

VIOLENT CRIMES AND DEMENTIA

STATEMENT OF

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BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

A HEARING ON

**CRIMES WITHOUT CRIMINALS?
SENIORS, DEMENTIA, AND THE AFTERMATH**

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Chairman Craig, Ranking Member Breaux, and Members of the Committee:

My name is Donna Cohen. I am a professor in the Department of Aging and Mental Health and Head of the Violence and Injury Prevention Program in the Louis de la Parte Florida Mental Health Institute at the University of South Florida. I am one of the original founders of the national Alzheimer's Association and a founding member of the association's Medical and Scientific Advisory Board. I also serve on a caregiving panel within the Roslyn Carter Institute on Human Development dealing with end of life issues regarding Alzheimer's disease.

Thank you for convening this important hearing about how persons with dementia are treated in our health care and criminal justice systems. This is another welcome demonstration of your vital concerns about improving geriatric mental health care and clarifying critical elder justice issues.

Thank you also for inviting me to testify about my research, experiences, and recommendations with regard to crimes involving older persons with dementia. There are many compelling issues, including but not limited to, assault and battery, sexual assault, vehicular injury, attempted homicide, homicide, and homicide-suicide. My comments before you today will focus on two types of lethal violence perpetrated by individuals with dementia—homicide and homicide-suicide—and I will address the following areas.

- The Magnitude of the Problem
- Risk Assessment for Dangerousness
- Legal Challenges
- Recommendations

However, I would first like to put a face on the lethal circumstances.

In August 1996, Howard Darst, an 89-year old man in Sarasota, Florida, was accused of beating his 88-year old wife to death with his cane. Both had been diagnosed with dementia. The night of the killing the couple had arranged with their home health aide to sleep on recliners in the living room, rather than their bedroom, in order to watch the closing ceremonies of the Olympic games in Atlanta. It appeared that Mr. Darst, who had been diagnosed for about ten years, had awakened sometime during the night in unfamiliar surroundings. He was probably frightened by something and beat his wife, not knowing who she was. Although an arrest warrant was issued after the law enforcement investigation, charges were dropped after the family agreed to place him in a secure nursing home. Mr. Darst had no memory or insight into what he had done but he did miss his wife. He became progressively frail and died six months later.

In November 2003, Frank Kuykendall, an 86-year old resident of an assisted living facility in Eugene, Oregon, shot and killed another resident, 89 year-old Joe Bruscia, in a commons area. He then went to the room he shared with his 86-year old wife, Ruby, and shot her before turning the gun on himself. Mr. Kuykendall died at the scene, but Mrs. Kuykendall and Mr. Bruscia died later at the hospital. Mr. Kuykendall had been

increasingly upset with Mr. Bruscia's many visits with his wife, including one the day of the killings. The homicide-suicide was the tragic end-result of an ongoing dispute among the three individuals, all of whom had been diagnosed with dementia.

The Context of the Challenge of Lethal Violence by Individuals with Dementia

There is an emerging literature on severe violence and dementia, but little is known about the prevalence and clinical patterns of severe violence leading to death perpetrated by individuals with Alzheimer's disease, vascular dementia, and related dementias towards other persons at home and in long term care. To my knowledge, there are no empirical studies of the prevalence, risk factors, and clinical patterns. Dementia homicides are probably rare, but they are of increasing concern to family members, health care providers, mental health care professionals, community leaders, and law enforcement.

It is important to underscore that there are several types of severe violence involving individuals with dementia and their family/formal caregivers that also have important and complex clinical, legal, and policy implications. Patients as well as caregivers can be perpetrators and victims of abuse, injury, and lethal violence.

Although lethal violence is relatively uncommon at the moment, it is possible that homicide and severe violence may increase as the population ages, accompanied by increasing numbers of individuals with Alzheimer's disease and related dementias. The American Public Health Association has classified dementia as an emergent epidemic. Alzheimer's disease is 1.5 times more common than stroke or epilepsy and as common as congestive heart failure.

In 2000 there were at least 4 million persons with Alzheimer's disease and related dementias in the U.S., and that number is estimated to increase to between 11.3 million to 16 million Americans by 2050. There were an estimated 36 million afflicted persons in the world in 2000, and this number is conservatively projected to increase to more than 85 million by mid-century. If we add another 18-16 million Americans with Mild Cognitive Impairment (MCI), a condition that may be a precursor to Alzheimer's disease, and add 170-340 million persons around the world with MCI to the projections for 2030, we are indeed facing a world crisis in caring.

Magnitude of the Challenge and Need for Surveillance

Research is needed to determine incidence and prevalence of dementia offenders. It has long been known that homicide rates for older persons are very low compared to younger persons. In the U.S. older offenders commit 3-6% of homicides, but there are no national or state data on homicide offenders with dementia.

The national reporting system of the Department of Justice (DOJ) is focused on crimes and victim characteristics, with little information about offenders. The National Incident-Based Reporting System (NIBRS) for crime statistics only codes the offender's age and relationship to the victim.

The Centers for Disease Control (CDC) has been implementing a National Violent Death Reporting System (NVDRS) to better understand the characteristics of violent deaths and find ways to prevent them. The NVDRS is based on the work of a research consortium developing a National Violent Injury Statistical System (NVISS). Discussions with staff at the coordinating site in the Harvard School of Public Health and staff at several of sites around the country confirmed that offender data are less comprehensive than victim data, given limitations in the law enforcement and medical examiner/coroner reports. The NVISS does not have a diagnosis specific code for dementia, but does code for the presence of mental health problems in offenders, when the information is available.

In the absence of national data, my Violence and Injury Prevention Program at the University of South Florida, conducted a two-year retrospective newspaper surveillance study using the BurrelleLuce's Information Service to ascertain news stories where a patient with dementia killed another person. The BurrelleLuce service surveyed 1734 United States daily newspapers from 2002-2003. A total of 9 cases were identified where a dementia patient, ranging in age from 74-68 yrs., committed homicide: 90% were men, 90% killed a spouse or intimate, 20% were homicide-suicides, 80% used a firearm, and 90% of the incidents occurred at home. Although newspaper surveillance has methodological limitations, my previous studies with Burrelle have shown congruence between medical examiner newspaper data for homicide-suicides. The observed estimated prevalence for dementia perpetrated homicide-- 0.22 per 100,00 persons with dementia--is likely an underestimate.

A previous newspaper surveillance study on homicide and dementia in our program showed that more than half of all incidents reported occurred in long term care facilities. Long term care reporting systems at the state level record resident-on-resident violence, but, unfortunately, they do not specify fatalities.

Over the past ten years my research team has been tracking homicide-suicides in Florida, and individuals with dementia perpetrate less than 1% of these incidents. Although homicide-suicides are rare compared to suicides and homicides, they have a dramatic and long term impact on family members and communities where they occur.

Risk Assessment for Dangerousness

There is a significant literature on the assessment of violence and dangerousness in persons with psychiatric disorders, but research on patients with dementia is limited. The best predictor for violence is a history of previous violence, and if there is no history, clarification of the closest the person ever came to being aggressive or violent. Active paranoia and psychotic symptoms are also risk factors. However, the prediction of the risk for dangerousness is difficult.

Research is critical to identify and clarify factors that increase vulnerability to homicidal behavior in persons with Alzheimer's disease and related dementias as well as to predict and prevent homicides. My clinical research and legal experience suggests that the

following antecedent factors increase the risk for homicidal behavior in persons with dementia:

- History of previous violence or “other-directed” behaviors
- History of alcohol abuse
- Active paranoia and other psychotic symptoms
- Psychotic depression
- Vascular dementia
- History of catastrophic reactions
- Traits such as low frustration tolerance and aggressivity
- Military/law enforcement/firefighter history

Precipitating factors are more difficult to identify. Homicides perpetrated by individuals with dementia are often violent. A 76-year old husband with dementia stabs his wife in the head with a pick-ax, killing her. A 62-year old daughter shoots her 90-year old mother before turning the gun on herself. An 80-year old husband beats his wife to death with a telephone and cane. An 85-year old man stuffs plastic in the mouth of a bedridden assisted living resident and smothers her with a pillow.

However, in almost all cases, these are not willful and intentional acts to injure and kill. They are tragic outcomes of a combination of circumstances: the individual’s sensory, cognitive, emotional, and physical status; the individual’s fearfulness and ability to communicate; awareness and preparedness of others who interact with the patient; biopsychosocial and environmental stressors; and the availability of firearms, knives, heavy objects, and other lethal means.

Random circumstances (e.g., food fights, sudden confrontations) or long term frustrations (e.g., jealousy) may escalate rapidly at home or long term care settings when patients are frightened, angered, or have catastrophic reactions to other persons, events, or circumstances. The testimony of U.S. Navy Cmdr. Gary Gotham about the death of his father, Ivan Gotham, February 7, 2004 should compel us, as professionals and human beings, to find ways to prevent these unnecessary tragedies in our communities.

Legal and Policy Challenges

Homicides and other crimes present complex legal challenges for law enforcement, prosecutors, defense lawyers, judges, mental health professionals, government officials, and caregivers to balance the humane needs of individuals with dementia with the need to protect the public.

Law enforcement officers are usually the first responders when violence occurs, and they often lack training to understand and handle individuals with dementia. Patients are often arrested, interrogated, and jailed for months because alternatives are not available. Model programs exist in many states that provide training programs for law enforcement, monitor jails on a daily basis for dementia patients, and provide mental health/law enforcement dementia response teams in the community.

Within the criminal justice system lawyers and judges are faced with considerations about the nature of the killing, the severity of the dementia, and competency to stand trial. Legal issues include decisions about whether to charge the patient, prosecute the case, transfer the patient to forensic wards, geriatric facilities, or other options. Most individuals are not prosecuted when they are clearly incompetent, but the determination can be difficult when the patient is mildly impaired. When killings occur in long term care facilities, lawsuits may be filed by a victim's family against the nursing home or assisted living residence.

Recommendations

There are several priorities for the future, including but not limited to the following:

- Lethal violence research, including surveillance, intervention studies to prevent violence and the effectiveness of traumatic family support
- Education and training for law enforcement
- Development of programs such as Crimes Against the Elderly Units within law enforcement agencies
- Active dementia violence policy and program development within the Attorney General offices of each state
- Education and training for health care professionals in acute and long term care
- Development of collaborative community efforts and programs to respond to the needs of patients who are violent and the victims of violence
- Consideration of state laws to not allow persons with dementia to possess firearms
- Consideration of state laws to ban firearms in assisted living settings

Commentary

Lethal violence by individuals with dementia may be a rare phenomenon, but abuse and violence by formal and informal caregivers towards patients is much more common. Both circumstances have a common denominator—the need to identify, intervene, and prevent the abuse, injury, and death.

I thank you for the opportunity to speak before you today.

