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Analysis of United States Compassionate and Geriatric Release Laws: Towards a Rights-Based Response for Diverse Elders and Their Families and Communities



A 'Just Aging' Shadow Report by:

Be the Evidence International in Collaboration with **International CURE**

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**An Analysis of United States Compassionate and Geriatric Release Laws:
Towards a Rights-Based Response For Diverse Elders and Their Families and Communities**

EXECUTIVE SUMMARY

The purpose of this report was to conduct a content analysis of the laws and regulations pertaining to the early release or furlough of incarcerated people within the United States in connection to advanced age and/or illness. The review of 52 federal and state corrections systems (50 states, Washington D.C, and Federal Corrections) demonstrate 47 have some legal procedure or precedent for incarcerated people or their families to petition for early release based on advanced age or health. Five corrections systems (e.g.. Illinois, Massachusetts, South Carolina, South Dakota, and Utah) do not have explicit legal mechanisms for early release, and therefore there is no obvious legal pathway, with a clear set of actions, to acquire early release for incarcerated people in these jurisdictions based on health or advanced age.

Among the 47 systems with early release or furlough, some common circumstances were observed that helped to determine release criteria. These areas of consideration include, but are not limited to: type of crime committed, level of incapacity or illness, anticipated survival time, a clearly-detailed process for application and/or appeal, level of supervision or support in place upon release, and potential impact or opinion of the victim and/or their family. Though there is some consistency in the criteria considered for early release, there is little consistency across systems in which distinct processes assess and determine advanced age or failing health. As the prison population in the US grows, and the cost to incarcerate is impacted by medical care, it is important to understand if and how various systems address the likelihood of treating incarcerated people who are older and/or who have a serious or terminal illness.

This content analysis prompts additional questions and offers guidance on how human rights standards can be used to construct policies, laws, and practice that respect and honor the dignity of the person, promote the political, civil, social, economic, and cultural rights of all citizens, and ensure nondiscrimination, transparency, and accountability on the part of governments. Future research, evaluation, and monitoring recommendations should include an assessment of the following: (1) the extent to which existing policies meet human rights standards; (2) how frequently incarcerated people are released following the submission of a request for early release and whether such requests monitored; (3) the nature of the barriers within each system that inhibit the development and operation of a consistent and orderly review process; (4) the attitudes of the public and lawmakers concerning early release for eligible incarcerated persons and the ways in which they influence the development and/or amendment of laws; (5) whether cost of care should be a consideration for release; (6) how, if at all, wishes of the families of victims and incarcerated persons should be taken into consideration; and (7) the most successful supports for incarcerated persons post-release?

Treatment of the aging and ailing population within prisons constitutes a moral, economic, social, legal, and human rights issue. Therefore it is important to understand how aging and ailing incarcerated people are perceived by ourselves and within the prison system before communities can meaningfully respond to their aging, seriously ill, and dying members and offer support to their families.

An Analysis of United States Compassionate and Geriatric Release Laws: Towards a Rights-Based Response For Diverse Elders and Their Families and Communities

INTRODUCTION

In America, about 200,000 adults aged 55 and above are behind bars, many of which have a complex array of health, social service, and legal needs that all too often go unaddressed prior to and after their release from prison (HRW, 2012). The large number of older people in prison is partially attributed to the passage of stricter sentencing laws, such as “Three Strikes You’re Out” and subsequent longer prison terms (ACLU, 2012; HRW, 2012). These restrictive policies have created a situation in which many sentenced to long-term prison sentences will reach old age and may even die while in prison or shortly after their release.

According to the United Nations (UNODC, 2009), older prisoners, including those with mental and physical disabilities, and terminal illnesses, are a special needs population and are given special health, social, economic practice and policy considerations (UNODC, 2009). The age at which individuals are defined as ‘older’ or ‘elderly’ in the community often differs from the definition of ‘elderly’ applied in corrections. Many social welfare systems, including in the United States, commonly view adults as older when they reach the age of 65 because that is when most individuals are eligible to receive full pension or social security benefits. However, although it varies among states, incarcerated persons in the United States may be classified as “older adult” or “elderly” as early as age 50 (HRW, 2012).

Incarcerated people have been shown to have an accelerated aging process in which their biological age or health status is more advanced than their chronological age by about ten to fifteen years (Aday, 2003). That is, a 50-year-old person in prison often has the health status of a 60 to 65-year-old person in the ‘free’ community. This accelerated aging process in prison is often attributed to a combination of high-risk personal histories (e.g., substance abuse, smoking, poor health histories, traumatic brain injury) coupled with the stressful social environmental conditions of confinement (Aday, 2005; Maschi et al., 2012; Williams et al., 2010, 2011). About 7 out of 10 older adults in prison report some type of medical problem,

including serious and terminal illnesses, such as cancer and HIV/AIDS (Anno et al., 2004; Maruschak, 2008). They often have comorbid physical and mental health symptoms, for example, symptoms of physical and mental decline accompany with dementia (Fazel, Hope, O'Donnell, & Jacoby, 2001).

Older people in prison often have histories of trauma and experience post traumatic symptoms that are associated with combat exposure or family, peer, community, and prison violence, which also puts a significant toll on their physical and mental health (Maschi, Dennis, et al., 2011; Maschi, Morgen, Zgoba, 2011). Official statistics suggest gender and racial disparities among the aging prison population. Most older incarcerated people are male (93%) and disproportionately minorities, such as African Americans (32%), Hispanics (14%), and those with histories of poverty and other social determinants of health and justice disparities (Maschi & Aday, 2014; Maschi, Viola, & Sun., 2012; Sabol & Couture, 2008; Shimkus, 2004).

Community reintegration of elders from prison is another significant consideration. Yearly estimates show that about 700,000 individuals of varying ages are released from prison. About two out of five adults recidivate and return to prison for parole violations or new convictions (BJS, 2014). Age is an important determinant of who will return to prison and who will not. Research suggests that adults aged 55 and older are less likely to recidivate than their younger counterparts (0-2% and 43%, respectively). That is, official statistics consistently show that the public safety risk for crimes committed by released inmates is much lower for those 55 and older compared to their younger counterparts (Jhi & Joo, 2009; Lansing, 2012). Evidence suggests that there is a positive association between age and desistance from crime, adults aged 55 and older pose a low risk to public safety. A growing body of literature also documents the complex legal, health, and social care needs of older people in prison of which in many states like New Jersey, the majority will be released over the next five years (e.g., HRW, 2012; Maschi, Viola, & Morgen, 2014).

A growing body of research suggests that there are barriers and factors that facilitate the reintegration of aging and seriously ill people in prison. Incarcerated elders, especially those with serious illness who are poised for release, have complex age-related health, mental health, social/environmental and legal needs that the current fragmented care systems are not

adequately prepared to address. Care transitions assessment and planning often include identifying linkages to housing, health, and social services, including Medicare and/or Medicaid benefits (Maschi et al., 2012; Mesurier, 2011; NCCH, 2002; Williams et al., 2010, 2011). Many community service providers, such as assisted living or skilled nursing facilities and hospices, often deny placement to formerly incarcerated people with serious and terminally illnesses often because of their offense histories, leaving them to linger in prisons past their official release date (Maschi, Viola, & Sun, 2012). The aging and seriously ill population in prison poses a significant challenge for care transition planning that corrections and community services do not adequately address (Maschi et al., 2013, 2014; Williams and Abradles, 2007). Transitional care planning is often problematic in states with large aging prison populations, such as New York, where a sizable number are racially and ethnically diverse elders and have served long term sentences for violent offenses (NYDOCCS, 2013).

The High Cost of Incarcerating the Aging and Seriously and Terminally Ill

Housing aging and seriously ill people in prison comes at a great financial cost to society. A 2012 Human Rights Watch report estimates that institutionalizing and providing care for the American prison population over the age of fifty-five, costs state and federal governments an annual sum of \$2.1 billion, which is three times the amount it costs to accommodate a younger prisoner. Beginning around the 1970's, compassionate and geriatric policies, such as medical parole and compassionate release laws and programs for mostly non-violent terminally ill incarcerated people, have been implemented in an effort to transition aging and/or serious or terminally ill incarcerated people to community-based care (Maschi, Marmo, & Han 2014; Williams et al., 2011). In theory, these laws are a possible cost-efficient option for the release of persons with serious and/or terminal illness in prison. However, states often do not use these laws, including New York, often due to bureaucratic red tape and negative public attitudes towards more compassionate approaches to criminal justice (Chiu, 2010).

The Purpose of this Report

To date there has not been a comprehensive comparative analysis of the legal provisions of the existing compassionate and geriatric release laws in the United States. Therefore, the purpose of this content analysis is to fill this knowledge gap by examining the

applicable legal provisions in the US to determine the characteristics of compassionate and geriatric release laws in the US and the extent to which they meet human rights standards.

This review was guided by the following research questions: (1) what are the characteristics of compassionate and geriatric release laws in the United States? (2) To what extent are existing compassionate and geriatric release laws consistent with core principles of a human rights framework? The results of this review have implications for developing or improving social responses to the treatment of aging and seriously ill people involved in the criminal justice system. Gaining a better understanding of the similarities and differences of these state laws can help to develop or refine existing laws that address the complexity of issues faced by aging and seriously ill people released from prison as well as the issues confronting their families. This information also can be used to better prepare communities, especially correctional and community service providers, that can facilitate the release process, smooth care transitions, and provide community placement of aging and seriously ill people. Advocates and policy makers also can be made more aware of how to craft responsive laws and policies, amend existing legislation, monitor and evaluate their implementation, and take action to galvanize public support.

METHODS

In order to identify all of the compassionate and geriatric release laws in the United States, the research team conducted a comprehensive search of the Lexis Nexus database using the Fordham University online research database portal. The following key word search terms were used: *compassionate release, medical parole, geriatric prison release, elderly (or seriously ill) and prison*. Identified laws were included in the sample if they met the following criteria: (1) identified aging or seriously ill people in prison and (2) were a law or policy that contained provisions governing prison release. Two trained research assistants reviewed the laws and coded the data. The team met weekly for a six-month period with the lead researcher until 100% consensus was reached for all categories of data extracted. As shown in Table 1, the search located 52 federal and state corrections systems (50 states, Washington D.C, and the Federal Corrections). Of the 52, 47 have some legal procedure or precedent for incarcerated people or their families to petition for early release based on advanced age or health. There

was no evidence of any applicable law or provision found in five corrections systems (Illinois, Massachusetts, South Carolina, South Dakota, and Utah).

Data Analysis Methods

Interpretive content analysis strategies as outlined by Drisko and Maschi (in press) were used to analyze the compassionate release laws from the United States. Interpretive content analysis is a systematic procedure that codes and analyzes qualitative data, such as the content of published articles or legal laws. A combination of deductive and inductive approaches can be used, and this strategy was used in the current review. Deductive analysis strategies were used to extract the data by constructing pre-existing categories for the criteria commonly found in compassionate and geriatric release laws (e.g., age, health status, length of sentence, and/or type of offense). Counts of these textual variables found in each category were then calculated to identify frequencies and percentages of each identified category (Drisko & Maschi, in press).

Inductive analysis strategies were used to analyze any emerging or new categories that could not be classified in existing categories. Tutty and colleagues' (1996) four-step qualitative data analysis strategies were utilized to analyze this data. Step one involved identifying 'meaning units' (or in-vivo codes) from the data. For example, the assignment of 'meaning units' included the assigning codes. In step two, second level coding and first level 'meaning units' were sorted and placed in their emergent categories. Meaning unit codes were arranged by clustering similar codes into a category and separating dissimilar codes into separate categories. The data was then analyzed for relationships, themes, and patterns. In step three, the categories were examined for meaning and interpretation. In step four, conceptually clustered matrices (or tables) were constructed to illustrate the patterns and themes found in the data (Miles & Huberman, 1994).

SUMMARY OF FINDINGS

As shown in Table 1, out of 50 states plus Washington, DC and a Federal Law (totaling 52 jurisdictions), 4 states do not have any publicly available records of compassionate or geriatric release laws (i.e., IL, SC, SD, UT). However, 46 states were found to have a compassionate or geriatric release law, as well as Washington, DC and the Federal Government. After a review of legal documentation from 48 systems in the United States (47 separate US states/D.C. and one

Table 1: List of State and Federal Compassionate or Geriatric Release Parole Laws in the United States

<i>Abbreviation</i>	<i>Compassionate or Geriatric Release Law (Y=Yes, N=No)</i>	<i>State/ Territory Name</i>	<i>Abbreviation</i>	<i>Compassionate or Geriatric Release Law (Y=Yes, N=No)</i>	<i>State/Territory Name</i>
1. AL	Y	Alabama	30. NJ	Y	New Jersey
2. AK	Y	Alaska	31. NM	Y	New Mexico
3. AZ	Y	Arizona	32. NY	Y	New York
4. AR	Y	Arkansas	33. NC	Y	North Carolina
5. CA	Y	California	34. ND	Y	North Dakota
6. CO	Y	Colorado	35. OH	Y	Ohio
7. CT	Y	Connecticut	36. OK	Y	Oklahoma
8. DE	Y	Delaware	37. OR	Y	Oregon
9. FL	Y	Florida	38. PA	Y	Pennsylvania
10. GA	Y	Georgia	39. RI	Y	Rhode Island
11. HI	Y	Hawaii	40. SC	N	South Carolina
12. ID	Y	Idaho	41. SD	N	South Dakota
13. IL	N	Illinois	42. TN	Y	Tennessee
14. IN	Y	Indiana	43. TX	Y	Texas
15. IA	Precedent	Iowa	44. UT	N	Utah
16. KS	Y	Kansas	45. VT	Y	Vermont
17. KY	Y	Kentucky	46. VA	Y	Virginia
18. LA	Y	Louisiana	47. WA	Y	Washington
19. ME	Precedent	Maine	48. WV	Y	Wyoming
20. MD	Y	Maryland	49. WI	Y	Wisconsin
21. MA	N	Massachusetts	50. WY	Y	Wyoming
22. MI	Y	Michigan	51. Federal	Y	US Federal
23. MN	Y	Minnesota	52. DC	Y	Washington DC
24. MS	Y	Mississippi	Note: Out of 50 states plus Washington, DC and a Federal Law (totaling 52), 46 states were found to have a compassionate or geriatric release laws as well as Washington, DC and Federal Government. Four states do not have any public records.		
25. MO	Y	Missouri			
26. MT	Y	Montana			
27. NE	Y	Nebraska			
28. NV	Y	Nevada			
29. NH	Y	New Hampshire			

Federal law), some basic structural consistencies are present that impact the determination and allowance for early release or furlough from prisons in the case of physical or mental incapacity or advanced age. In order to evaluate the factors that impact potential release and thereby evaluate various systems as a whole, it is useful to break down the key drivers into five

categories: (1) physical/mental health, (2) age, (3) pathway to release decision, (4) post release support, (5) personal and criminal justice history, and (6) stage of review. Stage of review is the initial ground-level investigation and does not mean to imply which choices made by various governing bodies are more successful or prolific in their relationship with early release or furlough for health-associated reasons. These issues, as noted later, need further investigation in future research studies.

Physical and Mental Health

	Illness is Terminal or Incapacitating		Mental Health Consideration	Age +/- Disability
	With a lifespan time limit	Without a lifespan time limit		
Number of states	17	19	17	14
Abbreviations	AK, AR, DC, HI, KS, KY, MO, MT, NC, NJ, NM, NV, PA, RI, TN, US FED, WY	AL, CT, FL, GA, ID, IN, KS, LA, MD, MN, NE, NH, NY, OH, OK, OR, TX, VT, WI	AK, AL, AR, DE, KS, MD, MI, MS, NH, NJ, RI, TN, TX, US FED, WI, WV, WY	AL, CT, DC, LA, MO, NC, NM, OR, TX, US FED, VA, WA, WI, WY

All parole or furlough opportunities have some measurements by which they determine if the incarcerated person will be eligible for release due to medical infirmity, age, and/or psychological or mental facility (See Tables 2 and 3). While some states are somewhat vague about what may be considered a condition viable for parole or furlough, others are very specific about what constitutes consideration for release. Some consider the inmate’s potential threat to society, while others focus on the high cost of treatment and some present a combination of factors to consider. There is little consistency, or even clarity, concerning attitudes toward the well being of the incarcerated person and his/her family included in the documentation.

When determining if the incarcerated person’s medical health warrants potential early parole or furlough, 36 laws make mention of terminal illness for consideration. Of those, 17 include a maximum anticipated survival period or time limit for patient life expectancy. The US

Federal law includes a time limit of 18 months for the patient to survive in order to be considered for parole, but the state documents that include a limit for patient life expectancy most frequently cite either 6- or 12-months to live. In one state, Kansas, the period is only 30 days life expectancy. In the 19 cases where states do not specify the time period for patient life expectancy, terminal illness is included as a potential factor for early release, as are terms such as “imminent peril of death” or “illness from which the inmate will not recover,” or simply “terminal illness.”

Table 3. Legal Considerations for Release				
	Considerations for early release for incapacitated or terminally ill patients included in legal language			
	No Threat to Society	Incapacitated so cannot care for self	Cost to treat is too high	General Healthcare to be qualitatively assessed
Number of States	15	27	4	16
Abbreviations	CT, DC, LA, MD, MN, MT, NM, NC, NV, OK, TN, TX, US FED, VT, WY	AK, AL, AR, CA, CT, DC, GA, ID, KS, KY, MI, MN, MO, NC, NE, NJ, NM, NV, NY, OR, TN, TX, US FED, VT, WA, WI, WY	AK, GA, RI, WA	AL, AR, CO, DE, FL, HI, IN, MI, MN, MS, ND, NH, NJ, OH, PA, WV

When considering mental or psychological health as a consideration for early release, 17 states include mental health capacity as an factor to consider for early release as well. All make note that any mental or psychological infirmity must result in incapacity to care for oneself, or render the person bedridden, and/or incapable of caring for his or her activities of daily living (ADL). All require evaluation by both medical and mental health care professionals. Only one state, Texas, mentions mental retardation as a potential consideration for parole. The US Federal prison system is quite specific in defining cognitive impairment associated with either brain injury or disease, such as Alzheimer’s.

When reviewing general health conditions that may be factors for early release or furlough, many laws, 27 use language that indicates the incarcerated person is incapacitated in such a way that he is incapable of performing activities of daily living, or is incapacitated in general. Other issues are also mentioned. For instance, 15 of the laws state as a precondition

for early release that the incarcerated person must be incapacitated - either due to age, mental health or illness – and are no longer a threat to society. Under some circumstances, threat to society is the only factor that the medical staff must evaluate before making an application to the parole board. In other instances, the cost of the healthcare to the prison system is a consideration for early release.

Interestingly many laws that identify criteria for early release simply use terms such as “serious medical syndrome” or “needing medical attention.” Many of the states that include vague language around what constellation of factors amount to the likelihood of early release seem to have fewer transparent processes, leaving the decision to the parole board’s discretion on a case-by-case basis. A better understanding of how broader discretion affects the prospects for early release among eligible incarcerated persons in those states should be ascertained through further study.

Age

Table 4. States Including Language Around Age as a Factor for Early Release	
States including language around age as a factor for early release	
State:	Age Specification:
Alabama	55+
Connecticut	65 or “advanced”
Louisiana	45+ and serving at least 20 years of a 30+ sentence
Missouri	“Advanced”
North Carolina	65+
New Mexico	65+
Oregon	No specification
Texas	No Specification
Virginia	60+
Washington	No specification
Wisconsin	No specification
Wyoming	65+
US Federal Law	65+ and dependent on % of time served

Table 4 shows the states that use age as a factor in decision-making around early release. Of the 47 laws, only 13 have regulations that consider age a determining factor for potential early

parole (12) or furlough (1). In each scenario, age itself is not the sole determinant for release, but age in association with some degree of being unable to care for oneself, or an indication of some lack of capability in terms of performing activities of daily living. Most states do not define “elderly” but some do, and usually define aging as 65+. Three states and the Federal government limit how long an incarcerated elder must have served prior to considering advanced age as a factor for early release.

The age of the applicant is almost always considered a determinant factor only in conjunction with a medical or cognitive condition. The elderly incarcerated are not considered a subset of incarcerated people that justify release in their own right without concomitant ailments. The few exceptions include Alabama and Louisiana, which consider age as a reason in it to release an incarcerated person early without incapacity, though the incarcerated person’s life history and crimes are considered heavily when determining release. Oregon is the only state whose law recites language on the humane treatment of the aging population, and states that without the release of the prisoner at the advanced age/infirmary, their incarceration may be considered “cruel or inhumane.” All other states require that an incarcerated person of advanced age, as defined by each, have some incapacity that either is permanent and costly, or renders the incarcerated person unable to physically harm society in any way.

Table 5. The Pathway and Process for Determination of Release			
	Process for Determination of Release		
	More malleable decision-process for release	Clearly-defined process and rules for release	Clearly-written rules around physician documentation
Number of States	28*	17	11
Abbreviations	AK, AZ, CO, CT, DE, FL, GA, HI, IN, KY, LA, MD, MI, MN, ND, NE, NH, NM, OH, OK, OR, PA, US, VA, VT, WA, WV, WY *IA and ME have precedent for early parole but no law in place	AL, AR, CA, DC, ID, KS, MO, MS, MT, NC, NJ, NV, NY, RI, TN, TX, WI	AK, AL, AZ, CA, MO, NC, NJ, NY, TX, WI, WY

Pathway to Release Decision

As shown in Table 5, as with the incarcerated person’s mental and physical health determinations, the pathways to release decisions vary from state to state. Only 18 of the states seem to have very specific, strictly defined pathways and regulations to follow for parole decisions. The more specific rules include the mechanism, such as who makes the final determination. In addition, 11 states have very clearly written rules governing physician documentation, how many or which physicians may be considered for review, and what factors must be included in their medical letter.

Though all applications are subject to official parole board review, the series of steps in order to reach the parole board and the supporting documentation varies. The above-mentioned 17 states often have clearly-written review procedures; most provide for a deputy warden in conjunction with the prison medical director reviewing all documentation prior making a submission to the parole board. Often, the prisoner or his advocate – either family or legal advocate – will petition directly. The medical director can also petition for early release if the prisoner cannot. The 29 states that have fewer procedures written into their laws and applicable regulations that provide that parole review boards consider all information prior to rendering a final decision. At least 3 states have requirements that the parole board must review the request for early parole within a certain number of days (e.g., 30 days), while most assume the case will be heard in a timely manner or be reviewed by the next meeting of the parole board.

Post Release Support

Table 6. Post Release Support in Place for Release				
	Post-Release Support in Place			
	Medical facilities vetted	Financial Coverage	Holistic support system	Family or Support conditions
Number of States	18	11	5	9
Abbreviations	AK, DC, ID, IN, KS, MD, MN, MO, NC, NE, NJ, NM, NY, TN, TX, US FED, VT, WY	AK, AL, CO, ID, KS, MO, MT, NY, TN, US FED, WY	ID, MN, NC, NJ, NY	ID, LA, MD, MN, MT, NC, NJ, NY, US FED

When presenting to the review board, submission of a post-release plan is customary (See Table 6). Issues such as where the incarcerated person will receive medical care or enter hospice is vetted by the medical staff of the prison, while case managers or social work professionals identify other issues. Eighteen of the laws note that, prior to release, the medical hospital or hospice – or family home with healthcare professionals – must be vetted prior to release to ensure both safety and proper healthcare. In addition, 11 of the laws mention that the incarcerated person must have financial resources to cover healthcare, such as Medicaid, in place prior to early release. Five of the laws mention a holistic style of care, including emotional support for the incarcerated person and family, as well as reintegration support. Of the states that allow for the patient to live in the home with medical care, 9 states cite "family conditions" or "support for the family as caregivers" as factors.

Interestingly, many states, including the federal system, also require that the released person be monitored by a parole or medical officer consistently to ensure that the released person's physical health does not improve; if the incarcerated person's condition should improve to the point they can function to perform activities of daily living or are no longer terminally ill, the incarcerated person must be returned to prison to complete their full sentence.

Personal and Criminal Justice History

As shown in Table 7, most states/Federal prisons exclude some incarcerated people – regardless of their overall health – from potential early release. Most provide that to get early parole or furlough, the incarcerated person must be convicted of an offense with potential for parole (25). Some jurisdictions also specify that the incarcerated person may not have been convicted of murder, either 1st or 2nd degree (7). However, most exclusions are focused upon the incarcerated person who has committed a Class A, B or C felony.

In addition, 11 of the states/Federal laws and regulations exclude incarcerated persons convicted of offenses of a sexual nature. For those incarcerated persons who are considered for early release or furlough that committed such crimes, a psychologist or psychiatrist must also investigate and determine potential harm to society. Finally, 9 states (KS, KY, MD, MT, NC, NV,

NY, TN, WI) have included in their laws that the victims or their families must be notified of an upcoming case for parole or furlough, and may participate in the hearing, if there is one, or submit a letter or an opinion concerning the potential release of the prisoner.

Table 7. Type of Crime Considered for Early Release				
	Type of Crime Considered for Early Release			
	Ability for Parole and/or without sentence of death	Excluding Murder	Consider % of time served	Excluding Sexually Oriented Crimes
Number of States	25	7	8	11
Abbreviations	AK, CA, CT, DC, FL, ID, KY, LA, MD, MO, MS, MT, NC, NE, NH, NJ, OR, RI, TN, TX, US FED, VA, WA, WI, WY	AL, DC, LA, NJ, NM, NY, OR	CT, DE, IN, MO, MS, NC, NY, OH	AK, AL, AR, CO, ID, KY, MS, NC, NJ, TX, WI

Style of Review

As noted earlier, there seems to be a difference in style from state to state, and determination of release can vary from strictly regulated to very discretionary release determinants – such as a state’s ability to grant medical release if the governor or Deputy Warden “deem it beneficial,” either for reasons of cost or overcrowding.

Without further investigation from state to state, it is unclear whether a less-regulated, more malleable system of review affords a more holistic and individual evaluation, or if the lack of regulation makes the outcome more difficult for the prison review boards to determine.

CASE STUDY: Review of NY Release on Medical Parole, McKinney’s Executive Law § 259-r

The state of New York tends toward more specific and clearly defined guidelines for consideration of early parole based on an inmate’s physical or cognitive impairment, or terminal illness. That is, incarcerated persons are eligible for consideration if they have a terminal condition – without limits to the amount of time prognosticated to death – or have a permanent syndrome or disease that is not terminal, but is physically or cognitively disabling to the point that they no longer pose any threat to society.

The state of New York has one of the more specifically outlined courses of action prior to and post release. However, merely outlining the steps on paper does not ensure a completely comprehensive care plan, timely process of the release decision, or implementation of the process to the point of release for petitioners. The request for parole can be made at any time during the sentence, and the incarcerated person or someone on his or her behalf may make the request for consideration. Once that request is made, the Office of Classification and Movement decides if the patient is eligible based on their sentence. Once that incarcerated person is potentially eligible, a state-licensed physician will evaluate the incarcerated person's condition, prognosis and provide a description of the incarcerated person's capabilities, including the performance of activities of daily living, ambulation and "predictions concerning duration of incapacity." All medications, services, future needs and recommendations on medical facility/environment are included as well.

Once the medical evaluation is forwarded, the Deputy Commissioner or Chief Medical Officer offers a recommendation within seven working days to be forwarded to the Parole Board to consider. At that point, a search for a potential victim associated with the incarcerated person is conducted, and if one is located, that victim or family will be notified that the case is up for parole based on medical request. Once all steps are complete, the parole board will consider the case.

The state also requires a complete evaluation of how and where the incarcerated person will be discharged and under what circumstances. Reports are created to describe and evaluate: the level of care the incarcerated person will require; where that care will be located (potentially taking into account the area of the incarcerated person's support system); identification of a surrogate to speak for the incarcerated person if he or she is cognitively incapacitated; creation of a home-care supervision plan if appropriate; and assessment of the status of institutional placement.

In addition, either private or public medical financial assistance will be documented and, if necessary, the Offender Rehabilitation Coordinator will file appropriate paperwork to obtain Medicaid/SSI/Public Assistance. Also important, a description of ancillary support needed for the incarcerated person and/or caregiver will be documented. The type of support or

definitions of caregiver are not provided, but this leads to potential assistance for the family of the incarcerated person to be afforded some support.

Incarcerated persons are not eligible for early medical parole if they are serving a sentence for murder in the 1st, attempted murder or conspiracy to commit murder in the 1st, or have served less than half the minimum sentence for committing or attempting murder in the 2nd, manslaughter in the 1st, and any offense defined in Article 130 of the Penal Law.

DISCUSSION AND RECOMMENDATIONS

This review was designed to describe and analyze the compassionate and geriatric release laws in the United States. As noted in the findings section, the legal provisions across the states and the federal government varied. These variations included, but are not limited to: type of crime committed, level of incapacity or illness, anticipated survival time or life expectancy, a clearly-defined process for application and/or appeal, level of supervision or support in place upon release, and potential impact upon or opinions of the victim and/or their family.

Ratified in 1948 as a response to the atrocities of World War II, the Universal Declaration of Human Rights (UDHR; UN, 1948) provides the philosophical underpinnings and relevant articles to guide our response to the aging and seriously ill in prison. The UDHR preamble underscores the norm of ‘respect for the inherent dignity and equal and inalienable rights’ of *all human beings*, which in this case includes older adults in prison. Of the 30 articles, two of them (article 3 and 5) are of fundamental importance to responding to the release of aging and seriously ill persons in prison. Article 3, which states, “Everyone has the right to life, liberty, and the security of person” and Article 5, which states, “no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment” (UN, 1948, p. 3). The articles provide a broad blueprint for designing and implementing policies and legal standards that protect older adults, especially for the right to freedom, safety and security, and humane health care and thus compassionate and geriatric release laws should clearly provide language that speaks to these fundamental human rights.

A human rights framework and implementing principles are critical to developing or evaluating the extent to which laws meets basic standards. Fundamental to human rights

values and principles are dignity and respect for all persons and the indivisible and interlocking holistic relationship of all human rights in civil, political, economic, social, and cultural domains (UN, 1948). Additional principles include participation (especially with key stakeholder input on legal decision-making), nondiscrimination (i.e., laws and practices in which individuals are not discriminated against based on differences, such as age, race, gender, and legal history), and transparency and accountability (especially for government transparency and accountability with their citizens; Maschi et al., 2012). As shown in our results, Oregon was the only state that included language suggestive of human rights in regards to the humane treatment of an aging population. Their law states that without the release of the prisoner at the advanced age/infirmity, their incarceration may be considered “cruel or inhumane.” Additionally, despite laws and policies that guarantee prisoner rights to healthcare and compassionate release for the serious and terminally ill in prison, there remains attitudinal and systemic barriers in which many seriously ill people in US prisons are denied community treatment from community service providers.

Many of the laws often fall short of nondiscrimination standards given that those with violent offense histories (despite their failing health status) or elderly in general are often excluded from conditional release provisions. Also rarely cited are undergirding principles that speak to the dignity and worth of the person, family and victim rights and supports, and accountability and transparency on the part of corrections to grant release or respecting agencies that deny access to the formerly incarcerated. A recent “Report of the United Nations High Commissioner for Human Rights” (UN, 2012) urges that special consideration be given to older adults and seriously ill people in prison and post release due to the accumulated disadvantages inherent in their status and grave human rights conditions. Following suit, correctional systems and laws and policies can recognize this standard classification in institutional and community practices and legal remedies.

The United Nations also provides some helpful guidelines for special needs populations, which includes “older prisoners” as a special needs population along with racial/ethnic minorities, persons with disabilities or terminal illnesses, homosexuals (LGBT), and death row incarcerated persons. These are non-binding guidelines for treatment that includes transitional

care planning and are outlined below (Maschi et al., 2012b; UNODC, 2009). These recommendations can be incorporated into the development or amendment of existing laws and policies⁴ from sentencing to compassionate and geriatric release.

1. Courts should review and revise, if needed, long-term prison sentencing policies. This would include minimal use of long-term sentences (unless there is significant evidence community safety is a concern).
2. The development or refinement of alternatives to incarceration and diversion programs for older, seriously or terminally ill involved in the criminal justice system.
3. In prison, developing special strategies for older prisoners.
4. Obtaining the input of a multidisciplinary team of prison specialists who work in conjunction with community service providers.
5. Providing geriatric-specific staff training and encouraging staff to participate in community organizations to best ensure a continuum of care.
6. Assisting older prisoners in accessing legal counsel and services to reduce discrimination based on age or disability status.
7. Conducting initial and ongoing comprehensive assessments to identify the varied and changing needs of incarcerated elders.
8. Providing appropriate accommodations, including special units within prisons.
9. Ensuring health care needs such as medical, nutritional, and psychological health, social engagement with interdisciplinary staff, and special programs to address mental health and psychosocial concerns.
10. Placing incarcerated elders close to their home to maintain family and community contacts, including the use of family visitation programs (UNODC, 2009).

Other recommendations relevant to serious/terminally ill incarcerated people include the establishment of palliative and end-of-life care practices and policies with ongoing:

1. Services of qualified interdisciplinary professionals;
2. Medical and psychosocial/spiritual assessment and care plans;
3. 24/7 staff availability;
4. Counseling services offered by qualified counselors or social workers; and

5. Spiritual care provided by a qualified chaplain of the interdisciplinary team (UNODC, 2009).

Correctional systems, state and federal governments, and advocates can compare these guidelines with existing organizational level policies and laws to adopt or modify existing provisions.

Using a rights-based approach, multi-stakeholder evidence-informed and evidence-based policies should incorporate the voices of the incarcerated and their families in the decision-making process along with other key stakeholders. At the grassroots and national levels, advocates and governments should assess the extent to which human rights declarations, covenants, and conventions are being realized in response to aging and seriously ill people in prison. Appendix A of this document, provides an advocacy toolkit worksheet that can be used by key correctional stakeholders to evaluate and monitor the extent to which a recommended minimum legal standard concerning the treatment of the aging and seriously ill is being achieved. Appendices B and C provide sensitizing experiential exercises using the first hand experiences of aging and seriously ill people in prison about their own health and their response to witnessing others dying in prison. These resources are awareness building advocacy tools or can be used as sensitivity trainings with key stakeholders, especially policy makers and community members, to facilitate dialogue and to devise an action plan.

When investigating inconsistencies amongst states and systems that include advanced age and/or deteriorating health as considerations for potential early release, results suggest that further research and evaluation is necessary to understand the impact of each law on the incarcerated person, their family members, their local communities, the corrections systems, and society. Cost benefit analyses also are needed to evaluate the financial cost to housing aging and seriously ill people in prison as opposed to the community.

It will be key to begin by understanding how the process of applying and receiving early release is perceived and carried out by various stakeholders. More specifically, in order to learn whether the people who qualify for early release are actually able to acquire that status, and to evaluate the early release process to determine whether the law is implemented as intended. Further, additional information is needed on which systems are most successful at achieving

their ends. For example, evaluating whether more quantitative measures versus qualitative decisions result in more successful early releases for qualified incarcerated people and their families. In addition, to better understand the context for the regulations adopted in each state or system, it would be useful to investigate the attitudes and influential factors that influence each community in how it regards aging or ailing people in prison and their families from both qualitative and quantitative viewpoints.

Limitations of the Current Review

These findings have methodological limitations that warrant discussion. First, although a comprehensive search of the Lexis Nexus database was conducted, the extent to which all of the subject laws and possible amendments were available is unknown. Second, although multiple coders were used to select a sample of laws, classify them, and analyze their findings, it is entirely possible that other research teams may obtain different results. Third, the content analyses of categories and themes were developed deductively and inductively by the research team and it goes without saying that a content analysis with a different set of categories and frequency counts would yield a different outcome. . Yet, despite these limitations, this comprehensive analysis of the compassionate and geriatric release laws in the United States offers insight into the next steps for research and evaluation to improve conditions for the elderly and seriously and terminally ill persons in prison and for their families and communities.

Conclusion

If there is enough awareness for 47 prison systems to include ailing and aging as potential characteristics for early release, it is important to determine whether those allowances are being accessed and utilized. If the legal and correctional systems prevent persons from acquiring the protections afforded by enacted law, then the applicable systems, as operated and as a structure, must be investigated in order to remove such barriers. From a human rights perspective, human beings – even considering the crimes committed – should receive adequate physical and psychological care in the prison system, and to ensure that their care and well-being will not be limited significantly by age or illness or by remaining incarcerated. If incarcerated individuals are unable to receive adequate care inside prisons, it is incumbent upon advocates and researchers to press for further investigation into the barriers

to care, including but not limited to potential cost of care for aging and terminally-ill patients, public perception of release, expediency of the process of consideration as mentioned above, and access of timely evidence-based treatment. Supports for family members, surrogates and/or guardians, and survivors of crimes should be part of compassionate or geriatric release legislation.

We, as a society, must be able to provide evidence that we are able to provide a humane standard of care to those within the prison systems, and if not, national and state-level legislation must be evaluated to determine if care outside the system – while adhering to state-determined factors for early release – is more effective than care offered to incarcerated persons inside. If the standard of care available in-prison remains suboptimal to a basic standard of care outside the prison system, society has an obligation to evaluate release policies --with or without parole policies. An interdisciplinary team-approach to determine those standards of care should include physicians, psychologists, social workers, and legal and community health experts. Evidence-based practices should be identified in consultation with national health organizations such as the National Institute of Health (NIH) or the National Comprehensive Cancer Network (NCCN). Issues for consideration might include: time to diagnosis of disease, access to adequate medical care, access to palliative care, family inclusion for support, psychological care, safety, cost assessments, and the impact upon others of caring for aging or ailing incarcerated persons.

Suggested Action Steps

Here are some suggested action steps to build upon these report findings:

- **Using Evidence-based Policy Making to Think Before You Act.** Use these findings and other evidence to develop, amend, or monitor implementation of existing policies and practices that address the aging, seriously ill, and dying in prison (See Appendix A-Worksheet).
- **Speak Up:** If you have a personal, practice, or advocacy story you would like to share for inclusion in future editions of this report, please email us at btep@fordham.edu
- **Sign this Petition.** Please sign our petition to improve policies and practices for elder, seriously ill, and dying in prison: http://petitions.moveon.org/sign/compassionate-and-restorativ-1?source=c.em&r_by=12132691
- **Write a Letter.** Write a letter to your county, state, or federal legislators or a newspaper op-ed or letter to the editor.
- **Build Awareness.** Use this report or other writings to generate awareness of about the aging in prison crisis and innovative solutions that attempt to remedy it.
- **Reach Out.** Volunteer to be a friendly visitor or pen pal with elders or seriously ill people in prison.
- **Form Partnerships and Coalitions.** Form partnerships and coalitions among key stakeholders, such as incarcerated and formerly incarcerated elders, family members, and community service providers to address the rights and needs of the aging, seriously ill, and dying in prison.
- **Innovate-Think and Act Outside the Box.** Be creative and think of a unique solutions that can influence improved policies and practices for the aging, seriously ill and dying, especially In prison.

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Appendices

Appendix A. Compassionate and Geriatric Release Worksheet. Human Rights Principles Assessment for Compassionate and Geriatric Release Laws Regarding Physical and Mental Health, Age, Pathway to Release Decision, Post Release Plan, Personal and Criminal History, Style of Review		
Assessor/s' Name:		Date:
Federal/State/Institutional Law/Policy:		
Yes	No	Does the law address any of the following minimum standards of existing laws? (Check yes or no)
		Dignity and respect of the person
		Notes (Developing or improving practice/policy response)
		Humane treatment of prisoners, esp. advanced aged and infirm
		Post release plan vetted for safety and appropriateness
		Placement are available in prison special medical units (e.g., hospice) prior to release
		Holistic care models-prison and post release
		Interprofessional pre and post release care plans
		Interprofessional pre and post release service linkages set in place
		Vetting post care placement for safety & appropriate healthcare services
		Promote Political, Civil, Economic, Social, and Cultural Rights
		Legal language that refers to 'cruel or inhumane' if release denied
		No life limit for release (expected life term)
		Benefits (Medicaid/SSI/public assistance) available prior to release
		Family and community involvement
		Assigned surrogate when no family are identified that can provide care
		Request made by incarcerated person or someone on their behalf
		Emotional and reintegration support for released person and caregiver/s
		If a person recovers, he or she does not need to return to prison
		Home care supervision plans
		No life limit for release
		If released and recover, must be returned to prison
		Nondiscrimination
		No constraint on sentence length to request release
		Released if determined there is no public safety threat to society
		Age classified as aged 50 or above
		Does not discriminate based on chronological age (without infirmity)
		Does not discriminate based on sex offense history
		Does not discriminate based on murder 1 st or 2 nd degree history
		Does not discriminate based on Felony (class A, B, C) history
		Does not discriminate based on length of time served
		Participation
		Age (older people)
		Persons with disabilities (physical or mental)
		Persons with terminal illness
		Correctional leaders (e.g., warden, commissioner, or medical director)
		Parole board
		Family members or surrogates
		Legal Advocates/Petitioners (including family)
		Crime survivors (victim involvement)
		Physician Involvement
		Other professionals: psychiatrist, psychologist, social worker, lawyer
		Transparency
		Laws with clear definition of key terms
		Clear pathways for release determination
		Laws with specific, measurable, specific, and time limited procedures
		% of parole petitions responded to in a timely fashion
		% of parole requests honored
		Accountability
		Time limits for each stage of review process
		Discharge planning evaluation
		Staff filing of release paperwork and follow-up
		Special Populations Addressed
		Older Persons (Elderly)
		Persons with Disabilities (Physical and/or Mental, Mental Retardation)
		Persons with Terminal Illness
		Other:

Appendix B

Releasing Their Stories: Awareness-Building Activities Qualitative Select Excerpts from Incarcerated Elders (Maschi, 2010)

These excerpts are verbatim quotes from older people in prison. This exercise can be completed individually or in groups. Please read each response and write or discuss your reaction to each quote. What do you and/or your group think should be done about it (if anything at all)? Please provide a rationale for your choice.

1. "Prison is a hard place. Pure Hell! As long as you are in khaki, you are considered non-human. The elder suffer the most because there isn't much for them, us. I have the starts of osteoporosis and seeing how some people young and old are treated makes me suffer and deal with it. Overall it's horrible and wouldn't wish this on my worst enemy". –Quote for a 56 year old incarcerated woman
2. "I am 72 and I am afraid of being assaulted again. I get stressed out because we are treated like pieces of garbage and always threatened with harm from officers. I have a sister in the rest home and have no contact with her. My son is in prison." –Quote from a 72 year old incarcerated man
3. "I was assigned to a job in the Prison Infirmary (E.C.U.) as a porter. The infirmary job was often very depressing. They have a couple of padded cells there and the screams of tormented souls could be heard throughout many shifts. There were also what we called the "death rooms". These were a row of 5-6 cells, which housed terminally ill inmates. They had been brought in from prisons throughout the state. Many were fairly young. The medical "professionals" working here had minimal interaction with them; they were largely cared for by-care inmate volunteers. When one of the terminal cases passed away, and ambulance would eventually arrive to take the body out of the prison. The guards and medical staff would not help "bag and tag" the body, so it was left to us porters to assist in it" 56 year old incarcerated man
4. "The apathy of the guards toward dying inmates was unconscionable. We had one inmate about 30 years old whose wife and 2 small children were given permission for a special visit because he was near death. As shift change approached, a nurse entered the room and the family had to stand outside of the door. A female guard yelled to the nurse, "Isn't he dead yet? I don't want to have to stay late to do the paperwork." The two little girls were sobbing in no time. We also had an inmate turn 100 years old there. He was completely bed-ridden. He passed away eventually. I was left wondering how society was being served by that. In the 6 months that I worked there, 6-7 inmates passed away. Hepatitis and diabetes cases abounded, with many amputations."
5. "When I had my last surgery in prison, um, there was a 93-year-old man, white guy, he was a nice guy. He was in there, I believe, for, um, assault. He's been in there for like 17 years or 18 years, but this guy is in a hospital. He can't even hold his bowels, so I'm like what is a guy like this going to do? What is he going to do? He can't, he can barely walk. He's been in a hospital, in a hospital or infirmary, for a year. What is he going to do? You'll see guys in there that just sit there staring into space."

Appendix C

To Release or Not To Release: Critical Dialoguing Activity

Directions: This exercise can be done with individuals or small or large group with a facilitator or co-facilitator. Please review each of the photos and vignettes below. For each one, answer the following questions: (1) Would you support the release of this elder from prison? (Yes, No, Maybe). Is there enough information to confidently make a decision? (Yes, No, Maybe) Please explain your decision-making process. After hearing others people perspectives did you change your response/s. Process the experience after each individual or group has had an opportunity to share.

Photos and Quotes Courtesy of Prisoners of Age Photos and Quotes (Ron Levine, 2014)



My God. When I get out I'm gonna sue those three judges and my attorney also. I'm gonna sue them. I was in because of a little girl who made remarks about me which did not happen. That was about 13 or 14 years ago. I didn't do anything. I didn't do a damned thing to this girl that was running around the park. I lived in a mobile home. And she ran around... and it was terrible.

Joseph Mannina, 96

Sex Crime



What brought me here? I killed my wife. It was in nineteen eighty-eight. What brought it on? She got to accusing me that I was going with some other girls, you know. And cussing at me. Same thing she always did. We would go to the super-market and girls speak to me and she would tell me, "Is that your girlfriend?" I tell you, she got jealous and all and you know how I feel about it. If I had to do it all, I'd do it over again, I would.

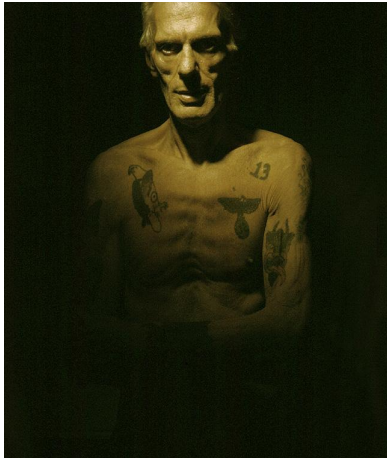
Leo Eason, 73

Murder



Well, I got 50 years. Snatching \$24 out of a man's hand. It was 1959, in Birmingham (Alabama). I'm in no shape to run now. I'd like the freedom. But I'd never get over the fence. I'm doing 50 years for robbery. But I never robbed anyone. I only took 24 dollars from one man. I consider robbery is when you use a weapon. I never used a weapon. What I would like to do. I would like to write a book for young black people. Tell them that this ain't the way. This ain't the way. You don't do it this way. That's what I would like to do. Maybe someday, I will.

William Howard 'Tex' Johnson, 67
Robbery



I started stealing when I was 15. I robbed banks. I always worked alone. In 1994, I was caught for attempted murder. I had mixed booze and medications. Eight months ago I got married to a woman my age and it's going well. That's why I want my release, to live with her. In 1996 I got lung cancer. Now, I'm getting treated but they won't release me. They're waiting for me to die. I lost 50 pounds since October 1999. I regret committing the crime that sent me here, but I think the system isn't fair for the situation I'm living in now. There should be improvements. Especially when someone has cancer. They should let them go live with their family. I was twice refused conditional release.

Jules Sauvageau, 59
Attempted Murder



I had trouble with a police officer in Utah. He shot me. I shot him back. That's what put me in trouble. He didn't hurt me too bad. I didn't hurt him too bad. And then they gave me ten years for that. I got two more to go. I might make it. I'm hanging in there.

John Wilson, 72
Attempted Murder



I've lived 81 years enjoying life, I was heavy, I was 210 pounds, I'm 116 now. It's a lot of weight to lose. I'll show you a picture of me, you'd say, "God were you ever beautiful". You'd take me out. I don't bother with men now.

[They say] that I beat the children and that I burnt the children ... I just love kiddies, I see them there crying, you know,.. they want to get picked-up,.. I always pick them up and say, "Come on to mommy".

Edith May Sanders, 81
Child Abuse



From young on, most time, I was locked up bad. I was in reformatory school back in the '40's. All black school. It was a mean place. I was in for shooting a boy with a shot gun. He owed another boy \$3.00 and threw it on the ground and told the boy to pick it up. The boy told him to pick it up himself and I said "give me the three dollars". I told the boy to pick it up off the ground and he didn't so I shot him with a shot gun. I did one year for that and he lived, but his right arm was crooked. After reformatory school I robbed a man and went to penitentiary. I was about 17 then. I did 12 year for that in Kilby prison. It was a rough place, but I was rough with it though. It was a segregated prison. Then you did six months for a year in the '50's. I did 12 full years for that.

Leon Davis, 73
Attempted Murder



I'm in here for 'helping my family'. I learnt my lesson. That won't happen again. But y'see they don't help me. I have children, but the last I've heard from them was in 2005.

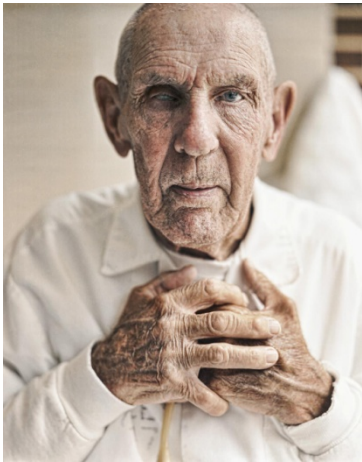
I just take care of myself the best that I can.

Theda Rice, 77
Murder



It's something in my life that happened and I took the law into my own hands.

Lucille Carter, 87
Murder



Back in the early 80's I met this old boy and we become closer and closer as time went on. At the time my wife died and left me alone. His wife left him. He was the kind of guy that you give him two drinks around a girlfriend, he was 20 feet tall and gonna prove it. He and his girlfriend was broke. I had given him a job. I was in the roofing business. And he wanted some money to go and play darts and drink some more. And I said 'no'. So he went out in the woods. He got some boards from a house and came back in and started running me across the head... started beating me. He was trying to beat me half to death. He had a pistol in his pocket. Well, when he come around in front of my truck, I raised the gun up and shot him in the neck. It should'a been self-defence.

Boyd Edward Whitely, 80
Murder



I know I'm blessed. All my troubles, I put them in the Lord's hands. I don't get mad. I take it a day at a time. While you're in here, life is still going on. You've got to make the best of it where you're at. I take pride in what I do. When I go to driving [the hearse], I'm working for the Lord. I'm bringing his children home. Everyone here's inmates just like me. All us got to die and that's something I don't worry about. One day, someone's gonna have to drive me.

Lord Bones, 72
Undisclosed Crime [in prison since 1971]

APPENDIX D: ABOUT US

BETHEEVIDENCE INTERNATIONAL

Be the Evidence International (BTEI) is a nonprofit (501c3) grassroots organization that promotes human rights and social justice issues through research, education, and advocacy activities. These are designed to raise critical consciousness and the recognition of psychological sociopolitical contexts in which injustices can occur, such as aging and the criminal justice system. Through this critical lens, individuals and communities can make informed decisions about how we want to 'co-construct' healthy and just communities. Transforming society first entails transforming ourselves to "be the evidence we want to see in the world". Through participation in self or project-sponsored activities, each of us can help promote the achievement of a socially just world in which human rights, social justice, and well-being are realized for all individuals, families, and communities across the developmental lifespan. On a daily basis, the lived reality of "being the evidence" challenges individuals everywhere to look inside themselves first to identify and eradicate stigmatizing and oppressive attitudes, thoughts, and practices towards one self and others so we can see each other's common humanity. BTEI provides the following services to the community: Research and Evaluation, Program Design, Policy, Advocacy, Public Education & Awareness Campaigns, and Forensic Social Work & Inter-Professional Education & Training. Be the Evidence Press publishes cutting research and practice report and briefs. For more information or to request project related publications, please visit our website at www.betheevidence.org or contact BTEI at btep@fordham.edu or tmaschi@fordham.edu



International Citizens United for Rehabilitation of Errants (CURE) is a grassroots organization dedicated to the reduction of crime through the reform of the criminal justice system (especially prison reform.). Prisons should be used only for people who absolutely must be incarcerated. And that those who are incarcerated should have all of the resources they need to turn their lives around. A person is sent to prison AS PUNISHMENT AND NOT FOR PUNISHMENT. We also believe that human rights documents provide a sound basis for ensuring that these goals are met. We encourage members to become VOCAL especially when you are struggling with a criminal justice system. Finally, **CURE is a membership organization**. We work hard to provide our members with the information and tools necessary to help them understand the criminal justice system and to advocate for changes.

Take Action: Compassionate Laws, Policies, and Practices for the Aging, Seriously Ill, and Dying in Prison and Their Families and Communities

After reading this report, if you want to get involved in promoting compassionate approaches for the aging, seriously ill, and dying in prison, below are some suggested action steps:

- (1) **Give Feedback:** We welcome your input and feedback about this report to include in future updates and editions. Please send to btep@fordham.edu
- (2) **Speak Up:** If you have a personal, practice, or advocacy story you would like to share for inclusion in future editions of this report, please email us at btep@fordham.edu
- (3) **Sign a Petition.** Please sign our petition to improve policies and practices for elder, seriously ill, and dying in prison: http://petitions.moveon.org/sign/compassionate-and-restorativ-1?source=c.em&r_by=12132691
- (4) **Write a letter.** Write a letter to your county, state, or federal legislators or a newspaper op-ed or letter to the editor.
- (5) **Join the Movement.** Contact us at btep@fordham.edu or 212-636-6640 to get involved in one of aging and CJ or other research projects, grassroots social innovation development and implementation, trainings, advocacy efforts or fellowship and volunteer opportunities.