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## **NATIONAL HOSPICE AND PALLIATIVE CARE MONTH SHOULD RAISE AWARENESS FOR ALL OF THE PEOPLE WHO ARE ELDERLY AND TERMINALLY ILL – INCLUDING THOSE WHO ARE IN PRISON**

### **Statement of the John Howard Association November 20, 2019**

November is National Hospice & Palliative Care Month, an appropriate time to draw attention to the importance of using more humane and effective ways to treat and manage elderly and terminally ill people in Illinois prisons. JHA has long stressed the importance of Illinois finding alternatives to address this growing problem, which is both extremely concerning from a human rights lens and an inefficient use of limited resources. This includes expanding hospice and palliative programs. JHA has been pleased to see an increased number of facilities offering such care and training to incarcerated caretakers in recent years, as we called for in our 2012 special healthcare and subsequent reports.

Hospice and palliative care programs promote and acknowledge the humanity of patients and caretakers. Often these programs allow for modifications to the harsh institutional prison environments and interactions, through providing or allowing things like non-standard bedding or property, rooms with colorful murals, or simply companionship and kindness. Dignity and caring are promoted in these programs, aspects of life that are too often seen as incompatible with prison operations and management. While we celebrate the efforts of those creating space for humane end of life and other needed medical and assistive care within Illinois prisons, Illinois has not yet undertaken the needed research and planning related to anticipating these increasing system demands. As JHA and others have continually recommended, to appropriately confront and address the exponential growth of the elderly prison population and the rising cost of correctional healthcare, these issues must be acknowledged.

In our 2016 cumulative prison monitoring report, we wrote of how “[w]e continue to observe healthcare unit (HCU) resources being devoted to dying inmates who do not need to be in secure settings, while inmates with treatable conditions report that they cannot take advantage of limited healthcare services onsite... JHA has also encountered numerous inmates housed in HCUs suffering from dementia to the extent that they have no idea of their surroundings, as well as individuals with significant mobility issues. ...[I]t is hard to see this level of care needed in secure custodial setting as anything other than a misuse of meager resources that is particularly problematic in high security settings.” The need to plan for this reality and best use limited State resources to protect public safety against genuine threats was also noted as a recommendation in the December 2016 final report of the Illinois State Commission on Criminal Justice and Sentencing Reform. In January 2019 IDOC entered into a settlement agreement attempting to address alleged unconstitutional provision of healthcare in the

Lippert class action litigation, which is yet another context that highlights the need to plan for and humanely treat people in prison who are dying.

In 2019, we continue to see people who are terminally ill or severely incapacitated housed in secure settings who very likely do not need to be there. As of June 30, 2019, IDOC's population was reported to be 19.4% over the age of 50. In August 2019, IDOC reported an end of the month count of 136 individuals in prison infirmaries who were considered permanently housed there, meaning they are not expected to ever return to general population housing. In IDOC's Fiscal Year 2019 Adult Offender Population Data factsheet there were reported to be 84 deaths in custody over the past year, 70 of which were classified as natural, with an average age for all deaths of 57 years old. Elsewhere, in monthly Operations & Management Reports, IDOC reported 79 deaths in custody, 40 of which were deemed "expected." JHA continues to advocate for increased transparency and accountability around death in custody reporting and consistency in counting across IDOC facilities.

Part of why some people will die in prison is because of lack of planning and failure to heed recommendations that Illinois ensure great continuity of care and coverage between communities and custodial settings, as IDOC and the Prisoner Review Board (PRB) require that people have somewhere to go meeting their criteria prior to considering early release, even when they deem the person otherwise eligible for release. Disturbingly, JHA continues to find great variation across facilities in their efforts, ability, or willingness to identify and assist individuals in seeking various existing limited mechanisms for medical release, some of which can be done administratively by IDOC and others of which require PRB approval. At some facilities we are told it is the responsibility of the person who is incarcerated to initiate the process, which seems grossly unfair to those who lack outside support and assistance, as this process can require things that are intimidating to anyone, let alone someone incapacitated or on their deathbed - including daunting paperwork, need for funds for copies and mailings, ability to contact medical providers, and having an approved plan for release. We have even heard that submissions must be typed when an incarcerated person may lack any means to do so, although officials assured JHA this written requirement can be waived. In order to be equitable, the path to medical release should be made clear and equally proactively available to eligible individuals.

We do not see why in 2019 someone deemed a minimum-security risk with less than 6 months left on his sentence for a Class 4 (lowest level) felony with family support would die in custody, other than lack of reasonable planning, assistance, or options. It is of little, but some, comfort to know that because of the existence of hospice and palliative care within IDOC, this man and others had or will have some compassion and people inside our prisons who tried to assist him until the end, if no mercy.

Again, we reiterate that Illinois must focus efforts so that there will be a reasonable way for some individuals to obtain alternate placement, compassionate release, medical release or clemency where appropriate, when they do not pose a threat to society. Meanwhile we are grateful for the efforts and support of hospice and palliative care programs in IDOC, and hope to see availability systemwide coupled with robust support and training for staff in assisting and obtaining alternative placements where appropriate going forward.

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