SHOULD ELDERLY CRIMINALS BE PUNISHED FOR BEING PRISONERS OF THE MIND?
AN ANALYSIS OF CRIMINALS WITH ALZHEIMER’S DISEASE

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INTRODUCTION

“Alzheimer’s respects no boundaries. It doesn’t care if someone is rich or poor, a man or a woman—or behind the bars of a cell.”

The rising life expectancy in the United States has resulted in social, economic, and health problems in our society. For instance, Alzheimer’s,

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among other diseases, has become increasingly prevalent among many individuals.\(^3\) It is becoming more and more difficult to find an American who does not personally know someone afflicted with Alzheimer’s or another form of dementia.\(^4\) In 2012, for example, one out of every eight elderly Americans had Alzheimer’s.\(^5\) The total number of Americans living with the disease in that year alone was calculated to be five million.\(^6\) Statistics show that one person in the United States develops Alzheimer’s every sixty-eight seconds.\(^7\) Furthermore, Alzheimer’s is cited as the sixth leading cause of death in America.\(^8\) As a testament to the serious nature of the increase of Alzheimer’s disease in our society, President Barack Obama signed the National Alzheimer’s Project Act in 2011 and has invested $50-$80 million into researching the disease during the fiscal years of 2012 and 2013.\(^9\)

Alzheimer’s puts an enormous amount of stress on both the American health care system and on the caregivers of the individuals afflicted with it.\(^10\) However, few people think about the effect that Alzheimer’s has on our country’s criminal system. The elderly prison population in the United States has substantially increased in recent years, leading to further overcrowding and to an increased lack of resources in prisons.\(^11\) As Alzheimer’s continues to afflict more and more Americans, it is important to consider this problem in the context of our elderly prison population.

Alzheimer’s disease is particularly relevant to consider with regards to the increasing elderly population in our the criminal system because, it is quite possible that a criminal with Alzheimer’s will not even remember what unlawful act he or she committed to break the law in the first place. Should an

\(^{5}\) ALZHEIMER’S ASS’N, supra note 3, at 13.
\(^{6}\) Id. at 19.
\(^{7}\) Id. at 16.
\(^{8}\) Id. at 22.
\(^{10}\) ALZHEIMER’S ASS’N, supra note 3, at 27.
individual afflicted with Alzheimer’s be sentenced for a crime that he or she committed but does not remember? What should be done with prisoners who become afflicted with Alzheimer’s while they are incarcerated? Also, does allowing a prisoner with Alzheimer’s to remain in prison violate a constitutional or legal right?

This Note will explore the problem of criminals with Alzheimer’s. Part I will provide a general discussion of Alzheimer’s as a disease. Part II will discuss what happens when individuals with Alzheimer’s commit crimes (before they are imprisoned for them). Part III will apply the Alzheimer’s problem to the prison population. Part IV will analyze the constitutional and legal arguments of cruel and unusual punishment and violations of the Americans with Disabilities Act as they pertain to elderly prisoners with Alzheimer’s. Part V will provide a framework of compassionate release programs in the United States. Lastly, Part VI will discuss options and viable alternatives for elderly prisoners with Alzheimer’s, as well as for individuals who already have Alzheimer’s when they commit their crimes.

PART I
ALZHEIMER’S: THE DISEASE

To better understand the problems facing prisoners with Alzheimer’s, it is necessary to first understand the disease. Alzheimer’s is a form of dementia that results in symptoms such as decline in memory and decrease in certain cognitive abilities. It is characterized by “unique hallmarks . . . [such as] nursing home placement, extensive personal care needs, possible assaultive and compulsive behaviors, and loss of decisional capacity.” Alzheimer’s occurs when the brain’s nerve cells die or stop functioning normally. In fact, researchers who have analyzed the brains of those with Alzheimer’s have observed a “dramatic shrinkage from cell loss and widespread debris from dead and dying neurons.”

Alzheimer’s cannot be reversed with treatment and will eventually lead to death in every case. The only available option is to slow down the progression of Alzheimer’s and to manage its corresponding symptoms of depression,

12. Alzheimer’s Ass’n, supra note 3, at 5.
15. Id. at 10.
16. Id. at 4-5; McDaniel, supra note 2, at 135.
agitation, and more, with medications.\textsuperscript{17} As the disease progresses, further symptoms include impaired judgment, disorientation, confusion, behavioral changes, as well as difficulty speaking, swallowing, and walking.\textsuperscript{18} Individuals with Alzheimer’s also tend to experience hallucinations and delusions.\textsuperscript{19} Generally, death occurs approximately eight years after the first symptoms of the disease appear.\textsuperscript{20}

Difficulty remembering recent events is one of the first symptoms of the condition.\textsuperscript{21} As the disease becomes more advanced, individuals will forget long-term memories as well.\textsuperscript{22} Also, afflicted individuals will eventually require assistance with regular and mundane activities such as eating and bathing.\textsuperscript{23} “Between thirty and fifty percent of [individuals afflicted with] Alzheimer’s disease become combative, assaultive, or . . . aggressive.”\textsuperscript{24} The final stages of Alzheimer’s are characterized by “los[ing] . . . [the] ability to communicate, fail[ing] to recognize loved ones and becom[ing] bed-bound and reliant on around-the-clock care.”\textsuperscript{25} Furthermore, individuals with Alzheimer’s who also have trouble moving are more likely to contract serious infections such as pneumonia.\textsuperscript{26}

There are three identifiable stages of Alzheimer’s.\textsuperscript{27} The first stage, “preclinical Alzheimer’s disease,” is characterized by “measurable changes in the brain, cerebrospinal fluid and/or blood . . . that indicate the earliest signs of the disease.”\textsuperscript{28} At this stage, symptoms such as memory loss have not yet developed.\textsuperscript{29} Some researchers believe that this stage of Alzheimer’s may even develop as early as twenty years before actual, evident symptoms of the disease occur.\textsuperscript{30} The second stage of Alzheimer’s is called “mild cognitive impairment due to Alzheimer’s disease.”\textsuperscript{31} Individuals in the second stage exhibit “changes
in thinking abilities that are noticeable to the person affected and to family members and friends."\(^{32}\) However, the individual is still able to perform everyday activities and daily functions.\(^{33}\) The third stage, “dementia due to Alzheimer’s disease,” manifests itself through symptoms that seriously inhibit an individual’s ability to function normally.\(^{34}\) Furthermore, the nature of the disease makes it extremely difficult for individuals with Alzheimer’s to participate in decisions about their medical or end-of-life care.\(^{35}\)

As a disease, Alzheimer’s is significantly under-diagnosed particularly because individuals afflicted with it often believe that its symptoms are merely indicators of old age.\(^{36}\) There are a few common factors that indicate a predisposition to Alzheimer’s. The statistics available show that two-thirds of the Alzheimer’s population in America consists of women.\(^{37}\) Alzheimer’s is also more prevalent in individuals with “fewer years of education” and in African-American and Hispanic communities.\(^{38}\) African-Americans in particular are more susceptible to Alzheimer’s because they are more likely to suffer from high blood pressure and high cholesterol.\(^{39}\) However, African-Americans are generally diagnosed with Alzheimer’s at a later stage than their Caucasian counterparts, which is even more detrimental to their health.\(^{40}\)

More research is being conducted on Alzheimer’s, but the exact causes of the disease and its triggering symptoms are still unknown.\(^{41}\) The greatest risk factor for Alzheimer’s appears to be advancing age, though, younger people can be affected as well.\(^{42}\) Studies have demonstrated that “the incidence of [Alzheimer’s] doubles for every 5-year interval past age 65.”\(^{43}\) There are other risk factors which include family history and genetics, factors regarding heart

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32. Id.
33. Id.
34. Id.
36. See ALZHEIMER’S ASS’N, supra note 3, at 14.
37. Id.
38. Id. at 15.
40. Id.
41. ALZHEIMER’S ASS’N, supra note 3, at 7.
42. Id. at 10-11.
43. Murphy, supra note 9, at 1246.
conditions and blood vessels, as well as factors dealing with social engagement, and even an individual’s diet.44

Early diagnosis of the disease can be beneficial - it allows doctors to begin to treat several of its symptoms as soon as possible.45 However, overall, the disease is becoming increasingly dangerous since it is continuing to affect a greater number of individuals every year.46 In fact, a recent MetLife study discovered that “almost three-fourths of Americans said they knew little or nothing about Alzheimer’s disease—though they were afraid of getting it.”47

PART II
WHEN PEOPLE WITH ALZHEIMER’S COMMIT CRIMES

A preliminary and significant issue to consider is what to do with individuals who already have Alzheimer’s when they commit their crimes. A study of patients with forms of dementia such as Alzheimer’s demonstrated that the abnormalities in their brains could influence them to partake in violent behavior.48 There are multiple examples of individuals with Alzheimer’s committing criminal acts. For instance, Joe McLeod was in his late sixties and suffering from Alzheimer’s when he became confused and pushed his wife.49 His wife sustained injuries and he was charged with assault.50 He stayed in jail for a month before the media became involved in his case, leading to his eventual release to a specialized health facility.51 There have also been numerous cases involving individuals with Alzheimer’s committing crimes such as sexual abuse and assault, and even beating others to death.52

Should these individuals be sentenced and imprisoned or should there be alternative

44. ALZHEIMER’S ASS’N, supra note 3, at 11.
45. Dilworth-Anderson et al., supra note 39, at 29.
46. See ALZHEIMER’S ASS’N, supra note 3, at 14.
47. Gillick, supra note 35, at 53.
50. Id.
51. Id.
options available for them because they may not fully understand what they are doing?

“Under a majority of capacity definitions [capacity being defined as ‘maintain[ing] the requisite level and classification of abilities relevant to a specific action or decision,’ a diagnosis of [Alzheimer’s] alone is not conclusive evidence that an individual lacks capacity.” However, incompetence and incapacity can be considered as factors during sentencing in some instances. Some judges even believe that criminal punishments should not be given to individuals for “being in a condition that he [or she] is powerless to change.” Some believe that “[i]t is unacceptable to jail someone with Alzheimer’s.”

A few states even have “special problem-solving centers for older offenders whose wrongdoings were caused by mental illnesses, such as [Alzheimer’s].” Individuals who already have Alzheimer’s at the time of their offense are unlikely to be “fit to stand trial, and hospital diversion is the most likely outcome” as these individuals are “not able to think through the consequences of criminal actions.”

The general test for determining whether an individual is competent or not is whether he or she “has sufficient present ability to consult with his lawyer with a reasonable degree of rational understanding — and whether he has a rational as well as factual understanding of the proceedings against him.” Kentucky, for example, has held that an individual must be “adjudicated incompetent” because of the “potential for abuse in declaring someone

54. Id.
55. Powell v. Texas, 392 U.S. 514, 533 (1968); see also Alvarez-Jacinto v. United States, 403 Fed. Appx. 423, 424 (11th Cir. 2010) (finding that an evidentiary hearing on competency must be held unless there was concrete proof that it was not required; “[plaintiff]’s competency was never formally evaluated before the plea hearing . . . [which] raise[s] the question whether [plaintiff] was competent when he pled guilty.”). But see Creasy v. Rusk, 730 N.E.2d 659, 661-62 (Ind. 2000) (“[A]dults with mental disabilities have the same general duty of care towards others as those without . . . [they] are held to the same standard of care as that of a reasonable person under the same circumstances.”).
58. S. Fazel et al., Dementia in Prison: Ethical and Legal Implications, 28 J. MED. ETHICS 156, 157 (2002).
incompetent” in any other way. If an individual claims to have an “unsound mind,” his or her guardian will defend that individual’s interests. If a guardian is unavailable, the court will appoint a guardian ad litem for the individual. This is particularly relevant for criminals with Alzheimer’s, because they are less likely to be able to communicate adequately with their counsel in order to explain their situation or to ask any questions.

Any intervention that would occur before an individual is imprisoned for a crime committed after an Alzheimer’s diagnosis would be extremely beneficial. Such an intervention would ensure that one less ill individual was imprisoned for a crime that he or she may not have been truly cognizant of committing. Additionally, such an intervention would also perhaps result in the individual getting the requisite medical care and help, which is likely not available in a prison setting.

PART III
PRISONERS WITH ALZHEIMER’S

A second, highly relevant issue is what to do with prisoners who develop Alzheimer’s while in prison. The number of geriatric prisoners is growing steadily and will undoubtedly be severely affected by the increasing prevalence of Alzheimer’s in society. There are various types of elderly individuals in prison. The first group consists of “the first-time older offender,” or an individual who is serving his or her term after committing a crime at an elderly age. The second group is the chronic offender, defined as a younger short-

60. Smith v. Flynn, 390 S.W.3d at 157, 159-160 (Ky. Ct. App. 2012); see also Arias, supra note 53, at 148 (“A majority of state laws require that a judicial body declare an individual incompetent before instituting protective measures.”).
61. Smith, 390 S.W.3d at 159.
62. Id.; see also Gigante, 996 F. Supp. at 198 (citing 18 U.S.C. § 4241(d) (2012)) (“If a defendant is presently suffering from a mental disease or defect rendering him mentally incompetent to the extent that he is unable to understand the nature and consequences of the proceedings against him or to assist properly in his defense, the court shall commit the defendant to the custody of the Attorney General.”).
63. See Nicole M. Murphy, Dying to be Free: An Analysis of Wisconsin’s Restructured Compassionate Release Statute, 95 MARQ. L. REV. 1679, 1688 (2011) [hereinafter Dying to be Free].
term offender who has been incarcerated before reaching the age of fifty-five.\textsuperscript{66} The third group includes “the prison recidivist,” who is a career criminal, while the last group encompasses “the inmate who has grown old” while in prison.\textsuperscript{67}

However, there is no general consensus regarding what age a prisoner must attain to be considered “elderly.”\textsuperscript{68} Some sources define a prisoner as “elderly” if he or she is sixty-five years old while others have lowered the threshold to fifty-five years old.\textsuperscript{69} The differences in the definitions of “elderly” are caused by the fact that prison often exacerbates previous conditions such as poverty, lack of health insurance, or drug addiction, and causes inmates to age faster than their counterparts in society.\textsuperscript{70} Furthermore, “prisoners [are actually] more prone to dementia than the general population because they often have more risk factors,” such as poor health.\textsuperscript{71}

Much of the disagreement exists between individuals who argue that justice must be served no matter a prisoner’s age or health condition, and those who claim that we should offer compassion to extremely ill persons instead of condemnation.\textsuperscript{72} In general, courts have held that age or the “worsening of a degenerative condition” are not factors that would justify a sentence

\begin{footnotes}
\footnote{66. Id.}
\footnote{67. Id. at 239-40.}
\footnote{69. CHIU, supra note 68, at 4.}
\footnote{72. Porcella, supra note 64, at 369; see also William B. Aldenberg, Bursting at the Seams: An Analysis of Compassionate Release Statutes and the Current Problem of HIV and AIDS in U.S. Prisons and Jails, 24 NEW ENG. J. ON CRIM. & CIV. CONFINEMENT 541, 550-52 (1998) (There are those who argue that “releasing inmates who are ill . . . is simply the humane and respectable thing to do” while others claim that “society must be tough on crime, and that illness should not warrant the release of criminals.”).}
\end{footnotes}
reduction. \(^73\) However, certain state statutes may allow for age to be considered as a factor in sentencing. \(^74\)

The cost for confining an elderly prisoner is significantly higher than the cost for imprisoning a younger inmate. \(^75\) Estimates show the average yearly cost for confining an elderly prisoner is between $60,000-$70,000 – three times the cost for housing a younger individual in prison. \(^76\) Additionally, the number of older prisoners has grown significantly in the past few decades. \(^77\) For example, “elderly criminals aged sixty and over [are] more likely than younger offenders to be incarcerated for crimes, such as aggravated assault with a weapon, negligent manslaughter with a vehicle, motor vehicle theft, [and more].” \(^78\) Due to the increasing life span of Americans, “one in five elderly prisoners can be expected to die [in prison], so the correctional system will be responsible for supplying comprehensive, end-of-life care.” \(^79\)

The cost of health care for inmates is a huge issue, because it constitutes over twenty percent of the correctional budget. \(^80\) Furthermore, prisoners’ health needs are mostly met through the prison’s health care system, which is paid for by states. \(^81\) Studies show that “if [some] elderly inmates are released, the

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\(^73\) Porcella, supra note 64, at 374; see also State v. Coppens, No. 90-0151, 1990 Wisc. App. LEXIS 641, at *3 (Wis. Ct. App. 1990) (“The worsening of a degenerative condition in a defendant who was old and in bad health at the time of sentencing does not constitute a new factor justifying reduction of sentence.”). \(^74\) But see N.J. Ct. R. 3:21-10(b) (“A motion may be filed and an order may be entered at any time . . . amending a custodial sentence to permit the release of a defendant because of illness or infirmity of the defendant.”).

\(^75\) Porcella, supra note 64, at 375; Jason S. Ornduff, Releasing the Elderly Inmate: A Solution to Prison Overcrowding, 4 Elder L.J. 173, 189 (1996); see also Aday & Krabill, supra note 57, at 241 (“[A] number of research studies have been conducted that support the position that criminal justice decision-makers give elderly offenders sentencing breaks.”).

\(^76\) Id.

\(^77\) Aging Inmate Committee, Aging Inmates: Correctional Issues and Initiatives, 44 Md. B.J. 22 (2011) [hereinafter Aging Inmates].

\(^78\) Aday & Krabill, supra note 57, at 242.


\(^80\) Paul J. Larkin, Jr., Clemency, Parole, Good-Time Credits, and Crowded Prisons: Reconsidering Early Release, 11 Geo. J.L. & Pub. Pol’y 1, 16 (2013); see also Gavin, supra note 70, at 250 (“Responsibility for inmate medical care is causing a fiscal crisis in state and federal correctional system budgets.”).

\(^81\) Yamamoto, supra note 11, at 445.
savings in the first year would be greater than $175 [m]illion."^82 The health care system is also in a current state of turmoil due to the advent of health care insurance initiatives through the Affordable Care Act, known colloquially as Obamacare. Obamacare may lead to further issues with health care in prisons in the future.\(^83\)

Generally, prison is also harsher for older inmates.\(^84\) "The benefits that free society provides to its senior citizens are generally denied to those behind bars."\(^85\) Older inmates are rarely given special treatment solely because of their advanced age.\(^86\) They are generally kept in the mainstream population and given the same work assignments as younger individuals.\(^87\) While prison is difficult for most individuals, it is particularly trying “for someone who is losing their strength and mental faculties.”\(^88\) Another major aspect of prison life is the fact that “[m]edical care in prison is modeled after military medical care.”\(^89\) This system is not conducive to caring for elderly inmates with terminal or chronic conditions.\(^90\) The current medical care system also completely lacks the ability to care for inmates with Alzheimer’s.\(^91\)

An important factor to consider in the context of this Note is that individuals suffering from Alzheimer’s require constant care and supervision, a feature that is not inherent in the United States’ prison system.\(^92\) Individuals

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82. Aging Inmates, supra note 77, at 26.
84. See Porcella, supra note 64, at 387; Aday & Krabill, supra note 57, at 245 (“[Prisons were] primarily designed to accommodate younger, healthier, and more energetic populations.”); Curtin, supra note 70, at 481; Lyle B. Brown, The Joint Effort to Supervise and Treat Elderly Offenders: A New Solution to a Current Corrections Problem, 59 OHIO ST. L.J. 259, 260 (1998).
85. Curran, supra note 65, at 244.
86. See Porcella, supra note 64 at 388; Heather Habes, Paying for the Graying: How California Can More Effectively Manage its Growing Elderly Inmate Population, 20 S. CAL. INTERDISC. L.J. 395, 404 (2011). But see CHU, supra note 68, at 5 (“In 2008, at least 13 states had dedicated units for older inmates, six had dedicated prisons, nine had dedicated secure medical facilities, five had dedicated secure nursing-home facilities, and eight had dedicated hospice facilities.”).
87. Porcella, supra note 64, at 387.
88. Curran, supra note 65, at 247.
89. Gavin, supra note 70, at 254; Curtin, supra note 70, at 476.
90. Gavin, supra note 70, at 254-55.
91. Id.
92. See Yamamoto, supra note 11, at 449.
with Alzheimer’s are in a frequent state of confusion and uncertainty.\textsuperscript{93} They often do not realize where they are or who surrounds them.\textsuperscript{94} Moreover, their symptoms and condition might not even be apparent in a prison setting due to the lack of individualized care.\textsuperscript{95}

Given that the elderly population in prisons is increasing and that one out of eight Americans has Alzheimer’s, it is very likely that prisons will be facing the significant problem of more prisoners with Alzheimer’s.\textsuperscript{96} In fact, “[e]xperts believe that Alzheimer’s disease in prisons could grow two or three times as fast [as in the outside population].”\textsuperscript{97} Prisons already lack the necessary resources to care for these prisoners,\textsuperscript{98} and Alzheimer’s has the potential to further cripple the American prison system, particularly because it is estimated to affect sixteen million people by 2050.\textsuperscript{99}

\textbf{PART IV

CONSTITUTIONAL AND LEGAL ARGUMENTS}

Some may argue that allowing elderly individuals to remain in prison when they are affected with Alzheimer’s constitutes a violation of the Eighth Amendment’s prohibition against cruel and unusual punishment\textsuperscript{100} or perhaps a violation of the Americans with Disabilities Act (ADA).\textsuperscript{101} In fact, the Eighth Amendment is one of the few rights “whose meaning expands in the context of prisons.”\textsuperscript{102} However, there are multiple factors that must be considered before claiming that such practices violate basic American laws. The age of the

\begin{quote}
\textsuperscript{93} \textit{See Alzheimer’s Ass’n, supra} note 3, at 5.
\textsuperscript{94} \textit{See id.}
\textsuperscript{95} \textit{See Yamamoto, supra} note 11, at 449.
\textsuperscript{96} \textit{Human Rights Watch, Old Behind Bars} (2012), \textit{available at} http://www.hrw.org/node/104747/section/1.
\textsuperscript{97} \textit{Belluck, supra} note 71.
\textsuperscript{98} \textit{Yamamoto, supra} note 11, at 446; \textit{see also} Brown v. Plata, 131 S. Ct. 1910, 1923 (2011) (finding that “overcrowding has overtaken the limited resources of prison staff, imposed demands well beyond the capacity of medical and mental health facilities, and created unsanitary and unsafe conditions . . . the overcrowding [leads to the violation of a federal right].”).
\textsuperscript{99} \textit{Yamamoto, supra} note 11, at 438; \textit{see also} Larkin, \textit{supra} note 80, at 17 (stating that “[t]he increase in arrests and long prison terms for drug traffickers, violent felons, and habitual criminals means that the number of elderly, infirm, and dying prisoners will increase, and, with it, the cost of their care.”).
\textsuperscript{100} \textit{See U.S. Const. amend. VIII.}
\textsuperscript{102} Curran, \textit{supra} 65, at 236.
\end{quote}
offender as well as the amount of time he or she has already served are undoubtedly of vital importance, as these factors impact the way in which the individual is viewed by society. Another important element to contemplate is the actual crime that was committed, since some crimes are much more reprehensible than others.103

The ADA requires prisons or jails to provide “reasonable accommodations” for inmates with disabilities.104 However, the precise meaning of “reasonable accommodations” is unclear.105 Moreover, some courts completely reject the ADA’s application to prisons.106 In regard to Eighth Amendment claims however, it has been previously held that courts which review Eighth Amendment claims must give “substantial deference to the broad authority of the legislature to set punishments for crimes.”107 At its core, the Eighth Amendment prohibits “cruel and usual punishment.”108

Case law has not resulted in a clear consensus on this issue. In Snipes v. DeTalla for instance, the court held that only unnecessary and wanton infliction of pain implicates the Eighth Amendment.109 To raise an Eighth Amendment issue, the infliction of punishment must be deliberate or otherwise reckless in the criminal law sense.110 In Estelle v. Gamble, the court found that “[t]he Eighth Amendment proscribes more than just ‘physically barbarous punishments.’”111 Furthermore, the government has an “obligation to provide medical care for those whom it is punishing by incarceration.”112 Inmates rely on prison authorities for treating their medical needs.113 In some cases, lack of

103. CHIU, supra note 68, at 9 (“[P]olicymakers often exclude individuals convicted of violent offenses or sex offenses and those sentenced to life imprisonment.”).
105. Id.
106. Id.
108. U.S. CONST. amend. VIII.
110. Id.
111. 429 U.S. 97, 102 (1976).
112. Id. at 103.
113. Id. See also Gavin, supra note 70, at 256 (stating that “[p]risoners are the only population in the United States with a constitutionally guaranteed right to medical care”); Curtin, supra note 70, at 475.
treatment may even produce physical torture or death. The prison is “required to care for the prisoner who cannot care for himself” because of the deprivation of his liberty.

_Gutierrez v. Peters_ also found that prison officials violate the Eighth Amendment’s ban on cruel and unusual punishment if their actions exhibit “deliberate indifference to serious medical needs of prisoners.” An individual is “deliberately indifferent when [he or she] acts in an intentional or criminally reckless manner.” Medical care that is simply negligent or an accidental failure to provide medical care is not considered to be a violation of the Eighth Amendment because “the requisite culpable state of mind” is missing.

In prison, medical needs are considered “serious” through an examination of several factors, including: “the severity of the medical problem, the potential for harm if medical care is denied or delayed, and whether any such harm actually resulted from the lack of medical attention.” Medical conditions that “significantly affect an individual’s daily activities” are also considered “serious.” _Chance v. Armstrong_ added to the case law regarding this issue, noting that “the standard for Eighth Amendment violations” requires “a condition of urgency” that might result in “degeneration” or “extreme pain.” However, “a condition of urgency” may not be required; Eighth Amendment claims can also be supported for delays in treating non-threatening painful medical conditions.

In applying such decisions to prisoners with Alzheimer’s, it is unlikely that it can be argued that these prisoners possess a condition of “urgency” that would result in “degeneration” if not treated. Alzheimer’s as a disease is not treatable and will degenerate anyway. Medications only exist that may slightly alleviate or blur the symptoms, but no current medical treatment can

114. _Estelle_, 429 U.S. at 103.
116. 111 F.3d 1364, 1369 (7th Cir. 1997).
117. Antonelli v. Sheahan, 81 F.3d 1422, 1428 (7th Cir. 1996) (citing _Salazar v. City of Chicago_, 940 F.2d 233, 238 (7th Cir. 1991)).
119. _Gutierrez_, 111 F.3d at 1370.
120. _Id._ at 1373.
121. 143 F.3d 698, 702 (2d Cir. 1998).
122. _Gutierrez_, 111 F.3d at 1371.
123. _See supra_ notes 14-19 and accompanying text.
cure the disease completely.\textsuperscript{124} Degeneration in symptoms and of the individual’s mind is an innate feature of the disease and is inevitable.\textsuperscript{125} Therefore, an argument claiming prisoners with Alzheimer’s need urgent care or can otherwise bring an Eighth Amendment lawsuit is not accurate.

\textit{Farmer v. Brennan} also confirmed that a prisoner’s treatment is subject to Eighth Amendment scrutiny.\textsuperscript{126} However, the deprivation must be “sufficiently serious” when viewed objectively and a “prison official’s act or omission must result in the denial of ‘the minimal civilized measure of life’s necessities.’”\textsuperscript{127} The official has to “know of and disregard an excessive risk to inmate health or safety” by taking no reasonable measures to prevent the risk.\textsuperscript{128} Yet, in this same case, Justice Blackmun’s concurring opinion states there is no evidence that the Eighth Amendment was “intended to prohibit cruel and unusual punishments only when they were inflicted intentionally.”\textsuperscript{129} Justice Blackmun, therefore, believed that an “express intent” was not required to make an Eighth Amendment violation claim.\textsuperscript{130}

In \textit{Coleman v. Wilson}, the plaintiffs were a class of prisoners who suffered from mental disorders.\textsuperscript{131} They brought a suit alleging that the mental health care provided by the California Department of Corrections was grossly inadequate and, thus, violated their constitutional rights.\textsuperscript{132} The court again found that the plaintiffs had to show a “deliberate indifference” by the defendants to their “serious medical needs” in order to prove a violation of the Eighth Amendment.\textsuperscript{133} In other words, the defendants had to act deliberately in order for the plaintiffs to succeed on such a constitutional claim, even when the lack of adequate medical care was otherwise evident.\textsuperscript{134} In this particular case, the court noted that California “prisons have . . . become the repository of an enormous number of the state’s mentally ill,” which exacerbates the problem of providing adequate medical care.\textsuperscript{135}

\begin{itemize}
\item \textsuperscript{124} See id.
\item \textsuperscript{125} See id.
\item \textsuperscript{126} 511 U.S. 825, 828 (1994).
\item \textsuperscript{127} Id. at 834.
\item \textsuperscript{128} Id. at 837.
\item \textsuperscript{129} Id. at 856.
\item \textsuperscript{130} Id.
\item \textsuperscript{131} 912 F. Supp. 1282, 1293 (E.D. Cal. 1995).
\item \textsuperscript{132} Id.
\item \textsuperscript{133} Id. at 1298 (quoting Estelle v. Gamble, 429 U.S. 97, 106 (1976)).
\item \textsuperscript{134} Id.
\item \textsuperscript{135} Id. at 1299.
\end{itemize}
Since the number of prisoners with mental issues was so high, the court found there needed to be a system in place within the prison to identify mentally ill individuals both before they became inmates as well as during their time in prison. Such a system had not existed in the California Corrections Department since 1987. The lack of an identifying mechanism resulted in only those prisoners who self-reported or exhibited the most bizarre and strange symptoms as being classified as being mentally ill. Alzheimer’s in particular, is particularly relevant in this context because of its difficulty to diagnose in a prison setting since many of its symptoms are also symptoms of old age.

Furthermore, the court also found that “the Eighth Amendment... requires prisons... to maintain a system in which inmates are able to make their need for mental health care known to staff competent to provide such care before inmates suffer unnecessary and wanton infliction of pain.” Due to the nature of their mental diseases, many inmates were not able to explain their condition to the prison’s staff. The court also noted that the prison did not have a sufficient amount of competent and trained staff members to care for the mentally ill population, as evidenced by the extremely long delays that prisoners faced before getting access to necessary care. Furthermore, studies have shown “[o]ne of the most reliable hallmarks of excellent dementia care is that caregivers know and understand the values, history, and personality of their patient.” This feature is obviously non-existent in a prison setting. The lengthy wait times for care combined with the prisoners’ existence in

136. Id. at 1305.
137. Id.
138. Id.
139. See supra note 36 and accompanying text.
140. Coleman, 912 F. Supp. at 1305; see also Brown v. Plata, 131 S. Ct. 1910, 1926 (2011) (stating that “prisons were ‘seriously and chronically understaffed... and had no effective method for ensuring the competence of their staff.” (citing Coleman, 912 F. Supp. at 1308)).
142. Id. at 1306, 1320; see also Brown, 131 S. Ct. at 1924 (determining that “[p]risoners in California with serious mental illnesses do not receive minimal, adequate care... that wait times for mental health care range as high as 12 months.”); John A. Beck, Compassionate Release from New York State Prisons: Why Are So Few Getting Out?, 27 J.L. MED. & ETHICS 216, 221 (1999) (“Not all infirmaries have staff qualified to perform more complex nursing care functions, and they do not have palliative care programs designed to deal with dying inmates.”).
143. Brodoff, supra note 13, at 258; see also Dubler, supra note 79, at 150 (claiming that “[d]ecent [medical] care in any setting requires a trusting alliance between care providers and patient, but forging an honest and supportive therapeutic relationship in prison is a formidable task.”).
“crowded, unsafe, and unsanitary conditions can [also potentially] cause prisoners with latent mental illnesses to worsen."\textsuperscript{144}

Alzheimer’s, in particular, has been viewed as a sufficiently serious condition to warrant an Eighth Amendment claim, but only if it is substantiated. In \textit{Wilson v. Thompson}, the prisoner in question was afflicted with Alzheimer’s.\textsuperscript{145} He claimed that the doctors in his institution “failed to provide him [with] adequate medical care for his Alzheimer’s disease” and that the lack of treatment violated the cruel and unusual punishment clause.\textsuperscript{146} The doctors in question refused to provide the prisoner with any medication or treatment and one even claimed he did not actually have Alzheimer’s.\textsuperscript{147} The court concluded that the plaintiff could “state a claim under the Eighth Amendment with respect to . . . claims related to treatment [or lack thereof] for his Alzheimer’s.”\textsuperscript{148}

In order to succeed on his Eighth Amendment claim, the prisoner would have to show that medication and treatment for Alzheimer’s were the only “appropriate responses” for his condition and that the defendants knew this.\textsuperscript{149} The court also concluded the prisoner did not have a valid claim under the Americans with Disabilities Act because he failed to show Alzheimer’s had “substantially limit[ed] one or more of his major life activities” and “that he [was] denied any services, programs or activities at the prison because of his Alzheimer’s.”\textsuperscript{150}

Case law remains unclear about the Eighth Amendment, but “cases where a prisoner complaining of mistreatment has been allowed to recover . . . under the Eighth Amendment . . . involve recklessness in the strong sense.”\textsuperscript{151} Courts have to determine whether “the officials acted with a sufficiently culpable state of mind” as well as “if the alleged wrongdoing was objectively harmful . . . to establish a constitutional violation.”\textsuperscript{152} In regard to medical care, it is not necessary for inmates to have unlimited and unqualified access to such care and

\begin{itemize}
  \item \textsuperscript{144} \textit{Brown}, 131 S. Ct. at 1934.
  \item \textsuperscript{145} No. 11-cv-1125-bbc, 2012 U.S. Dist. LEXIS 22998, at *4 (W.D. Wis. Feb. 23, 2012).
  \item \textsuperscript{146} \textit{Id.} at *5-7.
  \item \textsuperscript{147} \textit{Id.} at *5.
  \item \textsuperscript{148} \textit{Id.} at *7.
  \item \textsuperscript{149} \textit{Id.} at *8-9.
  \item \textsuperscript{150} \textit{Id.} at *10; \textit{see also} \textit{Yeskey v. Penn. Dep’t of Corr.}, 76 F. Supp. 2d 572, 573 (M.D. Pa. 1999) (finding that “[denial of] a major life activity [because of a disability is] an essential element of an ADA claim.”).
  \item \textsuperscript{151} \textit{Duckworth v. Franzen}, 780 F.2d 645, 653 (7th Cir. 1985).
  \item \textsuperscript{152} \textit{Hudson v. McMillian}, 503 U.S. 1, 8 (1992) (internal quotation marks omitted) (quoting \textit{Wilson v. Seiter}, 501 U.S. 294, 298, 303 (1991)).
\end{itemize}
a violation to the Eighth Amendment will be found only if there is deliberate indifference to serious medical needs.\textsuperscript{153}

Additionally, it has been held that the meaning of the Eighth Amendment should correspond with the “evolving standards of decency” in our society.\textsuperscript{154} This involves looking to the objective attitudes of the public and of society in general.\textsuperscript{155} Prisons that deny inmates “adequate medical care [are] incompatible with the concept of human dignity and [have] no place in civilized society.”\textsuperscript{156} In applying this proposition to the problem of prisoners with Alzheimer’s, perhaps it would be prudent to gauge the public’s opinions and suggestions on this issue as well.

After analyzing the precedent case law and opinions, it may be argued that keeping inmates with Alzheimer’s incarcerated does not violate either the Eighth Amendment of the Constitution or the Americans with Disabilities Act. Though there may be moral issues with such conduct, prisons and officials do not act “deliberately indifferent” to the needs of prisoners with Alzheimer’s and do not purposefully fail to provide adequate medical care. Prisons are simply ill equipped to deal with the specific needs of prisoners with Alzheimer’s, whether it is through lack of satisfactory staffing or lack of medical resources. Prisons are not purposefully denying appropriate care to inmates with Alzheimer’s, specifically because there is no actual treatment for the disease.

The Alzheimer’s population is extremely difficult to care for, especially as it is continuously increasing.\textsuperscript{157} Caring for individuals with Alzheimer’s requires special skills, time, and dedication – features not inherent in the American prison system through no real fault of its employees.\textsuperscript{158} Prisoners with Alzheimer’s also do not have valid claims under the Americans with Disabilities Act, because they are not prevented from taking part in any activity simply because they have Alzheimer’s.\textsuperscript{159} Therefore, even though keeping inmates with Alzheimer’s in prison may be morally questionable, it does not actually violate any of our nation’s fundamental laws, since any lack of care is not “deliberate.”

\textsuperscript{153} Hudson, 503 U.S. at 9.
\textsuperscript{155} Gregg, 428 U.S. at 173.
\textsuperscript{157} See ALZHEIMER’S ASS’N, supra note 3, at 19, 27.
\textsuperscript{158} See Yamamoto, supra note 11, at 449.
However, even though keeping prisoners with Alzheimer’s incarcerated may not violate any constitutional or legal rights, it is still important to consider alternatives for such inmates for humanitarian and financial reasons. By providing viable alternatives for prisoners with Alzheimer’s, prison officials will curtail future Eighth Amendment and ADA litigation regarding such issues, help conserve valuable resources, and act in a humanitarian manner towards individuals who are nearing the end of their lives.

**PART V**

**COMPASSIONATE RELEASE**

Due to budgetary issues, United States prisons have been experimenting with various kinds of programs that allow prisoners to be released before their maximum release dates. In particular, “legislators and policymakers have been increasingly willing to consider early release for those older prisoners who are seen as posing a relatively low risk to public safety,” since caring for the elderly is so expensive in prison. A major factor leading to the budgetary issues plaguing prisons is the fact that “[t]he United States has had the highest incarceration rate in the world since 2002, many times the rate of any other democratic, industrialized country.” The United States “imprisons its residents at a rate seven times higher than Western European nations.” Furthermore, the economic recession of 2008 exacerbated the huge costs of “confining people in jails and prisons.” During the early to mid-twentieth century, early release was actually a goal for the criminal system. Courts would set a prisoner’s sentence, and parole boards would determine an actual

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161. Chi, * supra* note 68, at 2; *see also* Aldenberg, * supra* note 72, at 549 (1998) (“[1][T]he prison population in the United States is reaching record levels, creating the problem of prison overcrowding; (2) the housing of aged ... prisoners is becoming more costly; (3) most of these prisoners no longer present a threat to society; (4) prisons are not designed as long-term healthcare facilities; and (5) by keeping these inmates incarcerated, the state has to provide for their medical care.”).

162. Aldenberg, * supra* note 72; *see also* Cecelia Klingele, *The Early Demise of Early Release*, 114 W. VA. L. REV. 415, 419 (2012) [hereinafter *Demise of Early Release*] (showing that “[t]he United States had the world’s highest incarceration rate, imprisoning approximately one of every 132 people[.]”).


165. *Id.* at 417-18.
release date of a prisoner based on the board’s assessment of the prisoner’s rehabilitation. However, states have eliminated or restricted parole eligibility in recent years, favoring “determinate sentencing philosophies . . . [and] . . . the overall punitive sentiment that animates penal policy.” For example, the Sentencing Reform Act of 1984 states that courts “must impose a sentence of the kind and within the range established for the applicable category of offense . . . as set forth in the Sentencing Guidelines.” The necessary factors to consider in imposing a sentence are the “gravity of the offense, the character of the offender, and the need for protection of the public.”

Additionally, three strikes laws, such as those that have emerged in California, have contributed to the increase in prison populations. These laws are targeted towards habitual criminals and “impose life imprisonment for a third felony conviction.” Three strikes laws have however, sometimes doled out life sentences for disproportionate crimes. Increasingly, states have also begun to imprison individuals for “minor and non-violent offenses, notably property and drug crimes.” However, “prisons . . . are not the solution for every type of offender.” There is a consensus among scholars that the United States overuses incarceration and that reform to the criminal system is necessary.

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166. Id.

167. Demise of Early Release, supra note 162, at 418, 449; see also Michael M. O’Hear, Beyond Rehabilitation: A New Theory of Indeterminate Sentencing, 48 AM. CRIM. L. REV. 1247, 1248 (2011) (stating that by the year 2000, several states as well as the federal government had eliminated parole completely while other states severely restricted it).

168. Surette, supra note 107, at § 2.


171. Larkin, supra note 80, at 13.

172. See id.


175. Id.
States that have conducted trials of early release programs have encountered varied results. Some states have seen significant relief from overcrowding while other states have failed to note any substantial changes. In some states, like New Jersey, early release programs have garnered particularly negative attention because of the seriousness of the crimes committed by some released prisoners. In fact, New Jersey decided to repeal its early release legislation as a result of such crimes. In Michigan, a sixty-five year old inmate was in a wheelchair because he was a double amputee. After obtaining compassionate release, he used a sawed-off shotgun to conduct a bank robbery. Decision makers are also frequently reluctant to utilize or enforce early release programs for “fear of public or political backlash.” They do not want to appear to be soft on crime.

The United States Sentencing Guidelines allow for a downward departure in sentencing for individuals with “extraordinary physical impairment[s].” But, courts are not obligated to allow downward departures in sentencing even if a defendant exhibits an “extraordinary physical impairment.” The courts may, however, do so at their own discretion, after taking into account the specific facts of the individual’s condition. Courts do not regularly offer downward departures; in fact, it is a rare occurrence. Courts will generally consider three factors in making their decisions regarding downward departure:

176. Demise of Early Release, supra note 162, at 429.
177. Id.
178. Id. at 432-433.
179. Id.
180. Curtin, supra note 70, at 499.
181. Id.
182. Demise of Early Release, supra note 162, at 443; see also Chu, supra note 68, at 8 (“Politics and public sentiment present obstacles to fully using statutes already on the books. Releasing older inmates can be viewed as politically unwise, fiscally questionable, or philosophically unpalatable.”). But see Fellner, supra note 11 (“[R]etribution can shade into vengeance. While being old should not be an automatic get-out-of-jail-free card, infirmity and illness can change the calculus of what justice requires.”).
183. See Demise of Early Release, supra note 162, at 429; see also Chu, supra note 68, at 8 (“A . . . survey of Pennsylvania residents in 2004 found that only 45 percent of respondents favored . . . early release . . . for chronically or terminally ill inmates, even if they posed no threat to society.”); Curtin, supra note 70, at 500 (“It is easy for a politician to gain political currency by appearing tough on crime. But once that politician is out of office, criminals will still be serving time and society will still be footing the bill.”).
184. Surette, supra note 107, at § 2.
185. Id.
186. Id.
187. Id. at § 14; Adams, supra note 68, at 478.
“1) serious and imminent medical threats, 2) which would be made worse by incarceration and/or 3) which the... Bureau of Prisons could not adequately treat.”

The Seventh Circuit in particular requires testimony that the defendant needs “constant care” or care that the defendant cannot obtain because he or she is in prison. Examples of medical conditions for which downward departure has been allowed include advanced HIV and advanced stages of cancer. Other conditions, like drug and alcohol addictions, do not fall within the category of an “extraordinary physical impairment.”

Compassionate release programs refer to procedures for granting parole to inmates for health reasons. Essentially, prisons release these inmates to die outside of prison before their sentence is completed. There are two rationales for the program: ethical justifications for releasing prisoners with life threatening illnesses and the financial benefits from such releases. Prisons save money from such programs because they do not have to expend large amounts of money on end-of-life care, which is often the “most expensive [time] in terms of health care.” As mentioned previously, many jurisdictions also impose the requirement that the prisoner cannot be adequately cared for in the prison setting. Additionally, “[m]ost states that permit the early release of older prisoners have set the age of eligibility at 60 or 65.”

Compassionate release decisions are extremely fact specific. Some laws state that prisoners who have been “convicted of murder, first-degree manslaughter, or sexual offenses, or attempts thereof, cannot be considered for [such programs at all].” Furthermore, “the eligibility criteria for [these programs in some states, like New York] is overly restrictive, disqualifying

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188. Surette, supra note 107, at § 15.
189. Id. at § 16.
190. Id. at §§ 34, 40.
191. Id. at § 45.
194. Williams et al., supra note 193, at 122; see also Dying to be Free, supra note 63, at 1681-82 (“Compassionate release... became popular among state governments as a fiscally attractive alternative in the last decade to reduce strain on state correction budgets.”).
195. Gavin, supra note 70, at 258.
196. Williams et al., supra note 193, at 122.
197. CHU, supra note 68, at 6.
199. Beck, supra note 142, at 218.
some terminally ill inmates . . . or deferring their eligibility until it is nearly impossible to complete the review process before they die."

New York, in particular, requires a process involving several different steps in order to apply for the program. First, a doctor must determine that an inmate has a terminal condition and is severely incapacitated. Depending on an inmate’s stage of Alzheimer’s disease, he or she may possibly be considered terminally ill as well. Next, the doctor must forward the diagnosis to the Commissioner of the Department of Correctional Services who then determines whether the inmate is so incapacitated he or she will not pose a risk to society if released. Finally, the Board of Parole must conduct a formal review prior to release. Medical parole in New York is allowed for six months, during which the parolee has to agree to remain under a doctor’s care and is required to have medical examinations. Additionally, New York allows the inmates themselves or family members and advocates to initiate the application for medical parole; other states allow only prison officials to initiate such proceedings.

But, states vary in their approach to compassionate release. Washington, for example, allows for the release of individuals meeting certain detailed criteria. Washington’s legislation balances the risk of releasing the prisoner to the community, the cost of medical treatment for the state, and the potential savings to the state from the release. Connecticut, Missouri, Oregon, Texas, and Wyoming include “age-related physical or mental debilitation” as one of the factors for early release. Mississippi legislation allows “non-violent, terminally-ill offenders [to be] . . . eligible for release, regardless of the time served on their sentence.” As a result of this legislation, Mississippi has

200. Id. at 216.
201. Id. at 216-17.
202. Id.
203. See id. at 227-28.
204. Id. at 217.
205. Id.
206. Id.
207. Id. at 218.
208. Alternatives to Incarceration, supra note 174, at 1288.
209. Id.
210. CHIU, supra note 68, at 6.
211. Alternatives to Incarceration, supra note 174, at 1290.
released eighty-nine terminally ill inmates, saving millions of dollars over the span of seven years.\textsuperscript{212}

Generally, the inmates who are released have to be incapable of committing further crimes.\textsuperscript{213} Studies actually show that elderly prisoners, particularly those with conditions such as Alzheimer’s, are less likely to commit another crime upon release.\textsuperscript{214} Scholars have even noted that “age and recidivism are inversely related.”\textsuperscript{215}

Nevertheless, endeavors to decrease prison populations have resulted in “public and institutional resistance.”\textsuperscript{216} States like California have compassionate release programs in place for terminally ill prisoners, but these programs are seldom utilized.\textsuperscript{217} Critics argue that “giving elderly inmates aget out free card simply because they are in the evenings of their lives is unfair and even dangerous to the community.”\textsuperscript{218} Victims’ rights groups, in particular, fervently argue against the use of such early release programs, claiming that the programs “show more compassion to prisoners than the offenders showed their victims.”\textsuperscript{219} There is also the major issue of releasing sick elderly inmates into society without them having somewhere to go.\textsuperscript{220}

\begin{itemize}
\item \textsuperscript{212} Id. at 1304; see also Gregory J. O’Meara, Compassion and the Public Interest: Wisconsin’s New Compassionate Release Legislation, 23 Fed. Sent’g Rep. 33, 35 (2010) (finding that “release of nonviolent elderly prisoners to communities would result in ‘astronomical’ savings.”).
\item \textsuperscript{213} Gavin, supra note 70, at 257-58.
\item \textsuperscript{214} See Porcella, supra note 64, at 381.
\item \textsuperscript{215} Larkin, supra note 80, at 20; see also Susan Lundstrom, Dying to Get Out: A Study on the Necessity, Importance, and Effectiveness of Prison Early Release Programs for Elderly Inmates Suffering from HIV Disease and Other Terminal-Centered Illnesses, 9 BYU J. Pub. L. 155, 156 (1994); California’s Sentencing Practice, supra note 170, at 947-48 (“Older prisoners do not need to be incarcerated in conventional prisons . . . recidivism rates drop significantly” with increasing age.). See also CHU, supra note 68, at 5 (stating that “releasing some elderly inmates before the end of their sentence poses a relatively low risk to the public.”); Laura M. Baber & James L. Johnson, Early Termination of Supervision: No Compromise to Community Safety, 77 Fed. Probation 17, 20 (2013) (finding that “offenders granted early termination . . . pose no greater danger to the community than offenders who serve a full term of supervision.”).
\item \textsuperscript{216} Demise of Early Release, supra note 162, at 416.
\item \textsuperscript{217} Alternatives to Incarceration, supra note 174, at 1300.
\item \textsuperscript{218} Habes, supra note 86, at 398; see also Dying to be Free, supra note 63, at 1706 (claiming that “the age or medical condition of a criminal should have no bearing on his ability to carry out his sentence behind bars.”).
\item \textsuperscript{219} Alternatives to Incarceration, supra note 174, at 1304, 1308.
\item \textsuperscript{220} Changing the Sentence, supra note 163, at 494; see also Gavin, supra note 70, at 260 (stating that “[r]eleasing elderly prisoners, unemployed, homeless, and without a support system, sets them up for failure.”).
\end{itemize}
Some critics argue that the most serious and violent criminals should never be released because of age or health reasons and that such programs should only be applicable to offenders who have not been convicted for violent, sexual, or other serious crimes.\textsuperscript{221} Others argue prisoners convicted of violent or sexual offenses should not be categorically barred from such programs because some of them are actually less likely to commit other crimes.\textsuperscript{222} A major humanitarian argument is that “even those who have committed a crime should be allowed the opportunity to spend their last days on Earth with family or friends - not behind prison walls.”\textsuperscript{223}

Another serious issue with these release programs is that in some cases, prisoners may have no incentive to apply for early release because they might then be looked over for parole that year.\textsuperscript{224} In some states, like Virginia for instance, “those who apply for [such] release forfeit that year’s automatic parole hearing.”\textsuperscript{225} Furthermore, criteria in certain states, such as only having six months left to live, significantly narrows the amount of inmates who are eligible for compassionate release programs. Death, even for inmates with terminal diseases or with degenerative diseases like Alzheimer’s, is difficult to forecast precisely.\textsuperscript{226}

The application process for early release programs is also difficult, confusing, and time consuming.\textsuperscript{227} Many prisoners will die before their application is completely processed.\textsuperscript{228} It is especially difficult for prisoners with Alzheimer’s to apply for such compassionate release or early release programs if an application procedure is required.\textsuperscript{229} Prisoners with Alzheimer’s may not even remember what crime they committed to land them in prison in the first place.\textsuperscript{230} They have issues remembering faces, days of the week, where they are located, personal information, and much more.\textsuperscript{231} It would be impossible for such prisoners to be expected to fill out paperwork asking for

\begin{thebibliography}{99}
\bibitem{221} Norris, \textit{supra} note 160, at 1590-91.
\bibitem{222} \textit{Demise of Early Release, supra} note 162, at 450-51. In this context, Klingele discusses battered spouses who murdered their significant others after years of encountering abuse or sex offenders who engaged in consensual sex with a minor.
\bibitem{223} \textit{Dying to be Free, supra} note 63, at 1691.
\bibitem{224} \textit{CHIU, supra} note 68, at 9.
\bibitem{225} \textit{Id.}
\bibitem{226} \textit{See} Gavin, \textit{supra} note 70, at 262; \textit{see also} Williams, \textit{supra} note 193, at 123.
\bibitem{227} \textit{CHIU, supra} note 68, at 10; \textit{see also} Williams, \textit{supra} note 196, at 123.
\bibitem{228} Dubler, \textit{supra} note 79, at 153.
\bibitem{229} Williams, \textit{supra} note 193, at 124.
\bibitem{230} Fazel et al., \textit{supra} note 58, at 156.
\bibitem{231} \textit{See supra} Part I.
\end{thebibliography}
early or compassionate release, unless somebody else filled out the paperwork on their behalf.

In August 2013 however, former Attorney General Eric Holder implemented reforms to the Bureau of Prison’s compassionate release programs. Now, dying prisoners can seek compassionate release within eighteen months of their anticipated death.\textsuperscript{232} Furthermore, inmates no longer have to be completely disabled; they just need to be “seriously debilitated . . . due to illness or injury from which they will never recover.”\textsuperscript{233} Another major change is that prisoners do not necessarily have to have these debilitating conditions at all.\textsuperscript{234} If they are aged sixty-five and older and have served fifty percent or more of their sentences, they can also apply for compassionate release.\textsuperscript{235}

Regardless of these recent developments, only a small number of inmates countrywide have been released due to compassionate release programs so far, and these programs have also been shown to have uneven implementation.\textsuperscript{236} Experts, like Tina Chiu of the Vera Institute of Justice, recommend other methods to improve the early release mechanisms for elderly prisoners.\textsuperscript{237} For example, states should calculate detailed estimates of the savings that they would incur from releasing elderly inmates who pose no risk to society, and make these estimates readily available to the public.\textsuperscript{238} Another recommendation is to have better reporting requirements for these programs and analyze the programs at every stage to “identify and address potential and existing obstacles.”\textsuperscript{239}

\textbf{PART VI}
\textbf{OPTIONS AND ALTERNATIVES}

Though the issue of criminals with Alzheimer’s is likely to continue generating much debate, it is essential to consider the various alternatives and


\textsuperscript{233} \textit{Id.}

\textsuperscript{234} \textit{Id.}

\textsuperscript{235} \textit{Id.}

\textsuperscript{236} Norris, \textit{supra} note 160, at 1592, 1602.

\textsuperscript{237} Chiu, \textit{supra} note 68, at 10.

\textsuperscript{238} \textit{Id.} at 10-11.

\textsuperscript{239} \textit{Id.} at 11.
solutions that are possible for dealing with this problem. By releasing an inmate who will require expensive end-of-life medical care, the correctional system will avoid [having to expend] those medical costs. The costs of medical care for the released inmate may be partially undertaken by federal programs such as Medicaid, and prisons will not have to dedicate more staff members to supervise such inmates. Another aspect to consider is that some of these inmates will go into their family’s care, meaning that their family members and not the state or the government, may be responsible for at least a portion of their medical costs. Aside from the monetary arguments, creating alternative options for prisoners with Alzheimer’s will ensure that they will “not be forced to die in prison.”

A. Options for Individuals with Alzheimer’s Before Sentencing

It is only reasonable that there should be fewer incarcerations of individuals who already have Alzheimer’s when they commit their crimes. One alternative for individuals with Alzheimer’s who commit crimes would be to divert them to the probation system instead of sentencing them to time in jail or prison. Probation may be a more humanitarian way to punish elderly criminals” because they will not have to deal with the myriad of issues that older criminals with Alzheimer’s face in an already over-burdened penal system. Such programs would entail continuous supervision and monitoring through “counseling, referrals, educational activities, and community volunteer work.” These features would also help individuals with Alzheimer’s feel busy and less depressed. Probation or diversion programs would aid in ensuring

240. *See Alternatives to Incarceration*, supra note 174, at 1275 ("[A]lternatives to incarceration are necessary, especially in light of the current budget crises in many states.").

241. Beck, supra note 142, at 224; *see also* Dubler, supra note 79, at 154 (stating that "[a]n effective compassionate release process . . . would cost many thousands of dollars less than providing adequate end-of-life care in the prison setting.").

242. Beck, supra note 142, at 224; *see also* Patricia S. Corwin, *Senioritis: Why Elderly Federal Inmates are Literally Dying to Get Out of Prison*, 17 J. CONTEMP. HEALTH L. & POL’Y 687, 688-89 (2001). *See also* Dying to be Free, supra note 63, at 1693 (stating that “if the elderly or ill inmates are released into the community, then the state can share the cost of medical care with the federal government instead of assuming responsibility for the entire financial burden.").


244. Aldenberg, supra note 72, at 549.

245. *See* Brown, supra note 84, at 260.

246. *Id.*

247. *Id.* at 285.
that the individual does not commit further crimes and would also ensure that the individual does not become incarcerated for an act that he or she may not be aware of committing.\textsuperscript{248}

Another option would be to have special courts for older criminals with Alzheimer’s.\textsuperscript{249} Such courts could consider age as well as the Alzheimer’s disease in determining an adequate remedy for the individual’s crime.\textsuperscript{250} The proliferation of such courts would support the idea that “defendants with mental [deficiencies, such as Alzheimer’s] should be treated differently at the time of trial.”\textsuperscript{251} The courts would also help divert these individuals into adequate facilities and treatments, as opposed to sentencing them to prison time.\textsuperscript{252} All of these options would be advantageous, because prisons would have to deal with a fewer number of inmates who are suffering from Alzheimer’s, and because these individuals would be more likely to get the help that they need from institutions outside of prison.

B. Alternatives for Prisoners with Alzheimer’s

Scholars recommend that “lengthy periods of incarceration . . . be reserved for offenders who pose the greatest danger to the community and who commit the most serious offenses.”\textsuperscript{253} In the alternative, states may streamline compassionate release programs to include prisoners who suffer from Alzheimer’s. As mentioned previously, current compassionate release programs are complex, confusing, and largely, ineffective.\textsuperscript{254} For these programs to be effective, they must be simplified and actually implemented.

Apart from changes to sentencing guidelines and government regulations however, it is possible to create special Alzheimer’s and dementia units in

\textsuperscript{248} \textit{See id. at 261-75.}
\textsuperscript{249} \textit{See Adams, supra note 68, at 482.}
\textsuperscript{250} \textit{See id.}
\textsuperscript{251} Jennifer S. Bard, \textit{Re-arranging Deck Chairs on the Titanic: Why the Incarceration of Individuals with Serious Mental Illness Violates Public Health, Ethical, and Constitutional Principles and Therefore Cannot Be Made Right by Piecemeal Changes to the Insanity Defense}, \textit{5} \textit{Hous. J. Health L. \\& Pol’y} 1, 40-41 (2005); \textit{see also} Vaughn E. James, \textit{No Help for the Helpless: How the Law Has Failed to Serve and Protect Persons Suffering from Alzheimer’s Disease}, \textit{7} \textit{J. Health \\& Biomedical L.} 407, 447 (2012) (stating that “[t]he judge [should] make a determination that is read into the record that the individual lacks mental capacity because of Alzheimer’s disease.”).
\textsuperscript{252} Bard, \textit{supra} note 251, at 40.
\textsuperscript{253} \textit{California’s Sentencing Practice, supra} note 170, at 911.
\textsuperscript{254} \textit{See supra} note 227 and accompanying text.
prisons and jails. A prison in New York recently created such a unit. The unit functions almost like a nursing home, but with the addition of bars. All employees go through a forty-hour course, learning how to deal with inmates who have Alzheimer’s. In fact, “[p]rison hospital wards are often transformed into nursing homes because inmates suffering from mental disorders are not able to be placed elsewhere.” Also, some prisons are “experimenting with designated death units . . . or hospice units to which terminally ill prisoners can be transferred at the end of life.” These units could be viable options for prisoners who are nearing the end of their battle with Alzheimer’s.

Furthermore, establishing separate units for housing those with Alzheimer’s “will [also] reduce security costs.” Prisoners with Alzheimer’s are less likely to be aggressive if they find themselves in a more stable environment. Keeping these prisoners separate from the mainstream population will additionally reduce the risk of violence between the younger prisoners and the older ones with Alzheimer’s. Alzheimer’s prisoners in these units could also receive simplified work assignments consistent with their condition.

Prisoners with Alzheimer’s would additionally receive specialized care in these separate units and “the money saved by establishing geriatric units [through reducing security issues] would enable prison administrations to refocus and improve services and facilities for the general population.” Having separate facilities for these kinds of inmates would further eliminate transactional costs such as transportation, since many prisons currently have to transport such inmates to different sites and hospitals in order for them to obtain appropriate medical care. The transportation of these prisoners places

255. See Michael Hill, N.Y. Prison Creates Dementia Unit, THE ASSOCIATED PRESS, May 29, 2007, available at http://www.policeone.com/corrections/articles/1267679-N-Y-prison-creates-dementia-unit; see also Aging Inmates, supra note 77, at 27 (stating that “over half the states provide geriatric housing facilities for older inmates or have separate areas of housing.”).

256. Hill, supra note 255.

257. Id.

258. Id.

259. Curran, supra note 65, at 248; see also Gavin, supra note 70, at 263-64.

260. Dubler, supra note 79, at 152.

261. Curran, supra note 65, at 261.

262. See Gavin, supra note 70, at 255.

263. Id. at 256.

264. Curran, supra note 65, at 261.

265. Gavin, supra note 70, at 261.
an additional financial burden on prisons because “[one or] two correctional officers are usually required to accompany a . . . prisoner to a location outside of the prison.”266 Finally, this option would be advantageous because these prisoners likely do not even remember the crimes that they committed in the first place. Therefore, there is no real justification for punishing them for something they no longer recall, especially when they can no longer be rehabilitated due to their illness, and when they have already likely served a portion of their time in prison.

Another option is to have other inmates care for those with Alzheimer’s.267 This includes assistance with daily tasks of life such as shaving, showering, and more.268 Louisiana and California, among other locales, have implemented this alternative, and have trained healthy inmates to care for prisoners with dementia.269 This option gives younger prisoners daily tasks and responsibilities and also alleviates the problem of lack of staff and resources to care for the elderly prisoners with Alzheimer’s.

Prisoners with Alzheimer’s could also be given home detention.270 Prisoners would wear “an electronic bracelet that [would notify] authorities if the prisoner [left] a predefined perimeter.”271 This method “is a viable solution for low-risk . . . inmates”272 and would be both more efficient and financially effective than keeping them in prison. Yet, this approach could only be possible if the individual actually has a home to go to upon release. Other factors would need to be considered, such as who would look after the individual at home.273

An additional alternative to consider would be to transfer prisoners with Alzheimer’s to nursing homes. However, this option presents its own issues. The public is concerned “that offenders placed in nursing homes may prey upon an already vulnerable population.”274 Furthermore, Americans often have problems affording nursing homes for themselves or their loved ones and

266. Ornduff, supra note 74, at 178.
267. Belluck, supra note 71.
268. Id.
270. See Surette, supra note 107, at § 24.
271. Gavin, supra note 70, at 263.
272. Curran, supra note 65, at 262.
273. There is also the issue of family members not wanting to take in the elderly inmate with Alzheimer’s. This could be due to deterioration in relations while the inmate was in prison or simply because family members do not have the resources and time to care for such individuals. See Belluck, supra note 71 (a family member is quoted as stating “[t]o be honest, the care he’s receiving in prison, we could not match.”).
274. CHIU, supra note 68, at 8; Curtin, supra note 70, at 478.
would not readily agree to have their taxpayer money funneled towards such endeavors for prisoners.\textsuperscript{275} Legislators are also more likely to use any available money to benefit educational programs or Medicare, which are available to more members of the general public.\textsuperscript{276} Furthermore, nursing homes do not want to admit these inmates.\textsuperscript{277} The homes fear their regular residents will want to leave the nursing home if inmates are allowed to reside there.\textsuperscript{278} Critics of this idea also maintain that the monetary burden would simply be shifted from prisons to Medicare and Medicaid – programs already overwhelmed and struggling to stay afloat.\textsuperscript{279}

However, there is a cost shifting argument that comes into play here. Prisons are already overcrowded and lack sufficient resources to care for prisoners with Alzheimer’s.\textsuperscript{280} The costs of caring for older prisoners is also much higher than for younger prisoners.\textsuperscript{281} It is possible to transfer the same cost of caring for older inmates in prison to nursing homes specifically built or converted for prisoners. This would in turn, free up resources in regular prisons.\textsuperscript{282} Furthermore, specific nursing homes for prisoners would have qualified staff, which, in turn, would decrease litigation concerning the Eighth Amendment and the ADA. In terms of mixing inmates with Alzheimer’s and regular individuals in nursing homes, “some states have out-sourced their responsibility for incarcerated elders” by contracting with private companies to run “high security nursing homes for state correctional systems.”\textsuperscript{283}

Prisons could also increase their utilization of telemedicine for treating inmates with Alzheimer’s.\textsuperscript{284} Telemedicine uses electronic communication to provide clinical care from a distance.\textsuperscript{285} Doctors can receive information about

\textsuperscript{275} Alzheimer’s Ass’n, supra note 3, at 44 (“Nursing home care . . . [costs] $79,110 to $87,235 per year.”). Furthermore, “[f]ew individuals with Alzheimer’s . . . have sufficient long-term care insurance or can afford to pay out-of-pocket for long-term care services.” Id. at 47.

\textsuperscript{276} See Demise of Early Release, supra note 162, at 447; see also Larkin, supra note 80, at 12 (stating “[t]here are numerous rivals for limited public funds. A dollar spent in the correctional system cannot be spent in the health care system.”).

\textsuperscript{277} Gavin, supra note 70, at 265.

\textsuperscript{278} Id.

\textsuperscript{279} Yamamoto, supra note 11, at 458.

\textsuperscript{280} See supra Part III.

\textsuperscript{281} Porcella, supra note 64, at 383.

\textsuperscript{282} California’s Sentencing Practice, supra note 170, at 951 (“Transferring older prisoners to a properly designed facility increases savings as well.”).

\textsuperscript{283} Gavin, supra note 70, at 264-65.

\textsuperscript{284} Curtin, supra note 70, at 490.

\textsuperscript{285} Id.
their patients from miles away.\textsuperscript{286} Telemedicine would decrease the wait times for care that many prisoners experience nowadays and would provide a “greater availability of quality specialists.”\textsuperscript{287} Telemedicine would also be useful for treating bilingual inmates with Alzheimer’s.\textsuperscript{288} However, issues continue to exist with the use of telemedicine, particularly focusing on ethics, licensing, and liability of the treating doctors.\textsuperscript{289}

\textbf{CONCLUSION}

A diagnosis of Alzheimer’s is really a diagnosis of inevitable death. Though all prisoners have committed an illegal act that resulted in their incarceration, they should not continue to be imprisoned for acts which they do not remember committing. If an elderly prisoner has Alzheimer’s, has served a portion of his or her time, and is no longer a risk to society, there is little to no harm in releasing this prisoner early or in diverting him or her to one of the alternative options mentioned in Part VI of this Note. There is also no sense in sentencing an individual with Alzheimer’s who committed a crime to time in prison. If these individuals become or stay incarcerated, the prison will be forced to spend enormous amounts of money on their care, and the care will not be adequate or effective.

Though Eighth Amendment and ADA claims will likely fail with regard to such issues due to nuances in precedent case law, there is still an extremely viable argument for instituting alternatives for these individuals for both financial and humanitarian reasons. “If the humane aspect of the elderly inmate’s [with Alzheimer’s] dying without dignity behind bars doesn’t tug at [one’s] heart strings, then maybe tugging at [one’s] purse strings will.”\textsuperscript{290} As the prevalence of Alzheimer’s in our society and in our prisons continues to increase, serious changes need to be made in order to ensure that elderly criminals with Alzheimer’s are either not behind bars or are at least getting adequate care. Justifications for incarcerating these criminals have become obsolete, and at this point, ethics and morality should begin to take over in our decision making.

\begin{thebibliography}{99}
\bibitem{286} Id.
\bibitem{287} Id. at 492.
\bibitem{288} Id.
\bibitem{289} Id.
\bibitem{290} Curran, supra note 65, at 264.
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