Written Testimony of Daniel Landsman
Deputy Director of State Policy, FAMM
In Support of H. 2448/S. 1599
Massachusetts Legislature Joint Committee on Public Safety and Homeland Security
October 21, 2021

Thank you Chair Timilty, Chair González, and members of the Joint Committee on Public Safety and Homeland Security for the opportunity to submit written testimony in support of H. 2448/S. 1599. I am the deputy director of state policy for FAMM, a national, nonprofit sentencing and corrections reform organization made up of currently and formerly incarcerated individuals and their loved ones. We aim to create a more equitable criminal justice system that respects the values of individual accountability and dignity while maintaining community safety.

For two decades, FAMM has worked to improve programs that provide for the safe release of medically vulnerable, aging, and dying individuals from prison. Our work has helped secure important improvements at the federal and state level, including in Massachusetts. In recent years, we:

- collaborated with other national organizations in 2018 to urge passage of the Massachusetts medical parole bill;[1]
- commented on regulations proposed by the Department of Corrections (DOC) that would have unduly burdened individuals seeking medical parole;[2] and
- co-authored an amicus brief with Prisoners' Legal Services of Massachusetts in *Buckman v. Commissioner of Corrections*, the case that successfully challenged the DOC's implementation of medical parole.[3]

We are pleased to support H 2448/S. 1599. In 2018, we examined the medical and geriatric early release programs in every state and the District of Columbia. We exhaustively reviewed statutes, agency regulations and policies, and other sources. We examined eligibility criteria, application requirements, documentation, and decision-making, as well as post-release and post-decision issues, such as appeals, revocations, and reporting requirements. Our research was published in 51 memoranda, which can be found on our website, www.famm.org.

We gathered our findings into a report, "Everywhere and Nowhere: Compassionate Release in the States." The report describes policies and practices that pose barriers to release and those that

[1] Letter from FAMM et al. to Sen. William Brownsberger, et al. (Jan. 8, 2018).
[2] Letter from Mary Price, FAMM, to John H. Melander, Executive Office of Public Safety and Security (July 8, 2019).
[3] Brief for Prisoners' Legal Services of Massachusetts and Families Against Mandatory Minimums as Amici Curiae, *Buckman v. Comm'r of Corr.*, 484 Mass. 14, 138 N.E.3d 996 (2020).

exemplify best practices. We also include a set of recommendations for states working to implement or update such programs.

Our support for H. 2448/S. 1599 is informed by that research and our analysis.

Today, all but one state has some form of early release for medically vulnerable people. States implement these programs in part due to the financial impact and challenges of caring for a graying prison population. Between 1993 and 2013, while prison populations increased by 55 percent,[4] the proportion of incarcerated people 55 years and older increased by 400 percent.[5] By 2030, it is projected that there will be more than 400,000 people over the age of 55 in American prisons.[6]

Nationally, people 55 years old and older make up 10 percent of state prison populations on average. In Massachusetts they comprise more than 15 percent of the population, making the commonwealth second only to Montana in the proportion of geriatric people in its prisons.[7]

This population is both the most expensive to incarcerate and least likely to recidivate. It has been estimated that older incarcerated people are three to nine times more expensive to incarcerate than their younger counterparts.[8] This is in part due to their vulnerability to age-related and chronic medical conditions. As prison populations get older, their medical expenses get larger. Medical care constituted fully one-fifth of prison spending nationwide in 2015.[9] Experts relate that the rising cost of state health care is due largely to the growing population of older prisoners with disabilities and chronic medical conditions.

Meanwhile, we have the least to fear in terms of public safety when releasing medically vulnerable and older people from incarceration. The U.S. Department of Justice found that individuals released through the federal compassionate release system had a recidivism rate of 3.5 percent, compared to an overall recidivism rate of 41 percent for released federal prisoners.[10]

---

[4] E. Ann Carson & William J. Sabol, U.S. Dep't of Justice/Bureau of Justice Statistics, Aging of the State Prison Population, 1993-2013, at 1 (May 2016), https://bjs.ojp.gov/content/pub/pdf/aspp9313.pdf.
[5] *Id*.
[6] George Pro & Miesha Marzell, *Medical Parole and Aging Prisoners: A Qualitative Study*, 23 J. of Correctional Health Care 162, 162 (2017), https://www.liebertpub.com/doi/abs/10.1177/1078345817699608?journalCode=jchc.1.
[7] Emily Widra, Since You Asked: How many people aged 55 or older are in prison, by state?, Prison Policy Initiative Briefing (May 11, 2020), https://www.prisonpolicy.org/blog/2020/05/11/55plus/.
[8] Cyrus Ahalt et al., *Paying the Price: The Pressing Need for Quality, Cost, and Outcomes Data to Improve Correctional Health Care for Older Prisoners*, 61 J. of the Am. Geriatrics Society 2013, 2014 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3984258/.
[9] Pew Charitable Trusts, Prison Health Care: Costs and Quality 23 (October 2017), https://www.pewtrusts.org/en/research-and-analysis/reports/2017/10/prison-health-care-costs-and-quality.
[10] Office of the Inspector General, U.S. Dep't of Justice, The Federal Bureau of Prisons' Compassionate Release Program, at iv (Apr. 2013), https://oig.justice.gov/reports/2013/e1306.pdf.

Furthermore, the U.S. Sentencing Commission report on recidivism and age concludes that, "recidivism measured by rearrest, reconviction, and reincarceration declined as age increased."[11]

The Massachusetts Medical Parole statute was originally enacted because lawmakers recognized that releasing dying or incapacitated people from prison who pose no threat to the community can both help contain correctional health care costs and ensure that these individuals receive humane care in the community. Enacting the statute was also an acknowledgement that continuing to lock up suffering and dying people does not serve any of the purposes of punishment.

The legislation you are considering responds to concerns that the DOC has failed to advance the parole of debilitated and terminally ill people who ought to benefit from the medical parole statute. The reforms included in these bills aim to ensure that the medical parole authority is used by the DOC as the legislature intended.

The proposed revisions are smart measures. They are designed to:

- clarify the dangerousness assessment;
- ensure that medical personnel are not tasked with risk-assessment responsibility;
- extend medical parole eligibility to people who are cognitively incapacitated and provide that they be identified and supported;
- provide for placement referrals to the Department of Public Health in the event the DOC cannot identify a private placement for a parole-eligible individual;
- improve due process protections in the event of a violation of the terms of parole; and
- expedite appeals.

Risk Assessment

Massachusetts' medical parole criteria are very narrowly drawn. Only those individuals at the end of life or suffering from permanently incapacitating conditions, who will not break the law, and whose "release will not be incompatible with the welfare of society" can be paroled.

Section 8 would clarify that the medical eligibility determination, made by a medical professional, would be distinct from the risk assessment determination, which would be made by the superintendent. The medical parole statute currently conditions a determination of terminal illness or permanent incapacitation on a finding that these conditions are "so debilitating that the prisoner does not pose a public safety risk."

These definitions appear to involve medical personnel in public safety assessments. These professionals do not have the training or expertise to make public safety determinations. **We know of no other system in the country** that conditions a physician's medical determination of terminal illness or incapacitation on a risk assessment. Requiring a physician to do so would

[11] United States Sentencing Comm'n, The Effects of Aging on Recidivism Among Federal Offenders, 3 (Dec. 2017), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171207_Recidivism-Age.pdf.

present them with a serious ethical dilemma. Medical professionals are not equipped or trained to perform risk assessments. Conducting these assessments would take the clinician outside the ethical scope of medical practice and, as such, violate the ethics rules that govern the profession. The role would also pose a clear conflict of interest for a medical professional whose duty is to their patient. Section 8 ensures that doctors need not concern themselves with measuring dangerousness.

Section 8 would further strengthen this separation of duties by directing, that when determining that an individual's release would pose a threat to society, the commissioner does so in light of the individual's current medical condition. This amendment places the risk assessment squarely in the hands of the commissioner, where it belongs, and focuses that assessment on a person's physical and/or cognitive capacity to pose a threat.

Adopting this reform would align Massachusetts medical parole with numerous other programs in the country that examine current dangerousness in light of current condition rather than past conduct or ability. **Rhode Island,** for example, has the corrections Health Services Unit assess the degree of a person's incapacity or disability, including an assessment of whether the person can walk, is capable of engaging in any substantial physical activity, and is able to independently provide for daily life activities.[12] The Parole Board will grant release if those medical criteria are met, only if, in light of their medical condition, it is reasonably probable the released individual will not break the law, release is compatible with the welfare of society, and release will not "depreciate" the seriousness of the crime and undermine respect for the law.[13] **New York** provides that terminally ill individuals be physically unable to present any danger to society due to their condition and those who are debilitated similarly be unable to endanger society due to the debilitation.[14] Like Rhode Island, New York separates the medical assessment from the risk assessment. A DOC physician provides an evaluation that includes a statement about whether the person is so debilitated or incapacitated that they cannot walk on their own or perform "significant" activities of daily living.[15] Then, the Parole Board grants parole only after it considers, in light of the medical condition, that it is reasonably probable the individual will not violate the law if released, release is compatible with the welfare of society, and release will not "deprecate" the seriousness of the crime and undermine respect for the law.[16]

Notification to counsel and duty to petition

The legislation in section 5 would oblige the DOC to identify and report to a prisoners' rights organization on a quarterly basis anyone who meets the eligibility criteria for medical parole. That notification would include information concerning outside contacts, the person's medical condition, and their sentence. A handful of states affirmatively require their corrections

---

[12] R.I. Gen. Laws § 13-8, 1-4 (c) (4); Department of Corrections Policy and Procedure (DOC Policy) 20.08-3, § (B) (3) (D).
[13] R.I. Gen. Laws § 13-8, 1-4 (f).
[14] N.Y. Exec. Law § 259-s (1) (a); New York Dep't of Corrections and Community Supervision, Directive 4304, Medical Parole (Directive).
[15] N.Y. Exec. Law §§ 259-r (2) (a) and 259-s (2) (b); Directive 4304, § III (B).
[16] N.Y. Exec. Law § 259-r (11) (a).

departments to identify medically eligible individuals and start the release assessment process. They include **Alabama**,[17] North **Carolina**,[18] and **California**.[19] A few permit counsel to be involved in advocating for medical release, and **Rhode Island** provides lawyers for medical parole hearings.[20] While many other states allow lawyers to begin the process by asking for a client's consideration, none that we know of requires that legal counsel be notified of parole eligible people.[21] This forward-thinking reform would make Massachusetts a leader in the nation by ensuring that the terminally ill and incapacitated will have skilled counsel assisting them at a time when they are least able to advocate on their own behalf.

Section 5 also provides that the Department submit a written petition on behalf of individuals found to be permanently cognitively impaired, after giving next of kin, surrogates, their attorneys, or Prisoners' Legal Services notice and the opportunity to petition, and providing them the records they need to proceed. We believe only the federal compassionate release statute requires the Bureau of Prisons to assist people who meet compassionate release criteria who are "mentally unable to submit a request," in addition to notifying their next of kin and counsel of their condition and eligibility for a sentence reduction motion.[22] With this innovation, Massachusetts would recognize the special challenges posed by severe cognitive impairment. It would guarantee that such individuals receive the consideration they deserve, despite their limitations. It ensures that people unable to advocate for themselves have the help they need.

Ensuring a path to placement in the community for eligible prisoners for whom placements cannot be found

It should go without saying that a person so debilitated by terminal illness or incapacitation that they have earned medical parole should be released. But Massachusetts struggles to place some of those in need of long-term care. This hurdle means that individuals remain in prison, contrary to the requirement that the DOC identify release options and facilitate their transfer. Massachusetts is not alone in grappling with this problem. Many states are challenged to release difficult-to-place individuals. In the federal system, compassionate release cannot even be granted without a verifiable release plan. In section 5, the legislation proposes a straightforward, commonsense solution to this recurring problem: Place the individual through the Department of Public Health under existing authority. This pioneering approach could be a model for other

---

[17] Ala. Code § 15-22-43 (a) (2), referencing Ala. Code § 15-22-28 (e); Ala. Admin. Code § 640-X-3-.05 (3); Board Rules, Article 1, § 14.

[18] North Carolina Department of Public Safety, Division of Adult Correction and Juvenile Justice, Prisons, Policy and Procedure, Chapter Q, § .0304 (a); North Carolina Department of Public Safety, Division of Prison Health Services, Health Services Policy and Procedure Manual CC-12, § I (B).

[19] Cal. Penal Code § 3550 (c); Cal. Code Regs. tit. 15, §§ 3359.1 (b) (1) and 3359.2 (a), referencing Department Form 7478-EMP, Medical Parole.

[20] R.I. Gen. Laws § 13-8.1-4 (i) (3)

[21] The federal law governing reduction in sentence for extraordinary and compelling reasons, known as "compassionate release," obliges the warden to notify the prisoner's attorney, partner, and family, and inform them they may submit a request for the prisoner's compassionate release on behalf of individuals who are identified as terminally ill or those unable to complete an application on their own due to physical inability. 18 U.S.C. § 3582 (d) (2).

[22] Id.

states that are forced to maintain even dying prisoners in expensive settings at the end of their lives.

Conclusion

Thank you for the opportunity to share our views on this important legislation. We encourage this committee to advance this legislation.