Source: Scientific American
https://www.scientificamerican.com/article/what-happens-when-people-with-dementia-commit-crimes/

The Dementia Defense?
When criminal behavior overlaps the degenerative cognitive disease, the justice system often fails.

By Jessica Wapner, 1 September 2023

David Rothman delivered his last baby in 2003 and shut down his obstetrics practice at the age of 62. A couple of years later he became the medical director of a newly opened clinic, called Medcore, that specialized in HIV care.

The clinic was in a nondescript office building in Miami, out near the airport. Reyes Cruz, who was diagnosed with HIV in 1994, first visited in the summer of 2005. He told Rothman that he had stomach cramps, bleeding gums and diarrhea. Rothman looked inside his mouth, took his pulse and pressed on his stomach. Cruz had his blood drawn. Afterward, a phlebotomist asked him to sign a form verifying his visit, then handed him $600 in cash. Cruz visited Medcore regularly for nearly a year, receiving $600 each time, sometimes in the clinic's bathroom, sometimes in the parking lot.

Cruz later testified that he had lied about his ailments. The clinic was a scam. The owners bribed people with HIV to serve as pretend patients. Rothman signed Medicare claim forms for HIV drugs that were never purchased by the clinic nor provided to the patients. Over about two years Medcore billed Medicare for $4,040,895 in fake expenses. Bank records indicate that Rothman received at least $600,000 from Medcore and other similar schemes that he was allegedly involved in.

FBI agents arrested Rothman and seven other people in October 2008. (By this time, he'd relinquished his medical license for a different reason: the state's Department of Health accused him of prescribing Viagra based solely on online questionnaires.) Rothman was charged with health-care fraud and health-care fraud conspiracy. He faced up to 20 years in prison. Four of the indicted defendants pleaded guilty, and four, including Rothman, chose to go to trial.

Shortly before the jury was set to assemble, Rothman's attorney filed a motion stating that his client was incompetent to stand trial. Five months before his arrest, Rothman had been diagnosed with Alzheimer's disease. The legal process that followed would last 11 years — a costly demonstration of just how unprepared the criminal justice system is to handle people with dementia.

Nearly 10 percent of U.S. adults age 65 and over have some form of dementia, and another 22 percent have mild cognitive impairment. Alzheimer's, the most common type, has symptoms we tend to associate with cognitive decline in the elderly — wandering, disorientation, memory loss, struggling to find the right word. In frontotemporal dementia, a person may become impulsive or lose their ability to sympathize. Lewy body dementia can cause tremors and change sleep patterns. A person with vascular dementia may hallucinate. Symptoms often overlap, which can make diagnosis tricky.

Some forms of dementia can trigger behaviors that society classifies as criminal. It's not that these conditions create an *intention* to violate the law—most dementia-related violations are not what neurologists call “instrumental behaviors,” which are calculated in advance and executed according to a plan. Rather the radical changes in a person's behavior and demeanor can erase their sense of social norms. They steal. They grope. They shout abusive language at fellow customers in the grocery store. Stacey Wood, a professor of psychology at Scripps College, recalled a patient who began hugging customers at a convenience store and didn't stop until the manager called the police. “Mostly we're talking about impulse-control problems,” says Wood, who has provided expert testimony in many cases involving defendants and victims with dementia. “They just have terrible judgment.”

These radical changes in a person's cognition and behavior tend to come from a loss of awareness about the world. Some people lose what psychologists call theory of mind—that is, the ability to comprehend that other people have minds and mental states just like they do. People with dementia can also lose self-conscious emotions or “where you see yourself through others,” says Mario Mendez, director of the Behavioral Neurology Program at the David Geffen School of Medicine at U.C.L.A. When that capacity evaporates, a person no longer feels shame or guilt about breaking with acceptable social patterns. The loss of these capacities may help explain the most common crimes among Alzheimer's patients — public urination, theft, traffic violations, sexual advances and trespassing.

Not everyone with dementia steals or runs red lights, of course, but it appears that people with this diagnosis are more susceptible to criminal behavior. It's difficult to determine just how often the police are called to intervene in dementia-driven behavior, but one way to look at it is through FBI data. More than 100,000 people older than 65 were arrested in 2019, a number that represents about 0.18 percent of *all* people older than 65 in the U.S. For comparison, 8.5 percent of the patients

seen at the University of California, San Francisco, Memory and Aging Center between 1999 and 2012 committed crimes after receiving their diagnosis.

Most dementia-related transgressions do not land the guilty party in prison or even in front of a jury. Guilt has two properties: that a person committed the crime and that they intended to do so. The latter, known as mens rea, is usually missing when dementia patients violate the law. Charges are typically dropped once the police, the victim or the prosecuting attorney realizes that a defendant is not of sound mind.

Still, a portion of older individuals who commit crimes because a neurodegenerative disorder has warped their sense of acceptable behavior do end up incarcerated. Mendez recalled a patient of his who was arrested for touching a child in a way that would have been acceptable ("something like patting on the head," he explained) if the patient had known the child. Another patient went to jail for taking something trivial from a store. In 2021 a 67-year-old man with Alzheimer's spent several months in an Oklahoma jail for allegedly stealing a car, even though it was clear to the arresting officer that the man didn't understand why he was being pulled over and was confused about where he was.

Jalayne Arias, who studies health policy and behavioral sciences at the School of Public Health at Georgia State University, wanted to know how attorneys handle people who are arrested for offenses stemming from their dementia, including how they discern whether the disease is what led to the criminal activity. She interviewed 15 attorneys between 2020 and 2021, and their responses (which will be published soon in the *American Journal of Law and Medicine*) indicated to Arias that the criminal justice system lacks a consistent approach for screening older offenders for dementia.

If the police realize that the suspect they've just arrested has Alzheimer's, they have nowhere to bring that person besides the nearest precinct or emergency room. The attorneys Arias interviewed recognized that jails and prisons aren't clinically appropriate, because simply being in unfamiliar places and situations can be harmful to people with dementia. Offenders without caregivers may be best served by placement at a long-term care facility, but often they cannot afford it. And the criminal record they now have may make them ineligible anyway. "Our legal system as a whole just really hasn't wrapped its head around this particular issue," Arias says.

Defendants with psychiatric illnesses may plead not guilty by reason of insanity, or they may insist they didn't have conscious control over themselves — they were sleepwalking when they stole a candy bar, for example. There are no such protections for elderly people with cognitive disease.

In general, people with Alzheimer's are known to be victims of scams, not the perpetrators. They don't start fake clinics to defraud Medicare. A crime like that "is not something that you can easily attribute to brain disease," Mendez says.

The FBI contacted Rothman about his work with Medcore in December of 2005. Later that month, according to his daughter Raquel Rothman, he testified before a grand jury. Raquel found out about the testimony only because her father showed up at her sister's house afterward wearing a suit, which was odd for him. When her sister asked their dad why he was so dressed up, he nonchalantly told her where he'd been. Raquel, an attorney, was alarmed to hear he'd testified without a lawyer present. (The details of grand jury hearings are publicly unavailable.)

Raquel immediately contacted her dad's former fraternity brother, Joel Hirschhorn, A 1995 New Yorker story described Hirschhorn as a white-collar defense attorney who had formerly defended drug dealers in 1980s Miami. The two men had run into each other occasionally since college, but it had been many years since the last time. When Hirschhorn met with Rothman, he seemed "disheveled and depressed," nothing like the sharp student he'd remembered. Hirschhorn says he gave Rothman the name of a psychiatrist. That doctor referred Rothman to a neuropsychologist, who diagnosed Rothman with mild cognitive impairment in March 2007 and sent him to a neurologist for further testing. In May 2008, more than two years after the first doctor's appointment and two months before the indictment, the neurologist diagnosed Rothman with Alzheimer's.

The Sixth Amendment of the U.S. Constitution entitles every criminal defendant to a fair trial. That includes ensuring that a defendant is fully capable of understanding the proceedings. The cognitive demands of a trial are substantial: understanding the evidence; weighing the benefits and risks of taking the stand; considering a plea deal; remaining alert and focused while

court is in session; communicating meaningfully with an attorney. When a person's ability to participate in their defense is in question, their attorney can request a competency evaluation, which is essentially an investigation of the defendant's mind.

The modern rules surrounding a defendant's competency stem from *Dusky v. United States*, a 1958 case in which a 33-year-old man named Milton Dusky was accused of kidnapping a minor. Dusky had schizophrenia, but the court ruled him fit to handle the criminal justice process. He was found guilty and sentenced to 45 years in prison. After an initial appeal failed, the Supreme Court reversed the decision in 1960, leading to the "Dusky standard" of competency: that defendants understand the charges against them and the possible penalties and that they can assist in the preparation of their defense.

Dusky applies to all neurological conditions. The law does not differentiate between mental illnesses that can be ameliorated with medication, such as schizophrenia, bipolar and clinical depression, and those that are incurable, such as dementia.

To determine whether a defendant meets the Dusky standards of competency, the court appoints an expert to conduct a forensic evaluation. These investigations use the same tools that a doctor would use to check for cognitive impairment. First come biological tests to rule out other causes of dementia, such as vitamin deficiencies, HIV and urinary tract infections, all of which are curable, which means the comprehension issues are resolvable. The evaluator may also order an imaging scan to check for signs of erosion inside the brain.

A battery of cognitive tests for dementia includes questions that check memory, recognition, language recall, executive function, and other brain skills. A patient might be asked to name the city and state they're in or to draw a clock with the hands showing a specific time. The evaluator may test a person's sense of right and wrong by asking them to explain the meaning of a proverb. In a clinical setting, the goal is to make a diagnosis. In a forensic setting, the goal is to determine whether the defendant can plan a legal strategy, understand courtroom procedure and decorum, comprehend the charges against them, challenge witnesses and feel invested in the outcome.

Competency evaluations are rigorous because they connect to a fundamental tenet of the U.S. justice system: that people must be held accountable for violating the law. People with early-stage Alzheimer's are no exception. The ability to consult with one's lawyer does not mean remembering every relevant fact; even defendants with amnesia have been ruled competent. "Having mild cognitive impairment or an early dementia, in most legal settings, would be insufficient to obviate responsibility for a crime," says Tom Wisniewski, who directs N.Y.U. Langone's Center for Memory Evaluation and Treatment.

Cognitive tests to determine competency to stand trial provide only a snapshot of the moment at which they're given, which doesn't capture the fluctuations that dementia can cycle through over a week or even a single day. They can miss the loss of feelings or inhibitions. Also, some people may exaggerate symptoms to stay out of prison. Forensic and clinical evaluators therefore also interview family and friends. Only people who know the defendant's history can provide insights about behavioral changes over time. "The cognitive assessment of the patient is critically dependent on having an informant," Wisniewski says.

When Hirschhorn requested a competency evaluation for Rothman, the judge appointed a local neuropsychologist, Enrique Suarez, to conduct it. Suarez gave Rothman four cognitive tests over two days in February 2009 and noticed some peculiarities that didn't match a typical Alzheimer's patient. For example, Rothman's recall was better than his recognition. Rothman got an average score on a word-list recall test but scored far below average when he was asked whether he recognized something he'd been shown a few minutes earlier. And in a test in which Rothman had to choose which of two words he'd seen before, he did much poorer than someone at his stage of Alzheimer's typically does. His IQ score was 85 (90 to 109 is considered average), which struck Suarez as unlikely for someone with Rothman's educational and professional background. It was also 20 points lower than he had scored on the same test administered by his regular neuropsychologist at around the same time. Suarez thought it was strange when Rothman disclosed that he'd been suffering from auditory hallucinations — hearing things — for the past 15 years because Rothman had never mentioned this to any of his doctors.

For the family component, Suarez interviewed only Raquel. The court records contain no explanation of why he did not interview Rothman's wife of 17 years, Amanda Rothman. It also omits the fact that Rothman and Raquel had been all but estranged since she was a teenager, so she would not necessarily know how her father had changed.

The competency hearing before the judge came a week after Suarez's evaluation. All the clinicians who had examined Rothman since 2006 gave the judge their test results, imaging reports and conclusions about whether Rothman was fit to stand trial. Everyone said Rothman was incompetent, except for Suarez, who insisted that Rothman didn't even have dementia. Rather Rothman's test scores were so inconsistent and, at times, so low that they could point to only one conclusion: Rothman was malingering, Suarez said. He was faking it.

United States v. Gigante is probably the most famous case involving malingering. Gigante faked a mental illness for decades to cover up his role as the head of the Genovese crime family, mumbling to himself as he walked the city streets in tattered clothes. He used that act to delay his conviction for years after he was arrested in 1990. A judge finally ruled him competent to stand trial, leading to a guilty verdict in 1997. (Gigante only admitted the ruse a couple years before he died in prison.)

Detecting that someone is malingering is not an exact science. Evaluators often get it wrong. Gigante-style fakes are rare. “People can be mentally ill and malingering; they can be demented and exaggerate,” says Rory Houghtalen, a forensic psychiatrist who consults on criminal legal cases in New York State. “You gotta be real careful about throwing the m-word around.”

Still, the judge found Suarez's testimony to be the most convincing. She didn't declare that Rothman was pretending, but she questioned why Rothman had not sought treatment until he discovered he was under investigation in 2005. She concluded that Rothman was suffering from “a mental disease or defect” but not one that compromised his cognition enough to render him legally incompetent. He had explained his innocence to his doctors; surely he could do the same before a jury. Rothman, she ruled, was competent to proceed to trial.

The judge would not permit expert witnesses to testify that Rothman's Alzheimer's diagnosis contributed to his participation in the Medcore scheme. Clinically, it's impossible to know when dementia first starts taking root in a person's brain or when it begins chipping away at a person's empathy or inhibitions. The legal system couldn't retroactively determine his state of mind when he was signing fraudulent Medicare forms.

The proceedings lasted two weeks in March 2009. Hirschhorn did not try to blame Rothman's criminal actions on Alzheimer's disease, but he did argue that issues with executive functioning muddled Rothman's ability to see Medcore for what it was. In his opening statement, he referred to Rothman as “a doddering old fool” who had “developed extremely poor judgment.” Later, he argued to the jury that Rothman was a devoted physician who was trying to take proper care of his HIV patients. He was a good doctor who had been taken advantage of by bad people.

The jury found Rothman guilty on all five counts against him, and the prosecution requested that he spend 135 months (more than 11 years) in prison. (All the co-defendants were also found guilty.) Rothman posted the $500,000 bond and remained under house arrest until the sentencing hearing in June.

Ten days before the hearing, Hirschhorn filed a new motion: he wanted the court to grant an evaluation to determine Rothman's competency to proceed to sentencing. *Dusky* applies at this stage, too, because defendants must fully grasp the situation before them. Simultaneously, a judge who was not part of the Medcore case appointed Raquel Rothman as her father's emergency temporary guardian on the grounds that he was incapacitated.

When a person is ruled unable to meet the Dusky standards, the law permits a competency restoration—a forced stay at a prison hospital or outpatient clinic during which the defendant can be appropriately medicated for their condition and educated on the criminal justice system. They may be trained to answer questions such as, “What is the role of a jury?” and “What is a plea?” Eventually they are deemed fit to return to court, and the case resumes.

But what if they are never deemed fit? Dementia is irreversible; no one makes a recovery. The medications available for Alzheimer's may slow disease progression, but they don't stop or reverse it. The June 2021 approval of aducanumab for mild Alzheimer's was controversial because neither of the clinical trials that led to the approval showed any improvement in symptoms. Lecanemab, approved in January 2023, also does not reverse symptoms. “Dementia just gets worse and worse,” Wood says.

That means that a defendant with Alzheimer's will undergo a restoration process that is doomed to fail. They typically end up committed to the hospital for longer periods than people who have more treatable psychiatric conditions, explains Yale University psychiatrist Tobias Wasser, a former chief medical officer at a forensic psychiatric hospital.

In response to Hirschhorn's presentencing evaluation request, the judge appointed Ranjan Duara, a neurologist who directs the Wien Center for Alzheimer's Disease and Memory Disorders at Mount Sinai Medical Center in Miami, to conduct the competency examination. Duara filed his report to the court in August 2009. Rothman did not have Alzheimer's, nor was he malingering, Duara wrote. He had frontotemporal dementia.

Humans have an innate ethical compass. The medial frontal region and anterior temporal region of the brain help us evaluate moral questions. The classic trolley problem draws on this feature: A train is headed toward five people tied to the track; Do you change its course to kill just one person instead? “It's very hard to do something for the greater good, for the greater many, if you feel like you're hurting somebody directly,” Mendez says.

Frontotemporal lobe dementia (FTD) attacks this moral circuitry. It erodes the parts of us that sympathize, that make us feel self-conscious, that help us distinguish right from wrong. A person with frontotemporal lobe dementia may know that stealing is wrong, but if you ask them whether it was wrong of them to take a scarf from a store without paying, they may say no. “They don't feel that their actions are wrong but that the action itself is wrong,” Mendez says. FTD would not lead a reputable obstetrician to design an elaborate scam to defraud Medicare, but it could stop him from recognizing his participation in the ruse.

In the U.C.S.F. study that identified high rates of criminal behavior among people with dementia, those rates were highest among the subset of patients with FTD: 64 of 171 patients, or 37 percent. “Patients with FTD can commit criminal violations while retaining the ability to know the moral rules and conventions,” Mendez wrote in a 2011 paper describing the predilection of people with FTD to break the law.

Duara was struck by Rothman's lack of insight about what was going on at Medcore, as well as his lack of remorse. “He really didn't think he had done anything wrong,” Duara says. “He didn't seem to ever admit that he had made any errors in judgment by being involved with this clinic.” An MRI scan revealed that the anterior part of Rothman's temporal lobe, the brain region just behind the ears, had shrunk. “There was no question there was something degenerative going on in the brain,” Duara says.

Given Duara's departure from the assessments of previous experts, the prosecution called for a longer evaluation. The judge sent Rothman for a 10-day evaluation at the Federal Medical Center in Rochester, Minn. The psychologists there concluded that Rothman was faking his symptoms, but the judge disagreed with their findings — it turned out that the evaluators had no experience with dementia. In August 2010, 17 months after Rothman was found guilty, the judge ruled that Rothman was incompetent to proceed to sentencing.

The prosecution wanted assurance that Rothman would never become fit for sentencing. Rothman surrendered to the Bureau of Prisons medical facility in Butner, N.C., for evaluation. This facility is well known among forensic psychiatrists (Unabomber Ted Kaczynski was housed there until his death in June 2023). The report provided by the forensic psychologist handling Rothman's evaluation confirmed that Rothman had not gotten any better and never would. On June 10, 2011, he was released to the custody of his family.

By this time, Rothman's wife had filed for divorce. Raquel Rothman relocated her father to an assisted living facility in Miami, which he could leave only with a member of the staff or his family. She was ordered to call her father's probation officer every week to confirm that he was at the facility and complying with the restrictions on his whereabouts. “I had two alarms on my phone for 10 years to make sure I didn't miss a single phone call,” Raquel says.

To the end, dementia is a shape-shifter. Duara remained Rothman's doctor, filing dozens of reports to the U.S. Department of Justice over eight years. In 2016 he took another look at Rothman's brain with a PET scan and found the image more consistent with atypical Alzheimer's — a variant that mimics frontotemporal dementia and causes problems with judgment, insight and executive function.

In 2019 the Department of Justice filed a request that the case against Rothman be dismissed, and the court agreed. Duara, who checked on Rothman most recently in January 2023, says that his patient was “moderately to severely impaired.” According to Raquel Rothman, her dad can no longer take care of himself and barely speaks. During a visit at the assisted living facility in the summer of 2022, when she was sitting in Rothman's room, watching him “go in and out of consciousness,” she says he started moving his hands delicately through the air, thumb and forefinger pressed together. “He was suturing in his sleep,” she says.

Rothman wasn't necessarily subject to any injustice. He may have avoided prison because the justice system was working well or because it was working poorly. Maybe he had a fair and careful judge—or a really good lawyer. Other defendants with dementia facing similar charges have not fared nearly as well. Wisniewski, who treats dementia at N.Y.U. Langone Health, recalled a patient — a physician — who began writing unnecessary narcotic prescriptions and ended up in prison for 15 years. “He was barely cognizant of his name after five years,” Wisniewski says, “but he stayed incarcerated. Dementia patients are dealt with in an extremely cruel fashion.”

Among the solutions suggested by experts like Arias would be an elderly, cognitively impaired equivalent of juvenile court, which recognizes that juveniles should be held to different legal standards than adults because their brains are not fully developed. At the federal level, that change would have to be led by the Department of Justice, which is currently more focused on protecting people with dementia *from* criminals such as scam artists rather than on helping people with dementia

who *are* criminals. States are hamstrung by political will. Another option would be to allow a plea of "not guilty by reason of dementia" or to enact sentencing limits similar to those protecting juveniles from lifelong incarcerations.

When the Bureau of Justice Statistics collects data on correctional facilities, it doesn't ask about dementia specifically, so the precise number of inmates suffering from it isn't known. One 2012 study estimated, somewhat unhelpfully, that dementia rates among inmates range from 1 to 44 percent depending on the type and size of the prison. But given the prevalence of dementia in the older population in general, it's reasonable to assume that number, whatever it is, is trending upward: In 2013 people older than 55 made up 10 percent of the state prison population — a 7 percent increase from 20 years earlier. One report projected that by 2030, people age 55 and older will make up a third of the U.S. prison population.

The reasons for this increase are multifold. When the U.S. banned the death penalty from 1972 to 1976, life sentences became more common and never receded even when the ban was lifted. The large Baby Boomer population has been entering the phase of life when dementia is most common, leading to increasing diagnoses. The lack of exercise and the psychological turmoil of prison life may exacerbate cognitive decline among aging inmates, especially if they have other mental health issues.

Most correctional systems offer no geriatric or dementia care services. Prison memory wards, such as the one that opened in 2019 at the Federal Medical Center Devens in Massachusetts, could help keep vulnerable inmates safe. But such interventions drive home a contradiction: If prisons are meant for rehabilitation, Arias explains, then why keep people locked up when they no longer understand why they are even there? Arias is continuing to accrue data from attorney interviews to evaluate the purpose of our criminal justice system. "Is there a willingness to concede that incarcerating someone with dementia," she asks, "is, maybe, questionable?"

Instructions

1. What is dementia (define it)
2. What percentage of adults age 65+ have some form of dementia and mild cognitive impairment?
3. There are many lifelong law-abiders for whom the dementia can trigger behaviors that society classifies as criminal. Explain how this is.
4. In paragraph 6 is says: "Rather the radical changes in a person's behavior and demeanor can erase their sense of social norms." Explain what is meany by this.
5. Guilt in the criminal justice system requires proving two things. What are they?
6. What does the Sixth Amendment guarantee to every criminal defendant?
7. What does a competency evaluation do? Why is it important?
8. What type of things do they ask in the competency evaluation?
9. Explain the Dusky Standard (think of the case Dusky v United states from 1958)
10. What did the legal case United States v Gigante address?
11. Is dementia reversable?
12. What are examples which illustrate how unprepared the criminal justice system is to handling people with dementia?