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Caring in Correctional Nursing: A Systematic Search and Narrative Synthesis

Kirnvir Dhaliwal, RN, MN and Sandra Hirst, RN, PhD, GNC(C)

ABSTRACT

Registered nurses are the primary healthcare providers for offenders in correctional facilities. The way in which correctional nurses care for offenders can be difficult in this context. Following a systematic review and narrative synthesis of literature regarding how correctional nurses show caring for offenders three themes emerged: the struggle of custody and caring (conflicting ethical and philosophical ideologies, correctional priorities that override nursing priorities, safety and security), the need to be nonjudgmental (judgmental attitudes can impact care; focus on health not the crime), and the importance of boundaries. Implications for practice focus on recommendations to promote caring in correctional nursing; the outcome of which will potentially enhance quality of care for offenders and improve working environments for nurses.

KEY WORDS:

Boundaries; correctional nursing; custody and caring; narrative synthesis; nonjudgmental attitude; systematic search

Background

The prison population is composed of diverse ethnic and racial groups, of varying socioeconomic status ("Caring in Corrections," 2010). Offenders have multiple health concerns including mental health problems, communicable diseases, chronic conditions, and histories of substance abuse ("Caring in Corrections," 2010; Cooke, 2002; Flanagan & Flanagan, 2001; Maroney, 2005; Melillo, 2009; Redgewell, 2010). The aging offender population represents a growing concern (Flanagan & Flanagan, 2001; Maroney, 2005), because this group in particular, experiences health disparities within the correctional environments (Melillo, 2009). Correctional healthcare is a nurse-driven system (Flanagan & Flanagan, 2001). Nurses play a key role in providing care to offenders in correctional facilities ("Caring in Corrections," 2010). Correctional nurses (CNs) attend to the healthcare needs of offenders from the time they enter the system, through transfers to other facilities, and to their release into the community ("Caring in Correction," 2010). Specific nursing responsibilities depend on the size of the institution and type of offender population (Flanagan & Flanagan, 2001).

CNs must possess exceptional communication, teamwork, and assessment skills to effectively meet their responsibilities. Essential attributes of CNs include professionalism, confidence, and autonomy, in addition to personal characteristics such as stability, integrity, and assertiveness (Day, 1983). As primary healthcare providers, CNs provide various healthcare services to offenders including emergency, medical–surgical, and mental health (Hunt, 2004; Stevens, 1993). The nursing role is performed within the context of correctional healthcare policies, professional standards, and correctional facility policies.

The potential for violence when caring for offenders in secure correctional environments is a common experience of CNs (Redgewell, 2010). Working with offenders is perceived to be dangerous and stressful (Coffey, 1999). Nurses are aware of the potential physical and psychological risks associated with working in correctional environments (Weiskopf, 2005). Coffey (1999) reported that nurses ranked working with patients with violent histories as a highly stressful factor. CNs' failure to address the potential for violence may shift their intentions from providing healthcare to attempting to cope in secure environments, thereby impacting quality of care. Hufft and Fawkes (1994) and Peternelj-Taylor and Johnson (1995) reported that institutionalization may occur when CNs align their practice with

Author Affiliations: *University of Calgary.*

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Correspondence: *Kirnvir Dhaliwal, RN, MN, Faculty of Nursing, University of Calgary, 2500 University Drive N.W., Calgary, Alberta, Canada T2N 1N4.*

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the mandate of corrections, and correctional officers, and as such are unable to meet their professional standards, thereby hindering the development of therapeutic relationships. Consequently, some CNs may experience diminished caring toward offenders (Alexander-Rodriguez, 1983), leading to the failure to provide individualized care (Hufft & Fawkes, 1994). The penal harm mentality common to most secure environments may overwhelm CNs, and negatively influence nursing practice (Maeve & Vaughn, 2001).

Caring is the core of nursing (Maeve & Vaughn, 2001). CNs must deliver healthcare services in a caring manner to facilitate offenders' health and well-being (Weiskopf, 2005). The way in which CNs show caring requires exploration. As a result, a systematic search and narrative synthesis was conducted. The goal was to identify the challenges of caring in corrections and to provide recommendations to promote caring in correctional nursing.

Method

The Systematic Search

The systematic search was guided by the Centre for Reviews and Dissemination (2009) document. Inclusion criteria included research and nonresearch articles and gray literature (dissertations, conference proceedings, and government or organization reports) published in English with no specific time lines. The focus was on CNs portraying caring, caring for, and working with adult offenders in secure correctional environments (e.g., prisons, jails).

Acknowledging the international differences in terminology is important. For example, the search term forensic nursing ("forensic nurs*") was used, which may be defined in various ways. The International Association of Forensic Nurses (2015), based in the United States, describes forensic nursing practice in various fields (e.g., sexual assault, death investigation, and corrections). In North America, the terms forensic psychiatric and correctional nursing may be interchangeably used (Kent-Wilkinson, 2009). Shelton (2009) noted that forensic nurses who work with offenders in the United States are identified as correctional or prison nurses, that is, "who provide care in secure environments" (Shelton, 2009, p. 131). In Ireland, forensic (psychiatric) nurses are employed in secure psychiatric facilities or hospitals, whereas nurses working in prisons are referred to as prison nurses (Timmons, 2010). Regardless of the different terminologies, forensic nursing consists of working with victims of crime and with offenders (Shelton, 2009).

The electronic databases used were CINAHL, Criminal Justice Abstracts, MEDLINE, ProQuest (dissertations and theses), Psychology and Behavioral Sciences, Social Work Abstracts, and SocIndex. The *Journal of Correctional Health Care* was hand searched (1[1] to 20[4]) using the same inclusion criteria. One electronic search using the search terms ("correction* nurs*," "forensic nurs*," "prison* nurs*," prison*, "forensic patient*," offend*, inmate*, jail*, and caring) was ran within each database, and the results were imported into Refworks. The process of eliminating the literature was based on the inclusion criteria.

Initial screening was conducted by two screeners at the title and abstract level. Articles either met or did not meet the inclusion criteria. When in doubt, full articles were obtained. Next, included and "when in doubt" articles were read in full and included or excluded accordingly (see Figure 1). Conversations between the two reviewers occurred to obtain agreement. Data extraction (Bonnel and Smith's [2014] example tool for research articles) and critical appraisal (McMaster University Qualitative [Letts et al., 2007] and Quantitative [Law et al., 1998] Critical Review forms) were conducted using established tools. Data extraction and critical appraisal tools for nonresearch articles and gray literature were obtained from Premji, Serrett, Benzies, and Hayden (2004), which were adapted with permission.

The Narrative Synthesis

A narrative synthesis was selected because most of the literature reviewed was nonresearch literature. This synthesis

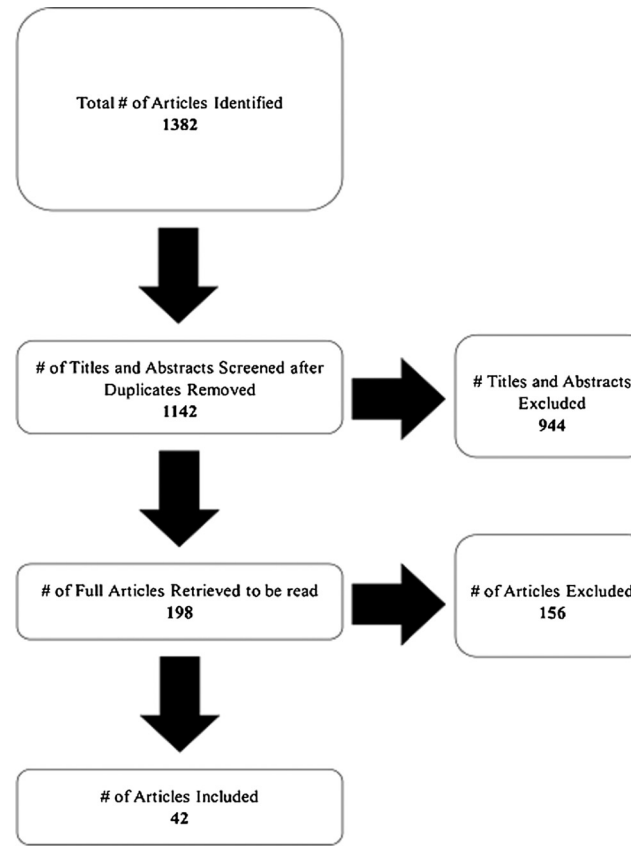

FIGURE 1. Process diagram.

relies on the use of words to summarize and explain the findings, a form of storytelling, and can be used when other forms of syntheses are not feasible (Popay et al., 2006). The narrative synthesis framework consists of four elements; these do not have to be followed in a linear manner (Popay et al., 2006).

The first element (developing a theory of how the intervention works, why, and for whom) is not always required (Popay et al., 2006). This element was not addressed because there were no interventions being evaluated. The second element (developing a preliminary synthesis) was addressed by identifying the recurrent themes across the included literature (Popay et al., 2006). This element was addressed with each document during reading, highlighting, and writing in the margins and the extraction and appraisal stages.

Concept mapping assisted in addressing the third element (exploring relationships and involved linking multiple pieces of evidence (e.g., emerging themes from the preliminary synthesis; Popay et al., 2006). Themes identified from the preliminary synthesis were written on cards (one card per article). The cards were organized according to the recurrent themes across the articles to form the final themes. The final themes were discussed by the reviewers to ensure agreement. The fourth element (assessing the robustness of the synthesis; Popay et al., 2006) occurred by addressing the strengths and limitations of the systematic search and narrative synthesis.

Results

A final 42 articles were included; 31 were nonresearch, and 11 were research (10 qualitative and one quantitative). Three of the 31 nonresearch articles were not peer reviewed. One article was a position statement. Six of the 31 nonresearch articles identified the type of literature (e.g., anecdote, editorial). There were no conference proceedings, dissertations, and government or organization reports located in the electronic databases, *Journal of Correctional Health Care*, and reference lists, which met the inclusion criteria.

From the 31 nonresearch articles, six were from Canada, 12 were from the United States, two were from Australia, eight were from the United Kingdom, and two were from New Zealand. The International Council of Nurses' (ICN, 2011) position statement was developed in Switzerland. From the 11 research articles, two were from Canada, four were from the United States, two were from Australia, one was from the United Kingdom, and two were from Sweden. Flanagan and Flanagan's (2001) article was the only quantitative study, which used surveys. For the remaining 10 studies, researchers used qualitative designs based on their research questions. All researchers appropriately used purposive sampling, thereby allowing the selection of participants who will provide rich data (Streubert & Rinaldi-Carpenter, 2011).

Foster, Bell, and Jayasinghe (2013) reported a small study sample size as a limitation. However, qualitative researchers should focus on obtaining rich data saturation (Streubert & Rinaldi-Carpenter, 2011). Maroney (2005) and Maeve (1997) reported sample sizes of 20+ participants, yet did not mention data saturation. Two qualitative studies by Foster et al. (2009) and Weiskopf (2005) provided adequate details regarding qualitative rigor (e.g., credibility and transferability). For example, Weiskopf used phenomenological experts to review data analysis and additional CNs to explore the study's fittingness. Foster et al. (2009) and Weiskopf recognized their findings may not be transferable to all settings.

Kumpula and Ekstrand's (2009) Swedish study met the inclusion criteria, yet was different when compared with other studies. Male nurses' culture of masculinity may impact the "caring culture" and how they care for male patients (Kumpula & Ekstrand, 2009). This focus on male CNs provides a gender perspective on caring requiring further exploration.

Themes

The Struggle of Custody and Caring

The struggle of custody and caring consists of the subthemes as follows: conflicting ethical and philosophical ideologies, correctional priorities that override nursing priorities, and safety and security. Authors mentioned custody and caring (Austin, 2001; Maroney, 2005; Peternelj-Taylor, 1999; Peternelj-Taylor & Johnson, 1995) and identified the competing demands that impacted on the moral climate in forensic (e.g., correctional) settings (Austin, 2001). Custody and caring was further described as adversarial because nurses practice within secure settings (Maroney, 2005). As such, CNs face dual obligations of social necessity (custody) and social good (caring; Peternelj-Taylor, 1999), which presents conflicting goals (Peternelj-Taylor & Johnson, 1995).

CNs have the dual mandate of therapy and social control, contributing to difficulties in establishing a nursing identity and carrying out nursing activities (Jacob, 2012). This fusion between care and custody may further contribute to role ambiguity for nurses (Jacob, 2012). An increased focus on correctional imperatives could lead to the loss of nursing values impacting the quality of care. Forensic psychiatric caring is complex because of the dilemma of providing custodial care (Hörberg, 2014). Caring versus custody is a main factor differentiating correctional nursing from other nursing specialities (G. Ferszt as cited in Hernandez-Sherwood, 2012).

Conflicting Ethical and Philosophical Ideologies

Authors mentioned conflicting ethical (Brodie, 2001; Burrows, 1995; Crampton, 2007; Hammer, 2000; Walsh,

Freshwater, & Fisher, 2012) and philosophical (Alexander-Rodriguez, 1983; Day, 1983; Doyle, 1999, 2003; Stevens, 1993) ideologies to indicate the struggle of custody and caring.

Little is known regarding nurses' understanding of caring in challenging situations (Crampton, 2007). Ethical dilemmas arise as nurses try to maintain objectivity (e.g., nonjudgmental attitude) "in the face of what maybe a trauma of significant magnitude" (Hammer, 2000, p. 22), as they address their patients' healthcare needs. "Double agentry" occurs when one (nurse) attempts to serve the interests of the client (offender), while serving the correctional institution who is their employer; Peternelj-Taylor & Johnson, 1995). Consequently, tensions among CNs and correctional officers may exist (Cooke, 2002; Maeve, 1997).

The ideological intrusion of a disciplinary philosophy is antithetical to the values of nursing (Doyle, 1999, 2003). Healthcare delivery in the correctional environments is a philosophical problem (Day, 1983) because of the conflicting goals inherent in correctional healthcare and correctional administration (Alexander-Rodriguez, 1983). Nurses are challenged to remain true to the nursing philosophy and not be "converted to the role of prison keeper" (Alexander-Rodriguez, 1983, p. 116).

Correctional Priorities Override Nursing Priorities

Healthcare is not the primary purpose of correctional environments (Berg, 2008; Brodie, 2001; Dale & Woods, 2002), yet CNs must provide quality unbiased care (Berg, 2008). Correctional mental healthcare is dominated by prison architecture and "the artifice of surveillance and control" (Doyle, 2003, p. 308). Physical environments are characterized by secure perimeters and technology and developed to seclude, segregate, and confine (Doyle, 1999, 2003; Hufft & Fawkes, 1994). Caring work in correctional environments is challenging because of control, coercion, security, order, and discipline (Walsh et al., 2012; Willmott, 1997). Individualized care is juxtaposed with the correctional mentality, which focuses on the "control of masses through application of strict regulations" (Jacob, 2014, p. 49).

CNs may be pressured to conform to the custodial mentality (Maeve & Vaughn, 2001), which could override the element of humanity (Willmott, 1997). Nurses may experience a loss of practice ownership because nursing values are compromised to accommodate the philosophical correctional priorities of compliance, segregation, and discipline (Doyle, 1999). Cognitive dissonance may be experienced because of the dichotomy of custody and caring (Jacob, 2014). Such dissonance occurs when individuals are asked to perform tasks, which conflict with their value system (Jacob, 2012, 2014). For example, correctional officers may recommend offenders be placed in segregation because of disruptive behavior, yet CNs believe this to be unethical because the behavior is due to mental illness requiring therapeutic interventions.

When correctional priorities override nursing priorities, CNs may feel they and their care provided are devalued (Stevens, 1993; Weiskopf, 2005), hence healthcare services may become a privilege, not a right (Stevens, 1993). Correctional officers sometimes treat CNs with the same disdain as they treat offenders, which may undermine nursing practice (Maeve, 1997). Consequently, CNs encounter difficulties developing positive relationships with correctional officers. Correctional officers are guided by different ethical principles than CNs, which may impact the development of positive relationships (Maeve & Vaughn, 2001). Maintaining positive relationships with correctional officers is required because of the violent environments (Maeve & Vaughn, 2001; Maroney, 2005). Nurses must integrate correctional priorities into their practice to contribute to the safety of these environments (Maeve & Vaughn, 2001). It may seem that correctional officers are restricting CNs from portraying caring, yet correctional priorities do not imply that caring is impossible (Maeve & Vaughn, 2001). There is a need for greater communication among staff (Maroney, 2005) to promote collaboration.

Safety and Security

The dominance of safety and security over healthcare practice exists (Brodie, 2001; Dale & Woods, 2002; Flanagan & Flanagan, 2001; Hernandez-Sherwood, 2012; Jacob, 2014; Redgewell, 2010; Rogalla, 2002). CNs are challenged to find the balance between providing care and the need for security (Berg, 2008; "Caring in Corrections," 2010; Foster et al., 2013; Hufft & Fawkes, 1994; Peternelj-Taylor & Johnson, 1995; Weiskopf, 2005). Nurses may experience difficulties in maintaining therapeutic relationships with the rigidity and emphasis on security (Jacob, 2014). Correctional environments may impose their "own internal frame of reference making it difficult for outsiders (nurses) to actualize" caring behaviors (Jacob, 2014, p. 49). Nurses must understand the importance of working within security policies (Brodie, 2001); not adhering to security policies may cause conflict with correctional staff (Willmott, 1997).

The conflicting philosophies of custody and caring will always exist, as the primary function of corrections is custody (Norman & Parrish, 1999). Dichotomous thinking regarding custody and caring may not be the solution to address this struggle (Peternelj-Taylor & Johnson, 1995). Crampton (2007) asked "how do nurses deal with this type of moral and ethical conflict?" (p. 32). CNs must comprehend and confront the provision of social good (caring) in environments devoted to social necessity (custody; Peternelj-Taylor, 1999). Custody and caring can coexist (Maroney, 2005).

The Need to be Nonjudgmental

CNs must recognize that judgmental attitudes can impact on the care that they provide, which leads to the need to focus on the offender's health and not the crime. Stigmas exist regarding characteristics of offenders, such as poverty, mental illnesses, substance abuse, and criminal behavior (Doyle, 2001; Maeve & Vaughn, 2001). As a result, recruitment of professionals is difficult because offenders are not viewed as valuable within society (Maeve & Vaughn, 2001).

Judgmental Attitudes can Impact Care

CNs must control their personal views (Abeyta-Phelps, 1993; Dean, 2013; Hammer, 2000). Nonjudgmental attitudes are essential to effectively portray caring (Day, 1983; Norman & Parrish, 1999; Peternelj-Taylor & Johnson, 1995; Weiskopf, 2005). CNs must cast off their biases because the offenders are disadvantaged (G. Ferszt as cited in Hernandez-Sherwood, 2012). The challenge is to put aside personal prejudices (Abeyta-Phelps, 1993). The way in which CNs view their patients may impact quality of care and outcomes (Brodie, 2001; Jacob, 2014). If staff label offenders, it may compromise professional practice (Foster et al., 2013; Hunt, 2004; Jacob, 2012; Rogalla, 2002). CNs must be aware of their assumptions, fears, and stereotypes (Cooke, 2002) and acknowledge when they are unable to work with offenders (Staines, 2007) because it may impact care.

Focus on Health, not the Crime

CNs should focus on providing quality care rather than judging offenders ("Caring in Corrections," 2010; Cooke, 2002; Dean, 2013; Routson, 2008; Staines, 2007). This may be achieved by looking past criminal behavior (Weiskopf, 2005) and acknowledging that offenders are human beings ("Caring in Corrections," 2010; Rogalla, 2002; Staines, 2007; Weiskopf, 2005) who have the right to healthcare (ICN, 2011; Maeve & Vaughn, 2001). CNs who successfully adapt to their environments "transcend judgemental and prejudicial attitudes" (Hufft & Fawkes, 1994, p. 39) and separate the crime from the offenders. Healthcare services provided "based on what a person might be charged with or convicted of, is a slippery slope that will undermine the integrity of all healthcare professionals" (Maeve & Vaughn, 2001, p. 61).

The process of reflection can raise awareness regarding the care provided (Hörberg, 2014). Reflexive healthcare providers are able to recognize when their personal views interfere with quality care (Cooke, 2002). When caring for offenders, it is crucial for CNs to adopt a nonjudgmental attitude and to recognize that judgmental attitudes can impact care and that health should be the focus and not the crime.

The Importance of Boundaries

Boundaries are set by correctional staff to uphold correctional priorities (Weiskopf, 2005). Weiskopf (2005) identified that boundaries restricted nurses' expression of caring. For example, the use of therapeutic touch and disclosing personal information to engage with offenders may be inappropriate (Brodie, 2001; Flanagan & Flanagan, 2001; A. Lewis as cited in Hernandez-Sherwood, 2012; Maeve, 1997; Weiskopf, 2005). Boundary development and maintenance can ensure relationships are therapeutic (Brodie, 2001) and could resolve issues arising in those relationships (Schafer, 1997). Nurses who establish boundaries for therapeutic relationships are attentive to engagement and disengagement issues (Austin, 2001).

Offenders may use manipulation and intimidation to assert power and control (Schafer, 1997). CNs must develop boundaries to prevent becoming victims of manipulation (Foster et al., 2013; Hernandez-Sherwood, 2012; Jacob, 2014). Causes of manipulation include fabricated healthcare concerns to avoid work assignments (Flanagan & Flanagan, 2001), "faking it" for medication (Foster et al., 2013), diversion or entertainment (Peternelj-Taylor & Johnson, 1995), and valid healthcare needs versus wants (Day, 1983; Hunt, 2004; Maroney, 2005). Offenders may use manipulation as a survival skill to have their needs met (Maeve, 1997; Maroney, 2005) because they have lacked opportunities to develop other life skills. Schafer (1997) stated that there is "no formula to triumph over violence and manipulation" (p. 205). Whereas, Peternelj-Taylor and Johnson (1995) reported that CNs must triumph over manipulation to avoid becoming victims of the offenders.

Caring without boundaries could cause exploitation of nurses (Schafer, 1997). Boundaries are key to maintaining objectivity and ensuring care is not compromised (B. Green as cited in Staines, 2007). CNs must embrace boundaries to develop therapeutic relationships with offenders, minimize manipulation, and uphold correctional priorities while providing quality care.

Discussion

The literature on caring in correctional nursing that was reviewed as part of this study originated from authors in developed countries. The emergence of this literature is perhaps because of strong human rights legislation for incarcerated populations (such as providing the same standard of care as provided in society), guiding philosophies of rehabilitation and reintegration into society, and mandated correctional healthcare policies. Governments and cultural practices of developing countries may not prioritize correctional healthcare. Abeyta-Phelps (1993) reported that offenders deserve the same standard of care as others in society. Flanagan and Flanagan (2001) reinforced that American "federal and state court decisions, statutes, and

agency regulations require correctional systems to provide healthcare services that approximate community standards" (p. 68). Canadian authors reported that offenders deserve the same standard of care as comparable with the community ("Caring in Corrections," 2010; Day, 1983; Peternelj-Taylor & Johnson, 1995). U.K. authors have discussed that the goals of correctional healthcare were to provide the same quality of health services provided for the public (Dean, 2013; Walsh et al., 2012; Willmott, 1997). Nurses must adhere to human rights and ethical principles when caring for incarcerated patients (ICN, 2011).

Limitations to this search and synthesis include the rigor of the search strategies and time constraints, hence references may have been missed. The narrative synthesis was guided by Popay et al.'s (2006) framework, yet there is a risk that the themes may not be completely data driven because of the authors' influence; this was addressed by outlining how the synthesis was conducted.

The type of literature located ranks lower on the hierarchy of evidence because most was nonresearch (n = 31). Evidence generated by descriptive studies, expert opinions, and case studies are at greatest risk for error and biases (Evans, 2003). Emphasis has been placed on basing healthcare decisions on the best available evidence. The available evidence has important implications for developing practice guidelines and clinical recommendations (Evans, 2003).

Implications for Correctional Nursing Practice

Implications focus on the following recommendations to promote caring in correctional nursing. The implementation of these recommendations will be influenced by the criminal justice system, in which the correctional facilities are located and operated. Critical questions remain however. How do CNs care for offenders without weakening the delicate relationship between the caring principles of nursing practice and the correctional policies? Effective nursing leadership is required to promote caring within the correctional environments, with a shared vision of quality nursing care (Brodie, 2001).

Recommendation 1

CNs should engage in scholarship by conducting correctional nursing research. The lack of research must be addressed as indicated by the type of literature located by this systematic search. Given the struggle between custody and caring, an example of a topic requiring further exploration is CNs and correctional officers' workplace relationships.

Recommendation 2

CNs in administrative positions should collaborate with correctional management to address the struggle of custody and caring, for example, the development of joint committees between healthcare and corrections to discuss communal challenges and solutions.

Recommendation 3

Nurse educators should provide joint educational activities for CNs and correctional officers using the best available evidence. Educational activities could assist in enhancing communication and collaboration among staff, thereby preventing the struggle of custody and caring. Nurse educators can develop educational activities for CNs (e.g., boundary development and maintenance).

Recommendation 4

CNs should mentor new nurses. For example, CNs could develop peer support groups to alleviate the workplace challenges.

Conclusion

This systematic search and narrative synthesis is a step toward understanding how CNs care for offenders. Caring in correctional nursing is portrayed by addressing the struggle of custody and caring and showing the need for nonjudgmental attitudes and by the importance of boundaries. The recommendations may assist CNs in caring for offenders; the outcome of which will potentially be enhanced quality of care for offenders and improved working environments for nurses.

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