderly conduct, or shoplifting in order to survive or to provoke attention. The public perception of women who commit offences, such as shoplifting, violence against a person, drug related offences is that they are younger and that they receive relatively short prison sentences. More especially, we are unlikely to associate elderly women with crime, or women in general with crime serious enough to result in prison sentences continuing into old age. The aim of this paper is centred around the experiences of female elders in prison with a particular emphasis on health-care. Furthermore, this paper will raise generic issues that are relevant to the elderly male prison population and contribute to ongoing work in this area.

Despite the geriatrification of the prison population little is known about the experiences of women who are in prison. Furthermore, it is difficult to draw precise conclusions about the extent of crimes committed by persons in later life owing to the

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<sup>1</sup> Due to the sensitive nature of the research study, names and identities have been replaced for the purposes of anonymity by pseudonyms.

lack of a comprehensive body of knowledge in this area. There are currently four thousand six hundred and eight men who are over fifty and in prison, and one hundred and seventy-six women<sup>2</sup>. This significant minority represents seven percent of the total prison population. From 1995 to 2003, the male over fifty population rose by one hundred and thirteen percent and for women by eighty-seven percent (Wahidin, 2004). Research has shown that from 1999 to 2004 the older prison population doubled from three thousand to almost six thousand (ibid).

### **Locating the Field**

The findings for this paper draw upon my doctoral thesis '*Life In The Shadows - A Qualitative Study of Older Women In Prison*', 2002 and on going research in this area. I visited both male and female prisons including the Elderly unit at HMP Kingston<sup>3</sup> and the only female prison in Northern Ireland. The prisons ranged from a maximum secure prison to an open prison, reflecting the various types of prison establishments and criminal offences found in the penal system in the UK. The study involved eight establishments and was based on thirty-seven semi-structured interviews and thirty-seven structured questionnaires; the ages of the participants ranged from fifty to seventy-three years old.

Prior to my visit to the prisons, a poster was put up notifying the women of my research topic and the dates of when I was going to be there. All the elders who participated in the research were given an explanation of the study, and the opportunity to ask questions about the topic. At the time of the interviews all of the eligible women who were on the prison roll consented to participate in the research. This was possible mainly because the women themselves approved of the study and had accepted it as relevant to their experiences. This approval of the study was endorsed through the prison grapevine. The shipping of women prisoners to other prisons assisted in facilitating the research process<sup>4</sup>. Due to the sensitive nature of the research study, names and identities have been changed for the purposes of anonymity

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<sup>2</sup> Statistics received in April 2003 taken from 31<sup>st</sup> of December 2002: Home Office 2003.

<sup>3</sup> See HMP Kingston - Portsmouth - *An Introduction for Lifers' to the Older Prisoner's Unit*. HMP Kingston (in house document) and for further information see: HMCIP (2001), Report on a Full Announced Inspection of HMP Kingston and HMCIP (2002), *Report on an Unannounced Follow-up of Inspection of HM Prison Kingston*.

<sup>4</sup> 'Shipped out' otherwise known as 'being ghosted', means being taken to another prison often without warning, sometimes as disciplinary measure but often due to overcrowding.

to pseudonyms, and only selected details of their biography have been used in order to protect the women in the research from identifying themselves and from being identified. The sample consisted of the following categories of 'prisoner':

1. The first time offender currently serving a term of imprisonment
2. The offender who has had previous convictions but not served a prison sentence before
3. The offender who has previously served a custodial term after conviction
4. Inmates serving a life sentence and who have simply grown old in prison
5. Long term inmates.

### **Defining the Older Offender**

The first interpretational problem arises with the definition of the 'elder', which can cause results that at first appear contradictory. Social scientists who have researched older persons and their criminal behaviour have failed to come to a uniform agreement on what age constitutes 'old'. Although there are no definitive guidelines of when an offender becomes an elder offender, the ages of fifty, fifty-five, sixty, and sixty-five are commonly used in discussing arrest and incarceration figures. The inability to agree on what constitutes an older offender is one of the most troubling issues involved in comparing research outcomes on both sides of the Atlantic. Although there is no definitive, nationwide or international standard for what constitutes an 'older offender', most researchers identify fifty as the threshold age. For the purpose of this paper the term 'elder' or offender in later life will be used to denote a person aged fifty or over.

Unlike America, there are no specific plans to develop or provide facilities for ageing female offenders in England and Wales<sup>5</sup> although there are two units for men over sixty-five years of age at HMP Kingston (HMCIP, 2001) and HMP Norwich. The Home Office Prison Department has no overall policy or strategy for dealing with

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<sup>5</sup> A good example of essentialising discourses in operation is the practice of separating older men from younger men in prison but, as yet, there are no facilities to separate older women from younger women, and this difference appears to be based on socially constructed roles of femininity and masculinity. The separation of older men from younger men is based on discourses, which serve to construct masculinity on the assumption that older men are predatory in nature and thus are more likely to corrupt younger men. It is within this space created by the expectations of the disciplinary machine, the interpolation of age by the prison estate, that other techniques of control and punishment emerge.

women who are in later life and in prison despite having policies in place for mothers and babies who constitute a similar group numerically (HMCIP: 1997, 2001; H.O 1995).

### **The Fear of *Being and Becoming Ill Inside.***

This section will focus on how the lack of health care provision multiplies the pains of imprisonment. The feeling of loss, lack of exercise, and lack of primary preventative health care, results for some in an overwhelming fear of becoming ill. For elders in prison, the intimate, private lines of the body are revered, sacred in an environment that aims to efface the importance of the private and the personal. The journey from prison to the hospital, the process of seeking and receiving medical treatment, becomes an ordeal in itself. The inhuman treatment, the omnipresent power of the penal scribes<sup>6</sup> begins before they leave the prison walls, as officers deride Alison's medical condition and her body, not only between themselves but also to a complete stranger, the taxi driver:

**A.A:** They were cracking jokes about me. They were saying things about my weight, you know, about my breasts. Even before I went. Even here on the wing, they were making jokes about *what* I was going for to the *male officers*. Things like, um *she's going to see if she can find her breasts - they'll be lucky!* That type of thing, you know, meaning that I was so thin that I didn't have any. (emphasis in original)

**A.W:** And how did that make you feel?

**A.A:** Oh, *it makes you feel terrible. Really terrible, you know.* You just feel that you are going to curl up in a heap. You are upset and you are choking back the tears and you know you've got to walk into the hospital with all of this. This particular time, it was something to do with this lump in my breast and they took me to the hospital by taxi. They take you in a van now.

ALISON ANWAR  
AGE: 51

The above testimonial demonstrates not only her vulnerability and feelings of anxiety and vulnerability, but the process of being silenced, effaced by the system. In her versatile ability to 'make do', Alison insists that, regardless of the dominant signifier of criminal / elder offender, she is entitled to a degree of 'care' as stipulated by the

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<sup>6</sup> The term is used describe how prison officers are produced as deliverers of state legitimated pain. The discursive product of the body of the other becomes modified by the processes of incarceration for example from being unable to walk due to the over use of psychotropic drugs and through to the lack of preventative health care treatment.

European Convention of Human Rights. By referring to her life before, she re-identifies with her life beyond the walls. Alison's life threads remind her that the world she has entered is unfamiliar, alien and unnatural:

**A.A:** I am *a normal human being*. I've been taken from a *normal family environment with children, grandchildren*. *To be treated like that is - In fact when I went for my mammogram, I said to the officer, 'have you any idea how upsetting and degrading this is? (emphasis in original)*

*ALISON ANWAR*  
*AGE: 51*

Women in later life are further humiliated and stigmatised by the visible signifiers of discipline, the jailers' tools. The women complained about being put in handcuffs and chained to an officer when they went to and from hospital. They found the process degrading and felt it showed no respect for their maturity or medical condition, which in many cases would have made it physically impossible to abscond when taken outside the prison for treatment. Alison recalls her experience of receiving hospital treatment on the outside:

**A.A:** First of all you've got these really great big cuffs on and they are really are heavy, thick and made for men. Then they put another pair on you, cuffed to the officer. You can't move. You can't even blow or scratch your nose. You have to be stripped before you go, completely, in front of two officers. When you come back the same again even though you've never been off the cuffs or out of sight of the two prison officers.

*ALISON ANWAR*  
*AGE: 51*

The process of receiving treatment is an emotionally degrading process. It becomes an intense attack on who they are as people, a process of producing the body under the prison gaze. For others the prison motif, the process of being punished in a public outside space, can be subverted by reversing the public gaze onto the jailer. Rather than surreptitiously cloaking the visible signifiers of punishment, the counter-technique is to make them public. This process enabled Kate, in the example given below, a means of controlling the viewers' gaze.

**K.K:** Those screws that leave the handcuffs on, I'll embarrass them in the hospital. I would hold my hand up and make sure that everybody in the hospital saw them. The screws take them off in the end because they [are] embarrassed. I don't let them get away with it. You just have to play them at their own game, don't you?

*KATE KING*  
*AGE: 53*

This is a good example of how ‘profaned bodies’ of elders and purloined looks of the outsider gaze can be reversed. Una Ulrich, a first time offender, in her late sixties, was recovering from a heart attack brought on by the stress of the trial. She found herself handcuffed and chained to two male officers. The measures of restraint used were excessive and inappropriate in relation to her medical condition:

**U.U:** I was taken onto the coronary unit from the hospital. The family came in and I’m wired up to the coronary unit and my daughter just burst into tears because I was handcuffed and chained to an officer. There were two officers sat at the foot of my bed. I will *never ever forgive* the system for that.

UNA ULRICH  
AGE: 68

The shackling of prisoners in hospitals is a common occurrence yet the media have only focused on women who give birth in chains. On 9th January 1996, the then Shadow Home Secretary Jack Straw MP, stated that: ‘in a civilised society it is inhuman, degrading and unnecessary for a prisoner to be shackled at any stage of labour’ (The Guardian: October 13<sup>th</sup>, 1998:4). Surely, this also holds true for any woman hospitalised and chained after suffering major operations. The humiliation of being handcuffed and the indignities of being strip-searched when moving to and from hospital prevented many from seeking vital medical treatment (see Carlen, 1998). These examples display the intransigent power of the penal system, impressing on both prisoners and public that not only do prisoners have no rights, but that not even the usual professional prerogative exercised by doctors and nurses holds sway when the patient is a prisoner.

### **The Role of Medicine in Prison**

The withholding of medical treatment prescribed on the outside and the over-use of psychotropic drugs in prison, provides one of many illustrations of the ways punishment can be delivered and in which prison regimes have been adapted for (but are not accommodating) female prisoners (Allen 1987; Sim, 1990). The underlying set of beliefs is that women are more mentally unstable than men. The use of medicine to control prisoners behaviour is a perverse result of the fact that rules and regulations are enforced in women’s prisons with such rigour, that a greater number of disciplinary offences are recorded for women, at least twice as many compared

with male prisoners (Fitzgerald and Sim 1979; Smith, 1984). This results both from regimes that aggravate and multiply the problems many of the women have, and from discriminatory social ideologies that, in general, demand higher standards from women than from men.

Molly Mossdale succinctly argues that the reason for this is that:

**M.M:** It is easier for them to have quiet people around, not people crying their eyes out, not people emotionally disturbed, give them night medicine. It's how to keep people quiet.

*MOLLY MOSSDALE*  
*AGE: 53*

One of the many complaints is that when the women genuinely feel ill, their request to see the doctor was refused. Illnesses are trivialised on the basis on an out-dated typification of women as hysterical hypochondriacs, or as nothing more than a gynaecological problem:

**MM:** I can approach the medical staff but the doctor is set in his ways. Anything wrong with a woman it must be menstrual, the time of the month or her age.

*MOLLY MOSSDALE*  
*AGE: 53*

The women, who required medical help, frequently felt belittled; infantilised and frustrated when medical notes go missing, lost in transit as they are shipped from one prison to the next. This results in their medication being delayed or withdrawn, causing quite serious and humiliating situations to arise. In the extract below, Rebecca Rose, frightened and silenced withdraws from help. She says:

**R.R:** This is the second time now I keep wetting myself. Well, you know I had this trouble on the outside. I came in with [the tablets] but they stopped all the medication when I first came into prison.

**A.W:** So how long did you have to wait to receive your medication?

**R.R:** Three months. I had problems with my waterworks, I was going to the toilet every half-an-hour instead of possibly every couple of hours.

*REBECCA ROSE*

The lack of facilities and inadequate care serves as a constant reminder of their status as prisoners who become lost in a system. It is also indicative of how age-related illnesses are not adequately understood, catered for or even acknowledged. The discontinuation of medication is problematic for women, having unforeseen and unacknowledged side effects.

Elders in particular those serving a life sentence were concerned that they had never been called for a mammogram or cervical cytology screening, although on the outside women over fifty are encouraged to have regular mammograms and cervical cytology screening in the light that cancers of the breast and reproductive system kill one in twelve women. The elders complained of the time it took to get their results back, compared to the waiting time of a maximum of ten days on the outside. The National Health Service (NHS) encourages all women over fifty to be tested for cervical cancer and breast cancer every three years. Of the establishments, not one conducted systematic cervical cytology or breast screening, despite the Thematic Review<sup>7</sup> on Women in Prison, stated that 'women prisoners come from a group with many of the risk factors for cervical cancer' (1997:108). Another example of the discrepancy in treatment is that it is recommended practice for women on Hormone Replacement Therapy (HRT) to have a gynaecological examination on a yearly basis. However, elders in this sample who were on HRT found that they were placed on a repeat prescription without further examinations having taken place. It has been argued that the long term use of HRT increases the risk of breast cancer and the British Medical Association (BMA) are still unaware of all the possible side-effects.

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<sup>7</sup> The Thematic Review of Women in Prison (1997), emerged from an inspection of female prisons in England and Wales. The aim of all inspections carried out by Her Majesty's Inspectorate of Prisons is to raise the operational standards of establishments being inspected. This is done by a mixture of planned, announced inspections, each lasting a week, to try to satisfy the long-standing requirement to inspect every prison every five years, and short, unannounced inspections, designed to examine a particular aspect or problem, to follow up a previous inspection, or to ensure that no prison goes for too long without some form of inspection. Each inspection is followed by a report, that is published, which contains a number of recommendations aimed at raising standards. The Thematic Report on Women in Prison showed how the needs of women in prison differ in many respects from those of male prisoners.



The National Service Framework (NSF)<sup>8</sup> for Older People (DOH, 2001:4) is one of the few policy documents in England and Wales to refer to older prisoners, and within this policy document it identifies the need for effective partnership between the National Health Service (NHS) and the Prison Service. It goes to state that:

‘The NHS and the Prison Service are working in partnership to ensure that prisoners have access to the same range and level of health services as the general public. [Elders] have a wide range of health and social care needs, both while in prison and on release. It is important that there is good liaison between prison healthcare staff and their colleagues in health and social care organisations in the community, to ensure that prisoners who are being released are assessed for, and receive services which meet their continuing health and social care needs’ (ibid).

Although this recommendation was made, the Prison Service Instruction (referred to as PSI), response was that: ‘there are no additional staff or non-staff resources required to implement this PSI’ (Prison Service Instruction No 13, 2003)

The notion of health care tailored to women’s needs should be seen in the context of a long-term trend towards a larger female prison population, and older population in society at large. The environment accelerates rather than arrests the deterioration of their health. For some their eyesight has weakened, from the constant glare of fluorescent lights. Replacement dentures are of poorer quality, leaving elders in some discomfort and in an extreme case prevents them from being unable to eat. The architecture, the draughty corridors of the old Victorian fortresses, sets off arthritic pain.

As the prison population ages, the costs of keeping older women and men will increase. This can include special diets, physiotherapy and long term medical care, through to help with personal care, which is another reason to consider alternatives to custody for elders, who are a low re-offending risk category. The lack of adequate physiotherapy and through-care once released places the responsibility to motivate

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<sup>8</sup> Department of Health, National Service Framework for Older People (2001), Section 15 states, ‘The NHS and Prison Service are working in partnership to ensure that prisoners have access to the same range and level of health services as the general public.’

and find means of keeping their body active, on the elders themselves, sometimes through a risky process of trial and error:

**S.S:** I feel heavy because there is nothing to keep me active - there's a *gym* here but for somebody like me it's no use. Because I went there once, and for one week I couldn't get up after that because of my arthritis.

*SASHA SIBLEY*  
*AGE: 72*

### **Punished for Being Ill**

While not all older prisoners are in need of high levels of medical attention, others may suffer from the chronic ill health experienced by many elders in society as a whole: emphysema, arthritis, cardiac problems, hypertensive disorders, osteoporosis etc. The questions which fuelled the women's fears were, 'what happens when women become infirm? Who looks after them? How do they get about and, finally, is there adequate provision? And if not, what are the alternatives and what facilities are available to cater for their needs?' The overall lack of standardised care leaves women in later life dependent on the support of other women who themselves have very little to give. Without other prisoners assisting them to bathe, filling their flasks and sharing toiletries, some elders become forgotten, neglected and cut off from the outside world. For older women in prison becoming ill is one of their greatest fears. It is a fear based on the loss of autonomy, and the knowledge that they would be left to serve their time on the periphery, dependent on a system which is overstretched and under-resourced.

For women in later life the lack of careful assessment of their health needs, or provision for their disability, and the cursory and dismissive attitudes of some of the doctors, have led to serious cases of neglect, increasing and fostering feelings amongst older prisoners of isolation, humiliation and fear of what the consequences of being ill in prison may entail. It is evident that the operational need of the prison is imposed on the individual. The lack of adequate provision, i.e. a health centre, turns being ill into a form of punishment when women become locked behind a faceless door excluded from association, the use of the phone and a decent wage which is necessary to be able to maintain links with the outside world:

**A.A:** If you are ill, and you don't go to work, you are locked in your cell. So you are punished for being ill. You can't phone home. You lose your association. So even if I'm feeling ill I still make the effort to go to work. Because I know I need to ring home everyday.

*ALISON ANWAR  
AGE: 51*

In these circumstances the needs of elders must be taken into account to fulfil the mission statement and avoid accusations of injustice and lack of care. For particular prisons, it is the absence of basic facilities, such as having a medical centre on site, and ground floor rooms, which emphasise how women throughout the life course are discriminated against within the penal system. It is through these discourses and the invisibility of their need that techniques of discipline have a cumulative effect based on ageist discourse (For example, it has been a salient feature of the text that problems of overcrowding and the restrictions on numbers mean that higher paid jobs, and education classes tended to favour the younger women).

Even when the women showed exemplary behaviour and were placed on an enhanced regime<sup>9</sup> they could be excluded from the privilege because of their age-related illness and the lack of adequate facilities in prison to cater for their needs. Thus, many felt they were punished further because they were excluded from earning a higher wage and from moving to better parts of the prison even though they were entitled to. The effect of this upon what is an already meagre wage in prison prevents many from seeking help or allowing themselves adequate time to recuperate fully. It is the fear and worry of losing contact with the outside world, that prevents many from using the time required to convalesce fully, thus exacerbating their condition.

Una Ulrich describes it as follows:

**U.U:** I mean being enhanced here means absolutely nothing to me because I am in a medical room on the ground floor, which is not an enhanced room. It is a shared room. It's a six-bedded room.

*NAME: UNA ULRICH  
AGE: 68*

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<sup>9</sup> Under the Incentives and Earned Privileges Scheme (IEPS) introduced in 1995, prison regimes are divided into Basic, Standard and Enhanced levels, and prisoners move from one to the other according to their behaviour. However, some women require ground floor facilities due to disability or illness. The term, 'flats' denote ground floor accommodation in prison.

Although entitled to enhanced privileges, her medical condition and the lack of adequate ground-floor facilities prevent her, like many others, from accessing the benefits of that level. Her health needs are marginalised by the lack of appropriate after-care provision, and her good behaviour loses its currency under a regime of 'privileges' designed for the young and able-bodied in mind. Although there is a room on 'the flats', obviating the need to use the stairs, she is denied the privileges that accompany enhanced status, e.g. a single room with a television and the sole use of a toilet. The heterogeneity of elders in prison makes understanding the health status of the elderly prisoner a perplexing endeavour. Special barriers contributing to this dilemma are associated with the vast differences in prison populations and the lack of research and statistical information available in the UK – for example, regarding the health-care expenditure per head of prison population by age.

As people age, certain physiological changes take place. While these changes may vary from individual to individual, they generally affect body tissue, sensory perceptions, circulation and other physical and mental functions. Tissue changes include the decline of the body and bone mass and the increase in fat mass (Henwood, 1993). Bones become brittle due to decreased mineral content and joints lose elasticity. Muscle strength decreases and susceptibility to debilitating injury from falls increases.

Like prisoners in general, ageing prisoners have not had proper access to health care on the outside. They come into the prison system with numerous chronic illnesses and consume multiple medications. Prisoners as a population traditionally have medical and social histories that put them more at risk to illnesses than their non-inmate peers. Studies have indicated that older prisoners in England and Wales report chronic ill-health at much higher levels than their peers in the community. This health profile matches that of the older prisoners in the USA who have been found to exhibit 'accelerated biological ageing' in prison, and 'to have aged roughly ten years beyond the average citizen'. A typical fifty year old prisoner is physiologically similar to the average sixty year old person outside (McShane and Williams 1999:202-208). The Florida Corrections Commission (2001:17) adds that on average each inmate over the age of fifty suffers from at least three chronic health problems, including cancer, emphysema and hypertension. These prisoners have a higher incidence of disease and

functional disabilities. Though exact costs are difficult to determine, most estimates calculate the cost of housing an older inmate as three times that of a younger prisoner (Department of Corrections, Georgia, 2002). The health needs profile of the ageing offender is hard to map in the absence of statistical information relating to health care costs in prisons in England and Wales. Statistics provided by the Florida Corrections Commission (2001) supports the above conclusions and demonstrates that prisoners over fifty, despite making up only nine percent of the total prison population, were responsible for nineteen percent of the costs paid for ambulatory surgery episodes; seventeen percent of costs for non-emergency room episodes; thirty-one percent of costs for ancillary care episodes; twenty percent of costs for specialty care episodes; and twenty-nine percent of costs for inpatient care episodes. As the number of older prisoners increases, the prison estate will be even more challenged to provide adequate physical and mental health services.

To alleviate some of the pains of imprisonment, the prison authorities should be turning their attention to literature relating to residential homes (Atherton, 1989; Coleman, 1993; Hockey, 1989). There are many simple measures which could be taken, which would allow elders control over their immediate physical environment, for example, installing doors and windows which they could open easily, and radiators which they could adjust themselves; replacing the harshness of the prison corridors with appropriate carpet tiles; use of electricity sockets which would allow all elders the opportunity to listen to the radio; and replacing the glare of the strip light with something less harsh. Such measures would at once make prison a less hostile and more accessible place. In addition, due to the impairment of sight, hearing, memory and the slowing of movement and mental responsiveness, elders need to be cared for by staff members who are specifically trained in the needs of elders in prison.

## **Conclusion**

The ageing prison population poses a true dilemma, and deserves recognition both amongst those interested in the well being of those in later life and those implementing prison policy. Age in time will be considered as one of the biggest issues that will continue to affect the criminal justice system and prison health care in the future. With the continued increase in criminal activity among the elderly

population as a whole, learning more about crime and ageing, and about institutional adjustment, recidivism and release, seems imperative.

Female elders are less likely to be a risk to society, and less likely to re-offend, and this allows for the possibility of designing future prisons / alternatives to prison with the older female in mind. In a report produced by the Florida Corrections Commission (1999), they argued that elderly prisoners have the lowest recidivism rate of any group examined. While further research is needed to ascertain how these figures breakdown for the female and male prison population, one could certainly imagine a future in which imprisonment of elderly females is a rarity, reserved for those who are convicted of abnormally serious crimes of a nature indicating a continuing risk to society. Male and female prisoners are not comparable; they have different criminal profiles, both in terms of types of offences committed and previous offending history, and have different adjustment patterns to imprisonment (NACRO 1992, 1993, 1994). It is argued that a gender-specific policy based on substantive equality will improve the plight of women in prison across the life-course (Carlen, 1989). By using this group to explore alternatives to imprisonment, what is for sure, is that there are savings to be made on both a humanitarian and fiscal level.

Unless we begin to address the points raised today, elders in prison, will be lost to the welfare contract and lost in the penal system. It is imperative, that the prison system provides not only comprehensive opportunities whilst in prison and appropriate resettlement programmes, but also alternatives to the traditional custodial framework that elders find themselves growing old in.

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