Dear Dr. Jeff:

Our state is planning to solve prison overcrowding issues and save money by transferring prisoners to skilled nursing facilities, where the costs will be federally reimbursed. I am worried about this whole process, however, I know that our owners will want to fill our empty beds. I saw in a recent issue of this paper that you are involved with this issue. What special concerns should we have?

A n article in the September issue of JAMDA reviewed state policies regarding the placement in long-term care facilities of current inmates, parolees, and those known to have been previously convicted of various criminal offenses (JAMDA 2011;12:481-6). Because these policies vary across the country, you should make sure that you are fully compliant with the regulations in your state.

For example, some states have laws forbidding the placement of registered sex offenders within various distances from schools or playgrounds. However, there is no specific federal regulation or advisory, and many states have no regulation limiting this process. The AMDA House of Delegates called for the association’s board to collect further information and to initiate discussions with the Centers for Medicare & Medicaid about balancing the needs of this growing population with the legitimate safety concerns of other residents and families. The authors of the JAMDA article wisely recommended independent assessments of the risk that potential residents might injure other residents or staff. To my knowledge, there is no validated assessment tool that is currently available for this purpose.

Also unfortunately, state regulations concentrate on interpreting laws addressing offenses, primarily sexual offenses, rather than the potential risk to people in contact with an offender. The teacher who had sexual contact with a senior student many years ago may be the subject of headlines, but probably poses little danger to other residents in a long-term care facility.

Even genuine pedophiles probably pose little threat in a geriatric facility. Indeed, the community may be safer with these people in geriatric facilities rather than at home. By contrast, most experts consider rape to be a crime of violence, not a sexual offense.

Although Bernie Madoff will not be eligible for parole in my lifetime, older white collar criminals generally receive short sentences and early parole. They often have community ties and available resources. Should they become ill and physically dependent, they are likely to get home care, but they might also require nursing home placement from time to time. Do these inside traders and embezzlers represent a potential threat to fellow residents? In most cases, our residents lack sufficient funds to be attractive victims.

Society and particularly elderly people may not be safe from scam artists, but a nursing home is ultimately not responsible for even thieves’ previous financial behavior.

Big House, Big Responsibilities

In the course of working with the New York State Department of Correctional Services to improve prison health care for aging prisoners, I have had the opportunity to review the statistics regarding prisoners older than age 55. Virtually every such “aging” inmate in a New York facility was sentenced for a crime of violence, primarily homicide with some armed robbery.

The department currently manages four skilled nursing units in prisons, as well as one specialized dementia unit and a hospice. In fact, the state has several prisoners who remain incarcerated, despite having completed their sentences, because they are too sick to return to the community and no skilled nursing home will accept them. They generally have complex medical problems that they can’t manage on their own, such as insulin-dependent diabetes with mild cognitive impairment, and are without community support.

New York is one of several states with a declining prisoner census, largely because the justice system is trimming sentences and decriminalizing various aspects of drug use. Our projects have focused on improving geriatric services within the prison health system and providing better transitions of released and paroled men to the community.

I have been positively impressed with the commitment of the corrections department, its parole division, and the health care professionals within the prison system to provide quality medical care for everyone.

The key issue for nursing homes, as well as skilled living facilities, and home health agencies is the protection of the people—both staff and residents—who live and work near an individual with a history of violent behavior.

Nursing home staff are already asked to have direct physical contact with many patients who display physically aggressive behavior. As medical directors who review employee accident and incident reports, we most commonly see injuries that are caused by residents who hit,scratch, or kick members of their care team. Generally—but not always—these residents have significant dementia.

Nursing homes are not designed or staffed to provide care for violent individuals, regardless of what a care plan might say. We have no right to put our employees at increased risk. Prison guards are armed; our staff are expected to be alone with residents in private places.

Federal and state inspectors are increasingly examining charts to evaluate facilities’ ability to protect residents from abuse and resident-on-resident violence. Clearly, the addition of new residents with significant histories of violent behavior presents a serious potential risk to residents and staff, to survey performance, and even to a facility’s liability situation.

For example, if the facility knowingly admits a new resident who has previously (albeit many years ago) committed a violent offense, and that resident violently injures or kills another resident, a negligence suit will be filed before the body hits the floor.

On the other hand, many current prisoners are serving long sentences for crimes they committed while under the influence of illegal drugs or alcohol, circumstances now long in their pasts and unlikely to be related to their behaviors in long-term care. The war on drugs has created a mass of prisoners, largely black and Latino underclass males, who are serving long sentences for crimes that have been disproportionately prosecuted as severe offenses even in the absence of violence.

As those who read mysteries or watch television certainly know, the majority of murderers are committed by family members. Those who loved Morgan Freeman and Tim Robbins in “The Shawshank Redemption” should remember that they were both convicted murderers. Aging does genuinely make some people, while others who might become violent under special circumstances are not necessarily violent psychopaths.

Crime and Banishment?

I believe that a responsible admissions process would include a full evaluation of the actual crime that resulted in an ex-prisoner’s conviction, and its potential relevance to a new environment. Clearly, the threat posed by a bed-bound patient with a tracheotomy would be different from that posed by a resident who is still vigorous and independent enough to walk around.

Also, there needs to be an honest sharing of information regarding a prisoner’s behavior in prison. Is the prisoner continuing the gang ties that contributed to the current incarceration? Is there a record of ongoing transgressions while in prison? Whenever doubt exists, an independent mental health professional should perform a psychological evaluation to determine the level of risk. States that are committed to a genuine process, rather than a fiscal maneuver to slough off problem prisoners, need to commit targeted funding to this process.

In the current long-term care climate, most admissions to nursing homes come directly from acute care hospitals. I am unaware of any hospital that collects parolee status, much less prior criminal history, along with the social history. Hospitals in New York City expect an acceptance or rejection within a few hours of a referral to a subacute center.

We don’t currently check the criminal records of our residents or potential admissions. Under these circumstances, most parolees or others with criminal records will probably enter long-term care facilities long before their record is revealed.

Some of the residents in my facility have been relatively open about their prior histories of prostitution, drug use and dealing, or fraud, although none has been forthcoming about prior violent crimes. Although one demented elderly resident did try to offer her sexual services to the housekeeping staff in exchange for packs of cigarettes, these former “offenders” have not presented any insoluble management problem to the facility.

On the other hand, the rare resident who we come to learn has had significant violent issues in the past, particularly physical abuse of a spouse or child, has usually had minimal contact with the criminal justice system.

A criminal record, per se, should not be a barrier to placement in long-term care. We must ensure that as a country that incarcerates the largest percentage of its population, we do not continue the process of punishment when individuals become old and frail. Reasonable precautions to protect vulnerable elders must not be used as a barrier to our care of the poor and disadvantaged.

By Jeffrey Nichols, MD

DR. NICHOLS is the vice president for medical services of the Cabrini ElderCare Consortium in New York City, which includes two skilled nursing facilities, three home care agencies, two adult day care programs, and a senior housing complex. He invites your questions for possible discussion in this column. Please submit them by e-mail to caring@elsevier.com.