

COMPASSIONATE RELEASE IN MARYLAND

*Recommendations
for improving
medical and
geriatric parole*

Most states have established release mechanisms for the aging population and those in prison who are battling a terminal illness, often referred to as compassionate release. Compassionate release policies typically permit individuals in prison to petition for early release after having served a pre-determined number of years for either health (medical parole) or advanced age (geriatric parole). However, the laws frequently have restrictive eligibility requirements and are applied sparingly, often when an individual is expected to survive only a matter of days or weeks.

While Maryland has both medical and geriatric parole options, approval is fleeting. Data are limited but provide a glimpse into their restricted use. Between 2015 and 2020, the Maryland Parole Commission approved 86 medical parole applications and denied 253. Further, the Governor granted nine medical parole requests from individuals serving life sentences and rejected 14 requests. Most notably, the lowest yearly approval rating occurred during the height of the pandemic in 2020 at seven percent. The Justice Reinvestment Act of 2016 expanded geriatric parole eligibility by lowering the age threshold from 65 to 60 years old. However, petitions are rarely approved. Currently, there are about 630 individuals over the age of 60 in Maryland's prison system who have served at least 15 years. These individuals are eligible to be evaluated for release. But, like in most states, Maryland seldom relies on these compassionate release policies to release the elderly and infirm from prison, despite posing a minimal risk to public safety and a significant cost burden on the state budget.

Without substantial reforms to compassionate release in Maryland, the aging population will continue to grow, and the onus will be on the Department of Public Safety and Correctional Services (DPSCS) to provide the adequate care.

The Growing Elderly Population

Over a span of 40 years, the U.S. prison population has experienced staggering growth, from nearly 200,000 in the 1970s to over 1,430,800 in 2019.¹ Research shows that this

¹ E. Ann Carson, *Prisoners in 2019* (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2020).

growth has been driven not by more crime, but by policies that send more people to prison and keep them there for longer periods of time. One consequence of this trend is a large and increasing number of older incarcerated individuals.² From 1999 to 2016, the prison population over 55 years old increased 280 percent.³ In 2017, the number of incarcerated individuals over 55 years old eclipsed 200,000, which is more than the entire prison population in 1970.

In Maryland, 6.4 percent of the prison population, or 3,324 individuals, are over 50 years old. Moreover, 2,341 individuals, or about 11 percent of the prison population, are serving life sentences. Unsurprisingly, these individuals are overwhelmingly Black. A 2019 Justice Policy Institute report found that nearly eight in 10 people who are serving the longest prison terms in Maryland are Black. Of the population serving those terms, 41 percent are Black men who were sentenced to prison as emerging adults (under the age of 25). These numbers suggest that the aging of the prison population will not slow down.

National Landscape of Compassionate Release

Medical Parole

Forty-nine states and the District of Columbia have medical parole provisions, but the definitions and parameters vary among the states and are often vague. This leaves releasing authorities and parole boards in charge of who can apply for medical parole. In general, eligibility for consideration of medical parole depends on an individual's inability to perform activities of daily living or, on the other hand, incapacitation resulting in the requirement of 24-hour nursing care.⁴ Of the 49 states, only 13 are required by law to track and report statistics, and even fewer release the information publicly. Only nine people were released from prison for medical reasons in Pennsylvania between 2009 and 2015, and only seven in Kansas during the same timeframe. Since 2010, only two individuals have been granted release in New Jersey. Maryland's legislative language is so ambiguous it results in excluding mostly everyone, "*an inmate who is so chronically debilitated or incapacitated by a medical or mental health condition, disease, or syndrome as to be physically incapable of presenting a danger to society.*"

One reason the statutory criteria are so restrictive is that most state legislatures, including Maryland's, do not develop their policies and practices in conjunction with medical professionals to statutorily define conditions such as "chronically debilitated" (see

² Chiu, Tina, *It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release* (New York, NY: Vera Institute for Justice, 2010).

³ Julia Vitale, *A look at the United States' aging prison population program* (Richmond, VA: Interrogating Justice, 2021).

⁴ George Pro and Miesha Marzell, "Medical Parole and Aging Prisoners: A Qualitative Study," *J Correct Health Care* 23, no. 2 (2017):162-72.

Appendix A).⁵ Generally, the application process includes a series of medical reviews, which consume precious time for individuals with worsening health or facing imminent death. Prognostication is often difficult and inaccurate, and requiring exact prognostication is an unreasonable criterion for medical parole.⁶

Maryland’s medical parole provision makes all individuals eligible to apply except those sentenced for a sex offense or those with sentences that are not parole eligible. However, Maryland’s process is problematic. There is no required medical examination, and an applicant never receives a hearing. Instead, a physician merely reviews medical records, designates a Karnofsky score measuring functional impairment, and sends a recommendation to the Maryland Parole Commission. This is often in the form of an email or a few-sentence memo. The Parole Commission is under no obligation to grant an in-person hearing or to accept that recommendation and, in fact, may come to a different conclusion based on the Code of Maryland Regulations, which are *more* restrictive than the statute and state that the person must be “imminently terminal” to be granted medical parole.

Denying a comprehensive medical review impacts the Parole Commission’s ability to grant medical parole. When the standards are applied to hospice care, the healthcare field determines the symptoms of declining health that trigger hospice care when they are expected to have a year or less left to live. Because of the difficulty of accurately predicting time of death, these guidelines are flexible. However, that flexibility is not present in the correctional setting. This has resulted in one tragic case after another.

Stories from the Inside

Barbra Hampton tragically passed away 12 hours after receiving a commutation. Despite her health condition, she was not eligible for medical parole because of her *life without parole sentence*. In the final 24 hours of her life, her sentence was commuted, but she passed away hours after being transferred to a convalescent home. This last minute decision did not allow enough time for Barbra’s family to visit her. Barbara’s story is a reminder that medical parole in Maryland should be expanded to everyone, including those with non-parolable life sentences.

Amid the COVID-19 global pandemic, family and advocates of Donald Leroy Brown petitioned for a medical parole release due to his waning health conditions. The initial attempt was denied. In the following month, his health worsened and sparked a second attempt of compassionate release. He was granted medical parole and was released from prison but passed away in a nursing home facility just four days later.

⁵ Mary Price, *Everywhere and Nowhere* (Washington, D.C. FAMM, 2018).

⁶ Nicholas A. Christakis and Elizabeth B Lamont, “Extent and Determinants of Error in Doctors’ Prognoses in Terminally Ill Patients: Prospective Cohort Study,” *British Medical Journal* 320 (2000): 469–73.

In comparison to the eligibility criteria for federally administered palliative care through Medicare, eligibility for consideration of medical parole has a much higher threshold. Medical parole evaluates the incarcerated person's ability to perform activities of daily living. If federal guidelines for access to hospice care do not require incapacitation to deem patients eligible for palliative care services, it seems that the expectation of complete deterioration before consideration of medical parole is out of line with other reasonably determined standards of care. Involving healthcare professionals in the development of eligibility criteria for medical parole would allow for medically relevant guidelines that are more in line with other widely accepted standards of care and provide a more reasonable threshold for incarcerated individuals to receive necessary health care.

Geriatric Parole

Geriatric parole is offered in only 17 states and Washington, DC. Like medical parole, the parameters of geriatric parole differ in each jurisdiction and often have exclusions for certain offenses. Typically, geriatric parole is an option when an incarcerated individual reaches a specific age and has served a minimum number of years. In Maryland, you must be 60 years of age and have served a minimum of 15 years before applying for geriatric parole. Additionally, eligibility is limited to people who committed a violent offense *and subsequent offenses*. Thus, someone who meets the criteria but has been convicted only one time in their life *cannot* apply for geriatric parole, but someone with two or more convictions is able to apply. In practice, this legal stipulation renders geriatric parole ineffectual. There are more than 600 people older than 60 who have served at least 15 years in prison, yet the current policy excludes most from submitting a geriatric parole petition.⁷ In addition, the law remains silent on release decision making guidance. Thus, the Parole Commission typically will resort to relitigating the controlling offense and sentence, rather than focusing on mitigating circumstances, such as age of the individual.

Risks to Public Safety

Older prisoners pose a low public safety risk due to their age, general physical deterioration, and low propensity for recidivism. Medical parole programs should be open to non-terminal patients over age 50 who have health conditions that render them unlikely to pose substantial public safety risks.⁸ Research has conclusively shown that by age 50 most people have significantly outlived the years in which they are most likely to commit crimes. For example, arrest rates drop to just over two percent at age 50 and are

⁷ Editorial Board, "Maryland should release more elderly inmates," *Baltimore Sun*, (Baltimore, MD), July 19, 2019.

⁸ I.M Chettiar, W. Bunting, and G. Schotter, *At America's Expense: The Mass Incarceration of the Elderly* (New York, NY: American Civil Liberties Union, 2012).

almost zero percent at age 65.⁹ Nationally, aging people return to prison for new convictions at a rate between 5 and 10 percent, and often far lower.¹⁰

The story of the people released from prison due to the *Unger* court decision best exemplifies the aging population's low risk to public safety. In 2012, a Maryland court determined a series of cases involved unconstitutional jury instructions. This resulted in 235 individuals, many of whom had committed serious violent offenses, becoming eligible for release. The average age of those released due to the *Unger* decision was 64, and they had served an average of 40 years in prison. In the eight years since the ruling, these individuals have posted a recidivism rate of under three percent. This is much lower than the 40 percent rate of recidivism after only three years for all persons released from Maryland prison. The rate for the *aging Unger* population is so low that the cohort was five times more likely to pass away from old age than to recidivate for a new crime.¹¹

Other states have had a similar experience. New York reported a 7 percent reconviction rate for those 50 to 64 years old and only 4 percent for those 65 and older; Virginia experienced a 1 percent reconviction rate for those 60 and older.¹² Overall, the benefit of medical or geriatric parole to incarcerated individuals comes at a very low cost to public safety.

The Toll of Incarceration on Individual Health and Health Disparities

The prison system has a duty to provide adequate health services while incarcerated. The need for adequate access to care is not only a moral duty but is a legal requirement. In 1976, the U.S. Supreme Court ruling *Estelle vs Gamble* found that deliberate indifference to healthcare for the incarcerated population constituted cruel and unusual punishment and was thus prohibited by the U.S. Constitution. Because the ruling mandated health care, doctors became an integral part of the correctional system. Despite this, conditions within corrections are often in direct conflict with optimal patient care.¹³

⁹ Ibid.

¹⁰ Ibid.

¹¹ Stanley Mitchell, email message to author, November 23, 2021. Note: as of this report, only two individuals have been re-arrested for a new crime, and 10 Ungers have passed away.

¹² Various Authors, *The Ungers, 5 Years and Counting: A case study in safely reducing long prison terms and saving taxpayer dollars* (Washington, D.C., Justice Policy Institute, 2018).

¹³ Scott A. Allen, Sarah E. Wakeman, Robert L. Cohen, and Josiah D Rich, "Physicians in US Prisons in the Era of Mass Incarceration," *International Journal of Prisoner Health* 6 no.3 (2010): 100–106.

The World Health Organization defines *quality of care* by identifying components that provide desired outcomes:¹⁴

- Safe – “Delivering health care that minimizes risks and harm to service users, including avoiding preventable injuries and reducing medical errors.”
- Effective – “Providing services based on scientific knowledge and evidence-based guidelines.”
- Timely – “Reducing delays in providing and receiving health care.”
- Efficient – “Delivering health care in a manner that maximizes resource use and avoids waste.”
- Equitable – “Delivering health care that does not differ in quality according to personal characteristics such as gender, race, ethnicity, geographical location or socioeconomic status.”
- People-centered – “Providing care that takes into account the preferences and aspirations of individual service users and the culture of their community.”

A large proportion of individuals who are incarcerated experience chronic medical and mental health illnesses. One study from 2009 found the following:¹⁵

- 38.5 percent of federal prison population suffered from chronic medical condition
- 25.5 percent of federal prison population received psychiatric medication before admission
- 42.8 percent of state prison population suffered from chronic medical condition
- 29.6 percent of state prison population received psychiatric medication before admission
- 38.7 percent of jail population suffered from chronic medical condition
- 38.5 percent of jail population received psychiatric medication before admission

The wellness of the prison population reflects their home community. For example, a neighborhood in Baltimore, Southwest Baltimore, accounts for the fifth-highest population in the justice system, as well as the fifth-highest number of babies born with unsatisfactory weights. This correlation is present in other neighborhoods for a series of health, socio-economic, and justice indicators. Providing adequate care in the justice system means before, during, and after an incarceration stay.

¹⁴ “Quality of Care,” *World Health Organization*, Accessed December 21, 2021. https://www.who.int/health-topics/quality-of-care#tab=tab_1

¹⁵ Andrew P. Wilper, Steffie Woolhandler, J. Wesley Boyd, Karen E. Lasser, Danny McCormick, David H. Bor, and David U. Himmelstein “The Health and Health Care of US Prisoners: Results of a Nationwide Survey,” *American Journal of Public Health* 99, no.4 (2009): 666–72.

Because such a large proportion of incarcerated individuals are impacted by chronic illness, it is even more important for them to have access to care. Older individuals who cannot access adequate health care in prison affect community healthcare systems, because more than 95 percent are eventually released, many to urban communities where healthcare disparities are common and acute healthcare resources are overused.¹⁶

Economic Impact of Aging in the Justice System

The criminal justice system cannot afford to ignore the expense associated with the anticipated growth in the aging prison population.¹⁷ The cost of incarcerating the older population is high. As a person advances in age, the likelihood of developing chronic health issues increases as well.

Medical expenditures for all within the prison industrial complex contribute substantially to the operating cost. Nationally, it costs about \$34,000 per year to incarcerate an individual, but that rises to an estimated \$68,000 per year for someone over the age of 50. The difference is largely attributed to higher health care costs.¹⁸

The *Unger* population in Maryland provides a glimpse into the costs of the continued incarceration of the aging population. According to the Department of Correctional Services and Public Safety, the annual cost of incarceration is \$46,000 per year, which includes a \$7,956 allocation for medical and mental health services. Similar to how health insurance premiums increase with older age, the medical allocation increases 34 percent in the prison system for the geriatric population. This results in an \$18,361 allocation for the geriatric population, or a low estimate of \$35.5 million a year individuals over 60 years old.

Recent estimates indicate approximately 500,000 individuals in America's prisons have at least one of the following diseases: diabetes, asthma, and hypertension.¹⁹ As a result, it is estimated that older adults are three to five times more expensive to incarcerate than their younger counterparts. Medical care provided inside prison facilities is not covered by federal government health insurance (Medicaid or Medicare), so the correctional system absorbs the cost of providing medical services to the aging population.²⁰

¹⁶ Cyrus Ahalt, Robert L. Trestman, Josiah D. Rich, Robert B. Greifinger, and Brie A. Williams "Paying the Price: The Pressing Need for Quality, Cost, and Prisoners." *Journal of American Geriatric Society* 11, no.61 (2019): 2013–19.

¹⁷ Tina Maschi, Mary Beth Morrisey, and Margaret Leigey "The Case for Human Agency, Well-Being, and Community Reintegration for People Aging in Prison: A Statewide Case Analysis." *J Correct Health Care* 19, no. 3 (2013): 194-210.

¹⁸ Pro and Miesha Marzell, "Medical Parole and Aging Prisoners: A Qualitative Study."

¹⁹ Angela S. Murolo, "Geriatric Inmates: Policy and Practice," *J Correct Health Care* 26, no.1 (2020): 4–16.

²⁰ Pro and Marzell, "Medical Parole and Aging Prisoners: A Qualitative Study."

The hardships continue when prisoners are released to the community. The incarcerated population generally are suspended from public health benefit programs (Medicare, Medicaid, Social Security Insurance, Veterans Health Administration) upon incarceration. After release, there is often a substantial lag time until benefits are reinstated. During this time, a formerly incarcerated individual who experiences health problems must rely on costly emergency services for health care.²¹ A survey of returning citizens of all ages found that one-third of those with physical or mental health conditions used emergency department care and one-fifth were hospitalized within a year of release. Furthermore, because most state correctional departments provide only a one- to two-week supply of medication, many returning citizens have little or no access to medication while they await their initial healthcare appointment.²²

Despite these barriers to receiving adequate healthcare in the community, leaving prison can give aging individuals access to community-based health care or end-of-life support at a fraction of the cost incurred behind bars. State criminal justice systems can use those savings toward other initiatives that increase public safety.²³

Moving Forward

Expand eligibility and develop standards for compassionate release

There are a number of eligibility barriers for an individual applying for geriatric or medical parole release. The primary obstacle is the lack of clarity of how the laws apply and the standard of eligibility.

As part of the recently passed Justice Reinvestment Act, Maryland law declares that all people at least 60 years of age who have served 15 years are eligible for geriatric parole. However, only those persons who meet those criteria and are serving sentences for subsequent violent offenses under 141-101 are eligible. This is problematic. If someone is sentenced to 80 years for a first-time offense when they are 40 years old, with standard parole eligibility at 50 percent, they will not be eligible for release until age 80. Geriatric parole is unavailable to them because it is a first-time offense. This technical issue within the geriatric parole law circumvents the spirit of an age-based release mechanism. Maryland should expand eligibility to all people in prison, not just those individuals' serving non-parolable subsequent sentences for crimes of violence. In addition, the 15-

²¹ Cyrus Ahalt, Robert L. Trestman, Josiah D. Rich, Robert B. Greifinger, and Brie A. Williams "Paying the Price: The Pressing Need for Quality, Cost, and Prisoners." (2019).

²² Ibid.

²³ Price, "Everywhere and Nowhere."

year minimum time served requirement should be removed, so that all individuals of geriatric age are eligible to apply, regardless of how long they have been in prison.

Medical parole has less restrictive eligibility requirements but should still be expanded to the entire prison population, regardless of offense or sentence type. In addition, the decision-making guidance for the Parole Commission must be improved. Those applying for medical parole must be “chronically” debilitated or incapacitated, according to the statute. But the implementing regulation and practice by the Parole Commission is much more restrictive. Code of Maryland Regulations 12.12.08.05 requires that individuals seeking medical parole be considered “imminently terminal,” an unworkable standard and one that is more restrictive than the statutory standard. This regulation is what allows the Commission to deny medical parole until the waning days of someone’s life and is in contradiction with the General Assembly’s intent.

To assess suitability, Maryland relies on the Karnofsky Performance Status Scale, without any in-person examination.²⁴ A physician issues a short memo to the parole commissioners that includes the score, and if it is below 20, they are typically considered a viable candidate for release. According to the scale, a score of 20 indicates *very sick, hospital admission necessary, active supportive treatment necessary*; 10 is *moribund, fatal processes progressing rapidly*. The applicants are often permanently ill, not chronically ill as outlined in the statute, by the time they reach this score. There is a provision in the law that allows a person to receive an outside medical assessment, but it is rarely used.

Meaningful standards of review, that are developed in conjunction with the medical community, must be adopted in order to introduce fairness, transparency, and predictability to this process. More specifically, Maryland should move away from a blunt, imprecise instrument like the Karnofsky Score as the primary medical determination to assess impairment and adopt a standard that considers illness and impairment more holistically, with an emphasis on future risk to public safety and whether the correctional system can adequately provide necessary medical care and rehabilitation.

Use hospice and nursing care as an alternative to continued incarceration of the ailing population

Medicare is a federally administered health insurance plan that has guidelines that govern access to palliative and hospice care. The Center for Medicare and Medicaid Services defines hospice care as a “*comprehensive, holistic program of care and support for*

²⁴ “Performance Status: Palliative Care,” *Stanford School of Medicine*, Accessed December 21, 2021. <https://palliative.stanford.edu/prognostication/performance-status/>

terminally ill patients and their families. Hospice care changes the focus to comfort care (palliative care) for pain relief and symptoms management instead of care to cure the patient's illness."

To qualify for these services, a medical professional makes the determination based on the decline of health over the last three to six months by a series of medical measures. While the incarcerated population is evaluated in a similar fashion, the parole commission often stands in the way of successful medical parole applications. Maryland could provide alternatives to continued incarceration and rely on the standards set for hospice and palliative care.

Maryland could take lessons learned from Connecticut, which received federal funds and built a 95-bed nursing home to house individuals medically paroled.²⁵ In the first few years of operation, two individuals transferred back to prison because of minor infractions, but no employees have been injured.²⁶ This type of innovation can be cost saving, uphold public safety, ensure a smooth transition from prison to the community, and prevent lapses in care and medication that can contribute to negative health outcomes.

Develop reentry programs for geriatric parole-returning citizens

Individuals returning home after long prison terms need individualized reentry support. Maryland must build off the lessons learned from the Ungers and develop a reentry system to deepen the capacity of geriatric parole.

As part of the 2019 Justice Reinvestment Oversight Board meeting, the workgroup recommended a pilot program for reentry. It included designated funding for case managers to connect returning citizens with community-based resources; establish presumptive eligibility and pre-release healthcare availability; expand home detention or residential reentry centers; and provide peer support and senior programs to increase social interactions and connections. The recommendations set by the oversight board, alongside the foundation of the Ungers, can provide an effective reentry system for Maryland's currently incarcerated aging population.

²⁵ Adam Wisnieski, "'Model' nursing home for paroled inmates to get federal funds" *Connecticut Health I-Team*, April 25, 2017.

²⁶ Christine Vestal, *For Aging Inmates, Care outside prison walls* (Philadelphia, PA: Pew Charitable Trust, 2014).

State	Medical professionals in decision-making	Medical professionals develop criteria (for parole)
Alabama	No	No
Alaska	No	No
Arizona	No	No
California	Yes	Yes
Colorado	No	No
Connecticut	N/A	No
Delaware	No	No
Florida	N/A	Yes
Georgia	N/A	Yes
Hawaii	N/A	Yes
Idaho	No	No
Indiana	No	No
Kansas	No	No
Louisiana	N/A	Yes
Maine	No	N/A
Maryland	No	Yes
Massachusetts	No	No
Minnesota	No	Yes
Mississippi	Yes	Yes
Missouri	No	Yes
Montana	No	N/A
Nebraska	No	No
Nevada	No	Yes
New Hampshire	No	No
New Jersey	No	Yes
New York	N/A	Yes
North Carolina	No	Yes
North Dakota	No	Yes
Ohio	No	N/A
Oklahoma	No	No
Oregon	No	Yes

Pennsylvania	No	No
Rhode Island	No	N/A
South Carolina	No	N/A
South Dakota	No	No
Tennessee	No	Yes
Texas	No	N/A
Utah	No	No
Vermont	No	N/A
Virginia	No	N/A
Washington	No	N/A
West Virginia	No	N/A
Wisconsin	No	N/A

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