HARVARD PRISON LEGAL ASSISTANCE PROJECT

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John H. Melander, Jr., Deputy General Counsel
Executive Office of Public Safety and Security
One Ashburton Place, Room 2133
Boston, MA 02108

RE: HARVARD PRISON LEGAL ASSISTANCE PROJECT'S COMMENTS ON PROPOSED REVISIONS TO 501 CMR 17.00 – MEDICAL PAROLE

Dear Mr. Melander:

Harvard Prison Legal Assistance Project (PLAP) appreciates the opportunity to comment on proposed changes to the regulations governing medical parole, 501 CMR 17.00. Law students at PLAP hear from Massachusetts county and state prisoners about a variety of legal issues, and PLAP student attorneys represent state prisoners in disciplinary and parole matters, commutation petitions, and occasional other matters. In the course of our work, we encounter and represent elderly, infirm, and seriously ill prisoners. We have repeatedly witnessed the ways in which a prison – physically and culturally – is ill-designed for such people.

The current COVID-19 pandemic underscores the mismatch between the prison environment and the needs of elderly, infirm, and seriously ill prisoners. At least eight prisoners in Massachusetts have already died from COVID-19.[1] A recent epidemiologic study of 16 Massachusetts Department of Correction (DOC) facilities and 13 county-level systems from April 5 through July 8, 2020 found that the rate of COVID-19 infections in these facilities was almost three times higher than the rate in the general Massachusetts population.[2] The study's authors concluded that the "[r]ates of COVID-19 in Massachusetts jails and prisons are alarmingly high and require urgent action."[3]

Unfortunately, no such urgent action has been taken. Although we have seen the court-ordered release of many pre-trial detainees, releases of sentenced prisoners have remained consistent with release rates prior to the pandemic.[4] The Massachusetts Supreme Judicial Court, while ruling that it lacked the power to order the release of sentenced prisoners at the time of its

[1] Becker, D. Mass. High Court Refuses To Release Convicted Prisoners Because Of COVID-19. *WBUR News*. June 2, 2020. https://www.wbur.org/news/2020/06/02/covid-19-coronavirus-prisoner-release-sjc

[2] Jimenez MC, Cowger TL, Simon LE. Epidemiology of COVID-19 Among Incarcerated Individuals and Staff in Massachusetts Jails and Prisons. *JAMA Netw Open*. 2020;3(8):e2018851. doi:10.1001/jamanetworkopen.2020.18851

[3] *Id.*

[4] Becker, D. Mass. High Court Refuses To Release Convicted Prisoners Because Of COVID-19. *WBUR News*. June 2, 2020. https://www.wbur.org/news/2020/06/02/covid-19-coronavirus-prisoner-release-sjc

decision, urged the DOC to take independent action to reduce prison populations.[5] The court specifically cited medical parole as one of the tools at the DOC's disposal to effectuate releases. *Foster v. Commissioner of Correction (No. 1)*, 484 Mass. 698, 709 (2020). However, only 26 DOC prisoners had been approved for medical parole from April 3 until June 2, 2020, when the court issued its ruling. *Id.* The procedural complexity and rigidity of the current and proposed medical parole regulations have impeded, and will continue to impede, the release of medically vulnerable petitioners unnecessarily. Now, EOPSS has the opportunity to remedy this unnecessarily stringent administrative scheme, bringing it more into line with the statute.

Without question, the medical parole statute (G.L. c. 127 § 119A) represents sound public policy. The law addresses the reality of an aging prison population, and also the fact that at any age, a prisoner might be stricken by an illness or condition that calls into question the need for further incarceration. Medical parole is not simply an act of charity to the prisoner; it is an intelligent reallocation of resources and reduction of risks. As to resources, the Commonwealth can more efficiently and inexpensively care for a patient on medical parole than in prison, where logistical challenges make all health care more resource-intensive. As to risks, prison medical providers can focus more of their attention on the needs of the other prisoners which, given the prevalence of chronic disease, mental illness, and substance use disorder among prisoners, is challenging enough. In addition, the medical parolee is one less vulnerable prisoner in the prison, and correctional staff can reallocate their attention accordingly.

The threat of COVID-19 further illustrates the wisdom of having a medical parole statute in place. The SJC has explained the additional benefits of releasing medically vulnerable prisoners during the present pandemic:

> First, the DOC has limited capacity to offer the sort of specialized medical interventions necessary in a severe case of COVID-19. Thus, as seriously ill individuals are transferred from correctional institutions to outside hospitals, any outbreak in a correctional institution will further burden the broader health care system that is already at risk of being overwhelmed. Second, correctional, medical, and other staff enter and leave correctional institutions every day. Should there be a high concentration of cases, those workers risk bringing infections home to their families and broader communities. *Committee for Public Counsel Services v. Chief Justice of the Trial Court*, 484 Mass. 431, 437 (2020).

The medical parole statute was a good idea. The statute is only useful if it can be used, however. That lesson has been learned in all too many other jurisdictions, where the process of obtaining a medical parole (or equivalent) is too slow or cumbersome to be useful. The full benefit of a medical parole process can only be realized if that process is nimble. It is with these thoughts in mind that PLAP offers comments on the proposed amendments to the medical parole regulations.

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[5] *Id.*

1. **The definition of "debilitating condition" should be removed or revised to exclude unnecessary and irrelevant conditions.**

PLAP objects to the definition of "debilitating condition," and we submit that the fairest and most effective remedy is to simply remove the definition from Section 17.02. Presumably this definition is intended to assist the officials tasked with deciding whether, pursuant to the statute, a permanent incapacitation or terminal illness is "so debilitating that the prisoner does not pose a public safety risk." G.L. c. 127 § 119A(a). The problem with the definition is that it becomes very specific in a way that is not only unduly limiting, but that will tend to bog down the analysis instead of aiding it. The word "debilitating" has a commonly understood meaning, and relying on that commonly understood meaning would be superior to following this proposed definition.

More specifically, the phrase "resulting from an illness, trauma, and/or age," is needless. All it serves to do is to place an unnecessary burden on the prisoner or petitioner to specify the origin of their medical or mental condition. PLAP does not see the relevance of the origin of the condition. Whether or not the condition exists is the only question at issue.

In addition, PLAP submits that the phrase "significant and serious impairment of strength or ability to perform daily life functions…so as to minimize the prisoner's ability to commit a crime if released on medical parole" is too narrow and is not faithful to the statute. For example, the current definition will exclude prisoners with conditions like Alzheimer's Disease or other types of dementia, which while permanently incapacitating, and sometimes terminal, may not impede the patient's ability to carry out daily functions.

Finally, the requirement that a prisoner's impairment "minimize the prisoner's ability to commit a crime if released on medical parole" should be replaced with the medical parole statute's more flexible imperative that the prisoner's condition be "so debilitating that the prisoner does not pose a public safety risk." G.L. c. 127, § 119A(a). The statutory language is more general than that in the current regulation and allows for balancing or weighing of competing interests. In some cases, other public interests will outweigh the desire to incapacitate potential criminal offenders, as evidenced in the SJC's order to release on personal recognizance a large number of pretrial detainees owing to the public health risks posed by their continued incarceration. *Committee for Public Counsel Services v. Chief Justice of the Trial Court*, 484 Mass. 431, 447 (2020). The statutory language is also more aligned with the principle of adaptability that should undergird the medical parole process.

2. **The assessment for risk of violence outlined in the proposed regulation should be revised to exclude irrelevant considerations.**

Several factors for consideration in the Risk for Violence Assessment (RVA) in Section 17.05 are irrelevant to determining a prisoner's likelihood of committing acts of violence upon release. Specifically factors (c) [clinical management of medical condition], (e) [prescribed and required medical equipment and assistive devices], (f) [ability to manage Activities of Daily Living], (h) [advance directives], and (i) [height, weight, and method of feeding] have at best a

tenuous connection to the probability that a prisoner will commit violence upon release. These factors should be deleted from the regulation.

The inclusion of physical fitness factors in the RVA also appears to narrow the category of debilitating conditions that may qualify for medical parole contrary to the will of the legislature. The statute explicitly encompasses both physical and cognitive incapacitation. G.L. c. 127 § 119A. However, the RVA required in Section 17.05 effectively excludes prisoners suffering from solely cognitive incapacitation from the medical parole process. Factors (d) [assessment for mobility, gait and balance] and (e) [prescribed and required medical equipment and assistive devices] apply uniquely to prisoners suffering from physical incapacitation. The requirement that the superintendent consider these factors disfavors prisoners suffering from cognitive incapacitation, who may have full mobility and may require no medical equipment, but may nonetheless pose no threat to public safety. For example, Alzeheimers patients are often fully mobile, but may still be functionally incapable of doing harm. These factors should be removed from the regulation to facilitate medical parole for cognitively impaired prisoners as the legislature intended.

In place of these largely irrelevant considerations, the RVA should explicitly require consideration of the prisoner's medical condition, the prisoner's age, and the extent to which these factors mitigates the risk for violence. A more holistic consideration of a prisoner's overall medical condition would better accommodate prisoners with cognitive (rather than physical) conditions.

Further, age is an important factor in determining the likelihood that a person will commit a crime in the future; this factor should be explicitly included in the Superintendent's considerations for the RVA The United States Sentencing Commission reports that federal prisoners who were age 65 or older at the time of their release were "substantially less likely" to be rearrested compared to their younger counterparts.[6] The Commission found that "Age exerted a strong influence on recidivism across all sentence length categories. Older offenders were less likely to recidivate after release than younger offenders who had served similar sentences, regardless of the length of sentence imposed."[7] A study of prisoners released from correctional facilities in North Carolina likewise found that the odds of recidivism decreased with age.[8] The researchers called for an expansion of geriatric parole, urging that "The growing population of incarcerated older adults pose challenges society must address. Most prisons are ill equipped to care for individuals experiencing age-related decline and related chronic medical conditions."[9] Given the evidence that old age decreased the public safety risk of a prisoner's release, this factor should be explicitly included in the RVA.

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[6] Hunt KS & Easley B. The Effects of Aging on Recidivism Among Federal Offenders. United States Sentencing Commission. December 2017. https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171207_Recidivism-Age.pdf

[7] Id.

[8] Rakes S, Prost SG, Tripodi SJ. Recidivism among Older Adults: Correlates of Prison Re-entry. Justice Policy Journal. 2018, 15(1).
http://www.cjcj.org/uploads/cjcj/documents/recidivism_among_older_adults_correlates_of_prison_reentry.pdf

[9] Id.

The RVA should explicitly differentiate between acts of violence *per se* and acts of violence for which the prisoner is culpable. Further, Section 17.05 should specify that only the latter category of violent acts is relevant to the RVA. Such a distinction is required to account for prisoners suffering from debilitating cognitive conditions where outward acts of violence are a manifestation of their condition rather than a volitional choice on the part of the prisoner. Prisoners suffering from Alzheimer's, for instance, may manifest physically aggressive outbursts as a result of their progressive mental decline. There is no additional public safety risk in releasing such a prisoner because they pose the same risk of violence as any other person suffering the debilitating effects of Alzheimer's. These prisoners would be better served, and could be safely served, by placement in a medical facility where they can be tended by trained health professionals. In such a setting, the likelihood of aggressive outbursts will decline with the benefit of specialized medical care. The failure to determine in the RVA whether a prisoner's behavior is a manifestation of their medical condition frustrates the medical parole process for such prisoners.

Finally, the consideration of a prisoner's current housing situation (Section 17.05) and of "risk level for classification evaluation purposes" (Sections 17.03(6)(c), 17.04(f), and 17.06(6)(c)) in the assessment of risk of violence introduces irrelevant and discriminatory factors into the medical parole process. DOC's Objective Point Based Score (OPBS) system, used in classification evaluations and reflected in the resulting housing placements, involves many factors that either should not be considered in the medical parole process, are already being considered in that process and so are being double counted, or should not be given the same weight as other factors. The severity of a prisoner's current and past convictions, a prisoner's history of escape attempts, and their history of prior institutional violence do not provide meaningful information about the likelihood today that a person suffering from an irreversible debilitating condition will commit violence in the future. The inclusion of program participation or work assignments in the OPBS also disadvantages the irreversibly impaired, who are unlikely to be able to participate in such activities. The OPBS also allows for a discretionary classification override to higher custody for prisoners "whose behavior, while not always negative enough to warrant disciplinary action, may serve to threaten security or undermine the exercise of proper control and maintenance of order within the institution or other correctional facility." Where a prisoner suffers from a medical condition or disability that interferes with their ability to hear orders, control their impulses, or respond appropriately to their environment, they are particularly vulnerable to such a discretionary reclassification. Further, considerations of education and employment during initial classification may result in discrimination against Black, Latinx, and Native American prisoners and prisoners of low socioeconomic status who are systematically more likely to be unemployed and undereducated. These factors have no place in the medical parole process and they should be removed from the proposed regulation.

The OPBS's heavy emphasis on recent disciplinary reports is particularly troublesome and would unfairly skew the assessment for those with dementia or other cognitive disabilities. PLAP has witnessed this phenomenon first hand as these people often receive disciplinary reports for behavior that is a product of their medical condition. Although a disciplinary hearing officer may account for a prisoner's cognitive disability by finding them guilty of the offense but waiving the sanction, the OPBS fails to make such an adjustment by looking solely at the number of guilty findings. This effect is compounded for prisoners found guilty of high level disciplinary offenses

such as "Conduct which interferes with the security or orderly running of the institution" (disciplinary offense 2-24), which count against the prisoner for two of eight OPBS variables. The inclusion of the OPBS in assessing a prisoner's safety risk also raises the possibility of improper double-counting of factors. Since the Superintendent or Sheriff is already likely to consider a prisoner's disciplinary history in their recommendation to the Commissioner, the same factor is double-counted when the OPBS is also included in the analysis. For these reasons, a prisoner's current housing situation and classification evaluation should not be considered during the medical parole process.

The requirement that medical parolees be subject to the supervision of the Parole Board provides further support for these changes. Medical parole is not a permanent decision, nor is it absolute freedom. The Parole Board imposes conditions and retains the authority to revoke medical parole from a parolee who violates them, including those whose behavior becomes concerning and cannot be managed adequately in the community. Incorporating the revisions outlined above, the medical parole process can better facilitate the release of prisoners based on medical need while retaining a means of recourse should a released prisoner pose an unexpected threat to public safety.

3. To avoid unnecessary inefficiency and delay, the medical parole petitioner should be afforded additional procedural safeguards.

Although the proposed regulation eliminates objectionable procedures struck down by the SJC, *Buckman v. Commissioner of Correction*, 484 Mass. 14, 16-17 (2020), the draft regulation fails to directly address the handling of incomplete petitions altogether. PLAP endorses the removal of the previous procedures for incomplete petitions; however, explicit procedural safeguards are required to facilitate the timely and effective review of medical parole imperfectly-filed medical parole petitions.

The medical parole regulation should explicitly state that a medical parole petition will be considered filed on the date it is first submitted, even if it is later deemed to be incomplete or filed on the incorrect form. Such a specification is necessary to avoid delays and to clarify the expected timeline for a proper medical parole petition review.

A one business day deadline should be added for the return of incomplete petitions, as well as a requirement of a written explanation for the return. The medical parole statute, recognizing that time is of the essence, includes deadlines for the processing of petitions, and the regulations implementing the statute should include deadlines for other procedural steps such as this one. As drafted, the proposed medical parole regulation has no deadline by which a DOC official must declare a petition incomplete. The absence of such a deadline is an outlier. The DOC's own Inmate Grievances regulation, 103 CMR 491, states that within one business day of receiving a prisoner's grievance, the Institutional Grievance Coordinator shall "[e]nsure that the grievance complies" with the regulation, and if it does not, shall "return the grievance to the inmate on the applicable form with a written explanation noted on the form." 103 CMR 491.15(3)(a). A similar deadline should be required with incomplete medical parole petitions, along with a requirement of an

explanation. The reason for deeming a petition incomplete is not always self-evident, and there is nothing to be gained from hiding the ball.

Section 17.03(6), detailing how and to whom a medical parole petition should be submitted, should be modified to ease rather than hinder the process of submitting a petition. First, the provision that petitions shall be returned to the petitioner if submitted to any Department employee other than the Superintendent will result in unnecessary delay. The regulation should call for any Department employee receiving a petition simply to forward it to the Superintendent, within three days. Second, the provision that prisoners at Lemuel Shattuck Hospital should have their petitions sent to the Superintendent of the sending facility is sensible, particularly if the petitioner is not the prisoner. A prisoner at Shattuck Hospital who is the petitioner, however, will not be able to get the petition to that Superintendent. Those who are housed at the hospital are generally considered temporary placements; in our experience, they do not have ready access to postage or the other means of getting a document to the Superintendent. Accordingly, the regulation should allow a prisoner at Shattuck Hospital to submit his petition to the Superintendent for the LSH Correctional Unit, or the highest ranking officer there. That official can see that the petition is forwarded to the proper Superintendent's office. This change would be consistent with other DOC policies. The grievance regulation states that if a prisoner is in a hospital unit, they should give the grievance to staff, "who shall immediately forward the grievance(s) to the [Institutional Grievance Coordinator]." 103 CMR 491.14(4).

PLAP's comments as to Section 17.03 (concerning DOC prisoners) apply equally to the corresponding subsections of Section 17.06 (concerning county prisoners), and the changes recommended for Section 17 .03 should also be made to Section 17 .06.

4. **The regulation should include specific provisions for serving cognitively disabled prisoners who, by reason of their disability, cannot otherwise access medical parole.**

As discussed above, the medical parole statute explicitly includes prisoners suffering from debilitating cognitive conditions. The prisoners, however, face particularly daunting challenges in accessing medical parole, even if the process is technically available to them. A person who cannot comprehend their surroundings, their circumstances, or even their identity would be clearly incapable of filing a medical parole petition. These individuals would likewise be unable to seek an advocate to file the petition on their behalf. Under the Americans with Disabilities Act and its state counterpart, the DOC and Sheriffs are required to make reasonable accommodations for disabled prisoners to allow them to access services, including medical parole. Such reasonable accommodations are clearly necessary in such cases.

Although the DOC and Sheriffs may act on its own initiative to seek medical parole for individual cognitively disabled prisoners on an ad-hoc basis, these measures are insufficient to ensure equitable access to medical parole. Rather, DOC and Sheriffs have -- and should embrace -- a duty to affirmatively identify disabled medical parole candidates and to enable them to file petitions, whether by themselves or through advocates or otherwise. The medical parole regulation should specify that 1) the DOC and Sheriffs must implement screening procedures to identify cognitively disabled prisoners who may be eligible for medical parole and 2) the DOC and Sheriffs

must assist these prisoners by either filing a medical parole petition on their behalf or by notifying external advocates of the prisoner's cognitive disability status. PLAP considers such accommodations necessary to bring the medical parole process into compliance with federal and state anti-discrimination mandates.

Further Considerations

PLAP recognizes that, in many cases, the feasibility of medical parole depends on a prisoner's placement options upon release. County Sheriffs and the DOC are limited by a lack of available placements for prisoners suffering from an irreversible medical or cognitive condition. Some of these people have a family member who can take them in and secure hospice or other care. Many others do not. The intent of the medical parole statute can only be carried out if adequate placements -- including skilled nursing facilities and other long term care options -- are available for petitioners. For that matter, such placements are needed in the Commonwealth for people being released to the community on regular parole, or at the expiration of their sentences. The Medical Parole regulations should be amended, as described above, so that this law's execution more closely hews to its intent, but we all should recognize that other barriers exist, and the Commonwealth should work to eliminate those barriers. Massachusetts must develop a comprehensive approach to the reentry of prisoners with permanent disabilities and significant illnesses. Private facilities will be part of the solution, but only if our Health and Human Services authorities lead the way.

Thank you for your consideration of these comments. Harvard PLAP would be happy to discuss any of the comments, or the regulations in general. Our office can be reached at (617) 495-3969 or our Policy Directors can be reached by email at jsteffen.jd22@hlsclinics.org and scunningham.jd21@hlsclinics.org.

Sincerely,

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