Aged and dangerous

Old-age forensic psychiatry

GRAEME YORSTON

The elderly are far more commonly the victims of aggression and antisocial behaviour than the perpetrators. A small minority of elderly men and women, however, do commit crimes, yet offending by the elderly is an under-researched area and few specialist old-age forensic psychiatric services exist. With an ageing population and ever dwindling continuing-care resources, the elderly are going to come into conflict with the law more often. If justice and humanitarian principles are to be upheld, the need for specialist assessment and management of elderly offenders is likely to increase.

EPIDEMIOLOGY

The elderly are involved in less than 1% of arrests in the USA (Covey & Menard, 1987) and the UK (Jacoby, 1997). Shoplifting is the most common offence, accounting for up to 80% of cases (Feinberg, 1984; Markham, 1981). Alcohol-related crime forms a greater proportion of the total for older age groups (Shichor, 1984). Violence features in 10% of offences made by the elderly (Barak *et al*, 1995), more often than in younger age groups. This statistic, however, may reflect the reluctance of police forces to arrest the elderly for anything but the most serious crimes. Alarmist newspaper headlines warning of crime waves of senile delinquents have appeared in recent years and although arrest rates of the elderly are increasing the numbers remain small.

STAGES OF THE CRIMINAL JUSTICE SYSTEM

Arrest

The elderly may experience disproportionate distress on arrest and as their case progresses through the criminal justice system. Essex Police pioneered a service to minimise this distress by speeding up the process of reaching a decision of whether to prosecute or use a police caution. Information from medical, probation and social services was used in making the decision and referral to these agencies was made in an attempt to alleviate distress where it was detected (Markham, 1981). Although successful, the service fell victim to changing priorities, moving away from the elderly to focus on child protection issues.

Court appearances

A court-based forensic clinic in New York examined 52 elderly defendants over a ten-year period, accounting for approximately 0.5% of the total referrals (Rosner *et al*, 1991). Charges of violent crime were faced by 83% of defendants. High levels of psychiatric morbidity were detected, including organic mental disorder in 19% and psychotic disorder and schizophrenia in 31%. No cases of depressive illness were seen, which suggests a possible failure to recognise the existence and significance of depression by the criminal justice system. It is not known whether elderly defendants facing more common but less serious charges share these high levels of psychiatric illness.

Remand

In Taylor & Parrott's (1988) study of men over the age of 55 years remanded in custody in London, over half had active psychiatric disorder and 80% had a history of previous psychiatric treatment. These rates were more than twice those seen in younger age groups.

Prison

Sentencing information suggests that the elderly are slightly less likely than younger offenders to have custodial sentences or fines imposed and are more likely to receive probation orders. Despite this apparent leniency, the number of elderly people sentenced to imprisonment is increasing, doubling through the 1980s in England and Wales. The overall percentage of older men in prison, however, remains small at 4%, most of whom have grown old during their imprisonment. Although offender units for the elderly are increasingly common in the USA, there are few in the rest of the world, an exception being a wing for frail and elderly life-sentenced prisoners at Her Majesty's Prison Kingston. The prevalence of psychiatric illness in convicted older prisoners remains unknown.

Maximum security hospital

Wong *et al* (1995) found that 8% of Broadmoor's current patients were aged over 60 years. Most had been admitted in their 20s and 30s and were detained into old age because of the seriousness of their offence. Those admitted who were aged over 50 years tended to have committed less-violent offences. Organic diagnoses were common and schizophrenia was uncommon. Until recently, there was no special provision for elderly patients within Broadmoor but new developments include a day centre outside the perimeter wall and a low-dependency ward for old, frail and vulnerable patients.

Medium/low security hospital

The moving of elderly forensic psychiatric patients to lower security settings can be difficult. The environment in regional secure units, intensive psychiatric care units and locked wards is rarely suitable for older patients. Their needs are unmet and so they remain in settings of higher security even when the need for the security has diminished. This gap in the market has been spotted by the independent sector and a low-security hospital recently opened in Berkshire.

THE OFFENCE

Sex offences

Cases of sex offences against children committed by men of previously blameless character are common both in the psychiatric literature and the lay press. Hucker (1984) examined 43 older sex offenders in Canada: 14% had organic brain syndromes, 21% had alcohol problems, 19% had neuroses and only 2% had personality disorders. This contrasts strongly with younger sex offenders, where personality disorder accounts for 80% of diagnoses.

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The elderly appeared to be dealt with more leniently, with only 1% being sent to prison in contrast to 26% of the younger group. However, differences in the nature of the offences committed by the older men probably account for the lower rate of imprisonment. The re-conviction rate of elderly sex offenders is lower and they may be excluded from treatment programmes being considered low risk.

Shop-lifting

Depression is not uncommon in older shop-lifters, but many other myths in this area were exploded by Curran (1984), who found a roughly equal gender distribution and that in 84% of cases the goods taken were valued under $10 and included household and car products more often than food and medicines. Sweets were more commonly taken than foodstuffs of greater nutritional value. Although, in general, elderly shop-lifters were more leniently dealt with, multiple regression analysis showed that the leniency was associated with the legal variables (i.e. value of goods and previous convictions) rather than age. In an attempt to halt the rise in shop-lifting by the elderly in Florida, a state with a large elderly population, a court diversion scheme was set up that aimed to provide supportive counselling, encouragement to increase social outlets and an obligation to perform community service as an alternative to receiving a criminal record.

Homicide

Homicide committed by the elderly is not common, accounting for 1–4% of the total (Wilbanks & Murphy, 1984; Jacoby, 1997). Lack of access to weapons and reduced physical strength and agility may partially explain the lower homicide rate in the elderly. This question was examined by Ticehurst *et al* (1992) in a study of 14 patients aged over 65 years who had attacked another person with the apparent intent of killing them. Only one had access to a gun and only this individual completed the homicide. Knight (1983) coined the term 'Darby and Joan syndrome' in a descriptive study of elderly spouse homicides. He found that there was often no warning of impending violence, the couple being perceived as close and caring. The homicide was characterised by extreme violence, often involving repeated blows to the head with a hammer or other blunt object and occasionally followed by bizarre post-mortem bondage. Homicide in the elderly is often followed by suicide.

DIAGNOSIS

Dementia

Irritability and aggression occur in approximately 30–50% of patients with Alzheimer's disease (Patel & Hope, 1993). Associations of aggression with hallucinations, delusions, misidentification and language impairment have been found, but there are contradictory findings on the association with severity of dementia. The vast majority of aggressive incidents involving patients with Alzheimer's disease are minor and, rightly, never come to the attention of the police or forensic psychiatric services. The economic importance of aggression in dementia, however, cannot be over-emphasised because it is the behavioural problems and aggression, in particular, that most closely predict institutionalisation (Steele *et al*, 1990).

Schizophrenia

Violence is not common among elderly patients with schizophrenia and hospital closures have not led to an increase in the conviction rate of discharged elderly patients. There is no evidence to suggest that there are increased rates of offending in patients with late-onset schizophrenia/paraphrenia.

Depression

Roth (1968) observed that acts of aggression carried out by elderly men often occurred against a background of depressive illness, worthlessness and suicidal ideation. The stated motive for homicide in such cases is often altruistic rather than malicious, reflecting a desire to spare a loved one of imagined suffering.

Alcohol

Alcohol misuse in the elderly is often missed or inadequately managed. There is a strong association between problem drinking and both self-reports of commission of crime and contact with the criminal justice system (Akers & LaGreca, 1988).

Personality disorder

There is a degree of reluctance on the part of psychiatrists to make personality disorder diagnoses in the elderly. Management is often difficult and protracted and tertiary referral units specialising in the treatment of personality disorders often exclude those aged over 65 years. The prognosis, therefore, is poor and management is often directed at little more than providing an environment in which antisocial behaviour can be safely contained.

OLD-AGE FORENSIC PSYCHIATRY

The concept of dangerousness alluded to in the title of this paper is rather outmoded today; rather, we are encouraged to think in terms of risk (Snowden, 1997). The elderly are at very low risk of committing serious violence and this has led to them being largely ignored as a focus for research and service development by forensic psychiatrists. Although the sub-specialities of forensic child and adolescent psychiatry and forensic learning disability psychiatry are emerging, there are no signs of anything similar happening for the elderly. This results in a lack of dialogue between old-age and forensic psychiatrists and a continuance of the dichotomous conceptualisation of offending and aggression in the elderly and a split in the literature. Homicide and serious violence remain lost in the literature on dangerousness, which can seem of little interest to old-age psychiatrists. The minor aggression in domestic, psychiatric and residential institutional settings merges with the literature on dementia and is rarely seen by forensic psychiatrists.

One of the advantages of the shift from the all-or-nothing phenomenon of dangerousness to the spectrum of risk is the recognition of the continuum from the mildest shove or kick on the shin through to the most brutal homicide. This conceptual shift has not yet taken place with regard to the elderly. The literature on offending by the elderly is extremely limited. The appropriate age cut-off in research is problematic, often appearing to be determined more by making up numbers than any age-related behavioural changes. Patterns of crime and judicial process vary widely in different countries and cultures and there is an urgent need for more research on offending by the elderly in the UK. With the current state of knowledge, we can only guess at what elderly offenders might be missing in terms of specialist assessment and treatment.

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Court diversion programmes for elderly shop-lifters, court assessment services for the elderly who are psychiatrically ill and elderly prison inmate units in the USA are examples of services being set up for elderly offenders that have few parallels elsewhere. The awareness of, and provision for, the special needs of elderly inmates remains limited in the prison service in the UK. The elderly unit at Her Majesty's Prison Kingston was set up as a local initiative by the Senior Medical Officer, rather than coming from central policy-making. There are, however, encouraging signs from the special hospitals (high security) and the recognition that the elderly form an important minority of mentally ill offenders with distinct problems and needs perhaps has to come from within the profession, to help create the necessary conceptual shift that can drive policy forwards.

The structure that a specialist old-age forensic psychiatry service might take is unclear. It would be undesirable and impractical for every aggressive incident or criminal offence to be referred. These are, and should remain, the province of all old-age psychiatrists. A regional tertiary referral service for the most difficult or serious cases, with close links to general forensic services, might be preferable. There needs to be a discussion between old-age and forensic psychiatrists at a national and local level, otherwise this important group of elderly mentally ill offenders will continue to be ignored, misunderstood and poorly served.

GRAEME YORSTON, MRCPsych, Udston Hospital, Farm Road, Hamilton ML3 9LA

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