UNITED STATES SENTENCING COMMISSION
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COMPASSIONATE RELEASE AND CONDITIONS OF SUPERVISION
TESTIMONY OF JEFFREY WASHINGTON, DEPUTY EXEUCTIVE DIRECTOR
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Good morning Madam Chairwoman and distinguished members of the Commission. My name is Jeffrey Washington and I am the Deputy Executive Director of the American Correctional Association (ACA). It is my pleasure to be with you today testifying on behalf of the ACA. I understand that the Commission is considering amendments regarding compassionate release. In considering your decision, I'd like to provide you with some context regarding the care and treatment of offenders in corrections, some of the challenges correctional professionals face and talk about end-of-life planning in correctional settings.

Founded in 1870, ACA is the oldest and largest professional correctional organization in the world. The American Correctional Association (ACA) represents all disciplines within the corrections profession including practitioners working in juvenile and adult prisons and jails, halfway houses, treatment facilities, probation, parole and community corrections agencies as well as academics in the field and other concerned citizens. It has members in the United States, Canada, Mexico and other nations, as well as 100 chapters and affiliates representing states, professional specialties, or university criminal justice programs. ACA promotes excellence in corrections by offering professional development and certification, online training, standards and accreditation, and research and publications.

For nearly 150 years, ACA has been the driving force in establishing national correctional policies and advocating safe, humane and effective correctional operations. Today, ACA is the world-wide authority on correctional policy and standards, disseminating the latest information and advances to members, policymakers, individual correctional workers and departments of correction. At its first meeting in Cincinnati, the assembly elected Rutherford B. Hayes, then governor of Ohio and later U.S. president, as the first president of the association. At that same meeting, a Declaration of Principles was developed, which became the accepted guidelines for corrections in the United States and Europe.

Perhaps our primary function is develop and publish national standards of policy, practice and procedures for corrections, to perform audits of corrections facilities and agencies based on these standards and to certify accreditation. The ACA's standards and accreditation process has been one of the most important correctional developments of the last century. It establishes internationally recognized standards for the field. The goals of standards and accreditation are: to provide staff and offenders with a safe and secure environment in which to work and live; to provide offenders with the basic rights as set forth by court rulings and the Constitution; to require that correctional systems comply with appropriate codes,

regulations and licensing requirements; to ensure that staff are provided with compensation and professional recognition at an adequate level to guarantee their continued advancement within the corrections profession; and to demonstrate to the executive, legislative and judicial branches of government that correctional systems are willing to establish and promulgate high professional standards and ensure compliance through peer review.

ACA also provides correctional officers and employees of all levels with multiple professional development opportunities. Corrections personnel require a variety of skills for planning, conducting and evaluating correctional programs. We provides training to corrections professionals in many ways including a correctional certification program which certifies correctional professionals after they have completed study and successfully passed a comprehensive examination in one of the following areas: Executive, Manager, Supervisor and Certified Correctional Officer, Nurse, Nurse Manager and Health Services Administrator. Specialization in juvenile corrections and security threat groups is also available.

As you are all well aware, the current federal offender population and many states' populations have risen to unsustainable levels. The Federal Bureau of Prisons reports its current offender population to be about 196,000 down slightly from past years when it had climbed to nearly 220,000. The current population is double what it was just twenty years ago. Roughly 10% of the current federal offender population is over the age of 55. However, the costs associated with providing them their Constitutionally-mandated care and treatment is an enormous burden on the federal budget, just as it is for the state correctional systems with aging offender populations.

It is estimated that 3,300 offenders die of natural causes each year. As offenders age it is critical that corrections is able to accommodate the needs of the geriatric and/or terminally ill offenders. Many would say that it doesn't matter how offenders die, nor do most even care whether or not they receive adequate health care treatment near the end of life. We in corrections do not share these views. Turning a blind eye is certainly not an option either. The United States Supreme Court in Estelle v Gamble established that offenders have a constitutional right to health care. The standard is "deliberate indifference to a serious medical need" is tantamount to 'cruel and unusual punishment' which is a violation of the 8th Amendment of the U.S. Constitution. Specifically, Estelle vs. Gamble established three basic rights for offenders:

1. The right to access care
2. The right to a professional judgement.
3. The right to receive care that has been ordered.

The ACA's ***Public Correctional Policy on Correctional Health Car***e states that, "Incarcerated individuals, or those in the custody of criminal justice and juvenile justice agencies, have a legal right to adequate health care in accordance with generally recognized professional standards utilizing a

comprehensive holistic approach that is sensitive to the cultural, age and gender responsive needs of a growing and diverse population."

When it comes to health care, specifically correctional health care, terminally ill offenders are a group we might call "the least among us." We all find our way into this category at some point in our lives. Death finds us all. Non-incarcerated persons with serious and terminal illnesses, debilitating conditions and/or impairments are not unlike offenders in some ways in that they become seriously devalued by society and are often viewed as a drain on community resources. Whether they are offenders or elderly or both, sometimes those with serious illnesses feel guilty about their circumstances. In particular, the guilt stems from the perceived hardship or burden it imposes on others.

Jails and prisons are designed for confinement. The question is how can we possibly secure a high quality of care for offenders as they die? Correctional facilities are crowded as it is, thus stretching facility staff and resources to their limits and beyond. Health care budgets are lean and are rarely adequately sufficient. The long held 'tough on crime' mantra of policy makers coupled with mandatory sentencing laws and the elimination of parole in many systems have in fact put people behind bars for longer and longer periods of time.

The American Correctional Association has several standards throughout our published manuals requiring facilities and agencies to meet the chronic care and special health care needs of all offenders either through available resources within the agency or by a timely transfer of an offender to an appropriate treatment facility that can meet their needs. The Public Correctional Policy on Correctional Health Care adopted by ACA requires: "*Health care programs for offenders include comprehensive medical, dental and mental health services and that such programs should: G. Establish hospice services for terminally ill offenders supported by a compassionate release program for those who qualify;"*

For corrections, like in the community, care for the terminally ill should start long before the final weeks of life. Twenty-eight correctional systems in the United States offer special care, treatment and programming for geriatric offenders. A number of systems also accommodate the needs of the geriatric offender in separate sections of one or more of their units. Iowa, Louisiana and Texas have complete facilities dedicated to geriatric care. Thirteen states have laws in place for the early release of geriatric offenders. However, most of these jurisdictions combine the requirements with those for terminally ill offenders. In Maine, for example, a geriatric offender may apply for a commutation of sentence from the governor.

Forty-three states provide special services for offenders who are chronically or terminally ill including chronic care clinics, separate housing units, palliative care, hospice services, skilled nursing, separate prison hospitals or inpatient medical referrals centers like in the Federal Bureau of Prisons. Twenty-six

states have statutes in place for the early release of terminally ill offenders under the title, 'compassionate release.' Conditions for release include: being mentally incapacitated or physically incapable of engaging in criminal activity; receiving clemency approval from the governor; and having a life expectancy of less than one year. It may be important to note than in all of these jurisdictions sex offenders are not considered eligible for compassionate release.

Regarding Maine, the state prison has enjoyed a strong partnership with the Maine Hospice Council and benefitted from strong community volunteer involvement. They have developed many end-of-life program components for the prison including staff training on issues of death and dying, pain management education, and a biennial memorial service for offenders. The program has been successful in helping both staff and offenders cope with bereavement and loss and understanding the many obstacles to mourning in prison. They understand that, like death outside of a correctional setting, experiencing death on the inside also requires special attention that includes special times and places to process the impact of the loss(es). The Maine State Prison has an End-of-Life Care Committee that has developed a program whereby offender volunteers can participate and support care of terminally ill offenders. They have had their challenges, including resolving security issues and concerns and to changes in clinical personnel. So Maine has had some successes and developed a good end-of-life program but it isn't easy and it is not without its challenges. Like anything else in a correctional setting, end-of-life programs have their challenges and it can be quite difficult to achieve success.

Maine is an excellent example of collaboration. Collaboration is important as agencies and facilities integrate professional and institutional standards into such programs. They need to work together but must have clearly defined roles so that security personnel are not performing clinical work and vice-versa.

Chronic illnesses, serious mental health disorders, intellectual impairment and seizure disorders have been historically prevalent in prisons. Offender populations also have disproportionate high rates of substance abuse, hepatitis, HIV, cancer, and tuberculosis; all of which put further pressure on correctional budgets.

Dr. Ira Byock wrote in "*Dying Well in Corrections: Why Should We Care*" (**Journal of Correctional Health Care**, 2002) that, "Several factors complicate attempts to provide care and consequently contribute to the suffering of dying inmates. Prisons are rife with personality disorders, racism and gangs. Aggressiveness is an adept asset. Isolation and anger abound and hostility finds fertile ground. Seeds of compassion among security personnel and inmates find little soil in which to take root. As illness-related disability progresses, an inmate becomes vulnerable in this environment. Isolation cuts patients off from family outside, and even "family" and friends inside. Inmate distrust of corrections causes tension between inmates and providers." Byock also says that, "Correctional physicians' expertise in palliative symptoms and counseling individuals confronting life's end also may be limited."

In Louisiana, Warden Burl Cain initiated a hospice program within his prison and offenders are directly involved in the delivery of custodial care services to terminally ill offenders within the facility. The thought of an offender trained as a hospice volunteer might be intriguing to you and might be frightening. Well I'm here to testify that the program at Angola State Penitentiary is something to behold. The offenders are interested and excited to be a part of the hospice program. Many will say that it gives them purpose and even a sense of redemption in their volunteer work with patients and with one another. It may, in fact, be an example of hospice services at its best! It is a true volunteer hospice program, practicing fundamental principles of compassion without any consideration for compensation or even reimbursement. In fact, the Angola Hospice was awarded the Circle of Life from the American Hospital Association for their "outstanding innovations and commitment" to improving end-of-life care. Due to successes at Angola, Louisiana now has six other correctional facilities with their own hospice initiatives. There are now seventy-five prison hospice programs in the country. The Federal Bureau of Prisons has six. Of the existing programs, about half use offenders as hospice volunteers.

Let me now provide you with a couple examples from a state department of corrections regarding the process and procedure in place for a "compassionate release." In Kansas, the Department of Corrections policy allows for the release of offenders due to functional incapacitation or those who are expected to die within thirty days. The Kansas policy defines "*Functional Incapacitation/Imminent Death" as: a medical or mental health condition, including one rendering the inmate terminally ill to the extent that death is imminent, resulting in the afflicted inmate not posing a threat to the public. An inmate suffering from a terminal medical condition likely to cause death within thirty days must have such prognosis determined by a doctor licensed to practice medicine and surgery in Kansas.*

The procedure allows any staff member, contractor, offender or family member to submit the request for release in writing to the unit team. A counselor then reviews the case, collects necessary information and discusses it with the unit manager, who then must consult with the classification administrator who consults with the Deputy Warden or Warden. He or she shall then consult the Deputy Secretary for Facilities Management who reviews all the facts with the Secretary of Corrections and the Chairperson of the Kansas Board of Parole.

If a decision is made to process the application, the Secretary of Corrections shall then notify the prosecuting attorney and sentencing judge as well as the victim through the Department of Victim Services. Upon receipt of their comments, the Secretary of Corrections shall then approve or disapprove the application. Approved applications are sent to the Parole Board for final consideration. Disapproved applications may be reconsidered but must be accompanied by a report of what has changed in the

offender's health status. If the parole board grants the release, the offender is then supervised by the Division of Community and Field Services.

Offenders released due to "Functional Incapacitation/Imminent Death may have their supervision revoked at any time if it is deemed that the individual presents a risk to the public, fails to abide by conditions of release, the medical condition improves, or if the release was based on a prognosis of death within thirty days and the offenders does not die within that period.

In New York State there are two forms of release: Medical Parole and Full Board Case Review. Medical Parole is used for offenders who have served greater than 50% of his or her sentence but has not yet had a parole hearing. A FBCR is used when inmates have already been before the parole board but are now being considered for release due to a medical condition. Like all states, New York has regulations that define which crimes make an offender ineligible for compassionate release. Just last year, in fact, the Commissioner of Corrections was given authority to release terminally ill non-violent offenders at his discretion but only after a review by the Parole Board Chairperson and notification and concurrence from the judge and prosecuting attorney. Registered victims are also notified prior to Parole Board consideration so that they too may have a chance to comment. Offenders need not be terminally ill to qualify for compassionate release. However, they must have a compromised mental state such as dementia or be physically disabled such that he or she is in need of major assistance with the activities of daily living and does not pose any danger/threat to society.

For those offenders who are not eligible for or who do not get approved for 'compassionate release' from confinement, they likely still have serious health conditions or terminal illnesses. However, many are still undergoing active treatment and have not progressed to palliative care only. Management of those offenders can be difficult and quite costly for correctional agencies. When terminally ill offenders are near the end, the first priority for correctional staff is adequate pain management. However, ensuring that an offender dies with dignity and comfort is the ultimate goal in evaluating success. For correctional administrators and managers, hospice programs are successful and cost-effective.

Dr. Byock says, "The period of living we call "dying" holds important opportunities for communication, for completing relationships, even reconciling strained relationships between family members, former spouses or close friends. Beyond this, there is a chance to tell one's stories and review one's life, to make a unique contribution to the family legacy, and for those around the dying person to listen and receive, to affirm for the person departing the value of their being and their story. There is a chance to explore soulful and spiritual aspects of life, those deeper questions of meaning and connection inherent in human condition."

Just because a person is an offender, this does not mean that they are not entitled to proper care and successful end-of-life measures. Whether the person dies while in prison/custody or at home surrounded by family, they should be provided every opportunity to die with dignity. We in corrections continue to make every effort to facilitate compassionate quality end-of-life care for the terminally ill offenders.

The American Correctional Association supports of compassionate release or medical release policies and urges the United States Sentencing Commission to adopt the proposed amendments.