

Testimony of Brie Williams, MD, MS

United States Sentencing Commission:
Public Hearing on Compassionate Release and Conditions of Supervision
February 17th, 2016

Dear Distinguished Members of the United States Sentencing Commission,

Thank you for asking me to provide testimony about the proposed changes to current Federal “Compassionate Release” policies.

I am an Associate Professor of Medicine in the Division of Geriatrics at UC San Francisco and among very few palliative care and geriatrics physicians with professional experience in correctional settings. *Palliative care* is specialized, patient-centered medical care for patients with serious illness that has been shown to result in better health outcomes and lower costs¹; *Geriatrics* is the medical discipline focused on delivering cost-effective, quality medical care to older adults². I conduct research to improve correctional healthcare and to help policy and law makers translate research into policy to transform correctional healthcare. I also train criminal justice professionals in palliative care and geriatrics. As an example of my work, I founded the *Geriatrics Consultation and Training Service* at San Quentin Prison, a 2-year clinical care consultation and training project, and I continue to consult on issues related to geriatrics and palliative care in correctional settings. I am a Founding Director of the U.S.-European Criminal Justice Innovation Program that supports policy makers, government officials and criminal justice leaders to create transformative change in their home criminal justice systems through exposure to alternative criminal justice models in Europe. In 2014, I served as the palliative care and geriatrics representative on the Institute of Medicine’s Workshop on Incarceration and Health. Following the 2011 publication of my review of U.S. compassionate release policy from a palliative care perspective in the *Annals of Internal Medicine*,³ I have consulted for policymakers in two states to help revise their compassionate release policies. Currently, I am the Founding Director of the UC Criminal Justice & Health Consortium, an interdisciplinary community of over 100 researchers from across the University of California system working to advance evidence-based policy reform at the intersection of criminal justice and health.

I have reviewed the Commission’s current policy related to Compassionate Release in the Bureau of Prisons and suggested alternative policies. I submit this written testimony to the United States Sentencing Commission to encourage the Commission to change its current Compassionate Release policy (“Reduction in term of Imprisonment as a Result of Motion by Director of Bureau of Prisons”).

As I am sure you are aware, in 2013, deaths among state and federal prisoners exceeded 3,800,

the highest number since the Bureau of Justice Statistics began tracking prisoner mortality.⁴ In the Bureau of Prisons alone, 400 prisoners died in 2013 representing a 32% increase in federal prisoner deaths since 2001.⁴ The rising number of deaths is being driven, in part, by the large - and precipitously growing - number of older prisoners.^{5,6} For example, over the past five years, from 2009-2014, the number of prisoners age 50 or older has increased 85% and the number of prisoners age 55 or older has increased 102% compared to the overall population of prisoners which has only increased 5% in the same timeframe.^{7,8} While the causes of death of federal prisoners are not comprehensively reported by the Bureau of Justice Statistics, over 88% of *state* prisoner deaths in 2013 were caused by illness, and more than 80% of state prisoner deaths occurred in prisoners age 45 or older.⁴

“Compassionate Release,” adopted by Congress as part of the Sentencing Reform Act of 1984, was enacted in part to curb the cost of incarcerating the seriously ill by allowing those who pose little societal risk to die outside of prison.⁹ Across the nation, nearly all jurisdictions have adopted some form of health-related early release policy, but relatively few dying or seriously ill prisoners are released under such mechanisms.^{10,11} In 2013, the U.S. Office of the Inspector General found that compassionate release saves money for the Federal Bureau of Prisons at minimal cost to public safety, but lacks clear eligibility guidelines.⁹ Given that, on average, older prisoners generate between 4 and 9-fold higher annual costs than younger prisoners,¹² and that older age is the only non-criminogenic factor known to be associated with a lower likelihood of recidivism after release,^{13,14} the estimated cost savings associated with Compassionate Release policies is not surprising. That Compassionate Release is underutilized in the Bureau of Prisons suggests an opportunity to achieve a more cost-effective system by incarcerating fewer older and seriously ill prisoners.

To evaluate this policy from a medical perspective, my testimony is focused on four overarching categories of recommended policy reforms: (1) Expanding access to the early release process for older prisoners without qualifying medical conditions; (2) Expanding access to the early release process for older prisoners with qualifying medical conditions; (3) Revising medical release policy to improve access for persons with serious medical conditions; and (4) Eliminating health-related administrative hurdles to early release that are common across all forms of early release policies and result in avoidable deaths in custody. Within these four overarching categories I have made a total of 10 recommendations that the Commission make to the Bureau of Prisons to reform its Compassionate Release policy.

(1) EARLY RELEASE FOR OLDER PRISONERS WITHOUT QUALIFYING MEDICAL CONDITIONS

In a proposed amendment, the court may reduce a term of imprisonment if it determines that “*the*

defendant is at least 65 years old; and has served at least 10 years or 75% of his or her sentence whichever is greater.”

Recommendation 1: Recommend that the Bureau of Prisons lower the age of eligibility to 55 years

Many older prisoners experience a phenomenon commonly referred to as “*accelerated aging*” in which a lifetime of exposure to risk factors for poor health – such as low socioeconomic status, low educational attainment, poor access to healthcare prior to incarceration, a history of substance use, and disproportionate diagnoses of mental health disorders, traumatic brain injury, and/or post-traumatic stress disorder (PTSD)– result in a physiologic age (their medical age and appearance) that is, on average, 10-15 years older than their chronologic age (their actual age).¹⁵ For this reason, most criminal justice systems use an age cut off of 50 or 55 to define the age at which a prisoner should be considered an “older” prisoner.¹⁶ By setting the age limit for accessing age-related early release at 65, the policy would be accessible to fewer than 5,000 of the over 180,000 prisoners in federal prisons and would exclude many of the very prisoners such a policy is designed to address: those between the ages of 55 and 65 who have served 75% of overly long sentences handed down in the 1990s, when many three strikes and similarly harsh mandatory minimum sentencing laws were passed federally and in several states across the nation. For example, a man who is 55 today and was sentenced to 30 years in 1995 (at age 35) has served 20 years and, using just the 75% rule, would be eligible for release at 57.5. Alternatively, under the 65 year old age requirement, such a prisoner would serve his complete 30 year sentence – and another 7.5 years at a time in his life when prisoners, on average, experience much high rates of chronic and serious illness and physical disability.¹⁷

While there is **no clear agreement on the exact cut-off (age 50 or 55) that should be used to define the age at which a prisoner should be described as an “older prisoner,”** a goal of the proposed amendments is to improve the accessibility of compassionate release programs to prisoners whose ongoing incarceration may require considerable health-related expenditure at little benefit to public safety. It is therefore my opinion that the Sentencing Commission adopts a definition of the “older prisoner” that takes into account the “*accelerated aging*” phenomenon described above. The most conservative approach would be to use the age of 55 or older as the medically appropriate age cut-off of eligibility for consideration for age-related early release, although one could easily justify using age 50 years of age as well.

Recommendation 2: Recommend to the Bureau of Prisons the elimination of the 10-year minimum time served

It is well established that older adults have the lowest rates of recidivism once released.^{11,13,18} In this

context, the recommendation to only include as eligible those persons who have already served at least 10 years of their sentence undercuts the policy's potential to dramatically reduce the incarceration of older adults who generate considerable economic cost but who pose little or no threat to public safety upon release. By requiring at least a 10 year sentence, the Commission runs the risk of inadvertently penalizing those it is most interested in reaching – older prisoners who have served 75% of a relatively short sentence for relatively minor crimes and who would be of less danger and/or risk if released back to the community early.

Some might argue that the reason for mandating a minimum of 10 years served prior to being eligible for early release is that medical conditions and health trajectories are taken into account at the time of sentencing. However, according to the preponderance of medical evidence from the field of geriatrics, this assumption is faulty. Precipitous and accelerated health and functional declines in older adults are both common and difficult to predict when a person is in good health.¹⁹⁻²¹ For example, it is well-established in the medical literature that persons with subclinical (i.e. undetected) early cognitive impairment who experience a change in living environment, such as the change from their home environment to prison, can experience precipitous cognitive decline resulting in the earlier onset of diagnosed dementia.²²⁻²⁴ Such a rapid trajectory of cognitive decline is not uncommon and raises costs for correctional facilities while also increasing the prisoner's risks of physical illness, victimization, and other adverse outcomes.^{25,26} Yet under the proposed amendment, such a prisoner who has served 7.5 years of a 10 year sentence, rather than being eligible for early release, would face an additional 2.5 years in prison.

Similarly, a cornerstone of the field of geriatrics is the assessment of “environment-function mismatch.”^{27,28} Mismatch occurs when an older person is placed into an environment in which they are not able to perform some or all of the activities required for independence (e.g. bathing, dressing, eating, transferring from one position to another, ambulating and toileting) that they were able to perform in their previous environment. Such a mismatch is of critical importance in the context of geriatrics because the loss of independence that can result often leads to rapid deconditioning (loss of muscle tone and impaired physical ability), the onset of new health conditions, and worsening mental health.²⁹⁻³¹ Examples of ways in which the prison environment can limit independence for older adults includes the navigation of very high or very low bunk beds, living in a loud environment that makes hearing and responding to others difficult and may lead to avoidable rules violations or social isolation, difficulty navigating the long transit to “chow” or dining halls which runs the risk of leading to under-nutrition, personal safety fears which can lead to self-imposed limitations in out-of-cell time which, in turn, runs the risk of accelerated physical decline, and many others.^{5,32,33} These potentially deleterious

effects of the prison environment for older adults cannot necessarily be reliably anticipated during trial but could result in an unexpected physical decline once the person is incarcerated.

To ensure that the proposed amendment is accessible to all older prisoners whose ongoing incarceration may require considerable health-related expenditure, **it is my opinion that access to early release policies should be based on percentage of time served and not on absolute number of years incarcerated.**

(2) EARLY RELEASE FOR OLDER PRISONERS WITH QUALIFYING MEDICAL CONDITIONS

In a proposed amendment, the court may reduce a term of imprisonment if it determines that the prisoner *(I) is at least 65 years old; (II) has served at least 50% of his/her sentence; (III) suffers from a chronic or serious medical condition related to the aging process; (IV) is experiencing mental or physical health that substantially diminishes his/her ability to function in a correctional facility; and (V) conventional treatment promises no substantial improvement to the prisoners mental health or physical condition.*

Recommendation 3: Recommend that the Bureau of Prisons lower the age of eligibility for this mechanism to 55 (or 50) years

For rationale, see Recommendation 1 above.

Recommendation 4: Recommend that the Bureau of Prisons develop a list of concrete examples clarifying what is meant by “chronic or serious medical condition(s) related to the aging process”

There is strong evidence that older prisoners have a disproportionately high burden of chronic medical conditions, cognitive impairment and disability compared to younger prisoners and compared to their age-matched counterparts outside of prison.^{17,34-37} Among older adults, many of the health-related conditions that have the greatest impact on healthcare utilization, personal safety, morbidity (illness) and death are referred to as “geriatric syndromes.”³⁸⁻⁴⁰ Again, *geriatrics* is the discipline of medicine that aims to improve the physical and mental health, maintain the independence and enhance the safety of older adults.⁴¹ A cornerstone of geriatric medicine is the steadfast attention to addressing geriatric syndromes.⁴⁰ These include conditions such as cognitive impairment (dementia and delirium); frequent falls and mobility impairments; functional impairments (e.g. difficulty performing activities that are

necessary for independence such as dressing, feeding, toileting, transferring, and bathing); sensory impairments (hearing and vision loss); incontinence; and elder abuse, among others.⁴⁰ Each of these is a chronic and potentially serious health-related condition related to the aging process that can have a substantive effect on a prisoner's likely prospects for independence and functionality in a correctional facility.

It is my opinion that the Commission recommend that the Bureau of Prisons provide a list of examples of what is meant by "chronic or serious medical condition(s) related to the aging process." I recommend that these include, at a minimum, profound cognitive impairment (moderate-severe dementia and/or severe unremitting delirium); frequent falls (including hip fracture); and functional impairments [e.g. inability to perform activities that are necessary for independence such as dressing, feeding, toileting, bathing, and transferring (ability to move from one position to another, such as from sitting to standing)].

(3) RELEASE OF PERSONS WITH SERIOUS MEDICAL CONDITIONS

It is my understanding that there are three proposed amendments that describe "extraordinary and compelling reasons" for consideration of a reduction in imprisonment that are relevant in this section:

- *(I) Has been diagnosed with a terminal, incurable disease; and (II) has a life expectancy of 18 months or less.*
- *Has an incurable, progressive illness; or*
- *Has suffered a debilitating injury from which he/she will not recover.*

Recommendation 5. Recommend the establishment of uniform, evidence-based medical eligibility criteria for compassionate release applications that accurately reflect the diverse ways people commonly experience serious illness and death and that acknowledge the limitations inherent in the science of prognosis.

In 2011, I published an article describing a new model for assessing medical appropriateness for compassionate release that is based on the medical evidence that describes how people die.³ In this article, I described the ways in which many eligibility guidelines for compassionate release policies, as currently written, are typically fraught with clinical flaws. As an example, some guidelines require that prisoners have a predictable terminal diagnosis and that physicians can estimate their prognosis for short-term death with confidence. However, as the medical literature affirms, prognosis is a difficult and oftentimes inexact science that, if applied correctly to an individual patient, provides a *probability* of

death over a certain time frame.^{42,43} As such, specific date-driven prognoses (accurately pinning down the date of death to a specific month) is *often* uncertain. Furthermore, even when physicians are relatively certain of a prognosis, they are often reluctant to prognosticate^{44,45} and, when they do, they are more often than not apt to significantly overestimate prognosis.⁴⁶⁻⁴⁸ Moreover, many conditions that are ultimately terminal are not predictably so. These include such conditions such as advanced liver, heart, and lung disease and dementia,^{21,49} which are increasingly common causes of death and disability among prisoners.^{4,32,50-52} For these conditions, prognosticating the exact date or month of death may be very difficult, but physicians will be much more apt and able to describe how the functional and cognitive trajectory for these patients is expected to worsen over time. Thus, even if a physician cannot say with confidence that the patient in front of them with End Stage liver Disease, for example, has an 18 month prognosis of death, they might be able to say, with confidence, that in 18 months the patient is very likely to develop profound cognitive and/or functional impairment requiring 24 hour care.

This misalignment of compassionate release eligibility policies (those that require physicians to attest to their certainty about prognosticating a date of death) with medical realities (in which many of the terminal conditions that lead to death are difficult to prognosticate to the date) has, in my experience, resulted in the relative few compassionate releases despite a quickly rising number of prisoner deaths in two important ways: (1) requiring a physician to have complete confidence in their prognosis of death, despite this being an inexact science, results in compassionate release petitions that are often requested far too late, and prisoners who, in retrospect, would have met eligibility criteria die before their petition is completed; and (2) requiring a predictably terminal illness means that compassionate release excludes myriad prisoners whose release is likely sensible from public safety, economic, and health care perspectives, including for example, those with severe, but not end-stage, dementia (severe memory loss and/or cognitive impairment), those in a persistent vegetative state (such as coma), and those with end-stage organ disease (such as heart failure or oxygen-dependent chronic obstructive pulmonary disease). Some of these patients may live for months to years, at great expense to criminal justice systems, but may be unlikely to pose harm to society; participate in rehabilitation; or even experience punishment (in the case of patients with dementia). To be most effective, the proposed amendments should be consistent with current medical evidence describing the several, common overarching trajectories of death and serious illness.

To ensure that compassionate release policies result in the prudent release of seriously ill prisoners whose ongoing care in the prison setting is undesirable, **it is my opinion that medical eligibility for compassionate release categorize seriously ill prisoners into 5 groups, each with its own implications for the compassionate release evaluation and implementation process.** In addition, I

strongly recommend revising the requirement of a prognosis of an 18-month life expectancy to “a predictable end of life trajectory” (see category 1). Use of such evidence-based categorization would provide a framework within which medical professionals can assess patients with seriously illness and implement medical eligibility criteria for compassionate release more consistently in accordance with current medical science. I outline these five groups, with modifications in bold from those above, here:

- (1) *Prisoners who have (I) been diagnosed with a terminal, incurable disease; and (II) have a **predictable end of life trajectory** of approximately 18 months or less.*
- (2) *Prisoners who have an **incurable, progressive illness with functional or cognitive impairment that substantially diminishes his/her ability to function in a correctional facility**;*
- (3) *Prisoners who have suffered a severe **cognitive or functionally** debilitating injury from which he/she will not recover;*
- (4) *Prisoners who have severe dementia, are in a persistent vegetative state or who suffer from another form of severe cognitive impairment;*
- (5) *Prisoners who have a quickly evolving serious illness for whom a decision about eligibility for release must be expedited (see next section for more discussion of the issue of expediting release).*

Recommendation 6. Recommend that the Bureau of Prisons (or other appropriate organization) convene a rotating, national panel of health care professionals from correctional medicine and nursing and from outside correctional health, representing geriatrics, palliative care and hospice to perform ongoing, biennial review and revision of compassionate release policies related to medical eligibility to ensure that policies keep pace with evolving science.

In its recent report, the Office of the Inspector General wrote that the Bureau of Prison’s Assistant Director for Health Services and Medical Director were not consulted on the development of the medical provisions for the Compassionate Release policy. Consequently, the report concluded, the provisions were vague.⁹ The report’s finding is consistent with the conclusions of our 2011 manuscript on Compassionate Release in the Bureau of Prisons, in which we found that 399 prisoner deaths in 2008 generated just 36 compassionate released requests that reached the final stage of review.³ Of these, one in six saw the applicant die before the final review was completed. If illness was the cause of death among federal prisoners at a rate similar to what it was among state prisoners (88% in 2008),⁴ then approximately 350 of these 399 2008 BOP deaths were due to illness, meaning that roughly one in ten federal prisoners who died of illness in that year reached the final stage of review for a compassionate

release request. There are likely two components underlying such inadequate access. One is undoubtedly the number of administrative hurdles required to successfully apply for compassionate release (see next section). The second is what the Office of the Inspector General termed “vague” medical eligibility criteria; what, in my opinion, are criteria that inadequately reflect the state of our current knowledge of prognostication and how people commonly experience serious illness and die.

To provide an evidence-based, sustainable solution to this latter challenge, **it is my recommendation that a panel of health care professionals from correctional health, geriatrics, palliative care and hospice, and nursing from both within and outside the correctional healthcare setting provide a review and revise compassionate release policies related to medical eligibility approximately every two years.** Ideally, this team would also conduct a review of a random sample of three types of prisoner files each year – successful compassionate release applicants including their current health status; rejected compassionate release applicants including reasons for rejection and their current health status; and prisoners who died of illness in custody but did not initiate a compassionate release request. These case reviews would result in a brief report submitted to the Bureau of Prisons to identify areas of opportunity for improvement. The report would include, at a minimum:

- a) The number of inmates who have applied for release since the last review;
- b) The numbers who have been: (i) granted release; (ii) denied release; (iii) died prior to having their application reviewed;
- c) The average length of time from petition to each of the outcomes listed in b) above;
- d) The nature of the illness of the applicant, and the nature of the placement for those released;
- e) The categories of reasons for denial for those who have been denied;
- f) The number of releases on compassionate release who have been returned to the custody of the Bureau of Corrections and the reasons for their return.

(4) HEALTH-RELATED ADMINISTRATIVE HURDLES THAT HAMPER ACCESS TO COMPASSIONATE RELEASE

It is critical that the Bureau of Prisons also give consideration to the (sometimes) onerous administrative hurdles that likely limit the use of compassionate release by prisoners who would be considered medically eligible and whose ongoing incarceration is suboptimal from both economic and healthcare perspectives.

Recommendation 7. Recommend that there be clear guidelines for: (a) soliciting prisoner’s desires to apply for Compassionate Release should they become eligible at the time of a diagnosis of serious

illness when they no longer have the capacity to request evaluation for compassionate release; and
(b) ensuring that a prisoner’s application can be processed by a prisoner-approved surrogate in the
event that the prisoner becomes too ill to advance his or her own compassionate release request.

These recommended guidelines reflect a wealth of evidence from the palliative care literature showing that advance care planning – eliciting the healthcare-related wishes of a patient – and the empowerment of surrogate decision-makers for patients no longer able to make their own medical decisions are critical components of community standard quality care in the context of serious and advanced illness.⁵³⁻⁵⁶ Without incorporating these elements into compassionate release policy, procedural barriers are likely to prevent medically eligible persons from obtaining compassionate release, even in cases where a correctional facility would be inclined to approve a release. For example, persons with profound cognitive impairment (which includes most patients with any form of advanced illness^{49,57}) could be incapable of initiating or completing a written petition for release, as would prisoners who experience a rapid descent into a vegetative state but have not had their wishes for compassionate release (and potential discharge plans) elicited by healthcare providers; or prisoners may never become aware that an early release program exists in cases where correctional healthcare providers themselves are poorly informed and/or trained on implementation of the policy.

The risk for such inefficiencies in the administration of compassionate release absent robust and consistently implemented guidelines is heightened because prisoners have the nation’s lowest literacy rates⁵⁸ and are frequently distanced from family or friends, impeding access to social support to navigate the process.^{59,60} However, formal mechanisms to train, assign and guide a prisoner advocate (e.g. a prisoner volunteer, community volunteer, or dedicated member of the healthcare or pastoral teams) to elicit prisoner’s wishes for compassionate release and undertake actions on their behalf in the event of incapacitation could address these hurdles and result in the evaluation of prisoners who may be eligible from a medical perspective.

To ensure that access to evaluation for compassionate release is optimized for the many prisoners who will ultimately meet medical eligibility criteria but may be unable to initiate or complete the onerous administrative process of applying for compassionate release themselves, **it is my recommendation that any compassionate release policy reform include clear guidelines for the appointment, training, and empowerment of prisoner surrogates for the express purpose of eliciting prisoner’s desires and aiding their applications for compassionate release once medical eligibility is determined.**

Recommendation 8. Recommend a significant streamlining of the approval process for compassionate release applications to reflect such applications' two essential components: one medical and one custodial

At the time our manuscript describing Compassionate Release in the Bureau of Prisons was published in 2011, the following process was required in order for a compassionate release application to reach the final stage of review.³ First, the application for release had to be initiated by the inmate, citing both his or her medical justification for release and post-release plans. The application then had to be recommended by the warden of the institution (including a sign off by the attending physician of his or her medical summary and life expectancy estimate). It was then reviewed and approved by the Regional Director, reviewed and approved by the General Counsel of the Bureau of Prisons, evaluated and forwarded by the Medical Director or Assistant Medical Director of the Correctional Programs Division, and ultimately approved by the Director of the Bureau of Prisons. Then, The Director of the Bureau of Prisons would forward a motion for release to the U.S. Attorney in the district where the prisoner was sentenced, which would then get forwarded to the sentencing court. Court officials would then review the application and render a release decision.

As noted above, it is likely that fewer than one in ten BOP prisoners who ultimately died from illness in the years 2000-2008 saw a compassionate release application even proceed to the final stage of review. It is my understanding that the stages of review at that time (described in the paragraph above) included 3 layers of medical review (inmate understanding of and description of medical justification, attending physician, Medical Director of Correctional Programs) and 7 layers of custodial or correctional review (the inmate's generation of a post-release plan, Warden, Regional Director, General Counsel of the Bureau of Prisons, the Director of the Bureau of Prisons, the U.S. Attorney, and the relevant sentencing court). Undoubtedly, one challenge to the many layers of review allowed for in the Bureau of Prisons process at that time is the log-jam that would exist should any considerable proportion of the approximately 350 prisoners who died of illness each year between 2000 and 2008 apply for compassionate release – or should the Bureau of Prisons desire to recommend for release any considerable proportion of its prisoners with serious illness via this mechanism. Such a system of complex and overburdened review is also likely to result in inequity among applicants whereby, for example, seriously ill prisoners held in facilities with more experienced medical staff may be more likely to have their applications reach final review.

To ensure that the effectiveness and equity of compassionate release policy are not undermined by administrative log-jams, it is therefore my recommendation that **a streamlined review process be written into any compassionate release policy reform. Such a streamlined system might rely,**

principally, on the medical determination of the facility Medical Director and on the custodial or correctional determinations of the facility Warden, the Director of the Bureau of Prisons, and the sentencing court. In such a system, I recommend a streamlined process such as the following:

1. The Facility Medical Director determines that the prisoner meets medical eligibility criteria for compassionate release and the Facility Medical Director and the Facility Warden agree on the post-release discharge plan for a prisoner who has, possibly with the help of his or her prisoner advocate, submitted the application for evaluation for compassionate release. This process should be completed within one week of the prisoner's submission. If approved, they would immediately forward the relevant case files to the Director of the Bureau of Prisons.
2. Upon review and approval, within 1 week, of the medical discharge plan the Director of the Bureau of Prisons would transfer the medical discharge plan together with the application for compassionate release to the relevant U.S. Attorney's Office for consideration to motion the court.
3. The report should contain, at a minimum, the following information (medical condition information provided by the facility medical director with assistance from the prisoner's attending medical clinician):
 - a) Diagnosis of the prisoner's medical conditions, including related medical history and whether the prisoner is elderly (by whichever definition the Bureau of Prisons decides upon);
 - b) Detailed description of the prisoner's medical conditions and treatments;
 - c) Estimated (ballpark) prognosis, including life expectancy (and when appropriate which prognostic tool was used to determine life expectancy), likelihood of recovery including likelihood of functional and/or cognitive recovery, likelihood of improvement including likelihood of functional and/or cognitive improvement, and trajectory and rate of current condition (including functional and cognitive impairment);
 - d) Degree of incapacity or disability, including an assessment of whether the prisoner is ambulatory (with mobility aids), capable of engaging in any substantial physical activity, ability to independently provide for their daily life activities as described above, and the extent of that activity (e.g. need for supervised help, need for 24 hour nursing care);
 - e) An opinion from the facility Medical Director as to whether the person meets eligibility criteria for compassionate release and, if so, why or why not. If the Medical Director's opinion is that the person does not meet medical eligibility requirements then the

denied application would still be forwarded on to the Director of the Bureau of Prisons for review.

Recommendation 9. Recommend the provision of a fast track option for prisoners deemed to face “imminent death” who are either actively pursuing or wish to pursue compassionate release.

As discussed above, time is a compelling procedural barrier to effective compassionate release policy. Because medical prognostication is inexact⁴² – and based on population-based risk estimates⁶¹ – not all medically eligible prisoners who request compassionate release and who the correctional system wishes to release will be released due to time constraints, even with the streamlined system described in the recommendation above. A few states have, at least at some time, had a “fast-track” option for imminently dying prisoners to meet this challenge.⁶² In the Federal Bureau of Prisons, a minimum of 51 prisoners died while their application for compassionate release was in the final stage of review between the years of 2000-2008,³ in addition to many more who may have died prior to the final stage of review. These individuals would likely have benefitted from a fast track option. Such an option would be unlikely to result in released prisoners who outlived their prognosis by considerable margins as patients who doctors determine face “imminent death” (e.g. death within days) are far less likely to contradict prognosis than are patients with prognoses on the order of months or years.^{47,63}

To ensure that prisoners who meet medical eligibility criteria and whose applications for compassionate release the correctional system would ultimately approve if given the time are in fact released to die in the community, **it is therefore my recommendation that any compassionate release policy reform include provisions for a fast-track option.** The specific details of the fast-track option should be included in the purview of the expert medical review panel described above. However, it is my recommendation that any patient who the facility medical director determines faces “imminent death” and has an active application for compassionate release - or wishes to apply for compassionate release in the event of a prisoner who experiences unexpected, precipitous and life-limiting decline in health – has his or her application for medical assessment and post-release planning advanced to the Warden within 24 hours, approved or rejected by the Warden and Regional Director within 24 hours of the Warden’s notification, and advanced to the relevant U.S. Attorney’s Office for a decision to be reached within 48 hours of their notification by the Director (a total allowance of four days from the determination of imminent death to a potential Motion to the Court).

Recommendation 10. Recommend that select medical and custodial staff routinely engaged in the care of seriously ill and/or geriatric patients receive comprehensive training in the compassionate

release policy and its implementation, in addition to training in how to identify and care for patients of older age (geriatrics training) and to those with serious and terminal illnesses (palliative care training).

As discussed at length above, serious illness care is complex. Limited life expectancy (or prognosis) is difficult to recognize and the care of patients with limited life expectancy requires a unique approach and unique skills among care providers.⁶⁴⁻⁶⁶ These realities have produced a rapidly growing field in medicine called *palliative care* to meet patients' unique healthcare needs, and their wishes, in the context of serious illness and at the end of life.⁶⁷ At present, access to palliative care in many prisons is limited. For example, only approximately 75 of 1719 state correctional facilities and 6 of 102 federal facilities have hospices.^{68,69} But, as with those in the community,⁷⁰ prison-based palliative care programs are likely to improve health care while lowering costs.^{10,60} Many of the recommendations I have advocated for here rely on palliative care principles, practices, and evidence. This is essential as compassionate release is itself a policy response to the growing number of prisoners experiencing serious illness and end of life in correctional facilities that are not optimally equipped to meet their needs using the most cost-effective and high quality approaches to care.

As a result, the effectiveness and sustainability of these recommendations will require foundational training in palliative care and geriatrics for select medical staff routinely engaged in the care of seriously ill and elderly patients. **Therefore, it is my recommendation that select medical and custodial staff at each prison facility housing such patients receive comprehensive training in the compassionate release policy and its implementation, in addition to training in how to identify and care for patients of older age (geriatrics training) and to those with serious and terminal illnesses (palliative care training).** My team has developed and delivered a similar training on the approach to geriatric patients and for patients with serious illness in the correctional setting, including hands-on training in key components of geriatric care and recommended policy reforms to reduce unintended adverse health outcomes among aging prisoners (e.g. falls, victimization).⁷¹ The training we developed is delivered to jail and prison healthcare staff over 2 days.

OVERALL POINT-BY-POINT RECOMMENDATIONS

I recommend that the new compassionate release guidelines put forth by the Commission recommend that the Bureau of Prisons: (1) embrace evidence-based principles by adopting medical eligibility criteria that reflects current medical knowledge about how people commonly die and experience serious illness; (2) incorporate into their compassionate release eligibility guidelines evidence showing that, from a medical perspective, adults in the criminal justice system on average are considered "older" in their 50s;

and (3) provide a transparent process for the preparation and review of release applications that includes (a) provisions for the assignment of a prisoner surrogate to help navigate the process and represent incapacitated prisoners, (b) a streamlined review process to ensure determinations are made prior to the death of an applicant whenever possible, (c) a special, fast-track option for evaluation of rapidly dying prisoners, and (d) required, comprehensive training for select medical and custodial staff routinely engaged in the care of seriously ill or elderly prisoners in geriatrics, palliative care, and compassionate release policy and its implementation.

My complete recommendations are listed here:

(1) Early Release For Older Prisoners Without Qualifying Medical Conditions

1. Lower the age of eligibility to at least 55 (a case can also be made to lower the age to age 50)
2. Consider eliminating the 10-year minimum time served

(2) Early Release For Older Prisoners With Qualifying Medical Conditions

3. Lower the age of eligibility to at least 55 (a case can also be made to lower the age to age 50)
4. List concrete examples of what is meant by “chronic or serious medical condition(s) related to the aging process

(3) Release Of Persons With Serious Medical Conditions

5. Establish uniform, evidence-based medical eligibility criteria for compassionate release applications that accurately reflect the diverse ways people commonly experience serious illness and death and that acknowledge the limitations inherent in the science of prognosis.
6. Convene a rotating, national panel of health care professionals from correctional medicine and nursing and from outside correctional health, representing geriatrics, palliative care and hospice to perform ongoing, biennial review and revision of compassionate release policies related to medical eligibility to ensure that policies keep pace with evolving science.

(4) Health-Related Administrative Hurdles That Hamper Access To Compassionate Release

7. Provide clear guidelines for: (a) soliciting prisoner’s desires to apply for Compassionate Release should they become eligible at the time of a diagnosis of serious illness when they no longer have the capacity to request evaluation for compassionate release; and (b) ensuring that a prisoner’s application can be processed by a prisoner-approved surrogate in the event that the prisoner becomes too ill to advance his or her own compassionate release request.

8. Significantly streamline the approval process for compassionate release applications to reflect such applications' two essential components: one medical and one custodial.
9. Provide a fast track option for prisoners deemed to face "imminent death" who are either actively pursuing or wish to pursue compassionate release.
10. Require that medical staff routinely engaged in the care of seriously ill and/or geriatric patients receive comprehensive training in the compassionate release policy and its implementation, in addition to training in how to identify and care for patients of older age (geriatrics training) and to those with serious and terminal illnesses (palliative care training).

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Balancing Punishment and Compassion for Seriously Ill Prisoners

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Compassionate release is a program that allows some eligible, seriously ill prisoners to die outside of prison before sentence completion. It became a matter of federal statute in 1984 and has been adopted by most U.S. prison jurisdictions. Incarceration is justified on 4 principles: retribution, rehabilitation, deterrence, and incapacitation. Compassionate release derives from the theory that changes in health status may affect these principles and thus alter justification for incarceration and sentence completion. The medical profession is intricately involved in this process because eligibility for consideration for compassionate release is generally based on medical evidence. Many policy experts are calling for broader use of

compassionate release because of many factors, such as an aging prison population, overcrowding, the increasing deaths in custody, and the soaring medical costs of the criminal justice system. Even so, the medical eligibility criteria of many compassionate-release guidelines—which often assume a definitive prognosis—are clinically flawed, and procedural barriers may further limit their rational application. We propose changes to address these flaws.

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Compassionate release is a program through which some eligible, seriously ill prisoners are able to die outside of prison before sentence completion. The program functions on 2 premises: It is ethically and legally justifiable to release a subset of prisoners with life-limiting illnesses, and the financial costs to society of continuing to incarcerate such persons outweigh the benefits. The U.S. Federal Bureau of Prisons and most state systems have a compassionate- or medical-release program (1, 2). Due to increasing numbers of older prisoners, overcrowding, increasing numbers of in-prison deaths, and the soaring medical costs of the criminal justice system, correctional and public policy experts are calling for broader use of compassionate release (2–4).

Compassionate release consists of 2 entwined but distinct elements: eligibility (based on medical evidence) and approval (based on legal and correctional evidence) (4). We argue that the medical eligibility criteria of many compassionate-release guidelines are clinically flawed because of their reliance on the inexact science of prognostication, and additional procedural barriers may further limit rational application. Given that early release is politically and socially charged and that eligibility is based largely on medical evidence, it is critical that such medical evaluation be based on the best possible scientific evidence and that the medical profession help minimize medically related procedural barriers. We propose changes to address these barriers to make compassionate-release guidelines more clinically meaningful.

THE HISTORY AND RATIONALE OF COMPASSIONATE RELEASE

Compassionate release is a matter of federal statute under the Sentencing Reform Act of 1984 (1), and now all but 5 states have some mechanism through which dying prisoners can seek release (2, 5, 6). Over the past 3 years, 12 states passed legislation to expand early-release programs for dying and incapacitated persons (7–11). Whereas medical eligibility guidelines vary by jurisdiction,

most states require the following: a terminal or severely debilitating medical condition, a condition that cannot be appropriately cared for within the prison, and a prisoner who poses no threat to society (4, 11).

Compassionate release was established under the premise that changes in health status may alter the justification for incarceration. Incarceration is based on the following 4 principles (4, 12): *retribution* through deprivation of liberty when other punishment is deemed insufficient, *rehabilitation* through drug treatment or educational programs, *deterrence* to committing future criminal acts, and *incapacitation* through separating prisoners from society to enhance public safety. These justifications may be substantially undermined for prisoners who are too ill or cognitively impaired to be aware of punishment, too sick to participate in rehabilitation, or too functionally compromised to pose a risk to public safety. Recognizing society's need for retribution for particularly heinous criminal acts, virtually all states exclude some prisoners from eligibility on the basis of crime severity (13).

The compassionate-release program was also designed to address correctional costs. Between 1982 and 2006, U.S. state and federal prison populations grew by 271% (14), prisoners aged 55 years or older increased by 418% (15–17), and spending increased by 660% (18). For the 79 100 prisoners older than 55 years (19), the cost of incarceration is more than 3 times that for younger prisoners, primarily due to health care costs (20). Although releasing prisoners who are very close to death (days to weeks) may simply shift health care costs to Medicare or Medicaid (21), in cases believed to be appropriate and safe, earlier release will probably reduce costs related to hospital security, medical transport for such treatments as dialysis, and

See also:

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Table 1. Outcomes of Compassionate-Release Requests That Reached the Final Review Stage in the Federal Bureau of Prisons*

Year	Federal Prison Population, <i>n</i>	Deaths, <i>n</i> †	Mortality Rate per 100 000 Federal Prisoners	Requests Reaching Final Review Stage, <i>n</i>	Requests Approved, <i>n</i>	Requests Denied, <i>n</i>	Applicant Deaths During Final Review Process, <i>n</i> ‡
2008	178 530	399	229	36	27	5	6
2007	176 346	368	211	30	16	10	6
2006	169 320	328	192	44	26	10	6
2005	175 954	388	233	36	18	10	8
2004	169 370	333	208	21	6	7	5
2003	173 059	347	227	46	25	11	8
2002	163 528	335	232	38	24	5	6
2001	156 993	303	221	34	26	4	3
2000	145 416	285	218	40	32	5	3

* To reach the final review stage, the application had already been initiated by the inmate, citing both justification and postrelease plans recommended by the warden of the institution where the inmate is held (including the attending physician's medical summary and life expectancy estimate), reviewed and approved by the Regional Director, reviewed and approved by the General Counsel of the Bureau of Prisons, evaluated and forwarded by the Medical Director or Assistant Medical Director of the Correctional Programs Division, and ultimately approved by the Director of the Bureau of Prisons. The Director of the Bureau of Prisons then forwards a motion for release to the U.S. Attorney in the district where the prisoner was sentenced and to the sentencing court (5). As reflected in this table, the data consider the Director of the Bureau of Prisons the final review stage. All data are from reference 27 unless otherwise noted. Of note, the data listed for each year reflect all activity during 1 calendar year. Approvals and denials may carry over from one year to the next. The numbers of approvals, denials, and deaths in 1 year do not always add up to the total number of requests from that year.

† Data in this column are from reference 26.

‡ Death occurred before final decision was made regarding compassionate release.

construction of disability-accessible protective housing (3, 11). Indeed, the average annual costs for health care, protective transportation, and guards for 21 seriously ill prisoners in California (just 0.01% of the state's prison population) exceed \$1.97 million per prisoner (22). In comparison, the median annual cost of nursing home care in California is \$73 000 per person (23). Further ethical, legal, and financial aspects of compassionate release are discussed elsewhere (4, 11).

The precise number of requests for compassionate release is unknown, in part because many prisoners die during review (3, 11, 21). What is known is that a small percentage of dying prisoners are granted compassionate release. For example, in 2008, 399 deaths occurred in the Federal Bureau of Prisons and 27 requests for compassionate release were approved. Six applicants died during the final review process (Table 1) (4, 24, 25). Given the importance of public safety, we do not mean to suggest that any death in prison be viewed as a failure of the compassionate-release process. However, the medical and procedural flaws in eligibility guidelines described here, coupled with the small number of persons who receive compassionate release, suggest the importance of reevaluating and transforming current guidelines.

THE COMPASSIONATE-RELEASE PROCESS

Compassionate release varies by jurisdiction. In federal prisons, a prisoner or an advocate initiates a written appeal describing the "extraordinary and compelling reasons" for release and proposes release plans; the application receives 4 additional levels of review after a medical evaluation. State prisons have different requirements for eligibility, application, and approval (13). The review process in both federal and state systems can extend for months and sometimes years (11).

MEDICAL-RELATED FLAWS IN COMPASSIONATE-RELEASE PROGRAMS

Eligibility guidelines for compassionate release are often fraught with clinical flaws. To meet most guidelines, prisoners must have a predictable terminal prognosis, be expected to die quickly, or have a health or functional status that considerably undermines the aforementioned justifications for incarceration. As such, compassionate release requires that physicians not only predict limited life expectancy but functional decline as well. Prognosis is difficult to establish for such conditions as advanced liver, heart, and lung disease and dementia (26, 27), which are increasingly common causes of death and disability in prisoners (28–30). Moreover, for patients with more predictable prognoses, such as cancer, functional trajectories vary and are unpredictable, often declining only in the last weeks of life (31, 32).

Reliance on prognostication can create a "catch 22": If compassionate release is requested too late, an eligible prisoner will die before the petition is completed; too early, and a terminally ill prisoner in good functional health can be released, live longer than expected, and may pose a threat to society. Requiring a predictable, time-limited prognosis (such as 6 months or less) excludes prisoners with severe, but not end-stage, dementia; in a persistent vegetative state; or with end-stage organ disease (such as oxygen-dependent chronic obstructive pulmonary disease). Some of these patients may live for months to years, at great expense to criminal justice systems, and are incapable of posing harm to society; participating in rehabilitation; or experiencing punishment, in the case of patients with dementia. These flaws reflect a fundamental tension between the eligibility guidelines for compassionate release and the actual disease trajectories of the patients in question.

Table 2. Proposed Categorization Scheme for Assessing Medical Eligibility for Compassionate Release for Seriously Ill Prisoners

Prisoner Group	Pace of Disease Progression and Predictability of Prognosis	Disease Examples	Primary Medical Criteria for Release	Need for Fast-Track Assessment for Compassionate Release?	Time Point of Assessment for Potential Medical Eligibility	Individual Responsible for Identifying Candidate for Potential Eligibility and for Initiating Process	Release Site	Alternative to Release
Terminal illness with predictable prognosis	Steady progression with predictable prognosis (months to years, depending on stage at diagnosis)	Metastatic solid-tumor cancer, ALS	Life expectancy/prognosis	No	Diagnosis of new cancer or rapidly progressive terminal illness	Physician/health care provider, patient, advocate*	Hospice, palliative care program, family home-hospice	Prison hospice
	Rapid progression with predictable poor prognosis (days to weeks)	Rapidly progressive cancer; acute infection or vascular event with rapid decline or multiorgan failure		Yes				
Profound cognitive impairment or dementia	Steady progression of disease, functional and cognitive impairment; predictable long-term prognosis (steady worsening of cognitive and functional abilities over years from diagnosis) until end-stage dementia when short-term prognosis is difficult to predict (months to years)	Alzheimer disease and other types of dementia, persistent vegetative state	Cognitive status	No	Annual medical evaluation or following acute event (e.g., stroke, hospitalization for pneumonia)	Physician/health care provider, advocate*	Nursing home, family caregiver	Prison dementia unit or long-term care unit
Serious, irreversible, progressive disease with profound cognitive and/or functional impairment†	Steady progression of symptoms and functional impairment, unpredictable prognosis (months to years)	Oxygen-dependent COPD, NYHA class IV heart failure, advanced liver disease with cirrhosis	Cognitive and functional status	No	Annual medical evaluation or following seminal events (3 or more hospitalizations in a year, ICU admission, new inability to complete self-care activities)	Physician/health care provider, patient, advocate*	Nursing home, family caregiver	Prison assisted-living facility until end stage, then prison hospice

ALS = amyotrophic lateral sclerosis; COPD = chronic obstructive pulmonary disease; ICU = intensive care unit; NYHA = New York Heart Association.

* The Society of Correctional Physicians Position Statement on Compassionate Release “encourages responsible prison and jail physicians to take a leading role in initiating and shepherding the medical release process for possible candidates” (39). Given that a prisoner with newly diagnosed profound dementia may be too cognitively impaired to initiate a request for release, the physician or a patient advocate would be the most appropriate person to initiate a request.

† “Functional impairment” refers to criteria for nursing home eligibility, specifically impairment in 2 or more activities of daily living.

Procedural barriers may also prevent medically eligible persons from obtaining compassionate release and invite potential inequity. For example, persons with profound cognitive impairment (which includes most patients with advanced illness [26, 33]) could be incapable of completing a written petition. Prisoners also have the nation’s lowest literacy rates (34); are frequently distanced from family or friends, impeding access to social support to navigate the process (35); and are often not aware that early-release programs exist (3). However, formal mechanisms to assign and guide a prisoner advocate have been neither universally accepted nor optimized. For example, for a terminally ill prisoner in California, the warden must enable the prisoner to designate an outside agent to act as an advocate (10);

however, once an advocate is appointed, there are no formal guidelines to help him or her navigate the system. In states without formal advocates (such as New York), implicit expectations have arisen that prison medical staff should advocate for such prisoners. This expectation is not formally codified and is infrequently operationalized (11). Another procedural barrier is time. Although a few states, such as Vermont, have a “fast-track” option, for imminently dying prisoners (11), the process may be too lengthy to achieve evaluation for release before death. While these procedural barriers do not relate directly to the clinician’s role, they may act as functional barriers to a meaningful process and should be reformed along with medical eligibility criteria.

ADDRESSING MEDICAL-RELATED FLAWS IN COMPASSIONATE-RELEASE ELIGIBILITY GUIDELINES

We recommend the development of standardized national guidelines by an independent advisory panel of palliative medicine, geriatrics, and correctional health care experts. Such external evaluation would require transparency and public sharing of information about the varied compassionate-release processes across jurisdictions and could help identify other avenues for improvement system-wide (36). At a minimum, the new guidelines should embrace evidence-based principles and a transparent process that includes assignment of an advocate to help navigate the process and represent incapacitated prisoners, a fast-track option for evaluation of rapidly dying prisoners, and a well-described and well-disseminated application procedure. The guidelines also must delineate distinct roles for physicians regarding assessment of medical eligibility and parole boards and correctional administrators to help balance medical evaluation, public safety, and retribution in the approval process (37). Other areas that should be reviewed include mechanisms for identifying potential candidates and avenues for addressing request denials (3, 11, 36). As with other guidelines (38), standardization of compassionate-release guidelines in conjunction with a patient advocate should help avoid inequities in access, particularly for persons too cognitively impaired to advocate for themselves.

We also propose that national criteria for medical eligibility for compassionate release categorize seriously ill prisoners into 3 groups based not only on prognostication but also disease trajectory and functional and cognitive status. These groups consist of prisoners who have a terminal illness with a predictably poor prognosis; prisoners with Alzheimer disease or related dementia; and prisoners with serious, progressive, irreversible illness with profound functional or cognitive impairment. Use of such evidence-based categorization could provide a framework within which the roles of medical professionals can be tailored (Table 2) and serve as the starting point for the redesign of medical eligibility criteria, release settings, and in-prison medical needs.

Finally, to address concerns about retribution and public safety, we propose that recall mechanisms for prisoners whose conditions improve substantially after release (15) be expanded to all state and federal programs.

PALLIATIVE MEDICINE AND THE CRIMINAL JUSTICE SYSTEM

Efforts to transform compassionate-release programs should concurrently develop prison-based palliative care. Prisoners being considered for compassionate release have an illness or a debilitating condition that is serious enough for them to benefit from a palliative medicine evaluation to decrease the symptom burden while they await a decision.

In addition, while incarceration may no longer be justified for prisoners who are both medically eligible and meet legal and correctional approval, palliative care should be provided to the many prisoners with serious illnesses who will not be eligible for early release. At present, access to palliative care in prison is limited. For example, only 75 of 1719 state correctional facilities and 6 of 102 federal facilities have hospices (39, 40). As with those in the community (40, 41), prison-based palliative care programs are likely to improve health care while lowering costs (2, 35).

CONCLUSION

Although compassionate release could address fiscal pressures created by the aging prison population, medical and procedural barriers may prevent its rational application. Determining medical eligibility, as distinguished from approval, for compassionate release, is a medical decision and falls within a physician's scope of practice. Moreover, many states are considering expanding medical eligibility to include physical incapacity and elderly prisoners, in addition to terminal diagnoses. Physicians and other medical professionals thus have an opportunity to use their unique expertise and knowledge of prognosis, geriatrics, cognitive and functional decline, and palliative medicine to ensure that medical criteria for compassionate release are appropriately evidence-based. Using this medical foundation, criminal justice professionals can balance the need for punishment with an eligible individual's appropriateness for release. As a society, we have incorporated compassionate release into most prison jurisdictions. As a medical profession, we must lend our expertise and ethical suasion to ensure that compassion is fairly delivered.

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