

A CASE FOR BROADENING ARIZONA’S APPROACH TO COMPASSIONATE RELEASE

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INTRODUCTION

The growth in U.S. incarceration rates over the past forty years is “historically unprecedented and internationally unique.”¹ Imprisoning approximately 2.3 million adults,² America presently has the highest incarceration rate in the world.³ This situation has drawn attention to the interplay between incarceration and health(care),⁴ with prisoners tending to suffer higher rates of disease than the general population,⁵ and correctional facilities often being “ill-equipped treatment providers.”⁶ States are constitutionally required to provide adequate healthcare for prisoners,⁷ but delivery can be challenging, especially in large prison systems. Recent

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¹ NATIONAL RESEARCH COUNCIL, THE GROWTH OF INCARCERATION IN THE UNITED STATES: EXPLORING CAUSES AND CONSEQUENCES, 2 (Jeremy Travis et al. eds., 2014) <https://doi.org/10.17226/18613> [hereinafter NRC].

² Wendy Sawyer & Peter Wagner, *Mass Incarceration: The Whole Pie 2019*, PRISON POLICY INITIATIVE (March 19, 2019), <https://www.prisonpolicy.org/reports/pie2019.html> (last visited Oct. 27, 2019) (“The American criminal justice system holds almost 2.3 million people . . .”).

³ NRC, *supra* note 1, at 68.

⁴ *Id.* at 203.

⁵ DAVID CLOUD, ON LIFE SUPPORT: PUBLIC HEALTH IN THE AGE OF MASS INCARCERATION 5 (Vera Institute of Justice ed., 2014) https://www.vera.org/downloads/Publications/on-life-support-public-health-in-the-age-of-mass-incarceration/legacy_downloads/on-life-support-public-health-mass-incarceration-report.pdf.

⁶ *Id.*

⁷ *See Estelle v. Gamble*, 429 U.S. 97 (1976).

litigation⁸ highlights that Arizona — a state with incarceration rates that “stand out internationally”⁹ — is grappling with such challenges.

Compassionate release procedures typically allow prisoners to seek early release due to serious terminal, non-terminal, and/or age-related health issues. As such, they are one possible pressure release valve for America’s challenging incarceration situation. In addition to a federal procedure,¹⁰ nearly every U.S. state has at least one compassionate release procedure.¹¹ Arizona has two. Compassionate Leave, an administrative procedure overseen by corrections, authorizes temporary and escorted release to receive “specialized health care for [a] verified terminal illness.”¹² By

⁸ See *Parsons v. Ryan*, 912 F.3d 486 (9th Cir. 2018) (“Inmates in the custody of the Arizona Department of Corrections (ADC) and disability law center brought putative class action against senior ADC officials, alleging systemic Eighth Amendment violations in Arizona’s prison system. The parties signed a settlement agreement, by which defendants agreed to comply with more than 100 performance measures designed to improve the ADC health care system and reduce the harmful effects of prisoner isolation.”); see also Am. Civil Liberties Union, *Parsons v. Ryan* (June 22, 2018), <https://www.aclu.org/cases/parsons-v-ryan> (The compliance process is ongoing).

⁹ *Arizona Profile*, PRISON POLICY INITIATIVE (last visited Oct. 27, 2019) <https://www.prisonpolicy.org/profiles/AZ.html>.

¹⁰ 18 U.S.C. § 3582(c)(1)(A)(i)(ii) (2018) (stating federal prisoners may apply for compassionate release, also referred to as a ‘reduction in sentence,’ in two instances. First, if they have “extraordinary or compelling reasons,” which can relate to medical condition(s), age, family circumstances, or other reasons. Second, if they are aged seventy or above, have served thirty years in prison, and the Director of the Bureau of Prisons (“BOP”) determines s/he is not a danger to others. Following a process involving federal corrections and the BOP, the prisoner’s federal sentencing court (directed by U.S. Sentencing Commission guidelines) makes a final decision. See also, U.S. DEP’T OF JUSTICE FED. BUREAU OF PRISON, COMPASSIONATE RELEASE/REDUCTION IN SENTENCE: PROCEDURES FOR IMPLEMENTATION OF 18 U.S.C. §§ 3582 AND 4205(G) (Jan. 17, 2019) https://www.bop.gov/policy/progstat/5050_050_EN.pdf.

¹¹ See generally Mary Price, *Everywhere and Nowhere: Compassionate Release in the States*, Families Against Mandatory Minimums (June 2018), <https://famm.org/wp-content/uploads/Exec-Summary-Report.pdf>; see also Families Against Mandatory Minimums, *State Memos*, (June 2018), <https://famm.org/our-work/compassionate-release/everywhere-and-nowhere/> (follow hyperlink; then scroll down page until reaching subheading “State Memos” and click on any state) (last accessed Oct. 27, 2019).

¹² See Arizona Department of Corrections, Release Types, Administrative Releases, Compassionate Leave, <https://corrections.az.gov/release-types#compassionate> (last visited Oct. 27, 2019) Scroll down page until reaching subtitle “Administrative release Compassionate leave (A.R.S. § 31-233, A.R.S. § 41-1604.11)” (“An authorized temporary absence from prison for the purpose of receiving specialized health care for verified terminal illness, attending a family members funeral, making a hospital or bedside visit to

contrast, Commutation of Sentence due to an Imminent Danger of Death (IDD) allows prisoners to apply to the Arizona Board of Executive Clemency (BOEC). Prisoners must produce medical evidence that “there is reasonable medical certainty that [their] medical condition will result in death within four (4) months.”¹³ The BOEC then votes on whether to recommend release to the Governor. Between January 2015 and March 2018, four Arizona prisoners were released via IDD.¹⁴

Compassionate release has been the subject of considerable research. This includes studies focused on identifying and deconstructing existing procedures;¹⁵ efforts that have allowed researchers to offer evidence-informed recommendations for reform. This paper proposes that Arizona should reform its current approach, specifically through replacing its IDD procedure with a broader Medical Parole procedure. Part I outlines the interplay between incarceration, health(care), and compassion in the United States, including specific challenges faced in Arizona. Part II summarizes existing research findings and recommendations about compassionate release, using them as a steer for how Arizona could shape a broader Medical Parole procedure. It concludes that, in the light of other state approaches, evidence of a national and local political will to broaden compassionate release, and due to the potential for a broader procedure to

a family member with a life- threatening illness or injury or preventing emotional instability when the need is justified. Escorted only.”).

¹³See ARIZONA BOARD OF EXECUTIVE CLEMENCY, BOARD POLICY #114, 114.3 <https://boec.az.gov/sites/default/files/documents/files/114-Commutation%20of%20Sentence%20Rev%2005-2018.pdf> (last accessed Oct. 27, 2019) [hereinafter ABOEC Policy #114].

¹⁴ Assoc. Press, *Arizona Governor Has Granted 1 Pardon So Far in 1st Term*, ABC15 ARIZONA (Mar. 12, 2018), <https://www.abc15.com/news/state/arizona-governor-has-granted-1-pardon-so-far-in-1st-term>.

¹⁵ See Price, *supra* note 11; Marjorie P. Russell, *Too Little, Too Late, Too Slow: Compassionate Release of Terminally Ill Prisoners—Is the Cure Worse Than the Disease?*, 3 Widener J. Pub. L. 799, (1994); Nancy R. Gartner & Rolando V. Del Carmen, *Releasing the Ailing and Aging: A Comprehensive Analysis of Medical Parole Legislation in the United States*, 52 No. 6 Crim. Law Bulletin ART 2 (Winter, 2016); and Sarah L. Cooper, *State Compassionate Release Approaches in the USA: A Blueprint for Discussion*, (unpublished, on file with author). (Reporting a provisional analysis of a 2017-2018 study undertaken by researchers at Stakeholder Institution, Birmingham City University and funded by a Leverhulme Trust/ British Academy Small Research Grant, to identify and unpack compassionate release procedures across United States. It aimed to learn from, and build on, the methodological approaches, findings, and recommendations of existing literature, and particularly the studies undertaken by FAMM, Russell, and Gartner and del Carmen).

offer resource-saving benefits, Arizona should be particularly motivated to consider reform.

I. INCARCERATION, HEALTH(CARE), AND COMPASSION

In 2014, the National Academy of Sciences (NAS) reported, “The growth in incarceration rates in the United States over the past forty years is historically unprecedented and internationally unique.”¹⁶ From 1973 to 2009, state and federal prison populations grew from about 200,000 to 1.5 million.¹⁷ The NAS concluded this situation was caused by an “increasingly punitive political climate surrounding criminal justice policy formed in a period of rising crime and rapid social change.”¹⁸ This political and social cocktail informed “a series of policy choices—across all branches and levels of government—that significantly increased sentence lengths, required prison time for minor offenses, and intensified punishment for drug crimes.”¹⁹ Despite evidence indicating a slight decline in numbers in state and federal prisons through 2012,²⁰ and initiatives aimed at reducing prison populations,²¹ America presently has the highest incarceration rate in the world,²² imprisoning approximately 2.3 million adults.²³ These people represent around 25% of the world’s known prisoners.²⁴ In America, “nearly 1 of every 100 adults”²⁵ is in prison or jail. Arizona follows this national trend, with both its prison incarceration rate and prison population increasing over the last forty years.²⁶ Arizona incarcerates approximately 62,000 people across various facilities.²⁷ Prison Policy Initiative describes Arizona as having incarceration rates that “stand out internationally.”²⁸

High incarceration rates have various implications. In particular, they have “drawn greater attention . . . to the relationships between incarceration

¹⁶ NRC, *supra* note 1, at 2.

¹⁷ *Id.*

¹⁸ NRC, *supra* note 1, at 4.

¹⁹ *Id.*

²⁰ *Id.* at 13.

²¹ See Fair Sentencing Act of 2010 Pub. L. No. 111–220.

²² NRC, *supra* note 1, at 68.

²³ Sawyer & Wagner, *supra* note 2.

²⁴ NRC, *supra* note 1, at 2.

²⁵ *Id.*

²⁶ *Arizona Profile*, *supra* note 9 (for increasing incarceration rates). See also *Arizona’s Prison and Jail Populations*, PRISON POLICY INITIATIVE (May 2017), https://www.prisonpolicy.org/graphs/AZ_Prison_Jail_Population_1978-2015.html (for increasing prison population numbers).

²⁷ *Arizona Profile*, *supra* note 9.

²⁸ *Id.*

and health.”²⁹ Following *Estelle v. Gamble*, the state has an “obligation to provide [adequate] medical care for those whom it is punishing by incarceration.”³⁰ A “deliberate indifference”³¹ to a prisoner’s serious illness or injury violates the Eighth Amendment’s prohibition of cruel and unusual punishment, although inadvertent and/or negligent failures to provide adequate care will not.³² The protections afforded by *Estelle* have been the subject of litigation in Arizona. In a class action *Parsons v. Ryan* Arizona prisoners have alleged systemic Eighth Amendment violations in Arizona’s prison system; arguing that policies and practices of the Arizona Department of Corrections (ADC) exposed them to a “substantial risk of serious harm,”³³ to which there was a deliberate indifference.³⁴ Ultimately, the parties entered into a settlement agreement (Stipulation).³⁵ As part of the Stipulation compliance process, the defendants “agreed to comply with over 100 performance measures... designed to improve the ADC health care system and reduce the harmful effects of prisoner isolation.”³⁶ Subsequently, the defendants have been subject to allegations of non-compliance, resulting in fines of \$1.4 million in 2018.³⁷

The implementation of legal frameworks, like *Estelle*, that aim to safeguard prisoner health(care) is important. One particular reason for this is that evidence shows prisoners have “dramatically higher rates of disease than the general population.”³⁸ This “high burden of disease”³⁹ includes problems associated with mental health, substance abuse, infectious diseases, chronic conditions, and health issues associated with specific cohorts, such as elderly, female, LGBTQ+, and juvenile prisoners.⁴⁰ Prisoners can come from “some of the most disadvantaged segments of

²⁹ NRC, *supra* note 1, at 203.

³⁰ *Estelle*, 429 U.S. at 103.

³¹ *Id.* at 104.

³² *Id.* at 105-6.

³³ *Parsons*, 912 F.3d at 493.

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.* See also Stipulation, *Parsons v. Ryan*, 289 F.R.D. 513 (D. Ariz. 2013) (No. CV 12-00601-PHX-DJH) available at <https://www.aclu.org/legal-document/parsons-v-ryan-stipulation>.

³⁷ Katie Campbell, *Judge fines state \$1.4 million for contempt in prison health care case*, ARIZONA CAPITOL TIMES (June 22, 2018). See ORDER AND JUDGMENT OF CIVIL CONTEMPT, *Parsons v. Ryan*, 289 F.R.D. 513 (No. CV-12-0601-PHX-DKD) (June 22, 2018), <https://prisonlaw.com/wp-content/uploads/2018/06/18.06.22-Doc-2898-Order-and-Judgment-of-Civil-Contempt-1.pdf> (last visited October 27, 2019).

³⁸ CLOUD, *supra* note 5.

³⁹ NRC, *supra* note 1, at 202.

⁴⁰ See *id.* at 202–230.

society”⁴¹, and, therefore, may enter prison with compromised physical and mental health. Their health status can then be worsened by general prison conditions, and even further exacerbated if they are subject to high incarceration rates. High incarceration rates have been accompanied by overcrowding, a reduction in rehabilitative programs, and an increased burden on medical and mental health services.⁴² This has led to a “range of poor consequences for health and behavior and an increased risk of suicide”⁴³ amongst prisoners. Through providing opportunities for routine screening, prevention, diagnosis, and treatment (inside and outside of prison),⁴⁴ correctional institutions play an important role in safeguarding prisoner health. However, these institutions “too often serve as ill-equipped treatment providers of last resort for medically underserved, marginalized people.”⁴⁵

This situation poses significant challenges for agents in the criminal justice system, including prisoners and their families, corrections institutions and staff, healthcare professionals, courts, legal representatives, parole boards, and policy and law-makers. One of these challenges relates to the exercise of compassion by the state. The pervasion of poor and/or declining health in a heavily populated prison system, which has limited healthcare resources, urges stakeholders to consider: what circumstances, if any, justify early release on the grounds of poor or declining health? These are complex questions that come with, as Greifinger puts it, “many distractions”⁴⁶ due to the person in need of compassion being a prisoner. Noting, however, the urgent need to address such questions emerging at the intersection of incarceration and health(care), the National Academies has called for researchers to “expand the number of systematic evaluations of prison-based programs.”⁴⁷ As Part II explains, this call has, in the context of compassionate release, been quite heartily answered.

⁴¹ *Id.* at 5.

⁴² *Id.* at 6.

⁴³ *Id.*

⁴⁴ *Id.* at 204.

⁴⁵ CLOUD, *supra* note 5.

⁴⁶ Robert B. Greifinger, *Commentary: Is It Politic to Limit Our Compassion?* 27 J.L. MED. & ETHICS 234, 234 (1999).

⁴⁷ NRC, *supra* note 1, at 11.

II. COMPASSIONATE RELEASE: RESEARCH AND RECOMMENDATIONS

There is much scholarship evaluating issues associated with compassionate release. This includes discussions around the broader relationships between incarceration and health(care);⁴⁸ the intersection of compassion with politics and the purposes of punishment;⁴⁹ international law standards for prisoners;⁵⁰ health issues for specific populations (e.g., the elderly);⁵¹ terminal illness in the prison context;⁵² and the roles and competencies of corrections, healthcare professionals, and parole boards.⁵³ Next to this, a number of studies have focused on identifying and deconstructing existing compassionate release procedures.⁵⁴ These studies demonstrate that compassionate release procedures are commonplace in the American justice system. In addition to a federal procedure,⁵⁵ there are approximately eighty-eight compassionate release procedures across the fifty states and DC.⁵⁶ Iowa is seemingly the only state absent a clearly

⁴⁸ See NRC, *supra* note 1; see also CLOUD, *supra* note 5; NATIONAL RESEARCH COUNCIL & AMY SMITH, HEALTH AND INCARCERATION: A WORKSHOP SUMMARY (Wash., DC: National Academies Press 2013) [hereinafter HEALTH AND INCARCERATION].

⁴⁹ See William W. Berry III, *Extraordinary and Compelling: A Re-Examination of the Justifications for Compassionate Release*, 68 MD. L. REV. 850, 873–81 (2009).

⁵⁰ See HEALTH AND INCARCERATION, *supra* note 48, at 10; Alvin J. Bronstein & Jenni Gainsborough, *Using Int'l Human Rights Laws and Standards for U.S. Prison Reform*, 24 PACE L. REV. 811, 814 (2004); G. A. Res. 70/175, The Nelson Mandela Rules (Dec. 17, 2015), <https://www.ohchr.org/Documents/ProfessionalInterest/NelsonMandelaRules.pdf>.

⁵¹ See NRC, *supra* note 1, at 211–12; Nadine Curran, *Blue Hairs in the Bighouse: The Rise in the Elderly Inmate Population, Its Effect on the Overcrowding Dilemma and Solutions to Correct It*, 26 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 225, 244–49 (2000); Ronald H. Aday, *Golden Years Behind Bars: Special Programs and Facilities for Elderly Inmates*, 58 FED. PROB. 47, 49–52 (1994).

⁵² See Jalila Jefferson-Bullock, *Are You (Still) My Great and Worthy Opponent?: Compassionate Release of Terminally Ill Offenders*, 83 UMKC L. REV. 521 (2015); Nancy Neveloff Dubler, *The Collision of Confinement and Care: End-of-Life Care in Prisons and Jails*, 26 J.L. MED. & ETHICS 149 (1998) (discussing treatment of HIV and AIDS in prisons).

⁵³ See Edward E. Rhine, Joan Petersilia, & Kevin R. Reitz, *The Future of Parole Release*, 46 CRIME & JUST. 279 (2016); Bryant S. Green, *As the Pendulum Swings: The Reformation of Compassionate Release to Accommodate Changing Perceptions of Corrections*, 46 U. TOL. L. REV. 123 (2014).

⁵⁴ See Price, *supra* note 11; Russell, *supra* note 15; Gartner & Del Carmen, *supra* note 15; and Cooper, *supra* note 15.

⁵⁵ 18 U.S.C. § 3582(c)(1)(A)(i)(ii).

⁵⁶ See Price, *supra* note 11; Cooper, *supra* note 15 (As part of the *The Blueprint Study* a cross-check of the procedures identified by the Families Against Mandatory Minimums study against those identified by the *Blueprint Study* was undertaken, totaling 88).

identifiable procedure.⁵⁷ These studies have resulted in researchers being able to make recommendations for achieving more functional compassionate release procedures. This section summarizes existing research findings and recommendations about compassionate release, using them as a steer for suggesting how Arizona could implement reform.

A. Method & Labelling

Compassionate release methods include parole,⁵⁸ executive clemency and commutation,⁵⁹ reprieves,⁶⁰ sentence modifications,⁶¹ extended confinement with supervision,⁶² respite programs,⁶³ and furloughs.⁶⁴

⁵⁷ See FAMILIES AGAINST MANDATORY MINIMUMS, IOWA STATE MEMO 2 (2018), https://famm.org/wp-content/uploads/Iowa_Final.pdf. Note, however, as the memo indicates, the media reports there has been a compassionate release case in Iowa, but there are no identifiable procedures.

⁵⁸ See WYO. STAT. ANN. § 7-13-424 (2019) (Wyoming’s “Medical Parole” procedure); ARK. CODE ANN. § 12-29-404 (2019) (Arkansas’ procedure for “[m]edical parole for a terminal illness or permanent incapacitation”); CONN. GEN. STAT. § 54-131a (2019) (Connecticut’s procedure for “[r]elease of an inmate on medical parole.”)

⁵⁹ See ARIZ. REV. STAT. § 31-403 (2019) (Arizona’s statute granting inmates eligibility for commutation if “in imminent danger of death due to a medical condition”); 220 IND. ADMIN. CODE 1.1-4-1.5 (2020) (describing Indiana’s procedure for “Special medical clemency”); MICH. DEP’T OF CORRS., EXECUTIVE CLEMENCY PROCESS SUMMARY (2020), https://www.michigan.gov/corrections/0,4551,7-119-1435_11601-223452--,00.html (last visited October, 27, 2019) (Michigan’s policy allowing recommendation for commutation for inmates with “a deteriorating and/or terminal medical condition.”)

⁶⁰ See GA. CONST. art. IV, § II, para. II(e) (granting Georgia’s parole board power “to issue a medical reprieve to an entirely incapacitated person”); 37 TEX. ADMIN. CODE § 143.34 (2019) (granting the Texas parole board to consider applications for “medical emergency reprieve.”)

⁶¹ See DEL. CODE ANN. tit. 11, § 4217 (2020) (giving Delaware courts the power to modify sentences for, among other things, “serious medical illness or infirmity”); WIS. STAT. § 302.113(b)(3) (2019) (allowing sentence modification for “an extraordinary health condition”).

⁶² See ME. REV. STAT. ANN. tit. 34-A, § 3036-A.10 (2020) (including “[t]erminally ill or incapacitated” inmates in Maine’s “Supervised community confinement” procedure); WIS. STAT. § 302.113(8) (2020) (describing Wisconsin’s “Release to extended supervision” procedure).

⁶³ See W. VA. DIV. OF CORRS., ANNUAL REPORT: FY2018, 45 tbl.7 (2018) (charting releases under West Virginia’s “Medical Respite” procedure), https://dcr.wv.gov/resources/Documents/annual_reports/WVDOC%2018%20Annual%20Report.pdf.

⁶⁴ See ARIZ. REV. STAT. § 31-233 (LexisNexis 2019) (allowing inmates to seek “medical treatment not available” to them); VT. STAT. ANN. tit. 28, § 808 (2019) (allowing inmates to be “place[d] on medical furlough”); ALA. CODE §§ 14-14-1–14-14-7 (comprising a range of statutes referred to in the text as the “Alabama Medical Furlough Act.”)

Approximately fifty different labels exist,⁶⁵ with ‘Medical Parole’ being the most common.⁶⁶ This reflects that parole—in its general form or in a specific form—is the most common method of compassionate release. It is recommended that methods employed should clearly state the releasing authority,⁶⁷ and harness decision-maker expertise. For example, physicians should only be required to make medical decisions; and parole authorities (or other such releasing authorities) should not be required to make medical prognostications.⁶⁸ This is about achieving functionality through harnessing specific expertise. As Russell remarks about parole authorities, “These panels deal with release determinations on a daily basis. They are accustomed to reviewing evidence, evaluating cases, balancing equities, and drawing conclusions. They are also well prepared to determine what conditions should be imposed in any given situation.”⁶⁹ Another example is the good experience corrections staff have with continuity of support on discharge (e.g., through parole, community corrections, and drug treatment programs), which could be harnessed when making decisions around the continuity of medical care for prisoners.⁷⁰

Also evident is that many of the labels used across compassionate release procedures are not an obvious shorthand of the procedure they describe, particularly for lay persons. For example, “extensions of the limits of confinement”⁷¹, “recall of sentence”⁷² and “supervised community

⁶⁵ Cooper, *supra* note 15, (unpublished report at 20).

⁶⁶ *Id.* at 21 (terms such as “medical/medically”; “extraordinary”; “special”; “geriatric/age”; and “compassionate” feature multiple times too).

⁶⁷ *See, e.g.*, Gartner & del Carmen, *supra* note 15, at 14–15 tbl.9 (“Core Provisions of Suggested Medical Parole Statute Inclusions”).

⁶⁸ *See Id.* at 16 (“It is important that each statute clearly indicate the employer and licensing status of the physician(s) who make the diagnosis.”); CAL. PENAL CODE § 1170 (West 2022) (requiring a physician employed by the department of corrections to determine whether a prisoner has six months or less to live); Russell, *supra* note 15, at 834 (“The physician should not be required to make a finding about the prisoner’s capacity to commit criminal acts or to determine whether he poses a threat to society”)

⁶⁹ Russell, *supra* note 15, at 836.

⁷⁰ Greifinger, *supra* note 46, at 236 (“Correctional systems have good experience with continuity on discharge through other programs, such as parole programs, work releases, community corrections, and linkages to drug treatment programs. This experience should help them with a broader agenda that includes continuity of medical care.”)

⁷¹ *See, e.g.*, FAMILIES AGAINST MANDATORY MINIMUMS, NORTH CAROLINA STATE MEMO 1 (2018), https://famm.org/wp-content/uploads/North-Carolina_Final.pdf (n.2 “N.C. Gen. Stat. § 148-4; Prisons Policy, Chapter C, § .2200-Extension of Limits of Confinement (February 2018).”)

⁷² *See, e.g.*, FAMILIES AGAINST MANDATORY MINIMUMS, CALIFORNIA STATE MEMO 1 (2018), https://famm.org/wp-content/uploads/California_Final.pdf (n.2 “Cal. Penal Code §

confinement”⁷³ could be considered unclear. Clarity and lay-accessibility is particularly important as research shows there tends to be a lack of legal representation for prisoners navigating compassionate release procedures, with one study commenting, “Given the complexity of rules and criteria, we were surprised to see how few systems allow for or provide counsel for prisoners, including prisoners who must go before a parole board.”⁷⁴ A review of cases involving appeals in the context of compassionate release also highlights a prevalence of prisoners acting *pro se*.⁷⁵

Like many states, Arizona could adopt a Medical Parole procedure, which would make use of a lay-friendly label that clearly captures the procedure’s function (i.e., a parole process related to medical issues), and which integrates compassionate release into Arizona’s established parole infrastructure. This approach would provide for a clear method (parole), and a singular releasing authority, namely the Arizona Board of Executive Clemency, as parole decisions do not require executive involvement (unlike commutation does). Placing release authority solely in the discretion of the BOEC could allow for a fuller harnessing of BOEC members’ expertise. For example, members will be experienced in release-related decision-making; receiving reports from third parties (like healthcare professionals); and coordinating with other agents, such as corrections and prisoners’ families.

B. Exclusions

Prisoners can be excluded from compassionate release procedures even if they meet the ill-health related eligibility criteria. Exclusions are relatively common, with grounds for exclusion including categories of

1170 (e); Cal. Code Regs. tit. 15, §§ 3076 through 3076.5.”)

⁷³ See, e.g., FAMILIES AGAINST MANDATORY MINIMUMS, MAINE STATE MEMO 1 (2018), https://famm.org/wp-content/uploads/Maine_Final.pdf (n.1 “Maine Rev. Stat. Ann. tit.34-A, § 3036-A.10; Maine Department of Corrections Policy (DOC Policy) 27.2, § VI, Procedure I - Supervised Community Confinement for a Terminally Ill or Severely Incapacitated Prisoner.”)

⁷⁴ Price, *supra* note 11, at 18.

⁷⁵ See, e.g., Aponte v. Bd. of Parole, No. 9:17-CV-0305(GTS/DEP), 2017 WL 8780766, at *1 (N.D.N.Y. July 14, 2017); Alexander v. Grounds, No. C 14-1928 EDL (PR), 2014 WL 5408407, at *1 (N.D. Cal. Oct. 22, 2014); Beal v. Ward, No. CIV-05-253-M, 2005 WL 1322877 (W.D. Okla. June 1, 2005).

offenders;⁷⁶ parole eligibility;⁷⁷ minimum sentencing requirements;⁷⁸ age requirements;⁷⁹ and more nuanced reasons.⁸⁰ Researchers have suggested exclusions be clearly explained⁸¹ and primarily based on a prisoner's present medical condition(s).⁸² Specifically, one study recommended that it be guaranteed that "all eligible prisoners are considered for compassionate release, notwithstanding their crime, sentence, or amount of time left to serve."⁸³

Fashioning a compassionate release procedure that is sensitive to concerns about public safety, the broader aims of punishment, the diversity of sentences and offences applied in the United States, and that accounts meaningfully for compassion is difficult. A starting point for Arizona, however, could be to shape a procedure that expressly states eligibility is not—save for those serving capital and life sentences—dictated by a prisoner's conviction, sentence, date of sentence or crime, amount of time-served, or parole eligibility. Such an exclusion practice is clear and narrow. It is also rational in that the excluded cohorts are subject to sentences that

⁷⁶ See, e.g., CAL. PENAL CODE § 3055 (2018) (excluding inmates convicted of first-degree murder of a "peace officer"); N.J. STAT. ANN. § 30:4-123.51c (2018) (excluding inmates convicted of "violent offenses" like murder, manslaughter, and aggravated sexual assault).

⁷⁷ See, e.g., CAL. PENAL CODE § 3055 (2018) (excluding inmates sentenced to life without the possibility of parole); KAN. STAT. ANN. §§ 22-3728 (2014) (excluding inmates sentenced to death or life without the possibility of parole).

⁷⁸ See, e.g., COLO. REV. STAT. ANN. § 17-2-201 (2019) (setting Five Year limits on eligibility for inmates convicted of Class 1 and Class 2 felonies); N.Y. EXEC. LAW § 259-r (McKinney 2015) (requiring inmates convicted of certain violent crimes to complete one-half of the sentence to become eligible for medical parole).

⁷⁹ See, e.g., CAL. PENAL CODE § 3055 (2018) (for inmates sixty years of age and older); VA. CODE ANN. § 53.1-40.01 (2001) (for inmates sixty-five years of age and older).

⁸⁰ See, e.g., ALA. CODE § 14-14-3 (2019) (requiring inmates to qualify for Medicare or Medicaid).

⁸¹ Gartner & del Carmen, *supra* note 15, at 15 ("It is equally important for statutes to state the reasons why an inmate is disqualified from consideration. The disqualification should be clear in the statute and references to disqualifying statutes, if any, should be included."). See *Id.* at 16 tbl.9 ("Core Provisions of Suggested Medical Parole Statute Inclusions." Listing reasons for which inmates are exempt from consideration).

⁸² Russell, *supra* note 15 at 833 ("All terminally ill prisoners should be eligible for compassionate release. Once we are dealing with someone suffering from a terminal illness, penologic considerations are secondary. In light of current societal values addressing death with dignity, considerations of punishment, deterrence, and rehabilitation should no longer come into play. The seriousness of the crime is not deprecated if we permit the terminally ill to die outside the hostile confines of prison. This is certainly true when a predicate to release is a finding that the prisoner no longer poses a threat to society. Thus, no crimes or sentences should serve as a basis for exclusion, nor should minimum time served requirements be imposed.").

⁸³ Price, *supra* note 11, at 21.

follow conviction for the most serious crimes, and that death in prison is an inherent consequence of such sentences. It would also remove unduly restrictive and arbitrary limitations currently placed on eligibility by various Arizona sentencing statutes.⁸⁴

C. Eligibility

Eligibility for compassionate release generally relates to serious terminal, non-terminal, and/or age-related health issues. Non-terminal conditions are described varyingly,⁸⁵ but typically require prisoners be subject to serious medical conditions/disabilities that significantly incapacitate them. Mental health is occasionally included.⁸⁶ Age is referenced in various ways.⁸⁷ Tens of procedures expressly reference ‘terminal’ within eligibility criteria, with many including a temporal reference.⁸⁸ These references range from that death must be “imminent,” to that it must occur within twenty-four months.⁸⁹ It has been posited that eligibility criteria not be unduly strict and/or vague,⁹⁰ but rather underpinned by “medical, end-of-life, and geriatric criteria,”⁹¹ which is

⁸⁴See ABOEC Policy #114, 114.1–114.3, <https://boec.az.gov/sites/default/files/documents/files/114-Commutation%20of%20Sentence%20Rev%2005-2018.pdf>. An Arizona prisoner can only apply for commutation of sentence if they are “statutorily eligible” or if their “sentence does not require a minimum amount of time to be served.” The Board will only consider those prisoners who have served two years from their sentence begin date and are not within one year of their release date for sentences more than three years. “The Board will not consider inmates with less than three years sentence.” The Board’s “imminent danger of death” procedure provides an exception to the time requirements only, but not eligibility requirements. An Arizona prisoner can only seek commutation based on imminent danger of death if they are within four months of death and, as stated above, only if their sentence allows release eligibility. Arizona’s “imminent danger of death” procedure does not apply beyond such health issues or to those serving flat day-for-day sentences.

⁸⁵ See Cooper, *supra* note 15, at 27 (including chronic, debilitating, extraordinary, incapacitation, disabled, severe, permanent, and grave).

⁸⁶ See, e.g., COLO. REV. STAT. ANN. §§ 17-22.5–403.5 (2019) (Colorado’s “Special needs parole”); ALA. CODE § 14-14-2 (2019) (including “mental health condition” in definition of incapacitation).

⁸⁷ Cooper, *supra* note 15, at 31–32 (1. procedures that are for the exclusive use of elderly prisoners, and which determine eligibility by reference to a specific age; 2. procedures that include elderly prisoners—as a specifically eligible cohort—within a broader procedure that is available to other prisoners; and 3. procedures that consider age generally as part of the decision-making process).

⁸⁸ See Sarah L. Cooper, List of Procedures with Temporal Reference (2019) (unpublished report) (on file with author).

⁸⁹ *Id.*

⁹⁰ Price, *supra* note 11, at 13–14, 21.

⁹¹ *Id.* at 21.

based “on evidence and best practices, with input from medical experts.”⁹² Other factors such as risk to public safety, prisoner well-being, and cost, can also inform decision-making about eligibility.⁹³ These factors should be carefully constructed. For example, assessments of risk to public safety should be nuanced, requiring decision-makers to determine if there are *material* concerns about public safety. It is considered good practice for procedures to “assess whether continued incarceration defeats the purposes of punishment”⁹⁴

Arizona could shape eligibility criteria that takes account of the above. Arizona’s current IDD commutation procedure bases a prisoner’s medical eligibility on their being terminally ill and [to a reasonable degree of medical certainty] within four months of death.⁹⁵ A first step, therefore, would be to broaden the categories of prisoners—in terms of medical issues—eligible to apply. Categories could continue to include terminal illness but make use of a longer life-expectancy period (e.g., death within twenty-four months). Or, indeed, express temporal references could be removed. Non-terminal illness could be shaped to cover a breadth of medical issues, for example, a physical, mental, and/or cognitive condition, disease or syndrome that debilitates, and/or incapacitates. In addition, deteriorating health due to advancing age could be included as a specific category. Criteria and interpretative guidelines could be developed in collaboration with medical experts. The second step would be to integrate medical experts within the procedure to undertake decision-making about whether a prisoner falls within any particular category. In short, licensed physicians would be required to harness their expertise and certify that a prisoner falls within an eligible category. Arizona already coordinates a similar approach.⁹⁶ The third step of the procedure would harness the expertise of BOEC members, who would weigh the criminal justice policy dimensions of eligibility. For instance, whether, in light of the certified medical issue, the prisoner’s release poses a substantial risk to public safety; is appropriate in terms of state resources and medical care; is in the interests of the prisoner’s well-being and dignity; and whether there is a comprehensive release plan prepared by corrections.

⁹² *Id.*

⁹³ Cooper, *supra* note 15, at 32–34.

⁹⁴ Price, *supra* note 11, at 17 (“We were also impressed with the handful of states that assess whether continued incarceration defeats the purposes of punishment, in the context of their state’s compassionate release program.”).

⁹⁵ ABOEC POLICY #114, at 114.3.

⁹⁶ *Id.*

D. Process

Compassionate release processes vary. It is generally recommended that processes should be streamlined,⁹⁷ and include time-limits that reflect the need for expedited review.⁹⁸ The proactive identification of eligible prisoners is also encouraged,⁹⁹ along with taking a broad approach to who can be a petitioner and initiate proceedings (e.g., any interested party, including correctional staff, family, and lawyers).¹⁰⁰ Processes should make use of competent decision-makers, specifying who they are and what their competence is within the process.¹⁰¹ As part of this, the reporting of reasons for decision-making is encouraged.¹⁰² Supporting evidence requirements should be clearly itemized,¹⁰³ focusing on medical evidence. The integration of an appeals process is also recommended.¹⁰⁴ Information about

⁹⁷ Russell, *supra* note 15, at 832–33 (“Because of the exigent nature of terminal illness, any compassionate release program should be constructed so that cases can be expeditiously processed The more complex the system, the less likely that it will be efficient in accomplishing its goal . . .”).

⁹⁸ See Gartner & del Carmen, *supra* note 15, at 17 (“For the process description to be even more useful, jurisdictions should state specific time limits for the consideration process and the length of the decision period from time of application to the final release decision.”); Price, *supra* note 11, at 21 (“Establish time frames within which document-gathering, assessment, and decision-making must occur that are realistic, provide sufficient time to develop informed decisions, and are sensitive to the need for expedited review in the case of terminal illness.”).

⁹⁹ See Price, *supra* note 11, at 21 (“Teach staff how to identify eligible prisoners and make it their duty to do so.”).

¹⁰⁰ *Id.* (“Involve families in identifying eligible prisoners and providing support, such as in coordinating release planning.”).

¹⁰¹ See Price, *supra* note 11, at 14 (“We found a number of states providing little if any policy guidance or procedures that prison staff, corrections officials, or final decision-makers could use to implement compassionate release.”).

¹⁰² See *id.* at 21 (“Require all agencies involved in compassionate release to provide annual data—including demographic information—on applications, approvals, denials, and revocations, including reasons for denials and revocations.”); Gartner & del Carmen, *supra* note 15, at 18 (“The final items that should be included in a well-constructed medical parole statute are . . . the reporting requirements for the releasing authority.”).

¹⁰³ Gartner & del Carmen, *supra* note 15, at 16 tbl.9 (“Core Provisions of Suggested Medical Parole Statute Inclusions - List and define necessary documentation for consideration.” *Id.* at 17 (“The statute must also describe how these documents should be delivered—full report, separately as they are completed, etc.—and to whom the documents must be delivered.”).

¹⁰⁴ Price, *supra* note 11, at 21 (“Provide the right to appeal denials or the right to reapply following a denial.”).

the process should be publicly available and signposted to prisoners,¹⁰⁵ including guidance about terminology employed.¹⁰⁶

Arizona's existing IDD commutation procedure already adopts some relevant qualities. The ADC and BOEC provide—separately—publicly available information about the IDD process. This information includes, for example, some express time limits. For instance, ADC policy states “[w]ithin one workday from receipt of the application,”¹⁰⁷ the Time Computation Unit will determine whether the prisoner is statutorily eligible to apply. Moreover, the BOEC's policy describes that the “Executive Director will make every effort to accommodate priority scheduling for imminent danger of death commutation hearings.”¹⁰⁸ Both policies also make some clear references to decision-makers (e.g., Time Computation, Human and Health Services, the BOEC, and the Governor);¹⁰⁹ harness expertise (e.g., a medical specialist must complete a written prognosis);¹¹⁰ and have some focus on medical evidence requirements (e.g., the need for a clinical summary and prognosis).¹¹¹ Arizona can build on these foundations in designing a new Medical Parole procedure. For example, by adding more express time-limits throughout the process to “keep applications moving;”¹¹² requiring decision-makers to provide reasons for their decision-making; itemizing and making clearly available all evidence requirements and documentation; and integrating an appeals process based on typical appeals principles, such as the showing of new information [about eligibility, for example], error, or inequity.

¹⁰⁵ *Id.* at 7 (“Compassionate release rules should be easy to understand. . . . Help should be available to prisoners and their loved ones, if needed, to apply for compassionate release. . . . Finally, compassionate release in every state should be transparent to the fullest extent possible.”). *See also* Price, *supra* note 11, at 21 (“Provide information about compassionate release options to each entering prisoner; ensure prison handbooks include a section that clearly explains eligibility and application.”).

¹⁰⁶ Gartner & del Carmen, *supra* note 15, at 16 tbl.9 (“Core Provisions of Suggested Medical Parole Statute Inclusions.” “Indicate terminology used for the release program.”) Gartner & del Carmen, *supra* note 15, at 18 (“The final items that should be included in a well-constructed medical parole statute are a statement of the appropriate terminology for the release program. . . .”).

¹⁰⁷ *See* ARIZONA DEPARTMENT OF CORRECTIONS, DEPARTMENTAL ORDER MANUAL, CHAPTER 1000, DEPARTMENT ORDER—1002 INMATE RELEASE ELIGIBILITY SYSTEM § 1.11.3(2018), https://corrections.az.gov/sites/default/files/policies/1000/1002_073019.pdf [hereinafter ADC ORDER].

¹⁰⁸ *See* ABOEC POLICY #114, *supra* note 13, at 114.3, 3.2.3.

¹⁰⁹ *See generally* ADC ORDER, *supra* note 107; ABOEC POLICY #114, *supra* note 13 (discussing roles of these decision-makers within release procedure).

¹¹⁰ *See* ABOEC POLICY #114, *supra* note 13, at 114.3, 3.2.

¹¹¹ *See* ADC ORDER, *supra* note 108, at 1.11.3.2.3.

¹¹² PRICE, *supra* note 11, at 21 (“Establish Deadlines to Keep Applications Moving”).

E. Release Requirements

Release conditions are typical but vary, ranging from agreeing to the public release of medical records¹¹³ and placements¹¹⁴ and being subject to periodic medical evaluations,¹¹⁵ to intensive supervision¹¹⁶ and fee payments.¹¹⁷ Release revocation based on a change in circumstances is also typical.¹¹⁸ Release requirements should be tailored to individual circumstances, clear in both terms and consequences,¹¹⁹ and there should be

¹¹³ See, e.g., ALASKA ADMIN. CODE tit. 22, § 20.605(c) (2019), <http://www.akleg.gov/basis/aac.asp#22.20.605> (“An applicant for special medical parole must provide the board and the department with full access to all medical records, and must sign a release assuring that access by the department and the board for the full duration of the period of parole.”).

¹¹⁴ See, e.g., CONN. GEN. STAT. ANN § 54-131d(a) (2013) (“The Board of Pardons and Paroles shall require as a condition of release on medical parole that the parolee agree to placement and that he or she is able to be placed for a definite or indefinite period of time in a hospital or hospice or other housing accommodation suitable to his or her medical condition, including his or her family's home, as specified by the Board of Pardons and Paroles.”).

¹¹⁵ See, e.g., N.H. REV. STAT. ANN. § 651-A:10-a(IV) (2015) (“The Adult Parole Board may request, as a condition of medical parole, that such inmate submit to periodic medical examinations while on medical parole . . .”).

¹¹⁶ See, e.g., NEV. REV. STAT. ANN. § 213.380(2)(c) (2019) (“Require intensive supervision of the offender, including unannounced visits to his or her residence or other locations where the offender is expected to be in order to determine whether the offender is complying with the terms and conditions of his or her confinement.”).

¹¹⁷ See, e.g., MISSOURI DEPARTMENT OF CORRECTIONS, RULES AND REGULATIONS GOVERNING THE CONDITIONS OF PROBATION, PAROLE, AND CONDITIONAL RELEASE 10 <https://doc.mo.gov/sites/doc/files/2018-01/White-Book.pdf> (“a monthly intervention fee in an amount set by the Missouri Department of Corrections”).

¹¹⁸ See, e.g., ARK. CODE ANN. § 12-29-404(e) (2012) (“The board may revoke a person’s parole supervision granted under this section if the person’s medical condition improves to the point that he or she would initially not have been eligible for parole supervision under this section.”).

¹¹⁹ Gartner & del Carmen, *supra* note 15 (“A medical parole statute should list and explain any general and/or medically specific conditions of release that are required of a medical parolee....A vital piece of a medical release statute is the discussion of the possible sanctions for the violation of parole conditions and the method through which those sanctions may be imposed — reprimands, graduated sanctions, revocation, etc. The statute should include, in clear terms, the number and/or nature of violations that will be grounds for revocation. The statute should also be clear regarding whether improvement in the parolee’s medical condition is grounds for revocation, and if so, the definition of improvement and how the determination of improvement will be made. The process whereby a medical parolee is found to have violated the conditions of parole and the reasons supporting revocation should be adequately detailed in the statute. These details should indicate whether individuals must be notified that they are in possible violation of their parole conditions, whether a hearing in front of a judge is necessary for formal

support available for pre and post-release planning, including identifying welfare support.¹²⁰ It is considered good practice to involve families in release planning (as well as the broader application process).¹²¹

Arizona's existing IDD commutation procedure includes a reference to prisoners agreeing to their medical records becoming public,¹²² and ADC policy describes support for medical-based release planning, including health insurance and federal benefits.¹²³ In considering a new Medical Parole procedure, Arizona could build on this footing. Enhancements could include sealing prisoners' medical records, which would allow decision-makers to consider all relevant information, but limit public discussion of sensitive content that is very likely to be unrelated to a prisoner's offence. As an additional motivation for undertaking comprehensive release planning, a check on completion could be integrated into the BOEC's eligibility-related decision-making. To support the BOEC to resolve concerns about release, the procedure could expressly allow the BOEC to — as is typical for parole practices — attach specific release conditions.

F. Reporting

Generally, compassionate release procedures lack comprehensive reporting and tracking systems, including systems that record applications, decisions, reasons for decision-making, and follow-up systems for those granted release.¹²⁴ Procedures should include mandatory reporting and

violation or revocation, and whether an individual is eligible for medical parole after an earlier parole revocation.”).

¹²⁰ Price, *supra* note 11, at 21 (“Assign dedicated staff to assist ill and elderly prisoners with pre-and post-release planning, including applying for public assistance, veterans’ benefits, housing and medical facility placements, Medicaid and/or Medicare, and other supports.”).

¹²¹ *Id.* (“Involve families in identifying eligible prisoners and providing support, such as in coordinating release planning.”).

¹²² See ABOEC POLICY #114, *supra* note 13 114.3(3.2.4) (“Inmates will be notified on the Commutation of Sentence Application that their medical records may become public record and discussed in public forum during the commutation hearing. They shall acknowledge this notice by their signature on the application form.”).

¹²³ See FAMILIES AGAINST MANDATORY MINIMUMS, *Compassionate Release Arizona State Memo* (June 2018), https://famm.org/wp-content/uploads/Arizona_Final.pdf.

¹²⁴ Price, *supra* note 11, at 19. (“More than half of the states do not track or collect any data on how many people apply for and receive compassionate release. We believe that if lawmakers were aware of how few people are granted compassionate release they might be moved to examine why and act to improve the programs. Knowing who asks for compassionate release, who is denied, and why and how those requests are decided is essential to improving outcomes so that, for example, more eligible prisoners are released and terminally ill prisoners get expedited reviews.”).

tracking requirements, which are subject to regular review and evaluation.¹²⁵ Establishing data collection systems is important,¹²⁶ but “a delicate balance”¹²⁷ must be struck so as not to impose unduly costly and intrusive requirements.¹²⁸

There is some published information about IDD commutation decisions in Arizona.¹²⁹ In shaping a new procedure, Arizona could establish more detailed tracking procedures, particularly across the two main agencies proposed to be involved in decision-making: the BOEC and ADC. This could include, for example, corrections being required to regularly report on the number and nature of applications, release planning support, and the recidivism of prisoners released. Similarly, the BOEC could be required to regularly report on the number and nature of Medical Parole hearings, outcomes, and appeals. Both agencies could be required to report on compliance with relevant procedural time-limits. The aim of such an approach would be to enhance transparency and accountability, and establish an evidence-base for regular review and evaluation.

G. Cross-cultural Competencies

Compassionate release procedures can involve various agents, including prisoners and their families, lawyers, corrections personnel, healthcare professionals, parole authorities, courts, and executives. Arizona’s current IDD commutation procedure reflects this. The development of cross-cultural competencies i.e., common understandings between these agents — who obviously have their own specific roles and training — is encouraged. Developing such understanding is largely about signposting, creating, and delivering education opportunities. Suggestions include publicizing compassionate release procedures and policies across stakeholder institutions, including the proactive signposting of procedure information to prisoners and families;¹³⁰ education programs (led by

¹²⁵ *Id.* at 21. (“Require all agencies involved in compassionate release to provide annual data—including demographic information—on applications, approvals, denials, and revocations, including reasons for denials and revocations.”)

¹²⁶ Russell, *supra* note 15, at 835.

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ See ARIZONA BOARD OF EXECUTIVE CLEMENCY, ANNUAL REPORTS (2014-17), <https://boec.az.gov/agendas-reports-and-policies/policies-and-reports>.

¹³⁰ Price, *supra* note 11, at 7 (“Compassionate release rules should be easy to understand . . . [h]elp should be available to prisoners and their loved ones, if needed, to apply for compassionate release . . . [f]inally, compassionate release in every state should be transparent to the fullest extent possible.”); see also *id.* at 21 (“Provide information about

healthcare professionals) for criminal justice system stakeholders (such as corrections personnel and BOEC members) about prisoner health(care) needs and the meaning of compassionate release eligibility criteria;¹³¹ and training for healthcare professionals (led by criminal justice system professionals) about the conditions of incarceration and the pressures faced by criminal justice institutions and actors.¹³² Fostering such cross-agency collaboration is of “practical importance”¹³³ so as to limit conflicts. Without it, “you’re just spinning your wheels.”¹³⁴

CONCLUSIONS

There are calls for compassionate release reform across the United States. Arguably, Arizona should feel particularly motivated to hear such calls and broaden its approach. As a start, research suggests, when compared against other state procedures, Arizona takes a particularly narrow approach to compassionate release. Both of its procedures are seemingly for the exclusive use of terminally ill prisoners, with Compassionate Leave providing only temporary release, and the IDD commutation procedure catering only for terminal prisoners certified to be within four months of death (and statutorily eligible). Compared to other state procedures using a temporal reference to dictate eligibility for terminally ill prisoners, Arizona ranks as one of the narrowest.¹³⁵

With this in mind, there is evidence of both a local and national political will to broaden compassionate release, with members of the Arizona state legislature and Arizona representatives in the US Congress supporting relevant bipartisan policies. The latter is shown by support for the First Step Act, which, *inter alia*, allows for compassionate release applications by federal prisoners in a relatively wide set of circumstances.¹³⁶ The First Step

compassionate release options to each entering prisoner; ensure prison handbooks include a section that clearly explains eligibility and application.”).

¹³¹ See HEALTH AND INCARCERATION, *supra* note 48, at 28–29.

¹³² *Id.*

¹³³ *Id.* at 29.

¹³⁴ *Id.*

¹³⁵ See Cooper, *supra* note 88.

¹³⁶ Nationally, the First Step Act, signed into federal law in late 2018, allows prisoners to circumvent a Bureau of Prisons denial of eligibility for compassionate release by appealing directly to the sentencing court. In considering a motion for a prisoner’s release, the federal court may grant the relevant motion if (1) the prisoner meets specific age and term-length criteria, or (2) “extraordinary and compelling reasons warrant” release. Determinations of “extraordinary and compelling” must align with “applicable policy statements issued by the [U.S.] Sentencing Commission.” Because of this stipulation, federal courts may consider a multitude of factors including a prisoner’s medical condition, age, and family

Act passed the House of Representatives (358–36)¹³⁷ and the Senate (87–12)¹³⁸ by a landslide, enjoying the bipartisan support of a majority of Arizona’s federal representatives in Congress.¹³⁹ There have been sustained efforts to legislate for a broader compassionate release procedure in Arizona too. Between 1991 and 2015, eight bills seeking to establish a Medical Parole procedure were introduced in the Arizona House of Representatives.¹⁴⁰ Half of them had bipartisan sponsorship.¹⁴¹ These bills—in short—aimed to allow prisoners with an “incapacitating physical condition, disease or syndrome” to apply to the BOEC for release if within one year of release, parole eligibility, or (if neither of the latter two applied) death.¹⁴² Political will is critical to achieving relevant reform, particularly in the context of prison policy, as relevant strategies require “determined political leadership.”¹⁴³

Political will is shaped by various factors, including by the availability of resources and the need to problem-solve systemic challenges. With regards to resource, significant expenses are associated with “[h]ousing, accommodating, and providing medical care for aging prisoners, prisoners who are ill or suffering from a significant and limiting disability, and prisoners nearing the end of their lives.”¹⁴⁴ Moreover, inefficiencies inherent to prison systems, such as insufficient medical monitoring procedures, minimal handicap accessibility, and inadequate staff training on specialized medical issues¹⁴⁵ contribute to increased costs. Medical care

circumstances. First Step Act of 2018, Pub. L. No. 115-391, 132 Stat. 5194 (Dec. 21, 2018).

¹³⁷ “First Step Act of 2018: Roll Call No. 448.” Congressional Record 358:36 (December 20, 2018) <http://clerk.house.gov/evs/2018/roll448.xml>.

¹³⁸ “First Step Act of 2018: Roll Call No. 271.” Congressional Record 87:12 (December 18, 2018) https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=115&session=2&vote=00271.

¹³⁹ See “First Step Act of 2018: Roll Call No. 448.” *supra* note 137; see also “First Step Act of 2018: Roll Call No. 271.” (Senator Flake and Representatives McSally, O’Halloran, Grijalva, Schweikert, Gallego, and Lesko voted “Yea.” Senator Kyl and Representatives Gosar and Biggs voted “Nay.” Representative Sinema did not vote.)

¹⁴⁰ See H.B. 2334, 40th Leg., 1st Reg. Sess. (Ariz. 1991); H.B. 2678, 48th Leg., 1st Reg. Sess. (Ariz. 2007); H.B. 2189, 49th Leg., 2d Reg. Sess. (Ariz. 2009); H.B. 2688, 49th Leg., 2d Reg. Sess. (Ariz. 2010); H.B. 2380, 50th Leg. Sess., 1st Reg. Sess. (Ariz. 2011); H.B. 2531, 50th Leg. Sess., 2d Reg. Sess. (Ariz. 2012); H.B. 2374, 51st Leg., 2d Reg. Sess. (Ariz. 2014); H.B. 2355, 52nd Leg., 1st Reg. Sess. (Ariz. 2015).

¹⁴¹ See legislative bills cited *supra* note 140.

¹⁴² See legislative bills cited *supra* note 140.

¹⁴³ NRC, *supra* note 1, at 343.

¹⁴⁴ Price, *supra* note 11, at 8, 9.

¹⁴⁵ ACLU, AT AMERICA’S EXPENSE: THE MASS INCARCERATION OF THE ELDERLY 29 (2012), <https://www.aclu.org/report/americas-expense-mass-incarceration-elderly>.

consumes a significant portion of state prison expenditures.¹⁴⁶ In 2018, ADC housed prisoners at a cost of \$71.13 per prisoner per day.¹⁴⁷ Comprising a significant portion of that expense is healthcare, as the state's new contract for healthcare services with Centurion of Arizona, LLC will cost \$16.60 per prisoner per day.¹⁴⁸ Broadening compassionate release could possibly contribute to reducing these costs. It could also contribute to problem-solving systemic issues that complicate the delivery of adequate healthcare in prisons. Large prison populations are one such issue, and, as shown in California through federal court orders associated with the *Plata* litigation, broadening compassionate release is one remedial strategy.¹⁴⁹ Texas has also utilized compassionate release to reduce its prison population.¹⁵⁰

Using research findings and recommendations as a steer, this paper suggests a direction for a new compassionate release procedure in Arizona. In sum, it suggests that Arizona considers replacing its current IDD commutation procedure with a Medical Parole procedure. This procedure would place releasing authority solely in the discretion of the BOEC and continue to harness professional decision-making expertise across the BOEC, corrections, and healthcare professionals. Sensitive to existing state practices and infrastructures, it would include broader eligibility categories, narrower and clearer exclusions, expedited and inclusive processes, nuanced release requirements, and useful reporting and tracking systems.

¹⁴⁶ Price, *supra* note 11, at 9 (noting “[m]edical care alone consumed one fifth of state prison expenditures . . .”).

¹⁴⁷ ARIZ. DEP’T OF CORR., FY 2018 OPERATING PER CAPITA COST REP. 8 (2018), https://corrections.az.gov/sites/default/files/REPORTS/Operating_Per_Capita/adc-percapcostreport_fy2018-final.pdf.

¹⁴⁸ *Inmate Corr. Healthcare Contract Awarded*, ARIZ. DEP’T OF CORR. (Jan. 18, 2019), <https://corrections.az.gov/article/inmate-correctional-healthcare-contract-awarded>.

¹⁴⁹ In 2014 a federal court ordered California to expand its medical parole program as part of the effort to reduce prison crowding. See Cal. Dep’t of Corr. & Rehab., *Medical Parole Hearings*, BD. OF PAROLE HEARINGS (last visited October 28, 2019) <https://www.cdcr.ca.gov/bph/mpb-overview/>.

¹⁵⁰ In 2007, faced with a state prison population of more than 170,000 and the need for a \$2 billion budget increase for an additional 17,000 beds, Texas turned to initiatives aimed at reducing incarceration rates. See Hannah Wiley, *Trump Administration Looks to Texas as it Pushes a Criminal Justice Reform Bill*, THE TEX. TRIB. (Dec. 3, 2018, 12:00 AM), <https://www.texastribune.org/2018/12/03/first-step-act-prison-reform-texas-criminal-justice/>. As part of this, between 2014 and 2018, Texas released an average of seventy-nine prisoners annually through compassionate release. See TEX. BD. OF PARDONS AND PAROLES, ANN. STAT. REP. FY 2018 11 (2018), <https://www.tdcj.texas.gov/bpp/publications/FY%202018%20AnnualStatistical%20Report.pdf>.