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The Pains of Being an Older Prisoner: Healthcare, Social Care and Dying in Custody

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Abstract

The ageing prisoner population in England and Wales presents a significant and growing challenge for both criminal justice and social policy. Despite increasing recognition of the complex health and social care needs of this cohort, these needs have not been adequately addressed by successive governments. This conceptual paper critically analyses the broader structural, policy, and practice-based limitations associated with the provision of health and social care for older prisoners through a Sykesian (1958) pain model, as well as through Crewe's (2011) analytical framework of weight, depth, tightness and breadth. It does this through consideration of three main pains of being an older prisoner—those related to healthcare, social care and death.

Keywords: older prisoners; ageing; pains of imprisonment; healthcare; social care; dying in prison

1. Introduction

The prison estate in England and Wales is composed of 120 prisons. These are a mixture of public and privately run institutions, with 15 private prisons operated by the private sector. It is home to approximately 87,000 prisoners. The prison estate can be best understood and viewed through a lens of crisis, a term which has become synonymous with the prison system in England and Wales (Gavin 2020). The term crisis has been used to describe the prison system for over 50 years now, and it stems from issues related to prison overcrowding, bad conditions, understaffing and staff unrest, poor security, the "toxic mix" of long-term and life-sentence prisoners, those experiencing mental ill health, and an ageing prisoner population (Gavin 2018, 2020).

The term "older prisoner" is commonly used to describe prisoners who are aged 50 and over, and the term is well established in criminological literature (Crawley and Sparks 2005, 2006; Forsyth et al. 2023a, 2023b; Gavin et al. 2024, 2026; Wahidin 2011). A starting point of 50, a relatively young age, reflects the concept of accelerated ageing, whereby prisoners typically present with a "health age" approximately ten years older than their chronological age. In practical terms, a 50-year-old prisoner may present with the health of a 60-year-old in the general population. Caution should be used when using chronological age to define the onset of old age. As in the general population, some individuals are considered old at 50 or 60 because of excessive chronic conditions, while others may be comparatively young from a health standpoint at 70 or 80 (Aday and Krabill 2013). This phenomenon is attributed to cumulative disadvantage, whereby health and social inequalities are produced across the life course and carried into, and intensified within, the prison environment (Social Exclusion Unit 2002). This may include health issues related to prior substance misuse,

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socio-economic marginalisation, and limited access to healthcare. Research also suggests that there is a biological response to imprisonment, whereby imprisonment was found to be a significant determinant of accelerated biological ageing and depressive symptoms (Berg et al. 2021). Tanksley et al. (2023) found that imprisonment was associated with a risk level for Alzheimer's disease and that people with a history of imprisonment developed cognitive impairment almost a full decade earlier than people who did not have a history of imprisonment. As a result, prison systems must increasingly adapt to the demands of healthcare management, social care needs and end-of-life care.

Older prisoners now represent the fastest-growing demographic within prison populations, and this trend is observable across much of the Western world (Gavin et al. 2024, 2026; Ridley and Waldegrave 2025; Wahidin 2011). For instance, in the United States the older prisoner population increased by 282% between 1995 and 2010, with projections suggesting that this group will constitute over one-third of the total prison population by 2030 (Skarupski et al. 2018). Similar patterns are evident in Australia, Canada and Ireland (Australian Institute of Health and Welfare 2020; Irish Penal Reform Trust 2015; Johansson et al. 2023; Stevens et al. 2018). In England and Wales, approximately 17% of the prison population—around 14,600 individuals—are aged 50 or over, including nearly 4000 in their 60s and 2000 aged 70 or above (Gavin et al. 2024; Prison Reform Trust 2024). Several interrelated factors underpin this demographic shift. These include broader population ageing, longer custodial sentences, and the prosecution of historical sexual offences, which often results in individuals entering prison later in life (Crawley and Sparks 2005, 2006; Ridley 2023; Ridley and Waldegrave 2025).

Older prisoners are not a homogeneous group, and research has identified several distinct categories of older prisoners. These include first-time prisoners, older prisoners who are repeat offenders, and long-term older prisoners who have aged within the prison system (Gavin et al. 2024, 2026; Ridley 2023). Each group presents with distinct management challenges and needs. First-time older prisoners often experience acute distress, characterised by anxiety, depression, and what has been termed "entry shock" (Gavin and Porter 2023; Ridley and Waldegrave 2025). This is exacerbated by unfamiliarity with prison routines, loss of autonomy, and exposure to a hostile or restrictive environment. By contrast, long-term prisoners who have aged in custody may confront issues such as social isolation, bereavement, and the prospect of dying in prison (Ridley 2023). Many experience ambivalence towards release, particularly where resettlement involves insecure or institutional accommodation (Moll 2013; Ridley and Waldegrave 2025). They may also suffer from a gradual decline in mental and physical health (Newman 1984, cited in Wahidin 2011). Recidivist prisoners, meanwhile, may demonstrate greater adaptability due to their familiarity with prison life (Price 2024). They may have developed coping mechanisms over the years which allow them to deal with imprisonment in their own unique way. For example, they will have some degree of familiarity with the prison system and its rules and regulations. They may be returning to a prison where they have been before, where they may know other prisoners and staff members. They may know what to expect in terms of the prison environment, the prison regime, the noise and the lack of privacy. These distinctions highlight the inadequacy of uniform approaches to care. Instead, they point to the necessity of tailored, age-sensitive, and pathway-specific interventions. Furthermore, they contribute to the pains of being an older prisoner.

2. The Pains of Being an Older Prisoner

A Sykesian perspective on imprisonment can best be described as the identification of deprivations, or more colloquially, pains, which are associated specifically with prison life. These are the deprivation of liberty, the deprivation of goods and services, the deprivation

of heterosexual relationships, the deprivation of autonomy, and the deprivation of security (Sykes 1958). Shammas (2017, p. 2) notes that the totality of these deprivations explains why prisoners "find prison life undesirable, and it is suggested that the deprivations are an innate, universal characteristic of imprisonment." While Sykes' work has lost none of its impact over the years, our understanding of life in prison has evolved considerably, and so has the language used to communicate this understanding. For example, Downes (1988) claimed that the "depth" of imprisonment was the impact of a series of inter-prisoner, inter-staff and prisoner–staff relationships, as well as prison conditions, rights, privileges and the overall quality of life in the prison regime, and these factors all contributed to the oppressive nature of the establishment. King and McDermott (1995) claimed that while Downes referred to depth, a more appropriate term was in fact "weight"—how the prison system weighed or even pushed down prisoners. "Depth," they claimed, was better suited to discussion of what they termed "deep-end custody."

Crewe (2011) has also argued that the pains of imprisonment are best understood through categories of depth, weight, tightness and breadth. Deep imprisonment refers to the experience of being far away from the surface of freedom. Crewe et al. (2014, p. 338) have stated that deep-end custody refers to "being in high-security establishments, many years from release, almost subterranean relative to the surface of liberty." The weight of imprisonment refers to the psychological onerousness of the prison experience. In heavy prisons, everyday life feels like a burden on prisoners' shoulders. Where prisoners feel they are treated more humanely and fairly, the experience is lighter. Crewe et al. (2014, p. 397) express this as a "heavy–light continuum," with light prisons being relaxed and cooperative and heavy prisons being oppressive and confrontational. The tightness of a prison is associated with the changes in it and, in particular, the softening of modern penal power. Finally, the breadth of imprisonment describes the dispersal of disciplinary mechanisms within civil society, including the rate of recall to prison and the level of post-release surveillance by penal agents. The creation of this analytical vocabulary "makes it possible to study differences and nuances between prisons, between different wings within a prison and even between the experiences of individual prisoners on the same wing" (Ugelvik and Damsa 2018, p. 1027).

In the context of older prisoners, these pains acquire additional layers of intensity and complexity. The weight of imprisonment may be compounded by declining physical health, reduced mobility, and increased dependency, while the depth of custody can be experienced more acutely in the face of long sentences and proximity to the end of life. Tightness may be felt through institutional control and through age-related vulnerability and limited access to appropriate care. The breadth of imprisonment may extend into issues related to social isolation, death, and disconnection from family. This paper considers how depth, weight, tightness and breadth are experienced by older prisoners, with particular focus on issues related to healthcare, social care, and death in prison. The diversity of the older prisoner population underscores the need to understand imprisonment as a differentiated and evolving experience. Crewe's (2011) framework is useful here, as the depth, weight, tightness and breadth of custody are not evenly dispersed throughout the prisoner population. Rather, they are shaped by sentence length, health status, and lived experiences. This reinforces the importance of situating ageing within the broader pains of imprisonment.

3. The Pains of Health Inequality

Prison populations experience significantly poorer health outcomes than the general population across a wide range of indicators, including mental illness, substance misuse, infectious disease, and chronic conditions (Favril et al. 2024). Rates of self-harm and suicide

are also disproportionately high (Gavin 2020; Gavin et al. 2024). These disparities are further intensified amongst older prisoners and highlight how pre-existing vulnerabilities are amplified within prison environments. A study of men over 60 across multiple prisons found that over 80% had a longstanding illness or disability, and the vast majority had at least one chronic condition, spanning psychiatric, cardiovascular, and musculoskeletal disorders (Fazel et al. 2001). Accelerated ageing compounds the prevalence of age-related conditions such as hypertension, diabetes, dementia, and cancer. These conditions are often exacerbated by prior lifestyle factors, limited access to preventative healthcare, and the stresses associated with imprisonment (Austin and Plugge 2026; Gavin et al. 2024; Forsyth et al. 2020, 2026; Munday et al. 2019). Additionally, structural barriers within prison systems impede access to timely diagnosis and treatment. For example, cancer care is hindered by issues such as low health literacy, complex appointment systems, and poor communication between prison and external healthcare providers (Armes et al. 2024). A lack of awareness further restricts engagement with screening programmes, particularly among older female prisoners (Austin and Plugge 2026).

Mental illness is especially prevalent, and estimates suggest that up to 90% of prisoners experience some form of mental illness, with many facing multiple conditions (Singleton et al. 1998; Fazel and Danesh 2002). Among older prisoners specifically, around half have a diagnosable psychiatric disorder, with significant levels of depression (House of Commons Justice Committee 2013). These issues are often pre-existing but can be exacerbated by imprisonment, with older prisoners exhibiting higher levels of mental illness and more complex, unmet needs than the general population (Birmingham 2003). In England and Wales, around 8% of the older prisoner population demonstrate symptoms of dementia (Forsyth et al. 2020). This equates to approximately 1100 older prisoners. Stoliker et al. (2022) found that 45% of their sample of older adults at a forensic psychiatric facility in Canada screened positive for dementia. In the United States, it is estimated that approximately 40,000 inmates suffer from dementia, but by 2050 this could increase to 250,000 (Wilson and Barboza 2010, cited in Moll 2013). Although imprisonment presents a potential opportunity to engage otherwise hard-to-reach populations with healthcare services (Favril et al. 2024; Reed and Lyne 2000), this opportunity is frequently missed. Many prisoners enter custody with undiagnosed or unmanaged conditions, which are not consistently identified at reception (Birmingham 2001, 2003; Gavin 2020).

Since 2006, the NHS has been responsible for commissioning prison healthcare, operating under the principle of equivalence of care. This stipulates that prisoners should receive healthcare equivalent to that available in the community. Section 249(1) of the National Health Service Act 2006 and relevant Prison Service Orders (PSOs) (see PSO 3200 on health promotion, PSO 3050 on continuing healthcare and PSO 3100 on clinical governance) reinforce the need for partnership and cooperation between HMPPS and the NHS to achieve the principle of equivalence, and it also recognised internationally by the Council of Europe (2006), the United Nations (2015) and the World Health Organization (2023). However, research indicates persistent tensions between this principle and practice, including delays in access, security constraints, and limitations on patient autonomy (Edge et al. 2020). These tensions illustrate how the institutional realities of imprisonment can undermine the delivery of equivalent care. Consequently, the pains of imprisonment for older prisoners are intensified through the embodied burden of ill health. In Crewe's (2011) terms, the weight of custody is not only institutional but also physical, as chronic illness, frailty, and unmet healthcare needs render everyday life more demanding. For example, older prisoners may experience physical pain, fatigue, restricted mobility, and dependence on medication. These can turn everyday prison routines into ongoing physical and mental strain for older prisoners, especially if they are worried about deteriorating health and

the level of care that the prison provides. At the same time, the depth of imprisonment is sharpened, as deteriorating health and proximity to end of life make the experience of long sentences more acutely felt. Mental and physical decline can increase dependence on others and may intensify feelings of invisibility or loss of dignity within the prison, and for prisoners who are nearing the end of their life, this can present an existential crisis. They may become resigned to the fact that they will die in prison, leading to reflections on guilt, morality, and descent into their own conscience, whereby they are forced to confront themselves, their conscience, and their mortality (Foucault 1977).

4. The Pains of Social Care Provision

In addition to complex healthcare needs, older prisoners frequently require substantial social care support. Legislative frameworks such as the Care Act (2014) in England and the Social Services and Well-Being (Wales) Act (2014) have established the responsibility of local authorities to assess and meet prisoners' social care needs, irrespective of prior residence (Gavin et al. 2026). The Acts also established 10 outcomes for adults with care and support needs. These are nutrition, personal hygiene, toilet needs, being appropriately clothed, making use of the home/cell safely, maintaining a habitable home/cell environment, developing and maintaining relationships, accessing and engaging in education or training and work/purposeful activity, making use of necessary services/facilities such as technology, and carrying out caring responsibilities for one's child.

However, there is still a lack of clarity when it comes to the scope and delivery of social care within prison settings. For example, some people with what are considered to be "low-level" social care needs do not meet the eligibility criteria under the Care Act. Nor do those who are considered to be "at the edges" of eligibility. For these people, national guidance specifies that local authorities must consider "what can be done to reduce, prevent, or delay the need for future care and support, and as far as possible to maintain their independence" (Buck et al. 2025). Under the Care Act, each local authority must determine how to best provide for levels of need. This is problematic from a cost perspective, as some local authority areas may have more than one prison within its boundaries, while neighbouring local authorities might not have any. This has led to the provision of social care in prisons being inconsistent and uneven, and has effectively created a "postcode lottery" (Gavin et al. 2024, 2026). Consequently, low-level social care, through informal peer support and orderly support systems, has developed in prisons (sometimes called buddy systems). Such support may include helping move older prisoners around the prison, tidying their cells and bringing them their food (Recoop, n.d.). Many prisons operate buddy/peer/carer support programs but with little or no training, consequently posing a risk from a safeguarding perspective. The Recoop Buddy Support programme ensures that buddies are trained to national care standards adapted for use in prison (Gavin et al. 2026). Local authorities may also use domiciliary care workers to provide hands-on care.

Prison Service Instruction (PSI) (2016) defines social care as encompassing support with daily living activities such as nutrition, personal hygiene, toileting, appropriate clothing, maintaining a clean living environment, and sustaining social relationships. It also includes enabling access to education, training, and recreational activities within the prison context. Older prisoners are disproportionately affected by these issues, as they are more likely to require assistance with mobility, personal care, and daily functioning (His Majesty's Inspectorate of Prisons 2018; National Institute for Health Research: School for Social Care Research 2020), areas that could be described as "low-level social care" (Buck et al. 2025). The physical infrastructure of many prisons exacerbates these challenges. A significant proportion of the prison estate in England and Wales comprises Victorian-era buildings that are ill suited to individuals with reduced mobility (Moran et al. 2022). Structural

limitations such as narrow doorways, staircases, and the absence of lifts in some prisons pose substantial barriers. Having ramps and doors wide enough for wheelchair access, having handles beside a bed to lift oneself, having showers and toilets that are suited to older or disabled people, having easy and regular access to toilets because of incontinence, and having easy access to other parts of the prison are all examples of practical changes that would make prison life easier for older prisoners. However, in some cases, the listed status of these buildings restricts the extent to which adaptations can be made, thereby limiting the feasibility of creating accessible environments, and even some newer and more modern prisons are often unsuitable for older prisoners (Turner and Peacock 2017).

These environmental constraints illustrate how the material realities of the prison estate reproduce carceral exceptionalism and inhibit the delivery of adequate care. They also raise an argument that social workers should be embedded in the prison system to advocate for and to underscore the delivery of social care for older prisoners (Gavin et al. 2024, 2026).

The Older Prisoner Health and Social Care Assessment and Plan (OHSCAP) was designed to improve help with health- and social care-related issues and everyday activities that might be affected by age. It consists of an assessment, a care plan, and a review section to provide a structured approach for identifying and managing the health and social needs of older prisoners (Forsyth et al. 2021). The OHSCAP did not, however, improve how older prisoners' needs were met, and it was not being delivered as expected due to a staffing crisis in the prison system (Forsyth et al. 2023a) and difficulties with rigid prison processes (Forsyth et al. 2023b). Furthermore, despite repeated calls for a national strategy for the care of older prisoners, one has yet to be developed (Forsyth et al. 2021). Consequently, current service provision in England and Wales is sub-standard, and is perhaps even unlawful, due to its failure to adhere to the Disability Discrimination Act, Equality Act and article 8 of the European Convention on Human Rights (Forsyth et al. 2021).

Social care for prisoners also aspires to equivalence of care. PSI 03/2016 seeks to provide social care equivalent to that available in the community, as per the Care Act (2014), with the intention that the local authority services can operate in the prison. However, research has demonstrated that the social care needs of women, including those with reduced mobility and neurodiversity issues, were not being met to any standard which could be considered equivalent. Both health and social care provision in the women's prison estate has been found to be inconsistent and require improvement (His Majesty's Prison and Probation Service and National Health Service 2023).

The limitations of social care provision highlight how the pains of imprisonment are reconfigured in later life. The concept of tightness is evident in the ways older prisoners' autonomy is constrained not only by the regime but also by dependency and restricted access to care. Older prisoners are less able to physically, socially, and psychologically negotiate the demands of imprisonment. The experience can become tighter through having to navigate the physical environment, the noise, the lack of privacy and the rules and regime. These factors can contribute to entry shock upon arrival in prison and can make the experience more restrictive, and the older a prisoner gets, the more likely that they will struggle with this navigation. Meanwhile, the uneven and fragmented delivery of services reflects the breadth of penal power, extending the reach of imprisonment into domains of welfare, care, and everyday survival. Older prisoners become reliant on other prisoners for social care provision rather than on the institution. It could be argued that this broadens the breadth of penal power as it puts other prisoners in a potentially dominant position over older prisoners. It could also be argued that it narrows the breadth of the institution as it demonstrates that the prison authorities cannot provide essential services without the engagement of the prisoners.

5. The Pains of Dying in Prison

In 2025, there were 394 deaths in prison custody. A total of 224 of these deaths were due to natural causes, while 79 were self-inflicted and 7 were homicides. There were 84 deaths recorded as "Other." Of those 84 deaths, 54 are "awaiting further information" prior to being classified. Prisoners aged 70 and over were more likely to die in custody compared to any other age group. Out of 109 deaths amongst this age group, 107 were classified as natural causes and 2 were classified as self-inflicted. Those aged over 50 accounted for 86% of all natural cause deaths in 2025. The rate of self-inflicted deaths was highest for prisoners aged 50 to 59 in 2025, and the next highest rate was for prisoners aged 60 to 69 (Ministry of Justice and His Majesty's Prison and Probation Service 2026). The statistics demonstrate that for prisoners with little realistic prospect of release, the possibility of dying in prison poses a very real and very distressing dimension to their experience of imprisonment (Crawley and Sparks 2006), one which adds significantly to their pains.

In Sykesian terms, this shows an acute form of deprivation relative to autonomy, dignity and the end of life. Separation from family at the time of death further compounds the deprivation of relationships. Death in prison may also place considerable weight on older prisoners. A long, drawn-out illness which culminates in death may result in the experience of imprisonment weighing down more on an individual. The provision of end-of-life care in the prison setting can also reflect the tightness of the environment. Although policy frameworks such as PSI 03/2016 and the Dying Well in Custody Charter (NHS 2018) emphasise the importance of dignity, choice, and person-centred care, the delivery of such care is impacted through rigid institutional, security, and resource constraints. It also demonstrates the breadth of penal power. However, this extension of health and social care into the prison environment does not necessarily mitigate the pains of imprisonment. Rather, it demonstrates how the experience of prison, especially for older prisoners, is full of vulnerability and dependency and highlights the need to reconsider how dignity, autonomy, and care are understood within the context of imprisonment.

6. Conclusions

This paper has shown that ageing, health and social care needs, and dying in prison radically reshape the pains of imprisonment amongst the older prisoner population. The growth of the older prisoner population, coupled with rising levels of physical and mental health concerns of this population, has increased the demand for tailored health and social care services in the prison system. This also extends to services related to dying in prison (Gavin et al. 2024). This paper has shown that the experience of older prisoners can be understood through revisiting the classic "pains of imprisonment" framework. While Sykes (1958) identified the foundational deprivations of custody, and Crewe (2011) developed a more nuanced analytical vocabulary, the position of older prisoners demonstrates how these pains are both intensified and transformed through the intersection of ageing, ill health, and unmet care needs. For older prisoners, the weight of imprisonment is inseparable from the management of chronic illness and frailty, while the depth of custody is amplified by long sentences and the prospect of dying in prison. Tightness is experienced through formal control mechanisms as well as through dependency and constrained access to healthcare and social support. At the same time, the breadth of imprisonment expands into domains of care, revealing how the carceral state extends into areas traditionally associated with welfare provision, often in fragmented and inadequate ways. This paper has also shown that the pains of imprisonment take on distinct and intensified forms in later life. Through the lens of depth, weight, tightness and breadth, it is clear that ageing, ill health, and inadequate care provision reshape the experience of custody in fundamental ways. The limits of care in prison are therefore not peripheral but central to understanding the

contemporary realities of growing old in custody. This perhaps highlights the need for more empirical research into this category of prisoners, their lives and their experiences.

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