

Compassionate Release Proposal

Insights, Findings, and Actionable
Recommendations to Strengthen North
Carolina's Compassionate Release Program

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Project Overview

Research on compassionate release programs nationwide suggests that North Carolina's holds significant promise but remains underutilized. Few prisoners ultimately secure compassionate release despite recent expansions in the law's eligibility criteria and an increasingly elderly prison population. When otherwise eligible individuals are not referred for medical release, the State incurs avoidable costs and terminally ill individuals are denied the dignity the North Carolina legislature intended to provide them at the end of life.

This outcome serves no one. The Department of Adult Corrections, advocacy organizations across the state, and the prisoners directly affected all share a common goal: a robust compassionate release program that functions as intended. The question, then, is not one of purpose, but of implementation—if we are all aligned on the goal, what barriers are preventing the program from working as it should?

In Fall 2025, our Clinic set out to answer that question. After confirming with DAC Chief Operating Officer Tammera Hill that strengthening North Carolina's Compassionate Release program is indeed a shared priority, we partnered with organizations already engaged in this work. We teamed up with FMM and the Wilson Center to identify where we could contribute most effectively and found that our role was best suited to building relationships with—and soliciting input from—those directly involved in the program's day-to-day operation. By meeting personally with physicians, DAC administrators, and other key stakeholders, we sought to develop an intimate understanding of how the program functions in practice and to identify realistic opportunities for improvement.

Through our meetings, we identified barriers we believe to be hindering the program from reaching its full potential and identified ways to respond to the most pressing issues. In this proposal, we aim to communicate our findings and ultimately contribute to the development of a more effective Compassionate Release Program through which candidates can be more readily identified and assisted. We are so appreciative of NCDAC's interest in this project and look forward to continued collaboration.



North Carolina's Compassionate Release Program: Objectives & Implementation

Purpose: In 2008, the North Carolina Legislature passed the Compassionate Release Statute in response to findings that a very small percentage of aging prisoners were accounting for a disproportionately large and growing percentage of the DAC's budget. In 2023, the legislature expanded eligibility criteria with the hopes of increasing the release numbers of seriously ill and aging prisoners. However, there has been no notable increase in either referrals or releases under the program in the years since.

Eligibility: To qualify for compassionate release, an incarcerated person must fall into one of the below categories:

1. Permanently and totally disabled
2. Terminally ill
3. Geriatric (55+)

The potential candidate must also

- Have a comprehensive "Medical Release Plan" detailing their proposed site and course of treatment after release (including documentation showing financing and that a medical provider is willing to provide services); and
- Be in minimum custody and be determined to "pose[] no risk or low risk to public safety."

Exclusions: Those convicted of capital or class A, B1, or B2 felonies or sexual offenses that require registration.

Referrals: According to the statute, an incarcerated person, their attorney, or their next of kin may submit a request or petition to the DAC for medical release consideration. The request may be made in writing, either via letter or by using the Medical Release Request form on the DAC website, to the Division of Comprehensive Health Services. Additionally, the DAC can make a referral based on a "recommendation from within the Division."



N.C. Gen. Stat § 15A-1369

State of North Carolina
Department of Public Safety
Prisons [Policy and Procedure](#) on Medical Release of Ill and Disabled Offenders

Families Against Mandatory Minimums
[Pamphlet on Compassionate Release in North Carolina](#)



UNC Clinic Project: Our Methodology & Approach

Collaborate with existing compassionate release projects

FAMM & the Wilson Center for Science and Justice at Duke University School of Law

1

Network with political stakeholders

Experts supporting reentry within the Stein Administration

2

Meet with physicians caring for prisoners within DAC

UNC-Contracted physicians in Oncology, Psychiatry, Gynecology, etc.

3

Consult with DAC personnel involved in later stages of the medical release process

Personnel in Social Work Services

4

Consolidate findings and confer with project partners to identify most pressing issues to pursue

FAMM & the Wilson Center for Science and Justice at Duke University School of Law

5



Overview of Identified Areas for Improvement from Research & Experts in the Field

1

Ambiguities in the Statute's Text: No authoritative interpretation from the legislature or DAC leadership regarding ambiguities in the statute's text, leaving experts and patients with little or contradictory guidance on the application process and medical release decision procedure.

2

Ambiguities in the Program's Referral Process: Unclear messaging regarding which physicians can make patient referrals and how they should do so; lack of education and training on referral process among other facets of the Compassionate Release Program.

3

Incorrect Application of Unambiguous Statutory Provisions: Geriatric category of statute treated in practice as requiring same heightened showing of incapacitation where it should be afforded status as a distinct eligibility category.

Issues (1) – (3) (**Stage 1**) represent threshold barriers to the program's success that are uniquely within DAC's capacity to address. In the pages that follow, we describe these challenges alongside what we hope are low-lift, practical solutions that would significantly advance our shared objectives. We are, of course, happy to support DAC's efforts on these initial steps in whatever way would be most helpful.

Once these foundational issues are resolved, whether through the approaches we suggest or alternative means, issues (4) and (5) (**Stage 2**) become more viable. While these latter efforts are more resource-intensive, we and our community partners welcome the opportunity to take them on in close collaboration with DAC, with the understanding that these efforts can be best pursued once the initial barriers are addressed.

4

Unclear Referral Process: Physicians are unaware of any centralized system to submit and monitor referrals, which many medical providers have expressed hinders their ability to assist patients who may be eligible under the program.

5

Barriers to Reentry: In addition to referral barriers, a significant hurdle to the program's success is the hesitancy of community medical providers (i.e., nursing homes) to accept justice-involved patients, resulting in difficulty finalizing required Medical Release Plans and ultimately securing release.



Ask #1: Internal Memo to Clarify Statute Interpretation

The Problem:

Physicians, advocates, and patients feel they have little or contradictory guidance on the application process. Some confusion derives from ambiguous statutory text and the lack of an authoritative stance from DAC on the meaning of key phrases.

Identified Ambiguities:

1. **“Division”**: The statute states that a compassionate release referral may be based “upon a recommendation from within the ‘Division.’” The term “Division” is presumably a relic from the old naming convention of the “Division of Prisons,” but it remains unclear who qualifies as someone within the “Division.” For example, DAC’s most recent Policy & Procedure [memo on medical release](#) says, “Medical staff within institutions,” while the Parole Commission [Manual](#) says “medical staff of the Section of Adult Facilities” (p. 43). This language causes confusion among professionals and patients, possibly preventing eligible individuals from being referred to the program by those authorized to make such referrals. UNC physicians contracting with DAC are unsure whether or not they qualify to make referrals under the existing guidance.
2. **“Risk to public safety”**: The statute doesn’t define criteria the Post-Release Supervision and Parole Commission ultimately consider when determining risk posed by the candidate. But it appears the Commission rarely, if ever, rejects a candidate who has received a positive DAC recommendation. Thus, the process surrounding the DAC risk assessment is an important point of clarity for advocates and patients.
3. **“Medically Incapacitated”**: The statute does not define what “medically incapacitated” means, nor does there appear to be a clear definition within the medical community. However, the phrase seems to be interpreted narrowly, which has made it more difficult for patients to meet eligibility criteria.
4. **Safety Risk Assessment**: While the general understanding is that the Classifications Section of Prisons handles this critical step in the process and relays their assessment to the parole commission, it is unclear which department personnel assesses a candidate’s safety risk in practice. The lack of transparency on this point causes concern that an expert with the role of evaluating medical condition is serving a dual function of risk-assessor. Given that those in Classifications are specifically trained/equipped with the breadth of knowledge needed to make this complicated and nuanced determination, putting in writing that it is within their exclusive purview to do so would ease concerns about role-blending and allow advocates to better understand the process.

Identified Solutions:

- **Policy Update & Circulated Memorandum**: The most effective way to clarify the above issues is to update and recirculate DAC’s implementation policy on the Compassionate Release Program through a memorandum. This would make clear to DAC personnel, medical professionals, patients, and the public at large how the program works, thereby addressing one of the most significant barriers to eligibility.
- **Clarifying Incapacitation**: Defining “medically incapacitated” to incorporate “Activities of Daily Living” factors (bathing, dressing, toileting, transferring continence, and feeding) provides greater clarity for patients, medical providers, and DAC alike, and makes the application and review process more accessible and easier to navigate.
- **Clarifying Classification**: Limiting the safety risk assessment to the exclusive purview of Classifications and the Parole Commission is most sensible given their specialized expertise and would clarify ambiguity surrounding the process.



Ask #2: Internal Memo & Increased Trainings to Clarify Program Referral Process

The Problem:

There is currently unclear messaging regarding not only which physicians can make patient referrals, but also how they should do so. For example, a DAC [policy statement](#) on the medical release process points to the DC-293 Medical Information Form. However, we were unable to locate this form. Speaking with medical providers and other experts in the field confirmed this, as these individuals were also uncertain about how the referral process works. This reflects a broader problem hindering the Compassionate Release Program: an overall lack of education and training on the program available to medical providers.

Identified Solutions:

- **Policy Update & Circulated Memorandum:** Circulating a memorandum to all UNC Contractors and Health Services Leadership would ultimately help medical professionals best assist patients who would otherwise be eligible under the program. Circulating the memo to these groups of medical professionals would likely also result in further circulation within their groups and others in the field, so all individuals know what to look out for under the program. This memorandum should provide active links to all available forms for referral.
- **Encouraging Medical Providers to Attend Webinars:** Several organizations and individuals have developed webinars specifically designed to educate medical providers on compassionate release. It would be helpful if DAC could encourage providers to attend these webinars and endorse them, since many medical providers are unaware they exist. Additionally, our organizations would be happy to assist DAC in developing specially designed webinars to train individuals. With respect to other resources, FAMM has created several comprehensive guides on North Carolina's Compassionate Release Program that detail the consideration process and how to make a referral. We have attached a few of them to this correspondence for reference. These resources can easily be circulated alongside a memorandum to inform providers on training options available to them while at the same time not requiring additional DAC resources to implement.



Ask #3: Internal Memo to Clarify Eligibility Categories

The Problem:

While there are three different categories under the statute (“permanently and totally disabled,” “terminally ill” and “geriatric”) with different standards applied to each respectively, in practice they are being interpreted the same way when eligibility determinations are made. In particular, the geriatric category – which has a relaxed incapacitation standard compared to the others – is not being correctly analyzed. This has made it significantly more difficult for otherwise eligible individuals to obtain relief under the statute. Additionally, as previously mentioned on **Page 7**, the lack of clarity on the meaning of “medically incapacitated” presents another barrier, further complicating interpretation of the three eligibility categories because patients, medical providers, and DAC personnel alike lack clear guidance on who qualifies under these three categories.

Identified Solutions:

- **Circulated Memorandum or Clarifying Policy Statement:** A memorandum clarifying the different categories under the statute, the differences in analyzing eligibility under each of these respective categories, and the meaning of key terms such as “medically incapacitated” will help ensure that individuals are well-informed about the program’s criteria and will support DAC personnel in consistently applying the statute correctly when evaluating submitted requests. One option is to include in the memorandum a chart outlining the three different categories and their respective requirements, specifically calling attention to the differences in level of impairment required to qualify. Below is a proposed chart:

Eligibility Category	Diagnosis	Prognosis	Impairment	Additional Information
(1) Geriatric	Infirmity, illness, or disease	Chronic	Medically incapacitated	Age 55 or older & Low or No Public Safety Risk
(2) Permanently and totally disabled	Physical or medical condition	Permanent and irreversible	Permanent and total disability	Condition was unknown at time of sentencing & Low or No Public Safety Risk
(3) Terminally ill	Illness or disease	Incurable and likely to produce death within 9 months	Debilitating	Condition was unknown at time of sentencing or has progressed since sentencing to become terminal & Low or No Public Safety Risk



Recap of Asks 1–3 (Stage 1)

Relevant to all three of these proposals is a goal of the DAC as laid out in the [DAC Strategic Plan for 2023 – 2025](#): to **increase transparency of NCDAC’s missions and operations by increasing employees’ awareness/understanding of operational decisions and requirements through improved internal communication and to share the positive things being done to the public through external communications.** A priority question identified was: How can NCDAC strengthen engagement with community partners? We believe these proposals provide a way to serve those goals.

VISION

All divisions of the Department of Adult Correction will work collaboratively to create a safer North Carolina.

MISSION

All divisions of the Department of Adult Correction protect the public by collaboratively focusing on rehabilitation, protection, innovation, accountability, and professionalism.

VALUES

Protect: We will strive to uphold and enforce the law as our duty to protect the public, staff and offenders.
Respect: We will perform our duties with respect for all.
Integrity: We will maintain the highest levels of integrity.
Diversity: We will embrace diversity, equity, and inclusivity as we fulfill our mission.
Excellence: We will strive for excellence.

As previously mentioned, our focus now is on collaborating with DAC to address the barriers to eligibility under the Compassionate Release Program identified above. We believe that only once these are improved will it be feasible to work on the more resource-intensive tasks of improving the referral process at large and addressing the barriers to reentry (“Stage 2”). The items below, therefore, depend on first addressing the barriers to eligibility and widening the pipeline of individuals who can access the benefits of the program as intended by the legislature. With that in mind, below is a brief explanation of these issues to provide some insight into our long-term goal of partnering to make the program more robust, efficient, and cost-effective for DAC.



Stage 2 – Insights and Forward-Looking Areas for Improvement

More on Area for Improvement #4: Referral Process



The lack of a centralized system for physicians to submit and monitor referrals has significantly delayed the program after an initial eligibility determination has been made. While medical providers are eager to assist patients who are eligible, they are managing many other tasks and responsibilities. Having a more efficient system would facilitate this process while at the same time ensuring that eligible patients are released at a faster rate. Some physicians with whom we have spoken suggested creating a form that they could quickly enter the system just as they can enter forms related to medical treatment.

More on Area for Improvement #5: Barriers to Reentry



For a medical release candidate, overcoming the hurdles to eligibility is not sufficient to be granted relief under the program. A recurring theme we have heard from experts is that many patients are not able to be released because of a lack of secured housing options available to them. Because many would require placement in nursing homes upon release – and many facilities refuse to accept formerly incarcerated individuals – options are often severely limited. This is particularly troubling given that patients are required by statute to have a post-release plan, meaning the lack of housing is a barrier to release in the first place.

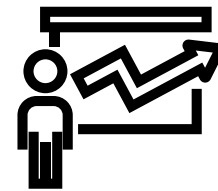
We do believe there are viable arguments to be raised under federal and state law that would limit the ability of nursing homes to have blanket bans against providing housing options to formerly incarcerated individuals. These are avenues our organizations are interested in exploring to assist DAC's social workers and legal team in this critical step of the medical release process.



Summary of Proposal & Solutions

Through collaboration and ongoing research, our organizations have identified several barriers limiting the ability of the Compassionate Release Program to be as robust as it has the potential to be. These primary issues include: (1) ambiguities in the statute's text, (2) ambiguities in the program's referral process, and (3) inaccurate implementation of the statute's eligibility categories. We believe that these issues can most easily and effectively be addressed by DAC, and our organizations are here to support DAC's efforts in any way possible.

As explained above, we hope the solutions we have proposed are low-lift, practical ones that would at the same time make a significant difference for patients, community advocates, and the DAC alike. Our goal through all of this is to advance our shared objectives in meaningfully assisting patients in receiving care at the end of their lives while at the same time reducing costs for the State.



Our solutions here can be summarized below:

- **Clarifying the questions experts and patients have regarding the statute**
- **Preparing and circulating a memorandum internally with these clarifications. This memorandum should also be posted in all DAC facilities throughout the state and the information therein should be made available to the public**
- **Encouraging DAC staff, medical experts, and other individuals central to the Compassionate Release Program to attend webinars and other trainings on the program**



Committed Community Partners

Each individual listed below has contributed in some way to these findings and/or recommendations and has expressed enthusiasm for helping to improve North Carolina's Compassionate Release Program. Their contact information is provided should the DAC require assistance in implementing improvements to the Compassionate Release Program.



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