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## The Older Inmate

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*Deerfield Correctional Center*

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## Case Study

### The Older Inmate

by Tara Livengood, M.A.

#### Educational Objectives

1. Present a general overview of elderly inmates, including statistics, characteristics, crimes, mental and medical illnesses, and disabilities.
2. Describe Virginia's only geriatric correctional facility.
3. Explain the practice of release planning, focusing especially on geriatric release.

#### Background

The number of elderly inmates in state prison systems has increased dramatically during the past decade. This increase reflects several realities. In general, people are staying healthy longer, are living longer, and are capable of committing crimes longer. The combination of the aging baby boomer generation and the crime and sentencing trends of the 1980s and 1990s has led to an older, grayer inmate population. Strict sentencing policies, such as Truth in Sentencing, which requires prisoners to serve at least 85 per-

cent of their sentence, and Three-Strikes sentencing, which calls for third-time felony offenders to serve mandatory sentences of 25 years to life, have also contributed to the increase of elderly inmates (Kerbs, 2000), as have longer sentences associated with the war on drugs. From 1992 to 2001, the number of state and federal inmates ages 50 and older grew from 41,586 to 113,358, a substantial increase of 172.6% (U.S. Department of Justice, 2004, p. 7). In the past five years, the aged 50 and older inmate population within the Virginia Department of Corrections has increased 5% (Virginia Department of Corrections, 2002, p.3). Not all inmates will adjust well to incarceration, and some may become difficult geriatric inmates (McShane & Williams, 1990). The mellow, gentle and calm stereotypes of the older adult do not always apply to elderly inmates.

Chronological age is only one factor used in the definition of aging; aging is also defined by physical, emotional, social, and economic situations. Accelerated biological aging is a rapid decline of health due to, in this case, incarceration

(Kerbs, 2000). The "age" of a typical male inmate is approximately 12 years older than his non-confining counterpart; so, an incarcerated 50 year old would be physiologically similar to a 62 year old person outside of prison. Several factors lead to accelerated biological aging, including unhealthy lifestyles prior to incarceration, unhealthy lifestyles cultivated during incarceration, and the stress of prison life, all of which intensify the aging process (Kerbs, 2000). Unhealthy lifestyles can include risky sexual behaviors and tobacco, alcohol and drug use and abuse.

The U.S. Department of Justice (2004) identifies three types of elderly offenders: first offenders, repeat offenders, and long-term offenders. Each group has its own characteristics and needs. First time offenders include inmates who have committed their crime after the age of 50. Approximately 50% of elderly inmates are first offenders who are incarcerated after the age of 60 (Florida House of Representatives, 1999, p. 12). Their crimes are likely to be serious, considering they have been imprisoned for a first-time offense at an advanced age; crimes

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of passion are often the cause of incarceration. Within the Virginia Department of Corrections, 81% of inmates over the age of 65 are first time offenders (Celi, 2007, p.7). According to the Florida House of Representatives (1999), first time offenders are incarcerated mainly because of changes associated with aging, such as reduced social interactions or increased stresses placed on primary relationships; these may create conflict, triggering a spontaneous crime or a crime of passion. Biological changes also can influence the high rate of first time offenders, such as any biological change in the brain that would decrease inhibition and impulse control. Loss of ordinary social rules and obstinacy often lead to aggression; consequently, this is a group prone to violence. Their criminal behaviors are often situational and spontaneous, so they rarely see themselves as criminals. Their most common offenses are aggravated assault, including sexual assault, and murder. First-time incarcerated older inmates are frequently severely maladjusted and are especially at risk for suicide, aggression, and other characteristics related to mental illness. They are likely to have problems adjusting to prison since they are new to the environment, which will cause underlying stress and possible health problems related to stress.

Repeat offenders are habitual criminals who have been in and out of prison for most of their lives. They frequently have substance abuse problems that can lead to chronic diseases, such as asthma, heart problems, circulatory problems, and kidney or liver problems. Repeat offenders tend to adjust better to

prison because of their histories of being in and out of prison. Substance abuse, a history of violence, and mental illness often play a part in their re-incarceration and they find life outside of the institution difficult because of these problems (Florida House of Representatives, 1999).

Long-term offenders include inmates who have earned long sentences and have “aged in place.” They are generally the best adapted to prison life because they have been in prison so many years that they have adjusted to the prison environment.

It is clear that older inmates have considerably greater health care needs than younger inmates in the general prison population. Many suffer from chronic illnesses, including but not limited to heart disease, hypertension, diabetes, cirrhosis of the liver, and chronic lung disease. They also experience a number of conditions commonly associated with the normative aging processes, including vision loss, hearing impairment, sleep disturbances, incontinence, mental illness, and gastrointestinal disorders (Florida House of Representatives, 1999). Compounding these health problems, psychological illness, lack of educational skills, and poor social support affect the elderly inmate’s ability to adapt to prison life (Kerbs, 2000). Sabath and Cowles (1988) found that low levels of education, poor health, and intermittent visits from family led to poor adjustment in prison because these factors decrease the inmate’s ability to fill time with activities.

The analysis conducted by the Florida House of Representatives (1999) revealed that older inmates have a higher rate of mental health problems than younger inmates; in general, 15 to 25% of the elderly inmate population has some type of mental illness. Morton (1992) found depression to be the most common mental illness found in elderly inmates, followed by dementia, including Alzheimer’s disease, and drug and alcohol abuse. Aday (1994) conducted a case study of 25 elderly inmates incarcerated for the first time. Reported first reactions to prison in late life included depression, family conflicts, fear of death in prison, and thoughts of suicide.

#### **Deerfield Correctional Center (DFCC)**

The original DFCC opened in Capron, Virginia in October 1977 and closed April 1991. After three years of construction, Deerfield reopened in August 1994. Since its initial opening in 1977, DFCC has operated as a medium security facility. Currently, it is classified as a Level II, which is a moderate level facility (Level I is minimum security and Level III is medium security) and has the capacity to house 1,080 inmates: 986 in the general population, 57 in assisted living, 17 in chronic care, and 20 in the infirmary (Deerfield Correctional Center, 2004). Recently, as a result of the Commonwealth of Virginia budget cuts, DFCC has acquired the Men’s Work Camp and Women’s Pre-Release Center, both of which were part of Southampton Correctional Center which closed in 2008. As a component of DFCC’s current mission, inmates who are

assigned to DFCC should be 55 years of age or older or in need of assistance with one or two activities of daily living, such as eating, bathing, toileting, dressing, hygiene, and ambulating. At present, 65% of inmates assigned to DFCC are 55 years of age or older. The main goal of DFCC is to address the long-term health care needs of aging inmates and inmates who have chronic illnesses or conditions which prevent them from caring for themselves (Virginia Department of Corrections, 2007). Deerfield hopes to expand over the next few years to allow for a dementia care unit and/or a hospice program.

DFCC has approximately 165 inmates who are taking psychotropic medication and 19 who are not on medication but receiving direct mental health services. The most common mental illnesses presented are depression, anxiety, bipolar and thought disorders, and dementia. Loneliness, bereavement, isolation, and poor health commonly contribute to a lack of effective coping during incarceration. Currently, DFCC maintains four qualified mental health professional (QMHP) positions on the mental health team who treat and monitor the mental health inmates at DFCC; in addition, a psychiatrist comes in to see patients two to three times a week.

### **Offender #1**

Offender #1 is a repeat offender who is serving the last few months of his 10 year sentence for fraud and grand larceny related to his drug addiction. He is a 51 year old white male who grew up in the western part of Virginia in an area

well known for its seclusion, family cohesiveness, and low socioeconomic status. Typical of inmates from this area, Offender #1 has a limited education and worked on farms or sold items in a flea market to earn a living. Since Offender #1 was a young teenager, he had been using drugs and alcohol to the point that now he is suffering nerve and muscle damage. He has a family history of drug and alcohol problems and, in fact, Offender #1 has siblings incarcerated in Virginia who have similar circumstances; this is not uncommon in the Department of Corrections. His medical problems include a hernia, heart condition, diabetes, hepatitis C, and hypertension. From a mental health perspective, he suffers from depression, anxiety, and psychosis. While his chronological age is 51, Offender #1 appears to be in his mid-60s because of accelerated biological aging. He has a defeated, weary, and depressive disposition reminiscent of one who is hanging onto his last thread. Currently, his only hope is to get out of DFCC alive and never return. He says that he has learned his lesson and states that entering prison has saved his life by getting him away from drug addiction. He says that he hopes to make something better of his remaining years. Offender #1 will be released this year.

Release planning is the process of finding housing and after care services for released offenders. For Offender #1, this process is relatively easy, for he has a home plan, is not a sex offender, and has family members or friends who are still alive. A home plan refers to the place of residence to which the offender will return upon release.

Typically, the home plan will be a family residence but it could also be a friend's house, homeless shelter, halfway house, or other type of private or public facility. Offender #1's home plan was unusually easy to determine, something quite uncommon for offenders being released from DFCC. Many offenders have neither living family members nor friends or, in some cases, family and friends are still alive, they do not want any contact with the offender. If the offender is a sex offender (there are approximately 350 sex offenders at Deerfield) the release planning is much more difficult due to specific legal requirements and facility rules, such as, the distance of child care or school facilities from the home plan, location of the victim, and the placement facility's discretion of allowing a sex offender to reside there. All home plans are verified by the supervising Probation and Parole Officer to determine its appropriateness. The Code of Virginia allows a geriatric offender to apply for geriatric release, under a section called Conditional Release of Geriatric Offenders (53.1-40.01). In order to meet the petition requirement, an offender must be serving a sentence for a felony, other than a Class I felony, be 65 years old or older, and have served at least five years of the sentence or be 60 years old and have served 10 years of the sentence.

All offenders being released who receive mental health services will receive placement assistance by a QMHP. For Offender #1, the QMHP made an appointment with the Community Services Board (CSB) so that the offender will receive mental health services

almost immediately after release. All offenders receive up to 30 days of medication upon release, including all medical and mental health medication. A 30-day prescription for the mental health medication is sent to the supervising Probation and Parole Officer so that the offender will be able to fill a prescription under supervision if the CSB appointment does not occur in time. Offender #1's home plan is at a location he resided previous to incarceration and is near his family's residence. His home plan will need to be approved by Probation and Parole and the QMHP will follow up as Offender #1's release date approaches.

### **Offender #2**

Offender #2 is a long-term offender who entered the Virginia Department of Corrections at the age of 35 for 1st degree homicide, a Class II felony. He has so far served 26 years of a life sentence. He is 61 years old but, due to accelerated aging, he looks to be in his early- to mid-80s. Coincidentally, he too grew up in the western part of Virginia. He has a negative, bitter, resentful disposition and is constantly hassling officers, medical staff, and other correctional staff because of his perception that they have failed to satisfy his needs, whatever they may be at the time. He has a significant number of health conditions and uses a wheelchair. His medical conditions include insulin-dependent diabetes, cirrhosis of the liver, pancytopenia (a disease in which there is a reduction of red and white blood cells), hypertension, and coronary artery disease. From a mental health perspective, Offender #2 suffers from

Major Depressive Disorder and receives medication to aid sleeping and reduce agitated depressive features as noted in the above description. Offender #2 receives quarterly psychiatric evaluations to monitor his mental health. Offender #2 does not require additional services because, although he is diagnosed with a mental disorder, the disorder is not currently at a level which requires additional services such as individual psychotherapy or group therapy. Offender #2 has, in the past, received both of those types of additional services and would be considered again if needed. Offenders like Offender #2 who have numerous medical problems are constantly being evaluated and monitored by medical staff. Medical and mental health staff work jointly to ensure that all offenders, and in our case mental health inmates, are receiving adequate care and medication. If Offender #2 or any other mental health offender needs services between the quarterly psychiatrist visits or psychotherapy visits, medical staff will notify the QMHPs.

### **Conclusion**

Elderly inmates represent a special population of incarcerated offenders. They are at a higher risk for medical complications, depression, loneliness, and bereavement. They pose unusual challenges for correctional, health, and mental health professionals. Those who remain in prison tend to experience an accelerated aging which affects their attitudes and behaviors. Those who are released tend to face difficulties in readjusting to a less structured environment. More states will likely find it necessary to focus further

attention on aging offenders and their need for additional services.

### **Study Questions**

1. What factors influence accelerated biological aging?
2. What are the most common types of elderly offenders? What crimes are they likely to have committed?
3. How are the medical and mental conditions of elderly inmates different from or similar to those of the older adult population not incarcerated?

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### **About the Author**



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She earned a bachelors degree in Psychology and Criminal Justice at Virginia Commonwealth University, and a masters degree in Forensic Psychology at the American School of Professional Psychology. She worked at the Virginia Center on Aging for four years and remains active in the aging community.