Patient or prisoner? Caring in a secure environment

Sara Redgewell considers the challenges of prison healthcare from a nursing perspective.

UK nurses registered by the Nursing and Midwifery Council (NMC) are expected to abide by a code of conduct which states that nurses must 'work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community and make care of people their first concern' (NMC, 2008).

Those working within a hospital, polyclinic, or community healthcare centre are able to work towards an environment which is conducive to building a therapeutic environment. Nurses trying to provide care within the confines of secure custody are faced with complex challenges which in my opinion necessitate an overhaul of prison regimes and governing mentality to ensure health and social needs are met. As a trainee nurse, I elected to go on placement in a women's prison. During the time I spent assisting nurses, three major issues emerged: (1) The complexity of the physiological, psychological, and social needs of women in prison; (2) Working in an environment in which health is secondary to security; (3) The challenges for an established but aging nursing population.

It is commonly recognised that mental health problems are more prevalent within the prison population alongside communicable diseases, substance misuse related issues and general poor health brought about by substandard living conditions, malnutrition, and misguided health beliefs. This requires the prison nurse to be an educator, adviser, and facilitator rather than simply someone who administers medication or as someone who can sign off 'fit to transfer' forms. In the aftermath of the Department of Health's 2007 public health promotion agenda (DoH, 2007), the modern nurse should have this down to a tee. However, without the empowerment they require most nurses are left to try and make best of the situation.

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The answer to bringing about such empowerment first lies in tackling the environment. A prison inherently creates an atmosphere which commands obedience and submission rather than independence and maturity and in doing so is partly responsible for the hostility and noncompliance of its residents. The numerous locking and unlocking of doors and limited staff numbers can make it difficult for nurses to quickly access their clients. This also creates a logistical challenge in getting patients to clinics or out of other activities and to an appointment. Healthcare is often a low priority for prison residents with legal issues, family worries, adjustment issues all taking precedence. This results in low attendance rates to appointments. Security costs and complicated logistics mean that specialist appointments outside may not be made. I witnessed one patient refuse a GP's offer to organise a specialist appointment noting the 'humiliation' of having to attend with a prison officer. Rotating prisoners around the country means that healthcare relationships need to be rebuilt and often there simply isn't the time for good medical handovers. Even more worrying is the lack of communication between the prison service and community clinics. Healthcare professionals often spend valuable time trying to obtain medical notes from clinics and gaining this information is dependent upon an often distressed and disorientated client knowing their GP's contact details, current medications, and medical history.

I listened to stories of failed attempts at creating a more welcoming environment – windows that had to be locked due to faeces being thrown from them, curtain rails removed due to suicide attempts, and carpets torn up due to the

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insanitary conditions. Creating a sense of safety, trust, and care comparable to hospital or home seems like a hopeless task within a prison. Many may argue that such modifications are unjustified– after all in many eyes these people are prisoners before they are patients.

All of the nursing staff I worked with held the compassion, empathy, and commitment that the profession is celebrated for. Yet, I felt that they were restricted by poor professional development and training opportunities, a lack of organised mentorship and peer review, and inadequate rotation between practice areas. Regardless of all this, most reported job satisfaction and many had dedicated many years to the prison service. Their experience in dealing with this challenging population within an even more challenging environment is invaluable. However, fresh faces are required to question old practices and provide new and innovative ideas for change. Better rotation of staff between practice areas both within the prison and community would provide better holistic understanding of health and social needs. The isolation of prison nurses from other primary, secondary, and tertiary healthcare can bring about deskilling and run the risk of nurses becoming desensitised to the situation.

As an observer it is easy to criticise and highlight areas of concern within prison nursing. The issues raised above are not intended to belittle or stamp upon the tireless efforts of those who have and are currently working to provide care in prison. In my opinion prison healthcare would benefit from a little shake up, starting with a move from a culture of independence to collaboration with services. We can do all we want to build therapeutic relationships and environments within prisons but, fundamentally, if this does not transcend to the community, efforts will be futile. ■

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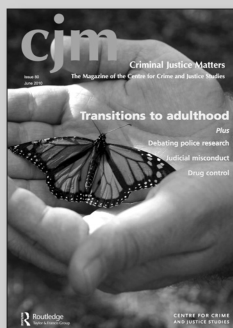

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