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Elderly Offenders

A Study of Age-Related Factors Among Custodially Remanded Prisoners

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Among custodially remanded male prisoners from Greater London and its surrounds, in 1979–1980, nearly 3% (63 men) were aged 55 or over, about one-third of these being over 65. More than 40% were detained on theft charges and few for more serious offences, although serious violence was not unknown and nearly one-fifth of those 65 or over were subsequently convicted of non-violent sexual assaults. Like their younger counterparts, less than one-fifth of those aged 55 or over appeared to be first-time offenders. About half of the men of 55 or over had active symptoms of psychiatric disorder on entering the prison and about half had some form of physical disorder, twice the rates for those under 55. Psychosis and alcoholism were the major psychiatric problems; 27% were alcoholics, to the extent of showing withdrawal symptoms on or soon after entering prison. Schizophrenia was less common than the younger age groups, but affective psychosis more so; 37% of the older men had a major functional psychosis. Two-thirds of the 55–64 age group and over three-quarters of the over 65s were without an address; most of both groups were personally isolated.

Criminal activity is most common among young men. Older people are responsible for only a tiny part of the total amount of recorded crime. From the 1979 Criminal Statistics for England and Wales (Home Office, 1980) – the nearest time period to the study reported below – of the 536 men convicted of homicide, only 9 were aged 60 or over. A similar proportion, 2%, of men in this age band were convicted of some form of theft, while only 0.5% of the 44 540 recorded non-fatal violence convictions were attributable to this older group. Their contribution to most other forms of indictable offences similarly appeared to be under 1%. Perhaps because the population of elderly offenders is not numerically large, there has been little empirical research in this area in the British Isles.

Old age is necessarily a period of social change and personal loss, and older people become increasingly prone to psychiatric and physical illness. It is generally assumed that when the elderly do offend they are treated with leniency. During a study of a selection of men remanded into custody in London (Taylor & Gunn, 1984), which covered only a four-month period, no less than 23 men of 65 and over were identified, together with an additional 40 men who were over the age of 55. This study describes the characteristics of the men singled out for imprisonment at such ages and compares them with their younger peers.

Method

The sample was generated from men remanded on criminal charges to Brixton Prison in South London during the first month of each quarter, from June 1979 to May 1980. At that time Brixton Prison received most male custodial remands from the Greater London area. The records were obtained for each new inmate who was on a violence charge or who was placed in the hospital areas of the prison. Violence included all fatal and non-fatal assaults and rape, but not sexual offences unaccompanied by force. It also included arson, criminal damage, carrying weapons and uttering threats. The hospital and hospital wing clientele included virtually all of the psychotic men, all of those who showed withdrawal symptoms on or soon after arrival at the prison and almost certainly all the men of 65 and over. Data were thus collected for 1241 men, who amounted to 45% of the total of the prison intake of 2743 new remands for the same time period.

A check-list was completed from the prison records for each man by one researcher (PJT). Reliability checks on the quality of the data collected by this means are reported elsewhere (Taylor & Gunn, 1984). In brief, demographic data and information about the man's current offence and his mental state seemed highly reliable, with the exception of the diagnoses of neurotic disorders, substance abuse without physical withdrawal, and personality disorders, which were underrecorded. By contrast, substantial quantities of historical data were missing and thus this sort of data had to be interpreted with great caution.

The findings from the prison sample were compared, where relevant, with age and diagnostic data from the Camberwell Register (Wing & Haley, 1972), at its 1977

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updating. This urban borough would be fairly typical of the greater part of the catchment area of the prison. In addition, we had available total population estimates for this borough for 1977. These were generated by linear projection from the national censuses in 1971 and 1981.

Results

Age distribution of the sample

The age range of the sample was 16–80 with a mean of 33.5 years. The distribution by age is shown in Table I. Men aged 65 and over account for just over 11% of the general population, but under 2% of the men remanded on violence charges and/or to the hospital areas of the prison. As it seemed that all men within this age range were held within the hospital areas, it is perhaps more appropriate to calculate their contribution in terms of the total prison intake for the period of the study, which was 2743. Thus, less than 1% of the men entering the prison were over 65 and this group, as expected, was considerably underrepresented for its size in the general population.

Those men of 55 and over were probably underrepresented too. According to the figures presented here, only about a quarter of those expected appear in the 55–64 age band, but the age distribution of men, other than those who had been violent, who were in ordinary locations in the prison was not known. The contribution of the 55–64-year-olds may have been greater than these figures imply. Similarly, although it seems that about three times the expected rate of 25–34-year-olds and twice the expected rate of 35–44-year-olds were present within the prison, the figures may not give a wholly representative picture. Except for young people on murder charges, almost no-one under the age of 21 was remanded to Brixton, so the youngest age group figures are almost certainly spuriously low. Nevertheless, the general trend of the younger age groups being overrepresented within a remand prison and the older age groups being underrepresented is almost certainly reliable.

TABLE I

Age distribution of the prison remand sample (all violent charges and all in hospital area) compared with the total population estimate for Camberwell for the year 1977

Age group	*Men in remand prison*		*Men in general population*	
	n	%	n	%
0–14	—	—	14 092	21.7
15–24	283	22.8	11 313	17.4
25–34	493	39.7	9 112	14.0
35–44	258	20.8	7 199	11.1
45–54	144	11.6	7 893	12.2
55–64	40	3.2	8 107	12.5
65+	23	1.9	7 185	11.1
	1 241	100.0	64 901	100.0

Type of offence

Non-violent offences

It appeared that a similar and substantial proportion of men within each age group – around 40% – were charged with theft, although conversely a tiny proportion of the theft was accounted for by the elderly (3.6% by those aged 55–64; 1.9% by those aged 65 and over). The non-violent offences particularly associated with the oldest men appeared to be sex offences, excluding rape. Only two men in the 55–64 age group were convicted of such offences, but otherwise the percentage of men within each age band convicted of such offences apparently rose steadily with increasing age, the trend being significant (3, 4, 8, 9, 5, 19; $\chi^2 = 17.6$, d.f. = 5, $P < 0.004$). Nevertheless, although nearly one fifth of the oldest group were convicted of sex offences, they accounted for only 6% of the total complement. Furthermore, not all such cases entering the prison would have fallen within this sample, which (as already noted) probably did contain all of the most elderly group. It is thus likely that the contribution of the elderly to custodial remands for theft and sex offending was perhaps smaller than it appears. Charges relating to drug offences were confined to the younger age groups; in this sample no-one of 55 or over had such a charge recorded against them.

Violent offences

There were no men aged 55 or over on murder charges taken into the prison over this four-month period, but this is perhaps not surprising, given that homicide was a relatively unusual offence and the older group was small. Certainly homicide does occur within this age group, and one older man, described below, appeared in the interviewed sample (Taylor, 1985), which was collected over 20 consecutive months.

The offence category of non-fatal violence to others stood out as an offence of youth. In the 65 and over age group there was only one man on such a charge, and among those aged 55–64 there were six (15% of the age group). The youngest age group committed 27% of the violence, and given that there are special juvenile remand centres, this almost certainly represents a considerable underestimate of the problem. Thereafter, the trend of declining personal violence with age was clear (39%, 20%, 11%, 2%, and 0% of convictions in the remaining groups) and, overall, significant ($\chi^2 = 11.88$, d.f. = 5, $P < 0.04$). It was also reliably reflective of custodial remands for London and its immediate surroundings, since all the violence cases entering the prison were studied. The rates of non-personal violence – criminal damage – by contrast seemed to stay steady across age groups. Although there was a hint that arson rates might increase with age, numbers in this category were too small for further comment.

In the records, following arrest, police warnings of exceptional risk of violence to others were much more likely to be given for the 25–34 age group. The over 55s, however, were not totally immune from such categorisation; two of them were judged as posing an exceptional risk in this respect, one being over 65.

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TABLE II
Age distribution of some of the medical problems on admission to prison

Age group	*Active symptoms of psychiatric disorder*		*Previous history of psychiatric treatment*		*Physical illness*		*Alcoholism*		*Endogenous psychotic affective illness*	
	n	*% within age group*	n	*% within age group*	n	*% within age group*	n	*% within age group*	n	*% within age group*
15–24	38	14.6	73	51.0	16	6.0	2	0.7	2	0.7
25–34	97	21.7	194	65.3	62	13.3	28	5.9	10	2.1
35–44	73	30.4	118	71.1	37	15.0	42	16.8	9	3.8
45–54	37	27.6	66	71.0	36	25.7	26	18.8	5	3.6
55–64	13	46.4	20	80.0	14	40.0	8	23.5	4	12.0
65+	11	55.0	12	85.7	12	60.0	7	33.3	3	14.3
χ^2		38.80		21.58		79.32		82.34		29.00
P		<0.00001		<0.0006		<0.00001		<0.00001		<0.00001

Previous convictions

Much data on criminal records was missing (over 20%), but it seemed that the older men were as likely to have previous convictions as those in the other age groups. Only five men in the 55–64 age group and four of the over 65s were definitely first offenders.

Medical aspects

The older men were more likely to show signs and symptoms of psychiatric or physical illness than their younger peers. Table II shows some of the key differences. The biggest change in rates of disorder, whether psychiatric or physical, appeared to occur in the fifties. About half of those aged 55 and over showed active symptoms of psychiatric disorder and about half had physical disorders on entering the prison, which was approximately twice the rate among the younger men in both cases. Again it has to be emphasised that this group, biased towards the sick and disturbed men, comprised only about half the prison intake, and the age distribution of the rest was not known. Furthermore, it was clear, after the interview study, that neurotic disorders and personality disorder were underdiagnosed as well as underrepresented. Within this limitation it is worth noting that neurotic disorders were more or less evenly distributed for age, but the difference for personality disorder was striking. Only two of the over 65s were definitely rated as having a personality disorder, but 46–57% of men in all the other age groups were said to be so disordered.

Almost all of the psychotic men and all the alcoholics and drug addicts were included in the sample studied. For these purposes, alcoholics and drug addicts were men who showed definite withdrawal symptoms soon after arrival in the prison. Substance abusers were rated separately and these data were less reliably available. Drug addiction (actual figures not shown) was a problem of the young, 16% and 20% of the two younger age groups respectively having this problem. Only eight men of the middle age groups were addicts by this definition, and no one over the age of 55 fell into this category. By contrast, the alcoholism rate steadily increased with age: less than 1% of the youngest men were alcoholics, but a third of those of 65 and over were.

The rate of endogenous or psychotic affective illnesses similarly increased with age. The patterns for schizophrenia, however, were different again (Fig. 1). The peak age groups to be affected within the prison sample were between 25 and 44, accounting for over two-thirds of the schizophrenics within the prison. This contrasts quite sharply with the distribution that one might expect to see in the general population, but is close in pattern to the distribution of non-schizophrenic remands. The schizophrenics for the Camberwell Register Study were almost evenly distributed for age on either side of a 44–45-year cut-off point (55%:45%). The schizophrenic patients on custodial remand were not – 83% were under the age of 45; a tiny minority of the schizophrenic patients were in the oldest age group. While about one-fifth of the schizophrenic patients in the community survey were 65 or over, only two of the schizophrenic patients in prison, about 1%, were in this age group.

For completeness, data on whether the men had ever had previous psychiatric treatment are also shown in Table II, although there was a large amount of missing data here – 503 cases. Treatment efforts seemed to accumulate with age and fewer than 15% of the over 65s had definitely never had any psychiatric care within the National Health Service.

Social and demographic characteristics

The majority of men (62–72%) for all age groups had been born in the United Kingdom. An attempt at marriage was more likely with increasing age. Only a third of the over 65s had never married, compared with over 80% of the under 25s. The main problem for the older men, nevertheless, seemed to be increasing isolation and increasing social chaos. From 55 onwards, widowhood or divorce had claimed most of the marital partners and no man over 65 was living with his spouse. The rate of homelessness was not insubstantial in any age group. In the youngest age

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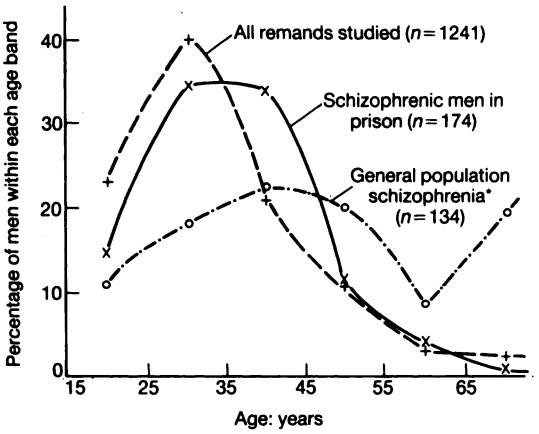


FIG. 1 Schizophrenics in and out of prison and the total custodial remand group compared (the general population schizophrenia line shows the one-year prevalence for schizophrenia for men in the general population)

group there were 30% without a fixed address, but nearly two-thirds of the 55–64 age group were homeless and only five of the oldest men, less than a quarter, had homes. The trend was significant (percentage within each age group homeless 30, 31, 48, 43, 65, 75; $\chi^2 = 50.51$, $P < 0.00001$).

Sentencing

Information about sentencing was missing in 128 cases, but an impression of the position could still be obtained. Nearly one-third of the elderly men who had been remanded in custody were eventually imprisoned, which is only slightly less than the rate for the younger age groups. Few men were put on hospital orders and the older ones were no more likely to be placed on such orders than the others (55–64, 2 men = 5%; 65 and over, 2 men = 9.5%). A supervised, non-custodial sentence, such as a probation order, was slightly more likely to be imposed within the most elderly group, 20% of whom were sentenced in this way compared with around 12% in the other groups, but the difference did not reach significance. Slightly more than one-third of the men in the four younger age groups were fined, compared with just under one-quarter of those in the two older groups.

Illustrative case histories

More detailed information on some of the men remanded in the prison was obtained through the interview study (Taylor, 1985). The following case histories illustrate some of the points already made and emphasise the considerable variety within the older age groups.

Mr A was aged 66. He was stopped by police when he was seen throwing dustbins on to the road. When questioned he became very violent and attacked a police officer. The man's own account of his offence was as follows: "This young man told me . . . I am a pensioner . . . I'm going to the Lord Mayor . . . why are so many rich people here? . . . so many foreigners . . . threw a dustbin . . . dammit . . . bluey, all of them". No more coherent account could be obtained from him.

His previous criminal history was extensive, having started when he was 29. His offences had fallen into two main categories, which seemed to be age-dependent. By the age of 54 he had been convicted twice of assault on police, three times of minor sexual offences, three times of property damage and twice of carrying an offensive weapon. After that he was frequently convicted, but only of theft, drunkenness, vagrancy, or failure to pay a fine.

His previous psychiatric history had been extensive, with numerous admissions dating from almost ten years prior to his first recorded offence. The most consistent diagnosis was schizophrenia, complicated by alcohol abuse, but the possibility of a manic–depressive disorder had been raised.

His mother had died when he was a young child and he was one of 11 children. He had had no contact with any of his family for 14 years and had not been in regular work since 1951. He had never married. At the time of his offence he was of no fixed abode and when asked about his interests he said "drink".

In court the charges against him were dismissed, although there seemed no doubt that the events leading to the charges had taken place, as described by the police. His three-week remand thus seemed to little purpose.

Mr B was a 62-year-old Sikh, born in the Punjab, although he had lived in Kenya, with his parents, between the ages of 9 and 60. He had had no schooling at all; he was single and had had no steady heterosexual or homosexual relationships or friendships. He had generally been employed in unskilled jobs but had had no employment since his arrival in England two years before the offence.

He was charged with murder. The victim was a 37-year-old man known to him throughout his time in England. The relationship was not intimate but they regularly got drunk together. On this occasion there was a fight but Mr B could not recall events clearly. The only previous offences known were drink offences. He denied all medical and psychiatric history, though he did admit to heavy drinking, since the age of 35. He had optic atrophy in the left eye.

(After many months of custodial remand, he was convicted of manslaughter and sentenced to three years' probation. Some time after discharge from prison he died, following a heavy drinking episode.)

Mr C was 64 when charged with grievous bodily harm after stabbing his lawyer. When the police went to arrest him at his home they found loaded firearms pointing towards the front door and he was also charged with possession of these weapons. In addition, he had wired up his door knob to the mains electricity and soaked the door mat with water.

Mr C's account of the offence and its antecedents dated back over about three years. He had had a mild heart attack and was prescribed propranalol. He then noticed that he was going deaf and believed that this was due to the drug. He sought multiple opinions on his deafness and then, beginning to believe that his eyesight was affected as well,

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also went to ophthalmologists and neurologists and then the Community Health Council. All advised that his deafness, and in turn his failing sight, were not related to the medication. He was, he said, beginning to understand that all medical facilities were in league with one another, so he turned to his former trade union, to lawyers and to his Member of Parliament for further action. He stabbed one solicitor for being slow and unhelpful and joining the conspiracy. Of the firearms he said, "the decision to set them was made on the spur of the moment. The neighbours kept switching off the burglar alarm and intercepting my mail. I wanted to frighten the intruders."

He had previous convictions for receiving stolen property at 33, causing death by dangerous driving at 41, and shoplifting at 59.

His childhood was unremarkable. His son had been killed in a car crash a year before he himself killed someone by his driving. At the time of this homicide offence he was drinking heavily, and following it he was admitted to a mental hospital, where psychopathy and agitated depression were diagnosed. Divorce followed and he lived a fairly solitary existence, albeit working regularly, until the age of 51, when he retired, disabled, following a foot injury.

He was convicted of the offences and sent to a special hospital on a hospital order, with restrictions on discharge without limit of time.

Mr D was 68 when he was charged with the murder of his wife. He said, "I felt dreadfully depressed that morning. I was washing my hands. She had her back to me and it just happened. I thought I would kill both of us. I didn't commit suicide, I knew it would upset the wife – that's why I didn't do it before. Quick as a flash it came to me, kill myself and take her with me. Her last words to me were 'stop trembling'." His account to the police was similar: "I strangled her so that she didn't feel what I did after."

"After", he cut his wrists and throat and drank Chloral. He was found unconscious, and revived. She was dead.

His childhood was unremarkable, he had no previous criminal history and had apparently lived the life of a devoted family man and successful skilled worker until retirement.

He had had previous psychiatric treatment for depression when he was 50 and again when he was 57, with apparently good recovery. About a year previously he had presented again as depressed and his general practitioner had started to treat him. His wife had previously given a good account of his depression to family and friends, who became informants after her death.

He was convicted of manslaughter on the grounds of diminished responsibility, and after several months on remand in prison went to a local psychiatric hospital under a hospital order.

Discussion

This study deals with a selection of men from a custodial remand sample and thus may give a biased impression of elderly offenders, in particular in respect of their offending patterns. Official criminal statistics for the time (Home Office, 1980), however, confirm the expectation that the contribution of the elderly to indictable crime is small. It is possible that a more lenient approach is taken towards older offenders than towards their peers and that the official figures, invariably underestimates of real offending rates, are particularly unreliable for older people, but it does seem that the elderly are far less likely to commit offences than the young. Roth (1968), for an earlier period, calculated that the crime rate per 100 000 of the population at risk was, for those over 60, one eighteenth of that among those of 59 and under. Not dissimilar estimates have emerged from the USA. Wilbanks (1984), studying the Uniform Crime Reports for 1970–1980, found that those under 60 were 13 times as likely to be arrested for an index offence as those over 60, but that the rates of offending among the elderly, in common with all crime rates, were showing an apparent increase. Feinberg (1984), using the same sort of data but over a 15-year period, remarked that the rates of offending for those of 65 and over were increasing at a greater rate than in the 55–64 age bands.

If some leniency might be expected in the charge or conviction, it might be anticipated that every effort would be made to avoid custodial remand for the older person charged with an offence. Although the numbers of men in the prison remand sample were relatively small, the figures of 40 aged 55–64 and 23 of 65 and older still seem surprising, particularly given that the former is almost certainly an underestimate. In fact, however, numerically and proportionally, they are remarkably similar to those described for one US local jail in New York (Golden, 1984). In this latter sample only three-quarters of the men were on remand and thus strictly comparable, and the jail was only one of many in New York, but it is worth noting that, for 1981, 3% of the sample were aged 55 and over. Why the need to remand in custody? Some of the older men in our Brixton sample had committed serious offences, and for those whose sentences were known, one-third of the oldest and 44% of the 55–64 age group were ultimately sentenced to imprisonment. The deciding factor in the remaining remands may well have been the rootlessness of so many of the men. Gibbens *et al* (1977) emphasised that the lack of a fixed address was a very important factor in the decision to remand in custody.

There are few offence categories in which the elderly do not figure at all. Occasionally they kill, although the criminal statistics for England and Wales for 1979 recorded only four cases of manslaughter and five cases of causing death by dangerous

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driving among those of 65 and over. Mr D illustrates the typically tragic pattern of manslaughter in this age group. Other violence is also unusual, although Mr B and Mr C both illustrate how serious it can be. Furthermore, as among younger men, a few elderly men who have been violent clearly bypass the criminal system, their admission to hospital being precipitated by violent behaviour (Tardiff & Sweillam, 1979; Petrie *et al*, 1982). Among the remaining indictable offences, the only category of note is sex offending, excluding rape. This remand sample hinted at and the official criminal statistics for 1979 confirm its relative importance among the elderly criminals. The myth of the 'dirty old man' is nevertheless worth little. Despite contributing proportionately more to the sex offending figures than to other indictable crime, those of 60 and over account for a mere 6%, which compares closely to the 5% found in the USA for the same year (Shichor, 1984). This remand sample suggested that drug offences were not committed by the elderly; in England and Wales as a whole it seems almost true. Only seven of the 10 164 indictable drug offence convictions in 1979 were committed by those of 60 or over. Non-indictable offending is harder to estimate, as criminal statistics are not routinely presented with a breakdown by all age groups.

Although vagrancy and drunkenness appears in this elderly sample, the numbers were not impressive and almost certainly fail to show the importance of these offences for elderly samples generally. Again using the US crime reports, Shichor (1984) showed that arrests for drunkenness contributed the highest absolute number of charges against elderly arrestees. In 1979 they accounted for 11.3% of the total arrests among the over 60s, while vagrancy and disorderly conduct offences, usually connected with drinking, accounted for a further 4.4% and 3.5% respectively. Gambling and driving under the influence of drink were the other related offences figuring at similar sorts of levels. This finding in relation to drink has been highly consistent over recent years (for example, see also Moberg (1953) and Keller & Vedder (1968)). For California alone, Epstein *et al* (1970) placed a slightly different emphasis on the statistics; arrest rates for drinking appeared high for all groups in San Francisco, but whereas it was one in two for adults under 60, four out of five of older men were on drunkenness charges. Returning to our own remand sample, the relatively high rates of alcoholism within the higher age groups tends to confirm the importance of drink in elderly offending where the actual nature of the offences merely concealed it. Recordings in the prison records of alcohol consumption in direct relationship to the offence was poor; over half of the files failed to mention it; all we can say is that a minimum estimate was that 12 of 63 older men (20%) had definitely been drinking around the time of their offence, compared with 195 (13%) of the others.

The health problems of this group of elderly offenders was striking, whether viewed quantitatively, as entered in the tables, or qualitatively, as in the four fairly typical examples described in the case histories. Given the relative youthfulness of the population, dementia had not been rated as a separate category of disorder. An examination of the nature of the 'other diagnoses' category suggested that no more than two or three cases of dementia within each of the older age groups accounted for the apparent proportionate increase within age groups of this category. In this context, it is of interest that Hucker & Ben-Aron (1984) reported that in neither their series of sex offenders, nor of elderly violent offenders, did organic brain syndromes appear with any greater frequency than among comparable age groups in the general population. Although personality disorder was probably underdiagnosed within this prison sample, the abrupt decline in the use of the term for the men of 65 and over was striking, and also compares closely with Hucker & Ben-Aron's findings. Psychosis was a major problem among the elderly remands, but again comparing closely with Hucker & Ben-Aron's sample, schizophrenia was not as frequently diagnosed as one might have expected, given the rate among the elderly in the general population. Did the apparent fall in the rate of offending by schizophrenics merely reflect the general fall-off of offending with age, as shown in Fig. 1, or, since much schizophrenic offending seems to be directly related to the illness (Taylor, 1985), does it reflect the tendency of the more positive symptoms to burn out over time? It is also possible that more older schizophrenics, compared with younger ones, remain institutionalised within National Health Service hospitals and are thus probably less vulnerable to offending. A fourth and more sinister possibility also presents itself. Gibbens & Robertson (1983) completed a 15-year follow-up of offender patients, at average age 34, who had been detained under hospital orders (section 60, Mental Health Act 1959) imposed by the courts. Among the mentally ill, most of whom were schizophrenic, 22.5% had died during the follow-up period, only half of these by natural causes. The mortality among psychotic offenders is thus high, and may even be the most powerful contributor to the relatively modest, if conspicuous, contribution of psychosis to offending among the elderly.

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Despite the high rate of illness of all kinds among the more elderly group, very few of the men in this sample were obviously treated as sick or even in need of social support, following their offending. Mr A perhaps illustrates one form of the barrier to appropriate help being found. As a man of no fixed abode and a heavy drinker, it was difficult for the prison to identify a psychiatrist, or indeed any service, willing to help him. Despite his undoubted illness, given the triviality of his actual charges the court apparently considered further remand in prison inappropriate for one of such age and, in common with a substantial minority of the others, he simply drifted back into anomia, his health still very damaged. Those serving terms of imprisonment may have faired slightly better from a health point of view; providing they would express willingness for appropriate treatment in prison, they might have gone on to receive it. Only two of the 40 men in the 55–64 year age group and two of those over 65 were sent to hospital, and only five and four respectively were ordered to receive any kind of formalised supervision after they had left prison.

Are existing systems adequately equipped to cope with the small but perhaps atypical group of offenders constituted by the relatively elderly? In the USA a number of schemes have been developed, as far as possible to deal separately with the older offenders at both pre-trial and post-sentencing stages (e.g. Fry, 1984; Newman & Newman, 1984). There is some tentative progress along these lines in some parts of England, for example in Essex, where the police have a special group of officers to deal with the elderly, and to facilitate, where possible, contacts with medical or social services. On the evidence of this preliminary study, the elderly offenders certainly do manifest excessive medical and social problems, and, despite the relatively small size of the problem, seem to merit both further research interest and overall a more humane approach to their management.

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