SENATOR BRUCE MCPHERSON, CHAIR: I call to order the meeting of the Senate Subcommittee on Aging and Long Term Care, the Senate Select Committee on the California Correctional System, and the Senate Public Safety Committee, which I chair. Senator Vasconcellos will be here shortly.

This is a very, very pressing and interesting topic that we have, one not only to give us a clearer idea of what we might be able to do with the aging prisoners who are in our prison system, as well as, if it can help us in this very dire circumstance that we’re having with the state budget.

We are very fortunate today to have some distinguished people who are going to testify. In speaking for Senators Vasconcellos and Romero, I just want to say that this is an issue we take very seriously. I’d like to just ask Senator Romero if she might have a few opening remarks that she might want to make.

SENATOR GLORIA ROMERO, CHAIR: Thank you very much. And I welcome everybody to today’s hearing. I want to thank everybody who is going to testify before us in advance, to say, thank you very much.
This is a great cooperation here. We essentially have three different committees in the state Senate taking a look at the issue of geriatric prisoners and Corrections quite seriously. This brings together the Senate Subcommittee on Aging and Long Term Care, which is chaired by, of course, Senator Vasconcellos. It brings together the Senate Public Safety Committee with Senator McPherson. And it brings together my Senate Select Committee on the California Correctional System. The three working together intend to focus specifically on looking at aging and the graying of the prison population in California.

Let me just at the start say that, looking at geriatric prisoners and the graying of our prison system is not unique to California. In fact, we’re going to hear testimony indicating that this is a national issue and other states are facing this issue. But I believe, and we will hear testimony today, that will indicate that California is ahead of the curve. It is a more sharp concern for us in California.

Our prison population is getting older. And of course, as they age, we, in California, do pay more and more to incarcerate these aged prisoners.

There are estimates that housing an aged prisoner can cost up to three times higher than that of a younger inmate. And in California right now, that means that approximately $80,000 per year to incarcerate a prisoner over the age of 55.

Some might ask, well, there aren’t that many senior citizens, older prisoners, in our system right now. In fact, it’s estimated to be about 4 percent of our total population with an inmate count of about 6,400 inmates. However, this number is growing and this number will continue to grow. This number is
not going to go away. The problem, the issue, the reality, and the cost are going to continue to exacerbate, because the population demographic shifts, as well as taking a look at changes in policy that have been enacted by the voters in this state and by this Legislature. We have seen the inclusion of “three-strikes” and the reality that as we implement and incarcerate around “three-strikes”, that we are now looking at, for a longer period of time, essentially seeing our inmates age in our prison system. More and more it’s been argued that our prison system has become a nursing home system with respect to public safety.

We’ve also seen the increase of enhancements and sentencing. So all of these policy issues also affect us as we take a look at the irreversibility of the aging process.

This does raise issues of concern. There are alternatives for us to take a look at. I do want to get specific answers from the Department of Corrections. Let me say at the start, that I am very disappointed in Corrections for not having, I believe, adequately or sufficiently addressed this issue. This is not a new issue. While it hasn’t yet reached its crest, we have known for some time that this is coming. Reports have been issued. I would like to, at least on my end, get some answers today from Corrections staff as to why we have not been more proactive in addressing this situation, and what we can do now in order to confront this issue head on.

So I want to thank everybody for being here today. And Senator Vasconcellos had to take care of some business this morning but he will be back shortly. Thank you.

**SENATOR MCPHERSON:** Okay. I’d like to welcome Senator Betty Karnette also. And I’d like to begin the hearing by hearing from Stan Neal, the
Senior Fiscal and Policy Analyst for the Legislative Analyst’s Office, Criminal Justice Section. The LAO gave some interesting points of view in their report recently. And so, he would like to update us and clarify, if that’s the way to put it, some of the issues that were brought up there. Mr. Neal, please take a seat.

MR. STAN NEAL: Thank you, Senators. I’m Stan Neal from Legislative Analysts. And I want to first review some of the demographics of the 6,400 inmates that Senator Romero mentioned.

Fifty-four percent of those folks are between 55 and 59 years of age. Twenty-five percent, between 60 and 64; 20 percent are 65 years and older. Not very many women. Only 300 females. Of that group of 6,400, 35 percent have been sentenced for non-serious, non-violent crimes.

I want to switch to that group, the non-serious, non-violent, because those are the folks we focused on.

Of the non-serious, non-violent offenders 55 years and older, some 50 percent of them have been incarcerated for drug related offenses; another 9 percent for driving under the influence; and perhaps 18 percent for petty theft and burglary. The average time served by this group, 55 and older, non-serious, non-violent, is 5 to 23 months for the offenders convicted of controlled substances. This is the time they have left to serve in the institution -- 5 to 23 months for a controlled substance; 12.7 months for the offense convicted of manslaughter; 11.6 months on average left for grand theft offenses; another 7 months for the driving under the influence. The point is, these people are not going to be in prison a very long time. It’s something to keep in mind as we go on here.

Prisons nationwide are having to deal with the fact that they’re going to
have to manage a growing number of elderly prisoners, if you want to call 55 elderly. How many is an argument of healthy dispute.

The CDC seems to come to the conclusion that 20 years from now we’ll be at around 7 percent of the prison population 55 and older. That is very much at odds with some other commentators who think that we’ll be up to 20 percent nationwide in just 10 years. The Census Bureau is way out in the end, and they feel that by 2025, a third of the prison population will be 50 percent and older. So we go from 7 on the low end, to a third.

The analyst came in somewhere in between. We think that a reasonable number is somewhere in the range of 16 percent of the prison population will be elderly in the year 2025. That’s somewhere, 30-, 40,000 prisoners. That is a lot to handle.

No matter what the growth trajectory is, I think everyone will agree that as percentage grows, the costs grow. How much? We took a look at that.

The department is unable to tell us how much it costs to house elderly inmates at this point. They just don’t keep track of that sort of thing by age.

So we looked at the data. We looked at other correctional systems. Fairly consistently we found that the answer was two to three times the cost of a younger inmate. In New York for instance, they reported housing costs of $50-to $70,000 for elderly inmates. That was about twice their normal costs. Texas reports a cost of three times what they pay for younger inmates. And at the National Center of Institution and Alternatives reports a $69,000 cost, or three times the national average of $22,000. So if the national average is $22-, they think it’s going to be at least three times, probably more.

Why are inmates so expensive to house?
Well, aging inmates make special demands on prison operations. Whether you’re talking about housing, programming, food service, or healthcare, they have special needs. However, healthcare is by far in the way the greatest cost driver. Aging inmates have the same kinds of special needs that the aging population does in the community.

For instance, as we get older we’re going to need eye glasses. Some of us are going to need hearing aids, walkers, canes, things that add to our daily expenses. These add to the prison’s healthcare expenses. We’re going to have more frequent healthcare episodes as we get older. Some of us are going to need special accommodations; bath rails, shower rails, special commodes, that sort of thing. And some subset of us, near the end, are going to need constant supervision. Inmates are all the same; have all the same needs.

On the other hand, inmates have unique needs. The demographics and the former lifestyle of inmates leave them susceptible to some unique problems: Hepatitis C -- over representation of folks with Hepatitis C in our system. HIV -- this is from the lifestyles that they’ve known.

In addition, when you talk about keeping inmates healthy, you’re talking about combining healthcare and custodial considerations. Guarding and taking care of people is an added cost. This shows up most immediately, most strikingly, when you talk about transportation costs, removing a prisoner out of the institution to some kind of healthcare contractor in the community; very expensive.

Once again, the department does not have exact costs, or even inexact costs, for transportation, but anecdotally, at least in the press, we were talking about possibly $200 a trip at an institution where they make 350 trips a year. I
think it’s a year. But $200 a trip for guards and gas, as they put it. So it’s very expensive.

In addition to that, inmates are unique in that there’s no sharing of costs. The rest of us are in private insurance where we pool our risks. Or, we can maintain eligibility for federal programs, like Medicaid, SSI; inmates can’t. The entire cost of their health care is a state problem, a state burden. That makes them unique.

But what exacerbates the problem is the fact that prisons aren’t really geared up to take care of elderly inmates. They just aren’t. Prisons work on a sick-call system. Sick-call system works if you have the flu, you sprained your wrist, broke your leg, but it really isn’t geared up to keep on top of chronic problems. Problems that if they aren’t taken care of early, can get to be very expensive.

Once again, I think of Hepatitis C because there are ways to deal with Hepatitis C at this point. But if you don’t, at the end we’re talking about a liver transplant. That’s hugely expensive. So chronic problems are a big consideration.

The institutions are also limited in their experience to staff the doctors, the nurses, the correctional officers. They’re not trained in age related illnesses. They don’t recognize them early enough too often. This is true nationwide. It’s true in California.

We also don’t have institutions that are dedicated to take care of the elderly. Now we have had in the past. I was reading in the newspaper that in 1954, from ’54 to ’71 in San Luis Obispo we had a, in the men’s colony, a dedicated senior facility. That’s gone.
Currently, we have the California Institution for Men, CIM, down in Chino, which originally had a unit that was dedicated to the elderly. That has transformed over the years. Now there are only 10 percent elderly there, and it’s really for the mobility impaired at this point.

So we have no institution that’s dedicated to the needs of these people and they do have special needs. What we do have are some institutions who, on an ad hoc basis, do things to accommodate prisoners, elderly prisoners. For instance, if they’re smart, they house them on the first floor. They bunk them in a lower bunk if there is a double bunk. But that is only catch is as catch can, and we find lots of anecdotal evidence that prisoners are pretty much left out there to fend for themselves once they get old.

So, these are among the problems that our institutions are facing in trying to deal with the elderly. And from our point of view at the Analyst’s Office, possibly the biggest problem, one of the biggest problems is, that there is no classification system for elderly.

If you don’t have a classification system, you can’t track costs. We’re very interested in the costs of health care for this group. You can’t identify spikes in costs. And you can’t take advantages of opportunities to combine people in institutions where you would have avoid these transportation costs, to consolidate, to take advantage of economies of scale. You just don’t know where these costs are coming from. You’re not tracking them.

So, those are some of the problems that we noticed.

Now, it’s clear that elderly are high cost. The question was, are they also high-risk? And we took a close look at that. And the short answer is, many inmates 55 and older are not high-risk. Criminologists have long known that
the propensity to commit crime declines noticeably after age 25. That’s borne out by the arrest statistics nationwide which peak at 25, decline sharply between 25 and 40, fall to less than 5 percent for persons 50 and older.

The lesson here for us was, if public safety is the goal, imprisoning a 55 year-old has much less of a crime reduction effect than imprisoning a 25 year-old. Perhaps more important when we looked at this was, what was the likelihood that an offender released on parole would commit another crime? What was the public safety implication? And though there are notable exceptions, national studies indicate that older offenders are much less likely to commit crimes.

One study that we looked at followed a cohort of parolees from 1991 and concluded that 45 percent of the parolees aged 18 to 45 were recommitted. In contrast to that, fewer than 3 percent of the inmates 55 and older returned to prison. So statistically, the risk that inmates post, elderly inmates post to public safety, is much lower than their younger counterparts.

And last year, the Analyst’s Office discussed releasing non-violent, non-serious elderly inmates as one of our options for addressing the state’s fiscal problems. This year, after revisiting the literature and corrections operations in other states, and recognizing just how expensive some 55 and older inmates are to house relative to their public safety risk, we are recommending trailer bill language that would require discharge to parole for certain non-violent, non-serious offenders 55 years and older. We believe this policy change would represent a number of important opportunities for California at this time. Releasing a select subset of the 6,400 that we talked about earlier, perhaps 250
to 300, could save the state’s General Fund up to $9 million in the budget year and even more in the out years. Early release would certainly have a positive effect on our over crowding problem. Early release might reduce, hopefully would reduce, the need to build and modify our facilities to accommodate this inmate population. Those capital costs would be very steep in the out years. And last but not least, definitely not least, to the extent that early release reduces the likelihood of expensive class action suits, we stand to gain quite a lot from reducing our exposure.

So, that’s where the Analyst is going to come down in this budget year, and we think we have a lot of opportunities to take advantage of.

Thank you.

**Senator McPherson:** On the cost of this -- of course, public safety, per se, as you’ve mentioned, is the most important aspect of all of this, to assure that for the people of California. But in hearing what you had to say about the reduction in cost of the prison system, would a released prisoner, a aged prisoner, pick up those costs elsewhere in the health care -- I mean, is it just a, you’re out of prison. You don’t have to worry about any costs at all? Or do you see the costs being borne by the health care institutions of California, or part of that? Is that taken into account in some of the figures that you’re talking about?

**Mr. Neal:** Well, Senator, we haven’t run figures on exactly what the cost would be after these prisoners were released. We do know that you would bear, possibly, increased costs to monitor them on parole, because we think that setting up the correct parole situation for these prisoners is extremely important to keep them from revoking back into the system. We know that some of them
will qualify for federal services, which are shared costs. We haven’t run numbers on exactly who and how much, but that could happen in the future.

SENATOR MCPHERSON: So the 3- or 400, I believe you said it would save $9 million?

MR. NEAL: Up to, depending on when you implemented the program.

SENATOR MCPHERSON: Okay. So that could be a net -- it could be less than that to the state of California?

MR. NEAL: That cost has subtracted out parolee supervision. But if there are any other costs, it would be less.

SENATOR JOHN VASCONCELLOS, CHAIR: Senator Karnette.

SENATOR BETTY KARNETTE: You commented, sir, that 25 was the peak of incarceration.

MR. NEAL: Arrests.

SENATOR KARNETTE: Is that true also for women, or did you look at that?

MR. NEAL: That’s a total, and I couldn’t split it out for women at this point. I could find out for you though.

SENATOR KARNETTE: Well, is it costlier to house women? I visited some prisons, and the older women, I mean, is it costlier for -- is there a difference between males and females? Did you look at that issue?

MR. NEAL: At that age?

SENATOR KARNETTE: Yes. At the elderly age.

MR. NEAL: I know that they’re both costly, because they both take a lot more prison resources. And if they have a very important health care episode, it’s going to be expensive. So, on average, I don’t think we have good data for
SENATOR KARNETTE: And to follow along with Senator McPherson’s comment that, if they leave the prison, they will still need health care. But some of it would be borne, you say, hopefully by the federal government.

MR. NEAL: We would hope.

SENATOR KARNETTE: And some by the counties, probably. If they have some place to go, and the probation officers have a place for them to go, they’re less likely to cost more, I would think. You know, I mean, if you just put them out in the street they’re going to -- so you didn’t really investigate the parole situation?

MR. NEAL: No, we didn’t. We haven’t taken a look at the after care. But certainly, if they’re in better health situations, it’s going to be less. If they have a very acute situations, that’s going to be something that has to be looked at.

SENATOR KARNETTE: If they’re extremely acute, there may be no place for them. Where would they go? If we release somebody who is bedridden, where do they go?

MR. NEAL: I think we would have to find places for them in the county.

SENATOR KARNETTE: Okay.

MR. NEAL: I don’t think we have an answer to that just yet, but I think it’s possible to find an answer.

SENATOR VASCONCELLOS: Senator McPherson.

SENATOR MCPHERSON: I have one more question and it might be Professor Turley who might be able to answer this more clearly. You might be
able to. But, the classification system nationwide, how is that developed? Is it how long ago they committed the crime; how serious it was and so forth; and the age in which they committed that crime? To get this classification system in general?

**MR. NEAL:** Well Senator, I don’t want to imply that there is a classification system nationwide. Most states don’t have a classification system. I think you have to remember that most states are looking at a fairly small elderly population relatively speaking; 4 percent here, less other places. What they have is what the department will probably say we have, a sort of not informal classification system. When a prisoner comes for health care, you see what age he is; you sort of notice him. If he’s really sick, you take that into account. And you kind of know you have some elderly that you’re taking care of. And a lot of states do it just that way. I don’t believe that most states have a classification system at this point.

**SENATOR VASCONCELLOS:** Senator Romero, any questions at this time?

**SENATOR ROMERO:** Yes. Let me ask, do you referred to the concern over the possibility of additional or the filing of class action lawsuits against the state. What has been filed to date? Can you give me some idea as to what we’re facing right now with respect to geriatric prisoners and class action suits?

**MR. NEAL:** I would need the help of the department on this one, but I don’t know that we are facing class actions immediately related to geriatric or treatment of the elderly.

**SENATOR ROMERO:** So we may not have anything right now, but it’s something certainly as we see the graying of the population we might
anticipate.

**MR. NEAL:** Absolutely. Absolutely. People will be able to make the case that the treatment of prisoners is not suitable to accommodate.

**SENATOR VASCONCELLOS:** Okay. Any other questions, comments? Thank you, Mr. Neal.

This morning I was late. I promised Senator Bowen I’d meet with her Manhattan Beach contingency for a half-an-hour. I did that, so I’m late here. My staff has given me some comments to make, but I’m not going to make them, because the witness, I think, can speak much more directly about the realities that are found out scientifically than I can in terms of the conclusions I read from his papers.

I come at this with a triple background. First, I chaired Public Safety in the Senate for four years. I’m vice chair now. When I became its chair six years ago, it was called Criminal Procedure. And I asked Senator Lockyer, then the pro Tem, to change it into Public Safety, because procedures are important, but I wanted the system to be about the public being safe. That, to me, is the right framework for everything we do. The most important one.

Second, I chair the Senate Aging and Long Term Care Subcommittee, and last year passed a major bill, 953, which recognizes that we’re an aging population of double numbers of people over the age of 65 before long, and a population at large tries to reform the whole system of providing services. And in that respect, I’m chair of the Aging and Long Term Care Subcommittee as a co-sponsor of this hearing, to look at what’s happening with prisoners who are aging, especially downstream as we hit “three-strikes” in for life, and people who are 85 and wheelchairs costing us $60 grand a year to keep locked up
somewhere, to me, sounds pretty silly for public safety. I want to hear the facts.

And third, I chaired the Budget Committee 15 years in the Assembly, so I’m keen and equipped to know how the taxpayer’s money ought to be used, and it ought to be used smartly and not for somebody’s myth, or somebody’s propaganda, or somebody’s campaign, but for public safety. And the cost involved here, or the implications could be in the billions of dollars that could be otherwise better spent if we find better ways of addressing issues in this arena of aging geriatric prisoners without in any way sacrificing public safety. So this hearing is really important. It’s sort of a wakeup call for all of us.

I learned a lot last night at dinner with Professor Turley. I want to introduce him now. He comes from George Washington University. Jonathon Turley, Professor of Public Interest Law. And I gather, probably the nation’s foremost expert, scientifically objective expert, in studying what’s happening in the prisons of America and what’s happening about geriatric prisoners in America. He’s the founder of a group called, POPS, Projects for Older Prisoners, which has a stunning 1,000 percent success rate. And in my estimation from listening to him last night for an hour at dinner, and listening, not just talking, he has a statement that we ought to pay attention to, learn from, and use as a basis for our own opening up this issue and making smart, not stupid, decisions for the public safety of California.

Professor Turley, welcome. Thanks for coming out. You’re on. You have about 15 minutes on the calendar if you need that much time.

PROFESSOR JONATHAN TURLEY: Thank you, Sir. As a law professor I’m trained to speak in 15 minute increments --

SENATOR VASCONCELLOS: Right. I remember that from way back
PROFESSOR TURLEY: Senator Vasconcellos, Senator McPherson, Senator Romero, I wish to thank you and the members of the two committees and subcommittees that you chair for the invitation to speak with you today at this important joint hearing. It’s an honor to appear before the California Senate to discuss your graying population and its implications for the state.

I come here, obviously, as both an academic and as executive director of POPS, the Project for Older Prisoners.

I’ll cut to the chase because I know our time is limited and we have much to talk of.

My purpose today is to give you the results of our initial findings as to the California system to put it into context of the country as a whole. This is not a comprehensive POPS report like the ones completed in states like New York and Illinois. Those take a little more time to put together. If such a report is desired, we can certainly do that if the state has a further interest.

But what is striking is the findings of our preliminary report, and we did a little more than usual for the state of California in the sense that our preliminary report is fairly detailed and we make copies available. It’s roughly 70 pages of data and analysis.

What that data shows is, that California has a classic profile in terms of its problems, it’s growing problems, with its older prisoner population. It’s classic in the sense that it follows the same curves that we’ve seen in other states, but there is a considerable difference.

To put this into context, in a prison system, to take a biblical reference, there are four horses of the apocalypse essentially; four issues that can cause
catastrophic problems in the system. Like the biblical reference, when they combine, if they combine, they are often very difficult to overcome. Any prison system has to avoid that combination. What is different about California is that in those four categories that we use to judge the condition of a correctional system, most states that we look at have a difficult problem in one or two. California is different. You are in what we consider to be the acute stage on all four, which means that your horsemen are combining.

Now, I want to emphasize before I get to these issues, that we felt that the data coming out of California was so surprising that I had our team of researchers check it two or three times because I just couldn’t believe the figures. They are the worst we’ve seen in states around the country.

Now, those four categories, those horsemen, if you will, are recidivism, overcrowding, budget shortfalls, and acute demographic shifts in population. To quickly run over our findings before we get to specifics. First, California has the highest recidivism rate in the country. It is a rate that is quite disturbing and in and of itself should be viewed as a crisis. That recidivism rate ranges, depending on studies, between 60 and 70 percent. That is astonishing. It means that in this state, your citizens are being victimized at a much higher rate than other states. You are releasing high-risk prisoners, or failing to supervise them, but the results are not borne by the correctional system. The results are borne by individual citizens who are being victimized when they shouldn’t be victimized. Your recidivism rate is twice that of comparative states. That is alarming.

Now, it is true that you have a larger number of parolees out there. And you also have a very high rate of revocation of parolees. Some for technical
violations. But even if you take the lowest figure for recidivism, you have a serious problem in this state. And that problem relates not just to older prisoners, but to some of the solutions that we’re talking about.

Second, the state is overcrowded by any estimation. It has all 33 of its major facilities are above design capacity. Once again, that is pretty remarkable. It is not uncommon for states to have facilities that are over capacity. But, I’m afraid California is something of an overachiever in this respect. Not only are 100 percent of your facilities over design capacity, about a third are twice design capacity. That is virtually an invitation for a lawsuit, and it is an invitation for the most dangerous form of prison reform. Court ordered releases. You get to that stage and your recidivism rate will go higher. It’s hard to believe it will go higher, but it will.

Third, California’s prison budget is rising faster than its population. This indicates that per capita inmate costs in your state are rising faster than the population itself. Part of that is due to your construction campaign which adds to those costs. But part of it is also due to the fact that your population is getting more expensive.

Then finally, and most of concern for us, is that California is looking at a major demographic shift in about a decade. To get an idea of what that means: Between 10 and 20 years, it will be as if someone comes into your prison and replaces the prisoners. You’re going to have a different prison population than you have today. So your projections, your systems, your processes, that are designed to handle a steady rate of growth now, to handle this prison population, is going to be handling the wrong prison population. It’s going to be different. And you’re going to experience exponential growth in costs in
other areas.

So, the recommendations that we have today in the findings will ultimately depend upon the willingness of California leaders to take the initiative to avoid a crisis. I mean, I’m not Hans Blic looking for violations, and I don’t have any authority. I am an endomorphic meaningless law professor. All I can do is tell you, based on our view, what you’re facing. And if I were you, I’d be pretty darn concerned.

The absence of meaningful reforms with older prisoners is something of a surprise for a system this size. California is the largest state system in the country. And at one time, it was the leader of correctional policy. It is filled with incredibly talented professionals, in your correctional officers, in places like the LAO. This state has more raw resource and expertise and people to solve this problem. It’s just that they’re not being used. You can turn the corner here because you can benefit from the work of other states.

But, I want to emphasize one thing and then I’ll get to our specific findings. Time is of the essence. Time is of the essence. This state cannot drift toward this coming crisis without putting not just its correctional system, but its society at risk. As someone with professional and personal ties to this state, even though I harken from the East Coast now, I’m very concerned with what I’ve seen about this data. If the state does nothing, it will be living in denial. That is a habit that is hardly healthy for individuals, but is down right dangerous for a correctional system.

Let’s turn to some of the figures and you’ll see what I mean.

The prison population nationally is graying; that upon which we can agree. In the federal system a remarkable 43.7 percent of the population is 41
years old or older. We’re going to be talking about the importance of years in
that cutoff in a little bit. But what is clear in all states is that the older prisoner
population is the fastest growing segment of the state’s system. This shift
comes with attendant costs and overcrowding and budgetary problems.

I won’t go through some of the figures we have about the rate of this
increase. But I just want to note that the federal system in 1988 had 33,000
prisoners; it now has the largest prison system in the country with 167,000. It
just recently surpassed California by a small degree, but that’s hardly a
competition you want to win. California and Texas have the largest prison
population with your own at 161,000 inmates. To put that in comparison,
you’ve got 161,000 inmates today. In 1977, you had 19,600. With this rate of
growth -- and I’ll leave the statistics. I won’t go through all of them to try to
avoid people falling off their chairs in slumber -- But the point of putting this
growth rate for you in terms of state and federal system, is to convey one very
important fact upon which to live your life as public officials. You cannot, and
you will not, build yourself out of this crisis. You simply can’t do it. The
federal government can’t do it. And believe me, states and the feds have tried.
We’ve had record construction in this country. But federal officials estimate
that in order to just take care of their increasing population, they’d have to add
a 1,000 bed facility every week. That’s not going to happen. We’ve had states
that tried to float bonds and to beat this race and they have failed.

SENATOR VASCONCELLOS: Including California.

PROFESSOR TURLEY: Including California. The result is that in
California, you’ve got some facilities now that are at almost 240 percent of
design capacity; 240 percent of design capacity. It is a virtual advertisement for
a lawsuit. And it’s going to come. The courts are quite clear. If you keep on stuffing prisoners into over capacity prisons, you’re going to get sued. But that’s not a problem. As a lawyer I can tell you, lawsuits just involve legal fees, which we are always grateful for. Your problem is that over design capacity at 240 percent, there’s not any mystery as to the conclusion of that lawsuit. At the end, the court is not going to order damages against the state, the court is going to order releases. And what happens with court ordered releases is, they take the prisoners with the shortest period to serve. This is not rocket science and it’s not surgery. It’s taking a cleaver; finding the leading end of your prison population and cutting it off. Ironically, that tends to contain your highest risk prisoners. So if you go into court ordered releases, you’re going to actually release the highest risk prisoners you can possibly release. The cost for that will be borne by citizens who meet those prisoners in their living rooms, and meet them on dark streets.

I’ve already mentioned that all 33 of your prisons are overcrowded and one-third is twice the design capacity. But let me get to your increasing older prisoner population.

There’s actually a typo on our report, something that academic just loves, and I’ll correct it now. In year 2000, the older prisoner population passed 100,000 inmates. Today we believe that population is around 110- to 120,000.

SENATOR VASCONCELLOS: In where? In the country? In here?

PROFESSOR TURLEY: In the country.

SENATOR VASCONCELLOS: In the country.

PROFESSOR TURLEY: Yes, Sir.

SENATOR VASCONCELLOS: All the systems together, or the federal
systems?

PROFESSOR TURLEY: All the systems together, Sir.

SENATOR VASCONCELLOS: Thank you.

PROFESSOR TURLEY: In the last 20 years, older prisoners have grown by 750 percent. To give you an idea using the federal system, in 1986, if you look at prisoners over the age of 50, they represented 11.3 percent of the federal system. In ’89, they represented 26 percent. By 2010, at a minimum with the most conservative projections, they’ll represent 33 percent.

In California, you have an estimate from the LAO, which does remarkably good work, and I commend the state for having such an office. Their estimate is that by year 2025, you’re looking at an over 55 population of 50,000, roughly. We think that figure is fairly conservative, but that’s what you should do if you’re projecting things for the Legislature, is be conservative. We believe it’s actually going to be higher. There’s no reason why California is going to be below the national average. And in fact, our indications are, it should be above the national average in both numbers and costs.

But there is one very important thing that I want to add here. It is a mistake for you to base your policy on the chronological age of your prison population. If you’re concern is with the ballooning hidden cost associated with older prisoners, do not, I recommend, make the mistake of looking at chronological ages. It’s easier because you have data on that, you can just simply pop it up, although California has some serious problems in terms of data. Very serious. But it should be easier to pick up those chronological ages. But what happens is that if you set policy on chronological ages, your reforms will not address the problems in 10 years. The reason is, that a prisoner is on
average between seven and roughly 10 years older, physiologically, than they are chronologically. Seven years is the lowest age.

**SENIOR VASCONCELLOS:** But that’s on account of the lifestyles that they’ve led --

**PROFESSOR TURLEY:** Yes. There’s a number of --

**SENIOR VASCONCELLOS:** Causing their bodies to deteriorate more rapidly.

**PROFESSOR TURLEY:** Yes, Sir. There’s a number of reasons for that. One is, most prisoners come to prison with a poor dietary history, chemical abuses. But more importantly, prison is a highly stressful place. There’s what’s called the wolf/prey syndrome for older prisoners. And stress ages people in a much faster rate. And, you can imagine the stress for an older prisoner. The best thing is, when you speak to someone who is in their 60’s and 70’s today, they’ll often talk about how they stay in their homes because they’re afraid to go out at night because of dangers in the neighborhood. Well imagine being a geriatric at 70 in a neighborhood entirely composed of certifiably violent people, and you get an idea of the stress level for older prisoners. That’s one of the reasons when geriatric units opened, they have an incredibly long waiting list as geriatric and older prisoners attempt to get into them. What we find is we go to facilities is that geriatric prisoners tend to congregate in hospitals or stay in their cells. We often have to go to cells to find these prisoners because they’re concerned. Even being in a hallway during a rush hour could be a very dangerous situation for an older prisoner.

So the health costs go up. So when you look at your population -- for example, Florida just finished a very interesting report that indicated that their
research shows that their prisoners are 11.7 years older than their chronological age. That’s on the top end. Seven years, we believe, is too low. But we, as a policy at POPS, tend to take the most conservative figures because we don’t like to be wrong. And so we tend to go with the lowest most conservative figures so we don’t overstate the case here. But in my personal view, it’s probably closer to 10 years.

So that means that when you’re looking at a 45 year-old prisoner, you’re very likely looking at a 55 year-old physically. A 50 year-old prisoner is likely to look like anything between a 57 year-old and 60 year-old prisoner.

You have to be concerned because that’s the reason you have some of these hidden ballooning costs. The per capita costs of your prisoners will increase because they will become more expensive because they’re getting older. And so what your system sees is physiologically older prisoners. What you see are chronologically older. And if you just deal with chronologically older, you will not control the ballooning costs.

Right now in terms of physiologically older prisoners, if you take the most conservative figure, right now you have about 17 percent in terms of physiologically older or geriatric prisoners in your system.

Now California also has a very familiar profile in terms of its demographic population. But the difference is, that California is more extreme in how it is expressed in your population numbers. The reason is, that all states engaged in some level of sentencing reform, but your state led that process. That is, as your state was early on in “three-strikes”, longer sentencing, some limitations on parole, limitations on compassionate release, practical or direct, so you’ve been doing it longer, which means that what’s happening is that that
bulge that we see between age 30 and age, roughly 45, is bigger, generally, in California than it would otherwise be. It also means that when that demographic shift, you think of this as sort of a boa constrictor and it’s moving down the snake. You’re about 10 years for when those prisoners are largely all in a category of chronologically or physiologically older and geriatric inmates. That’s why your prison system will change, is those will be different people. Same identity. Same names. Different people. Over 46 percent of your population, prison population is now 35 years or older. That’s the bulge in the snake. And that’s the wall you’re going to hit.

Now in terms of -- we put in the various charts and figures -- a couple of these charts did not make it with our transmittal from Washington, D.C. It’s another example of East Coast, West Coast lack of communication, but you have to forgive. A couple of these tables apparently exploded during our transmittal. As an academic, I just ask you to avert your eyes. But, our projection is that by 2010, you’re likely to be above the average 33 percent. All of our figures indicate that that bulge is just a bit bigger, so you should be above that figure if nothing is done.

The report then turns to what are called asymmetrical costs for maintaining an older prisoner population. This is where you hit that wall.

Nationally, states are spending between $30- and $50 billion a year, a rate that is twice that of 10 years ago. And it will likely double to $60 billion by 2010. Some of that is due to increasing wages and benefits for correctional staff. Correctional staff often cost as much as 50 percent of the operating budget of a facility. But much of it is due to the increase per capita costs.

Right now the cost of an older prisoner is roughly $70,000 a year, or
$67,000 a year. It is found to be two, and very often, three times the cost of states. That has been the situation since POPS was formed. What we see is that most states are pushing towards the three times provision rather than two times because medical costs are increasing.

To give you an idea, Pennsylvania spends about $78 per day on a prisoner. For older prisoners, they spend over $200. Now, those costs are fueled by a number of issues. But first, in terms of general costs, in terms of social costs, there are three types of basic social costs. One is, older prisoners occupy cells that are in short supply and extremely expensive to construct. At $100,000 a pop, these are not cells that are easily substituted.

So the second cost is that for older prisoners serving long term sentences, they fuel your overcrowding problem which can result in early releases. And so when you enter the overcrowded status, you then get into that perverse situation I talked about. That as states like California that are moving into acute overcrowding stages -- now your population has leveled a bit. But as it increases just with the natural growth, and it will increase, you’re looking at the danger of mandatory releases. Then we get into this rather perverse problem where you have a system that will be releasing younger prisoners at the height of their risk, and struggling to retain older prisoners who are statistically less dangerous. So you actually have a system that’s working the opposite of what public safety would demand. Some younger prisoners who are released are going to have a recidivism rate that will just spin your head, but they’ll still be released. Because what we know about recidivism, as we’re going to talk about, is that recidivism generally falls around age 30. So in acute overcrowding situations you have a state rushing to release that category.
In California, the annual cost of a prisoner is about $26,000. That’s about $4- to $6,000 more than most states that’s associated with your higher costs, which is not other worldly, it’s basically what a lot of states are experiencing.

An older prisoner in this state is likely to top out at over $60,000 to $70,000 a year. But once again, there is a surprising paucity of data in California. States that I generally to be less scientifically and administratively developed in terms of charting costs, have a lot more information than California does. We were able to get much, much better information from a lot of other states. You simply don’t have that data.

But let’s take some of these figures and run them through a projection. Let’s take the average cost of a prisoner in 2025 as $35,000 a year, which is the conservative cost we’ve been talking about with your staff. I consider that very conservative. And all the figures I’m about to give you I quite frankly think are wrong in the sense that they are too low. But let’s be conservative.

Let’s say by 2025 you’ve got a $35,000 per capita cost. And let’s take the most conservative projections. Now the LAO was looking in terms of their growth, I believe at 60 years and older. Obviously, we use 55 years, and we think that is low if you look at physiological age. So the LAO figures are already on the low side because they’re cutoff is higher than most states. But let’s just put all that aside and take your 60 and over figure and assume that that is going to be the figure, which I think is conservative. Now, let’s look at the multiplier. We know it’s between 2 and 3 percent. Because you looked at 60 percent and older, it should be three times higher.

But once again, let’s take a more conservative view and take a maybe 2.5
multiplier. That gives you a projected cost in that out year of $87,500 per prisoner. Once again, that is really conservative, because the figure today is believed to be $69,000 would mean that the rate of increase would have to decline dramatically. But just let’s take $87,500. If we multiply to the year out in terms of the growth, you’re looking at over $4 billion budget for your older and geriatrics. That is equivalent of your current correctional budget just using to maintain your older and geriatric prison population. The implications of that are pretty serious.

If you hit the wall and you have the demographic shift, the budgetary growth exponential in some categories, something is going to give. And you’ve got a very good correctional staff, and sometimes correctional staff look at this and are uneasy sometimes with reform, but, what should concern your correctional staff quite simply is, if you hit that wall, something is going to give. You’re going to have to freeze and cost contain. You’re going to have to rollback on benefits for correctional officers. You’re going to have to freeze construction. When you get to that point, you sort of reach a correctional version of the China Syndrome. Things get out of control. You can’t just freeze and stop because your system is overheating. So that’s the reason time is of the essence. You can wait around, and this ticking bomb will go off. But at that point, there is going to be a world of hurt. And so that’s the reason we’re encouraging you to take steps now.

Let’s finally look at that last horseman as I referred to in recidivism. And I’m just going to briefly talk about this because I’m running out of time.

I talked about earlier that your recidivism rate is one of the most astonishing things I’ve seen. This is a pretty dangerous state, quite frankly. I
used to spend every summer here when I was a kid and I never thought it was nearly this dangerous. But it sure is dangerous. Your recidivism rate is a public safety crisis right now. It’s not a projection, it’s a crisis right now.

With all of the expertise California has, with all of the smart people in this state, you can throw a stick and hit 10 universities in this state. I can’t imagine why this state has allowed recidivism to get this high. Recidivism is not that difficult to figure out. There’s ways to reduce it. And those methods are not being used in California. But it’s not an abstract academic issue. The thing that concerns me most about here is, there’s real people that are being victimized because the state isn’t making logical choices. It’s not managing the prison population. It is dealing with sort of a warehouse approach in which prisoners are released in a conduit system. And that’s sort of having a system without any safety effects. It’s like having a nuclear reactor with just a turn on and off switch. It doesn’t have safety features.

And what concerns me as an academic is, usually when I do this stuff it’s a fairly abstract cold record. But when I look at your recidivism rate, all I see is a whole bunch of people being victimized that don’t have to be victimized.

Now clearly, that recidivism rate is probably higher because you have so many parole releases. You’ve got as many as 100,000 who might be released in a year or more. And a lot of those parolee revocations are for technical reasons. But if you take those off the board, you’re still looking at a really high recidivism rate.

Recidivism is a tough thing to gauge because it depends on how you define it; whether it’s a return within two years or three years; whether you’ve got a revertible recidivist or a habitual offender; all of those are terms that
frankly we debate all the time. I don’t like cutoffs on recidivism. I think that looking at two to three years is remarkably stupid, but we all do it. Because it doesn’t matter to a citizen that they happen to be knocked over the head by someone in their third year. I mean to me, the recidivism rate you should look at is how many end up back in prison? I don’t care if it’s three years; if it’s seven years or 10 years. Your obviously, this is someone who’s ending up back in prison, and so those figures are subject to debate. But even if you take the most conservative ones, this state is pretty bad.

Let me push ahead. I gave you some of the statistics on New York and Illinois which sort of chart these things, and I’m not going to tell you about the history of the Project for Older Prisoners. We have some pictures of some of our prisoners from the Project of Older Prisoners. I use those pictures because they show me when I was about 30 pounds lighter and with not a gray hair to be seen, otherwise I’d be confused with our clients.

But this POPS project, the Project for Older Prisoners, started when I was teaching at _________ Law School and has grown to have offices around the country. We talk about, in the report, of how we were founded. But let me cut to what we do.

POPS basically does three things. We do individual case evaluations. We do state evaluations and recommendations. And we do legislative drafting. We do this pro bono. All of the POPS offices work out of law schools. Volunteer students occupy the offices with a supervising law professor and a staff of attorneys.

For individual recommendation, POPS, individual case evaluations, POPS will take a prisoner, assign a caseworker who will interview the prisoner a
number of times, will look at the prisoner’s criminal history, medical history, chemical dependency history, that pattern of criminality that we talk about. They will look at the prison jackets, speak to the correctional staff, look at the write ups, disciplinary accounts and hearings. They will then chart the prisoner in terms of two separate recidivism analysis. We’ve gotten very good at predicting recidivism in this country because of the advent of computers. We’ve become very good at it. And it’s a resource you can use. What we do is, we take, once again, a very conservative recidivism evaluation and only recommend prisoners for release who are low risk on both tests. If the prisoner passes that test, the student goes back out into the field and determines what the view of the victims are on this issue.

We’ve had a victim’s consultation stage since the beginning of POPS. It was the first that I had heard of and we’re very proud of that. We have, in fact, turned down people on the basis of the interviews with victims even though they’re statistically low risk. Sometimes in the victim’s interview you find out things that a cold record does not indicate. Sometimes you find out that prisoner left something out.

The rule we give prisoners that we interview when we go into a state, we gather them together in their facility and I tell them that they have one rule. If they lie to us, they will never, ever be considered for POPS again. If there is one fact that they have misrepresented, augmented, changed, they will be taken out of the system and we will not review them.

So, sometimes in the victim’s interviews we find that prisoners have left something out and that could be quite significant. If it turns out that the victims do not oppose release or do not have anymore information, the student
presents the case to the POPS members. They vote on it and we often, if all of those things check out, will recommend the prisoner for parole or probation or pardon, depending on the state. And we present all of our findings, including where the prisoner will live and what the prisoner will live on, to the appropriate board. That is the reason we have had hundreds of releases and zero recidivism.

SENATOR VASCONCELLOS: Zero.

PROFESSOR TURLEY: Zero. As far as we know, no POPS prisoner has been reincarcerated. Eventually we’re going to have one. It’s just a matter of statistics. But we’re very proud of that recidivism rate. But it’s because we really sweat the specifics.

We also do state recommendations for reform and legislative drafting. But let me finally get to -- and I’ve overstayed my welcome -- let me finally get to the specific reforms that we encourage for the state of California.

Attorney General Janet Reno, while she was still attorney general, who made the common sense observation that you don’t want to be running a geriatric ward for people who are no longer dangerous, that seems pretty true and unassailable. However, an older prisoner population has the same range of prisoners as the general population. So just looking at age alone is a dangerous thing.

We don’t want this state to say, yeah, if you’re 55 years or older, you’re going to be eligible for early release. In fact, we opposed and helped defeat such a law that was proposed in Washington, D.C. to release people primarily on age. We opposed that law because we believed it did not adequately take into consideration risk to the public.
You have to assume that your prison population will have three basic categories of inmates; low-risk, mid-risk, and high-risk prisoners. Your task in the next two decades will be to develop a system that can isolate and evaluate where the prisoners fall in those three categories and then have a corresponding method to deal with them.

And on this, I want to emphasize that we often talk about releases. I strongly encourage you not to do this as an issue of early release. Early releases have to be a part of your solution and some of your greatest savings are not going to be in early releases. But if you just do early release, you’re going to have that problem that they describe in the military, that if you only have a hammer, everything looks like a nail. So if you only have release, everything gets put into terms of can we release them, that’s a dangerous thing. Because if that’s your only valve, you’re going to release people that you shouldn’t release.

Now, the low-risk prisoners are the ones that you’re going to want to identify first. Now, since you all are sort of starting from scratch, you should have some considerable savings up front. And so, you identify your low-risk prisoners using recidivism tests.

First, doing a cutoff -- we use 55. You can actually go to 50 for women. Women have a lower recidivism rate, period. And, you can go lower if you want, or you can make it 50 and have a staggered criteria, where the recidivism test is more extracting between 50 and 55. There’s lots of ways to do it. You certainly don’t want to end with an equal protection issue, so you have to be careful on that.

And so, you’re going to have a group of prisoners that can be released.
On that, the only real vehicle you currently have is your compassionate release provision. That provision from what we can make out, is underused, has increasingly been used less, and has all the normal problems of compassionate release. It’s not California, and I don’t mean to dump on California here. I really don’t. Compassionate release in your provision reads a lot like some other states. That’s not good, because most state’s compassionate release programs are virtually not used and neither is the federal system. And the reason is, is that there is a lot of paperwork, a lot of delay. Often the prisoners or families don’t know how to do it. They’re not given very much help. But also, compassionate release programs are designed largely for people who will be dead in six months. That’s the standard. Most people look to say, we want a doctor to come and say, this guy is going to be dead in six months. And if you use that practical requirement, very few doctors are going to stand there and say, talk to me in seven months at the funeral. They’re not going to do that.

And so you have lots of problems in terms of medical projections when you use the compassionate release. But your compassionate release program will create a bottleneck problem. You can’t use it for these purposes.

But what I encourage you to do is, when you look at compassionate release, you should look at it generally because it’s not just for older prisoners, but incapacitated prisoners, HIV positive prisoners. Lots of prisoners that California has to deal with where you could tinker with it and have a better effect.

But what you need is a formal system looking at low-risk prisoners for release that also contains a post-release plan which I’m going to get to. These releases can obviously save you a lot of money. The release of only 500
inmates could save you as much as $15- to $20 million. LAO is projecting in terms of 200 and 300 inmates, a savings of $9- to $14 million, I believe. In that in 20 years you could divert as many as 12,000 prisoners for a net savings that could be in the hundreds of millions of dollars.

But the reason I passed over that quickly is because that’s a part of the report that legislators often put a little sticky on.

Every time I go into a state, particularly like California, because you can have a huge amount of savings because you’re starting from zip, people look at that figure of hundreds of millions of dollars and it’s like Pavlov’s bell.

But, here’s my caveat, and I hope you will take this seriously. Some of that money has to be put back into the post-release plan. The reason POPS has been successful is because we sweat the specifics and find where this person’s going to live; what they’re going to live on. We even submit pictures of where they’re going to live. We make sure they’ve got room where they’re living. We find out who owns the house. We find out how much room they’ll have. Is the place accessible to an older person? It’s not that expensive to do that. But it can be the difference between zero recidivism and greater recidivism. It’s called a soft landing.

And a soft landing requires you to setup the older prisoner with some regiment. Older individuals actually prefer regiment that we’ve found in studies. They tend to gravitate towards regiments in terms of taking their pills, in terms of their movements. Regiments are good. If you setup a regiment for a geriatric prisoner, the prisoner will stick with that regiment and will not divert.

One of the biggest problems we have with older prisoners and we get
them released -- we had one guy named Noah Wade, who went to prison in 1944. We got him out in like 1991. The man was like Rip Van Winkel. He didn’t know how to open my door of my car because it had a flush handle on it.

Now, take a Noah Wade out into society was a problem. And the biggest problem we had with Noah was, he wouldn’t leave his room at the nursing home. Older prisoners are terrified of going back to prison. And so, faced with the outside, they’ll often stay like they do in a cell. They’ll stay in their room and we get calls from nursing homes that say, Noah won’t come out. Noah won’t go into the hallway.

So, that gives you an idea of how these older prisoners respond. They don’t want to go back in. They are more frightened of society than society is frightened of them. These people who have low recidivism rates, are projected risks than the students I drive to prison with.

The other thing that you have to avoid is what you had recently in California, which was an individual like Covell Russell, who was released in his 90’s without any soft landing. He quickly exhausted what savings he had. He was suffering from geriatric illness, gerintological illnesses. And he described release as a form of physical and mental torture, and he tried to get help. And when it wasn’t forthcoming, he committed suicide.

When I read about Russell’s case, it moved me considerably because I know people like Russell across the country. And I viewed his death as entirely unnecessary. This was obviously an individual who was prepared to live and not recidivate, and it would have taken very little to keep that man alive.

For mid-risk prisoners, you’re not looking at early release. Now what we consider to be mid-risk prisoners, most states would view as low-risk. But we
tend to be more conservative so we call them mid-risk prisoners. And for mid-risk prisoners we recommend alternative forms of release, which would be electronic bracelet programs which can reduce your costs from over $60 a day, and some cases, $70 a day, down to less than $8. Some states have brought it down to $5. I expect yours is going to be closer to $8 or a little higher. For a lot of these prisoners, particularly ones that are barely mobile, you can put an electronic bracelet on them, improve their care, reduce their costs.

For high-risk prisoners, we recommend geriatric units but can reduce your costs by the economics of scale by collecting them and buying in bulk and dispensing in bulk medical services. You can dramatically reduce your costs and improve care. It is a win/win situation. You avoid illnesses. You reduce the cost of those illnesses.

What I encourage you to do -- and I’ve got to tell you this, and I don’t mean to be cocky here, but, you’re going to have geriatric units. I mean, right now you don’t have them, but you’re going to have geriatric units. Whatever the feeling, the current feelings of CDC or anyone else’s, by 2025, you’re going to have geriatric units because you will have no choice. The question is, do you create them now or then? Do you create them with time, or do you create them in an emergency? But you’re going to get geriatric units and that’s the trend across the country.

What I recommend is, that your geriatric units are spread throughout the state. One of the concerns we have with consolidation, it’s better for the older prisoners. There’s less stress, better care. But one concern we have is, putting them at a distance from family members. Older prisoners have a higher incidence of depression, of angst. Having access to their families reduces that.
And so, it’s better to have not one gigantic geriatric facility, but a series of smaller ones between 3- and 500 units preferably, that will put them in rough geographic proximity to their families.

Let me conclude -- and thank you very much for your patience -- let me conclude that I commend you for the leadership that you’ve shown here. Maybe this was caused by the budgetary issue. I know many of you have been citing this for years. I know that Senator Romero recently wrote a piece in the L.A. Times. I know that Senator McPherson, Vasconcellos, have been working on these issues for many years.

But what’s happening is that in the budgetary crisis, you see the superstructure issues of the prison and it is forced you to look at what’s below the surface, which is a far more serious problem. It is, in fact, a ticking bomb. And you can disarm it right now. You can make sure it doesn’t go off, or you can wait. But waiting will come at a cost in our view, and it won’t be just borne fiscally.

Thank you very much, and I’ll just stop there.

**SENATOR VASCONCELLOS:** Okay. Bruce. Questions? Comments?

**SENATOR MCPHERSON:** A lot of information that we have to really take into account here. It’s just the cost factor is much in the recidivism. It’s down to 3 percent or so, did you say of most of those prisoners? Was it the Illinois or New York study, recidivism of the older prisoners who were taken out of the system?

**PROFESSOR TURLEY:** Yes. In fact, when you go to 60 and above, the recidivism rate is right on the floor, like 3 percent, which is nothing. That’s going to be just a statistical reality. And, you have to assume that if you release
older prisoners, or any prisoners, you’re going to have some recidivism. But 3 percent is something for this state to dream of right now. But if you go from 50 to 60, it will be slightly higher. But the highest we’re seeing in this areas is like 10 percent, which is pretty good for citizens.

And the other thing to keep in mind, Senator McPherson, is that in its state of chronic overcrowding, the question is not whether someone is going to be released, but who? And you can choose who. If you don’t choose, then the way the system works is the wrong ones are going to be chosen.

SENATOR KARNETTE: I have a question on that.

SENATOR VASCONCELLOS: Senator Karnette.

SENATOR KARNETTE: You say that the courts would automatically release the prisoners that had the least time to serve. Well why is that so? I mean, why can’t that be changed? Why can’t good cases be brought to release the people who are the least at-risk. I don’t understand why. I’m not an attorney.

PROFESSOR TURLEY: No, no, Senator. It’s an excellent question. There’s a couple of reasons. One is, political, and one is legal.

The political reason is that at a time of overcrowding, what’s interesting is that you’ll turn on the news and you’ll find an official standing in front of a prison condemning some federal judge for releasing dangerous prisoners. What is not expressed is that that official knew probably four years before, that prisoners were going to be released and could have done releases. But the difference is that, when those prisoners are released, there’s a judge’s signature at the bottom of the paper and not their own. So if one of them ends up committing a new crime, you can just blame the courts, even though you
created the conditions that lead to the releases. So there’s a political dimension there. It’s a terrible dimension, where many officials prefer to go into chronic overcrowding simply to force some judge to release them and take responsibility indirectly. The legal reason is, that if you don’t have any releases by the time the court order hits, when these court orders -- a vast majority of states have been, or are under court ordered releases or overcrowding orders. Look at them in that virtually none of them really made significant early releases. So when the deadline comes up and the federal judge is not going to wait for perpetuity -- when that deadline comes up, that judge is going to say, you’ve got to reduce by 10 percent. And the judge says, how many of your people are serving for less than a year? That’s typical. Or less than two years? They get the numbers and they say, they go first because they are offenses that are lessor offenses. Well the irony is, that the people who are committing those lessor offenses are often young prisoners who may have a record going from juvey all the way up to early adulthood. So that’s what would happen.

SENATOR KARNETTE: Well it seems like that would be a logical thing to change. I don’t know how to do it, but if I were going to change something, I think I would change that. If I thought a bill would do it, I would introduce one. But I don’t know how to go about doing that.

PROFESSOR TURLEY: Well it can be done as part -- you can do a couple of things. One is, you can do it as part of an overall reform package for older prisoners.


PROFESSOR TURLEY: The other thing that you can do is, you can
actually legislate emergency steps taken for overcrowding. I mean with 33 of your prisons beyond design capacity and one-third twice that, you could actually do legislation if you wanted to. That would be a formalized system of releases when you get beyond a certain capacity. That would become automatic.

**SENATOR VASCONCELLOS:** Senator Romero.

**SENATOR ROMERO:** Professor, I want to thank you very much for your remarks, for your paper. I very much have appreciated you coming and examining this issue for us. And we look forward to working with you as we work on -- as we scrutinize this issue this particular year.

With respect to recidivism. I absolutely agree with you 100 percent, that we do have a major recidivism problem in California. Under the auspices of the California Correctional System Select Committee a few weeks ago, we did have a hearing taking a general look at Corrections. And, of course, the issue of recidivism stood out. The timeline by which we monitor as well, two years makes no sense. I hope that we can look at the long range. As well too, I think also beginning to examine our youth population -- and we haven’t even touched on the youth authority and how that feeds into CDC as well. So there is much to be done there with respect to recidivism.

I think that in terms of policy issues though, I do think that we need to take a look at why California appears to be parole happy, and how we revoke and put people back into the system based on minor technical violations. I do think that’s a major issue.

I’d like to say that I very much concur with one of your conclusions that we can’t build ourselves out of this problem. We cannot simply say, there is a
major crime problem out there. I think more so what we’re looking at is, how do we sentence and how do we manage and how do we assess those inmates who come into this situation. And I would add to that as well, to nor could we simply vote ourselves out of this problem as well. I fundamentally believe that more “three-strikes” type legislation is not going to solve the problem. And certainly for our children and our grandchildren, as well.

With respect to your distinction between the chronological age and the physiological age, I think that’s very valuable for us to examine. And I think it also, I believe, raises the veneer as well too, to take a look at even the people who we see in our criminal justice system, and raises the questions as to a whole host of other sociological factors that bring people into the system to begin with.

So we have a lot of reading to do once you leave. I very much appreciate and want to take a look at what has been done in other states. I would be very interested in further exploring with you the program with POPS and how we can achieve and reduce recidivism, because it should not simply be a revolving door.

And one final thing that I would add as well too, I think that much of this scrutiny of our geriatric population, as well as all the population, is to also reexamine the mission of CDC. I do believe that at some point we have to take a look at rehabilitation as a vital part of CDC’s mission and not simply a warehouse to incarcerate people. And until I think we can get to a philosophical change with policies and programs to get to that, I think we’re going to keep seeing those four horsemen coming at us faster and faster. So thank you very much.
SENATOR VASCONCELLOS: Thank you very much. The next up we have an old friend, Mr. Secretary, Senator Presley. Bob Presley was in the Senate for some number of years; once upon a time a sheriff. Secretary of the Youth and Adult Correctional Agency. Bob, welcome back. With him, Michael Pickett, Deputy Director of the California Health Care Services Division.

SENATOR ROBERT PRESLEY: Mr. Chairman, it’s a pleasure to be here. I think we have heard a lot of information. I agree, a lot to digest. We have people around the table here representing the medical side of Corrections and parole side of Corrections, which I think can respond to a number of your questions.

Having voted for “three-strikes”, maybe I -- I know you didn’t.

SENATOR VASCONCELLOS: I didn’t. I proudly didn’t.

SENATOR PRESLEY: But in terms of what we’ve been trying to do. We did put together a report, a taskforce on aging population three or four years ago.


SENATOR PRESLEY: And we wanted to place a geriatric prison pretty much over at San Luis Obispo. And one of the reasons for that is, there’s a 100-bed hospital there. It’s an older prison, built, I think, around 1960, somewhere in there. We think that by doing that we could have prisoners, all geriatric in this particular prison, that would make life better for them, and they’d have the medical facilities available. And we thought we could probably save some money on the side of security. It would probably lessen your security cost. And
a big one is, to lessen the medical transportation cost. So many of the prisons have to transport people out for hospitalization, for dialysis, for all these kinds of major medical purposes. It takes correctional officers to go with them, stay with them the whole time for security reasons, custody reasons. So it’s a very expensive proposition. To the extent that we can do all of that in one facility where the transportation costs are reduced would save considerable amounts of money.

We’re pursuing now, a way to try to establish a dialysis units within the prison system so that you cut down these transportation costs.

In terms of what to do about all of this. I had a couple of ideas, but after hearing the professor, I’m not sure any of them fit. I thought that, just thinking off the top of my head, if you want to find a way to release some of these people earlier, and I don’t like that term either, that’s a political no no, if you release people early. But I was thinking of a system where you could setup through the Legislature here, a process and a procedure where, I don’t know how you could do it, on a basis of classification or you could do it on low-risk, or you could do in it on age and say that when they reach that particular level or age, whatever you select, they would be eligible for a hearing before the parole board. In that case, they would all be treated individually. You could take in each individual case.

As was pointed out, a person released with 10 months could be very dangerous and another one on the other hand would not. So a system like that, I think could be worked out, where they could be treated in a lot more individually so that the individual review before they’re released out to the public.
I don’t think that much further, Mr. Chairman, I can answer any questions later. But we do have people that can respond in the medical and parole area, particular, which I hear mentioned here this morning. I don’t know which one you want to start with. Mike, do you want to start with the medical?

MR. MICHAEL PICKETT: Good morning, Senators. My name is Michael Pickett. I’m Deputy Director for Health Care Services for the Department of Corrections.

Just briefly, Senator Romero, to answer one of your questions earlier, there is no class action litigation as far as the elderly or geriatric. There is, or are, a number of class action lawsuits which have scripted, if you will, and set forth certain requirements on how we deliver mental health and physical medicine healthcare within the Department of Corrections.

The physical medicine side, we’re in the first year of a seven-year rollout which will determine how, and somewhat fundamentally change, how we deliver healthcare in this department. We are focusing on a chronic care delivery system. We’re in the first year of it, as I said, for seven institutions this year. It does not differentiate, if you will, specifically by age. It focuses on chronic care issues, sets up the procedures and protocols, if you will, no matter whether you are 30 years-old, or whether you are 60 years-old, and it starts when you enter the system; it follows you all the way through.

The obvious hope is, if we are to do a better job of treating initially, that there will be some benefit of that as far as health care costs later in life, especially if the inmate stays with us for a prolonged period of time, which is not unusual now.

Within that, and to address the LAO briefly, we do have a highly evolved
classification system for inmates in the state of California. Overlaid on that is the medical need, or the psychiatric need, for the inmate. If there are specific needs, be they aged or for some other chronic medical problem, or psychiatric problem, we then place the inmate within one of the 33 prisons we have commensurate with what that need is where we can best provide the service, be it medical or psychiatric.

Four of our institutions have licensed hospitals. Another 17 or 18 have step down facilities which are still licensed beds, which we call correctional treatment centers, and then a further step down past that for what we call outpatient housing units, what we used to call infirmaries. They are spread statewide and give us an opportunity to deliver a broad range of health care to the inmates.

We would not disagree with some of the information you’ve been presented with. Number one, I don’t think we would disagree that the chronological age and the medical age, if you will, there’s probably a 10-year offset in that. And I think that a lot of the information, some of which we provided with the committee, would tend to validate that.

At least two-thirds of our medical expenses are for inmates that are younger than age 55. The population that is over 55 does not drive the bulk of the money that we spend in contract medical, per se, which is medical services outside of our institutions that we contract with. It’s more in line with 35, 36 percent. The rest is spent on inmates that are younger than that, and a lot of them in that mid age, their 30’s and 40’s.

**SENATOR VASCONCELLOS:** What percentage of inmates are in the older category?
MR. PICKETT: About 3 percent to 4 percent, Senator.

SENATOR VASCONCELLOS: About 3 percent, so they don’t take a majority. That’s no big surprise, man.

MR. PICKETT: I would agree with you.

SENATOR VASCONCELLOS: But what I heard this morning from Professor Turley and the Analyst, as well, is that younger group now that’s taking the majority is going to be older and still in prison under “three-strikes”, and it will be explosive. They won’t be a minority anymore. They seems like they’ll be 30 percent.

MR. PICKETT: I cannot disagree with that, Senator. That age group, or the bulge as you refer it, any reasonable person would agree that it is going to move along the age continuum. And I would also tell you that some of the data we have given you will show that there has been an increase in the last 10 years in the average age of our inmates who are using outside medical beds. It is up to about 43 ½, age 44. And it started out in the mid 30’s maybe 10 years ago. So we are also seeing the increase.

For better or for worse, the litigation that we have, and the course that the department has taken for some time has been not to look at the geriatric population as a separate entity, I guess, if you will, but rather as a part of the total population that we deliver health care to.

I will tell you that one of the problems I think we face, is as the number grows, and the number -- that 3 percent number gets higher. It’s roughly 6,000 now, that are age 55 and older. Surely that number will grow. We’ve seen it grow in the last 10 years. That population becomes more difficult to separate out and to treat if you were to try and isolate it, for lack of a better word. Thus,
we have it. We maintained that it’s spread throughout the system and within
the delivery system that we have. It becomes more and more problematic to
build big units just for that purpose, especially when you have to consider the
mentally ill; how we treat them; where we have them housed; which are specific
entities and then try and overlay the medical on top of that.

I will tell you that for years, and we --

**SENATOR VASCONCELLOS:** I have no idea what you’re talking about.

**MR. PICKETT:** Oh, I’m sorry, Senator.

**SENATOR VASCONCELLOS:** It doesn’t make sense at all. You’re meaning, as you’re going to have 15,000 folks who are in wheelchair geriatric, you’re going to keep them in the same prison place as everybody else? Is that what you just told me?

**MR. PICKETT:** I would tell you that, no, we’re not going to do that, Senator. It’s very problematic to do that.

**SENATOR VASCONCELLOS:** Okay.

**MR. PICKETT:** Which is basically why we have them spread throughout the system. So my only point was, that it’s very difficult for us to try and put all of one group in one prison It’s impossible. We can’t do it.

**SENATOR VASCONCELLOS:** Because? You’re declaring it doesn’t make it so. Tell me why.

**MR. PICKETT:** Basically, we don’t have enough room.

**SENATOR VASCONCELLOS:** Oh.

**MR. PICKETT:** So the system remains decentralized, if you will, throughout our 33 prisons.
SENATOR VASCONCELLOS: I guess either I’m slow, or you’re not clear.

MR. PICKETT: Senator, I’m probably not explaining it well.

SENATOR VASCONCELLOS: I mean, you’ve got so many people and so many prisons, and why you couldn’t move 20 from here to here and 20 from here to here, and have those who are geriatric and fragile and can’t move in the same place, you still have 20 here and 20 here and I don’t understand -- there is something missing in your logic or else in my understanding.

MR. PICKETT: I don’t think anything is missing in your logic, Senator. I mean, it’s basically how we’ve setup our system.

SENATOR VASCONCELLOS: It’s how you set it up. It makes no sense, but that’s the way you set it up.

MR. PICKETT: Right.

SENATOR VASCONCELLOS: Senator Romero.

SENATOR ROMERO: Let me ask a question, and this can go as well to Senator Presley, as well too. You’re giving us these figures, or these, I guess, observations probably more so, because I haven’t heard any hard statistics. The report that was done internally to the CDC in 1999 did make a number of recommendations. It did call for the creation of a taskforce and working groups in order to go through this. I mean, I’m sitting here looking at two pages at least, of recommendations. And I would hope at some point we can walk through these. And I would ask for one by one to walk through this.

The first question I would ask is, has this taskforce ever been convened since 1999? My understanding, it hasn’t, and it’s now 2003. But I hope I’m wrong.
MR. PICKETT: That’s my understanding also, Senator. It has not.

SENATOR ROMERO: So the internal planning document back in 1999 called for the taskforce to be created and as of 2003, something as simple as that, hasn’t been done? I mean, can I just get an answer as to what happened along the way? I mean, why was it never --

MR. PICKETT: Senator, I’m not sure if I can give you an answer to that.

SENATOR ROMERO: Can anybody?

MR. PICKETT: I don’t think any of us were in health care at the time. And that’s not a copout, so to speak. But my guess is --

SENATOR ROMERO: Let me as Secretary Presley. Can you just let me know why?

SENATOR PRESLEY: The nearest thing that I could come to in answering your question is, after this was put together we submitted what’s called a GAR to the governor’s office and we never got a green light on it.

SENATOR ROMERO: Was there a response? Was there any discussion?

SENATOR PRESLEY: No.

SENATOR VASCONCELLOS: So you blame the governor for this?

SENATOR PRESLEY: Pardon me.

SENATOR VASCONCELLOS: You blame the governor for this then?

SENATOR PRESLEY: No. I’m not blaming the governor.

SENATOR VASCONCELLOS: No, we should. We might as well. I mean, someone --

SENATOR PRESLEY: I think they were just loaded with big problems and this was --
SENATOR VASCONCELLOS: Well, we asked for a study. You people do a study and recommendations and a report and nothing happens, someone’s responsible. And if you aren’t, then I guess the governor is. And I guess _______ thinking we can trust you people to do something, which is a really tragic failure of __________

MR. PICKETT: Senator, if I could add one more -- I think shortly after that, the department and the plaintiffs in the most recent class action for medical services began in earnest the negotiations, if you will, for a settlement in the Platta lawsuit, which determines how we provide physical medicine that we currently have. And I think that the focus at that time became less on the aged, if you will, and on dispensing health care in general. And I’m not making excuses, I’m just saying that shortly after that at about that point in time, I think the focus primarily shifted towards medical in general, and in working out the agreement.

SENATOR ROMERO: You know, I appreciate that there are lots of balls bouncing, but this is a very complex issue. But nonetheless, delivering services is an important reality that you have to undertake. But at the same time, the issue of the aging of our prisoners continues to go forward, and I don’t necessarily see it as an either or. They really are two different components of our prison population that we need to address.

Secretary Presley, if I could ask, I’d like to actually see a copy of that GAR. If you would provide it to the committees I would appreciate it.

So, I guess the rest of my questions are almost irrelevant at this point because given that the taskforce has never met --

SENATOR VASCONCELLOS: Your questions aren’t irrelevant, the
answers would be irrelevant.

SENATOR ROMERO: Right. Any of these questions that I think, and actually some of these are quite good. Basically I guess we really are starting at scratch today, that we have, even though it’s been some years since this was recognized as a problem, and I do applaud the CDC for recognizing that a problem exists, the conclusion is, at this point we simply ignored what we realized some years ago and we’re starting from scratch today.

SENATOR VASCONCELLOS: Okay. Do you have more that you wanted to tell us?

MR. PICKETT: Just one more. There was some discussion earlier by Senator Karnette in reference to parole placement, Millicent Gomes is at the table, who was in charge of the transitional unit which transition inmates with mental health and physical medicine needs from the institutions to paroles, and I’ll turn it over to her to provide the senators with any information she can.

MS. MILLICENT GOMES: Good morning. My name is Millicent Gomes. I’m the health administrator for the Parole and Community Services Division, and I would like to share with the committee a brief statement on some of the program impacts, or some of the parole problems that we’ve experienced with just releasing inmates that have onto parole normally with medical problems. I know that some of the questions that Senator Karnette was asking was in regard to Medi-Cal and Medicare and those issues.

I’ve been personally involved in over 150 medical placements during the course of my employment in the last couple of years with parole, so I’m intimately familiar with some of the problems that are associated with finding facilities to take our folks.
Privately owned and operated skilled nursing facilities are not required to take parolees. Many of them fear the stigma associated with treating and housing ex-offenders, and their reputations in the community may suffer by taking ex-offenders.

In one particular recent case, we had a skilled nursing facility that was being picketed in the Los Angeles area for having accepted a sex offender into their facility.

Parole has had to continuously pick up the tab, if you will, for paroled medical placements with no budget for medical services in the interim time before Medi-Cal or SSI or other federal benefits can be secured at sometimes a very long delay. It is very difficult to preplan to get benefits in place when you can’t guarantee a placement ahead of time because the skilled nursing facilities are unable to guarantee whether or not a bed will be available in that particular county to accept these individuals. Keep in mind, this is just in regards to people who require medical attention and skilled nursing facilities upon their release, but knowing that the impact that it does have and the program areas it does impact.

Imagine if you will, a case that we currently have looking to secure a skilled nursing facility is a quadriplegic yet can use one arm to hit people that get close enough to him. To bathe, or feed, or otherwise provide services to him, he is verbally abusive and loud due to traumatic brain injury, incontinent, has Hepatitis A, B, and C, and spits on people.

Over 400 skilled nursing facilities were contacted in this particular case throughout the state and needless to say, this case was not an attractive candidate for the skilled nursing facilities. Seeing as Medi-Cal rates are $149 a
day, which adds to about $54,000 a year, and this particular person was only 49 years-old and not eligible for Medicare, which would have paid $169 a day at a cost of about $61,000 a year.

This is just but one example that requires the special assistance in pre-parole planning. Now to combat these issues, we’ve been able to divert limited resources from our transitional case management program for the HIV population, to assist in the pre-parole planning for these individuals who are coming out on parole anyway. So we have four social workers throughout the state that assist the parole division in these difficult placements.

So, I just wanted to share with the committee some of those particular issues and what parole has been doing to sort of get ahead of the game in this particular case.

**SENATOR VASCONCELLOS:** Well one suggestion that has been floating around, I have a bill to either create some skilled nursing facilities within our system where we would take care of our own people at a far lessor cost and take care of those placement problems that you’re experiencing.

**MS. GOMES:** Yes. Yes. And we do have severe placement problems.

**SENATOR VASCONCELLOS:** Thank you. The next up.

**SENATOR KARNETTE:** I have a comment.

**SENATOR VASCONCELLOS:** Senator Karnette.

**SENATOR KARNETTE:** Do any of the inmates, and I know this is a problem, you have to work with the unions on this, I understand that, but can any of the inmates take care of others? Do you use inmates to -- you must do that some -- that want to take care of patients as sort of a training, job training or something? I would think that there would be some.
MS. GOMES: You mean within the community?

SENATOR KARNETTE: Within the prison itself.

MS. GOMES: Oh.

MR. PICKETT: No, Senator.

SENATOR KARNETTE: Could that be done?

MR. PICKETT: I believe not, and I’d have to check to be specific. But licensing requires that it be licensed medical personnel, doctors, RNs, medical technical assistants. And we used to use inmates, but have gotten away from that in the last 10, 15 years. All of our facilities have gone to be licensed.

SENATOR KARNETTE: But is it possible? There is training of one kind or another in prisons. Not enough, but there is some. Is it possible to train inmates to be -- to have a license that they could use later on? Is that a possibility?

MR. PICKETT: That I am aware of, we don’t have any programs that train inmates for anything in the health care field.

SENATOR KARNETTE: Is there some reason why we don’t, or is it something nobody thought of, what?

MR. PICKETT: We used to have some programs, and I’m -- this is going back a ways -- for x-ray techs, but as far as a caregiver, that I am aware of, we have never done that.

MS. GOMES: Also, Senator, I believe that there are some issues in regards to confidentiality of information with other inmates having access to that information.

SENATOR VASCONCELLOS: Well there’s certain levels of service that require for licensure, some professional training and probably
credentialing, but there are some like feeding people who are ill that probably
don’t require that.

**SENATOR KARNETTE:** That’s what I was thinking, yes.

**SENATOR VASCONCELLOS:** _______ imagination could be thought up if someone were thoughtful about it. It wouldn’t require confidentiality.

**MR. PICKETT:** The only area I’m aware we do it is at the hospice at CMF. They’re not specifically used as caregivers. I believe they do feed. But past that, I’d have to go to check and see what the requirements are and what precludes us from doing that. I can just tell you that, we don’t have any programs where we’re formally, as a vocational issue so to speak, where we are doing that.

**SENATOR VASCONCELLOS:** Okay. The next up.

**MR. MIKE BRADY:** My name is Mike Brady. I’m with the Youth Adult Correctional Agency in the Board of Prison Terms. I wanted to address a couple of issues here. And we’ve broken out some numbers on the recidivism rate for the 55, 60, and 65 population in our population and California doesn’t track with the national statistics.

In 1998, the age 55 plus we had a 20.3 percent recidivism rate on the 55 plus population. We had a 17.1 percent population of recidivism rate on the 60 plus population in the first year. And in the 65 population in 1998, it was 16.7 percent. In 1999 and 2000, it was about 20- to 21 percent for each of those age groups.

**SENATOR KARNETTE:** But were a lot of those technical, like they forgot where their office was?

**MR. BRADY:** The way they’ve defined this in the data that I have, Ms.
Karnette, is, new crimes. So, it’s not technical violations.

SENATOR KARNETTE: So it’s not technical violations.

MR. BRADY: No, Ma’am. According to the definitions that were provided to me by our research office, the definition of a recidivist is a felon who commits another offense. And so applying that definition to these statistics. And then the two-year data for age 55, from ’97 for 55 plus is 53 percent. It’s over 50 percent for all the way up to 2000, which data is not available. For the age 60 plus it’s about 45 percent. The age 65 plus is 39 percent. So, our recidivism rate is considerably higher than the national average, as you discussed with your expert.

SENATOR VASCONCELLOS: It’s hard to believe those figures.

MR. BRADY: I understand that, Sir. I’m just giving you the data that I have. I’m not testing to the validity.

SENATOR ROMERO: Did you also bring into share with us the data for looking at recidivism as it pertains to technical violations?

MR. BRADY: I don’t have that in front of me, Ma’am. I have to tell you that I’m a new person at YACCA, so I don’t -- I did not have an opportunity to get that. I talked to Ms. Sutrow and I got this information last Thursday. So, I have not had -- but I will be happy to provide that at a later time.

I would also indicate that we’ve broken out for you the difference in the population of 55 and older from the seriously violent felons, for the non-seriously violent felons, and the actual population that they categorize for non-serious and violent felons are 2,026 with the caveat that understand that when we talk about seriously violent felons we’re talking about 1192.7 and 667.5 Penal Code sex offenders and first-degree burglars, murders, second-degree
murders. And we also have some data here that why they include manslaughter, assault, battery, other sex offenses, escape, arson, possession of a weapon, all those are in non-violent categories. So if you take those out, you have 1,834 inmates that are 55 and older in the non-violent category. And of the drug offenses that the LAO talked about, 40 percent of the drug offenses that they’re talking about in the 55 and older are, possession for sale. So they’re not just straight possession offenses, they are for sale offenses. And there’s another about 3 percent that involves manufacturing. So you really have to get into the detail of the categories to understand the issues that are at least from my perspective, when we’re talking about what to do with this population.

And I wanted to answer Senator Karnette’s question about the female population. The female population does track with regard to felony offenses from age 20 to about 40 with that of the male population, that you had asked that question a little earlier.

**SENATOR KARNETTE:** So when we get into classifications, which we haven’t, particularly, but we could classify, we could have a classification system that would show males versus females and such, could we?

**MR. BRADY:** I think we do have a classification system.

**SENATOR KARNETTE:** We do?

**MR. BRADY:** Yes, Ma’am. We’ve got a tracking system that shows the offense ages for admittees to the CDC by year and by age.

**SENATOR KARNETTE:** And recidivism is there too?

**MR. BRADY:** I believe it is, yes, Ma’am. Yes it is.

**SENATOR KARNETTE:** Okay. I’d like to see that if I could later on.
MR. BRADY: I’ll provide that to you.

SENATOR PRESLEY: Mr. Chairman, the one thing that hasn’t been discussed that maybe your committee might want to give some thought to is, you know, we have a primarily a determinate sentencing structure. There’s a little bit of indeterminate murder and some of the others.

SENATOR VASCONCELLOS: Yes, I know that. I voted against that. I remember it.

SENATOR PRESLEY: In a lot of these paroles, for example, people wonder why these people are paroled. Well, they’re mandatorily paroled because they’re time is up. So that maybe something you want to look at. That would be a horrendous change, because it was a horrendous change when it was made. But, when we had the population in the late ‘70s of, I recall, I think this gentleman said 19,000, I recall about 28,000. When we went from indeterminate to determinant. And that just immediately, as you recall, the population just really went sky high.

SENATOR VASCONCELLOS: Yes. Okay. Who else is going to speak?

SECRETARY PRESLEY: Excuse me a second. I understand this gentleman here might want to add something to recidivism, as long as you’re on that subject.

MR. ARTHUR CHUNG: Hi. Good morning, senators. I’m Art Chung. I think I’ve testified in front of your committee before in regards to recidivism rates. I do have some information in regards to, I think we gave you a copy of this earlier, but I can make copies of it for you. It’s a recidivism table basically for calendar year 2000. It shows you the types of returns that the department
had and it’s broken down into administrative criminal returns, type one, type twos, and then we have administrative non-criminal returns, and we have some statistics on this information. This is based upon the Board of Prison Terms recidivism information and who they’ve revoked, and why they revoked them. Would you guys like a copy of this?

SENATOR ROMERO: Yes. If we could get copies for the members, let’s go ahead and call that up.

SENATOR VASCONCELLOS: Somebody else want to speak? Are you here to speak?

DR. RENEE KANAN: Hi, Senators. My name is Renee Kanan and I’m a physician. I’m one of the assistant deputy directors with Health Care Services, and I’m relatively new to the department and to the state of California.

I’m really here to answer any questions that you may have about the health care program. But I did want to elaborate just a little bit on the system that we currently have in CDC.

Although we don’t have a geriatric program per se, we do actually have a fairly comprehensive health care program that begins at reception. And based on that initial screening and evaluation, we determine that particular person’s healthcare needs based on their health status and their functional status. And we do have fairly extensive preventative services and chronic care standards that have been developed that do focus on the geriatric population but again, meet the needs of different subsets of patients.

SENATOR VASCONCELLOS: Okay. Anything more to say?

MR. CHUNG: Yes, I do. I just wanted to point out that when Mike was talking about the recidivism rates, that the rates we’re talking about basically
the 21 percent for 1999, the 51 percent for two-year return rate, those are all based upon returns and revocations so that those included the people that had committed an offense and received a court commitment. It also included people who were revoked by the Board of Prison Terms, and also the individuals who are continued on parole who basically came back to prison after some hearing or whatever, or they want to ________ or a drug treatment program, and they were released back on parole. But those numbers and those percentages, they’re not just court commitments, they’re all the people who came back from parole across the portal into prison.

SENATOR ROMERO: Okay. That makes more sense. I appreciate that clarification.

SENATOR VASCONCELLOS: Mr. Neal, anything that you wanted to say in response? Senator Romero first.

SENATOR ROMERO: Let me just ask again too, the professor had emphasized that it’s important to make an assessment of the physiological state of the inmate as opposed to simply the chronological and looking at basically lifestyle issues. We talked about reception. We talked about the assessment that’s done. Can you give us an indication as to what is taken in so that we can assess the physiological condition and how is this monitored over time? And then as well too, I would just ask, has there been any study or any reflection as to the deterioration of that physiological status over a period of time. I’m not sure who on the panel would be best suited to answer that, but I’d like, looking at the physician --

DR. KANAN: I’m probably going to regret telling you that I was a physician. Yes, at reception in addition to obviously taking a history and
finding out what that person’s chronological age is, you also get a history of any chronic illnesses that they may have had. What preventive services they have? What medications they may have been on? What previous hospitalizations they’ve required? Their family history, for instance. You also do an examination that’s really head to toe. You check their vision, their hearing, their thyroid. You listen to their heart, their lungs. And you do an assessment of their functional status. That includes whether they’re able to perform activities of daily living, including mobility. And based on that initial history, physical and some initial laboratory studies, you determine a treatment plan, essentially. And again, it’s not based on age, per se, but after you’ve collected that kind of data you determine what their health status is and what their functional status is, and determine a treatment plan which takes into consideration housing needs, adaptive devices, any kind of medications, and any other sorts of services and whether they need to be enrolled in the chronic care program.

The chronic care program that we have is actually eight different clinics, and it does include diabetes, hypertension, other cardiovascular conditions, asthma, emphysema, and other lung conditions, HIV, general medicine. It does include the vast majority of our patients with Hepatitis C, gynecologic clinic, TB clinic. I’m not sure I’ve covered all of them, but there are about eight of them.

SENATOR VASCONCELLOS: Professor Turley, you talked, as I recall in your testimony, you talked about the absence of data. Do you want to elaborate on that?

PROFESSOR TURLEY: There’s a number of things that are
shortcomings in terms of data. What I was just handed doesn’t have an age breakdown. This is just your general -- There’s a couple of things that are a problem in California that concerns us.

One is, the ability to track by age, to break out age with a little more detail. The two things California is going to want to do it seems to me, in order to project your budget requests annually and project your demands on your system is going to be to put into place ways to track age and track costs a little better. My understanding is that when much of your medical costs are still contained within the CDC budget, but some of them ________(tape turned over) -- report that breaks down by age. The feds actually have that, and you actually report to the feds every couple of years some of that information. So all you would have to do is actually create what you give to the feds; expand it a little, and you’d have an internal reporting system based on age.

But the figures that we’re given, some of these still don’t quite make sense, even with the revocations. Like, 50 percent, 45 percent, 39 percent, if you include all revocations that sort of makes sense because it contains anyone who’s returning basically for any purpose.

What I would point out is that the recidivism rate even on those high figures is significantly below the overall recidivism rate. That it is still tracking a fraction of what your general recidivism rate is. What’s interesting to me is, that that low recidivism rate is without making qualitative judgment. That is, once you make qualitative judgments, you bring it down further. But, we would need more specific information to chart where you are in comparison to the national data than we have here.

Can I just note very quickly, two other things? In terms of benefits, that
is a big concern because you’ve got this release issue. In Louisiana, for example, we found out that a lot of the prisoners that we could get released on things like compassionate release, could not get funding. And so that’s something you have to work out with any type of legislative change because it won’t give you the benefits that you need, and they will have a cliff problem once they leave. For someone who is HIV positive, for someone who has got -- in a sense that’s really going to be a problem.

Many of these guys actually qualify for things like veterans benefits. They can qualify for social security, obviously. They can qualify, in some cases, for other types of benefits. But you need someone who’s working specifically with the population to chart it. And more importantly, to get the system working so that when they get out, they’ll get the check in short-term. Because what we have found, it takes three to four months, at least, for them to get that first check, and they don’t have that cushion.

The other thing I was going to note in response in terms of facilities is that the good thing about geriatric units is that most of these geriatrics who are high-risk are not high-risk for escape. They may be high-risk for embezzlement because they went in at 56 and you can hardly say at 60, is a new man. So the prisoner is going to have to stay in, but it does make him a high-risk for escape, which means you can use a higher percentage of minimum security facilities which dramatically reduce your costs because of guard costs. But more importantly, for a lot of these individuals you can do easy conversions at low cost. For example, a lot of states have looked at the former TB hospitals and other ready made structures that can be converted into minimum security systems particularly for low mobility inmates and you can create a system by
which you keep the costs within the CDC with a special budget by converting those units. And they are generally lower cost then what you’ll find otherwise. And then finally, in terms of training of inmates that is done, in fact, in other states. And I know California is absolutely correct, I mean you’ve got issues of confidentiality and there’s only so much you can do, but states like Louisiana and other states actually do train their inmates to deal -- allow the rudimentary issues. And generally, those don’t violate privacy laws. If the inmate is certified as a nurse. The other good thing is, this is a burgeoning area and so it’s also a form of job training. So, you both reduce costs to the system, but then these people actually pick up a useful skill that can be put into effect.

So, I just wanted to note those things for you.

**SENATOR VASCONCELLOS:** One more question for you. Your POPS program operates in how many states now?

**PROFESSOR TURLEY:** We have offices in North Carolina, Michigan, D.C., which serves the East Coast, and Louisiana.

**SENATOR VASCONCELLOS:** What’s it take for a state to get involved with you?

**PROFESSOR TURLEY:** Well, actually California is in a great position because you’ve got a lot of law schools. And so, all that’s required -- most law schools are interested in doing it. We will setup the POPS office. We’ll give everything we’ve got; all of our computer data. Everything we’ve got; all of our forms. We’ll go and we’ll train them and then they’re there. And the value of the law students is that they’re not prisoner advocates. In fact, that’s something we train them to make sure they understand. They’re public advocates. They work as a liaison between the inmates and the correctional
system and the state. Their job is to be right in their evaluations. So we train them in recidivist evaluations and they take it very, very seriously. And what they do basically, is they give you some extra resources the state doesn’t have to carry. What the state has to do is give access, usually access to prison jackets can be done with an approval of the prisoner. Much of that can be waived, which the prisoners obviously give. And then, POPS can go into a facility, bring all of the older inmates together, speak to them, explain the system to them and start to conduct some interviews, and then bring what we find to the state, usually the parole board, as the low-risk, high cost prisoners first. And then, obviously it’s up to the state on how good the data is and what else they need.

**SENATOR VASCONCELLOS:** So it simply takes the state to make a request of you?

**PROFESSOR TURLEY:** Yes. Basically, if you want a POPS office, the two things you have to do is that the executive and legislative components have to essentially say, yes, we want to participate. It’s really of no risk to the state. I mean, it doesn’t cost really anything except maybe some rudimentary costs. And then you just have to give access in the sense that you don’t have POPS go through the usual attorney/client interview system. That the state, the prisoners are simply told that there is a POPS pilot program that they should arrange the meetings with the consent of the prisoners.

**SENATOR VASCONCELLOS:** Okay. I guess what’s clear amongst all -- I understand the need to have a coherent all persons health care system. It was a disgrace before and the court suits led to some salutary negotiations. Above and beyond that, is this emerging startling development that’s going to be --
we’re getting more and more people in the prisons who are older and older and who cost us more to incarcerate and who are less and less of a risk to the public safety. It’s a kind of ironic double twist. They’re going to cost more to get less. At some point we have to figure out what we do about that, rather than go bankrupt.

So I’ve got a bill in the area. I’ve asked Senator Romero to look at co-authoring with me. It talks now about the state engaging in some skilled nursing facility operations to take care of your placement problems and reduce the costs. I think it’s going to be expanded after this hearing to include some data, and I’ve asked Professor Turley to help us figure out what we need to get and to expect somewhat of a plan for what to do with this emerging challenge or crisis before it gets overwhelming. And I’ve asked the analyst to work with us on that in devising that language. And then I think we ought to have POPS people come into California. If they’ve got a 100 percent success rate, it’s worth looking at, you know. I mean, they’ve got not one person so far who has gone back. That’s certainly a far cry from our rates.

So I think we’re at the front end of something major that we ought to get ahead of before it gets so overwhelming on our part.

So thank you, Senator Presley. I’d like to invite you all to work with us in designing it so we can get a coherent, smart, safety oriented and efficient system.

**SENATOR PRESELY:** I just want to leave you with a couple of other thoughts. And one is, overcrowding. I hope that really sticks with you. You heard the figures from the professor here. We have them as well.

Given that situation today in 2003, and the population of California is
increasing every year, what? 5-, 600,000 people every year?

Senator Vasconcellos: About that, yes.

Senator Presley: And crime is increasing. So you can see where that’s going to take us.

Senator Vasconcellos: It’s going to take us to closing schools to build prisons, and I’m not going there. But I’ll be gone in two years and maybe you can get that then. But I’ll be gone. And I’m not building anymore prisons and closing anymore schools. I mean, did you see the piece in the Chronicle?

Senator Presley: If you don’t build anymore prisons, then you’ve got to do something else because they’re going to be coming. You’re going to have to do some kind of--

Senator Vasconcellos: I understand. Something else probably is in order. Maybe home tags, home surveillance, you know, assessing people who are drug users that ought to be in prison. Prop. 36 changed that for us. The people did that. We didn’t have the courage to do it ourselves. But we ought to be smart about seeing what’s coming and making sense.

Senator Presley: There is a fertile field where we work in, no question about that. I want to leave -- another thought is, you heard a lot here about we don’t have the data, and that’s very true. We have not been able to get the resources for a good technology system in the Department of Corrections.

Senator Vasconcellos: Okay. We’ll try to identify that.

Senator Presley: We can’t even tell you which people are in what prison. It’s that bad unless you do a hand count.

Senator Vasconcellos: Okay. You’ve got some allies up here.
SENATOR PRESLEY: Instead of saving money, you’re spending money. The other thing is, that as unfortunate as it is, over the years, as Corrections has tried to get money, particularly in the medical field, to do some of these things, they couldn’t do it. Then the courts would come in with the lawsuits and order something that is a lot more expensive. So we’re operating -- and I’ve got this book here. I gave Senator Romero one and I’ll give you one, of all the mandates and the court decisions that impact Corrections right now. You can’t move in this system without some -- there is some authority here of some kind. It’s either statute, federal or state. It’s court decree, federal or state. Mostly federal. Or, it’s MOUs. All these impact our operations and our costs. It boxes us in.

SENATOR VASCONCELLOS: Did you see the piece in the Chronicle about three weeks ago on a Sunday, the woman who suggested we ought to convert all of our schools to prisons? So our kids could get, rather than $5,000 a year, get $30,000 a year and get health care, get food. I mean, it’s a pretty neat idea.

SENATOR PRESLEY: It would be a good bill for you, Senator.

SENATOR VASCONCELLOS: Right. Okay. Thank you all. Just stay around because there are some witnesses who are coming up who have stories about Corrections I’d like you to hear, Bob. So, thank you very much.

Two things. Next we have witnesses coming up on a personal side, and Ms. Killian and Ms. Kavrik, and also anybody else who would like to testify from the public before we close. We’re going to close at 1:00. If you would identify yourselves to the sergeant-at-arms in the booth here so we can get a rooster of who’s coming up. So the two witnesses please, come on forward.
Okay. So, Ms. Killian. Please.

MS. GLORIA KILLIAN: Good afternoon. I am the aging, graying prisoner that everyone has been talking about today. I’m 56 years-old, and I spent 16 years and four months in prison for a crime that I didn’t commit. Fortunately, I was vindicated and I was released about six months ago. I say this to assure the committee that I have actual and personal experience in the matters of which I speak. As a matter of fact, I’ve prepared a brief submission for the committee members which the sergeant-at-arms has, with some anecdotal data.

All of the discussions that concern the release of elderly and ill prisoners focus on releasing prisoners convicted of non-violent crimes. However, this approach overlooks the group of inmates who cost the state the most money and are the least likely to re-offend. That group is female lifers and long-termers.

The recidivism rate for female lifers, regardless of the age at which they are released, is less than one percent. Even the group categorized as elderly, non-violent prisoners has a recidivism rate of two percent. Female lifers rarely re-offend.

On a closer examination of the cases also indicate that despite their convictions for crimes of violence, substantial extenuating circumstances are often involved. One-third of all female lifers are battered women who either killed or attempted to kill their abuser. Another third of the female lifer population did not actually commit the crime themselves. They were passive participants or accessories. But under California’s felony murder rule, they are convicted and sentenced the same as the target offender. The final third of the female lifer population did commit a violent crime which is usually due to drug
addiction or fear of an abuser who forced them to commit a crime, but they, like all other female lifers, are the most rehabilitative and the least likely to re-offend. And as you’ve noted, there is a burgeoning population of “third-strikers” who receive a term of 25 to life even though the target offense may have been merely a petty theft.

It is important to note that I’m not discussing or advocating an early release program, as many female lifers are well beyond their minimum parole dates. The statistics compiled by Professor indicate that the average inmates 55 years and older will suffer three chronic illnesses while incarcerated. But it’s been my experience that the disease process with female lifers usually is well commenced by the age of 40.

Eighty percent of all female inmates have been abused either physically, sexually, or emotionally, during their lives. And when you combine that factor with the horrific stress of long-term incarceration, you have physical manifestation of chronic illness by a minimum of age 40. This means that the state is spending millions of dollars over and above the $26,000 it spends per inmate per year to incarcerate each person.

In addition, as you know, the medical care in California prisons is often poor, and treatable conditions are exacerbated by medical negligence and neglect. Female lifers are not the dangerous violent felons that you think they are, nor are they even the people who they used to be.

Females sentenced to life terms on the whole are quick learners and they do what they can to change themselves and to make amends for the crimes that brought them to prison. They attend psychological self-help groups; they do community service work; and they try desperately to atone for the crimes that
brought them to prison. Many have been in prison for decades and their health is deteriorated to the point that they can barely fend for themselves.

An example, Helen Loyack is 80 years-old. She’s five feet tall, and she weighs approximately 90 pounds. Three times a week she is placed in waist chains so that her hands are held by her side. Her feet are shackled. And she is driven 40 miles to the Riverside County Medical Center where she receives dialysis for chronic kidney failure. This is an all day trip. It is exhausting for any prisoner, but especially for an 80 year-old woman. She often has severe bruising on her hands and feet from the shackles and chains. And the stress of the trips themselves increase the severity of her kidney problems. It is the only way she can stay alive.

She was convicted of being a passive participant in a conspiracy with her son, but it’s very possible she had no comprehension of the situation. There was no victim in this crime. No death occurred. A letter from Helen is submitted as Exhibit 1.

Marie Nestle is 76 years-old. She suffers from heart disease, severe asthma, which necessitates breathing treatments, frequent hospitalization, and she also has rheumatoid arthritis. She takes nine separate medications several times per day. She’s been incarcerated for 24 years on a term of 7 to life. She has a perfect institutional record, and she’s held in high regard by most of the staff, as well as inmates. She refuses to admit guilt to a crime that she didn’t commit, and she has stated that she will die in prison before she admits guilt, when she is innocent. She will undoubtedly die in prison.

Carol Hargess is 63 years-old. She’s had one lung surgically removed. The remaining lung is severely damaged. She can’t walk more than a few yards
without stopping to breathe. She’s a battered woman who’s served 24 years on a term of 7 to life for conspiracy to kill her abusive husband to protect her children.

Stella Bassinger is 72 years-old. She suffers from emphysema, COPD, heart disease, arthritis. She can’t walk more than 50 feet without stopping to catch her breath. She has a pace maker which has been replaced once and which has been worked on again on a second occasion. She’s been hospitalized on several occasions. She was told by the doctors at the hospital that her cardiac care alone has cost three quarters of a million dollars. She’s served 17 years on a term of 15 to life.

Glenda Virgile is a 56 year-old woman who suffers from asthma, emphysema, diverticulitis, Hepatitis C. She has bone spurs in her spine and several spinal discs that are bulging and require surgery. Her knees are in very poor condition due to injury and several beatings. On many occasions I’ve seen her cry from the pain in her back and her legs, because they don’t treat pain in prison, nor do they allow things like heating pads or egg crate mattresses or extra pillows that might help to alleviate pain. She’s a battered woman who killed her abuser the night that he tried to kill her, and she has served 17 years on a 15 to life.

Nicky Lambert was 72 years-old when she died. Both of her legs had been amputated and she had served 26 years in prison. She was found suitable for parole, but her parole date was taken by Governor Davis on the grounds that she was a threat to society.

SENATOR VASCONCELLOS: With no legs. Yes. Sure.

MS. KILLIAN: Her legs had been amputated almost to her hips. Many
of these women have family and friends that can bear the cost of their care. But even if they required care or assistance from the state or the county, it is far cheaper to provide medical care, assistant, and any necessary treatment outside of the correctional setting.

And I thank you for the opportunity to present these issues to you.

SENATOR VASCONCELLOS: Thanks for bringing them to our attention. Appreciate it. Yes, Ms. Kavrik.

MS. LAURA KAVRIK: My name is Laura Kavrik, and my father is now at the piece says he’s at CMF. He’s at the California Medical Center. That’s where he is housed now. He was 70 when he was incarcerated. He’s been in for four years. And prior to his sentence, he’s never been in the system. He’d worked all his life. He was an active functioning man. He was on no medication. And he had insurance.

Through this whole process we’ve tried to talk to people to find out how my father’s insurance bills will be paid, and we’ve never gotten an answer. So we still have, and are paying, his insurance costs.

He was sent to DVI and he was classified because of his surname and because of the location where he was, as a northerner. He was then housed with northern gang members. And we’ve tried many times with correspondence and with written, verbal and written, and we’ve been flatly told that that’s how classification is done, by his surname. It has nothing to do with his age, his medical background or anything. We were also told that it’s the department’s practice to house young inmates with older inmates because it tones down the violence. They’re hoping that this is the way of toning down the violence.

It took eight months before my father was able to get a declaration or a,
what they call, a chronicle, where he was able to sleep on a bottom bunk and be placed on the bottom floor. Until that point, he was placed in different cells throughout the -- Dual Vocational Center. And they are not classified by age. He was classified purely by his surname and the location where he lived prior to being institutionalized.

And because he was classified as a northerner, he was at Dual Vocational Institution for two years. And during that time he was on lockdown more than he was not. The shortage time being a three-month period; his longest time being an eight-month period. At that point, his health and safety was compromised not only physically, but mentally. He was in his cell not able to move at any time. He wasn’t able to go out and get any library books. He was housed with a young person that played rap music 24-hours a day. And that was up to eight months, where they were locked down.

Because of the lockdown institution and him being elderly, he was --now he has medical problems. He’s declining. He has high blood pressure and high cholesterol. And being in a lockdown situation, there were times, two and three weeks at a time, where his medication was delayed.

Recently he was moved to California Medical Center in September, and he’s now housed in dorm with 45 other men, he being the oldest. The next oldest being 66. All the others are young.

In that dorm, he says that it’s dark. It’s noisy. There are times that he can’t hear to be called for dinner, for lunch. And the reason it’s dark in there, they’ve got lights and the younger inmates don’t like it so they knock the lights out. They’re replaced and again they block the lights out, or hit them to the
point where the lights no longer work. So they’ve stopped replacing them. And 
because he’s in, there’s no consideration of his age. He’s there with the younger 
inmates.

Recently -- well right after he was sent to the medical center, he didn’t have any problems medically other than having the high blood pressure and the high cholesterol. He now is suffering with back pain and having his legs get numb on him. He’s been seen by a neurologist who has ordered an MRI and also ordered a back brace, as well as shoes for support and he wanted him also to be seen by a neurological surgeon because he told him with what’s happening with his back and his numbness of his legs, now the next thing that’s going to happen is, he’s going to become incontinent of bowel and bladder.

The dignity of my father, this happening to my father is just, he talks about it and the tears start because he is -- he’s in a place where there’s young men and he, this elderly man now that may become incontinent with bowel and bladder if he doesn’t get the medical needs that he needs.

We were told, or the doctor told my father that family could be present, so immediately we started writing letters. We started corresponding with administration there at the center and we’ve gone the whole gamut of talking from the very bottom person all the way up to the warden, the doctor, the medical director and we’ve been told different stories. So I don’t know what is what. But at this point we’ve been told for security reasons, family cannot be present, which I understand.

But, and with that understanding I wrote a letter in detail asking questions, having questions for my father to ask with the surgery the risks and the benefits that will incur. If the surgery has to be done, if it’s not happened,
what will talk place, so that he could have that with him just in the event that 
family wouldn’t be there to advocate for him. He is 74. He’s in an environment 
where it’s frightening. He’s going into a medical procedure which is 
frightening so he’s not going to remember all the things in my mind that he 
should to ask and advocate for himself.

A month ago he did go to the outside consultation. And again, I can 
testify that my father, who is 74, has difficulty ambulating. He can ambulate for 
short distances. He has to stop and get the circulation back in his legs with 
shackles, his hands, to his waist, down to his feet. And with the transportation, 
this trip to Napa, he has to take a letter that I specifically wrote for him to ask 
the questions what the risks and the benefits, he was told he couldn’t take it. 
That he couldn’t take anything with him.

So, he went. They transported him. It took two guards to transport him, 
shackled the entire trip. He got thrown a sack lunch and said, there’s your 
lunch. At no point were his hands ever untied so that he could eat lunch, even 
for the examination he was not -- the chains were not unshackled. The doctor 
came in, took his shoes and socks off, which I guess they’re transported with a 
thong type shoe. The socks and the thongs were taken off, the chains were not. 
He felt his ankles and felt his knees and asked for his medical records, and they 
didn’t bring the medical records. He was transported to a medical appointment 
but none of the medical records were given to the correctional officer to take 
with him.

So, in essence there was nothing the doctor could do for him and the 
doctor told him, the surgeon said, you have a problem. There’s nothing I can do 
for you. I need your records. I need the MRI, the x-ray. Those records -- these
two correctional officers transport people on a daily basis to medical appointments. It just seems to me that because my father said, can I take this letter to ask medical questions, that should have triggered something to say, we need this gentleman’s medical records.

Since then, the doctor had said, I’ll get back to you in a week. That was a month ago. He’s not heard anything. It took two months to get the supportive boots that he needed. The doctor at correctional medical center ordered a back brace. He still -- that’s been three months. He has not received that.

I just, with things that have been said this morning, I can testify that with sick call, they are called out immediately. My father recently was sick and he didn’t go to school, so they immediately sent someone down. He told them that he didn’t feel well. They sent him to the doctor. The doctor said, yeah, sure. You have a flu type virus. He gave him medication. To this day he has not received that medication. This was probably two months ago.

With the current problems they don’t -- he’s written a doctor note to see the doctor to ask about the back brace, to ask when he’ll go back to Napa. Those things don’t happen.

You asked about where would families be released? That question. There’s families and loved ones out there, and as I stated earlier in my testimony, we have insurance in place for my father. We’ve continued to pay for that. And he’s got a home to come to.

I just want to end with the very frightening -- with what’s going on with the elderly people. My father has a family to advocate for him. But it’s difficult because you try and go one direction, and you get pointed to another direction and nothing ever gets completed.
Prior to going into -- being incarcerated, when my father was young he had surgery and he had a reaction to the anesthetic that he received, and it took ten people to hold him down. I have tried to state that to everyone that I know. I’ve written medical letters. I’ve told my father to tell everyone that if he should have a reaction to whatever he gets, that the anesthesiologist gives him -- my fears are, if he reacts and he starts acting violently, will he get beaten to death? Will he get shot? Will he get -- how will they prevent him from reacting to a medication?

With that, I think I want to end and I want to thank all of you for giving me the opportunity --

SENATOR VASCONCELLOS: Senator Presley, I’d like you and Mr. Pickett to be with this woman and figure out what’s going on, where those medications are and make this thing coherent. This new health system sounds like it’s a true story, a fraud. If the story is true, the system is a fraud. Do you want to respond to this now, Bob?

SENATOR PRESLEY: No, I think we’ll get the information --

SENATOR VASCONCELLOS: Okay. All right. Thank you. Senator Romero.

SENATOR ROMERO: And if I may comment as well.

SENATOR VASCONCELLOS: I mean, there’s a doctor here. Doctor, you’ve got a patient here I want you to talk before you go. Not here, but you know.

SENATOR ROMERO: It’s my understanding as well too, in terms of looking at these transportation costs. That it’s estimated that at times these costs to transport, in this case your father, can cost up to $1,000. And I think
again too, that those are the questions we have to ask is, are we more safe when we hear about this kind of a story.

The other I’d like to as well too is, just this profile that has been put together with respect to aging women in prison. Again too, it’s something that absolutely astounds me and I would once again say that under the auspices of the select committee and the correctional system, we are going to be holding a joint hearing with the Women’s Caucus of the Legislature to specifically examine the conditions of women in our state prisons and we intend to focus, as well, on these cases.

**MS. KAVRIK:** Thank you so much, Senator. And if you would like any further information or data, I do have it.

**SENIOR TO CONCELOS:** Okay. Thank you very much. Thanks, Bob. Now there are 11 more people signed up who want to testify. We have about 15 minutes left. Let me just say that at 1:00 we’re supposed to terminate. I think we’ve got a pretty good fix on what the problem is, and so I want to let each of you come up and say -- I’ll give you about a minute. But, you don’t repeat what’s already been said. I think we’ve got a pretty good grip on what’s missing in the way of the system and any awareness or sensitivity. So come on up.

First, Cat Haynes, Allan Komarek, Karen Shain. Cat Haynes? Which one? Let’s go. Let’s move quickly please. Why don’t you all come up and sit down and just start talking. Identify yourself and in a minute, just figure out what you most want to say that we haven’t heard already.

**MS. CAT HAYNES:** Thank you. My name is Cat Haynes. And I’m here just to add a layman’s perspective to looking at the aging population and those
that have been incarcerated and are sick.

My husband is serving a 7 to life sentence, and I’ve been married to him for 28 years. He’s been in prison almost 30 years, so I’ve practically grown up under the Department of Corrections.

When we began to serve time, rehabilitation was the norm at that time. So, you did your time; you bettered yourself; you came out into the community; and you contributed good behavior. Women had only begun to work in the system as prison guards. Youth were just being reprimanded to the prison system at that time. I found it appalling then, I think it’s appalling now.

And then came the 1980’s, where it was crime and punishment. This was eight years into my husband’s serving time and I said to him, if you do not get out of here you are going to be stuck in this system at the rate things are going.

I began to look at a picture of what was developing from my perspective as a woman visiting prison every weekend, which is still what I do today. And I guess the point that I’d like to make is that we were 21 and 22 when we came into this system. My husband will be 50 years old this year. One of the things that we need to look at is, who we are containing and why we are keeping people incarcerated who need to be out.

At this point, my husband was a passive participant. He’s serving a 7 to life. There is no such thing as determinant sentencing. If it was determinant sentencing, he would not still be serving time without a date. He’s disciplinary free. He has high blood pressure now. And one of the reasons why I’m here is, I’m looking at, you know, are we going to be looking at having to take advantage of new geriatrics resources in prison. Because at the rate that it’s
going, this is where he’s going to be. And why? He needs to be among the population, he’s done everything. He can’t take anymore classes. He can’t take school. He can’t learn anymore trades. He’s maxed out. He’s at the pinnacle of prisonology. What is he still doing here? This is the population that we need to look at and we need to look at our governor and we need to look at the Board of Prison Terms.

We have people who are just bent on -- we don’t need 34 and 33 prisons. When we came to prison there were only 11. And when you convince the public and the voters that they need prisons, then it’s your political responsibility to make them stay filled. What are we going to look like with 10 and 15 empty prisons? We cannot. But you know what’s going to happen? The profile and the image of the prisoners are going to change.

We have new prisoners now. They’re in the corporate world. They wear suits. And we need to look at that and we need to look at the population. Prison is making us safe. Prison is making me safe. And we need to look at that population.

SENATOR ROMERO: Thank you, Ms. Haynes. Thank you, Ms. Haynes.

MS. HAYNES: Thank you.

SENATOR ROMERO: Mr. Komarek.

DR. ALLAN KOMAREK: Hello. My name is Dr. Komarek. I’m the executive director at Delano Regional Medical Center in Delano, California. We recently proposed to the Department of Corrections to build a free-standing long-term care unit for them, and are very interested in partnering with the Department of Corrections to provide long-term care. I think there’s a place for
private industry in helping with the solution that you have before you, especially long-term care for the elderly.

Delano has a history of being the first hospital in California to put in the sub-acute long-term care unit. We were the first hospital in California to do that. And we think that we can provide cost-efficient care for the state in a manner that will retain the dignity for the inmates and provide you with the solutions that you need for the future.

**SENATOR ROMERO:** Thank you. Karen Shain. I’m going to limit to one minute.

**MS. KAREN SHAIN:** My name is Karen Shain. I’m administrative director of Legal Services for Prisoners With Children. And we are one of those law firms that had one of your law suits. And, I’m just really here to beg you to look at this question in the broadest possible terms; to look at compassionate release; to look at what’s happening with lifers; because we’ve now heard from several different representatives of the lifers. And, because we do visit women in the women’s prisons, we’ve been in touch with many of the women that Gloria has talked about at CIW. Those women are also at the other women’s prisons around the state.

And the problem with California prisons at this point is, that it reminds me more of the roach motel than anything else. These prisoners are all coming in and very few of them are getting out. And, it is a crisis. It’s a crisis that affects the prisoners. It affects the families. It’s affecting our entire communities. Thank you.

**SENATOR ROMERO:** Thank you. Cynthia Chandler.

**MS. CYNTHIA CHANDLER:** My name is Cynthia Chandler. I’m the
co-director of an organization based out of Oakland, California called, Justice Now. I had wanted to -- actually, I should say over the past seven years I’ve had a primary focus in my legal practice of representing clients in compassionate release cases. And I’ve also made a practice of helping establish release plans for prisoners who are very seriously ill and also terminally ill.

It’s shocking to me that with a budget sometimes of $150,000 that every year we are able to put together comprehensive plans for over 20 prisoners when this state, for some reason -- and including getting their benefits solidified, helping them get their ID’s. Sometimes that money coming out of my own pocket. Somehow we were able to do that, but the state isn’t.

I really wanted to offer a possible solution though, because I think we’ve heard a lot of problems. With Senator Romero’s help and Lucy Armandaro’s help, we were able to introduce a spot bill this legislative session to re-introduce a bill, Assembly Bill 675, from the 2001 legislative calendar, that would have expanded the compassionate release criteria to include people who are permanently physically incapacitated, and also expand the criteria to include people who are within one year of death. Obviously, there would be a risk assessment criteria as well. But it would also allow for certain procedural safeguards that could help streamline and facilitate prisoners in representing themselves and having advocates assist them.

We were unable to get an author for that bill, but it’s something that we think is extremely important and potentially a very valuable solution. And it’s something that we would encourage all of you to think of as something to approach in terms of budgetary issues as well.

SENATOR ROMERO: Thank you. Lanie Vamatter.
MS. LANIE VAMATTER: I represent Families of Prisoners, a prison advocacy organization, and Californians United for Justice, of which I’m an executive board member. I’m a former CDC officer. I saw from the inside how bad this situation is and it almost put me in a mental hospital, and I fought very hard for a year to regain my mental faculties and come back and fight back for those who can’t fight back.

I’ll start with the medical issues.

CMF. Oh yeah, they say they do these things. I happened to deal with dozens of people on a weekly basis who cannot get their medication. The cops want to play a game with it. I’ve got one young man with Hep C. His parents have had faxed over all of his medical records twice, and yet every time they send him a — when he sends a docket to the doctor; he goes to the doctor; they don’t have his medical records. He’s dying. He’s just one of the many.

My fiance, David, broke his leg. They took him in; they x-rayed him; they said, yeah, your leg is broken. Go back to your cell. He said, can I have some crutches. They said, we don’t have any. I had to involve Dr. Vismara, who should have been here today, in the fight just to get him his crutches and to finally get his leg cast. Then they took it off too soon. He’s still in pain with it. Then they kept him in an upper bunk.

Now, he is a term to life prisoner. He went in at 19 years-old on a murder conviction, on a drug related murder. Somebody ripped him off. He ran into them again. They got into a fight and somebody got killed. Unfortunately, that’s life.

You’re not safe. We’re not safe. The whole country is not safe. You get shot sitting in your house. I felt safer working inside with a gun over me than I
ever have anywhere else.

My David is not a threat to public safety. He’s 43 years-old physically. He’s older than I am, 58, emotionally, from just being in prison. At his age he would like just his program, go to work. This is what they would all like. But the new prisoners coming in have no respect. They don’t understand respect. They’re out to make a name for themselves and so they want to take on these older prisoners; cause a fight; they go back to the hole for it because they’re not going to let this youngster murder them; and then the parole board, who rarely ever reads the file -- there are so many mistakes at every parole hearing that it is incredible -- it says, oh, you’re not ready to go home even though there are psychiatric reports saying, this person is not dangerous. We don’t ever need to see this person again. This is what I’m talking about. He’s been in 26 years on a 7 to life.

**SENATOR ROMERO:** Thank you. C’Rene Dana.

**MS. C’RENE DANA:** Thank you. My husband and I contracted the POPS program in Washington at Georgetown University back in 1989 or 90. And it took about four years before we got a response back from them because they had so many applicants. At that time -- and a student attorney was assigned to my husband, Robert Dana -- you know Michael Evanetti was the student -- he went through the process of getting him qualified and interviewed and everything, and would have gone through the program except for the fact that AB 456, Assembly Bill, in 1999/2000 session, did not get approved. So we’re anxious to get this program started again.

My husband has two herniated discs. He has mobility problems. He has corrective shoes. He is diabetic. He has high blood pressure.
I have a home. We own a home together. He can come home, and there’s no reason for him not.

Some inmates are disabled by social security before they went in there. My husband was. All he has to do is present himself to a social security office when he gets out, and they will verify, that fact and his case will pick up with all the benefits that he’s entitled to through that program, as well as Medicare.

And I guess that’s about all I have to say, except that last September when there was a lockdown at CMF, that’s where he is at, he laid in his cell for five days in excruciating pain on his bed, unable to get up, and nobody would come and help him. He had a -- I don’t know if it’s a herniated disc, or if it’s the gallbladder that he just recently passed a stone in, in excruciating pain in that.

Thank you.

**SENATOR ROMERO:** Thank you. Judy Greenspan.

**MS. JUDY GREENSPAN:** Hi. My name is Judy Greenspan. I chair the HIV/Hepatitis C In Prison Committee of California Prison Focus. I’ll make it very brief.

First of all, Senator, I just want to say, I want to thank you for having this hearing. It really is historic, and I hope that there are recommendations that come out of it and policy decisions that come out of it that change the face of prison today in California.

I think we’ve skirted around a couple of things today that I would urge you to consider for a future hearing. And that is the issue of parole. Because I think that there would be a tendency to -- and with all due respect to Professor Turley, who I have a lot of respect for over the years -- I don’t think that California is parole happy. I don’t think that that’s the problem, and I think it’s
actually parole stingy, and it’s a very haphazard parole problem.

When you still have thousands of prisoners in prison on 7 to life, you have to look at that system and say there’s something wrong. They’re not doing 15; they’re not do 50 to life. Seven to life; they’ve been in for 30 years. Why? It’s because the parole system has failed. It has shutdown. It’s not letting people out. Those are the people getting old. Those are the people that are costing millions in medical care.

The other issue I just wanted to say, California Prison Focus, and I’m sure a lot of groups here do not want to see geriatric units in the prisons. We want to figure out a way to release the elderly prisoners back into the community as much as possible.

My great fear is that our prisons -- I mean, you go to any visiting room in a prison and I would urge you to do that. I’ve been to the California Medical Facility of Vacaville, or the California Institution for Women, and you already have an old age home. But you have, of course, an old age with bars and punishment and prisoners deteriorating due to lack of medical care. I don’t want to create that system. I think we need to work together and figure out a way to release the prisoners back to the community. It’s the only humane thing to do and it’s certainly the only way to save taxpayers money.

And I would just urge you again, let’s have some more hearings. Let us really go into depth in the parole. Let’s find out what is behind the parole problem.

SENATOR ROMERO: And under the auspices of the Select Committee, we do have a hearing on parole coming up in a few months, so we’ll keep you posted on that.

**MS. LINDA ROBERTS:** I’m representing Gray Panthers today, with Older Womens League. We put in a joint letter to the Legislature supporting the Legislative Analyst’s proposals regarding early release. The money that was saved can be used to prevent cuts that will hurt elderly people. They’re proposing to cut the senior ____ program, the foster grandparents program, Medi-Cal, durable medical needs. The same venerable folks and families will be hit from many different cuts that are being proposed and we could save money by going along with the Legislative Analyst’s suggestions in this realm.

Someone asked earlier about the differences between male and female prisoners. In your packet and the Stephanie Pfeifer Meadow News Service thing, there is a quote: “Female prisoners are at greater health risks,” and I assume they mean then male prisoners -- for instance, cervical and breast cancer screenings, nutrition containing calcium and fresh vegetables. I attended a hearing on compassionate release for a woman dying of cervical cancer. If her cancer had been caught earlier, would she have been dying?

Ann Fagan Ginger of the Mickel John Institute has stated that the way we house female prisoners in this country violates the international law.

And I was very disturbed by what I hear the CDC thinks it’s doing as far as medical care. An excellent book on this by Terry Cuppers is, *Prison Madness*. He describes mentally ill prisoners. And of course that percentage gets worse as you get older. Seeing a different psychiatrist once a month and only once a month, no one with mental illness can be treated effectively that way. We know of an elderly veteran who was able to walk with assisted devices, adaptive devices, they were not provided to him and he is now in a
wheelchair. We are deteriorating people and making them more expensive to care for.

And it is also my understanding that they don’t test for AIDS when you go in, so I think you should ask very clearly about that because we’re getting the opposite description from people who have loved ones in.

We also get complaints about people being referred to a prison guard to be evaluated for psychiatric care.

So, again, I want to state that we very strongly support the Legislative Analyst’s proposals on this issue.

SENATOR ROMERO: Thank you. Jamie Meyer.

MS. JAMIE MEYER: Yes. Good morning. I’m just going to validate what everybody has said since we’re beginning to run out of time. However, I would like to add just a couple of things.

I had called Mr. Turley’s office way back in 1990 after he had first opened the POPS program. My father went into prison at age 67 for a first time offender. And through the process it took me four years, but I did get him out. He was one of the last ones that was released on the compassionate release in 1994, which I think it ended in 1996, basically, of no one else being released on a compassionate release. But I was told at the time the reason that the POPS program wasn’t here in California was that it was political and whoever didn’t want to have the POPS program because California was for punishment, period.

The other thing that I’d like to mention is that I do in totality agree with the request for parole, or to look into the older inmates who are serving the 7, 15, and the 25 indeterminate sentences, which would include the life prisoners and the indeterminate sentencing prisoners.
And one other thing, we had turned in a report to you, Senator Romero, as of yesterday, along with Senator McPherson and John Vaconcellos. It should be at your office. And in that report we had found on the internet, through the CDC web page, as far as the recidivism rate and the percentages, what we saw on the net and what we took and pulled off of their information was that inmate population by age, the lowest percentile of the total prison population, the male ages 45 to 49 was 8.0 percent; age 50 to 54 was 4.3 percent; 55 to 59 was 2.9 percent; and 60 over was 1.6 percent. It also listed the population. And as far as the highest percentile, they were showing 20 to 24 in age was 22.1 percent. So that can be found on the website of the CDC.

Thank you.

UNIDENTIFIED: Excuse me. Can I add one minor thing?

SENATOR ROMERO: We’ve really go to leave the room. Susan Gary is our last speaker.

MS. SUSAN GARY: I can speak from right here. And I just wanted to say, my husband is serving a 7 year to life. He’s been in for 22 years. During this time ______ that I’m an RN, and I’m able to speak to the CDC in Sacramento. I usually have to go above up to Sacramento.

But I’ve watched him endure a triple bypass. He was told he should have had five. So the state’s going to ____ five if he survives. He had a stroke in 2001. He knew it was coming. He couldn’t get seen fast enough, so he had a stroke and didn’t receive the blood clot -- he qualified for that, but because __________. The stroke protocol is in place. He was given incorrect medication. He was strapped into his bed on his paralyzed side. He’s paralyzed on his right side and has severe _______. And when he appeared before the
board in 2002, he was told he was a threat to public safety. And I’ve watched him deteriorate. He’s _______. But the fact that I’m an RN, I do know how to work within the bureaucracy in the system, and I will commend the Department of Corrections for implementing two things, ombudsman. The gentleman have been very helpful.

And number two, Kathleen Wallace, ________ has helped me tremendously. _____ medical. And again, 22 years _______.

SENATOR ROMERO: Thank you very much. Any final comments, Senator McPherson?

SENATOR MCPHERSON: No.

SENATOR ROMERO: Okay. Again, this brings to a conclusion, this hearing. I want to thank everybody for your presentation, your testimony. We will go back and take a look at this very carefully and hopefully move forward on this issue. For all who came, Professor, as well, thank you very much. And this hearing is now concluded. Thank you.