In a previous editorial I wrote for the Journal of Gerontological Nursing (Loeb, 2009), I made the case for introducing advanced practice nurses with geriatric/gerontological nursing expertise into correctional settings to better address the needs of the growing population of older adults living in our nation’s prisons. An increasing portion of these older prisoners require 24-hour-a-day care in what are sometimes referred to as “barbed wire nursing homes”—a service that prisons were never designed to deliver. I now ponder if not only the expertise of gerontological nurses is needed inside prisons, but also if the reverse will soon be a pressing need as well: enlisting nurses, including advanced practice nurses, from correctional health care settings to share their knowledge with staff in community-based long-term care facilities. Regardless of personal views on releasing aged, infirm prisoners, the reality is that correctional settings are overcrowded as well as cash strapped, and selective decarceration has been proposed by some as an approach to dealing with prison overcrowding and the considerable cost of caring for old and infirm inmates who no longer pose a threat to others (Kerbs, 2000; Snyder, van Wormer, Chadha, & Jaggars, 2009). In fact, prison officials have “begun to recognize that older offenders might be better candidates for early release because of their low recidivism rates” as compared to young offenders (Snyder et al., 2009, p. 121). Similarly, Williams, Sudore, Greifinger, and Morrison (2011) point out that many states are looking beyond just those with terminal diagnoses for medical release to also include older prisoners in general and those with physical incapacity.

The question that cries out to be answered is: how does a nursing home prepare if some of its future residents will be transitioning not from their free-world home, but rather from prison? Key issues to include in preparing for this new population of long-term care residents are paying for community-based long-term care; developing relationships with the referring correctional institutions; promoting the smooth transition of older inmates; and overcoming community resistance.

One important consideration is payment for nursing home services. If a prisoner has completed his or her sentence and is now a free person, Medicaid eligibility is likely, with the exception of the presumably small number of older inmates with personal wealth—those individuals could be required to private pay. Some released prisoners who are still technically incarcerated (Zietlow, 2012) may not be eligible for Medicaid; therefore, nursing homes may be challenged in particular cases to decide whether they are willing to...
use charitable dollars to care for these individuals.

Developing valuable relationships with the correctional institutions could be achieved through an interdisciplinary team of key nursing home staff visiting the prisons. Viewing prison conditions will raise nursing home staff awareness about the environmental context from which their new residents are transitioning. Also, the visits will facilitate the building of important connections and promote future communication across these different institutional settings. Programs can be developed to help inmates during the transition from prison to long-term care in the community and help the prisoners to be better prepared for the changes that await them upon their release/parole. Finally, staff members who visit the prison settings can share what they learned with their coworkers to make the entire long-term care institution ready to receive this new type of resident.

Transitioning prisoners to nursing home settings can be facilitated through careful release planning by prison nurses, physicians, social workers, and security staff working in tandem with admission planning by long-term care facility staff (e.g., nurses, social worker, physicians, and chaplain) in the weeks prior to release, similar to what was reported by Zietlow (2012). Considerations include putting in place programming to meet any special needs (e.g., end of life, mental health, dementia, and rehabilitation); and facilitating connection or reconnection with family members. If family ties are lacking, connections could be made with community faith-based organizations or Veterans Affairs to help fill the void. Counseling is needed to help these older adults (more than 90% who are men) transition from prisonization, where they depend on prison to give them structure and direction (Aday, 2006). Finally, ensuring a feedback loop is critical so that processes can be refined and communication lines can remain open between corrections and long-term care staff.

Getting community cooperation and overcoming community resistance (including “not in my backyard” groups) will be accomplished through open communication regarding how former prisoners will be housed (e.g., assessing if locked units are needed) and earning the community’s trust in the long-term care facility’s management of their previously imprisoned residents. In addition, educating the public that old, infirm people released from prison are far less likely to harm others or recidivate than their younger counterparts is important to help the community understand the alternative solutions being faced by society.

Gerontological nurses and advanced practice nurses can be key players in promoting the transition of older prisoners from correctional institutions to long-term care facilities—reaching out to work hand-in-hand with fellow nurses from the frontlines behind the walls of prison. Such collaborations can facilitate sharing of best practices, including those for safety. For example, safety practices that I shared with undergraduate clinical students prior to them caring for inmate patients in community hospital settings included giving respect; setting limits on personal information shared (e.g., not providing last name, home location, or family member information); providing good quality care; not wearing stethoscopes or necklaces around their necks; and securing supplies outside of residents’ rooms (e.g., needles, tape, scissors). Together these nurses can contribute in small but important ways to addressing what Masch (2012) describes as a “morally and financially expensive humanitarian crisis” (para. 6) of long-term confinement of older adults.

REFERENCES


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