



July 8, 2019

Submitted by Email
John H. Melander, Jr.
Deputy General Counsel
Executive Office of Public Safety and Security
Commonwealth of Massachusetts
One Ashburton Place, Room 2133
Boston, MA 02108

Re: 501 CMR 17.00 – Medical Parole

Dear Mr. Melander,

Please accept this written testimony from FAMM, a national organization of prisoners, their families and loved ones, and diverse people concerned about criminal justice reform. FAMM’s mission is to create a more fair and just criminal justice system that respects values of individual accountability and dignity while maintaining community safety. We promote sentencing reform, particularly individualized sentencing; prison reform, so that prisoners get the support they need while incarcerated to return to their communities and succeed; and compassionate release, so that debilitated and dying prisoners, whose continued detention no longer advances the goals of incarceration, can be released.

Last year, FAMM published the results of an in-depth research project that documented compassionate release programs¹ in the 50 states and the District of Columbia. We included an exhaustive review of statutes, agency regulations and policies, and to a lesser extent, handbooks, FAQs, statistical reports, and news accounts. 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 that 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 summarizes policies and practices that pose barriers to release

¹ While we use the term “compassionate release” to describe this authority, we are aware that many jurisdictions, including Massachusetts, have different names for programs that enable early release for qualifying prisoners. Due to what are sometimes experienced by sick and dying prisoners as insurmountable barriers to engaging early release programs, we believe every program could benefit from taking a compassion-based look at what it means for a prisoner to go through the process. We call these programs compassionate release so that the human experience is foremost in our minds and those of policy makers.

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

Our public comment on 501 CMR 17.00 is informed by that research and our analysis, especially those best practices that we identified and that we believe the Executive Office of Public Safety and Security could draw on to improve regulations implementing Medical Parole in Massachusetts.

1. Massachusetts should not define “debilitating condition” as one requiring long-term specialized medical setting placement

FAMM joins the Prisoners’ Legal Services of Massachusetts’ critique of the regulation’s gratuitous definition of “debilitating condition” as including the requirement that one needs to be placed in a “specialized medical setting for long term care.” We agree it is both unreasonable and unauthorized by the statute. It would also make Massachusetts an outlier among the states. FAMM is aware of only two other states that require placement in a long-term facility as a condition of release or evidence of debilitation. Delaware requires institutional placement for so-called “old law” prisoners (those sentenced prior to June 1990) seeking medical parole.² Pennsylvania requires institutional placement for terminally ill prisoners who can petition the court, which in turn can “defer” the sentence and “place the prisoner in a hospital, long-term care nursing facility, or hospice care location.”³ Pennsylvania’s program has been widely criticized, in part due to the stringent placement requirements and the difficulty of finding institutions to accept prisoners. Advocates, practitioners, legislators, and even the Department of Corrections are working to reform it.⁴

While the need for a specialized setting is used by some states, for example Missouri, as one measure of a prisoner’s debilitation, it is not a criterion of eligibility or prerequisite for release.⁵ States such as Nebraska⁶ and Minnesota⁷ require placement in suitable medical housing for some period of time, but that can include the prisoner’s home. New York has a similar requirement for terminally ill prisoners only.⁸

Making long-term specialized placement a threshold eligibility criteria would defeat the purpose of the medical parole reform by unduly restricting access to medical parole.

² 22 Del. Code Ann. tit. 11, § 4346 (e); Delaware Board of Parole Rules, § 7.

³ 42 Pa. Cons. Stat. § 9777 (a) (1) (iii).

⁴ See Elizabeth Hardison, *Most of PA’s Sick and Elderly Inmates Die in Prison. Medical Parole Could Change That*, PENNSYLVANIA’S CAPITAL-STAR, March 8, 2019, <https://www.penncapital-star.com/criminal-justice/most-of-pa-s-sick-and-elderly-inmates-die-in-prison-medical-parole-could-change-that/>.

⁵ 4 Mo. Rev. Stat. § 217.250; Missouri Department of Corrections Board of Probation and Parole, Procedures Governing the Granting of Paroles and Conditional Releases, § 23.A (2).

⁶ 7 Neb. Rev. Stat. § 83-1,110.02 (3); Nebraska Board of Parole Rules § 4-601(C).

⁷ Minnesota Department of Corrections Policy 203.200.

⁸ 1 N.Y. Exec. Law § 259-s (4) (b).

2. The Massachusetts Department of Correction should develop the medical parole plan

We were quite concerned that the regulations implementing Medical Parole would require a dying or permanently incapacitated prisoner, apparently without any assistance from the Department, to formulate a release plan.⁹ We note that the Massachusetts Medical Parole Plan requirements are admirably comprehensive, ensuring that debilitated prisoners will have a course of and site for medical treatment; medical professionals prepared to provide the care; and finances in place to cover the costs of that care. In this regard, Massachusetts can be considered to be among those states that lead in this area given that nearly half the states have no requirement for release planning or are nearly silent on the matter.¹⁰

But the requirement that the prisoner formulate and document all aspects of the plan, and failing that, risk having the plan returned for resubmission, places a nearly insurmountable barrier in front of prisoners who otherwise meet the strict eligibility requirements for a debilitating condition. The medical parole statute does not require, or even suggest, that prisoners come up with the plan and in fact, the most natural reading of the statute places the responsibility for doing so squarely with the Superintendent.¹¹

Moreover, it is impractical and inhumane to require a prisoner, who is so debilitated by permanent incapacitation or terminal illness that Massachusetts will release him or her before the end of their prison term, to take all the steps necessary to put such a thorough medical parole plan in place. By definition, the prisoners on whom the regulation would place this burden are so affected that they will not pose a risk to public safety. In fact, the regulation provides for a risk for violence assessment conducted by the Superintendent that, among other things, takes into account cognitive and physical condition and prognosis.¹² By way of example, the risk assessment considers certain debilitating conditions including: Alzheimer's disease; Amyotrophic lateral sclerosis (ALS); dementia; and Multiple sclerosis (M.S.). Prisoners are also assessed to determine if they are unable to perform Activities of Daily Living such as eating, breathing, speaking, or getting around, without assistance.

People suffering such limitations would be quite challenged to undertake the various tasks related to gathering documents and securing financing and placements needed for the plan. Prisoners with these and other physical and cognitive limitations will find even simple tasks such as placing phone calls beyond their abilities, much less gathering and providing documentation about medical conditions and financial eligibility for public assistance, filling out forms and getting them submitted to the right office, and handling the bureaucratic minutia that eludes and frustrates people outside prison who are not incapacitated or dying.

⁹ See 501 CMR 17.03(4).

¹⁰ Mary Price, EVERYWHERE AND NOWHERE: COMPASSIONATE RELEASE IN THE STATES at 18 (2018), <https://famm.org/wp-content/uploads/Exec-Summary-Report.pdf>.

¹¹ See G.L. c. 127, §119A(c) (1) (requiring the Superintendent to transmit a medical parole plan to the commissioner).

¹² See 501 CMR 15.0: Risk For Violence Assessment.

Denying medical parole because a prisoner is too ill to prepare a release plan defeats the very purpose of the important reform that Massachusetts undertook in the medical parole law. It is as unnecessary as it is cruel, given that the Department of Correction has an entire division devoted to reentry planning that encompasses finding housing, securing medical care, and applying for public assistance.¹³

Instead, Massachusetts should take a page from states that provide release planning services to complement any resources and information the prisoner can bring to the table. Providing such supportive release planning is sensible and humane. Were Massachusetts to do so, it would not only ensure the Department complies with the statutory requirement, but it would help ensure every eligible prisoner is prepared with the very comprehensive release plan that Massachusetts wisely requires.

For example, Minnesota provides excellent resources and support to prisoners identified as eligible for Conditional Medical Release.¹⁴ Release planning starts when the Department of Corrections identifies a potentially eligible prisoner. Specialized release planners and case workers develop the plan. They arrange for county social services to pre-assess prisoners for eligibility; submit applications to community placement facilities if necessary, ensuring that the prisoner's individual needs are taken into consideration; and apply for Medicaid and other health care funding.¹⁵

North Carolina assigns a social worker to develop a wrap-around plan for prisoners who are seeking Medical Release.¹⁶ The social worker meets with the prisoner and develops a "comprehensive, viable, and appropriate" release plan, that identifies medical treatment and who will provide it. Social workers also locate and apply on the prisoner's behalf for financial resources.¹⁷

Massachusetts' neighbor, New York, also affords comprehensive support once a referral for Medical Parole has been forwarded to the Parole Board.¹⁸ Staff working on the planning select care providers and develop plans that account for the level of care needed, any special equipment or transportation required, and the prisoner's input.¹⁹ Release planning also assesses

¹³ See Mass. Dep't of Correction Reentry Policy, 103 DCO 493.

¹⁴ Conditional Medical Release is available to prisoners who suffer from a grave illness or medical condition and/or who require extended medical management, with health care needs that would be better met by "specialized community services," or have a terminal condition with death expected within twelve months. Minnesota Dep't of Corrections Policy 203.200.

¹⁵ *Id.* at § C.

¹⁶ North Carolina Medical Release is available for prisoners who are permanently and totally disabled; terminally ill with death expected within six months; or geriatric, being 65 years old or older with a chronic infirmity, illness or age-related disease that is incapacitating. For all three categories the condition must be so debilitating that the prisoner is unable or unlikely to pose a public safety risk. N.C. Gen. Stat. § 15A-1369.

¹⁷ N.C. Dep't of Public Safety/Prisons, Policy, and Procedures, Chapter E. §.0903.

¹⁸ N.Y. Dep't of Corrections and Community Supervision Directive 4304, § II.G.

¹⁹ *Id.* at § III.F.

the status of applications for public assistance or insurance and for institutional placement, if needed, and staff must identify an individual to confirm the availability of the placement.²⁰

Any of these approaches to developing a release plan would be preferable to forcing an incapacitated or dying prisoner to tackle the job alone. The proposed barrier is unnecessary and counterproductive.

3. Massachusetts should not release confidential information to victims or survivors

Massachusetts should not provide confidential medical information to victims, their families, or survivors. Conditioning a prisoner's consideration for medical parole on a waiver of medical privacy rights guaranteed under federal and state law is not only contrary to law, it puts the prisoner in an impossible and perhaps vulnerable position, and provides little more than a thin veneer of legality to the disclosure.

Most state laws governing medical release, like Massachusetts in G.L. c. 127, § 119A, provide for registered victim notification when a prisoner seeks or is granted medical release. Our review found no state that goes so far as to release private and confidential medical and personal information contained in the request by a prisoner to a victim. In fact, some states go out of their way to underscore legal protections against the release of such information.

For example, Kansas takes pains to notify victims and consider their input when a prisoner seeks Functional Incapacitation Release.²¹ Kansas also takes pains to protect prisoners' confidential information. The Prisoner Review Board, which reviews applications, must notify the victim, or the victim's family, of the application. The victim's notice must not include any of the prisoner's confidential medical or mental health reports, but does include a general description of the prisoner's incapacity.²²

North Carolina similarly works to inform and seek the views of victims when considering Extension of the Limits of Confinement for debilitated and terminally ill prisoners. The Office of Victim Services makes "reasonable" efforts to contact registered victims. Once it has made contact, the office explains that the prisoner is being considered for an Extension and will ask for the victim's input, which is communicated to the Director of Prisons and ultimately considered by the Secretary. The confidentiality of the prisoner's medical condition must be maintained, and no specifics about his or her health will be released.²³

We urge Massachusetts to follow the practice of every other state and eschew the provision of the medical parole petition, medical parole plan, and supporting documents to victims.

²⁰ N.Y. Exec. Law §§ 259-r (4) (b) and 259 (s) (4) (b).

²¹ Kan. Admin. Regs. § 45-7-2 (b) (2).

²² *Id.*

²³ North Carolina Department of Public Safety/Prisons, Policy and Procedure, Chapter C, § .2100-Medical Release of Ill and Disabled Offender, at (a) (5), (a) (7) and (b) (10).

4. Massachusetts should identify prisoners who may be eligible for medical parole

As discussed above, we were dismayed to see that Massachusetts would bar prisoners from eligibility for incomplete release plans, given the conditions these prisoners endure. We were spurred to write our report, *Everywhere and Nowhere*, after hearing from prisoners and their loved ones who did not know about release for sick and dying prisoners, much less the criteria or how to apply. We would encourage Massachusetts to find and help prisoners who may meet medical parole criteria so that Massachusetts Medical Parole is used as robustly as intended. Instead of placing a barrier to release, the Department of Correction can lend a hand.

Once again, there are states that provide excellent examples of good practices in this area. Alabama requires that applications and release forms be provided to all correctional medical care providers and made available at every institution so they can be distributed to prisoners.²⁴ While many states require that applications be initiated by corrections staff, a few states direct staff to actively seek prisoners who might qualify. In North Carolina, facilities housing acute and long-term care patients are required to identify on a quarterly basis prisoners who match the compassionate release medical and age criteria.²⁵ Similarly California prison doctors are directed to identify and recommend individuals who might meet the medical parole eligibility criteria.²⁶

Clinical staff are in the best position to know when a prisoner has crossed the eligibility threshold. We can think of no reason Massachusetts would not wish to know at the earliest opportunity of prisoners who might qualify for release so that their fitness for Medical Parole can be assessed.

Conclusion

We were very encouraged when Massachusetts passed the new Medical Parole statute. While it does not go as far as we would hope, the law is definitely a big step in the right direction. We urge Massachusetts to follow the example of the states discussed here and support the legislation with clear and comprehensive regulations that avoid barriers, embrace best practices, and help ensure the Medical Parole program is implemented as intended.

Thank you for considering our views.

Sincerely,



Mary Price
General Counsel
FAMM

²⁴ Ala. Code § 14-14-5 (a).

²⁵ N.C. Dep't of Public Safety/Prisons, Policy and Procedure, Chapter C, § .2104 (a).

²⁶ Cal. Penal Code § 3550 (c); Cal. Code Regs. tit. 15, §§ 3559.1 (b) (1) and 3559.2 (a).