



December 2017

Aging Out

Using Compassionate Release to Address
the Growth of Aging and Infirm Prison Populations

Rebecca Silber, Alison Shames, and Kelsey Reid

Contents

2 Introduction

6 The aging prison population

8 The challenges of compassionate release

11 Case studies

12 South Carolina

14 Mississippi

15 Expanding the reach of compassionate release policies

19 Conclusion

20 Endnotes

Introduction

The Justice Reinvestment Initiative (JRI), a partnership between the Bureau of Justice Assistance of the U.S. Department of Justice's Office of Justice Programs and the Pew Charitable Trusts, is a data-driven approach to criminal justice policy that seeks to improve public safety, curb corrections costs, and reinvest the savings in evidence-based public safety strategies. Since its launch in 2010, 29 states have engaged in this process. For most, the resulting legislative package includes policies aimed at reducing the state's reliance on incarceration by using it primarily for those convicted of serious and violent crimes; strengthening probation and parole practices; expanding behavioral health treatment services; reinvesting a portion of the expected savings in public safety measures; and measuring the legislation's outcomes.¹

A ripe opportunity for strengthening the justice system examined by a number of states is the prospect of reducing the population of elderly or severely infirm people in prison.² Corrections professionals typically consider people in this population elderly as of age 55, because adults tend to age much faster when they are incarcerated.³ Decreasing these populations is consistent with two common goals of the JRI process: reserving prison for people who pose a high risk for re-offending, and reducing costs.⁴ Nationally, the percentage of older adults in prison has increased dramatically: from 1993 to 2013, the number of people 55 or older in the custodial state prison population increased 400 percent, from 3 percent of the total state prison population to 10 percent.⁵ For instance, when Mississippi started its JRI work in 2013, it found that 799 people (out of more than 22,000) age 60 and older were in its prisons.⁶ In 2015, Maryland's JRI task force reported that the number of people older than 55 housed in its prison system had nearly doubled in the past 10 years, to 1,875.⁷ State policymakers have learned from national research or their own data that the cost of incarcerating older people is double that of housing younger ones, due to health care expenses.⁸ These spiraling expenditures do not result in substantial gains in public safety, because people of advanced age pose a low risk of re-offending.⁹

Most states have some form of what is referred to as a "compassionate release" policy, which allows people who meet certain aging or medical criteria to be released earlier than their statutory release dates.¹⁰ While serving both a compassionate purpose (allowing elderly or seriously ill people to spend

their final months or years with their closest loved ones) and a practical purpose (corrections institutions are poorly equipped to care for seriously ill people), these early-release policies are also supported by recidivism research, which demonstrates that age is a significant predictor of re-offending: arrest rates drop to just more than 2 percent in people ages 50 to 65 years old and to almost zero percent for those older than 65.¹¹

✍

The cost of incarcerating older people is double that of housing younger ones, due to health care expenses.

✍

To date, JRI legislation in eight states—Alabama, Alaska, Arkansas, Louisiana, Maryland, Mississippi, North Dakota, and South Carolina—have created or expanded release policies designed to reduce the number of elderly or infirm people in their custody. (See Table 1.)

Most of the legislation reflected in Table 1 were enacted in only the past few years, so it is too soon to determine whether they are effective at safely and significantly reducing the elderly and infirm prison population or if they have had a broader impact on the prison population or spending as a whole. Nonetheless, there are lessons to be learned from the policies implemented in JRI states.¹² Drawing on the experiences of these JRI states as well as the existing literature about incarcerating elderly and seriously ill people, this report examines the challenges states face in using compassionate release mechanisms to reduce these populations and related costs. Case studies of Mississippi and South Carolina—two states that expanded their compassionate release laws as part of their JRI legislation—illustrate both the shape these laws take and the barriers faced in designing and implementing these policies. The report ends with suggestions that target the most common challenges faced by states that adopt or modify compassionate release policies.

Table 1

Compassionate release in JRI legislation

State	Statute	Decision maker
Alabama	2015: SB 67	Department of Corrections
Alaska	2016: SB 91	Parole Board
Arkansas	2011: SB 750/Act 570	Parole Board
Louisiana	2011: HB 138/Act 253; 2017: SB 139/Act 280	Committee on Parole
Maryland	2016: SB 1005	Parole Commission (Governor must be notified and can veto applications from individuals with life sentences)
Mississippi	2014: HB 585	Parole Board
North Dakota	2017: HB 1041	Parole Board
South Carolina	2010: SB 1154	Parole Board

Medical criteria	Age	Conviction/sentence exceptions
“Permanently incapacitated” to an extent that prevents committing a violent or criminal act	No age specification	Capital murder and sex offenses
For medical release: “Severely medically or cognitively disabled”	For geriatric release: 60+ (and have served 10+ years of their sentence)	Certain felonies and sex crimes
“Permanently incapacitated” and “terminally ill”	No age specification	If the individual would be required to register as a sex offender and is assessed as a Level 3 offender or higher; or the victim of the sex offense was 14 or younger
For furlough: “Limited mobility offender..who is unable to perform activities of daily living without help or is bedbound”	For parole: 60+ (and have served 10+ years of their sentence)	For parole: sex or violent crimes For furlough: individuals on death row
“Chronically debilitated or incapacitated by a medical or mental health condition, disease or syndrome”	For geriatric release from mandatory minimum sentences: 60+ (and have served 15+ years of their sentence)	For medical parole: must be parole eligible
People with “a significant permanent physical medical condition with no possibility of recovery”	Automatic parole hearings for people age 60+ who have served 10+ years of their sentence	Sentences under habitual offender enhancements; for violent crimes, offenses that prohibit parole, drug trafficking, and sex crimes; and for those who have served less than a quarter of their sentence
Serious or terminal medical condition	No age specification	No specified exclusions. Some people whose sentences are normally parole ineligible are eligible: those convicted of “armed offenses,” sentenced as “violent offenders,” or sentenced to life without parole
For medical release: “Terminally ill” with a two-year or less life expectancy; or permanently, irreversibly incapacitated and requiring immediate and long-term care	For geriatric release: 70+ and are incapacitated with a chronic condition related to aging	Sentence without parole eligibility

The aging prison population

In 2013, 10 percent of the total U.S. state prison population—approximately 131,500 people—were age 55 or older.¹³ A 2014 survey conducted by the Pew Charitable Trusts and the Association of State Correctional Administrators (Pew/ASCA survey), found that the average proportion of older people in state prison across 42 states in 2011 was 8.2 percent—and more than 13 percent in Oregon, Vermont, and West Virginia.¹⁴ In most states, the number of elderly adults in prison is increasing and represents a growing percentage of the prison population. From fiscal year 2007 to 2011, the share of older people in prison in the 42 states that provided data to the Pew/ASCA survey increased by an average of 33 percent.¹⁵ Based on the aging of the current population and approximations of admissions, it is estimated that by 2030, adults who are 55 or older will constitute one-third of the people incarcerated in state and federal prisons.¹⁶ This would be a dramatic change from just 25 years ago, when elderly adults made up just 3 percent of the state prison population nationwide.¹⁷

The growing size of the elderly population is driven both by long sentences, particularly for violent offenses, and an increase in admissions of people who are age 55 or older. (Although some theories exist as to why older people are being admitted to prison in greater numbers despite their overall lower recidivism rates as compared to younger adults, there is no definitive explanation.¹⁸) Adults who are 55 and older made up 4 percent of admissions in 2013, compared to just 1 percent in 1993.¹⁹ Of those in that age group who were incarcerated in state prisons in 2013, 40 percent had served more than 10 years of their sentences, and about one-third of older adults were serving sentences of life imprisonment or death.²⁰ Many of these people were not eligible for parole, either because of a sentence of death or life imprisonment without parole, or because of truth-in-sentencing laws that eliminated discretionary parole release.²¹

Under the Eighth Amendment of the United States Constitution, states are obligated to provide adequate medical care for people they imprison.²² Many people in prison suffer from poor medical conditions even before they are incarcerated.²³ People who are poor and people of color—two groups that are disproportionately represented in prison populations—tend to have less access to quality medical care.²⁴ Incarceration has also been found to worsen health and cause excessive stress, speeding up the rate at which incarcerated people age.²⁵ These factors contribute to older adults in prison experiencing disabilities and illness at much higher rates than that of their younger counterparts.²⁶

Caring for elderly and infirm people in prison

Because prisons are not designed to accommodate elderly, infirm, or disabled people, some corrections systems have created specialty housing units or allocated entire facilities for these populations.^a For example, Pennsylvania's State Correctional Institution at Laurel Highlands is equipped with medical facilities for people in need of long-term daily nursing care or dialysis, those who use wheelchairs, and geriatric adults.^b The facility, formerly a state hospital, converted several units to medical wards for people who are incarcerated and require care otherwise available only at a hospital.^c The state of Washington also equipped a special unit in its Coyote Ridge Corrections Center to house a portion of its population of people who are 50 and older.^d New York State has a prison unit designed to accommodate the needs of people with cognitive impairments, such as dementia, at its Fishkill Correctional Facility.^e At the Colorado Territorial Correctional Facility, a special recreation period for people who are older or have mobility

impairments and developmental disabilities allows them to participate in physical activities appropriate for their age and conditions.^f

A number of prison systems have created hospice units where incarcerated adults are cared for, sometimes by fellow incarcerated people who have been trained in hospice care. Hospice is an approach to end-of-life care that provides palliative care and other support for patients and their family members.^g Hospice volunteer workers provide comfort and company to people in the late stages of a terminal illness.^h Other systems have implemented programming on self-care for elderly and infirm people in custody. Some Oklahoma prisons have offered chronic disease self-management programs to help incarcerated people develop practical skills to address chronic health issues and enable them to feel more comfortable engaging with medical staff about their health needs.ⁱ

^a Williams, Stern, Mellow, et al., 2012.

^b Pennsylvania Department of Corrections, "SCI Laurel Highlands," <https://perma.cc/K258-SXSM>.

^c Francesca Sacco, "Elderly inmates cared for at SCI-Laurel Highlands," *Observer-Reporter*, September 1, 2014, <https://perma.cc/MBA8-9LM3>.

^d "Aging Inmates Prompt Creation of Assisted Living Center at Washington Prison," Fox News, August 16, 2010, <http://www.foxnews.com/us/2010/08/16/aging-inmates-prompt-creation-assisted-living-center-washington-prison.html>.

^e In 2015, 24 people were held there, with an average age of 62. Maura Ewing, "When Prisons Need to Be More Like Nursing Homes," *The Marshall Project*, August 27, 2015, <https://perma.cc/JQL6-4J5E>.

^f Human Rights Watch, *Old Behind Bars: The Aging Prison Population in the United States* (New York: Human Rights Watch, 2012), 69, <https://perma.cc/M8HK-MAMJ>.

^g For more information about hospice care, see the website of the National Hospice and Palliative Care Organization at <https://perma.cc/5T52-6YBC>.

^h See Missouri Hospice and Palliative Care Association, "Missouri Hospice and Palliative Care Association Helps MoDOC Implement New Hospice Training Program," press release (Jefferson City, MO: Hospice & Palliative Care Association, May 15, 2015); and Missouri Department of Corrections, "Women's Prison Receives Special Hospice Training," press release (Jefferson City, MO: Missouri Department of Corrections, November 28, 2012), <https://perma.cc/YSV9-ZR3Y>.

ⁱ Zohre Salehezadeh, Naneida Lazarte Alcalá, and Candace Smith, *The Chronic Disease Self-Management Program (CDSMP) in Oklahoma* (Oklahoma City: Oklahoma Department of Human Services, Office of Planning, Research and Statistics, 2013), 4, <https://perma.cc/SDZ7-MTEQ>.

An increasing number of elderly people in the prison population correlates with higher prison health care spending. Research has found that states with the highest percentages of people who are 55 and older in prison tended to have higher annual health care spending per person.²⁷ Although the average cost of housing an individual in state prison for a year is \$33,274, annual costs for incarcerating older adults are double the cost of incarcerating younger ones.²⁸ Given that 131,500 people age 55 or older were in state prisons in 2013, and based on an average annual cost of \$66,548 to imprison an individual this age, the United States spends nearly \$9 billion every year incarcerating people in this age group in state prisons.²⁹

The challenges of compassionate release

Nearly every state has some form of compassionate release policy.³⁰ The laws generally authorize the state's parole board and/or department of corrections to release people who meet certain aging or medical criteria earlier than their statutory release dates or ordinary parole eligibility date. Although compassionate release policies vary by state in their details, most have one important thing in common: they provide narrowly circumscribed opportunities for release and have not had a significant impact on reducing the number of older and infirm people in prison. In most states, the policies are not widely used and, when the

✂

Compassionate release policies are not widely used and, when the provisions are invoked, people are infrequently released.

✂

provisions are invoked, people are infrequently released.³¹ For example, as of March 2016 in Alabama, only 39 people had been released on medical furlough since it was instituted in 2008: there were nine such releases in fiscal year 2014 and only four each in fiscal years 2015 and 2016.³² In Texas, more than 2,000 people were screened and only 176 applications for medical parole advanced to review by the Texas Board of Pardons and Paroles in fiscal year 2016; of that number, only 86 people were approved for release.³³

Although state officials express a desire to address the size and cost of their elderly and infirm prison populations, research and other reporting have identified a number of barriers to releasing more people under compassionate release laws and policies. Thus, even where compassionate release policies do exist, they are infrequently used, in part due to these restrictive and burdensome criteria.³⁴

- > ***Statutory exclusions limit eligibility.*** A key obstacle that limits the reach of compassionate release policies is a state's narrow eligibility criteria, which usually exclude people convicted of the most severe offenses. Because serious felonies command the longest sentences, many people with long sentences are not eligible for these policies. For example, Alaska excludes people who have been convicted of certain sex offenses, and Alabama excludes those convicted of sex offenses and capital murder.³⁵ Additionally, many policies apply only to people who are otherwise eligible for parole, and therefore exclude people sentenced to life without parole or under truth-in-sentencing laws. With one-third of older incarcerated people serving sentences of life imprisonment or death, these exclusions render only a fraction of them eligible for compassionate release. Furthermore, for those states that enacted truth-in-sentencing laws—typically in the mid-1990s—people sentenced after a certain year are no longer eligible for discretionary parole and are therefore excluded from consideration for compassionate release.

- > ***Medical criteria can be restrictive and not medically informed.*** The medical criteria included in the special release policies impose another barrier. In many states, people in prison must establish that they are “terminally ill” or “permanently incapacitated.”³⁶ Some states also require a doctor to certify that the patient has a limited life expectancy, typically six months to two years. Arkansas’ medical parole statute specifies two years, while Mississippi’s conditional medical release policy (a furlough policy) specifies six months.³⁷ This requirement overlooks the fact that prognosis, unlike diagnosis, is an inexact science and that doctors tend to be overly optimistic in their assessments.³⁸ What’s more, life expectancy is not always an accurate indicator of an individual’s incapacitation, as many people who have serious and terminal illnesses are incapacitated for months or years prior to their deaths.³⁹ Although focusing on age as an eligibility factor has the virtue of objectivity, it may bar younger people who could be good candidates for early release because age alone may underestimate their medical needs. As discussed earlier, the chronological ages of people in prison do not necessarily reflect the state of their health, particularly for those who are serving long sentences.⁴⁰

- > ***Application processes pose burdens.*** The process of applying for compassionate release differs in each state. In some states, the responsibility to apply and to navigate the process falls solely on the individual who is incarcerated and, in many cases, is terminally ill, incapacitated, or otherwise inflicted with a serious medical condition. For those people, the burden of managing the process can be overwhelming.⁴¹ Other states, such as Maryland, allow family members or attorneys to initiate the application process.⁴² But incarcerated people with limited literacy or cognitive impairments may not be capable of initiating this process.⁴³ In other states, such as Arkansas, the authority to initiate the process lies with corrections officials.⁴⁴ Unless a department of corrections explicitly assigns this responsibility to a staff member, it may be overlooked by those employees who otherwise have pressing day-to-day responsibilities.⁴⁵

- > ***Hearing processes are protracted.*** The application and review processes for compassionate release typically parallel that of general parole in that they require several steps, including notification to or consent of victims and law enforcement and, when relevant, a hearing before the parole board. Other steps involve assessing the individual's medical condition, the care needed and, in some states, development of a plan for their care if they are released. These steps can be protracted, despite the importance of a timely review, given that the reason for seeking release is the imminence of death. Indeed, in some cases, old and seriously ill people do not survive the process.⁴⁶

- > ***Granting third parties veto power can hinder releases.*** Many compassionate release policies provide victims/survivors, law enforcement, prosecutors, and/or the courts an opportunity to veto or comment on a release decision. Some policies require that these stakeholders affirmatively consent to release; others allow victims, law enforcement, and judges to veto an application. This process is important to many parole board members who want to know what victims/survivors and law enforcement officers—the people most deeply affected by a crime or most knowledgeable about it—have to say about whether the person applying for parole should be released. Some states grant victims/survivors and law enforcement greater rights to object to and veto compassionate release than

they would under a typical parole process.⁴⁷ While victim and law enforcement input can help inform parole decisions, if not streamlined, these notification or consent requirements create barriers to compassionate release or, at a minimum, delays in the process when timing is urgent.

- > ***Post-release conditions are inadequate.*** Even if incarcerated people qualify and are able to navigate the application process, they still may not be released due to concerns about the nature of the care and services they would need once back in the community. Many states require that a transitional care plan be prepared to accompany the application for release. The decision maker—either the parole board or director of corrections—may deny release if it is determined that adequate services are not available or affordable in the community. Unfortunately, many community-based resources for elderly adults and others with serious illnesses, such as nursing homes, will not treat or house people who have a criminal history.⁴⁸

Case studies

The challenges described above have limited the effectiveness of compassionate release policies historically—and also seem to apply to some of the new or expanded policies implemented by states participating in JRI. To better understand the ways that JRI states have implemented and experienced compassionate release policies, this brief examines the experiences of two JRI states that have had new compassionate release policies in place in recent years: South Carolina and Mississippi.⁴⁹ Both states are notable national leaders in reducing their prison populations, having demonstrated a deep commitment to the JRI process and implementation. South Carolina's prison population decreased 14 percent from 2009 to 2016—and is 20 percent lower than what was projected in 2009.⁵⁰ Mississippi's population decreased 16.5 percent from 2013 to 2015 year and, in 2015, was 19.1 percent lower than what was projected in 2013.⁵¹

Both South Carolina and Mississippi already had compassionate release laws when the JRI process began and adopted more expansive

policies under JRI. In South Carolina, the 2011 JRI legislation created a medical parole provision that was broader than the previous policy, which considered only those people who were terminally ill and had a prognosis of a year or less. Mississippi's 2014 JRI legislation granted automatic geriatric parole hearings for anyone 60 or older who has served 10 years and was not sentenced to an excludable offense. In addition to their JRI policies, both states already had medical furlough policies (known in Mississippi as "conditional medical release"). Because the parole and furlough policies are still in use and complement each other, these case studies examine both.

South Carolina

Medical parole: As part of its JRI legislation, South Carolina adopted a new medical parole policy. The previous policy applied only to people who were within a year of their regular parole hearing.⁵² The state JRI task force recommended a more expansive policy in response to the growing number of elderly and infirm people in prison.⁵³ The law allows the parole board to consider people for release who are terminally ill, are permanently incapacitated, or are age 70 or older and have a chronic and incapacitating condition related to aging, regardless of their parole eligibility dates. But they must be statutorily eligible for parole to qualify for medical parole.

Outcomes: As of December 2016, under the policy enacted by the Sentencing Reform Act (which went into effect in 2011), a total of 29 people were referred to medical parole; 22 people had hearings and 12 of those 22 people were granted parole. (Only nine of those 12 were released: one person died before release, one completed her sentence prior to release, and one had a new disposition before release.) Of the nine people who were released, no parole violations have been reported: as of December 2016, five people remained on parole, three had died, and one person's parole term had expired.⁵⁴

Despite the expanded medical parole policy, the percentage of people in the state's prisons who were age 55 or older increased from 8 percent at the end of fiscal year 2012 to 10.3 percent at the end of fiscal year 2016.⁵⁵ The impact of the new policy has been limited, likely because it applies only to people who are otherwise statutorily eligible for parole, and South Carolina eliminated parole eligibility for many people under its 1996 truth-in-sentencing law. The law

mandates that people sentenced to A, B, or C felonies (the most serious felonies in South Carolina, with some exceptions for drug dealing), must serve 85 percent of their sentences and are not eligible for discretionary parole.⁵⁶ The JRI medical parole law did not expand eligibility to those affected by the 1996 law.

Medical furlough: South Carolina already had a medical furlough law when it enacted JRI legislation. The law allows the director of the South Carolina Department of Corrections (SCDC) to release a “terminally ill” person when there is “reasonable cause to believe that the inmate will honor his trust.”⁵⁷

The department’s policies define “terminally ill” as having a prognosis of 12 months or less. The department’s medical director is responsible for identifying candidates, preparing applications, and organizing adequate care upon release. Other medical providers may also identify candidates. The law and the department’s policy establish a detailed process of application and approval and include the following requirements:

- > two doctors must confirm the terminal diagnosis;
- > the person must be released to a spouse or other relative residing in the state; and
- > in the case of someone who has committed a violent crime, the victim/complainant, the arresting law enforcement agency, and the solicitor (prosecuting attorney) must approve the furlough release.

Outcomes: Although the medical furlough law does allow the SCDC to release people who are not otherwise eligible for parole, it applies only to “terminally ill” adults, which leaves many people who have serious illnesses but a longer prognosis with no chance of medical release. The requirement of being released to family residing in the state also poses a barrier: the individual’s closest relatives are often elderly themselves and not capable of housing the person. Additionally, the medical director reported that victims often deny the requests and, in some counties, the sheriff and district attorney routinely veto applications.

In fiscal year 2015, 18 cases were presented for medical furlough: 11 were furloughed and seven were denied. Of the cases denied, there were six objections from the solicitor’s office (the prosecutor of the original case) and one from the police department that handled the case. One violation was

reported among the 11 furloughs: someone left a sponsor's home without the sponsor. In fiscal year 2016, 12 cases were presented and two people furloughed. Of the cases denied, the solicitor objected in seven cases, the sheriff objected in two cases, and a victim or complainant objected in three cases. One violation occurred due to a misunderstanding about a furlough residence, but the person later completed his sentence and was re-released.⁵⁸

Mississippi

Geriatric parole: In Mississippi, the Justice Reinvestment Task Force concluded in December 2013 that a relatively large number of people age 60 and older were incarcerated in the state's prisons. At the time, 799 people age 60 and older were in state prisons (3.5 percent out of a population of 22,600).⁵⁹ The task force noted the high cost of medical care for this population—swelling the Mississippi Department of Corrections' (MDOC) medical budget to \$65 million.⁶⁰ In response to these costs and research demonstrating that older people pose a low risk of recidivism, the task force recommended a geriatric release law.

As part of its JRI legislation, Mississippi supplemented its existing compassionate release provisions and passed a provision for geriatric parole eligibility, entitling people age 60 and older who have served at least 10 years of their sentence (provided that they have served at least a quarter of that sentence) to an automatic parole hearing. It excludes people who are sentenced under the state's habitual offender sentencing enhancements and those convicted of violent crimes, drug trafficking, sex crimes, and offenses that prohibit parole.

Mississippi has not yet published data on releases under this law, which was enacted in 2014, but corrections officials say there have been only a few. The most significant barrier to releasing more people under this provision is the exclusion of those who are not otherwise entitled to parole. As of September 2017, although 979 people in prison were age 60 or older, 661 people—or 67.5 percent of them—were not eligible for parole and thus were excluded from the geriatric parole policy.⁶¹

Medical furlough: In 2004, Mississippi adopted a medical furlough law, which is called conditional medical release (CMR) and authorizes the commissioner of the department of corrections and the department's medical director to release someone the latter certifies as "suffering from a significant permanent

physical medical condition with no possibility of recovery”; the statute also uses the term “bedridden” to describe the condition of the patient.⁶² People who have been convicted of sex offenses are not eligible, and people convicted of violent offenses must have served at least one year of their sentence.

Outcomes: As of September 2017, there were 124 releases through the CMR program since it began in 2004, an average of nine to 10 people per year. Of those cases, 17 people, or 14 percent, returned to prison within three years of release.⁶³ Four returns were for new convictions, 13 were for technical violations.⁶⁴

Expanding the reach of compassionate release policies

The experiences of South Carolina and Mississippi illustrate the following challenges that states face with compassionate release:

- > statutory exclusions (people must be parole-eligible or cannot have been convicted of certain offenses);
- > restrictive medical criteria (people must have a prognosis of one year or less for medical furlough in South Carolina);
- > protracted processes (during which people sometimes die);
- > victim/survivor and law enforcement objections; and
- > insufficient availability of appropriate community placements.

Although many states identify their elderly and infirm prison populations as a growing segment of the overall prison population and a source of rising corrections costs, the compassionate release policies they put in place do not necessarily produce the desired outcomes. This section sets forth a number of suggestions that states should consider if they wish to expand the reach of their compassionate release policies.

- > ***Expand eligibility.*** Many compassionate release policies do not apply to a significant proportion of older adults because they exclude those convicted of the most serious offenses or under truth-in-sentencing laws. If a state's leaders truly want to address the size of their elderly prison population, compassionate release laws must be drafted expansively to include these people. North Dakota did this in its recent JRI legislation.⁶⁵ Its medical parole law expressly applies even to those sentenced for parole-ineligible offenses, such as armed offenses, violent offenses, and class AA felonies (the state's highest felony class). The bill was signed on April 21, 2017, and only recently went into effect, so it is too soon to know whether this expanded eligibility will have the intended impact.⁶⁶

- > ***Include expansive medical and geriatric criteria.*** States that provide medical release could expand opportunities by considering release based on age alone (as in Mississippi and Alaska). Such objective criteria would clarify subjective medical-eligibility standards. But if a state desires to use medical or physical functional criteria, those terms must be well-defined with input from medical professionals who will conduct the assessments specified in the criteria. Prognostic criteria should be expansive, allowing for longer prognostic windows than six months to a year, because of the progressively debilitating but longer trajectory of some illnesses.

- > ***Make geriatric consideration automatic.*** Establishing a docket for all people beyond a certain age who are periodically reviewed would eliminate subjective, time-intensive medical evaluations, ensure that more people go before the parole board or the department of corrections, and allow consideration of those who are too debilitated to initiate the application process. Mississippi implemented this practice and, although few people have been released, that is due to narrow eligibility, not limited consideration.

- > ***Assign correctional staff to coordinate and help people navigate the process.*** Assigning staff to identify eligible applicants and assist them with the application process may result in a greater number of compassionate release hearings. This person could also serve a coordinating function between the parole board and the department of corrections. Although many corrections agencies assign the medical furlough task to their medical directors (as in

South Carolina), they do not necessarily expand the responsibility to include medical or geriatric parole-board releases. The staff person could also assist people in referring themselves and applying. Given the complex application process, facilities should also designate an advocate or navigator who assists people with their applications, advanced care planning, or both.⁶⁷

- > ***Train correctional staff to recognize signs of aging and encourage them to refer people for consideration.*** Corrections staff should be trained in identifying symptoms so they can provide early identification of people who may benefit from specific care or case management with the navigator. For example, symptoms of dementia can be subtle, and corrections officers may mistake them for behavioral issues rather than a medical condition. Staff with training on dementia could better approach and interact with someone who has cognitive impairments and refer the individual to appropriate medical care and case management by an advocate. The advocate could also identify people whose applications should be accelerated due to the rate of their physical and/or cognitive decline.
- > ***Improve coordination and communication between the parole board and the department of corrections.*** A number of states, such as South Carolina and Mississippi, provide opportunities for compassionate release through the parole board and the department of corrections. The parole board and the department should consult and coordinate on their policies to ensure that they are used efficiently and to the fullest extent possible for appropriate cases. Decision makers should ensure that they have the information they need to make well-informed determinations on medical or geriatric parole, including lay descriptions of medical, physical, and cognitive conditions.
- > ***Speed up the process.*** For anyone who has a terminal illness, every day in the process is significant. Each step in the process should be subject to enforced time limits. Given that only gravely ill people are eligible for compassionate release in most states, time limits must be put in place to ensure that all of the components of their applications are reviewed in a timely manner. Each stage of the referral, application, and review process should be subject to strict timelines to reduce the chance that people will die while awaiting review.

- > ***Modify the approval process for victims and law enforcement.*** State parole policies commonly have procedures for notifying victims and law enforcement to solicit their approval or comment on parole cases. A state could modify the requirement without losing this input. For example, states could limit notification to an opportunity to comment, as is the case in Alaska, rather than give these stakeholders veto power or require that they consent in order for release to be granted. In Alaska, officials are obligated to attempt to notify victims before a hearing and are required to inform them about the decision within 10 days, but victims are not required to consent.⁶⁸ That would amount to soliciting meaningful input from victims and giving them a voice, but not the final word in the decision. If a state also wishes to include law enforcement stakeholders in the notification process, it may make sense to seek comments from victims/survivors first, as their opinion may sway others. Finally, all stakeholders should be educated on the realities of growing old and dying in prison, and the purpose of compassionate release and its distinctions from typical parole or furlough cases.

- > ***Improve release options and relationships with community providers.*** If a state wants to return a greater number of elderly and ill who have been imprisoned to the community, its leaders can play a critical role in facilitating adequate and affordable care upon the person's release. In 2013, Connecticut pioneered a "nursing-home-release" parole policy.⁶⁹ Responding to a growing number of infirm people who are incarcerated, the lack of adequate care in its prisons, concerns about people finding appropriate care in the community, and the fact that many nursing homes refused to accept referrals from the Connecticut Department of Correction, the department—through a contract with a private nursing home—made a 95-bed nursing home available to people being released on parole.⁷⁰ The facility was the first of its kind to be approved for federal nursing home funding through the Centers for Medicare & Medicaid Services (an agency of the U.S. Department of Health and Human Services). As a result, Medicare or Medicaid covers half of the cost of these patients' care.⁷¹

Some communities have improved post-release care through transition clinics, which provide medical care and case management for people who have chronic illnesses and have recently been released from prison. In

addition to medical professionals, the clinic staff consists of community health workers who themselves were once incarcerated. Evaluations of the clinics found that the treatment resulted in fewer emergency room visits and an increase in care-seeking behavior among patients.⁷² Fourteen facilities now participate in the Transition Clinic Network nationwide.⁷³

Beyond investing resources in community care, departments of corrections and parole boards can take some active measures to build relationships with community providers. The chairman of the Mississippi Parole Board identified a nursing home willing to take people released from prison, although as of September 2017, no such referrals had been made. States should also assist potentially eligible people to apply for Medicare or Medicaid coverage as part of discharge planning, to ensure continuity of care.

Conclusion

Developing effective policies and practices to respond to elderly and infirm prison populations is a critical issue for all state corrections departments, which are facing a growing number of older people in prison and the associated increasing costs of medical care.

The compassionate release policies that states like South Carolina and Mississippi adopted under JRI are a significant step forward in expanding medical and geriatric release in those states. But the impact of these policies remains limited because so many people are ineligible, the criteria for release are so restrictive, and the process for approval is so burdensome. Designing compassionate release policies to maximize coverage of geriatric and infirm people in prison is no easy task. These are some of the hardest cases presented to parole boards or departments of corrections for release consideration. But narrow compassionate release laws cut against the aspiration of these policies—regardless of whether they are rooted in compassion for people who are elderly or dying or a desire to decrease costs. To substantially reduce the number of elderly and infirm people under their custody, states can, at a minimum, design policies that allow departments and boards to consider more cases and decide fairly whether continuing to incarcerate someone who is old, severely infirm, or dying is a wise use of public safety resources.

Endnotes

- 1 A number of reports describe the outcomes achieved by JRI across dozens of states. See, for example, Samantha Harvell, Jeremy Welsh-Loveman, Hanna Love, et al., *Reforming Sentencing and Corrections Policy* (Washington, DC: Urban Institute, 2017), <https://perma.cc/BK7G-KBPW>; Nancy La Vigne, Samuel Bieler, Lindsey Cramer, et al., *Justice Reinvestment Initiative State Assessment Report* (Washington, DC: Urban Institute, 2014), <https://perma.cc/P5U7-S7E3>; Pew Charitable Trusts, *State Reforms Reverse Decades of Incarceration Growth* (Washington, DC: Pew Charitable Trusts, 2017), <https://perma.cc/3G9Y-PU4Y>; and Council of State Governments [CSG] Justice Center, *Lessons from the States: Reducing Recidivism and Curbing Corrections Costs Through Justice Reinvestment* (New York: CSG Justice Center, 2013), <https://perma.cc/WP9G-AK8A>.
- 2 A common definition of “older” people in prison includes those age 55 or older. See *State Prison Health Care Spending: An Examination* (Washington, DC, and Chicago: State Health Care Spending Project, Pew Charitable Trusts, and John D. and Catherine T. MacArthur Foundation, 2014), 9, <https://perma.cc/UH8U-JQUG>. Although many states use a higher age threshold to define geriatric or older people in prison, the U.S. Department of Justice’s Bureau of Justice Statistics and other researchers use 55. See Brie A. Williams, James S. Goodwin, Jacques Baillargeon, et al., “Addressing the Aging Crisis in U.S. Criminal Justice Healthcare,” *Journal of the American Geriatrics Society* 60, no. 6 (2012), 1150-56, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3374923>.
- 3 See R.V. Rikard and Ed Rosenberg, “Aging Inmates: A Convergence of Trends in the American Criminal Justice System,” *Journal of Correctional Health Care* 13, no. 3 (2007), 150-62, https://libres.uncg.edu/ir/asu/f/Rosenberg_Ed_2007_Aging_Inmates.pdf.
- 4 See Harvell, Welsh-Loveman, Love, et al., 2017, 19; and *Mississippi Corrections and Criminal Justice Task Force Final Report* (Jackson, MS: Mississippi Corrections and Criminal Justice Task Force, 2013), 15, <https://perma.cc/595S-ZRHD>.
- 5 E. Ann Carson and William J. Sabol, *Aging of the State Prison Population, 1993-2013* (Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics, 2016), 1, <https://perma.cc/L8GM-Z45X>.
- 6 Mississippi Corrections and Criminal Justice Task Force, 2013, 3.
- 7 Maryland Justice Reinvestment Coordinating Council [JRCC], *Final Report* (Annapolis, MD: JRCC, 2015), 21, <https://perma.cc/UVJ7-KEYH>.
- 8 See Morris L. Thigpen et al., *Correctional Health Care: Addressing the Needs of Elderly, Chronically Ill, and Terminally Ill Inmates* (Washington, DC: U.S. Department of Justice, National Institute of Corrections, 2004), <https://perma.cc/2MF2-QMCW>; Tina Chiu, *It’s About Time: Aging Prisoners, Increasing Costs, and Geriatric Release* (New York: Vera Institute of Justice, 2010), 5 (reporting that elderly adults in prison “have five times as many visits to health facilities per year than similarly aged people who are not incarcerated”), <https://perma.cc/DRT2-5ZB6>; Pew Center on the States, *One in 100: Behind Bars in America 2008* (Washington, DC: The Pew Charitable Trusts, 2008), 12, <https://perma.cc/GTC6-FJZY>.
- 9 See Williams, Goodwin, Baillargeon, et al., 2012, 2.
- 10 A recent report found that as many as 45 states have such policies. See Tina Maschi, Alexandra Kalmanofsky, Kimberly Westcott, et al., *Analysis of United States Compassionate and Geriatric Release Laws: Towards a Rights-Based Response for Diverse Elders and Their Families and Communities* (New York: Be the Evidence Press, Fordham University, 2015), 3, <https://perma.cc/9CU8-6TGS>.
- 11 Inimai Chettiar, William Bunting, and Geoffrey Schotter, *At America’s Expense: The Mass Incarceration of the Elderly* (New York: ACLU, 2012), 21, http://lsr.nellco.org/cgi/viewcontent.cgi?article=1345&context=nyu_plltwp.
- 12 In some instances, this paper also cites policies and release data from non-JRI states, to draw on useful information from those jurisdictions.
- 13 Carson and Sabol, 2016, 1.
- 14 Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, 2014, 11, and table C.4.
- 15 Ibid.
- 16 Chettiar, Bunting, and Schotter, 2012, 5.
- 17 Carson and Sabol, 2016, 1.
- 18 Ibid., 15. Part of the reason the elderly population in prisons has grown is that more older adults are being admitted to prison. (See Carson and Sabol, 2016, 15.) Although this may seem at odds with recidivism research, one theory attributes the increase to generational differences—aging baby boomers being more criminally active later in life than earlier generations were—and older defendants having longer criminal histories, making them more likely to receive a prison sentence. See Keith Humphreys, “Older Adults More Likely to Be Imprisoned,

- Data Show,” *Washington Post*, October 31, 2016, <https://www.washingtonpost.com/news/wonk/wp/2016/10/31/older-adults-more-likely-to-be-imprisoned-data-show/>
- 19 Carson and Sabol, 2016, 13.
- 20 Carson and Sabol, 2016, 5, 23.
- 21 William J. Sabol, Katherine Rosich, Kamala Mallik Kane, et al., *The Influences of Truth-in-Sentencing Reforms on Changes in States’ Sentencing Practices and Prison Populations* (Washington, DC: Urban Institute Justice Policy Center and U.S. Department of Justice, National Institute of Justice, 2002), <https://perma.cc/S7ZY-2MU8>.
- 22 *Brown v. Plata*, 563 U.S. 493, 511 (2011): “A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society. If government fails to fulfill this obligation, the courts have a responsibility to remedy the resulting Eighth Amendment violation.”
- 23 See Williams, Goodwin, Baillargeon, et al., 2012.
- 24 *Ibid.*, 2.
- 25 *Ibid.*
- 26 Brie A. Williams, Marc F. Stern, Jeff Mellow, et al., “Aging in Correctional Custody: Setting a Policy Agenda for Older Prisoner Health Care,” *American Journal of Public Health* 102, no. 8 (2012), 1475-81, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3464842>. Common illnesses among older incarcerated adults that often require extensive care include diabetes, heart failure, cognitive impairments, and advanced liver and heart disease.
- 27 Pew Charitable Trusts and John D. and Catherine T. MacArthur Foundation, 2014, 12.
- 28 See Chris Mai and Ram Subramanian, *The Price of Prisons: Examining State Spending Trends, 2010-2015* (New York: Vera Institute of Justice, 2017), <https://perma.cc/4CDC-G9J9>; and Steve Angelotti and Sara Wycoff, *Michigan’s Prison Health Care: Costs in Context* (Lansing, MI: Senate Fiscal Agency, 2010), 4-5, <https://perma.cc/9B4L-8R68>.
- 29 Calculation based on Mai and Subramanian, 2017. That amounts to about 20 percent of state prisons’ annual spending in the 45 states that responded to the survey.
- 30 Maschi, Kalmanofsky, Westcott, et al., 2015, 3.
- 31 See Chiu, 2010, 6 (reporting on the impact of geriatric release provisions), <https://perma.cc/DRT2-5ZB6>; Louis Hansen, “Uncommon Freedom: Geriatric Release from Prison Rare,” *The Virginian-Pilot*, December 28, 2013, <https://perma.cc/Y8CG-2CUN>; Emily Ramshaw, “Dying on the State’s Dime,” *Texas Tribune*, June 3, 2010, <https://www.texastribune.org/2010/06/03/few-texas-inmates-get-released-on-medical-parole/>; and Cara Buckley, “Law Has Little Effect on Early Release for Inmates,” *New York Times*, January 29, 2010, <http://www.nytimes.com/2010/01/30/nyregion/30parole.html>.
- 32 Alabama Department of Corrections, *Monthly Statistical Report for March 2016* (Montgomery, AL: Alabama DOC, 2016), 8, <https://perma.cc/B4DS-GQ7V>.
- 33 Texas Board of Pardons and Paroles, *Annual Statistical Report FY 2016*, 11-12 (Austin, TX: Texas Board of Pardons and Paroles, 2017), 20, <https://perma.cc/4T56-TT8G>.
- 34 Chiu, 2010, 8.
- 35 Alabama Code §14-14-1-7 (2017).
- 36 “Permanent incapacitation” refers to debilitating and irreversible conditions that are not necessarily terminal and require extensive nursing care, such as chronic liver disease or dementia. Incapacitation is sometimes measured by someone’s functional capacity, particularly in the practice of geriatric medicine, based on the ability to undertake “activities of daily living” (ADLs). Six ADLs are commonly understood to be key indicators of independence: bathing, dressing, toileting, transferring, continence, and feeding. Some compassionate release laws, such as Alabama’s, use ADL criteria as part of the definition of permanent incapacitation. See Bassem Elsaywy and Kim E. Higgins, “The Geriatric Assessment,” *American Family Physician* 83, no. 1 (2011), 48-56, 49, <https://perma.cc/5Q6E-FRLP>. “Terminally ill” means that a person has been diagnosed with a terminal condition, with a prognosis of death within a specified time, which differs by state.
- 37 See Arkansas SB 750 (2011), <https://perma.cc/6LSY-RJRZ>; and Mississippi Department of Corrections, “Conditional Medical Release,” Policy No. 25-15-G, 1.
- 38 Brie Williams, Alex Rothman, and Cyrus Ahalt, “For Seriously Ill Prisoners, Consider Evidence-Based Compassionate Release Policies,” *Health Affairs Blog*, February 6, 2017, <https://perma.cc/UR5G-5HWY>.
- 39 *Ibid.*
- 40 Chettiar, Bunting, Schotter, et al., 2012, 1.

-
- 41 Williams, Stern, Mellow, et al., 2012, 1479.
- 42 Maryland’s JRI medical parole allows the following people to request medical review for an incarcerated person: the person, an attorney, a prison official or employee, a medical professional, a family member, or any other person. See Maryland SB 1005 (2016).
- 43 Williams, Stern, Mellow, et al., 2012, 1479.
- 44 Arkansas SB 750 (2011), §75, amending Ark. Code §12-29-404.
- 45 Brie A. Williams, Rebecca L. Sudore, Robert Greifinger, et al., “Balancing Punishment and Compassion for Seriously Ill Prisoners,” *Annals of Internal Medicine* 155, no. 2 (2011), 122-26, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3163454>.
- 46 For example, in a review of the 525 applications for New York’s medical parole program from 1992 to 2014, the state’s Department of Corrections and Community Supervision found that 108 people died prior to their interviews with the parole board. Other applicants died between their interview and release, and seven people died between their postponed interview dates and their next appearances before the board. On average, interviews took place 23 business days after an application was received, in part because 15 days were allotted for the victim(s), the sentencing court, the district attorney, and defense counsel to comment on the application. See *New York State’s Aging Prison Population* (Albany, NY: Office of the New York State Comptroller, 2017), 4, <https://perma.cc/S7Y2-3A6F>.
- 47 South Carolina Code §24-3-210(D) (2017).
- 48 Human Rights Watch, *Old Behind Bars: The Aging Prison Population in the United States* (New York: Human Rights Watch, 2012), 80-81, <https://perma.cc/M8HK-MAMJ>.
- 49 To complete these case studies, the authors reviewed the statutes and agency directives from South Carolina’s and Mississippi’s departments of corrections; received data on releases from both states’ departments of corrections; and talked to the following people: Jonathan Howell from the South Carolina Board of Pardons and Paroles; Julia Hess, a registered nurse from the South Carolina Department of Corrections; Steven Wayne Pickett, chairman of the Mississippi Parole Board; and Audrey McAfee of the Mississippi Department of Corrections. The authors also spoke with technical assistance providers from the Council of State Governments and the Crime and Justice Institute of the Community Resources for Justice.
- 50 See Pew Charitable Trusts, *Data Trends: South Carolina Criminal Justice Reform – Six Years After Legislation, the State’s Prison Population Has Declined 14%* (Washington, DC: Pew Charitable Trusts, 2017), 1, <https://perma.cc/4ENF-NWMU>; and Harvell, Welsh-Loveman, Love, et al., 2017, 35, Table 1.
- 51 Harvell, Welsh-Loveman, Love, et al., 2017, 35, Table 1.
- 52 See S.C. Code Ann. §24-21-610.
- 53 South Carolina Sentencing Reform Commission, *Report to the General Assembly* (2010), 15, 26, <http://www.scstatehouse.gov/Archives/CitizensInterestPage/SentencingReformCommission/CombinedFinalReport020110SigPage.pdf>. See also S.C. Code Ann. §24-21-715 (“Parole for terminally ill, geriatric, or permanently disabled inmates”).
- 54 Analysis provided to Vera by the South Carolina Department of Probation, Parole and Pardon Services, July 2017.
- 55 South Carolina Department of Corrections, “Age Distribution of Total Inmate Population as of June 30, Fiscal Years 2012-2016,” <https://perma.cc/RF46-KPEY>.
- 56 South Carolina Code §24-13-100 and §24-13-150 (2017).
- 57 South Carolina Code §24-3-210 (2017).
- 58 Analysis provided to Vera by the South Carolina Department of Corrections, September 2017.
- 59 Mississippi Corrections and Criminal Justice Task Force, 2013, 15.
- 60 Phone interview with Steven Wayne Pickett, chairman of the Mississippi Board of Parole, by Alison Shames, July 24, 2017.
- 61 Analysis provided to Vera by the Mississippi Department of Corrections, September 2017.
- 62 Mississippi Code §47-7-4 (2016).
- 63 Analysis provided to Vera by the Mississippi Department of Corrections, September 2017.
- 64 Analysis provided to Vera by the Mississippi Department of Corrections, October 2017.
- 65 North Dakota HB 1041 (2017), §3, amending North Dakota Century Code §12-59-08, <https://perma.cc/9455-37MD>.

-
- 66 Council of State Governments (CSG) Justice Center, *North Dakota's Justice Reinvestment Approach: Investing in Community-Based Behavioral Health Services Instead of Prisons* (New York: CSG Justice Center, 2017), 2, <https://perma.cc/RWT6-SCEY>.
- 67 Williams, Sudore, Greifinger, et al., 2011.
- 68 22 Alaska Admin. Code §20.615.
- 69 Under this policy, the corrections commissioner may release people from prison into nursing homes unless they are convicted of capital murder or murder under special circumstances. See Connecticut Public Act 12-1, §104 (2012). In 2016, the parole board in Connecticut released two individuals on medical parole and one individual on compassionate parole. Adam Wisnieski, "'Model' Nursing Home for Paroled Inmates to Get Federal Funds," *Connecticut Health I-Team*, April 25, 2017, <https://perma.cc/9H73-LUPV>. The nursing-home-release policy, in contrast, has resulted in at least 19 releases since the law went into effect in 2012. As of August 2017, seven people were under a form of supervision called "nursing home supervision." See Connecticut Department of Correction, Connecticut Open Data, "Correctional Community Program Daily Population Count," https://data.ct.gov/Public-Safety/Correctional-Community-Program-Daily-Population-Co/5d7h-at3*/data.
- 70 Christine Vestal, "For Aging Inmates, Care Outside of Prison Walls," Pew Charitable Trusts, August 12, 2014, <https://perma.cc/N6WC-593U>.
- 71 Wisnieski, 2017.
- 72 Emily A. Wang, Clemens S. Hong, Liz Samuels, et al., "Transitions Clinic: Creating a Community-Based Model of Health Care for Recently Released California Prisoners," *Public Health Reports* 125, no. 2 (2010), 171-77, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2821844>.
- 73 For more information on the Transition Clinic Network, see <http://transitionsclinic.org/transitions-clinic-network>.

Acknowledgments

The authors would like to thank corrections and parole staff in South Carolina and Mississippi for their time answering our questions and providing data: Jonathan Howell of the South Carolina Department of Probation, Parole and Pardon Services; Julia Hess, medical parole and medical furlough coordinator at the South Carolina Department of Corrections; Chairman Steven Wayne Pickett of the Mississippi Board of Parole; and Dr. Gloria Perry, medical director, Audrey McAfee, MIS director, and Grace Fisher, communications director, of the Mississippi Department of Corrections. In addition, we thank our technical assistance provider colleagues at Pew, the CSG Justice Center, and the Crime and Justice Institute for providing background information about the states featured in this report. Richard Stroker of the Center for Effective Public Policy's National Parole Resource Center provided helpful guidance about compassionate release generally. We also thank our reviewers at BJA, Juliene James and Heather Tubman-Carbone, for their wise feedback. Nancy Fishman and Ram Subramanian provided vital guidance and direction for this report. Finally, we thank the communications team at Vera: Mary Crowley, Cindy Reed, Jules Verdone, and Karina Schroeder; and Carl Ferrero for design.

About Citations

As researchers and readers alike rely more and more on public knowledge made available through the Internet, “link rot” has become a widely acknowledged problem with creating useful and sustainable citations. To address this issue, the Vera Institute of Justice is experimenting with the use of Perma.cc (<https://perma.cc>), a service that helps scholars, journals, and courts create permanent links to the online sources cited in their work.

Credits

© Vera Institute of Justice 2017. All rights reserved.

Cover photo credit: © Andrew Burton/Getty Images

An electronic version of this report is posted on Vera's website at www.vera.org/aging-out. The Vera Institute of Justice is a justice reform change agent. Vera produces ideas, analysis, and research that inspire change in the systems people rely upon for safety and justice, and works in close partnership with government and civic leaders to implement it. Vera is currently pursuing core priorities of ending the misuse of jails, transforming conditions of confinement, and ensuring that justice systems more effectively serve America's increasingly diverse communities. For more information, visit www.vera.org.

For more information about this report, contact Ram Subramanian, editorial director, at rsubramanian@vera.org.

For more information about Vera's technical assistance under the Justice Reinvestment Initiative, contact Nancy Fishman, project director at Vera's Center on Sentencing and Corrections, at nfishman@vera.org.

Suggested Citation

Rebecca Silber, Alison Shames, and Kelsey Reid. *Aging Out: Using Compassionate Release to Address the Growth of Aging and Infirm Prison Populations*. New York: Vera Institute of Justice, 2017.

Vera Institute of Justice
233 Broadway, 12th Fl
New York, NY 10279
T 212 334 1300
F 212 941 9407

Washington DC Office
1111 14th St., NW, Ste 920
Washington, DC 20005
T 202 465 8900
F 202 408 1972

New Orleans Office
1307 Oretha Castle
Haley Blvd., Suite 203
New Orleans, LA 70113
T 504 655 6277

Los Angeles Office
707 Wilshire Blvd., Ste 3850
Los Angeles, CA 90017
T 213 223 2442
F 213 955 9250