PLS NOTES

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FCC Caps Prison Phone Rates Nationwide

The Federal Communications Commission (FCC) on October 22 announced comprehensive regulations of Inmate Calling Service (ICS), capping 12 years of proceedings. The impact of testimony from scores of prison families, prisoners, activists and attorneys was evident in the FCC's declaration that "we answer the call of those millions of citizens seeking ICS reform." The announcement stated:

> While contact between inmates and their loved ones has been shown to reduce the rate of recidivism, high inmate calling rates have made that contact unaffordable for many families, who often live in poverty. Reducing the cost of these calls measurably increases the amount of contact between inmates and their loved ones, making an important contribution to the criminal justice reforms sweeping the nation.

This Order, which was issued on November 5, 2015, will benefit prison telephone consumers in every state, including Massachusetts, by setting rates that apply to both in-state (or "intrastate") and interstate calls. PLS is proud to be among those who pressed the FCC for reform, channeling the voices of the many prisoners and loved ones who have written to us. At the same time, the challenge to Massachusetts rates that PLS initiated in 2009 remains pending before the Department of Telecommunications and Cable.

The FCC Order

The FCC's Order will go into effect in prisons 90 days after publication in the Federal Register, and will go into effect in jails 6 months after publication, though prison telephone companies are likely to challenge the regulations in court and may seek to stay the new rates and reforms. The Order establishes the following:

1. **Rate caps depending on the size of the facility:** The FCC determined that the cost of providing prison telephone service is higher in smaller facilities, because (1) the population turns over more rapidly and thus the provider must open and close accounts more often, and (2) calls are shorter, requiring the provider to initiate more calls. So it established tiered rates depending on the size of the facility
   - 11 cents/minute for debit and prepaid calls in state or federal prisons.
   - 14 cents/minute for debit and prepaid calls in jails with 1,000 or more inmates.

- 16 cents /minute for debit and prepaid calls in jails with 350-999 inmates.
- 22 cents /minute for debit and prepaid calls in jails of up to 349 inmates.
- Collect call rates will be slightly higher in the first year and will be phased down to these caps over a two-year transition period.

2. **Other fees ("ancillary service charges") are strictly limited:**
   - Automated payment by phone or website: $3.
   - Payment through a live agent: $5.95.
   - Paper bill fee: $2.
   - Third-party financial transaction fees, such as fees charged by MoneyGram or Western Union, may be passed through with no mark-up.
   - No other ancillary service charges are allowed.
   - Mandatory taxes and regulatory fees may be passed through with no mark-up.
   - Minimum pre-payments are prohibited, and maximum payments may be no less than $50.

3. **Discourages but does not ban payment of "site commission" by telephone companies to correctional facilities:**
   - The FCC reaffirms that site commissions (kickbacks) are profits, not a cost of providing ICS.
   - The FCC excluded the payment of site commissions from the service providers to the correctional facilities from its determination of the tiered rate caps.
   - While the FCC does not prohibit providers from paying site commissions, it strongly encourages parties to move away from site commissions and urges states to take action on this issue.

4. **Bans flat-rate calling**
   - Disallows providers from imposing so-called "flat-rate calling," that is, a flat rate for a call up to 15 minutes regardless of actual call duration.

5. **Facilitates access for people with disabilities**
   - Requires providers to offer free access to telephone relay service (TRS) calls for inmates with communications disabilities and applies a steeply discounted rate (25% of the regular phone rates for that facility) for TTY-to-TTY calls.
   - Reminds correctional institutions of their obligation to make TRS available to people with communications disabilities.
   - Encourages jails and prisons to allow commonly used forms of TRS such as videophones and requires the facilities to report service quality issues.

6. **Further Monitoring and a Third Further Notice of Proposed Rulemaking.**
   - The FCC will require the telephone companies to provide data on their costs and revenue in two years.
   - The FCC issued a third rulemaking notice seeking comment on several issues, including:

     6.a. Rate caps for international ICS.

     6.b. How to promote competition in inmate calling services to reduce the need for regulation.

     6.c. The use, costs and rates of video visitation and other advanced

inmate communications, services, and whether these services could be used to circumvent traditional ICS rates.

6.d. The use of revenue-sharing agreements and whether additional reforms are necessary

6.e. Whether the FCC should adopt a recurring mandatory data collection and submission of contracts.

6.f. What the implications are of providing video phones for deaf and hard of hearing prisoners who communicate via American Sign Language.

7. **The FCC encourages states to take further action.**

- States may not permit rates that exceed the new, federal limits. At the same time, the FCC made clear that states may set lower rates. "[T]here is no credible record evidence demonstrating or indicating that any requirements that result in rates below our conservative caps are so low as to clearly deny providers fair compensation. Evidence in the record shows that ICS can be provided at rates at or below $0.05 a minute. We applaud the effort some states have made to lower ICS rates and hope other states follow their lead."

The Massachusetts Proceeding before the Department of Telecommunications and Cable.

PLS in 2009 filed a petition on behalf of prisoners, their family members and attorneys challenging Massachusetts telephone rates and the quality of prison telephone service. In response to the telephone companies' motion to dismiss, the Department of Telecommunications and Cable (DTC) held that the Petitioners could challenge the per-call surcharge, which is currently limited to $3.00 by state law, but could not challenge the current limit on per-minute charges of $0.10. The DTC has taken no action in this case since motions to compel discovery were completed in September 2104, perhaps awaiting FCC action.

The FCC's new rates, if and when they go into effect, will bar all surcharges on prison phone calls in Massachusetts. The order will also eliminate many fees tagged on to prison phone calls by the phone companies and strictly limit others. Both of these are major goals sought in the DTC petition. The Massachusetts limit of $0.10 per minute is lower than the new tiered rate caps set by the FCC. PLS will vigorously oppose any effort by the phone companies to raise the per-minute rate from $0.10 per minute up to the new FCC rates. PLS is also assessing whether, in light of the FCC's encouraging states to set even lower rates, DTC may be willing to reconsider its previous ruling that we cannot challenge the existing $0.10 per minute cap. Finally, PLS still has pending before the DTC complaints about the quality of prison telephone call connections, dropped telephone calls, and the companies' billing practices.

PLS SUIT ENDS DOC POLICY THAT CONTINUOUSLY

EXTENDED DEPARTMENTAL DISCIPLINARY UNIT (DDU) SENTENCES

When the DOC revised its disciplinary regulations in 2006, 103 CMR § 430, as revised, appeared to eliminate a harsh and counter-productive policy affecting prisoners in long-term segregation in the Departmental Disciplinary Unit. The new regulations no longer authorized a practice whereby DDU prisoners lost a month of credit toward serving DDU sentence for each month in which they were convicted of ordinary (non-DDU) disciplinary violations. (Under the old regulation, DDU prisoners lost credit if convicted of one major offense or two minor offenses.) In reality, of course, this "loss of credit" really just added a month to the DDU sentence without any new DDU conviction. As a result, some prisoners were trapped for months or years beyond the original expiration date of their DDU sentence, one for 18 years, as the effects of solitary confinement made it harder for them to conform their own behavior to prison rules. So removing this policy from the regulations at first seemed like a step forward.

Yet even after the regulations changed, DOC did not end the loss of credit policy. DDU prisoners were still subjected to extensions of their DDU sentences if they received D-reports in the DDU even though the policy now clashed directly with the disciplinary regulations. For example, prisoners who committed offenses not eligible for a DDU sanction (the lesser, Category 3 and 4 offenses) were effectively sentenced to an extra month in the DDU if they committed two or more such offenses in one month. Even prisoners serving the longest allowed DDU sentence of 10 years were held beyond that maximum when they "lost credit" toward their sentences.

In 2012, prisoners Eugene Ivey and Francis Lang – both of whom had their DDU sentences extended by over a year -- sued to stop the practice, represented by PLS. And in August they prevailed. In *Ivey et ano. v. Commissioner of Corr. et al.*, - Mass. App. Ct. -, 35 NE2d 757 (August 13,2015), the Court ruled that once DOC removed the loss of credit policy from the regulations, it effectively repealed the policy. Thus it violates the disciplinary regulations to deny credit against a DDU sentence for ordinary disciplinary convictions.

As a result, DDU prisoners may no longer have time added to their DDU sanction unless they are convicted of a new DDU offense with a new DDU hearing, as required by the regulations. DOC has recalculated the DDU sentences of prisoners now in the DDU to eliminate the extra months added on by the loss of credit policy. PLS has heard from prisoners who have been freed from extra months of isolation in the DDU, which is gratifying. The mystery remains, though, as to why it was necessary to file this lawsuit, when the DOC itself had changed its regulations to make this senseless policy unlawful.

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Reaching PLS

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Massachusetts State Prisoners: *9004#
Intake hours: Modays 1-4 P.M. (general pop.); 9-11 and 1-4 daily (seg.)
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Upcoming Litigation Against Parole Board Revoction Procedure For Second Degree Lifers

Prisoners' Legal Services is preparing to file a court case challenging the manner in which the Parole Board conducts revocation proceedings for individuals serving second degree life sentences. It is PLS' position that the Parole Board's procedure and the resulting delays violate Massachusetts regulations concerning parole revocations and the constitutional rights of second degree lifers subject to it. The case will seek only declaratory and injunctive relief, not money damages. The goal is to put an end to the Parole Board's improper procedure and the terrible effects that it can have on those awaiting decisions, including the delay in the start date of setbacks.

Please contact PLS as soon as possible if you are a second-degree lifer and: (1) your parole has been revoked in the past six months or (2) you are currently waiting for your final parole revocation decision from the full Board. When you contact us, please let us know the date of each decision and hearing that you have received concerning your revocation and whether you have exercised your right to appeal the Parole Board's revocation decision. If you have not appealed yet, we suggest that you appeal the decision right away and include in your grounds for appeal that the Parole Board's procedure and the long delay in issuing your revocation decision violated your constitutional right to Due Process and applicable Massachusetts regulations. Appeals must be filed within 30 days of the date you received the written decision. Be advised that you must appeal the Parole Board's decision if you wish to be eligible for inclusion in PLS' intended court case.

PLS Legislative Priorities for the 2015-2016 Legislative Session

PLS will concentrate on the following bills in the two-year legislative session that ends in January 2017. We provide the official title of the bill, its Senate or House number, the name of the chief senator or representative sponsor(s) of the bill, and a brief explanation of its purpose.

Medical Placement of Terminal and Incapacitated Inmates

S.843, Sen. Pat Jehlen, H.1628, Rep. Tim Toomey

Old, Sick and Dying in Prison: There's a Better Way

Massachusetts should not spend tens of millions of dollars to keep dying people who are not a public safety threat in our prisons and jails. Corrections officials and advocates agree: Massachusetts should join the majority of other states and create a way for people who are terminally ill or permanently incapacitated to be placed at alternative locations, such as nursing homes, or in hospice care.

Three Stories Illustrating Why We Need This Legislation

Michael

Michael was a 65-year-old man serving a 5-7 year sentence for insurance fraud. He had been approved for parole with the condition that he serve 6 months pre-release. Then he became violently ill with acute pancreatitis and spent 7 months at the Boston Medical Center. Twenty surgeries later, he was left in critical condition – incapacitated, on a breathing tube and with his abdomen completely open from previous surgeries. Still, there was no way for him to be released to a nursing facility or hospice. While dying at BMC, multiple corrections officers were assigned to watch him, and his wife could only visit him twice a week for short periods.

T**imothy**

Tim is quadriplegic as the result of a spinal cord injury suffered 20 years ago at the time of his offense. . Tim was in the car with three other men and was not the shooter. When he was incarcerated, he was able to sit up in an electronically controlled wheelchair that he controlled with his elbow using a joystick. He could feed himself with assistive devices. Over time in DOC facilities, his joints have stiffened to the point where they cannot be moved. He lies in bed on his back at all times and has required total care by medical staff for years, which DOC is not well equipped to provide.

James

James is over 80 years old. He has been incarcerated nearly 50 years for a felony in which a store attendant was shot by a person James was with. He has suffered from advanced dementia for almost a decade. His limbs are completely contracted and he has been unable to move on his own or speak for several years. James's medical providers confirm that there is no chance that his condition will improve. Because he is bedridden, he has been in and out of the hospital with various infections including pneumonia, MRSA and other staph infections. James has been on a feeding tube since 2008.

An Act Relative to Ensuring Quality Mental Health Services in State Correctional Facilities

H. 1171, Rep. Ruth Balser.
This bill provides for Department of Mental Health supervision of mental health care in the Department of Correction, including review of DOC contracts with vendors of mental health services and the setting of minimum standards for mental health care in prisons.

Why This Matters

In recent decades, Massachusetts prisons have been flooded with prisoners that have mental illness, but have struggled to provide adequate care to these prisoners. One quarter of all male prisoners, and nearly 60 percent of female prisoners, receive mental health care; most of these are prescribed psychotropic medication. Although the DOC contracts with outside vendors for mental health care services, it lacks sufficient expertise to craft and supervise a contract ensuring treatment. Furthermore, the contractor may have a financial incentive to reduce costs, underdiagnoses mental disorders and limit access to clinicians, medications and treatment modalities. Prisoners can wait weeks after an urgent request to see a clinician, generally receive therapy only once a month, , and many go without the medications that managed their

mental illness before incarceration. Without specialized expertise the DOC is unable to adequately monitor these practices. Untreated or undertreated mental illness creates prison management problems and increased recidivism. Too many prisoners are released without the mental health treatment that would enable successful reentry.

What this Bill Would Do

The primary mission of the Department of Mental Health is to ensure that all citizens of the Commonwealth with mental illness receive appropriate treatment. Currently DMH is responsible only for supervising the mental health care of prisoners in segregation units, but this responsibility should be extended to all DOC prisoners. DMH has the necessary expertise that DOC lacks to ensure that minimum standards for mental health care delivery are met. It would review and approve the contract for mental health services, ensuring that its provisions are adequate to ensure appropriate treatment for all prisoners. It would also audit mental health care delivery in each DOC facility twice a year to determine compliance with the minimum standards. By ensuring adequate mental health treatment, DMH supervision will benefit prison management and public safety.

An Act to Provide for Enhanced Public Safety By Reforming the Parole Board

H.1170, Rep. Ruth Balser

This bill calls for changes to the composition of the Parole Board in order to ensure that the Board members have essential expertise. It also enhances public safety by increasing the number of Board members to improve its efficiency and reduce delay.

Why This Matters

Composition of the Parole Board: The existing statute governing appointments to the Parole Board, G.L. c.27, §4, calls for people to be appointed to the Board who have education and experience in “psychology,” “psychiatry,” “sociology,” “social work,” and “law” (other than law enforcement work), as well as people with backgrounds in “law enforcement,” “corrections,” “parole,” and “probation.” Unfortunately, existing law does not require the Governor to make these appointments. In the 1970s and 1980s, Governors honored the intent of the statute and the Parole Board had educators, psychologists, psychiatrists, social workers, ministers, and defense attorneys among its members. More recently, the Board has been dominated by law enforcement.
Expansion of the Parole Board: The Parole Board is overworked. Prisoners with life sentences often face long delays before their hearing can be scheduled, and usually wait months, and sometimes years, before receiving their decisions. The current average wait between the lifer hearing and receipt of the written decision is 262 days, with the longest wait 688 days – almost two years. Two people, both of whom were sick and elderly, died waiting for action by this Parole Board.

In other states, parole boards generally issue decisions within a few weeks of the hearing. Waiting anywhere from eight months to twenty-two months for a decision is fiscally

wasteful, has increased tension and hopelessness in already overcrowded prisons and is disrespectful of prisoners, their families and representatives, as well as victims.

What This Bill Would Do

Composition of the Parole Board: This bill requires that at least three members of the Parole Board be selected from the fields of psychiatry, psychology, social work, or sociology – persons who have the demonstrated expertise to evaluate a person's needs and to predict his or her likelihood of success in the community.
Expansion of the Parole Board: This bill increases Parole Board membership from seven to nine and allows six members to sit as the full Board for the purpose of second-degree lifer hearings. Increasing the number of Parole Board members to nine would expedite hearings and decisions. Allowing six of the nine Board members to hear second-degree lifer hearings, instead of the full Board, would also make scheduling easier and would permit Board members to attend to other duties, rather than tying up the entire Board for every lifer hearing. It would also be more in keeping with intent of recent amendments to the current statute that require a ⅔ vote before a lifer can be paroled.

An Act to Promote Public Safety By Improving the Parole Process

H. 1559, Rep. Dave Rogers

This bill promotes prisoner reentry into society under parole supervision, which, in turn, promotes public safety by assisting prisoners in their transition from an institutional environment back to living in their communities. By the same measure, H.1559 would encourage prisoner engagement in rehabilitative programming and increase prison safety. Having a system of presumptive parole also serves to ensure objectivity and consistency in parole decisions and to significantly reduce corrections costs by increasing parole permits.

The Special Commission to Study the Criminal Justice System and the Boston Bar Association have both recommended that the legislature adopt a system of presumptive parole. These recommendations are well-founded. According to data published by the Parole Board in March 2014, less than 40% of Massachusetts prisoners who had hearings before the Parole Board in 2012 were released to community supervision.1 With the average annual cost of $47,102 to house a Massachusetts state prisoner, failure to maximize parole supervision is costly for taxpayers. Evidence shows that it also bodes poorly for recidivism. A research study conducted by the Department of Correction found that prisoners released without supervision had a reconviction recidivism rate nearly 10% higher than prisoners released with supervision.

Improvements to the Parole Process

H.1559 establishes a rebuttable presumption that prisoners should be released under parole supervision when they are eligible in order to facilitate their successful reintegration into the community. The new language of M.G.L. c.127, §130 would maintain the Parole Board's ultimate discretion in granting parole while shifting the burden to the Parole Board to justify the denial of parole after consideration of a risk and needs assessment.
In addition, H.1559 calls for prisoners serving sentences of two or more years in state

prison or a county correctional facility to be released on parole six months before they complete, or "wrap," their sentences. Only people who are still serving the minimum required term of their sentence and people who have chosen to decline parole release would be exempted from this provision.

An Act to Reduce Recidivism, Curb Unnecessary Spending, and Ensure Appropriate Use of Segregation

S. 1255 / H. 1475, Sen. Jamie Eldridge, Rep. Elizabeth Malia

This proposed legislation seeks to reform the use of segregation in Department of Correction facilities as well as county jails and houses of corrections.

Solitary Confinement Reform

Massachusetts is one of only three states that allow prisoners to be placed in solitary confinement for up to ten years for disciplinary infractions. The Commonwealth also allows prisoners to be placed in long-term administrative segregation for a variety of non-disciplinary reasons. These prisoners are locked in segregation for at least twenty-three hours per day in what is typically a 7x9 foot cell.

Studies have shown that solitary confinement neither deters violent behavior nor reduces recidivism. In Massachusetts, many prisoners are released back to society directly from segregation, traumatized and unprepared for life on the street, making them statistically more likely to recidivate. Persons of color as well as persons who suffer from mental illness are disproportionately represented in segregation units across the country. Voluminous research substantiating the damaging effects of solitary confinement is leading states across the country to pass reforms aimed at reducing costs, reducing the harm to individuals placed in solitary confinement, and reducing the negative impact that overuse of segregation can have on communities.

This legislation will reform the use of segregation in Department of Correction facilities as well as county jails and houses of corrections in several ways.

Provide Greater Protection for Vulnerable Populations

Divert vulnerable groups from solitary confinement, including those with serious mental illness, pregnant women, youth, protective custody prisoners, deaf and blind prisoners, and prisoners who are otherwise likely to deteriorate due to a medical or physical disability.

Allow the commissioner or a designee to still place such vulnerable prisoners in solitary confinement on an emergency basis so long as he/she certifies in writing the reason why the prisoner cannot be safely held elsewhere and the steps taken to locate suitable less-restrictive housing.

Provide for minimum out-of-cell time, programming, and enhanced mental health services for vulnerable prisoners held in solitary confinement on an emergency basis.

Reform Disciplinary Segregation

Limit the use of solitary confinement as a disciplinary tool in the Department of Correction to fifteen days for one offense.

Establish minimum humane standards for disciplinary segregation, including a requirement that prisoners receive at least one hour per day of exercise and recreation (current regulations require that prisoners receive only five hours per week).

An Act to Collect Data Regarding the Use of Solitary Confinement in Massachusetts Prisons / Jails

H.1381, Rep. Russell Holmes

Solitary confinement (or segregation) is the practice of housing prisoners separately from the general population, usually twenty-three hours a day in their cell. The short time prisoners spend outside of the cell is also spent in isolation from fellow prisoners and often occurs indoors or in an fenced , outdoor cage known as a "dog run." A typical solitary cell is 60-to-80 square feet, contains a small metal toilet and sink, and a concrete slab to hold a prison-issued mattress.

This is the reality for more than 80,000 incarcerated individuals on any given day in the United States. And Massachusetts prisoners who commit disciplinary infractions can be sentenced to these conditions for ten-year terms. Yet there is a growing consensus in the scientific community that individuals with mental illness rapidly decompensate in solitary confinement, and that solitary confinement can create mental illness in persons who had no such illness before. Equally troubling are findings across the country that persons of color are overrepresented in solitary confinement, and that prisoners released directly to society from solitary confinement are statistically more likely to reoffend. Citing this developing body of evidence, doctors, public health experts, and advocates around the world are calling for meaningful reform of our solitary confinement practices. The United Nation's Special Rapporteur on Torture now seeks to ban all indefinite or prolonged solitary confinement, which he defines as lasting longer than fifteen days. No law currently requires that Massachusetts correctional facilities publicly report the critical information regarding our state's solitary confinement practices that this bill identifies. This bill would require quarterly reporting from prisons and jails on the number of Massachusetts prisoners in solitary confinement; the length of time spent in solitary confinement; the number of Massachusetts prisoners with serious mental illness who are in solitary confinement; the number of suicides of Massachusetts prisoners in solitary confinement; instances of force used against Massachusetts prisoners in solitary confinement; the number of Massachusetts prisoners released directly from solitary to the community; and the racial composition of Massachusetts' solitary confinement units.

It is past time for Massachusetts to carefully examine its solitary confinement practices. Information regarding solitary confinement in Massachusetts must be collected and made available to the public.

An Act Relative to Improve Public Safety By Facilitating Access to Addiction Services

H. 1167, Rep. Ruth Balser

This bill requires that all prisoners held in state and county custody in Massachusetts must be screened for substance abuse history and, if they have such a history, offered treatment upon request.

Why This Matters

Substance abuse is a major cause of incarceration and afflicts a majority of prisoners. Nationally, approximately 80% of prisoners self report drug addiction . Yet, nationally only 11 percent of those with substance abuse and addiction disorders receive treatment during their incarceration yet the DOC has only 600 long-term substance abuse drug treatment beds for its 10,500 prisoners.

Massachusetts is no exception to this trend. Prisoners in state and county facilities who seek treatment for drug or alcohol addiction often are thwarted by the lack of programs or long waiting lists to enter those programs. They return to their communities without the tools to escape the addiction that landed so many in prison.

The costs of failing to treat addiction are enormous. Alcohol and drugs are involved in over three quarters of violent crimes, property crimes, and other offenses. According to the National Institutes of Health, "treatment can cut drug use in half, decrease criminal activity, and reduce arrests." Nationally, the cost of providing every prisoner with addiction treatment and after-care would be covered if just over 10 percent remained substance- and crime- free and employed. Every additional success story would reap an estimated economic benefit of $90,953 per year.

What This Bill Would Do

This bill would ensure substance abuse treatment for all prisoners who seek it. It would allow sheriffs and the Commissioner of Correction to directly engage a qualified treatment provider, to collaborate with other agencies, and/or to use volunteers from community recovery programs. Increased treatment will lead to increased success on reentry and decreased recidivism.

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If You Are Pregnant And Incarcerated

Contact PLS for information about your rights.

In May 2014, Massachusetts passed a law, G.L. c. 127, § 118, making it illegal to shackle pregnant women for transportation in most circumstances, outlawing restraints on women in labor and requiring correctional facilities that hold women to provide basic prenatal education and care. Its requirements apply to all women incarcerated in the state, in DOC or county facilities. PLS is monitoring Implementation of the new law via a project sponsored by the **National Institute for Reproductive Health**.

If you are pregnant and locked up in Massachusetts, **please contact PLS for assistance in obtaining the rights provided by this law and to help us track and address any improper use of restraints on women who are pregnant or who have recently given birth.** If you feel the correctional or medical staff are not following the requirements of the law, you should file a

grievance (a medical grievance if it is medical staff who are not following the law, a facility grievance if it is the correctional staff not following the law) and be sure to appeal any denial of that grievance. You should file the grievance even if you also contact PLS for assistance.

If you are shackled while you are in labor, this office will advocate for you to be removed from restraints immediately. You can contact us from any DOC facility at *9004# or any county facility by calling collect at 617-482-4124. If you are unable to call, you can also ask your medical provider or your family to contact our office to report this problem. We will need your signed releases of information to get any information when we advocate, so **we will need releases of information on file with this office in advance if you think you will be incarcerated when you give birth. If you are expecting to give birth while incarcerated, please contact PLS in advance of your due date and discuss your situation with us.**

Please encourage other pregnant prisoners to also contact PLS. Even if you don't want us to contact the facility regarding your situation, we would appreciate you contacting us to let us know what your experience was so that we can tell whether each facility is following the law.

PLS Seeks Information on DOC Treatment of Deaf and Hard of hearing Prisoners

PLS seeks information about deaf and hard of hearing prisoners in the DOC. Specifically, PLS would like to know about problems with: access to interpreters for medical appointments and administrative hearings, access to educational and rehabilitative programs, access to religious services, awareness of safety alarms and announcements, and ability to communicate with their loved ones in the community. If you have information to share with PLS, please write, or call PLS and ask for attorneys **Tatum Pritchard** or **Lizz Matos.**

PLS Seeks Information on Treatment of Prisoners with Mobility Disabilities

PLS is seeking information about the experience of persons with mobility disabilities in the DOC and county facilities. For example, PLS would like to know more about problems that persons with mobility disabilities have with accessible housing, mobility assistance devices (e.g., wheelchairs, walkers, canes, braces), access to medical appointments and administrative hearings, access to educational and rehabilitative programs, access to religious services, treatment in segregation, and safety. If you have any information that you would like to share with PLS, please write or call PLS and ask for attorney **Maggie Filler**.

PLS Sues DOC For Access to Hepatitis C Cure

In June of 2015, PLS and two Lawyers' Guild firms, Shapiro, Weissberg & Garin and David Kelston, filed a class action in federal court that seeks to compel DOC to treat prisoners with Hepatitis C with new medications that were approved by the FDA in 2014. These medications are a dramatic improvement over all earlier treatments and cure almost all of patients who receive them. Yet DOC has treated only a handful of prisoners , primarily

because the medications are extremely expensive. The complaint in the case, *Paszko v. Commissioner of Correction,* alleges that failure to provide this treatment violates the Eighth Amendment rights of the more than fifteen hundred prisoners in DOC custody who have Hepatitis C.

Many prisoners (12% to 35%) have Hepatitis C (HCV) and do not know it. In Massachusetts, 11% of all people age 18 to 25 who have HCV were incarcerated at some point in the past. The Department of Public Health (DPH) paid for a study of prisoners at the Barnstable County Jail and House of Correction which looked at the value of using incarceration as an opportunity to diagnose and treat people who had HCV.

Barnstable's population is about 500 and it books about 2,800 people per year. From July 1, 2009 to December 31, 2010, 405 Barnstable prisoners were tested for HCV. Ninety of them (22%) tested positive. Forty percent of the 90 said that they used injected drugs during the year before they were incarcerated.

Because Hepatitis C infections are common among prisoners, medical authorities recommend that jails and, especially, prisons, be used by health departments as preferred locations for diagnostic and treatment services for HCV. Not only are prisoners available to participate in treatment and education, but treating them – especially in programs that transfer them to health services in the community after release – should reduce the spread of HCV in the public at large, but especially among injection drug users. Shared needles are (along with sex) roads of transmission for HCV, just like they are for HIV, the virus that causes AIDS. HCV left untreated destroys the liver over a period of years, either directly or by causing liver cancer. Treatment for people dying of advanced liver disease is very expensive. Catching and treating HCV early, before symptoms develop, will save money because the cost of early treatment, which is in the fifty thousand dollar range, is much less than the cost of caring for people with end-stage liver disease. Because the newest treatments for HCV now produce cure rates above 95%, institutional treatment programs coupled with transfer to community health care, now offer real hope for presently affected people, presently *infected* people who don't have symptoms, and other injection drug users and sexual partners, whose risk of catching Hepatitis C would be greatly reduced.