Report on the Response of the Department of Corrections to the Impact of the Aging of Virginia's Population

November 15, 2007

Pursuant to legislation enacted by the General Assembly of Virginia, the Department of Corrections submits this report of its progress in addressing the impact of the aging of Virginia's population.

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Gene M. Johnson, Director	**Date Submitted**

I. Executive Summary

In the field of Corrections, an inmate age 50 and older is typically regarded as 'geriatric' because their previous lifestyles have tended to make these individuals reach 'old age' faster than non-inmates (Morton, 1992). Inmates physically appear between 10 and 15 years older than their chronological age due to the strains of a criminal lifestyle and incarceration (Madden, Rossiter, & Klock, 2003). In FY2006 the 'geriatric' population in the Virginia Department of Corrections (DOC) increased to 4,132 or 11.4% of the confined population. This is a five-fold increase from the 715 geriatric inmates confined in FY1990. During FY2006 a total of 882 geriatric inmates out of 12,523 new court commitments were sentenced to DOC. This represents 7% of DOC new court commitments. This is approximately three times the number (223) of geriatric inmates sentenced to DOC in FY1990. Additionally, 8.1% or 5,315 of Parole and Probation (P&P) clients are over the age of 51.

While older prisoners are housed in a number of institutions throughout the Department, Deerfield Correctional Center (DCC) primarily houses inmates with special health care needs and the older inmates. Deerfield's Warden Davis refers to the older adult population as a "Continuing Care Community." DCC just expanded their bed capacity from 497 to 1,080 in early 2007. Currently 60% of Deerfield's population is over the age of 50. The average age of the Deerfield inmate is 53 years old and has a projected length of stay of 18 years. Over 75% of Deerfield's geriatric population is incarcerated for violent offenses.

The geriatric population in prison has a unique set of considerations apart from the general population. Geriatric inmates can not be assigned to a bunk-bed or hold strenuous work assignments and require specialized treatment programs designed to encourage independent living skills and good health. Common spaces need to be handicap accessible and medical costs are significantly higher for geriatric inmates. In FY2006, the average inmate under the age of 50 has had annual off-site medical costs of $602 while the average inmate age 50 and older has had annual off-site medical costs of $3,064. Geriatric clients on parole or probation also have a unique set of circumstances due to increased need for medical care. This population also has a lesser chance of finding viable employment in the community due to their physical limitations.

In summary, in DOC, the confined geriatric population has increased (from 715 to 4,132) more than five-fold since 1990. Because of the serious and violent nature of the crimes the older inmate has committed, many will be with the DOC until they close to 75 years and older before they are eligible for release. Placement in the community will be difficult. The DOC will be the last resort for housing and caring for many of the older inmates. As the population ages, DOC health care costs will also increase. There will be additional needs such as enhanced medical staff and equipment, special security risks, and staff training. The Master Plan for Health Care Services study on alternatives for developing additional medical, mental heath and geriatric facilities has recently been completed and submitted to the SPS and General Assembly Committees for approval and funding. Finally, the DOC workforce is also affected by the aging process. More than 25% of the total DOC workforce will be eligible for retirement in the next 5 years. The Department has begun succession planning activities and training to accommodate this anticipated knowledge drain of veteran staff and turnover.

II. Agency Description

The mission of the Virginia DOC is to enhance public safety by providing effective programming and supervising sentenced offenders in a humane, cost-efficient manner, consistent with sound correctional principles and constitutional standards. The mission of the Community Corrections Unit is to enhance public safety by positively impacting offenders so they will lead pro-social and crime-free lives.

The Virginia DOC is a model correctional agency and a proven innovative leader in the profession. Virginia is a safer place to live and work because the Department provides appropriate custody, supervision, and programs for offenders through its exemplary services. The employees of the Department are the cornerstone of the agency. They share a common purpose and a commitment to the highest professional standards and excellence in public service. The Department, through its unwavering commitment to its employees, is a satisfying and rewarding place to work and grow professionally.

III. Data Requested

1. Number of Geriatric Offenders Receiving Services:

❒ It is commonly regarded in Corrections that an inmate age 50 and older is typically regarded as 'geriatric' because their previous lifestyles have tended to make these offenders reach 'old age' faster than non-inmates (Morton, 1992). Such an inmate chronologically 50 is actually 10 to 15 years older physiologically than someone not incarcerated. Lifestyle reasons that contribute to offenders being physically older than their stated age include a history of alcohol and drug use and abuse, limited health care and the stressors of prison life (Madden, Rossiter, & Klock, 2003).

❒ Over the past 15 years, the inmate population of the Virginia DOC has been getting older. In FY1990, there were 715 'geriatric' inmates, age 50 and older, and they comprised 4.9% of the confined population. In FY2006 the 'geriatric' population increased to 4,132 or 11.4% of the confined population.

❒ During FY2006 a total of 882 geriatric (age 50 and older) inmates out of 12,523 new court commitments were sentenced to the DOC. This represents 7% of DOC new court commitments. This is approximately three times the number (223) of geriatric inmates sentenced to DOC in FY1990. In FY1990 the 50 and older inmate represented 3.6% of new court commitments.

❒ In addition, at the end of June 2007 there were approximately 57,523 offenders on P&P release status of whom 5,315 or 8.1% were 51 and older.

❒ Last years' Secretary of Public Safety (SPS) projected state responsible (SR) population of 50 for December 31, 2007 it is expected to increase to 4,461 or 11.8% of the projected SR population and increase to 4,824 or 12.6% of the projected SR confined population by the end of CY2008. By the end of 2009, the expected 50 year and older confined population will reach 5,052 and comprise 12.9% of the expected SR population.

❒ Based on the most recent SPS official state responsible new court commitment forecast, the total number of inmates expected to be sentenced to DOC from FY2007 through FY2008 is 13,042 and 13,417. It is estimated that for these same two years there will be an additional 913 and 940 geriatric offenders sentenced annually to DOC.

❒ In FY2002 there were 510 geriatric inmates release out of 8,997 total releases. This was an overall geriatric release rate of 5.7%. In FY2006 there were 1,140 geriatric releases out of 11,816 or a 9.6% release rate. The DOC estimates an output by geriatric releases of approximately 10% over the next two years.

❒ The current overall DOC recidivism rate is 28.5%. The geriatric release recidivism rate for FY1999 was 3.1% for inmates 50 years or older at time of (discharge or parole) release who were recommitted to DOC within three years. For geriatric inmates released in FY2002 and tracked for three years, 129 of 728 or 17.7% recidivated. While the recidivism rate of geriatric releases has increased from FY1999 to FY2002, it is still lower than the overall rate. The geriatric rate increase might indicate that it had become more difficult for the older offender to successfully integrate into the community after release in FY2002 than in prior years.

❒ Under ***Code of Virginia Section 53.1-40.01***, Virginia has a conditional 'geriatric release' clause that allows certain inmates who were not convicted of a Class 1 felony to apply for early release. If they are 60 years old and have served at least 10 years or are 65 years old and served at least 5 years, the inmate may apply to be heard by the Virginia Parole Board. There have only been 200 to 400 inmates eligible annually to apply for 'geriatric release' between CY1999 and CY2006. Only 35 of the 400 eligible inmates applied for 'geriatric release' in 2006 and only one was granted. Of the inmates who applied for 'geriatric release' in 2006, 29 were denied because of the serious nature of their crime (homicide, rape, robbery and kidnap), 3 were denied because of the risk to the community and 2 granted for medical leave and not as a geriatric release. According to the Parole Board there have only been 4 'geriatric releases' in the past 3 years (CY2004-2006). While the 'geriatric release' mechanism might have been originally enacted to help offset the increasing numbers of elderly offenders, few offenders have been released under 'geriatric release' policy since it was enacted in 1994.

2. Agency Geriatric Services and Needs:

Agency Services:

❒ The DOC is legislatively obligated to meet the needs of its population. This includes providing needed health care for medical, dental and mental services consistent with community standards. Older inmates are not targeted for specialized service on the basis of their age, but rather, on the basis of their need. All offenders are assessed and given appropriate level of care and treatment according to their needs.

❒ While older prisoners are housed in a number of institutions throughout the Department, Deerfield Correctional Center in Southampton County, Virginia mainly houses inmates with special health care needs and the older inmates. Currently 60% of the Deerfield's population is 50 and older. The average age of the Deerfield inmate is 53 years old and has a projected length of stay of 18 years. Over 75% of Deerfield's geriatric population is incarcerated for violent offenses; the most common primary offense is rape and/or sexual assault. The DCC expanded to 1,080 beds in early 2007 and have a two ward infirmary with a capacity of 18 and 2 medical observation (negative/positive pressure) rooms. Deerfield also has the supervision of the Secure Medical Unit at Southampton Memorial Hospital (13 beds and holding cell).

❒ Deerfield Correctional Center's operating per capita was $31,065 in FY2006. Medical costs are becoming a bigger part of total expenditures. Medical expenditure data, within the DOC, is not available currently by age. A large portion of the total medical expenses, the off-site is available by age. Off-site medical expenses would be greatly impacted by an aging population and would be reflective of the increased costs associated with an older group. Off-site costs are almost 23% of the total medical expenditures and are referenced here to reflect a trend. In FY2006, the average inmate under the age of 50 has had annual off-site medical costs of $602 while the average inmate age 50 and older has had annual off-site medical costs of $3,064.

❒ If not housed at Deerfield, the geriatric inmate is more likely to be confined at other DOC facilities that have the ability to care for the more acute medical needs of the geriatric inmate and at a skilled nursing facility including Greensville and Powhatan Correctional Centers and Marion Treatment Correctional Center which has an infirmary. Currently inmates that have medical needs beyond DOC's on-site abilities are transported to off-site medical facilities. This health care is expensive not only because of the nature of the medical treatment needed, but also because of the transportation and security costs involved with off-site health care. Additional requests to fund 24 hour nursing at various correctional centers housing geriatric inmates are likely.

Agency Needs:

❒ In early 2007, Deerfield expanded from 497 to 1,080 beds and opened a new 18 bed medical infirmary. The medical infirmary provides skilled nursing level of health care. Among other special health care equipment, it is expected that additional handicap accessible equipment and vans will be needed with the continuing increase in the expected aging population. DOC would also anticipate needing to expand this infirmary over time with a special diagnostic and disease prevention/care unit as more Deerfield housing units and pods need to be expanded.

❒ The Master Plan for Health Care Services study was directed by Item 387 of the 2006 Acts of the General Assembly to "...provide a planning report on alternatives for developing additional medical, mental health and geriatric facilities." This final report was submitted in the Summer of 2007. A response from the General Assembly regarding approval and funding is needed.

❒ There is no special training offered at the Academy Staff Development (ASD) for the special needs of the geriatric population. New curriculum has been drafted but has not been currently implemented. Such training will need to be approved and effected.

❒ There currently are no reentry programs currently dedicated to the geriatric inmate. A geriatric transition coordinator will have to be hired and trained and responsible for the following: arrangement for social security, Medicare, Medicaid, possible nursing home placements, durable medical equipment purchases (wheelchairs, crutches, splints, home nebulizers, braces, elevated toilet seats), possible special medical treatment follow-up for dialysis, Alzheimer's' and special medicines.

❒ There needs to be improved coordination and communication between the DOC and the Parole Board concerning the 'geriatric releasee'. Possibly the current process whereby the geriatric inmate must apply to the Parole Board for 'geriatric release' needs to be reconsidered and made automatic. It should be noted that only 139 geriatric inmates applied for release over the three year period between CY2004 to CY2006. The current geriatric release process has only resulted in 4 geriatric releases over that same time period.

❒ Current projected total P&P caseload indicates that there will be close to 59,243, 61,612 and 64,077 under supervision by the end of FY2008 through FY2010. Since currently 8.1% of the P&P population are 51 and older, it is assumed that a minimum of 8.1% of the future P&P population will be 51 and older. That would equate to a geriatric population of at least 4,799, increasing to 4,991 and to 5,190 from FY2008 to FY2010. For every 1,000 additional geriatric P&P offenders, an additional 13.3 P&P Officer and Supervisors will be needed to manage these geriatric releases due to their unique health care needs in the community.

3. Agency Programs Designed to Serve the Geriatric Population:

❒ Currently the Department offers the following geriatric treatment programs at Deerfield: horticulture, library with large print books, board games, assisted living services, reality orientation to check for dementia, Alzheimer's Disease and cognitive abilities. There is peer tutoring and a cooperative effort with the Virginia Beach library to assist with material for blind and visually challenged. Activities such as arts and crafts, music and games are used to keep the inmates physically active and mentally alert. The activities are designed to encourage independent living skills and good health. There are programs such as productive citizenship, anger management, and sex offender treatment, plus, pre-release services that are also offered. Because of the special needs of these inmates, employment may not be an option so placement and assistance are planned for some of the inmates' release. While all sex offenders are difficult to return to the community, older sex offenders are a special challenge. Families may no longer know the inmates who have been incarcerated for a long period of time or may not be willing to take them in due to the nature of the crime. Similarly, nursing homes and assisted living facilities may reject them. In addition, substance abuse, sex offender treatment, educational services and recreational services, including special exercise equipment and machines are available that not only provides an activity for the geriatric inmate but also helps keep them as healthy as possible, thus, reducing medical and rehabilitation costs. These latter services are also offered to geriatric inmates who are at other prisons throughout the state.

❒ Many older inmates have different physical and mobility requirements than younger inmates. Geriatric inmates will require special equipment, more assistance and are not necessarily able to be double-bunked (climb up to the top bunk). Geriatric chairs (shower and wheel chairs and higher legged chairs), beds, walkers and special bathroom facilities should be provided based on recommendations from medical officials. They may also require a special, more costly diet.

❒ The Division participates in the interagency Prisoner Re-Entry Policy Academy coordinated through the SPS. Medicare, Medicaid and Veterans benefits are denied during incarceration. Among its work are efforts to strengthen the Memorandum of Agreement with the Social Security Administration and the pilot re-entry programs which hope to improve the benefit Social Security and Medicaid application process so that eligible inmates can receive benefits immediately upon release. Three Community Placement Coordinators are in the Offender Release Unit focused on working to place problematic offenders which include geriatric and disabled people.

❒ As directed by Item 387 of the 2006 Acts of the General Assembly to "...provide a planning report on alternatives for developing additional medical, mental health and geriatric facilities, a final report was submitted by June 1, 2007 to the Secretary of Public Safety, Senate Finance Committee and House Appropriations Committee concerning a Master Plan for Health Care Services. The majority of the Executive Summary of this plan is quoted below in italics:

"The purpose of this study, a Master Plan for Healthcare Services, is to address and answer by recommendation, the following General Assembly directive to the Virginia Department of Corrections: Item 387 #3c of the 2006 Acts of Assembly states: "The Department of Corrections shall provide a planning report on alternatives for developing additional medical, mental health, and geriatric facilities. The report shall consider the potential for cost savings through the expansion or replacement of the medical unit at Powhatan Correctional Center, the optimum mix of services and facilities at other facilities, the use of contract services, requirements for mental health services, requirements for geriatric services for older inmates, and financing options. Copies of an interim report, including a scope statement and work plan, shall be provided by October 16, 2006, and a final report by April 30, 2007, to the Secretary of Public Safety and the Chairmen of the Senate Finance and House Appropriations Committees." The Master Plan for Healthcare Services study began in August 2006 and concludes the process of research, analysis, and recommendation as outlined in the Interim Report of October 16, 2006 to the General Assembly. Working with representatives from the Department of Corrections (DOC), Moseley Architects and HKS, Inc. (the Team) has developed facility recommendations to meet the future healthcare, including medical and mental health, needs of the male state responsible offender (SRO) population. The study reports that no additional female capacity was needed. Specifically, it cites: "…*it was confirmed by the Department of Corrections that the Fluvanna Correctional Center for Women has adequate medical and mental health capacity to accommodate the projected healthcare needs of the female state responsible offender population for the foreseeable future. Current capacity at FCC includes 46 infirmary/medical beds, 46 acute mental health beds and 144 residential mental health beds for a total of 236 healthcare beds.*"

The study details that currently DOC provides the following levels of inpatient care: Infirmary, Assisted Living, Acute Mental Health and Residential Mental Health service in a total of 482 beds. Existing bed capacity is deficient by 254 beds to meet the projected need of 736 beds in 2007. In addition, DOC does not currently provide such specialty units such as Skilled Nursing, Medical Alzheimers, Axis II (personality disorder) and Mental Health – Transitional Care units but it is anticipated will be or are needed.

4. "Senior Friendly" Publications and Websites:

The DOC posts numerous publications and reports on its public website (www.vadoc.virginia.gov). This information is as easily accessible for all interested consumers of any demographic group. These publications are not designed to be specifically "senior friendly," rather are designed to be easily read and understood for all citizens.

5. Aging of the Department of Corrections Workforce:

❒ In 2006 the median age of the DOC workforce was 42.3 years, up from 40.9 in 2002. 26% of the DOC workforce is over the age of 51. Security staff and probation officers are considered part of the Virginia Law Officers Retirement System (VaLORS) and can retire with 25 years of service after the age of 50. Non VaLORS employees can retire with 30 years of service after the age of 50.

❒ 12.5% of VaLORS employees are currently eligible to retire and an additional 9.3% will be able to retire within the next 5 years. A total of 22% of the VaLORS employees will be eligible to retire within the next 5 years. Almost 4% of non VaLORS employees will be eligible for retirement (30 years of service) in the next 5 years. This means **more than** 25% **of the total DOC workforce will be eligible for retirement in the next 5 years**.

❒ The Department has already begun succession planning activities. The LEAD (Leadership Enhancement & Development) Council has been formed and has already put into place two significant programs. The first is the LEAD Program to develop mid level managers to be ready to move into senior level manager positions when those positions become vacant due to retirement and other separations.

❒ After identifying the leadership and managerial competencies needed for senior level positions, the Department contracted with the American Correctional Association (ACA) to provide a program to build and develop these skills. The two week program and the additional individual project have been very well received. Two sessions have been completed, a third is in progress and the fourth is in the application stage.

❒ The second program is “Smooth Start for New Supervisors”. It is a two day program for newly appointed supervisors to attend within 30 days of their appointment. The program is designed to open the window of supervision for new supervisors and expose them to the basics of supervision, answer their questions, meet with the Director’s Staff, and provide an orientation to the Department’s Strategic Plan.

6. Other Services or Programs:

❒ The DOC plans to continually evaluate the geriatric population in our institutions and community corrections centers to ensure the appropriate services and/or programs are provided. The aging inmate population will present challenges in:
– Specialized care and services
– Costs and
– Release planning.

❒ To prepare for challenges of an older inmate population, DOC will study the older inmate and community client. Topics of interest include:
– Continued monitoring of population trends and costs
– Special needs of older inmates
– Specialized training and staff development needs
– Identification of successful release strategies and resources.

❒ Additionally, the DOC plans to evaluate and handle the anticipated workforce transition and training that is necessary.

REFERENCES

Madden, H.T., Rossiter, L.F., & Klock, D.F. (2003). Study of the Older Prison Population in Virginia and its Budget Implications. The Center for Excellence in Aging and Geriatric Health and The College of William and Mary

Morton, J.B. (1992). An Administrative Overview of the Older Inmate. Washington, DC: U.S. Department of Justice, National Institute of Corrections.