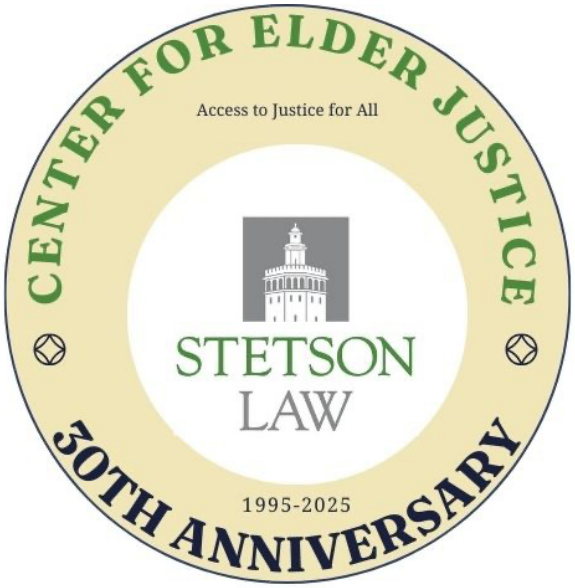
Journal of Aging Law & Policy



STETSON LAW
Stetson University College of Law

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CONTENTS

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VOLUME 16 SPRING 2025

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Letter from the Editor

Dear Readers,

Welcome to this exciting new volume of the Journal of Aging Law & Policy, where we are pleased to introduce a refined and critical focus on domestic legal issues that directly affect some of the most vulnerable populations in our society. In this volume, we explore a range of timely and pressing topics that intersect law, public policy, and the lives of older adults, individuals with disabilities, and those navigating complex healthcare and criminal justice systems in their older years. We aim to spark important conversations and offer thought-provoking solutions to the systemic issues these groups face.

This year, we are especially proud to celebrate the **30th anniversary of Stetson's Elder Law Program and Center for Elder Justice**. For three decades, this program has been at the forefront of legal education, advocacy, and innovation in elder law, and we are honored to continue that legacy through the work showcased in this journal.

As our nation grapples with aging demographics, healthcare reform, and shifting criminal justice policies, our contributors provide innovative legal analysis and research on how the law can better protect, serve, and empower those seniors in need. The articles in this volume address some of the most critical issues, including prison and law enforcement reform, Medicare accessibility, elder guardianship, end-of-life rights, and the complex challenges of elderly animal hoarding.

Here's a summary of the featured articles in this issue:

Redefining Compassionate Release to Address the Dementia Crisis in Prisons
This article examines the growing crisis of dementia among incarcerated individuals and argues for a redefinition of "compassionate release" laws. It proposes reforms that would allow individuals with severe cognitive impairments to be released from prisons, thereby ensuring humane treatment and addressing the practical realities of aging in the carceral system.

How Medicare Advantage Plans Are Swindling Medicare-Eligible Persons and the Federal Government
This critical analysis of the Medicare Advantage program unveils systemic fraud and misleading practices that target vulnerable Medicare-eligible persons. It explores the ways in which these private plans profit from misleading information and substandard care, ultimately undermining the goals of the Medicare system.

Live Free or Die? Analyzing the Right to Medical Aid in Dying Through a Constitutional/Antitrust Law Matrix
This groundbreaking article explores the intersection of constitutional law and antitrust principles in the context of medical aid in dying. By combining these two legal fields, the author proposes a novel framework for understanding the right to die, particularly as it applies to individuals in jurisdictions where assisted suicide laws remain a topic of debate.

Animal Hoarding in Florida's Older Adults: Analysis of Current Laws and Suggestions for Reform
This piece highlights how animal hoarding, particularly among older adults, is a serious yet underexplored issue. This article evaluates Florida's current laws and offers suggestions for reform that balance animal welfare with the needs of aging individuals. It advocates for legal strategies that can help address this complex problem without stigmatizing or harming older adults in the process.

Balancing Protection and Autonomy: A Person-Centered Approach to Older Adult Guardianship Adjudication: The Use of a Guardianship Worksheet
This piece offers a practical tool for judges, suggesting a new "Guardianship Worksheet" designed to foster a more person-centered approach to older adult guardianship cases. It emphasizes the need for individualized adjudication and safeguards that better respect the autonomy and dignity of older adults under guardianship.

Book Review: Global and Domestic Views on Aging Law
This article presents a book review that examines the evolving field of aging law, both within the United States and globally. The book highlights key legal challenges, innovative approaches, and the social implications of aging as a legal issue, providing a broad perspective on how legal systems are adapting to the realities of an aging population.

Criminal Grandparents: How the Criminal Justice System Impacts Individuals Living with Dementia and How We Should Fix It
This article brings attention to the intersection of dementia and criminal justice, particularly how individuals with dementia are treated in the legal system. It proposes comprehensive reforms to improve outcomes for this population, advocating for more tailored and compassionate approaches to their care and treatment by law enforcement.

Each of these articles contributes to a deeper understanding of how the law intersects with the lived experiences of older adults. Together, they reflect the need for reform, compassion, and a forward-thinking approach to some of our most pressing societal issues.

As always, we are grateful for the contributions of our authors and the continued support of our readers. We hope this volume provides valuable insight into how the law can evolve to meet the needs of a changing society, and we look forward to the conversations these pieces will undoubtedly spark.

Sincerely,
Brianna Faenza
Editor-in-Chief
Journal of Aging Law & Policy

WHY AM I HERE: REDEFINING COMPASSIONATE RELEASE TO ADDRESS THE DEMENTIA CRISIS IN PRISONS

Rima Nathan[1]

Our prison population is increasing and aging at a rate that will undoubtedly require shifts in policy. One component of this crisis is how we will manage elderly prisoners who are suffering from dementia. This paper will demonstrate how prison settings are currently failing at adequately addressing the needs of inmates with dementia and will explore the retributive nature of the criminal justice system and how that negatively interacts with the unique circumstances of a dementia diagnosis. Through an Eighth Amendment lens, this paper will explore legal frameworks for compassionate release and reduced sentencing as it relates to dementia. To account for the lack of compassionate release reform, this paper will also recommend holistic approaches to enhancing care within the prison system for people struggling with dementia.

[1] Rima Nathan is the Director of the Claude Pepper Elder Law Clinic at Florida State University College of Law. Thank you to Fabrizia Wade for her significant research on Florida's conditional medical release system and assistance in drafting this paper.

I. Introduction

The elderly prison population has grown faster than any other age group in prison *and* the population of non-incarcerated older Americans.[2] One study shows that from 1999 to 2016, the number of state and federal prisoners aged 55 and older increased 280%.[3] Another study shows that between 2007 and 2010 the number of state and federal prisoners aged 65 and older grew at a rate 94 times the overall prison population, making it the fastest growing demographic.[4] The extraordinary size of the United States' jail and prison population reflects the inevitable consequences of more than three decades of "tough on crime" policies like mandatory minimum sentences and "three strikes" laws, in which the punishments for repeat offenders severely ratchet up.[5] For instance, the Violent Crime Control and Law Enforcement Act of 1994, commonly known as the 1994 Crime Bill, incentivized states to build more prisons and keep people in those prisons for a longer percentage of their sentences.[6] These policies largely contribute to why many people who went to prison decades ago are still there.[7]

Compounding this already overburdened system is the fact that many aging prisoners are at risk of developing dementia. "Dementia" is a meaningful decline in neurocognitive ability as a result of illness or injury.[8] An estimated 6.2 million Americans aged 65 and older currently have dementia and that number is projected to increase to 13.8 million by 2060.[9] As the U.S. population ages and rates of dementia increase, the prevalence of dementia among persons involved in the criminal legal system can also be expected to increase. It is projected that between 70,341 and 211,020 of the estimated 400,000 incarcerated elderly in 2030 will develop dementia.[10] No national study has been done to estimate the current prevalence of dementia among the U.S. prison population,[11] but one study found that 8% of the older prison population in the United Kingdom has suspected dementia or mild cognitive impairment.[12] A senior officer at the Federal Medical Center Devens in Massachusetts, which houses federal prisoners who require medical care, estimates that 90% of the men he oversees don't know what they did or why they are there; one example being that an inmate is convinced he is actually the warden of the institution.[13] Moreover,

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[2] Brie A. Williams et al., *Addressing the Aging Crisis in U.S. Criminal Justice Health Care*, J. Am. Geriatrics Soc'y 1150, 1157 (2012).
[3] Matt McKillop & Alex Boucher, *Aging Prison Populations Drive Up Costs*, Pew Trusts (Feb. 20, 2018), https://www.pewtrusts.org/en/research-and-analysis/articles/2018/02/20/aging-prison-populations-drive-up-costs. Emily Widra, *The aging prison population: Causes, costs, and consequences*, Prison Policy Initiative (Aug. 2, 2023), https://www.prisonpolicy.org/blog/2023/08/02/aging/) ("Younger inmates did not grow at this same rate, resulting in older inmates growing from 3 percent of the total prison population to 15 percent from 1991 to 2021.")
[4] *Old Behind Bars: The Aging Prison Population in the United States*, Hum. Rts. Watch (Jan. 27, 2012), https://www.hrw.org/report/2012/01/28/old-behind-bars/aging-prison-population-united-states.
[5] *Id.*
[6] Lauren-Brooke Eisen, *The 1994 Crime Bill and Beyond: How Federal Funding Shapes the Criminal Justice System*, Brennan Ctr. for Just. (Sept. 9, 2019), https://www.brennancenter.org/our-work/analysis-opinion/1994-crime-bill-and-beyond-how-federal-funding-shapes-criminal-justice.
[7] Human Rights Watch, *supra* note 4.
[8] *About Dementia*, Ctr. for Disease Control (Aug. 17, 2024), https://www.cdc.gov/alzheimers-dementia/about/index.html.
[9] *2021 Alzheimer's disease facts and figures*. Alzheimers Dement. (March 23, 2021), https://pubmed.ncbi.nlm.nih.gov/33756057/.
[10] Rachel E. Lopez, *The Unusual Cruelty of Nursing Homes Behind Bars*, 32 Fed. Sent'g Rep. 264, 264 (2020).
[11] Tina Maschi et al., *Mental health, trauma, and stress among older adults in the criminal justice system: a review of the literature with implications for social work*, 54 J. Gerontological Soc. Work 390, 393 (2011).
[12] Katrina Forsyth et al., *Dementia and mild cognitive impairment in prisoners aged over 50 years in England and Wales: a mixed-methods study*, Health Serv. and Delivery Rsch., June 2020, at 14, https://www.journalslibrary.nihr.ac.uk/hsdr/hsdr08270#/abstract.
[13] Katie Engelhart*, I've Reported on Dementia for Years, and One Image of a Prisoner Keeps Haunting Me*, N.Y. Times (Aug. 11, 2023), https://www.nytimes.com/2023/08/11/opinion/dementia-prisons.html.

only 9% of social service organizations in the United States that provide support for older adults have programs for older prisoners; suggesting that our approach to elderly care in prison is nevertheless lacking.[14] Given these alarming numbers, the American Bar Association adopted a resolution specifically calling for government agencies to address the issue of people involved in the criminal justice system who are living with dementia.[15]

Prisons will soon, if not already, be filled with elderly inmates who do not even understand why they are there. Even outside of the prison setting, it is challenging to provide equitable care for people living with dementia.[16] But the prison setting introduces unique hurdles to managing dementia including confinement, behavioral issues, and simply giving and following proper directions. This crisis calls for a pause and deep dive into the Eighth Amendment implications of holding people in prison who can no longer remember the purpose of their punishment or what they did to result in the punishment. Keeping people who are struggling with their daily reality due to cognitive impairment in prison does nothing for a system focused on rehabilitation or deterrence.

This paper begins with an overview of current trends in the aging prison population and cognitive decline generally. The paper outlines current compassionate release (or conditional medical release) policies, focusing on Florida as a case study. The discussion then turns to an examination of whether the Eighth Amendment can provide a basis for redefining compassionate release and whether current compassionate release policies ignore crucial Eighth Amendment jurisprudence. I argue that the Eighth Amendment requires compassionate release statutes to include a dementia diagnosis as a reason permitting conditional medical release. Moreover, elderly inmates who otherwise qualify for compassionate release but remain in prison due to a lack of resources run up against Eighth Amendment jurisprudence. The paper then covers how dementia intersects with Eighth Amendment arguments and sentencing. The paper concludes by outlining ways in which prison systems must be enhanced, including improving hospice care and dementia care within prison walls.

II. Accelerated Aging in Prison & Cognitive Decline

Not only is our prison population rapidly aging, but time spent in prison is significantly more costly for one's body. Incarcerated life accelerates the aging process, such that many longtime prisoners appear more than a decade older than their chronological ages. In fact, each year spent in prison takes two years off an individual's life expectancy.[17] For example, despite full retirement age being considered 67 by the Social Security Administration[18], Florida Statute § 944.02 defines people in prison as elderly if they are 50 years of age or older. And research suggests the average 59-year-old inmate presents geriatric conditions similar to non-inmates 75 or older.[19]

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[14] *Supporting America's Aging Prison Population: Opportunities & Challenges for Area Agencies on Aging*, NAT'L ASS'N OF AREA AGENCIES ON AGING (Feb. 23, 2017), https://www.ncchc.org/ wp-content/uploads/n4a_AgingPrisoners_23Feb2017REV-2.pdf.

[15] *ABA House adopts host of new policies, including support for ethics code for U.S. Supreme Court*, A.B.A. (Feb. 6, 2023), https://www.americanbar.org/news/abanews/aba-news-archives/2023/02/midyear-house-actions-recap/.

[16] *2021 Alzheimer's disease facts and figures*, *supra* note 9.

[17] Emily Widra, *Incarceration shortens life expectancy*, PRISON POL'Y INITIATIVE (June 26, 2017), https://www.prisonpolicy.org/blog/2017/06/26/life_expectancy/.

[18] *Retirement Benefits 2024*, SOC. SEC. ADMIN., (2024), https://www.ssa.gov/pubs/EN-05-10035.pdf.

[19] Jesse Scheckner, *Recidivism, elderly health problems among inmates are serious issues in Florida. This nonprofit is offering solutions*, FLA. POL. (Oct. 18, 2023), https://floridapolitics.com/archives/640044-recidivism-elderly-health-problems-among-inmates-are-serious-issues-in-florida-this-nonprofit-is-offering-solutions/(citing Thomas Baker, *Addressing the Elderly Prison Population in Florida: Reducing Correctional Costs and Improving Lives*, FLA. POL'Y PROJECT(Oct 2, 2023), https://floridapolicyproject.com/wp-content/uploads/2023/11/Report-FPP-Elderly-Report_Final10.15.23.pdf.

It may seem obvious that one's quality of life in prison is drastically different from the outside, but older prisoners face an unusually harsh reality. Adjustment to and life within prison is more challenging for older inmates for several reasons. Older inmates have very different needs than the rest of the prison population and often require more orderly conditions, emotional feedback, and familial support than younger inmates.[20] To compound these issues, most prisons were not designed to house older inmates or inmates who struggle with mobility and are, therefore, physically setup in very dysfunctional ways for someone who struggles with walking or might get lost if all of the hallways look similar .[21]

There are also many psychosocial and economic ways in which aging prisoners experience disadvantages. One unique way in which older prisoners experience a much different prison environment is with visitation. "Visitation while in prison is one of the few opportunities inmates have for direct contact with their outside social networks, and its benefits for improving behavior and reducing some of the stressors associated with prison life have been well documented."[22] However, older people are less likely to be visited during their time in prison.[23] This decreased social interaction can exacerbate cognitive decline. This also limits elderly prisoners in finding and communicating with trusted agents to assist in planning and carrying out necessary advance health care and estate planning documents, a privilege that elders outside of prison can engage in and that is highly recommended for aging gracefully and autonomously.[24] Moreover, holistic estate planning enhances the ability of families to pass down generational wealth.[25] The inability to plan for aging disadvantages lower-income families and often results in title issues which further deprive families from realizing the benefits of their ancestor's labor during their lifetime.[26]

Overall, older adults in prison are much more costly to taxpayers than younger adults in prison given the significant health care issues which arise with age.[27] "Facilities that house more people over 50 spend on average five times more on medical care and 14 times more on prescription drugs."[28] "Older adults use more prison healthcare services than younger adults and are commonly treated in outside community hospitals for costly acute events related to chronic disease."[29] The National Institute of Corrections estimates that the annual cost of incarcerating elders with chronic conditions is two to three times the cost of other incarcerated age groups.[30] And in 2013, the Federal Bureau of Prisons (BOP) spent 19% of its total budget to incarcerate older adults.[31] Moreover, from 2001 to 2018, over 30,500 elderly people died in prison, 97% of

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[20] Jessica Rich & Julie N. Brancale, *Behind the gray walls: an examination of prison visitation among older inmates*, 5 J. CRIME AND JUST., 662, 662 (2024).
[21] *Id.* at 663
[22] *Id.*
[23] *Id.*
[24] *See* The Miller Elder Law Firm, The Future of Aging Gracefully is Life Care Planning, YOUTUBE (Apr. 14, 2023), https://www.youtube.com/watch?v=5GAxZwsoWPQ
[25] *See generally* Danaya C. Wright, *Trapped Between the URPTODA and the UPHPA: Probate Reforms to Bridge the Gap and Save Heirs Property for Modest-Wealth Decedents*, 127 PENN ST. L. REV. 749, 757 (2023).
[26] *Id.* at 756.
[27] Tina Chiu, *It's About Time: Aging Prisoners, Increasing Costs, and Geriatric Release*, VERA INST. OF JUST., (April 2010), https://www.vera.org/downloads/publications/Its-about-time-aging-prisoners-increasing-costs-and-geriatric-release.pdf.
[28] Thomas Baker, *Addressing the Elderly Prison Population in Florida: Reducing Correctional Costs and Improving Lives,* FLA. POL'Y PROJECT (Oct. 2, 2023), https://floridapolicyproject.com/wp-content/uploads/2023/11/Report-FPP-Elderly-Report_Final10.15.23.pdf (citing U.S. DEP'T OF JUST.,*The Impact of an Aging Inmate Population on the Federal Bureau of Prisons*, OFFICE OF THE INSPECTOR GENERAL, https://oig.justice.gov/reports/2015/e1505.pdf. (Feb. 2016)).
[29] Williams, *supra* note 2, at 1150.
[30] McKillop & Boucher, *supra* note 3, at 5.
[31] *Id.*

which were due to illnesses that are undoubtedly exacerbated within the prison setting.[32] Overwhelmed prisons paired with inadequate medical care lead to situations like those outlined in the quote below, from an older prisoner.

> When I had my last surgery in prison, um, there was a 93-year-old man, white guy, he was a nice guy. He was in there, I believe, for, um, assault. He's been in there for like 17 years or 18 years, but this guy is in a hospital. He can't even hold his bowels, so I'm like what is a guy like this going to do? What is he going to do? He can't, he can barely walk. He's been in a hospital, in a hospital or infirmary, for a year. What is he going to do? You'll see guys in there that just sit there staring into space.[33]

While the health care implications of aging in prison are costly enough, time spent in prison also directly increases the possibility of developing dementia.[34] Prison provides an overall lack of stimulation and generally poor quality of life, factors that increase the likelihood of cognitive decline.[35] This puts elderly prisoners more at risk because having dementia makes one more vulnerable to abuse and bullying, including sexual abuse, in part due to the erratic and unpredictable behavior that encompasses the condition.[36] The inability to follow rules and directions often aggravates other prisoners and staff in an environment that is already tense. If inmates become aggressive toward staff, they're more likely to be reprimanded.[37] Confused behavior associated with dementia may often appear as though one is acting out, resulting in reprimand or punishment. An elderly prisoner with dementia is more likely to be noncompliant with correctional rules and directions (as simple as not wearing slippers outside of the cell block), but that noncompliance is likely to be treated as a "disciplinary issue rather than a medical issue."[38] Moreover, many behaviors related to dementia (such as not being able to follow directions) coupled with a "highly volatile prison environment may place persons at risk of becoming victims or perpetrators of violence."[39]

Often, vulnerabilities within the prison setting lead to individuals being placed in solitary confinement or isolated.[40] It is estimated that "more than 44,000 people 45 and older experience solitary confinement in state prisons each year."[41] Solitary confinement conditions "shorten lives and can be detrimental to physical, mental, and emotional health."[42] This is often one of the worst

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[32] E. Ann Carson, *Mortality in State and Federal Prisons, 2001-2018 – Statistical Tables*, U.S. DEP'T OF JUST. at 3-4, 12 (April 2021), https://bjs.ojp.gov/content/pub/pdf/msfp0118st.pdf.
[33] Tini Maschi & Keith Morgen, *Aging Behind Prison Walls: Studies in Trauma and Resilience*, COLUM. U. PRESS (2021), http://www.jstor.org/stable/10.7312/masc18258.
[34] Bryce Stoliker et al., *Older People in Custody in a Forensic Psychiatric Facility, Prevalence of Dementia, and Community Reintegration Needs: An Exploratory Analysis,* 10 HEALTH AND JUST. 4 (January 24, 2022),https://healthandjusticejournal.biomedcentral.com/articles/10.1186/s40352-022-00168-8.
[35] *Id.* at 6.
[36] Tina Maschi et al., *Forget Me Not: Dementia in Prison*, 52 THE GERONTOLOGIST 441, 444 (2012).
[37] *Id.*
[38] A.B.A. Comm'n on Law & Aging et al., *Persons Living with Dementia in the Criminal Legal System,* A.B.A 27 (2022), https://www.americanbar.org/content/dam/aba/administrative/law_aging/2022-dementia-crim-just-rpt.pdf.
[39] Maschi, *supra* note 36, at 444.
[40] *Id.*
[41] Emily Widra, *The Aging Prison Population: Causes, Costs, and Consequences*, PRISON POLICY INITIATIVE (August 2, 2023), https://www.prisonpolicy.org/blog/2023/08/02/aging/#:~:text=Aging%20throughout%20the%20criminal%20legal%20system&text=Meanwhile%2C%20older%20people%20make%20up,%25%20to%20a%20whopping%2015%25.
[42] *Id.*

solutions for someone struggling with dementia because it will likely increase paranoia. Extensive research shows that one of the most fruitful activities for elders struggling with dementia is something that involves creativity and socialization.[43] The BOP does not provide programming specifically focused on elderly inmates and elderly inmates often struggle to become involved in regular programming due to having already completed most of the eligible programs.[44] This leads to elderly inmates being more idle and often not participating in any activities or programs at all.[45]

Proper treatment for dementia is especially challenging inside prison settings.[46] And detection is very difficult, resulting in many cases going unnoticed. Moreover, environmental influences, like the stress of living in prison, can easily exacerbate symptoms of dementia.[47] Federal prisons do not routinely screen older people for Alzheimer's disease and other forms of dementia unless they exhibit symptoms, which the rigidity and monotony of institutional life can often aid in masking.[48] In order to diagnose and treat dementia, health care workers evaluate an individual's activities of daily living (ADLs). These include activities relating to personal care and include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating.[49] It is extremely difficult to properly assess ADLs within a prison setting because of the constraints on daily life.[50] And failing many of these ADLs may more often be seen as a reason for punishment rather than a requirement for proper treatment. For example, people with dementia often wander[51] and "experience changes in how they respond to sex, be inappropriate or aggressive, mistake a person for someone else, or behave sexually in public."[52] These kinds of actions will often lead to punishment within the prison setting if not seen as a symptom of disease.

One common band-aid for dementia is medication. This is true of both long-term care facilities outside of the prison setting as well as within prisons.[53] For example, in nursing homes, people are given antipsychotic drugs despite requesting not to be placed on them, and often without the informed consent of family members.[54] This lack of informed consent is no-doubt exacerbated in a carceral setting.[55] Moreover, many common nonpharmacological treatments for dementia, such as behavior modification, scheduled toileting, and massage are all much more difficult to administer within a prison setting.[56]

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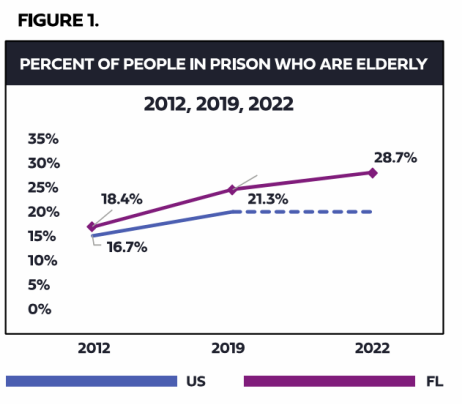
[43] *See* Opening Minds Through Art, *Research-Backed,* https://scrippsoma.org/.
[44] U.S. DEP'T OF JUST., *supra* note 28, at 31.
[45] *Id.*
[46] *See* Anne Feczko, *Dementia in the incarcerated elderly adult: Innovative solutions to promote quality care*, 26 J. AM. ASS'N NURSE PRACT. 640 (2014).
[47] *Repetition*, ALZHEIMER'S ASS'N., https://www.alz.org/help-support/caregiving/stages-behaviors/repetition (last visited Sept. 14, 2024).
[48] Engelhart*, supra* note *13.*
[49] *Activities of Daily Living (ADLs): Activities of daily living are activities related to personal care*, CTR. FOR MEDICARE & MEDICAID SERVS. (2008), https://www.cms.gov/research-statistics-data-and-systems/research/mcbs/downloads/2008_appendix_b.pdf.
[50] Feczko, *supra* note 45, at 642.
[51] Maura Ewing, *When Prisons Need to Be More Like Nursing Homes*, THE MARSHALL PROJECT (Aug. 27, 2015), https://www.themarshallproject.org/2015/08/27/when-prisons-need-to-be-more-like-nursing-homes.
[52] *Dementia and Challenging Sexual Behavior*, ALZHEIMER'S SOC'Y, https://www.alzheimers.org.uk/get-support/daily-living/challenging-sexual-behaviour-dementia (last visited Sept. 14, 2024.)
[53] *US: Nursing Homes Misuse Drugs to Control Residents*, HUM. RIGHTS WATCH (Feb. 5, 2018), https://www.hrw.org/news/2018/02/05/us-nursing-homes-misuse-drugs-control-residents#:~:text=The%20use%20of%20antipsychotic%20drugs%20without%20permission%20from%20the%20resident,informed%20consent%20for%20these%20medications.
[54] *Id.*
[55] *How Nursing Homes in the United States Overmedicate People with Dementia*, HUM. RIGHTS WATCH (Feb. 5, 2018), https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia.
[56] *Id.*

Seeking proper screening and treatment for dementia while in prison presents numerous hurdles. For example, experts recommend an MRI of the head for suspected dementia patients.[57] This means that patients likely have to be transported off-site by escorts, and administration will have to work around standard prison procedures like head counts, wrist restraints, and waist chains.[58] Further, any metal restraints would need to be removed or replaced by plastic devices for the MRI.[59] Prison administration would likely question the necessity of this hassle considering the time, expense, and safety risks involved.[60] But if such procedures are standard practice outside of the prison setting and are recommended by clinicians, does not following them result in an Eighth Amendment violation?[61]

III. Florida Compassionate Release as a Case Study

The combination of a rapidly increasing elderly prison population and a lack of access to adequate health care has led to a crisis within Florida's prison systems, whose elderly prison population is growing even faster than the national rate (Figure 1).[62] Florida has the third largest correctional system in the United States, behind only Texas and California, but leads the nation in the number of older inmates.[63] Florida also effectively abolished parole in 1983.[64] The abolishment of parole, along with many tough-on-crime laws, has led to Florida having an incarceration rate of 795 per 100,000 people, locking up a higher percentage of people than any democratic country on Earth.[65]



[66]

As of 2022, approximately 29% of Florida prisoners are considered elderly.[67] Moreover, "healthcare accounts for over 20% of the daily costs of housing people in Florida's prisons or about $18 per elderly inmate per day."[68] In contrast, California, which runs multiple prison facilities that

[57] Feczko, *supra* note 46, at 644-45.
[58] *Id.* at 645.
[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] Thomas Baker, *Addressing the Elderly Prison Population in Florida: Reducing Correctional Costs and Improving Lives*, FLA. POL'Y. PROJECT (Oct. 15, 2023), https://floridapolicyproject.com/wp-content/uploads/2023/11/Report-FPP-Elderly-Report_Final10.15.23.pdf, Figure 1.
[63] *Annual Report Fiscal Year 2021-2022*, FLA. DEP'T. OF CORRECTIONS (2022), https://www.floridaoig.com/library/Annual_rpts/2021-2022/2021-22-FDC-Annual%20Report.pdf.
[64] *Release Types,* FLA. COMM'N. ON OFFENDER REV., https://www.fcor.state.fl.us/release-types.shtml (last visited Sep. 14, 2024).
[65] *Florida Profile*, PRISON POL'Y INITIATIVE (2023), https://www.prisonpolicy.org/profiles/FL.html.
[66] Baker, *supra* note 62, at 3 Figure 1.
[67] *Id.*
[68] Baker, *supra* note 62, at 4.

specifically address the needs of elderly inmates, expects to spend about $26,000 per inmate in their specialized facilities next year, which house inmates experiencing cognitive decline.[69]

Prisons in the United States were not designed for short-term placement, rather, they were designed to deter those that committed offenses from committing future crimes.[70] This principle completely unravels in the context of elderly prisoners suffering from dementia. Research has conclusively shown that long before age 50, most people have outlived the years in which they are most likely to commit crimes.[71] Older inmates are also significantly less likely to reoffend, according to a July 2022 U.S. Sentencing Commission study, which found older offenders' recidivism rates sat at 21% compared to 53% for those under 50.[72] And recidivism rates in Florida are lowest for the 60 and up population.[73]

Given Florida's unique position, one may expect increased attention toward developing policies which address the aging prison population. However, many systems which other states have revised and supported, like compassionate release statutes and hospice programs within prisons, are lacking in Florida.[74] While elderly inmates, on average, cost far more to take care of than younger inmates, adequately addressing dementia care requires a whole host of resources outside of simple things like just providing adequate medical care and making facilities more accessible for elderly inmates with ramps and handrails. Holistic care requires prison employees who are trained in dementia awareness and management systems which address the cognitive hurdles of navigating a day while experiencing dementia. People running prisons are usually the first to point out that they desperately need more funding to retrofit current facilities to meet these demands, and that hiring appropriately trained staff for adequate wages has become a huge issue.[75] Therefore, solving this issue in Florida requires much more than simply updating statutes and regulations. It requires resources and direct funding.

Florida currently incarcerates over 8,600 people 60 or older.[76] Releasing even a fraction of the people over 60 could result in millions of dollars in savings for Florida taxpayers with minimal risk to public safety considering recidivism rates for the elderly.[77] However, it is difficult to ensure that the compassionate release systems which are in place are adequately followed because there is little oversight of the process, and policies vary widely. [78]

Florida's Conditional Medical Release (CMR) statute has not undergone substantial change since its creation in 1994. Unlike conditional release, conditional *medical* release specifically addresses the challenge of release for medically vulnerable individuals.[79] As it currently stands, Florida's CMR statute does not include language specific to dementia or cognitive decline, but

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[69] Sharon Bernstein, *California deals with dementia among aging inmates*, REUTERS (June 19, 2018), https://www.reuters.com/article/business/healthcare-pharmaceuticals/california-deals-with-dementia-among-aging-inmates-idUSKBN1JF1XH/.
[70] Maschi, supra note 36*, at* 443.
[71] *See* Travis Hirschi & Michael Gottfredson, *Age and the Explanation of Crime*, 89 AM. J. SOC. 552, 558–59 (1983).
[72] Kristin M. Tennyson et al., *Older Offenders in the Federal System*, U.S. SENT'G COMM'N at 5 (July 2022), https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2022/20220726_Older-Offenders.pdf.
[73] Baker, *supra* note 62, at 6.
[74] *See infra* Pt .VI. b. for a discussion on policies in California, New York, and Massachusetts.
[75] Meg Anderson, *The U.S. Prison Population is Rapidly Graying. Prisons Aren't Built for What's Coming*, NPR (Mar. 11, 2024), https://www.npr.org/2024/03/11/1234655082/prison-elderly-aging-geriatric-population-care.
[76] Baker, *supra* note 62, at 9.
[77] *Id.*
[78] Margaret Holland et. al., *Access and utilization of compassionate release in state departments of corrections,* MORTALITY 49, 58 (April 2020).
[79] FLA. COMM'N. ON OFFENDER REV., *supra* note 64.

such medical issues are not necessarily barred from being raised under the statute.[80] The CMR statute also fails to provide a reliable and consistent procedure to ensure eligible inmates are being identified and recommended for release consideration. The statute authorizes the Florida Commission on Officer Review (FCOR) sole discretionary power to deny, grant, or revoke an inmate's conditional medical release.[81] Three commissioners currently sit on FCOR.[82] Further, the statute only permits the Florida Department of Corrections (DOC) to refer an inmate for conditional medication release.[83] However, the statute lacks specificity regarding who within DOC has the power to identify and refer inmates for consideration. Due to the lack of specificity, DOC promulgated an administrative code designating the "Chief Health Officer of an institute" as the DOC employee who must identify a potentially eligible inmate.[84] The Chief Health Officer then refers the inmate to the "Director of Health Services."[85] Then, the Director of Health Services has the discretion to reject the recommendation, defer the referral until further investigation, or refer the inmate for consideration by FCOR.[86] This creates a double-tier discretionary regime in which an eligible inmate must first be subjectively identified and preliminarily screened by DOC prior to being referred to FCOR for full and complete consideration. Under the statute, inmates do not have the right to conditional medical release, to a medical evaluation to determine eligibility, or to appeal a denial of release. [87]

Typically, the process of a CMR hearing goes as follows: the moderator identifies the eligible candidate by name, any parties in support of the inmate's medical release have ten minutes to offer any testimony, then any parties in opposition of the inmate's medical release have ten minutes to offer any testimony. Then each commissioner states their ruling, and in the event the release is granted, one of the commissioners in favor of release details the conditions of the inmate's release.[88] There is no opportunity to offer a rebuttal argument.[89]

Moreover, the chances of finding yourself in front of FCOR are extremely low. Over the past five years, FCOR on average grants CMR to half the inmates who are referred, with an average of 68 inmates being referred per year.[90] It is not uncommon to go before the board multiple times and still be denied CMR.[91] The low referral numbers are also inconsistent with the elderly

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[80] FLA. STAT. § 947.149 (2024).
[81] *Id.* at § 947.149(3).
[82] *Organization*, FLA. COMM'N ON OFFENDER REV. (last visited Sept. 13, 2024), https://www.fcor.state.fl.us/overview.shtml).
[83] FLA. STAT. § 947.149(3).
[84] FLA. ADMIN. CODE §§ 33-401.201(2) (2002).
[85] *Id.*
[86] *Id.*
[87] FLA. STAT. § 947.149(2) (2024).
[88] Telephone call: Florida Commission on Offender Review Vote (Feb. 21, 2024) (on file with author). All commission voting schedules are publicly available and anyone can call in to a hearing(https://fpcweb.fcor.state.fl.us/Schedule.aspx.)
[89] *Id.*
[90] This average is taken from FCOR 2018–19 to 2022–23 Annual Reports. FCOR grants a certain inmates release from those who were referred, each year is as follows: FY 2018–2019 38/76 granted CMR; FY 2019–2020 35/65 granted CMR; FY 2020–2021 46/79 granted; FY 2021–2022 26/65; FY 2022–2023 28/57; for an average of 35/68 inmates being granted CMR. https://www.fcor.state.fl.us/reports.shtml.
[91] Tina Maschi et al., *Analysis of United States Compassionate and Geriatric Release Laws: Towards a Rights-Based Response for Diverse Elders and Their Families and Communities*, FORDHAM U., 35 (May 9, 2015).
Jules Sauvageau, a 59-year-old man in prison for attempted murder:

> I started stealing when I was 15. I robbed banks. I always worked alone. In 1994, I was caught for attempted murder. I had mixed booze and medications. Eighth months ago I got married to a woman my age and it's going well. That's why I want my release, to live with her. In 1996 I got lung cancer. Now, I'm getting treated but they won't release me. They're waiting for me to die. I lost 50 pounds since October 1999. I regret committing the crime that sent me here, but I think the system isn't fair for the situation I'm living in now.

population in prisons. Part of this may be a result of the decision to recommend an inmate to FCOR resting with the Chief Health Care Officer and Director of Health Services.[92] An inmate's family can only encourage DOC to recommend the inmates release through calls, emails, and letters.

The exclusive responsibility of identifying eligible inmates, and a lack of awareness of the program in general, prevents eligible individuals from making a direct recommendation of an inmate to FCOR. For example, Bob, an inmate serving the remainder of his 5-year sentence at Jefferson Correctional Institute in Monticello, Florida (C.I.), works as a medical orderly and emergency response assistant at the institute's medical center. [93] Bob explained that the vast majority of the inmates currently occupying beds on the medical unit are elderly suffering from dementia or are stroke victims, and that rarely does the unit see a younger inmate.[94] Only 12 beds make up this medical unit, two of which are isolation beds for inmates in administrative confinement or who otherwise pose a threat but still require medical attention.[95] Currently, some patients on the unit include a patient who suffers from repeated seizures, a paraplegic patient with Multiple Sclerosis, a stroke victim who lost the use of one arm, and two patients with portable defibrillators.[96] When asked about conditional medical release, Bob stated he heard about the program but did not know any details regarding eligibility or the process.[97]

While simple statutory modifications can be seen as a straightforward remedy, the reality of a successful whole-scale amendment to Florida's CMR system is likely years away. During the 2024 legislative session, Rep. Dianne Hart introduced a general bill that revised the definition of "permanently incapacitated inmate" to include physical disability, disability, impairment, or handicap.[98] Upon enactment, this revision would broaden the scope of who can be considered a "permanently incapacitated inmate," thereby allowing a wider range of inmates to be eligible for consideration, including a dementia diagnosis. Unfortunately, this bill died in the Senate Criminal Justice Subcommittee.[99] Nevertheless, it is important to note that several components of Florida's CMR statute can be easily improved to better address the rapidly increasing elderly population in Florida's prisons.

a. Expand Referrals

First, the statute should permit non-DOC employees to formally refer eligible inmates. Then FCOR can make the final determination on "whether or not to grant conditional medical release and establish additional conditions" of release.[100] Illinois has adopted such an approach and has experienced a shift from institution referrals to inmate-filed referrals, which enhances

> There should be improvements. Especially when someone has cancer. They should let them go live with their family. I was twice refused conditional release.

[92] REGGIE GARCIA, HOW TO LEAVE PRISON EARLY: FLORIDA CLEMENCY, PAROLE, AND WORK RELEASE 33 (2015).
[93] Interview with anonymous inmate.
[94] *Id.*
[95] FLA. ADMIN. CODE. ANN. r. 33-602.220 (2022). "Administrative Confinement – refers to the temporary separation of an inmate from inmates in general population in order to provide for security and safety until such time as a more permanent inmate management decision process can be concluded, such as a referral to disciplinary confinement, close management, protective management, or a transfer."
[96] Interview with anonymous inmate.
[97] *Id.*
[98] H.B. 233, 2024 Leg., Reg. Sess. (Fla. 2024).
[99] HB 233: Treatment of Inmates, FLA. SENATE (Mar. 8, 2024), https://www.flsenate.gov/Session/Bill/2024/233/?Tab=BillHistory.
[100] FLA. STAT. 947.149(3) (2023).

inmate autonomy.[101] Moreover, by allowing more parties to recommend an inmate, Florida could alleviate the burden shouldered by the Chief Health Officer of an institute. The Chief Health Officer is responsible for all inmates in their institute and must ensure that each inmate receives a current medical, dental, and mental assessment.[102] Unencumbered from having to make the medical determination of eligibility and a risk-assessment of the inmate's dangerousness, the Chief Health Officer can focus on his or her primary responsibilities.[103]

b. Include Dementia and Cognitive Decline Factors for CMR Eligibility

Second, although Florida amended the CMR statute in 2015 to include an elderly and infirm eligibility definition,[104] the statute should also address release for geriatric inmates suffering from non-terminal illnesses, like dementia. An inmate is determined to be "terminally ill" when he or she has a condition caused by injury, disease, or illness that "renders them terminally ill to the extent there can be no recovery and death is imminent."[105] Language narrowly construing what is considered terminally ill significantly reduces the number of inmates eligible for conditional medical release who are otherwise suffering in prison for no retributive purpose.

Florida should expand the eligibility criteria to include inmates who are suffering from a permanent, debilitating, non-terminal illness to broaden the pool of eligible inmates and formally include diagnosable medical conditions such as dementia, recurrent strokes, and severe permanent medical or cognitive disability as a third category of eligibility.[106] The new eligibility requirement could be titled "chronically ill" to specifically permit elderly inmates an avenue for requesting medical release.[107] In conjunction with an added eligibility category, Florida should define "imminent" in order to establish a governing timeframe for assessment and decision-making.[108] A defined time frame will afford DOC, or any initiating individual, adequate time to initiate the referral process. Further, the approach of a generous time frame will likely result in eliminating the possibility that an inmate will pass away prior to FCOR consideration.

c. Reporting

Third, the CMR statute should provide guiding considerations and mandate reporting of FCOR's determinations. The Florida Sunshine Laws establish a basic right of access to most meetings of "boards, commissions, and other governing bodies of state and local governmental agencies or authorities."[109] These statutes are construed in favor of public access and are comprehensive but require no specific information to be provided by individual agencies.[110] FCOR

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[101] *Joe Coleman Act 2022 Annual Report*, ILL. PRISONER REV. BD.(2022), https://prb.illinois.gov/content/dam/soi/en/web/prb/documents/22JCanlrpt02.pdf.
[102] *Health Services*, FLA. DEP'T CORR. https://fdc.myflorida.com/org/health.html (last visited Sep. 15, 2024).
[103] FLA. STAT. § 947.149(1) (2023).
[104] Reggie Garcia, *Prison Conditional Medical Release: Good for Public Health and Safety, Taxpayers and Inmates*, 2020, FLA. DEFENDER 18, 20.
[105] FLA. STAT. § 947.149(1) (2023).
[106] 730 III. COMP. STAT. 5/3-3-14 (2023).
[107] Families Against Mandatory Minimums, *Special Needs Parole*, FAMM COMPASSIONATE RELEASE (Mar. 2022) https://famm.org/wp-content/uploads/2018/06/Colorado_Final.pdf. This portion is modeled after Colorado's Special Needs Parole statute since neither Illinois nor Florida adequately provide for exclusive release criteria for elderly inmates.
[108] Families Against Mandatory Minimums, *About Us*, FAMM (2024), https://famm.org/about/.
[109] Office of Attorney General Ashley Moody, *The "Sunshine" Law*, MY FLA. LEGAL, https://www.myfloridalegal.com/open-government/the-quotsunshinequot-law (last visited August 15, 2024).
[110] *Id.*

publishes an Annual Report that reports the number of inmates granted or denied conditional medical release for that fiscal year. [111] However, unlike, for example, the Illinois Prisoner Review Board, FCOR does not have to detail under which eligibility criteria the inmate was granted relief.[112] Creating guidelines for how FCOR determines eligibility for cognitive decline would assist all parties involved in having a better idea of how to navigate the CMR system and how individuals can best advocate for their loved ones. Providing guidelines will encourage the review board to evaluate each inmate's recommendation according to the same factors, leading to more consistent results.

However, even if statutory changes are adopted, this does not solve the resource issue of ensuring that inmates who are released are properly taken care of given their significant medical needs. As discussed below, the Eighth Amendment provides a framework for this further analysis.

IV. Dead Time Incarceration & Compassionate Release

Even people with dementia who do obtain early release may still find themselves stuck in prison due to a lack of resources outside the prison setting and an inability to find appropriate housing and medical care.[113] DOC is tasked with developing a "release plan" for each individual, and such a plan cannot be developed without outside resources.[114] This becomes an impossible task for DOC because many elder prisoners have lost contact with family members and don't have anyone on the outside able to provide or fund round-the-clock care.[115] And nursing homes are often unwilling to house people on compassionate release.[116] It is clear that CMR may be inappropriate for an inmate with severe medical needs if that person has no family home, nursing home, or other care facility to go to because prison may be the only place where their needs can be adequately met. DOC has expressed that they are eager to utilize the CMR statute when appropriate, but that a majority of folks eligible for release are forced to stay in prison because they have nowhere else to go and DOC cannot simply release them with no place to sleep that night or to a home that does not contain adequate medical equipment to care for their needs.

This lack of resources results in extended periods of incarceration for elderly prisoners suffering from dementia or other severe medical conditions. In other contexts, scholars have characterized this extended period of incarceration due specifically to the lack of a suitable post-release residence as "dead time" incarceration.[117] For example, Christopher B. Scheren has analyzed dead time incarceration in the context of convicted sex offenders, who experience a host of locational prohibitions when it comes to finding housing due to their criminal status.[118] Scheren argues that the Eighth Amendment prohibits forcing those convicted of sex offenses to remain in prison after they have served their entire sentence when they cannot find approved housing for reasons of indigency due to the extreme lack of affordable and accessible housing for this unique

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[111] *See 2023 Annual Report*, Fla. Comm'n on Offender Rev. (2023), https://www.fcor.state.fl.us/docs/reports/Annual%20Report%20%2022-23%20-%20Final.pdf.
[112] Fla. Stat. 947.149(1) (2024).
[113] Engelhart, *supra* note 13.
[114] Michael Manguso & Deborrah Brodsky, *Florida's Aging Inmate Population*, Project on Accountable Just. 19 (Mar. 27, 2015), https://www.splcenter.org/sites/default/files/florida_aging_prisoners_march_27_2015_-_project_on_accountbale_justice.pdf.
[115] Engelhart, *supra* note 13.
[116] *Id.*
[117] Christopher B. Scheren, Note, *Sentence Served and No Place To Go: An Eight Amendment Analysis of "Dead Time" Incarceration*, 118 Nw. U. L. Rev. 1167, 1170 (2024).
[118] *Id.* at 1167.

group.[119] Scheren's Eighth Amendment argument is based on *Robinson v. California*, in which the Supreme Court held that punishment based on "status" violates the Eighth Amendment's prohibition of "cruel and unusual" punishment.[120] Under Scheren's analysis, the "status" of being a sex offender results in the unique punishment of having to remain in prison due to a lack of resources.[121] Similarly, the status of being an elderly prisoner suffering from dementia and eligible for compassionate release results in the specific punishment of having to remain in prison due to a lack of resources.

In *Robinson v. California*, the defendant was convicted under a California statute that prescribed a jail sentence for being "addicted to the use of narcotics."[122] The defendant was arrested based on his appearance of being an addict given various scabs and needle marks, despite police not witnessing the defendants use of narcotics and the defendant denying such use.[123] The defendant was convicted based on his "condition or status" of being an addict.[124] The Supreme Court subsequently held that punishment for the status of being an addict was unconstitutional and specifically analyzed the status of being an addict as a disease, rationalizing that criminalizing someone based on their health status was cruel and unusual.[125]

While *Robinson* established that forms of disease are a status that one cannot be punished based on, the Court has been less reluctant to extend the Eighth Amendment's ban on status-based punishment to include economic status, such as indigency or homelessness, which in many cases is a determining factor for people eligible for compassionate release.[126] However, The Fourth and Ninth Circuits recently issued rulings that laws directed toward homeless individuals are unconstitutional under the Eighth Amendment because the unavoidable effects of involuntary homelessness cannot be criminalized.[127] Moreover, the Northern District of Illinois has, on three occasions, acknowledged an Eighth Amendment violation when the state continued to incarcerate indigent people convicted of sex offenses who have completed their sentence, but who have not been released due to their inability to find and secure an appropriate residence.[128] And courts in New York have addressed similar scenarios but have failed to find an Eighth Amendment violation based on the facts presented, despite adopting the principle that punishing someone for the unavoidable results of his or her status is unconstitutional.[129]

Academic discussions and legal arguments on "dead time" incarceration have primarily focused on those convicted of sex offenses.[130] I posit that a "dead time" incarceration lens is ideal for analyzing the experience of elderly prisoners otherwise eligible for compassionate release. Dead time incarceration for convicted sex offenders is similar to when people eligible for compassionate release face extended incarceration because they cannot find appropriate housing.

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[119] *Id.* at 1170-71.
[120] *Id.* at 1167. (citing Robinson v. California, 370 U.S. 660, 666-67 (1962)).
[121] *Id.* at 1192.
[122] 370 U.S. at 660.
[123] *Id.* at 661-62.
[124] *Id.* at 662-63.
[125] *Id.* at 666-67; *see also* Powell v. Texas, 392 U.S. 514 (1968) (refining *Robinson* to make it clear that the Court viewed punishment of one's status, rather than one's actions, as unconstitutionally cruel and unusual).
[126] Tim Donaldson, *Criminally Homeless? The Eighth Amendment Prohibition Against Penalizing Status* 4 CONCORDIA L. REV. 1, 19 (2019).
[127] Scheren, *surpra* note 118, at 1188-1189 (citing City of Martin v. Boise, 920 F.3d 584, 617 (9th Cir. 2019), and Manning v. Caldwell, 930 F.3d 264, 283 (4th Cir. 2019)).
[128] *See* Murphy v. Raoul, 380 F. Supp. 3d 731, 738 (N.D. Ill. 2019); Barnes v. Jeffreys, 529 F. Supp. 3d 784, 787 (N.D. Ill. 2021); Stone v. Jeffreys, No. 21 C 5616, 2022 WL 4596379, at *1 (N.D. Ill. Aug. 30, 2022).
[129] Scheren, *surpra* note 118, at 1196-97.
[130] *See, e.g.*, *Barnes*, 529 F. Supp. 3d at 791 (after completing a prison sentence, plaintiff spent more than 18 months of "dead time" in prison because of his inability to find an acceptable host site due to his sex offender status.).

When the government's response to a lack of adequate services is to continue to incarcerate those people on "dead time", this violates the Eighth Amendment by inflicting punishment on people who simply have the dire combination of a severe medical status and a lack of funds to maintain their health. This essentially results in punishment for being poor or because nursing facilities refuse to take them specifically due to their criminal status despite any ability to pay.

Scholars have suggested that the original purpose of the Eighth Amendment focused on treating like-offenders equally, a view which would require a lack of community housing upon release to not affect time spent in prison.[131] Continuing to incarcerate people otherwise qualified for compassionate release due to their inability to secure approved housing is unconstitutional under the Eighth Amendment. This is because their status in prison rests on the fact that they are indigent; someone who has the financial means to find a residence which meets their medical needs would be eligible for release.

According to the 2022 American Bar Association report, compassionate release is rarely used and many federal prisoners will die over the months it takes for applications to be reviewed.[132] Compassionate release is even more rare for prisoners struggling with dementia because the Federal Bureau of Prisons has interpreted the statute as applying only to prisoners who are terminally ill or close to death.[133] This is where the next component of a holistic approach comes in: hospice and dementia care in prisons.

V. Dementia & Sentencing Under the Eighth Amendment

Correctional institutions have a constitutional obligation to provide an acceptable level of health care to inmates, which includes care specifically for the elderly.[134] In *Estelle v. Gamble*, the U.S. Supreme Court recognized that the "deliberate indifference to serious medical needs of prisoners constitutes 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment."[135] The Court stated that the "denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose."[136]

Where does dementia care fall on the scale of medical care? Surely people struggling with dementia are also going through much mental pain and suffering, as well as physical anguish connected to their cognitive decline. Does a lack of proper dementia care in prison rise to the level of an Eighth Amendment violation if gone unaddressed? Should dementia be a factor in sentencing reductions? The rumblings of related questions are starting to find their way into Eighth Amendment jurisprudence.

a. The Eighth Amendment

While *Estelle* requires a certain level of general medical services, no such case law exists supporting the same minimum standard of care specifically for geriatric services or dementia services. In 2000, only 4% of state institutions provided any type of geriatric-specific health care

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[131] Scheren, *surpra* note 118, at 1183 (citing Laurence Claus, *The Anti-Discrimination Eighth Amendment*, 28 HARV.. J.L. & PUB. POL'Y 119, 121-122 (2004)).
[132] Engelhart, *supra* note 13.
[133] *Id.*
[134] Estelle v. Gamble, 429 U.S. 97, 108 (1978).
[135] *Id.* at 103 (citing Gregg v. Georgia, 428 U.S. 153, 172 (1976)).
[136] *Id.*

services.[137] No data was available for federal facilities in more recent years.[138] If the criminal system's organizational management of geriatric or dementia care is vague, legal challenges involving dementia in prison will inevitably take longer to find their way through the courts.

Although death is different for the purposes of sentencing and release when it comes to cognitive issues, case law still suggests that the Eighth Amendment could influence sentencing and compassionate release policies when it comes to elderly prisoners struggling with dementia. For example, in the capital context, the U.S. Supreme Court, in *Ford v. Wainwright*, held that the Eighth Amendment's ban on cruel and unusual punishments precludes executing a prisoner who has "lost his sanity" after sentencing.[139] Years later, in *Panetti v. Quarterman*, the Court then set out the appropriate competency standard: a State may not execute a prisoner whose "mental state is so distorted by a mental illness" that he lacks a "rational understanding" of "the State's rationale for [his] execution."[140] The *Panetti* standard focuses on whether a mental disorder has had a particular *effect*, not on the cause of any particular disorder.[141]

While the *Ford* and *Panetti* jurisprudence focuses more acutely on psychotic delusions associated with incompetency and does not directly address dementia, the U.S. Supreme Court recently found this precedent instructive and clarified that dementia *may* preclude an execution under the Eighth Amendment in *Madison v. Alabama*.[142] The Court noted that a "prisoner's inability to rationally understand his punishment" removes the "retributive purpose" from a prisoner's execution.[143] The Court, in *Madison*, articulated that "*Ford* and *Panetti* hinge on the prisoner's '[in]comprehension of why he has been singled out' to die, and kick in if and when that failure of understanding is present, irrespective of whether one disease or another is to blame."[144]

The Court clarified that the Eighth Amendment does not forbid execution whenever a prisoner shows that a mental disorder has left him without any memory of committing his crime "because a person lacking such a memory may still be able to form a rational understanding of the reasons for his death sentence."[145] The Eighth Amendment applies similarly to a prisoner suffering from dementia as it does to one experiencing psychotic delusions because either condition may "impede the requisite comprehension of his punishment."[146] The principles from *Panetti* indicate how to identify prisoners whom the State may execute, but the critical question is whether a "prisoner's mental state is so distorted by a mental illness" that he lacks a "rational understanding" of "the State's rationale for [his] execution."[147] The difference is whether a person has a "rational understanding" and not whether they have any particular memory.[148]

The *Panetti* standard concerns not the diagnosis of illness, but the consequence of illness.[149] Because dementia comes in many forms, some resulting in complete disorientation and some which allow a person to preserve the understanding of consequences, the Court explained that the Eighth Amendment may, but does not automatically, require a bar on execution.[150]

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[137] Maschi, *supra* note 36, at 448.
[138] *Id.* at 449.
[139] Ford v. Wainwright, 477 U.S. 399, 406 (1986).
[140] Panetti v. Quarterman, 551 U.S. 930, 958-959 (2007).
[141] Madison v. Alabama, 139 S. Ct. 718, 721 (2019).
[142] *Id.* at 718 (citing *Ford*, 477 U.S. at 39; *Panetti*, 551 U.S. at 930).
[143] *Id.* at 728.
[144] *Id.* at 721 (citing *Ford*, 477 U.S. at 409).
[145] *Madison*, 139 S. Ct. at 722.
[146] *Id.* at 722.
[147] *Id.* at 723 (*quoting Panetti, 551 U.S.* at 958–959)
[148] *Madison*, 139 S. Ct. at 727.
[149] *Id.* at 728.
[150] *Id.*

Many plaintiffs suffering from dementia are also likely to have other significant cognitive issues, like in *Madison*, which makes it difficult to keep cases focused specifically on Eighth Amendment claims, as they relate narrowly to dementia. Moreover, courts have recognized that cognitive disorders are "difficult to identify and diagnose"[151] and many cases have remanded or simply not addressed issues when they felt evidence was insufficient that the plaintiff had dementia.[152] But issues involving dementia are not uncommon in the criminal context, despite not always being the center of litigation. For example, if a prisoner is diagnosed with dementia, improper medications may lead to an Eighth Amendment violation because proper health care might not be administered.[153]

b. Sentenced for Life

There is no national consensus against sentencing those with dementia to life imprisonment or what role dementia should play in sentencing.[154] Several jurisdictions, including the Ninth Circuit Court of Appeals and the Superior Court of Pennsylvania, have held that it is not cruel or unusual to sentence an elderly defendant with infirmities to either death or life imprisonment.[155]And the Court of Appeals of Washington has held that "sentencing a defendant diagnosed with dementia to mandatory life imprisonment is not cruel punishment."[156] The Washington Court disagreed with the argument that those diagnosed with dementia should be treated similarly to juveniles, who are categorically barred from being sentenced to life imprisonment without the possibility of parole in Washington State, due to their difficulty with regulating behavior.[157] This argument was rejected by the court because it failed to demonstrate that those who suffer from dementia have diminished culpability in the same way that a child might.[158]

Other jurisdictions, like the Court of Appeals of Oregon, have held that dementia *should* be considered in sentencing. In *State v. Sanderlin*, a defendant appealed a first-degree conviction for sodomy and sexual abuse.[159] On appeal, he contended the sentence imposed violated the Eighth Amendment because, prior to the conduct at issue, he had suffered brain damage and multiple strokes that resulted in "dementia, impaired intellectual function, compromised judgment, and a reduced ability to control his impulses."[160] The Court remanded the case to determine the proportionality of the sentence because the lower court had not properly considered the defendant's diminished capacity.[161]

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[151] Wilson v. Adams, 901 F.3d 816, 821 (7th Cir. 2018).
[152] *See Wilson*, 901 F.3d at 822; Hart v. Sennah, No. 2:21-cv-01127-DGE-JRC, 2022 WL 3973678, at *4 (W.D. Wash. Aug. 3, 2022).
[153] Hart v. Sennah, No. 221CV01127DGEJRC, 2022 WL 3973678, at *9 , *report and recommendation adopted*, No. 2:21-CV-01127-DGE, 2022 WL 3926601 (W.D. Wash. Aug. 31, 2022); Abernathy v. Myers, No. 3:19-CV-01062-MAB, 2023 WL 3285443, at *4, 5 (S.D. Ill. May 5, 2023), *appeal dismissed*, No. 23-2271, 2023 WL 9054664 (7th Cir. Oct. 27, 2023).
[154] State v. Moen, 4 Wn. App. 2d 589, 601 (2018).
[155] *Id.* (citing Allen v. Ornoski, 435 F.3d 946, 954 (9th Cir. 2006) (holding that the Eighth Amendment does not forbid execution of "elderly and infirm" death-row inmates); Commonwealth v. Green, 406 Pa. Super. 120 (1991) (holding that sentencing an elderly defendant who suffers from a number of infirmities to life imprisonment does not violate the prohibition against cruel and unusual punishment)).
[156] *Id.*
[157] *Id.* at 602.
[158] *Id.*
[159] State v. Sanderlin, 276 Or. App. 574, 575 (2016).
[160] *Id.*
[161] *Id.* at 576.

Some courts have even specifically held that dementia requires a reduction in sentence. For example, the United States District Court for the Eastern District of Michigan, in *United States v. Miller*, held that a 67-year-old defendant who suffered from dementia was entitled to a reduction of sentence to a period of probation specifically because he was unable to relate his imprisonment to the conduct for which he was convicted and was no longer physically or mentally capable of perpetrating crimes at issue.[162] The Court reasoned that "[w]here a defendant suffers dementia to such a degree that he is unable to appreciate the reasons for his incarceration, imprisonment fails to serve any useful purpose."[163]

Further, in *United States v. Dreyer,* the defendant, a licensed psychiatrist, began providing prescriptions of oxycodone and hydrocodone to patients outside of the usual course of professional practice and had suffered from dementia for years but went undiagnosed for many of those.[164] He was indicted on charges related to his participation in a conspiracy to possess and distribute controlled substances due to his providing of prescriptions like oxycodone and hydrocodone to patients outside his usual course of practice.[165] Although the defendant had difficulty recognizing or admitting that his actions were inconsistent with professional standards of conduct, he pleaded guilty to two counts of the thirty-count indictment.[166] In 2013, the Ninth Circuit Court of Appeals held that the court erred by not evaluating competency and ordered a hearing *sua sponte.*[167]

Other defendants have had success in arguing that dementia qualifies as a compelling reason for a sentence reduction. For example, in 2020 in *United States v. Lochmiller*, the United States District Court for the District of Colorado held that "there is no reason to believe that granting compassionate release to someone with advanced dementia who is 100 months into a 405-month sentence will fail to provide general deterrence."[168] The defendant's medical records indicate that he has suffered from dementia since at least 2014 and that his dementia was severe and worsening, qualifying it as a serious medical condition, which the state sentencing commission noted can qualify as a reason to reduce a defendant's sentence. [169] Moreover, the Court noted that the defendant was not a danger to the safety of any other person or the community and granted a sentence reduction.[170] The Court further noted that the defendant "lacks the mental capacity to perpetrate the type of crimes he was convicted of" and struggled with many things people take for granted, "such as making telephone calls or speaking in complete sentences."[171] The Court even referenced that "he was seen tearing up a photograph of he and his wife. When asked why he did it, he responded that the man in the picture is not him and he did not know 'the lady.'"[172]

The Court then went on to note that the most important factor was "the need for a sentence that provides 'just punishment for the offense,'" and that continued incarceration did not "serve a punitive purpose if [the defendant] does not know that he is being punished or why."[173] In reasoning that reducing the sentence is sufficient, but not greater than necessary, to accomplish the goals of sentencing, the Court noted the following:

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[162] United States v. Dreyer, 705 F.3d 951, 953 (2013).
[163] *Id.*
[164] *Id.* 957.
[165] *Id.*
[166] *Id.* at 957-58.
[167] *Id.* at 957.
[168] United States v. Lochmiller, 473 F. Supp. 3d 1245, 1248 (2020).
[169] *Id.*
[170] *Id.*
[171] *Id.*
[172] *Id.* at 1248-49.
[173] *Id.* at 1249 (citing *Madison*, 139 S. Ct. at 728; quoting 18 U.S.C § 3553).

> At the time Mr. Lochmiller was sentenced, the Court found that he deserved a sentence of over 33 years, which, for a 64-year-old man, was in all likelihood a life sentence. Now, however, Mr. Lochmiller's mental condition has dramatically changed. When committing his crimes, Mr. Lochmiller could look a retiree in the eye and take her life savings, knowing she would never get them back. Today, Mr. Lochmiller looks at his own face in a photograph and does not recognize himself. Courts considering compassionate release have acknowledged that a prisoner's severe medical conditions can outweigh the purposes of continued incarceration, even for serious offenses. *See United States v. Gray*, 416 F. Supp. 3d 784, 790 (S.D. Ind. 2019) (granting compassionate release to seriously ill defendant despite the seriousness of his conduct because "further incarceration in his condition would be greater than necessary to serve the purposes of punishment"). Here, the Court is not persuaded that the continued incarceration of Mr. Lochmiller in his condition promotes respect for the law, provides just punishment, or affords deterrence to criminal conduct.[174]

c. Is Release the Best Option?

Although it should be more easily available and administered consistently, compassionate release may not be the ideal solution for an across-the-board fix considering that re-entry resources are scarce for people with significant medical issues and a large number of elder inmates are in prison due to serious, violent felonies.[175] Concerns surrounding victim advocacy and inmates feigning symptoms are also relevant public policy factors to consider when building the most comprehensive approach to this crisis.

For many opponents of expansive compassionate release, "the desire to keep individuals confined may trump all other considerations."[176] In particular, Florida's countervailing state interest in public safety is apparent in the statute's language, which conditions eligibility on the inmate's lack of dangerousness.[177] In other states, like Illinois, dangerousness is but a consideration weighed by the decision-making body.[178] Arguments in favor of dead time incarceration in the sex offender context focus on the need for public safety, but this concern is not present in the conditional medical release context wherein people would not be eligible for release if public safety was still a concern.[179] With safety being a lessened concern, opponents may turn to victim advocacy as an argument against more expansive compassionate release. However, given the age of many inmates suffering from dementia, crimes may have been committed so long ago that the victims have had more time to heal, or they may no longer be alive. Victim's rights are always at play when developing criminal policies, but many such concerns are significantly diminished in the context of compassionate release.

Feigning symptoms is also a serious concern if we are to adopt across-the-board changes making compassionate release more accessible. It is extremely unlikely that inmates will be successful at getting to the compassionate release stage if symptoms are not supported by significant medical evidence. Courts have recognized that cognitive disorders are "difficult to

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[174] *Id.*
[175] McKillop & Boucher, *supra* note 3, at 5.
[176] Chiu, supra, at 8-9.
[177] *Id.* at 9.
[178] 730 III. COMP. STAT. § 3-3-14(f) (2022).
[179] *Id.* § (f)(iv).

identify and diagnose"[180] and many cases have opted to remand or simply not address issues when they felt evidence was insufficient that the plaintiff had dementia.[181] The heightened standard that the court system requires when it comes to proving medical conditions will likely keep a majority of these concerns at bay.

VI. Holistic Care in Prison

Although simple, changes to the current compassionate release regime are unlikely. But what if holistically developed programs in prison would take better care of many individuals than life on the outside would anyway?[182] How can we prepare our prisons for this crisis outside of expanded release options? Holistic programs within carceral settings are also necessary to develop a system which treats older prisoners humanely and addresses our increasing prison population which will inevitably suffer from hosts of medical issues spanning cognitive decline to cancer. Especially if dead time incarceration for elderly inmates suffering from dementia is going to continue, the system needs to adapt to an appropriate caretaking model that respects the Eighth Amendment.

a. Hospice Care

Many older prisoners may receive a death by imprisonment sentence, making end-of-life care crucial. "The first formal prison hospice program in the United States was initiated in 1987 by a pair of inmates at the United States Medical Center for Federal Prisoners (MCFP) in Springfield, Missouri."[183] The inmates then recruited eight other inmate volunteers, creating a model for prison hospice that "has since proliferated nationwide in scores of state and federal prisons and jails."[184] Programs like these "can become a transformational experience for both the caregiver and the one receiving the aid."[185]

Lesley Sharp, a medical anthropologist, has done extensive studies on how volunteer prison hospice programs affect attitudes and perceptions of dying in prison, a fate that many elderly inmates are forced to grapple with. She underscores the significant "fear[s] associated with dying in prison, especially among those who have always hoped for the reward of parole, a pardon, or completing their sentence, followed by release . . . death in prison is the greatest failure imaginable for an incarcerated man."[186] She goes on to explain that, "[s]et against a backdrop of health care

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[180] *Wilson*, 901 F.3d at 821.

[181] *Id.* (The Seventh Circuit Court of Appeals affirmed the district court's dismissal of a prisoner's Eighth Amendment claims and state-law negligence claim. The court held that insufficient evidence was presented, both in the medical records and in the form of expert testimony, to determine that the defendants had been deliberately indifferent or negligent in their treatment of the prisoner's mental and physical health).

[182] Engelhart, *supra* note 13, at 7. ("On the day I visited the unit, a few of the medical staff members told me that they previously worked in community nursing homes and that the M.D.U. prisoners are probably receiving better care than they would on the outside, in whatever Medicaid-subsidized beds they were likely to find themselves. Behind bars, the men have easy access to psychologists, social workers and a pharmacist with a specialty in geriatrics.")

[183] Lesley A. Sharp, *Death and Dying in Carceral America: The Prison Hospice as an Inverted Space of Exception*, 36 MED. ANTHRO. Q. 177, 181 (2022).

[184] *Id.*; *Our Work*, HUMANE PRISON HOSPICE PROJECT, https://humaneprisonhospiceproject.org/ (last visited Sept. 15, 2024); Open Society Foundations, *Angola Prison Hospice: Opening the Door*, YOUTUBE (Sept. 8, 2011), https://www.youtube.com/watch?v=mMLjANwBRDk.

[185] *Humane Prison Hospice Project Is Transforming the Way Terminally Ill People in Prison Die*, COMPASSION & CHOICES (Nov. 17, 2023), https://compassionandchoices.org/news/humane-prison-hospice-project-is-transforming-the-way-terminally-ill-people-in-prison-die/.

[186] Sharp, *supra* note 184, at 182.

neglect, punitive medicine, and the soft violence of aging on the inside, hospice volunteers fashion and protect an inverted space of exception for dying men. Through empathetic acts of patience, kindness, non-judgmental care, and simply staying the course, volunteers work to facilitate, at the very least, possibilities for a 'death without indignity.'[187] If our aging prison population continues to steadily increase, funding for programs to support older people after release from prison continues to be lacking, and compassionate release statutes are not updated to respond to the expanding population, hospice care within prisons will be the least we can do to respond to this policy crisis and optimize care for aging prisoners.[188] When facilities do invest in holistic care for elderly inmates, the number of doctor visits and medication taken by elderly inmates significantly decreases.[189] Investing in holistic care may include ensuring better lighting and windows, access to the outdoors, and more comfortable social spaces.[190] Having specifically trained interdisciplinary staff also enhances health outcomes for elderly inmates.[191]

b. Dementia Care Units

While hospice can address the health care needs during the end-of-life, not all elderly inmates suffering from dementia are in end stages. A dementia diagnosis often means a shortened lifespan (on average people live between three and eleven years after diagnosis), but some people live as long as twenty years after a diagnosis.[192] This is where developing programs which specifically meet the needs of inmates struggling with dementia must come into play. California, New York, and Massachusetts are examples of states that have prisons with specific dementia units set up that take into account the complexities of dementia behavior.[193] Because of these units, a prisoner who behaves in a way that would normally get them in trouble, such as batting away a doctor's hand during an injection, are not penalized when they act out behaviors as a result of their disease.[194] In a normal prison facility, an inmate who exhibited such behavior would be handcuffed, lose privileges, or even be sent to an isolation unit.[195]

Inside the dementia unit at California's main prison medical facility in the San Joaquin Valley, physicians and nurses are specifically trained to work with elderly prisoners who are experiencing cognitive decline.[196] About 500 prisoners are being treated for dementia or Parkinson's Disease in California prisons.[197] The beginning of these specialized facilities in California started with the AIDS crisis, which resulted in hospice facilities being set up decades ago.[198] California's unique history with health care in prisons may still be influencing their ability to divert funding to more holistic dementia care units. In *Plata v. Brown*, the U.S. Supreme Court

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[187] *Id.* at 191 (quoting Peter Allmark, *Death with Dignity*, 28 J. of MED. ETHICS, 255, 256 (2002)).
[188] Amanuel K. Hagos et al., *Optimizing the Care and Management of Older Offenders: A Scoping Review,* 62 THE GERONTOLOGIST, 508, 509 (2022).
[189] Maschi, *supra* note 36, at 445.
[190] *Id.*
[191] *Id.*
[192] *Alzheimer's stages: How the disease progresses*, MAYO CLINIC (June 7, 2023), https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/in-depth/alzheimers-stages/art-20048448#:~:text=On%20average%2C%20people%20with%20Alzheimer's,of%20progression%20of%20Alzheimer's%20disease.
[193] Lay Kodama et al., *Prioritizing Diversion and Decarceration of People With Dementia*, 25 AMA J. OF ETHICS 783, 785 (2023).
[194] Bernstein, *supra* note 69, at 4.
[195] *Id.*
[196] *Id.*
[197] *Id.*
[198] *Id.*

affirmed a district court order requiring California to remedy its longstanding constitutional deficits in prison medical and mental health care by reducing prison crowding, holding that a prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.[199] At the time of the decision, the California prison system housed approximately twice as many inmates as the facilities could handle, resulting in widespread Eighth Amendment violations.[200] "As a result, the California Department of Corrections and Rehabilitation (CDCR) worked to redistribute inmates and parolees safely and decrease the overall population to the mandated levels."[201] The Court, in *Plata*, held that a court-mandate population limit was necessary to remedy Eighth Amendment violations.[202] Therefore, the current dementia-focused programs available in California may be an alternative approach to a statutory regime to enhance the care available to elder prisoners.

Although so few state institutions offer programs specifically aimed at aging or dementia, some programs, like California's, have proven to be incredible examples of a holistic (and cost-saving) approach to the aging prison population.[203] Programs such as that at the California Men's Colony in San Luis Obispo, where prisoners with dementia are housed separately and inmates are given opportunities to become trained on dementia-awareness in order to help their fellow inmates, have shown reduced overall agitation among inmates and reduced behavioral problems.[204]

Similarly, in Massachusetts, the Memory Disorder Unit at F.M.C. Devens, which opened in 2019 and was designed to resemble a memory care facility, offers an alternative path for such a prisoner.[205] "Its correctional officers have received training from the National Council of Certified Dementia Practitioners and currently supervise around two dozen men with an average age of 72."[206] Many prisoners in this unit are weak and don't remember doing the act that placed them in prison.[207] The unit is different from a typical prison facility in many ways, some big and some small. For example, the walls are pink because it is seen as a noncombative color and aids in dementia care.[208] A more complex difference is that the staff members "maintain a binder with profiles of the prisoners, including information on how to soothe them."[209] The binder entry for one man advises officers to reference Tom Brady if the man is ever upset, a tactic that often brings him from screaming to calm and conversational.[210]

If we are going to keep elders in prison, we need to create a system that addresses the root philosophies of criminal justice and one that is not just a more restricted version of a nursing home. Prison facilities need to have staff trained in evaluating disciplinary actions based on the cognitive awareness of the inmate,[211] which research has shown that prison staff themselves benefit from.[212] From intake to release, there must be systems in place which specifically address the needs of older

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[199] Plata v. Brown, 563 U.S. 493,510 (2011).
[200] W.J. Newman & C.L. Scott, *Brown v. Plata: prison overcrowding in California*, 40 J. AM. ACAD. PSYCHIATRY L. 547, 547-52 (2012).
[201] *Id.*
[202] *Plata*, 563 U.S. at 538.
[203] GeriPal – A Geriatrics and Paliative Care Podcast, *Hospice in Prison Part 1: An Interview with Michael DiTomas and Keith Knauf,* YOUTUBE, (June 22, 2023), https://www.youtube.com/watch?v=EDN01FC3Z-E..
[204] Feczko, *supra* note 46, at 646.
[205] Engelhart, *supra* note 13.
[206] *Id.*
[207] *Id.*
[208] *Id.*
[209] *Id.*
[210] *Id.*
[211] Engelhart, *supra* note 13.
[212] Samantha Treacy et al., *Dementia-friendly prisons: a mixed-methods evaluation of the application of dementia-friendly community principles to two prisons in England,* BMJ OPEN, July 2019, at 9, https://bmjopen.bmj.com/content/9/8/e030087.

inmates and facilities that are prepared to screen for dementia independently of screening for general mental health concerns.[213] Lynn Biot-Gordon, of the National Council of Certified Dementia Practitioners, points out that moral education is impossible for a person who cannot be educated, so incarceration for someone with dementia does not fit within the rehabilitation framework of our criminal justice system.[214] Many of the people in the Devens unit are not being assisted in rehabilitation, but rather managed until their sentence comes to an end.

VII. Conclusion

Across the country, sentencing laws and practices governing the administration of criminal justice should be revised to account for the degeneration of brain function that occurs later in life, and the rapid degeneration that specifically occurs as a result of living in prison. If we fail to adopt these changes as our prison population continues to age, society will pay for it not only in additional health care costs but also with a moral cost. We must provide education about person-centered care that will engage elder prisoners with dementia in a process of making choices, fostering personal agency or recovery of lost agency, and improving quality of life. Caring for our elders should be of utmost importance, regardless of where they are forced to lay their heads at night.

This paper provides a holistic path forward for developing a response to dementia in prison. Through updated compassionate release laws and increased focus on creating prison settings which are attuned to the unique issues with geriatric and hospice care, we can better manage the dementia crisis in prisons. Practitioners should all be questioning whether we should be punishing people with dementia if they can no longer remember the crime they committed and are otherwise deprived of the mental capabilities to understand the system they are placed in.[215] Why would society continue seeking out punishment for elder prisoners when recidivism rates drop to nearly zero for people over 65?[216] This paper has explored a few of the key points to consider in adapting our criminal system to address this crisis, but much more must be done.

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[213] *Id.* at 11.
[214] Engelhart, *supra* note 13.
[215] *See generally*, Jeffery Howard, *Punishment, Socially Deprived Offenders, and Democratic Community,* 7 CRIM. L. & PHIL., 121–36 (2013), https://doi.org/10.1007/s11572-012-9179-4.
[216] Rebecca Silber et al., *Aging Out: Using Compassionate Release to Address the Growth of Aging and Infirm Prison Populations*, VERA INST. OF JUST. (2017), https://www.vera.org/downloads/publications/Using-Compassionate-Release-to-Address-the-Growth-of-Aging-and-Infirm-Prison-Populations%E2%80%94Full-Report.pdf.

BAIT AND SWITCH: HOW MEDICARE ADVANTAGE PLANS ARE SWINDLING MEDICARE-ELIGIBLE PERSONS AND THE FEDERAL GOVERNMENT

Victoria Benson

I. Introduction

Fitness programs, over-the-counter medication credits, and hearing aid benefits, are just a few of the many benefits UnitedHealthcare offers to its Medicare Advantage Plan (Part C) enrollees.[1] Among those enrollees was 97-year-old, Paula Christopherson.[2] While under a UnitedHealthcare Medicare Advantage Plan, Ms. Christopherson suffered a severe fall, landing her in a skilled nursing facility for eleven days.[3] At the eleven day mark, her nurses and doctors knew she was not healthy enough to return home, but her insurers—individuals who had never laid eyes on her—told her further care was unnecessary and she needed to return home; they were no longer covering her health services at the facility.[4] In addition to the stress of recovery, the 97-year-old was forced to make a decision, return home and risk further injury or failed recovery, appeal the insurer's decision, or pay thousands of dollars out of pocket to stay in the skilled nursing facility.[5]

Unfortunately, Ms. Christopherson is not alone in her difficulties. In 2022, the U.S. Department of Health and Human Services (HHS) found private insurers improperly deny "medically necessary care" to tens of thousands of Medicare Advantage (MA) Plan enrollees every year.[6] Despite hundreds of thousands of claims being inappropriately denied, individuals are enrolling in MA Plans at seemingly exponential rates.[7] By expanding advertisement mediums to robo-calls, mailers, and television commercials, MA Plans are reaching a larger population than ever before.[8] These advertisements promise larger Social Security checks, increased benefits, and lower co-pays, incentivizing Medicare-eligible individuals to enroll in an MA Plan.[9] While the benefits seem unrefusable, these advertisements often fail to properly disclose the fine print conditions of these benefits, misleading and misinforming enrollees, perpetuating marketing abuse

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[1] UNITEDHEALTHCARE**,** https://www.uhc.com/medicare/shop/medicare-advantage-plans.html (last visited Apr. 12, 2023).
[2] Jaffe, Susan, *Nursing Home Surprise: Advantage Plans May Shorten Stays to Less Time Than Medicare Covers*, KFF HEALTH NEWS (Oct. 4, 2022, 8:00 AM), https://khn.org/news/article/nursing-home-surprise-medicare-advantage-plans-shorten-stays/.
[3] *Id*.
[4] *Id*.
[5] *Id*.
[6] U.S. DEPT. OF HEALTH AND HUM SERV. OFF. OF INSPECTOR GENERAL, SOME MEDICARE ADVANTAGE ORGANIZATION DENIALS OF PRIOR AUTHORIZATION REQUESTS RAISE CONCERNS ABOUT BENEFICIARY ACCESS TO MEDICALLY NECESSARY CARE (2022) [hereinafter HHS-OIG Report].
[7] STEVEN FINDLAY, GRETCHEN JACOBSON, FAITH LEONARD, *The Role of Marketing in Medicare Beneficiaries' Coverage Choices*, THE COMMONWEALTH FUND (Jan. 5, 2023), https://www.commonwealthfund.org/publications/explainer/2023/jan/role-marketing-medicare-beneficiaries-coverage-choices?utm_source=alert&utm_medium=email&utm_campaign=Improving+Health+Care+Quality (finding Medicare Advantage Plan enrollment is up nearly 36% from 2016, with over 28 million enrollees in 2022).
[8] U.S. COMM. ON. ON FIN., DECEPTIVE MARKETING PRACTICES FLOURISH IN MEDICARE ADVANTAGE: A REP. BY THE MAJORITY STAFF OF THE U.S. SENATE COMM. ON FIN. (2022) [hereinafter Finance Committee 2022 Report].
[9] Amanda Seitz, *Biden Administration Proposes Crackdown on Medicare Scam Ads*, Associate Press News (Dec. 14, 2022), https://apnews.com/article/health-medicare-government-and-politics 19ce28f3a5919d27cbff3dcb6d19c6e7.

of a vulnerable population.[10] In addition to the false and misleading advertising, MA Plans are facing scrutiny for overstating and falsifying enrollees' diagnoses and illnesses, resulting in substantial overpayments to the private insurers.[11]

Despite promising greater and more inclusive benefits, MA Plans have restricted healthcare access for participants, deceived Medicare-eligible individuals through advertisements, and inappropriately over collected payments at the expense of their plan participants.[12] Given the ongoing misbehavior of private organization's MA Plans, the current laws need to be changed to protect MA Plan participants from improper prohibition to healthcare access, mitigate aggressive and misleading MA Plan advertisements, and prevent overcompensation of Medicare Advantage Organizations (MAOs). The law should provide a streamlined, expedited process for MA denial appeals, implement harsher penalties for improper marketing, and require CMS to utilize mechanisms currently in place to reduce overpayments to MAOs.

II. The History of Medicare and Medicare Advantage Plans

In 1965, President Lyndon B. Johnson signed Title XVIII and XIX of the Social Security Act into law, creating what is now known as Original Medicare.[13] The first federally-funded health insurance, Original Medicare provided health insurance benefits to a majority of individuals 65 and older.[14] Original Medicare benefits only covered two categories of health services—Part A, hospital coverage, and Part B, physician and out service coverage.[15] Any individual who satisfied the basic qualifications, was automatically enrolled in Part A.[16] Any person enrolled in Part A was eligible to receive Part B coverage, but they had to select enrollment and pay a small premium for the benefits.[17] In less than a year, over 19 million individuals were enrolled in the original Medicare program.[18]

This expansive program is overseen by the HHS, and after the exponential enrollment, the Health Care Financing Administration (HCFA) subagency was formed to monitor, regulate, and oversee Medicare and Medicaid.[19] In 2001, the HCFA was renamed to Centers for Medicare and Medicaid Services (CMS), but its function of managing, maintaining, and regulating Medicare remained the same.[20]

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[10] U.S. Comm. On Fin., *supra* note 8.
[11] Amanda Seitz, *Feds Expect To Collect $4.7B In Insurance Fraud Penalties*, Associate Press News (Jan. 30, 2023), https://apnews.com/article/health-business-fraud-medicare-c17b938660ff8b211871b455b49cf8c9. The Biden Administration expects to recoup as much a $4.7 billion in overpayments over the next ten years.
[12] Fred Schulte, *Did Your Health Plan Rip Off Medicare?*, KFF News (Jan. 27 2022), https://khn.org/news/article/medicare-advantage-audits-investigation-cms-overpayment-recoup-billions/; Seitz, *supra* note 11.
[13] CENTERS FOR MEDICARE AND MEDICAID SERV., https://www.cms.gov/About-CMS/Agency-Information/History (last visited Apr. 12, 2023).; NAT'L ACAD. OF SOC. INS., https://www.nasi.org/learn/medicare/the-history-of-medicare/. (last visited Mar. 3, 2023).
[14] CENTERS FOR MEDICARE AND MEDICAID SERV., MILESTONES 1937-2015 (discussing how Medicare's funding comes from a federal tax collected on the earnings of employees and matched by employers).
[15] *Id.*
[16] NAT'L ACAD. OF SOC. INS., *supra* note 13 (finding that to qualify for Social Security, a person must be 65 years old and eligible for Social Security. Social Security eligibility requires a person work for at least forty quarters (ten years) throughout their life).
[17] *Id.*
[18] MILESTONES 1937-2015, *supra* note 14 at 3.
[19] HEALTH CARE FINANCE ADMINISTRATION, https://www.federalregister.gov/agencies/centers-for-medicare-medicaid-services (last visited Mar. 18, 2023).
[20] *Id.*

In 1982, the Tax Equity and Fiscal Responsibility Act (TEFRA) was passed, creating the foundation for MA Plans.[21] TEFRA allowed Medicare to contract with private health insurance providers, making the private insurers responsible for enrolled participants, in exchange Medicare paid the insurer capitated payments.[22] In 1997, the Balanced Budget Act (BBA) formally recognized the at-risk contracting, naming it Medicare+Choice, and allowed providers to offer different types of plans, including preferred-provider organizations (PPO), provider-sponsored organizations (PSO), and private-fee-for-service plans (PFFS).[23] In passing the BBA, Congress sought to reduce the exponentially growing Medicare costs by contracting with private insurers.[24] However, this original intent proved to be incredibly off-base, as current MA Plans cost the government approximately $321 more per person than Traditional Medicare (TM).[25]

Since 1982, several other Parts of Medicare have formed, giving Medicare-eligible individuals options for health care coverage and prescription drug coverage.[26] However, the foundations of coverage options remain the same—eligible persons may elect Traditional Medicare (TM), whose healthcare coverage is provided by the government, or a Medicare Advantage (MA) Plan, in which a private insurer provides healthcare coverage.[27]

III. Understanding Medicare Advantage Plans

When an individual elects to enroll in an MA Plan, they pay the elective Part B premium to Medicare, as well as any supplemental premium required by the private health insurance provider.[28] Each month, the private companies receive a fixed payment from Medicare, in addition to any supplemental premium paid by the plan participant.[29] Because the programs are federally supervised and partially funded by the government, MA Plans are required to maintain minimum benefits which are reflective of Original Medicare, Part A and Part B.[30] Thus, to compete with TM and other plans, private insurers use supplemental benefits to incentivize participants.[31] Though the programs are required to provide health care services in line with those of TM, they

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[21] THOMAS MCGUIRE, JOSEPH NEWHOUSE, & ANNA SINAIKO, *An Economic History of Medicare Part C*, 89 THE MILBANK QUARTERLY (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117270

[22] *Id*. (Explaining that this allowed Medicare-eligible individuals to select a private plan as opposed to traditional Medicare).

[23] *Id*.

[24] *Id*.

[25] JEANNIE BINIEK, JULIETTE CUBANSKI, & TRICIA NEUMAN, *Higher and Faster Growing Spending Medicare Advantage Enrollee Adds to Medicare's Solvency and Affordability Challenges*, KFF News (Aug. 17, 2021), https://www.kff.org/medicare/issue-brief/higher-and-faster-growing-spending-per-medicare-advantage-enrollee-adds-to-medicares-solvency-and-affordability-challenges (Finding CMS spent an additional $7 billion on MA Plan spending, compared to Traditional Medicare).

[26] MEDICARE, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices (last visited Mar. 23, 2023) (noting, since 1982, Part D has been added which provides prescription drug coverage, and Medigap policies now exist to provide supplemental benefits for Parts A and B).

[27] *Id*.

[28] THOMAS MCGUIRE, JOSEPH NEWHOUSE, & ANNA SINAIKO, *supra* note 21, at 4 (stating that not all MA plans require an additional premium); MEREDITH FREED, JEANNIE BINIEK, ANTHONY DAMICO, & TRICIA NEUMAN, *Medicare Advantage in 2022: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings*, KFF News (Aug. 25, 2022), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/) (finding 69% of MA Plans do not require supplemental premium).

[29] THOMAS MCGUIRE, JOSEPH NEWHOUSE, & ANNA SINAIKO, *supra* note 21 (finding capitations paid by Medicare are risk-based, fixed payments. Medicare uses formal risk adjustment to set a "per-member-per-month" payment price for each participant using demographics like age, gender, Medicaid eligibility, institutional status, and geographic location).

[30] *Id*.

[31] *Id*. (Noting MA Plans originally only offered supplemental benefits like: dental coverage for cleanings; vision coverage for eyeglasses and eye exams; and reduced premiums, co-payments, and out-of-pocket costs. These supplemental benefits have now extended to both health non-health related benefits like, fitness club memberships, credits for groceries, pet food, transportation to appointments, and increased Social Security payments).

are permitted to regulate how a participant receives health services and charge different costs for services, out-of-pocket expenses, and deductibles.[32] While those enrolled in TM may receive health services from any physician or facility that accepts Medicare, MA Plans often restrict participants' coverage to "in-network" physicians and facilities, require prior authorizations or referrals, and/or limit supplemental coverages, like drug benefits.[33] These limitations may result in a smaller pool of treatment facilities, physicians, and providers. [34]

MA Plans typically also come with geographical restrictions, limiting enrollees to coverage within their plan's service area.[35] While TM travels with enrollees anywhere within the confines of the United States, MA Plans typically only provide coverage for health services within the Plan's service area.[36] Service areas vary based on the Plan, some may be restricted to a single county, while others may provide nationwide coverage.[37] Location, namely zip code, will impact the plan options offered to a participant, network of physicians and facilities, participant's premium costs, supplemental benefits, and covered service area.[38]

Although they are not permanent, a participant may not drop or switch an MA Plan at any time.[39] A majority of MA plans prohibit unenrollment for one calendar-year after joining the MA Plan.[40] Even after the one-year period has expired, MA Plan participants may only drop or switch their MA Plan during two periods a year: Open Enrollment Period, which runs from October 15-December 7, or Medicare Advantage Open Enrollment Period, which runs from January 1-March 3.[41] Thus, it is crucial MA Plan participants inquire as to whether their providers are in-network, understand the offered supplemental benefits and their limitations, and consider other potential prohibitors, before enrolling in a MA Plan.[42]

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[32] U.S. DEPT. OF HEALTH AND HUM. SERV. CENTERS FOR MEDICARE AND MEDICAID SERV., UNDERSTANDING MEDICARE ADVANTAGE PLANS (2022).

[33] Anna Porretta, *Know The Pros & Cons of Medicare Advantage Plans*, EHEALTH (Aug. 4, 2022), https://www.ehealthinsurance.com/medicare/parts/what-are-the-pros-and-cons-of-switching-to-a-medicare-advantage-plan (noting "in-network" refers to a group of physicians and facilities who have contracted with the private insurer to provide services at a lower cost to the insurance company).

[34] GRETCHEN JACOBSON, MATTHEW RAE, TRICIA NEUMAN, KENDAL ORGERA, AND CRISTINA BOCCUTI, *Medicare Advantage: How Robust Are Plans' Physician Networks?*, KFF News (Oct. 5, 2017), https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/ (finding in 2017, KFF's survey of 391 MA plans in twenty counties found Medicare Advantage networks included less than half (46%) of all physicians in a county, on average).

[35] U.S. DEPT. OF HEALTH AND HUM. SERV. CENTERS FOR MEDICARE AND MEDICAID SERV., *supra* note 32 at 5.

[36] UNITEDHEALTHCARE INSURANCE COMPANY, https://www.uhc.com/medicare/medicare-education/medicare-advantage-plans.html (last visited Apr. 14, 2023).

[37] DEPT. OF MGMT. SERV., 2023 CONTRACTED ADVANTAGE & PRESCRIPTION DRUG (MA-PD) PLAN SERVICE AREAS (2023) (describing visual aid representing the service coverage areas for the Medicare Advantage and Prescription Drug (MA-PD) Plan Service Areas of the two HMOs and PPO offered by the Division of State Group Insurance in 2023. One HMO program offered limits its service area to seven counties in the Panhandle of Florida. The second HMO program extends its service area throughout forty-three Florida counties, sporadically covering counties from the western-most point through the southeastern coast. Seventeen counties do not qualify as a service area for any HMO offered by the Division of State Group Insurance. A third option, and the only PPO, provides nationwide coverage, including all sixty-seven Florida counties).

[38] U.S. DEPT. OF HEALTH AND HUM. SERV. CENTERS FOR MEDICARE AND MEDICAID SERV., *supra* note 32, at 5.

[39] *Id*. at 14.

[40] *Id*. (Stating that enrollees may only drop MA Plans within three months if they enrolled during their initial enrollment period. The initial enrollment period is only offered once a person's lifetime, it begins three months before the enrollee's 65th birthday and extends three months after their 65th birthday. If a person enrolls during this period, they may drop the MA Plan within three months of enrollment).

[41] U.S. DEPT. OF HEALTH AND HUM. SERV. CENTERS FOR MEDICARE AND MEDICAID SERV., *supra* note 32, at 13 (noting participants who change plans will not be switched over until January 1st of the upcoming year. During the Open Enrollment Period, any Medicare-eligible person may drop, add, or switch their plan between TM and MA Plans. During the Medicare Advantage Enrollment Period, only MA Plan participants may drop or switch their MA Plan. MA Plan participants are also limited to one change during this MA Open Enrollment Period, thus if a person switches from MA Plan X to MA Plan Y, they may not switch to a different MA Plan, nor drop the plan for TM.

[42] UNDERSTANDING MEDICARE ADVANTAGE PLANS, *supra* note 32.

IV. Improper Denials

In 99% of MA Plans, the Plan participant must receive prior authorization from their plan provider before receiving health care services.[43] So, if a patient requests authorization for medical services, but the insurer denies or delays approval of the service, that patient is left with limited options: (1) pay for the service out of pocket with the risk of not receiving reimbursement, (2) forego the health service, or (3) appeal the denial.[44] In 2021 alone, more than two million MA Plan participants were denied authorization for medical or health services.[45] Approximately 220,000 of those denials were appealed; of those appealed, over 82% were overturned and authorized.[46] In its 2022 Report[47], the HHS Office of the Inspector General (HHS-OIG)[48] found an estimated 1,631 requests were improperly denied in a one-week span—projecting nearly 85,000 improper denials that year.[49] Through its investigation, the HHS-OIG found MA Plan providers were "applying…clinical criteria that are not contained in Medicare coverage rules," thus making it unreasonably burdensome for participants to receive authorization for health services.[50]

Among these denials was Patient X, a 76-year-old plan participant who requested a walker due to disabilities caused by post-polio syndrome. Despite Patient X's medical history and risk of falling, coupled with the doctor's notes deeming the walker medically necessary, Patient X's MA Plan denied the request.[51] The Medicare Advantage Organization (MAO)[52] stood by its denial, claiming the participant received a cane in the five years prior and was only entitled to one

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[43] MEREDITH FREED, JEANNIE BINIEK, ANTHONY DAMICO, & TRICIA NEUMAN, *supra* note 21.
[44] JILL HALLORAN, *CAN MY MEDICARE ADVANTAGE PLAN DENY MY COVERAGE?*, EHEALTH (JAN. 17, 2023), https://www.ehealthinsurance.com/medicare/parts/can-my-medicare-advantage-plan-deny-my-coverage/.
[45] JEANNIE BINIEK & NOLAN SROCZYNSKI, OVER *35 Million Prior Authorization Requests Were Submitted to Medicare Advantage Plans in 2021*, KFF News (Feb. 2,2023), https://www.kff.org/medicare/issue-brief/over-35-million-prior-authorization-requests-were-submitted-to-medicare-advantage-plans-in-2021/.
[46] *Id*. (Determining the rate of overturned denials is up 5% from the 75% overturn rate in the 2014-2016 audit conducted by HHS-OIG).
[47] HHS-OIG REPORT, *supra* note 6, at 2 (clarifying the audit **"**sampled 250 denials of prior authorization requests and 250 payment denials issued by 15 of the largest MAOs during June 1−7, 2019.").
[48] STATEMENT OF ORGANIZATION, FUNCTIONS, AND DELEGATIONS OF AUTHORITY, 83 FED. REG., 55553 (Nov. 6, 2023) (explaining that as the federal agency overseeing Medicare, HHS has created the Office of Inspector General (OIG) to "carry out the mission of preventing fraud and abuse and promoting economy, efficiency, and effectiveness of HHS programs and operations." In achieving this mission, the OIG is tasked with supervising operations, conducting investigations and audits, and detecting "wrongdoers and abusers of HHS programs[….]so appropriate remedies…including imposing administrative sanctions against providers of health care under Medicare[…]who commit certain prohibited acts.").
[49] HHS-OIG REPORT, *supra* note 6, at 13 (explaining that MA Plans are required, at minimum, to provide the same coverage Traditional Medicare would provide, and they must follow the national and local coverage determinations provided by TM. MAOs may implement requirements like prior authorizations and coverage for in-network providers only, but they may not develop criteria "more restrictive than [Traditional] Medicare's national and local coverage policies." In its report, the HHS-OIG deemed denials improper for the heightening the treatment requirements set forth in the national and local coverage determinations. By imposing stricter clinical criteria, the MA Plans improperly denied coverage that would have been provided through TM).
[50] *Id*. at 10 (Stating that in its report, the HHS-OIG found an MA Plan improperly denied a patient's prior authorization request for a follow-up MRI because the patient's lesion was less than two centimeters in length. Eight months prior to the denied request, the patient received an MRI to examine adrenal lesions; after eight months, the doctors wished to perform a second MRI of the non-cancerous lesions. The patient's MA Plan denied the prior authorization because the lesion was under two centimeters and any lesions under two centimeters only permitted coverage for one MRI per year—a clinical criteria outside of Medicare coverage rules).
[51] *Id*. at 14.
[52] CENTERS FOR MEDICARE AND MEDICAID SERVICES, MEDICARE DIABETES PREVENTION PROGRAM (2022) (explaining that "[a]n MAO is the legal entity that has a contract with the Medicare program to provide coverage.").

assistive-walking device every five years.[53] After reviewing the denial, the HHS-OIG found the Plan's reasoning in violation of local coverage requirements and found the ambulatory device medically necessary, as the patient "could not walk safely with only a cane."[54]

Though Patient X's quality of life was deeply hindered, other victims of denial might consider her a "lucky one", since her condition was not as time sensitive as other denials for service requests like cancer treatment.[55] Patient D421, an 81 year-old woman, faced substantial delays in her endometrial cancer treatment when her MA Plan denied coverage for a Computed Tomography Scan (CT Scan) to determine the progression of the cancer.[56] The MAO supported their denial by citing their clinical criteria requiring "information to support that the disease had spread[…]or that the tumor was advanced."[57] More than five weeks later, the HHS-OGI's investigating physicians found the CT Scan was medically necessary and deemed the Plan's denial improper for creating stricter clinical than the local and national coverage determinations.[58]

For patients suffering from critical, aggressive, and/or time sensitive health issues, these denials may result in adverse outcomes, including permanent disabilities and death.[59] The delays brought on by improper denials are not just a burden, they are a danger for patients receiving medical care.[60] While some patients are fortunate enough to have their improper denial overturned in just five weeks, like Patient D421, few see such quicks responses, as less than 3% of improper denials are overturned within ninety days.[61]

Despite the hundreds of thousands of improper denials, these private insurers fail to face any serious repercussions.[62] In February 2022, CIGNA Corp., the third largest insurance company in America—worth more than $150 billion—was fined $126,988 for failing to properly provide coverage to its MA Plan participants.[63] Less than one month later, CIGNA was fined another $85,436 for "fail[ing] to comply with Medicare requirements."[64] Together, these civil monetary punishments cost CIGNA less than .00004% of its annual profit, and less than .0000015% of its total wealth.[65] Because of these inconsequential monetary punishments imposed by CMS, third-parties, like American Optometric Association (AOA), are calling upon the Department of Justice (DOJ) to take action against Medicare Advantage Organizations (MAOs) for illegally denying and

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[53] HHS-OIG REPORT, *supra* note 6, at 10.
[54] *Id*. (Noting that MA plans cannot implement additional treatment requirements not set forth by the national and local coverage determinations. The HHS-OIG found requiring five years to pass before a participant could receive an additional ambulatory device exceeded the requirements laid out in traditional Medicare and therefore violated the local coverage determination, making the criteria overly burdensome and improper).
[55] MEGAN BROOKS, '*Bane of My Existence:' The Burden of Medicare Advantage* Denials, MEDSCAPE (May 10, 2022), https://www.medscape.com/viewarticle/973718?reg=1.
[56] HHS-OIG REPORT, *supra* note 6, at 38.
[57] *Id*.
[58] *Id*.
[59] AMERICAN MEDICAL ASSOCIAT'N, *2022 AMA Prior Authorization (PA) Physician Survey* (2022) (finding that "34% of physicians reported that prior authorization led to a serious adverse event for a patient in their care, including hospitalization, medical intervention to prevent permanent impairment, and even disability or death.").
[60] *Id*.
[61] HHS-OIG REPORT, *supra* note 6, at 31 (finding less than 3% of denials of prior authorization requests that met Medicare coverage rules and were reversed within three months).
[62] DIANE ARCHER, *Government Rules Will Not Curtail Medicare Advantage Bad Acts Without Stiff Penalties*, JUSTCARE (Dec. 21, 2022), https://justcareusa.org/government-rules-wont-curtail-medicare-advantage-bad-acts-without-stiff-penalties/.
[63] DEPMT. OF HEALTH & HUM. SERV. CENTERS FOR MEDICARE & MEDICAID SERVICES, NOTICE OF IMPOSITION OF CIVIL MONEY PENALTY FOR MEDICARE ADVANTAGE-PRESCRIPTION DRUG CONTRACT NUMBERS: H0354, H0439, H1415, H2108, H3949, H4407, H7020, H9460, AND H9725 (2022).
[64] DEPMT. OF HEALTH & HUM. SERV. CENTERS FOR MEDICARE & MEDICAID SERVICES, NOTICE OF IMPOSITION OF CIVIL MONEY PENALTY FOR MEDICARE-MEDICAID PLAN CONTRACT NUMBERS: H0354, H0672, H1415, H2108, H3949, H4407, H4513, H7020, H7787, H7849, H9725, S5617, S5660 (2022).
[65] FORBES, https://www.forbes.com/companies/cigna/?sh=3faeffea9742 (last visited Apr. 3, 2023).

improperly restricting plan participants' "access to medically necessary care."[66] Groups like the AOA are rightfully advocating, for without proper and significant punishments, MAOs will continue to improperly deny coverage and restrict participants' health care access, as evidenced by the increase from an estimated 84,000 improper denials in 2019[67] to approximately 180,000 in 2021.[68]

V. Misleading, Abusive, and False Marketing

Pet food, carpet shampooing, acupuncture, pest control, and gym memberships are a few of the supplemental benefits MA Plans may offer for their participants.[69] Originally, MA Plans were only permitted to provide supplemental benefits which were primarily health related.[70] However, in 2018, CMS elected to reinterpret the definition of "primarily health related" and extended the scope to include "item[s] or service[s] … used to diagnose, compensate for physical impairments, acts to ameliorate the functional/psychological impact of injuries or health conditions, or reduce[] avoidable emergency and healthcare utilization."[71] So, while MA Plans may market these lavish services to all enrollees, participants are only entitled to services which are "recommended by a licensed medical professional" and directly benefit their health. [72] Thus, pet food and other animal-related expenses may only be covered for participants who have a service animal, while the pest control may only be provided for participants whose condition is aggravated by bugs, pests, or rodents.[73]

In 2019, CMS once again extended supplemental benefits to allow MA Plans to offer non-health related supplemental benefits like: meals, transportation to and from grocery stores, food and produce to improve nutritional intake, structural home modifications, and social club memberships, for chronically ill Plan participants only.[74] While these supplemental benefits are attractive to all, they only apply to *chronically ill* enrollees.[75] Yet despite this barrier to qualification, MA Plans advertise these benefits to all without drawing attention to the requirements; as a result, consumers enroll in MA Plans seeking supplemental benefits for which they do not qualify for and thus never receive.[76] In a survey conducted by The Commonwealth

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[66] AMERICAN OPTOMETRIC ASSOCIATION, https://www.aoa.org/news/advocacy/third-party/medicare-advantage-claim-denials?sso=y (last visited Apr. 16, 2023).
[67] HHS-OIG REPORT, SUPRA note 6, at 9 *(*finding in just one week 1,631 improper denials occurred, resulting in an estimated 84,812 improper denials in the 2019 service year).
[68] JEANNIE BINIEK & NOLAN SROCZYNSKI, *supra* note 45 (determining MAOs denied over 2 million prior authorization requests, only 11% were appealed, and 82% of the appeals resulted in a partial or full overturning of the denial).
[69] JON BLUM, *Pet Food, Pest Control, A Ride to Church: Medicare Advantage Has Expanded Benefits, but Will They Make People Healthier?*, ARNOLDVENTURES (Feb. 24, 2020), https://www.arnoldventures.org/stories/pet-food-pest-control-a-ride-to-church-medicare-advantage-has-expanded-benefits-but-will-they-make-people-healthier).
[70] DEPMT. OF HEALTH & HUM. SERV. CENTERS FOR MEDICARE & MEDICAID SERVICES, REINTERPRETATION OF "PRIMARILY HEALTH RELATED" FOR SUPPLEMENTAL BENEFITS (2018).
[71] *Id*.
[72] STEVE ISRAEL, *Medicare Plans: Be Wary of Joe Namath, Other Celebrity Pitchmen*, TIMES HERALD-RECORD (Nov. 5, 2021), https://www.recordonline.com/story/opinion/2021/11/05/steve-israel-celebrities-pitching-medicare-plans/6297275001/.
[73] PAIGE MINEMYER, *Insurance Coverage For Pest Control and Dog Food? Anthem Unveils 2020 MA Supplemental* Benefits, FIERCE HEALTH (Oct. 2, 2019), https://www.fiercehealthcare.com/payer/anthem-unveils-slate-ma-supplemental-benefits-for-2020-including-pest-control-coverage.
[74] DEPMT. OF HEALTH & HUM. SERV. CENTERS FOR MEDICARE & MEDICAID SERVICES, IMPLEMENTING SUPPLEMENTAL BENEFITS FOR CHRONICALLY ILL ENROLLEES (2019).
[75] *Id*.
[76] LINDSEY COPELAND, *Report Examines Complaints About Medicare Advantage* Marketing, MEDICARE RIGHTS CENTER (Nov. 10, 2022), https://www.medicarerights.org/medicare-watch/2022/11/10/report-examines-complaints-about-medicare-advantage-marketing.

Fund, one in four of MA Plan participants indicated they elected to enroll in an MA Plan because of the "extended benefits and limits on out-of-pocket costs."[77]

The most recent supplemental benefit being pushed is the increased Social Security check.[78] Brokers, agents, and telemarketers are using "bait and switch" tactics to mislead Medicare-eligible individuals to enroll into MA Plans.[79] The marketers promise an increased Social Security check when the MA Plan "buys down" the enrollee's Medicare Part B premium.[80] However, they typically fail to inform the enrollee that the lower Part B premiums may not be offered by plans in their location, their current providers will not be covered by the plan, and/or items like prescription drugs may not be covered by the plan.[81] As a result, the enrollees may receive a small boost in their Social Security check, but they are often economically harmed or unduly burdened by the MA Plan's restrictions.[82] This was the case for an Oregon resident who selected to enroll in a MA Plan after a broker informed him he would receive an additional $135 on his Social Security check if he enrolled.[83] The broker failed to mention the terms of the plan, and did not disclose this new MA Plan would not cover his prescription drugs, a prescription he had been taking for an extended period.[84] After enrolling in the MA Plan, the man went to his pharmacy to pick up his prescription drugs, but upon arrival, the pharmacist informed him his prescription drugs were not covered by his new insurance. [85] Any prescription drugs would require an out-of-pocket payment—the plan did not cover any prescription drugs.[86]

In an effort to protect Medicare-eligible individuals from misleading and abusive marketing, CMS enacted the Medicare Improvement for Patient and Providers Act of 2008 (MIPPA).[87] Among other things, MIPPA prohibits MA Plans from making unsolicited direct contact, like cold calling, with prospective enrollees, thus preventing MA Plans from directly soliciting prospective enrollees, unless the prospective enrollee reaches out first.[88] As a result, MA Plans have developed strategies to work around these rules using third-party marketing organizations (TPMOs), companies which serve solely to generate leads.[89] Because TPMOs' only purpose is to generate leads, they "fall[] outside the definition of solicitation under the National Association of Insurance Commissioners (NAIC) Producer Licensing Model Act"; thus, they are not subject to the rules and regulations of insurers which would require they submit all marketing

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[77] FAITH LEONARD, GRETCHEN JACOBSON, LAUREN HAYNES, & SARA COLLINS, *Traditional Medicare or Medicare Advantage: How Older Americans Choose and* Why, THE COMMONWEALTH FUND (Oct. 17, 2022), https://www.commonwealthfund.org/publications/issue-briefs/2022/oct/traditional-medicare-or-advantage-how-older-americans-choose.

[78] FINANCE COMMITTEE 2022 REPORT, *supra* note 8, at 2.

[79] *Id*. at 7.

[80] *Id*. at 6.

[81] *Id*. at 9 (noting that Medicare Advantage plans are permitted to buy down a participant's Medicare Part B premium, meaning they will pay a portion or all of the participant's premium. Because the government automatically garnishes a Medicare-eligible person's Social Security check to cover this premium, it appears to the plan participant that they are receiving additional funds in their Social Security check).

[82] *Id*. at 12 (explaining that the Committee's inquiry revealed a complaint from a 94-year-old woman living in a rural area. She was essentially coaxed into enrolling in an MA plan but was not informed she would not be able to see her current doctors. The only doctors and providers within her network were located several miles outside of her town).

[83] *Id*. at 7.

[84] *Id*.

[85] *Id*.

[86] *Id*.

[87] Medicare Improvements for Patients and Providers Act of 2008, H.R.6331, 110th Cong.§103 (2008).

[88] *Id*.

[89] FINANCE COMMITTEE 2022 REPORT, *supra* note 8, at 11.

materials to CMS for approval, follow all Medicare marketing guidelines, and comply with the respective state's insurance laws.[90]

In response to the growing concerns surrounding MA Plan marketing, the Senate Finance Committee Majority Staff (Committee) launched an inquiry into the misleading, false, and over-aggressive marketing tactics.[91] Based on the evidence gathered from fourteen states, the Committee determined MA Plan marketing is not monitored closely enough, and bad actors are not being held accountable for their bad acts.[92] While some insurers used misleading tactics, others blatantly broke MIPPA rules and lied to enrollees.[93] Using the work around of a TPMO, an insurance agency in Arizona sent out mailers resembling tax documents from the IRS and official documents from CMS.[94] Upon receiving what appear to be time-sensitive government forms, prospective enrollees contact the numbers, websites, and emails.[95] Once the potential enrollee has made contact, MIPPA no longer applies and the prohibited marketing tactics are fair game for MA Plan brokers, agents, and salespeople.[96] The Committee's inquiry also revealed complaints of insurers completely disregarding MIPPA, CMS regulations, and state law regulations by lying to Medicare-eligible individuals, telling them their current treating physicians and providers would be covered in the new plan.[97] These enrollees switched plans then found out months later their doctors were not in-network and any visits to these providers would be an out-of-pocket expense.[98] Thousands of complaints also cited misleading websites, overly-aggressive marketing, and inappropriate marketing to individuals with diminished capacity.[99]

Reacting to the MAO's egregious circumvention of CMS rules, CMS developed new rules which expand the definition of marketing to include TPMOs.[100] Under 42 CFR § 422.2261, the new interpretation requires "all marketing materials, election forms, and certain designated communications materials … including those used by third-party and downstream entities … be

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[90] *Id*.

[91] *Id*. at 2 (Describing a seemingly exponential increase in marketing complaints to CMS. In 2020, CMS reported receiving 15,497 complaints regarding false, misleading, or inappropriate marketing. In 2021, that number more than doubled and CMS received 39,617 complaints from January-November).

[92] *Id*. at 3.

[93] *Id*.

[94] *Id*. at 11 (Describing the MA Plan marketing materials in which the form copied stylistic characteristics of official tax documents, like bolded numbers and letters in the corner. Where a tax form may have a bolded and capitalized "W-2" in the top left-hand corner, these mailers had "T-2" bolded and enlarged in the top left-hand corner. The title was centered on the top of the document and read "Medicare Savings Program". In the top right hand corner, the mailer read "2022" with the 20 being thinner, not bolded, and outlined numbers (the numbers were not filled in and had no background), while the 22 was bolded in a similar font to the T-2. This copies the format used on federal IRS documents. Under the title, a textbox read "**Do you qualify** to have your Medicare Part B premium paid for by the state?? **If you do qualify, you will receive $170.10 back into your Social Security check.** Do you qualify for the Extra Help Program with your prescription drugs from SS? Do you qualify for Medicaid or have you been receiving all the extra benefits such as Dental, Vision, and Hearing, Transportation, and FREE over the counter Health Products? **Return this inquiry card today. This is a FREE service to you, PLEASE READ.**" Under the text, only a box indicating interest in the benefits listed above was provided. Next to the text box, the mailer requested the following information: Name, Age, Spouse's Name, Spouse's Age, Street Addresses (no PO boxes), and Phone Number with Area Code. Under this box, in nearly illegible font, the mailer read "Not affiliated with or endorsed by any government agency." In the same fine print font, the card informed the recipient they could opt out of mailings by calling a number and entering a 9-digit code).

[95] *Id*.

[96] *Id*.

[97] *Id*. at 2.

[98] *Id*.

[99] *Id*. at 7-8 (Demonstrating misleading marketing when a company physically advertised its website, "MedicareBus.com" on a red, white, and blue bus. The website title never mentions Advantage Plan, or Part C, and the website was a decoy website, meaning when a prospective enrollee visited the "MedicareBus.com" website, they were immediately redirected to the website of an independent insurance agent. No notice of the redirect was ever provided).

[100] AIP MARKETING ALLIANCE, https://aipma.com/media/aipma-blogs-articles/understanding-medicare-marketing-rules-for-third-party-marketing-organizations/ (last visited Apr. 7, 2023).

submitted to CMS for review."[101] As a result, TPMOs will not be permitted to contact prospective enrollees, market Plans prior to October 1st, or use decoy websites without alerting users they are being redirected.[102] TPMOs are also required to record all calls, in their entirety, between the TPMO and enrollees, both prospective and active.[103] The new CMS rule works to minimize misleading promises of unapplicable benefits by requiring the following disclaimer: "We do not offer every plan available in your area. Any information we provide is limited to those plans we do offer in your area. Please contact Medicare.gov or 1-800-MEDICARE to get information on all of your options."[104]

The federal government has also taken action to combat the extreme rise in misleading MA Plan marketing.[105] In response to the Committee's alarming and egregious findings, the Biden Administration enacted laws which require all MA Plan marketing materials to indicate the MAO which they represent, prohibit marketing benefits and plans that are not available to people in the marketed area, and limit the scope in which "the Medicare name, logo, and Medicare card" may be used.[106] These new rules aim to reduce any confusion on who the Plan provider is and boost the transparency of benefits provided to enrollees.[107] Together, these federal actions are taking a step in the right direction to protect a population being exploited by marketing abuse.

VI. Overpayments from CMS to Medicare Advantage Plans

Once a person enrolls in an MA Plan, CMS agrees to pay the private insurance company a capitated payment based on the "risk" the insurer is taking.[108] Thus, when an MA Plan enrolls a sicker individual with numerous, severe diagnoses, the federal government will pay out additional funds for the medical treatments of that person.[109]

Sicker enrollees, means a higher risk score, a higher risk score means a higher payment, and higher payments mean more money in MAOs' pockets.[110] Given their financial motive, it is no surprise MA Plan enrollees tend to have a 9.5% higher risk score than TM enrollees.[111] As a

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[101] 42 C.F.R. § 422.2261 (2022).
[102] 42 C.F.R. § 422.2263 (2022). (working to prohibit TPMOs from using decoy websites, which have no content of their own and merely serve to redirect users' browser from the website they originally visited to the website of an independent agency. No alert is given to the user that they are being redirected from the original website to a new website. This may lead to confusion on who the Plan provider is).
[103] AIP MARKETING ALLIANCE, *supra* note 100.
[104] *Id*.
[105] FINANCE COMMITTEE 2022 REPORT, *supra* note 8 at 6 (stating of the 14 states surveyed by the Finance Committee of the Senate, only one state saw a decrease in the number of misleading advertisement complaints. However, this decrease was substantially outweighed by the increase in the others which collected data on the issue, "[m]ost notably Arizona [which] saw a 614% increase" in complaints from 2020-2021).
[106] Medicare Program: Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly**,** 88 Fed. Reg. 22120, 22122 (proposed Apr. 12, 2023) (to be codified at 42 C.F.R. pts. 417, 422, 423, 455, & 460).
[107] JACQUELINE HOWARD, *Biden Administration Finalizes Rule to Target 'Misleading' Medicare Advantage Ads*, CNN (Apr. 5, 2023, 6:34 PM), https://www.cnn.com/2023/04/05/health/hhs-medicare-advantage-ads/index.html.
[108] BETTER MEDICARE ALLIANCE, *Medicare Advantage Payment Structure*, (2017), https://www.bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_OnePager_Payment_Structure_2017_10_18-Final.pdf (explaining CMS considers a patient's, "[diagnoses, [s]ex, [working [a]ged [s]tatus, Medicaid [s]tatus, [d]isabled [s]tatus" when determining their risk to the insurer. Section 1853(a)(1)(C) of the Social Security Act requires CMS to risk-adjust payments made to MAOs).
[109] THOMAS MCGUIRE, JOSEPH NEWHOUSE, & ANNA SINAIKO, *supra* note 21 at 309.
[110] MARTHA HOSTETTER, *Taking Stock of Medicare Advantage Risk Adjustment*, THE COMMONWEALTH FUND (Feb. 7, 2022), https://www.commonwealthfund.org/blog/2022/taking-stock-medicare-advantage-risk-adjustment.
[111] ALISON BINKOWKSI, JEFF STENSLAND, DAN ZABINSKI, LEDIA TABOR & BRIAN O'DONNELL, *The Medicare Advantage Program: Status Report and Mandated Report on Dual-Eligible Special Needs Plans,* MEDPAC (Jan. 13, 2021), (https://www.medpac.gov/meeting/january-13-14-2022/).

result of these increased risk scores, CMS paid out an additional $12 billion to MA Plans in 2020 alone.[112] To combat these ulterior motives, CMS applies a coding intensity adjustment to account for the higher risk scores.[113] This adjustment cuts MA Plan payments by a set percentage, with a minimum adjustment of 5.9%.[114] Although it has the power to increase the adjustment percentage, CMS has not increased the adjustment percentage over the federal minimum since its implementation in 2018.[115] While the average risk score for MA Plan enrollees continues to grow, CMS fails to offset the costs by increasing the coding intensity adjustment.[116] Without increasing the 5.9% code intensity adjustment, studies suggest MA Plan payments may be "$413 billion higher over the 2023-2030 period," as MA Plans continue to inflate enrollees' risk scores by overstating and falsifying enrollees' conditions.[117]

Under the Payment Integrity Information Act of 2019 (PIIA), the HHS OIG is required to annually review and report any improper payments of their agencies, including payments for falsified and unsupported conditions.[118] In recent years, HHS has conceded its failure to comply with PIIA, citing over $15 billion in overpayments to insurers for MA Plan beneficiaries in the 2021 fiscal year alone.[119] This may come as a potential result of the miniscule ninety audits over the past decade,[120] despite the nearly 4,000 MA Plans that exist nationwide.[121] Even more staggering, independent analysis of MA billing data suggests CMS overpaid more than $106 billion to the private insurers from 2010-2019, with a vast majority of these overpayments coming from overstated sicknesses, false diagnoses, and improper billing for conditions enrollees did not have.[122]

Among these bad actors is a Florida Humana Plan, audited in April 2021 ("April 2021 Audit").[123] In conducting its audit, the HHS-OIG used "a medical review contractor to review the medical records" of the 200 randomly selected enrollees, to determine whether their conditions and diagnoses were consistent with those reported by the Humana Plan.[124] Out of the sample's

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[112] *Id.* (Finding based on 2020 data, CMS would have saved $12 billion in payments if MA Plan enrollees held the same risk score of TM enrollees).
[113] COMM. FOR A RESPONSIBLE FED. BUDGET, REDUCING MEDICARE ADVANTAGE OVERPAYMENTS (2021).
[114] *Id*.
[115] *Id*.
[116] *Id*.
[117] RICHARD KRONICK & MICHAEL CHUA, *INDUSTRY-WIDE AND SPONSOR-SPECIFIC ESTIMATES OF MEDICARE ADVANTAGE CODING INTENSITY* (November 11, 2021).
[118] U.S. DEPT. OF HEALTH AND HUM SERV. OFF. OF INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES MET MANY REQUIREMENTS, BUT IT DID NOT FULLY COMPLY WITH THE PAYMENT INTEGRITY INFORMATION ACT OF 2019 AND APPLICABLE IMPROPER PAYMENT GUIDANCE FOR FISCAL YEAR 2021 (2021) (explaining that CMS classifies any payment "that should not have been made or that was made in an incorrect amount" as an improper payment).
[119] U.S. DEPT. OF HEALTH AND HUM SERV, FY 2021 HHS AGENCY FINANCIAL REPORT (2021).
[120] Fred Schulte &Holly Hacker, *Hidden Audits Reveal Millions in Overcharges by Medicare Advantage Plans*, NPR (NOV. 21, 2022), https://www.npr.org/sections/health-shots/2022/11/21/1137500875/audit-medicare-advantage-overcharged-medicare (noting CMS only conducted 90 audits from 2011-2022).
[121] Meredith Freed, Anthoony Damico & Tracia Neuman, Medicare Advantage 2022 Spotlight: First Look, KFF (Nov. 2, 2021), https://www.kff.org/medicare/issue-brief/medicare-advantage-2022-spotlight-first-look/ (stating in 2022, there were 8,384 MA Plans available for enrollment).
[122] Fred Schulte, *Researcher: Medicare Advantage Plans Costing Billions More Than They Should*, KFF HEALTH NEWS (Nov. 11, 2021),
https://kffhealthnews.org/news/article/medicare-advantage-overpayments-cost-taxpayers-billions-researcher-says/
[123] U.S. DEPT. OF HEALTH AND HUM SERV. OFF. OF INSPECTOR GENERAL, MEDICARE ADVANTAGE COMPIANCE AUDIT OF DIAGNOSIS CODES THAT HUMANA, INC., (CONTRACT H1036) SUBMITTED TO CMS (2021) (finding in April 2021, the HHS OIG audited contract H1036's 2015 service year. H1036 is a plan which serves approximately 485,000 enrollees, located primarily in South Florida. Of the 485,000 enrollees, the OIG randomly selected 200 enrollees for sampling. In total, this group of 200 enrollees accounted for $3,522,179 of the $5.6 billion, less than 7%, of payments to Humana for this coverage).
[124] *Id*.

1,525 conditions and diagnoses, 203 were invalidated, meaning the medical records did not support the claim.[125] Review of one enrollee's records indicated annual overpayment of $4,380 due to the diagnoses of "malignant neoplasm of the larynx," which coded the patient as having a form of a major cancer.[126] However, the patient was never "monitored, evaluated, or treated" for that diagnosis in the 2015 service year.[127] Another enrollee's medical records revealed the overstating of their diabetes, resulting in overpayments of $1,956 annually.[128] Contrastingly, Humana failed to report, or misreported, fifteen conditions to CMS; these would have resulted in a higher risk score for the respective enrollee.[129] After accounting for CMS's underpayments for those fifteen unreported or misreported conditions, the HHS-OIG found CMS still overpaid Humana $249,279 for those 200 enrollees and "estimated…at least $197,720,651 of net overpayments in 2015."[130]

In response to private insurers' fraudulent activities, like those evidenced by the April 2021 Audit, several lawsuits have launched under the False Claims Act (FCA).[131] CIGNA, Independent Health, Keiser Permanente, and UnitedHealth Group are four insurers currently involved in pending litigation after DOJ investigations revealed the companies knowingly falsified diagnoses.[132] The outcome of these lawsuits will likely determine the trajectory of MAOs moving forward, as each insurer could face tens of millions of dollars in judgments.[133]

Separate from pending litigation, CMS has proposed Risk Adjustment Data Validation (RADV) audit rules which will result in approximately $4.7 billion in repayments to the federal government.[134] These rules will allow CMS to extrapolate RADV findings and apply them across the entire MA Plan.[135] As a result, Plans are expected to pay back an estimated $4.7 billion from 2023-2032,[136] less than 4.5% of the estimated overpayments from 2010-2019.[137] Though they face some adverse repercussions in the future, CMS relieved previously-audited MAOs of nearly $1.96

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[125] *Id*. at 5 (Explaining twenty of the invalidated conditions were invalidated because the OIG "identified 22 other [categories] for more and less severe manifestations of the diseases).
[126] *Id*.
[127] *Id*.
[128] *Id*. at 8 (Finding that the diagnosis reported by Humana was "'Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled.'" The enrollee's medical records indicated the enrollee had Diabetes without complications, a "less severe manifestation[]" of the condition, which would have resulted in a lower risk score and in turn a lower payment to Humana).
[129] *Id*.
[130] *Id*. at 5.
[131] U.S. DEPARTMENT OF JUSTICE, UNITED STATES INTERVENES AND FILES COMPLAINT IN FALSE CLAIMS ACT SUIT AGAINST HEALTH INSURER FOR SUBMITTING UNSUPPORTED DIAGNOSES TO THE MEDICARE ADVANTAGE PROGRAM (2021) (describing under 31 U.S.C. 3729(a)(1)(G), any person who receives an overpayment under the Medicare Act is required to "report and return" the overpayment within 60 days of the overpayment being identified. The FCS prohibits anyone from perpetuating fraud against federally funded programs by knowingly submitting false claims).
[132] U.S. DEPARTMENT OF JUSTICE, FALSE CLAIMS ACT SETTLEMENTS AND JUDGMENTS EXCEED $2 BILLION IN FISCAL YEAR 2022 (2023).
[133] *Id*.
[134] Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, *supra* note 109 (explaining that an RDAV is an audit that reviews a randomly selected sample population from an MA Plan to check for improper reports. The auditor cross-references the diagnoses and treatments reported by the Plan with the enrollee's medical records to determine whether the Plan properly reported an enrollee's condition. Auditors then determine whether the Plan was properly paid, underpaid, or overpaid, for the coverage they provided. The new rule allows the HHS-OIG to continue performing its standard RADV audits, which review a sample population's health data as opposed reviewing all enrollees' medical records, to calculate over and under payments to MA Plans. The error rate from the RADV audit, the sample population, will then be applied to the plan as a whole.
[135] *Id*.
[136] *Id*.
[137] COMM. FOR A RESPONSIBLE FED. BUDGET, REDUCING MEDICARE ADVANTAGE OVERPAYMENTS, *supra* note 118.

billion in paybacks by only extrapolating RADV overpayments from 2018 and on.[138] CMS also plans to implement changes to capitation rates and payments, which will decrease the amount of money CMS pays MAOs for diagnoses that appear to be manipulated and over abused by MA Plans.[139] Contrary to initial CMS plans, these capitations and decreased payments will be phased in over a three-year period, resulting in continued federal funding for payments "Medicare officials do not consider appropriate."[140]

VII. Recommendations

Given the consistent misbehavior of MA Plans, new processes, harsher punishments, and changed protocols should be implemented to protect MA enrollees and limit the overspending of taxpayer dollars.

To ensure MA Plan enrollees receive adequate medical treatment, an expedited administrative court should be created for MA Plan healthcare service denials. Rather than waiting over three months for an appellate body's decision, MA Plan enrollees should have the opportunity to immediately appeal a prior authorization denial with an Administrative Law Judge (ALJ), as opposed to the MAO.[141] However, unless a party shows egregious bias or bribery, the ALJ's decision shall be final and binding. Thus, patients who are appealing a denial with uncertainty are encouraged to proceed with the current appeals process. Due to the nature of the issues at hand, an enrollee's hearing shall take place within three business days of the filing. Enrollees should provide the ALJ all medical documentation provided to the MAO for prior authorization, while the MAO shall be required to cite their reasoning for denial. An ALJ will then review the evidence at hand to determine whether the denial was proper or failed to comply with Medicare policies. To fund the program, any MAO who wishes to contract with CMS must contribute a pro-rated amount, based on the number of enrollees within their Plans, to a fund which will be used to pay out all MA Plan ALJ's salaries. This pro-rated calculation will be determined by dividing the sum of the ALJs' salaries by the number of MA enrollees. MAOs must contribute this dollar amount per enrollee to contract with CMS.

In addition to the marketing rules and regulations recently mandated by the Biden Administration and CMS, harsher punishments, like a "Three Strikes Rule," should be created to punish MAOs for continuous, improper bad marketing acts. Under such a rule, MA Plans would be prohibited from contracting with CMS after receiving three warnings for improper marketing. With catastrophic repercussions on the line, MA Plans may be incentivized to further scrutinize their marketing materials, including those designed and distributed by TPMOs. Under the Three Strikes Rule, MA Plans will be required to abide by all CMS regulations, federal laws, and state laws that both restrict marketing and require specific disclaimers. Since recently enacted regulations require all MA Plans to disclose themselves on any marketing materials, any complaints received by CMS should require the complainant to disclose the named Plan. Once a

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[138] *Id*. (explaining if CMS began extrapolation in 2011, MA Plans would owe an estimated $2 billion for improper payments. Under the proposed rule, MA Plans will only pay an estimated $41.1 million for improper payments).
[139] Margot Sanger-Katz, Reed Abelson, *Medicare Delays a Full Crackdown on Private Health Plans*, New York Times (Mar. 31, 2023), https://www.nytimes.com/2023/03/31/health/medicare-overbilling-insurance.html (finding that "[a]ltogether, Medicare estimates that Medicare Advantage plans will be paid 3.32 percent more next year than this year. Under the original limits proposed by the administration, that increase would have been around 1 percent.").
[140] *Id*.
[141] HHS-OIG REPORT, *supra* note 64.

Plan has received 150 complaints, CMS should open an investigation into the Plan's marketing materials. If found in violation of the regulations and rules, the violating Plan will receive a warning for improper marketing. Upon their third violation, the Plan's contract with CMS will be voided, and the Plan will not be permitted to contract with CMS for one full enrollment period. Thus, if a Plan receives a third violation on July 15, 2025, they will not be permitted to contract with CMS until October 1, 2027. Any enrollees adversely affected by the dropped contract will receive TM until the next Open Enrollment Period begins. Should any Plan's contract be voided three times throughout the Plan's existence, it will be prohibited from ever contracting with CMS. This rule serves to toughen marketing rules and mitigate the number of repeat offenders in the market.

The final recommendation aims to minimize federal MA Plan spending by requiring CMS to increase or decrease the code intensity adjustment every year, with respect to the annual MA payment percentage.[142] Though different models of determining a proper code intensity adjustment exist, CMS should reserve the authority to determine the adjustment's magnitude.[143] However, CMS should be required to modify the adjustment percentage by at least 25% of the annual MA payment percentage. With risk-scores acting as the crux of MA payments, an annual adjustment of the coding intensity adjustment will result in at least some offset of increased costs. While unfavorable audit reports and FCA judgments encourage MAOs to properly report enrollees' diagnoses, taking direct action against the source guarantees a reduction in improperly inflated MA Plan payouts. Changing the coding intensity adjustment annually will result in a reactive system that protects taxpayer dollars and minimizes the effects of MAOs' financially motivated, false statements.

Collectively, these recommendations work in conjunction with the rules and regulations already set forth by CMS, federal statutes, and executive declarations to expedite the appeals process for MA Plan participants, provide appropriate and transparent marketing to Medicare-eligible people, and minimize funds paid by CMS to MA Plans for improper, exaggerated claims.

VIII. Conclusion

With enrollment skyrocketing and reports of misbehavior increasing at a similar rate, MA Plans' misbehavior is a growing concern for Medicare-eligible people and the federal government.[144] MA Plans continue to improperly deny healthcare treatment for thousands of enrollees each year, but with minimal repercussions, few incentives exist for MA Plans to properly consider prior authorizations.[145] MA Plans' misbehavior is not limited to its current enrollees, but extends into the community, affecting prospective enrollees who are victims of misleading, false, and abusive marketing.[146] Using the "bait and switch" tactic, MA Plans are swindling prospective enrollees, leading them to believe they will receive incredible supplemental benefits.[147] Yet, the Plans' marketers often fail to disclose the fine print which restricts who these benefits apply to,

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[142] Author suggests, if the annual MA payment percentage increases, CMS will be required to increase the code intensity adjustment by the minimal percentage. If the annual MA payment percentage decreases, CMS will be required to decrease the code intensity adjustment by the minimal percentage.
[143] RICHARD KRONICK, MICHAEL CHUA, *supra* note 120.
[144] STEVEN FINDLAY, GRETCHEN JACOBSON, FAITH LEONARD, *supra* note 7; FINANCE COMMITTEE 2022 REPORT *supra note 8.*
[145] NOTICE OF IMPOSITION OF CIVIL MONEY PENALTY FOR MEDICARE ADVANTAGE-PRESCRIPTION DRUG CONTRACT NUMBERS: H0354, H0439, H1415, H2108, H3949, H4407, H7020, H9460, AND H9725, *supra* note 66 (noting CIGNA received a fine of $126,988 in February 2022 followed by another fine of $85,436 for improper coverage of MA Plans).
[146] *See generally*, FINANCE COMMITTEE 2022 REPORT, *supra* note 8.
[147] *Id*. at 2.

commonly disqualifying the enrollee at hand.[148] Given the continuance of these misbehaviors, coupled with the failure to correct after being penalized, new procedures and stricter punishments should be implemented to curb the bad acts of MA Plans which negatively affect enrollees.

MA Plans' bad acts also have negative impacts on the federal government, costing over $100 billion in the past decade, with projections expecting an additional $400 billion in overspending over the next decade.[149] MA Plans notoriously overstate enrollees' conditions and treatments, resulting in the implementation of a coding intensity adjustment—an adjustment which cuts all MA Plan payments by a fixed percentage.[150] However, CMS has failed to maintain the adjustment, keeping the adjustment percentage stagnant over the past five years.[151] While the government may seek recourse for overpayment through the FCA and audits, stronger actions should be taken to cauterize the issue at its source. Enacting laws that require CMS to adjust the code intensity rate in relation to the change in annual percentage of MA Plan costs would cut federal overspending on MA Plans.

Taking actions to eliminate and correct the misbehavior of Medicare Advantage Plans is crucial to the future of healthcare for MA Plan enrollees and federal spending. Thus, the law should create an expedited administrative process for MA Plan prior authorization denials, implement stricter, more significant punishments for misleading marketing, and require CMS use existing mechanisms to reduce payments to MAOs.

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[148] *Id*. at 5.
[149] FRED SCHULTE, *supra* note *126;* RICHARD KRONICK, MICHAEL CHUA, *supra* note 120.
[150] REDUCING MEDICARE ADVANTAGE OVERPAYMENTS, *supra* note 116.
[151] *Id*.

LIVE FREE OR DIE? ANALYZING THE RIGHT TO MEDICAL AID IN DYING, THROUGH A CONSTITUTIONAL/ANTITRUST LAW MATRIX

A. Maresa Semper[*]

The sunshine state is turning silver, and the rights that individuals possess over their life and bodily autonomy remain hot button issues. With the percentage of Florida's elderly population increasing, issues surrounding aging and end of life planning will continue toward the foreground of the social consciousness. This Note focuses on the right to exercise one's liberty at the end of life and to decide when and how they wish to pass on from this world. Social and legal tradition have painted a paternalistic gloss on the discussion around seeking medical aid in dying – referred to in this paper as opting out – and either ignored or declined to meaningfully examine the nuance surrounding the issue. This paper argues that Florida's prohibition of the right to opt out is both an unconstitutional violation of liberty and a contravention of anti-trust law principles. Suppressing one's right to opt out effectively suppresses the existence of a corresponding market in the economy's healthcare sector. Such action by the state is functionally anti-competitive and in restraint of trade.

Table of Contents

[*] Ms. Semper, J.D., Florida State University, 2024.

I. Introduction

What is the point of life—to live as long as possible or to live well? It may be an oversimplistic dichotomy, but the question is one of particular relevance to the elder population of the United States.[1] As the country's elders reach projections of increased population share,[2] their needs will demand commensurate attention in the policy landscape. These needs vary among individuals and include greater nuance in age discrimination law that addresses the "intersectionality of age and sex,"[3] increased health equity in the Medicare program,[4] counter-financial exploitation support,[5] hospice or palliative care services near the end of life,[6] and—of critical importance to this Note—a formalized and comprehensive acknowledgment of autonomy in end-of-life planning.[7]

In a 2017 report, 71% of study participants viewed helping people die without pain, discomfort, and stress as more important than preventing death and extending life as long as possible.[8] At

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[1] David Busscher, Note, *Linking Assisted Suicide and Abortion: Life, Death, and Choice*, 23 ELDER L.J. 123, 124 (2015).

[2] *See* U.N., Dep't Econ. & Soc. Aff., Pop. Div., *World Population Prospects: The 2017 Revision, Key Findings and Advance Tables*, at 11, U.N. Doc. ESA/P/WP/248 (2017).

[3] Joanne Song McLaughlin, *Limited Legal Recourse for Older Women's Intersectional Discrimination Under the Age Discrimination in Employment Act*, 26 ELDER L.J. 287, 289–90 (2019) ("The increasing number of older women in the labor market raises the concern that older women face unique challenges in the workplace, for being both old and female, that are not adequately covered by the [Age Discrimination in Employment Act] ADEA. This unique type of discrimination, based on two protected classes (i.e., age and sex), is referred to as intersectional discrimination (also called "age-plus-sex" or "sex-plus-age" discrimination). The ADEA has never recognized this intersectionality of discrimination. In other words, older women may be *more* discriminated against for being old *and* female, but our current federal age discrimination law cannot protect older women from this intersectional discrimination. Older women's discrimination is different from age discrimination or sex discrimination individually, but their discrimination claims can be classified as only age discrimination under the ADEA.").

[4] *See* Kata Kertesz, *Expansions of Medigap Consumer Protections are Necessary to Promote Health Equity in the Medicare Program*, 13 J. AGING L. & POL'Y 39, 39 (2022).

[5] *See* Jesse R. Morton & Scott Rosenbaum, *An Analysis of Elder Financial Exploitation: Financial Institutions Shirking Their Legal Obligations to Prevent, Detect, and Report this "Hidden" Crime*, 27 ELDER L.J. 261, 263–264 (2020) ("To address and attempt to mitigate the growing issue of elder financial exploitation, the Financial Industry Regulatory Authority ("FINRA"), the Securities and Exchange Commission ("SEC"), and other agencies have recently enacted various guidance and rules specifically designed to better protect seniors and other at-risk adults, such as those who are disabled."). Yet, the authors assert that "[l]awmakers at both the state and federal levels should both enhance existing laws and enact new laws that emphasize the importance and criticality of financial institutions preventing, detecting, and reporting elder financial exploitation." *Id.* at 292.

[6] *See* Zachery Sager et al., *Making End-of-Life Care Decisions for Older Adults Subject to Guardianship*, 27 ELDER L.J. 1, 4 (2019) ("As a philosophy, hospice recognizes that dying is a normal part of life and aims to restore an individual's dignity while focusing on efforts to improve quality of life and provide comfort. As such, the goals of hospice may stand in contrast to a state's 'unqualified interest in the preservation of human life'… palliative care is intended for any individual with a serious life-limiting disease. Palliative care can be offered concurrently with life-sustaining care or may be independent. Palliative care also provides services across the continuum, including in the inpatient, outpatient, nursing facility, and home settings.").

[7] *See* Kathy L. Cerminara & Barbara A. Noah, *Removing Obstacles to a Peaceful Death*, 25 ELDER L.J. 197, 197 (2018) ("We all will die, but the American health care system often impedes a peaceful death. Instead of a quiet death at home surrounded by loved ones, many of us suffer through overutilization of sometimes-toxic therapeutic interventions long past the time when those interventions do more good than harm.").

[8] Liz Hamel et al., *Views and Experiences with End-of-Life Medical Care in the U.S.*, KAISER FAM. FOUND., Apr. 2017, at 7, https://files.kff.org/attachment/Report-Views-and-Experiences-with-End-of-Life-Medical-Care-in-the-US. The Kaiser Family Foundation, in partnership with The Economist, conducted a survey of adults in the United States, Italy, Japan, and Brazil regarding participants' views on preparing and providing care for people nearing the end of life. *Id.* at 1.

present, seven countries have laws that allow for citizens to seek medical aid in dying: Belgium, Luxembourg, Canada, New Zealand, Spain, the Netherlands, and Colombia.[9] Switzerland also provides a comparatively less-regulated environment in which death assisted by nonphysicians is permitted.[10]

The Supreme Court has affirmed the right to refuse life-saving medical care[11] as the arc along which the state's "unqualified interest in the preservation of human life" bends.[12] It has failed, however, to recognize a comprehensive right to autonomy in one's medical decision-making process, by leaving the legality of physician-assisted dying or, opting out, to the discretion of the states.[13]

This Note recognizes there are various terms used to describe one's decision to end their life.[14] Going forward, this Note uses the term "opt out" interchangeably with "physician-assisted suicide" and "seeking medical aid in dying."

The argument put forth in this Note aims to provide a backstop to the Supreme Court's (and lower courts') reliance on tradition as a justification for the suppression of one's right to opt out.[15] This note argues that this right is derived from a fair reading of the Due Process Clause of the Fourteenth Amendment and the Delegation of Powers Clause in the Tenth Amendment, which explicitly reserves the difference in the central versus state government balance of power "to the people."[16]

As to the question of whether life and death fall within the realm of trade or commerce – which antitrust law aims to protect from unfair practices – this Note argues that the former is inextricably linked with the latter[17] and, as a result, should be subject to protection by the laws that regulate the market. Laws that prohibit the very existence of what would otherwise be a micromarket regulated for fairness and competition are, in effect, anticompetitive. Free and unfettered competition in this area of the healthcare market would empower elders to exercise a comprehensive right to live and die with dignity, under a legitimate and ethical rule of law.

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[9] Albinson Linares, *These People Want to Die. Will Their Countries Allow Euthanasia?*, NBC NEWS (Oct. 21, 2021), https://www.nbcnews.com/news/latino/people-want-die-will-countries-allow-euthanasia-rcna3307.

[10] Sarah Vilpert et al., *Social, Cultural and Experiential Patterning of Attitudes and Behaviour Towards Assisted Suicide in Switzerland: Evidence from a National Population-Based Study*, 150 SWISS MED.WKLY., July 2020, at 1, https://smw.ch/index.php/smw/article/view/2816/4567.

[11] Washington v. Glucksberg, 521 U.S. 702, 723 (1997) (citing Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 279 (1990)).

[12] Busscher, *supra* note 1, at 143.

[13] *Glucksberg,* 521 U.S. at 735.

[14] *See Glossary of Terms*, DEATH WITH DIGNITY https://deathwithdignity.org/resources/assisted-dying-glossary/ (last accessed Oct. 26, 2022).

[15] *See generally Glucksberg*, 521 U.S. at 721.

[16] U.S. CONST. amend. X.

[17] *See* Mohamed Rabie, A Theory of Sustainable Sociocultural and Economic Development 67 (Palgrave Macmillan N.Y., 2016). "The existence of an economy is essential to the formation and sustenance of society. No society can survive without an economy efficient enough to meet, at the very least, the basic needs of its members. Every economy exists for the sole purpose of meeting the growing needs of people as life conditions change. Economy, therefore, is a component of society; and society is the framework within which economy functions. Because of this relationship, every society has its own economy, and every economy reflects the needs and cultural attributes of society, as well as the major traits of the civilization in which it lives."

Using Florida—the state with the highest percentage of people aged sixty-five or older[18] — and Oregon—the first state to adopt a Death with Dignity Act[19]—for reference, this Note advances the argument in favor of the right to opt out by analyzing its merits: first, through a constitutional lens and, second, in consideration of antitrust law principles. It argues that (1) taken together, the Due Process Clause and the reservation of powers "to the people" in the Fourteenth[20] and Tenth[21] Amendments create a fundamental right to opt out and (2) that state law prohibiting the decision to opt out violates antitrust law principles which promote "free and unfettered competition as the rule of trade."[22]

Summary of the Law

A. Due Process, the Right to Privacy, and the Ninth Amendment

In the seminal 1997 case *Washington v. Glucksberg*, the Supreme Court held that the state of Washington's law banning assisted suicide did not violate the Due Process Clause of the

[18] Maria Toscano & Emma Rubin, *Population over 65 by State*, CONSUMER AFFAIRS https://www.consumeraffairs.com/homeowners/elderly-population-by-state.html (last updated Feb. 6, 2024).

[19] *Oregon*, DEATH WITH DIGNITY https://deathwithdignity.org/states/oregon/ (last accessed Dec. 8, 2022); Death with Dignity, *Glossary of Terms*, DEATH WITH DIGNITY https://deathwithdignity.org/resources/assisted-dying-glossary/ (last accessed Oct. 26, 2022). Assisted Death, also known as "physician-assisted dying" or "aid in dying" is legal in all states with existing death with dignity laws. It permits mentally competent, adult patients with terminal illness to request a prescription for life-ending medications from their physician. The patient must self-administer and ingest the medication without assistance; Euthanasia, this is translated literally as "good death" and refers to the act of painlessly, but deliberately, causing the death of another who is suffering from an incurable, painful disease or condition. It is commonly thought of as lethal injection, and it is sometimes referred to as "mercy killing." All forms of euthanasia are illegal in the United States. The Glossary identifies and provides definitions for five classes of euthanasia. Suicide is generally defined as the act of taking one's own life voluntarily and intentionally. Because an adult patient with terminal illness who is deemed mentally competent chooses to hasten their death through a physician's assistance, "physician-assisted dying" is more accurate than "physician-assisted suicide." Terminal (or Palliative) Sedation, generally practiced during the final days or hours of a dying patient's life, this coma-like state is medically induced through medication when symptoms such as pain, nausea, breathlessness, or delirium cannot be controlled while the patient is conscious. Patients generally die from the sedation's secondary effects of dehydration or other intervening complications.

[20] U.S. CONST. amend. XIV, § 1. The Due Process Clause of the Constitution states, in relevant part, that "[n]o state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

[21] U.S. CONST. amend. X.

[22] *The Antitrust Laws*, FED. TRADE COMM'N., https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws/antitrust-laws (last visited Nov. 20, 2024). "Congress passed the first antitrust law, the Sherman Act, in 1890 as a 'comprehensive charter of economic liberty aimed at preserving free and unfettered competition as the rule of trade'… Courts have applied the antitrust laws to changing markets, from a time of horse and buggies to the present digital age." *See also* FLA. STAT. § 542.16 (2022). The statute provides that, "[t]he Legislature declares it to be the purpose of this act to complement the body of federal law prohibiting restraints of trade or commerce in order to foster effective competition. It is the intent of the Legislature that this act be liberally construed to accomplish its beneficial purpose."

Fourteenth Amendment,[23] nor was it unconstitutional.[24] The Court held that the "asserted 'right' to assistance in committing suicide is not a fundamental liberty interest protected by the Due Process Clause."[25] The Court focused on the deeply entrenched Anglo-American "tradition" of viewing the decision to end one's life, and assistance by another to affect that outcome, as criminal and counter to state interests—even in instances where one suffers from a terminal disease.[26]

The Court asserted that a substantive due-process analysis proceeds along two axes: (1) whether the right asserted constitutes a fundamental right and liberty interest that is "deeply rooted in the [n]ation's history and tradition," and (2) whether the asserted interest has been articulated with "careful description."[27] The claimants and the Ninth Circuit on appeal used several descriptors to characterize the asserted right, including: the "right to determine the time and manner of one's death, the right to die, a liberty to choose how to die, a right to control of one's final days, the right to choose a humane, dignified death, and the liberty to shape death."[28] The Court held that these descriptors did not precisely characterize the right being argued. Rather, the Court determined that the accurate articulation was the "right to commit suicide which itself includes a right to assistance in doing so."[29]

The Court also weighed the interests being infringed upon against those of the state, to determine whether the constitutional requirement that an infringing law or action (here, a ban on physician-assisted suicide) be "rationally related to legitimate government interests," was satisfied.[30] The Court found that the state had several interests which satisfied the rational basis requirement, including "prohibiting intentional killing and preserving human life," and the protection of vulnerable populations, like the elderly, from "indifference, prejudice, and psychological and financial pressure to end their lives."[31] And thus, the Court concluded that the legal precedent did not support an acknowledgment of the right to opt out.[32]

The right to privacy has also provided little aperature through which courts are willing to perceive the implicit right to opt out. Despite the Supreme Court inferring a constitutional right to privacy from the document's explicit provisions[33] and states, like Florida, enshrining to citizens a

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[23] U.S. CONST. amend. XIV, § 1. The Due Process Clause of the Constitution states, in relevant part, that "[n]o state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws."

[24] 521 U.S. at 719.

[25] *Id.* at 703.

[26] *Id.* at 702. The Court held that, "An examination of our Nation's history, legal traditions, and practices demonstrates that Anglo–American common law has punished or otherwise disapproved of assisting suicide for over 700 years; that rendering such assistance is still a crime in almost every State; that such prohibitions have never contained exceptions for those who were near death…"

[27] *Id.* at 703.

[28] *Id.*

[29] *Id.*

[30] *Id.* (citing Heller v. Doe, 509 U.S. 312, 319-320 (1993)).

[31] *Id.* at 703-04.

[32] *Id.* The Court held that "[t]o hold for respondents, [it] would have to reverse centuries of legal doctrine and practice, and strike down the considered policy choice of almost every [s]tate."

[33] *E.g.,* Griswold v. Connecticut, 381 U.S. 479, 485-86 (1965) (holding that Connecticut's law prohibiting the use of contraceptives on the grounds that it unconstitutionally intruded upon the right to marital privacy); Eisenstadt v. Baird, 405 U.S. 438 (1972) (construing the right to privacy identified in *Griswold v. Connecticut* by holding that "[i]f the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear

constitutional right to privacy,[34] courts have declined to extend the right to privacy to find opting out permissible where lawmakers have not so legislated.[35]

In the late nineties, the debate around the right to die entered the foreground of the national consciousness. This was due, in large part, to the actions of Dr. Jack Kevorkian, at times referred to by the media as Dr. Death.[36] The state of Michigan brought suit against him for administering a lethal injection.[37] The subject of this lethal injection, Thomas Youk, suffered from the debilitating infirmity, amyotrophic lateral sclerosis (ALS), otherwise known as Lou Gehrig's disease.[38] Youk had reached out to Dr. Kevorkian who was then relatively well known for his work with terminal and severely ailing patients. The former racecar driver had lost the use of his legs, struggled to speak due to his diminished control over the muscles in his mouth and neck, and greatly feared choking to death.[39]

Dr. Kevorkian argued that the right to be free from "inexorable pain and suffering" – and thus, the right to euthanasia – is among the unenumerated rights reserved to the people under the Ninth Amendment.[40] The Court rejected this argument, however, on the grounds of a lack of sufficiently supportive rationale.[41] Because Michigan state laws – the state in which Dr. Kevorkian

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or beget a child."). *See generally* Cornell Law School Legal Information Institute, Privacy, https://www.law.cornell.edu/wex/privacy (last accessed Oct. 27, 2022) (explaining that the Court has since relied more on Justice Harlan's concurrence in *Griswold v. Connecticut* than the majority opinion in subsequent privacy cases, in which derived the right to privacy from the Fourteenth Amendment rather than the constitutional penumbras. Also noting that "after the ***Dobbs*** decision, the Court overturned both *Roe* and ***Casey***. Consequently, the right to abortion no longer falls under the broader right to privacy. Additionally, the *Dobbs* opinion mentioned potentially examining *Griswold* and *Eisenstadt* in the future. While it is unclear to what extent that may have on the right to privacy in the current time; it is likely that the case law around this right will continue to evolve with more recent Supreme Court decisions."

[34] FLA. CONST. art. I, § 23.

[35] People v. Kevorkian, 639 N.W.2d 291, 297 (Mich. Ct. App. 2002). Relying on *Glucksberg*, the court held, "[d]efendant, in what is now apparently something of an afterthought, asks us to conclude that euthanasia is legal and, therefore, to reverse his conviction on constitutional grounds. We refuse. Such a holding would be the first step down a very steep and very slippery slope. To paraphrase the United States Supreme Court in *Washington v. Glucksberg,* it would expand the right to privacy to include a right to commit euthanasia and thus place the issue outside the arenas of public debate and legislative action."

[36] Keith Schneider, *Dr. Jack Kevorkian Dies at 83; A Doctor Who Helped End Lives*, N.Y. TIMES (June 3, 2011), https://www.nytimes.com/2011/06/04/us/04kevorkian.html.

[37] *Kevorkian*, 639 N.W.2d at296.

[38] CBS News: 60 Minutes, An Interview with Dr. Jack Kevorkian https://www.youtube.com/watch?v=BiZKY6FSfwA; *See also* ALS Association, What is ALS? https://www.als.org/understanding-als/what-is-als (last accessed Oct. 27, 2022). "ALS, or amyotrophic lateral sclerosis, is a progressive neurodegenerative disease that affects nerve cells in the brain and spinal cord… As this area degenerates, it leads to scarring or hardening ("sclerosis") in the region. Motor neurons reach from the brain to the spinal cord and from the spinal cord to the muscles throughout the body. The progressive degeneration of the motor neurons in ALS eventually leads to their demise. When the motor neurons die, the ability of the brain to initiate and control muscle movement is lost. When voluntary muscle action is progressively affected, people may lose the ability to speak, eat, move, and breathe."

[39] CBS News: 60 Minutes, *supra* note 38.

[40] *Kevorkian* 639 N.W.2d at 303.

[41] *Id.* The court held that, "Defendant's argument that the people have reserved the right to euthanasia under the Ninth Amendment and its Michigan counterpart is basically formless. He states that a right to be free from inexorable pain and suffering "must be among" the rights protected by these two constitutional provisions. Further, he argues that states "should recognize such a right and give it force." Defendant does not cite a single case for this extraordinary request." The court further held that "It is not enough for an appellant in his brief simply to announce

administered the lethal injection to Youk – did not sanction euthanasia, the assisted death of Youk was illegal, and Kevorkian was ultimately convicted of second-degree murder and sentenced to concurrent prison terms of ten to twenty-five years.[42]

B. Death with Dignity

In the statutory context, Death with Dignity refers to codified legislation that permits "an end of life option that allows certain eligible individuals to legally request and obtain medications from their physicians to end their life in a peaceful, humane, and dignified manner."[43] At the time of writing, "dying with dignity" is legal in eleven states and jurisdictions in the U.S.[44]

Oregon was the first state to adopt a Death with Dignity Act (DWDA),[45] and the state places restraints on who can assert a right to die with dignity under the state law:

> To participate, a patient must be: (1) 18 years of age or older, (2) capable of making and communicating health care decisions for him/herself, and (3) diagnosed with a terminal illness that will lead to death within six months. It is up to the attending physician to determine whether these criteria have been met. As of March 2022, the Oregon Health Authority is no longer enforcing the DWDA's residency requirement.[46]
>
> The state of Oregon does not collect information about the costs of utilizing its DWDA statute nor does the statute specify who must pay for services under the act.[47] It also does not intimately regulate the use of the statute by patients and physicians, unless there is cause for investigation into claims of noncompliance.

The law does not include any oversight or regulation that is distinct from what is done for other medical care. The DWDA assigned the Oregon Health Authority (OHA) the responsibility of keeping track of data on participation and issuing an annual report but did not assign any specific regulatory responsibilities. OHA does not investigate whether patients met the DWDA criteria, nor how their diagnosis, prognosis, and treatment options were determined. OHA does not interpret the statute, other than the portion related to the reporting requirements. However, if any instances of non-compliance are found in the

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a position or assert an error and then leave it up to this Court to discover and rationalize the basis for his claims, or unravel and elaborate for him his arguments, and then search for authority either to sustain or reject his position. The appellant himself must first adequately prime the pump; only then does the appellate well begin to flow. Failure to brief a question on appeal is tantamount to abandoning it," citing the Supreme Court of Michigan in Mitcham v. Detroit, 94 N.W.2d 388, 388 (Mich. 1959).

[42] *Id* at 291. Kevorkian was also sentenced to seven years for his controlled substance conviction.

[43] *Frequently Asked Questions*, DEATH WITH DIGNITY, https://deathwithdignity.org/resources/faqs/ (last accessed Oct. 26, 2022).

[44] *In Your State*, DEATH WITH DIGNITY, https://deathwithdignity.org/states/ (last accessed May 5, 2023). The states and jurisdictions with a Death with Dignity statute are California, Colorado, New Jersey, New Mexico, Hawai'i, Oregon, Maine, Montana, Vermont, Washington. and Washington D.C. Pennsylvania and New York are considering Death with Dignity legislation.

[45] Death with Dignity, *supra* note 19.

[46] Oregon Health Authority, *Frequently Asked Questions*, STATE OF OREGON, https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/pages/faqs.aspx (last accessed Oct. 27, 2022). Oregon's DWDA does not permit euthanasia.

[47] *Id*.

information received by OHA, it is reported to the Oregon Medical Board for further investigation.[48]

The law requires that the patient voluntarily request a prescription under the DWDA on their own behalf; family members cannot request participation in the DWDA on behalf of the patient.[49] Patients always retain the right to rescind a request to participate in the DWDA.[50]

Though a majority of Oregon voters supported the DWDA in 1994,[51] the Act did not traveled through the political or legal landscapes unscathed. The statute faced opposition from public and religious groups as well as federal legal action seeking injunction under the Controlled Substances Act (CSA).[52] In 1971, the Attorney General promulgated a rule which required that Schedule II substances be prescribed "for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice."[53]

In 2001, the Attorney General issued an interpretive rule in response to Oregon's Death with Dignity Act, which declared that under the CSA, "using controlled substances to assist suicide is not a legitimate medical practice," and "dispensing or prescribing them for this purpose is unlawful."[54] On a challenge to the rule, the trial court enjoined enforcement of the Act.[55] On appeal, the Ninth Circuit invalidated the rule and concluded that the plain language of the CSA did not permit the Attorney General to prohibit doctors from prescribing regulated drugs to patients seeking to opt out in states where the choice may be legally made.[56] The Supreme Court granted the Government's petition for certiorari and affirmed the Ninth Circuit's holding, concluding that the CSA "did not grant expansive federal authority to regulate medicine by defining scope of legitimate medical practice, in view of the CSA's silence on the practice of medicine generally and its recognition of state regulation of the medical profession."[57] Thus, Oregon's Death with Dignity Act was saved.

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[48] *Id.*
[49] *Id.*
[50] *Id.*
[51] *Death with Dignity Act History*, OREGON GOV'T, (https://www.oregon.gov/oha/PH/PROVIDERPARTNERRESOURCES/EVALUATIONRESEARCH/DEATHWITHDIGNITYACT/Documents/History.pdf) (last visited Oct. 28, 2022). "The Oregon Death with Dignity Act (DWDA) was a citizen's initiative first passed by Oregon voters in November 1994 with 51% in favor."
[52] *Id.* ("Implementation was delayed by a legal injunction, but after proceedings that included a petition denied by the United States Supreme Court, the Ninth Circuit Court of Appeals lifted the injunction on October 27, 1997. In November 1997, a measure asking Oregon voters to repeal the Death with Dignity Act was placed on the general election ballot (Measure 51, authorized by Oregon House Bill 2954). Voters rejected this measure by a margin of 60% to 40%, retaining the Death with Dignity Act. After voters reaffirmed the DWDA in 1997, Oregon became the first state allowing this practice. On November 6, 2001, U.S. Attorney General John Ashcroft issued a new interpretation of the Controlled Substances Act, which would prohibit doctors from prescribing controlled substances for use under the DWDA. After multiple hearings and appeals, the Oregon DWDA was upheld and remains in effect today.").
[53] 21 CFR § 1306.04 (2020).
[54] Gonzales v. Oregon, 546 U.S. 243, 243 (2006).
[55] *Id.* at 244.
[56] *Id.*
[57] *See generally id.* at 269. West Headnote 11.

C. Florida Law

Florida recognizes the right to refuse or terminate life-preserving medical care.[58] This issue was the source of intense public debate during the latter half of the 1990s through the early 2000s, as the matter of Terri Schiavo—a woman who fell into a persistent vegetative state after suffering cardiac arrest—played out in the state and national news.[59] Courts ultimately found in favor of Terri's husband who decided to have her feeding tube removed after fifteen years.[60]

Florida prohibits all individuals from assisting in one's decision to opt out.[61] In 1997, the Florida Supreme Court concluded that, contrary to the finding of the trial court, there is a distinction between "the right to refuse medical treatment and the right to commit physician-assisted suicide through self-administration of a lethal dose of medication," with the latter being impermissible under state law.[62] The key difference, according to the court, is the affirmative step taken to end a life in the latter scenario. The court has previously refused to allow the state to prohibit affirmative medical intervention in the context of abortions (which necessarily involve the termination of life),[63] due to a lack of sufficiently compelling government interests as presented by the state. In *Krischer v. McIver*, however, the court—drawing upon *Washington v. Glucksberg*— found that the state's interests in: (1) the preservation of life; (2) preventing suicide; and (3) maintaining the integrity of the medical profession[64] outweighed the individual liberty of a terminal patient to opt out. While the court ultimately reversed the trial court's finding that opting out is permissible under state law, it also declined to hold that "a carefully crafted statute

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[58] FLA. STAT. § 765.102(1) (2022). "The Legislature finds that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession." *See also* Schiavo ex rel Schindler v. Schiavo, 358 F.Supp.2d 1161, 1161 (M.D. Fla. 2005).

[59] Radhika Chalasani, *A Look Back: The Terri Schiavo Case*, CBS NEWS, (March 31, 2016), https://www.cbsnews.com/pictures/look-back-in-history-terri-schiavo-death/18/. ("From 1995, Schiavo's husband began fighting to allow his wife to die. No doctor who examined Terri believed she had a chance to recover. Terri's family vehemently disagreed, producing a bitter family struggle that became very public as the fight was taken to the courts.").

[60] *Id.*

[61] FLA. STAT. § 782.08 (2022). (The statute provides that "[E]very person deliberately assisting another in the commission of self-murder shall be guilty of manslaughter, a felony of the second degree, punishable as provided in s. 777.082, s. 775.083, or s. 775.084.").

[62] Krischer v. McIver, 697 So.2d 97, 102 (Fla. 1997). In this case, a patient became terminally ill by contracting AIDS via blood transfusion; he sought, along with his doctor, declaratory judgment that Fla. Stat. § 782.08 violated the federal and state constitutions.

[63] *Id.* at 102 ("We have previously refused to allow the state to prohibit affirmative medical intervention, such as the case with the right to an abortion before viability of the fetus, only because the state's interests in preventing the intervention were not compelling.").

[64] *Id.* at 103. In relevant part, regarding the state interest in preventing suicide, the court noted that, "those who attempt suicide—terminally ill or not—often suffer from depression or other mental disorders… Research indicates, however, that many people who request physician-assisted suicide withdraw that request if their depression and pain are treated."

authorizing assisted suicide would be unconstitutional."[65] The court ultimately held that the permissibility of opting out under state law was a question to be determined by the legislature.[66]

In 2020, a Bill was introduced in the Florida Senate for the first time with the aim of adopting a "Death with Dignity Act."[67] The Bill was indefinitely postponed, withdrawn from consideration, and died in committee.[68] A renewed attempt to enact a DWDA similarly failed in the Florida Legislature in 2023.[69] In relevant part, the Bill provided that:

> The Legislature finds that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, and recognizes that for some faced with a terminal condition, prolonging life may result in a painful or burdensome existence. It is the intent of the Legislature to establish a procedure to allow a competent individual who has a terminal condition, and who makes a fully informed decision that he or she no longer wants to live, to obtain medication to end his or her life in a humane and dignified manner.[70]

In the 2025 legislative session, the Florida End-of-Life Options Act was introduced in the state House of Representatives with a companion bill in the senate.[71] Eligibility under the bill includes state residency, diagnosis of a terminal condition, oral and written requests, waiting periods, and the ability to rescind requests at any time.[72] The bill summary further provides that:

> [The] bill introduces new provisions regarding the responsibilities of healthcare providers, ensuring they verify the patient's condition and mental capacity while documenting all requests in the medical record. It mandates that at least one witness to the patient's request must not have a financial interest in the patient's estate. The legislation also addresses the disposal of unused medication, stipulates that death certificates must list the terminal condition as the cause of death, and protects healthcare providers from penalties for refusing to participate in the act. It clarifies that actions taken under this chapter do not constitute suicide or homicide, thereby safeguarding providers from prosecution.[73]

The state legislature did enact a Bill in 2015 – known as the "Right to Try Act" – which allows terminally ill patients to obtain from a physician a prescription for an experimental drug that has

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[65] *Id.* at 104.
[66] *Id.* ("However, we have concluded that this case should not be decided on the basis of this Court's own assessment of the weight of the competing moral arguments. By broadly construing the privacy amendment to include the right to assisted suicide, we would run the risk of arrogating to ourselves those powers to make social policy that as a constitutional matter belong only to the legislature.").
[67] 2020 Fla. S. Death with Dignity Act. SB 1800 (died in committee).
[68] *Id.*
[69] *Timeline of Death With Dignity in Florida*, DEATH WITH DIGNITY, 1, 1 (2024), https://deathwithdignity.org/states/florida/. SB 864/HB 1231 were introduced and assigned to committees in February, 2023, but did not advance by the close of the legislative session.
[70] 2023 Fla. S. A bill to be entitled. SB 864 (died in committee).
[71] 2025 Fla. H. Florida End-of-Life Options Act. HB 471.
[72] *Id.*
[73] *Id.*

not been approved for general public use by the USFDA.[74] While patients obtaining a prescription under this Act must acknowledge and consent to the possibility that, "new, unanticipated, different, or worse symptoms might result and death could be hastened," as a result of using the prescribed drug, the purpose of the drug is to attempt to treat or reverse an otherwise terminal illness.[75] Effectively, the law provides a last ditch attempt at life. As this law is not part of a regulatory scheme that permits one to opt out contingent on them first seeking an experimental, potentially curative prescription for their terminal illness, on its face it is not a barrier to Death with Dignity legislation. However, it fails to mitigate two critical concerns. First, prescriptions obtained under the Act may lead to death. The uncertainty of that outcome limits the ability of one to make fully informed decisions in their end-of-life planning and could lead to a death in which one experiences a diminished sense of dignity than they otherwise would have, had they been able to decisively choose to opt out. Second, a person may only seek a prescription under this Act for a terminal illness.[76] Those suffering with life-debilitating illnesses or diseases that are not classified as terminal by a physician cannot avail themselves of this legislation.[77] Therefore, while this law supports autonomy to a degree, it does not empower autonomous medical decision-making to the extent permitted under Death with Dignity legislation and called for by its advocates.

II. Antitrust Law

The Federal Trade Commission asserts that "aggressive competition among sellers in an open marketplace gives consumers – both individuals and businesses – the benefits of lower prices, higher quality products and services, more choices, and greater innovation."[78] Even the Supreme Court has held that "[t]he heart of our national economy has long been faith in the value of competition."[79] There are three major antitrust laws enforced by the Federal Government: the Sherman Antitrust Act, the Clayton Act, and the Federal Trade Commission Act.[80]

The Sherman Antitrust Act[81]

This Act outlaws all contracts, combinations, and conspiracies that unreasonably restrain interstate and foreign trade. This includes agreements among competitors to fix prices, rig bids, and allocate customers, which are punishable as criminal felonies. The Sherman Act also makes it a crime to monopolize any part of interstate commerce. An unlawful monopoly exists

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[74] FLA. STAT. § 499.0295 (2015). This section is also known as the "Right to Try Act," and defines an eligible patient as one who "(1) Has a terminal condition that is attested to by the patient's physician and confirmed by a second independent evaluation by a board-certified physician in an appropriate specialty for that condition; (2) Has considered all other treatment options for the terminal condition currently approved by the United States Food and Drug Administration; (3) Has given written informed consent for the use of an investigational drug, biological product, or device; and (4) Has documentation from his or her treating physician that the patient meets the requirements of this paragraph."

[75] FLA. STAT. § 499.0295(2)(d)(4) (2015).

[76] FLA. STAT. § 499.0295 (2022).

[77] *Id*.

[78] *Guide to Antitrust Laws*, FED. TRADE COMM'N (last accessed Dec. 9, 2022), https://www.ftc.gov/advice-guidance/competition-guidance/guide-antitrust-laws.

[79] Nat'l Soc'y Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978).

[80] Antitrust Div., *The Antitrust Laws*, DEPT. OF JUSTICE, https://www.justice.gov/atr/antitrust-laws-and-you (last updated Dec. 20, 2023).

[81] *Id. See also* 15 U.S.C. §§ 1-38 (2006).

when one firm controls the market for a product or service, and it has obtained that market power, not because its product or service is superior to others, but by suppressing competition with anticompetitive conduct. The Act, however, is not violated simply when one firm's vigorous competition and lower prices take sales from its less efficient competitors; in that case, competition is working properly.

The Clayton Act[82]

This Act is a civil statute (carrying no criminal penalties) that prohibits mergers or acquisitions that are likely to lessen competition. Under this Act, the Government challenges those mergers that are likely to increase prices to consumers. All persons considering a merger or acquisition above a certain size must notify both the Antitrust Division and the Federal Trade Commission. The Act also prohibits other business practices that may harm competition under certain circumstances.

The Federal Trade Commission Act[83]

This Act prohibits unfair methods of competition in interstate commerce, but carries no criminal penalties. It also created the Federal Trade Commission to police violations of the Act.

Section four of the Clayton Act works in tandem with the Sherman Act in that it creates a private cause of action for violations of the Sherman Act.[84]

Most states also have antitrust statutes.[85] Florida's statutes are complementary to the federal laws, particularly the Sherman Act, and prohibit "[e]very contract, combination, or conspiracy in restraint of trade or commerce" in the state as unlawful.[86] These statutes aim to regulate private action and its impact on the public and, in that regard, have been analyzed robustly.[87] Where they lack is in their applicability to the state, which is also capable of and engages in anti-competitive conduct.[88] This is not a blind spot in the existing regulatory framework but rather a gaping hole that has been intentionally left open by the "state action immunity doctrine."[89] This doctrine applies the interpretive canon of expressio unius – the expression of one thing is the exclusion of

[82] *Id. See also* 15 U.S.C. §§ 12-27 (2006).
[83] 15 U.S.C. §§ 41-59 (2006).
[84] Benitez v. Charlotte-Mecklenburg Hosp. Auth., 992 F.3d 229, 233 (4th Cir. 2021).
[85] Fed. Trade Comm'n, *supra* note 22.
[86] FLA. STAT. § 542.18 (2022).
[87] Jarod M. Bona, *The Antitrust Implications of Licensed Occupations Choosing Their Own Exclusive Jurisdiction*, 5(2) U. ST. THOMAS J. L. & PUB. POL'Y 28, 29 (2011).
[88] Jarod Bona, *Applying the Antitrust Laws to Anticompetitive State and Local Government Conduct,* THE ANTITRUST ATTORNEY BLOG (Sep. 1, 2019), https://www.theantitrustattorney.com/applying-antitrust-laws-anticompetitive-state-local-government-conduct/ (provides the example of state licensing boards which "engage in all sorts of anticompetitive conduct from limiting limit the number of taxi-cab medallions in a city to professional advertising restrictions to actual price or opt out restrictions").
[89] Parker v. Brown, 317 U.S. 341, 351 (1943). The Court found that, "In a dual system of government in which, under the Constitution, the states are sovereign, save only as Congress may constitutionally subtract from their authority, an unexpressed purpose to nullify a state's control over its officers and agents is not lightly to be attributed to Congress. The Sherman Act makes no mention of the state as such, and gives no hint that it was intended to restrain state action or official action directed by a state.")

the other – to the Sherman Act and holds that, because the statute does not speak on state conduct in restraint of trade, states are exempt from liability under the Act.[90]

In response to the wellspring of local government liability created by case law recognizing state but not municipal government immunity under the Act,[91] Congress amended the Sherman Act to "exempt local government entities from liability for damages arising under the antitrust statute."[92] The Act as amended is interpreted to "preclude lawsuits seeking injunctive relief."[93] The result of this case law is that "state and municipal authorities are immune from federal antitrust lawsuits for actions taken pursuant to a clearly expressed state policy that, when legislated, had foreseeable anti-competitiveness effects."[94] Florida also bars suits for damages, injunctive relief, and criminal penalties against local governments under its antitrust statutes.[95]

III. Contextualizing the Issue

While Oregon's Death with Dignity Act amassed vast public attention in the late 2010s because of the advocacy of a twenty-nine-year-old participant who was diagnosed with incurable brain cancer,[96] the most recent report published by the Oregon Health Authority shows that most participants are aged sixty-five or older.[97]

Consider the case of Peter Fernald. Once a faculty member at the University of New Hampshire, the former psychology professor had a pragmatic view on death. "I want my friends and family to remember me not as a crippled, helpless vegetable, but rather as they knew me during my more vibrant healthy moments."[98] Peter passed in 2021 from incurable lymphoplasmacytic lymphoma (a low-grade, non-Hodgkin lymphoma),[99] at home in New Hampshire – a state whose motto of "Live Free or Die," carried a grim irony for the octogenarian.

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[90] *Id.*
[91] Benitez v. Charlotte-Mecklenburg Hosp. Auth., 992 F.3d 229, 234 (4th Cir. 2021).
[92] *Id.* (The court also noted that "the Act was [amended] to prevent taxpayers from bearing the financial of their local governments' anticompetitive activity and to allow local governments to effectively govern without devoting significant time and resources to antitrust litigation.")
[93] *Id.*
[94] *State Action Antitrust Immunity*, CORNELL LEGAL INFORMATION INSTITUTE, https://www.law.cornell.edu/wex/state_action_antitrust_immunity (last updated June 2024).
[95] FLA. STAT. § 542.235 (2024).
[96] Nicole Weisensee Egan, *Terminally Ill Woman Brittany Maynard Has Ended Her Own Life*, PEOPLE, https://people.com/celebrity/terminally-ill-woman-brittany-maynard-has-ended-her-own-life/ (last updated May 9, 2017).
[97] *Death with Dignity Act 2023 Data Summary*, OR. HEALTH AUTH. PUB. HEALTH DIV., CTR. FOR HEALTH STAT., OR. (2024) ("In 2023, 560 people were reported to have received prescriptions under the DWDA. As of January 26, 2024, OHA had received reports of 367 people who died in 2023 from ingesting the prescribed medications, including 30 who had received prescriptions in previous years. Demographic characteristics of DWDA patients were similar to those of previous years: most patients were age 65 years or older (82%) and white (94%). The most common diagnosis was cancer (66%), followed by neurological disease (11%) and heart disease (10%). OHA made no referrals to the Oregon Medical Board for failure to comply with DWDA reporting requirements.") https://www.oregon.gov/oha/ph/providerpartnerresources/evaluationresearch/deathwithdignityact/Documents/year26.pdf.
[98] Peter Fernald, *Live Free and Die – Peacefully*, DEATH WITH DIGNITY, https://deathwithdignity.org/stories/peter-fernald-live-free-and-die-peacefully-4/ (last visited Oct. 26, 2022).
[99] Ned Megargee, *In Memory – Peter Fernald*, AMHERST MAG., https://www.amherst.edu/news/magazine/in_memory/1958/peterfernald (last visited May 5, 2023).

Peter suffered from both heart disease and cancer.[100] In a state with no legislation permitting physician-assisted death, he saw two options for himself: legally discontinue his medical treatment (pacemaker deactivation and no further lung fluid drainage), or to voluntarily stop eating and drinking (VSED).[101] A third option presented to all folks suffering from terminal or life-debilitating illnesses in states without a Death With Dignity Statute is to continue medical treatment as the illness grows progressively worse; essentially, waiting for the body to fail. In Peter's view, the state motto presents a false binary – "Live Free and Die Peacefully," is the option he advocated for.[102] What he wanted, ultimately, was comprehensive autonomy in his end-of-life medical decision-making.

IV. Analysis

A. Rationality, Reason, and a Fundamental Right

In *Washington v. Glucksberg*, the Supreme Court declined to interpret the Constitution as reserving the right to opt out to the individual.[103] Where the scaffolding of this decision falls away is not in its result, but in its process. The structure is unsound.

In *Glucksberg*, the Court applied rational basis — a test that lower courts have since applied to cases involving infringements by the government on individual liberty that do not involve protected classes or fundamental rights, in which state interests are weighed against those of the individual. Rational basis requires only that the law could have been rationally related to a legitimate government interest when adopted.[104] In *Glucksberg*, the Court concluded that the government satisfied this test.[105]

The main state interests evaluated in cases that examine the right to opt out are: (1) preservation of life; (2) preventing suicide; (3) the integrity of the medical profession; and (4) protecting vulnerable populations from abuse and undue influence. These interests are not without merit. The first two, however, imbue the analysis with a level of paternalism that – if it were removed – might elicit a different outcome. They assume, in Orwellian fashion, that the government knows best – even in matters that are extremely personal, like being faced with an incurable, debilitating disease that progressively inhibits one's ability to enjoy life.

The first interest also presents an incongruity worth noting. That is, in states that permit capital punishment, like Florida, courts have asserted that the state has an "unqualified interest in preserving life,"[106] while also upholding the legality of punitive life termination. So strong is the state's interest in protecting life, that it "may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual,"[107] yet, the state may still exercise its authority to terminate a life on punitive grounds. This reasoning illustrates a metaphorical arrow always pointing away from individual autonomy. That is not to say that because Florida permits capital punishment it should not act in ways that

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[95] Fernald, *supra* note 96.
[101] *Id.*
[102] *Id.*
[103] 521 U.S. at 719.
[104] Thomas B. Nachbar, *The Rationality of Rational Basis Review*, 102 VA. L. REV. 1651, 1651 (2016).
[105] *Washington*, 521 U.S. at 703.
[106] Krischer v. McIver, 697 So. 2d 97, 103 (Fla. 1997).
[107] Cruzan v. Dir. Mo. Dep't of Health, 497 U.S. 261, 282 (1990).

protect life elsewhere. Rather, the state should formally recognize a right to autonomy in medical decision-making where one's choice is rationally in their competent, self-determined best interest based on their health.

The interest in maintaining the integrity of the medical profession can be upheld while still allowing for self-determination in medical end-of-life planning. As shown in the Oregon Death with Dignity Statute and in the text of the DWDA proposed in the Florida Legislature, ethical safeguards can be embedded into legislation.[108] Likewise, the interest in protecting vulnerable populations from coercion and undue influence – possibly the most poignant – can be upheld while permitting comprehensive autonomy through careful and precise legislation.[109]

Judicial treatment of the distinction between negative and affirmative rights (i.e., the right to refuse treatment versus the right to receive medication that would affect one's choice to opt out) is not sufficiently coherent in this context, but appears rather attenuated at best.

Note also that in *Glucksberg* the Court applied rational basis – as opposed to strict scrutiny, which requires that the government prove its actions were narrowly tailored to a compelling interest and used the least restrictive means to achieve that interest[110] – after it concluded that the right to opt out was not fundamental because it was not "deeply rooted in the [n]ation's history and tradition."[111] A critical question arises under such analysis – at what depth is something sufficiently "rooted" in history and tradition? That question came up recently when, in 2022, the Supreme Court overturned fifty years of precedent and held that there is no constitutional right to abortion.[112] The answer thus remains imprecise.

Since *Glucksberg*, the Supreme Court of the United States has held that the "identification and protection of fundamental rights is an enduring part of the judicial duty to interpret the constitution," and that responsibility "has not been reduced to any formula," but rather, "it requires courts to exercise reasoned judgement in identifying interests of the person so fundamental that the State must accord them its respect."[113] This means that "history and tradition guide and discipline this inquiry but do not set its outer boundaries," resulting in an analytical mode that "respects our history and learns from it without allowing the past alone to rule the present."[114] The reasoning of this conclusion is echoed in the development of the rational basis test in equal protection cases, which the Court has applied nominally since *Glucksberg*, but in a manner that has effectively shown it is willing to apply a heightened version of the standard where state action infringes on constitutional rights. The Court has elsewhere proven a willingness to depart from the mandates of *stare decisis*.[115]

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[108] OR. REV. STAT. §§ 127.800-97 (2021).

[109] Recall Oregon's Death with Dignity eligibility requirements. A request to for assistance under the act must be made by the patient and no one else.

[110] *Strict Scrutiny*, CORNELL LEGAL INFORMATION INSTITUTE, https://www.law.cornell.edu/wex/strict_scrutiny#:~:text=Strict%20scrutiny%20is%20a%20form,national%20origin%2C%20and%20alienage) (last updated September 2024).

[111] Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2229 (2022).

[112] *Id.* at 2234.

[113] Obergefell v. Hodges, 576 U.S. 644, 663-64 (2015).

[114] *Id.*

[115] *See generally Id.; See also* Cleburne v. Cleburne Living Center, 473 US 432, 433, 446 (1985), where the Court held that a city's requiring a special needs group home to obtain a special use zoning permit appeared to "rest on an irrational prejudice against the mentally [disabled], including those who would occupy the proposed group home" and, additionally, that "the State may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *See generally* Dobbs, 142 S.Ct. at 2234, where the Court overturned five decades of precedent and held that there is no constitutional right to abortion.

Thus, the balancing test in *Glucksberg* could have been properly applied and yet come out in favor of individual liberty if the Court required more than a mere justification from the State. That it didn't presents a question of whether and how the doctrine of preemption should operate when a liberty interest – though not expressly enumerated in the Constitution – is at issue. It follows that, the Constitution being the supreme law of the land,[116] a liberty interest that exists at the edges of its text if not implicitly within, should trigger heightened regard for the individual when their liberty is infringed upon, and the state should be required to prove more than whether it could have had a reason for the infringement.

Separately, leaving the decision to the discretion of the states, as the Court did in *Glucksberg*, denies that the right is fundamental. The Supreme Court declined to acknowledge a right to opt out in *Glucksberg* not because it could not conceive of its existence, but rather because it had not been looked upon favorably in history. Yet, to deny that a right exists because previous generations have not acknowledged it is intellectually lethargic. Given that courts may use reasoned decision-making to identify fundamental rights contemporaneously with their decisions,[117] this Note asserts that the Court erred in declining to establish a fundamental right to opt out in *Glucksberg*. Had it done so, state efforts to prohibit individuals from seeking medical aid in opting out would be preempted by the Constitution. It defies reason that one should be prevented from seeking to pass on from this world with dignity and the assistance of medical aid even if they suffer with a terminal or unimprovable, debilitating illness.

V. Discussion

A. A Matter of Interpretation

The Fourteenth Amendment supports the acknowledgment of a right to autonomy in medical decision-making because of its promise that citizens shall not be deprived of life, liberty, or the pursuit of happiness without due process of law.[118] While it is implicit in the Constitution that a right to liberty includes a right to determine the manner of one's death when life deteriorates beyond enjoyment, it is neither explicit nor implied in the Constitution that states have the power to prevent one from making that choice with dignity. Current posture permits the deprivation of one's liberty to exercise autonomy over how they choose to end their life – not on the basis of law, but on the absence of law to the contrary. This is an incomplete definition of the parameters of the Fourteenth Amendment which this Note argues should be discontinued. The Tenth Amendment provides that the "powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."[119]

While the federal and state governments should protect the right to opt out, it is ultimately reserved to the people specifically and exclusively. The current posture that states are allowed to take effectively deifies them, attributing to themselves the role of both creator and destroyer. They are, in other words, allowed to separate life from death – subjugating the individual to incarceration

[116] Marbury v. Madison, 5 U.S. 137, 180 (1803). "Thus, the particular phraseology of the constitution of the United States confirms and strengthens the principle, supposed to be essential to all written constitutions, that a law repugnant to the constitution is void; and that *courts*, as well as other departments, are bound by that instrument."
[117] *Obergefell*, 576 U.S. at 663.
[118] U.S. CONST. amend. XIV.
[119] U.S. CONST. amend. X.

within their own person (or, in other words, to a death without dignity). This contravenes the very spirit of liberty upon which this country and its jurisprudence is founded.

B. Analogizing to the Supremacy Clause

Article VI, Paragraph 2 of the Constitution, generally referred to as the Supremacy Clause, establishes the primacy of federal law over state law. In matters where the two conflict, federal law supersedes.[120] This implies a dual, hierarchical construction of American citizenship. In one respect, Americans are citizens of the United States and subject to its federal laws. In another, Americans are citizens of the states in which they reside and are subject to those state laws. While state citizenship can change with relative ease, an American citizen remains as such regardless of which U.S. state they reside in. This Note asserts that because of this "dual citizenship," rights that are not denied at the federal level should not be denied at the state level. As the current posture of the Supreme Court is that it is up to the states to determine whether one can opt out, the right remains unprohibited at the federal level and should, therefore, be enjoyed in all states by all citizens.

C. Pulling from Principles of Anti-Trust Law

The posture of the courts illustrated above has identified but not resolved a tension between the goals of antitrust law and the principles of federalism.[121] States derive "police powers" which allow them to regulate public affairs from the Tenth Amendment,[122] and currently enjoy immunity under the "state action immunity doctrine," which holds that because the Sherman Act is silent on state conduct in restraint of trade, states are exempt from liability under the Act.[123]

By the express language of the Constitution in the Supremacy Clause, where state and federal law conflict, the state must bow.[124] State regulation of any market effectively restrains competition; "[r]ent control, conservation measures, and occupational licensing, for example, fix prices, restrict output, and exclude entry."[125] In many circumstances, such action by the state works for the public good. Still, tension exists because "regardless of the regulatory motive…the regulation has rejected the antitrust premise that what is in the public interest is competition – specifically that brand of competition prescribed by federal antitrust law."[126] Accordingly, "the role of antitrust state doctrine under this paradigm is thus to reach an appropriate accommodation between the federal

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[120] U.S. CONST. art. VI, para. 2.
[121] Einer Richard Elhauge, *The Scope of Antitrust Process*, 104(3) HARV. L. REV. 667, 668-69 (1991). Elhauge argues that "A paradigm of conflict and accommodation dominates current understanding of antitrust state action doctrine…The role of antitrust state action doctrine under this paradigm is thus to reach an appropriate accommodation between the federal interest in fostering competition and the conflicting state interests in restricting competition by immunizing some, but not all, state-authorized or enforced restraints from antitrust scrutiny."
[122] *Police Powers*, CORNELL LEGAL INFORMATION INSTITUTE. (Dec. 2020), https://www.law.cornell.edu/wex/police_powers
[123] Cornell Legal Information Institute, *supra* note 92.
[124] U.S. CONST. art. VI, para. 2. *See also* Einer Richard Elhauge, *The Scope of Antitrust Process*, 104(3) HARV. L. REV. 667, 669 (1991). "The very meaning of the supremacy clause is that conflicts between federal and state law must be resolved in favor of federal law. This principle is fully applicable to conflicts involving federal antitrust law."
[125] *Id.* at 668.
[126] *Id. at* 669.

interests in restricting competition by immunizing some, but not all, state authorized or enforced restraints from antitrust scrutiny."[127]

The healthcare industry is estimated to account for 18% of the U.S. economy, a number that – except for China, Japan, and Germany – exceeds the size of the world's other economies.[128] Elder Americans ages sixty-five and older accounted for 34% of all healthcare spending in the U.S. in 2014.[129] These numbers suggest that a subset of the healthcare market that has not yet emerged due to state imposed prohibitions, but that would accommodate a current need in the marketplace, would certainly trigger antitrust law protections and regulations. If New Hampshire permitted its citizens to seek medical aid in dying, by the law of supply and demand a sub-market within the healthcare sector would emerge to support elders like Peter Fernald. Not only would he have had access to the aid required to opt out with dignity, but he would also have had a choice in which providers he sought that aid from, which insurance carriers and plans he was a member of and where he ultimately received the aid (possibly at home through a palliative care program, for example). Regulation of this sub-market under antitrust law would ensure competition and fair prices to the benefit of patients like Peter.

By Florida prohibiting the right to opt out, it prohibits the emergence of a market to facilitate access to that right. This state prohibition is therefore inherently anti-competitive and impermissibly inconsistent with federal antitrust law goals and principles, due to the constitutional analysis supporting recognition of opting out as a fundamental right. Thus, two more questions arise. First, what metric does the state use when permitted to exercise discretion in determining whether a market should or should not exist? Second, for rights on the periphery of the constitution or otherwise characterizable as emergent, should the courts decline to grant immunity to states in challenges to state actions on antitrust grounds? While the first question is currently unanswered, this Note asserts that the answer to the second is yes.

D. Counter Arguments

Opponents of the right to opt out may argue that allowing the exercise of this right will lead to a slippery slope to the particular detriment of vulnerable communities like the elderly. While all laws and markets in the economy have facets that impact various groups differently, these undesirable impacts can be mitigated against with carefully planned legislation and interdisciplinary practice at the community health level. It may also be argued that such a policy is against social mores because life is sacred and should be protected. That argument is true and is further support for the right to opt out – life should not be a burden. Further, with clear and comprehensive legislation (like the proposed Death with Dignity Act which died in the Florida legislature), safeguards can be put in place to ensure that this policy is not used as a terminal coping mechanism by those suffering with mental illness. Others may argue that this policy will result in disparate impacts and overuse in certain – possibly marginalized – communities. With the Repeal of the Assisted Suicide Funding Restriction Act of 1997, federal dollars can be appropriated and used for community outreach and education programs to address and mitigate against this concern.

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[127] *Id.*, in reference to the tendency for courts to find in favor of the state in antitrust challenges to state action.
[128] Where is the *U.S.* Healthcare Industry Headed*?,* Kellogg Insight, (Jun. 21, 2022), https://insight.kellogg.northwestern.edu/article/healthcare-economics-why-healthcare-costs-so-much.
[129] Mariacristina De Nardi et al., *Medical Spending of the US Elderly,* NCBI (Nov. 21, 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6680320/#:~:text=the%20national%20average.-,2,at%20the%20end%20of%20life.

Concerns of mental capacity align with those of overuse or abuse in certain communities, and thus the same remedies of outreach, education, and intentional legislation apply.

E. Recommendation

At the federal level, Congress should legitimize the right to opt out by adopting comprehensive Death with Dignity legislation, repealing the Assisted Suicide Funding Restriction Act of 1997, and allowing social programs like Medicare and Medicaid to be used to make the choice to opt out available to people engaged in end-of-life planning. The Florida legislature should amend section 765.309 of the state statutes, which prohibits all forms of assistance toward ending one's life, to permit medical assistance by a physician. The Supreme Court should, if presented with litigious opportunity (and otherwise Congress should pass a law) suspend state immunity from antitrust scrutiny when fundamental rights are implicated. The Court should also conclude when the opportunity next arises that the right to opt out is fundamental. This will have the dual effect of promoting efficiency in and outside of the courts.

VI. Conclusion

The state holds legitimate interests when it comes to life and death. These interests should be leveraged as tools to craft empowering legislation that allows individuals to exercise comprehensive autonomy in their end-of-life planning. Current Florida law prohibiting the right to opt out violates both constitutional and anti-trust law principles and deprives folks, especially those who are part of the elder population, of the fully realized ability to choose dignity at the end of their life. At the state level, there are two corrective options available: (1) interpret the Constitution liberally and recognize the inherent right to opt out, (2) exercise present authority to permit individuals to seek and assist those seeking to opt out. The same options exist for Congress at the federal level; while, in both instances, the judicial branches are best positioned to empower the people.

ANIMAL HOARDING IN FLORIDA'S OLDER ADULTS: ANALYSIS OF CURRENT LAWS AND SUGGESTIONS FOR REFORM

Brianna Faenza[1]

This paper discusses the under-recognized issue of animal hoarding in Florida and its significant consequences for both animal and human health with a particular focus on older adult animal hoarders. This article defines animal hoarding, outlines the current Florida statutes under which animal hoarding cases are prosecuted, and highlights the inconsistencies and ambiguities in their application. It addresses the health implications for both humans and animals, with a focus on the impacts of older adults who become animal hoarders and discusses the vulnerability of older adults to become animal hoarders. It also explores the distinct legal treatment of animal hoarding offenses, the high recidivism rates, and the judicial burdens of these cases. This article concludes with suggestions for reform, including updating statutes to specifically address animal hoarding, adopting local ordinances, and implementing case management practices including services of Adult Protective Services to reduce the overall incidence and recidivism of animal hoarding in Florida.

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Table of Contents

I. Introduction

In Florida, animal hoarding is an under-recognized problem that has significant consequences for both animal and human health.[2] The Hoarding of Animals Research Consortium (HARC) – a group of mental health, social service, veterinary, and animal welfare experts – first coined the term "animal hoarding" in 1999 to differentiate from the hobby known as animal collecting.[3] HARC defines animal hoarding as someone who has: (1) "accumulated a large number of animals, which has overwhelmed the person's ability to provide even the minimal standards of nutrition, sanitation, and veterinary care" (2) "failed to acknowledge the deteriorating conditions of the animals (including disease, starvation, and even death) and the household environment (severe overcrowding, very unsanitary conditions) and" (3) "failed to recognize the negative effect of the collection on his or her own health and well-being, and on that of other household members."[4] The American Society for the Prevention of Cruelty to Animals (ASPCA) recognizes that animal hoarding often leads to over-breeding, starvation, illness and even death among the animals.[5]

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[2] Gregg Riley Morton, *Animal Hoarding in Florida: Addressing the Ongoing Animal, Human, and Public Health Crisis*, F.L. BAR J. (April 2017), https://www.floridabar.org/the-florida-bar-journal/animal-hoarding-in-florida-addressing-the-ongoing-animal-human-and-public-health-crisis/.

[3] Gary J. Patronek, *Animal hoarding: its roots and recognition*, DMV 360 (August 1, 2006), https://www.dvm360.com/view/animal-hoarding-its-roots-and-recognition.

[4] Gary J. Patronek, *The Problem of Animal Hoarding*, 19 MUNICIPAL LAWYER, 6-9 (May/June 2001).

[5] *Animal Hoarding*, ASPCA, https://www.aspca.org/helping-people-pets/animal-hoarding (last visited September 15, 2024).

Several surveys suggest that within a year, at least a quarter of a million animals are involved in a total of 3,000 reported cases of animal hoarding in the United States.[6] A significant number of additional cases likely go unreported due to the secretive nature of animal hoarding.[7]

Currently, animal hoarding cases are prosecuted under various Florida criminal statutes leading to ambiguities and inconsistencies in their application. In Florida, animal hoarding cases are often prosecuted under FL Stat 828.12(1) or (2), or FL Stat 828.13. FL Stat 828.12(1) outlines committing animal cruelty as, "a person who unnecessarily overloads, overdrives, torments, deprives of necessary sustenance or shelter, or unnecessarily mutilates, or kills any animal, or causes the same to be done, or carries in or upon any vehicle, or otherwise, any animal in a cruel or inhumane manner, commits animal cruelty."[8] FL Stat. 828.12(2) defines the commission of aggravated animal cruelty as "[a] person who intentionally commits an act to any animal, or a person who owns or has the custody or control of any animal and fails to act, which results in the cruel death, or excessive or repeated infliction of unnecessary pain or suffering, or causes the same to be done, commits aggravated animal cruelty."[9] Finally, FL Stat. 828.13 defines the withholding of sufficient food, water, or exercise, or the abandonment of animals as a first degree misdemeanor.[10] These statutes do not specifically address animal hoarding crimes, leading to issues in their application against animal hoarders.

There is inconsistent handling of animal hoarding cases "regarding the length of time and way in which cases unfolded."[11] There are also inconsistencies in the number of charges brought against perpetrators.[12] In one study analyzing cases of animal hoarding, 16 cases showed different perpetrators were charged with only one count of animal cruelty for the group of animals hoarded, rather than one count of animal cruelty per involved animal.[13] Additionally, often hoarders are charged with one count of failure to license or provide rabies vaccination rather than for each animal in the home.[14] These inconsistencies highlight the failure to properly handle the animal hoarding crisis.

This paper will address the health implications of both humans and animals involved in animal hoarding, focused on the older population's vulnerability to become animal hoarders. Additionally, this paper will address the factors influencing the distinct treatment of animal hoarding crimes as well as suggestions for reform to reduce overall incidence of animal hoarding, including by reducing recidivism.

II. Implications of Animal Hoarding

a. Animal Welfare

Animal welfare is often the first thing that comes to mind when discussing the problems of animal hoarding. Cats and dogs are the most common animals to be hoarded.[15] In one study of 56 cases, at least one dead animal was found in 19 of the cases. Filthy and severely crowded

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[6] Patronek, *supra* note 3.
[7] *Id.*
[8] FLA. STAT. § 828.12(1) (2024).
[9] FLA. STAT. § 828.12(2) (2024).
[10] FLA. STAT. § 828.13 (2024).
[11] Colin Berry et al., *Long-Term Outcomes in Animal Hoarding Cases*, 11 LEWIS & CLARK ANIMAL L. REV. 167, 183 (2005).
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.* at 175.

conditions can lead to easy transmission of parasites, infections, parvo, distemper and other diseases amongst the animals.[16] Often, animals that are the victims of hoarding, are deprived of veterinary care including spaying and neutering which can lead to even more animals.[17] When animals in hoarding situations are injured including by becoming injured in fights with other hoarded animals, their wounds turn into infection, due to lack of care.[18] One study conducted by Dr. Patronek, a researcher in the field of animal hoarding, found that in 80% of animal hoarding cases, animals were found dead or suffering from "obvious disease or injury."[19]

Dogs in hoarding situations often become aggressive or fearful due to being chained or kept in pens for years.[20] Cats in hoarding situations often produce feral offspring and can become skittish when deprived of human-contact.[21] Any animals rescued from hoarding situations must be screened for disease and potential public health risks before considering adoptability.[22] Dogs owned by hoarders also require re-socialization before adoption.[23] Potential adopters should also be given background information on the dog and acknowledge it may exhibit abnormal behavior,[24] which could lead they to become less likely to be adopted.

One less obvious issue affecting hoarded animals is the animals are often left in a "legal limbo" due to being treated as property under the law and as evidence rather than victims of a crime.[25] There is no legal mandate that animals involved in animal hoarding prosecutions have their interests considered.[26] In one study, most animals involved in animal hoarding cases were seized and taken to a shelter after veterinary evaluation, but some animals were held until the end of the trial.[27] In one particularly horrible case, the hoarded animals were held for over a year.[28] This long-term holding victimizes the animals a second time in addition to using shelter space and resources that could otherwise be used for other animals.[29]

b. Human Welfare

Several aspects of human life are impaired and negatively affected by animal hoarding. In a study of 71 animal hoarding cases, one-half to three-quarters of cases were reported to have "very much impaired" activities of daily living such as the use of bath or shower, use of sink, preparing food, sleeping in bed, exiting home in case of danger, and more.[30] In the same study, essential utilities and major appliances were commonly reported as not functioning, especially the stove,

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[16] *Animal Hoarders: The Illness and The Crime*, PETA, https://www.peta.org/issues/animal-companion-issues/animal-companion-factsheets/animal-hoarders-illness-crime/ (last visited Sept. 15, 2024).
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] Louise Bach Kmetiuk et al., *"Dying alone and being eaten": dog scavenging on the remains of an elderly animal hoarder-a case report*, FRONTIERS IN VETERINARY SCIENCE (August 29, 2023), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10495567/.
[23] *Id.*
[24] *Id.*
[25] Randy O. Frost & Gary Patronek, *The Hoarding of Animals: An Update*, PSYCHIATRIC TIMES (April 30, 2015), https://www.psychiatrictimes.com/view/hoarding-animals-update#.
[26] *Id.*
[27] Berry et al., *supra* note 11, at 180.
[28] *Id.*
[29] *Id.*
[30] Arnold Arluke, *Health implications of animal hoarding: Hoarding of animals research consortium (HARC)*, HEALTH AND SOCIAL WORK 125, 128 (May 2002), available at https://www.researchgate.net/publication/288423991_Health_implications_of_animal_hoarding_Hoarding_of_animals_research_consortium_HARC.

kitchen sink, laundry facilities, and shower or bathtub.[31] Household function, food preparation, and basic sanitation are impossible in animal hoarding situations.[32] Children living in the home where animal hoarding is occurring also become victims.[33]

Ammonia that is produced in animal urine is one dangerous part of having excess animals that are not properly cared for in the home. In one case of animal hoarding, the ammonia level in the home was 152ppm, after the fire department had ventilated the home.[34] The National Institute for Occupational Safety and Health states 300ppm as the concentration of ammonia immediately dangerous to human life, and 25ppm as the maximum average occupational exposure during the workday.[35] Exposure to ammonia at such high levels is obviously dangerous to human life.

Animal hoarding can also impact the broader community. Clutter in an animal hoarder's home can create fire hazards.[36] Insect and rodent infestations and odors can impact the surrounding areas and create a nuisance.[37] Additional problems can include flooding, backed-up sewage, and becoming an eyesore to the surrounding area.[38] These problems can also decrease the value of the home where the animal hoarding is occurring as well as the value of homes in the entire neighborhood.[39]

c. Older Adults Vulnerability with Animal Hoarding

The impact of hoarding is worsened by age and older adults are three times more likely to exhibit hoarding behavior.[40] Several studies confirm that animal hoarders tend to be older. In one of the largest reports prepared by animal control agencies and humane societies, nearly half of the 54 hoarders were 60 years or older.[41] An animal hoarder case report detailing 71 cases, prepared by HARC, showed the average age of the hoarder as mid-50s.[42] A Spanish study found similar results amongst the age of animal hoarders.[43]

Older adults are particularly vulnerable to becoming animal hoarders and can have more gravely negative impacts when they do. There are several factors that influence this behavior in older adults. Memory loss, physical frailness, and transportation limitations, are signs of self-care challenges that can be a sign of animal neglect.[44] Animals in hoarding situations with an older adult can be in particular danger due to being over or underfed.[45] Often times, older adults become

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[31] *Id.*
[32] Patronek, *supra* note 4.
[33] *Id.*
[34] *Id.*
[35] *Id.*
[36] *Id.*
[37] *Id.*
[38] Griswold Law, *How Hoarding Affects Property and Communities*, GRISWOLD LAW (Dec. 21, 2020), https://blog.griswoldlawca.com/how-hoarding-affects-property-and-communities.
[39] *Id.*
[40] Kmetiuk et al., *supra* note 22.
[41] Frost, *supra* note 25.
[42] *Id.*
[43] *Id.*
[44] Phil Arkow et al., *Animal Abuse, Animal Hoarding, and Elder Abuse: Challenges and Strategies for Adult Protective Services*, NAPSA, 12 (April 12, 2020), https://www.napsa-now.org/wp-content/uploads/2020/05/Link-for-APS-NAPSA-webinar-2020.pdf.
[45] *Id.* at 28.

isolated, leading them to accumulate a large number of animals.[46] Having an intense emotional connection to the animals also perpetuates the accumulation of animals.[47]

In animal hoarding situations, urine and feces may cover the walls or floors which poses a serious health risk due to the ammonia.[48] Repeated exposure to ammonia can cause chronic irritation of the respiratory tract.[49] This can be particularly dangerous for older adults who have conditions like chronic obstructive pulmonary disease (COPD), where the mean age of someone with COPD is 73 years old.[50] In addition to the aforementioned health risks, animal hoarding creates conditions for tripping, falling, and even fatal outcomes in severe situations.[51]

There are some particularly disturbing cases that have occurred in situations of older adult animal hoarders. Media reports can be found reporting post-mortem scavenging by dogs of lone animal hoarders.[52] Two examples include an old man in Ohio being eaten by his 50 dogs, and an old woman in Arkansas, who succumbed to Hepatitis C, and was partially eaten by her 46 dogs.[53] A Brazil case report approved by the Ethics Committee in Human Health of the Brazilian Ministry of Health, examined the death of a reclusive elderly animal hoarder who was almost entirely consumed by his dogs.[54] In this case, the man in his 80s had a total of 13 dogs, three of which were found dead, and the remaining ten that had to be euthanized due to public health risk and aggressive behavior.[55] Cases like these are extremely disturbing realities that older animal hoarders face.

III. Considerations Influencing the Distinct Legal Treatment of Animal Hoarding Offenses

a. Animal Hoarding as a Mental Illness

Animal hoarding is described in the DSM-5 as a condition associated with hoarding disorder and is defined by "the accumulation of a large number of animals and a failure to provide minimal standards of nutrition, sanitation, and veterinary care and to act on the deteriorating condition of the animals (eg. disease, starvation, death) and the environment (eg. severe overcrowding, extremely unsanitary conditions)."[56] The association with hoarding disorder presents the issue of potentially criminalizing behavior related to a mental illness.[57] Researchers have suggested three ways to classify animal hoarders: overwhelmed caregivers, rescuers, and exploiters.[58]

An animal hoarder classified as an "overwhelmed caregiver" typically owns a large number of animals that were reasonably well-cared for until a change impaired the ability to care for the large number of animals.[59] This "change" is often health related, loss of a job, death of a spouse, or loss of resources, and leaves the individual attempting to give care to the animals but ultimately leaves

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[46] *Id.* at 32.
[47] *Id.* at 29.
[48] Frost, *supra* note 25.
[49] National Center for Environmental Health, *Ammonia: Exposure, Decontamination, Treatment*, CDC https://www.cdc.gov/chemicalemergencies/factsheets/ammonia.html (last updated Feb. 6, 2023).
[50] Deigo Morena, et al., *The Clinical Profile of Patients with COPD Is Conditioned by Age*, JOURNAL OF CLINICAL MEDICINE, (Dec. 9, 2023) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10743861/.
[51] Kmetiuk et al., *supra* note 22.
[52] *Id.*
[53] *Id.*
[54] *Id.*
[55] *Id.*
[56] Frost, *supra* note 25.
[57] Arkow, *supra* note 44, at 40.
[58] Frost, *supra* note 25.
[59] *Id.*

them overwhelmed and conditions deteriorate.[60] Acquisition of animals in this situation tend to be passive, by breeding that occurs among animals the overwhelmed caregivers already have.[61] Overwhelmed caregivers tend to have fewer problems complying with intervention as compared to rescuers and exploiters.[62] Additionally, isolation in these situations may be a reason these individuals are reluctant to seek help, even though they exhibit some awareness of their need for help.[63]

Mission and rescue from presumed threat is the main motivation for those animal hoarders considered rescuers.[64] These animal hoarders are strongly against euthanasia and are fearful of the deaths of their own animals, although they fail to realize the lack of care they are providing for their animals.[65] This type of hoarder believes they are the only person who can care for their animals, and continue to collect new animals despite being overwhelmed.[66] Acquisition of animals by a rescuer is more active by seeking out new animals that they think need rescuing.[67] Rescuers can go to great lengths to avoid authorities.[68] They often present themselves as representatives from a legitimate shelter or sanctuary equipped to care for hundreds of animals – when in reality that is not the case.[69]

Animal hoarders classified as exploiters are the most serious and hard to resolve.[70] They deny any form of help and reject legitimate concerns.[71] They believe their knowledge is superior to anyone else's in the situation.[72] These individuals acquire animals to serve their own needs, having little to no attachment to them.[73] Exploiter type animal hoarders also have sociopathic characteristics.[74] They lack empathy to both humans and their animals, appearing indifferent to their animals' suffering.[75] Exploiters also exhibit characteristics of antisocial personality disorder such as superficial charm; they lack guilt and remorse and are manipulative, cunning, and narcissistic.[76] It is important to note that this type of animal hoarder may not fit the criteria in the DSM-5 due to their lack of emotional connection to the animals.[77]

Little research has been completed looking into the number of cases classified in this manner. One study, in 2009, reviewed a small number of animal hoarding cases and found 40% were overwhelmed caregivers, 20% were rescuers and 40% were exploiters.[78] Another larger study in Australia which used additional descriptions of types of animal hoarders found, 24% were overwhelmed caregivers, 22% rescuers, and 10% exploiters.[79]

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[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] R. Elliott et al., *Characteristics of animal hoarding referred to RSPCA in South Wales Australia*, PUBMED, https://pubmed.ncbi.nlm.nih.gov/31025326/ (last visited Sept. 16, 2024).

Animal hoarding is a self-perpetuating cycle.[80] Specifically in older people, isolation can be a cause of animal accumulation, and animal accumulation can be a cause of isolation.[81] This may make intervention more difficult as with isolation amongst older people, it is unlikely visitors will see and learn of the animal hoarding problem. Additionally, due to transportation issues amongst the elderly, veterinaries who may ordinarily report animal hoarding situations, will not have the opportunity to do so.

b. Recidivism

Many studies report that recidivism rates of animal hoarding is between 60% and 100%.[82] Recidivism of animal hoarding refers to the person requiring multiple animals after having previous animals legally removed from their care.[83] Recidivism of animal hoarding differs from relapse which refers to the return of symptoms after successful treatment of a disorder.[84] Although animal hoarding may be considered a form of hoarding disorder, there is a lack of appropriate treatment given to animal hoarders.[85]

Animal hoarders are in the unique position to be treated both as a criminal and victim. Specifically, older animal hoarders are a group that can elicit sympathy. Older people find themselves with animals as their sole companions later in life, leading them to collect more animals.[86] Animals can provide older people with acceptance, conflict-free relationships, and a sense of self-worth, leading to hoarding tendencies.[87] Older people can become a victim of their own crime of animal hoarding. As discussed in the above sections, the health implications that coincide with animal hoarding can be life threatening. Animal hoarding and animal cruelty are crimes that must be taken seriously.

c. Judicial Burdens of Animal Hoarding Cases

Animal hoarding cases are burdensome on the judicial system. These cases are procedurally cumbersome, costly, and time consuming.[88] They can fall between the cracks of multiple governmental agencies concerning mental health, public health, zoning, animal control, aging, sanitation, building safety, fish and wildlife, and child welfare.[89] Intervention and resolution are also complicated by issues of personal freedom, lifestyle choices, mental competency, and property rights.[90]

One famous case that highlights the difficult judicial process that animal hoarding cases undergo is the Kittles case. Kittles is representative of an animal hoarder classified as an exploiter.[91] In this case, a woman was living in a school bus with 115 dogs all of which had been

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[80] Arkow, *supra* note 44, at 32.
[81] *Id.*
[82] Frost, *supra* note 25.
[83] *Id.*
[84] *Id.*
[85] *Id.*
[86] Arkow, *supra* note 44, at 28.
[87] *Id.* at 31.
[88] Patronek, *supra* note 4.
[89] *Id.*
[90] *Id.*
[91] *Case Study: Animal Hoarding – Vikki Kittles*, ALDF https://aldf.org/case/animal-hoarding-case-study-vikki-kittles/ (last visited Sept. 16, 2024).

kept on the bus for at least three weeks without going outside.[92] When animal control officers in Oregon became aware of the situation, they had to use gas masks to enter the bus, due to the odor.[93] It became apparent that Kittles had been doing this all over the United States – in Florida, Mississippi, Washington, and Colorado.[94] There, law enforcement or the district attorney had given her a tank of gas and told her to leave town, with not one state prosecuting her.[95] Kittles was arrested in Oregon in April of 1993 but did not go to trial until February of 1995 where she represented herself after eight court-appointed attorneys and six judges.[96] During this process, it was determined that 16 of the dogs had heartworm, a parasitic infection.[97] Initially, the court would not allow treatment of the dogs because they were being used as evidence and treating the dogs would be considered altering evidence.[98] The prosecutor in the Kittles case described the process as "the world's longest root canal with no anesthetic."[99] Kittles was charged under "Animal Neglect in the First Degree and Animal Neglect in the Second Degree," which in means an individual failed to provide adequate medical care and food for the animals.[100] Kittles was charged with only 42 counts of animal neglect rather than 115 counts, equal to the amount of dogs she hoarded.[101] Kittles's defense was it was not the state's business if she chose to live amongst animal feces.[102] The prosecutor rebutted, and ultimately succeeded, by arguing that while it was her lifestyle choice, it was not the animals' choice and she condemned her dogs to an awful life.[103] Fortunately, nearly all the dogs were saved and adopted throughout the state of Oregon.[104]

The Kittles case cost the county $150,000 even with the Animal Legal Defense Fund providing extensive legal research for the prosecution.[105] Ultimately, Kittles was sentenced to four months in jail, an additional 71 days for contempt of court, five years of unsupervised probation, a psychiatric exam, and to avoid contact with animals and any person who helped her obtain her animals.[106] After her release, she refused to go to court-ordered counseling instead choosing to serve an additional two months in jail.[107] After her second release, she was not required to stay in-state and her probation was unsupervised, therefore appropriate officials had no way to monitor her.[108] In less than a year, she had moved to Wyoming and adopted over 70 dogs.[109] Authorities took no action and ultimately Kittles was evicted along with 80 dogs and 40 cats – even though she was still under orders to not possess animals, from her Oregon conviction.[110] Kittles continued to collect animal cruelty cases related to her hoarding along with other criminal violations not related to animals.[111]

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[92] Joshua Marquis, *The Kittles Case and Its Aftermath*, 2 ANIMAL L. REV. 197, 197 (1996).
[93] *Id.*
[94] *Id.*
[95] *Id.*
[96] *Id.*
[97] *Id.* at 197-198.
[98] *Id.* at 198.
[99] *Id.*
[100] *Id.*
[101] Animal Legal Defense Fund, *supra* note 91.
[102] Marquis, *supra* note 92, at 198.
[103] *Id.*
[104] *Id.*
[105] Animal Legal Defense Fund, *supra* note 91.
[106] *Id.*
[107] *Id.*
[108] *Id.*
[109] *Id.*
[110] *Id.*
[111] *Id.*

In the aftermath of the Kittles case, the Animal Legal Defense Fund was determined to strengthen animal protection laws in Oregon.[112] Pamela Frasch, an attorney with the Animal Legal Defense Fund, drafted the "Kittles Bill" which changed aggravated animal abuse from a misdemeanor to a felony and allowed shelters to provide veterinary care to impounded animals and allowed them to be moved from shelters to foster homes.[113] The Kittles Bill was passed and signed into law in September 1995.[114] Another Oregon bill that passed in the same session concerning animal abuse cases allowed courts to order forfeiture of abused animals prior to the disposition of a criminal case.[115] Also in Oregon in 1997, the City Council revised an animal control ordinance: requiring licensing of cats and dogs, requiring a kennel permit to house more than four cats or four dogs, regulating the number of animals that can be adopted from the city shelter, defining animal cruelty and nuisance, and giving city officials authority to control potential public health threats.[116]

IV. Current Ambiguities in Florida Law

Most animal hoarding in Florida is prosecuted under the above-mentioned statutes, Fla. Stat. § 828.12(1) and (1), and Fla. Stat. § 828.13 2024. These statutes involve animal cruelty or confinement of animals without sufficient food and water.[117] These statutes address only the symptoms of animal hoarding and do not even mention the term "hoarding".[118] In this sense, Florida's statutory language fails to encompass the severity animal hoarding crimes.

Evidence suggests that Florida courts struggle with applying the statutory language in current animal cruelty statutes.[119] In *Hynes v. State*, a worker at an apartment complex discovered a dog that had jumped the defendant's second story window.[120] The worker entered the defendant's apartment and located one dead dog, two dead turtles, one dead lizard and one dead bird, as well as a barely living bird, snake, and dog.[121] The living dog, Pepsi, was surrounded by urine and feces and was so weak, he had to be carried from the apartment.[122] No water or food was found in the apartment.[123] This defendant was convicted of two animal cruelty felonies.[124] The trial court in the this case expressed several concerns over these convictions such as "reservations about whether veterinary testimony that Pepsi was malnourished, dehydrated, too weak to stand, and without muscle mass was sufficient proof because there was no testimony that he suffered pain due to the withholding of food."[125] Ultimately, the trial judge reduced the felonies convictions to misdemeanors because the language in the statute was unclear.[126] On appeal, the district court said that it "lacked jurisdiction to review the trial court's decision to reject the jury's verdict and to reduce the defendant's conviction."[127] Judge Jacqueline Griffin wrote a concurring opinion on the

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[112] *Id.*
[113] *Id.*
[114] *Id.*
[115] *Id.*
[116] *Id.*
[117] Morton, *supra* note 2.
[118] *Id.*
[119] *Id.*
[120] *Id.* describing *Hynes v. State* 1 So. 3d 328, 329 (Fla. 5th DCA 2009).
[121] *Id.*
[122] *Id.*
[123] *Id.*
[124] *Id.*
[125] *Id.*
[126] *Id.*
[127] *Id.*

case calling it "a felony to starve a dog to death, or deprive it of sustenance to the point where, like Pepsi, it has no muscle mass and is too weak even to stand" and characterizing the trial court's decision as "dangerously wrong."[128]

In *State v. Wilson*, Wilson was arrested for not providing food, water, and sufficient air to approximately 77 poodles in cages in the back of a van.[129] The trial court initially dismissed the charges because the statutory language was unconstitutionally vague because "[A] person of common intelligence would have to guess at what conduct constituted a failure to supply an animal with a sufficient quantity of good and wholesome food and water, as well as what were the requirements regarding how frequently an animal must be exercised or when the air in the area of confinement must be changed."[130] The appellate court reversed this decision, allowing prosecution to occur.[131]

In 2002, there was litigation concerning the constitutionality of Fla. Stat. 828.12(2) that went all the way to the Florida Supreme Court.[132] The defendant, Ronald Reynolds, was convicted of animal cruelty as a felony under Fla. Stat. 828.12(2) and appealed arguing the statute should be construed to require specific intent or alternatively is unconstitutional because it does include a specific intent element.[133] The First District Court of Appeal disagreed with Reynolds stating the language of the statute only required general intent, not require specific intent, and further explained specific intent was not constitutionally required.[134] The Florida Supreme Court found the First District's findings were correct and the statute was not unconstitutional due to lack of requiring specific intent.[135]

V. Suggestions for Reform

There are several things that should be done to reform the current state of affairs relating to Florida's animal hoarders. The statutes should be altered to include and define the term "animal hoarding" as well as suggest penalty options. Local ordinances should be updated to effectuate opportunities to intervene and track at a local level. Animal hoarding case management practices should be updated. Practices specifically targeting the older population of animal hoarders should also be implemented. Enacting several changes across these platforms will help lower the overall incidence of animal hoarding in Florida and help to reduce recidivism.

a. Statute & Local Ordinance Reform

Florida's current animal cruelty statutes should be updated to specifically address animal hoarding.[136] Further, updated statutes should address other sentencing options for defendants as well as order mental health counseling for offenders.[137] Florida should adopt a statute similar to

[128] *Id.*
[129] *Id.*
[130] *Id.*
[131] *Id.*
[132] See *Reynolds v. State*, 842 So. 2d 46 (Fla. 2002).
[133] *Id.* at 47.
[134] *Id.*
[135] *Id.* at 51.
[136] Morton, *supra* note 2.
[137] *Id.*

Oregon's "Kittles Bill" which changed aggravated animal abuse to a felony as well as orders mental health evaluations for offenders convicted of animal hoarding.[138]

Florida nearly made the step to amend its statute 828.12 in 2017 when Senator Steube introduced legislation that would define the term "animal hoarding," prohibit animal hoarding, and provide penalties and remedies for animal hoarding.[139] This Bill would have amended two sections of Chapter 828 of the Florida Statutes. The first being, Florida Statute 828.02 "Definitions" to include "as used in this chapter, the term "animal hoarding" means the act of: (a) Keeping a large number of companion animals in overcrowded conditions; (b) Failing to provide such animals with minimal standards of nutrition, sanitation, shelter, and medical care; and (c) Displaying an inability to recognize or understand, demonstrating a reckless disregard for, or refusing to acknowledge the conditions under which the animals are being kept and the impact of such conditions on the well-being of the animals, the person engaged in the act, or other persons."[140] Further, the Bill would have added a subsection 6 to Florida Statute § 828.12 to include "a person who engages in animal hoarding as defined in § 828.02 commits animal cruelty, a felony of the third degree, punishable as provided in § 775.082, or by a fine of not more than $10,000, or both. (a) If a court finds probable cause to believe that a violation of this subsection has occurred, the court shall order the seizure of any animals whose health and welfare are in imminent danger and provide for appropriate and humane care or disposition of the animals. (b) A court may order a person, upon a finding of probable cause that such person has violated this subsection, to undergo a psychological evaluation. (c) The court shall order a person convicted of a violation of this subsection to undergo psychological counseling."[141] Senate Bill 212 would have been a monumental step toward the legislature taking action against animal hoarding in Florida. Unfortunately, Senate Bill 212 ultimately died in committee; it was indefinitely postponed and withdrawn from further consideration.[142] The Florida legislature should strongly consider proposing and passing a similar bill in the near future.

Local ordinances should also be adopted to provide additional authorization and tools to intervene and prevent animal hoarding situations.[143] Similar to Oregon, Florida cities should aim to adopt ordinances requiring licensing of cats and dogs, requiring a kennel permit to house more than four cats or four dogs, regulating the number of animals that can be adopted from the city shelter, defining animal cruelty and nuisance, and giving city officials authority to control potential public health threats.

b. Case Management Practices

HARC released a set of preliminary case management techniques to consider when addressing animal hoarding cases. HARC advises interveners be aware of their own emotional responses, despite the likelihood of not feeling sympathy for the animal hoarder.[144] Animal hoarders may need to be referred to medical attention which may require social services to help find medical care due to an animal hoarder's financial trouble.[145] It is also advised that, if possible, a slow

[138] Animal Legal Defense Fund, *supra* note 91.
[139] S.B. 212, 2017 (Fla. 2017).
[140] *Id.*
[141] *Id.*
[142] The Florida Senate, *SB 212: Animal Hoarding*, Florida Senate, https://www.flsenate.gov/Session/Bill/2017/212/?Tab=BillHistory (last visited Sept. 21, 2024).
[143] Morton, *supra* note 2.
[144] Patronek, *supra* note 4.
[145] *Id.*

reduction in the number of animals may make the animal hoarder more receptive to intervention as discussions of relinquishing all animals at once will likely be met with strong apprehension and may block future communication.[146] There are also several advisable things an intervener can do to build trust with the animal hoarder, increasing the chances of a successful discussion. Depending on the type of animal hoarder, it may be helpful to acknowledge the hoarder's attempts to provide care and their special connection to the animals.[147] Animal hoarders are often suspicious of the motives of a person trying to help, due to their view that the world is hostile to animals and people.[148] Interveners should consider inviting a friend, neighbor, or veterinary in as part of the discussion with the animal hoarder to act as a more comforting third party to facilitate the conversation.[149] Instead of entering the discussion with a hostile tone, analyze how the household functions while animal hoarding is occurring.[150] For example, if the hoarder has trouble accessing kitchen appliances or their own bed, working on these issues will allow the intervener to address the animal hoarding indirectly.[151] The intervener should expect denial and should not argue the point; animal hoarders often fail to recognize the significant suffering they are causing the animals they attempt care for.[152] Interveners working with animals hoarders should also expect the process to be lengthy and require frequent monitoring.[153] Finally, HARC suggests avoiding an over-standardized approach and instead treating each animal hoarding case as unique.[154] Implementing these practices when intervening in an animal hoarding situation will greatly increase the chances of successfully addressing the issues and will ideally alleviate some level of stress from both the intervener and the animal hoarder.

c. Managing Older Animal Hoarders

In animal hoarding cases perpetrated by older adults, Adult Protective Services (APS) should be involved. APS is a program "responsible for preventing further harm to vulnerable adults who are victims of abuse, neglect, exploitation, or self-neglect."[155] APS case workers should, upon investigation, ask questions about the older person's financial and physical ability to care for pets at home.[156] APS case workers should also visit the home to assess the amount of pets, adequacy of food, water and shelter for the animals, as well the risk of the older person falling due to the number of animals.[157] APS case workers should also be prepared to make counseling or other social service referrals.[158] Frequent check-ins should be done with older adult animal hoarders to ensure a case management plan is being followed properly.[159] In all cases, there should be a multi-

[146] *Id.*
[147] *Id.*
[148] *Id.*
[149] *Id.*
[150] *Id.*
[151] *Id.*
[152] *Id.*
[153] *Id.*
[154] *Id.*
[155] *Adult Protective Services*, Florida Department of Children and Families, https://www.myflfamilies.com/services/abuse/adult-protective-services (last visited Sept. 21, 2024).
[156] Arkow, *supra* note 44, at 46.
[157] *Id.* at 47.
[158] *Id.* at 41.
[159] *Id.*

disciplinary response from APS, animal shelters, law enforcement, public health officials, code enforcement, fire department, mental health professionals and veterinarians.[160]

d. Balancing Prosecution versus Rehabilitation

Officials should also focus on reducing recidivism by balancing prosecution and rehabilitation in animal hoarding cases. Currently, there are no management plans in place to create a check-in system with adults found to be animal hoarding. The following case studies are examples of potential successful outcomes to animal hoarding cases when agency's develop relationships with the animal hoarders.[161] In one case, a couple who were suspected animal hoarders greeted the officer with hostility and claimed they only had "a few dozen dogs."[162] Over several months, the officer worked to gain the husband's trust and the husband agreed to surrender 18-20 dogs as long as he could walk them to the vehicle himself.[163] Eventually, the officer recovered 120 dogs from the couple's home.[164] When the officer and other officials decided what charges to bring, the officer knew the couple would not be able to afford the $150,000 fine they would face with 120 counts of animal cruelty.[165] The husband accepted a plea deal "to plead guilty to eighty-eight counts of unlicensed dogs and accept a fine of $4,000."[166] Additionally, the arrangement allowed the couple to keep five dogs, given they were spayed/neutered with four days, and after those dogs died, the couple were to never own animals again.[167] The officer in the case would also continue to make surprise visits and ultimately reported the couple had become responsible pet owners, partially because of the handling of their case.[168]

In another case, a couple had 82 dogs and 14 cats.[169] The local humane society made weekly home visits even throughout the court case and sentencing hearing, to build a relationship with the couple ensure they would not revert to their animal hoarding behaviors.[170] At the time this study was reported in 2002, the couple had not begun to hoard animals again and continued to cooperate with humane society officers.[171] These cases showcase the reduction in recidivism that is possible by creating and maintaining relationships with animal hoarders to ensure their behaviors do not continue and cause the suffering of animals.

Several types of agencies must not only work together to investigate and address animal hoarding situations, but they must also work together to ensure the animal hoarding behavior does not reoccur, through monitoring and follow-up processes.[172] APS can provide a plan for a plethora of services including counseling, home-care, nutrition, transportation and money management.[173] However, APS typically only assesses quarterly with a goal of short-term involvement, which

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[160] *Id.* at 30.
[161] Berry et al., *supra* note 11, at 186.
[162] *Id.*
[163] *Id.*
[164] *Id.*
[165] *Id.*
[166] *Id.*
[167] *Id.*
[168] *Id.*
[169] *Id.* at 187.
[170] *Id.*
[171] *Id.*
[172] GARY PATRONEK ET AL., *ANIMAL HOARDING: STRUCTURING INTERDISCIPLINARY RESPONSES TO HELP PEOPLE, ANIMALS AND COMMUNITIES AT RISK*, at 28 (HARC 2006).
[173] *Id.* at 27.

means an animal welfare agency that is willing to monitor for years will help shift this burden.[174] Volunteers may be useful in these situations because they are far more likely be involved much longer than human service agencies.[175] In some severe cases a guardianship may be needed. This need may become obvious during the investigation of an animal hoarding case when control over the hoarder's actions is needed to protect their own interest.[176] Guardianship of the person would allow the guardian to make decisions about keeping or turning over animals in the animal hoarder's possession.[177] By several agencies working together on animal hoarding cases, it is possible to reduce recidivism and keep both the animal hoarder and animals safe.

VI. Conclusion

Animal hoarding a serious problem that Florida needs to address. Animal hoarding carries significant costs and brings suffering to the animals being hoarded as well as the humans perpetrating the hoarding. Several cases studies examined above, show the inconsistencies among the law, and the shortcomings of agencies – all failing to address the severity of this type of crime. Florida should aim to take several steps to address these failures. By revising the animal cruelty statutes to define and prohibit animal hoarding, similar to Senate Bill 212, Florida would take a monumental first step to decreasing animal hoarding. Secondly, Florida should encourage its local governments to adopt ordinances that will provide tools and delegate proper authority to local officials to help prevent animal hoarding and intervene early. Case management teams in Florida should also follow HARC's suggested approach to dealing with animal hoarding cases.

Florida's older population is specifically vulnerable to becoming animal hoarders. APS should be involved at the earliest point possible to address potential animal hoarding and help seniors avoid the negative outcomes of animal hoarding. APS should work with other state and local agencies to address animal hoarding situations and ensure the safety of both the animals and the older adults.

Florida should aim to strike a balance between prosecuting and rehabilitating animal hoarders to reduce recidivism. Prosecutors should focus on comprehensive plea-bargains that outline all aspects of animal care and ownership and provide for mandatory supervision with unannounced home visits for a period of years following the original offense.[178] Enacting these reforms and strategies in Florida will hopefully result in a decrease of overall incidence of animal hoarding as well as decreasing recidivism rates.

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[174] *Id.* at 29.
[175] *Id.*
[176] *Id.* at 30.
[177] *Id.*
[178] *Id.*

BALANCING PROTECTION AND AUTONOMY: A PERSON-CENTERED APPROACH TO OLDER ADULT GUARDIANSHIP ADJUDICATION

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Over the past few years, the public debate on guardianship abuse and misuse has prompted a re-examination of judicial decision-making in guardianship cases. To address the need for informed, consistent, and reliable rulings that protect older adults while preserving their fundamental rights, the Department of Justice supported the development of the Judicial Guardianship Evaluation Worksheet.[1] The Worksheet was pilot tested in 51 courts nationwide and was found to enhance judicial confidence, objectivity, and consistency in guardianship decision-making.[2] This evidence-informed tool guides judges in aggregating the relevant evidence; assessing an older adult's retained abilities and areas of vulnerability; considering a respondent's preferences and goals; evaluating risk factors for elder mistreatment; and examining the potential to order less restrictive alternatives or more limited guardianship rulings.[3] It may also serve as a guide for attorneys and other professionals working within the guardianship ecosystem to better safeguard the rights and preserve the dignity of older adults.

Key Words*: guardianship; judges; qualitative methods; older adults; worksheet; person-centered care; less-restrictive alternatives; elder abuse*

Table of Contents

[1] U.S. Dept. of Justice, Elder Justice Initiative, Award No. UP-20-00313.
[2] Bonnie Olsen & Susie Norby, *Webinar: Judicial Guardianship Evaluation – A New Tool for Judges*, VIMEO (June 22, 2022), https://vimeo.com/722938044.
[3] *Id.*

I. Introduction

Over the past few years, factual reports and fictional dramas depicting the perils of guardianship have abounded in the media, drawing attention to the tenuous balance navigated by courts to protect older adults with waning capacity while preserving their fundamental liberties. In the wake of Rachel Aviv's expose in the New Yorker, "How the Elderly Lose Their Rights,"[4] Netflix's movie "I Care a Lot,"[5] and the #FreeBritneySpears movement,[6] public debate on guardianship abuse and misuse has incited re-examination of the scope, breadth, and function of guardianship. A critical appraisal of the system has also provoked discussion of the propriety of judicial decision-making in guardianship cases; specifically the need to make person-centered, less restrictive rulings that offer protections if needed, and preserve elder rights, whenever possible. To better meet the needs of the growing older population with significant cognitive deficits, eroding decisional capacity, increased care needs, and safety concerns, the Department of Justice funded development of The Judicial Guardianship Evaluation Worksheet (the "Worksheet"),[7] an evidence-informed approach to guide consistent and reliable judicial decision-making.[8] This practical tool complements statutory authority while facilitating person-centered guardianship evaluation and circumscribed court-ordered protections. The Worksheet also provides a blueprint for attorneys and other members of the guardianship ecosystem to effectively and meaningfully consider an older adult's retained abilities, areas of vulnerability, preferences, and goals.

I. Background

Probate judges are routinely required to make findings of capacity and determinations of guardianship[9] to protect individuals who are unable to make decisions in their own behalf or are unable to manage their personal needs to support their welfare.[10] Although definitions of capacity vary between states, and procedural rules often differ among jurisdictions, courts typically review petitions for guardianship accompanied by medical/psychological[11] declarations, investigative reports, and testimony to evaluate the necessity and limits of

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[4] *See generally* Rachel Aviv, *How the Elderly Lose Their Rights*, THE NEW YORKER (Oct. 2, 2017), https://www.newyorker.com/magazine/2017/10/09/how-the-elderly-lose-their-rights.

[5] *See generally* Netflix, *I Care a Lot*, NETFLIX (2021), https://www.netflix.com/title/81350429 (last visited Sept. 17, 2024).

[6] *See* Brittany Spanos, *#FreeBritney: Understanding Fan-led Britney Spears Movement*, ROLLING STONE (Feb. 8, 2021), https://www.rollingstone.com/feature/freebritney-britney-spears-legal-829246/.

[7] Keck Sch. of Med. of USC, *Judicial Guardianship Worksheet*, U.S. DEPT. OF JUSTICE, https://www.justice.gov/elderjustice/file/1206636/dl?inline= (last visited April 14, 2024). See also attached at the end of this article.

[8] *Judicial Guardianship Worksheet Implementation Project*, USC CENTER FOR ELDER JUSTICE, https://eldermistreatment.usc.edu/projects/judicial-guardianship-worksheet-implementation-project/ (last visited April 14, 2024).

[9] Though legal terminology differs by state, for purposes of this proposal all references to guardianship will include and are interchangeable with the term conservatorship.

[10] *Help for Judges Hearing Guardianship Cases*, U.S. DEPT. OF JUSTICE, https://www.justice.gov/elderjustice/help-judges-hearing-guardianship-cases (last updated April 16, 2025).

[11] All references to medical/psychological will hereinafter be construed to embrace all medical, psychological, psychiatric, primary care, and mental health providers charged with evaluating and rendering an opinion on the status and capacity of older adults.

protective measures.[12] In assessing an individual's capacity, jurists are advised to adopt a best practice, case-specific and person-centered approach.[13] To this end, courts must balance the individual's right to self-determination and need for safety, consider less restrictive alternatives to guardianship, make findings based upon the evidence presented, and circumscribe orders to promote the individual's best interests.[14]

Many cases before the court involve persons who have varying degrees of neurocognitive disorder, which manifest in myriad ways impacting individuals' decision-making and functional capacity. Capacity is complex, variable by task and context, and distinguished by decisional and executional tasks. The degree of ability across domains is nuanced and influenced by a number of factors in addition to cognition. Assessment of capacity in impaired older adults is additionally complicated by the need to consider, for example, deficits in mobility and sensory loss, such as hearing and vision, which may further compromise independent functioning.[15]

Indeed, older adults with cognitive and functional impairment are at significantly greater risk for elder mistreatment.[16] In cases of guardianship, while judges typically prefer appointing family or a trusted other as guardian, abuse is often committed by family members, those ostensibly closest to the subject and with whom they may share a history of complicated family dynamics.[17] Professional court appointed guardians may likewise pose a risk of mistreatment to older adult wards through malintent, neglect, paternalism or less awareness of their wards' values and preferences.[18] Courts must assess and weigh individual, relational, and contextual factors in imposing familial, friendship-based, and professional fiduciaries and the likelihood of mistreatment.

Increasingly, courts also hear cases of individuals, with or without vulnerability, whose decision-making authority has been subverted through the manipulation and deceit of others. Undue influence is a common form of elder financial exploitation, especially among individuals who are isolated, lonely, or dependent.[19] These elements when combined with cognitive deficits, can render individuals even more susceptible to mistreatment.[20] Thus, as

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[12] U.S. Dept. of Justice, *supra* note 10.

[13] UNIF. GUARDIANSHIP, CONSERVATORSHIP, AND OTHER PROTECTIVE ARRANGEMENTS ACT § 301, (UNIF. L. COMM'N & NAT'L CONF. OF COMM'RS ON UNIF. STATE LS. 2017).

[14] U.S. DEPT. OF JUSTICE, *supra* note 10.

[15] Am. Bar Ass'n (ABA) Comm'n on L. and Aging et al., *Judicial Determination of Capacity of Older Adults in Guardianship Proceedings*, AM. BAR ASS'N, https://www.americanbar.org/content/dam/aba/administrative/law_aging/2011_aging_bk_judges_capacity.pdf (last visited March 3, 2024).

[16] *See* Laura Mosqueda et al., *The Abuse Intervention Model: A Pragmatic Approach to Intervention for Elder Mistreatment*, *64*(9) JOURNAL OF THE AMERICAN GERIATRICS SOCIETY 1879 (Aug. 22, 2016), https://pubmed.ncbi.nlm.nih.gov/27550723/.

[17] Michaela M. Rodgers et al., *Elder Mistreatment and Dementia: A Comparison of People with and without Dementia across the Prevalence of Abuse,* JOURNAL OF APPLIED GERONTOLOGY (Dec. 23, 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10084452/.

[18] *See Mistreatment and Abuse by Guardians and Other Fiduciaries*, U.S. DEPT. OF JUSTICE, https://www.justice.gov/elderjustice/mistreatment-and-abuse-guardians-and-other-fiduciaries (last visited Sept. 18, 2024).

[19] *See* Mary Joy Quinn, *Defining Undue Influence*, AMERICAN BAR ASSOCIATION (Feb. 1, 2014), https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_35/issue_3_feb2014/defining_undue_influence/.

[20] Rodgers, *supra* note 17.

necessary, courts must assess the risk that an older adult's vulnerability to undue influence will further diminish his/her ability to independently manage personal matters.

Courts are charged with adjudicating the ultimate determination of capacity, and crafting orders that enable subjects to retain or relinquish essential rights, analyze and assimilate psychological, psychiatric and medical evidence.[21] With the rise of the older adult population and the attendant surge in cognitive and functional limitations, courts are increasingly required to evaluate the legal impact of medical and mental health issues. These matters require courts to have substantial knowledge and understanding of these disorders.

Since the court's orders implicate a subject's fundamental rights to liberty and autonomy, they are critically important to individual dignity, and wellbeing.[22] To assess both capacity and the risk of mistreatment or self-neglect, jurists are informed by reports prepared by court investigators, capacity declarations of medical/psychological providers and expert clinicians, and the court testimony of the subject, witnesses, and professionals.[23] Notwithstanding the observational data collected, expert opinions rendered, and lay testimony offered, the court must not substitute its own judgment for the testimony of others, expert or otherwise, and need to independently evaluate the evidence to issue its rulings.[24]

Statutes and interpretive case law provide a structure for governance but offer little guidance in translating laws into applied practice, especially as they relate to the individual. Understanding the unique characteristics and complexities of each individual facing guardianship, the specifics of their situations, while integrating their medical, mental health, cognitive function and preferences and values, is a weighty and consequential task.[25] Clinician-executed court forms addressing capacity vary widely across jurisdictions, but often focus on the individual's diagnosis rather than their practical capabilities.[26] Yet, an individual's functional aptitudes and retained abilities can mitigate cognitive deficits to some extent and may be more germane to the court's adjudication of capacity and consideration of limited or less restrictive orders.

A holistic, organizational paradigm for jurists to comprehensively evaluate and integrate relevant evidence of capacity, consider less restrictive alternatives to guardianship, and weigh the contextual factors that can forewarn abuse in guardianships is lacking. Similarly, court investigators, attorneys litigating guardianship cases, and guardians ad litem could more effectively assess older adult respondents if provided an analytic lens to view their clients' needs.

Without a conceptual framework for investigation and judicial review, courts are hampered in understanding and appreciating the totality of ambient circumstances. They are similarly impeded in identifying evidentiary gaps and requesting necessary data to advise their guardianship adjudications.[27] This may hinder jurists ability to identify modifiable risk factors of mistreatment and domains of retained capacity, which would favor less restrictive alternatives to guardianship. This deficit also impacts a court's ability to craft person-centered, situation specific orders that are narrowly tailored to the need, while promoting autonomy and preserving personal rights where practical. A uniform national approach to guardianship

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[21] *See* U.S. Dept. of Justice, *supra* note 10.
[22] *See id.*
[23] *Id.*
[24] Olsen & Norby, *supra* note 2.
[25] *Id.*
[26] ABA et al., *supra* note 15.
[27] Olsen & Norby, *supra* note 2.

determinations across states, despite the disparate laws and definitional elements, will contribute to procedural and substantive consistency.

II. The Project

In 2021, the Department of Justice, Elder Justice Initiative, supported researchers at the University of Southern California, Department of Family Medicine to develop an evidence-based, standardized construct and pragmatic tool for jurists, to evaluate evidence of an older adult's capacity to manage their personal affairs, the propriety of imposing protective measures, including supported decision making and limited guardianships, while assessing the potential risk of maltreatment.[28] The interdisciplinary project team was led by Bonnie Olsen, PhD, a geropsychologist, researcher-practitioner, and expert in both elder abuse and capacity, and included a physician's assistant, an attorney, and an evaluator.[29] The project goals were to 1) Provide a consistent theory-informed framework for guardianship evaluation; 2) Assess the potential for abuse in guardianship cases; 3) Identify gaps in evidence collection; 4) Clarify respondent's strengths and limitations; 5) Consider less restrictive alternatives to guardianship; and 6) Identify opportunities for limited guardianship.[30]

III. Theoretical Foundation

From the outset, the project was anchored in the Abuse Intervention Model (AIM), a theoretical framework for considering the risk factors associated with elder mistreatment, viewed through the complex interrelationship between the victim, the trusted other, and the context of their interaction.[31] Given the high prevalence of abuse within the growing older population, and a key concern among those under guardianship, risk mitigation was a primary goal.[32]

It is estimated that one in 10 older adults experiences some form of abuse each year, though the number of incidents is believed to be markedly underreported to authorities.[33] Mistreatment among individuals with neurocognitive impairments is much higher, with nearly half of the population impacted.[34] Types of abuse include physical, psychological/emotional, financial abuse, neglect, and self-neglect.[35] Polyvictimization, or co-occurring forms of abuse, is not uncommon.[36] Most often, elder abuse is committed by family or chosen family, within the context of complicated, multidimensional, and longstanding family dynamics.[37] AIM posits

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[28] USC Center for Elder Justice, *supra* note 8.
[29] *Id.*
[30] Olsen & Norby, *supra* note 2.
[31] Mosqueda, *supra* note 16.
[32] Olsen & Norby, *supra* note 2.
[33] Ron Acierno et al., *Prevalence and correlates of emotional, physical, sexual, and financial abuse and potential neglect in the United States: The National Elder Mistreatment Study*, AMERICAN JOURNAL OF PUBLIC HEALTH, *100*(2), 292-297 (Feb 2010) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804623/.
[34] XinQi Dong et al., *Elder Abuse And Dementia: A Review Of The Research And Health Policy*, PUDMED (Feb. 24, 2023) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9950800/.
[35] *What is Elder Abuse*, NATIONAL CENTER ON ELDER ABUSE, https://ncea.acl.gov/elder-abuse#gsc.tab=0 (last visited Sept. 18, 2024).
[36] Rodgers, *supra* note 17.
[37] *Id.*

a pragmatic and cohesive approach to examine the known, and potentially modifiable, risk factors for the older victim, trusted other, and the circumstances under which they co-exist.[38]

For the vulnerable elder, predictors of mistreatment include impaired physical function, diminished cognition, emotional or mental distress, and frailty, factors which often require complex caregiving.[39] Any of these or other vulnerabilities may expose elders to an increased risk of abuse. Offenders often are trusted others known to the older person, such as a family/chosen family, friend, caregiver, or financial advisor.[40] The risk of mistreatment rises where the trusted person is financially or emotionally dependent upon the elder; has a mood, personality, or substance use disorder; or suffers a physical limitation inhibiting caregiving effectiveness.[41] Contextual factors that impact this dyad include social isolation of the older adult, low-quality relationship between the elder and other, and the impact of their shared or respective cultural norms.[42] AIM offers a broad conceptual framework to assess the often dissonant, conflictual interplay between older adults and trusted others, in context.[43]

IV. Application of the AIM Model in Court Proceedings

The American Bar Association Commission on Law and Aging (ABA) in collaboration with the American Psychological Association and National College of Probate Judges created a handbook on Judicial Determination of Capacity of Older Adults in Guardianship Proceedings in 2006.[44] The guide laid the foundation for translating the AIM approach to judicial practice. AIM provided an organizing framework to develop a practical, efficient tool for judges to meaningfully aggregate and analyze the totality of relevant evidence in guardianship proceedings, including the complex nuances of capacity while capturing the older person's core values.[45] The AIM model provides a pragmatic construct to help judges gather relevant data, consider the evidence adduced in probate proceedings, integrate components of capacity, and give a case-based lens for adjudication.[46] The AIM judicial application illuminates domains where critical evidence is lacking, providing jurists clarity as to the scope and type of information that may be either intentionally or inadvertently withheld from judicial review. Using the Worksheet, review of capacity is framed within a person-centered, in-context lens, recognizing the complex relational factors which comprise the proposed ward's environment and needs.

With this organizational structure, courts may be less apt to impose overbroad guardianships and circumscribe more limited protective orders which enable subjects to retain designated rights and preserve relative autonomy. Rather than resorting to plenary guardianships where all rights are extinguished, courts can recommend less restrictive alternatives such as supported decision making, or order temporary and limited guardianships, enabling individuals to retain prescribed rights, as warranted by the facts. This model also serves as a risk assessment

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[38] Mosqueda, *supra* note 16.
[39] *Id.*
[40] *Id.*
[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *See* ABA et al., *supra* note 15.
[45] *See* Mosqueda, *supra* note 16.
[46] *Id.*

tool to evaluate and mitigate the likelihood of mistreatment.[47] Courts will be able to identify the red flags that may portend an increased likelihood of abuse.[48] This includes potential vulnerabilities within the older adult respondent (including medical, cognitive, mental health, and functional deficits) and characteristics within the proposed guardian (including economic or emotional dependency on the older adult) that may signal heightened concern and safety considerations. The AIM is a best practice approach to inform judicial inquiries, court findings, and orders of protection, while promoting procedural consistency reducing variability of judicial review across jurisdictions.[49]

V. Development of the Judicial Guardianship Evaluation Worksheet

The two-year project was informed by an expert advisory panel comprised of probate judges, attorneys, researchers, and academics.[50] Each iteration of the Worksheet was reviewed and discussed by the panel, and responsively revised.[51] With the AIM construct as a foundation, the project team built a prototype that mirrored the larger domains of vulnerable older adult, trusted other, and context.[52] Given the guardianship setting, the categories were correspondingly renamed: "Respondent," "Proposed Guardian," and "Context." A fourth category was added, "Less Restrictive Alternatives."[53]

Each section contains subcategories. There are nine subcategories within the Respondent section: "Background," "Cognition," "Mental Health," "Medical Conditions and Physical Functioning," "Basic Activities of Daily Living," "Instrumental Activities of Daily Living," "Judgment, Reasoning, and Executive Functioning," "Social Connectedness," and "Values and Preferences." Subcategories within the Proposed Guardian section include, "Background," "Dependency," "Functional Limitations," and "Guardian History."[54] In "Context," the subcategories are "Respondent Resources," "Living Arrangements," "Relevant Relationships," "Relationship with Proposed Guardian," and "Current Legal Instruments."[55] For Less Restrictive Alternatives, the subcategories are "Decisional and Executive Supports," "Retained Capacities," "Areas to Limit Guardianship Powers," and "Summary Notes."[56] The subcategories have selection options for judges to identify with greater specificity risk or protective factors for the Respondent, Proposed Guardian, and Context, as well as options for less restrictive alternatives to guardianship.[57]

VI. Focus Groups

Once the draft Worksheet was developed and vetted by the advisory panel, the instrument was reviewed by three focus groups, each comprised of eight judges.[58] The judges

[47] Olsen & Norby, *supra* note 2.
[48] *Id.*
[49] *See* Mosqueda, *supra* note 16.
[50] Olsen & Norby, *supra* note 2.
[51] *Id.*
[52] *Id.*
[53] Keck Sch. of Med. of USC, *supra* note 7.
[54] *Id.*
[55] *Id.*
[56] *Id.*
[57] *Id.*
[58] Olsen & Norby, *supra* note 2.

represented probate and general jurisdiction courts nationwide.[59] They were asked to review the Worksheet and respond to a series of questions about the tool in general and each subsection and category.[60] Content from the focus groups was qualitatively analyzed to assess the relevance, resonance, usability, and efficacy of the tool.[61] Among other topics, in discussion the judges shared their thoughts about the gravity and complexity of guardianship adjudications.[62] Many expressed the need for additional case-specific information to make fully informed decisions and found the tool a helpful guide to facilitate informed decision-making.[63] Focus group discussion further aided development and modification of the tool.[64] It also helped lay the foundation for a pilot study of the Worksheet in 51 probate, general jurisdiction, and tribal courts across the country.[65]

VII. Pilot Study

Judicial recruitment for the pilot study coincided with COVID-19, which led to unanticipated complexities and delays. Judges were navigating pandemic uncertainty, masking and distancing restrictions, reduced case assignments, and remote hearings. Eventually, 51 courts agreed to participate in the pilot study.[66] They were asked to use the Worksheet in at minimum five older adult guardianship cases.[67] Each judge received a 30-minute explanatory training session on the use of the Worksheet.[68] Technical assistance was offered by the project team through the course of the pilot study.[69]

On average, participants used the Worksheet in 10 cases.[70] One court used the worksheet in 93 cases.[71] Exit interviews were conducted with 33 of the pilot study judges to assess a number of factors including the benefits and barriers to use of the Worksheet in judicial practice.[72] The project team was not prescriptive about the specific integration of the tool in guardianship decision-making.[73] Thus, each judge used the Worksheet in ways that aligned with their own case review and regular practices. Some judges filled out the worksheet in each of the cases they adjudicated.[74] Others referred to the Worksheet as a benchcard or checklist to identify issues to address and consider.[75] A few judges suggested that the Worksheet could be used at subsequent hearings in the same case to more efficiently review relevant factors.[76]

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[59] *Id.*
[60] *Id.*
[61] *Id.*
[62] *Id.*
[63] *Id.*
[64] *Id.*
[65] *Id.*
[66] *Id.*
[67] *Id.*
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.*
[72] *Id.*
[73] *Id.*
[74] *Id.*
[75] *Id.*
[76] *Id.*

Overall, the consensus was overwhelmingly positive. The Worksheet was found to provide a ready and easily accessible comprehensive register of relevant factors.[77] For many judges, the tool highlighted gaps in evidence, and prompted further inquiry and requests for information from litigants.[78] The Worksheet was found most useful in complex and contested cases, but also provided a reliable record for subsequent or ongoing case review.[79] Significantly, judges observed that the tool reinforced confidence, objectivity and consistency in decision-making, while facilitating holistic, person-centered case review and providing a check on potential biases.[80] The vast majority of judges also noted the perceived utility of the Worksheet, if not for their own personal use, then for use by others within the court system.[81]

VIII. Attorney Application

The Worksheet has been found to be an effective structured assessment and decision-making tool to facilitate informed judicial review in guardianship cases.[82] Integration of the Worksheet by professionals across the guardianship ecosystem may promote culture change that better supports older adults whose fundamental rights are at issue. Both private and court appointed attorneys representing older adults in guardianship cases may utilize the Worksheet to understand the risk and protective factors within each of the Respondent, Proposed Guardian, and Contextual domains. Utilizing a common framework and guide to identify relevant, person-centered, case-specific evidence in guardianship cases would promote consistent evidence collection and judicial review, supporting more consistent, tailored, and nuanced rulings that impact older adults.

IX. Additional Takeaways

In balancing safety with countervailing considerations of autonomy, judges have been inclined to order broad plenary guardianships that offer greater protection rather than limited orders or less restrictive alternatives.[83] Plenary orders are motivated by the perceived need for protection.[84] However, the court should guard against the risk that they act from latent paternalism, ageist assumption, or a reluctance to tolerate potential risk and avoid, as possible, the removal of fundamental rights and rulings that run counter to the older person's preferences, values, and life goals. The Worksheet may offer a mechanism to pinpoint an older person's retained abilities, preserved function, as well as areas of limitation to better inform person-centric, tailored orders that align with the older person's wishes and needs. The tool can enable judges to better assess ambient risk, and potentially provide them with the confidence to issue rulings that embed reasonable risk to advance the dignity and desires of older people.

Finally, research is essential to assessing the efficacy of practices across domains. Within the guardianship arena, robust research initiatives can help assess the effectiveness of existing practices and vet promising innovations that directly impact - and may ameliorate - the

[77] *Id.*
[78] *Id.*
[79] *Id.*
[80] *Id.*
[81] *Id.*
[82] *Id.*
[83] *See id.*
[84] *See id.*

lives and wellbeing of older adults under guardianship or who are otherwise exposed to the removal of fundamental rights. Research studies at the intersection of law and aging may advance knowledge and encourage the translation of validated methods into applied practices to elevate legal practice and judicial decision-making.

Copy of Judicial Guardianship Evaluation Worksheet:

Judicial Guardianship Evaluation Worksheet

CONFIDENTIAL

Case #:
Respondent:
Petitioner:
Proposed guardian:
□ Person □ Estate □ Other

Hearing date:
Precipitating event, if any:

Link to Worksheet Orientation
Link to State Probate Statutes

Contested by: □ Respondent □ Multiple petitions □ Other

1. RESPONDENT

A. Background

Age: _____ Highest education: _____ Marital/Partnership status: _____
Occupational history: _____ English literacy: □ speak □ read □ write
Preferred language:_____ □ interpreter required Other language: _____ literacy: □ speak □ read □ write

B. Cognition

Areas of concern: □ memory □ concentration □ wandering □ aggression □ confusion □ episodes of delirium
Diagnosis of dementia: □ mild □ moderate □ severe Rx: _____ □ no known deficit
□ other: _____
Retained abilities:

C. Mental Health

Areas of concern: □ depression □ anxiety □ hallucinations □ delusions □ impulsive behavior □ substance abuse
□ hoarding □ other: _____ diagnosis: _____ Rx: _____ □ no known deficit
Comments:

D. Medical Conditions and Physical Functioning

Relevant medical diagnoses: _____ **A**cute **C**hronic **R**eversible
Areas of concern: □ inadequate self-management □ mobility □ frequent falls □ pain □ physical frailty □ incontinence
□ legally blind □ hearing impaired □ adaptive equipment: _____
□ other: _____ □ no known conditions

E. Basic Activities of Daily Living

Areas of concern: □ eating/feeding *Retained* □ bathing □ dressing □ toileting □ grooming □ no known deficit
abilities:

F. Instrumental Activities of Daily Living

Areas of concern: □ meal preparation/adequate nutrition □ housekeeping □ personal finances □ shopping □ medications
□ arranging transportation □ internet use □ telephone use □ other: _____ □ no known deficit
Retained abilities:

G. Judgment, Reasoning, and Executive Functioning

Areas of concern: □ identify abuse/neglect/protect self from harm □ recognize potential danger/respond to emergencies
□ understanding of care needs □ susceptibility to exploitation/undue influence □ prior episodes of mistreatment
□ other: _____ □ no known deficit

H. Social Connectedness

Areas of concern: □ limited contact with family/friends/community □ recent relocation □ recent loss of significant relationship
□ lack of significant longterm relationships/attachments

I. Values & Preferences

Accepts/desires guardian? □ no □ yes: _____
Current most valued relationships/associations/activities: _____
Consistency of preferences with past patterns: _____
□ importance of religious/cultural/spiritual influences □ insistence on family care □ pets
□ preference to age-in-place □ rejection of needed care □ other: _____

Keck School of Medicine of USC
Department of Family Medicine

Support for this project was provided to the University of Southern California's Keck School of Medicine by the U.S. Department of Justice through the Elder Justice Initiative.

2. PROPOSED GUARDIAN

□ lay guardian □ private/professional guardian □ public guardian □ financial institution □ certification

A. Background

Age:_____Highest education:_____Employment history:_____

B. Dependency

□ financially dependent on respondent □ emotionally dependent on respondent

C. Functional Limitations

Cognitive concerns:_____□ no known deficit □ info unavailable
Mental health/Substance abuse concerns: _____□ no known deficit □ info unavailable
Physical concerns: _____□ no known deficit □ info unavailable

D. Guardian History

Of cases: current_____previous_____□ ever removed □ revoked license □ surcharge imposed □ rep payee
□ bonded/insured □ poor credit history □ criminal history □ APS complaints □ protective orders □ bankruptcy
Guardian history: _____

3. CONTEXT

A. Respondent Resources

Sources of income: □ pension □ social security □ annuity monthly total income: $_____value of estate: $_____
Veteran status: □ yes □ no Health insurance: □ Medicare □ Medicaid □ other: _____
□ barriers to access/services/assessments □ internet access

B. Living Arrangements_____Adequate?/Appropriate?_____With whom?_____
Comments:

C. Relevant Relationships

Family structure: _____
Family dynamics: _____
Other supportive relationships: _____
Other involved parties: _____
Areas of conflict:_____□ pending legal action/protective order: _____

D. Relationship with Proposed Guardian

Nature and history of relationship? _____
Actual/potential conflict of interest?_____Respondent dependent on proposed guardian: □ yes □ no

E. Current Legal Instruments

Will/Trust: Executor/Trustee_____Date executed:
Medical POA:_____Date executed: Financial POA:_____Date executed:

4. LESS RESTRICTIVE ALTERNATIVES

A. Decisional and Executive Supports

□ hired/family caregiver □ home/community-based services □ memory aids □ assistive technology □ medical POA
□ hired/family fiduciary □ direct deposit □ joint account □ rep payee □ financial POA □ trust □ SDM agreement □ other

B. Retained Capacities:

C. Areas to Limit Guardianship Powers:

D. Summary Notes:

Support for this project was provided to the University of Southern California's Keck School of Medicine by the U.S. Department of Justice through the Elder Justice Initiative.

BOOK REVIEW
RESEARCH HANDBOOK ON LAW, SOCIETY, AND AGEING[1]

Rebecca C. Morgan[2]

According to the 2024 World Population Data Sheet[3] from the Population Reference Bureau,[4] in many countries, "ten percent of the population is ages 65 and older" and in some countries, it is closer to twenty percent or more.[5] This translates into 800 million people worldwide who are 65 and older.[6]

Since the aging of the population happens globally, it is useful to have a resource that looks at aging from a multi-country perspective. This new publication is a welcome resource for those who work in the field of aging and law. The book is part of the series *Research Handbooks in Law and Society*.[7] In addition to the two editors,[8] there are fifty-eight contributing authors from a variety of countries and disciplines.[9] The book is organized into seven sections, with multiple chapters provided for each section.[10] The book contains many of the typical topics one finds in writings about elder law, but there are also some unique and interesting additions.[11]

For some time now, many countries have worked on the issues of ageing, resulting in several declarations regarding the rights and treatment of older people.[12] Most recently, the Second World Assembly on Ageing (Madrid Spain Apr. 8-12, 2002),[13] resulted in a Plan of Action that commits to multiple levels of acts domestically and worldwide, "on three priority directions: older persons and development; advancing health and well-being into old age; and ensuring enabling and supportive environments."[14]

Many of the chapters in this book follow and expand on these priorities. As the editors explain in Chapter 1, elder law has evolved from its beginning focus to a more "widening of different ages and stages of older age" recognizing the variety of experiences and needs of older people.[15] It is not just demographic diversity but also the breadth and depth of the various legal

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[1] RESEARCH HANDBOOK ON LAW, SOCIETY, AND AGEING, Sue Westwood and Nancy J. Knauer (eds.), Edward Elgar Publishers (2024). [hereinafter RESEARCH HANDBOOK AGEING].

[2] Professor of Law, Stetson University College of Law. Note that not every chapter in this handbook was reviewed, and the author picked specific chapters to discuss in this review. The author writes this review from a U.S. perspective.

[3] *2024 World Population Data Sheet*, PRB, https://2024-wpds.prb.org/ (last visited April 20, 2025).

[4] *Population Reference Bureau*, PRB, https://www.prb.org/ (last visited April 20, 2025).

[5] *Highlights from the 2024 World Population Data Sheet*, PRB, https://www.prb.org/articles/highlights-from-the-2024-world-population-data-sheet/ (last visited April 20, 2025). (Noting that countries with the larger percentage included countries found in East Asia, Europe, and Northern America).

[6] *Id.* (noting that by 2050, there will be 9.6 billion people worldwide age 65 and older).

[7] RESEARCH HANDBOOK AGEING, supra note 1.
(The front piece notes that each of the books in the series, RESEARCH HANDBOOK AGEING, "is designed by the leading expert to appraise the current state of thinking and probe the key questions for future research on a particular topic." The individual chapters are written by "leading academics, and practitioners, as well as those with an emerging reputation and is written with a global readership in mind.")

[8] *Id*. at *viii.* (noting that one editor is from the U.K., and the other from the U.S.).

[9] *Id*. at *ix-xviii.*

[10] The sections are *Law, Ageing and International Rights; Specialist Legal Services for Older People; Law, Ageing, Space and Place; Law, Ageing, Work and Pensions; Law, Ageing and Justice; Law, Ageing, Health and Wellbeing;* and *Law, Ageing, Care and Support. Id*. at *v.-vii.*

[11] *See id., e.g.,* at 200-29 and 566-79.

[12] *See e.g., Report of the Second World Assembly on Ageing*, UNITED NATIONS, 5, (2002).

[13] *Id*. (Resulting in the Political Declaration and the Madrid International Plan of Action on Ageing)

[14] *Political Declaration and Madrid International Plan of Action on Ageing,* UNITED NATIONS, 1, (2002).

[15] RESEARCH HANDBOOK AGEING, supra note 1, at 1.

and social issues faced by older adults. Consider the National Academy of Elder Law Attorneys (NAELA)[16] explanation of elder law:

> Elder law encompasses many different fields of law. An elder law attorney specializes in how to best use their knowledge to fit the needs of seniors. Some of these fields include: Preservation/transfer of assets seeking to avoid spousal impoverishment when a spouse enters a nursing home; Medicaid; Medicare claims and appeals; Social security and disability claims and appeals; Supplemental and long-term health insurance issues; Disability planning, including use of durable powers of attorney, living trusts, "living wills," for financial management and health care decisions, and other means of delegating management and decision-making to another in case of incompetency or incapacity; Conservatorships and guardianships; Estate planning, including planning for the management of one's estate during life and its disposition on death through the use of trusts, wills, and other planning documents; Probate; Administration and management of trusts and estates; Long-term care placements in nursing home and life care communities; Nursing home issues including questions of patients' rights and nursing home quality; Elder abuse and fraud recovery cases; Housing issues, including discrimination and home equity conversions; Retirement, including public and private retirement benefits, survivor benefits, and pension benefits; Health law; [and] Mental health law.[17]

Looking at this list, it is clear that the focus is on the legal issues facing the clients. In Chapter 7, *The Development of 'Elder Law' in the United States*,[18] Nancy J. Knauer writes that the success of Elder Law as a practice area in the U.S. is due to demographics, policies, the market, attorney specialization, and government programs and benefits.[19] However, Knauer notes, that academics have written about the shortcomings of elder law as a discipline, especially regarding the scope and lack of interdisciplinary an intersectional approaches.[20] She notes that the criticisms have led to the development of the field of law and aging, which she describes as "an emerging area of academic study that engages ageing policy and the law and has produced a growing body of theoretical work."[21] A call to action on this theme is echoed in the section, *The Limits of Elder Law as a Construct: Toward a Theory of Law and Ageing*.[22] Here, Knauer writes that the elder law practice in the U.S. is "a pragmatic and evolving response to an outmoded ageing policy and an inadequate safety net" which has been criticized as "not conducive to intellectual study or theory building."[23] But in counter to the criticism, Knauer points out that the cause is U.S. policy on aging

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(The authors write that "[t]his wide spectrum of functionality among ageing populations is further nuanced by an increasingly diverse ageing population, with population demographics in developed countries in particular becoming increasingly ethnically diverse and with increasing visibility, social acceptance and legal recognition of older lesbian, gay, bisexual, transgender and queer (LGBTQI+) people in some, though by no means all, parts of the world. This means that older people are affected by an increasingly wide range of issues relating to law and society.")

[16] The National Academy of Elder Law Attorneys or NAELA is an American organization for attorneys who practice in the fields of special needs and elder law. NAELA is open to membership internationally.

[17] Nat'l Acad. Of Elder L. Attorneys, *Transitioning into Elder Law*, NAELA, https://www.naela.org/Web/Join_NAELA/Transitioning_into_elder_law.aspx (last visited Mar. 24, 2025).

[18] RESEARCH HANDBOOK AGEING, supra note 1, at 95-111.

[19] *Id.* at 95.

[20] *Id.* at 96.

[21] *Id*.

[22] *Id.* at 108.

[23] *Id.*

rather than a push by the legal profession.[24] Knauer cites a leading elder law scholar to support her call for action, seeing an opportunity for development of the "academic interdisciplinary field of inquiry."[25]

This theme described in Knauer's chapter is continued in Ann Numhauser-Henning's Chapter 8, *Elder Law: A Critique and Some Suggestions*.[26] Looking beyond U.S. borders, Numhauser-Henning writes about the evolution of elder law in other countries and considering the view of elder law through the lens of human rights.[27] Numhauser-Henning acknowledges the impact of an age-based practice area that results to some extent of elder law being considered both paternalistic and discriminatory.[28] This leads into a discussion of Ageism and Age Discrimination,[29] with examples drawn from Elder Law, Labor Law, and Mandatory Retirement.[30]

Looking at the shared issues of law and ageing on a global scale, Joan R. Harbison writes about the need for an international convention on the rights of older people.[31] Harbison works through the efforts to gain an international convention, at one point describing it as a "slow progress of international efforts."[32] She explains the arguments for and against the adoption of such a convention and why the goal has not yet been achieved.[33] The potential for the ideals and goals of a convention support the approach of issues of human rights for older persons.[34]

As noted earlier in this review, there are some interesting topics in this book that are not always seen in books about elder law. Writing this review while wildfires rage in California[35] and Florida experienced an unprecedented two hurricanes within two weeks in late September and

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[24] *Id.*

[25] *Id.* at 108-11. (Knauer concludes her chapter by explaining the opportunity for the academic discipline of law and aging and how academics can respond to the various critiques that have arisen from elder law as a practice driven discipline.)

[26] *Id*. at 112-24.

[27] *Id.* at 112-13

[28] *Id.* at 113.

[29] *Id.*

[30] *Id.* at 114-24.

[31] *Id*. at 12-27.

[32] *Id.* at 13. (The history of the various efforts Harbison details in this chapter is very valuable information for academics and others.)

[33] *Id.* at 16-27.

[34] United Nations, supra note 12.

(For example, Article 5 states "We reaffirm the commitment to spare no effort to promote democracy, strengthen the rule of law and promote gender equality, as well as to promote and protect human rights and fundamental freedoms, including the right to development. We commit ourselves to eliminating all forms of discrimination, including age discrimination. We also recognize that persons, as they age, should enjoy a life of fulfilment, health, security and active participation in the economic, social, cultural and political life of their societies. We are determined to enhance the recognition of the dignity of older persons and to eliminate all forms of neglect, abuse and violence." Madrid International Plan of Action at 2. Articles 12 and 13 continue the theme of the human rights focus for older people:

> Article 12: The expectations of older persons and the economic needs of society demand that older persons be able to participate in the economic, political, social and cultural life of their societies. Older persons should have the opportunity to work for as long as they wish and are able to, in satisfying and productive work, continuing to have access to education and training programmes. The empowerment of older persons and the promotion of their full participation are essential elements for active ageing. For older persons, appropriate sustainable social support should be provided.
>
> Article 13: We stress the primary responsibility of Governments in promoting, providing and ensuring access to basic social services, bearing in mind specific needs of older persons. To this end we need to work together with local authorities, civil society, including non-governmental organizations, the private sector, volunteers and voluntary organizations, older persons themselves and associations for and of older persons, as well as families and communities.).

[35] *See, e.g,* David Gelles and Ausytn Gaffney, *'We're in a New Era': How Climate Change Is Supercharging Disasters,* NEW YORK TIMES, (Jan. 15, 2025), https://www.nytimes.com/2025/01/10/climate/california-fires-climate-change-disasters.html.

early October 2024;[36] I found the inclusion of Chapter 15[37] to be forward-thinking and critically important. The author cogently makes a social justice case for fighting climate change, explaining the impact on older people.[38] Having read about the caregiving issues in the U.S., I was quite interested in Chapter 38 written by Amanda Sharkey and Noel Sharkey, discussing the use of robots in caregiving.[39] This is an excellent example of how the field of law and ageing lends itself to academic inquiry with interdisciplinary approach. The authors detail six ethical issues that arise in using caregiving robots that offer intriguing research opportunities.[40]

The Handbook is comprehensive in scope and content and is a useful resource for those in the field of ageing, law, policy, and older people. I only reviewed a few chapters for this review, which is not intended to reflect on the other chapters; the ones included here fit within my theme for this review. If you are working at all in the field with an opportunity for research, you should obtain this book for your library.

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[36] Michaela Mulligan, *Last hurricane season cost Tampa Bay billions. Here's the breakdown.* TAMPA BAY TIMES, (Jan. 15, 2025), https://www.tampabay.com/hurricane/2025/01/15/last-hurricane-season-cost-tampa-bay-billions-heres-breakdown/.

[37] RESEARCH HANDBOOK AGEING, supra note 1, 216-29.

[38] *Id.* at 216-23.

[39] *Id*. at 566-79.

[40] *Id.* at 571-77. ("Sharkey and Sharkey identified six main ethical issues in robot care for older people:

(1) Reduction of human contact.
(2) Increase in feelings of objectification and loss of control.
(3) Loss of privacy.
(4) Loss of personal liberty.
(5) Deception and infantilization.
(6) The circumstances in which older people can control robots.")

For one example of Hollywood's foray into the issue, *see, e.g., Robot and Frank*, WIKIPEDIA, https://en.wikipedia.org/wiki/Robot_%26_Frank (last visited April 21, 2025).

CRIMINAL GRANDPARENTS: HOW THE CRIMINAL JUSTICE SYSTEM IMPACTS INDIVIDUALS LIVING WITH DEMENTIA AND HOW WE SHOULD FIX IT

Stephanie C. Greer

Abstract: The worldwide population of those over the age of sixty is growing quickly and the law is working to catch up. With increased age comes an increased risk of age-related diseases such as various dementias that can lead to criminal behavior. Individuals living with dementia (ILWDs) may experience behavioral changes such as poor impulse control and challenges with executive functioning. Outbursts may be common and many of these symptoms become exacerbated upon law enforcement intervention. Due to a lack of de-escalation and awareness training, actions by law enforcement officers may lead to potentially violent and escalated conflicts with ILWDs. Although changes across the country are necessary, police training is state-specific, and Connecticut has the opportunity to improve mandatory training as a way to protect ILWDs within its borders. Currently, the criminal justice system is used as a means of intervening on behalf of or managing those with dementia; however, this does not serve the interests of punishment, and thus an alternative solution is necessary. To address the issues of violence and arrests by law enforcement, increasing the amount of compulsory training is crucial as forty hours every three years is insufficient to ensure that law enforcement is aware of current recommendations and techniques for de-escalation and aiding those with mental illness. Although training is not a perfect solution, it is a low-cost and readily available option that departments may initiate immediately and is necessary to promote the safety of older adults in Connecticut.

TABLE OF CONTENTS

INTRODUCTION

The population of those over the age of sixty is growing in Connecticut and throughout the world.[1] With increased age comes an increased likelihood of the development of age-related diseases like dementia.[2] Although individuals living with dementia (ILWDs) may have tendencies toward criminal behavior,[3] punishing these individuals does not further our society's goals of punishment and wastes resources that could be reallocated to other care programs. The already-strained court system will face a greater burden as the number of aging adults increases and becomes more diverse in language, ethnicity, race, culture, and education.[4] The courts will be required to accommodate a greater number of cases and a variety of mental health conditions.[5] With larger numbers, there will be more arrests for violent and non-violent crimes and misdemeanors that may involve ILWDs.[6]

Due to a lack of de-escalation and awareness training, actions by law enforcement officers may lead to potentially violent and escalated conflicts with ILWDs. These contentious encounters may turn a search for a wandering ILWD into a criminal charge, leaving an older adult sitting in a jail cell. Arrests are an ineffective and costly means of intervention and are of little benefit to the ILWD or the public. Using the criminal justice system as a means of intervening on behalf of or managing those with dementia does not serve the interests of punishment, and thus, an alternative solution is necessary. To address the issues of violence and arrests by law enforcement, increasing the amount of compulsory training is necessary as forty hours every three years is insufficient to ensure that law enforcement is aware of current recommendations and techniques for de-escalation and aiding those with mental illness.[7]

In Part I, I present an overview of dementia, the various types of dementia, and the challenges physicians face in diagnosing dementia. In Part II, I discuss the connection between dementia and criminally appearing behavior, relying on statistics demonstrating the extent of the connection and arrests. In Part III, I analyze the philosophy of crime as applied to ILWDs to demonstrate that punishing ILWDs does not further the goals of the penal system. In Part IV, I compare Connecticut's training requirements and model policies with those of Washington state. I also address the model policy provided by the International Association of Chiefs of Police (IACP) and present recommendations regarding training for law enforcement.

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[1] *Ageing and Health*, WORLD HEALTH ORG. (Oct. 1, 2022), https://www.who.int/news-room/fact-sheets/detail/ageing-and-health (Between 2015 and 2050, the proportion of the world's population over 60 years will nearly double from 12% to 22%.); *See also Senior Citizens Less Diverse, Growing in Percentage of State's Population*, CONN. BY THE NUMBERS NEWS (Dec. 19, 2017), https://ctbythenumbers.news/ctnews/tag/seniors (The 65 and older population is expected to grow by 56 percent in Connecticut between 2010 and 2040, compared with 1.5 percent growth in the population between ages 20 and 64.).

[2] Rita Guerreiro & Jose Bras, *The Age Factor in Alzheimer's Disease*, 7 GENOME MED. 1, 1 (2015), https://genomemedicine.biomedcentral.com/articles/10.1186/s13073-015-0232-5.

[3] Fei Sun et al., *Police Officer Competence in Handling Alzheimer's Cases: The Roles of AD Knowledge, Beliefs, and Exposure*, 18 DEMENTIA 675 (2017), https://journals.sagepub.com/doi/10.1177/1471301216688605.

[4] *Crime Without Criminals? Seniors, Dementia, and the Aftermath: Hearing Before the Special Committee on Aging*, 108th Cong. 108-31 (2004). (Statement of Max B. Rothman, J.D., LL.M, Executive Director, The Center on Aging, College of Health and Urban Affairs, Florida International University) [*hereinafter* Crime Without Criminals].

[5] *Id.*

[6] *Id*.

[7] CONN. GEN. STAT. § 7-294(d)(a)(9).

I. WHAT IS DEMENTIA?

Dementia, a common illness experienced by older adults, will "continue to ascend in global health importance" as the worldwide population continues to age and effective cures are nowhere to be seen.[8] Dementia is a leading cause of cognitive and functional decline among older adults worldwide; roughly 10% of adults over sixty-five, and as many as 50% of those over eighty-five are ILWDs.[9] Currently, more than six million Americans are living with Alzheimer's Disease (AD), the most commonly diagnosed form of dementia, and many others are living with other forms.[10]

Dementia touches most people's lives in one way or another. In fact, for many, it is incorrectly considered part of the typical aging process.[11] Dementia serves as a general term for "loss of memory, language, problem-solving, and other thinking abilities" that significantly "interfere with daily life."[12] As one ages, mild changes in cognition are normal, such as general forgetfulness, slower processing, and lack of attention. While the symptoms of normal aging and dementia may sound similar, the latter leads to much more severe declines in cognition as the condition progressively affects the nerve cells in the brain.[13] These affects produce additional behavioral and mental changes such as poor memory, becoming lost easily, difficulty engaging in routine problem-solving, poor self-awareness, and unusual and inappropriate behavior.[14] In many ways, dementia takes symptoms of normal aging and magnifies them to an extent that dramatically impacts normal functioning.

As one ages, one develops a greater susceptibility to developing dementia.[15] In studies investigating this relationship, researchers have separated high-income countries from lower-income countries due to the impact of the wealth of a country on available health care and other relevant variables. In high-income countries such as the United States (US), the prevalence of dementia ranges from 5% to 10% in those over the age of seventy, to at least 25% thereafter.[16] The data collected through the US census estimates that about 7% of individuals diagnosed with AD are between sixty-five and seventy-four years old, 53% are between seventy-five and eighty-four years old, and 40% are eighty-five or older.[17]

The preeminent authority and guide for diagnosing mental disorders across the population is the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). The DSM-5 defines dementia as a "Major Neurocognitive Disorder" in the category of Neurocognitive Disorders (NCD). Disorders

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[8] APA Task Force on the Evaluation of Dementia and Age-Related Cognitive Change, APA Guidelines for the Evaluation of Dementia and Age-Related Cognitive Change , APA, (Feb 2021), https://www.apa.org/practice/guidelines/guidelines-dementia-age-related-cognitive-change.pdf.https://www.apa.org/practice/guidelines/guidelines-dementia-age-related-cognitive-change.pdf

[9] *Id.*

[10] Rashmi Goel, *Grandma Got Arrested: Police, Excessive Force, and People with Dementia*, 57 U. RICH. L.REV. 335, 342 (2023).

[11] *Healthy Aging vs. Diagnosis*, U.C.S.F. WEILL INST. FOR NEUROSCIENCES, https://memory.ucsf.edu/symptoms/healthy-aging (last visited Nov. 17, 2023).

[12] *What is Dementia?,* ALZHEIMER'S ASS'N, https://www.alz.org/alzheimers-dementia/what-is-dementia.https://www.alz.org/alzheimers-dementia/what-is-dementia (last visited Nov. 17, 2023).

[13] Marc Blatstein & Fay F. Spence, Chapter 1, *in* REPRESENTING PEOPLE WITH DEMENTIA 3 (Elizabeth Kelly ed. 2022).

[14] Healthy Aging vs. Diagnosis, *supra* note 11.

[15] Guerreiro & Bras, *supra* note 2.

[16] AM. PSYCHIATRIC ASS'N, THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 612 (5th ed. 2013) [*hereinafter* DSM-5].

[17] *Id.*

that fall under the NCD category are those in which "the primary clinical deficit is in cognitive function," and specifically those that are "acquired rather than developmental."[18] While the authors of the DSM-5 note that "cognitive deficits are present in many if not all mental disorders," the NCD category is intended to include only those disorders "whose core features are cognitive" and have "not been present since birth or very early life," and "represent[] a decline from a previously attained level of functioning."[19]

A. DEMENTIA CLASSIFICATIONS

More than just memory loss, there are a variety of dementias, each with unique manifestations and leading to different symptoms. Dementia serves as an umbrella term under which subtypes include: AD, frontotemporal lobe dementia (FTD), Lewy body dementia (LBD), vascular dementia (VD), and dementia associated with Parkinson's Disease (PD). AD is the most common form of dementia, and VD is the second most common.[20]

While each type of dementia is caused by different changes in the brain, many symptoms are similar. Mood changes, impaired and declining functioning, executive function impairment, and vision changes can be present in each form of dementia.[21] Over time, as dementia becomes more severe over time, symptoms and effects of dementia also escalate in severity.[22] With moderate to severe dementias, "psychotic features, irritability, agitation, combativeness, and wandering are common."[23] Certain behaviors and manifestations are seen more frequently in certain types of dementia depending on the cause of the dementia and underlying diagnoses.[24] In PD, apathy, hallucinations, delusions, personality changes, and sleep changes are frequent.[25] With LBD progressive cognitive impairment, recurrent hallucinations, depression, and delusions are more common than in other forms of dementia.[26] Unlike other dementias, in LBD, rather than cognitive impairment manifesting as learning and memory deficits, there are changes in complex attention and executive functioning.[27]

FTD is one of the most common forms of dementia known to create challenges with the law.[28] In addition to its reputation as a legal challenge, FTD is the most common cause of dementia among persons younger than sixty.[29] In FTD, behavioral disinhibition is commonplace and often manifests with "overspending, sexually inappropriate remarks, and socially unacceptable behavior," occasionally leading to a misdiagnosis of bipolar or other psychiatric conditions.[30] Poor self-insight and awareness often lead to delays in medical treatment, and a psychiatrist often provides the first intervention and referral to gerontological care.[31] Rather than prominent

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[18] *Id*. at 591.
[19] *Id*.
[20] What is Dementia?, *supra* note 12.
[21] *Id.*
[22] *Id.*
[23] DSM-5, *supra* note 16, at 612.
[24] *Id.*
[25] *Id.* at 637.
[26] *Id.* at 619.
[27] *Id.*
[28] Hal S. Wortzel, Chapter 7, *in* REPRESENTING PEOPLE WITH DEMENTIA 86 (Elizabeth Kelly ed. 2022) ("the behavioral changes that come with FTD can lead, not infrequently to "violations of both social norms and the law.").
[29] *Id.* at 85.
[30] *Id.* at 88.
[31] *Id.* at 86.

cognitive impairment, "individuals may develop changes in social style, and in religious and political beliefs."[32]

Moreover, a 2015 study investigating the frequency and type of criminal behavior of those with dementia found that violence was more common in those with FTD because this population has a particular "vulnerability to impulsive and disinhibited behavior."[33] Stealing has been reported as a symptom of FTD, creating an increased risk of larceny charges.[34] The most challenging aspect part of FTD is that, while those living with FTD can "understand their actions and sometimes [are] even able to verbalize that they were wrong," they lack the connections in the brain necessary to prevent the recurrence of the inappropriate behavior.[35] Although those with FTD may demonstrate "profoundly disabling brain changes," they often demonstrate normal performance on cognitive tests assessing memory and executive function, including planning goal-oriented activities.[36] While other forms of dementia impair the ability of the ILWD to recognize the wrongfulness of their behavior, dementias such as FTD do not impair the ILWD's capacity in the same way.[37] Because criminal culpability depends on the offender's requisite mental state, or mens rea, satisfaction of this "guilty mind" requirement is much easier in dementias like FTD wherein these individuals retain the ability to articulate right from wrong, even if they do not understand the implications of their behavior.[38]

B. CHALLENGES TO OF DIAGNOSIS

Physicians face significant challenges when diagnosing dementia as there is currently no single test to determine if someone has dementia.[39] In suspected dementia cases, physicians conduct comprehensive medical assessments, which usually include collecting a complete medical history, routine exams, and neurological, psychological, blood, and genetic testing.[40] Cognitive screening measures are used occasionally to identify dementias that may be treatable or reversible, but these tests are not dispositive and are merely screening tools.[41] Diagnostic changes create obstacles, stalling the development of ways to prevent ILWDs from acting illegally, especially when there is a risk to the safety of the ILWD or others.

After struggling to arrive at a diagnosis of dementia, physicians face a more challenging hurdle of narrowing the specific cause or type of dementia. Physicians may only be able to deduce the type of dementia, as some causes are not known. This can make the use of brain scans and diagnostic testing limited if not futile.[42] Additionally, cases of dementia can be classified as "mixed

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[32] DSM-5, *supra* note 16, at 615.

[33] Madeleine Liljegren, *Criminal Behavior in Frontotemporal Lobe Dementia and Alzheimer Disease*, 72 J. AM. MED. ASS'N NEUROLOGY 295, 298–99 (2015); *See* Mario F. Mendez, *The Unique Predisposition to Criminal Violations in Frontotemporal Dementia*, 38 J. AM. ACAD. PSYCHIATRY L. 318, 318 (2010).

[34] *Id.* at 299.

[35] *Id.*

[36] *Id.*

[37] *Id.*

[38] *Id.*

[39] Dana Miller, *Dementia and Competency in United States Courtrooms: A Case Law Review* at 6, CUNY ACADEMIC WORKS, (2020), https://academicworks.cuny.edu/jj_etds/156

[40] *Id.*

[41] Margaret S. Russell & Robert Ouauo, Chapter 5 *Testing*, *in* REPRESENTING PEOPLE WITH DEMENTIA 55, 57 (Elizabeth Kelly ed. 2022).

[42] *Washington State Plan to Address Alzheimer's Disease & Other Dementias*, WASH. STATE DEP'T SOC. & HEALTH SERVS. 28 (2023) ("many primary care practitioners report they are not comfortable making a diagnosis of Alzheimer's or other dementia.") [*hereinafter* Washington Plan].

dementia," meaning that there is more than one dementia affecting the individual.[43] Courts have considered these obstacles in the diagnostic process, especially in considering a person's competency to assist in their own defense under the Fifth Amendment to the US Constitution.[44]

Illustrating the difficulty faced by lay persons and even physicians without a specialty in dementia, *United States v. Rothman* demonstrates the challenges faced by Florida courts when physician-witnesses lack dementia training. If untrained physicians have difficulty recognizing the signs and symptoms of dementia, law enforcement officers without medical licenses certainly struggle to recognize ILWDs and carry lethal weapons.

In this case, the defendant, a physician, Dr. Rothman was indicted for conspiring to commit healthcare fraud.[45] In determining Dr. Rothman's competency, the prosecution and defense each presented physician-witnesses to consider the extent of Dr. Rothman's dementia.[46] Although the prosecution conceded that the defendant likely had dementia, it argued that his dementia was insufficiently incapacitating.[47] The prosecution's witness relied on the inconsistency of the results of Dr. Rothman's cognitive assessments and noted that these "fluctuations could only be the result of Dr. Rothman's intentional suppression of his performance."[48] The defense witness explained that "the inconsistencies in Dr. Rothman's score were just a manifestation of the fluctuations and behavior in persons who suffer from [FTD]."[49] He further concluded that those bothered by the inconsistencies in the defendant's score were "not familiar with the manifestations of frontotemporal dementia or Alzheimer's disease when it primarily affects the frontal lobes likely because the . . . evaluators lacked sufficient training in neuropsychology."[50]

Because of this testimony, the court found that the defendant was not competent to proceed to sentencing due to his dementia.[51] Had a trained physician not testified to the symptoms of dementia, it is possible that the court would have ruled differently.

Ohio courts, like courts in Florida, have also acknowledged the challenges in diagnosing dementia. While *Rothman* considered competency for sentencing, *State v. Ford* heard witness testimony that argued that it was "virtually certain" that the defendant's violent behavior was a result of his FTD.[52] With the assistance of trained physicians, some courts, as in *Ford*, have recognized the role dementias can play in individuals' criminal behavior. Here, Mr. Ford's attorneys argued that he had not been competent to stand trial at the time of his conviction and that his no-contest pleas should not have been accepted.[53] The defense demonstrated that Mr. Ford was living with FTD[54] and offered two physicians' letters, indicating that the criminal behaviors he exhibited were a direct result of "this entity."[55] In addition, in one of these letters, the physician recommended that Mr. Ford be sent to an inpatient mental health facility, rather than jail or prison. [56] While the doctor stated that insanity does not necessarily follow a diagnosis of dementia, he noted the causative and

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[43] *Id.* at 135.
[44] U.S. CONST. amend. V.
[45] No. 08-20895, 2010 U.S. Dist. LEXIS 127639, at *2 (S.D. Fla. Aug. 18, 2010).
[46] *Id.* at *106.
[47] *Id.* at *104
[48] *Id.* at *106.
[49] *Id*.
[50] *Id.* at *107.
[51] *Id.* at *111.
[52] State v. Ford, 2007-Ohio-5722, ¶ 6 (Ct. App.).
[53] *Id.* at ¶ 1.
[54] *Id.* at ¶ 6.
[55] *Id*.
[56] *Id.*

correlative association between FTD and a "lowered threshold for behavior dyscontrol and criminality."[57]

Because the conviction and sentencing had already occurred, the defense faced a high burden of attempting to overturn a conviction.[58] Although the court did not rule in favor of Mr. Ford, this case demonstrates an improved analysis both on the part of courts and physicians as to the broad range and awareness of behavioral symptoms of dementia in the criminal justice system.[59]

I. CRIME

A. EXTENT AND TYPES OF CRIME

It is unlikely that many people picture their grandparents in the back of a police car. How do older adults become involved with the criminal justice system? In the case of dementia, neurological changes in the brain may lead some dementia sufferers to exhibit unusual behavior such as "getting naked in public, wandering away from their home, ignoring traffic signs at an intersection, or becoming violent toward others."[60] The nature of these offenses makes training and awareness more essential. Because many of these behaviors are understandably inappropriate and illegal, or risk the safety of the ILWD or others, neighbors or onlookers are likely to request the intervention of police officers.[61] Statistics show, however, that police are arresting more older adults than in the past, with higher rates of dementia among older adults than any other group, police are arresting more ILWDs.[62] Yet, arrestees can be released and the charges dropped when the dementia comes to light.[63]

When law enforcement recognizes and understands the various manifestations of dementia, police interactions with ILWDs are less likely to escalate and can lead to improved outcomes for both the individual and the officer. In *Edwards v. City of Martins Ferry*, an eighty-two-year-old ILWD brought a civil suit against the city for an officer's use of excessive force and failure to properly train and supervise.[64] Officers were called by neighbors who reported seeing Mr. Edwards urinating in public, a behavior commonly seen in ILWDs.[65] Mr. Edwards had been diagnosed with AD and was simply taking a walk.[66] Because there was no public restroom, Mr. Edwards made sure no one was around, relieved himself in a bush, and then continued his walk.[67] Neighbors called the police, and when the officer approached Mr. Edwards and gave commands, Mr. Edwards did not comply and repeatedly complained that he wanted to go home and that it was hot outside.[68] Thinking that Mr. Edwards was simply being obstinate, the officer escalted the situation by "slamm[ing] him against the hood of the police cruiser" and, while the officer was restraining Mr.

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[57] *Id.*
[58] *Id.* at ¶ 9.
[59] *Id.* at ¶ 15.
[60] Sun et al, *supra* note 3.
[61] *Id*.
[62] Goel, *supra* note 10, at 340.
[63] *Id*.; Edwards v. City of Martins Ferry, 554 F. Supp. 2d 797 (S.D. Ohio 2008).
[64] 554 F. Supp. 2d at 799.
[65] Wortzel, *supra* note 28, at 90.
[66] *Edwards*, 554 F. Supp. 2d at 800.
[67] *Id.*
[68] *Id.*

Edwards, the officer used his taser and "told Mr. Edwards 'The next fucking time I tell you to come here, you'll come here.'"[69]

Despite this violent treatment, the court found against the plaintiff, Mr. Edwards, and granted summary judgment for the officer. In its decision, the court noted that officers cannot legally ignore complaints about the commission of a crime or allow the person committing the crime to walk away because of their age.[70] The court suggested that Mr. Edwards and his family would have preferred that the police allow Mr. Edwards to walk away, rather than follow this law; however, they would likely have preferred a different response from the officer.[71]

After Mr. Edwards was taken to the police station, a different officer, one with experience with ILWDs, spoke calmly with him and concluded that "there was something wrong with him," deciding not to charge him with a crime.[72] The second officer told the court that his concern after noticing Mr. Edward's dementia was to contact his family to help get him home rather than send him to jail, get him home.[73] This is the response many families would want for their loved ones, which can be achieved through appropriate training for law enforcement officers.

With training, the first officer may have recognized that Mr. Edward's behavior is common in ILWDs, especially for those who have experienced changes and deficiencies in their executive function leading to a diminished ability to think and plan.[74] This can lead ILWDs to go about their daily routine, like Mr. Edwards on his walk, but they may easily forget to go to the bathroom before leaving.[75] "When faced with the physical need to urinate, they have no choice but to do it on a roadside or behind a tree."[76]

As discussed in Part I, dementia presents differently depending on its cause and the particular person it affects. In certain types of dementia, sufferers are more prone to criminally appearing behavior.[77] ILWDs often are introduced to the criminal legal system as new arrestees, but data separating the numbers of "persons aging into dementia in the correctional system, and persons entering the criminal legal system with existing dementia" is limited.[78] There have been four relevant factors identified that may explain the reasons older adults can experience the criminal legal system for the first time: family and relationship issues, including the death of loved ones and changes in family dynamics, which may contribute to abuse; substance use; changes in mental health, potentially contributing to aggression, agitation, and inappropriate sexual behavior; and cognitive deficiencies, such as dementia.[79]

To address these first-time offenders, some jurisdictions have created specific diversion programs for criminal offenses by older adults with mental illness, including dementia.[80] Some have suggested that the acceptability of these alternatives depends on whether society considers retribution to be a preeminent justification for criminal punishment, especially when charges and allegations involve violent or felony offenses.[81] As Miller puts it, "The more significant the offense

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[69] *Id.* at 801.
[70] *Id.* at 806.
[71] *Id*.
[72] *Id.* at 801.
[73] *Id.*
[74] Goel, *supra* note 10, at 359.
[75] *Id.*
[76] *Id*.
[77] Liljegren, *supra* note 33, at 295.
[78] David Godfrey, *The Experience of Persons with Dementia in the Criminal Legal System*, 43 J. AM. BAR ASS'N COMM'N L. & AGING 109, 110 (2022-110 110 (2022).
[79] Dawn Miller, *Sentencing Elderly Criminal Offenders,* 7 NAT'L ACAD. ELDER L. ATT'YS 221, 225 (2011).
[80] *Id.* at 230.
[81] *Id.* at 229.

and the more retribution is valued, the less viable such alternative approaches to sentencing appear."[82] As will be discussed in Part III, retribution likely has little application to the justification of punishments for ILWDs. Rather, access to these alternatives may be directly tied to awareness of their existence. One of the more effective ways to ensure this awareness is achieved is through training law enforcement officers to encourage effective interventions, thus avoiding arrests.

B. EMPIRICAL DATA

While it may be difficult to envision one's grandparents in the criminal justice system, it happens frequently. The Federal Bureau of Investigation Crime Data Explorer (FBICDE) notes that in 2022, there were a total of 5,901,2838,075,886 arrests, of which 254,184245,034, or 4.313.03%, of these arrests, were of persons over the age of sixty years of age or older, over an estimated 696 arrests each day.[83] Although 4.31% may seem insignificant, as the population over the age of sixty grows, so too will the number of individuals included in this percentage.[84] In the general population violent arrests make up merely 5.924.07% of total arrests, and the population over sixty accounts for only 4.063.05% of these violent arrests.[85] Table 1 shows that the category of sex offenses is one with the greatest number of arrests among older people with more than 9.27% of arrestees being at least 60 years old and 8% of total arrests of those over the age of sixty, which can be explained through criminal charges such as indecent exposure, and in the case of Mr. Edwards.[86] While it may be surprising that many of the arrests are for sexually based offenses, Rashmi Goel, Associate Professor at Strum College of Law, explains that ILWDs are frequently charged with crimes of public exposure, which are frequently regarded as sexually-based offenses.[87] Symptomatic of certain types of dementia such as FTD, these behaviors can result from hypersexuality, leading some ILWDs to inappropriately "expose themselves or touch others sexually without permission."[88] Public urination is usually classified as indecent exposure, which can happen when ILWDs, like Mr. Edwards, forget to use the restroom before leaving home.[89] While violent crimes such as murder and nonnegligent homicide account for less than one percent 3.02% of arrests of those over the age of sixty,[90] murder cases usually involve an ILWD causing the deaths of family members in a state of delusion and disorientation.[91] Offenses such as resisting arrest or assault may occur after officer intervention when the officer has engaged inappropriately with the ILWD. These cases can be mitigated through appropriate training and recognition of ILWDs. While not all situations are mitigated sufficiently, training is essential for the safety of the IWLD and the officer. In one case, an ILWD was arrested for attempted murder because they shot at a social worker's head.[92] The social worker had approached the ILWD to bring them to a nursing home. While the social worker was not killed, the bullet grazed their head, demonstrating the

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[82] *Id*.
[83] *Crime in the United States Annual Reports: Persons Arrested 2022*, FED. BUREAU OF INVESTIGATION CRIME DATA EXPLORER (2022), https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/ downloads [hereinafter *Persons Arrested 2022*].
[84] Senior Citizens Less Diverse, *supra* note 1.
[85] *Persons Arrested* 2022, *supra* note 83 ("Violent crimes are offenses of murder and nonnegligent manslaughter, rape, robbery, and aggravated assault.").
[86] *See infra* Table 1.
[87] Goel, *supra* note 10, at 358-359.
[88] *Id*.
[89] Often this includes public urination. *See Edwards*, 554 F. Supp. 2d at 806.
[90] *See infra* Table 1.
[91] *Persons Living with Dementia in the Criminal Legal System*, ABA Comm'n on L. & Aging, at 35 (2022), https://www.nri-inc.org/media/0h0fbcju/2022-dementia-crim-just-rpt. pdf.
[92] *Id.*

danger that can be posed by some offenders.[93] Although no solution is perfect, preparation and training can aid in addressing similar situations, even if such situations are infrequent.

II. PUNISHMENT

ILWDs interact with the law in four phases of the criminal justice system: upon arrest, upon adjudication of competency,[94] at trial, and at sentencing. Dementia calls into question current policies and the assessment of this process as our goals of punishment do not comport with the application of the legal system to ILWDs. Rather than reform the legal system as a whole, it is beneficial to both ILWDs and the state to avoid the criminal justice system altogether when not necessary.

Punishing ILWDs may not accomplish the individual and broader societal goals of preventing crime. As for ILWDs punishment may not have the intended effect. Rather, it may have adverse effect; and arrest itself may be sufficient punishment due to its mental and potentially physical costs.[95] Additionally, arrests can directly impede goals, such as isolation, while incapacitation of offenders, which may inhibit access to residential and long-term care facilities.[96]

We need to reform the current system and create alternative forms of punishment. Rather than rebuilding the current criminal legal system, an attainable solution is improving law enforcement training and intervention to connect ILWDs to community resources. These changes must be made and implemented, as the population continues to age, these incidents will continue to grow as well. We must rethink how we as a society handle certain behaviors that either violate the law or are seen as public safety threats, but are in fact a product of dementia. To begin to consider alternative solutions, we must ask ourselves what we are trying to generally achieve through punishment.

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[93] *Id*.

[94] After waiting for a spot in a hospital to become available, a physician performs a competency evaluation. In 2019, there were an estimated 91,000 competency evaluations conducted, about half of which were for people charged with misdemeanors. Hallie Fader-Towe & Ethan Kelly, *Just and Well: Rethinking How States Approach Competency to Stand Trial*, THE COUNCIL OF STATE GOV'TS JUST. CTR., at 3, (Oct. 27, 2020), https://csgjusticecenter.org/publications/ just-and-well-rethinking-how-states-approach-competency-to-stand-trial/.

Dementia, however, is unlike many other mental illnesses that have the potential to improve with medication and therapy. Dementia is progressive and only becomes more debilitating as time passes. The goal of rehabilitation is to eventually release the individual back into society where they can participate fully, but for an ILWD, this is never going to be a reality. *See e.g.* Dusky v. United States, 362 U.S. 402, 402 (1960) (for court's determination of competency). *See also Alzheimer's Stages: How the Disease Progresses*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/in-depth/alzheimers-stages/art -20048448 (last visited Nov. 24, 2023).

In the federal system, a person can be held at the hospital for a maximum of four months to determine whether "there is a substantial probability" that the person will attain "in the foreseeable future" sufficient capacity for the proceedings to continue. If there is such a determination, the court can continue to hospitalize the person for an "additional reasonable period of time," or until the pending charges are dropped. 18 U.S.C. § 4241(d)(1), (2)(A)-(B).

This process is expensive, and yet, during this period, the person has neither been tried, nor rehabilitated and is probably more disoriented due to the change in routine and environment. Meanwhile, it costs the federal or state government about $800 to $1500 per day to provide treatment to patients in forensic hospitals that likely could have been obtained outside of the court system and on an outpatient basis. W. Neil Gowensmith et al., *Lookin' for Beds in All the Wrong Places: Outpatient Competency Restoration as A Promising Approach to Modern Challenges,* 22 PSYCH. PUB. POL'Y & L. 293, 294 (2016); Thea Amidov, *Mentally Ill and Locked Up: Prisons Versus Inpatient Wards for Psychiatric Patients*, PSYCH CENTRAL (Apr. 1, 2015), https://psychcentral.com/ pro/mentally-ill-and-locked-up-prisons-versus-inpatient-wards-for-psychiatric-patients#1.

[95] Christie Thompson, *As Police Arrest More Seniors, Those with Dementia Face Deadly Consequences*, MARSHALL PROJECT (Nov 11, 2022, 5:30 AM), https://www.themarshallproject. org/2022/11/22/police-arrests-deadly-texas-florida-seniors-dementia-mental-health.

[96] Donna Cohen et al., *State Policies for the Residency of Offenders in Long-Term Care Facilities: Balancing Right to Care with Safety*, 12 J. POST-ACUTE AND LONG-TERM CARE MEDICINE 481, 481 (2010).

A. WHY DO WE PUNISH?

Punishment is a social construct that relies on the foundations of religion and philosophy. Although many ILWDs may find that they face no criminal charges, this may be because the interaction with the officer already led to sufficient suffering, as in the case of Mr. Edwards.[97] Others may instead be charged for their illegal acts. While Mr. Edwards had AD, courts have struggled with potential diagnoses of FTD.[98] Because of FTD's impact on impulse control, but not necessarily memory, courts proceed cautiously when considering defendants' abilities to assist in their own defense.[99] The goals of our legal system include ensuring that the accused have legal process and individual criminal culpability leads to punishment.[100]

The US criminal justice system stems from areas of philosophical thought, including utilitarianism and retributivism.[101] From these origins, we derive four main purposes for "punishment": deterrence, rehabilitation, isolation, and retribution.[102] However, despite these influential rationales for "what we do to criminal law offenders, . . . in the final analysis, basically, we punish because it makes us feel good to get even."[103]

These rationales are echoed in the Model Penal Code (MPC), which prioritizes deterrence over rehabilitation and retribution.[104] In addition to these themes, the MPC notes that the recommended sentences and punishments are meant to rehabilitate offenders, provide "fair warning" of the potential sentences, individualize their treatment, coordinate the penal system, promote the use of scientific methods and research in treatment, and centralize the administration of correctional institutions.[105]

Deterrence has little application to ILWDs as it wildly overestimates the cost-benefit analysis that occurs when those who commit crimes act according to these impulses.[106] If the ILWD does not know that what they are doing is wrong or cannot comprehend why they are being punished, or even that what they are experiencing is intended as punishment, punishment for the purpose of deterrence is futile and a waste of resources. The person being punished likely will not remember the punishment at all, and administrative time and resources will have been wasted as a means to an unachievable end.

Rehabilitation aims to provide resources to change behavior, but the way we currently approach these efforts is failing and the population of ILWDs is growing and affecting more people in our society.[107] In the criminal system, dementia may lead to competency problems. The current process of competency determination may not be able to handle certain types of dementia, particularly FTD.

In the current system, when a person has dementia or another mental condition, regardless of their age, whether they are fit to participate in proceedings depends on their "competency," which is determined by a judge by a preponderance of the evidence after considering arguments and

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[97] *Edwards*, 554 F. Supp. 2d at 806.
[98] *Rothman*, No. 08-20895, 2010 U.S. Dist. LEXIS at *2; *Ford*, 2007 Ohio App. LEXIS at ¶6.
[99] *Rothman*, No. 08-20895, 2010 U.S. Dist. LEXIS at *2.
[100] Richard Lowell Nygaard, *On the Philosophy of Sentencing: Or Why Punish?*, 5 WIDENER J. PUB. L. 237, 248 (1996).
[101] *Id.* at 245, 262.
[102] *Id.* at 252.
[103] *Id.* at 249.
[104] MODEL PENAL CODE, foreword (AM. L. INST. PROPOSED OFF. DRAFT 1962) (This code was created in 1962 and, intending to influence the revision and codification of criminal law, led to at least thirty-four states codifying substantive criminal law.).
[105] *Id.* at § 1.02(2)(a)–(h).
[106] Nygaard, *supra* note 100, at 256.
[107] Ageing and Health, *supra* note 1.

evidence from the defendant and the prosecution.[108] Once the court comes to this conclusion, the goal is to "restore" the person to competency.[109] However, this is unrealistic for ILWDs and often leads to ILWDs spending time in jail waiting for an evaluation or a bed at a forensic hospital.[110] Not only does this leave the state or federal government open to liability, but it also worsens the condition of the ILWD.[111] Reforming this process would benefit both the state and the ILWD, but reformation may take an alternative approach to rehabilitation specific to dementias.

Unlike many other mental illnesses that have the potential to improve with medication and therapy, dementia is progressive and only becomes more debilitating as time passes.[112] The goal of rehabilitation is to eventually release the individual back into society where they can participate fully, but for an ILWD, this will never be a reality.

The need to protect society from those who cannot conform to society's rules, and perhaps the safety of others, leads to the principle of incapacitation, which often takes the form of isolation. One can say that isolation and detention are effective, but the offender simply cannot commit other crimes when detained, whether they would do so regardless.[113] For ILWDs and the population at large, isolation can lead to greater harm than benefit.[114] Because many of the offenses committed by ILWDs are nonviolent, isolation in a holding cell in an unfamiliar place can be detrimental to their condition, and is associated with increased aggression and agitation, jeopardizing the safety of the ILWD and the staff of the institution.[115]

Immanuel Kant's retributivist philosophy of punishment originated from the idea that when one commits a crime, one deserves punishment, and that punishment should be proportional to the crime committed.[116] Punishing because of the "wrongfulness" of the action and the violation of social laws is considered "retribution." [117] The balance necessary to bring about the result retributivism intends is difficult to strike, especially when the person committing the crime may not have the ability to understand that such an act was wrong. This goal of "teaching someone a lesson"[118] costs the US an average of more than $38 million each day, just in pretrial holdings.[119] These goals and philosophies of punishment do not serve their purposes when applied to ILWDs in the criminal justice system. In rethinking these goals and the means of achieving them, one must consider whether the criminal justice system must be involved at all. I argue that it does not.

B. IMPACT OF PUNISHMENT

Societal constructs and foundations stemming from our criminal justice system's priorities of deterrence, rehabilitation, isolation, and retribution impact how we treat the criminal behavior of

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[108] 18 U.S.C. § 4241.
[109] *Id.*
[110] In 2017, a man accused of stealing fries and a hamburger spent 55 days in jail waiting for a bed to become available at a state hospital to begin the restoration process. Katie O'Connor, *Psychiatrists, Judges Work to Address Competency to Stand Trial Process*, PSYCHIATRIC NEWS, AM. PSYCHIATRIC ASS'N (July 26, 2021), https://doi.org/10.1176/appi.pn.2021.7.39.
[111] *Id*.
[112] *Alzheimer's Stages: How the Disease Progresses*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/alzheimers-disease/in-depth/alzheimers-stages/art-20048448 (last visited Nov. 24, 2023).
[113] *Id.*
[114] Adesh Kumar Agrawal et al., *Approach to Management of Wandering in Dementia: Ethical and Legal Issue*, 43 INDIAN J. PSYCHOL. MED., no. S5, 2021, at S53, S56.), https://doi.org/10.1177/ 02537176211030979.
[115] *Id.*
[116] Kevin Murtagh, *Punishment*, INTERNET ENCYCLOPEDIA PHIL., https://iep.utm.edu/punishme/ (last visited Feb. 16, 2025).
[117] Nygaard, *supra* note 100, at 262.
[118] *Id*. at 253.
[119] *Pretrial Justice: How Much Does It Cost?*, PRETRIAL JUST. INST. 2 (Jan. 12, 2017) https://portal.ct.gov/-/media/Malloy-Archive/Reimagining-Justice/Reimagining-Justice---Pretrial-justice-at-what-cost-PJI-2017.pdf.

ILWDs, and much of it originates from a lack of understanding. Aside from the harm legal punishment can cause to many ILWDs, such punishment does not serve the purposes of the criminal legal system and is creating a great cost to society.[120] ILWDs and other mental illness] "are better served outside of the criminal justice system," and this can be accomplished through law enforcement training to identify ILWDs and direct them to appropriate resources.[121]

ILWDs are a burden on the criminal justice system due to poor capacity to "rehabilitate" ILWDs, and such attempts come with significant costs. For those living with FTD, it is typical to maintain a "superficial ability to distinguish right from wrong."[122] However, this trait "combined with the proclivity towards illegal behaviors, presents real challenges to the criminal justice system."[123] While general concepts of culpability often depend on prongs, such as knowledge that the act was wrong, but fails to consider "the degraded moral rationality caused by FTD, or the impaired ability to comport behavior with the requirements of the law."[124]

Upon arrest, a person is brought to a police station and is held. During this period, the person has neither been tried, nor rehabilitated and is disoriented due to the change in routine and environment, which can lead to ILWDs exhibiting increased aggression and agitation.[125] This process puts both the ILWD and the officers at risk due to the heightened possibility of escalation. Once a person is brought to court, a fine may be all that is given for someone like Mr. Edwards, but for those with high recidivism, states like Nevada or Georgia impose a mandatory minimum sentence.[126] For many ILWDs, it is unlikely that their behavior will change drastically when considering acts of trespassing or shoplifting unless they are institutionalized or highly supervised, also a means of isolation or incapacitation that can lead to loneliness and depression.[127] Rather than typical isolation or incapacitation in a correctional facility, ILWDs may be admitted to long-term care facilities, however, having a history of criminal behavior, even an arrest, can preclude a person from obtaining admission.[128] In using the criminal justice system as a means of intervention, it forecloses opportunities for support of ILWDs. To ensure this cycle is not exacerbated, law enforcement training would allow for direct communication with diversion programs and resources to avoid an arrest record when unnecessary. The goal of this paper is to consider early interventions and measures that can be taken by law enforcement to hopefully avoid arrests of ILWDs and de-escalate situations effectively when necessary and possible.

III. RECOMMENDATIONS

A. NEED FOR REFORM

The current attitude toward dementias and older adults by enforcement officers is due to a lack of training and education.[129] Police and first responders are relied upon to support community

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[120] *Id.* at 6.
[121] Washington Plan, *supra* note 42, at 27.
[122] Wortzel, *supra* note 28, at 90.
[123] *Id.*
[124] *Id.*
[125] Gowensmith et al., *supra* note 94.
[126] For indecent exposure and public nudity, see NEV. REV. STAT. § 201.220 (2023); GA. CODE. ANN. § 16-6-8 (2023).
[127] Alzheimer's Ass'n, *supra* note 89.
[128] Cohen, *supra* note 96, at 481.
[129] *Crime Without Criminals*, *supra* note 4, at 4 (statement of Rorie Lin Gotham) ("From what I understand, officers who enroll in special courses and go through proper training on how to deal with those who are mentally ill, are shocked of the responsibility

members and are often the first call citizens make in the case of an emergency. However, we have seen a hesitation in recent years to call law enforcement when something goes wrong.[130] With insufficient training on dementia, additional violence may ensue, and older adults can be arrested and remain in jail for months without officer awareness of alternatives.[131] Diversion and community programs vary across states, but the best means of facilitating the connection between ILWDs and community resources upon interaction with law enforcement is effective training. As police power falls to the states, each state may create its programs for law enforcement officers.[132] Although a country-wide reformation is in order, due to governmental constructs, focusing on one state is the most effective way to create tangible change in local communities, which leads to my focus on the state of Connecticut.

There has been a call for additional training for law enforcement officers to improve awareness and understanding of dementia, including by the Supreme Court of Florida.[133] In considering significant reform to its state policies, the State State of Florida held a hearing before its Special Committee on Aging in 2004.[134] At this hearing, Commander Gotham shared how his father and Sheriff's Deputy Brian Litz died due to a deficiency in police training and the mental health system.[135] Commander Gotham had previously called for wellness checks for his father, who was living with dementia, and they had given him great peace of mind regarding his father's safety.[136] When he called for the second check, the Commander told the dispatcher that his father had a gun in the house and was having mental challenges due to his dementia and delusions, ensuring all relevant safety information was provided.[137] However, when Deputy Litz arrived to conduct the wellness check, he was shot and killed by the Commander's father, and "forty-two minutes later, in what is still shielded in confusion, misunderstanding, and lacking in truth, [his] dad, unarmed, was shot and killed in a blaze of gunfire from police and swat teams."[138]

This response is absurd, unnecessary, and horrifying. The death of Deputy Litz is no small matter, and certainly warranted a response. Had the responding officers considered the dispatch notes, wherein the Commander provided relevant information as to his father's condition, perhaps an alternative response would have been considered. Although situations to this extent may be rare, this case illustrates the extent to which law enforcement can escalate a situation, and how officers' behavior may dictate the result of an interaction.

There have been incidents in which officers do not have the requisite training to ensure the safety of those they are meant to protect.[139] Table 3 shows that, so far in 2023, there have been 1030

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they have had on their shoulders. I recently heard second hand of one officer who attended a training session. He stated that he was so enlightened that he wonders how he ever made it through 12 years of service making the tough decisions he had to make. And more importantly he felt that he might have wronged victims due to his lack of this special training earlier in his career.").

[130] *See* Gloria Oladipo, *'We're Tired of Being Beaten': Protestors Across US Call for Justice for Tyre Nichols*, GUARDIAN (Jan. 28, 2023, 11:58 AM), https://www.theguardian.com/us-news/ 2023/jan/28/tyre-nichols-protests-marches-police-violence; *See also* Sam Levin, *'It Never Stops': Killings by US Police Reach Record High in 2022*, GUARDIAN (Jan. 6, 2023, 6:00 AM), https://www.theguardian.com/us-news/2023/jan/06/us-police-killings-record-number-2022.

[131] *Crime Without Criminals*, *supra* note 4, at 51 (statement of Donna Cohen, PH.D., Professor and Head of the Violence and Injury Prevention Program of the Department of Aging and Mental Health at the Louis De La Parte Florida Mental Health Institute at the University of South Florida).

[132] Berman v. Parker, 348 U.S. 26, 32 (1954) ("Public safety, public health, morality, peace and quiet, law and order -- these are some of the more conspicuous examples of the traditional application of the police power to municipal affairs. Yet they merely illustrate the scope of the power, and do not delimit it.").

[133] *Supreme Court Commission Urges Changes to Baker Act,* SUPREME COURT OF FLORIDA (Dec. 28, 1999).

[134] Crime Without Criminals, *supra* note 42, at 1.

[135] *Id*. at 4 (statement of Commander Gary A. Gotham, United States Navy, Woodbridge, VA).

[136] *Id*. at 28.

[137] *Id*. at 7.

[138] *Id.*

[139] Table 3; *Mapping Police Violence*, https://mappingpoliceviolence.us/ (last visited Feb. 13, 2025).

people killed by police, and 5.73% of those deaths are of individuals over the age of fifty-nine.[140] Providing education to law enforcement about dementia and de-escalation tactics can be a highly effective tool to ensure the safety of ILWDs and law enforcement officers.[141]

Studies have shown that training is effective at aiding officers in de-escalating conflicts.[142] The Police Executive Research Forum advocates for a training program that emphasizes the importance of de-escalation tactics and self-awareness for officers.[143] In one study, officers graduating from the program reported 28% fewer incidents where force was used, 26% fewer complaints, and fewer injuries than those without training.[144] In a second study, use-of-force incidents declined by 40%.[145]

B. Police Training and Development of a Comprehensive Policy for Law Enforcement

Common calls received by law enforcement for ILWDs include falls, mistreatment accusations, wandering, and disorderly behavior.[146] It is estimated that 60% of ILWDs will wander from home, and in an unfamiliar environment they can become anxious and hostile.[147] Law enforcement officers often rely on family members to provide information about the ILWD when they receive a call that a person has left home unaccompanied.[148] However, this reliance creates a challenge if the person lives alone, or the person being consulted does not know about the wandering person's dementia diagnosis.[149]

Violent and inappropriate police actions have come to the forefront of media, but excessive force especially impacts ILWDs.[150] If a brain disease is not recognized, police may view a combative dementia sufferer as a threat and respond accordingly.[151] Police brutality towards older adults has drawn attention recently.[152] An article from The Marshall Project notes that older adults are experiencing problems with police officers more frequently as the population ages and a greater number of people develop dementia.[153] Due to the effects that occur in the brain as a result of dementia itself, "[a]ny use of force or arrest can be devastating."[154]

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[140] *Id*.
[141] Factsheet*; Dementia Training for First Responders*, Alzheimer's Impact Movement, (2020), at 1, https://portal.alzimpact.org/media/serve/id/5d23aea86c77c.
[142] Isidoro Rodriguez, *Why Police Training Needs to Evolve–and How,* The Crime Report (Mar. 26, 2021), https://webcf.waybackmachine.org/web/20210326131240/https:/thecrimereport.org/2021/03/26/why-police-training-needs-to-evolve%E2%80% 95and-how/.
[143] *Id.*
[144] *Id.*
[145] *Id.*
[146] Washington Plan, *supra* note 42, at 26.
[147] Factsheet; *Dementia Training for First Responders*, *supra* note 141.
[148] Washington Plan, *supra* note 42, at 26.
[149] *Id.*
[150] *See Amy B. Wang, An 87-Year-Old Woman Carried a Knife Outside to Cut Dandelions. Police Tasered Her.,* Wash. Post (Aug. 17, 2018, 4:03 PM), https://www.washingtonpost.com/ nation/2018/08/17/an-year-old-woman-carried-knife-outside-cut-dandelions-police-tasered-her/.
[151] Thompson, *supra* note 95.
[152] *Id.*
[153] *Id.*
[154] *Id.*.

Illustrating just how detrimental force can be to an older adult, Armando Navejas, an ILWD, wandered away from his home, prompting his wife to call 911 for assistance.[155] When the police found him, he seemed agitated and was uncooperative.[156] The situation escalated when Mr. Navejas threw a piece of wood "limply toward the officer," which landed on the car windshield, bouncing off and leaving the vehicle undamaged.[157] However, when Mr. Navejas turned away, the officer shot a stun gun, hitting Mr. Navejas and causing him to fall face-down on the pavement.[158] After he was brought to the emergency room with fractures and bleeding around his brain,[159] Mr. Navejas never returned home. Yet, the police department found the use of force "reasonable and necessary."[160]

When departmental leadership does not address situations like that of Mr. Navejas, it sets a precedent that other officers follow and condones similar interactions and use of force. These circumstances understandably lead to more arrests and legal interventions. The trend shown by Graph 1 demonstrates that police are arresting 30% more adults over the age of sixty-five than were arrested in 2000, while overall arrests have decreased by 40% since 2000.[161] With the prevalence of dementia among those over the age of sixty, more training is warranted. After police officers in Colorado injured an older woman with dementia who tried to leave a store with items worth fourteen dollars, the officers faced criminal charges and resigned. [162] Additionally, the remaining officers underwent "de-escalation training": a response that should be encouraged more frequently.[163] Although training is beneficial, there is no national standard for police training, and the length and content of the trainings varies widely.[164] When ILWDs commit crimes, police must be aware of the symptoms and risks faced by ILWDs. I will first consider the Model Policy provided by the International Association of Chiefs of Police (IACP). Then, I will compare the Connecticut training requirements for law enforcement to those of Washington State. Arrests are necessary in some circumstances, but it is essential that they are handled appropriately. While training is not a complete solution, it is a step forward.

i. IACP MODEL POLICY

The IACP provides many resources for police in the form of videos, model policies, and pocket cards that officers can keep with them, including "10 Signs & Steps," which provides warning signs that a driver has dementia and tips to respond, and "Alzheimer's Do's and Don'ts."[165] The model policy is dementia and AD-specific, provides a brief overview of the "disease," and outlines initial contact considerations for officers.[166] Despite these guidelines failing to address criminal encounters with ILWDs specifically, they can prevent escalation of the situation and charges

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[155] *Id.*
[156] *Id.*
[157] *Id.*
[158] *Id.*
[159] *Id.*
[160] *Id.*
[161] *See infra* Graph 1, Data graph complied by Jacob Kaplan,.
[162] Leigh Paterson, *The Violent Arrest of a Woman with Dementia Highlights the Lack of Police Training*, NAT'L PUB. RADIO (June 15, 2021, 5:00 a.m.), https://www.npr.org/2021/06/15/ 1004827978/th-violent-arrest-of-a-woman-with-dementia-highlights-the-lack-of-police-traini.
[163] *Id.*
[164] *Id.*
[165] *Alzheimer's Initiatives*, INT'L ASS'N OF CHIEFS OF POLICE (last visited Nov. 21, 2023), https:// www.theiacp.org/projects/alzheimers-initiatives.
[166] Missing Persons with Alzheimer's Disease, Model Policy, INT'L ASS'N OF CHIEFS OF POLICE, 1, 3–4 (2010), https://www.theiacp.org/sites/default/files/all/a/AlzheimersPolicy.pdf.

resulting from such escalation. Although it would be ideal that each officer-ILWD encounter resolved amicably, there are circumstances in which an arrest is appropriate, in which case training relating to these cases would allow such arrests to take place less violently.

This model policy also provides comprehensive questions to ask family or caregivers when investigating missing persons or wandering reports, expediting the speed at which the search can begin, and ensuring a thorough understanding of the subject of the search.[167] The IACP website also provides a guide created by the Alzheimer's Association, specifically to inform and guide law enforcement. While the guide was created in 2006, a majority of the incidents of police violence toward ILWDs mentioned herein occurred after this date.[168] Although there is no way to know specifically the number of departments that have similar model policies, it is unlikely that there is any causal or correlative relationship between this specific policy as currently offered and officer interactions with ILWDs.

While the IACP makes resources such as the model policy available, these resources are not easily accessible. To access these resources, one must first go to "resources" on the website, locate the "Alzheimer's Initiatives" webpage, and sift through over 100 articles. It was far easier to search specifically for Alzheimer's resources. One of the many benefits of compulsory training is that it is just that: compulsory. It is accessible and required, rather than an optional search of the Alzheimer's Initiatives webpage tucked away on the IACP website. While the model policy provides a guide for law enforcement to improve their understanding of interacting with ILWDs, it does not recommend any form of mandatory training.

ii. CURRENT CONNECTICUT POLICY AND TRAINING REQUIREMENTS

The Connecticut Police Officer Standards and Training Council (POST) has adopted a model policy for "handling missing persons investigations."[169] Like the IACP model, this policy does not recommend any training for officers, but it does provide resources for officers to consult when investigating missing persons reports, such as SILVER Alert, and the necessary criteria for law enforcement to consider.[170] It is disappointing that Connecticut has not developed a mental-health specific model policy, as much of the information contained in the policy applied to mental health incidents and considerations.

Although the model policy does not require training, state law requires law enforcement to receive mental health and de-escalation training.[171] In basic training, officers attend a total of twelve hours of training on awareness and interactions with those living with mental health conditions.[172] This is far from sufficient training, especially for those officers with no prior training on this issue in their new capacity as law enforcement. Additionally, as of October 2023, when officers become certified, they must renew their certification every three years, which requires a demonstrated forty hours of review training on mental health[173] which can be completed remotely through a computer program.[174]

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[167] *Id.* at 2.
[168] *See Edwards*, 554 F. Supp. 2d at 800; Thompson, *supra* note 95; Paterson, *supra* note 162.
[169] Conn. Police Officer Standards & Training Policy for Handling Missing Persons Investigations, CONN. POLICE OFFICERS STANDARDS AND TRAINING COUNS, 1 (2012), https://portal.ct.gov/-/media/POST/GENERAL_NOTICES/2016/GN1206POSTPolicyforHandlingMissingPersonsInvestigationspdf.pdf.
[170] *Id.*
[171] CONN. GEN. STAT. § 7-294(o), (v).
[172] Basic Training Curriculum Final Revision 2015, CONN. POLICE OFFICER STANDARDS AND TRAINING COUNS. (2023).
[173] CONN. GEN. STAT. § 7-294(d)(a)(8).
[174] *See id.* § 7-294(d)(a)(9).

Despite the importance of mandatory training, the length of time required for training and the method of delivery are insufficient to adequately meet the needs of the community. Computer training is demonstratively less effective than in-person training.[175] As teachers around the world have agreed post COVID-19, "a computer is no match for a classroom,"[176] and when citizens' lives are at stake, this is hardly a risk that society can afford to take.

Connecticut has made advances lately with an amendment to previous training requirements through Public Act 22-64, including a requirement for a new training curriculum.[177] Connecticut has also recently adopted "Bring Me Back Home," (BMBH), a voluntary registration system that allows families to register their wandering relatives.[178] This program asks that caregivers call 9-1-1 in the case of wandering and tell the dispatcher that the missing person is registered with BMBH to alert first responders that the person has dementia or a related mental condition.[179] While this program sounds like a great initiative, it has not yet been established,[180] and its efficacy cannot be evaluated. Even if the program was instituted, first responders would have to know what to do with the mental health information to safely bring the person home. Training would allow for synergy between these programs.

iii. WASHINGTON STATE TRAINING REQUIREMENTS

Washington State's laws regarding officer training are regarded as the most progressive in the country.[181] According to Justice in Aging, the plan notably includes an approach encompassing many different health and wellness providers, staff involvement in the development of training programs, and a curriculum with examinations to ensure mastery of the content and requirements for continuing education.[182]

During a 2023 Dementia Action Collaborative meeting in Washington State, police officers noted that officers face challenges when responding to calls from and on behalf of ILWDs. [183] Police may inadvertently leave an ILWD at home alone without needed supervision or support because there is no reliable way to ascertain whether the person who needs to be transported is an ILWD or the caregiver for an ILWD.[184] The Alzheimer's Association notes that "an overarching gap is a lack of dementia-specific training and knowledge of local resources available to help this population."[185]

Washington requires a greater number of mental health training hours in basic training for law enforcement than Connecticut does,[186] yet Connecticut has a greater population of older adults by

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[175] Li-Kai Chen et al., *Teacher Survey: Learning Loss is Global – and Significant*, MCKINSEY & CO., (March 1, 2021).
[176] *Id.*
[177] CONN. GEN. ASSEMBLY, PUB. ACT 22-64
[178] *Bring Me Back Home*, CONN. STATE DEP'T EMERGENCY SERVS. & PUB. PROT. https://portal.ct.gov/DESPP/Division-of-Emergency-Service-and-Public-Protection/Bring-Me-Back-Home. (last visited Nov. 24, 2023, 9:04 a.m.)
[179] *Id.*
[180] *Id.*
[181] Georgia Burke & Gwen Orlowski, *Training to Serve People with Dementia: Is our Health Care System Ready?*, JUST. IN AGING (Aug. 2015), https://justiceinaging.org/wp-content/uploads/2015/ 08/Training-to-serve-people-with-dementia-Alz5_FINAL.pdf.
[182] *Id.*; WASH. ADMIN. CODE § 388-112-0132 (2013).
[183] Washington Plan, *supra* note 42, at 26—27.
[184] *Id*. at 29.
[185] *Id*.
[186] Connecticut requires 8 hours in basic training, while Washington requires 200 hours. WASH. ADMIN. CODE § 139-11-020.

1.5%.[187] While the recertification hours are the same for both states, forty hours every three years,[188] this number is not sufficient to ensure the safety of the rapidly increasing population of older adults.

Although the number of hours is not ideal, unlike Connecticut's, Washington's Administrative Code § 139-11-020(2) requires specific training topics such as tactics to reduce escalation that may lead to violence and evoke situations requiring the use of force. These tactics include managing the distance between the officer and the "subject," and engaging in communication with the person.[189] Washington's code also recognizes that officer self-awareness can mitigate poor response and encourage appropriate action by the officer, which can be taught by an appropriate authority.[190] An important requirement specifically for police interaction with ILWDs is mandating training on alternative programs and options to prevent jail and arrest.[191]

C. ACTION STEPS

While there is no consensus on the amount or the form of mental health training that is required for law enforcement,[192] Connecticut must prioritize the safety of the public that law enforcement is intended to protect. The state should require more frequent training of law enforcement officers, perhaps including a specific interval at which training must be completed, such as bi-monthly or even bi-annually.[193] Because medicine and science are constantly evolving, recommendations three years in the future may be vastly different from those of today. Additionally, Connecticut law should outline the necessary curriculum for this training similar to those topics enumerated in the Washington statutes.[194]

While arresting and holding citizens is expensive,[195] there is no-cost law enforcement and first responder training offered by many organizations such as the Alzheimer's Association[196] and the IACP.[197] The IACP program is administered in person and offers a train-the-trainer option, which allows individual departments to certify an officer to then conduct training for the team.[198] While the IACP training's format may create barriers to training initially, once an officer from that team is certified, access is constant. The training from the Alzheimer's Association is online and easily accessible. The use of these programs would also ensure compliance with topics required by statute, further reducing barriers to administering training to officers. The certificate awarded after the passage of a final quiz allows easy oversight and verification of completion by the police

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[187] Persons 65 and over, Connecticut – 18.3%, Washington – 16.8%, as of the 2020 census. *QuickFacts, Connecticut*, U.S. CENSUS BUREAU, (2020), https://www.census.gov/quickfacts/ fact/table/CT#; *QuickFacts, Washington*, U.S. CENSUS BUREAU, (2020), https://www.census.gov/ quickfacts/fact/table/WA/PST045222.

[188] WASH. ADMIN. CODE § 139-11-020(2).

[189] *See id.* § 139-11-020(1)(a)(i), (iv).

[190] *See id.* § 139-11-020(1)(b)-(e).

[191] *See id.* § 139-11-020(1)(r).

[192] Audie Cornish et al., *The State of Police Training in the U.S.*, NAT'L PUB RADIO (Apr. 27, 2021, 4:07 P.M.), https://www.npr.org/2021/04/27/991343004/the-state-of-police-training-in-the-us.

[193] Burke & Orlowski *supra* note 181.

[194] WASH. ADMIN. CODE § 139-11-020(2).

[195] Amidov, *supra* note 94.

[196] *Approaching Alzheimer's: First Responder Training*, ALZHEIMER'S ASS'N, https://training.alz.org/products/4021/approaching-alzheimers-first-responder training?_gl=1*1v0qsuv*_ga*MTQ5ODgyMjIwNi4xNjk5NjQ1OTcw*_ga_9JTEWVX24V*MTcwMDg0MTc1Ny4xMi4wLjE3MDA4NDE3NTcuNjAuMC4w (last visited Nov. 24, 2023)

[197] *Alzheimer's Training Center*, INT'L ASS'N CHIEFS POLICE, https://www.theiacp.org/alzheimers-training-center. (last visited Nov. 24, 2023).

[198] *Id.*

administration. Not only will these measures ensure improved knowledge by law enforcement, but they have economic benefits as well.

IV. CONCLUSION

Connecticut has the opportunity to improve mandatory training as a way to protect ILWDs within its borders. As the population ages, age-related mental illnesses, such as dementia, will become increasingly common.[199] Despite the propensity for criminally appearing behavior committed by ILWDs,[200] processing ILWDs through the criminal justice system does not further society's philosophical goals of punishment and wastes valuable resources that could be reallocated to programs such as law enforcement training. Such programs may also improve law enforcement's social approval and promote the community's welfare by leading to the de-escalation of potentially violent conflicts and enhanced trust.

Forty hours in three-year intervals is insufficient to bring about these benefits.[201] Because medical and scientific recommendations are constantly evolving, first responders with frequent contact with ILWDs must understand the signs and symptoms of the disease and ways to approach interactions with ILWDs. Although training is not a perfect solution, it is a low-cost and readily available option that departments may initiate immediately and is necessary to promote the safety of older adults in Connecticut.

[199] Guerreiro & Bras *supra* note 2.
[200] Sun, Gao, Brown & Winfree, Jr, *supra* note 3.
[201] CONN. GEN. STAT. § 7-294(d)(a)(9).

APPENDIX

Table 1

Crime	Total Male Arrests	Total Female Arrests	Total Arrests	Male 60+	Female 60+	Total Arrests 60+	% Total 60+
Murder and nonnegligent manslaughter	8,901	1,146	10,047	287	36	323	3.21%
Rape	15,470	460	15,930	831	7	838	5.26%
Robbery	40,378	7,429	47,807	597	68	665	1.39%
Aggravated assault	211,559	63,940	275,499	10,164	2,190	12,354	4.48%
Burglary	79,225	18,565	97,790	2,079	381	2,460	2.52%
Larceny-theft	288,105	180,734	468,839	12,770	6,952	19,722	4.21%
Motor vehicle theft	49,466	13,876	63,342	743	121	864	1.36%
Arson	5,910	1,801	7,711	325	66	391	5.07%
Other assaults	533,132	232,684	765,816	25,829	7,809	33,638	4.39%
Forgery and counterfeiting	16,117	7,198	23,315	543	135	678	2.91%
Fraud	40,834	21,301	62,135	1,664	564	2,228	3.59%
Embezzlement	4,060	3,720	7,780	116	90	206	2.65%
Stolen property; buying, receiving, possessing	53,807	14,020	67,827	1,000	167	1,167	1.72%
Vandalism	101,371	30,483	131,854	3,180	829	4,009	3.04%
Weapons; carrying, possessing, etc.	132,860	13,925	146,785	2,894	240	3,134	2.14%
Prostitution and commercialized vice	5,349	7,106	12,455	448	112	560	4.50%
Sex offenses (except rape and prostitution)	18,742	1,079	19,821	1,804	34	1,838	9.27%
Drug abuse violations	538,712	188,034	726,746	16,863	3,402	20,265	2.79%
Gambling	811	292	1,103	68	41	109	9.88%
Offenses against the family and children	24,644	13,421	38,065	781	298	1,079	2.83%
Driving under the influence	463,775	158,569	622,344	31,585	9,449	41,034	6.59%
Liquor laws	52,026	24,343	76,369	2,735	573	3,308	4.33%
Drunkenness	11,475	2,849	14,324	799	173	972	6.79%
Disorderly conduct	137,093	56,356	193,449	8,317	2,204	10,521	5.44%
Vagrancy	9,722	2,951	12,673	860	170	1,030	8.13%
All other offenses (except traffic)	1,464,947	520,800	1,985,747	73,249	17,541	90,790	4.57%
Suspicion	52	10	62	1	-	1	1.61%
Curfew and loitering law violations	3,855	1,793	5,648	-	-	-	0.00%
TOTALS	**4,312,398**	**1,588,885**	**5,901,283**	**200,532**	**53,652**	**254,184**	**4.31%**

% total arrests of those 60+ to total arrests all ages	4.31%
% total 60+ violent arrests to all 60+ arrests	5.58%
% total 60+ violent arrests to violent arrests all ages	4.06%
% total violent all ages compared to total arrests all ages	5.92%

***Reminder that one person can be arrested multiple times

***According to the FBI, violent crimes include murder, nonnegligent manslaughter, robbery, rape, and aggravated assault

Table 2

Violent crime by age

key	value		
20 to 29	232451	Under 20	15.54%
30 to 39	194835	20 - 39	48.58%
10 to 19	134576	40 - 59	18.36%
Unknown	125809	60+	3.22%
40 to 49	101386		
50 to 59	60138		
60 to 69	21569		
70 to 79	4883		
0 to 9	2110		
80 to 89	1095		
90 to Older	741		

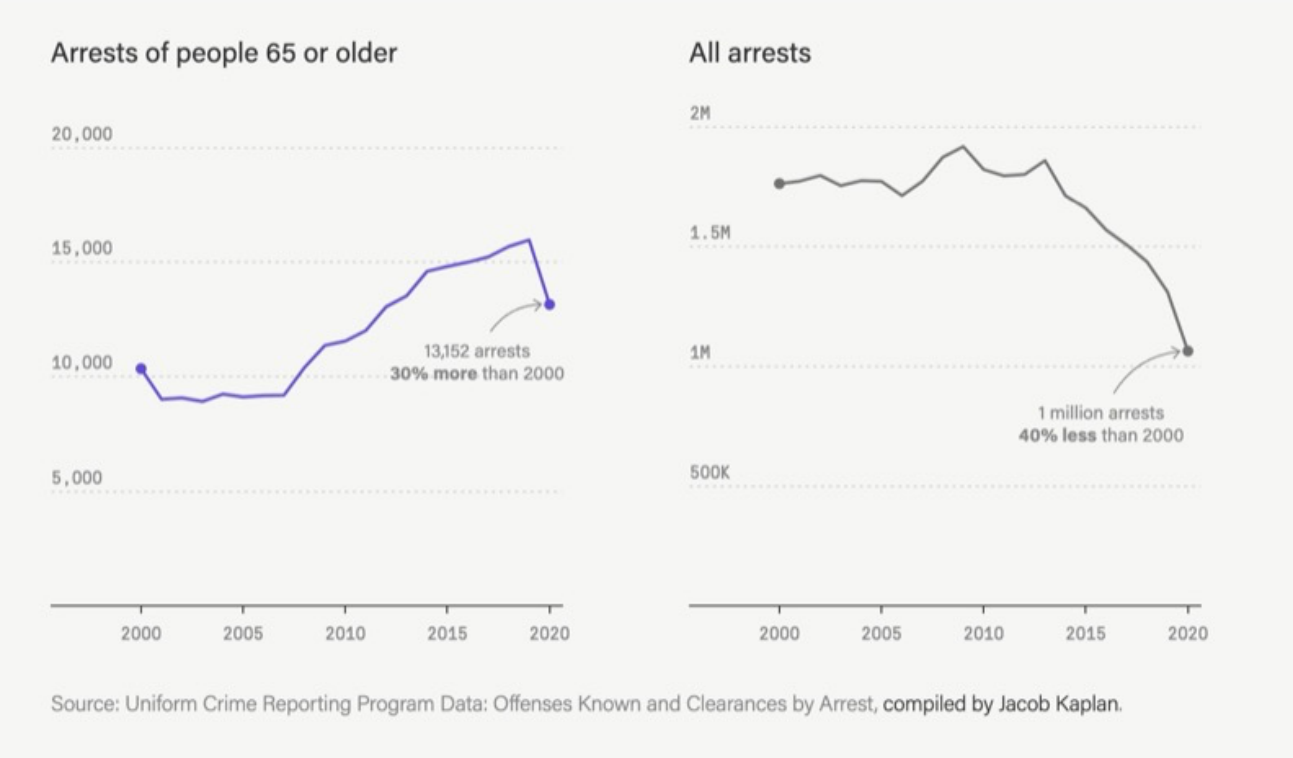
Total # Crimes	879593
# Crimes +60	28288
% Crimes +60	3.22%

*https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/explorer/crime/crime-trend

Table 3

	Police Killings of Persons age 60 and over			
60	7		% over 60	5.73%
61	4			
62	3		Total killed	1030
63	5			
64	5			
65	5			
66	8			
67	3			
68	3			
69	2			
70	1			
71	0			
72	0			
73	2			
74	1			
75	2			
76	3			
77	0			
78	2			
79	0			
80	0			
81	0			
82	1			
83	1			
84	0			
85	0			
86	1			
87	0			
88	0			
89	0			
90	0			
91	0			
92	0			
93	0			
94	0	* data synthesized from https://mappingpoliceviolence.us/		
95	0			
96	0			
97	0			
98	0			
99	0			
100	0			
Total	59			

Graph 1


Arrests of people 65 or older
20,000
15,000
10,000
5,000
13,152 arrests
30% more than 2000
2000
2005
2010
2015
2020
All arrests
2M
1.5M
1M
500K
1 million arrests
40% less than 2000
2000
2005
2010
2015
2020
Source: Uniform Crime Reporting Program Data: Offenses Known and Clearances by Arrest, compiled by Jacob Kaplan.

ELDER LAW RESEARCH:
AN UPDATED BIBLOGRAPHY

This bibliography is an update of the work published in Volume 16 of the Journal of Aging Law and Policy. While earlier volumes addressed elder law from an international perspective, Volume 16 narrows its focus exclusively to developments in U.S. elder law. This bibliography is intended to serve elder law practitioners, legal scholars, and policymakers who concentrate on the American legal landscape as it relates to aging.

As an update, this bibliography highlights recent publications and resources, supplementing the foundational material compiled in Volume 16. The selected sources reflect evolving legal issues, policies, and practices affecting older adults in the United States, including legislation, case law, long-term care, guardianship, retirement planning, and elder abuse prevention.

A wide variety of search terms may be used to locate U.S.-based elder law resources, including but not limited to:

Aged-legal status

- Elder abuse
- Elder law or elderlaw
- Geriatrics
- Gerontology
- Guardians
- Legal assistance to the aged
- Long-term care
- Nursing homes
- Older people
- Retirement
- Retirement Communities
- Senior Law

Materials in this bibliography are arranged in the following categories:

- Agencies and Organizations that focus on elder law issues.
- Conventions, Documents, and Reports relating to elder law.
- Websites, and Databases with a specific elder law focus.
- Web Bibliographies that provide additional resources related to elder law.
- Journal Articles that provide references to articles and titles focusing on elder law.
- Cases that provide emerging case law from areas within elder law such as benefits eligibility, and probate law.

It should be noted that this is a selective bibliography, and no attempt has been made to include every agency, organization, convention, document, report, database, web site, article, or book relating to elder law. Given the tremendous growth in resources in the area of elder law, such an undertaking is beyond the scope of this bibliography. Rather, this bibliography is intended to serve as an overview of materials published in this field and to provide a starting point for further research in elder law. The Authors welcome your comments and suggestions regarding this project.

Agencies and Organizations

AARP
https://www.aarp.org/

A nonprofit dedicated to supporting the rights and well-being of individuals aged 50 and older. AARP offers resources and services related to health, financial security, and advocacy, along with a variety of member discounts and benefits.

1601 E Street, NW, Washington DC 20049
Phone: 1-888-OUR-AARP (1-888-687-2277)
Email: member@aarp.org

ABA COMMISSION ON LAW AND AGING
https://www.americanbar.org/groups/law_aging/

The Commission on Law and Aging is dedicated to educating and advocating for the protection of older adults' rights and dignity. It offers legal resources focused on aging, developed through collaboration between public and private legal organizations and the broader aging services network.

1050 Connecticut Ave. NW, Suite 400, Washington, DC 20036,
Phone: (202) 662-8690
Email*:* aging@americanbar.org

NATIONAL CENTER ON ELDER ABUSE (NCEA)
https://ncea.acl.gov/home#gsc.tab=0

NCEA offers resources on research, training, policy, and best practices for preventing and addressing elder mistreatment—including physical, emotional, sexual, financial abuse, and neglect. The organization promotes education, data collection, legal and policy initiatives, and collaborative outreach efforts.

1201 15th St NW #400, Washington, DC 20005*,*
Phone*:* 1-855-500-3537
Email*:* ncea-info@acl.hhs.gov

SENIOR FRIENDSHIP CENTER
https://friendshipcenters.org/location/sarasota-friendship-center/

This organization provides a wide range of activities including classes, exercise sessions, arts and crafts, live music, and social events to foster community and engagement. Serves nutritious weekday lunches to promote seniors' health and well-being. Offers educational programs that support lifelong learning and personal growth. Delivers daytime care for older adults with cognitive or physical challenges, giving caregivers a much-needed break. Assists with applications for Medicare, Medicaid, and SNAP, and offers access to

legal consultations and support groups. Also provides emergency financial assistance, helping seniors with rent, utility bills, and other urgent needs.

Sarasota, Venice, Charlotte, Desoto, & Lee Counties in Florida
Phone: (941) 955-2122

THE CENTER FOR MEDICARE ADVOCACY
https://medicareadvocacy.org/about/

The Center is a national nonprofit legal organization dedicated to advancing access to comprehensive Medicare coverage, promoting health equity, and ensuring quality healthcare for older adults and individuals with disabilities. Established in 1986, the Center focuses on legal assistance, advocacy, education, policy analysis, and impactful litigation, particularly for those with chronic and long-term health conditions. It operates out of offices in Connecticut and Washington, D.C.

P.O. Box 350; Willimantic, CT 06226
Phone: 860-456-7790
Email: mshepard@medicareadvocacy.org

FLORIDA ALLIANCE FOR ASSISTIVE SERVICES & TECHNOLOGY
https://faast.org

Provides assistive technology support to Floridians with disabilities and their families. The program offers a variety of services—including device loans, demonstrations, reuse programs, and training—to help ensure access to the latest assistive technology throughout the state.

Tallahassee Florida
Phone*:* 1-877-506-2723
Email*: Info@FAAST.org*

ELDER JUSTICE COALITION
https://elderjusticecoalition.com/

This nonpartisan coalition, founded in February 2003 alongside the introduction of the Elder Justice Act, includes 3,000 members across all generations. Made up of individuals and organizations, it serves as a key resource for Congress, the Administration, media, and the public to raise awareness of elder abuse, neglect, and exploitation, and to advocate for strong national policies to address the crisis.

Elder Justice Coalition
1612 K. Street NW #200
Washington, DC 20006
Email: info@elderjusticcecoalition.com

Conventions, Documents, and Reports

Conventions

UN CONVENTION ON THE RIGHTS OF OLDER PERSONS
https://social.un.org/ageing-working-group/documents/Coalition%20to%20Strengthen%20the%20Rights%20of%20Older%20People.pdf

> This convention advocates for the establishment of a legally binding United Nations convention to safeguard the rights of older adults, aiming to fill the gap in current international human rights law. It underscores the growing global aging population and stresses the importance of ensuring adequate income, employment opportunities, and access to health and social services for older individuals.

Documents & Reports

WORLD HEALTH ORGANIZATION (WHO) GLOBAL REPORT ON AGEISM (2021)
https://iris.who.int/bitstream/handle/10665/340208/9789240016866-eng.pdf?sequence=1

> This global report explores the definition and effects of ageism, particularly in the context of the COVID-19 pandemic. It reviews existing policies and laws aimed at addressing ageism, highlights current educational initiatives, and outlines future actions needed to combat age-based discrimination and promote equity moving forward.

FLORIDA CARE PLANNING COUNCIL
https://www.careforflorida.org/list11_florida_senior_centers.htm

> This report lists senior centers in Florida, depicted by county.

REPORTING OF SUSPECTED ELDER FINANCIAL EXPLOITATION BY FINANCIAL INSTITUTIONS
https://files.consumerfinance.gov/f/documents/cfpb_suspected-elder-financial-exploitation-financial-institutions_report.pdf

> This update to the 2016 Advisory Recommendations for Financial Institutions on Preventing and Responding to Elder Financial Exploitation emphasizes Recommendation 4, which addresses the importance of reporting suspected elder financial abuse to the appropriate local, state, or federal authorities. It reinforces key guidance from the original advisory, particularly in light of ongoing uncertainty among financial institutions about reporting such incidents due to privacy concerns.

Websites and Databases

Websites

CENTER FOR ELDER LAW AND JUSTICE
https://www.elderjusticeny.orgSummary

> The organization works to improve the quality of life for older, disabled, and low-income adults by providing free legal services, primarily in Western New York.

BRITISH COLOMBIA LAW INSTITUTE CANADIAN CENTRE FOR ELDER LAW
http://elder-law.ca

> The BCLI carries out law reform initiatives that serve the public interest. By partnering with academics, experts, and community members, it works to clarify and enhance the law, create innovative and inclusive solutions, and promote greater access to justice.

THE ELDER AND DISABILITY LAW CENTER DC
https://www.edlc.com

> Resources for elderly people who need Elder Law resources in Washington D.C. including life care planning and management, Medicaid Planning and Eligibility, Guardianships and Conservatorships, Probate, Trust Administration, Special Needs Trusts, Disability planning and more.

ELDER JUSTICE INITIATIVE
https://www.justice.gov/elderjustice

> The mission of the Elder Justice Initiative is to support and coordinate the Department's efforts in enforcing and implementing programs aimed at preventing elder abuse, neglect, and financial fraud and scams targeting older adults in the United States.

US AGING
https://www.usaging.org/initiatives

> US Aging offers a broad range of services provided by its members to support older adults, individuals with disabilities, and caregivers. This includes enhancing health and quality of life, assisting those with chronic conditions, and developing and coordinating community-based and home services.

CENTER FOR ELDERS AND THE COURTS (CEC)
https://www.eldersandcourts.org/

> The Center for Elders and the Courts (CEC), part of the National Center for State Courts, serves as a key resource for the judiciary and court administrators on aging-related issues. The center aims to raise judicial awareness of aging concerns, offer training and

resources to enhance court responses to elder abuse and adult guardianships, and foster a collaborative community of judges, court personnel, and aging specialists.

NATIONAL INSTITUTE OF AGING
https://www.nia.nih.gov/health/elder-abuse

This institute has spearheaded extensive scientific research to understand the aging process and promote longer, healthier, and more active lives. Additionally, the NIA is the leading federal agency supporting and conducting research on Alzheimer's disease and related dementias.

LONG TERM CARE OMBUDSMAN PROGRAM
https://ombudsman.elderaffairs.org/

This Florida agency works to enhance the quality of life for all long-term care residents in the state by advocating for and safeguarding their health, safety, well-being, and rights.

DISASTER RESOURCES FOR OLDER ADULTS & PEOPLE WITH DISABILITIES
https://www.disasterassistance.gov/get-assistance/forms-of-assistance/4505

This federal agency's website offers resources and assistance for older adults and individuals with disabilities before, during, and after natural disasters.

FLORIDA DEPARTMENT OF ELDER AFFAIRS
https://elderaffairs.org/

This federal agency's website offers resources and support for older adults and individuals with disabilities, including food assistance, Medicaid information, and elder abuse hotlines.

VA GERIATRICS AND EXTENDED CARE
https://www.va.gov/geriatrics/

This federal agency's website provides resources and support for older veterans, including assistance with aid and attendance and long-term care.

<u>Databases</u>

ELDERCARE LOCATOR
https://eldercare.acl.gov/

Created by the U.S. Administration on Aging, the Eldercare Locator is a nationwide service that connects older Americans and their caregivers with reliable local resources. It helps users find services like meals, home care, transportation, and caregiver support, making it easier to access state and community-level assistance.

Web Bibliographies

ELDER LAW RESEARCH GUIDE: JOURNALS
Published by Loyola University Chicago Law School
https://lawlibguides.luc.edu/c.php?g=610779&p=4239338

SELECTIVE BIBLIOGRAPHY OF ELDER LAW MATERIALS
Published by the University of Georgia
https://digitalcommons.law.uga.edu/law_lib_rg/7/

ELDER LAW: ORGANIZATIONS AND CURRENT AWARENESS
Published by Florida State University College of Law
https://guides.law.fsu.edu/c.php?g=539084&p=3772181

Journal Articles

PRIVATE LONG-TERM CARE INSURANCE: NOT THE SOLUTION TO THE HIGH COST OF LONG-TERM CARE FOR THE ELDERLY
https://publish.illinois.edu/elderlawjournal/files/2016/02/Frolik.pdf

> This article explores why few elderly Americans purchase Long-Term Care Insurance (LTCI), despite the high costs of long-term care. It outlines the rational reasons behind this trend, including limited need, Medicaid as a safety net, high premiums, and insufficient coverage. It also examines how changing care preferences and policy design affect decisions. The article concludes by proposing a policy solution: making LTCI mandatory to better distribute costs and reduce Medicaid reliance.

APPROPRIATE HOUSING FOR OLDER CLIENTS
https://scholarlycommons.law.hofstra.edu/acteclj/vol46/iss1/10

> This article offers estate planners guidance on helping clients evaluate their current and future housing needs as they age. It emphasizes the importance of discussing age-appropriate housing, exploring options like downsizing, renting before relocating, or moving into age-restricted communities. The article also highlights key factors to consider, including physical and mental health, financial situation, and long-term suitability of different housing arrangements.

CHALLENGING PREVENTATIVE CARE, THE ACA'S PHILOSOPHY OF ACCESS AND DEFERENCE TO SCIENTIFIC EXPERTISE: IMPLICATIONS FOR A HEALTHY AGING POPULATION
https://theelderlawjournal.com/wp-content/uploads/2025/02/Gluck.pdf

> This article explores the Affordable Care Act's (ACA) mandate for preventive services, which requires insurers to cover these services without cost-sharing. It analyzes the legal challenges to this mandate, with a particular focus on the case of *Braidwood Management Inc. v. Becerra* and places these challenges within the larger context of debates surrounding healthcare policy and the administrative state.

Cases

Federal

Health & Hosp. Corp. v. Talevski, 143 S. Ct. 1444 (2023)
In a 7-2 ruling, the U.S. Supreme Court determined that private individuals can file lawsuits against public nursing homes under 42 U.S.C. §1983 for violations of patient rights established by the Federal Nursing Home Amendments Act of 1987 (FNHRA). Justices Thomas and Alito dissented.

Massachusetts

Dermody v. Exec. Office of Health & Human Servs., 201 N.E.3d 285 (Mass. 2023)
The Massachusetts Supreme Judicial Court ruled that the Executive Office of Health and Human Services is the beneficiary of an annuity purchased by a husband to qualify his wife for Medicaid.

Nebraska

Koetter v. Meyers (In re Estate of Koetter), 980 N.W.2d 376 (Neb. 2022)
Koetter, aged 88, passed away in 2017, and his son filed a petition to probate his father's 2014 will. Koetter's daughter contested the will, claiming it was partially the result of undue influence. Over the previous 14 years, Koetter had executed several wills, but his final will represented a significant departure from the terms of his earlier ones. At the time the will was executed, Koetter required physical and medical care from family members and neighbors, and he had become agitated and restless. The court concluded that undue influence was present.

Illinois

Estate of Watts v. Watts, 456 Ill. Dec. 608, 193 N.E.3d 848 (2022)
Watts, a disabled adult, had a guardian ad litem (GAL) appointed, and after his death, the GAL petitioned the court for the payment of fees from the Legal Aid Society's involvement in the case, which the trial court approved. However, the Appellate Court reversed the decision, ruling that the trial court lacked the authority to assess fees under §11a-10c of the Illinois Probate Act when the person under guardianship is unable to pay and when the party being directed to pay falls under a statutorily exempt category, such as APS.

Iowa

Driesen v. Kerr-Davis, 967 N.W.2d 367 (Iowa Ct. App. 2021)
The claimant, Driesen on behalf of Ms. Cindy Davis, alleged that the guardian of her adult son was committing elder abuse by preventing Davis from visiting her son, who was Ms. Katherine Kerr-Davis's ward. The court ruled that the prevention of visitation did not constitute elder abuse, as Cindy Davis was not considered a "vulnerable adult" solely because she was over 60. The court stated that she would need to assert that her age prevented her from protecting herself, but she only claimed that she was unable to obtain legal representation.

California

Indian Harbor Ins. Co. v, Casa de Monte Vista, LLC, No. CV 23-2019-SMG (SPx), 2024 U.S. Dist. LEXIS 110936 (C.D. Cal. June 20, 2024)
This case involved a dispute over an insurance claim for fire damage to property owned by Casa De Monte Vista LLC and the Luisi family. Indian Harbor Insurance accused the Luisis of making misrepresentations on their policy application. In response, the Luisis filed a counterclaim for financial elder abuse based on the denial of their claim. The court determined that the counterclaim included enough factual allegations to meet the pleading standard under Rule 9(b). At this stage, the court could not conclude whether Indian Harbor's denial of the claim was reasonable or made in good faith.

Annie Ma v. Bank of Am., N.A., No. CV 23-09456-MWF (AGRx), 2023 U.S. Dist. LEXIS 23428 (C.D. Cal. Dec. 20, 2023)
The plaintiff, a 74-year-old senior citizen and long-time customer of Bank of America (BANA), was given a phone number by a BANA employee in January 2021 to add a beneficiary to her account. When she called the number, scammers pretending to be from BANA and Chinese authorities informed her that she owed debts and needed to wire money to assist with an investigation. The plaintiff sent a total of $690,000 from her BANA account to the scammers, incurring wire transfer fees. The plaintiff claims that BANA failed to prevent the transfers or report the fraud. The complaint failed to state a claim for financial elder abuse under California Welfare and Institutions Code Sections 15610.30(a)(1) or (a)(2) because it did not allege that the bank itself took, retained, or assisted in taking the plaintiff's property with wrongful intent or actual knowledge of the scam.

Georgia

In re Sessions, 367 Ga. App. 426 (2023)
The evidence supported the probate court's decision to award the widow the value of a life estate in the marital home. It was determined that the widow would face a shortfall of about $36,000 to cover her regular expenses based on her usual standard of living, and the value of the life estate fell within the range of this annual shortfall. The court concluded that the award appropriately considered the estate's solvency and explained its equitable rationale, addressing the widow's immediate financial needs after her husband's death.