REPORT OF THE BOARD OF TRUSTEES

B of T Report 10, November 2020

Subject:	Compassionate Release for Incarcerated Patients (Resolution 430-A-19)
Presented by:	Russ Kridel, MD, Chair
Referred to:	Reference Committee D

Resolution 430-A-19, introduced by the Medical Student Section and referred by the House of Delegates asked that:

> Our American Medical Association support policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; collaborate with appropriate stakeholders to draft model legislation that establishes clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

BACKGROUND

Compassionate release, also known as medical release, is a program or policies that allow eligible, seriously ill prisoners early release or parole before sentence completion.[1] Compassionate release was authorized on the federal level under the Sentencing Reform Act of 1984 and subsequently adopted by 49 states and the District of Columbia.[2] Medical eligibility guidelines vary by jurisdiction, but most states require 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.[1]

Compassionate release is a matter of ethics as the continued incarceration of patients with serious or debilitating illness can constitute a violation of human dignity if appropriate palliative care is unavailable.[3] In addition to ethical reasons, compassionate release has been called for to address the aging prison population, overcrowded facilities, increasing deaths in custody, and soaring medical costs of the criminal justice system.[1,4]

In 2016, a total of 6.6 million persons were involved in the US criminal justice system, including 1.5 million in state and federal prisons.[5] From 1993 to 2013, the population in state prisoners age 55-and-older more than tripled, increasing from 3 percent to 10 percent.[6] Between 2009 and 2013, the population of US federal prisoners aged 49 or younger decreased by 1 percent, whereas the number of prisoners aged 50 or older increased by 25 percent.[7]

Racial and ethnic minority groups are disproportionately represented in the justice-involved population. In 2017, blacks represented 12 percent of the US adult population but 33 percent of the sentenced prison population. Whites accounted for 64 percent of adults but 30 percent of prisoners. And while Hispanics represented 16 percent of the adult population, they accounted for 23 percent of inmates. From a health perspective, it is not uncommon for justice-involved individuals to

experience multiple chronic conditions, mental health disorders, and physical disabilities at relatively young ages.[9] They are also more likely to have experienced stress and trauma, have a substance use disorder, experienced homelessness, and have limited access to health care.[9]

EXISTING AMA POLICY

It is the AMA's position that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism (Policy D-430.997, "Support for Health Care Services to Incarcerated Persons"). The AMA supports of the National Commission on Correctional Health Care (NCCHC) standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities, and encourages all correctional systems to support NCCHC accreditation (D-430.997, "Support for Health Care Services to Incarcerated Persons").

The AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated individuals who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid. The AMA encourages states to suspend rather than terminate Medicaid eligibility upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community. The AMA urges Congress, the Centers for Medicare & Medicaid Services, and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism (Policy H-430.986, "Health Care While Incarcerated").

Furthermore, the AMA has urged the Society of Correctional Physicians and the NCCHC to work to develop policies and guidelines on how to transition to long-term care facilities for individuals recently released from incarceration, with consideration to length of incarceration, violent tendencies, and medical and psychiatric history (Policy H-280.948, "Long-Term Care Residents With Criminal Backgrounds "). The AMA does not have policy specific to compassionate release.

DISCUSSION

Compassionate release policies were authorized in recognition of the fact that appropriate care for patients with severe or debilitating illnesses is difficult, and sometimes impossible, to achieve in the correctional setting.[3,10,11] In 2013, the U.S. Department of Justice, Office of the Inspector General found that the Federal Bureau of Prisons (BOP's) compassionate release program was "poorly managed and implemented inconsistently," resulting in eligible inmates likely not being considered for release and terminally ill inmates dying before their requests were decided.[12] During a one year span in the BOP, only 85 (3.24 percent) out of 2,621 requests for compassionate release were granted.[12] State prison systems are likely to have similar rates of release, though only 13 states are required to track and report compassionate release statistics and few of them are required to make the information publicly available.[2]

Barriers to Implementing Compassionate Release Policies

The limited use of compassionate release is due to barriers at the patient, professional, policy, and administrative levels. At the patient level, individuals who are incarcerated may not be aware that they are eligible for compassionate release or incorrectly believe that they are ineligible. In a

survey of medically complex patients across three geographically disparate prisons and jails, 43 percent of respondents lacked the knowledge necessary to apply for compassionate release, and 75 percent indicated they would apply if eligible.[11,13]

At the policy level, both the medical eligibility criteria, based on medical evidence, and the administrative approval process, based on legal and correctional evidence, can limit the compassionate release process.[1] The federal criteria for a reduction in sentence for medical circumstances require either a terminal medical condition (a life expectancy of 18 months or less) or a debilitated medical condition (See Table 1). While some states have adopted the federal medical eligibility criteria, others have adopted their own criteria, resulting in variability in requirements across jurisdictions.

In determining medical eligibility, clinicians may have concerns about the legal consequences of releasing someone who lives beyond the expected timeframe since there are terminal illnesses with unpredictable trajectories.[4] Furthermore, the correctional evidence review process is often complex and time-consuming, requiring multiple layers of review.[2] A final decision may require approvals by the warden, a parole or review board, and even the state's governor.[10] These barriers can be compounded by administrative barriers such as objections by a victim advocate or prosecutor, concerns about public safety, and availability of post release community care plans to ensure placement in community hospice or return to the family home for care as well as arranging insurance coverage (i.e., applying for Medicaid coverage).[3, 10]

CONCLUSION

The use of compassionate release laws has been advocated for as a mechanism to address the growing number of older prisoners, overcrowding, increasing numbers of in-prison deaths, and the soaring medical costs of the criminal justice system, but also as a matter of medical ethics as the continued incarceration of patients with serious or debilitating illness can constitute a violation of human dignity if appropriate palliative care is unavailable. While most jurisdictions have adopted laws authorizing compassionate release, this authority is being underutilized due to barriers at the patient, professional, policy and administrative levels. In order to increase the use of compassionate release policies, there needs to be better communication and education on these policies, not only to individuals who are incarcerated, but also to their families, correctional health care professionals, and parole board members.[11]

The medical profession plays a significant role in the compassionate release process in that physicians are required to determine medical eligibility for potential candidates. The eligibility criteria should be clear to clinicians and they should be comfortable determining if someone meets the criteria without fear of liability. The Board of Trustees recommends that the AMA collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release. This guidance can be shared with legislators and other relevant stakeholders once it is developed.

Finally, to ensure that compassionate release laws are being appropriately managed and implemented consistently, the AMA should support the transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

RECOMMENDATION

The Board of Trustees recommends that the following policy be adopted in lieu of Resolution 430-A-19 and the remainder of this report be filed.

Our American Medical Association supports policies that facilitate compassionate release on the basis of serious medical conditions and advanced age; will collaborate with appropriate stakeholders to develop clear, evidence-based eligibility criteria for timely compassionate release; and promote transparent reporting of compassionate release statistics, including numbers and demographics of applicants, approvals, denials, and revocations, and justifications for decisions.

Fiscal Note: Modest - between $1,000 - $5,000

Table 1 - Federal Criteria for a Reduction in Sentence

Medical Circumstances	
Terminal Medical Condition	Inmates diagnosed with a terminal, incurable disease and whose life expectancy is 18 months or less, and/or has a disease or condition with an end-of-life trajectory under 18 USC § 3582(d)(1)
Debilitated Medical Condition	Inmates who have an incurable, progressive illness or who have suffered a debilitating injury from which they will never recover. If the inmate is: completely disabled, meaning the inmate cannot carry on any self-care and is totally confined to a bed or chair or capable of only limited self-acre and is confined to a bed or chair more than 50 percent of waking hours. Review should also include any cognitive deficits of the inmate. A cognitive deficit is not required in case of severe physical impairment, but may be a factor when considering the inmate's ability or inability to reoffend.

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