TESTIMONY OF:
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Good afternoon, my name is Melissa Tanis with the Release Aging People in Prison/RAPP Campaign. I would like to thank you for the opportunity to present testimony before you. The RAPP Campaign works to end mass incarceration and promote racial justice by getting older people out of prison through changes to the "back-end" of the legal system, including, parole, medical parole, and clemency. This testimony draws on the expertise and leadership of currently and formerly incarcerated older people, including founding members of the RAPP Campaign who have served long prison sentences, were denied parole many times, and have seen firsthand the retrofitting of prisons as nursing homes.

We believe that Governor Cuomo's calls to reform New York's criminal legal system are potential steps in the right direction. We particularly acknowledge and will comment on his proposal to expand medical parole for incarcerated older people with debilitating health conditions, the exorbitant healthcare costs of keeping older people in prison, as well as proposed initiatives related to other release mechanisms and the New York State Parole Board.

The relatively new crisis of New York's graying prison population represents a systemic, human-made epidemic rooted in the legacies of racism, punishment, and misconceptions of violence in the United States. Although there is no commonly agreed-upon age at which an incarcerated individual is considered "old," definitions usually begin between 50 and 55 given medical practitioners and corrections professionals agree that adverse life circumstances both during and prior to incarceration lead to accelerated aging: a phenomenon that increases the physiological pace at which a person ages.

The Rise of Older People in Prison:

There are currently 10,337 older people in Department of Corrections and Community Supervision (DOCCS) custody. This hasn't always been the case. In 2000, the New York State (NYS) prison population reached its peak at 71,466 people. At the same time, slightly less than seven percent of the population—4,706 people—was aged 50 or older. **Less than two decades later, the number of older people has more than doubled and now makes up 21 percent of all people in DOCCS prisons. Like the entire prison population, the vast majority of older people in prison are Black or Latino people.**

Despite the fact that older people, especially those convicted of the most serious crimes, pose the lowest, if any risk to public safety in New York and beyond, they are denied parole at nearly the same and often higher rates than their younger colleagues. DOCCS' own recidivism numbers validate this low risk phenomenon: **while the overall recidivism rate in NYS is 43 percent, with a new commitment rate of 15 percent, people aged 50-64 have a new commitment rate of just six percent, a percentage that falls to a mere one percent for those aged 65 or older.** The Parole Board's own evidence-based risk and needs instrument—COMPAS—which the legislature mandated guide the Board's decisions, also validates older people's low-risk, as they almost always receive a low-risk COMPAS score before Parole Board hearings. Denying older people who pose little to no risk to public safety is inhumane, counterproductive, and comes with huge healthcare concerns and costs.

The Connection to Healthcare:

In April, 2017, these costs prompted New York State Comptroller Thomas DiNapoli to release a report, "New York State's Aging Prison Population," showing the rise in medical costs associated with the increase in the aging prison population. The report states, "Aging [incarcerated people] generally are more costly to incarcerate than younger cohorts, primarily due to their increased need for medication and other medical care." The report continues by stating, "…health care costs for [those incarcerated in] New York State generally rise with an individual's age. **Overall the health care costs [for people incarcerated in] New York State prison[s] reached $380.6 million in State Fiscal Year 2015-16, an increase of $64.5 million from three years earlier.**"

Nearly all research on aging prison populations concludes that compared to the general prison population, older people have the highest prevalence of chronic and communicable diseases, including hepatitis C, HIV, hypertension, cardiovascular disease, cancer, and dementia. Such health difficulties amongst the older prison population are validated when considering the ages of people in DOCCS' five Regional Medical Units (RMUs), which provide services to people who require complex care. **As of January 2016, 64 percent (183 people) of the total RMU population was aged 50 or older and 47 percent (135 people) was aged 65 or older.**

Even more troubling than the costs associated with care for older people is the quality of care itself, and the fact that older people are often given inadequate treatment or no care at all. What is more, this same category of older people is frequently denied parole release despite their healthcare difficulties and minimal risk to public safety.

The following four anecdotes offer insights into the sort of devastating harm faced by many currently and formerly incarcerated older people and show how barriers to release can effectively turn a parole-eligible sentence into a death sentence.

Mark Shervington was incarcerated for 29 years on a 15-year-life sentence for a crime he committed when he was 20 years old. During his time inside, Mark engaged in meaningful acts of self-transformation, including earning a certificate in International Relations from Cornell University and Legal Specialist and Paralegal certificates for his exceptional work as a jailhouse lawyer. Despite his many accomplishments, Mark was denied parole a total of nine times. While incarcerated, Mark experienced classic symptoms of heart attack twice, including shortness of breath and intense chest pain. DOCCS medical staff told Mark that his pain was minor and provided no care or medication. Despite continued discomfort, Mark was never treated for the remainder of his time inside. Upon release at age 50, Mark went to the doctor and discovered he was misdiagnosed in prison. Doctors informed Mark that he had undergone two undiagnosed heart attacks and a torn heart valve (mitro valve prolapse) while incarcerated. Mark received emergency heart valve replacement surgery in late August, without which he likely would have died.

Robert Seth Hayes is 69 years old and has served 45 years on a 25-year-life sentence after being denied parole 10 times. During his time inside, Mr. Hayes has worked as a prison librarian, prerelease advisor, and AIDS counselor. He has also maintained deep connections to his loved ones in the outside community. In the past decade, Mr. Hayes began experiencing various health difficulties, including type II diabetes. Due to his diabetes, Mr. Hayes often experiences dizziness, sudden falls, dangerously high sugar levels, and diabetic ulcers. He has been rushed to DOCCS' Regional Medical Units on many occasions. It is clear that DOCCS healthcare system is not able to manage Mr. Hayes's diabetes by offering a consistent and reliable standard of care. The legal requirement of providing healthcare in prison that is identical to the standard of care on the street has been shown to be impossible in Mr. Hayes's case, leading to dangerous uncertainty to his health and unneeded stress to him and his family. Like so many, he should be released immediately.

John MacKenzie was sentenced to 25-years-life in 1975 for a serious crime he committed while under the heavy influence of drugs. While in DOCCS custody, MacKenzie earned college degrees, mentored other incarcerated people, and had not committed a single disciplinary infraction since 1980. MacKenzie also took exceptional pains to atone for the harm he caused, most notably by starting an in-prison program that gave victims of crime the opportunity to speak directly with incarcerated people about the impact of homicide related crimes. Despite his incredible accomplishments, MacKenzie was denied parole 10 times. After his 10th denial, MacKenzie became hopeless and did not receive any psychological or emotional care or support from DOCCS. Regarding his frequent parole denials, MacKenzie once wrote, "Legitimate hope

is laudable…false hope is utterly inhumane." Nine days after his 10th parole denial, MacKenzie died by the act of suicide at the age of 70 after a total of 40 years in prison. He is survived by his two daughters, a granddaughter, and many other loved ones.

Charles "Chas" Ransom spent a total of 33 years in prison on a 25-year-life sentence for a violent crime he was convicted of in his early 20s. During his time in prison, Chas was devoted to his own personal growth and the improvement of the lives of those around him. Chas was President of the Lifers and Longtermers Organization at Otisville, helped to found and organize Otisville's annual Parole Summit, worked in DOCCS Transitional Services, and was a lead facilitator for the Tribeca Film Institute Community Screening Series. In addition to his personal accomplishments and advocacy, Chas insisted that every conversation about incarceration first begin with a recognition of the suffering experienced by those harmed by crime and violence. After being denied parole four times, Chas was eventually released after his fifth Parole Board hearing at age 53. Just weeks after his release, Chas obtained a job at the Appellate Advocates and took other profound strides in his reintegration process. On Sunday, October 22nd, Chas went into cardiac arrest and died just a few months after his release. Chas is survived by countless loved ones who keep his legacy alive in their advocacy efforts and loving relationships.

"Geriatric Parole":

The Governor's proposed "geriatric parole" initiative, which would create an additional medical parole provision for incarcerated older people with debilitating health conditions, comes at a crucial moment in the history of New York State prisons. With few meaningful opportunities for release, the older prison population is increasingly aging, growing ill, and dying. For far too long, New York's rarely used, limited, and at times exclusionary medical parole program has directly contributed to this problem. Older people who pose minimal risk to public safety with medical conditions that could be adequately and safely cared for in the community are frequently not qualified, certified, assessed for or released on medical parole and instead die in prison.

Only 13 total people were released on Medical Parole in 2016, a number that falls to just 8 people in 2017. So few medical parole releases occur despite the fact that DOCCS' five Regional Medical Units (RMUs), which provide services to the sickest imprisoned New Yorkers who require complex care, continue to be mostly occupied by older patients. Some in the RMUs are bedridden by terminal illness while others are so cognitively impaired that they don't remember their crimes or why they are in prison. **Therefore, it is not that New York's medical parole program releases few people because of a limited number of candidates, but instead due to restrictive medical parole policies and a lack of political will to change them.**

The Governor's "geriatric parole" proposal is potentially a step in the right direction. While we define older people in prison as those aged 50 and older, we appreciate that the qualifying age for

the proposal—55 years old—is rooted in evidence associated with older people in prison and the degree to which aging accelerates with incarceration. We also agree with the proposal's provision to mandate the Parole Board consider three additional factors for "geriatric parole" applicants: the nature of the conditions, diseases, syndromes or infirmities and the level of care; the amount of time the person must serve before becoming eligible for release; and the person's current age and their age at the time of the crime. Finally, we acknowledge that the extent of the Commissioners' determination to certify an individual for "geriatric release" and send them to the Parole Board is limited to matters of health and not an individual's risk to public safety, which is already assessed by the Board. We welcome and agree with this change.

For decades, the narrow medical criterion used to determine whether or not an individual was released on medical parole was based on their ability to self-ambulate in light of their serious condition. Despite recent changes to the Executive Law, which broadened this medical standard beyond self-ambulation, few people are still granted medical parole. If implemented appropriately and as intended, we believe that certifying "geriatric parole" applicants based on a condition "exacerbated by age, that has rendered the person so physically or cognitively debilitated or incapacitated that the ability to provide self-care within prison is substantially diminished" will lead to better, safer, and more humane outcomes. To ensure that this better health standard is not convoluted with criteria or procedures of the past, the new "geriatric parole" proposal should be amended by removing language related to self-ambulation—"…and a statement by the physician of whether the [incarcerated person] is so debilitated or incapacitated as to be severely restricted in his or her ability to self-ambulate…" Such language is proven to lead to poor outcomes, is inconsistent with the new, broader language, and is potentially contradictory to the overall intent of the proposal.

While we are cautiously optimistic by some components of this proposal, others are deeply concerning. To start, the initiative excludes some incarcerated older people based exclusively on crime of conviction—people convicted of murder in the first degree, aggravated murder, a conspiracy to commit first degree or aggravated murder, and those serving life without parole sentences. This provision is rooted entirely in retribution and not evidence. Older people convicted of the most serious crimes in New York and beyond are least likely to return to prison after being released despite the serious harm they may have caused. Between 1985 and 2012, only 1.9 percent of people released after serving time for a murder conviction returned to DOCCS custody on a new commitment, compared to 14.5 percent of all people released during the same time period. Additionally, by excluding certain people based on crime of conviction, New York guarantees that some older people will die in prison, effectively reinstating the death penalty in New York. **If our state truly values compassion, mercy, and rehabilitation, then this new policy will be inclusive of all people regardless of their crime.**

Similarly retributive is the continued use of Executive Law language that allows the Parole Board to determine medical parole release, as well as discretionary parole release, based on whether or not their "release is not incompatible with the welfare of society and *will not so deprecate the seriousness of the crime as to undermine respect for the law*," (emphasis added). This punitive language is used in boilerplate fashion in the standard parole denials of tens of thousands of currently and formerly incarcerated New Yorkers. It allows the Parole Board to deny someone based solely on the nature of their crime. **Denying "geriatric parole," medical parole, or discretionary parole based on one, unchangeable factor runs fundamentally counter to the philosophy of rehabilitation and the intent of this pending initiative. Such language should be removed from this proposal and all other Executive Law statutes in which it appears.**

The Governor's proposal does nothing to better trigger or accelerate the process by which DOCCS, approved medical professionals, and the Parole Board evaluate individuals for release. In fact, the 30-day comment period this proposal gives to the Sentencing Court, relevant District Attorney, and others before the Parole Board is able to conduct a "geriatric parole" interview is twice as long as the 15-day waiting time included in the existing medical parole statute. Medical parole in New York is often so slow-moving that many medical parole applicants already certified by DOCCS and relevant medical staff die prior to their interview with the Parole Board. **DOCCS' most recently published data on medical parole shows that between 1992 and 2014, 108 of the 525 total certified medical parole applicants died prior to their Parole Board interview.** In order for "geriatric parole" to prevent death and meet its intended purpose of releasing more people, it must be amended to include strict and urgent time limits on the various procedures included in the proposal. DOCCS should also create rules that require facility medical providers to do initial "geriatric parole" screenings for people aged 55 and older with serious chronic illnesses to see if such incarcerated people might be eligible for medical parole. This process requirement could begin in the RMUs and DOCCS' hospice units.

As is the case with discretionary parole release, neither the current medical parole process nor the "geriatric parole" proposal offers crime survivors and victims any opportunity to understand who incarcerated people are today. Those who may have been harmed by a medical parole applicant years or decades ago are asked to support or oppose release without being provided any information related to the applicant's health condition, rehabilitation, in-prison conduct, or current risk to public safety. Unless through outside means, survivors and victims of crime have no way of knowing the degree to which incarcerated people have taken steps to express remorse or take accountability—information often critical for their healing process. "Geriatric parole" could by strengthened by creating a voluntary and HIPAA compliant mechanism by which crime victims and survivors have the opportunity to better understand who an incarcerated person is today. Such information should also be accessible to the District Attorney, Sentencing Court, and all others to whom the Parole Board sends notification for comments.

Finally, DOCCS should use the "geriatric parole" proposal to create more transparency and accountability that has rarely if ever existed with medical parole. The most recently published and available DOCCS medical parole report is dated May 2015 and while providing some information, lacks the detail and data required to adequately inform advocates and the public. Medical and "Geriatric Parole" reports should be published and accessible on DOCCS website at least annually and include HIPPA compliant information related to medical parole applicants' demographics and health conditions (general medical conditions, crime of conviction, race, gender, age, etc.). Such reports should also include more detailed summaries of the number of applicants who reached each of the various phases in the application processing.

Coupling the positive components of the proposal with the aforementioned recommendations would likely meet this administration's intended outcomes of more compassion and cost-savings. We hope that this proposal promotes the release of more older people with hard-to-manage conditions and is a catalyst for the expanded use of medical parole for all eligible people.

Beyond Medical Parole: "If the Risk is Low, Let Them Go"

While some incarcerated older people are sick enough to qualify for medical or "geriatric" parole, most aren't. Despite the welcomed, proposed addition to medical parole, thousands of incarcerated older people will continue to languish and despair in prison despite in-prison accomplishments and a minimal risk to public safety. This comes at a great human cost to them and their loved ones and a growing financial cost to all New Yorkers.
Incarcerated older peoples' wellness should not limit opportunities for release—older people should not have to become ill in order to be considered worthy of returning home. People should be able to come home before they're stricken with a debilitating illness. If New York truly values compassion, redemption, and rehabilitation, and seeks to reduce the costs associated with incarcerating older people, then much more is needed to end the mass incarceration of older people in New York. Additionally, such a move makes fiscal sense. Releasing elders when they are still able to care for themselves and contribute to society is clearly more cost effective than releasing them only when they require additional public healthcare spending.

Of the many parole reform initiatives RAPP supports, we believe that two in particular are most important and thus should be prioritized in this budget and legislative session:

1. **Presumptive Release:** Parole Board decisions should be rooted in a holistic and lawful evaluation of the factors outlined in the Executive Law and not reliant on the punitive introductory language of the statute, which allows the Board to deny release based on one, unchangeable factor: the nature of the crime. The Governor and legislature should take the

appropriate steps to require the Parole Board to release individuals unless there is a clear, unreasonable and current public safety reason to keep them in prison.

Assembly Member Weprin's proposed bill—A.7546—would do just that and require a presumption of release on incarcerated peoples' subsequent Board appearances, unless the Board determines that an incarcerated person poses an unreasonable, current public safety risk. To be clear, this legislation would not be necessary if the Parole Board adequately and fairly determined release based on evidence-based public safety standards. However, their practice indicates an unwillingness to do so. Therefore, the Governor and legislature should legislate this change this session.

2. **"A Second Look":** We also believe that older people 55 years of age plus who are not parole-eligible, serving prison terms that amount to death sentences, should be given a "second look," and appear for parole consideration after serving 15 consecutive years. **Based on an overwhelming quantity of evidence indicating that incarcerated people typically engage in meaningfully transformative and rehabilitative change within 10-15 years of their incarceration, combined with the incredibly low-risk older people pose to public safety, some states are already engaging in this sort of initiative.** Decades-long and life sentences pose as nothing more than harmful punishment at great costs to all New Yorkers.

Elder Reentry and Continuity of Care:

The legislature and Governor should also ensure that the unique health needs of older people are met after being released from DOCCS custody. Upon release, older people face particular barriers in seeking employment, accessing healthcare and community resources, reconnecting with family, using technology, and especially finding housing.

In 2016, 58 percent of older people—1,699 people—were homeless immediately upon release from a DOCCS prison. Of these people, 1,198 went directly from a NYS prison to a homeless shelter. Such a dearth of housing and community resources significantly decreases the likelihood that older people experience a safe, secure, and healthy reentry process. To address this, RAPP formed the Aging Reentry Task Force—a collective of community-based organizations focused on older adult reentry—and recently partnered with the New York City Council to pass Intro 1616, the Compassion and Assistance for Reentering Elders or CARE Act, which establishes an interagency task force to further examine the needs of older adults returning from incarceration. The administration and members of the legislature should work directly with community-based organizations that support formerly incarcerated older people and allocate the resources needed to ensure successful elder reentry.

Conclusion:

While Governor Cuomo's calls to reform New York's criminal legal system are potential steps in the right direction, much more is needed to bring meaningful changes to safely and effectively practice justice in New York. In regards to incarcerated older people in particular, the values of mercy and redemption must be at the center of bolder, more transformative measures that go beyond "geriatric parole." Fundamental change to the Parole Board is needed, and short of a mass clemency program, is the only way to release the significant number of older people whom the Board ought to release. **Without such changes, aging in prison will continue to be New York's new death penalty.**

RAPP's priorities and suggestions will require political will from the Governor and all branches of state government across the political spectrum. We hope that all parties work with us and listen to the statewide community of formerly incarcerated leaders, families, and concerned New Yorkers. Taking meaningful and expanded action to release older people in prison will prevent death, despair, aging, and illness behind bars, and under Governor Cuomo's leadership, make New York a true leader in the struggle to end mass incarceration. Thank you for consideration and we look forward to working with you.

Attachments: 2018 Health Budget Hearing Executive Summary

For further questions and inquiries, please contact Dave George, Associate Director of RAPP, at 631-885-3565 or ddgeorge23@gmail.com.