POLICY BRIEF

Compassionate Release:

A practical, human rights-based response to the aging prisoner crisis

Executive summary

Few prisons are set up to meet the complex health care needs of the growing global cohort of older prisoners. Deficits include unsuitable physical environments, inadequate health care facilities, lack of trained specialist staff and appropriate medicines, including controlled medicines for the relief of pain and other symptoms, and tight budgets. As a result, in law, continued incarceration, especially if it deprives inmates of appropriate health care, constitutes disproportionately severe punishment. As the number of older prisoners is projected to drastically increase in the future – due to natural population ageing and ongoing conviction and incarceration of sex offenders in particular – the development of new policies is warranted to respond to the needs of this vulnerable prison population in a manner that respects their human rights.

Prisoners who are either terminally ill, or who have severe physical or cognitive impairments that require specialist nursing care, should be considered for compassionate release from prison to be cared for in an appropriate setting in the community, taking into account public safety requirements. Compassionate release policies should be codified, made fit for purpose, and operationalized in coordination with local units of government.

Palliative care services equivalent to services provided in the community should be available in prison for prisoners who are ineligible for compassionate release and whose release applications are pending.[1]

The aging prisoner crisis

Older persons constitute a sizable population in prisons in many countries in the world, one that is expected to grow even more dramatically in the future. This large number of older persons behind bars is due to several factors; a general increase of life expectancy in many societies, harsher penal policies such as an increase in long sentences, life sentences, limited utilization of parole, and an increased number of convicted offenders with 'historical' sexual charges.[2]

According to scholars, there are three groups of older persons in prison; some are incarcerated for the first time when they are already in older age; some received very long prison sentences when they were young and are growing old in prison; and some are repeat offenders who are released and who chronically reoffend.

Case: Prison-based palliative care patient

An article in the *Journal of Pain and Symptom Management* tells of a 53-year old prisoner living with HIV/AIDS, hepatitis C, cirrhosis, and severe hematologic disease. He was sentenced for a nonviolent crime. As his kidneys and liver began to fail, palliative care began in prison and symptom management was provided, while his family was supported by a social worker. Throughout this process, he was handcuffed to his bed at both wrists and continuously guarded by two prison officers. Due to strict visitation rules, his family was allowed to see him for a maximum of one hour a day only. Although an attorney was able to lessen the handcuff requirement to one wrist, he died while restrained and without the presence of his family.[3]

As older prisoners frequently exhibit considerable health problems, this growing demographic presents a significant challenge for criminal justice systems.

[1] United Nations General Assembly. (2015). General Assembly Resolution 70/175 - United Nations standard minimum rules for the treatment of prisoners (the Nelson Mandela Rules). New York: United Nations.
[2] Turner, M. Peacock, M., Payne, S., Fletcher, A., & Froggatt, K. (2018). Ageing and dying in the contemporary neoliberal prison system: Exploring the 'double burden' for older prisoners. *Social Science & Medicine, 212*, 161-167.
[3] Klock, Z., & Liantonio, J. (2018). End-of-life care in imprisoned persons. Journal of Pain and Symptom Management, 55(4), e4-e6.

There is a general consensus among academics that imprisonment triggers accelerated ageing and that the health status of prisoners is equivalent to that of people 10 years older in the community.

This is partly because prisoners often come from economically deprived communities and have histories of poor nutrition, substandard health care, substance use disorder and chronic stress, including from incarceration. As a result, prisoners aged 50-55 are commonly considered geriatric.

Prison can constitute a challenging environment for older persons who have difficulty washing, getting out of bed, or climbing stairs, and are visually or hearing impaired. In addition, older persons in prison are more likely to exhibit chronic health problems, and the majority have more than one major illness. Older prisoners frequently suffer from arthritis, hypertension, diabetes, hepatitis C, cancer, sexually transmitted diseases, a range of physical disabilities, as well as mental illnesses such as depression, anxiety, alcohol and drug addiction, and dementia. Dementia, in particular, represents a considerable problem for elderly people in prisons, who often go undiagnosed because symptoms may go unnoticed within strict prison regimes.

As prison facilities and prison regimes have been designed with younger populations of inmates in mind, prisons and prison staff are often inadequately equipped to deal with the health problems of older prisoners. Older prisoners often require consistent and specialist medical treatment that significantly burdens prison health care services. These are chronically under-staffed and under-resourced and usually unable to provide adequate care.

As a result, older prisoners face double punishment that deprives them of both their liberty and appropriate health care for serious and distressing symptoms. Many older prisoners die behind bars. Although global figures are difficult to come by, in the U.S. for example, the number of inmates dying in prison has increased steadily, and is now reported at more than 5000 per year, with almost 90 per cent of those deaths being the result of medical illness.[4] Many extended sentences may, for older persons, constitute *de facto* life sentences. These issues raise important questions of ethics and justice.

Compassionate release

Regulations allowing for "compassionate release" in some countries allow prisoners at the end of their lives, or those suffering from critical health conditions, to receive care in the community and die with dignity. Other countries provide for medical or geriatric *parole*, so prisoners who are suffering from critical health conditions incompatible with imprisonment can be transferred to an institution in the community to receive care, until they are well enough to return to prison. However, where compassionate release provisions exist on paper, procedural barriers make them inaccessible in practice and result in underutilization.[5] A disproportionately low number of prisoners are released under the auspices of such provisions, likely because the application process is vague, complex, arduous and lengthy, and can involve many different authorities (parole board, sentencing court, governor, director of corrections, etc.), resulting in some prisoners dying while their application is pending. In addition, criteria are overly restrictive and exclusion criteria often list:

- a minimum age of eligibility
- minimum length of sentence served
- life sentence
- convictions for specific offences, such as sex offences and murder
- absence of a diagnosis of a terminal illness
- life expectancy beyond specified number of months
- existence of a health issue at the time of sentencing

These criteria mean that some prisoners, who might be considered most in need of compassionate release and adequate care in the community, might be excluded from consideration. For example, a requirement of a terminal illness excludes people with severe dementia, chronic illness, or those in a persistent vegetative state. The exclusion of convicted sex offenders may ignore prisoners who are most in need of compassionate release for terminal illness as these crimes often lead to particularly lengthy sentences.

In addition, many potentially eligible prisoners, and the prison staff who supervise them, are often unaware of the provisions or the application process.

[4] Kanbergs, A., Ahalt, C., Cenzer, I. S., Morrison, S., & Williams, B. A. (2019). "No one wants to die alone": Incarcerated patients' knowledge and attitudes about early medical release. *Journal of Pain and Symptom Management, 57*(4), 809-815.

[5] Wylie, L. E., Knutson, A. K., & Greene, E. (2018). Extraordinary and compelling: The use of compassionate release laws in the United States. *Psychology, Public Policy, and Law, 24*(2), 216-234.

Palliative care in prison

Palliative care is the active holistic care of individuals across all ages with serious health-related suffering due to severe illness, and especially of those near the end of life. It aims to improve the quality of life of patients, their families and their caregivers.[6]

Some prisons have established palliative care services to respond to the number of aging prisoners in their care. In the absence of clear and comprehensive compassionate release regulations, international law obliges member states to provide palliative care in prison that is equivalent to that in the community.[7] The equivalence of care standard for terminally ill prisoners who are either awaiting release or for various reasons are ineligible for release ensures compliance with human rights obligations.

Although prison based palliative care units would undoubtedly provide important services, they are significantly absent even in Upper Income countries. Limitations include:

- physical environment and infrastructure
- contradiction between the philosophies of custody and care; prison culture, norms and practices emphasize security and prisoners at the end of their lives are often not considered as patients
- pain management; patients may be left in pain due to concerns about diversion of essential medications
- lack of trust in prison health care providers, because of the institutional culture and compounded by a frequent requirement of do-not-resuscitate orders for admission into palliative care units

Example of good practice: Inmate volunteer model of prison-based palliative care[8]

Louisiana State Penitentiary (at Angola): Through a peer-care model, trained inmate volunteers provide psychological support, assistance with activities of daily living such as personal hygiene, feeding, mobility, as well as companionship and symptom monitoring to fellow inmates who are terminally ill. This innovative model reduces the burden on prison health care staff and also teaches volunteers valuable skills they can market upon release.

Although palliative care may be available in some prisons, for some prisoners, institutional limitations of prison, such as restrictive rules, especially with regard to visitation, are not entirely compatible with contemporary philosophies or best practice end-of-life care. There is little or no dignity to dying in prison. Therefore, a dignified death in the community may be preferred if adequate support is available.

The existence of a palliative care unit in prisons should not result in a lowered likelihood that a prisoner will be considered for compassionate release. Providing quality palliative care and compassionate release are not mutually exclusive.

Conclusion

Member states would gain several benefits by implementing effective compassionate release policies;

- *Fiscal*: prison service health care costs for older prisoners can be 3x higher than for younger prisoners
- *Governance*: increased utilization of compassionate release would alleviate prison overcrowding and associated social problems
- *Legal and ethical*: fit for purpose compassionate release honors member states' human rights obligations

Health status is often considered a leniency factor at the sentencing stage. However, post-sentencing may not allow for any consideration of a prisoner's circumstances or sentence modification. This challenges both penological goals and humanitarian principles. International human rights law does not justify punishment if prisoners are too impaired, physically or cognitively, to be aware of the punishment or to engage in rehabilitative programmes. Compassionate release should be distinct from the parole system, just as criminal history, or correctional behavior are irrelevant for humanitarian assistance. Decisions should be predicated on only two evidence-based criteria; health and risk status. The implementation of the recommendations contained in this document will require the establishment of community/correctional multi-disciplinary teams and budget lines that will be offset by long-term savings.

[6] IAHPC Definition of Palliative Care. https://hospicecare.com/what-we-do/projects/consensus-based-definition-of-palliative-care/definition/
[7] General Comment 14, ICESCR. 34. https://www.refworld.org/pdfid/4538838d0.pdf
[8] Cloyes, K. G., Rosenkranz, S. J., Supiano, K. P., Berry, P. H., Routt, M., Llanque, S. M., & Shannon-Dorcy, K. (2017). Caring to learn, learning to care: Inmate hospice volunteers and the delivery of prison end-of-life care. Journal of Correctional Health Care, 23(1), 43-55.

Recommendations for operationalizing compassionate release

- Modify or develop legislation and policies to allow prisoners with a terminal illness or severe physical or cognitive impairments that require complex medical care and/or are incompatible with the prison environment, who do not pose a public safety risk, to be considered for compassionate release and to receive appropriate medical care in the community;
- Ensure that eligibility criteria for compassionate release concern only the health status (either terminal illness or a health condition incompatible with imprisonment) and potential risk to the public, and do not exclude prisoners on the basis of their age, lack of a prognosis, the type of offence, the length of their sentence or amount of their sentence served;
- Ensure that compassionate release provisions operate independently from the parole system;
- Ensure that the process is expeditious, to prevent avoidable suffering and deaths of eligible prisoners in prison while a decision is pending, for example by assigning a special body to consider and adjudicate upon compassionate release requests;
- Promote awareness of compassionate release rules and procedures among prison staff, parole officers, case managers, prisoners and families and enable these parties to submit applications for compassionate release on behalf of the prisoners if they are unable to do so themselves;
- Establish linkages with institutions in the community, such as nursing homes and hospices, to ensure continuum of care upon release, taking into account the individual needs of prisoners;
- Ensure that provisions are in place to appeal denials of compassionate release and to re-apply, and ensure that prisoners have access to legal counsel in this process;
- Monitor the implementation of compassionate release practices, including the reasons for denial of compassionate release;
- Promote non-custodial alternatives for older prisoners or prisoners with substantial cognitive or physical impairments at the sentencing stage.

Recommendations for providing palliative care in prisons

- Ensure that palliative care that it is equivalent to the quality of care provided in the community is available in prison for all prisoners who need it;
- Organize palliative care services in prisons in close partnership with palliative care services in the community, also to facilitate the transfer of patients from prisons to appropriate institutions in the community, providing a continuum of care;
- Avoid segregation of older prisoners or prisoners with severe physical or cognitive impairments in special units and instead house them among the general prison population, in accordance with their assigned security level; prisoners should only be segregated in special units if it is necessary to provide special medical care;
- Conduct comprehensive health and needs assessments of older prisoners on admission to prison and at regular intervals throughout their sentence;
- Involve a multidisciplinary team in the provision of medical, psychological and spiritual care;
- Ensure that all staff involved in the custody of older prisoners receive training to understand and notice signs of impairments related to the ageing process, as well as receive guidance on how to constructively work with this vulnerable prison population;
- Allow for contact with family and friends, as appropriate;
- Encourage the training and involvement of prisoners as volunteer palliative caregivers who can assist in activities of daily living and provide psychological support;
- Monitor the quality of implementation of palliative care services.

Further reading

United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). Available at https://www.unodc.org/documents/justice-and-prison-reform/Nelson_Mandela_Rules-E-ebook.pdf

Council of Europe, Committee of Ministers Recommendation No. R. (98) 7 Concerning the Ethical and Organizational Aspects of Health Care in Prisons. Available at https://rm.coe.int/09000016804fb1

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