RE: Support Compassionate Medical Release Reform, SB 1560

Senate Committee on Judiciary

February 6th, 2024

Chair Prozanski, Vice Chair Thatcher, and members of the Senate Committee on Judiciary,

My name is Justin Low, and I am the Associate Director of Policy and Research at the Oregon Justice Resource Center. We work to promote civil rights and improve legal representation for communities that have often been underserved in the past: people living in poverty and people of color among them. Our clients are currently and formerly incarcerated Oregonians. We work in partnership with other, like-minded organizations to maximize our reach to serve underrepresented populations, train public interest lawyers, and educate our community on civil rights and civil liberties concerns.

Accordingly, we strongly support Compassionate Medical Release Reform, SB 1560, which will establish a legislative task force that researches and analyzes the matter of adults in custody who are aging, dying, and medically infirmed in prison, as well as the pitfalls of the current compassionate medical release process. It is our hope that the information gathered will lead to policies and procedures that help incarcerated Oregonians who are sick or dying have an opportunity to be safely and humanely released to get the care they need at home with their loved ones.

Since 2015, Oregon has had the fourth-largest aging prison population in the country, which has resulted in needless prison deaths and millions of taxpayer dollars spent—just in the 2023-2025 biennium, the Department of Correction's Health Services was allocated $441 million, which is a 120.5% increase over the past decade. More importantly, Oregon's current early parole release process is not working properly for individuals in custody who are dying, aging, and/or struggling with activities of daily living.

From 2013 to 2021, 166 adults in custody with severe medical conditions applied for compassionate medical release. Of those applicants, only 12 (roughly 7%) were able to complete the process and were granted release. In that same period, 11 applicants passed away while waiting for an outcome.

Studying Compassionate Medical Release can lead to recommendations that place decisions about release in the hands of those that are medical professionals, expand medical eligibility to those who have serious health issues and ailments, and provide support and resources to applicants during the process.

Below, I've included excerpts from a report I helped publish in 2023 that highlighted the pressing concerns and issues related to the current compassionate release process and the impact it had on aging, dying, and infirmed adults in custody for whom the state is responsible for caring for. The report is titled "Relieving the Crisis of Dying in Prison" and can be found using this link:

https://static1.squarespace.com/static/524b5617e4b0b106ced5f067/t/641defd9ded69e4440d21e5f/1679683546758/OJRC-Compassionate+Release+Report+v.23.03.01.pdf.

The Physical Cost

The most pressing costs that medically vulnerable AICs experience within ODOC institutions are the harsh physical realities that come with aging inside the carceral system. The sole act of being incarcerated has been shown to bring about new health conditions and illnesses in an individual that did not exist prior to incarceration. Speaking on how incarceration impacts AICs, Attorney Juan Chavez explained to Street Roots, "Their bodies are physiologically older because of socioeconomic or health-related things that have happened in their lives or that are currently happening to them in prison."6 Increased physical aging, and the ailments that come with it, can be brought about by isolation, substance use, poor nutrition, inadequate preventative and primary care before or during incarceration, and the violent nature of prison itself.7 Common health issues experienced by aging AICs include cancers, cardiovascular and respiratory issues, dementia, impaired mobility, and loss of hearing and vision.8 A report from the Journal of the American Medical Association further supports these findings: "[A]ging AICs have an average of three chronic illnesses and as many as 20% of them have a mental illness."9

The carceral system was never built with the aging population's needs in mind, let alone the proper physical and mental care of individuals of any age or need. From a structural standpoint, aging AICs often require lowered beds and bunks, physically accessible cells, ramps and wide pathways for mobility devices, or elevators that can help individuals with limited mobility better navigate through their facility.10 From a programmatic point of view, most correctional programming for AICs is related to education and job training, but those are not always the type of re-entry programs that meet the needs of older and less-able-bodied AICs. From a skills and staffing capacity, qualified medical staff is scarce in prisons, and other corrections staff lack the training and mindset necessary to compassionately aid aging AICs.11 Finally, from a systems perspective, the prison system does not treat individuals like patients with time-sensitive health care needs. For example, for AICs that require nurse aid or medication, there is no direct or immediate path to receiving care.12 AICs must either ask correctional staff to send for direct nursing care or notify officers anytime they need access to something as simple as over-the-counter medications.13 In either situation, an AIC needing medical treatment relies on a non-medical professional that gatekeeps their access to life-saving care.

Finally, the health risks that aging AICs are subjected to through continued incarceration are cruel: the immune system diminishes over time, prisons can become crowded, and incarceration itself is a brutal and stressful environment. An AIC's immunity can drop exponentially with age and with the abuse experienced in prison. This compromised immunity is then threatened by the cramped and tight environment of overcrowded prisons where bacteria and viruses can thrive and overwhelm. The Bend Bulletin described incarceration during the height of the COVID-19 pandemic, which exemplified a health crisis that ran rampant due to the aforementioned factors, as an "unwelcome death sentence."14

Offering AICs the opportunity to be considered for compassionate medical release will improve the quality of living for the medically vulnerable and reunite families, all while transitioning the prison system away from responsibilities it is not qualified or capable of handling.

The Human Cost

A cost that is not often discussed in research articles and policy roundtables when it comes to incarcerating the medically vulnerable is the human cost. Many individuals who apply for EMR while on hospice never benefit from the process; and the seven percent that do make it through are still subjected to logistical hurdles before being released, like providing proof of access to medical care and housing once released. The bulk of individuals that do not seek EMR, or are denied, must endure their medical condition or end-of-life process in prison. For AICs with severe medical conditions, their continued incarceration only exacerbates their pain, progression of illness, or overall loss of quality of life. Issues that can arise include loss of access to or ability to participate in AIC programming, loss of work placements, difficulty in accomplishing activities of daily life (i.e., bathing, eating, moving, toileting, etc.), and loneliness.

For those that enter hospice for their end-of-life process, the infirmary becomes their home, which can keep them separated from friends and family during the final moments of their life. Loved ones that do attempt to visit an incarcerated patient in hospice express that ODOC's administrative processes for visitation can be a logistical labyrinth. To start, friends and family can only begin the process of visiting if word gets out in time and through the proper channels. Each AIC has just one emergency contact who will receive word from ODOC if a health emergency occurs. If the emergency contact is inaccessible when ODOC reaches out, there is seldom any additional, proactive outreach by carceral staff to track that person down or identify an alternative contact person.

Even worse, if the emergency contact is estranged from the individual in custody or is not on good terms with any other friends or family that should be notified of the AIC's diminishing health, other people that might want to visit in person may not find out until it is too late. The task of ensuring folks in the community receive word about an AIC entering hospice then falls on peers and hospice volunteers to conduct outreach on behalf of the individual, who by that point may not have the physical or mental capacity to make calls or write letters out themselves.

Discovering that an individual is receiving hospice care in ODOC is only one of the major hurdles in getting friends and family to visit. ODOC's stringent protocols and procedures make the visiting process unnecessarily complicated—and they highlight how, even in a person's last days, control and subjection are always a priority for the prison agency. From getting proper authorization and clearance to visit an ODOC facility, to being limited to specific visiting hours (usually from 7:00 am to 10:00 am or from noon to 3:00 pm), an individual receiving hospice care while in custody does not have open access to friends and family members as they would if they were on hospice beyond the bars of the prison. It is

only when a hospice patient approaches their final 24–72 hours that two visitors are allowed to be with them at all times (referred to as “standing vigil”), to ensure that the individual does not pass away while alone. For those that do not end up receiving visitors while on hospice, this role is filled by their peers serving as around-the-clock volunteers and company up until their last breath.

While not strictly a human cost—but one that is incurred directly by family and friends rather than the state—loved ones must account for transportation, take time off work to be able to visit during the strict visiting hours, arrange lodging options if they do not live within a reasonable distance of the prison facility, and navigate the agency’s red-tape all on their own when visiting a patient. Even if all the personal logistics line up for a family member or friend to make a visit, they could still be shut out due to administrative lockdowns and other short-term restrictions that the prison facility could be experiencing at that time. Instead of being able to prioritize time spent with a dying loved one, friends and family must spend precious time, energy, and money to make the logistical preparations necessary to gain limited access to their patient that is on hospice.

Lastly, as if these barriers and human costs were not enough, family members and friends that are under the age of 18 or have a past conviction on their record are prohibited by ODOC facility rules from visiting hospice patients in the infirmary. This means that minor children of hospice patients cannot spend the last few months, weeks, or hours with their parent before they pass away, nor can loved ones—who might be the only relative or support system the patient has—who have been convicted of a prior offense. This system was not built to treat people with the dignity all humans deserve during their final hours, and its unnecessary barriers and restrictions exacerbate pain for community members that just want to be by their loved one’s side.

We strongly urge you to pass SB 1560 out of the committee.

Thank you,

Justin Low

Oregon Justice Resource Center

Associate Director of Policy and Research