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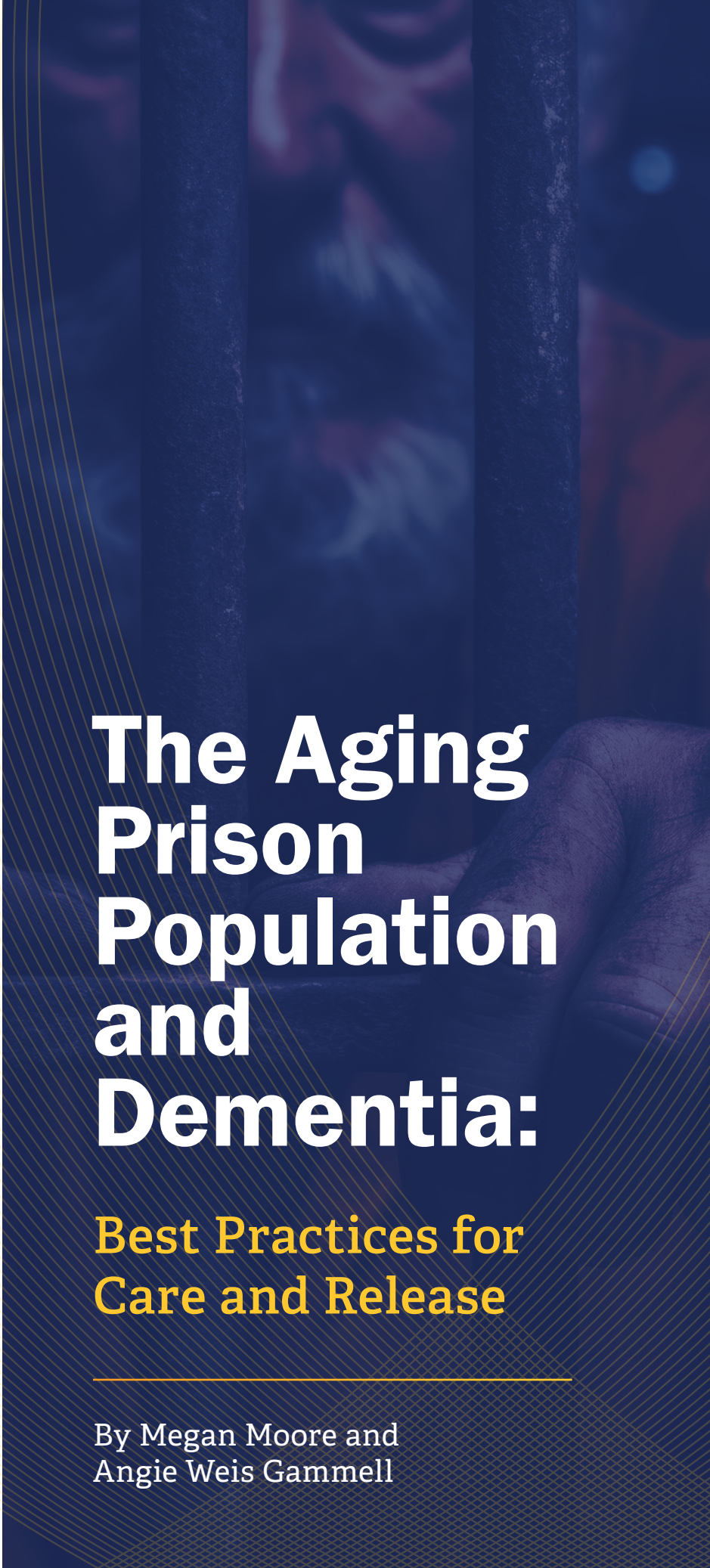

The Aging Prison Population and Dementia:

Best Practices for Care and Release

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Executive Summary

In 2020, 165,700, or 23%, of incarcerated individuals were seniors.[1] This represents a 280% increase in incarcerated older adults since 1999 and is in stark contrast to the steady decline of total prison populations since peaking in 2009.[2] The growing number of older adults has a distinct set of healthcare needs that must be met, including aging-related cognitive impairments like dementia. Older adults behind bars are at a greater risk for developing cognitive impairment and carceral facilities are not properly staffed or equipped to recognize, assess, or care for incarcerated individuals with cognitive decline.[3]

The U.S. Census Bureau projects that by 2030, U.S. prisons will hold 400,000 older adults who will comprise one-third of the total incarcerated population. Between approximately 70,000 and 210,000 of those incarcerated older adults will develop dementia.[4] With few national standardized dementia trainings, screenings, and practices across carceral facilities, there is a pressing need to address the diagnostic, medical, and rehabilitative needs of the aging prison population.

Importantly, none of the purposes of punishment—incapacitation, rehabilitation, retribution, and deterrence—are advanced by the continued incarceration of individuals living with dementia. Many are unaware of their surroundings or the "why" of their existence in a carceral institution. They are already incapacitated by their medical condition. They no longer have the opportunity for rehabilitation. They are unable to understand their living environment as a consequence of their crime, rendering retribution impossible. Additionally, incarceration is not an effective deterrent against crime, and may actually serve to increase crime.[5] Despite this, state programs providing for geriatric release or release based on cognitive decline are rare. This leaves many individuals living with dementia in prison, burdening states with hefty medical bills. Prison systems must provide adequate medical care to allow those living with cognitive decline to maintain their dignity and protection to prevent their victimization.

1 in 4

incarcerated individuals are seniors

The number of incarcerated seniors has nearly tripled in the last 20 years

In 2020, there were **165,700** incarcerated seniors, and by 2030, U.S. prisons will hold

400,000

older adults

By 2030, between

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incarcerated people may develop dementia

Recommendations

- **Regularly screen older adults in carceral settings for dementia and other cognitive impairments.** In most carceral institutions, older adults do not receive regular dementia screenings.[6] All incarcerated adults over the age of 50 should be considered for dementia screening by medical professionals. Doing so establishes a baseline against which to measure future cognitive health. Carceral institutions should develop protocols for dementia screening which allow for individuals to be screened after any patient or peer concerns, behavioral changes, or mental health changes (e.g., increased depression or anxiety). Additionally, correctional staff should receive training on dementia, both to effectively refer individuals for screening if symptoms develop between regular screenings, and to better exercise compassion and understanding.
    - Additionally, no dementia screening tool validated for effectiveness in incarcerated populations currently exists. Researchers should work to develop and validate a tool specific to this population.
- **Modify medical release statutes to provide meaningful opportunities for release to individuals living with dementia and other cognitive impairments.** Older incarcerated adults with dementia often face numerous barriers in obtaining medical release. This is due to stringent eligibility criteria containing categorical exclusions for certain types of crimes and requiring subjective determinations by medical staff, prison officials, and/or parole boards that the person does not pose a public safety risk. These requirements unreasonably limit the applicability of these statutes, preventing many seriously ill individuals who pose no threat to public safety from obtaining release.
    - Due to the increased rate of aging in incarcerated individuals, the eligibility age should match the correctional geriatric standard and be no greater than 50 years old.
    - Medical providers should not be required to make subjective determinations that an individual does not pose a public safety risk. The criteria should rely solely on objective factors such as an individual's diminished capacity or increased medical needs and should include individuals with living with dementia and cognitive decline.
    - Categorical exclusions based on offense type should be removed.

- States should issue clear and consistent guidance on eligibility requirements so that individuals, advocates, and governmental decisionmakers understand the process.
- Prison staff should proactively identify individuals potentially eligible for release and begin the application process.
- Prison staff should involve family members in the compassionate release process. Additionally, individuals should be able to receive assistance from advocates, such as a lawyer or social worker, in completing any application.
- Prison officials should develop a process for tracking compassionate release applications to identify and resolve roadblocks.
- Prison officials and advocacy groups should engage with stakeholders, including public defenders, judges, and other state agencies, to educate them on the process and the need for medical release.
- States should collect and publicly release data on medical release applications.

- **Provide robust release planning services and support reentry programs targeting older adults.** Formerly incarcerated older adults, particularly those living with dementia, face many barriers when developing a release plan, including housing and income instability and lack of community connections. In some cases, individuals do not receive medical or geriatric release due to their inability to develop release plans. Incarcerated individuals would benefit from robust release support by dedicated social workers or release navigators.
  - Pre-release planning should begin when an individual is identified as eligible for medical or geriatric release to allow adequate time to assure resources are available to address the individual's needs if they are granted release.
  - Jurisdictions should explore public-private partnerships to develop long-term care facilities targeting justice-impacted individuals with cognitive impairments.
  - State officials should facilitate applications for public benefits, such as social security, Medicare, Medicaid, and the Supplemental Nutrition Assistance Program, prior to release.
- **To the extent individuals cannot qualify for early release, provide adequate medical care for older adults living with dementia and other cognitive impairments in carceral settings.** Prison systems should develop treatment programs for older incarcerated adults with dementia, ranging from specialized care units to low-cost "dementia friendly" environmental modifications (e.g., large font signage or color-coding rooms by function).
  - Memory care units in carceral settings should mirror standards for such units in the wider community.
  - Researchers should evaluate the effectiveness of dementia care programs in carceral settings to develop a set of best practices for treatment of individuals living with cognitive impairments in carceral settings, including programs which provide non-medical assistance with navigating life while incarcerated (e.g., peer assistance).

The Aging Prison Population

While total prison populations have steadily declined since 2009, the number of older adults in prison has increased. This trend mirrors a national trend: The total number of individuals in the United States over the age of 65 is projected to double over the next forty years.[7] By 2035, the percentage of seniors over the age of 65 will surpass the percentage of children for the first time. [8] Increases in incarcerated populations are attributed to a 30% increase in elder arrests from 2000-2020 as well as legislative changes that made extreme and life sentences more common.[9] In the 1980s and 90s, three-strikes laws, mandatory minimums, mandatory life sentences, and zero-tolerance policies were enacted as part of a "tough on crime" approach.[10] As a result, the number of older adults in prison has skyrocketed. Individuals in their 20s and 30s during the onset of these laws are in their 50s and 60s now.[11] In 2013, 11% of incarcerated individuals 65 and older were serving life sentences for property or drug offenses.[12]

This trend is compounded by the fact that carceral environments trigger stress responses that accelerate the detrimental effects of aging and worsen mental health.[13] In 2016, cognitive impairments were reported for 23% of individuals incarcerated in state and federal prisons.[14] Many incarcerated individuals face more significant physical and cognitive impairments due to the nature of carceral life and lack of access to quality healthcare. In fact, 50-year-olds' physiological ages are, on average, 10-15 years older than their biological age, and each year spent in jail erases two years from an individual's life expectancy.[15] As a result, the more accurate age classification, according to correctional and medical standards, for older adults in correctional institutions is 50 or 55 rather than 65, as it is typically used for the general population.[16] As the prison population ages behind bars, factors including social deprivation, poor nutrition, substance abuse, and inactivity put them at a greater risk for developing dementia.[17] Additionally, persons entering carceral facilities with pre-existing cognitive impairments have an increased risk for developing dementia and require more robust standards of care.[18]

Dementia in Carceral Settings: Understudied and Underscreened

Dementia is a medical condition characterized by impaired brain function, affecting memory, cognition, and the ability to carry out everyday tasks.[19] Older incarcerated adults, suffering from dementia, can become targets for victimization, sexual assault, and bullying.[20] They are also more likely to be subjected to frequent sanctions and harsh punishment while incarcerated because they struggle to understand and follow prison rules.[21] Additionally, many people who function poorly and need protection are isolated in solitary confinement. This effectively punishes them for their unmet medical needs, in turn worsening their cognitive functioning and eroding their quality of life.[22]

Alzheimer's disease, the most common form of dementia, accounts for 60-80% of all dementia cases and is ranked in the top ten leading causes of death.[23] With the projected increase in non-carceral settings, it is expected that dementia will be equally, if not more, prevalent in prisons.[24] Although no cure for Alzheimer's exists, there are some medications that can temporarily improve the signs and symptoms of the disease. Additionally, those living with Alzheimer's and other forms of dementia can maintain their quality of life by staying physically active, participating in activities that stimulate the brain, and implementing a routine.

Nationally, in non-carceral settings, dementia rates are expected to rise. In 2020, more than 7 million people 65 and older in the United States had dementia. By 2030, that number is projected to grow to 9 million.[25] The prevalence of dementia in prison populations has not been documented extensively. A systematic literature review published in 2020 finds only four studies that reported on dementia prevalence, which ranged from 0.08% to 18.8% of the prison population.[26] A separate study notes similar wide-ranging estimates of dementia prevalence in prison spanning from as low as 1% to as high as 30%; however, the methodology behind these estimates lacked rigor or standardization.[27]

Correctional facilities often lack the funds and equipped medical staff to screen and document dementia cases adequately. While the Federal Bureau of Prisons recommends annual check-ups for incarcerated older adults, many prisons fail to provide them.[28] Regular check-ups are critical to preventative healthcare and present an opportunity for health and mental health screening. Because check-ups are not routine, cognitive decline is more likely to go undetected and dementia to go undiagnosed.

Correctional facilities often lack the funds and equipped medical staff to screen and document dementia cases adequately.

This fast-growing and vulnerable population is often not provided the resources to function in such an environment that requires independence. Many people

Evaluating Dementia in Prisons

Dr. William Weber is volunteer physician with the Medical Justice Alliance, which conducts dementia screenings in Massachusetts prisons.

> Unfortunately, dementia is very under screened and underdiagnosed in [prisons] ... Many of these patients are not able to advocate for themselves.
>
> It's one of the most tragic things I've noticed: patients just don't even realize why they're in prison. I did a dementia screening on an elderly lady. And when I asked her where she was, she had some idea she was in prison, but I asked her why, and she just had no clue. [She] wakes up every morning in prison not aware of anything she did. And then she wakes up the next morning again, confused. She's in prison and she doesn't know why...It really begs the question: why are we keeping these people incarcerated if they don't even know why they're there? It's not punishing them for an action, because they're not even aware that they had a conviction in the past.
>
> And we also see they can often struggle in a prison environment. So, for instance, one of the patients that we evaluated would continue to get agitated because she thought people were stealing her things from her cell. She thought her cellmate was stealing things from her, even though she had no cellmate. But because of her disorganized thinking, she would oftentimes misplace things and then think it had been stolen. Things like that can be disruptive both to prison staff and especially to patients who are just confused."

living with cognitive impairment are unable to perform the regular activities of daily living, including bathing, dressing, and feeding, and will eventually require around-the-clock nursing care.[29] Unfortunately, the U.S. prison system, as a whole, lacks the infrastructure to care for its older adult incarcerated population. It often neglects the unique needs of those living with dementia; research finds that most U.S. prisons lack geriatric healthcare services and correctional officers do not have adequate training to respond to seniors with dementia.[30]

Additionally, there is very little published literature on detecting and managing dementia in correctional systems.[31] A researcher at The School of Professional Psychology at Wright State University conducted qualitative interviews with staff members from three Ohio facilities to understand how dementia is recognized within the state's prisons.[32] At the time of these interviews, there were no institution-wide policies directing dementia assessment in Ohio corrections. Several themes emerged from the analysis of these interviews, including:

- Correctional staff have difficulty distinguishing dementia symptoms from other conditions;
- Screening tools are inaccessible and administering lengthy assessments is infeasible;
- There is a lack of formal staff training in dementia assessment.[33]

Although these findings were specific to one statewide study, it is safe to presume that similar challenges and observations are

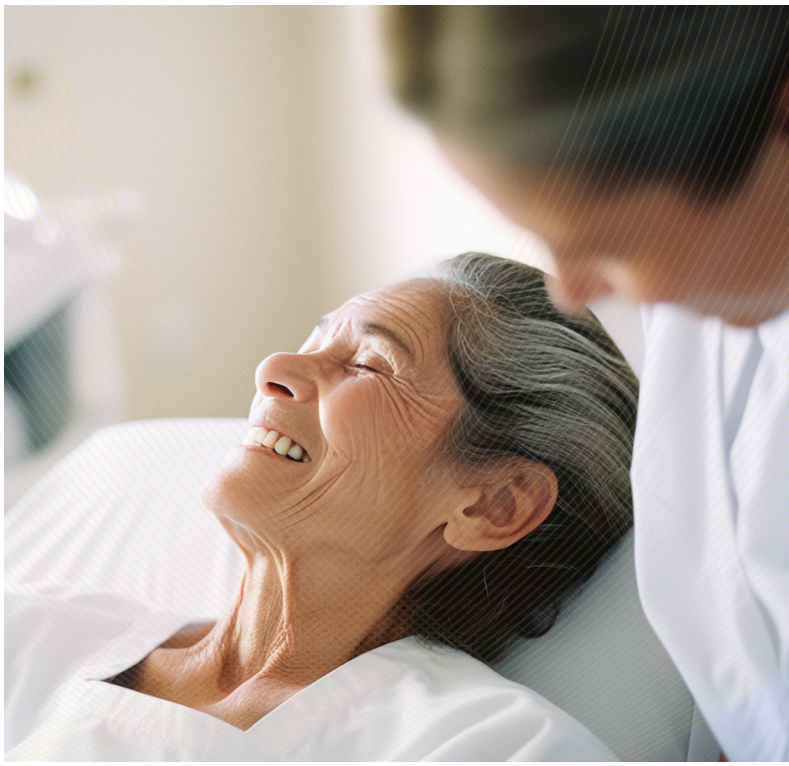
experienced across the United States. Additionally, studies suggest that regular dementia training and information sessions may lead to significantly increasing staff and peer knowledge about dementia inside prisons.[34]

One of the first steps in developing a standardized dementia diagnosis process for prisons is selecting a screening tool. Common dementia assessments include the Mini-Cog and the Montreal Cognitive Assessment. Lengthier screening tools include the Cambridge Assessment of Memory and Cognition and the Alzheimer's Disease Assessment Scale-Cognitive Section.[35]

Researchers in the United Kingdom suggest dementia screening tools in prisons undergo a validation process since no existing screenings were developed specifically for correctional facilities.[36] A literature review reveals three suggested diagnostic processes for dementia in prisons. One, informed by the qualitative interviews from the Ohio prisons, consists of a four-part plan including pre-identification, identification, assessment, and diagnosis.[37] The second protocol is structured as a flow chart and was developed by Anne Feczko, an adult care nurse practitioner, to guide clinicians in diagnosing and managing dementia among incarcerated individuals.[38] In a third study, researchers in Canada developed a modified Community Screening Instrument for Dementia (CSID) tool specific to individuals living in custodial settings.[39] The tool includes questions testing memory, abstract thinking, higher cortical function, orientation to time, and orientation to place. It is essential to note that none of the three existing suggested protocols details a process for screening incarcerated individuals for dementia prior to release from incarceration, which is critical to proper release planning.

Recommendations

- Prisons and carceral institutions should conduct regular staff training on cognitive decline, including content related to the subjective experience of individuals living with dementia.
- Prisons and carceral institutions should conduct regular cognitive decline screening on incarcerated older adults, both as indicated during regular check-ups and in response to potential symptoms of dementia (including, for example, peer and staff concerns, behavioral changes, increased anxiety or depression).
- Medical researchers should conduct additional research to validate practical cognitive decline screening tools in institutional settings.



Limitations of Medical Release Mechanisms

Carceral facilities were not designed to provide the long-term care needed for older adults with cognitive decline.[40] A May 2022 report issued by the American Bar Association in collaboration with other researchers determined that "care of people with dementia needs to occur outside of the correctional health care system."[41] Individuals living with cognitive decline should have meaningful opportunities to return to communities and receive proper medical care. Additionally, individuals living with severe dementia often do not understand why they are in a carceral setting and do not have the capacity to commit any future crimes outside of the prison system, weakening some of the primary justifications for criminal incarceration as punishment.

A potential mechanism for relief is medical release, where incarcerated individuals with serious medical conditions can apply for early release. Eligibility requirements vary across states, but generally include that the individual have a qualifying medical condition (e.g., terminal cancer), be of a certain age (e.g., over 65 years old), a specific life expectancy (e.g., six months to live), and, in many states, a certification that the individual does not pose a public safety risk.

Although some form of medical release is available at both the federal level and in forty-nine states plus the District of Columbia, very few individuals receive relief through these mechanisms.[42] At the federal level, only approximately three percent of compassionate release applications were granted in the one-year period from August 2013 to September 2014.[43] Although the majority of states do not track and publish data on compassionate release applications, the available data suggests that a similar pattern holds true for state compassionate release mechanisms.[44]

In **Pennsylvania**, the state released only **9** individuals through compassionate release between 2009 and 2015.[45]

In **Kansas**, only **7** individuals were released between 2009 and 2016.

In **New Jersey**, no more than **2** individuals received release per year since 2010.[46]

In **North Carolina**, **29** individuals were released through medical release in 2021 out of thirty-nine applications.[47]

Despite the limited use of compassion release, research suggests that the general public and prison administrators generally support the release of individuals with serious illnesses.[48] A 2018 review of compassionate and medical release laws in all fifty states and the District of Columbia conducted by FAMM (formerly Families Against Mandatory Minimums) found that the limited number of releases through these barriers could be due to specific barriers created by the structure of these laws.[49] Specifically, FAMM identified the following barriers:

- **Vague or stringent eligibility requirements.**[50] Vague requirements may impede individuals (or prisons) from determining whether they qualify for release, while stringent requirements may preclude many individuals from being released through the compassionate release mechanism.

Mississippi's stringent statue only permits release of individuals if they are "bedridden," which may disqualify many individuals with cognitive impairments such as dementia.

Stringent requirements, such as those requiring certification that an individual only has a certain amount of time to live, may prevent those living with cognitive decline from qualifying for early release. Although dementia is a terminal illness, it is exceedingly difficult to determine life span for individuals living with dementia. Many state statutes, such as in Mississippi, base qualifications on physical impairments, completely excluding many individuals living with dementia. Additionally, vague requirements may make it difficult for prisons, or advocates representing individuals living with dementia, from identifying potentially eligible individuals.

- **Categorical exclusions of certain individuals due to offense category or nature of the sentence.**[51] Numerous states limit eligibility to only a subset of offense types, often severely limiting eligibility for individuals convicted of violent or sexual offenses. However, over half of all individuals in state prisons were convicted of violent offenses, with approximately two out of three individuals over the age of 55 convicted of a violent offense.[52] Because of their incapacity to commit future crimes, these categorical exclusions needlessly limit the number of individuals living with dementia who may obtain release.

- **Lack of clear and consistent guidance.**[53] FAMM found that many states do not provide clear policy guidance to assist prison staff or decisionmakers in implementing compassionate release programs. Additionally, without clear policy documents, it may be difficult for family members or advocates to assist potentially eligible individuals with the process, especially those living with cognitive impairment such as dementia.

Research bears out the findings in the FAMM review. A 2022 systemic review of studies of compassionate release policies across the United States found four main barriers to release: complicated statutory or regulatory language; complex eligibility criteria; reliance on limited prognosis certified by medical professionals; and social stigma.[54] To improve compassionate release policies, the study authors suggested: increasing research into effectiveness and limitations of state policies; advocacy from healthcare providers to amend policies; and educating incarcerated individuals and prison staff on compassionate release policies.[55]

Discussions with prison healthcare stakeholders provide additional context to institutional barriers to obtaining compassionate release for incarcerated older adults. For instance, in one large state, the prison system hospice director reported they made intentional efforts to improve compassionate release outcomes for incarcerated

Living with Dementia in Prison

John* lives with Parkinson's Disease and has aphasia as a result, which affects his ability to understand verbal communication and makes speaking difficult.

> It's hard for me to comprehend what was being said sometimes, and when I do comprehend it...it's hard to get [out] what I want being said. And when I get it out, they still don't understand it.
>
> I try to get my speech and my thoughts together. One time [the doctor would] say things, and you know, I understood him, but I couldn't really respond to him when he wanted me to respond. And then I'd try to respond. But you know I couldn't. So he just left me alone, and I didn't get care.
>
> In prison, [correctional officers] come in and they ask me certain things and they need an answer. If I don't respond like I needed to, they write me a ticket and I'm in disciplinary.

Molly Crane was John's attorney and said more about his experience.

> And the corrections officers we were talking about too, sometimes didn't understand. They would tell him to do something and then his dementia would cause him to lose track of what they asked him to do, and then they'd give him tickets for it. And sometimes that meant that he was in more restrictive conditions, which is very hard when you're in a wheelchair and have memory issues."

John* is a pseudonym used for purposes of this report.

individuals in response to undue delays in applications. Specifically, the prison medical staff implemented a process for tracking the status of applications to identify obstacles and work to improve the process. As a result of this process, the hospice director trained public defenders representing release-eligible individuals on the process, including statutory timeframes not always followed by judges. The hospice director identified a compassionate release champion for each county in the state to ensure one individual in each jurisdiction understood the process and relevant caselaw.

Recommendations

- States should adopt eligibility requirements that include individuals living with dementia and other disorders causing severe cognitive decline. For instance, states could include a provision allowing for compassionate release when individuals reach a certain level of mental incapacitation. To the extent possible, provisions which require certification that an individual only has a specified amount of time to live should be removed, or at the very least, an alternative should be offered that encompasses cognitive impairment diagnoses. Statutes should also be amended to have an age eligibility requirement of no greater than 50, which is the age at which an incarcerated individual is generally considered geriatric by the correctional system.
- State policymakers should amend statues and regulations to remove categorical exclusions and implement objective criteria. Public safety risk determinations should be informed by the individual's medical diagnosis, but states should not require medical professionals to certify that an individual would pose **no** public safety risk. Additionally, any blanket prohibition on granting release for individuals who committed a violent offense should be removed.
- States should clarify eligibility requirements and provide guidance regarding the release process to incarcerated individuals and the public.
- Prison officials, including medical staff, should work to proactively identify individuals who may be eligible for release. Because individuals with dementia may have received disciplinary infractions due to cognitive deficits, the individual's record of infractions should not categorically disqualify them from release.
- States and prison systems should involve family members and advocates in the application and release process. Individuals with cognitive impairments, such as dementia, which may impact their ability to advocate for themselves should be connected to pro bono advocacy groups to assist through the application process.
- States should begin collecting and publicly releasing data on compassionate release applications. Transparency would allow advocates and policymakers to understand the effectiveness of the release mechanisms and identify any obstacles.

Reentry and Release Planning for Release-Eligible Individuals Living with Dementia

In addition to the statutory barriers discussed above, eligible incarcerated individuals may not be granted medical release due to difficulties in developing workable reentry plans. In general, incarcerated individuals often face severe obstacles to reentering society even if released at the end of their term rather than through an early release mechanism; these difficulties are further exacerbated for older individuals, especially those with dementia or mild cognitive impairments.

Housing Instability

Stable housing is one of the most challenging components of social reintegration. Transitional housing programs provide an excellent opportunity to establish a short-term solution and to help individuals adapt to life outside prison while looking for longer-term housing alternatives for many whom their families and friends cannot support. However, this is often not an option for the older adults who suffer from dementia because they require additional medical attention and cannot live alone. Additionally, many care facilities and transitional programs considers formerly incarcerated individuals "high risk," making it difficult to obtain housing, especially for individuals with serious behavioral and medical needs.[56]

In one large state, the prison system hospice director reported significant challenges in finding long-term care institutions willing to accept formerly incarcerated individuals.[57] Additionally, some individuals could not develop release plans because of the delay in receiving government benefits (e.g., disability or social security). In the director's experience, transitional housing programs often required some financial means to accept individuals. Terminally ill patients often did not have the time to wait for benefits to begin to obtain housing.

While there are some states with targeted programs, they are extremely limited nationwide. For instance, in Connecticut, 60 West operates a nursing home, funded through a public-private partnership, targeting difficult to place justice-impacted individuals.[58] The Connecticut Department of Mental Health and Addiction Services, Department of Corrections, and Department of Social Services entered into a contract with 60 West to develop and operate this facility after identifying a gap in service providers for these individuals.[59]

Income Instability

Formerly incarcerated individuals with cognitive decline struggle to find reliable and paid work with living wages that reasonably accommodates their limitations. Age discrimination and cognitive impairment, compounded with their felon status, make it extremely difficult or impossible to secure and keep employment. Some employers may not be willing to employ senior ex-offenders based on their health status and the nature of the job.[60] Formerly incarcerated individuals eligible for government benefits – such as social security or disability – often face significant delays in receiving payments or proving their eligibility for these programs.[61] Carceral institutions can enter into prerelease agreements with the Social Security Administration ("SSA") to facilitate application for Supplement Security Income ("SSI")[62] and Supplemental Nutrition Assistance Program ("SNAP") benefits several months prior to release to ensure individuals receive their benefits immediately upon release.[63] Although many state institutions have entered into agreements with the SSA, there is very little data as to the effectiveness of these state programs and advocates report that many individuals still do not have approved benefit applications upon release.

Mental Health

Long-term incarceration has profoundly detrimental mental health impacts and may exacerbate pre-existing conditions. Mental health impairment, compounded by dementia, creates a difficult psychological experience to navigate outside prison. Released individuals need to work with experts or receive support services to help them cope and successfully navigate such psychological challenges. This is a particular challenge for individuals with moderate to severe functional impairments who struggle to manage activities of daily living.

Function and Reintegration

After years of being away from their communities, senior incarcerated populations struggle to identify where they fit within their family structures, social networks, and communities. Often, the duration of separation fosters fractured communities that make it hard for these individuals to feel as though they belong to a community upon release.

Additionally, formerly incarcerated people may struggle with their sense of belonging and identity outside of the prison structure. Prolonged prison exposure, coupled with cogntiive decline, puts released individuals at risk of losing their autonomy and can foster a sense of entrapment and possible resentment.[64]

Individuals living with dementia or severe cognitive decline may also lack the ability to assist prison officials in identifying potential family members to assist with housing and financial security. This is compounded by the fact that many of these individuals have spent significant amounts of time in carceral settings, fraying their relationship with family members. A prison hospice director reported that prison staff, including chaplains and medical providers, called churches and tracked down other family members to find housing options for individuals eligible for release.[65]

Recommendations

- As release approaches, incarcerated individuals living with dementia or severe cognitive decline should receive robust release support planning services.
  - At each step of the process, from housing to healthcare, older adults eligible for compassionate release could benefit from robust release planning services from prison officials.
  - Release planning social workers could complete applications for SSI, SNAP, Medicaid, and other relevant government benefit programs.
  - These social workers could also assist in identifying housing options, including long-term care facilities or transitional housing. The social workers could also assist in locating family members who may be willing to house and support individuals after release.
  - The need for pre-release planning support is particularly sharp for individuals living with cognitive illnesses who may not be able to contact family members or complete benefit applications on their own.
- Jurisdictions should consider public-private partnerships to develop nursing facilities to reduce barriers for older adults who may be eligible for release through compassionate release mechanisms.
  - Without nursing facilities specifically for formerly incarcerated individuals, some older adults may not qualify for release because they cannot secure appropriate housing.
- Public benefit policies should be amended to remove barriers affecting older adults returning to communities.
  - States should evaluate the effectiveness of their prerelease agreements with the SSA and devote sufficient resources to ensure that eligible individuals receive benefits upon release.

Improvements to Dementia Care in Carceral Settings

Release should be the first option for individuals living with dementia or other conditions causing severe cognitive decline in carceral settings. Experts agree that carceral settings do not provide the best quality of care for these individuals and continued incarceration does not further the justifications for criminal punishment. In addition, caring for older adults, particularly those with significant medical needs, creates significant financial burden on state prison systems. The Marshall Project has reported that healthcare costs for older incarcerated individuals can be twice as expensive as the care provided to younger ones.[66] Prisons can spend $60-$70,000 per older adult compared to $27,000 per younger adult.[67] Comparatively, senior healthcare expenditures in non-carceral settings mirror this trend. By 2029, the federal government will spend 10 percent of its gross domestic product (GDP), or $3 trillion, on senior healthcare, displaying a 4% increase since 2005.[68] Current dementia costs range from $159-$259 billion annually. These are projected to increase to $511 billion by 2040.[69]

Dementia care in carceral settings is understudied, with very few evidence-based solutions providing a framework for best practices.[70] Many jurisdictions have experimented with dementia-specific care units in prisons to maintain individuals' dignity, with the programs generally falling into one of three categories:

i) special care units staffed only by medical professionals; ii) special care units staffed by a mix of medical professionals and trained incarcerated individuals as patient care assistants; and iii) environmental modifications within the standard institutional setting. Regardless of the approach taken, memory and specialty care unit standards in carceral settings should model standards for such units in the wider community.

Specialty neurocognitive care units staffed by medical professionals are rare, likely due to the cost to develop and maintain them.[71] Because of this, some institutions have created programs where other incarcerated individuals provide support to those living with cognitive decline in carceral settings.[72] While these programs show some promise, they have not been thoroughly evaluated and more research is needed to determine their effectiveness. Within already existing units, prisons can implement relatively low-cost environmental modifications to improve the experiences of individuals living with cognitive decline. For instance, using large signs and different colors of paint to mark separate areas of the prison, allowing more time for individuals living with cognitive decline to respond to directives, and implementing special programming (e.g., arts-based activities) could improve the experiences of individuals living with cognitive decline in carceral settings.[73]

Recommendations

- To the extent individuals cannot secure early release, prison systems should develop specialized units to provide adequate medical care and maintain dignity for those living with cognitive decline.
    - All staff on the unit, whether medical professionals, correctional officers, or other incarcerated individuals, should receive robust training on dementia care. Organizations like the National Council of Certified Dementia Practitioners offer training and certifications specific to those working in correctional settings.[74]
    - Prisons should make low-cost environmental modifications (e.g., large font signage) and provide special programming to improve the experience for individuals living with cognitive decline.
    - Prisons must carefully review and avoid, whenever possible, segregation of individuals living with dementia.
- Prison systems should proactively seek out researchers to evaluate any innovative treatment programs and specialty units developed to care for individuals living with cognitive decline.
- Medical researchers and dementia care providers should conduct more research into best practices for treatment of individuals living with cognitive decline in carceral settings.

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