Chapter Three: The role of the nurse in prison

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Abstract

This chapter is divided into four sections and will commence with the history of healthcare within prisons in the USA and England and Wales. This section will introduction landmark litigations and pioneers who successfully influenced the development of prison healthcare, and a timeline of relevant policies and partnerships including the how the role of the nurse emerged and developed. The second section will explore the professional identity of nursing and more specifical the professional identity of a nurse working within a prison and explore concepts of emotional labour and moral distress. The third section focuses on the therapeutic relationship between a nurse and a patient (prisoner), and a discussion on care versus security, when security of the prison, staff and prisoners is a priority over the provision of healthcare. The last section explores the need of nurses to collaborate with non-healthcare professionals to provide care to prisoners, including prison officers, but also prisoners, who may have been trained to support and care for fellow prisoners, and charitable organisations.

This chapter contains a **case study** of a nurse's reflection, thoughts, and experiences of working collaborating with prison officers.

History of prison nursing

Nursing practice within prison has only begun to be developed and recognised alongside the development of systems to provide healthcare to prisoners (Schoenly, 2012). Therefore, the development of nursing in prison is entwined with the progression of healthcare services for prisoners. Examples, within this section will be drawn from different countries, including the USA and how civil litigation, such as the 1976 Supreme Court decision of Estelle versus Gamble, established the obligation of the governments to provide healthcare to prisoners. The discussion of the development of health care within the prisons in England and Wales will commence from 2000, when the responsibility of healthcare in prisons became the responsibility of the Department of Health (Hayton and Boyington, 2006), and this section will finish with how the role of the prison nurse has developed in the 21st Century, both in the USA and England.

Civil litigation in the USA

In the USA litigation has supported prisoners' rights to healthcare, in particular the case of Estelle v. Gamble, 429 U.S. 97 (Marshall, 1976). This case arose from an injury that occurred when a prisoner was allocated to the work in a textile mill, which involved loading and unloading cotton bales from a truck. In the Texas Department of Corrections on 9th November 1973, J.W. Gamble sustained an injury when one of the 600-pound cotton bales fell unexpectantly. Gamble continued working for a couple of hours until his back began to spasm, and he was allowed to attend the hospital unit within the prison. The doctor checked Gamble for a hernia and sent him back to his cell, but later that day the pain became unbearable, and Gamble returned to the hospital unit. On this occasion Gamble was prescribed and given analgesia, but no further treatment. The following day Gamble was assessed by a different doctor, and analgesia was again prescribed and administered. On this occasion Gamble was provided a 'cell-pass cell-feed' routine, which was a pass to state he was unfit to work, and supported Gamble to rest in his cell, apart from meal times. When the cell-pass cell-feed routine ended Gamble was declared fit to work, however, his back pain had not improved and he was disciplined for refusing to work and the prison administration placed him in administrative segregation, which is similar to solitary confinement. This process was repeated on many occasions over the next three months. Gamble also complained of chest pain, for which he was treated for an irregular heartbeat in hospital, but later he was denied any further requests for treatment by the prison administration. During these three months Gamble was assessed on 17 occasions by healthcare professionals.

Gamble submitted a civil rights action on 11th of February 1974, against the medical director of the state corrections department and two prison officers. Gamble claimed he has been subjected to cruel and unusual punishment, which was in violation of the Eighth Amendment. Gamble considered the inadequate treatment of his back injury, which was sustained whilst he engaged in prison work to be cruel and unusual punishment. The District Court dismissed Gamble's action. However, the Court of Appeals reinstated the action for two reasons, firstly, due to insufficient medical treatment provided to Gamble, specifically the lack of a diagnostic examinations, such as an x-ray. Secondly, due to the use of solitary confinement by the prison administration rather than the provision of adequate healthcare. The decision on 30th of November 1976 by the Court of Appeals was to uphold Gamble's action, as the *'deliberate indifference by prison personnel to a prisoner's serious illness or injury constitutes cruel and unusual punishment contravening the Eight Amendment"* (Marshall, 1976). However, Gamble's action against the medical director was not upheld as *"the failure to perform an X-ray or to use additional diagnostic techniques does not constitute cruel and unusual punishment, but is, at most, medical malpractice"* (Marshall, 1976). This case established that principle of cruel and unusual punishment included the failure of prison administrations to address the healthcare needs of prisoners (Dimitrakopoulos, 2007).

Development of health and social care in England and Wales Prison Service

The provision of healthcare in England and Wales Prison Service became the responsibility of the Department of Health in 2000 (Hayton and Boyington, 2006). This was due to a highly critical report of the provision of healthcare by the Prison Service by Her Majesty's Chief Inspector of Prisoners in 1996, which led to the development of a Joint Prison Service and National Health Services Executive Working Group in 1999. The working group identified inconsistencies of healthcare provision across prisons in England and Wales, which lacked both strategic planning and clear lines of accountability. Good practice by healthcare professionals was identified by the working group, but many healthcare professionals lacked appropriate knowledge, training, and continued supervision. The Joint Prison Service and National Services Executive Working Group recommended the joint responsibility of healthcare provision for prisoners, to include both the Prison Service and the NHS, and the development and implementation of primary health care within prisons by NHS Trusts and access to secondary care within local NHS hospitals.

Important changes, developments, and implementation of healthcare within prisons in England and Wales have occurred since 2000, below is a timeline outlining these changes. The timeline ends with the National Partnership Agreement for Prison Healthcare in England 2018-2021 (HM Government, NHS England, 2018), which is discussed in more depth in Chapter 2.

2001 – the introduction and implementation of in-reach mental health care service for prisoners in England and Wales following the publication of the new health policy by the Department of Health
2003 – the development of the National Partnership Agreement, including the Home Office and the Department of Health, and the responsibility of the Department of Health for the funding of primary care in prisons in England
2006 – the commissioning of primary care services was transferred to Primary Care Trusts, who partnered with Prison Partnership Boards of their local prisons to commission services that address the needs of individual prisons and national agreements
2007 – a reform of services occurred with the implementation of new services, such as an Integrated Drug Treatment, and a new National Partnership Agreement occurred in this year between the Department of Health and Her Majesty's Prison Service for both the Accountability and Commissioning of Health Services for Prisoners
2008 – the Prison and Probation Services were transferred from the Home Office to the Ministry of Justice, and then to the National Offender Management Service (NOMS)
2011 – a co-commissioned programme by the Department of Health and the Ministry of Justice was implemented to treat, and support the mental health of prisoners, such as the Dangerous and Severe Personality Disorder Programme. Other changes included the responsibility for commissioning non-

clinical substance misuse services, which became the responsibility of the Department of Health, and rather than the NOMS

2013 – the commissioning of primary care services was transferred from Primary Care Trusts to Clinical Commission Groups, following the Health and Social Care Act (2012)

2013 – a further update of the National Partnership Agreement occurred to include development of the tripartite agreement of the NHS England, NOMS and Public Health England (PHE), to identify priorities, commissioning, and delivery of healthcare in prisons in England

2016 – the impact of the commissioning of healthcare services by the NHS were explored by PHE, in a rapid review of the evidence, which identified positive impacts, areas that required further improvement included the need for further community engagement and partnerships

2017 – NOMS became Her Majesty's Prison and Probation Service (HMPPS)

2018 – A further development of the National Partnership Agreement for Prison Healthcare in England, which included the Ministry of Justice, HMPPS, PHE, the Department of Health and Social Care, and NHS England, although this agreement expired in 2021, a new version has yet to be published at the time of writing

2022 – the commissioning of primary care services was transferred from Clinical Commission Groups to Integrated Care Groups

The provision of healthcare within prisons and the access of healthcare by prisoners in England has significantly improved over the past two decades, especially in the last decade and the National Partnership Agreement. Improvements have occurred due to the introduction of NHS healthcare services for prisoners, which are provided by appropriately qualified healthcare professionals. Other systems embedded within NHS Trusts have also supported improvements, such as the introduction and implementation of the patient advice and liaison services and national standards defined by the National Institute for Health and Care Excellence (NICE). However, there remains the need for specialist education and training of qualified healthcare professionals to understand the complex healthcare needs of prisoners, and further clarity and development of collaborative working of healthcare professionals, prison officers and prison administration.

The role of the nurse in prison

The first prison to develop and implement a hospital and pharmacy in the USA was the New York City Newgate Prison in 1797, this was led by the Thomas Eddy, the warden at the time (American Nursing Association [ANA], 2013). The implementation of a hospital required nurses to care for the prisoners, and therefore, 1797 has been recognised as the beginning of the specialism of correctional/prison nursing. During the 1800s a nurse by the name of Dorothea Lynde Dix advocated for the need to provide support and care for prisoners who were experiencing mental health issues and

petitioned for reform, which in 1845 included the separation of different types of prisoners. However, it wasn't unit 1976 that an amendment to the constitutional rights of prisoners to received healthcare was implemented. The amendment occurred following the Supreme Court ruling on the case of Estelle v. Gamble (1976). The rights of prisoners encompassed three specific elements of healthcare provision, firstly the right to access care, which focuses on the responsibility of the prison to provide healthcare services to support medical emergencies but also the continuation of medical management. Secondly, the right to professional judgement, which focusses on prisoners' access to healthcare and the timely provision of prescribed treatment. Thirdly, the right to prescribed healthcare treatment, which focuses on the right of prisoners to be provided healthcare by qualified healthcare professionals with appropriate medical equipment within medical units (ANA, 2013).

The amendment of the constitutional rights of prisoners in 1976 supported the need and development of correctional or prison nursing as a specialism (Schoenly, 2011). In 1985 the American Nursing Association published the Scope of Nursing Practice in Correctional Facilities, which has now been updated on a number of occasions, most recently in 2013 and 2020. The latest edition, the Correctional Nursing: Scope and Standards of Practice, Third Edition (2020) defines the scope of practice of correctional nurses and more widely the environment of healthcare within prisons, the unique education requirements to become a correctional nurse, as well as issues and trends within prison healthcare and the ethical bases of correctional nursing. The Scope and Standards of Practice (2020) contains 16 standards of correctional nurses, each standard contains specific competencies, which correctional nurses need to achieve competence.

The development of healthcare within prisons in the UK also commenced in the late 1700s, which was led by John Howard, who was appointed High Sheriff of Bedfordshire in 1773, which involved the responsibility of the county prison. On visiting the prison John Howard was appalled by the conditions of the prison, the degrading treatment of prisoners, and the approach of prisoners paying for their basic amenities, such as bedding and food. John Howard travelled and visited prisons across England and Europe to further understand the conditions and treatment of prisoners. On his travels between 1775 and 1780 John Howard found appalling conditions of prisons and treatment of prisoners, which he detailed in his book 'The State of the Prisons in England and Wales' (Howard, 1777). Following this work, John Howard campaigned for the reform of healthcare within prisons and was instrumental in an Act of Parliament in 1774, which required prisoners who were sick to be placed in separate rooms and each prison was required to appoint a prison surgeon. This reform led to the development of healthcare units and hospitals within prisons in England. A charity formed in 1866 continues this work today, which is the Howard League for Penal Reform.

The implementation of healthcare and hospitals in prisons in the early 1800s in England and Wales did not support the role of the nurse within prisons. Although a few nurses did work in the prison hospitals, the Prison Service implemented 'hospital officers' who were prison officers that had been chosen to work in prison's hospital. Therefore, it was not until the implementation of new policies, such as the National Partnership Agreement in 2003, and the transfer of healthcare in prisons to the NHS, were qualified nurses routinely employed to permanently work within prisons. The ongoing development of prison healthcare in England and Wales through the policies outlined above has further supported the specialist role of the nurse in correctional or prison healthcare. The development of the prison nursing has also been supported by different forums, such as the Nursing in Justice and Forensic Health Care Forum, hosted by the Royal College of Nursing, and the provision of clinical placements in healthcare in prisons for nursing students.

Unlike the USA, in England and Wales there are no specific scope, standards or competencies for nurses working within prison. Although, the NHS describe the requirements of a prison nurse, which include the need to be a qualified registered nurse with the Nursing and Midwifery Council, and describe essential generic skills of resilience, communication, and conflict management, as well as an understanding of the criminal justice system. However, there is no need for a specialist qualification as training is provided through comprehensive induction programmes and prison-specific training. The role of the prison nurse in prisons in England and Wales in the 21st century is highly skilled and varied and includes nurses from different specialities such as mental health, psychiatry, learning disability, and general nurses, although many nurses have post-registration qualifications, including specialisms such as primary care, trauma, or substance misuse.

Professional identity

This section will commence with a definition of professional identity as applied within nursing, and how this has changed over time (Johnson et al. 2012), followed by the development of an individual nurse's professional identity throughout their career (Larson et al. 2013). This will lead to a discussion on the professional identity of a nurse working within a prison (Goddard et al. 2019; Choudhry et al. 2017a; Stephenson, 2018), and the concepts of emotional labour and moral distress, which impact on all nurses, but especially nurses working within this unique setting (Humblet, 2020; Walsh, 2009; Walsh and Freshwater, 2009; Walsh et al. 2013; Lazzari et al. 2020).

Professional identity of nursing

Professional identity of nursing and nurses continues to evolve. The original concept and identity of nurses as a doctor's assistant from the early 20th century has been challenged. Nurses are now

qualified autonomous practitioners who are active members in the decisions and provision of patient care (Johnson et al. 2012). A professional identity refers to a person's occupational identity and is only one element of a person's self and has been described as the *"self-conception of requirements, values, tributes, and norms concerning a profession or a vacation"* (Mao et al, 2021). There is an association between the professional identity of a nurse, their satisfaction with nursing and/or their commitment to nursing, which increased their likelihood of remaining in nursing (Lu et al. 2019; Sabanciogullari and Dogan, 2015). Therefore, the development of both nurses and nursing students' professional identity is important to understand, as globally, as especially within NHS England, there remains a significant shortfall of nurses, which is predicted to continue, increase, and negatively impact on the delivery of healthcare (Buchan et al. 2020).

The development of a professional identity involves a number of processes including socialisation into the profession, and the acquisition of knowledge, skills, attitudes and values of the profession (Miller, 2010; Rose et al., 2018). The development of a professional identity as a nurse has been described as an iterative process involving both education and practice, which must occur within the values, ethics, and code of conduct of the professional regulatory body of nursing (Larson et al. 2013), which in the UK is the Nursing and Midwifery Council. Others argue the professional identity of a nurse is developed through a combination of the integration of their own values and ethics, alongside the development of both knowledge and practice, as well as socialisation into their profession (Hercelinskyj et al. 2014). However, the professional identity of nurses by nurses can be influenced both positively and negatively by the same factors, including public image, media representation, doctors, other nurses (Goddard et al 2019).

An example of a professional identity pathway and factors that influence professional identity throughout the career of a nurse has been developed by Johnson et al. (2012):

- The first stage of the pathway, 'initiating the professional identity pathway', commences prior to nursing students start their nurse education programme, and their beliefs and values at this time, which may include an image of a nurse and nursing.
- The second stage of the pathway 'academic content, teachers, and mentors', commences during nursing students' education programme, and involves both a deconstruction and then a reconstruction of the professional identity of nurses and nursing. During this stage nursing students are influenced by both lecturers and mentors, from whom they commence their understanding of professional values and the skills and competency required by nurses.
- The third stage of the pathway 'clinical placements and their effects', clinical placements are essential to support nursing student's socialisation into nursing and the development of their

own professional identity. Clinical placements support nursing students to being to link theory and practice and organise their newly acquired knowledge with the values and practices of becoming a nurse.

- The fourth stage of the pathway 'professional identity and the transition to practice', is the stage when nursing students transition to a qualified nurses. However, this stage involves more than successful graduation, as a nurse may experience dissonance between their expectations of becoming a nurse and their experiences, therefore, the support of new nurses is essential through preceptorship programmes.
- The fifth and final stage of the pathway 'evolving professional identity within a changing world of health care', this element is essential as the healthcare needs of the population continue to change, for example the COVID-19 pandemic, other changes include technology and the development of new and advance techniques to treat dieases, which require expertise.

The development of professional identity of nursing students has recently been explored and defined following a review of contemporary published literature (Vabo et al. 2022) and a research study (Wu et al. 2020). Two main themes were identified from the literature review, firstly 'a caring practice-academic partnership', with subthemes of clinical supervisors, self-confidence, ethical competence, and preparation. This theme identifies nursing students' need for support and consistency across learning in the classroom and clinical practice. Secondly, 'support in the learning environment', with subthemes of predictability and safety, structure and cooperation, and reflective space and safety. This theme identifies nursing students' need to learn in a safe consistence space to support their professional identity as a nurse (Vabo et al. 2022). These findings consolidate the identification of positive influences on the development of nursing students' professional identity, which include long clinical placements and positive perceptions of the clinical learning environment (Wu et al. 2020). The two themes and subthemes identified by Vabo et al. (2022) and the two elements identified by Wu et al. (2020), support and develop the second and third stage of the professional identity pathway identified by Johnson et al. (2012). The contemporary studies support the need to understand the complexities of developing a professional identity that occurs across education and clinical practice, including an organised robust partnership between academic education and clinical practice.

Professional identity is also influenced by factors outside of nursing and a nursing students' education. Further concepts, which may influence the development of both nurses and nursing students' professional identity, may include individual's self-efficacy and resilience (Mei et al. 2022), as well as coping styles, especially during extremely stressful healthcare events, such as COVID-19 (Zhao et al. 2021). A significant increase of psychological stress was identified by one cohort of nursing students due to studying and caring through the COVID-19 pandemic, however, this experience influenced their professional identity, which improved significantly and reinforced their

reasons for choosing the nursing profession (Zhao et al. 2021). Although, this study did not involve nursing students studying in England, the events during COVID-19, and the identification of the NHS workforce as frontline staff, the clapping and support of these staff, including nurses, may be one of the reasons for the positive influence on professional identity of nurses during this time.

A further element that has only just begun to be explored and may significantly impact on nurses' professional identity is social media (Alharbi et al. 2020). Nursing students identified the use of social media to both understand and share their understanding of the professional identity of nursing, which supported them to develop their sense of belonging to the nursing profession. Nursing students also used social media to share their experiences of nursing, with the aim of influencing outdate images and concepts of the role of the nurse (Alharbi et al. 2020). However, this study appeared to lack a discussion of the possible negative impacts of social media on nursing students and the development of their professional identity, as nurses who are disillusioned with nursing may have a negative influence. The professional identity of nurses, student nurses and nursing continues to develop and evolve, and involves many complex constructions, all of which need to be understood and addressed through nursing education.

Professional identity of a nurse in a prison setting

Nursing within healthcare in a prison setting is a specialised and highly skilled role, due to the provision of care and treatment for diverse conditions in a challenging environment, that is largely unseen, unacknowledged, undervalued, and under-resourced (Goddard et al. 2019). Nurses working in healthcare in prison experience emotional labour and moral distress, which will be discussed in-depth in the next section. However, these feelings impact negatively on nurses and lead to burnout, which is more common in nurses working in healthcare in a prison and may be enhanced by a lack of a strong professional identity as a prison nurse. Therefore, the professional identity of prison nurses has begun to be explored (Choudhry et al. 2017a). Five factors that positively and negatively influenced the development of prison nurses' professional identity included relationships with colleagues, the prison regime, autonomy, delivery of patient care and prison culture (Choudhry et al. 2017a).

The negative impact of the prison regime, prison culture and autonomy on the professional identity of nurses is important to understand and address. **Firstly**, nurses have identified the security of the prison and the prison regime is always a priority, although this is recognised as a necessity, security and the prison regime takes precedence over the provision of healthcare (White and Larsson, 2012; Solell and Smith, 2019). The priority of the prison regime creates a conflict between custody and care, as the prison regime influences how nurses provide assessment, treatment, and care for prisoners (Weiskopf, 2005; Dhaliwal and Hirst, 2016). The conflict between custody and care requires nurses to negotiate

their provision of care within the boundaries of the prison regime, which is imposed by prison authorities. The complex challenge of negotiating care for prisoners includes obtaining physical access to prisoners, which may be limited to providing care for a prisoner behind bars or a door, or whilst they are shackled and in front of prison officers (Foster et al. 2013). Further difficulties arise for nurses due to the inflexibility of the prison regime, for example, if a nurse has been assessing a prisoner with complex needs and requires more time to finish the assessment this may not be possible. The prison regime also impacts on how a nurse organises her work, for example a nurse may identify the need to implement a vaccination clinic, however, depending on the prison regime, the nurse may have to collect the prisoner from their cell and bring them to the clinic (Powell et al. 2010). These aspects impact on the professional identity of a prison nurse, as they have identified the inability to provide appropriate care in a timely way in an appropriate environment.

Secondly, the prison culture impacts negatively on nurses' professional identity as nurses identified the need to be cautious with prisoners, as some prisoners attempted to manipulate them, and had an ulterior motivative for their need to see a healthcare professional. For example, prisoners may try to obtain medication they do not require, or to simply have time out of their cell and enjoy a social interaction with someone other than a prisoner or prison officer (Weiskopf, 2005; Peternelj-Taylor, 2004; Choudhry et al. 2017b). Nurses found this behaviour particularly difficult to both understand and provide appropriate support and advice (Choudhry et al. 2017a). However, nurses' approach of being firm, fair and consistent helped to prevent prisoners from taking advantage of them. This approach also supported an understanding by prisoners that nurses were there to provide care and support following an accurate assessment of their needs. The professional identity of prison nurses was supported by this approach, as they remained focused on providing appropriate treatment to prisoners by acknowledging, understanding, and addressing prison culture (Solell and Smith, 2019).

Thirdly, the element of autonomy had a positive impact on nurses' professional identity compared to the prison regime and the culture of the prison, as nurses recognised the autonomy within their role as a prison nurse, which was described as more autonomous than working outside of a prison (Walsh, 2009). Nurses identified the need to work within the prison regime, and this supported their autonomous practice, as they could visit prisoners within their cells (Powell et al. 2010). Nurses were able to develop their knowledge and skills whilst working in a prison, for example nurses became specialists in bloodborne viruses and sexual health, and the implementation of diagnostic techniques such as dry blood spot testing (Stephenson, 2018). Both the autonomy of prison nurses and the ability to develop specialist skills supports the professional identity of a prison nurse. All of the negative and positive factors that impact on how nurses provide assessment, treatment and care in a prison impact on their professional identity, which has only recently gained attention.

Emotional labour and moral distress of nurses

This section will commence with a description and impact of emotional labour with relevance to the role of the nurse, and specifically prison nursing. Emotional labour has been described as the process of how an individual copes with their feelings and expressions within the requirements and expectations of their job (Hochschild, 2003). Emotional labour is demonstrated through how a person acts, and this may be through surface level acts or deep level acts. A surface level act is when an individual acts in a way their colleagues would expect, although the individual is not demonstrating their true beliefs or values. Whereas, a deep level act, may involve the individual acting in a way that demonstrates their true beliefs or values, or the individual is emotionally adopting the beliefs or values of their organisation or workplace, which involves emotive effort (Hochschild, 2003). The impact on an individual of controlling how they act, whether their actions demonstrate their true values or not, creates high levels of emotional labour. In nursing emotional labour consists of **therapeutic** interactions between nurses and patients, **collegial** interactions with other nurses and colleagues, and **instrumental** interactions, which involves nurses' skills and confidence in performing clinical tasks (Theodosius, 2008).

The three forms of emotional labour identified in general nursing, therapeutic, collegial, and instrumental, are relevant to prison nursing, and maybe more poignant and prevalent in the prison environment. A comprehensive review of the literature exploring each of these forms of emotional labour in nurses has been completed by Delgado et al. (2017), the following section will be informed by this work and explore the three forms of emotional labour and discussed these with relevance to prison nursing:

1. Therapeutic interactions include emotional labour through the suppression of frustration when trying to support and care for a patient who may be uncooperative, demanding, aggressive or threatening to self-harm. Emotional labour may also occur due to the suppression of feelings of rejection or offence when a patient is expressing their personal views. Encounters such as these occur in prison healthcare, as prisoners may be experiencing withdrawal from alcohol, drugs, or under the influence of an illegal substance, such as spice, or prisoners may be frustrated and angry with their situation and their only method of control is to self-harm.
2. Collegial interactions include emotional labour when nurses needed to instigate conversations regarding treatment decisions for patients, or when care was identified to fall below nursing expectations or standards, or when unprofessional behaviour was demonstrated by a colleague. In the prison healthcare environment, these interactions involve interactions between nurses and prison staff, which are discussed in more depth in a following section.

3. Instrumental interactions include emotional labour when an invasive or intrusive clinical intervention, assessment or treatment was required that would cause pain, but was necessary. During these tasks nurses focused on the technical aspect of the task to emotionally distance themselves and manage their feelings of fear and distress. In the prison environment, nurses providing invasive or intrusive interactions with prisoners in shackles may focus on the task to emotionally distance themselves from their negative feelings of preforming such a task under these circumstances.

The impact of emotional labour on nurses, including student nurses has been identified to be positively correlated with emotional exhaustion, stress, burnout, and intention to leave the profession (Kinman et al. 2016; Delgado et al. 2017; Theodosius et al. 2020). There is a lack of studies exploring the impact of emotional labour within the prison nursing workforce, however, due to the impact of custody versus care, prison nurses may experience higher emotional labour than those working in non-custodial settings. A number of elements have been identified to reduce the impact of emotional labour on nurses, and include clinical supervision, resilience, job satisfaction, and perceived organisational support (Delgado et al. 2020; Gulsen and Ozmen, 2020; Lartey et al. 2019). The implementation of initiatives to reduce the impact of emotional labour of nurses, especially prison nurses is essential to support the care provided to prisoners and retain the prison nursing workforce.

Moral distress

This section will commence with a description and impact of moral distress with relevance to nursing and specifically prison nursing. The concept of moral distress was developed and defined by Jameton (1984) and occurs when a healthcare professional *"when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action"* (p.6). The immediate impact of moral distress on a nurse is a painful sensation due to psychological dissonance, this occurs due to the nurse's knowledge of the morally appropriate care that should have been provided to a patient, but this did not occur to institutional constraints. A number of institutional constraints have been identified and include a lack of time, managerial support, limitations due to institutional policies and the contractual role of the nurse (Corley, 2002; Negrisolo and Brugnaro, 2012). The concept of moral distress has been expanded to include moral decisions made by healthcare professionals, which inadvertently have a negative impact on the patient. Therefore, a nurse may be able to make a moral decision and act on this decision with institutional support, but moral distress occurs due to elements within the situation rather than the institution (Tigard, 2018).

The long-term impact of moral distress on nurses is important to acknowledge and understand, as may include both physical and psychological symptoms. Physical symptoms may include sleeplessness,

reduced appetite, as well as palpitations and headaches (Austin et al. 2005; Fard et al. 2020). Whereas, psychological symptoms may include guilt, loss of self-esteem, avoidance behaviours, and an emotional detachment from work leading to an intention to leave (Austin et al. 2005; Borhani et al. 2014; de Villers et al. 2013). Th moral distress of nurses working in prisons in Italy has been explored, which identified a moderate level of moral distress, which was not influenced by the length of time they had worked in a prison setting (Lazzari et al. 2020). The mean length of prison nurses experience in this study was six years, suggesting the prison environment contains numerous situations that are potentially a source of moral distress for nurses. Therefore, within a short period of time nurses working in the prison environment develop high levels of moral distress, which influences their intention to leave prison nursing (Lazzari et al. 2020).

On many occasions, nurses do not recognise when they are experience moral distress (Wilson et al. 2013). Therefore, there remains the need for all healthcare services, especially those within prison settings to support their staff, including nurses, to identify moral distress, and the implementation of interventions to support those experiencing moral distress. Interventions need to consider all aspects of the organisation, and for healthcare provision within prisons this needs to involve both the prison regime and prison culture. Interventions need to address the causes of moral distress, as preventing or acknowledging these causes can impact on the moral distress of nurses and provide an explanation for their professional performance, increase job satisfaction and retention (Lazzari et al. 2020). An example of an intervention to reduce moral distress in the implementation of a resiliency bundle, which was identified to reduce moral distress in healthcare professionals working in a paediatric intensive care unit (Davis et al. 2020). The bundle included an ethical issue resolution process, mindfulness reminders through a phone application, a patient death process, case conferences and discussions, structured debriefings with pastoral care, discussions with colleagues, social events, and educational courses aimed at healthcare professionals' well-being (Davis et al. 2020).

Therapeutic relationships

This section will concentrate on the therapeutic relationships between a nurse and a patient, which within the prison, is also a prisoner. The therapeutic relationship within a prison setting requires all healthcare professionals, including nurses to understand the balance between care and custody (Nolan and Walsh, 2012; Foster et al. 2013). Further aspects that impact on the therapeutic relationship, between a nurse and patient-prisoner will also be explored, such as practice dilemmas and the emotional impact of a nurse knowing or imagining the patient's crime, and finally the concept of ethical caring (Crampton and Turner, 2014).

Care versus custody

An important element of the provision of care and support by nurses is the development of a therapeutic relationship with prisoners and within the context of the prison setting. A therapeutic relationship has been defined by many scholars, which encompasses a supportive, caring, non-judgmental relationship between a nurse and a patient within a safe environment (Mottram et al. 2009). A therapeutic relationship continues for throughout the provision of care and support, which may be brief or continue over time (Priebe and McCabe, 2006). This is especially important within the prison setting due to prisoners limited interactions with others, as therapeutic relationships with nurses facilitates effective communication and can support their physical, mental, and emotional wellbeing (Step et al. 2009). Elements of a therapeutic relationship in an acute hospital environment include therapeutic listening and responding to both a patient's emotions and unmet needs from a patient-centred approach (Kornhaber et al. 2016). These elements are also essential to develop therapeutic relationships between nurses and prisoners to develop trust and support prisoners to engage with healthcare and being to address the health inequalities of prisoners.

The development of a therapeutic relationship between a nurse and a patient can be influence by a number of factors, some of which may be more prevalent in healthcare in a prison environment. In mental healthcare services, factors which impact negatively on the development of a therapeutic relationship can be classified as nurse-related, patient-related, and organisational-related (Pazargadi et al. 2015). **Nurse-related** factors may relate to the personal characteristics of a nurse, which may include a nurse's natural response to patient presenting with anger towards them and are unable to commence a therapeutic relationship with the patient. Although other nurse-related factors may be due to overwork and exhaustion leading to job dissatisfaction, which may impact on a nurse's motivation to develop therapeutic relationships with their patients. Whereas **organisational-related** factors include a continued lack of staff and the recommended patient capacity exceeded, which will negatively impact on the development of therapeutic relationships. Further organisational factors may include a focus on the responsibility of the organisation in the provision of clinical supervision and the development of nurse's skills and resilience. This approach demonstrates the responsibility of organisations to both support and develop their staff, rather than the identification of nurse-related factors that impact negatively on the development of therapeutic relationships (Pazargadi et al. 2015).

In secure forensic settings, similar internal and external constructions were identified to impact on a therapeutic relationship, but also further elements related to the nature of a secure setting (Stevenson and Taylor, 2020). For example, external factors included security, as within forensic and prisons settings nurses are not working within the care principle of the least restrictive option, as patients are serving a custodial sentence. Nurses adhere to the Mental Capacity Act (2005) *"before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as*

effectively achieved in a way that is less restrictive of the person's rights and freedom of action". Another important element to consider within custodial settings is the boundaries imposed to maintain both security and safety of those within the prison, which restrict both nurses and patients from developing a therapeutic relationship. Firstly, the boundaries implemented by secure settings restrict nurse's expressions of caring (Weiskopf, 2005). Secondly, the use of shackles or handcuffs on prisoners, impacting on their dignity, autonomy, and privacy, which reinforces the restrictive practice of the prison (Bayuo, 2018).

The development of a therapeutic relationship within a secure setting needs to incorporate or at least acknowledge the custodial aspects experienced by patients, and for nurses to understand how the issues of safety and security impact on the development of a therapeutic relationship. An important aspect that needs further consideration is the difficulty in developing a therapeutic relationship if the nurse is concerned the patient may become aggressive or violent, as this impacts on the nurse's ability to engage empathetically (Moreno-Poyato et al. 2016; Stevenson and Taylor, 2020; Pazargadi et al. 2015). However, nurses, and other healthcare professionals have identified when they feel fear, this is reduced by their understanding of the security and prison regime, which demonstrates the complex relationship between safety and security and the impact on therapeutic relationships.

Practice dilemmas

A practice dilemma identified by prison nurses regards the need to know or not to know a prisoner's crime and the consequences if they did know a prisoner's crime, for instance would this knowledge impact on the care and support they provided. However, Crampton and Turner (2014) identified nurses held different beliefs and reasons for wanting or not wanting to know a prisoner's crime:

- A reason nurses did not want to know a prisoner's crime was the concern it might impact on the care and support they provided to that prisoner, as one nurse stated, *"I've never ever known what the patient (prisoner) has done, and I'd probably prefer not to. I would be concerned that it might affect the way I care for them. If I know they've hurt little children or raped innocent women or beat up the elderly, it would just make me not want to help them as much, it might make me feel funny"* (Crampton and Turner, 2014, p.114).
- A reason nurses wanted to know a prisoner's crime was due to their concern for their own safety, as one nurse stated, *"I'm always curious about what they've done. Some people say that you shouldn't know because it can interfere with your care for the patient. But I don't discriminate, no matter what. Sometimes for my safety it's been something I've wanted to know about, especially when they've been looking mean and tough and I'm thinking I could get a broken jaw or something out of it. I'd like to know whether I should keep at arm's length*

'cause sometimes the guards don't pay enough attention" (Crampton and Turner, 2014, p.115).

- However, on occasions, even when nurses did not want to know a prisoner's crime, they became aware of the crime due to media attention. When this did occur, nurses described an inner turmoil of not wanting to care for the prisoner, as one nurse stated, *"a prisoner was awaiting trial for terrorism charges. and I did look at that patient quite differently. And I did find it quite difficult, to look after this patient, because I knew the story. I knew this person and others were planning to potentially kill a lot of people in my own country. I just didn't feel like I wanted to look after that person because of that and I did find it difficult to overcome"* (Crampton and Turner, 2014, p.115).

Nurses working within healthcare in a prison setting need support to work through their beliefs and attitudes towards providing care and support for prisoners, who may have committed crimes that are contrary to their own personal beliefs. Therefore, nurses require continuous support and supervision form their organisation and/or experienced prison nurses to reflect and on these practical dilemmas and develop their professional practice. Prisoners need support from healthcare professionals within prison and on release. However, it also important to recognise the impact of discrimination on prisoners by healthcare professionals, as 42 percent of male prisoners who had recently been released from prison stated they experienced discrimination by healthcare professionals in primary care settings (Frank et al. 2014). Ex-prisoners who experienced discrimination were older, had served a long sentence, and were more likely to have a college education. The impact of discrimination on ex-prisoners was a lack of engagement with primary care provision on release and a higher attendance at emergency departments (Frank et al. 2014), which suggests a negative impact on the health outcomes for these ex-prisoners.

A further practice dilemma identified by healthcare professionals working within a prison setting is confidentiality and when does it become necessary for healthcare professionals to breach a patient's confidentiality. The dilemma occurs when prisoners are engaging or seeking voluntary care and support, rather than court-ordered therapies, as prisoners are informed the results or outcomes of these therapies will be shared with the court. Confidentiality within a closed prison setting is difficult, as healthcare professionals collaborate closely with prison officers, who are involved in the movement of prisoners to healthcare. Confidentiality is especially difficult to maintain if healthcare professionals are treating prisoners with infectious diseases, such as tuberculosis, hepatitis or HIV/AIDS, as these involve long term regular treatment, which can include specialists outside of the prison (MacDonald, 2006). Although the process of trying to maintain a prisoner's confidentiality is different from the dilemma of when should healthcare professionals breech the confidentiality of prisoners.

The dilemma for healthcare professionals is when should medical information be shared with anyone outside of the healthcare team. There are clear exceptions to maintaining confidentiality, for instance when healthcare professionals identify risk, such as the safety of the prisoner, other prisoners, prison staff or disruption to the prison regime. However, there is the need for healthcare professionals to decide when they need to breech confidentiality if they consider this to be in the best interest of the prisoner. Healthcare professionals have been identified to adopt their own approach to addressing this dilemma and applying one of four approaches (Elger et al. 2015):

1. Healthcare professionals reminded the prisoner of the limits of confidentiality with a prison setting and gained informed consent to share information
2. Healthcare professionals reminded prisoners all medical information would remain confidential except in certain situations, and these were explained
3. Healthcare professionals believed information should be shared in the best-interests of the prisoner, this approach was not discussed with the prisoner
4. Healthcare professionals dealt with the dilemma on an individual bases with each prisoner.

However, breaches of confidentiality by healthcare professionals without informed consent from competent prisoners, unless a risk has been clearly identified, remains an unethical practice. Healthcare professionals, including nurses, need clear guidance and support to understand how to support prisoner's confidentiality and when it is necessary to break confidentiality. Policies, guidance, training, and supervision should be provided jointly by the prison administration and health and social care NHS Trusts.

Confidentiality is a practice dilemma for healthcare professionals working in a prison and has also been identified by prisoners as a concern. Prisoners tend to believe prison staff, including prison officers have access to their medical records, as all records are stored on a secure sever, which prison officers have access. One prisoner explained *"they (prison officers) say they won't check but that's bullshit, they can go into any computer and access whatever they want"* (Crowley et al. 2018). The process of attending healthcare appointments was also identified by prisoners as breeching their confidentiality, as they would be called on the landing to attend healthcare for a certain blood test or hospital appointment, therefore the prisoner officers were aware of their medical history and other prisoners were made aware due to this process (Crowley et al. 2018). The issue of confidentiality of prisoner's medical history is complex, and there is a need to share information appropriately and when necessarily, but there is also the need to protect prisoners' confidentiality and this can only be achieved through the collaboration of healthcare professionals, prison administration and prison staff.

Collaborative working with non-healthcare professionals

This section will explore and discuss the need for multi-disciplinary team collaboration of both healthcare and non-healthcare professionals supporting the health and social care needs of prisoners. Firstly, the need for collaboration between nurses and prison officers will be discussed, examples will include the support of nurses to reduce prison officer's stigmatisation of prisoners with mental illness (Melnikov et al. 2017), and the continued need to improve interprofessional collaboration between nurses and prison officers (Hean et al. 2017). The final element of this section will be the reflections, thoughts and experiences of a nurse working in a prison and collaborating with prison officers Secondly, the need for collaboration between nurses and prisoners who provide care for other prisoners, with examples such as Gold Coats in the USA, and buddies within the UK (Berry et al. 2016; Brooke and Rybacka, 2020; Moll, 2013). Thirdly, the need for collaboration between nurses and third sector or charitable organisations, such as the Alzheimer's Society (Purewal, 2020).

Collaborative working of nurses and prison officers

Nurses working in a prison environment are required to collaborate closely with prison officers due to the need to provide care within a secure regime. For example, when a nurse is delivering a clinic, the prison officers are responsible for unlocking each prisoner and escorting them to the clinic, which needs to occur within a specific timeframe to ensure all prisoners on the clinic list are seen. The process and protocols of the provision of assessments, care and treatment of prisoners reiterate the requirement of prison officers to be present or in close proximity. However, the relationships between nurses and prison officers have been identified to be difficult, as the priority of prison officers is safety and security, whilst the nurse's priority is the provision of healthcare. Difficulties occur when prison officers question the legitimacy of the need for a prisoner to attend healthcare and the nurse's decision regarding the care needs of a prisoner. When these circumstances have occurred, nurses avoided conflict with the prison officer as they acknowledged they continued to require their cooperation and support, but also protection, if the need arose (Almost et al. 2013).

Nurses have identified the attitudes and presence of prison officers whilst providing care can be a barrier to appropriate empathetic care, due to the relationship between the prison officer and the prisoner and the power imbalance (Solell and Smith, 2019). Nurses have also reported a lack of insight of mental health conditions by prison officers, such as self-harm, and their adoption of a medicalisation approach to self-harm, which causes tension when providing care to prisoners (Marzano et al. 2015). The approach of medicalisation of self-harm focuses on the prescription of medication to prevent self-harm, which is often unnecessary, but from the perspective of prison officers would support the prison regime (Marzano et al. 2015). An approach to challenge prison officers' attitudes and for prisoners to view prison officers as supportive of their healthcare needs has

been to include prison officers as members of the multi-disciplinary team. This approach enables prison officers to understand both the physical and mental healthcare needs of prisoners, and how they can support individual prisoners within the prison regime (Powell et al. 2010).

There remains the need to continually improve interprofessional collaboration between nurses and prison officers (Hean et al. 2017; Brooke and Jackson, 2019; Brooke and Rybacka 2020; 2021). The perceptions of prison officers current and desirable levels of interprofessional collaboration has been explored, with the identification of desirable and highest levels of collaboration with primary care nurses (Hean et al. 2017). Although, the largest difference between current and desirable collaboration occurred with mental health specialists, including nurses and doctors, especially when prison officers needed support with a prison who was struggling with their mental health. Prison officers have also identified their lack of understanding of other health conditions, such as dementia and psychosis, and how to identify if a prisoner is experiencing poor health or the effect of an illegal substance (Brooke and Jackson, 2019). As one prison officer stated,

"Sometimes we have problems identifying whether it is mental health or dementia or learnt behaviour, because we are not trained in that type of stuff. . . we don't know, with the older guys, is it because they have been in prison for years or is it drug induced, or alcohol induced, or an illness, we don't know . . ." (Brooke and Jackson, 2019, p.813).

The needs of the prison officers, as well as the nurses, are essential to understand to support interprofessional collaboration and deliver healthcare within a prison. Nurses working in the prison are optimally placed to support prison officers understanding of the healthcare needs of prisoners. Nurses have begun to implement initiatives to challenge and develop prison officers' perceptions and knowledge of both physical and mental health conditions, including mental illness, dementia, and ageing (Melnikov et al 2017; Brooke and Rybacka, 2020). For example, one nurse-led initiative involved a six-day workshop to address prison officers' negative attitudes to mental health illness of prisoners (Melnikov et al. 2017). The workshop explored cognitive, psychoeducational and behaviour components of negative attitudes, alongside the opportunity for prison officers to observe care and treatment on an acute mental health ward, as well as case reviews, formal lectures and simulation learning. The evaluation suggests prison officers who attended the six-day workshop demonstrated a decrease in negative attitudes and an increase in knowledge.

Another example involved a development and implementation of a brief (two hour) nurse-led prison dementia education programme (Brooke and Rybacka, 2020). The nurse-led programme was developed specifically to support prison staff and prisoners to identity and support prisoners with dementia. Three phases were included in the development of the programme, firstly the current

understanding of prisoners and prison officer's knowledge of dementia, secondly understanding prisoners and prison officers' experiences of supporting prisoners with dementia, and thirdly, the development of a programme to include and address the elements identified in the first and second phase. The dementia education programme included barriers identified and an explanation of current initiatives, a short PowerPoint presentation, videos, handouts, and group activities. The programme was evaluated positive by both prisoners and prison offices, who engaged fully in discussions that challenged their misconceptions.

Case study of a nurse's reflection, thoughts, and experiences of working in a prison and collaborating with prison officers:

The officers are actually one of the biggest challenges to healthcare within the environment. A good officer will facilitate the clinic you are trying to run, bring your patients to and from their areas within the establishment and allow you adequate time to make your assessments, or discuss treatment. However, a less agreeable officer can cause missed appointments, may try to impose time limits upon your consultations, or even interfere in the schedule and offer their own advice as to how the patient needs treating.

The mood of your patient may well depend upon the attitude of the officer who has accompanied them to the appointment, a friendly professional officer usually indicates a productive pleasant healthcare appointment. A moody, tired or arrogant officers will most definitely reflect his feelings, and this is likely to impact upon the attitude of the inmate when he arrives in your consultation room.

Working in a prison is an interesting experience, a lot of people have concerns around safety, but I think it is far safer than a lot of community environments. Nurses have an emergency radio, there are alarm bells, security cameras and officers. Nurses can get 'burnt out', it is a violent oppressive environment with lack of respect, care, empathy and understanding you must challenge poor practice from officers and nurses otherwise you risk being part of it.

Collaborative working of nurses and prisoners

Nurses working within the prison environment also support prisoners who care for other prisons, two examples will be discussed, one implemented in the USA, the Goldcoats (Berry et al. 2016), and secondly in the UK, the buddies (Brooke and Rybacka, 2021; Moll, 2013). The two examples presented identify the need to support older prisoners, especially those with cognitive impairment, and how this can be successfully implemented for both the older prisoner requiring care and the prisoner

providing care. Prisoners who provided care are supported through the completion of recognised training schemes which enables them to engage in worthwhile employment in prison and may lead to employment on release. Nurses may not be directly involved in training of prisoners to provide care, but require an understanding of these roles, including both the responsibilities and limitations of care prisoners can provide. Nurses need to support these prisoners and be aware of the emotional impact of caring within a prison setting and ensure the needs of prisoners requiring care are met. Nurses also need to support and empower prisoners providing care to become involved in multi-disciplinary team meetings as they will be able to give an accurate description of a prisoner's needs, identify if these needs are changing, and/or their condition is deteriorating.

The Gold Coats

The Gold Coat programme was developed and implemented in a state prison in the USA, the California Men's Colony. The prison was opened in 1954, holds up to 3,414 prisoners, and is a minimum to medium security male prison. The name of the programme 'Gold Coat' is due to the uniform provided to prisoners who have completed the programme, which is a gold-coloured smock. A bright colour was chosen to ensure these prisoners were easily identifiable. The programme was developed to provide training, education, and support to prisoners to empower and enable them to support and care for older prisoners with cognitive impairment (Berry et al. 2016). An important element of the Gold Coat programme and the role of prisoners who have completed the Gold Coat programme is to protect older prisoners, and especially those with cognitive impairment, from bullying and victimisation from other prisoners. Any prisoner may apply to complete the Gold Coat programme however the inclusion criteria is necessarily restrictive and includes only prisoners with no disciplinary actions within the last 10 years, still have a long sentence ahead of them, do not have any psychological or mental health problems, and have completed the necessary rehabilitation that accompanied their original sentence can apply to be a Gold Coat.

The Gold Coat programme is comprehensive and is provided over three to four months by a clinical psychologist within California Men's Colony prison. The focus of the programme is providing the necessary skills to a prisoner to enable them to support and care for an older prisoner with cognitive impairment, including:

- Communication skills to respond to a prisoner who may become agitated or aggressive, including how to either redirect or deescalate a situation
- Cognitive focusing techniques, such as cognitive exercises and cognitive simulation therapy
- Providing care to a prisoner to assist with their activities of daily living
- Coaching or supporting involvement in physical exercise and sports activities

- Supporting involvement in social interactions and recreational activities
- Providing companionship at meals, and supporting nutritional intake
- Further support as necessary, such as reading or writing of letters

The Gold Coats role is to support and care for older prisoners with cognitive impairment and to ensure their health and social care needs are met, and potentially slow the progression of the prisoner's cognitive impairment, but their role is not to replace a professional healthcare professional. Prisoners who become Gold Coats also need ongoing support from both the clinical psychologist and other healthcare professionals such as nurses, as the impact on providing care in the enclosed environment of prison can be emotionally draining. As one Gold Coat expressed:

"My first client was an angry, disabled patient who would not eat. Staff tried to bribe him to eat but it only made him angry. I sat with him, and he finally said he liked coffee. I was able to get him coffee but told him he had to eat a little first. He did and then started eating regularly. We became very close, and I cared for him for a long time – I cleaned up when he soiled himself, helped him shower etc. all the while trying to protect his dignity. Eventually, he ended up in the hospice, where I continued to visit him. Just before he passed, he told me 'Thank you for everything.' I cried like a baby" (Berry et al. 2016 p.65).

Buddy Support Worker

England has a similar programme to that of the Gold Coats and is referred to as the Buddy Support Worker programme, and on completion of the training within this programme prisoners are referred to as 'buddies.' This programme has been implemented across prisons in the South West of England (Moll, 2013) and supports any prisoner who has health and social care needs, not just older prisoners with cognitive impairment. The training within this initiative is led by the charity RECOOP (Resettlement and Care of Older ex-Offenders and Prisoners) and has been adapted from the standards for health and social care workers in England. The training includes a series of modules, all of which need to be successfully completed to be awarded a National Care Certificate. The modules encompass an understanding of the role, duty of care, equality and diversity, and how to maintain a prisoner's dignity and privacy. However, the modules also focus on how to support a fellow prisoner from within a person-centred-approach, including the development of communication and advocacy skills, safeguarding, health and safety, handling confidential information, and awareness of mental health and learning disabilities. Buddies are also trained to support a prisoner in a wheelchair, and the provision of adequate fluids and nutrition, although buddies are not allowed to support a prisoner with their personal hygiene, and the rule is no physical contact from a prisoner's nipples to knees.

Once a prisoner has completed the training element of the Buddy Support Worker programme, a probation period needs to be successfully completed. The probation period includes observations of the prisoners providing care and support by trainers from RECOOP, and written statements from the prisoners they have supported. The probation period may last for a couple of months, until both the trainer and the prisoner are assured of the competence of the care and support provided (Brooke and Jackson, 2019). An important element of the Buddy Support Worker programme is the ongoing support through monthly meetings with trainers to discuss any concerns or difficulties and to share good practice. The buddies have described these meetings as essential as the buddies may be moved to another prison without notice, and therefore they believed it was essential to share good practice. The needs of buddies to share good practice, demonstrates their commitment to caring and supporting fellow prisoners. As one buddy stated: *"It is about best practice; we tell each other what we have been doing, what is working well for us because at the end of the day if I get shipped out to a different jail they have got to step in, it kind of alleviates the teething problems"* (Brooke and Jackson, 2019 p814). The Buddy Support Worker programme has been awarded the Health Service Journal Patient Safety Award in 2019, which is an award judged by experts from both health and social care sectors.

Collaborative working of nurses and third sector or charitable organisations

Nurses working within the prison also need to collaborate with third section or charitable organisations supporting prisoners, such as the Alzheimer's Society (Purewal, 2020). The Alzheimer's Society has provided training for prison officers to enhance their understanding of dementia and how to support prisoners with dementia, and delivered 'dementia friends' sessions to prisoners, and trained prisoners to become 'dementia champions'. Thereby supporting prisoners to facilitate 'dementia friends' sessions for fellow prisoners and sustain a basic understanding of dementia amongst prisoners. The development of prisoners as dementia champions has created a sense of community within individual prisons, some of which have begun to discuss and address wider aspects of brain health. The Alzheimer's Society have also developed criteria for 'dementia-friendly communities' (DFC), which have begun to be applied in prisons (Treacy et al. 2019) with the support of prison administration. However, it is essential for prison nurses to have an oversight of these initiatives to ensure the information and provision of advice is both accurate and appropriate.

Nurses caring for prisoners also need to understand the charities and the process of referring prisoners to access support from different charitable organisations working within prisons, these vary depending on the prison, and may not be directly related to health, but may include:

- PACT – Prison Advice and Care Trust, a charity in England and Wales, which supports prisoners, people with convictions, and their families across each stage of the criminal justice

process. PACT supports those in prison through initiatives such as the first night and early days in custody and a prison-based social worker who support mothers during their sentence and their children.

- Koestler Arts – although based in West London, the charity has partnered with other organisations across the UK. Koestler Arts supports and works with prisoners to express themselves through art and support them to lead more positive lives.
- Story Book Dads – A UK charity, which supports prisoners who are Dads to record bedtime stories for their children, these recordings are edited by prisoners who are completing training/work experience in audio software. There are also many other creative initiatives to support Dads to remain in touch with their children.
- Fine Cell Work – A UK charity, which supports prisoners to develop skills and earn money through high-quality needlework. This aim is to engage prisoners in rehabilitation through meaningful activities, develop accountability and hope for independent living on release.
- Prisoner Education Trust - A charity in England and Wales, which supports prison education by funding distance learning at levels and subjects not available in prisons. The courses are completed in prisoners own time and from within their cells.
- Shannon Trust – A charity in England, Wales, and Northern Ireland, which supports prisoners who can read to support and teach those you cannot read. The charity provides support and resources, and learning occurs outside of formal education provided by prisons. Learning to read is an essential skill that can transform a person’s life.

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