A Focused Ethnography of Correctional Nurses Who Care for Incarcerated Women with Mental Health Concerns in Canada

by

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Abstract

Background: Worldwide, the number of incarcerated women has been grown by more than 50% in the past twenty years. In Canada, when women are incarcerated, they make up 15% of the provincial/territorial admissions, and 8% of federal admissions. Within the correctional system, women remain disproportionally burdened with higher prevalence rates for chronic and infectious diseases, mental health concerns and substance use. Once incarcerated, research has identified that opportunities do exist to improve the physical and mental health of women. For women who are incarcerated, their regular and consistent point of contact with healthcare is through their interactions with nursing staff as they are the principal providers of healthcare in correctional facilities. The literature notes that interventions by nurses in correctional facilities have the potential to improve the lives of women beyond incarceration, and at the heart of this potential is the nurse-patient relationship which is a core component of nursing practice. For incarcerated women to undergo an improvement in their health it was worthwhile to look at how the nurse-patient relationship was perceived and enacted, more specifically by examining the experiences of the nurses working with incarcerated women.

Purpose: The purpose of this study was to explore nurses' experiences working with incarcerated women with mental health concerns to bring greater understanding to the practice of correctional healthcare professionals.

Method: A focused ethnography was used. Eighteen correctional nurses from three provinces participated in individual semi-structured interviews. The participants worked in federal and provincial/territorial centres, including sentenced and remand facilities. Data analysis consisted of thematic analysis. Data were managed with Quirkos, a qualitative data analysis software.

Results: Data analysis developed seven themes: jack of all trades; seeing beyond the clinical task; being an expert; moments of opportunity; building the patient up; complex relationships, and culturally safe correctional nursing care. Complex relationships revealed that the nurse-patient relationship should be better described as a triad that includes the correctional officer. Culturally safe care was evident throughout the themes but also developed into a separate theme.

Conclusion: This study revealed that nurses were drawn to working in correctional facilities because of the intersection of complex patients, healthcare and the criminal justice system. The study also found that nurses experienced the pressure to acculturate into the correctional culture from when they first were employed and throughout their correctional career. Finally, it learned that the therapeutic nurse-patient relationship includes the correctional officers and can be thought of as a triad. Limitations of the study include sample diversity. Several recommendations were identified for future research, as well as for correctional nursing clinical practice and educational institutions.

Keywords: correctional nursing, cultural safety, interpersonal relations, focused ethnography

Preface

This thesis is an original work by Cybele Angel. The research project, of which this thesis is a part, received research ethics approval from the University of Alberta Research Ethics Board, Project Name: A Focused Ethnography of Correctional Nurses Who Care for Incarcerated Women with Mental Health Concerns in Canada, Pro00110611, 1 June 2021.

Dedication

I would like to dedicate this work to my parents. I could not have done this without the love and support of my mother Betty and father Kevin. I am forever grateful to them. To my closest friends, Karen and Rabia, you have been my main source of support and have given me strength when mine was failing. Finally, to my friends Randi and Danielle, you showed up in those moments when I needed a friend to listen, no matter what you had going on in your own lives. This community helped make my research possible.

"Phoenix, you've been in and out of centres your whole life. What makes you think that's going to change now?" The Strangers, Katherena Vermette (2021)

"I would define correctional nursing practice is probably one of the most important areas a nurse could ever work, the impact that we can have on health, when you look at nursing planning, assessment, with nursing diagnoses, and the goal setting interventions and evaluation there's no population and greater need than the women who are incarcerated, yet there's probably no greater population that is more ignored." (Participant 15)

Acknowledgement

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Table of Contents

List of Abbreviations

CIHR	Canadian Institutes of Health Research, National Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada.
CSC	Corrections Services Canada
LPN	Licenced Practical Nurse
NP	Nurse Practitioner
REB	Research Ethics Board
RN	Registered Nurse
RPN	Registered Psychiatric Nurse
TCPS	Tri-Council Policy Statement
UN	United Nations
WHO	World Health Organization

Glossary of Terms

Correctional Facility – any facility that houses individuals involuntarily. This includes pre-trial detention facilities, remand centres, jails, and prisons.

Correctional Nurses – nurses who work in correctional facilities including remand centres, pre-trial detention centres, and provincial or federal prisons (Dole, 2006).

Correctional System – I have chosen this term to refer to the system of involuntary incarceration of adults, either in pre-trial detention/remand facilities, jails or prisons. In Canada, this system refers to both the provincial and federal government departments. It also refers to the organizations that administer these facilities daily.

Disempower – I have chosen this term to refer to taking away an individual's ability to act as an agent in their own life or to be a decision-maker. It further refers to a state of helplessness and loss of control.

Forensic Nurse – nurses who consolidate psychiatric and mental health nursing practice in a setting that includes the criminal justice system (Peternelj-Taylor, 2008). Forensic nurses include psychiatric nurses, nurse death investigators, sexual assault examiners and legal nurse consultants among others (Lynch, 2006).

Gender – "the socially constructed roles, behaviours, expressions and identities of girls, women, boys, men, and gender diverse people. It influences how people perceive themselves and each other, how they act and interact, and the distribution of power and resources in society." (CIHR, 2015).

Indigenous people – "self-identification as indigenous people at the individual level and accepted by the community as their member [and] historical continuity with pre-colonial and/or pre-settler societies." (United Nations, n.d.)

Inmate – a detained individual, no presumption of guilt (Cambridge Dictionary, 2021a).

Jail – In the United States, this term refers to a facility that holds incarcerated adults involuntarily as they await trials or those sentenced to 12 months or less (Schoenly, 2013). In Canada, this is a colloquial term for a remand centre.

Living Unit – an area in a correctional facility where a group of incarcerated people live together. A living unit will be comprised of many individual rooms or cells (holding one or two people each).

Mental Health - A "state of well-being in which an individual realizes his or her own abilities, can cope with the normal stressors of life, can work productively and is able to make a contribution to his or her community" (WHO, 2018, March 30).

Mental Health Concerns – This term has been chosen to describe a "combination of abnormal thoughts, perceptions, emotions, behaviours and relationships with others." (WHO, 2019, November 28). The term broadly includes bipolar affective disorder, depression, anxiety, schizophrenia, dementia, developmental disorders, intellectual disabilities, personality disorders, substance use and addictive disorders, and any disorders outlined in the DSM-5. However, the term is not limited to concerns diagnosed by a physician or psychiatrist, it is inclusive of patient-reported issues or concerns.

Offender – a detained individual who has been found guilty of a crime (Cambridge Dictionary, 2021b).

Pre-trial detention – is the temporary detention of an adult in custody while awaiting trial (Malakieh, 2019).

Prison – facilities that hold adults convicted of a crime. In the United States, this refers to a facility holding adults sentenced to longer than 12 months (Schoenly, 2013). In Canada, this refers to adults sentenced to 2 years or more. I have chosen to use this term to refer to any facility that holds adults convicted of a crime, regardless of the length of sentence.

Remand – the temporary detention of an adult in custody while awaiting trial or sentencing (Malakieh, 2019).

Sentenced – judgement formally given on an individual after they have been convicted of a crime (Pink & Perrier, 2003).

Sentenced Facility – any facility that holds an adult convicted of a crime, regardless of the length of sentence.

Social Determinants of Health - the social conditions people work and live that directly affect their health (Raphael et al., 2020; WHO, 2010).

Chapter 1: Introduction and Background

Worldwide, women account for 6.9% of the correctional system population, a small proportion of incarcerated adults but this number has increased by 53% in the past two decades (Walmsley, 2017). This increase has occurred in every continent and is unrelated to global population growth or growth in the number of prisons (Walmsley, 2017). In Canada, women account for 25% of those accused in a police-reported criminal episode (Savage, 2019). When these women are incarcerated, they make up 15% of the provincial/territorial admissions, and 8% of federal admissions (Malakieh, 2019). Commonly women are accused of non-violent offences such as drug offences, property crimes, or theft. For women accused and incarcerated multiple times, the seriousness of the crime does not increase over time (Kong & AuCoin, 2008; Savage, 2019; WHO, 2009). The Kyiv Declaration on Women's Health in Prison noted that incarcerated women demonstrate higher prevalence rates for mental health issues, linking increased proportions of trauma and victimization as contributors to women's mental health and criminology (WHO, 2009). Most recently, Karlsson & Zielinski (2020) found the evidence had not changed: prevalence rates for major depressive disorder (MDD) were up to 2.9 times higher, bipolar disorders were up to 4.6 times higher, and substance use disorders (SUD) were up to 6.7 times higher, while these women continue to experience disproportionally higher rates of victimization. The situation of incarcerated women makes clear how important access to healthcare in a correctional setting is; yet, in the past twenty years, little has changed to improve healthcare in corrections. Within the correctional system, women remain disproportionally burdened with higher prevalence rates for chronic and infectious diseases (such as cancer, diabetes, arthritis and hepatitis), mental health concerns and substance use (Binswanger, et al., 2010; Brown et al., 2015; Fazel et al., 2006; Fuentes, 2014; Kouyoumdjian et al., 2012; Tyler et al., 2019).

Research has further shown that women accessing health services post-release are challenged by health disempowerment, interruption in treatment, and relapse into addiction and crime (Ahmed et al., 2016a & b; Kulkarni et al., 2010; Martin et al., 2012).

Outside of the correctional system, the literature is consistent in reporting that incarcerated individuals are less likely to have completed secondary education, more likely to be unemployed, have low-income status, low health literacy and lack safe, secure housing (Harris et al., 2006; Kouyoumdjian et al., 2016; Landry & Sinha, 2008; Lukasiewicz et al., 2007). These are all elements of the social determinants of health (SDH), which refer to the social conditions where people work and live that directly affect their health (Raphael et al., 2020; WHO, 2010). In Canada, gender is a social determinant of health that both stands on its own and intersects with all other determinants to influence health (Raphael, 2004). Women in Canada are less likely to work full-time (affecting eligibility for unemployment benefits) and more likely to be employed in lower-paying jobs, carry more of the responsibility of childcare and housework, facing greater discrimination in the workplace (Raphael et al., 2020). Incarcerated women are disproportionately more affected by these determinants, experiencing low socioeconomic status that is reinforced by gender. To complicate matters, Massoglia (2008) found that post-incarceration adults have fewer employment opportunities, lower wages and greater instability in marital and other social relationships. Incarcerated women frequently come from positions of social inequities that are exacerbated by the experience of incarceration.

Corrections in Canada

The pathway from Arrest to Incarceration to Release

Some background to the Canadian correctional system will help contextualize this research project. In Canada, in 2017/2018 there were 391,692 adults admitted to provincial/territorial facilities, and a further 14,470 into federal institutions (Malakieh, 2019).

While these admissions are not all unique adults, these numbers indicate the activity correctional facilities experience yearly (Malakieh, 2019). An adult will almost always be admitted to a remand facility before they are placed in a sentenced facility, which explains to some degree why the admission rates for provincial/territorial facilities are so much higher than federal institutions. The pathway for adults in Canada from arrest to incarceration is complex. When an adult is arrested and charged, they begin with being held in police or Royal Canadian Mounted Police (RCMP) cells. Generally, the individual will have a bail hearing with a judge to decide if they will be released into the community while the charges are being dealt with or if they will be remanded into custody. Most individuals will have this bail hearing before being transported to a remand facility, but some do not and are held on remand until they appear before a judge.

To be remanded into custody means a person is being held in a secure facility while they are awaiting their next court date and 'remand' legal status means they have not been found innocent or guilty of their charges. These facilities are also called pre-trial detention centres and are colloquially referred to as "jails." Across Canada "remand" is the term in use for anyone awaiting trial/conviction. In the United States, "jail' is used for facilities that house both those awaiting trial (remanded) and those sentenced to up to twelve months of custody (Schoenly, 2013). Remand facilities in Canada and jails in the United States also house adults who are waiting to be deported, referred to as immigration holds (Mullen et al., 2003). Another group of adults often held in remand centres are those who have breached their bail or parole conditions. In Canada, almost seventy percent of admissions to remand facilities are for non-violent offences, the majority of which are bail or parole breaches, not new criminal charges (Porter & Calverley, 2011). The term for an adult remanded into custody is "inmate," while those who are sentenced are "offenders." The difference between the two terms is critical. "Inmate" refers to a detained individual, with no presumption of

guilt; whereas “offender” indicates the individual has been found guilty of a crime (Cambridge Dictionary, 2021a & b).

Remand centres accept and hold all manner of inmates. The patient population of remand facilities is heterogeneous, and transient (Mullen et al., 2003). The average length of stay in a remand facility is short. Half of the adults spend one week or less in a remand facility, and 75% spend less than a month in remand (Malakieh, 2019). For adults that enter these facilities, their lives have been “abruptly interrupted and suspended” (Mullen et al, 2003, pp. 161).

Once a person’s legal case is decided there are three pathways. A verdict of not guilty releases the individual back into the community, the first pathway. A verdict of guilty is followed by a sentencing hearing, which can be immediate or can occur months after the trial has ended. In Canada, adults sentenced to two years less a day will take the second pathway that keeps the individual under the care and custody of the provincial/territorial jurisdiction. Within the provincial /territorial jurisdiction, adults can be sentenced to a correctional facility, or they can serve time through other options such as home arrest, community service, or have an intermittent sentence, in which they serve their sentence periodically over a long period (such as weekends only; Malakieh, 2020). The third pathway occurs when the individual is sentenced to two years or more, placing them under federal jurisdiction in an institution run by Corrections Services Canada (CSC).

Access to healthcare while incarcerated

Access to healthcare for incarcerated individuals is underpinned by the belief that this population is entitled to healthcare and has become the standard from which all subsequent guidelines exist. This standard begins with the United Nations Universal Declaration of Human Rights Article 25 that states everyone has the right to medical care (United Nations,

1948). The United Nations (UN) has gone further to clarify these entitlements in the Nelson Mandela Rules (UNODC, 2015), which sets out the minimum standards for the treatment of prisoners, stating “Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status.” (pp. 12). The WHO also supports prisoners’ entitlement to healthcare at the same standard as those in the community (Enggist, et al., 2014; Møller et al., 2007). Canada guarantees access to healthcare to incarcerated individuals through the Canada Health Act, under the principle of Universality, which mandates each province to provide health services to one hundred percent of the insured persons in that province (Minister of Justice, 2017). Because adults serving two years or more in a federal facility are not living under the provincial jurisdiction for the length of their sentence, healthcare is guaranteed in the Corrections and Conditional Release Regulations (Minister of Justice, 2019). There is no single organization that sets mandatory requirements for correctional healthcare delivery across Canada, but Accreditation Canada does provide a voluntary program of assessment for correctional facilities and health authorities (Accreditation Canada, n.d., 2018).

The delivery of healthcare in provincial/territorial correctional facilities is provided in several ways. Provinces such as Alberta, British Columbia and Nova Scotia provide healthcare through the provincial healthcare authority, while other jurisdictions use the governmental authority responsible for corrections (Kouyoumdjian et al., 2016; Simon, Salamat et al., 2020). For federally sentenced adults, CSC provides both correctional and health services to offenders across the country. In centres where healthcare services do not fall under the same leadership as correctional services, healthcare staff not only follow the policies, procedures and guidelines of their organization, but they must also be aware of and follow the rules and regulations of the correctional authority (Schoenly, 2013).

The release of a patient from a correctional facility is most challenging for those with remand legal status. When a patient is released after serving a sentence, the patient knows their release date in advance, as do the health and justice staff working with them. Community services can be arranged, prescriptions and medical supplies can be organized and there is the potential for the transition to be smooth. In remand facilities the final date and time of transfer are unknown. For patients that engage with healthcare while incarcerated, release into the community can bring barriers to continued healthcare such as lack of secure housing and food, lack of transport, lack of medical coverage, children and family taking priority, substance use, or even the act of trying to live day to day means personal health frequently takes last place (Ahmed et al., 2016a & b; Kulkarni et al., 2010; Martin et al., 2012).

My Experience with Correctional Nursing

Midway through the PhD process, I reached my twenty-fifth anniversary of being a Registered Nurse (RN). This achievement was a surreal experience, very far from where I thought I would be. I was an RN for just over a decade when I entered correctional nursing. The shift away from traditional hospital nursing occurred as I moved back to Canada after living abroad. I do not fully know what spurred me into the unknown realm of correctional nursing, likely it was a combination of crime dramas, literature and a desire not to return to hospital nursing. As I prepared to return to Canada, I applied for a casual RN position in Provincial Corrections with Alberta Solicitor General. I had no idea what the job entailed but I was game to try a new experience. I can still recall the first time I walked into the old Edmonton Remand Centre (ERC) in downtown Edmonton. The manager at that time began every interview with a tour of the facility; she called it the "shock and awe tour." The purpose was to sift out those nurses unsuited to the environment. I remember feeling energized

throughout the tour and interview. I begin with this account not to introduce sentimentality; but rather because this path turned out to be more meaningful than I ever envisioned.

I classify my time in corrections into three periods. The first phase of my career in the remand facility was under the management of the Solicitor General. My manager was a long-time corrections nurse with a passion for the patient population, especially the incarcerated women. The majority of healthcare was delivered by nurses, staffing the facility on a 24-hour basis. Physicians and psychiatrists were contracted to provide services in weekly clinics, and psychologists completed mental health assessments and reports on a Monday to Friday shift schedule. The nursing staff [comprising solely of RNs and Registered Psychiatric Nurses (RPNs)] had a wide scope of practice and great autonomy. The nursing team I worked with was steeped in knowledge and experience. We worked in close quarters, almost on top of each other. Each nurse may have had an assignment, but the nature of the building and the work rotation meant that everyone knew everything that was going on. Clinical discussions were open, with everyone involved to facilitate learning and best practice. This created an environment of excellence in nursing care underpinned by checks and balances in place to ensure patient safety. These years provided grounding in correctional healthcare that set me up for the next stage of my career development.

The second phase of my career was marked by a shift in the organization. In 2010, Alberta Health Services (AHS) took responsibility for health care within correctional facilities across the province. This shift opened a new opportunity as my role changed to that of mental health nurse. This new scope required that I interview patients in great depth about their addiction and mental health history. These interviews opened my eyes to the lives of my patients, experiences I had not realized contributed to incarceration. I quickly came to appreciate the impact of the SDH; creating a passion and a sense of responsibility to affect change in the health of my patients beyond one-on-one care. At the same time the opportunity

arose to participate in a study with remanded women that examined the link between health, housing and incarceration (Ahmed et al., 2016 a & b). This project resulted in the development of a Women's Health Clinic at ERC and a handbook for female inmates: Women's Guide to Health in Jail (Ahmed et al., 2016c). This experience crystallized how research could affect change, beyond creating new knowledge, a very exciting possibility I had not thought was possible. I came away from this project wanting to continue to do the work to understand and improve the health and experience of incarcerated women. I found the women's descriptions of their lives powerful and heartbreaking. I could identify with some of their words and images, but in a limited capacity, due to my work in the jail and being a woman.

I am now in the third phase, working in a clinical nurse educator position in provincial corrections while pursuing doctoral studies. My career has seen four healthcare managers. Only two of these managers had previous front-line correctional nursing experience, a difference I noted as each brought their perspective on correctional health care delivery. It has also been marked by the cancellation of the Women's Health Clinic as funding for the program was never secured. Doctoral studies expanded my thought processes and challenged how I perceive my clinical work and the role of research in the clinical world. Moreover, my experiences and my role as a clinical nurse educator drove me to examine the nurse-patient relationship, asking how the individual correctional nurse can affect change within the context of their therapeutic relationships with patients.

Statement of the Problem

My earlier statement that incarcerated women frequently come from positions of social inequities that are reinforced by the experience of incarceration encouraged this study. For women experiencing mental health concerns, the act of incarceration becomes entwined

with their mental health, a revolving relationship in which each contributes to and is an outcome of the other.

The WHO defines mental health as “a state of well-being in which an individual realizes his or her abilities, can cope with the normal stressors of life, can work productively and can make a contribution to his or her community” (WHO, 2018, March 30). Mental health is therefore more than the absence of mental disorders, which are defined as “a combination of abnormal thoughts, perceptions, emotions, behaviours and relationships with others” (WHO, 2019, November 28). In 1939, Lionel Penrose was the first to examine the prevalence rates of mental health concerns in correctional facilities across 14 European countries. He proposed that there was an inverse relationship between the proportion of people with mental health concerns in hospitals and correctional facilities (Biles & Mulligan, 1973). Penrose postulated that in systems with highly developed mental health systems the crime rates were lower because the “defective or insane” was unable to break the law (Biles & Mulligan, 1973, p.278). His theory became known as Penrose’s Law and became the foundation for what was termed by Abramson as “the criminalization of the mentally ill” (as cited in Brink, 2005, pp. 536). The criminalization of people with mental health concerns across North America began in the mid-20th century as traditional psychiatric institutions were dismantled in favour of community placement for patients, a social movement known as deinstitutionalization (King et al., 2018; Piat, 1992). The philosophy of deinstitutionalization was rooted in a belief that patients had the right to live in the least restrictive environment while receiving community services, which were to be developed to provide support in the community rather than in large institutions (Piat, 1992). In essence, these community mental health services were meant to be more humane, more therapeutic and more cost-effective (Lamb & Bachrach, 2001). The process of deinstitutionalization had three branches: 1) decreased reliance on specialized psychiatric hospitals by limiting the number of beds

available to patients; 2) transinstitutionalization, in which more beds became available in emergency departments or general hospitals, allowing for short term admissions for mental health concerns; 3) increased resources for community based mental health services (Sealy & Whitehead, 2004). In Canada, deinstitutionalization took place over four decades, from the 1960s through the early years of the 21st century (Sealy & Whitehead, 2004). The process was never carried out uniformly across the country. Instead, deinstitutionalization was implemented unevenly by the provinces, with significant regional differences (Sealy, 2012; Sealy & Whitehead, 2004). However, in general, deinstitutionalization began with transinstitutionalization by quickly placing the most stable patients in the community and increasing the number of available beds in general hospitals or emergency departments (Sealy & Whitehead, 2004). Across the country, the process of decreasing the number of beds in specialized psychiatric hospitals genuinely began in the 1990s (Sealy & Whitehead, 2004). Expenditures on mental health services over those forty years show a shift in resources from specialized psychiatric hospitals to community based mental health services (Sealy & Whitehead, 2004). The process of deinstitutionalization slowed down in the early years of the 21st century, especially among those provinces that had begun deinstitutionalization early (Sealy, 2012).

Unfortunately, the success of deinstitutionalization was hampered by a lack of integration of services and by ongoing stigmatization experienced by people with mental health concerns (Piat, 1992; Spagnolo, 2014), which meant many individuals with mental health concerns were set up for failure as they transitioned. Over time, the number of mental healthcare beds available for patients decreased by 95%, forcing individuals with mental health concerns to rely on inadequate community resources (King et al., 2018). Thus, deinstitutionalization is understood to be a policy with mixed results, most notably increasing

the number of homeless people and the number of incarcerated people with mental health concerns (Boschma et al., 2008; King et al., 2018; Piat, 1992).

However, in the years since deinstitutionalization, our view must be cast wider to understand that the relationship between mental health concerns and incarceration is multifactorial. First, the service requirements for individuals with mental health concerns are different now than it was when deinstitutionalization began (Lamb & Bachrach, 2001). While developments in psychiatric medications have allowed many people with mental health concerns to achieve stable mental health, for others increased access to alcohol and other substances have exacerbated negative outcomes (Lamb & Bachrach, 2001). Furthermore, it has been noted that the currently incarcerated individuals with mental health concerns closely resemble the people who were admitted to long-term psychiatric hospitals before deinstitutionalization (Lamb & Bachrach, 2001). A second consideration is the continued stigmatization experienced by people with mental health concerns (Lamb & Bachrach, 2001; Spagnolo, 2014). Discrimination and prejudice against these individuals began in the 19th century when Canadians protested the building of psychiatric hospitals in their neighbourhoods and continued well into the process of deinstitutionalization when the public objected to patients being released into their communities (Spagnolo, 2014). It is clear that the public has little tolerance for individuals with mental health concerns, preferring to keep these individuals 'out of sight,' initially in psychiatric hospitals and later in jails or prisons (Lamb & Bachrach, 2001; Spagnolo, 2014).

Researchers have more closely considered how incarceration is linked with mental health concerns. Raphael and Stoll (2013) proposed that instead of deinstitutionalization being the cause of higher incarceration rates, higher incarceration rates may be driving declines in mental health hospitalizations. They make two arguments of note. First, as incarceration rates increase, fiscal pressure may drive resources away from health into the

correctional system (Raphael & Stoll, 2013). Second, a more aggressive sentencing structure places more individuals into the justice system, diverting them from the mental health system (Raphael & Stoll, 2013). Another hypothesis by Horowitz and Scheid (as cited in McPhail et al., 2012) suggested three channels that link individuals with mental health concerns with incarceration: a) when they commit misdemeanour offences in relation to survival behaviours; b) when they also abuse drugs and alcohol that may lead to criminal behaviours; c) when they engage in both violent and nonviolent criminal offences. Since Abramson (as cited in Brink, 2005) published his 1972 paper, studies on prevalence rates have consistently documented higher rates of mental illnesses in prisons and jails than in the community (Bernier & MacLellan, 2011; Binswanger et al., 2010; Brink, 2005; Brown et al., 2015; Derkzen et al., 2013; Fazel, et al., 2016; Kouyoumdjian et al., 2016; Mukherjee, et al., 2014; Tyler et al., 2019). Moreover, the relationship between mental health concerns and recidivism is acknowledged. Individuals with mental health concerns are more likely to return to incarceration than those with stable mental health (Blank Wilson et al., 2014; Cloyes et al., 2010; Torrey, et al., 2014). More recently, Jones et al. (2020) found that incarcerated adults with schizophrenia or bipolar affective disorder (BPAD) were twice as likely to be reincarcerated. They proposed four factors to explain this overrepresentation: a) the existence of a relationship between criminal behaviour and mental health concerns; b) adults with schizophrenia/BPAD exhibit disorganized behaviour that contributes to breaching conditions; c) less access to mental health services and safe housing contributes to criminal behaviour for survival; d) substance use destabilizes mental health and daily functioning leading to criminal behaviours (Jones et al., 2020). Clearly, the links between incarceration/reincarceration and mental health concerns are not fully understood, but what is accepted is that a relationship does exist.

Since the 1990s there has been a growing body of research around the effects of early life experiences on the health and wellbeing of adults; with the focus on potentially traumatic experiences, referred to as Adverse Childhood Experiences (ACEs). These traumatic experiences include abuse (physical, sexual, and psychological) and household dysfunction but are not merely limited to these events (Campbell et al., 2016; Felitti et al., 1998). The general findings from the literature are that for adults who report ACEs there are increased risky behaviours and health risk factors, especially in adults who report 4 or more ACEs (Campbell et al., 2016; Felitti et al., 1998; Hughes et al., 2017). In general, the mechanism of action for individuals is a rise in stress, which exacerbates any poor coping mechanism, underpinning risky behaviours and further endangering their health (McEwen & Gregerson, 2018). For example, toxic stress in childhood can manifest as depression, anxiety and anger. When a child has weak protective factors, (i.e. a lack of supportive adults and stable relationships), they may learn to seek out other coping mechanisms that provide an immediate relief from physical and/or psychological pain, such as smoking, overeating, self-harm, substance use or multiple sexual partners (Campbell et al., 2016; Felitti et al., 1998; McEwen & Gregerson, 2018; Hughes et al., 2017). If these coping mechanisms prove to be effective, their use may become chronic and may lead to further health problems in the long term (Felitti et al., 1998). For instance, an adolescent may begin using substances to cope with exposure to ACEs, which can lead to chronic substance use as an adult and later lead to a diagnosis of cardiovascular disease, infectious disease or psychosis. ACEs can have a twofold impact on individuals: first in the biological reaction to toxic stress, and in the "delayed consequences of various adverse coping methods" (Campbell et al., 2016, p. 350). Studies within Canada demonstrate similar findings (Edalati et al., 2017; Fuller-Thomson, Baird et al., 2016; Fuller-Thomson, Roane et al., 2016; Kealy & Lee, 2018). The influence of ACEs is not limited to health outcomes, such that adverse events impact other social

determinants including housing, employment and education (Hughes et al., 2017). For some adults, engaging in risky behaviours and substance use can lead to criminal justice involvement and for certain women it has been hypothesized a unique pathway from early experiences of trauma to incarceration exists.

Women report higher prevalence rates for mental health concerns than their male counterparts (Bernier & MacLellan, 2011; Binswanger et al., 2010; Brink, 2005; Brown et al., 2015; Derkzen et al., 2013; Harris et al., 2006; Mukherjee, et al., 2014; Tyler et al., 2019). Compared to other women, women who are incarcerated report higher lifetime prevalence rates for schizophrenia (2.9 to 10 times higher) and MDD (2.4 times higher) (Karlsson and Zielinski, 2020). The same review found higher lifetime prevalence rates for people with Post Traumatic Stress Disorder (PTSD), substance use disorders, Obsessive-Compulsive Disorder (OCD) and dysthymia (Karlsson & Zielinski, 2020). Compounding this circumstance are the higher rates of victimization reported among incarcerated women, including but not limited to childhood and adult sexual/physical assault, intimate partner violence and experiences of corruption by adults (Crisanti & Frueh, 2011; Karlsson & Zielinski, 2020; Kelly et al., 2014; Lynch et al., 2017; Malloy et al., 2019). Moreover, Karlsson & Zielinski (2020) suggest that women who are incarcerated experience sexual violence victimization earlier in their development than similar women in the community. For incarcerated women, childhood trauma frequently precedes mental health concerns and substance use, which can in turn lead to participation in criminal behaviour culminating in incarceration and chronic re-incarceration (Caravaca-Sánchez et al., 2019; Kelly, et al., 2014; King et al., 2018; Tripodi et al., 2019). This may be “a gender-specific pathway to prison” (Karlsson & Zielinski, 2020, pp. 17).

Women who become incarcerated also become marginalised as they enter an unequal power relationship with the justice system. Within this justice system exists the healthcare

system that is responsible for providing healthcare. My nursing practice with women who were incarcerated exposed the impact of the SDH on their mental and physical health; and, paradoxically how incarceration and reincarceration could improve and worsen their health. As a nurse and a doctoral student, I sought out a framework to understand and provide healthcare to a unique group of women. I learned about cultural safety as nursing model to inform Indigenous healthcare, and after further research learned that cultural safety can also inform healthcare of marginalized patients, which could include women who are incarcerated (Blanchet Garneau et al., 2018; Kellet & Fitton, 2017).

Cultural safety developed within the context of the colonisation of Indigenous people in New Zealand/Aotearoa. The many and varied Indigenous peoples of New Zealand/Aotearoa became linked through the shared experience of colonisation that created poverty of culture, economics, political power and ultimately health (Ramsden, 2002). For Canadian Indigenous people, colonisation created similar circumstances, with similar health outcomes (Gracey & King, 2009; King et al., 2009). However, cultural safety need not be limited to the health of Indigenous people in former colonies. The heart of cultural safety is in comprehending some groups occupy different positions in society and how these groups are viewed and treated within the healthcare system (Polaschek, 1998). People who are incarcerated share similar experiences with Canadian Indigenous people in that they report living in a lower socioeconomic position, which has a direct impact on their health (Harris et al., 2006; Kouyoumdjian et al., 2016; Landry & Sinha, 2008; Lukasiewicz et al., 2007).

The choice of cultural safety as a nursing model to understand the healthcare of women who are incarcerated grew first from the recognition that this patient population was a special patient population, distinctive from other female patients in the healthcare system and from incarcerated men. They often occupy positions of greater social inequities as the social determinants of health intersect with gender and may be compounded by the “gender-specific

pathway to prison" (Karlsson & Zielinski, 2020, pp. 17). The social and health inequalities they carry may limit the health choices offered to them in the correctional setting. Culturally safe nursing practice seeks to recognise and respect incarcerated women as a distinct group and to meet their healthcare expectations, needs and rights (Polaschek, 1998). Cultural safety then goes further to acknowledge the unequal power relationships present in nursing practice (Polaschek, 1998; Ramsden, 2002), and once inside the criminal justice system this power imbalance becomes even more pronounced. Culturally safe nursing care seeks to overturn the idea that a marginalised patient is 'exotic' to the nurse, instead it is the nurse who is 'exotic' to the patient; hence, the "cultural dimension in health care is not abstract" (Polaschek, 1998, p. 456).

Once incarcerated, research has identified that opportunities do exist to improve the physical and mental health of women (Ahmed et al., 2016a & b; Binswanger et al., 2011; McPhail et al., 2012). Traditionally, this research has focused on the transition into and out of incarceration, or in the community between instances of incarceration (Binswanger et al., 2011; Colbert et al., 2016; Jalali & Hashemi, 2019; Kouyoumdjian et al., 2018; McPhail et al., 2012; Parsons & Warner-Robbins, 2002; Schonbrun et al., 2017; Sered & Norton-Hawk, 2019; Thomas et al., 2019). However, there is evidence that health disparities can be mitigated during custody. First, women report wanting to engage with health care services while incarcerated, seeing incarceration as an opportunity to prioritize and access services 'under one roof' (Ahmed et al., 2016a & b; Drapalski et al., 2009; Karlsson & Zielinski, 2020; Kelly et al., 2014). Next, incarcerations provide an opportunity for health education, addressing a knowledge gap often present in the lives of incarcerated women (Ahmed et al., 2016a & b). Finally, women who participated in treatment programs while incarcerated were less likely to be re-incarcerated (Gobeil et al., 2016).

When women are incarcerated their regular and consistent point of contact with healthcare is through their interactions with nursing staff as the principal providers of healthcare in correctional facilities (Dhaliwal & Hirst, 2019; Flanagan & Flanagan, 2001; Schoenly, 2013; Smith, 2005). Like other healthcare settings, nurses in correctional facilities are the most influential members of the multidisciplinary team; with a global view of the patient's physical and mental health concerns (Kalyani et al., 2014; Simon, Salamat et al., 2020). Correctional nurses are the first to assess the patient, manage issues through triage, consultation and patient education, and finally coordinate treatment and ensure completion (Dhaliwal & Hirst, 2019; Schoenly, 2013; Simon, Salamat et al., 2020). Moreover, interventions by nurses in correctional facilities have the potential to improve the lives of women beyond incarceration (Kelly et al., 2014). At the crux of this potential is the nurse-patient relationship which is a core component of nursing practice. The literature speaks of positive therapeutic relationships as being important to incarcerated women, seeking health professionals who exhibit non-judgemental, compassionate, empathetic, responsive and supportive healthcare (Ahmed et al., 2016a & b; Plugge et al., 2008; Young, 2000). As McPhail et al. (2012) noted "an environment based on safety, respect and dignity can drastically improve behavioural outcomes for incarcerated women" (p. 21). Hence, I am interested in the nurse-patient relationship and how cultural safety can inform the relationship.

Purpose of the Study

It is worthwhile to look at how the nurse-patient relationship is perceived and enacted by examining the day-to-day experiences of nurses working with incarcerated women. The objectives of the project were to increase our understanding of a) how the nurse-patient

relationship is perceived by nurses and enacted in the context of a correctional facility, and b) how cultural safety is perceived and incorporated into their practice.

Research Questions

This research study employed questions to provide an understanding of the correctional nurse-patient relationship through the eyes of the nurse. This study contributes to the existing body of knowledge concerning correctional nursing, including ways the nurse-patient relationship has the potential to improve the practice of healthcare professionals. The primary research question was: *What are the experiences of nurses who care for incarcerated women with mental health concerns?* The secondary research questions in this study were:

- How did the nurses become employed in corrections as a career choice?
- How do the nurses define correctional nursing practice?
- What are the core values of nurses working in corrections?
- How do the nurses describe nurse-patient relationships?
- How do the nurses understand the concept of cultural safety?

Significance of the Study

Incarcerated women with mental health concerns are disproportionally burdened in the corrections healthcare system. Once inside a correctional facility, among healthcare staff it is the nursing staff that has the closest contact with incarcerated women. The nurse-patient relationship may mitigate the health burdens patients face, increasing their capacity for self-care and thus decreasing their disempowerment (Kelly et al., 2014). This study aimed to shed light on this relationship and to understand the nurses' experiences in caring for incarcerated women with mental health concerns. By uncovering what it means to live and work as a correctional nurse, the practice of correctional nurses will be better understood.

Chapter 2: Theoretical Perspectives

Introduction

The purpose of this chapter is to review what is known about the role of interpersonal relations, cultural safety, and correctional nursing. These are the three theoretical perspectives that underpin this study. Each perspective is discussed in detail in this chapter starting with a short history, the founding principles of the perspective and the interconnectedness of the perspectives.

Interpersonal Relations

History

Hildegard Peplau first published her theory of interpersonal relations in Nursing in 1952. At that time, Peplau's theory was a response to the lack of advanced psychiatric graduate nursing programs and her desire to communicate ideas that would improve nursing practice (Forchuk, 1993). Her book was reissued in 1988 and again in 1992, expanding on her original theory that the interpersonal relationship between a nurse and patient has a qualitative effect on health outcomes for patients (Peplau, 1988). In the reissued book, Peplau anchored her theory on two assumptions:

1. *The kind of person each nurse becomes makes a substantial difference to what each patient will learn as he is nursed through his experience with illness.*
2. *Fostering personality development in the direction of maturity is a function of nursing and nursing education* . . . (Peplau, 1988, p. x).

She went on to clarify that the development of personality (*what each nurse becomes*) impacts how the nurse will interact with a patient in every nursing situation; in turn, it means how well a nurse understands herself will determine how well she can understand the patient's situation and their point of view (Peplau, 1988). Thus, the nurse-patient relationship

was situated at the center of nursing practice (Peplau, 1992), which was a clear ethical choice on the part of Peplau (Gastmans, 1998).

Principles of Interpersonal Relations

Relationships are at the heart of the human condition. In our private lives, these relationships connect us with others and may confirm self-worth and self-esteem (Peplau, 1997). The professional relationship between the nurse and the patient has a different goal which is, to make a positive change in the health of the patient (Peplau, 1992). While the relationship is unscripted and unique in every situation (Peplau, 1965; Peplau, 1997), there are inherent characteristics that set it apart. First, the relationship is built upon communication, verbal and non-verbal interactions where the patient invites the nurse to be a partner (Gastmans, 1998). However, the nurse has a responsibility to remain professional in that their speech should promote therapeutic outcomes, not be social in nature (Gastmans, 1998). The second characteristic is the paradox created in this professional relationship as the nurse both views the patient as 'the other,' a separate person, while also becoming attached in the context of 'caring' (Gastmans, 1998). Thus, the nurse experiences both separation and connectedness, becoming involved in their patient's lives while maintaining the patient as an autonomous, independent entity (Gastmans, 1998). Third, to assist the patient toward more positive health outcomes the nurse must have full knowledge of the patient's condition (Gastmans, 1998). Peplau saw indifference and ignorance as having no place in the nurse-patient relationship (Gastmans, 1998). For the nurse, this knowledge is not only about the patient's health issues, but also about them as a person (Peplau, 1997). The final characteristic of the nurse-patient relationship is for the nurse to see their involvement as real and lasting, not filled with sentimentality (Gastmans, 1998). Nurses must balance their intellectual abilities to respond to the patient's concerns with their intuitive skills that connect

them to their patient's "existential life-world" (Gastmans, 1998, p. 1317). The professional relationship is thus an expert activity of technique as well as the cultivation of human thoughts and feelings (Gastmans, 1998).

Relational Practice

Peplau's theory identified three phases in the nurse-patient relationship, a structure that she observed was present in every professional-patient relationship. The first phase was the Orientation Phase, characterized as a one-way exchange where the nurse is eliciting essential information (Forchuk, 1991; Peplau, 1997). In this phase, the focus is solely on the patient as the nurse conveys interest in getting to know both the patient and their health issue, either succeeding or failing at signalling receptivity through their behaviour with the patient (Peplau, 1997). A key consideration in this first phase is the preconceptions and stereotypes the nurse and the patient have about one another that enter into the interpersonal relationship as it forms (Peplau, 1997). Peplau placed the responsibility for examining and challenging these preconceptions onto the nurse as part of their personal and professional development (Peplau, 1992; Peplau, 1997). The Orientation Phase is the most important of the three phases " it sets the stage for the important work that is to follow" (Peplau, 1992, p. 14) and a failure to establish a therapeutic relationship in this phase correlates to poor treatment outcomes (Forchuk, 1994b). The second phase is the Working Phase, the focus is on patient's responses to their illness and the journey they take toward understanding themselves and their health issue (Forchuk, 1991; Peplau, 1997). In this phase, nurses fulfill a variety of roles and responsibilities, from taking physical care of the patient to health teaching and counselling. Each role has unique boundaries and expectations, and nurses should be able to fluidly move between the roles (Peplau, 1997). Most of the work with the patient is completed in this phase and the guiding principle "is to struggle with the problem not with the patient" (Peplau, 1997,

p. 164). The final phase is the Termination Phase, where the relationship between the nurse and the patient comes to an end (Forchuk, 1991; Peplau, 1997). It is a critical component of the professional nurse-patient relationship that there is a time limit, an ending; unlike social relationships in our private lives. The relationship may be short (emergency departments) or prolonged (long term care), and in some cases, it is the death of the patient that triggers the end of this phase. Peplau was clear that in all cases, this phase necessitated self-reflection on the part of the nurse (McCarthy & Aquino-Russell, 2009; Peplau, 1997).

Patient as Expert

The nurse-patient relationship is not a relationship of equals or one of reciprocity (D'Antonio et al., 2014; Gastmans, 1998). The needs of the patient are the priority, and the nurse should encourage the patient to be their own decision-maker (Gastmans, 1998). It is for the patient to define the problems to be worked on because only they truly know what their needs are; and they are the only ones who can make changes in their behaviour (Peden, 1993). The patient brings personal knowledge and competencies (some developed, some not) to the relationship (Reed, 1996). The patient sees the nurse solely as a professional, without care or concern for the nurse's family, hobbies or relationships (D'Antonio et al., 2014; Forchuk, 1994b; Peplau, 1997). Patients want nurses who are competent, sympathetic, show dignity and respect, and above all, they want to be heard (Peplau, 1997). In contrast, the nurse sees the whole patient, getting to know the person, the health issue (Peplau, 1997) and what it "might mean to be the person" (Barker, 1998, p. 215). The nurse brings nursing knowledge and a theoretical understanding to assist patients in using their competencies for improved health (Reed, 1996). Thus, the responsibility of the nurse in the relationship is more complex; but, in essence, it is to foster quality in the interpersonal relationship as a participant observer, in which they observe their own behaviour, the patient's behaviour and the interaction

between them (Peplau, 1992). The work of observing the self begins with assessing the nurse's behaviour with the patient, including the verbal and non-verbal communication patterns they use with the patient (Peplau, 1997). By observing the self and how the patient interacts, the nurse can evaluate the effectiveness of their interpersonal communication and has the opportunity to make changes as required (Peplau, 1997). This work of participant observer happens both in the moment of patient interaction and throughout the lifespan of the nurse as they develop professionally (Peplau, 1965; Peplau, 1997). Peplau (1997) identified this responsibility to be a challenge for nurses as they alone must lessen the unintended effects of their behaviours with patients, as the patients hold little obligation for their part in the relationship.

Previously the concept of preconceptions was introduced as part of the orientation phase of interpersonal relations. Preconceptions and stereotypes are brought to the relationship by both the nurse and the patient, and they are the initial impressions that exist before knowing one another (Forchuk, 1993). Patients bring past experiences with other nurses and the healthcare system, images from media, other relationships and personal need (Peplau, 1997). Patients frequently have a preconception of what a nurse should be and act like (Peplau, 1997). Likewise, nurses bring ideas of what a patient with a certain diagnosis is like (Peplau, 1997). They may also bring ideas linked to age, gender, ethnicity, and socioeconomic status (Peplau, 1997). For both the nurse and the patient, these preconceptions and stereotypes can impact the outcome not only of the interpersonal relationship but also the health outcome of the patient (Peplau, 1988; Peplau 1997). Forchuk (1994a) found in her study of preconceptions with nurses and chronically mentally ill adults that preconceptions existed early in the interpersonal relationship and that participants were willing to share their preconceptions.

Cultural Safety

History

Cultural safety was developed by Irahapteti Ramsden (1946 – 2003), an indigenous RN and nursing educator in New Zealand/Aotearoa. Cultural safety (*Kawa Whakaruruhua* in Maori) began with Ramsden's personal experience that the then nursing education system in New Zealand/Aotearoa graduated nurses who did not comprehend the Maori's experience of colonisation (Ramsden, 2002). She cited a lack of understanding between economic and political agendas, historical events and poor health that was underpinned by a nursing education system that neglected to critically examine the impact of colonisation on Maori health (Ramsden, 2002). She aspired to awaken nurses to their social conditioning, which affected their nursing practice (Ramsden, 2002). Evidence to support her personal and professional experiences was published in 1988 in a report on Maori health status that established the cultural, social and economic disadvantage underpinning higher rates of physical and mental illness; shortly after acknowledged by the Director-General of Health as the result of a century and half of colonisation (Papps & Ramsden, 1996). In this same year, Cultural Safety was formalized in a series of meetings and a set of standards was developed (Papps & Ramsden, 1996). The Nursing Council of New Zealand made Cultural Safety a requirement for nursing education in 1991, formally adopting *Kawa Whakaruruhua* in 1992 (Papps & Ramsden, 1996).

Principles of Cultural Safety

Cultural safety was foremost a pedagogy and educational model situated in the Maori experience of colonisation in New Zealand/Aotearoa (Ramsden, 2002); thus, power relations in health care were foundational to this work. Ramsden began by recognizing that by omitting the New Zealand colonial history in the education system meant the outcomes and

effects of this colonisation were unknown to individuals as they entered nursing (Ramsden, 2002). Ramsden sought to shed light on the social and institutional racism that came out of colonisation and was present in both the health care system of the time and the individual healthcare provider, importantly without shaming the nurse through historical guilt (Ramsden, 2002). She connected power relations with Maori distrust and avoidance of the health care system by observing that prejudicial or demeaning attitudes (whether conscious or not) displayed by health care providers contributed to this distrust and avoidance (Papps & Ramsden, 1996; Ramsden, 2002; Ramsden & Spoonley, 1994). Ramsden noted at the time that the majority of nursing students (and thus practicing nurses) were non-Maori and unaware of the risk when patients from one culture believe they are disempowered by the actions and health system of people from another culture (Ramsden & Spoonley, 1994).

Ramsden's educational model began with teaching nurses to see themselves as bearers of their own culture and to recognize how their culture influences patients (Ramsden & Spoonley, 1994). However, this personal culture was joined by the institutional culture of health and professional power. Ramsden (2002) observed in herself that nursing taught her about "inflexibility, conformity, control and oppression and fear of change" (p. 44-45). She further noted that nurses assumed a role that gave them the right to enter the lives of their patients "in the name of public health and public good and that those social practices were sustained by an ethical ideology which would support them" (Ramsden, 2002, p. 56). Thus, for non-Maori nurses, Ramsden (2002) saw interactions with indigenous patients as "cultural tourism" (p. 78), in which nurses were secure in the nursing culture while the patient was an exotic individual in deficit compared with the culture of health care, giving the nurse power and the ability to be patronizing. The concept of culture for Ramsden was never meant to refer solely to the Maori culture in New Zealand/Aotearoa, despite the cultural safety framework developing from the Maori reality. Ramsden defined culture broadly, to

encompass differences whether they be based on ethnicity, gender, nationality, religion, political beliefs or socioeconomic status (Papps & Ramsden, 1996; Ramsden, 2002; Ramsden & Spoonley, 1994). What Ramsden (2002) identified as key was the conviction in multiculturalism that individuals were to be nursed the same, irrespective of their differences with each other or healthcare providers. She rejected this belief in favour of embracing and respecting difference:

> The idea of nursing ignoring the way in which people measure and define their humanity is unrealistic and inappropriate . . . it is not the place of nursing services to attempt to deny the vital differences between people however altruistic the rationale may be (p.79).

Ramsden wanted nurses to acknowledge the relationship between difference and unequal distribution of resources, which gave power to healthcare providers and affected both nursing practice and patient wellbeing (Ramsden, 2002). Cultural safety looked to make two important shifts in this power relationship. First, the nurse would be perceived as the exotic one (Papps & Ramsden, 1996; Ramsden, 2002). This new paradigm accepted that the culture of healthcare and nursing is foreign to patients, thus when a patient entered the system it was the healthcare provider who was 'the other' (Ramsden, 2002). As the patient retained their own identity and individuality the second shift was to redress the power imbalance by giving power to the healthcare consumer by conceding only the consumer of the service can define the quality of that service (Papps & Ramsden, 1996; Ramsden, 2002).

Relational Practice

At the heart of culturally safe practice lies bicultural interactions leading to a partnership between the nurse and the patient (Papps & Ramsden, 1996; Ramsden, 2002; Ramsden & Spoonley, 1994). As mentioned, culture was defined in the broadest sense to

mean any person or group who differed from the nurse based on gender, age, ethnicity, socioeconomic status, disability, religious beliefs or migrant status (Ramsden, 2002). Ramsden (2002) was clear that to see 'culture' only through the lens of ethnicity promoted a stereotypical view over time, which not only assumed that ethnicity was the most important facet of the patient but also made it difficult to respond to patient diversity. She did recognize that the culture carried by an individual provides a framework for how we see and evaluate those around us, meaning we define others by our norms (Papps & Ramsden, 1996). Hence, with every nurse-patient relationship, two cultures come together to interact. In New Zealand/Aotearoa prior to the introduction of culturally safe practices, this was the interaction of people with different ethnicities, and also different colonial pasts with different current economic, political and social advantages (Papps & Ramsden, 1996). The power redistribution brought about by culturally safe practices required an attitude change on the part of nurses, namely challenging nurses to an awareness that there are other ways to view the world and experience life (Papps & Ramsden, 1996). To foster this change in attitude, Ramsden (2002) started by identifying those attitudes that existed, then tracing their origin to demonstrate the power these attitudes had on practice. In examining her own culture Ramsden (2002) was "astonished at the level of racism and victim blaming attitudes that I carried with me as part of the social class in which I had been raised" (p.46). Through reflective practice, cultural safety would achieve action in the beliefs and behaviours of the healthcare provider (Ramsden, 2002). Ramsden's (2002) personal reflection recognized "I could very well become the oppressor of Maori and others who were less powerful than myself" (p.47). By pinpointing these attitudes and their origins Ramsden (2002) was able to fully engage in the bicultural interaction, a skill she identified as the "professional acquisition of trust" (p. 118). Ramsden (2002) described this process as "fleeting and unspoken . . . and influences all future interactions" (p.120). Furthermore, the inability to establish trust means

that the patient will protect their differences from the nurse and never feel safe in the relationship (Ramsden, 2002). Establishing the trust moment and sharing the meaning of power and vulnerability is the praxis of cultural safety (Ramsden, 2002).

Patient as Expert

The final element of cultural safety that must be understood is how Ramsden's pedagogy situated the patient as the expert as the power shifted from the healthcare provider to the consumer. As patients engage with health services, they leave their community and enter a world where someone else makes the rules, speaks a different language, and when admitted to a hospital they become physically isolated, all of which takes them out of their comfort zone (Ramsden, 2002). Cultural safety invested value in the knowledge held by the patient and reinforced they could evaluate health services within the framework of their life (Ramsden, 2002). The practical implication for the patient was that when cultural safety was active the individual would enter the health system (developed by someone from another culture) and retain their self through the experience (Ramsden, 2002). Cultural safety was meant for all patients, everywhere to protect them from the culture of healthcare, from the attitudes and power whether intentional or not (Ramsden, 2002). This was the reason 'safety' was chosen as part of the concept's name. Ramsden wanted to embed competency in nursing practice, a requirement to protect patients from danger or decrease the risk of hazards to health and wellbeing (Papps & Ramsden, 1996). In situating the patient as an expert, nurses were reminded not to make assumptions about their patients, to work with the patient and be humble (Ramsden, 2002).

All of these principles, relational practice and the patient as an expert were condensed into four educational objectives for nurses (Papps & Ramsden, 1996; Ramsden & Spoonley, 1994):

1. To examine their own cultural realities and the attitudes they bring to every person they encounter in professional practice.
2. To be open minded and flexible in their attitudes toward people from differing cultures to whom they deliver service.
3. Not to blame the victims of historical and social processes for their current plight.
4. To produce a workforce of well-educated self-aware nurses who are culturally safe to practice, as defined by consumers of the service (Papps & Ramsden, 1996, p. 493; Ramsden & Spoonley, 1994, p. 164).

Through these objectives, Ramsden was able to communicate her concept and pedagogy to nursing students and educators in the hope of improving the health of Maori and others in New Zealand/Aotearoa.

Connections between Interpersonal Relations & Cultural Safety

There are parallels between Peplau's interpersonal relations and cultural safety in how they approach the nurse-patient relationship. Fundamentally, at the heart of both frameworks is the belief that the character and development of the nurse lays the groundwork for the nurse-patient relationship, which must include a degree of self awareness. For Peplau, this self awareness and reflection was to focus on the nurse's behaviour (communication) with the patient and how the patient responds with the goal to be that the nurses can alter their behaviour to make communication more effective (Peplau, 1992). Within cultural safety, the goals of self awareness and reflection are for the nurse to know their own cultural background and how that background influences the nurse-patient relationship (Ramsden, 2002). Peplau's self-reflection focused on the current interpersonal communication between the nurse and the patient, while cultural safety took a personal stance by asking nurses to look inward with honesty at personal biases and beliefs. For both frameworks, the responsibility

for success in the nurse-patient relationship lies with the nurse, and the nurse is expected to treat each situation as unique, adjusting their own behaviours to meet the individual patient's needs. By engaging in self-reflection and awareness, both frameworks propose this will build trust with the patient, the basis of a positive healthcare relationship.

A second parallel in interpersonal relations and cultural safety is the convergence of preconceptions and stereotypes. Peplau was clear that both nurses and patients come to every relationship with preconceptions and stereotypes (Forchuk, 1993; Peplau, 1997). The context of these preconceptions and stereotypes was mainly healthcare, but Peplau did acknowledge that some of these prejudices are associated with ethnicity, gender, age and socioeconomic status (Peplau, 1997). For Peplau, these preconceptions and stereotypes were present but not dominant. In contrast, within cultural safety preconceptions and stereotypes are central to the framework, their existence being the reason cultural safety arose. The distinction between the two lies in the acknowledgement of power inequities that exist in every nurse-patient relationship. Cultural safety places power inequities up front with preconceptions and stereotypes because Ramsden observed the damage that was done to the health of marginalised populations when nurses were unaware of their social conditioning (Ramsden, 2002). Nevertheless, once a nurse knows about their personal prejudices, both cultural safety and interpersonal relations places the responsibility on the nurse to challenge and explore these prejudices for self development (Peplau 1992; Peplau, 1997, Ramsden, 2002).

Self-reflection and awareness that are present in both frameworks speaks to Peplau's guiding principle "to struggle with the problem not with the patient" (Peplau, 1997, p.164), although this is less evident in cultural safety. Within interpersonal relations, struggling with the problem characterised the Working Phase of the nurse-patient relationship in which together the nurse and the patient did battle with the health issue, not with each other. Again, the success or failure of their communication was the responsibility of the nurse (Peplau,

1997). The concept of this struggle lies within the goal of culturally safe practice: shifting power away from the nurse to the patient. Once power is redistributed, cultural safety offers the conviction that the impact on health will be positive, reflecting the shift in struggling not with the patient but with the problem.

The final connection between cultural safety and interpersonal relations that must be explored is the concept of "the other". For Peplau, seeing the patient as "the other" was important to the professional relationship as it underpinned the division between the nurse and the patient (Gastmans, 1998). Within Peplau's theory of interpersonal relations nurses were tasked with gaining a holistic knowledge of the patient and expected to become involved in their patient's lives (Gastmans, 1998; Peplau, 1997). Without viewing their patient as "other," the act of caring for a patient threatened to change the professional relationship into a personal one if boundaries were not maintained. In contrast, cultural safety interpreted seeing the patient as "the other" as part and parcel of culturally unsafe practices. Ramsden saw the use of "the other" as making Indigenous or marginalised patients as "exotic," while the nurse retains power within the healthcare system (Ramsden, 2002). Instead, cultural safety looks to recast the roles such that the nurse becomes the "exotic" one or "the other" and the patient retains their personal identity and power as they enter the healthcare system.

Cultural Safety in the 21st Century

Cultural safety as a concept has grown beyond New Zealand/Aotearoa, being taken up most enthusiastically in Canada and Australia. In both countries, the concept and practice of cultural safety has been closely linked to the healthcare of Indigenous people. This link is not surprising as the three nations have a shared colonial history, with a similar impact on the health of Indigenous people (Gracey & King, 2009; King et al., 2009). Most frequently

cultural safety is discussed as a concept that can underpin or improve nursing with Indigenous people (Dell et al., 2016; Hole et al., 2015; Kelly, 2013; Lopes et al., 2012; Maar et al., 2009; McGough et al., 2018; Moffitt & Vollman, 2006; Parker, 2010; Smye et al., 2006). There is a growing body of literature that examines cultural safety in the context of nursing immigrant or refugee populations (Baker, 2007; Khawaja & Stein, 2016; Mortenson, 2010; Ogilvie et al., 2008; Ogilvie et al., 2013; Salt et al., 2017). While this research has been limited mainly to Canada, some have examined immigrant patient populations in New Zealand and the United States. Blanchet Garneau et al. (2018) examined how cultural safety can be applied to health research with religious minorities; being one of the first to develop 'culture' beyond ethnicity as Ramsden intended. Cultural safety has also been identified as a useful concept when working with disempowered patient populations, such as those with mental health concerns, substance use issues, as well as gender and sexual minority groups (Healey et al., 2017; Kellett & Fitton, 2017; Pauly et al., 2015; Wilson & Neville, 2009). As correctional patient populations are another vulnerable group, cultural safety is a worthwhile concept to underpin this nurse-patient relationship.

Location: A Personal Narrative

When Ramsden (2002) conceptualized and developed cultural safety her vision was to help the students and teachers in nursing education "to become aware of their social conditioning and how it affected them and therefore their practice" (p. 2). She modeled that vision in her own thesis by utilizing autobiographical narrative over three chapters to consider her own historical, educational, physical, moral and emotional origins that contributed to the development of cultural safety (Ramsden, 2002). She also reflected on the political, historical and economic influences that shaped the development of New Zealand/Aotearoa. Ramsden identified herself "as an indigenous woman who became a

nurse" (2002, p. 2) in an educational system that could not comprehend or share her experience of colonisation in New Zealand/Aotearoa. The description of her narrative is both a personal and professional story, and one in which I will also engage in to locate my own narrative so I too can become aware of my own social conditioning and how it affected my practice and graduate pathway. I will begin with a history of Canada and Alberta, my birthplace and home for most of my life.

Canada in 2022 is a multicultural nation but before the arrival of the European explorers in the 16th century the land was inhabited by Indigenous people. The coming of the French and English settlers to North America in the 17th century began the development of an economy based on agriculture, transport and the exportation of natural resources (Government of Canada, 2015, October 26). As the economy grew, control of the land was desired by both the French and English governments, with an English victory in 1759 (Government of Canada, 2015, October 26). The Dominion of Canada was formed in 1867 under the British North American Act and the country continued to expand through the 20th century to what is modern Canada. As the country grew, settlers from across the world immigrated, further developing the economy, contributing to the government, and building population centres. Politically, there are three levels of governance: federal, provincial and municipal. Each province and territory have a Premier as a leader and the head of the federal government is the Prime Minister (Government of Canada, 2012, April 11). The hereditary sovereign of the British royal family reigns as Canada's head of State (Government of Canada, 2012, April 11).

In the midst of this development was the relationship with the first peoples of the land. This relationship was complex and changed over the centuries. The adoption of the "Civilizing the Indian" in 1820 began the formalized colonisation of the Indigenous peoples that framed Canadian-Indigenous relationships for a century and a half (Government of

Canada, 2017, May 2). The effects of this policy, which included residential schools, continues to impact Indigenous people today.

My parent's families were early settlers. My mother's ancestors left Ireland for Newfoundland in the 1790s and my father's ancestors emigrated from England and Ireland in the 1820s. The English and Irish cultural roots survived in my family over the generations. My father's family settled in St. John's. They went from a very low socioeconomical status to a middle class status. In contrast, my mother's family lived in an out port, isolated in the winter and dependent on farming and fishing for food, often living hand to mouth. For my mother's family education was the only way out of poverty. Both my parents were born and raised while Newfoundland was a Dominion, an independent colony of Britain and member of the Commonwealth. When my uncles and great uncles fought in World War I and II they fought under the British ensign, not for Canada. It was not until 1949 that Newfoundland joined Canada and my parents left behind their British citizenship. At a national level I have always defined myself as a Canadian over many generations, taking pride in how long my family has lived in this 'new world' despite arguably being a first generation Canadian.

Like any 'good' Canadian, I also take pride in my provincial heritage, which is firmly bound to Edmonton, Alberta, where I was born in the early 1970s. Like the rest of Canada, Alberta was home to many Indigenous peoples for thousands of years before the arrival of the European fur traders in the mid-18th century (Alberta Champions, n.d.). The area was part of the Rupert's Land, the name of the land granted to the Hudson's Bay Company (HBC) in a charter by King Charles II (The Canadian Encyclopedia, 2022a). This charter gave the HBC exclusive right to trade and colonize Rupert's Land, which included the establishment of trading posts along major rivers. Fort Edmonton was one such post, established in 1795 (Alberta Champions, n.d.; The Canadian Encyclopedia, 2022a). After Confederation the Canadian government worked with the British crown to acquire Rupert's Land from the HBC

in 1870, in part to halt the threat of American expansion. Within a few years, Treaty 6 was signed between representatives of the Crown and leaders of the Cree, Assiniboine and Ojibwe nations (The Canadian Encyclopedia, 2022b). The boundaries of this treaty extend across central Alberta and Saskatchewan, including present day Edmonton. The history of this and other treaties in Canada is complex but described simply in the 1870s the Indigenous people were concerned about the arrival of European settlers and the shrinking stock of bison while the new Canadian federal government wanted to ensure the access and development of the lands in the West (The Canadian Encyclopedia, 2022b). It was in the 1870s that new European settlers (mainly French-Canadians and British farmers) began to arrive in western Canada, building an economy based on agriculture (Alberta Champions, n.d.; Whitson et al., 2021). Alberta became a province in 1905 and for almost fifty years the province was economically poor, relying on agriculture as the main industry (Whitson et al., 2021). The discovery of oil in the 1940s changed the economic outlook for the province, and the provincial government was able to use the increased revenue to invest in infrastructure and post-secondary education (Whitson et al., 2021). From the late 1800s, settlement began to increase in western Canada bringing people from various European origins. As time passed more waves of immigrants continued to arrive. For Indigenous people living in Alberta the increased migration of immigrants and Canadians from other provinces shifted the population makeup, rendering the province's first people a minority as the number of settlers grew.

The economic prosperity of the oil boom was the opportunity that attracted my parents as they moved to Edmonton from Newfoundland shortly before my birth. My father attended the University of Alberta, earning a teaching after-degree and my mother worked as a registered nurse after earning a BScN at the University of Ottawa in the 1960s. Both my parents found steady jobs in Edmonton, buying a home, and settling into the community. Our family was small, I am an only child, and the extended family was left behind when my

parents moved to Alberta. My father's family are spread out across Canada while my mother's family remained mainly in Newfoundland. Aside from one great-aunt on my father's side who followed us to Edmonton, and one cousin who moved to Fort McMurray to escape unemployment in Newfoundland, I had limited contact with my extended family as it was expensive to call or visit in the 1970s & 1980s. Thus, the community of people I grew up around were mainly nurses, teachers and Roman Catholic church members who themselves were settlers from other provinces or other countries.

Politically, Alberta has been a conservative province since the 1930s, with a brief exception of a New Democratic Party (NDP) a social democrat political party from 2015-2019 (Whitson et al., 2021). My parents' political leanings were not aligned with the Alberta conservative parties, instead supporting the provincial Liberal and NDP parties. I was raised with a belief in the social safety net and in the importance of the social determinants of health for all. My parents shared the household work equally. My mother was active in the Alberta nurse's union, modelling social justice and participation to improve the circumstances for everyone.

I grew up in a middle-class neighborhood. I attended Catholic school, and it was an expectation that I would finish high school and attend university. Socially, I had a few close friends and I was not a part of any school clique, instead being friendly with many of my peers some of whom I had known since elementary school. I graduated high school with honors and went directly to the University of Alberta to study general science.

The first two years of university were a challenge. I had chosen to study science but soon found that my history classes were my favorite courses. Confounding these years was my devotion to my part time job, teaching swimming. I compensated for my lackluster interest in science by working as much as I could. In my second year of university, I was faced with the decision of where to go with my life. I was passionate about history but did not

believe it was a reasonable path toward a career. I decided that nursing would be a better path, providing an economic basis for a future study of history.

It is fair to describe the first 25 years of my life as living in a bubble of middle class, mainly Caucasian community of well-educated individuals. I entered nursing school in 1991, attending the Misericordia Hospital School of Nursing in west Edmonton for two years before moving onto the University of Alberta Faculty of Nursing, graduating with a BScN in 1995. The Misericordia Hospital School of Nursing and the associated hospital were founded by Roman Catholic nuns, the Misericordia Sisters of Montreal, and situated in a middle-class area of the city. I can remember few nursing students who were visible minorities. Our patients were mainly Caucasian, with few homeless patients or patients with substance use concerns. Once I moved to the University there was little change in the ethnicity of my peers or patients. I recall a brief student placement in the Edmonton inner city, but my only substantial memory is of a walking tour of the area with little contact with marginalized populations.

Soon after I entered nursing school the Alberta government began a program of economic restraint in the health sector. Hospital beds were closed, and nursing positions were eliminated. Before I graduated, I knew there would be no jobs available in Alberta. After I graduate with a BScN, instead of pursuing a nursing job outside the province as did many of my peers I went back to school to earn a business diploma specializing in Asian studies. Part of that program included an overseas working experience in Malaysia. When that program was finished the situation for nurses had improved in Alberta and I began working at the University of Alberta Hospital as an RN in general medicine. At that time, the University Hospital was considered a premier hospital, with funding for research and serving patients of higher socioeconomic status. This was not accurate in terms of patients served, however there was an air of competition with the other main city hospital, the Royal Alexandra Hospital, an

inner-city hospital serving many more marginalized people. While at the University Hospital, I worked across all inpatient medicine units, eventually accepting a position on the Tuberculosis (TB) unit. This unit was my first opportunity to work closely with patients who were Indigenous and/or marginalized, to see firsthand how the social determinants of health impacted the individual. During this same time, I pursued my passion for studying history, specializing in Asian history. I earned a Master of Arts in the history of nursing in Japan. When those studies ended, I took a break from nursing to live in Japan for three years teaching English to elementary and junior high school students.

My time in Malaysia years earlier and this period in Japan taught me a great deal about what it is like to be a minority living amongst a culturally foreign majority. When I lived in Malaysia I worked in a private university as an administrative assistant. The government had a program of balanced employment in which the three major ethnic groups (Malay, Chinese and Indian) had to be proportionally represented in almost all businesses. I witnessed how the Malay population who were disadvantaged in education and socioeconomic position had fewer opportunities. I also experienced a government that could not be criticized openly. This was an encounter in which I was disadvantaged, losing some of the white privilege I had unwittingly held. However, I was still in a position to have all my basic needs met and opportunities to experience the community around me.

Japan was my second experience living as an ethnic minority. This was a more influential event as I had a longer period in Japan. My main experience was that my foreignness was celebrated, as it was the reason for my job; but, there were times when I was discriminated against because I was foreign, such as not being welcome at clubs with signs that proclaimed “no foreigners allowed.” Yet, the longer I lived in Japan the more I strove to become Japanese and wanted to continue to live there. Unfortunately, immigration to Japan was nearly impossible without marriage to a Japanese man as expats are limited in the

number of years they can hold work permits. Like my time in Malaysia, I lived a comfortable life in Japan with opportunities to travel and experience the best the country could offer. I lived and worked with Japanese people of the same socioeconomic position, seeing marginalized Japanese adults only once. I had one experience with a junior high student who was struggling with family problems, learning the teachers and the school system were not in any position to effect any change in her life course. This was a powerful incident because I realized there were likely more adolescents with family issues that I was unaware of due to the language barrier and my own unenlightened mind. After three years in Japan I began to sincerely reflect on my own biases, origins and point of view. I was not sad to have taken that break from nursing. Medicine nursing had not been inspiring. I found the work environment to be negative, as other nurses were overworked and unhappy after years of difficult working conditions. My work on the TB unit had started to change that, but I knew I required a shift in perspective. When I reflect on who I was prior to living in Japan, if I had returned to medicine nursing I would have lost the self-awareness I had gained and I would have become closed minded to my patient population. Japan set me up to learn more about myself and to accept my patients without judgement. Thus, as I returned to Edmonton, my journey to correctional nursing began.

I returned to Edmonton as a sessional instructor at the University of Alberta with the Faculty of Nursing. I spent two years working at the Faculty of Nursing, teaching third- and fourth-year students. I enjoyed the time with the students and other faculty. I especially enjoyed working with fourth year students who had chosen to work with marginalized people in their final practicum. It was inspiring to see how excited the students were to begin their nursing careers and how they imagined effecting a positive change in their patient's lives. While teaching I had also accepted a casual position at the Edmonton Remand Centre (ERC), a provincial pre-trial detention facility. Despite enjoying my time as an instructor, it was my

work with incarcerated adults that altered my perception of what nursing was and could be in my life.

Provincial correctional nursing opened my eyes and my mind to a foreign world, in the same way Japan did. The language, culture and experiences of the majority of patients who were incarcerated was like nothing I had encountered before. Likewise, the culture and language of the correctional facility's health personnel and correctional officers was like no other workplace. I began as a general nurse, responsible for medication administration, treatments (dressing changes, diabetic and hypertension monitoring) admission screenings, and suicide risk screens. The nurses I worked with reminded me of the nursing instructors I had in the first two years of my education at the Misericordia, they were experienced older men and women who took patient care seriously. These nurses inspired me to be a better nurse and to recognize the potential in the nurse-patient relationship, lessens I had not learned or been ready for years previously. I learned to work closely with officers, men and women who did not always agree with my role or with providing health care at all. But there were other officers who taught me about kindness, dignity and respect toward incarcerated people. Likewise, through a few key nurse-patient interactions I learned to put aside the privilege I had through my ethnicity and socioeconomic status. The years that I was both a sessional instructor and a casual correctional nurse was a steep period of absorbing knowledge and reflecting on who I was as a nurse and who I wanted to be going forward. After two years I decided that pursuing correctional nursing full time was the right path, resigning my teaching position to become a full-time correctional nurse.

The first five years of my career as a correctional nurse I would characterize as my time to learn about myself and how I could be an effective professional nurse in this challenging environment. I then had the opportunity to move into a mental health nurse role within the same correctional facility. It was this new position that taught me about the

experiences of my patient population. The work involved interviewing patients to get their full life history, rather like individual interviews in an ethnography. Hearing their stories first person changed how I perceived substance use, mental health concerns and incarceration. I began to link the social determinants of health with the lived experiences of my patients. Soon after I had the opportunity to work with a University of Alberta research team examining the health and housing experiences of women who were incarcerated. The research led to the creation of a women's only health clinic within the correctional facility. With each passing year, I compared the advantages and privileges of my own life to that of many of my patients. I engaged in readings, both fictional and non-fictional to integrate my life with what I witnessed each day at work. This self-reflection placed me on a path to graduate studies in the nursing, choosing to study the relationship between correctional nurses and incarcerated women with mental health concerns in Canada.

I feel that my ability and desire to work with and study justice involved women was made possible by my time spent in Japan. Prior to that period, I experienced nursing from a safe place of Caucasian middle-class opportunity. Living in a vastly different culture granted me the chance to shift my perspective, which I was able to engage in part to the foundations built by my parents and my educational opportunities. The time in Japan also gave me space away from a nursing position that was lackluster. Living and working abroad instilled confidence that I took to the next adventure: working with incarcerated adults and working on myself as a nurse and a person.

Correctional Nursing Knowledge

History

The history of jails and prisons in Canada is rooted in the English penal system and predates the formation of Canada. In the early nineteenth century, jails were attached to

courthouses and managed by the local district government (Duckett & Mohr, 2015, June 8; Penitentiary Museum, 2020). The first penitentiary (a facility built for punishment and rehabilitation) was Kingston Penitentiary in Upper Canada, built-in 1835 (Penitentiary Museum, 2020). Soon after two more penitentiaries were built: Saint John Penitentiary in New Brunswick in 1842; and Halifax Penitentiary in Nova Scotia in 1844 (Penitentiary Museum, 2020). A year after Canada was formed these three penitentiaries were transferred from provincial jurisdiction to federal responsibility with the Penitentiary Act in 1868 (CSC, n.d.). While the records of provincial correctional facilities are sparse, the Ontario Board of Inspectors of Asylums and Prisons formed in 1859 provides evidence that across Upper and Lower Canada (now Ontario and Quebec) there were 52 jails, two reformatory prisons, one large penitentiary, two hospitals and four lunatic asylums (Ontario Government Agency History, n.d.). As the country grew and provinces joined the confederation so too were correctional facilities built. The early 1900s saw provincial correctional facilities built in Saskatchewan and Alberta, with more centres built around the nation throughout the twentieth century. Most recently, the two largest remand centres in Canada were completed: Edmonton Remand Centre in 2013 which houses 1950 adults, and Toronto South Detention Centre in 2014 which houses 1650 adults. Despite the many facilities around the country, the incarceration options for women were few. The first federal facility for women was opened in 1934 in Ontario (CSC, n.d. & 2020, May 21). This maximum-security prison housed all federally sentenced women, regardless of security level (CSC 2020, May 21). It was not until 1995 that three new federal facilities were opened in Nova Scotia, Alberta and Saskatchewan, with three more opening in the following decade (CSC, 2020, May 21).

Early evidence of nurses working in correctional facilities is sparse, coming mainly from the United States. Two of these early records (DeP, 1917; Hubbard, 1906) describe correctional nursing as a new and unique field for employment. Farley (1917) describes the

development of a prison eye clinic in New York's Sing Sing Prison. This is an important article not only because it demonstrates the recognition of health care needs and a program of response for adult prisoners, but it also identifies the role of the nurse in the clinic as autonomous from the physician. A seminal narrative by Minnigerode in 1931 shared the experience of being a prison nurse and identified that correctional nurses required experience, as well as an understanding of addictions and mental illness to provide good health care. More importantly, she identified three foundational themes that remain relevant to correctional nurses today: the internal conflict between being a nurse and working in a prison; the need to conform to the prison authority (security before health care); and the need to be impersonal about the crime.

The bulk of information about correctional nursing entered the healthcare discourse in the 1970s and 1980s (Schoenly, 2013). During these two decades, the healthcare of incarcerated people in the United States was improving in response to the civil rights movements (Schoenly, 2013). Initially, the articles about correctional nurses remained mainly narrative pieces describing the experience of being a correctional nurse (Brooks, 1979; Dighton, 1986; McDowell, 1975; Murtha, 1975; Ptak, 1975; Stepaniuk, 1981; Winstead-Fry, 1975). However, the discourse began to include the role of the nurse as an agent for change as the previous status quo in the health of incarcerated people were no longer acceptable (Chaisson, 1981; Little, 1981). Minnigerode's (1931) themes were joined by three new themes: inmates as a marginalized group; nurses as moral compasses for incarcerated adults and youths; and corrections as pushing the boundaries of where nursing happens. During this time correctional nursing was becoming intimately linked with psychiatric nursing, a relationship born out of the historic link between prisons and asylums. Finally, correctional facilities became a nurse-driven system (Flanagan & Flanagan, 2001; Reimer, 2007). Correctional nursing achieved a great measure of success in the United States in 1985 when it

was recognized as a nursing specialty by the American Nurses Association. Furthermore, specialty certificates exist through the American Corrections Association and the National Commission on Correctional Health Care.

The development of corrections nursing in Canada has followed a similar path, as the presence of nurses in correctional facilities expanded in the closing decades of the 20th century. In Alberta in the early 1970s, nurses were employed in the first correctional centres (the Belmont Community Correction Centre in northeast Edmonton and the Old Fort Jail in Fort Saskatchewan) to set up medications for correctional officers to distribute to patients (V. Lee, personal communication December 5, 2020). In the late 1970s a new nursing manager at the Old Fort Jail was able to expand the nursing role to set up and distribute these medications, increasing the nursing presence from a few hours to a full day (V. Lee, personal communication December 5, 2020). In 1979, Edmonton Remand Centre was opened in downtown Edmonton and had a dedicated healthcare department staffed by RNs and RPNs. This new centre had twenty-four-hour nursing care. As other Alberta correctional centres were built and opened, healthcare departments and nursing staff became ubiquitous, ensuring a minimum of day and evening nursing coverage for incarcerated individuals. Unfortunately, there are very few primary documents to shine a light on the development of this field in Canada. The Canadian healthcare discourse and the popular press see correctional nursing as a new arena for nursing care, pushing the boundaries of where nursing happens (Canadian Nurse, 2010; Saik, 2020; Wakefield, 2018, June 24). Correctional nursing has not achieved specialty nurse status in Canada, nor has an education or certificate programme been developed.

Principles of Correctional Nursing

Correctional nursing is simply delivering patient care through the practice of nursing in the distinct and unique setting that is the criminal justice system (Schoenly, 2013). In Canada, the criminal justice system includes pre-trial detention centres or remand facilities, sentenced facilities (both provincial and federal) and juvenile detention centres. The unique environment does not fundamentally change the practice of nursing, but it must bend to accommodate the unique setting.

The correctional environment itself is distinct in that the priority of the building and the correctional system is security and safety (Dhaliwal & Hirst, 2016; Dhaliwal et al., 2021; Droes, 1994; Flanagan & Flanagan, 2001; Peternelj-Taylor, 2004; Solell & Smith, 2019). Often these correctional facilities were not designed with healthcare delivery in mind, and services are frequently underequipped or unable to grow as correctional populations grow (Schoenly, 2013). Patient privacy is challenged by correctional officer oversight, a requirement to maintain the safety and security of staff and inmates alike (Schoenly, 2013). Healthcare does not run on a hospital schedule, instead follows the court schedule or facility count schedule. Special housing units, such as segregation or protective custody, or high-security designations can challenge the nurse's ability to access patients. Alternatively, these settings may force patient care to occur at the inmate's cell away from treatment rooms stocked with needed supplies or equipment (Schoenly, 2013). Since the priority is safety and security healthcare can be interrupted or withheld at any time at the direction of correctional officers, forcing nurses and other healthcare providers to not only learn how to triage care effectively but also the art and skill of patient advocacy in an environment where healthcare has little control. This can be difficult in an emergency because nurses are trained to react quickly, as well as in daily practice where something as simple as moving an inmate for

healthcare can take longer than anticipated. Nurses also must be aware of how health care is affected by constant vigilance over supplies and of the inmates themselves.

Correctional professionals have their own perspective as they become socialized during training through work experience (Schoenly, 2013). In the setting of safety and security correctional officers and their leadership value and uphold discipline, order and control (Schoenly, 2013). Correctional nurses build relationships with correctional officers, who view correctional health care and inmates in a different light (Dhaliwal & Hirst, 2016; Goddard et al., 2019). Droes (1994) identified a continuum of correctional officers' tolerance level of health care. At one end was a view of health care as accepted but considered an interference in the officer's workday. On the other end, health care was considered both beneficial to inmates and assisting the officers in their work. Frequently, the correctional officer hierarchy is likened to a paramilitary organization where lines of authority are clear and expected to be adhered to. The same is expected of the inmates in their interaction with officers. Nurses therefore must find a balance between collaborating with officers and upholding their own professional culture, while advocating and caring for their incarcerated patients.

Relational Practice

Trust, a precarious commodity in all health serving environments, is complicated by the correctional environment. Inmates must trust that the nurses are acting professionally and advocating for their health; but nurses cannot trust the intentions of inmates because seemingly simple objects take on new meanings and represent opportunities for offenders to which most of us are naïve (Brodie, 2001; Holmes, 2002; Jacob, 2012; Schafer & Peternelj-Taylor, 2003). The next key difference in correctional nursing is how the nurse-patient therapeutic relationship is constructed, framed as the custody versus caring dialogue. Inmates

are vulnerable victimizers as both patients and offenders, which creates role conflict in correctional nurses, especially new employees (Baxter, 2002). The heart of this conflict lies in how to feel compassion towards inmates and how to feel connected (Holmes, 2002; Maeve & Vaughn, 2001) without making oneself unduly vulnerable to manipulation or harm. Just as trust is not reciprocated, connectedness is not shared equally. Correctional nurses are aware of manipulation tactics used by inmates for personal gain, which fundamentally alters the nurse-patient relationship (Holmes, 2002; Maroney, 2005). In daily practice, this requires nurses to balance the social good of health care with the social necessity of custody (Dhaliwal & Hirst, 2016; Holmes, 2002; Jacob, 2012; Peternelj-Taylor, 2004). As the therapeutic relationship is lost, the custodial role takes over (Peternelj-Taylor, 2004). In Canadian remand centres, a move too much in either direction is undesirable and potentially unsafe.

Patient as Expert

In considering what makes the incarcerated population's health care needs unique it is useful to conceive of this group as a vulnerable population. The term "vulnerable population" refers to a group of people with shared characteristics that place them at a higher risk for risk itself (Frohlich, & Potvin, 2008). The characteristics most closely linked with vulnerable populations in Canada are socioeconomic status, Indigenous identity, and gender (Frohlich, & Potvin, 2008). Using this framework, adult incarcerated populations meet the criteria for consideration as a vulnerable population. Almost half of the individuals who are incarcerated are typically unemployed and have only completed some secondary education (Landry & Sinha, 2008). Furthermore, the overrepresentation of Indigenous peoples who are inmates is noteworthy. The federal and provincial/territorial admission rates for Indigenous people sit at 30% in a group that represents only 4% of the Canadian adult population (Malakieh, 2020). For all people who are incarcerated, evidence of higher prevalence rates for mental health

concerns and substance use disorders is well documented (Brooke et al., 2000; Binswanger et al., 2010; Brown et al., 2015; Calzavara et al, 2007; D'Souza et al., 2005; Fazel, et al., 2016; Kouyoumdjian et al., 2016; Mukherjee, et al., 2014; Tyler et al., 2019). Since incarcerated adults experience higher rates of poor health than the general population, they may therefore be considered a vulnerable population residing within a unique environment.

For people who are incarcerated, healthcare is an adjunct service. They have not entered the correctional system willingly, nor have they entered the system seeking healthcare. Inmates in remand centres have little or no autonomy, are removed from their family and support system and are at greater risk for violence, all of which promote stress, depression, and hostility (Brodie, 2001). This group cannot be described as seekers of health care; instead, health care is available as a secondary outcome of incarceration. In addition, addressing personal health issues is rarely the priority for inmates, settling their legal issues is first and foremost on their minds. For the most part, this group can be described as transient. Half of those admitted are released within seven days, and the numbers of long-stay inmates are small (Malakieh, 2019). Besides the sheer numbers of health histories taken in larger remand centres, many inmates exist in a revolving door world of admission and discharge making continuity of health care complex.

In addition to rapid discharge rates, remand health care units and personnel do not always receive notification of inmate release. The result may be unfinished treatments and a loss of medication compliance. The characteristic of transience is what sets remand centres apart from prisons. The offer of healthcare services may be a blessing, proving an opportunity to address issues the individual did not have the time or ability to deal with before arrest (Ahmed et al., 2016a & b). Even in a public healthcare system such as in Canada, individuals will avoid seeking services such as the emergency room because it can trigger arrest if they have an outstanding warrant. For those people incarcerated in remand facilities, an uncertain

length of stay makes the completion of treatments precarious. Those in sentenced facilities often have more treatment options available, as well as knowledge about how long they will be incarcerated to plan their healthcare interventions with providers. Hence, there are opportunities for more complex health programs and discharge planning. The challenges of transience and healthcare as an adjunct service translate into a system that does not see the patient as the expert, nor are they partners in health care with autonomy and agency.

Conclusion

The three theoretical perspectives that inform this project are interwoven. Peplau's Interpersonal Relationships and Ramsden's cultural safety place a high value on the nurse-patient relationship and situate the patient at the centre. Correctional nursing is challenged by the uniqueness of the environment and the vulnerability of adults who are incarcerated. These perspectives are important frameworks from which this study will examine the correctional nurse-patient relationship.

Chapter 3: Literature Review

The purpose of this literature review is twofold. First, it will examine what is known about correctional nursing in general and correctional nursing with women who are incarcerated and have mental health concerns. Then, it will examine what has been written about cultural safety with mental health, forensic, substance-related issues, and correctional populations.

Correctional Nursing

Strategies

This narrative or traditional literature review (Efron & Ravid, 2019) on correctional nursing is intended to determine what is known about the correctional nurse-patient relationship and the experience of nurses working with women who are incarcerated. The review begins with what is known about correctional nurses in general, followed by what is known about correctional nurses who work with criminal justice-involved women. After detailing the results of the literature search, I will synthesize and summarize the findings. A librarian was consulted to identify and refine the search terms for this narrative literature review. The search began with correctional nursing/corrections nursing and corrections/prison/jail/incarceration/correctional facilities, with a second search that included woman/women/female. The databases searched were MEDLINE (EBSCO interface), and CINAHL Plus with Full-text (EBSCO interface). Additionally, the Journal of Correctional Health Care was hand-searched. The review focused on English-only publications and did not limit the date of publication. The review included peer-reviewed published works, grey literature and dissertations were excluded. Literature was restricted to patient populations that were adults defined as 18 years of age or older. Given that the focus is the correctional nurse-

patient relationship, the experiences of undergraduate nursing students and incarcerated adults with specific diseases (e.g. diabetes) were excluded. For correctional nursing, the search returned 2565 results, after a title/abstract review there were 95 results. After reviewing these articles, it was determined that 44 fit the inclusion criteria. For correctional nursing and women who are incarcerated, there were 475 results, with 23 results after a title/abstract review. Two articles fit the inclusion criteria after the articles were reviewed.

Results: Correctional Nursing

The literature search returned 44 articles that spoke to correctional nurse-patient relationships and the experience of nurses working in correctional facilities. The bulk of the articles came from the United States (US), the United Kingdom (UK), Australia and Canada. Ten articles were personal observations (Fedele, 2015; Holly, 1972; Kennedy, 1975; Manchester, 2009; McDowell, 1975; Murtha, 1975; Protzel, 1972; Ptak, 1975; Smith, 2010; Williams & Heavey, 2014). Twelve articles were general commentaries (Canadian Nurse, 2010; DuBose et al., 1996; Lehrer, 2021; McNiff, 1973; Norman, 1999; Norman & Parrish, 1999; Norman & Parrish, 2000; Shelton et al., 2020; Stevens, 1993; Veal, 2001; Willmott, 1997; Winstead-Fry, 1975). Fifteen articles were original research (Cukale-Matos & Champion, 2021; Doyle, 1999; Doyle, 2002; Droes, 1994; Foster et al., 2013; Holmes, 2002; Holmes, 2005; Holmes et al., 2007; Jacob, 2014; Nolan and Walsh, 2012; Perron & Holmes, 2011; Sasso et al., 2018; Solell & Smith, 2019; Walsh, 2008; Weiskopf, 2005). Three articles were literature reviews (Choudhry et al., 2017; Goddard et al., 2019; Wirmando et al., 2021). Finally, four articles examined philosophical/ethical issues (Ellis & Alexander, 2017; Gadow, 2003; S. Smith, 2021; Walsh & Freshwater, 2009;

Personal Observations. There were 10 articles in this category, eight of which were firsthand accounts from correctional nurses (Fedele, 2015; Holly, 1972; Manchester, 2009;

Murtha, 1975; Protzel, 1972; Ptak, 1975; Smith, 2010; Williams & Heavey, 2014). These accounts described what the work of a correctional nurse entailed, what made nursing in correctional facilities unique from other nursing areas, and the patient population. Three of the earliest articles (Holly, 1972; Murtha, 1975; Ptak, 1975) can be styled as examples to educate other nurses about the opportunities and advancements in correctional health care. These personal observations present correctional nursing as challenging but rewarding, and the nurses working in these settings as models for good nursing with atypical patients. Protzel (1972) was the only early account that discussed the conflict between healthcare and the penal system, and the need to build trust with correctional officers. These first articles all described correctional nursing in the United States (US). Like the earliest articles, Fedele (2015) and Smith (2010) were straightforward pieces that educated British and Australian nurses about correctional nursing. The two remaining personal accounts (Manchester, 2009; Williams & Heavey, 2014) not only described the work of correctional nurses but reflected in more depth on the challenges unique to the correctional environment. These articles, from the United States and Aotearoa/New Zealand, discussed working with officers, professional boundaries with patients and officers, how professionalism and nursing ethics are challenged in correctional environments, and self-care.

The article from McDowell (1975) was the first of two that discussed correctional healthcare from another point of view. McDowell (1975) wrote her account as a nurse educator with no direct correctional nursing experience, who was tasked with building leadership in a prison healthcare department. Her observations on the challenges of working in a prison reflected what was written by the other authors, including the conflict between healthcare and the penal system. This article was the first to reflect on the nurse-patient relationship. McDowell reported how nurses believed that when they took the time to listen

to patients' mutual respect grew. Moreover, how the nurse perceived the patient was "reflected in her treatment and exchange with him" (p. 424).

The final article of this group was written by Jane Kennedy (1975), who was an American nurse and anti-Vietnam War activist (Barry, 1975; Gross, 1977). She wrote her observations as a prisoner over 14 months in the early 1970s. Kennedy's reflections on healthcare in prison are a criticism of the system and the care provided by nurses. Kennedys' reflections included how the nurses inside the prison were not professional in their interactions, did not provide healthcare and withheld healthcare as a form of punishment. She touched on the conflict between healthcare and the corrections system when she illustrated a poor interaction with one nurse: "What had I unleashed? Clearly something very painful. Did she suspect that caring for patients and incarcerating prisoners can never mix because each is founded on beliefs about human nature which are antithetical?" (p. 420). Kennedy's observations are unique in that as a nurse she had the knowledge to assess nursing care and as an activist, she drew the attention of the media, such as when the CBC's Peter Gzowski interviewed her in 1975 (Barry, 1975). Her firsthand observation was the only literature reviewed to cast correctional nursing wholly in a negative light.

General Commentary. Building on personal observations, 12 articles discussed correctional nursing in general terms. Two articles from the 1970s and both from the United States described the experience of correctional nursing in greater depth than the personal observations of the same era. McNiff (1973) focused on the challenges of working within a correctional environment, noting that nurses must cultivate positive relationships with officers for access to their patients, lest they become prisoners of security themselves. McNiff noted, whether the nurse used the term "patient" or "prisoner" and the mindset that accompanied those terms seemed to affect the nurse-patient relationship and the type of care the patient received. McNiff further discussed clear boundaries for correctional nurses,

keeping healthcare as the priority and not drifting into the role of jailor or lawyer. The second article from that decade (Winstead-Fry, 1975), focused on "three main subsystems" (p. 425) that were the officers, inmates, and healthcare staff. Winstead-Fry described each subsystem as having its own goals. Officers were concerned with security and inmates with freedom. For healthcare personnel, she observed their goals were incidental to the other groups, and that nurses bounced between identifying with each group. One of her conclusions was that correctional nurses must address issues with patients in a manner that both benefits the patient and maintains good relationships with officers.

There were seven articles published between 1993 and 2001 that provided insight into correctional nursing. Stevens (1993) wrote about nursing in US jails, in contrast to the work done in prisons. After illustrating what made nursing in jails different, she turned her attention to the "collision of cultures" (p. 6) between healthcare and the correctional system. She compared the values, beliefs and norms of each system before drawing out the daily practices and customs (termed folkways and moreways) of each system. Stevens' article is a clear discussion of the tangible differences between healthcare and the correctional system, pointing to the basic beliefs (healthcare is a right vs. a privilege) and symbols (stethoscope vs. keys) that exemplify the conflict. A few years later, DuBose et al., (1996) reported on the ethical concerns present in the US correctional healthcare setting. Their article grew out of the concerns raised by a group of correctional nurses that identified conflicts between professional duties and the work setting. DuBose et al. (p. 2) asked four questions:

1. To what extent should value judgements about prisoners' character . . . affect [the nurse's] ethical duties . . . ?
2. To what extent should a nurse act as a patient advocate . . . ?
3. Do prisoners have a right to expect humane and compassionate health care, . . . ?
4. Is it realistic to expect prison nurses to live up to the ideal of their professional codes?

Similarly, Willmott (1997) examined the conflict between custody (correctional settings) and care (healthcare) in the United Kingdom (UK) prison system. Like the articles before, Willmott noted that healthcare is incompatible with the goals of correctional settings. In this piece, Willmott argued that these competing goals threaten correctional nurses' professional standards and that only by adjusting their expectations and responsibilities could nurses hold onto these standards. Willmott ended her discourse by remarking that if roles and responsibilities are not identified then all parties experience dissatisfaction.

Three more articles from the UK were published in the late 1990s (Norman, 1999; Norman & Parrish, 1999; Norman & Parrish, 2000). In these articles, Norman and Parrish focused on describing what correctional nursing was in the UK prison system. The conflict between custody and caring was included in all the articles, and there was some discussion of the ethical dilemmas faced by prison nurses (Norman, 1999). While these articles do not fall under the personal observations group, Parrish did contribute to Norman (1999) by writing his account of shadowing a prison nurse for a day.

In this subset of seven articles and the 12 for this group, Veal (2001) was the only piece from Australia. Veal's work described the work and clinical challenges of correctional nurses, followed by the skills required by the nurses to be successful. Security is noted in the context of violence from prisoners, but there is no discussion of the relationship between nurses and officers or the ethical challenges present in the field.

In 2010, an article was published in the Canadian Nurse that described the work of correctional nurses in a Canadian Federal prison (Canadian Nurse, 2010). After describing the work, the article touched on the competing demands of security and patient health confidentiality. It also examined the role nurses can have in helping patients make better life and health choices, including spending time and listening to their patients.

The final two articles of this group are recent publications reflecting on the state of correctional nursing in the United States. Shelton et al. (2020) examined not only the current state of correctional nursing but the challenges facing the field in the future. The authors went further to outline how to transform correctional healthcare and presented concrete recommendations for action. In contrast, Lehrer (2021) wrote about compassion in correctional settings, asking how nurses can make an impact on their patients' lives. This article examined the custody and caring debate from the perspective of the nurse-patient relationship, and how traditional caring actions are forbidden in the penal system. Lehrer went on to discuss deliberate indifference (knowingly ignoring a patient's medical need) and how to mitigate it in the correctional setting. This, along with the other 11 articles in the group of general commentary, illustrates the complexity of correctional nursing that lies behind the basics of what makes this field of nursing unique.

Research Literature. There were 15 original published research papers, all of which are qualitative studies. The first research study was by Droes (1994), in which 40 US correctional nurses were interviewed to understand the experience and challenges of their work. This study discussed three facets of correctional nursing: the unique world, the work done, and interactions. Within the interactions facet, Droes identified a continuum of officers' tolerance of healthcare, from contentious tolerance (grudging acceptance) to considered tolerance (recognizing healthcare as beneficial). Droes also categorized the nurses' conceptions of their work as either limited (focusing on acute medical problems), expanded (managed acute and social-psychological issues) or other-directed (saw nursing only as others in the facility did). These concepts were then mapped against one another, finding that in situations where officers exercised contentious tolerance, all three conceptions of nurses existed; but, where officers exercised considered tolerance there only existed nurses with an expanded concept of nursing. Out of this work, the most significant findings were that

officers had a great influence in the healthcare setting and that when officers saw healthcare as beneficial, nurses could work to their fullest scope and ability, relating best to officers, patients and their peers alike.

Two research studies by Doyle (1999; 2002) examined the practices of mental health nurses in Australia. In both studies, Doyle began with focus groups comprised of mental health correctional nurses to identify issues, which were then explored in-depth through individual interviews with some of the same or new mental health correctional nurses. The findings of the first study (Doyle, 1999) were five themes: challenging patients, incarceration as a threat to the prisoner, the ingenuity of confinement, conflicting values of custody and care, the stigma of working in a correctional facility, and prison patients seeing nurses as part of the correctional system. Doyle's second study (2002) had a similar finding, which developed into three themes: the patient's adjustment to incarceration, the challenging patient population, and the unique prison setting. In both studies, the participants saw incarceration as a traumatic event for the patients. As well, participants in both studies noted the correctional setting as a place of surveillance and isolation, which exacerbated patient health issues. Additionally, the studies observed the conflict between custody and caring as significant to all relationships, noting that both nurses and prisoner patients "are exposed to the constant commentary and rhetoric of prison officers" (2002, p. 309). Finally, the two studies identified that nurses were associated with the officers as part of the correctional system that imprisoned the prison patients.

In 2005, Weiskopf published the results of a study that interviewed nine US correctional nurses to understand the experience of caring for prisoners. Her descriptive phenomenology uncovered four themes: "Negotiating the Boundaries Between Custody and Caring; Struggling to Create a Caring Environment; Striving to Turn a Life Around; A Risky Situation; and Staying Vigilant" (p. 339). The first theme examined the boundaries between

the culture of the correctional and healthcare systems. Participants in this study noted that the relationships with officers were significant, such that when officers valued healthcare the nurses felt supported and autonomous and vice versa. This theme reflects the findings of Droes' (1994) study a decade earlier. The second theme, Struggling to Create a Caring Environment, reflected the prison environment, the hostile behaviours of the prisoner patients, and some indifferent attitudes of other correctional nurses. The participants' observation that correctional nurses displayed non-caring behaviours is the earliest mention in the research literature and substantiates the personal observations of Kennedy (1975). The theme Striving to Turn a Life Around spoke to the correctional nurse-patient relationship. Weiskopf's participants discussed working with the prisoner patients in the present, choosing to ignore past conduct and crimes. Furthermore, this theme reflected the ability of participants to form caring relationships with their patients through non-judgmental interactions laced with dignity and respect. The fourth theme, A Risky Situation, described the types of risks inherent in the work of correctional nurses. The risks described by participants were related to advocating for prisoner patients or in trying to change the system to better the health and well-being of the patients. The final theme, Staying Vigilant, referred to the correctional nurses having to keep security at the forefront of their practice. They noted that prisons were volatile, and violence could erupt at any time, so the participants felt they had to be cautious in their interactions with prisoner patients. The participants found the officers helpful and supportive in keeping nurses safe. Overall, Weiskopf noted that correctional settings affect the nurse-patient relationship in a way that differed from any other healthcare setting, specifically noting that "custody boundaries . . . restricted nurses' free expression of caring" (p.341).

A suite of studies by Holmes (2002; 2005; Holmes et al., 2007; Perron & Holmes, 2011) examined power in correctional nursing using a Foucauldian lens. Holmes' first two

publications grew out of his doctoral work. He employed a grounded theory approach to examine how nurses balanced their roles as caregivers and agents of the correctional system in a Canadian Federal prison that housed psychiatric patients. He interviewed 21 nurses and 3 correctional officers, as well as made direct observations. Holmes (2002) found that correctional nurses have two roles, as agents of social control and agents of care; and they govern mentally ill prisoner patients using sovereign, discipline and pastoral power. These three types of power impact the nurse-patient relationship, but it is pastoral power that relies on relationships. Thus, Holmes (2002) noted that nurses were actively establishing a bond with the prison patients to achieve nursing interventions, which in turn guaranteed the patient's obedience and therefore control. Holmes's second publication (2005) followed up on this perspective, seeing nurses as both subjects and objects of power within the correctional milieu. As subjects, nurses used sovereign, discipline and pastoral power to maintain order while also providing care. As objects, nurses are forced to adapt to prison norms. In the 2007 study, Holmes et al. used grounded theory to compare correctional nursing practice in Canada with France. This study reported that the correctional setting affects nursing practice, and in both countries, there existed a conflict between health and correctional ideologies. In Canada, nurses are agents of social control and care that impacts the nurse-patient relationship. However, within the French penal system nurses reported a greater ability to practice caring because there was "a complete schism between the ideologies of incarceration and health care" (p.129). French participants reported limited contact with officers which preserved their professional identity. The final study (Perron and Holmes, 2011) sought to understand how correctional psychiatric nurses constructed patient subjectivities through interviews and reviews of nurses' progress notes (charting). This study identified five types of subjectivities: "the (in)visible patient, the patient at risk, the deviant patient, the disturbed patient and the disciplined patient" (p. 191). Perron and Holmes noted that in addition to revealing what the

nurses thought about their prison patients, it also revealed what they understood about themselves.

In the same period, Walsh (2008) published a reflexive methodology to study the emotional labour of correctional nurses in Wales and England. Walsh identified that correctional nurses take on emotional labour because of their work in correctional settings, and this labour is as important as the care vs custody conflict. Walsh examined how emotional intelligence enabled prison nurses to manage emotional labour, which has three parts: "faking of emotion that is not felt and/or hiding of emotion that is felt and the performance of emotion management to meet expectations within a work environment" (Mann, 2004, as cited in Walsh, 2008, p. 144). One of her key findings was that the way correctional nurses experience emotional labour was evident through four relationships: with patients, with officers, with the correctional facility as an institution, and the relationship they have with themselves internally. She noted the effects of these relationships impacted how they practice. Four years later, Nolan and Walsh (2012) published a synthesis of their dissertation work, in which these four relationships were explored through intersubjectivity. In both publications, clinical supervision was recommended as a way for correctional nurses to gain support and explore the emotional labour of their work.

The next year Foster et al. (2013) published the results of their study that examined "good practice" in a UK prison hospital unit. The team used interpretive phenomenological analysis in three stages: focus groups with nurses and officers, participant observation, and individual interviews with a variety of professionals interactive in the prison hospital unit. Four themes became apparent: issues of risk and safety, tensions between care and control, teamwork, and communication issues. However, the researchers found the tension between care and control to be most pronounced. They also found that the nurses were almost exclusively focused on the officers, rarely mentioning any other department during the focus

groups. The study did not examine the nurse-patient relationship, instead, it looked at collaborative practice recommending augmenting the role of correctional nurses in prison hospital units so healthcare could be the priority.

In 2014, Jacob sought to better understand the dual roles of agent of care and agent of social control through a grounded theory study that interviewed 25 correctional nurses in Canada. Jacob examined the role of mistrust in the correctional nurse-patient relationship. For patients, the role of the nurse as an agent of social control was a barrier to divulging information. For the nurses, the perception that prisoner patients are dangerous or manipulative prevented the participants from entering into an honest relationship because they must alter their caring behaviours to avoid harm. Jacob found that the participants created physical, emotional and professional distances, and these distances were socially reinforced by other correctional nurses.

The correctional healthcare literature comes mainly from Australia, Canada, the UK and the US, but, in 2018 a study was published that asked Italian correctional nurses to describe their experiences (Sasso et al., 2018). This study recruited 31 correctional nurses to participate in 5 focus groups. Sasso et al. developed the data into five themes: prisoner's healthcare needs, negotiating between custody and care, the satisfaction of working in prisons, obstacles to quality care, and safety. They also found that 'manipulation' was another theme present in the other five. Similar to other studies, the participants reported on the unique healthcare needs of incarcerated adults, and the conflict between healthcare and custody values. The participants reported a therapeutic nurse-patient relationship was essential to correctional healthcare. Manipulation was explained as prisoner patient behaviour to take advantage of the nurse-patient therapeutic relationship. The authors described situations in which correctional nurses must possess a heightened awareness of the danger of revealing personal information that compromise the safety of all staff. The potential

consequence for correctional nurses is that the nurse-patient therapeutic relationship is compromised.

In 2019, Solell & Smith published their study on possibilities and barriers to person-centred care in correctional facilities. Their study was an online survey that included open-ended questions, with 78 participants. The research team reported three themes: types of care, barriers to care, and strategies for change. The theme types of care reported on how the participants characterized their work, in which the nurse-patient relationship should be "fair and consistent to all, while also being compassionate and non-judgmental" (p. 7). The theme of barriers to care included the prisoner patient's personal history, the attitudes of correctional officers, and the tension between care and custody. The final theme, strategies for change, reflected how the participants worked to overcome the barriers in either their individual practice or as a group. Some of the strategies mentioned were the humane treatment of their patients and nurses as patient advocates.

In the final study in this group, Cukale-Matos & Champion (2021) examined cognitive dissonance among eight correctional nurses in the Southwestern United States. Six themes emerged from their data: "We have a sense of purpose, We don't trust each other, We want respect, We experience unique stress, It changes who you are and We try to leave it all there" (p. 545). The themes reinforced previous studies and personal observations that correctional nursing is unique. Likewise, this study reflects the findings of Walsh (2008) and Nolan & Walsh (2012) that correctional nursing is emotional work that affects how the nurse-patient relationship forms and how healthcare is provided.

Literature Reviews. Three articles reviewed varying aspects of correctional nursing and the nurse-patient relationship. Literature reviews are a recent addition to the correctional nursing discourse, setting the stage for new directions in research. The first review that fit the criteria of this dissertation was Choudhry et al (2017) which reviewed literature published

since 2006 on nurses' feelings, beliefs and thoughts on healthcare in correctional settings. Choudhry et al. found that nurses adapt to the unique environment which in turn leads to an altered identity. In 2019 Goddard et al. also examined the literature on correctional nurses' professional identity, looking to inform recruitment and retention among UK prison nurses. The final article in this group (Wirmando et al., 2021) is a systematic review to learn what is known about "the complexity of caring for criminals both in . . .a hospital or in a prison" (p. 1034). The findings of this review were that nurses caring for prisoners face ethical dilemmas and emotional conflict, thus personal reflection is important to practice caring behaviours.

Philosophical/Ethical Issues. There are four papers that fit this group. The first article was published by Gadow (2003). In this article, Gadow's baseline was that correctional nurses practice between acting for the patient's good and the purpose of imprisonment. She explored three ethical regions based on the philosophies of punishment as retribution, rationality or paradox. Her findings are that when correctional nurses pursue healthcare based on paradox, there is engagement with prisoner patients. The second article is Walsh & Freshwater's (2009) discussion of the mental well-being of correctional nurses. It follows Walsh's earlier study on emotional labour and clinical supervision in the field of correctional nursing. The third article from Ellis & Alexander (2017) looked at the role of mental health nurses in jails that care for patients with serious mental illness. The authors framed the discussion in part as a piece to examine and offer clinical suggestions for best practices with these patients. Ellis & Alexander comment that to support the health of the prison patients, the roles of correctional nurses and officers "are intrinsically weaved together . . . It is therefore imperative that [correctional nurses] recognize, appreciate, and nurture the valuable clinical contribution of correctional officers" (p.219). The final article in this group is from S. Smith (2021), which examined moral distress in correctional nurses, the consequences of this include impaired ethical reasoning and blurred professional boundaries.

S. Smith noted that blurred professional boundaries impact nurses' relationships with patients, officers and their scope of practice. Impaired ethical reasoning stemmed from the care vs. custody conflict inherent in correctional nursing practice, and much of this conflict hinged on whether or not officers accepted the healthcare services. S. Smith's discussion brings this review back full circle to the observations of Droes in 1994.

Results: Correctional Nursing and Incarcerated Women

The published articles that addressed what is known about the experience of correctional nurses working with women who are incarcerated were few, with only two fitting the inclusion criteria. Neither of the articles for this dissertation review was original research from the perspective of correctional nurses caring for women who are incarcerated.

Young (2000) is a qualitative study of healthcare asking women who were incarcerated about their care. The participants in this study (15 women) spoke about their experiences with nurses and correctional officers. The participants were mainly disapproving of the care they received, but not entirely negative. Instances of inadequate care fell into four groups: partial care, no care, delayed care and misdirected care. Instances of adequate care encompassed three groups: thorough care, responsive care and immediate care. Young also examined the nurse-patient relationship by inquiring about the manner of treatment provided as either empathetic or nonempathetic. Nonempathetic treatment was described by the participants as being lumped together, disregarded or abrupt treatment. Empathetic treatment was characterized as nurses taking a personal interest in the patient, showing respect and courtesy, and taking the time to listen and answer questions. Despite a small sample size, this study informs the nurse-patient relationship from the patient's perspective.

Christensen (2014) examined the culture of incarceration as experienced by women and the challenges this situation presents to correctional nurses. The article was framed using

Leininger's Theory of Culture Care and the Sunrise Enabler. Christensen described the culture present in correctional facilities and how women admitted to these facilities undergo the process of acculturation (p. 224). She then went on to describe the challenges correctional nurses face in caring for incarcerated women, focusing on custody issues, the public perception of correctional nursing and the challenge of caring for criminals. Then the theory of Culture Care and the Sunrise Enabler were analyzed as frameworks for nurses to use to engage in therapeutic relationships and provide positive healthcare.

Themes

The predominant themes that have emerged from this literature are twofold; correctional nursing is unique and the custody versus caring conflict. What makes correctional nursing exceptional is the environment, the patient population and the expression of caring. The prison patient population is unique as it represents the intersection of the social determinants of health, marginalization and penal culture (Canadian Nurse, 2010; Manchester, 2009; Murtha, 1975; Norman & Parrish, 2000; Ptak, 1975; Shelton et al., 2020; Veal, 2001; Williams & Heavey, 2014). Within correctional facilities, the threat of violence from patients cannot be discounted and was mentioned in the literature reviewed (Lehrer, 2021; Veal, 2001; Weiskopf, 2005; Williams & Heavey, 2014). Conversely, the literature speaks to nurses practicing by putting aside the personal history of the patient, such as their crimes or past violent behaviour, to provide standard healthcare while also practicing with compassion (Lehrer, 2021; Norman, 1999; Solell & Smith, 2019; Veal, 2001; Weiskopf, 2005). Medical and mental health comorbidities make healthcare multifaceted, and treatments more challenging (Doyle, 1999; Doyle, 2002; Ellis & Alexander, 2017; Fedele, 2015; Holly, 1972; Manchester, 2009; McNiff, 1973; Protzel, 1972; Sasso et al., 2018; Smith, 2010; Wirmando et al., 2021). For nurses, the ability to construct the nurse-patient relationship is

tested by the environment in which standard nursing caring behaviours are prohibited (Christensen, 2014; Ellis & Alexander, 2017; Gadow, 2003; Jacob, 2014; Kennedy, 1975; Manchester, 2009; McDowell, 1975; Solell & Smith, 2019; Walsh, 2008; Walsh & Freshwater's, 2009; Weiskopf, 2005; Wirmando et al., 2021). Second, is the conflict between healthcare values (caring) and correctional values (custody). This theme was embedded in the literature, and cannot be divorced from correctional nursing because healthcare is delivered outside of a traditional medical environment. The care vs. custody conflict is at the root of all the relationships correctional nurses must engage in to provide healthcare to incarcerated adults (Canadian Nurse, 2010; Doyle, 1999; Doyle, 2002; Droes, 1994; Ellis & Alexander, 2017; Holmes, 2002; Holmes, 2005; Gadow, 2003; Kennedy, 1975; McDowell, 1975; Norman & Parrish, 1999; Protzel, 1972; Sasso et al., 2018; S. Smith, 2021; Stevens, 1993; Walsh, 2008; Walsh & Freshwater's, 2009; Weiskopf, 2005; Willmott, 1997). On the surface, it is this debate that frames the nurse-officer relationship, a relationship that many authors and researchers characterized as critical to correctional healthcare. But on a deeper level, this debate frames the nurse-patient relationship and the relationship the nurse has with themselves professionally and personally (Christensen, 2014; Doyle, 1999; Doyle, 2002; Foster et al., 2013; S. Smith, 2021; Walsh, 2008; Walsh & Freshwater's, 2009; Williams & Heavey, 2014). The care vs. custody conflict challenges the roles correctional nurses take on, which impacts how patients view nurses and how they chose to interact with them (Canadian Nurse, 2010; DuBose et al., 1996; Gadow, 2003; Jacob, 2014; Lehrer, 2021; McNiff, 1973; Perron & Holmes, 2011; Solell & Smith, 2019; Walsh, 2008; Walsh & Freshwater's, 2009; Weiskopf, 2005; Winstead-Fry, 1975; Young, 2000). The debate creates ethical and professional dilemmas, that contribute sometimes negatively to the mental well-being of correctional nurses, and effects how nurses interact and approach their patients (Choudhry et al, 2017; Cukale-Matos & Champion, 2021; Goddard et al., 2019; Holmes et al., 2007; Jacob,

2014; Kennedy, 1975; Manchester, 2009; Nolan and Walsh, 2012; Norman, 1999; Norman & Parrish, 1999; Smith, 2010; S. Smith, 2021; Walsh, 2008; Walsh & Freshwater's, 2009; Weiskopf, 2005; Willmott, 1997; Wirmando et al., 2021).

The themes identified by this review are present in the writing on correctional literature beyond the literature discussed. As mentioned in chapter 2, Minnigerode's (1931) personal narrative was the earliest published account of these foundational themes. Her account distinguished correctional nursing as unique because of the internal conflict between nursing work and the prison setting; the need to conform to the prison authority (security before health care); and the need to be non-judgmental about the crime. It is clear that in nearly a century the care vs. custody conflict, and the factors that make correctional nursing unique are so established in the field that we should no longer be surprised when the themes appear in the literature. Instead, we should look to other gaps for inspiration.

Gaps in the Research

This review does identify where the gaps in the literature remain. There is agreement that professional identity is unduly influenced by the care vs. custody debate, as the research from Canada, Australia, Italy, the UK and the US noted. However, Holmes et al. (2007) observed that correctional nurses in France had a stronger professional identity. There is room to explore correctional nurses' professional identity in other nations and cultures to see if the care vs. custody conflict is negotiated in new ways that can inform better practice. Another gap is the disconnect between what correctional nurses report about their experience in caring for patients and what patients report. The personal accounts and research with correctional nurses were positive, while albeit limited accounts from prisoner patients were less positive (Kennedy, 1975; Young, 2000). These reports cannot be dismissed as out of date, nor can the optimistic descriptions of correctional nurses be accepted as universal.

Instead, more work is needed to understand how correctional nurses can meet the healthcare needs of incarcerated women (and men). This work should include dialogue that provides specific strategies to manage the consequences of the care vs. custody debate. Walsh (2008) was singular in providing a possible strategy for clinical supervision. This review will now turn its attention to correctional nursing and cultural safety.

Cultural Safety in Correctional Health Literature

Strategies

The original purpose of this review on cultural safety was to discover what is known in the existing literature about the role of cultural safety with correctional populations. However, a preliminary literature search on cultural safety and correctional populations yielded no results. Therefore, search terms were expanded to include mental health, forensic, and substance-related issues in patient populations because these groups are intimately linked with incarcerated adults. Mental health and substance-related issues are defined as any disorder found in the DSM-5. Correctional patient populations are those adults residing in correctional facilities, such as remand centres, pre-trial detention centres, provincial correctional facilities or prisons. Forensic patient populations refer to adults held in secure psychiatric hospitals or psychiatric units of a general hospital for a psychiatric evaluation, or those found unfit to stand trial, or found not criminally responsible due to a mental health concern (Peternelj-Taylor, 2008). I only considered literature that discussed adults, defined as 18 years of age or older. The review included theoretical, research, practice and policy literature. Opinion pieces, letters to the editor, and personal narratives were excluded.

The following databases were searched: MEDLINE (OVID interface, 1946 onwards), EMBASE (OVID interface, 1974 onwards), PsycInfo (OVID interface, 1806 onwards), CINAHL Plus with Full-text (EBSCO interface), Scopus (Advanced Search), Health Policy

Reference Center (EBSCO interface), Criminal Justice Abstracts (EBSCO interface), SocIndex with Full-text (EBSCO interface), ProQuest Canadian Business & Current Affairs, ProQuest ERIC, ProQuest Education Journals, ProQuest International Bibliography of the Social Sciences, ProQuest Sociological Abstracts, ProQuest PAIS International, and Web of Science Core Collection. I did not include grey literature or dissertations; seeking peer-reviewed published works.

Since the aim of this literature review was not to conduct a concept analysis, the concept 'cultural safety' was kept intact. It was also important to keep the concept separate from 'transcultural nursing' and 'culturally competent nursing,' both of which have their own definitions. To that end, terms representing the correctional, mental health and substance use populations were combined with terms specific to cultural safety.

Results

The literature search returned 15 articles that examined cultural safety within these populations. None of the articles discussed cultural safety and correctional patient populations. Ten articles were concerned with mental health patient populations (Auger et al., 2019; Cheong Poon et al., 2020; Cox & Simpson, 2015; Josewski, 2012; Lopes et al., 2012; McGough, 2016; McGough et al., 2018; Smye & Browne, 2002; Webkamigad, Cote-Meek et al., 2020; Webkamigad, Warry et al., 2020). Three were concerned with substance-related issues (McCall et al., 2017; Pauly et al., 2015; Urbanoski et al., 2020). The final two were concerned with forensic patient populations (Durey, Wynaden, Barr & Ali, 2014; Durey, Wynaden & O'Kane, 2014). In terms of ethnicity, the bulk of the articles spoke about cultural safety and Indigenous patients; however, one study focused on cultural safety and immigrants of Chinese and Vietnamese heritage in Australia (Cheong Poon et al., 2020). Similarly, the bulk of the literature was generated in Australia and Canada. Finally, only five

of the articles spoke about nurses (Durey, Wynaden, Barr & Ali, 2014; Durey, Wynaden & O'Kane, 2014; McCall et al., 2017; McGough, 2016; Pauly et al., 2015); the rest either did not address healthcare providers, spoke about patients or their carers, or looked at allied health professionals.

Forensic Patient Populations. The two articles that examined forensic patient populations were Durey, Wynaden, Barr & Ali (2014) and Durey, Wynaden & O'Kane (2014). Both articles were part of a single research project that studied cultural safety in terms of mental health nurses (and other mental health professionals) and how they provide care to Indigenous forensic patients. The study recruited nurses and other mental health professionals that worked in the government forensic mental health services, caring for offenders with mental health concerns outside of the prison environment, although the patients move between the health and criminal justice systems.

The results of the study (described in Durey, Wynaden, Barr & Ali, 2014) were that continuous education, including information on Aboriginal values, beliefs and knowledge, was needed for staff to provide culturally safe care. It was also found that education should include critical reflections on power differentials between Aboriginal patients and Anglo-Australian healthcare providers. Durey, Wynaden & O'Kane (2014) continued from these findings to examine the "intercultural space" as a strategy to educate nurses to provide culturally safe care. The recommendations from the study were for organizations to be committed to ongoing education so healthcare providers could improve their relationships with Aboriginal patients and families. Furthermore, the researchers felt that critical self-reflection should be a key component of this education. The strength of these articles for my current study is in identifying the importance of critical self-reflection in nursing practice.

Critical self-reflection is a core component of cultural safety because it is the work done by the nurse that achieves culturally safe care (Ramsden, 2002).

Patients Who Use(d) Substances. The three articles that spoke to substance-related issues were McCall et al. (2017), Pauly et al. (2015), and Urbanoski et al. (2020).

McCall et al. (2017) and Pauly et al. (2015) were two publications from a single research project. The project was a community-based participatory research (CBPR) study that explored cultural safety as a strategy to diminish the stigma of substance use in the hospital setting, recruiting both nurses and patients who use(d) drugs. Pauly et al. (2015) asked the question "What constitutes culturally safe care for people who use(d) illicit drugs and are affected by social disadvantages such as poverty and homelessness?" (p. 122). A key finding from the study was that patients who use(d) illicit drugs felt unsafe in the healthcare system, choosing to endure pain instead of seeking help. This finding is a reflection not only of prior research with this population, but it reflects the conditions that contributed to poor health for the Maori of Aotearoa/New Zealand that influenced the development of cultural safety (Ramsden, 2002). Like the above studies with forensics patient populations, Pauly et al. (2015) noted self-reflection on the part of the nurse to be critical in developing therapeutic relationships with patients who use(d) illicit drugs.

The follow-up publication by McCall et al. (2017) reported on one aspect of their study, namely the impact knowledge brokers had on power imbalances within their research team in a CBPR. Two knowledge broker roles were created, one who worked with the hospital nurses' advisory group, and the other who worked with the community patient advisory group. The publication reported that the knowledge brokers were successful in minimizing power differentials between the study participants and the research team, an important element of cultural safety.

The study and subsequent articles recommended that nurses working with patients who use(d) substances should have more education on substance use, pain management, and the history of drug policies. As well, support should be in place for nurses to critically think about substance use in the context of healthcare and how that influences how nurses provide care.

The final article in this group (Urbanoski et al., 2020) studied how adults who use(d) illicit substances define culturally safe care. Like in the previous study, the researchers used a community-based participatory research method to develop a concept map of safe primary care. Eight themes were identified that the researchers believe to be a starting point for further system improvements; these included respect, confidentiality, and professional care on the part of healthcare providers. Their findings outline a baseline of care expectations that can be implemented by any healthcare professional with this or a similar patient population. Practically, nurses would have a roadmap of care that met the criteria of cultural safety as defined by patients. Urbanoski et al. (2020) proposed similar recommendations that support what is needed for healthcare providers in building positive therapeutic relationships. They noted that people with lived experience with substance use be connected with care providers as a method to build these relationships. In reflecting on these studies, by considering patients who use(d) illicit substances as a subgroup, cultural safety was shown to be a framework for nursing practice that did not respond only to ethnicity.

Patients with Mental Health Concerns. The ten articles that examined cultural safety and mental health populations reflected diverse areas of research about cultural safety.

The two articles by Webkamigad, Cote-Meek et al. (2020) and Webkamigad, Warry et al. (2020) examined cultural safety in the context of dementia education for Indigenous people in Ontario. Webkamigad, Cote-Meek et al. (2020) conducted a Community Based

Participatory Research (CBPR) study with an Indigenous advisory group and carers of patients with dementia asking about how to develop dementia health promotion materials that meet the needs of the Northern Ontario Indigenous community. The authors reported there was a need for education on Indigenous culture to better communicate health information to Indigenous patients. The second article, Webkamigad, Warry et al. (2020), reported on the development of two Indigenous dementia fact sheets using a collaborative two-eyed seeing framework. The authors highlighted knowledge translation in an Indigenous context to improve health literacy for Indigenous patients and their families. The project illustrated one way to engage Indigenous patients with dementia health using the principles of cultural safety, a failing of the dominant health care system in Canada.

Seven articles looked at cultural safety and mental health care, education, or support for patients. Lopes et al. (2012) and Auger et al. (2019) examined the role that cultural safety could play in improving mental health resources for Indigenous communities. Lopes et al. (2012) used cultural safety to evaluate an Indigenous training resource on suicide. The qualitative study used direct observations, individual interviews and a focus group. Participants were Indigenous and non-Indigenous, and both facilitators and trainees were interviewed. The researchers found that the training resource did increase the participant's knowledge and understanding. The researchers went on to suggest that technology should be used to keep resources up to date and relevant. Auger et al. (2019) evaluated a Mental Health First Aid programme for First Nations through a mixed-methods two-eyed seeing approach in four Canadian provinces. One of the most important findings from the Auger et al. (2019) study was the significance of cultural safety through all stages of programme planning and administration.

Lopes et al. (2012) and Auger et al. (2019) demonstrated the advantage of using cultural safety as a framework to develop better education material for Indigenous

communities. Both publications did note the education content should be adjusted to be reflective of local Indigenous communities because it is inappropriate to assume all indigenous communities are homogenous. However, these studies consider that at the heart of cultural safety is the therapeutic relationship between the healthcare provider and the patient. Moreover, cultural safety expects the healthcare provider to be self-reflective of the power differential in the therapeutic relationship. While better education material supports improved healthcare for Indigenous patients, attending to the dialogue in the relationship is at the center of cultural safety.

Two articles looked at the experience of nurses and psychologists providing mental health care to Indigenous people in Australia (McGough, 2016; McGough et al., 2018). These studies found that mental health professionals felt unprepared to provide culturally safe care to Indigenous patients. The 2016 article by McGough was very sparse, thus I could not confirm whether these were two separate studies or two articles are reporting on the same study. McGough et al. (2018) found that the participants had a fundamental problem of "being unprepared" to care for Aboriginal patients. The participants then had a basic process to manage this problem, which included changing their attitudes and behaviours toward their patients to provide better care. This study saw cultural safety as an action that should occur at the individual and organizational levels. Employers and leaders not only hold the responsibility to make patient care culturally safe, but they are significant agents in supporting staff growth.

The last article of the seven that looked at mental health supports was Cheong Poon et al. (2020). This study was concerned with the support available to Chinese and Vietnamese carers of patients with mental health concerns. Of the fifteen articles in total, this was the only one to examine an ethnic group other than Indigenous people. Cheong Poon et al. (2020) used a mixed-methods design framed by cultural safety to evaluate the supports available to

these carers. The results of the study were identification of culturally unsafe practices within Australian mainstream mental health services, although the participants did report culturally safe care within their support groups. The researchers cited the work done with cultural safety and Aboriginal communities in Australia but recommended more work be done with other linguistically and ethnically diverse communities.

The final three articles looked at cultural safety and mental health policy development or research practice. Smye & Browne (2002) were the first researchers to explore the applicability of cultural safety in the mental health care of Indigenous people in Canada. Their article is theoretical, finding that cultural safety is a worthy framework through which mental health Indigenous policy can be assessed and critiqued. Smye & Browne advised that cultural safety be the framework applied to Indigenous health in a context that includes micro, meso and macro levels.

A decade later, Josewski (2012) used cultural safety as a critical lens in mental health policy reform with Indigenous patients. This was a critical policy review with ethnographic interviews. The interviewed participants were mainly Indigenous, and all were involved with mental health policy and programme planning. The results of this study were thought-provoking: "CS [cultural safety] in mental health and addictions policy clash with neo-liberal and biomedical ideologies, creating situations of cultural risk for both people working within the area of Aboriginal mental health and by extension for Aboriginal people who are seeking care for those issues." (p.230). Josewski endorsed that health policies cannot be dissected without consideration of the underpinning policies.

The final article of the three was by Cox & Simpson (2015). This work is a critical appraisal of the research collaboration with mental health service users, looking to focus researchers on inherent power imbalances. The researchers examined the mental health service users movement in the UK and Australia. Their findings and recommendations

include cultural safety as an appropriate framework for mental health research, associating current social and mental health concerns with the colonial past of the UK and Australia.

Themes

The overarching themes that have emerged from this literature review reflect the foundational concepts of cultural safety. First, the voices of patients continue to express discrimination in the mental health and substance use areas of healthcare. Furthermore, this discrimination continues to drive patients away from healthcare services. Next, for healthcare providers engaging with Indigenous patients, there is a clear feeling they are not prepared to provide safe care. The reflections and suggestions from providers consistently include a desire to learn more about Indigenous culture. However, this desire for specific knowledge of the Indigenous culture is not a core component of Ramsden's cultural safety, instead, she called on nurses or other health professionals to know their own culture and recognize how their culture influences their relationship with patients (Ramsden & Spoonley, 1994). The disconnect between knowledge of another culture and knowledge of your own culture is not surprising as it is easier to learn about another culture than it is to be self-reflective. As Durey, Wynaden, Barr & Ali (2014) noted there is often an invisible privilege, and it is easier to " 'tick a box' for attending a workshop or seminar on 'cultural education' " such that "education and training that critically reflect on the 'invisibility' and/or normalization of mainstream beliefs and practices are necessary" (p.200). The final theme that emerged is that power differentials continue to be present, not only in provider-patient relationships but in core research and policy areas for mental health and substance use. The presence of these power imbalances highlights the potential for cultural safety to be a framework for change on two levels. For policymakers and researchers, cultural safety works at the philosophical and theoretical level, fitting in with Foucault and Bhabha to shift paradigms that underpin the

"neo-liberal and biomedical ideologies" (Josewski, 2012). But, just as critically, cultural safety can impact the interpersonal relationship between a health provider and a patient, changing the health experience and outcomes at a grassroots level.

Gaps in the Research

This literature review demonstrates where the gaps in the literature remain. To begin, at this time there is no published work on cultural safety and incarcerated populations. The work in much of the literature continues to focus on ethnic populations, mainly Indigenous people. The three articles on substance users (McCall et al., 2017; Pauly et al., 2015; Urbanoski et al., 2020) were the only ones to engage with culture that was not specific to ethnicity. Ramsden defined culture broadly including ethnicity, gender, nationality, religion, political beliefs or socioeconomic status (Papps & Ramsden, 1996; Ramsden, 2002; Ramsden & Spoonley, 1994). Despite not explicitly including subcultures within healthcare, choosing to examine patient populations such as people who use substances or incarcerated adults is appropriate especially when they experience many of the same health challenges and outcomes as Ramsden's original population of concern. A second gap in the literature is a nursing focus. Cultural safety began as a nursing model, looking at the relationship between nurses and their patients. It is reasonable to examine culturally safe practices between the patient and other healthcare providers; however, the interpersonal therapeutic relationship is a cornerstone of nursing knowledge and practice. There is still much work to be done with culturally safe practice in the nursing literature. Most notably, work must be done on how to create a workforce of culturally safe nurses after they have graduated. In Aotearoa/New Zealand cultural safety was embedded in the nursing curriculum since 1992 (Papps & Ramsden, 1996; Ramsden, 2002; Ramsden & Spoonley, 1994). Cultural safety is more successfully integrated into nursing practice if it is taught alongside other nursing skills. It is

more challenging to change practice once nurses are in the workforce. The final gap is a more focused examination of how to practice cultural safety in nurse-patient relationships. For this gap, I am speaking specifically to actions that improve the nurse-patient therapeutic relationship by helping nurses to become self-aware and culturally safe in their practice (Papps & Ramsden, 1996; Ramsden & Spoonley, 1994).

Conclusion

This literature review looked at what is known about correctional nursing, correctional nursing with women and cultural safety within correctional nursing. While there has been very little written about correctional nursing with women who are incarcerated, the literature that speaks to correctional nursing in general has identified the unique nature of the field and the care vs. custody conflict as being integral to correctional nursing fundamentally influencing the nurses' myriad professional relationships. The review of cultural safety has shown that there is potential for further work with correctional nurses and adults who are incarcerated, beginning with targeted research of cultural safety and these marginalised adults.

Chapter 4: Research Method

Introduction

This study aimed to develop a better understanding of the experience of nurses who care for incarcerated women with mental health concerns. Qualitative research methodology specifically focused ethnography, was an appropriate framework to explore the experiences of these nurses while gaining new knowledge in the field of correctional nursing practice. This chapter describes the selected method. The following topics are addressed in this chapter: ethnography, focused ethnography, the study method, rigor and reflexivity.

Ethnography: An Overview

Ethnography is considered the oldest qualitative method, with roots in anthropology going as far back as the 19th century (Mayan, 2009; Morse, 2016). It began as a design that researchers would use to understand cultures other than their own, which through the 19th and 20th centuries was the study of non-Western cultures because they were the most different, alluring and exotic (Mayan, 2009; McFarland, 2014). Culture was and remains central to ethnography (Cruz & Higginbottom, 2013; de Chesnay, 2014a&b; Higginbottom et al., 2013; Mayan, 2009; McFarland, 2014; Oliffe, 2005); so central in fact that it is a foundational element of how ethnography is defined: "the process and product of describing cultural behaviour" (Schwandt, 2007, as cited in Cruz & Higginbottom, 2013, p. 37). Early on culture itself was expressed as traditional ideas and values, as well as patterns of behaviour, of a distinct human group (Krober & Kluckholm, 1966, as cited in Agar, 2006). To be an ethnographer the researcher was expected to differ completely from the culture they were studying, they were outsiders entering an alien world (Knoblauch, 2005; Mayan, 2009).

Traditional ethnography has several essential characteristics. First and most indispensable to this method is the researcher in the role of participant observer (McFarland,

2014). In this role the researcher becomes immersed in the culture they are studying, both observing the culture around them and partaking in it (de Chesnay, 2014a; McFarland, 2014). Participant observer is a continuum where the researcher can move fluidly between simply observing to fully participating in the culture (de Chesnay, 2014a; Richards & Morse, 2013). The degree to which the researcher participates in the culture is dependent on gaining the trust and acceptance of the community (de Chesnay, 2014b; Richards & Morse, 2013). When a researcher has gained the trust of the community, they become a temporary member of that community, almost becoming one of the cultural group, measured by how comfortable the community is in their presence (de Chesnay, 2014b). This role of participant observer is also known as field work or entering the field in traditional ethnography.

The second essential characteristic is how data is collected in traditional ethnography. Researchers collect data using field work, interviews and documents (Mayan, 2009; McFarland, 2014). Field work is the act of becoming a participant observer, recording data through field notes. The purpose of field work is to gain an understanding of the culture from the perspective of the people inside the culture (McFarland, 2014). Data from field work can be formal, such as attending a community meeting, or informal such as driving around the community to get a sense of 'rhythm' (de Chesnay, 2014b). Next, researchers rely on interviews with members of the community to capture perspectives (McFarland, 2014). These interviews can take many forms, including quantitative data collection, they can be with individuals or with groups and may also be formal or informal (such as making general conversation with members of the community; de Chesnay, 2014b; McFarland, 2014; Richards & Morse, 2013). Finally, ethnographers collect historical data through documents, such as meeting minutes, maps, census reports and policies (Cruz & Higginbottom, 2013; Richards & Morse, 2013). In ethnography, it is important to consider that these three data collection strategies are separate from each other and not to be triangulated (compared to

each other to give a comprehensive understanding of the problem; Mayan, 2009; Morse, 2001). Each of these data collection strategies is considered a unique perspective that requires their own adequate samples and level of analysis, "to be reflected on in light of the others" (Morse, 2016, p. 875).

The final essential characteristic of ethnography is describing the culture from the perspective of the group, the insider or *emic* view (Mayan, 2009; McFarland, 2014; Richards & Morse, 2013; Oliffe, 2005). This point of view strives to present the culture as the individuals inside see it, and how they construct meaning, in essence, the *emic* view says 'I want to walk in your shoes' (Mayan, 2009). This view contrasts with the *etic* perspective, or the researcher's / outsider's point of view, which is generally considered the view of quantitative studies (Mayan, 2009; Richards & Morse, 2013; Oliffe, 2005). However, the perspective of the researcher (*etic*) is part of ethnography through interpretation of the culture (McFarland, 2014). The etic view in ethnography is managed through reflexivity, which makes the *etic* visible by acknowledging inherent subjectivity (Oliffe, 2005).

The end product in ethnography is a holistic or thick description of the culture, one that is theoretical in nature (Morse, 2016). Traditional ethnography does not test hypotheses, it does not search for solutions to problems, nor does it seek to critique or judge the culture (Mayan, 2009; Morse, 2016). Ethnography "captures dimensions of the social world that are covert and tacit" (Cruz & Higginbottom, 2013). Thus, it is not possible for another researcher to reproduce the same results by replicating the study (Cruz & Higginbottom, 2013; Savage, 2000). The goal of ethnography is to produce a reliable and sincere account of a culture from the perspective of those within it. Within healthcare, ethnography has become a valuable method for qualitative research. It provides the patient's view on health and illness, it uncovers the culture of healthcare providers and increases our understanding of health

organisations (Morse, 2016; Savage, 2000). Traditional ethnography has evolved into many forms. This study utilized one of those forms: focused ethnography.

Focused Ethnography

Focused ethnography developed out of traditional ethnography in the latter half of the nineteenth century (Knoblauch, 2005). It grew out of ethnography, becoming focused by examining a small element of a culture or society as opposed to the whole (Knoblauch, 2005). Focused ethnography has been taken up by many academic departments, mainly practice-based fields as an effective method to learn unique perspectives that may be put into practical use (Wall, 2015). Within nursing, focused ethnography has contributed to: understanding health beliefs of various cultures, how subcultures assign meaning to their health experiences, and the study of nursing practice culture (Cruz & Higginbottom, 2013). Focused ethnography shares features with traditional ethnography, but it is the differences that say more about this methodology.

Focused ethnography differs most crucially in how culture and the study of culture is conceived. In defining culture beyond geographic and ethnic boundaries, new spheres of culture and subcultures became apparent (Mayan, 2009). Using focused ethnography, researchers began to study the culture of organisations such as hospitals and schools, as well as individuals who share a common experience but do not know one another or live together (Cruz & Higginbottom, 2013; Mayan, 2009; Richards & Morse, 2013). Hence, focused ethnography is first characterised by the study of a distinct group or a subculture, no longer the whole society (Cruz & Higginbottom, 2013; Richards & Morse, 2013). Moreover, by changing the size of the group of interest, the research question driving the study must likewise become specific and selective (de Chesnay, 2014a; Knoblauch, 2005, Mayan, 2009). These two fundamental differences from traditional ethnography draw out how this method

became ‘focused’ as it evolved. Then, to remain a ‘focused’ study, it also became necessary for the researcher to move away from being the outsider that Agar termed the “professional stranger” (Agar, 1996, as cited in Richards & Morse, 2013). Instead, the researcher is expected to possess some insider and background knowledge of the group being studied (Knoblauch, 2005; Wall, 2015). These fundamental changes in turn alter data collection.

As mentioned, traditional ethnography uses data collected through field work, interviews and documents. In focused ethnography, data from documents are unchanged, but the information from field work and interviews are modified. The largest shift in data collection occurs with field work. Field work in focused ethnography is no longer time intensive, with the expectation the researcher will live amongst their subjects for months or years (de Chesnay, 2014a). Visits to the field in focused ethnography are not expected to be continuous, often they are short and limited in duration; while in some cases, there are no visits to the field at all (Knoblauch, 2005, Mayan, 2009; Wall, 2015). As these visits are limited, the researcher moves away from the participant-observer role to observer-as-participant role, which allows the researcher to collect specific information when they are not able to participate in the activity (Cruz & Higginbottom, 2013; Higginbottom et al., 2013). As in traditional ethnography, the interviews take many forms, but they are conducted with smaller, key group of participants selected for their knowledge and expertise on the subject (Cruz & Higginbottom, 2013; Higginbottom et al., 2013). These interviews are recorded, at least by audio or when possible by video; and these recordings are transcribed verbatim (Cruz & Higginbottom, 2013; Knoblauch, 2005, Wall, 2015). The recordings make data available to many listeners / viewers, and thus open to multiple perspectives (Knoblauch, 2005). Furthermore, by using these technologies the researcher is free to make specific observations, reflections or questions, which in turn reinforces the move away from the participant-

observer role (Knoblauch, 2005). Like traditional ethnography, focused ethnographers will continue to keep field notes of their experiences.

The elements that make focused ethnography unique do not detract from the *emic* point of view. While researchers have background knowledge, focused ethnography aims to tell the story of the participants in terms of the specific research question (Knoblauch, 2005). Nor is the holistic or thick description of traditional ethnography lost. Instead, the focused nature of this method generates detailed, rich data that is relevant to the particular subgroup of interest (Knoblauch, 2005). Finally, Wall (2015) noted that focused ethnographies provide flexibility in new settings of interest, going even further to note that this field of ethnography allowed researchers to enter cultural contexts that are otherwise closed to traditional ethnographers.

Study Method

Research Questions

This focused ethnography focused on understanding the correctional nurse-patient relationship, thus the sub-culture I was concerned with was correctional nurses. The primary research question was: *What are the experiences of nurses who care for incarcerated women with mental health concerns?* The secondary questions were:

- How did the nurses become employed in corrections as a career choice?
- How do the nurses define correctional nursing practice?
- What are the core values of nurses working in corrections?
- How do the nurses describe nurse-patient relationships?
- How do the nurses understand the concept of cultural safety?

Credibility of the Researcher

Focused ethnography requires the researcher to have insider and background knowledge with the field of study; thus, possessing not only the *etic* point of view but also the *emic* view. I was exceptionally positioned to carry out this research. Between starting my work at ERC and this PhD thesis, I have sixteen years' experience as a correctional nurse. My starting point was the more than five years of hospital-based nursing, as well as two years as an undergraduate clinical sessional instructor with the University of Alberta Faculty of Nursing. This experience provided knowledge and ease with general nursing culture and the nurse-patient therapeutic relationship. More critically I had fifteen years' experience as a correctional nurse. My experience as a correctional nurse began at Edmonton Remand Facility in 2006 as a front-line general nurse, then under the employment of the Ministry of Justice and Solicitor General. This gave me insider and background knowledge of how correctional services operate within the province of Alberta. In 2010 Alberta Health Services (AHS) was contracted by Alberta Justice and Solicitor General to provide healthcare to all correctional facilities in the province. This change in healthcare organisation gave me insider knowledge on how healthcare was administered in Alberta provincial facilities. After AHS took over administering healthcare, I had the opportunity to specialize in mental health nursing. I earned and currently maintain the Certificate in Psychiatric and Mental Health Nursing in Canada (CPMHN (C)). Most recently, my clinical role as a correctional nurse was as a Clinical Nurse Educator (CNE) at Edmonton Remand Centre. I have comfort and knowledge with general correctional nursing practice and the nurse-patient therapeutic relationship in a multitude of correctional healthcare associations. Thus, I shared a background in correctional clinical nursing with the study participants fulfilling the focused ethnography requirement for the researcher to have insider knowledge.

Sample and Setting

This unique study population involves a relatively small group of nurses in Canada. Across the country there were likely as few as 2000 to 2500 nurses working in provincial and federal correctional facilities. The most recent available figures report for 2013 that Ontario had about 511 registered nurses in provincial facilities (Almost et al., 2013), Corrections Services Canada reports there were 700 nurses in federal facilities across the country (CSC, 2013), while in Alberta there were approximately 250 nurses working in 10 provincial facilities. Nurses in correctional facilities were made up of a variety of registered professionals. Registered Nurses (RNs), who were the bulk of nurses in Canada (Almost, 2021), were expected to make up the bulk of correctional nurses. Licensed Practical Nurses (LPNs) and Nurse Practitioners (NPs) were also represented in this setting. Registered Psychiatric Nurses (RPNs) have a focus in mental health nursing and are a distinct profession in Manitoba, Saskatchewan, Alberta and British Columbia. This study recruited RNs, RPNs, NPs and LPNs from provincial and federal correctional facilities across the country. There are 45 provincial and federal correctional facilities across the country that house women. Five of those centres are federal sentenced facilities housing women only, the remainder were provincial centres (including the three territories) that are a mix of women only and coed facilities (see Appendix A).

For this focused ethnography, I used a purposive sampling approach, whereby participants were selected based on their experiences and expertise in the area of study (Creswell & Plano Clark, 2007; Fawcett & Garity, 2009). Complementary strategies included snowball sampling and solicitation. Snowball sampling makes use of referrals from participants to other potential study participants (Fawcett & Garity, 2009; Higginbottom et al., 2013). Solicitation refers to cold-calling individuals in relevant organizations (Higginbottom et al., 2013). The inclusion criteria for the study were:

- RN, RPN, NP, or LPN;
- Have ever worked in or currently work in a provincial or federal correctional facility in Canada;
- Have ever worked with or currently working with incarcerated women;
- Ability to consent to the interview;
- Over 18 years;
- Ability to speak and understand English.

Recruitment

This focused ethnography was approved by the University of Alberta Research Ethics Board, study ID number Pro00110611 (see Appendix F). Nurses were recruited through two streams. The first stream was to recruit correctional nurses through an information email (see Appendices B & C) distributed through correctional nursing email lists including:

- Custody & Caring: Biennial International Conference on the Nurse's Role in the Criminal Justice System mailing list
- Canadian Forensic Nurses Association
- Canadian Federation of Mental Health Nurses
- Ontario Correctional Nurses Interest Group

The second stream was to recruit correctional nurses through provincial nurses' associations. This stream was not accessed because the first recruitment process generated a suitable sample size to achieve saturation. An incentive for participation was included in the study. An incentive is a form of reimbursement or compensation for participation in research (CIHR, 2018; Matheson et al., 2012). The Tri-Council Policy Statement (TCPS 2) acknowledges that incentives encourage participation in research, but they should not compromise voluntariness through undue inducement (CIHR, 2018). Furthermore, the TCPS

2 places the responsibility on the researcher to justify the use of incentives to the Research Ethics Board. In this study, the participants were offered a $10 coffee card to either Tim Horton's, Starbucks or McDonald's upon completion of the formal interview. This amount was not so large as to encourage the participants to recklessly disregard risk (CIHR, 2018). An amount of $10 is a third or less of the hourly wage of LPNs, RNs, RPNs, or NPs across Canada.

Ethical Issues

There were several ethical issues within this focused ethnography with regards to the study participants. First, was the issue of recruiting nurses from Edmonton Remand Centre. My current role as a Clinical Nurse Educator (CNE) placed me in an unofficial leadership position. Thus, if I were to personally recruit nurses in the workplace there may be a perception of coercion, that participation was not truly voluntary. While my work at Edmonton Remand Centre did not absolutely preclude the nurses that work there from participating in the study, they had to learn about the study through the identified recruitment streams. Thus, these nurses were not be contacted by me in my researcher role until they have given permission for access (Olson, 2011). It is also important to acknowledge that while it seemed convenient and quicker to recruit from my workplace, my study sought to recruit correctional nurses from across Canada. ERC had but a small percentage of the correctional nursing population and was not over-represented in the data.

The second issue to acknowledge is consent. This study had an information letter and a consent form (see Appendix E). However, since the interviews took place virtually over Zoom, I obtained consent verbally, as I could not rely on the participants to sign and return the consent form via email. The information letter outlined what the participants were expected to do (complete one semi-structured interview of about 1 hour in length).

Confirmation of eligibility was done prior to the interview via email when the participant first contacted me. Participants were notified that the interview would be recorded and consent to be recorded was obtained. Participants were aware that they could withdraw their consent at any time during the interview itself.

Anonymity and confidentiality were assured for the participants. All participants were informed that their personal data would be kept confidential. Each participant was assigned a research identification number and personal information such as names and location were removed from the transcripts (Olson, 2011). The generic label 'Participant #' was used in any reports of publications when short passages from the transcripts were used (Olson, 2011); and the plural pronouns 'they' and 'them' were used to avoid gender attribution (Spiers & Wood, 2010). These measures were important as protection of identity is a requirement in all qualitative studies (Olson, 2011). In addition, attention was paid to anonymity because the number of correctional nurses in Canada is small, a subculture in the larger culture of nurses. However, the fact that this group was spread across a wide area with disconnected social communities means the measures discussed here were enough to protect participants (Olson, 2011).

The final two ethical issues to acknowledge were boundaries and power. Boundaries were related to the tension between my professional role and my role as a researcher, arising out of information revealed during the interviews with participants (Olson, 2011). The possibility existed that the participant may signal the need for professional therapeutic intervention or may reveal a breach in professional practice that was beyond my role as a researcher but was within my professional responsibility as a RN (Olson, 2011). It was critical that I would not take on the role of nurse-therapist (Ashton, 2014). Since this study interviewed participants only once, the threat of this boundary violation was lessened. If a participant required further therapeutic support, the researcher had the contact details of the

local distress line, or in extreme cases where the participant was unable to do so the researcher would have contacted the local crisis team. In the event that a professional breach of practice was disclosed, the researcher would have discussed the disclosure with my supervisor and decided on appropriate next steps, using the current risk of harm to the participant or a named individual as the measure of evaluation (Ashton, 2014). Power was an issue in the relationship between the researcher and the participant. In the semi-structured interviews both the interviewer and the interviewee had power. As the interviewer I controlled the setting, the questions being asked, and I decided how the data collected were presented in the study (Anyan, 2013). I was responsible for sustaining the interview by motivating the participant to continue the interview and answer the questions (Anyan, 2013). The participant had power in that they controlled what they said, how they said it, and the information they provided (Anyan, 2013). The interviewee influenced their own level of cooperation, their behaviour in the interview, and ultimately, they had the power to end the interview at any time (Anyan, 2013). Participants also chose to say what they thought the interviewer wanted to hear (Anyan, 2013). Since I could not control the actions of the participants, I was reflexive in my analysis of the interview process (Aléx & Hammarstrõm, 2008). I will discuss reflexivity shortly, but in this regard, I reflected on the power relations for each interview, acknowledging my own position in the interview, my own biases and my own behaviour (Aléx & Hammarstrõm, 2008).

Data Collection and Analysis

The data collection strategies I used reflect the unique characteristics of focused ethnography. Field visits were not required in focused ethnography, and I did not conduct field observations for two reasons. First, the geographic dispersion of the study participants meant there was no shared physical space in which I could take on the role of participant

observer. Second, for me to observe nurse-patient interactions would have involved a separate security clearance for each correctional facility and the costs of travel to each site would have been prohibitive as this research did not have funding. I relied mainly on interview data to uncover the elements of the corrections nurse-patient therapeutic relationship. Each participant was interviewed once using a semi-structured interview format, with questions approved by the committee (see Appendix D). A semi-structured format was appropriate because I had enough background and insider knowledge to develop questions, but I was not able to anticipate answers (Richards & Morse, 2013). The interviews lasted for approximately 1 hour each. Each interview took place on-line using zoom and was audio or video recorded. The interviews were transcribed verbatim. Field notes were kept of all the interview experiences. Finally, I collected relevant documents such as correctional nursing and healthcare policies and position statements, correctional nursing job descriptions, and websites describing and advertising correctional nursing.

In traditional ethnographic studies there is no sample size calculated based on previous research using the same or similar tools, instead data are collected "until the workings of the cultural-group are clear" (Creswell, 2007, pp. 128). Focused ethnography is similar in that there is no recommended or exact number of participants a researcher can plan for to answer the research question (Higginbottom et al., 2013). Instead, researchers are guided by saturation, the point at which no new themes or information would be identified from additional participants (Cleary et al., 2014; Fawcett & Garity, 2009; Higginbottom et al., 2013; Mayan, 2009; Richards & Morse, 2013; Walker, 2012). This conceptualization of saturation is obscure, and there is little information in the literature to guide researchers in knowing when saturation has been achieved (Onwuegbuzie & Leech, 2007; O'Reilley & Parker, 2013; Saunders et al., 2017; Walker, 2012). However, Morse (2015a) describes saturation as "building rich data within the process of inquiry" (pp. 587). Morse (2015a)

suggests scope and replication as the characteristics that can be used to measure when saturation has been achieved. Scope means that all facets of the phenomenon are considered, and researchers must remember that the number of participants does not equal the amount of data (Morse, 2015a). Replication refers to similar characteristics across multiple participants (Morse, 2015a). Limited participants or too few data will prevent replication (Morse, 2015c). Thus, Morse (2015a) suggests that saturation is fulfilled when the number of participants is sufficiently big enough to allow for replication and the expertise of the participants are appropriate for scope. This study knew saturation was achieved when the data gathered in interviews demonstrated similar characteristics across participants and all facets had been explored (Morse 2015a). Having said that, it was also feasible to look to other focused ethnographies that conducted individual interviews for sample size guidance. Higginbottom et al. (2013) and Cruz & Higginbottom (2013) are examples of 15 healthcare focused ethnographies that show a range of sample size from eight to thirty-six participants. In this study, 18 correctional nurses were interviewed.

Higginbottom et al. (2013) outline that when analyzing focused ethnographic data, the process is self-reflective, cyclic and iterative. The steps in the process I engaged included: reading and re-reading the transcripts to become immersed in the data; manually and electronically coding the data for descriptive labels; searching for patterns and themes; identification of outliers and negative cases; and finally generalizing the data (Higginbottom et al., 2013). I also employed word clouds to visualise emerging themes and patterns. Word clouds are graphic representations of written text, where the most frequent words are largest and therefore the focus (Heimerl et al., 2014; Jayashankar & Sridaran, 2017; Philip, 2020). While word clouds are a beneficial technique to visualise bigger patterns, it was but one tool in qualitative analysis and did not outweigh reading and re-reading for data immersion. Quirkos qualitative software was used for the electronic coding. I kept a methodological

journal as soon as the interviews commenced to record how I analyze and make sense of the data (Higginbottom et al., 2013; Spiers & Wood, 2010). Data analysis and emerging themes and categories were discussed in meetings with my supervisor and committee members.

Rigor

Rigor is defined as the state of being accurate and thorough; and it is vital for researchers to pay attention to rigor due to the probable subjectivity that is inborn in qualitative research (Cypress, 2017). Rigor must be built into the research plan from the beginning, that is constructed, instead of being a post hoc detail because research without rigor is both useless and worthless (Morse et al., 2002). I used Lincoln and Guba's (1985; Cypress, 2017) four criteria for assessing rigor in qualitative studies: credibility, transferability, dependability and confirmability. These criteria assist the researcher to answer the question "How can I persuade my audience that the research findings of my inquiry are worth paying attention to, and worth taking account of?" (Cypress, 2017, pp. 257). Credibility asks whether the research findings make sense and accurately represent the participants, replacing the quantitative concept of internal validity (Mayan, 2009). Transferability asks whether the findings can be transferred to other settings, replacing external validity (Mayan, 2009). Dependability replaces reliability, looking post hoc at how research decisions were made through the process (Mayan, 2009). Finally, confirmability looks at the interpretations of the data, happening in the data collection and analysis phase to assess how logical the results are (Mayan, 2009). Confirmability replaces objectivity (Mayan, 2009). To be able to show how to 'do' rigor Mayan (2009) and Morse et al. (2002) recommend verification strategies.

The verification strategies I had in place were thick data description, peer reviewing, openness with researcher bias, and finally an audit trail (Cypress, 2017; Lincoln & Guba,

1985; Mayan, 2009; Morse, 2015a). Thick data description is concerned with the quality of both individual interviews and the entire data set. Keystone in collecting good qualitative individual interview data lies in the relationship between the interviewer and participant. Since the study was a focused ethnography there was no opportunity for prolonged engagement or persistent observation, instead I built in time for the participants to get to know the interviewer (Morse, 2015b). To ensure a thick, rich data set, Morse (2015b) notes attention must be paid to sample size and appropriateness. As noted above, I identified that saturation guided sample size in this study. Next, peer reviewing involves presenting my findings to my supervisor and committee (peer review) as I moved through data analysis, which helped me to synthesize the data as a novice researcher (Morse, 2015b). Peer reviewing obliged me to listen to the points of view of my peers; however, the onus remained on me for data analysis and I take final responsibility for the results (Morse, 2015b). The third strategy, openness with researcher bias, is concerned with the inherent bias in sampling and misattribution of the data (Morse, 2015b; Morse & Mitcham, 2002). Inherent bias in qualitative sampling is rooted in small, purposeful selection of participants, a requirement for validity because using a random selection of participants would not provide the necessary understanding of the concept in question (Morse, 2015b). Misattribution is the inclination for a researcher to see what is expected or emphasize characteristics unequally (Morse, 2015b; Morse & Mitcham, 2002). Both of these biases were accounted for in the verification processes of data gathering as the collection and analysis of the data itself provided checks and balances, along with the processes for saturation (Morse, 2015b; Morse & Mitcham, 2002). The final strategy, an audit trail, was a record of the entire research process. The audit trail was a record of all decisions made throughout the process (Cypress, 2017; Mayan, 2009). These multiple strategies were built into the study to ensure rigor; however, these

strategies do not address the relationship between the researcher and the data. This part of rigor is known as reflexivity.

Reflexivity

Reflexivity is a strategy in qualitative research that examines the intersection between who the researcher is and how the researcher presents the data, demonstrating that the researcher is aware of her point of view throughout the study (Mayan, 2009; Olson, 2011). Reflexivity is valuable in clarifying researcher bias beyond that of the process of data collection and analysis (Boadu & Higginbottom, 2014). The reflexive processes I practiced began with a pre-data collection interview in which I wrote out my own answers to the semi-structured questions to identify personal biases and expectations that will mitigate misattribution of data. I kept field notes throughout the process of data collection and analysis, including writing immediately after each interview with a participant. Field notes are integral to ethnography, helping the researcher to understand and integrate the data (de Chesney, 2014b). As well, I kept a personal journal that provided a record of my own assumptions and perspectives as data collection and analysis happens (Mayan, 2009). The personal journal was separate from the audit trail and field notes, as this journal allowed me to record successes and frustrations I experienced (de Chesney, 2014b; Mayan, 2009). Finally, I engaged in debriefing sessions with my supervisor, writing reflections after each session to capture my own experiences and how I interacted with the data set.

Conclusion

This study used qualitative research methodology, specifically focused ethnography, to explore the experiences of correctional nurses who cared for incarcerated women with mental health concerns. A semi-structured interview format was used to interview 18

correctional nurses from across Canada to better understand the nurse-patient therapeutic relationship in the context of correctional facilities. Attention was paid to recruitment, sample size, rigor and reflexivity. My work was overseen by my supervisor and committee, as well as the University of Alberta Research Ethics Board.

Chapter 5: Findings

Understanding Who The Nurses Were

There were 18 participants in this study. There were 11 RNs, four RPNs, one nurse who was both a RN and a RPN, and one LPN. The participants had been in nursing from five to 45 years, with an average of 17 years in nursing. The participants had worked in corrections from two to 40 years, with an average of 12 years. Of the 18 participants, 15 were employed in a correctional facility at the time of the interview, two had left corrections for other nursing positions and one was retired. The participants came from three provinces, Alberta, Manitoba and Ontario. Six nurses reported they currently were working or had worked in more than one correctional facility. Provincial remand facilities were represented by 13 nurses, seven reported they worked in provincial sentenced facilities and five nurses worked in federal facilities. There were two nurses who self-identified as male, with the remaining self-identifying as female. Many of the participants reported that they knew very little or nothing about correctional nursing prior to working in the field.

> *I knew there were jails, obviously, but I didn't really know anything about the health care that was provided within them or anything like that (Participant 10).*

The participants were employed in corrections through three pathways. A small group reported they applied to a job posting after a friend or coworker recommended the work.

> *Primarily because I had a friend who was the supervisor of the health care department . . ., who basically recruited me verbally and said, 'you would be a good person to come and work, so apply and come work for work for me,' essentially (Participant 1).*

Many of the participants reported they saw a job posting and were interested despite knowing nothing about the actual work.

> *You know what, why not? I think that'd be really **interesting**[1] to start working there (Participant 3).*

However, an equal number were drawn to correctional nursing by either previous experience with the patient population,

> *I was a nurse in a female detox programme and kept meeting women who were involved in the criminal justice system (Participant 5).*

or interest in the connection of social justice, the criminal justice system, and a marginalized patient population.

> *When I was going through nursing school, nothing was really hitting the mark for me, . . . then I toured a correctional facility in my community rotation, ... And as soon as I did it, I was like, this is where I'm meant to be. I really love mental health and addictions nursing, and I just like working interprofessionally with **officers**, and I love vulnerable **marginalised** populations. So corrections just like hit all those marks for me (Participant 11).*

> *. . . my whole nursing practice has been geared toward towards **social inequities**. And so it just kind of like the next possible extent, I guess (Participant 5).*

As I was analysing the interviews, it came into my mind how many of the participants had long careers as nurses in correctional settings. I noted as well that many of the participants worked in correctional facilities for the bulk of their nursing careers. I contemplated their commitment to this setting as I was developing the themes to be discussed next.

[1] In this chapter bolded words link the words of the participants to the theme title.

Thematic Presentation of the Findings

Data was analyzed by reading and re-reading the transcripts to become immersed in the data; manually and electronically coding the data for descriptive labels; and searching for patterns and themes (see Chapter 3 for a more detailed description). Seven themes were developed and are discussed: jack of all trades; seeing beyond the clinical task; being an expert; moments of opportunity; building the patient up; complex relationships, and culturally safe correctional nursing care.

Jack of All Trades

Across all three types of correctional facilities, all the participants described correctional nursing work as a diverse set of tasks and responsibilities. Medications, diabetic checks, wound care, admissions, assessing for suicidal thoughts and responding to emergencies were some of the typical duties noted by almost all participants. Two participants describing themselves as a jack of all trades.

> *A typical day? I'd say involved getting their meds ready, doing meds, then seeing people in clinic and then seeing anyone that had any emergencies or urgent things like anyone that might be feeling suicidally unwell, or mentally unwell to medically unwell, and then processing orders, and doing more meds (Participant 12).*

Within this theme, four features emerged to better understand what it means to be a jack of all trades correctional nurse. First, the participants noted that care entailed everything from age 18 through to end of life. Besides current medical or mental health issues, participants reported educating clients on sexual and reproductive health, running physician clinics, discharge planning, initiating and following up on community referrals and connecting patients to social services.

> *We take care of **everything from age 18 to end of life**. And so it's a very broad practice. . . . Anything that a patient could have going on in the community, or even in a hospital, we will deal with in corrections (Participant 11).*

Participants noted that as nurses they had to have a little knowledge about a lot of health issues or know how to find out about issues quickly to address the patient's concerns.

> *We had a manager that . . . basically said, 'You guys go out and take care of things. And if you don't know something, I expect you to go and find it out.' (Participant 1).*

For those nurses whose work was focused on medical care, the expectation that they understand addiction and mental health nursing was also present.

> *I think when you look at like the rates of addiction, mental health concerns within the incarcerated population, no matter whether you're a mental health nurse or a medical nurse, you are a mental health nurse. If 70 to 80% of your population has an addiction or mental illness, that's what you are now (Participant 15).*

> *But after hours, we are the mental health on call, which is tough, because we're not actually really trained in mental health. Right? So we are sort of a band aid solution after hours. How can I just keep you safe until tomorrow morning . . . (Participant 7).*

The second feature to emerge was dancing on your toes, in which the nurses described expectations of being able to fluidly move or pivot between patient concerns quickly.

> *Really just **dancing on your toes** through a myriad of any health issue or concern (Participant 18).*

Pivoting quickly highlighted the importance of critical thinking, knowledge and time management to meet the patient's concerns and complete the nurse's work during their shift.

> *And it was just the sheer volume that was challenging, because you would be sitting there at 10 o'clock at night or 9:30, at night, getting ready to go out for your bedtime medication lineup, and all of a sudden, the phone's ringing and somebody threatening suicide. So it becomes, stop what you're doing, interview this person, or make sure they're safe. And then interview them after you've done your medication lineup. And here you are, it's 10:30 at night, and you're trying to make an assessment of somebody's mental health status. And you know that you want to go home by 11. And you haven't signed your medications (Participant 1).*

I pondered the similarities and differences in how the participants described correctional nursing care across three provinces. I reflected on my own correctional experience and how reassuring it was to hear participants in other locales describe their work using comparable language. It was also encouraging to hear what made their experiences different from my own.

The participants also described being in the role of an agent. Participants reported patients who were incarcerated were often limited in how they could meet their healthcare needs, such as having to ask a nurse for headache medicine. Thus, in the role of agent, nurses described being on a spectrum from helping the patients with minor concerns to connection with the multidisciplinary team both inside and outside the correctional facility to address more serious issues.

> *. . . in the correctional environment, the patients have very little ability to meet their needs on their own, they usually have to go through some kind of an* ***agent*** *to get what they need, they have very limited resources within*

> *corrections. So, the nurse becomes one of those agents to help them meet their needs, if they're having mental health concerns, they come to me or I go to them and help them identify those issues. And then we work together to try to, you know, I make a referral to psychiatry, for instance, I'm an agent that helps them meet their needs (Participant 10).*

The final feature of this theme is limited resources, which all participants discussed across all types of facilities and all work roles. Participants identified lack of policies, equipment, team members, privacy, confidentiality, and time as the resources most lacking.

> *. . . then trying to sort out resource allocation with **limited resources**, like you're stuck with pretty much what's inside the walls (Participant 18).*
>
> *There's a lot of feelings of helplessness, and just limited in what you can do (Participant 16).*

However, a lack of time and privacy were identified as the most critical of the deficient resources.

> *. . . we don't have a whole lot of time, that's one thing, we're always time broke here in corrections (Participant 9).*

> *I don't feel that there were any private places where we could talk to patients where no officers could hear (Participant 15).*

The lack of time had the greatest impact in building rapport with patients and in managing patient concerns.

> *. . . when you're a floor nurse, you don't, you have a huge list and no time to do it. So there's no time for 'Hi, how are you?' (Participant 7).*

> *However, it's hard to build rapport because a lot of the times, the time you have with the patients is very limited, and that you have to go on to the next task (Participant 3).*

While lack of time was identified in all facilities, nurses from remand facilities felt the shorter, uncertain length of stay made this resource even more precious.

> *In the remand facility I worked in, I felt like it was just putting out little fires. I feel like sometimes you didn't feel like you had the resources or the time to fully invest in ongoing counselling with someone, which they probably would benefit from. Where in the sentence provincial Correctional Centre, I felt like very much you had the luxury of meeting someone ongoing to know more about them to build rapport to work on things, which I think it makes work more rewarding than just putting out little fires and giving little skills here and there (Participant 4).*

Likewise, the lack of privacy affected how much the patients would open up to nurses and how care could be provided.

> *She will never speak about anybody else in front of an officer. She won't tell us that she's in drug withdrawal. She won't tell us that she's been taking somebody else's medication. She won't tell us anything. Because they're there, that authoritative presence, shuts them up 100%. (Participant 7).*

> *Because sometimes the patients don't feel as comfortable talking to you. They don't want to tell you some information depending on who the officer is (Participant 12).*

It was interesting that nurses in both remand and sentenced facilities identified time as a limited resource, both to get tasks done and to build therapeutic relationships with female

patients. From my own experience, I had imagined that building therapeutic relationships was easier in a sentenced facility. This was evidence of my own biases that was noted in my reflective journal.

Seeing Beyond the Clinical Task

Participants were unanimous in their belief that it was important to see the patient as a whole person. This belief went beyond the physical – psychological duality to include their spiritual health and the social determinants of health and the factors that contributed to their incarceration. Thus, seeing the whole person or taking a holistic approach was deemed essential for good patient care.

> *So not just seeing the patient in front of you, as a clinical practice. You don't just see the patient in front of you that has a dog bite on their arm that's infected and needs care. You* ***see beyond*** *that person, to yes, this person got a dog bite that was on their arm. So yes, they need antibiotics, they need dressing changes, they might need physio or something like that. But also the social factors that brought them to the corrections as well to that's I think that's a very important piece of correctional nursing, that always needs to be fore fronted . . . And if you don't acknowledge the larger social issues, you're usually going to end up providing suboptimal care . . . (Participant 3).*

Many participants went onto identify that trauma was a significant part of their patient's past and could not be ignored.

> *I personally find working with women very hard, in the sense that I find it the most heartbreaking. Most of them have been through significant trauma. So I find whenever you're having an interaction with mental health concerns, you always have to take trauma into account. You kind of go back to those like*

> *ACE [Adverse Childhood Experiences] factors from childhood to most of them had very unstable childhoods, most of them have had unhealthy relationships, some of them had children that have been taken away (Participant 14).*

For the participants, seeing beyond the clinical task meant that correctional nurses would further expand their jack of all trades repertoire to topics such as consent and boundaries.

> *There's a lot of just like impromptu education that I do with the girls, that's kind of my go to is I'll sit, and we'll chat but we're having conversations about consent, and we're having conversations about healthy boundaries, and just things that no one is, or few people in their lives have taken the time to have those conversations (Participant 5).*

The participants were aware that the experience of incarceration itself placed limits on how much the women's health and circumstances could be improved.

> *. . . you never can make a person feel **100% better**, because they're always incarcerated. So, you're doing what you can to make them a little bit better and seeing maybe them going from like, a five to a seven, . . . (Participant 14).*

Thus, for the participants it was critical to accept what nurses had the agency to change and what they could not. Incarceration, diagnosis, and social conditions were out of the nurses' control, but how they interacted with the women was something they could regulate.

> *Nothing in the sense that I can't change why they're in there. I can't change their diagnoses. I can't change, at least in this point, their outside conditions of living that they will go out go to, I can't change their interactions with other patients on the unit. However, I can also be a person that if they need to, they can just have a conversation with and in which they're treated like a human being for once or in a while, whether just be listening, having a conversation, like hearing about their life or their experiences (Participant 3).*

A critical component of seeing beyond the clinical task included providing unbiased care to the women. Every participant highlighted the importance of being non-judgemental and unbiased in their nursing care.

> *It's like **seeing the human** behind the charges, or **in front of the charges**, honestly, is how that is because like the charges are just secondary health care. We don't provide different health care based on your charge. We just see a person with health problems and we're trying to help them solve problems (Participant 10).*

The participants identified unbiased care was important in building rapport and trust with these women who were incarcerated, encouraging the patients to become more at ease.

> *. . . she's called herself a hooker. I was like 'oh you're like sex trade worker.' And then she's like, 'yes,' and she was a bit off, you could tell she didn't really want to say that. But then when she kind of said that, I was honestly, 'that doesn't mean anything to me, I'm just here to help you out,' we have a conversation. And from that moment we could build a bit of rapport. And by the end, she's kind of laughing, chit chatting, a lot more **at ease** (Participant 3).*

However, the participants also identified that the act of providing unbiased care was a choice correctional nurses had to make every day.

> *I think that really just putting those things aside that we might judge or not agree with, be fully accepting of the patient. . . . and really working hard to be compassionate. . . . because clearly, they've been accused of something and sometimes the things they've been accused of are horrific, so that's sometimes it's hard to swallow, right but it's actively telling yourself every day that it doesn't matter what these people have done. I'm here as a health care*

> *provider, and I will provide that health care. And providing health care doesn't mean having a rude look on your face and carrying out a skill. That's not true care (Participant 15).*

As this theme was developed, I wondered why providing unbiased care to incarcerated women was a special part of correctional nursing compared to hospital nursing and how this reflected the principles of cultural safety. I considered what it was about the environment and the work that made this an imperative part of the correctional nursing experience across all participants.

Being an Expert

The third theme identified by the participants was being an expert in their role as a correctional nurse, which began with being up front with the patients regarding their scope of practice.

> *So just maintaining those professional boundaries, and also being clear about what you're able to do and what you're not (Participant 8).*

Nurses cited having to remind patients that physicians and psychiatrists decided on medications, however it was the nurses who faced the patients daily to respond to their concerns. The participants reflected that they played a role of intermediary between patients and prescribers, which was not the case in the community.

> *I felt like being kind of a gatekeeper of medication, which I feel like is not anywhere else I've worked. It's always been people could access on their own, they have the freedom to choose who they want to access for care providers, they could go find someone else and go to walk in clinic, see the doctor directly. There's no middleman more so in other settings, so that makes it a bit unique (Participant 4).*

The role of intermediary placed the nurses in difficult position of having to say no to patient requests, which in turn challenged the therapeutic relationship.

> *And when I tried to talk to this girl about it, she wouldn't have any of it. She wouldn't hear it, she wouldn't anything. And when it came down to it, I got so frustrated because she was so mad. And then I was becoming the bad guy. Because I was like, people listen, I don't make the decisions. Like the doctor is the one who orders this medication (Participant 7).*
>
> *if there was a favourable outcome, where I could help them with something that they were asking, then sometimes it would build that relationship (Participant 16).*

The participants recognised that another aspect to being an expert meant that after they defined their practice, they needed to present themselves as an equal. Being equal entailed acknowledging the power imbalance and adjusting the nurse's approach to the patient.

> *So we have to be, we have to present ourselves to be **experts** from a medical kind of place, but at the same time, they're **equal.** So there's a power imbalance. So it's delicate in that way, you have to be aware of that power imbalance so that you don't accidentally exploit it, or not exploited necessarily, but you don't kind of like, you have to make sure that you're not belittling the patients, because they come from an environment and a background where they've been belittled . . . So you have to be aware of that. . . . But in a casual way, you have to be subtle about it in the way that you're respectful, you can't be like formally respectful, because I find the patients here, they don't really come from a formal background. And they don't respond well to that. Because I think that formal background for them, has always*

> *represented, like a power authority type of person who's been controlling them, or some kind of an adversarial force in their life (Participant 10).*

This was another instance when I thought about the work of being a culturally safe nurse, which was included in my reflective journal.

Moments of Opportunity

The fourth theme that came out of the interviews was moments of opportunity. This theme had three features: building trust, offering patients something to give them ease, and teachable moments.

Building trust was the most important feature of this theme, laying the groundwork for other moments of opportunity. Participants noted that despite having little time with female patients' small moments were sufficient to build trust.

> *But we have a female offender that is our cleaner, comes every day. So you say 'good morning,' she says, 'good morning.' That's it. But as time has gone by, I start, 'How's the weather outside?' because I don't have an outside window? 'What's it like outside'? And then Friday comes, 'Do you have any plans this weekend? Anything good going on card games, movies? What's going on?' So anyway, as our relationship grows, one day, she just sort of like, 'Can I talk to you?' 'Absolutely.' Anyways, we ended up chatting for an hour and a half about life, about stresses, about medications about the COVID vaccine about all these things that she just didn't know who to talk to (Participant 7).*

In fact, most participants identified these small moments of opportunity to build trust as a crucial component of correctional nursing care for two reasons. First, often these moments were all that was available and therefore had to be exploited.

> *So I think with the nurse patient relationship, what you have to think of is, if I'm going to see this person, one time, I want to make this one of the, do my best to develop that therapeutic relationship as best I can in the moment, and try to do my best to be honest, so that we* ***build trust****, that I am genuine in my interactions (Participant 15)*

When I heard this story from Participant 15 (and similar stories from other participants), I was envious of the opportunity she had to build a relationship with that female patient. My emotional and rational response was to envy the time she had, both in seeing the patient daily and in having the time to talk when the patient asked. I also admired the participants who described taking these moments of opportunity to engage fully in the interpersonal relationship. When I reflected on this, I scrutinised how I had been shaped by my own experiences as a front-line correctional nurse, specifically how I was taught to interact with patients.

Second, the participants noted that trust was frequently lacking in the lives of the female patients. Patients either lacked trust due to experience of trauma, or they had poor interactions with the health care system in the past.

> *. . . sometimes they would be a bit sharper or less likely to respond maybe to any type of kindness, because wondering what that might mean in terms of manipulation or whatnot like the ability to form* ***trust*** *is really, really hard (Participant 16).*
>
> *They've maybe had negative interactions with the healthcare system in the past. So, they're sometimes slow to open up or, or slow to* ***trust*** *medical professionals, not only while incarcerated . . . (Participant 13).*

Many of the participants noted that the easiest method to build trust when small moments were only available was for nurses to be truthful in their interactions and follow through with their words.

> *. . . you have to do what you're saying, because that's how you're **building trust** with them. That's the beginning of trust for them (Participant 2).*

Moments of opportunity were mentioned by participants across all types of correctional facilities. However, those participants who worked in multiple facilities asserted building trust was simpler in sentenced facilities.

> *So, I think it is, it is a little bit more, a little easier to establish a relationship there, especially with people that are there for an extended period of time that you're seeing frequently for their health needs (Participant 13).*

Just as correctional nurses used small moments to build trust, the participants discussed finding small opportunities to provide a kindness or something extra.

> *I loved when we did have moments where we could offer something or we could help somebody facilitate something or, you know, just even take a moment to just try to be a bit kind . . . because at least then you could offer something that would maybe allow their life a little bit of **ease** . . . (Participant 16).*

These moments were either part of a scheduled treatment where more time was spent listening or providing an extra service (such as cutting toenails when the client couldn't). These extras were seen as opportunities to connect with the women and a chance to demonstrate holistic, unbiased care.

> *Well, the other day I have a patient who's particularly has mental health issues and is particularly behavioural with some people, but I agreed to cut her toenails for her. And it was very good. She was very excited. And she was*

> *really nice about it. And then it helped her to tell me other things that were going on, and kind of helped me to be able to provide better care by doing something out of the ordinary, I guess, because I don't normally cut people's toenails for them, but she isn't really capable of doing it herself. But by doing that, she also was less behavioural than normal and easier to interact with and actually had like a conversation with me that was positive and you know, she was happy to which was not necessarily her normal. So that was good (Participant 12).*

The moments were also a chance to coach the patients in positive behaviours that would not clash with facility rules and expectations.

> *I spoke to the client as well about the fact that she can make her stay more enjoyable or more difficult, just based on her interactions with officers as well (Participant 4)*

The final feature, teachable moments, was identified by participants to be different from coaching about facility rules. Teachable moments were a way to impart health education that would be remembered over multiple admissions or once the women returned to the community.

> *. . . trying to help them in their moments of crisis and manage their needs and manage their requests, . . . So it's almost a **teachable moment**. It's hopefully you can impart something that is that is important to them, or that they can use in that moment in time, and maybe they'll remember it later on (Participant 1).*

The participants were clear that patients remember their healthcare providers over time and admissions. Therapeutic relationships were built over time through these moments of opportunity when the nurses were respectful and unbiased in their care.

> *I have found that our patients will remember, female patients will remember when you've provided good care, they're open to receiving care from you again, . . . (Participant 6).*

Building the Patient Up

Across many interviews was the theme to build patients up. The participants described building patients up through three activities. First, the participants noted nurses should meet the patient where they are at, which meant accepting the female patient as they presented not imposing expectations on their choices or perspective.

> *And I find it's very important to **meet the person where they're at**, let them know the resources that are available. And if they want to access them great, but just know that they're there (Participant 14).*

Furthermore, participants defined accepting how the patient was engaging with healthcare in the moment, again not imposing judgement or expectations on interactions.

> *Because if you give up, they give up. So, you can't give up on them. They say . . . that if your client can give 50%, you can give 50% and meet them in the middle. But I think that's bogus. Because our population, if you get your pants on in the morning and you come to the slip that I sent you to be here for nine o'clock, that's giving it their everything that they've got that day. That's what they have to get. They got their pants on, and they made it here. I do the rest of the work. So it's not 50/50. So I go back to **meeting them where they're at**. And so you have to be understanding that what they have to offer you is generally their all, which isn't much, let me tell you . . . for the most part, they are run down there. They're burnt out, life has burnt them out (Participant 7).*

For participants, meeting them where they are at entailed client-centred care and addressing the priorities identified by the female patients.

> *. . . you have to **meet the patient's where they're at**, if a patient identifies that recurrent incarceration is a problem, then we should help them with that. But if they don't have a problem with it, then we're wasting our time addressing recidivism for that particular patient (Participant 10).*

The second activity was to promote patient autonomy, which went beyond client-centred care. Participants discussed building up the female patient's self-esteem and helping them to recognize and act on their own autonomy. This was possible either by providing a listening ear or through education.

> *So we just had this conversation, and she just opened up about all of the things she was feeling with this pregnancy and how she knew she wasn't in a good place to parent . . . . And then she very independently just used me as a sounding board to come to decision that she didn't want to continue the pregnancy. . . . She just said I needed someone to be here. And to see that I can make this decision on my own. . . . I talk to the girls very openly about how they're treated, and to make sure that they know that they can advocate for themselves and should advocate for themselves, and I will help them as much as I can with any of that, that needs to get done. (Participant 5).*

Promoting autonomy also meant giving the patients back some control over their healthcare in centre. Participants discussed negotiating the timing of medications or treatments with patients or following through on patient's decision to decline treatments without abandoning the woman due to noncompliance.

> *I've met a couple ladies who don't want to do medication, but they'd rather do a smudge on the unit, and they think that might help. And so it's working with,*

> *okay, they probably need a medication because they're not presenting that well. But let's try to work together on things that can happen (Participant 14).*

Promoting patient autonomy was noted as being a challenge within correctional healthcare as paternalism was ubiquitous in correctional facilities.

> *I think one of the main problems that I've always sort of had with corrections is you're having a bunch of professionals telling a bunch of people who are outside of a professional realm, how they should live, and what their health outcomes should be. It's too preachy. . . . we should allow the patients to be more **autonomous** in telling us what they want (Participant 10).*

The final activity identified by the participants was to give the female patients hope despite their circumstances. Giving hope happened through two channels. Participants talked about the positive impact of incarceration on the patient's whole health.

> *. . . we build them back up and give them everything they need from food and water to a house to friends to treatment, to medications to everything that they need. And we make new people out of them, we give them **hope** for the most part (Participant 7).*

Participants reported hope was passed on through acts of celebration and encouragement of the women's achievements and milestones.

> *. . . it's just really nice to see them accomplish something. And the pride that you can see that they feel it's just really cool to be part of that because some of these girls and they don't have a lot of people who celebrate them (Participant 5).*

It was also evident from the participants comments that building the patient up went beyond the actions of a single nurse. To effectively improve the situation for these women the

activities had to be part of every nurse's practice so the impact would compound over time and interaction.

> *But if we show kindness, compassion, and a willingness to listen and meet the person where they're at, that might be the time they think, somebody wants me to live, somebody wants me to get better. And those sorts of things are additive over time. So if you and I are both working in a corrections centre, and you see this person and you have that behaviour, and I see that person and I have that behaviour, we're building their self worth, rather than I give them that compassion and then someone else comes and chips that away with their behaviour so that we're building on those things for the individual (Participant 15).*

Complex Relationships

The final theme was complex relationships. All participants spoke to the complexities within the nurse-patient relationship and identified three factors that were integral to how these relationships functioned: the setting of correctional facilities, individuals, and acculturation.

Setting. The weight of the correctional setting could not be overlooked as an influencing factor in the nurse-patient relationship. All participants acknowledged that healthcare was not the priority in provincial/territorial and federal correctional facilities, which is distinctive from all other healthcare settings.

> *you really are beholden to the officers and that whole structure. . . . health care is **secondary** (Participant 15).*

Instead, the priority is security which the participants saw as compromising privacy and confidentiality. Participants reported there was the least amount of privacy in remand

facilities, with the most in federal facilities. Officers were noted to almost always be present, or within earshot.

> *The officers have to be there to kind of guarantee our **safety**. . . . the officers do a risk assessment and if they determine that it's safe for me, then I'm allowed to see that patient on my own. You know, and they're near, they're not in the same room, but they're watching me on camera (Participant 10).*
>
> *[officers are] physically present depends on the situation, but I think ears wise, almost always (Participant 15).*

Moreover, the final decision lay with the officers as to whether nurses could assess a patient.

> *Occasionally, officers will just say you're not doing this medical admission alone (Participant 11).*

Although the same participant did acknowledge that they have never been absolutely barred from seeing a patient, they only had to wait until the situation was safe.

> *And it's not that I can't assess the patient going forward or in a little bit, but in that moment, they need to control the situation (Participant 11).*

The setting, including the rules and regulations, was contrary to wellness, making it difficult for nurses and female patients to promote and maintain good health.

> *In the grand scheme, they might be more minor, but they don't have the freedom or options of I don't know, coping strategies or different activities to manage these symptoms, or this mental health concern, because they do have freedoms taken away and activities are restricted. . . . Well, you can't go for walks when you're in there. So even basic coping strategies are not always available (Participant 4).*

Overall, one participant felt a correctional facility took on a presence of its own, gathering and projecting negative emotions that impacted all within.

> *And that kind of spirit of sadness, and bitterness and anger, goes into the longer that you're in that building for it affects the inmates, it affects the officers, affects the nurses (Participant 3).*

Individual. The second factor in understanding complex relationships is the individual. Participants discussed how almost every interaction involved three people: the patient, the nurse, and the officer.

> *I find it's also a very interesting place, because it's not only patient-nurse, there's also correctional officers that are involved, and they're not privy to their healthcare information, but they're usually involved with every interaction that you have. . . . So it's a very tricky relationship, I would say (Participant 14).*

The participants noted that the inclusion of an officer in the relationship changed the patient's behaviour. Participants described that patients were less likely to disclose information either due to the lack of privacy and confidentiality, or to avoid repercussions from that disclosure.

> *Clients wouldn't feel like they could discuss confidential things either, right? They probably wouldn't tell me they're using substances on the unit with officers there. Yeah, so it probably limits some things, if it's gonna end in some repercussions from an officer side, they might not express them to me in the presence of an officer (Participant 4).*

The participants acknowledge that in knowing that officers were always present their nursing practice was also changed, altering the questions they would ask when there is an officer present.

> *My practice, that doesn't change regardless of, it might well, no, that's not true, because it might actually impact some of the questions that I would ask, some things I probably wouldn't ask if there was an officer present. Just because I know that the answer couldn't be confidentiality maintained (Participant 8).*

Participants described how patients have been known to act differently with officers than with nurses, acting aggressively with some officers. When patient behaviours are dissimilar, especially when they are aggressive with officers, that creates barriers in patient care as security comes to the forefront of the nurse-patient interaction.

> *But it seemed like the patient, her behaviour specifically, was aggressive towards the one officer and not other people. . . . But after they did let me speak with her by myself, because the patient demonstrated that she was okay with me, I guess there was no angst towards me (Participant 4).*

In extremes, participants were able to identify that poor officer-patient relationships could change the course of nurse-patient relationships for the worst. In some instances, the tension between officers and patients would hinder the work of nurses. Patients would either behave differently with the nurses or refuse to engage in healthcare at all.

> *. . . when you're trying to assess a patient post code . . . and emotions are high, and sometimes the officers like interrogating the patient while you're trying to do a physical assessment. And it's really frustrating, because I feel like it's not therapeutic, the patient is, you know, stressed and the officers are stressed. And yeah, it's not a good situation." (Participant 11).*

Even when nurses were able to make connections with patients, at least a third of participants had examples of officers interrupting those interactions.

> *. . . you'll be getting them to take their antibiotics and they'll be kind of calmed and settled. And then they might kind of say something snarky to me. But that's okay. Because I understand you're feeling terrible right now. You're not happy, you're in a lot of human pain, you have infection, you're incarcerated. And then the officers though, will like jump in and be like, "you do not talk to them that way," like this interaction is cancelled, and then the patient just explodes. And just like goes off and becomes extremely agitated to the point that you can't now do anything with them because the officers intervened and escalated above the point where you could have just been like, just exercise a bit of patience and understanding (Participant 3).*

Another participant felt the root of this officer behaviour stemmed from the competing goals and visions of justice and health services.

> *I think the officers would make their own judgments about the individuals, but from a much different lens. And plus, didn't always understand the purpose of what we were doing, like the intervention (Participant 16).*

I pondered the words of the participants as this theme developed. I wondered how it affected nurses and patients to have a third person present during private healthcare interactions. Especially how having a third person seemed to be the cost of needing healthcare in a correctional facility. This was noted in my reflective journal.

Despite these barriers, five participants noted that the presence of officers could have a beneficial impact on nurse-patient relationships. Participants conceded that some officers had positive, trusting relationships with patients. These positive relationships were especially influential when the nurses did not know the patients.

> *. . . if it's an officer that has a good relationship with the woman that I'm meeting with, then not so much, because then she feels that she has her team around her (Participant 5).*

Furthermore, due to the length of time that officers spend with incarcerated women across all three types of centres, participants noted that 'good' officers were aware of changes in the patient.

> *So the officers are on the ball. They're on the ball. They're good. And they know when something's not right, with an offender, they know the ones who are the most at risk (Participant 7).*

Generally, the presence of an officer in the triad reminded the female patients they were in custody and held no power. Five participants were able to identify how power shifted immediately with the officer presence, and how it changed the focus away from health care to incarceration.

> *And then an officer came in to let us know, that our time was up for I can't remember exactly what the reason was, but it was to enforce an institutional rule. And I mean, the conversation instantly changed. And so did her, her sort of approach the conversation. She completely shut down, and then started some very classic splitting behaviour in terms of saying to the officer, she was trying to help me and you're here to remind me where I stand in the scheme of things (Participant 6).*

Acculturation. Acculturation may be the most critical factor in understanding complex relationships. Across all three types of centres, well over half of the participants reflected the fundamental challenge of 'whose side is the nurse on?'

> *Because I think it became a question of not choosing sides . . . the officers expected you to be on their side, but the patient also wanted you to take care of their needs. So it was a very difficult line to walk (Participant 1).*

The five previous themes reflect the layers in the correctional nurse-patient relationship, and despite the barriers thrown up by officers, the relationship between officers and nurses must be cultivated. Participants were clear that the nurse-officer relationship had two key functions. First, participants knew that it was officers who guaranteed their safety, and no matter how good the nurse-patient relationship the constant potential for violence remained.

> *I was very cognizant of what I was doing and my relationship with officers because they're the ones that are going to save you if something happens, if the situation goes sideways, they're the ones that are going to restrain that person and step in between you and that individual, because often people are not going to be happy with the message that you're delivering (Participant 1).*

Second, participants admitted that cordial or positive relationships with officers were required to make healthcare happen.

> *But yet you were also aware, if you didn't cooperate in some sense with officers, they were not going to help you facilitate your work. You know they might not allow me to call somebody down, or they limit your exposure, . . . (Participant 16).*

Thus, there is pressure on nurses to conform to the justice services culture. The participants reported that when the justice culture clashed with the healthcare culture nurses experienced distress.

> *But a very common situation that I observed there was that women who had a psychosis would often be seen as being personality disordered by the officers. . . . And so then they didn't want to give them any attention or care because they*

> *thought that they were just like putting this on even though the person was like, objectively psychotic. And then you would see women who were probably personality disordered, and using some attention seeking behaviours, and those people would be seen as being higher need and that caused a lot of moral distress for me that we were locking people up in rooms who needed acute psychiatric care . . . (Participant 15).*

Three participants reflected on the image of nursing staff being affiliated with justice staff and how that image was perceived by the female patients. The participants suggested that when nurses appear to be too closely tied to officers put up a wall between the nurses and the patients.

> *. . . I'm curious if the patients on the unit view me as more being sort of on the officers team. I'm curious because when I come onto the unit, I immediately go behind the officers panel . . . because I need to talk to the officers because I have to get their permission to go on the unit. . . . And so the patients tend to be a distance away, well outside of where they could hear exactly what we're talking about. . . . You know, they're my co workers. So I talked to them in that way. And I'm curious if the patients see me as being sort of in in that role more if they're seeing me like I'm on the other team instead of a neutral agent. . . . I've been kind of questioning is this the reason why this guardedness has been coming about . . . (Participant 10).*

In a similar vein, another participant suggested that nurses may be seen as part of the system that persecutes the patients.

> *Because though I am apart, when you see my skin and everything and then you look at all the officers and a lot of the other nurses and you see two white male*

> *officers escorting a line of eight indigenous woman down the hallway . . . I'm a part of that system of oppression and the entire system (Participant 3).*

The third participant admitted that acculturation even to a small degree was a natural result of working in the environment and could not be avoided. They reflected that as time passes, the challenge as to whose side the nurse is on does not go away but must remain in the nurse's conscious to prevent being fully immersed in the justice culture.

> *". . . you can't help become a little bit institutionalized, a little bit jaded, you know, some of the things that I think new eyes walking into this facility find a little bit shocking don't necessarily shock people who have been here for a long period of time. So I do think that that probably affects how I provide care. But I mean, I still think, I would still like to think that I'm still advocating for our patients . . . (Participant 13).*

The comments from these participants were powerful for me. I thought considerably about how I had been part of that system, and I reflected on this as the interviews progressed. I wondered not only how much nurses were perceived by patients to be part of that system of oppression; but also whether these and other correctional nurses were aware of this perspective. I thought more about opportunities for self-reflection within the workplace, reflections and conversations that could happen without shame or judgement on the correctional nurses.

However, one participant was able to frame acculturation and complex relationships in a more positive light. They noted that in a positive setting, with positive nurse-officer relationships, patient care changed for the better.

> *. . . when you have a well environment, so our officer group as well, the building is functioning well, the patients are more likely to be well, even if I'm not having specific one on one interactions (Participant 6).*

One participant seemed to sum up the six themes by focusing back on who the nurse is and what they bring to all the relationships in a correctional facility.

> *But your relationship is really dependent upon who you as a nurse, the experiences that you bring their corrections and your kind of beliefs and attitudes towards people who are incarcerated, or kind of like just the general, because in my opinion, incarcerated, correctional facilities are pretty much the safety, the net that catches all of the social issues of society (Participant 3).*

Culturally Safe Correctional Nursing Care

Cultural safety is an underpinning theoretical perspective of this study. When I analyzed the data, it was evident that cultural safety was threaded throughout the findings. However, I wanted to hear what the participants thought of cultural safety in the framework of correctional nursing. In the interviews, three questions were asked to explore cultural safety and correctional nursing. I explored with the participants their familiarity with the concept and how they defined it. Then, I inquired about how the participants saw their own culture. This was an important question because culture safety asks nurses to be aware that they are carriers of their own culture. Finally, I asked participants if they felt that their personal culture had any effect on their relationships with female patients. The findings of those questions are presented below.

Are you familiar with cultural safety and what does it mean to you?

Five participants were not familiar with the concept of cultural safety. The remaining 13 nurses agreed that cultural safety centred around respect for the patient's individuality, identity and beliefs. Many participants expressed that correctional nurses should not force their own beliefs onto the patients.

> *. . . my understanding is that you do your practice, kind of to meet the individuals culture, you're not trying to influence them based on kind of what your decision might be, you're trying to incorporate their cultural decision, kind of cultural ideas and that kind of stuff into their care and treatment, to the best of your ability, and to make sure it's appropriate for them (Participant. 5).*

> *For me to feel culturally safe, I have to feel like the people providing health care to me, are either from my culture, or they're respectful of my culture. And I'm in no way being shamed or judged or treated differently, because of the culture that I'm from. That's what cultural safety means to me (Participant 10).*

Three participants displayed a deeper knowledge of cultural safety, one of whom had mentioned the concept early in the interview before it was introduced by me. These three participants were distinct in defining culture as unrelated to ethnicity, instead encompassing many of the core values of cultural safety as originally characterized by Ramsden.

> *When I think of cultural safety. I think it's being attentive to like the social, economic kind of political issues that a group of people face. And that includes the history (Participant 3).*

> *Cultural safety means to me that in order to know the culture of another, I need to know the culture of myself (Participant 15).*

> *I think it's about recognising that we can do we can do harm (Participant 16).*

As I reflected on the interviews individually and as a whole, I observed that culture was mainly thought of in terms of ethnicity, and frequently the question prompted the participants to talk about Indigenous people who were incarcerated.

How do you identify with your own culture?

Many of the participants expressed difficulty with this question, reflecting that it was hard to think of their own culture. For the majority, their culture was an expression of their ethnicity or nationality and their profession.

> *I am obviously Caucasian. I grew up in Canada, I went to post secondary school. And so in Correctional Health, I mean, certainly identify as a nurse as my culture (Participant 6).*

> *I'm a Caucasian female, but I identify as Canadian. . . . And in my corrections role, I believe strongly that every life matters, Canada believes that (Participant 11).*

As well, many of the participants saw their culture as one of privilege in comparison to their incarcerated patients. Indeed, a few also acknowledged that their culture instilled biases that they were aware of in their work in correctional facilities.

> *I have grown up and been privy to all these things in my life, like being able to go to university and all these things. So I think I try to be very aware that I've had potentially more access to things . . . and I try not to take that for granted (Participant 14).*

> *the biases that I might have, just because of my culture, and my background, and my experience, I think that's important, too (Participant 8).*

How do you think your culture impacts your nurse-patient relationship?

Almost all participants responded that their culture did have an impact on the nurse-patient relationship. And, for the majority, they talked about culture in the context of ethnicity. In this context, the participants saw their "white" culture in contrast to Indigenous patients.

> *as a white . . . settler . . . I'm the face of the correctional institution, . . . like all the other white correctional officers, all the other white correctional nurses. . . . So I think that's very important to be aware of your social positioning, and who you are and what you bring to your relationships (Participant 3).*

> *I think you have to also check yourself to and make sure you're not identifying with correctional officers, . . . I think you can support them and be aware of where you are, but I also don't think that we should be identifying as that justice component in our practice (Participant 13).*

For many of the participants, the difference in ethnicity was not about what the nurse brought to the relationship but rather the perceptions the patients had of the nurses. Some participants spoke of not being affected by the patient's perceptions or how they communicated with nurses.

> *But I think it's maybe the perception of what a patient might think my culture is. . . . But I do think that lots of our female population in [place name deleted] is Indigenous. And I do think that they could perceive me in a certain way based on how other Caucasian people have treated them in the past and I think that could have an impact on nurse patient relationships (Participant 11).*

A few participants saw the impact of culture on the therapeutic relationship as having to be aware of the barriers between nurses and patients, and provide care as they would with a patient in any other setting. As well, a few participants did not perceive differences in culture to be negative. They expressed that finding common ground would help build a therapeutic rapport, no matter how small that common ground was.

> *I'm sure everyone has some biases, I'm sure they do affect you, but I don't let them affect necessarily my nursing care. I have opinions and beliefs. But I don't ever let that affect how I might think something but then I realised that I thought it and then 'Oh no, that's just me.' That's not anything to them (Participant 12).*

> *I have to realise that my ability to do that might be a little bit easier than individuals who are incarcerated. . . . I'll say to someone . . . go see a psychiatrist [when you get out]. And then I take a pause . . . well, there's various barriers to getting there that I need to be aware of and help that person overcome, whether it's transportation, finances, something like that. . . . I find in the positive that it's sometimes you can find that common ground, whatever that may be. So, for individuals who are indigenous, and then I'm not indigenous we could both identify as [place name deleted] for example. And then that kind of helps with the therapeutic rapport. And then when you get more deep, then that's when you kind of see the difference, but different doesn't have to be a bad thing (Participant 14).*

Conclusion

In this chapter, the participant's response to the research question “What are the experiences of nurses who care for incarcerated women with mental health concerns?” uncovered seven themes: jack of all trades; seeing beyond the clinical task; being an expert; moments of opportunity; building the patient up; complex relationships, and culturally safe correctional nursing care. The next chapter will discuss the themes and findings on cultural safety in more detail.

Chapter 6: Discussion

The purpose of this chapter is to reflect on the potential meanings of the findings and intricacies of the experiences of correctional nurses who care for incarcerated women with mental health concerns. Overall, the findings revealed correctional nurses must be simultaneously aware of the experiences and motivations of patients and correctional officers, in addition to their responsibilities to provide care for incarcerated women with mental health concerns. Specifically, analysis of the findings developed seven interconnected themes: jack of all trades, seeing beyond the clinical task, being an expert, moments of opportunity, building the patient up, complex relationships, and culturally safe correctional nursing care. Embedded in these themes are the principles of interpersonal relations and cultural safety. In addition, many of the participants identified connections between social justice, the criminal justice system, and a marginalized patient population. In this chapter, I have organized the discussion and interpretation of the findings according to the secondary research questions as taken together they answer my research question:

- How did the nurses become employed in corrections as a career choice?
- How do the nurses define correctional nursing practice?
- What are the core values of nurses working in corrections?
- How do the nurses describe nurse-patient relationships?
- How do the nurses understand the concept of cultural safety?

I will also review the strengths and limitations of this study and provide recommendations on nursing care for women who are incarcerated for clinical practice, education, and research. Dissemination strategies and concluding remarks will also be presented.

How did the nurses become employed in corrections as a career choice?

The majority of participants in this study reported they knew very little or nothing about correctional nursing before being employed. They recounted responding to a job posting out of general interest, seeking out a correctional nursing position because a co-worker suggested it, or because they had experience with a similar marginalized population. When the participants pursued employment in this setting, they did so because of the uniqueness of the setting. They were secure in their nursing knowledge and skills but looking for an experience that was not hospital nursing. The participants were prepared to provide nursing care to the adults who were incarcerated; however, they were not prepared for the challenges that make nursing in correctional facilities distinctive.

The view that correctional nursing is special and requires specific education to prepare or support nurses working in this environment is noted in the literature (Goddard et al., 2019; Kent-Wilkinson, 2009 & 2011; Terblanche & Reimer-Kirkham, 2020). Overall, the argument for special education is to prepare nurses for the challenges of navigating the correctional justice system and how to reconcile conflicting health and correctional values, which if not accounted for can contribute to poor patient care (Evans, 1999; Goddard et al., 2019; Kent-Wilkinson, 2011). Within Canada, correctional nursing is not a nursing specialty. This means there are no minimum standards of knowledge and education, core competencies or any central body to set standards of practice or consolidate educational opportunities (CNA; as cited in Almost, 2021). The lack of standards and specific educational opportunities leave the nurses to learn the nuances of correctional nursing on the job from their peers, other allied healthcare staff and the correctional officers (Kent-Wilkinson, 2011).

Despite the scarcity of support, the participants were happy with their decision to work in a correctional facility, with most citing the complex patient population as underpinning their enthusiasm for the work. Specifically, the participants were strong in their

opinions that the interplay of the criminal justice system, social justice, and marginalized complex patient populations was recompense for the difficulties in working in a correctional setting.

How do the nurses define correctional nursing practice?

The first two themes, jack of all trades and seeing beyond the clinical task, explained how the participants defined correctional nursing practice. Over the three provinces and the three types of facilities, the participants were analogous in their descriptions.

Jack of All Trades

The participants defined correctional nursing as a diverse set of tasks and responsibilities, a jack of all trades in which their daily work required them to be nimble in providing care across the lifespan with limited resources. The four features of the jack of all trades theme are: care across the lifespan, dancing on your toes, limited resources, and being an agent.

Care across the lifespan refers to the nursing activities that support health and manage illness at every life stage from age 18 onward, encompassing a diversity of tasks and responsibilities. No matter whether the participants worked in a remand, sentenced, provincial or federal facility, they all described the work they do as diverse. This variety is supported in the literature as care in adult correctional facilities spans the life course, including aging patients, palliative care and death (Burles et al., 2019; Harner & Riley, 2013; Kitt-Lewis et al., 2020; Reviere & Young, 2004). The literature and the participants reported activities like healthcare assessment upon entry, management of acute and chronic physical and mental health conditions, emergency care, and social care amongst others (Flanagan &

Flanagan, 2001; Goddard et al., 2019; Karaaslan & Aslan, 2019; Lapworth et al., 2010; Perry et al., 2010 a & b; Reeves, 2014; Shelton, 2009; Stephenson & Bell, 2019).

In their interviews, the participants shed light on the reality of the responsibility to know about many health assessments and conditions. To have this responsibility was described as daunting by some participants, especially by nurses in the early years of their career in correctional health. As an example, many participants perceived there was an expectation to have specific nursing knowledge of addictions and mental health concerns, but they felt unprepared to manage patients in crisis. The participants had all completed their nursing education and were registered, thus the issue was not that the participants were incompetent as nurses. Rather, they had basic knowledge about many conditions without expertise, or in some cases little direct experience. It is the lack of expertise and direct experience that provoked unease. When the nurses were faced with unfamiliar issues, the participants reported the expectation was that they would learn quickly. As the participants gained experience, they gained expertise which decreased feelings of apprehension.

Dancing on your toes or pivoting quickly to meet patients' needs describes the requirement to adjust nursing priorities rapidly to respond to fluctuating conditions. This feature is closely linked to care across the lifespan in that the participants described it as daunting to pivot quickly. Whether a nurse was new to the setting or had many years of experience, they discussed having to be prepared to meet any issue at any time, again sometimes without experience or training specific to this skill. Dancing on your toes was reflected in the literature, though less attention was given to this feature of correctional nursing. Pivoting to meet the patients' needs was identified by Flanagan & Flanagan (2001) as "time spent fighting fires rather than working to a plan" (p. 74). Shelton's (2009) study described the role of the correctional nurses, finding that an important function was to

prioritize individual needs while managing multiple requests. It maybe that pivoting to meet the patient's needs receives less attention because it occurs across all nursing areas. However, as a participant described there are not many nursing settings where medication delivery is interrupted by a suicidal patient as a regular occurrence. Unlike the hospital setting, correctional nurses in this study described being solely responsible to manage these sharp turns in patient care. Prescribers and other specialists are not consistently available across all centres. Even in situations where the patients could be referred to other disciplines, there remained a period when the correctional nurse was responsible for patient safety and appropriate consultations.

Like care across the lifespan, the correctional nurses were challenged most when dancing on your toes involved a skill they did not feel competent about. Most frequently cited was having to manage mental health crisis when they did not define themselves as mental health nurses. The literature also reported correctional nurses can feel unprepared for the challenge of pivoting quickly when the practice is broad and unfamiliar (Shelton, 2009). Education, including simulation, to better manage knowledge and confidence deficits was identified to help correctional nurses feel more prepared and better able to pivot quickly (Goddard et al., 2019; Lapworth et al., 2010; Shelton, 2009). It was not in the scope of this study to inquire about the educational needs of correctional nurses, but many participants indicated they wanted more orientation and education to meet this challenge.

Limited resources include physical items such as supplies, abstract items like the time it takes to complete a task, and design features such as the space to engage in healthcare. Limited resources were an undisputed challenge for most of the participants, with a lack of time and private space discussed specifically. Studies have shown that correctional nurse's job satisfaction is influenced by limited resources including lack of time to complete nursing

care (Flanagan & Flanagan, 2001; Stephenson & Bell, 2019). Limited time and lack of privacy has also been reported as a concern by incarcerated women (Condon et al., 2007; Plugge et al., 2008; Young, 2000). Young's (2000) study on women's health perceptions reported few patients experienced an instance when the nurse had time to listen. Plugge et al. (2008) and Condon et al. (2007) each reported privacy was a major concern to incarcerated women, including having to discuss health issues in the corridor or at the medication distribution centre.

Across all types of centres, the participants reported limits on time and privacy effected how they cared for patients, including how they constructed therapeutic relationships. Participants expressed regretting not even having to the time to ask female patients how they were, a basic function of nursing care. Likewise, the participants were troubled when a lack of private spaces meant the incarcerated women would not share their health concerns.

Frequently, a lack of privacy is related to the physical spaces where healthcare takes place and with the staff surrounding them. I will discuss privacy and staff later in this chapter, but for now my focus is on physical spaces. Prison design and construction takes years and is an expensive undertaking (National Institute of Corrections, 2011). Buildings are not designed for privacy or healthcare but are designed to "seclude, segregate, confine, regulate, and observe the actions of every individual" (Doyle, 1999, p. 32). These facilities put space (both physical and psychological) between staff and adults who are incarcerated (Almost et al., 2020; Dhaliwal & Hirst, 2016, Doyle, 1999). In Canada there have been two new provincial correctional facilities opened in the past two decades, Edmonton Remand Centre opened in 2013 and Toronto South Detention Centre opened in 2014. Both facilities were designed years before construction began, took about six years to build, and cost $600 million Canadian (approx.). As best practice around designing and building healthy prisons emerges

in the literature (Jewkes et al., 2019; Wagenfeld & Winterbottom, 2021), justice services and governments are challenged to respond by building new facilities or renovating old ones. Even design literature does not place privacy as a goal ahead of security and supervision (NIC, 2011).

The participant's disquiet about the limited time and private spaces is because they recognize the impact on the patient's health. The intersection of time and space is essential for the development of trusting relationships. These resources are important for nurses and patients to begin to build therapeutic relationships and for the nurse to become knowledgeable of the patient's condition and who they are as a person, as identified in interpersonal relations (Forchuk, 1994b; Peplau, 1988). Similarly, cultural safety speaks to the establishment of trust in the bicultural nurse-patient interaction as critical to allowing the patient to feel safe (Ramsden, 2002). When an incarcerated woman does not feel safe, they will not disclose who they are or what their health concerns are. Thus, when the participants and their patients are faced with a continued lack of resources, especially time and private places, the patients are in danger of receiving suboptimum healthcare and the nurses experience distress in their practice.

The last feature of the jack of all trades theme is being an agent. The participants described being an agent for the women, managing or helping with aspects of their healthcare that they were unable to do for themselves in the secure setting that is a correctional facility. It is born out in the literature that adults who are incarcerated often require assistance having their healthcare needs met (Condon et al., 2007). The role of agent has not been described in the correctional nursing literature, and the participants did not describe in detail what they meant by the term 'agent.' The descriptions from the participants of helping women who are incarcerated meet their health goals has some connections with being a case manager, where

the nurse is in an advocacy role that has been described in the correctional literature (Hooper and Chamberlin, 2000; Perry et al., 2010b). Peplau (1988) identified many roles that nurses take on in nurse-patient relationships, some roles are decided by nurses, others by patients. As mentioned, the literature supports the participants' observation that patients are not able to fully manage their healthcare while incarcerated (Condon et al., 2007). However, patients are not entirely incapable of managing their own health and the literature is lacking on what roles patients would like correctional nurses to take on. It seems that in correctional nursing there remains much to be explored around identity, nursing roles and the work done within facilities.

Seeing Beyond the Clinical Task

Seeing beyond the clinical task was central to how all the nurses in this study defined correctional nursing practice. This theme encompassed holistic care, the effects of incarceration, and being unbiased in care.

The nurses in this study were steadfast that patients could not be viewed within a narrow frame and that holistic care was foundational to correctional nursing practice. The participants described holistic care that went beyond medical and mental health care to include their lives prior to admission into the facility. The nurses described the importance of considering past trauma(s), the social determinants of health and what led the patients to their current situation. Moreover, putting these dynamics first or as one participant said in front of the criminal charges, was critical for best nursing practice. The participants commonly described the patient was not to be seen as an inmate first, but as a person who has experienced a complicated life.

The participants' belief that the female patients must be viewed holistically is well established in general nursing literature and in emerging literature regarding the population of interest. Along with studies that report prevalence rates for physical and mental health concerns (Binswanger, et al., 2010; Brown et al., 2015; Fazel et al., 2006; Fuentes, 2014; Kouyoumdjian et al., 2012; Tyler et al., 2019) there is a growing body of knowledge that examines how other negative experiences intersect with women's health and the criminal justice system. Lynch et al. (2017) investigated the links between mental health, offending and women in the United States. They found that childhood and adult trauma exposure were indicators related to poorer mental health in this population, although it did not predict the number of convictions. Another study by Caravaca-Sánchez et al. (2019) examined Adverse Childhood Experiences (ACEs), mental health, and social support among women who were incarcerated in Spain. Their findings were that women who reported histories of ACEs have increased prevalence of mental health concerns and lower levels of social support. Two other studies examined this phenomenon through qualitative interviews with women who were incarcerated. Kendall et al. (2019) interviewed Aboriginal women in Australia about their health. Those participants identified that past and recent trauma intersected with current health concerns. Likewise, Blair-Lawton et al. (2020) interviewed incarcerated women in Canada who spoke of complex pasts and childhood trauma. The participants echoed the current literature as many saw optimal care as including the social issues at play in the lives of their patients.

The participants indicated that holistic care was manifested within the therapeutic relationship. More specifically, it was depicted as being understanding in nurse-patient interactions, responding compassionately in conversation, and offering (when possible) extra care that may include education beyond the current health concern. The nurses in this study

went on to include considering the effects of incarceration as being another important component of this theme.

Considering the effects of incarceration meant that within a correctional facility there was a limit to what healthcare staff and patients could do to improve their health and wellbeing. Just as privacy was restricted by the physical institution, there are elements of the experience of incarceration that are embedded in the system. The physical and social environments of these institutions storm the senses: the food tastes different, there are loud noises such as doors slamming or inmates yelling, the cells are made of concrete so feel different, as do the bunks patients sleep on, even the look of the living unit is generally stark and unwelcoming. Facility rules mean that patients are expected to be obedient and may be locked up for extended periods of time in small space potentially with a stranger for a roommate (Doyle, 1999; Mollard & Brage Hudson, 2016; Nurse et al., 2003).

Women who are incarcerated may be far from family or support networks as there are fewer facilities in Canada that house women (Caufield, 2016; Nurse et al., 2003). Increased distance from family and support networks requires women to rely on telephones or video calls for contact. Maintaining regular contact with children, family and even their legal team can be challenging as they must queue for access to telephones or other technology (Nurse et al., 2003). These challenges take a toll on the mental health of incarcerated women (Caufield, 2016).

For women with pre-existing medical or mental health concerns, their vulnerability within the correctional facility increases just by the existence of those conditions (Hatton et al., 2006). In fact, Awofeso (2010) identified that the prison setting itself exacerbated health conditions, proposing that prison be considered a social determinant of health. Thus, the participants and the literature acknowledge that nurses should look at the whole person,

including the current correctional environment, when caring for women who are incarcerated, (Mollard & Brage Hudson, 2016).

By acknowledging the effect of the facility on the patient, the participants in this study conceded that there were elements of the patient's health that could only be improved by leaving the facility. Furthermore, the participants identified that seeing beyond the clinical task encompassed identifying and accepting what was within the nurse's control to change. Since the environment and the female patients' health history could not be changed, how the nurse interacted with the patient was one of the few factors totally within the nurses' control. For all of the participants, that meant treating the women as humans.

The participants in this study were unanimous that a part of correctional nursing was to be non-judgemental in their care of women who were incarcerated, which is also well documented in the literature (Dhaliwal & Hirst, 2016; Doyle, 1999; Flanagan & Flanagan, 2001; Mollard & Brage Hudson, 2016; Weiskopf, 2005). As the participants identified that being unbiased in nursing care was a choice made every day, it follows that it is easier to provide unbiased care when the nurses holistically see the female patients, including the effect of the correctional environment. To provide unbiased care is to acknowledge how each woman is unique and requires individualised healthcare.

Seeing beyond the clinical task is a convergence of interpersonal relations and cultural safety. Interpersonal relations posit that nurses have full knowledge of their patient's health condition and of them as a person (Peplau, 1997). Likewise, cultural safety expects nurses to accept patients' identities as they define it, embracing differences and providing healthcare individually (Ramsden, 2002). Consequently, seeing beyond the clinical task encompassed seeing the total experiences of the patient and choosing to accept the patient for who they are in the moment, without judging them on their past actions.

What are the core values of nurses working in corrections?

Three themes were developed through the analysis to explain the core correctional nursing values held by the participants: being an expert, moments of opportunity, and building the patient up.

Being an Expert

Being an expert is a theme which reflects the roles correctional nurses hold in their work and the way the roles fit into the therapeutic relationship. The participants were clear that it was vital to be up front with the patients regarding the nurse's scope of practice, especially because being transparent was critical to creating and maintaining professional boundaries. Boundaries define the border between two spaces, usually referring to the professional and personal selves for nurses and other health professionals (Adshead, 2012). Healthy boundaries exist when the nurse keeps the focus on the client and their healthcare needs or goals, and does not disclose details of their personal selves (Peplau, 1988; Peternelj-Taylor & Yonge, 2003).

Within correctional healthcare scholarship, boundaries have been described as one of the most vital competencies for nurses working in forensic and correctional settings (Peternelj-Taylor & Yonge, 2003; Pettman et al., 2019; Schafer & Peternelj-Taylor, 2003; S. Smith, 2021). The issue of boundaries in correctional nursing is well documented in the correctional nursing literature and is closely connected to the care versus custody conflict. The discussion of boundary crossing generally centres on two matters: the context of personal boundary crossing and violations between correctional nurses and their patients (Cook et al., 2019; Peternelj-Taylor & Yonge, 2003; Schafer & Peternelj-Taylor, 2003); and when nurses drift from the role of healthcare provider to the role of officer (Doyle, 1999; Doyle, 2002; Holmes, 2002; Holmes, 2005; Jacob, 2014; Kennedy, 1975; McNiff, 1973). However, in this

study the discussion of boundaries revealed what the participants thought the patients believed of the nurses' role in correctional healthcare and touched on nurses blurring their role with officers.

Nurses hold many roles in healthcare (Peplau, 1988). Some are roles are defined by the nurses themselves and others are defined by the patient. In this study the participants identified two roles that they believed were influential to the therapeutic relationship. First, correctional nurses had a gatekeeper role in that they had the power to decide whether the female patients had a concern that justified an appointment and which prescriber the patient could access. This contrasts with the community setting where patients select their own prescriber and make appointments independently without having to go through another person. In studies with women who were incarcerated, patients have also described nurses taking on a gatekeeper role and having the power to control access to prescribers (Condon et al, 2007; Plugge et al., 2008). The second role identified by the participants was that of a messenger, communicating decisions and being blamed when those decisions were negative. This role has not been described in the correctional healthcare literature.

Nurses hold many roles in their professional lives. Among the many roles is the role that allows them to enter their patient's lives, bestowed by the health system that confers professional power (Ramsden, 2002). Once inside a correctional facility, that professional power is magnified by the justice system. When the participants and the literature described the gatekeeper role it confirmed that patients had lost some autonomy to manage their own health. For patients, the gatekeeper role invests some of the principles of the justice system into the correctional nurse, making the gatekeeper a surrogate role. Peplau (1988) identified the surrogate role as one kind role patients place on nurses where the nurse symbolizes another person. Patients thus relate to the nurse in the context of the other relationship,

instead of relating to the nurse as an individual (Peplau, 1988). It is possible that when a correctional nurse acts as a gatekeeper the patient is reminded of the actual gatekeepers in the facility, the correctional officers.

The role of messenger is another surrogate role that reflects the correctional officer. When delivering unwelcome news, the nurse may be seen as the representative of the power held by the system. Officers uphold the rules of the facility and the justice system, they are the embodiment of that power. In the framework of a surrogate role, nurses as messengers may become the embodiment of the combined power of the healthcare and the justice systems. Meanwhile the individual nurse struggles as they are criticized for decisions out of their control.

Despite that frustration, Peplau's interpersonal relations does expect nurses to be aware of the roles cast onto them by patients (Peplau, 1988). However, Peplau also believed that through these surrogate roles nurses can help patients learn as they move through roles on a continuum (Peplau, 1988). Peplau framed this process as acknowledging the roles cast by a very ill patient onto the nurse while they help the patient get well. In the correctional setting, nurses can acknowledge that patients may have cast the role of officer onto them, but it is possible to work through this role on a continuum with the incarcerated patient. In the orientation and working phases of interpersonal relations, correctional nurses act as experts when they identify their scope of practice and set boundaries. Even during frustrating moments as described by the participants, they also described working through the surrogate role with the patient. While correctional nurses may not be helping very ill patient get well as hospital nurses do, they do help patients move through the correctional healthcare system, and by building trust with the patients they have the opportunity to delineate their surrogate roles away from those of the correctional officers.

Both the gatekeeper and messenger roles exacerbate the power imbalance inherent in the correctional nurse-patient relationship. This will be discussed more shortly; however, at this time it is important to be aware that in being an expert in the correctional setting the nurse carries more power than in other settings. Some of this extra power is conferred by the justice system, while another part of it may be perceived by the patient. By drawing boundaries around their scope of practice, correctional nurses can lessen the influence of these two surrogate roles.

Another aspect the participants identified as part of being an expert was to present themselves as an equal to the patient. In this study, being an equal to the patient was meant to acknowledge the heightened power imbalance present in the correctional nurse-patient relationship and a way to lesson or address that imbalance. The participants spoke of two issues in relation to this power imbalance. First, that it was easy to exploit the power imbalance in how they talked with the patient. The participants felt it was easy to belittle the patients. An example of this is in the literature is whether correctional nurses use the terms ‘inmate’ or ‘offender’ which are inherent in the correctional environment. The challenge for nurses is whether it is professionally and ethically appropriate to use these terms versus ‘patient’ or ‘client’ and what the expectations are from the employer. The literature reports significant effects on the nurse-patient relationship when the terms ‘inmate’ or ‘offender’ are the norm. Peternelj-Taylor (2004) argued that when nurses use these terms it changes the therapeutic nursing role to one of a guard. Furthermore, when a term like ‘inmate’ or ‘offender’ is used, it removes humanity from the patient and detaches the nurse from the therapeutic relationship (Lowdell & Adshead, 2009). When this happens, the type of care the patient receives changes (McNiff, 1973). The second issue on power imbalances from the participants was that the patients often came from multiple past experiences of powerlessness with a variety of other organisations. The participants discussed how important it was to use

language that was casual and echoed equality with the patients because formal language was a reminder of past experiences with authority figures.

While this study did not focus on the language used by correctional nurses in their practice, a cursory review of how the participants referred to the women who are incarcerated will provide some insight into the nurse-patient relationship and how correctional nurses could be the equal of the patient. In this study, the words ‘inmate’ and ‘offender’ were used 77 times by the participants, while ‘patient’ and ‘client’ were used 573 times. Indeed, all participants used ‘patient’ or ‘client’ during the majority of the interview. By refraining from using ‘inmate’ or ‘offender’ the participants were using the same language used by nurses in other healthcare settings, undercutting the potential to belittle the patients further than they may already have been through incarceration. In the correctional setting, the participants were perhaps unknowingly reinforcing the therapeutic nursing role, instilling humanity and subconsciously ensuring the patient receives appropriate nursing care (Lowdell & Adshead, 2009; McNiff, 1973; Peternelj-Taylor, 2004). Cultural safety did not speak to language precisely, but the practice of culturally safe nursing does encompass a caring language, and the exclusion of communication that puts patients down (Ramsden, 2002). Furthermore, cultural safety speaks to these kinds of interactions by drawing attention to the quality of healthcare relationships and how marginalized patients can be obstructed from engaging when they do not feel safe with the nurse (Ramsden, 2002). Hence, when the participants acknowledged where the power existed and materialised, they were being honest with where they felt their professional boundaries should be and how they could engage effectively with female patients.

Moments of Opportunity

Moments of opportunity was another way the participants expressed the core values of correctional nursing. Moments of opportunity had three features: building trust, offering patients something to give them ease and teachable moments. The participants in this study were adamant that trust was crucial in the correctional nurse-patient relationship, and they reported trust developed over time through small interactions.

One study indicated that patients must approach the healthcare relationship by trusting the nurses because they have no other option if they want help (Schafer & Peternelj-Taylor, 2003). The same study reported that patients build trust by testing staff, which included monitoring for congruency between a healthcare provider's verbal and nonverbal communication. Other studies have shown that patients build trust through open and honest interactions with healthcare staff, especially when they feel listened to and cared about (Condon et al., 2007; Mollard & Brage Hudson, 2016; Schafer & Peternelj-Taylor, 2003; Young, 2000). Urbanoski et al. (2020) also reported that patients who use(d) illicit substances placed a high value on trust and professionalism in the therapeutic relationship. These studies corroborate what the participants reported.

The nurses in the current study all discussed that it was imperative to be truthful and transparent with the female patients to build a positive therapeutic relationship. The participants acknowledged that the female patients were more likely to have lacked trust in past relationships or had previous bad experiences with the healthcare system. They expressed that by being consistently honest and transparent in their nurse-patient interactions they could open the patients up to the health system, which would improve the health of the patient. Patients must trust nurses if they want to address their health care, but in those interactions the patients are testing the nurses to see if they can be trusted. When the

participants reported consistently acting truthfully, they were passing the test put to them by the women. Thus, the participants earned the patient's trust through honesty, professionalism, and small moments of opportunity.

Besides building trust over many small interactions, some participants talked about providing care that went beyond the normal routine. These were opportunities to give the patients ease. The nurses who talked about this saw these moments as a time to connect with the women and demonstrate unbiased care. These moments to provide some ease are examples of when nurses would make female patients feel listened to and cared about.

Building trust and providing some ease to the patients had the potential to culminate into teachable moments. The participants believed that when trust underpinned the therapeutic relationship opportunities arose for health teaching that the patient could take with them either back to the living unit or into the community. These opportunities were seen as addressing a healthcare issue that was important to the patient, not simply what the nurse saw as the priority.

There is nothing in the literature that specifically speaks to the impact of small moments of opportunity. Nor is there evidence that these small opportunities are remembered later and help female patients in future correctional health situations. Yet, many of the participants were adamant that building trust over time would be remembered by the women who would then be open to care in the future. There is correctional literature which notes that women who are incarcerated seek healthcare professionals who are non-judgemental and supportive (as demonstrated by trust building) (Ahmed et al., 2016a & b; Plugge et al., 2008; Young, 2000). Furthermore, when a supportive healthcare environment exists that fosters the dignity and respect of women who are incarcerated, the behaviours of these women are altered (McPhail, 2012). However, in the context of this study it can only be gathered that the

participants were experiencing a positive moment in the nurse-patient relationship. By engaging in short, seemingly simple and guileless interactions that appear to be social in nature (as opposed to healthcare driven), the participants were reflecting some of the basic principles of Peplau's interpersonal relations. These moments built positive verbal and non-verbal interactions, and demonstrated caring behaviours (Gastmans, 1998). Moreover, by actively pursuing these small moments, the correctional nurses demonstrated awareness of their patients' full condition (Peplau, 1997), such that the participants believed through anecdotal evidence that these interactions improved the well-being of their patients. Peplau believed that ignorance of the patients or indifference toward them had no place in the nurse-patient relationship (Gastmans, 1998), and by pursuing these moments of opportunity the participants were signifying a similar value in their own professional relationships.

Comparably, cultural safety speaks to the value of these small moments of opportunity. Cultural safety was built upon the effects of negative interactions between Indigenous and other marginalized people and the New Zealand healthcare system: revealing that negative interactions drove marginalized patients away from the healthcare system (Papps & Ramsden, 1996; Ramsden, 2002). In this case a connection was drawn between the individual nurse-patient relationship and the wider effects on the healthcare system. Again, the same connection is not suggested in this study. Thus far, what can be noted is that if the participants were able to build trust with patients through these small moments, they succeeded in the "professional acquisition of trust" (Ramsden, 2002, p. 118). Cultural safety sees the acquisition of this trust as influencing future nurse-patient interactions, encouraging a feeling of safety on the part of the patient and hopefully leading to the patient sharing their whole self with the nurse (Ramsden, 2002). The reflections of this study's participants coupled with the existing literature suggest that positive interactions with nurses, especially with many nurses over many interactions, have the potential to encourage greater engagement

with nurses. This is certainly an area of correctional nursing that could benefit from more investigation.

Building the Patient Up

Building the patient up is the final theme that informed the core values of correctional nurses. Building the patient up occurred through three activities: meeting the patient where they are at, promoting patient autonomy and providing hope.

Many participants saw meeting the patients where they are at as the first way to empower the patients. This activity was an opportunity for the participants to accept the female patients as they presented, without imposing the perspectives of the nurse onto the patient. Meeting the patients where they are at was one way the participants described unbiased care in action; in essence they put seeing beyond the clinical task into action. The nurses would accept the patients as they were, listening to what the patients' goals were adopting a shared decision-making model of care regarding the patient's health. Moreover, the participants were recognising the power imbalance between themselves and the women, giving the women the ability to claim and exercise their power in that moment, putting cultural safety into practice. This activity was the foundation for promoting patient autonomy.

Patients in correctional facilities lack full personal autonomy by the nature of the system. As mentioned previously, the patients are not in the position to completely attend to their health needs independently (Condon et al., 2007). At the same time, access to prescribers and other healthcare staff is controlled by both nurses and correctional officers (Condon et al, 2007; Hatton et al., 2006; Plugge et al., 2008), both of which erodes the patient's ability to be fully responsible for their own health. The participants gave examples of promoting autonomy such as negotiating how treatments or medications would be

completed. Some participants expressed that listening to the patients talk about their health as one of the most significant ways to promote autonomy within a correctional centre. By listening the nurses were showing respect for the women and reinforcing that despite being incarcerated they were valuable people who could make decisions about their lives and health. Some of the nurses in the study acknowledged that patient autonomy was difficult to promote due to the paternalistic nature of the correctional milieu. However, for most participants promoting autonomy was an important element to reach the goal of better health for the female patients. Peplau supported investing as much autonomy in the patient as possible, thereby reducing dependence and encouraging the patient to make their own decisions (Gastmans, 1998). There is little in the literature that speaks to promoting patient autonomy with patients who are incarcerated. Mollard & Brage Hudson (2016) examined Trauma Informed Care in the correctional setting, recommending that nurses invest responsibility for personal health in female patients and to encourage the women to make decisions.

The third activity that was part of building the patient up was providing hope. The nurses in this study identified two ways in which hope was offered. The first path was through the potential positive impact that incarceration could have on the health of the women. The participants identified that for some women being incarcerated was a chance to have basic needs met and to access health care in a single place. This is somewhat contentious as other participants identified correctional facilities as detrimental to women's health. The literature is similarly divided. Some studies have reported that incarcerated patients see correctional healthcare systems as the chance to improve their health (Ahmed et al., 2016a & b; Condon et al., 2007); while there is at least one study that reports the opposite (Sered & Norton-Hawk, 2019).

The participant's belief that incarceration could have a positive impact on the health of the women speaks to more than access to healthcare. One participant described building the patient up as an opportunity for the female patient to become a new person. This reflects the presence of preconceptions and stereotypes in the correctional nurse-patient relationship. Within the context of Peplau's interpersonal relationship (Peplau, 1997), the participant signaled that they continue to hold preconceived ideas about their female patients. This may be seen as contradiction with meeting the patients where they are at; however, it can also be seen to reflect the reality that is nursing. While Peplau did not see these preconceptions and stereotypes as dominant in the nurse-patient relationship, she did acknowledge their presence was important to how the relationship formed and progressed (Peplau, 1997). Parallel to this is how cultural safety saw these preconceived ideas as central to the nurse-patient relationship, reflecting the power imbalance that persists. The goal to make the patient into a new person speaks to the conditioning of correctional nurses (Ramsden, 2002). From both frameworks, correctional nurses are challenged to examine how their perceptions of health goals differ from their patient's perceptions and what that means to their practice. When the participants speak of meeting the patient where they are at, they reflect shifting the power back to the patient.

The second path that could give hope to incarcerated women was in celebrating patient's achievements. The participants stated these celebrations did not happen often and were in the context of younger female patients, but it does reflect the positive impact of building trust with the clients that would allow the participants to share in their patient's success. Overall though, there is little in the literature to support how or whether nurses can provide hope to women who are incarcerated.

While the participants in this study sought ways to promote hope and autonomy while accepting whatever the patient could give (meeting them where they are at), the nature of the justice and healthcare systems in correctional facilities means there is a fiduciary duty to attend to health concerns. In extreme cases, deteriorating patients who reject healthcare will be transported to the hospital and the transfer of care cannot be refused by the patient. The participants highlighted the compounding positive effects of building the patient up when correctional nurses work together in same direction to make the health experiences of female patients better. This is another area that has not been explored in the correctional literature as the focus has been on the relationships between individuals.

How do the nurses describe nurse-patient relationships?

In analysing the data in this study, it was clear that nurse-patient relationships were complex relationships. These complex relationships had three intersecting factors: the setting of correctional facilities, the individuals within the relationship, and the process of acculturation that correctional nurses experience.

Complex Relationships

The Setting. Peplau discussed the hospital setting as part of the orientation phase of interpersonal relations (Peplau, 1988). The hospital has its own "cultural boundaries" (Peplau, 1988, p. 26), in effect rules of behaviour that marked clear expectations for the patient. It was during the orientation phase that the nurse was expected to familiarise the patient to this new culture and setting to decrease their anxiety, which would help them productively deal with the health issue at hand (Peplau, 1988). When women go into a correctional facility they enter a setting where they lose most of their control and agency, with distinct expectations on behaviour. Then, if and when the women engage with

correctional healthcare and nurses, they encounter another set of rules that lie somewhere between healthcare and justice. The participants rarely spoke of orienting patients to the healthcare environment, although a few did mention giving patients advice on how to make their time in the facility better but this was mainly in the context of advice on how to interact with officers. It was evident in the interviews that the participants were not able to engage in the general discussion of the healthcare environment that characterises the orientation phase of Peplau's theory. Thus, a key element that builds the nurse-patient relationship could be missing. Furthermore, the setting frequently places an officer as a step between patients and nurses (Doyle, 1999; Schoenly, 2013; Shelton, 2009), allowing officers to influence the healthcare relationship. Overall, the correctional setting is influential in the work of the nurses.

Participants described the weight of the correctional setting in their relationships with patients. As one participant in this study noted, the buildings themselves projected negative emotions which seeps into patients, nurses and officers affecting how they live and work. Upon entering a facility, the patient loses liberty, autonomy, and their support network, becoming alienated and disempowered (Condon et al., 2007; de Viggiani, 2007; Doyle, 1999). While living in a correctional facility, patients lose control over their daily life, conforming to rules that prescribe when they eat, exercise, shower and sleep (Gilbert, 1997). The loss of personal autonomy extends to patients being denied access to basic coping strategies such as walks, baths, or a quiet environment to focus and meditate, as noted by another participant in this study. The result for the patient is often a worsening of their physical and mental health (Maxwell, et al., 2013; Mollard & Brage Hudson, 2016). Kouyoumdjian et al. (2017) found that incarceration accelerated aging in adults, with higher mortality rates for women who were incarcerated. Thus, it is not surprising there is an air of

negative emotions present in correctional facilities. These negative emotions do not just affect the patients.

Compounding the weight of the correctional facility is the priority of security over healthcare as identified by the participants and the literature (Dhaliwal & Hirst, 2016; Dhaliwal et al., 2021; Droes, 1994; Flanagan & Flanagan, 2001; Peternelj-Taylor, 2004; Solell & Smith, 2019). For the nurses in this study, security as the primary concern compromised privacy and confidentiality in therapeutic relationships because it introduced a third person into the nurse-patient relationship. All of the participants' reported officers were present for all healthcare interactions, though their presence could be at a distance or through audio / visual technologies. The same is reported in the literature (de Viggiani, 2007; Dhaliwal et al, 2021; Doyle, 1999; Solell & Smith, 2019). Furthermore, some participants reported the officers' control whether, when, and for how long a nurse can see a patient.

It is expected officers control the environment, including inmate movement throughout a facility, the living units, and who has access to units and inmates. However, this control means they also control nurses' movements and when they can access their patients (Doyle, 1999; Shelton, 2009). Because the safety and security of staff and inmates is paramount (Schoenly, 2013), the officers also have the ability to control how long a nurse-patient interaction lasts or sometimes whether a patient sees the nurse at all. Just as nurses were gatekeeper to physicians, studies have reported that officers were gatekeepers to nursing care by having verbal and written requests go to correctional offices before healthcare staff (Hatton et al., 2006; Plugge et al., 2008). For nurses in this study and in the literature, this hampered the nurses' ability to adequately advocate and care for patients (Solell & Smith, 2019).

Thus, the setting that is the correctional facility becomes what I term a silent majority stakeholder in the nurse-patient relationship, changing the dynamics not only by interfering in the course of the therapeutic relationship but by introducing a third person.

Individual. In analysing the interviews with the participants, it became clear that most nurse-patient interactions involved three people as the correctional officers were present in all interactions in various forms. In this section I will discuss a proposal to re-imagine the nurse-patient relationship as a triad, a nurse-patient-officer relationship.

The Patient. The patient in the triad is the focal point in the relationship, but they are the most vulnerable and have the least power. Both interpersonal relations and cultural safety frameworks view the needs of the patients as the priority where the nurse has the greater responsibility to create a safe situation and support the patient to their fullest (Gastmans, 1998; Ramsden, 2002). Additionally, Peplau believed that patients express themselves within the context of relationships with others (Gastmans, 1998), which will be altered as the nurse-patient relationship becomes a triad in correctional facilities.

The participants in this study noted that patients were generally less likely to disclose personal health information when an officer was present, either because they did not want an officer to know their personal knowledge or because they were afraid of punishment from disclosing activities such as in centre drug use. This has also been noted in Dhaliwal et al.'s (2019) study of nursing practice in correctional facilities. The literature reports that to overcome this, patients have been known to choose open spaces when officers are not present to discuss their health with nurses (Condon et al., 2007; Plugge et al., 2008). Unfortunately, this means that patients must choose between officers or their peers as to who may overhear their private health conversations. By conceiving the therapeutic relationship as a triad,

correctional nurses must continue to support the patient in an environment in which patients may or may not disclose important information.

Participants in this study also noted that some patients were known to act differently with officers than nurses, sometimes so aggressively that officers would deny or postpone interactions with the nurse because safety was a concern. Other times, the participants observed that the effect of negative patient-officer relationships was that the patients distanced themselves from the nurse-patient relationship. These are reflections of Peplau's assertion that patients express themselves within the context of relationships with others (Gastmans, 1998). Correctional officers are tasked with ensuring the safety, security, and control of their facility, a relationship that is generally described as adversarial but does not have to be (Gilbert, 1997). The sum effect of many hours of interpersonal interactions between officers and inmates is what creates either an adversarial or cooperative relationship (Gilbert, 1997), and this relationship spills into the nurse-patient relationship.

From a health point of view, the goal for both the nurse and the officer should be to either maintain or improve the mental and physical health of the incarcerated person because neither wants them to decompensate or die. However, it is clear in the literature that officers do not necessarily share that goal and may not find value in the work of correctional nurses (Almost et al., 2020; Dhaliwal et al., 2021; Droes, 1994). When the work of healthcare is devalued, the outcome for the patient is poor. Just as a negative officer-patient interaction was noted to have poor therapeutic outcomes, the participants in this study observed there were some officers who built a positive relationship with incarcerated women which improved the nurse-patient relationship and increased patient outcomes. In this instance, patients had been known to call the involvement of officers and nurses their team. Droes (1994) and Weiskopf (2005) found similar findings in their studies on correctional nursing

practice. Overall, it is evident that whether an officer is physically present or at a distance, they have an important impact on how patients view and interact with nurses. Hence, we can begin to see how this triad forms in correctional centres.

The Nurse. In the triad the nurse is a participant that is at once powerful and vulnerable and holds the greatest responsibility to make the triad function.

As discussed, the participants described nurses in the roles of gatekeeper and messenger. In relation to the patient, the gatekeeper role gives nurses the power to control access to healthcare. This is in addition to the power held by the nurses by the nature of healthcare and compounded by their position in the correctional healthcare system (Condon et al, 2007; Dhaliwal & Hirst, 2019; Flanagan & Flanagan, 2001; Plugge et al., 2008). As messengers, the participants described having information that the patient wants to know, such as decisions on requests to prescribers. While the participants saw this role in a negative light, it did add to the power they already had bestowed by the correctional healthcare system.

Within the triad, nurses are also in a position of vulnerability. Officers control access to patients, including how much time nurses can spend with the patients. One participant told of an encounter with a patient that was halted by an officer to enforce a rule unrelated to health. This was distressing to some participants because it made proving healthcare more difficult, sometimes halting care all together. Furthermore, some participants did acknowledge that the presence of an officer altered how they interacted with patients. A few nurses reported they would not always enquire about a patient's health in the same way when an officer was present, in the same way other female patients were less willing to disclose information with officers present.

It is clear then that the lack of privacy has an important impact on the delivery of healthcare in correctional facilities. The participants in this study have reported frustration over a lack of private places and how the presence of an officer changes how they provide nursing care. There is a great deal of discussion in the scholarship over the caring versus custody quality of correctional nursing, which explores how nurses negotiate the competing goals of nursing and security (Almost et al., 2020; Choudhry et al., 2017; Flanagan & Flanagan 2001; Holmes, 2005; Holmes et al., 2007; Maeve & Vaughn, 2001; Peternelj-Taylor, 2004; Schafer & Peternelj-Taylor, 2003). While this scholarship is cornerstone in the correctional nursing discourse, it does not form part of this discussion. However, I will propose that nursing actions such as altering how conversations with patients about health are conducted may be an example of how the custody and caring challenge is handled in practice. What is evident from this study is that when an officer was present the participants did not feel free to act within the full scope of their respective role and they believed the patients did not feel they could be fully engaged and open with their concerns.

I have proposed the nurse-patient relationship is in practice a triad that includes the officers. Within this triad, I also propose the nurse hold the greatest responsibility to ensure it functions. Peplau's interpersonal relations and cultural safety frameworks are the theoretical underpinnings of this study, and both place the responsibility for the nurse-patient relationship onto the shoulders of the nurse (Peplau, 1988; Ramsden, 2002). Similarly, the participants in this study discussed the importance of having good relationships with the officers to be able to complete their nursing care. The correctional healthcare scholarship also recognises that the relationship between nurses and correctional officers is critical to correctional healthcare, and the responsibility for a cordial relationship rest with the nurse (Maeve & Vaughn, 2001; Shelton, 2009; Weiskopf, 2005).

The importance of collaborative relationships is not unique to correctional healthcare. Stein-Parbury & Liaschenko (2007) noted the more critically ill a patient was the more there was a need for a collaborative nurse-physician relationship within the Intensive Care Unit (ICU) setting. Collaboration refers to collectively moving toward a common goal that involves respect, mutual responsibility and open communication (Stein-Parbury & Liaschenko, 2007). The correctional setting and the complexity of incarcerated patients points to the need to having a similar collaborative relationship between nurses and correctional officers. However much a collaborative relationship would keep the focus on the patient in the triad, but the health and justice systems have not yet been able to openly share a common health goal or a willingness to collaborate in the direction of healthcare beyond that of keeping patients alive (Martín-Rodríguez et al., 2005). Thus, as the participants in this study described, correctional nurses take on a great deal of responsibility in managing the nurse-officer relationship to achieve the healthcare goals of the patient.

The Correctional Officer. In this study when the participants spoke of their interactions with patients they talked of the presence of officers in various forms, such as being physically present, close by the treatment area, or just having ears on the situation. Previously, I have examined how there is little physical space for privacy in correctional settings and that when correctional officers are present, patients and nurses change how they interact to account for the presence of a third person. In this section I will look further into the impact that officers have on the nurse-patient relationship. It is important to keep in mind that in imagining the nurse-patient relationship as a triad, officers have the least involvement in health but hold most if not all the power.

The participants in this study provided examples of how officers interacted with nurses and patients, which fall into three rudimentary functions in the triad relationship. The

first function was to ensure the safety of the nurse when they were engaged with patients in healthcare. Participants described how officers interrupted interactions when they perceived the patient to be acting inappropriately. The participants described being disappointed because the interruption would endanger patient health and it undermined the nurse's skills in managing the therapeutic relationship. Equally though, the participants acknowledged that the officers were there to keep nurses safe. In the triad it seems that nurses and officers are struggling to manage the same situation from their different points of view. However, because correctional officers have the duty to maintain the safety and security in the facility that is their locus of control, they step in when they perceive a threat.

The second function the participants described was that of hindering patient care. Participants described officers interrupting care to enforce a facility rule that was unrelated to health or safety. These interruptions not only changed the quality of the therapeutic nurse-patient interaction but undermined the value of health care in correctional facilities. One such interaction was described by a participant as the patient engaging in 'splitting behaviour,' which refers to seeing another person as either all good or all bad (Shahrokh & Hale, 2003 as cited in A. Smith, 2021). In this interaction the officer was cast as all bad after halting the nurse-patient interaction and reinforcing how little power the patient had in the correctional setting. While this was a single case in the study, it does also allude to Peplau's aforementioned belief that patients express themselves within the context of relationships with others (Gastmans, 1998). Thus, when an officer hindered patient care in the triad, the patient reacted within the triad by casting the nurse and officer in simple roles of good or bad. In this case, while the value of healthcare was undermined, we cannot know if the officer's behaviour influenced the patient's perception of the nurse or whether it had any impact on the nurse-patient relationship.

Another participant described how officers had their own view of patient's behaviours and illnesses, using their own perception to decide who was deserving of healthcare. The participant described situations in which officers viewed a patient experiencing active psychosis as simply inappropriate behaviour underserving of nursing care that was handled by locking the patient up. The participant expressed how these situations created distress for them, as well as harming the mental health of the patient. While situations such as this are not evident in the literature, research does speak to officers having a gatekeeper role to healthcare where patients must submit requests to officers before they can see a nurse (Hatton et al., 2006; Suarez, 2021).

Participants in this study described a variety of health goals held by women who are incarcerated. When officers step in to ensure safety or hinder patient care, they are interfering with the achievement of the patient's health goals. This interference was addressed by Peplau (1988) in interpersonal relations. She described that when goals are interfered with, the patient become frustrated; and in this study the participants also described being frustrated. Peplau (1988) described that frustration in achieving health goals can give rise to patient aggression in a variety of forms. She described aggression in adults as being less direct in how it is expressed; however, within a correctional facility aggression can come out very directly. The participants in this study gave examples of both direct and indirect expressions of aggression. Frequently, the frustration and aggression were directed at the officers, but the nurses also had to contend with the situation and the change in the therapeutic relationship. As well, when patients show their frustration and aggression directly, it supports officers in continuing to take over the management of nurse-patient interactions. Hence, in correctional settings it is important to include the officers in the nurse-patient relationship as they can be obstacles to goal attainment for the nurse and the patient.

The final function in the triad was more positive, in which officers promoted better healthcare for the patients. Many participants expressed positive experiences when officers encouraged patients to talk openly with nurses or helped patients express their concerns. Moreover, some participants reported the officers had an important role to play in monitoring patients for changes in their health. These three functions that have come out of the analysis in this study reflect an early study on officers' perceptions of healthcare. Droes (1994) discussed officers' perceptions of healthcare falling on a continuum from contentious to considered tolerance, or to put it another way is they see nurses as either an interference or beneficial to their work. When officers fall into the contentious category, facility rules will be prioritized in almost all situations. For those officers who fall into considered tolerance, the health of patients is more highly ranked. For example, participants were able to identify that when officers had good relationships with nurses and patients, they became a front-line warning system for decompensating patients.

Stein-Parbury & Liaschenko (2007) referred to 'patient knowledge' as the ability to understand an individual's experience of disease that is not meaningful outside a specific context. It requires proximity to the person's care over time so comparisons can be made, and interpretations suggested. This is the knowledge that may be thought of as nurses being the eyes and the ears of physicians (Stein-Parbury & Liaschenko,2007). Patient knowledge is traditionally held by nurses, however because correctional officers spend so much time with inmates on living units some of this knowledge is invested in them. Hence, correctional officers hold a position usually attributed to nurses, and act as an early warning system. This shift in traditional knowledge keepers blurs the relationships within the nurse-patient-officer triad.

This study did not explore the relationships between correctional officers and patients specifically, instead I will look to the literature to better understand how these relationships contribute to the triad. Gilbert (1997) discussed how the work produced by correctional officers is not safety and security but is "personal interactions between themselves and inmates" (p. 53). Hence, safety and security become a by-product of those interactions. To achieve this by-product, correctional officers use interpersonal relations to get inmates to comply with the least confrontation as possible. Gilbert went on to explain that verbal skills, leadership and coercive authority achieve the voluntary collaboration of incarcerated adults. However, within this officer-patient relationship there is the consideration that officers must also be suspicious of patient's activities to maintain security within the facility (Maeve & Vaughn, 2001). This sets the stage for a complex relationship that can be both adversarial and collegial (Foster et al, 2013; Hatton et al., 2006; Nurse et al., 2003; Suarez, 2021).

Clearly, the triad relationship is a very complex one. Patients interact differently with nurses and officers, as do the nurses. Whether officers also interact differently with nurses and patients has yet to be explored. The only role that is clearly defined is that of the patient. Nurses do not fully act as they would due to the setting – the silent majority stakeholder. The setting places officers in a position to hold patient knowledge, usually the responsibility of nurses, while working to achieve their own responsibilities of safety and security. Inmate's report feeling like they are being treated like children after incarceration has rendered them mostly dependent on the system (de Viggiani, 2007). For women who are incarcerated, they are constantly reminded not only of where they are but also of their lack of autonomy and value. Nurses must also follow the rules of the justice system, becoming dependent on officers to access their patients (Doyle, 1999; Shelton, 2009).

Neither interpersonal relations nor cultural safety touched on triad relationships. Peplau and Ramsden focused on the nurse-patient dyad, seeing others as either part of the patient or as outside of the relationship. However, I propose the role of the officer in attending to the patient's healthcare cannot be overlooked and must be included as a separate contributor. The officer holds too much power and control to be excluded. Moreover, the officers' impact on the other two members has so much influence that acknowledging their role would bring transparency to the therapeutic relationship. Thus, including the officer in the therapeutic relationship would be accepting the setting has an impact on everyone inside.

Acculturation. Nurses who work in traditional healthcare settings have their patients as their primary concern. However, within the correctional setting, nurses will face two pulls on their loyalty, an ethical dilemma in which nurses report feeling torn between their patients and the goals of the correctional facility (Simon, Beckman et al., 2020). In this study, well over half the participants remarked they were challenged by this pull on their loyalty. However, the intricacies of what drives this strain for correctional nurses is not clear. Some participants discussed feeling beholden to officers in order to have access to their patients, which I interpret as officers driving the question of loyalty by demanding allegiance. Yet, other nurses considered their awareness that officers are the ones who keep them safe in an unpredictable and potentially violent setting. Again, this could be interpreted as officers driving the question of loyalty or it could simply be awareness that nurses and officers are a team in maintaining safety for everyone. Within interpersonal relations and cultural safety the question of loyalty to the patient is not an issue, as in both frameworks the needs of the patient should be primary. However, when the nurse-patient relationship is conceived as a triad, loyalty does become an issue as long as the needs of the patient are in conflict with the goals of the officers. When nurses begin their employment in correctional facilities, they start a process that challenges who actually is their primary concern. This is a process of

acculturation that wants to make the goals of the correctional system more important to the nurse than patient care.

The concept of acculturation, that is the process of changing to become more like someone from another culture (Cambridge Dictionary, 2022), helps us to understand the journey of the nurse-patient relationship in correctional healthcare and why nurse-patient relationships are complex. Initially, newly employed nurses are oriented to the correctional facility with a security orientation that teaches never to trust incarcerated adults, to never let their guard down, and that inmates are master manipulators (Gorman, 2018; Jacob, 2012; Maeve & Vaughn, 2001). This is contrary to nursing education and ethics, but it is the cornerstone of the correctional system. New nurses are then taught and expected to uphold the ban on touching patients and sharing personal information, which are actions recognised in the nursing discourse as part of caring behaviours (Christensen, 2014; Flanagan & Flanagan, 2001; Maeve, 1997; Solell & Smith, 2019; Weiskopf, 2005). As every nurse-patient interaction has an officer present in some form this is like walking a tightrope.

As nurses go through their career as correctional health staff the challenge to walk that tightrope is never resolved. Many of the study participants shared examples of how they had to be careful in their interactions with officers, always reassuring the officers they were on their side while also being on the patient's side. The participants were honest in expressing that without the cooperation of the officers they could not complete their nursing tasks. Furthermore, some participants reported needing to maintain good relationships with officers to keep themselves safe in a volatile setting. The requirement to keep a colleague on their side was never anything that would have occurred to Peplau or Ramsden as they examined nurse-patient relationships. Both focused on how the nurse could cultivate positive relationships with patients to achieve positive health goals, acknowledging the challenges in

that relationship. It is clear from the participants that cooperation with officers was gained by tending to the nurse-officer relationship carefully, sometimes to the detriment of the nurse-patient relationship. Research has shown similar findings, such that empathy is discouraged, and nurses are encouraged to remain aloof and suspicious of their patients (Maeve, 1997). However detrimental, both the participants and the scholarship has identified that building these relationships were critical (Christensen, 2014; Maeve & Vaughn, 2001; Shelton, 2009; Weiskopf, 2005). Additionally, to cultivate good relationships with officers the literature discussed that correctional nurses sometimes take on a surveillance role and chose not to advocate for the patient for fear of offending their correctional nursing partners (Foster et al, 2013; Peternelj-Taylor, 2004). Instead of calling this acculturation it has been referred to as cultural migration by Cashin et al. (2010).

How then does the correctional nurse build trust in instances where they feel they must choose the officer instead of their patient? One perspective is to see building trust with the officers as a path to placing the patient first in their nursing practice. Many participants spoke about nurturing the relationship to protect their nurse-patient relationship. As well, by acknowledging the presence of the officer in the healthcare relationship it speaks to Peplau's understanding and knowing the whole patient since the officers cannot be divorced from the situation. It also speaks to cultural safety, correctional nurses can accept that because correctional officers form part of the system, they can shift the power back in favour of the patient by challenging officers to examine their own attitudes and not to blame patients for the historical and social experiences that frame their current circumstances (Papps & Ramsden, 1996, Ramsden & Spoonley, 1994). Nevertheless, the ever-present challenge to loyalty alienates the patient from the nurse, threatening a breakdown of the therapeutic relationship. When the participants described that they drifted closer to justice services it caused distress in their practice. Overall, the pressure to conform to the values and goals of

the justice system never ceases, putting pressure on the triad nurse-patient-officer relationship.

Complex Relationships Reimagined

The patient-nurse-officer relationship is a unique affiliation with few parallels in healthcare. The focus is always on the patient or inmate however with different lenses. Nurses want to have positive health outcomes and officers want patients to follow the facility rules. However, while the goals appear to be competing, they are not that dissimilar. The goals of the health and justice systems are entwined, they intersect. Likewise, any relationship between two of the actors in the triad affects the third. There is discourse from the nursing academy that explore the nurse-officer relationship, focusing on how to reconcile the custody caring debate in correctional nursing practice or how the therapeutic relationship is constructed between patients and nurses. To date there is no literature on the patient-nurse-officer relationship.

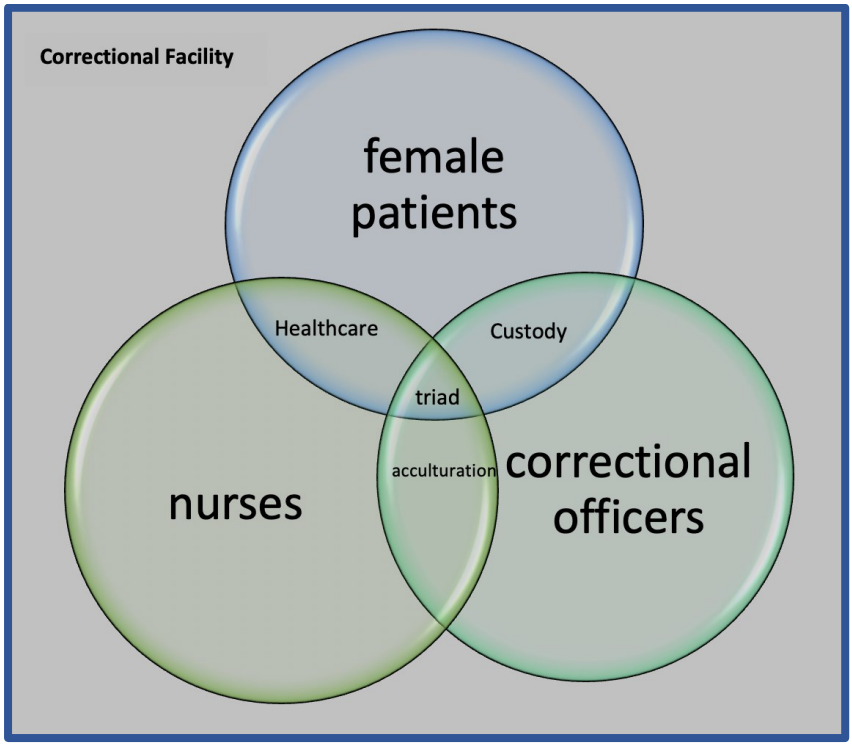
In looking to other fields to inform this relationship, I explored two other triad relationship. The first triad relationship is the student-parent-teacher relationship in education. The research on this triad has shown that positive collaborations between parents and teachers have an advantageous effect on children in both the home and school setting (Dawson & Wymbs, 2016; Mautone et al., 2014; Rimm-Kaufman et al., 2003; Serpell & Mashburn, 2012). Second, was the parent-nurse relationship in the Neonatal Intensive Care Unit (NICU) examined by Reis et al. (2010). This study developed the model of Negotiated Partnership as a framework for how NICU nurses and parents could build a relationship. While infants do not have the same participation as incarcerated women, parents and nurses have optimal care as the common goal and both parties must be present and willing to engage

in the relationship. It is also important to note that the safety of the patient and/or the public is not usually a central concern. What the participants noted in this study were the nursing actions of engagement, presence and guidance. Most interestingly, Reis et al. (2010) noted that the "astute and intuitive skills on the part of the nurse that were not quantifiable" (p. 680) were essential skills in building a positive relationship. This speaks to the skills already being brought to the correctional triad by nurses who cultivate good interactions with officers to meet their healthcare goals. Moreover, Reis et al.'s study reported that the NICU nurses set the tone in encouraging parents through physical and verbal nudges. While correctional nurses are not expected to nudge officers into caring for incarcerated women, this study demonstrates how nurses can take the lead in healthcare activities. There is little in the discourse that addresses taking the lead in the nurse-officer relationship beyond how correctional nurses can negotiate care versus custody in their personal practice.

While Peplau did not discuss relationships outside of the nurse-patient, she did briefly touch on how the entry of the physician can impact the nurse and the patient. Peplau considered the arrival of the physician can "determine the solidarity of their efforts" (1988, p. 59). Peplau described how mutual respect influences their efforts, but she also described how personal beliefs and attitudes about one another make a difference in the health outcome of the patient. Peplau (1988) felt that to improve the health of the patient required trust, respect and collaboration on the part of professionals. The participants in this study (and the literature (Droes, 1994)) reflect Peplau's beliefs, becoming frustrated when there is little collaboration and praising officers when collaboration is present.

What the correctional nursing discourse can take away from this body of knowledge is that it is time to think of correctional healthcare as "a set of interdependent systems that simultaneously exert their influence" (Serpell & Mashburn, 2012, p. 22) on the health of

women who are incarcerated. To best conceptualize these interdependent systems, the triad can be represented as a Ven diagram of connected circles living within the correctional facility setting. Where the circles intersect are separate realities. The intersection of nursing and female patients is where nursing practice lives, and where female patients and correctional officers intersect is where custody lives. The intersection of nursing and officers is where assimilation lives. The final intersection of all three is where the triad relationship lives, where all three actors come together to improve the health of incarcerated women.



Culturally Safe Correctional Nursing Care

Cultural safety was designed as a pedagogy and an educational model in Aotearoa/New Zealand to address the health inequities experienced by the Maori people. Over time, the model became intimately linked with Indigenous people, especially in Canada. However, the use of "culture" was never meant to be consideration of ethnicity alone, it was meant to encompass the historical and socio-political experiences of the patient/group with

who the nurse was working with (Ramsden, 2002). By encompassing the socio-political and historical experiences of the patient, cultural safety was focusing on the power differential between the patient and the nurse. Thus, the model was developed to be able to use with patient/group.

For most of the participants in this study, cultural safety continued to be linked to ethnicity and Indigenous populations. Only three participants saw cultural safety as including incarcerated women as a group, with their own socio-political and historical experiences that contributed to the power differential. There are two factors at play that I believe contribute to this construct of cultural safety among the participants. First, the model has become closely linked with Indigenous populations in Canada over the past two decades. To link cultural safety with Canadian Indigenous populations is appropriate, especially after the Truth and Reconciliation Committee released the Call to Action which included seven recommendations to improve the health of Indigenous people across Canada (Truth and Reconciliation Commission of Canada, 2015). However, this is a failing of cultural safety in Canada. It has excluded other marginalised groups that experience institutional and social racism within healthcare, and that experience has led to poorer health and a distrust of the system.

The second factor is that I believe the participants do not see the patients as a unique group, one that would require a culturally safe response. They saw that their patients required unbiased care and a holistic approach, but it was not a culture in the same way as Indigenous people are. We have not yet been fully successful in providing culturally safe care to Indigenous people in Canada despite the resources devoted to it. Learning to practice culturally safe nursing care is much more than “ticking a box,” it requires systemic change.

Since little attention has been given to other groups that would benefit from cultural safety, bringing this concept into the care of all incarcerated adults remains a challenge.

The danger in viewing culture as ethnicity is that it places the focus of cultural safety onto the patient and away from the nurse (Ramsden, 2002). The activity of cultural safety happens within the nurse. The model challenges the nurse to look inward, to be self-reflective and to alter their behaviours to meet the expectation of culturally safe care. When the participants were asked about their own culture, many saw the question only related to ethnicity. A small number of participants were able to reflect on who they were from the position of privilege that underpins the power differential of cultural safety.

The participants in the study may not have disclosed very much about their own culture in relation to their patients, but they were conscious of the power differential in their work. When asked about how their culture impacted the nurse-patient relationship, they identified they were in a privileged position. And they were aware of the consequences of becoming too closely connected with the officers, of that acculturalisation. A few participants reflected on how they were perceived by the patients and how that could make therapeutic relationships better or worse.

After analysing the interviews and considering how cultural safety fits into correctional nursing, I put forth that cultural safety is being practiced in its infancy among the participants. The participants' discussions of providing unbiased and holistic care, as well as the importance of building trust reflect the objective to be open minded and flexible. Some of the participants also reflected the objective to not blame victims of historical or social processes for their current predicament. While this study did not interview incarcerated women to see how they define culturally safe care, Urbanoski et al. (2020) and Pauly et al. (2015) did study how patients who use(d) illicit drugs defined culturally safe practice. This

group can inform correctional nursing care because they share many of the same circumstances with incarcerated adults, often experiencing both identities simultaneously. In those studies participants expressed that culturally safe practice included not feeling judged or treated poorly and respecting them as a person. Overall, the participants were certainly aware of how much more power they had over the patients, power that was derived from both the healthcare and justice systems.

However, cultural safety is lacking in three important areas. First, because the participants defined culture more as ethnicity the full potential of cultural safety cannot be met in this healthcare environment. Incarcerated women with mental health concerns are complex patients beyond their health issues. They hold multiple identities that should be accounted for in daily care. Incarcerated adults, and women who are incarcerated in particular, need to viewed as a unique population, a cultural group. If this can happen, correctional nurses may begin to understand the many ways in which the power imbalance inherent in the nurse-patient relationship transpires in correctional settings. Moreover, this shift in viewpoint would reinforce Peplau's premise that the nurse must know about the whole patient (Peplau, 1988). Second, the role of the patient is to decide if the nurse successfully provided culturally safe care. Correctional nurses can look to similar populations for recommendations on how to be culturally safe, but that conversation should be happening with women who are incarcerated both through research and in clinical practice.

Finally, there is a lack of self-reflection built into the experience of being a correctional nurse. Very few participants talked about self-reflection as part of their nursing practice. And in reviewing the literature on cultural safety (see Chapter 3), when staff were asked what they felt they needed to be more culturally safe education was the frequent response. Education, while valuable, is very much a one-way relationship in correctional

nursing practice where nurses receive information. Cultural safety calls for nurses to examine their own attitudes and cultural realities, as does interpersonal relations. Both frameworks ask that nurses reflect on their own person, their prejudices and stereotypes and in how they interact with their patients. While neither interpersonal relations nor cultural safety discussed how self-reflection should occur, there is discussion in the literature over the value of clinical supervision in correctional healthcare contexts to support self-reflection (Walsh, 2008; Walsh & Freshwater, 2009). In this milieu, clinical supervision allows practicing correctional nurses to share the whole experience of their work with peers in a confidential and secure setting which is expected to lead to responsibility and reflective practice (Lyth, 2000 as cited in Walsh, 2008). Given the unique patient population coupled with the challenges of proving care in correctional settings, clinical supervision may offer more support than individual self-reflective work, although that has yet to be explored in the dialogue on correctional nursing. What is clear is that if interpersonal relations and/or cultural safety is to underpin correctional nursing practice, self-reflection must become part and parcel of nursing practice. Without active self-reflection the correctional nurse-patient relationship may be challenged to reach it full potential. Clinical supervision could also support addressing issues of ethical dilemmas and distress that may arise in correctional practice.

Recommendations

Correctional Nursing Clinical Practice

Correctional nursing does need specific education to support nurses working in the environment. Current nursing education prepares nurses to care for the health of the patients; but it does not prepare nurses for the unique environment or how to work within the justice system. Substantive orientation over learning on the job would teach new correctional nurses how to advocate and navigate in the correctional environment and how to interact with

patients who are incarcerated. Complex relationships in correctional health are as important as being a jack of all trades.

Cultural safety and interpersonal relations frameworks provide foundations for working with marginalized populations such as women who are incarcerated and have mental health concerns and the complex relationship that is the nurse-patient-officer triad. The challenge in clinical practice is how to embed and engage the principles of interpersonal relations and cultural safety into daily nursing practice. I recommend two programs for correctional nursing staff, targeted education and support for clinical reflection.

Targeted education should cover two areas: cultural safety and intersectionality theory. Cultural safety has a great deal to offer correctional nurses, especially in the complex relationship that is a triad. While Ramsden did not conceive of cultural safety beyond a meeting of two cultures, it is a framework for nurses to use in this setting. Cultural safety starts by providing a foundation for how to approach and engage with incarcerated people and correctional officers. Nurses could become more aware and reflective of the interplay of the three actors in the triad and how those interactions help or hinder the health of the patient. Cultural safety could also empower nurses in their relationship with correctional offices, helping them to evaluate the roles they play. Cultural safety could also be a method to improve the relationship between officers and patients by modeling behaviour that does not judge or place blame on patients.

Next, I recommend education around the experiences of incarcerated women. It was evident from the data that much of what the participants reported about the lives of their patients mirrored intersectionality theory. Intersectionality theory was developed by Kimberle Crenshaw (1989, 1991) to demonstrate how women of colour in the United States were marginalized within two identities, that of race and gender. Writing within the context of

politics and the law, Crenshaw (1989, 1991) established that the experiences of women of colour could not be understood by examining race or gender individually, instead for interventions to be effective the convergence of multiple identities must be accounted for. In the decades since, the intersectionality viewpoint has been developed to recognise disparities are not the consequence of a single factor or identity, but the consequence of multiple social identities that occur within connected systems and power organisations (Hankivsky, 2014).

Intersectionality offers much to health research, helping researchers to reframe and attend to health disparities and inequalities or those concerned with the social determinants of health (Bowleg, 2012; Kapilashrami et al., 2015). Kapilashrami & Hankivsky (2018) noted that by mapping health inequities and social identities with greater accuracy, social programmes and policies can be more effective at the micro, meso and macro levels. Finally, the use of intersectionality theory in healthcare can be linked to excellence in practice by attending to the disparities and inequities caused by connected systems that underpin current standards of practice (Alani, 2022). This theory would complement cultural safety and help correctional nurses to better understand holistic care in correctional settings.

Targeted education should begin with nurses who are new to the work setting. I recommend the orientation process start before new nurses enter the clinical environment, thus time should be set aside to prepare new staff for the unique setting that is correctional healthcare. Cultural safety and intersectionality theory can then frame nurse-patient and nurse-officer interactions, with specific education on the triad relationship. For nurses already working in the correctional healthcare environment, an equal amount of time could be set aside for in-services to cover the same topics, albeit adjusted to recognise their experience. The content of the orientation and in-services could be in person or delivered virtually. I

recommend that the focus of the content be correctional nursing, cultural safety and intersectionality theory, not a review of clinical nursing skills.

To compliment education around cultural safety and intersectionality theory, I further recommend including literature that explores the experiences of women who are marginalised or incarcerated. Literature is an opportunity for correctional nurses to gain a better understanding at their own pace and in their own space. One such novel I recommend for all correctional nurses is *The Strangers* by Katherena Vermette. Set in Canada, this novel explores many themes including incarceration, intergenerational trauma, and substance use. Written from the point of view of Indigenous women, this novel opens a window into the experience of a young woman who is incarcerated in adult and youth correctional facilities. Non-fiction memoirs such as *In My Own Moccasins: A Memoir of Resilience* by Helen Knott, *Heart Berries* by Terese Marie Mailhot, or *A Mind Spread Out on the Ground* by Alicia Elliott (2020) also illustrate complex identities to better understand intersectionality theory. *From the Ashes* by Jesse Thistle (2019) is a memoir that explores substance use, homelessness, and incarceration from the perspective of Metís-Cree man. Despite not studying the specific experience of Indigenous adults who are incarcerated, and despite my perspective that culture should not be limited to ethnicity in correctional facilities, it is of great value to correctional nurses to engage with Canadian Indigenous writing. Indigenous people are over-represented in the Canadian correctional system, and non-Indigenous incarcerated adults share many similar health disparities. Thus, I believe that when nurses understand the Indigenous experience the healthcare of all incarcerated adults will improve. General resources that can contribute to this understanding include works by Richard Wagamese and Wab Kinew; or *Five Little Indians* by Deckle Edge (2020) and *Seven Fallen Feathers* by Tanya Talaga (2017). Correctional healthcare organisations would benefit from assembling a reading list of these authors and requiring staff who work with incarcerated

patients to read at least one book yearly. This list could be expanded to include relevant movies, podcasts or other social media that foster engagement with the patient population and correctional nursing issues. Equally, a community of practice for correctional nurses that supported discussions of people who are marginalised and incarcerated is another strategy that can be explored.

Support for clinical reflection should be developed to be an expectation of practice. In this context, I define clinical reflection as the individual act where a nurse thinks about their actions and experiences to learn and improve their practice. There is a viewpoint in clinical practice that once nurses are provided in-services and education then any concern can be fixed, or the box can be "ticked." Education is important, but without sincere clinical reflection the principles of interpersonal relations and cultural safety cannot be fully integrated. Correctional facilities are rich environments for self-reflection as nurses face challenges daily in the intersection of health and justice. Thus, I recommend a clinical intervention such as reflective journaling supported by a multi-faceted knowledge translation intervention protocol to support correctional nurses in achieving the clinical intervention. This clinical reflection should be supported at two levels. First, clinical reflection should be integrated into clinical practice within every correctional health site; ideally following from targeted education and be built into workplace expectations. Then, beyond the workplace or organisation, I recommend a community of correctional nurses that would provide nurses with an opportunity to connect with peers and engage in a discourse. Either provincially or as a cross country organisation, resources could be harnessed for information sharing and self-reflection. Overall, clinical reflection should be supported by employers, with dedicated resources to both education and ongoing clinical reflection.

The education provided to correctional nurses should also be provided to correctional officers as they are a part of therapeutic relationships inside a correctional facility. Officers

and nurses have competing goals but as I have discussed the work of officers is dependent upon their relationships with inmates. It is time to apply the nursing principles of interpersonal relationships and cultural safety with correctional officers. Likewise, support for clinical reflection should be introduced to correctional officers, in a way that is appropriate for their culture.

Research

There are four recommendations for future research. First, more research is required around cultural safety and incarcerated populations. Specifically, incarcerated patients should be asked how they define culturally safe care. It would be informative to see if this care is defined differently in remand centres and sentenced facilities. Knowledge translation strategies would be another useful area to explore how cultural safety can be taught and implemented with practicing correctional nurses.

Next, it is salient to look at how intersectionality theory can inform the health of persons who are incarcerated. There have been a few articles published that examine intersectionality in relation to justice involved people. An early article assessed adolescent identity development and intersectionality in the context of adolescent fatherhood (Shade et al., 2011). More recently, Sun et al. (2018) examined intersectionality in the context of Black men living with HIV / AIDS; and Davison et al. (2019) examined it in the context of food security for families with incarcerated fathers. There has been one article examining women who are incarcerated. Gunn et al. (2018) employed an intersectional lens to understand the stigma experienced by women who report substance use and were incarcerated. None of these publications have examined intersectionality and health in a correctional setting. By studying intersectionality within this context, I believe there would be a better understanding of

incarcerated women as a unique group, therefore expanding cultural safety studies away from ethnicity.

The third recommendation is to seek out the patient's perspectives on the theme moments of opportunity. To the best of my knowledge, no other research with correctional health nurses has identified this theme in correctional-nurse patient relationships. It is worth exploring if this theme is present with other correctional nurses or whether women who are incarcerated feel the same way about these moments of opportunity. By exploring moments of opportunity researchers could get a clearer picture of how correctional health services meets with the expectations or goals of incarcerated adults.

The final recommendation is to have more specific research on the proposed patient-nurse-officer relationship. To the best of my knowledge, the correctional nursing discourse has not considered the nurse-patient relationship to be a triad with the officer included as an intimate actor. Thus, more exploration is required to better understand this phenomenon, including seeking the voices of patients and officers. It would also be wise to probe how nurse-officer relationships are perceived by and affect patients who are incarcerated, another area with little in the discourse.

Educational Institutions

Learning about nursing in a correctional environment is a challenging topic in nursing education. It is a unique placement that few students can enter. However, these placements do provide an opportunity to learn about complex patients. I think what correctional facilities offer the most to nursing students is learning how to negotiate healthcare in an environment where security is the priority, or where healthcare is not in control. As well, correctional centres expose students to challenging situations through their interactions with patients and

officers. I recommend case studies and simulations on how to manage therapeutic relationships when correctional officers are present be included in the nursing curriculum.

I think the most important recommendation for education is to embed the principles of interpersonal relations and cultural safety into correctional officer education and to coordinate reflective practice between officers and nurses. This can begin with partnerships between nursing education programs and officer education certificates. I recommend building relationships between these faculties, offering courses or seminars where both nurses and officers are present. This could either be built into the basic nursing program to introduce correctional nursing to graduating students or as part of post-graduate certificate for nurses. Resources such as the Canadian Interprofessional Health Collaborative would also be useful to help build the relationship (CIHC, 2019). If we can acknowledge that the therapeutic relationship is a triad in correctional facilities, then we need to foster that relationship. Time and guidance to review interactions will build on the skills that each professional already has. A more coordinated approach, one that is not built on the security alone should improve the health of patients and may support better compliance with facility rules.

Limitations

There were several limitations to this study. First were demographic make-up of the participants. While this is the first study of correctional nurses to interview participants across Canada, not every Province/Territory was represented. Nor was there equal representation across the three provinces that were included. The sample had only two male participants. Males may have a different perspective and experience in caring for women who are incarcerated. As well, only one LPN participate in the study, and LPNs have a different perspective on nursing care than RNs.

The participants in this study may not be representative of other correctional nurses who did not participate. The nurses who did participate may be more engaged in correctional nursing and be more reflective of their practice than those who did not volunteer. My limited experience in performing qualitative interviews may have impacted my ability to ask questions that would yield rich responses. I may missed questions that would have stimulated disclosure of relevant information.

Dissemination of Research Findings

The value of this research is that it provided a deeper understanding of correctional nurses' experiences caring for incarcerated women. Additionally, this study has provided a different understanding of the correctional nurse-patient relationship by reimaging it as a triad. The findings of this study will be presented at the International Association of Forensic Mental Health Services in June, 2022; and at the International Mental Health Nursing Conference in September, 2022. There will be timely submission of research articles to key journals such as the *Journal of Forensic Nursing*, the *Journal of Correctional Healthcare*, and the *International Journal of Mental Health Nursing*. Abstracts for poster and oral paper presentations at relevant conferences will also be prepared. The findings of this study will also be shared with the Alberta Health Services Correctional leadership. Lastly, I intend to provide an executive summary of the study to the participants.

Conclusion

This study revealed that correctional nurses began working in correctional settings knowing little about it. The nurses chose to apply out of interest that included the intersection of complex patients, a marginalised population and the criminal justice system. The participants defined correctional nursing practice as a jack of all trades approach in which

they had to be prepared to care for a variety of issues. They also described holistic and unbiased care as critical to their practice through the theme seeing beyond the clinical task. Their definition of correctional nursing practice is a convergence of interpersonal relations and cultural safety, where the nurse gets to know the whole patient, accepting the patient for who they are without judgement.

The participants' view of core correctional nursing values began with the theme being an expert. In this theme, it was clear the participants had to have boundaries in their care and be upfront with these boundaries to the patient. Two roles were identified in the greater role of expert, that of gatekeeper and messenger. These roles shed light on the power imbalance inherent in their nurse-patient relationship. Moments of opportunity was the second theme to inform core values. This theme explored the importance of building trust and being truthful with women who are incarcerated. The final theme to inform core values was building the patient up. This theme was about empowering patients and providing hope in a setting where their autonomy has been restricted.

When the participants were asked about the nurse-patient relationship, the analysis revealed complex relationships characterised the therapeutic relationship. The complex relationship began with the setting as a silent majority stakeholder that impacted how the nurse-patient relationship took place. Within the correctional environment, the officers are always present, either in close proximity or in the vicinity. This makes the complex relationship a triad as the nurse-patient-officer relationship. The nature of the setting and the triad relationship mean nurses undergo acculturation, in which they are pressured to conform to the culture of the correctional officers.

As cultural safety was one of the underpinning of this study, I concluded the discussion with an analysis of what the participants revealed about this model. The analysis

showed that the participant were practicing small elements of cultural safety already by valuing holistic care and building trust with their female patients. However, the practice of cultural safety is challenged by being defined by ethnicity, a lack of self-reflection, and an absence of the patient's definition of culturally safe care.

This is the only focused ethnography to date that has examined the experiences of correctional nurses from across Canada. This study revealed that nurses were drawn to working in correctional facilities because of the intersection of complex patients, healthcare and the criminal justice system. Future research should focus on how intersectionality can better inform healthcare in correctional settings. The study also found that nurses experienced the pressure to acculturate into the correctional culture from when they first were employed and throughout their correctional career. Finally, it learned that the therapeutic nurse-patient relationship includes the correctional officers and can be thought of as a triad. This relationship should also be explored further with nurses, patients and correctional officers. Findings from the study can inform what it means to be a correctional nurse in Canada across remand and sentenced facilities. The knowledge gained can focus further research into correctional best practice, as well as identifying new directions for correctional nursing education.

References

Accreditation Canada. (2018). *Correctional Health Services*. Alberta Health Services Accreditation Canada Standards. https://insite.albertahealthservices.ca/main/assets/tms/acrd/tms-acrd-ver13.1-correctional-health-services-standard.pdf

Accreditation Canada (n.d.). *About Accreditation Canada*. https://accreditation.ca/

Adshead, G. (2012). What the eye doesn't see: Relationships, boundaries and forensic mental health. In A. Aiyegbusi & G. Kelly (Eds.), *Professional and therapeutic boundaries in forensic mental health practice* (pp.13-32). Jessica Kingsley Publishers.

Agar, M. (2006). Culture: Can you take it anywhere? *International Journal of Qualitative Methods, 5*(2), Article 11. http://www.ualberta.ca/~iiqm/backissues/5_2/HTML/agar.htm

Ahmed, R. A., Angel, C., Martell, R., Pyne, D., & Keenan, L. (2016a). The Impact of Homelessness and Incarceration on Women's Health. *Journal of Correctional Health Care 22*(1), 62-74.

Ahmed, R. A., Angel, C., Martell, R., Pyne, D., & Keenan, L. (2016b). Access to Healthcare Services During Incarceration Among Female Inmates. *International Journal of Prisoner Health, 12*(4), 204-215.

Ahmed, R., Angel C., Martell R., & Keenan L. (2016c). *A Women's Guide to Health in Jail*. Alberta Health Services.

Alani, Z. (2022). Exploring intersectionality: an international yet individual issue. *Orphanet Journal of Rare Diseases, 17*. https://doi.org/10.1186/s13023-022-02255-3

Alberta Champions. (n.d.). *A brief Alberta history*. https://albertachampions.org/brief-alberta-history/

Aléx, L. & Hammarstrõm, A. (2008). Shift in power during an interview situation: Methodological reflections inspired by Foucault and Bourdieu. *Nursing Inquiry, 15*(2), 169-176.

Almost, J. (2021). *Regulated nursing in Canada: The landscape in 2021.* Canadian Nurses Association.

Almost, J., Doran, D., Ogilvie, L., Miller, C., Kennedy, S., Timmings, C., Rose, D.N., Squires, M., Lee, C.T. & Bookey-Bassett, S. (2013). Exploring work-life issues in provincial corrections settings. *Journal of Forensic Nursing, 9*(1), 3-13.

Almost, J., Gifford, W., Ogilvie, L. & Miller, C. (2020). The role of nursing leadership in ensuring a healthy workforce in corrections. *Nursing Leadership, 33*(1), 59-70.

Anyan, F. (2013). The influence of power shifts in data collection and analysis stages: A focus on qualitative research interview. *The Qualitative Report, 18*(18), 1-9. https://doi.org/10.46743/2160-3715/2013.1525

Applebaum, K.L., Hickey, J.M. & Packer, I. (2001). The role of correctional officers in multidisciplinary mental health care in prisons. *Psychiatric Services, 52*(10), 1343-1347.

Ashton, S. (2014). Researcher or nurse? Difficulties of undertaking semi-structured interviews on sensitive topics. *Nurse Researcher, 22*(1), 27-31.

Auger, M., Crooks, C. V., Lapp, A., Tsuruda, S., Caron, C., Rogers, B. J., & van, d. W. (2019). The essential role of cultural safety in developing culturally-relevant prevention programming in first nations communities: Lessons learned from a national evaluation of mental health first aid first nations. *Evaluation & Program Planning, 72*, 188-196.

Awofeso, N. (2010). Prisons as social determinants of Hepatitis C Virus and Tuberculosis infections. Public Health Reports, 125(Supp 4), 25-33.

Baker, C. (2007). Globalization and the cultural safety of an immigrant Muslim community. *Journal of Advanced Nursing, 57*(3), 296-305.

Barker, P. (1998). The future of the theory of interpersonal relations? A personal reflection on Peplau's legacy. *Journal of Psychiatric and Mental Health Nursing, 5*, 213-220.

Barry, E.(Producer) (1975). *Jane Kennedy – Activist* [CBC Documentary]. Past Daily. https://pastdaily.com/2017/03/08/jane-kennedy-activist-1975-past-daily/

Baxter, V. (2002). Nurses' perceptions of their role and skills in a medium secure unit. *British Journal of Nursing 11*(20), 1312-1319.

Bernier, J.R. & MacLellan, K. (2011). *Health status and health service use of female and male prisoners in provincial jail.* The Atlantic Centre of Excellence for Women's Health. https://cdn.dal.ca/content/dam/dalhousie/pdf/diff/ace-women-health/3/ACEWH_prisoners_health_provincial_jails_en.pdf

Biles, D. & Mulligan, G. (1973). Mad or Bad? - The Enduring Dilemma**.** *British Journal of Criminology, Delinquency and Deviant Social Behaviour, 13*(3), 275-279.

Binswanger, I.A., Merrill, J.O., Krueger, P.M., White, M.C., Booth, R.E. & Elmore, J.G. (2010). Gender differences in chronic medical, psychiatric, and substance-dependence disorders among jail inmates. *The American Journal of Public Health, 100*(3), 476-82.

Binswanger, I.A., Redmond, N., Steiner, J.F. & Hicks, L.S. (2011). Health disparities and the criminal justice system: An agenda for further research and action. *Journal of Urban Health: Bulletin of the New York Academy of Medicine 89*(1), 98-107.

Blanchet Garneau, A., Farrar, H., Fan, H., & Kulig, J. (2018). Applying cultural safety beyond indigenous contexts: Insights from health research with Amish and low German Mennonites. *Nursing Inquiry, 25*(1), e12204.

Blank Wilson, A., Draine, J., Barrenger, S., Hadley, T. & Evans Jr., A. (2014) Examining the impact of mental illness and substance use on time till re-incarceration in a county jail. *Administration and Policy in Mental Health and Mental Health Research, 41*(3), 293-301.

Blair-Lawton, D., Mordoch, E. & Chernomas, W. (2020). Putting on the same shoes: Lived experiences of women who are incarcerated. *Journal of Forensic Nursing,16*(2), 99-107.

Boadu, N. Y & Higginbottom, G. M. A. (2014). Using malaria rapid diagnostic tests in Ghana: A focused ethnography. In M. De Chesney, (Ed.), *Nursing research using ethnography: Qualitative designs and methods in nursing* (139-169). Springer Publishing Company.

Boschma, G., Groening, M. & Boyd, M.A. (2008). Psychiatric and mental health nursing from past to present. In W. Austin & M.A. Boyd (Eds.) *Psychiatric nursing for Canadian practice* (pp. 3-17). Lippincott Williams & Wilkins.

Bowleg, L. (2012). The problem with the phrase *women and minorities*: intersectionality – an important theoretical framework for public health. *American Journal of Public Health, 102*, 1267-1273.

Brink, J. (2005). Epidemiology of mental illness in a correctional system. *Current Opinion in Psychiatry, 18*, 536-541.

Brodie, J.S. (2001). Caring: the essence of correctional nursing. *Tennessee Nurse, 64*(2), 10-12.

Brooke, D, Taylor, C., Gunn, J. & Maden, A. (2000). Substance misuse as a marker of vulnerability among male prisoners on remand. *British Journal of Psychiatry*, *177*(3), 248-251.

Brooks R.E. (1979). Behind the heavy metal door. *American Journal of Nursing 79*(9), 1546-50.

Brown, G.P., Hirdes, J.P. & Fries, B.E. (2015). Measuring the prevalence of current, severe symptoms of mental health problems in a Canadian correctional population: Implications for delivery of mental health services for inmates. *International Journal of Offender Therapy and Comparative Criminology, 59*(1) 27-50.

Burles, M., Holtslander, L. & Peternelj-Taylor, C. (2019). Palliative and hospice care in correctional facilities. *Cancer Nursing, 44*(1), 29-36.

Calzavara, L., Ramuscak, N., Burchell, A.N., Swantee, C., Myers, T., Ford, P., Fearon, M. & Raymond, S. (2007). Prevalence of HIV and hepatitis C virus infections among inmates of Ontario remand facilities. *Canadian Medical Association Journal, 177*(3), 257-261.

Cambridge Dictionary (2022). Acculturation. In *Cambridge Dictionary*. https://dictionary.cambridge.org/dictionary/english/acculturation

Cambridge Dictionary (2021a). Inmate. In *Cambridge Dictionary*. https://dictionary.cambridge.org/dictionary/english/inmate

Cambridge Dictionary (2021b). Offender. In *Cambridge Dictionary*. https://dictionary.cambridge.org/dictionary/english/offender

Campbell, J.A., Walker, R.J.,& Egede, L.E. (2016). Associations between adverse childhood experiences, high-risk behaviours, and morbidity in adulthood. *American Journal of Preventative Medicine, 50*(3), 344-352.

Canadian Institutes of Health Research (CIHR). (2015 June 15). *Definitions of Sex and Gender*. Government of Canada. https://cihr-irsc.gc.ca/e/47830.html

Canadian Institutes of Health Research (CIHR), National Sciences and Engineering Research Council of Canada, Social Sciences and Humanities Research Council of Canada. (2018). *TCPS-2 2018 Tri-Council policy statement: Ethical conduct for research involving humans*. Government of Canada. https://ethics.gc.ca/eng/documents/tcps2-2018-en-interactive-final.pdf

Canadian Interprofessional Health Collaborative (CIHC) (2019). *About us.* Author. http://www.cihc-cpis.com/about-us.html

Canadian Nurse. (2010). Caring in Corrections. *Canadian Nurse, 106*(4), 22-27.

Caravaca-Sánchez, F., Fearn, N. E., Vidovic, K. R. & Vaughn, M.G. (2019). Female prisoners in Spain: Adverse Childhood Experiences, negative emotional states, and social support. *Health & Social Work, 44*(3), 157-166. https://doi.org/10.1093/hsw/hlz013

Cashin, A., Newman, C., Eason, M., Thorpe, A. & O'Driscoll, C. (2010). An ethnographic study of forensic nursing culture in a n Australian prison hospital. *Journal of Psychiatric and Mental Health Nursing, 17*(1), 39-45.

Caufield, L.S. (2016). Counterintuitive findings from a qualitative study of mental health in English women's prisons. *International Journal of Prisoner Health, 12*(4), 216-229.

Chaisson M. (1981). Correctional health care: beyond the barriers. *American Journal of Nursing 81*(4), 736-38.

Cheong Poon, A., Casaniti, M., Sapucci, M. & Ow, R. (2020). Wellbeing and experiences of Chinese and Vietnamese carers of people with mental illness in Australia. *Transcultural Psychiatry.* https://doi.org/10.1177/1363461520952629

Choudhry, K., Armstrong, D. & Dregan, A. (2017). Prison nursing: Formation of a stable professional identity. *Journal of Forensic Nursing, 13*(1), 20-25.

Christensen, S. (2014). Enhancing nurses' ability to care within the culture of incarceration. *Journal of Transcultural Nursing, 25*(3), 223-231.

Cleary, M., Horsfall, J., & Hayter, M. (2014). Data collection and sampling in qualitative research: does size matter? *Journal of Advanced Nursing 70*(3), 473-475.

Cloyes, K.G., Wong, B., Latimer, S. & Abarca, J. (2010). Women, serious mental illness and recidivism: A gender-based analysis of recidivism risk for women with SMI released from prison. *Journal of Forensic Nursing, 6*(1), 3-14.

Colbert, A.M., Goshin, L.S., Durand, V., Zoucha, R. & Sekula, L.K. (2016). Women in transition: Experiences of health and health care for recently incarcerated women living in community corrections facilities. *Research in Nursing & Health, 39*(6), 426-437.

Condon, L., Hek, G., Harris, F., Powell, J., Kemple, T. & Price, S. (2007). User's views of prison health services: A qualitative study. *Journal of Advanced Nursing, 58*(3), 216-226.

Cook, B.K., Hall, R.C.W., Friedman, S.H., Jain, A. & Wagoner, R. (2019). Professional boundaries in corrections. *Journal of the American Academy of Psychiatry and the Law, 47*(1), 91-98.

Correctional Services Canada (CSC). (n.d.). *History of the Canadian correctional system.* https://www.csc-scc.gc.ca/educational-resources/092/ha-student-etudiant-eng.pdf

Correctional Services Canada (CSC). (2013). *Job profile – nurse.* https://www.csc-scc.gc.ca/careers/003001-1301-eng.shtml

Correctional Services Canada (CSC). (2020, May 21). *History of women's corrections.* https://www.csc-scc.gc.ca/women/002002-0007-en.shtml

Cox, L. G., & Simpson, A. (2015). Cultural safety, diversity and the servicer user and carer movement in mental health research. *Nursing Inquiry, 22*(4), 306-316.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*(1), 139-167.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241-1300.

Creswell, J.W. (2007). *Qualitative inquiry & research design: Choosing among five approaches*. Sage Publications.

Creswell, J.W. & Plano Clark, V.L. (2007). *Designing and conducting mixed methods research*. Sage Publications.

Crisanti, A.S. & Frueh, B.C. (2011). Risk of trauma exposure among persons with mental illness in jails and prisons: What do we really know? *Current Opinion in Psychiatry, 24*(5), 431-435.

Cruz, E.V. & Higginbottom, G. M. A., (2013). The use of focused ethnography in nursing research. *Nurse Researcher, 20*(4), 36-43.

Cukale-Matos, S. & Champion, J.D. (2021). Exploring cognitive dissonance in correctional nursing experience. *Public Health Nursing, 39*(3), 545-552.

Cypress, B.S. (2017). Rigor or reliability and validity in qualitative research: Perspectives, strategies, reconceptualization, and recommendations. *Dimensions in Critical Care Nursing, 36*(6), 253-263.

D'Antonio, P., Beeber, L., Sills, G. & Naegle, M. (2014). The future in the past: Hildegard Peplau and interpersonal relations in nursing. *Nursing Inquiry, 21*(4), 311-317.

Davison, K.M., D'Andreamatteo, C., Markham, S., Holloway, C. Marshall, G. & Smye, V.L. (2019). Food security in the context of paternal incarceration: Family impact perspectives. *International Journal of Environment Research and Public Health, 16,* 776.

Dawson, A.E. & Wymbs, B.T. (2016). Validity and utility of the Parent-Teacher Relationship Scale-II. *Journal of Psychological Assessment, 34*(8), 751-764.

de Chesnay, M. (2014a). Overview of ethnography. In M. De Chesney, (Ed.), *Nursing research using ethnography: Qualitative designs and methods in nursing* (pp. 1-14). Springer Publishing Company.

de Chesnay, M. (2014b). Ethnographic methods. In M. De Chesney, (Ed.), *Nursing research using ethnography: Qualitative designs and methods in nursing* (pp. 37-51). Springer Publishing Company.

de Viggiani, N. (2007). Unhealthy prisons: Exploring structural determinants of prison health. *Sociology of Health & Illness, 29*(1), 115-135.

Dell, E. M., Firestone, M., Smylie, J., & Vaillancourt, S. (2016). Cultural safety and providing care to aboriginal patients in the emergency department. *Canadian Journal of Emergency Medicine, 18*(4), 301-305. doi:10.1017/cem.2015.100

DeP, L.L. (1917). Nursing in institutions. *American Journal of Nursing 18*(3), 238.

Derkzen, D., Booth, L., Taylor, K. & McConnell, A. (2013). Mental health needs of federal offenders. *Psychological Services, 10*(1), 24-36.

Dhaliwal, K. & Hirst, S. (2016). Caring in correctional nursing: A systematic search and narrative synthesis. *Journal of Forensic Nursing, 12*(1), 5-12.

Dhaliwal, K. & Hirst, S. (2019). The suitability of grounded theory research for correctional nursing. *Journal of Forensic Nursing, 15*(1), 35-41.

Dhaliwal, K., Hirst, S.P., King-Shier, K.M. & Kent-Wilkinson, A. (2021). The implementation of correctional nursing practice – Caring behind bars: A grounded theory study. *Journal of Advanced Nursing, 77*(5), 2407-2416. https://doi.org/10.1111/jan.14772

Dighton S. (1986). Tough-minded nursing. *American Journal of Nursing 86*(1), 48-51.

Dole, P.J. (2006). Chapter 51: Caring for offenders: Correctional nursing. In V.A. Lynch (Ed.) *Forensic Nursing* (pp. 533-558). Elsevier.

Doyle, J. (1999). A qualitative study of factors influencing psychiatric nursing practice in Australian prisons. *Perspectives in Psychiatric Care, 35*(1), 29-35.

Doyle, J. (2002). Custody and caring: Innovations in Australian correctional mental health nursing practice. *Contemporary Nurse, 14*(3), 305-311.

Drapalski, A.L., Youman, K, Stuewig, J. & Tangney, J. (2009). Gender differences in jail inmates' symptoms of mental illness, treatment history and treatment seeking. *Criminal Behaviour and Mental Health, 19*(3), 193-206.

Droes, N.S. (1994). Correctional nursing practice. *Journal of Community Health Nursing, 11*(4), 201-210

D'Souza, R.M., Butler, T. & Petrovsky, N. (2005). Assessment of cardiovascular disease risk factors and diabetes mellitus in Australian prisons: is the prison population unhealthier than the rest of the Australian population? *Australian and New Zealand Journal of Public Health, 29*(4), 318-323.

DuBose, E.R., Schneiderman, L., Koch, T., Woods, G.L. & Spielman, B. (1996). Prison infirmary nurses: Professionalism and principles. *Making the Rounds in Health, Faith & Ethics, 1*(21), 1-4.

Duckett, M.T. & Mohr, J.W. (2015, June 8). *Prison*. The Canadian Encyclopedia. https://www.thecanadianencyclopedia.ca/en/article/prison#

Durey, A., Wynaden, D., Barr, L., & Ali, M. (2014). Improving forensic mental health care for aboriginal Australians: Challenges and opportunities. *International Journal of Mental Health Nursing, 23*(3), 195-202.

Durey, A., Wynaden, D. & O'Kane, M. (2014). Improving forensic mental health care for aboriginal Australians: Theorizing the intercultural space. *Journal of Psychiatric and Mental Health Nursing, 21*(4), 296-302.

Edalati, H., Nicholls, T.L., Crocker, A.G., Roy, L., Somers, J.M. & Patterson, M.L. (2017). Adverse childhood experiences and the risk of criminal justice involvement and victimization among homeless adults with mental illness. *Psychiatric Services, 68*(12), 1288-1295.

Edge, Deckle (2020). *Five Little Indians*. Harper Collins.

Efron, S.E. & Ravid, R. (2019). *Writing the literature review: A practical guide.* Guildford Press.

Elliott, A. (2020). *A Mind Spread Out on the Ground.* Anchor Canada.

Ellis, H. & Alexander, V. (2017). The mentally ill in jail: Contemporary clinical and practice perspectives for psychiatric-mental health nursing. *Archives of Psychiatric Nursing, 31*(2), 217-222.

Enggist, S., Møller, L., Galea, G. & Udesen, C. (Eds.) (2014). *Prisons and Health*. World Health Organization Regional Office for Europe.

Evans, N. (1999). Preparing nurses to work effectively in the prison environment. *British Journal of Nursing, 8*(19), 1324-1326.

Farley, F. (1917). A prison eye clinic. *American Journal of Nursing 17*(10), 686-87.

Fawcett, J. & Garity, J. (2009). Chapter 8: Evaluation of samples. In J. Fawcett and J. Garity, *Evaluating Research for Evidence-Based Nursing* (pp. 135-152). F.A. Davis.

Fazel, S., Bains, P. & Doll, H. (2006). Substance abuse and dependence in prisoners: a systematic review. *Addiction, 101*(2), 181-91.

Fazel, S., Hayes, A.J., Bartellas, K., Clerici, M. & Treatman, R. (2016). The mental health of prisoners: A review of prevalence, adverse outcomes and interventions. *Lancet*

Psychiatry, 3(9), 871-881.

Fedele, R. (2015). Healthcare on the inside. *Australian Nursing & Midwifery Journal, 23*(2), 31.

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P. & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventative Medicine, 14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Flanagan, N.A. & Flanagan, T.J. (2001). Correctional nurses' perceptions of their role, training requirements, and prisoner healthcare needs. *Journal of Correctional Healthcare, 8*(1), 67-85.

Forchuk, C. (1991). Peplau's theory: Concepts and their relations. *Nursing Science Quarterly, 4*(2), 54-60.

Forchuk, C. (1993). *Hildegarde E. Peplau: Interpersonal Nursing Theory.* Sage.

Forchuk, C. (1994a). Preconceptions in the nurse – client relationship. *Journal of Psychiatric and Mental Health Nursing, 1*(3), 145-149.

Forchuk, C. (1994b). The orientation phase of the nurse-client relationship: testing Peplau's theory. *Journal of Advanced Nursing, 20*(3), 532-537.

Foster, J., Bell, L. & Jayasinghe, N. (2013). Care control and collaborative working in a prison hospital. *Journal of Interprofessional Care, 27*(2), 184-190.

Frohlich, K.L. & Potvin, L. (2008). Transcending the known in public health practice: the inequality paradox: the population approach and vulnerable populations. *American Journal of Public Health 98*(2), 216-221.

Fuentes, C.M. (2014). Nobody's child: The role of trauma and interpersonal violence in women's pathways to incarceration and resultant service needs. *Medical Anthropology Quarterly, 28*(1), 85-104.

Fuller-Thomson, E., Baird, S.L., Drodia, R. & Bernnenstuhl, S. (2016). The association between adverse childhood experiences (ACEs) and suicide attempts in a population-based study. *Child: care, health and development, 42*(5), 725-734.

Fuller-Thomson, E., Roane, J.L., & Bernnenstuhl, S. (2016). Three types of adverse childhood experiences, and alcohol and drug dependence among adults: An investigation using population-based data. *Substance Use & Misuse, 51*(11), 1451-1461. http://dx.doi.org/10.1080/10826084.2016.1181089

Gadow, S. (2003). Restorative nursing: toward a philosophy of postmodern punishment. *Nursing Philosophy, 4*(2), 161-167.

Gastmans, C. (1998). Interpersonal relations in nursing: A philosophical-ethical analysis of the work of Hildegard E. Peplau. *Journal of Advanced Nursing, 28*(6), 1312-1319.

Gilbert, M.J. (1997). The illusion of structure: A critique of the classical model of organization and the discretionary power of correctional officers. *Criminal Justice Review, 22*(1), 49-64.

Gobeil, R., Blanchette, K. & Stewart, L. (2016). A meta-analytic review of correctional interventions for women offenders: Gender-neutral versus gender-informed approaches. *Criminal Justice and Behavior, 43*(3), 301-322.

Goddard, D., de Vries, K., McIntosh, T. & Theodosius, C. (2019). Prison nurses' professional identity. *Journal of Forensic Nursing, 15*(3), 163-171.

Gorman, G. (2018). A new kind of nursing: Walking the labyrinth of Cook County Jail. *Public Health Nursing, 35*(2), 144-149. https://doi.org/ 10.1111/phn.12387

Government of Canada. (2012, April 11). How Canadians govern themselves. https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/discover-canada/read-online/how-canadians-govern-themselves.html

Government of Canada. (2015, October 26). *Discover Canada.* https://www.canada.ca/en/immigration-refugees-citizenship/corporate/publications-manuals/discover-canada/read-online/canadas-history.html

Government of Canada. (2017, May 2). *First nations in Canada.* https://www.rcaanc-cirnac.gc.ca/eng/1307460755710/1536862806124

Gross, H. (1977). Jane Kennedy: Making history through moral protest. *Frontiers: A Journal of Women's Studies, 2*(2), 73-81.

Gracey, M. & King, M. (2009). Indigenous health part 1: determinants and disease patterns. *The Lancet 374*(9683), 65-75.

Gunn, A.J., Sacks, T.K. & Jemal, A. (2018). "That's not me anymore": Resistance strategies for managing intersectional stigmas for women with substance use and incarceration histories. *Qualitative Social Work, 17*(4), 490-508.

Hankivsky,O. (2014). *Intersectionality 101*. The Institute for Intersectionality Research & Policy, SFU.

Harner, H.M. & Riley, S. (2013). Factors contributing to poor physical health in incarcerated women. *Journal of Health Care for the Poor and Underserved, 24*(2), 788-801.

Harris, F., Hek, G. & Condon, L. (2006). Health needs of prisoners in England and Wales: The implications for prison healthcare of gender, age and ethnicity. *Health and Social Care in the Community, 15*(1), 56-66.

Hatton, D.C., Kleffel, D. & Fisher, A.A. (2006). Prisoners' perspectives of health problems and healthcare in a US women's jail. *Women & Health, 44*(1), 119-136.

Healey, P., Stager, M. L., Woodmass, K., Dettlaff, A. J., Vergara, A., Janke, R., & Wells, S. J. (2017). Cultural adaptations to augment health and mental health services: A systematic review. *BMC Health Services Research, 17*(1), 8.

Heimerl, F., Lohmann, S., Lange, S. & Ertl, T. (2014). Word cloud explorer: Text analytics based on word clouds. 47th International Conference on System Science. IEEE Computer Society. https://doi.org/10.1109/HICSS.2014.231

Higginbottom, G. M. A., Pillay, J. J., & Boadu, N. Y. (2013). Guidance on performing focused ethnographies with an emphasis on healthcare research. *Qualitative Report, 18*: 16p.

Hole, R.D., Evans, M., Berg, L.D., Bottorff, J.L., Dingwall, C., Alexis, C., Nyberg, J. & Smith, M.L. (2015). Visibility and voice: Aboriginal people experience culturally safe and unsafe health care. *Qualitative Health Research, 25*(12), 1662-1674.

Holly, H. (1972). Jail matron, R.N. *The American Journal of Nursing, 72*(9), 1620-1623.

Holmes, D. (2002). Police and pastoral power: governmentality and correctional forensic psychiatric nursing. *Nursing Inquiry, 9* (2), 84-92.

Holmes, D. (2005). Governing the captives: forensic psychiatric nursing in corrections. *Perspectives in Psychiatric Care, 41*(1), 3-13.

Holmes, D., Perron, A. & Michaud, G. (2007). Nursing in corrections: Lessons from France. *Journal of Forensic Nursing, 3*(3/4), 126-131.

Hooper, E. & Chamberlin, G. (2000). Correctional nurse case managers: A financial justification. *Journal of Correctional Health Care, 7*, 263-275. https://doi.org/10.1177/107834580000700206

Hubbard, K. (1906). Juvenile court work, from a nurse's stand-point. *American Journal of Nursing 6*(4), 228-29.

Hughes, K., Bellis, M.A., Hardcastle, K.A., Sethi, D., Butchart, A., Mikton, C., Jones, L. & Dunne, M.P. (2017). The effects of multiple childhood experiences on health: A systematic review and meta-analysis. *Lancet Public Health, 2*, e356-366.

Jacob, J.D. (2012). The rhetoric of therapy in forensic psychiatric nursing. *Journal of Forensic Nursing, 8*, 178-187.

Jacob, J.D. (2014). Understanding the domestic rupture in forensic psychiatric nursing practice. *Journal of Correctional Health Care, 20*(1), 45-58.

Jalali, F. & Hashemi, S.F. (2019). Group lifeskills training for promoting mental health in women after release from prison: A randomized pilot efficacy trial. *Health Care for Women International, 40*(3), 314-327.

Jayashankar, S. & Sridaran, R. (2017). Superlative model using word cloud for short answers evaluation in eLearning. *Education and Information Technologies, 22*, 2383-2402.

Jewkes, Y., Jordan, M., Wright, S. & Bendelow, G. (2019). Designing 'healthy' prisons for women: Incorporating trauma-informed care and practice (TICP) into prison planning and design. *International Journal of Environmental Research and Public Health,16*(20), 3818. https://doi.org/10.3390/ijerph16203818

Jones, R.M., Manetsch, M., Gerritsen, C. & Simpson, A.I.F. (2020). Patterns and predictors of reincarceration among prisoners with serious mental illness: A cohort study. *The Canadian Journal of Psychiatry, 66*(6), 560-568. https://doi.org/10.1177/0706743720970829

Josewski, V. (2012). Analysing 'cultural safety' in mental health policy reform: Lessons from British Columbia, Canada. *Critical Public Health, 22*(2), 223-234.

Kalyani, M. N., Kashkooli, R. I., Molazem, Z. & Jamshidi, N. (2014). Qualitative inquiry into the patient's expectations regarding nurses and nursing care. *Advances in Nursing,2014*. https://doi.org/10.1155/2014/647653

Kapilashrami, A. & Hankivsky, O. (2018). Intersectionality and why it matters to global health. *The Lancet, 391,* 2589-2591.

Kapilashrami, A., Hill, S. & Meer, N. (2015). What can health inequalities researchers learn from an intersectionality perspective? Understanding social dynamics with an inter-categorical approach. *Social Theory & Health, 13*, 288-307.

Karaaslan, A. & Aslan, M. (2019). The relationship between the quality of work organizational commitment of prison nurses. *The Journal of Nursing Research, 27*(3), e25. https://doi.org/10.1097/jnr.0000000000000286

Karlsson, M.E. & Zielinski, M.J. (2020). Sexual victimization and mental illness prevalence rates among incarcerated women: A literature review. *Trauma, Violence and Abuse, 21*(2), 326-349.

Kealy, D. & Lee, E. (2018). Childhood trauma among adult clients in Canadian community mental health services: Toward a trauma-informed approach. *International Journal of Mental Health, 47*(4), 284-297.

Kellett, P., & Fitton, C. (2017). Supporting transvisibility and gender diversity in nursing practice and education: Embracing cultural safety. *Nursing Inquiry, 24*(1)

Kelly, J. (2013). Decolonizing sexual health nursing with aboriginal women. *Canadian Journal of Nursing Research, 45*(3), 50-65.

Kelly, P.J., Cheng, A., Spencer-Carver, E. & Ramaswamy, M. (2014). A syndemic model of women incarcerated in community jails. *Public Health Nursing, 31*(2), 118-125.

Kendall, S., Lighton, S., Sherwood, J., Baldry, E. & Sullivan, E. (2019). Holistic conceptualizations of health by incarcerated Aboriginal women in New South Wales, Australia. *Qualitative Health Research, 29*(11), 1549-1565.

Kennedy, J.A. (1975). Health care in prison: A view from inside. *The American Journal of Nursing, 75*(3), 417-420.

Kent-Wilkinson, A. (2009). An exploratory study of forensic nursing education in North America: Constructed definitions of forensic nursing. *Journal of Forensic Nursing, 5*(4), 201-211. https://doi.org/ 10.1111/j.1939-3938.2009.01055.x

Kent-Wilkinson, A. (2011). Forensic nursing educational development: An integrated review of the literature. *Journal of Psychiatric and Mental Health Nursing, 18*(3), 236-246.

Khawaja, N. G., & Stein, G. (2016). Psychological services for asylum seekers in the community: Challenges and solutions. *Australian Psychologist, 51*(6), 463-471.

King, M., Smith, A. & Gracey, M. (2009). Indigenous health part 2: the underlying causes of the health gap. *The Lancet, 374*(9683), 76-85.

King, E.A., Tripodi, S.J. & Veeh, C.A. (2018). The relationship between severe mental disorders and recidivism in a sample of women released from prison. *Psychiatric Quarterly, 89*(3), 717-731.

Kitt-Lewis, E., Loeb, S.J., Wion, R.K., Myers, V.H., Jerrod, T. & Strickfaden, S. (2020). Developing computer-based learning on cared of aged and dying incarcerated people. *Journal of Forensic Nursing, 16*(1), 36-46.

Knoblauch, H. (2005). Focused ethnography. *Forum: Qualitative Social Research, 6*(3). https://doi.org/10.17169/fqs-6.3.20

Kong, R. & AuCoin, K. (2008). *Juristat: Female offenders in Canada*. Statistics Canada.

Kouyoumdjian, F.G., Andreev, E.M., Borschmann, R., Kinner, S.A. & McConnon, A. (2017). Do people who experience incarceration age more quickly? Exploratory analysis using retrospective cohort data on mortality from Ontario, Canada. *PLos ONE, 12*(4), e0175837.

Kouyoumdjian, F.G., Cheng, S.Y., Fung, K., Orkin, A.M., McIsaac, K.E., Kendall, C., Kiefer, L., Matheson, F.I., Green, S.E. & Hwang, S.W. (2018). The health care utilization of people in prison and after prison release: A population-based cohort

study in Ontario, Canada. *PLoS ONE 13*(8): e0201592. https://doi.org/10.1371/journal.pone.0201592

Kouyoumdjian, F.G., Leto, D., John, S., Henein, H. & Bondy, S. (2012). A systematic review and meta-analysis of the prevalence of chlamydia, gonorrhea and syphilis in incarcerated persons. *International Journal of STD and AIDS, 23*(4), 248-54.

Kouyoumdjian, F.G., Schuler, A., Matheson, F.I. & Hwang, S.W. (2016). Health status of prisoners in Canada. *Canadian Family Physician, 62*(3), 215-222.

Knott, H. (2020). *In My Own Moccasins: A Memoir of Resilience*. University of Regina Press.

Kulkarni, S.P., Baldwin, S., Lightstone, A.S., Gelberg, L. & Diamant, A.L. (2010). Is incarceration a contributor to health disparities? Access to care of formerly incarcerated adults. *Journal of Community Health, 35*(3), 268-274.

Lamb, H. R. & Bachrach, L. L. (2001). Some perspectives on deinstitutionalization. *Psychiatric Services, 52* (8), 1039-1045.

Landry, L. & Sinha, M. (2008). Adult Correctional Services in Canada, 2005/2006 (Statistics Canada Catalogue no. 85-002). *Juristat, 28*(6). https://www.150.statcan.gc.ca/n1/en/pub/85-002-x2008006-eng.pdf?st=cYxAjQ-b

Lapworth, T., Bennett, C. & Perry, J. (2010). Assessment of acutely ill patients in the criminal justice system. *Nursing Standard, 24*(41), 35-41.

Lehrer, D. (2021). Compassion in corrections: The struggle between security and health care. *Journal of Correctional Health Care, 27*(2), 81-84.

Lincoln, Y.S. & Guba, E.G. (1985). *Naturalistic Inquiry*. Sage.

Little, L. (1981).A change process for prison health nursing. *American Journal of Nursing 81*(4), 739-42.

Lopes, J., Lindeman, M., Taylor, K., & Grant, L. (2012). Cross cultural education in suicide prevention: Development of a training resource for use in central Australian indigenous communities. *Advances in Mental Health, 10*(3), 224-234.

Lowdell, A. & Adshead, G. (2009). The best defence: Institutional defenses against anxiety in forensic services. In A. Aiyegbusi & J. Clarke-Moore (Eds.), *Therapeutic relationships with offenders: An introduction to the psychodynamics of forensic mental health nursing* (pp.53-67). Jessica Kingsley Publishers.

Lukasiewicz, M., Falissard, B., Michel, L., Neveu, X., Reynaud, M., & Gasquet, I. (2007). Prevalence and factors associated with alcohol and drug-related disorders in prison: a French national study. *Substance Abuse Treatment, Prevention, and Policy, 2*(1), 10p.

Lynch, S.M., Dehart, D.D., Belnap, J., Green, B.L., Dass-Brailford, P., Johnson, K.M. & Wong, M.M. (2017). An examination of the associations among victimization, mental health, and offending in women. *Criminal Justice and Behaviour, 44*(6), 796-814.

Lynch, V.A. (2006). Chapter 1: The specialty of forensic nursing. In V.A. Lynch (Ed.) *Forensic Nursing*, (pp. 3-13). Elsevier Mosby.

Maar, M. A., Erskine, B., McGregor, L., Larose, T. L., Sutherland, M. E., Graham, D., Shawande, M. & Gordon, T. (2009). Innovations on a shoestring: A study of a collaborative community-based aboriginal mental health service model in rural Canada. *International Journal of Mental Health Systems, 3*, 27.

Maeve, M.K. (1997). Nursing practice with incarcerated women: Caring within mandated (sic) alienation. *Issues in Mental Health, 18*(5), 495-510.

Maeve, M.K. &Vaughn, M.S. (2001). Nursing with prisoners: the practice of caring, forensic nursing or penal harm nursing? *Advances in Nursing Science, 24*(2),47-64.

Mailhot, T.M. (2018). *Heart Berries.* Doubleday Canada.

Malakieh, J. (2019). *Juristat: Adult and youth correctional statistics in Canada, 2017/2018*. Statistics Canada.

Malakieh, J. (2020). *Juristat: Adult and youth correctional statistics in Canada, 2018/2019*. Statistics Canada.

Malloy, L.C., Sutherland, J.E. & Cauffman, E. (2019). Sexual disclosure among incarcerated female adolescents and young adults. *Child Abuse & Neglect, 116*(Pt 1). https://doi.org/10.1016/j.chiabu.2019.104147

Manchester, A. (2009). Prison nursing extends skills in a unique primary health setting. *Kai Taiki Nursing New Zealand, 15*(8), 20-21.

Maroney, M.K. (2005). Caring and custody: two faces of the same reality. *Journal of Community Health Nursing, 11*(2), 157-169.

Martin, R.E., Buxton, J.A., Smith, M. & Hislop, T.G. (2012). The scope of the problem: The health of incarcerated women in BC. *BC Medical Journal, 54*(10), 502-508.

Martín-Rodríguez, L., Beaulieu, M-D., D'Amour, D. & Ferrada-Videla, M. (2005). The determinants of successful collaboration: A review of theoretical and empirical studies. *Journal of Interprofessional Care, 19*(Supp 1), 132-47. https://doi.org/10.1080/13561820500082677

Massoglia, M. (2008). Incarceration, health, and racial disparities in health. *Law & Society, 42*(2), 275-306.

Matheson, F.I., Forrester, P., Brazil, A., Doherty, S. & Affleck, L. (2012). Incentives for research participation: policy and practice for Canadian Corrections. *American Journal of Public Health, 102*(8), 1438-1442.

Mautone, J. A., Marcelle, E., Tresco, K. E., & Power, T. J. (2014). Assessing the quality of parent-teacher relationships for students with ADHD. *Psychology in the Schools, 52*(2), 196-207. doi:10.1002/ pits.21817

Maxwell, Y., Day, A. & Casey, S. (2013). Understanding the needs of vulnerable prisoners: The role of social and emotional wellbeing. *International Journal of Prisoner Health, 9*(2), 57-67.

Mayan, M.J. (2009). *Essentials of qualitative inquiry*. Left Coast Press.

McCall, J., Mollison, A., Browne, A., Parker, J., & Pauly, B. (2017). The role of knowledge brokers: Lessons from a community based research study of cultural safety in relation to people who use drugs. *Canadian Journal of Action Research, 18*(1), 34-51.

McCarthy, C.T. & Aquino-Russell, C. (2009). A comparison of two nursing theories in practice: Peplau and Parse. *Nursing Science Quarterly, 22*(1), 34-40.

McDowell H.M. (1975). Leadership at the cell-block level. *American Journal of Nursing 75*(3), 423-24.

McEwen, C.A. & Gregerson,S.F. (2018). A critical assessment of adverse childhood experiences study at 20 years. *American Journal of Preventative Medicine, 56*(6), 790-794.

McFarland, D.M. (2014). How to do ethnography. In M. De Chesney, (Ed.), *Nursing research using ethnography: Qualitative designs and methods in nursing* (pp. 95-102). Springer Publishing Company.

McGough, S. (2016). Culturally safe mental healthcare. *Australian Nursing & Midwifery Journal, 23*(8), 45.

McGough, S., Wynaden, D., & Wright, M. (2018). Experience of providing cultural safety in mental health to aboriginal patients: A grounded theory study. *International Journal of Mental Health Nursing, 27*(1), 204-213.

McNiff, M.A. (1973). Nursing in a psychiatric prison service. *The American Journal of Nursing, 73*(9), 1586-1587.

McPhail, M.E., Falvo, D.R & Burker, E.J. (2012). Psychiatric disorders in incarcerated women: Treatment and rehabilitation needs for successful community reentry. *Journal of Applied Rehabilitation Counseling, 43*(1), 19-26.

Minister of Justice. (2017). *Canada Health Act RSC 1985, c C-6.* Author. https://laws-lois.justice.gc.ca/PDF/C-6.pdf

Minister of Justice. (2019). *Corrections and Conditional Release Regulations SOR/92-620.* Author. https://laws.justice.gc.ca/PDF/SOR-92-620.pdf

Minnigerode L. (1931). Nursing in federal prisons. *American Journal of Nursing 31*(9), 1056-58.

Moffitt, P. M., & Vollman, A. R. (2006). At what cost to health? Tlicho women's medical travel for childbirth. *Contemporary Nurse : A Journal for the Australian Nursing Profession, 22*(2), 228-239.

Mollard, E., & Brage Hudson, D. (2016). Nurse-Led Trauma-Informed Correctional Care for Women. *Perspectives in psychiatric care*, *52*(3), 224–230. https://doi.org/10.1111/ppc.12122

Møller, L., Stöver, H., Jürgens, R., Gatherer, A. & Nikogosian, H. (2007). *Health in Prisons: A WHO guide to the essentials in prison health*. World Health Organization.

Morse, J.M. (2001). Qualitative verification: Building evidence by extending basic findings. In J.M. Morse, J.M. Swanson & A.J. Kuzel (Eds.), *The nature of qualitative evidence* (pp. 203-220). Sage Publications.

Morse, J.M. (2015a). "Data were saturated . . .". *Qualitative Health Research 25*(5), 587-588.

Morse, J. M. (2015b). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative Health Research 25*(9), 1212-1222.

Morse, J. M. (2015c). Analytic strategies and sample size. *Qualitative Health Research 25*(10), 1317-1318.

Morse, J.M. (2016). Underlying ethnography. *Qualitative Health Research, 26*(7), 875-876.

Morse, J. M., Barrett M., Mayan, M. Olson, K., & Spiers, J. (2002). Verification Strategies for Establishing Reliability and Validity in Qualitative Research. *International Journal of Qualitative Methods, 1*(2), 13-22.

Morse, J.M. & Mitcham, C. (2002). Exploring qualitatively-derived concepts: Inductive-deductive pitfalls. *International Journal of Qualitative Methods, 1*(4). Article 3. from http://www.ualberta.ca/~ijqm

Mortenson, A. (2010). Cultural safety: Does the theory work in practice for culturally and linguistically diverse groups? *Nursing Praxis in New Zealand, 26*(3):6-16

Mukherjee, S., Pierre-Victor, D., Bahelah, R. & Madhivanan, P. (2014). Mental health issues among pregnant women in correctional facilities: A systematic review. *Women & Health, 54*(8), 816-842.

Mullen, P.D., Cummins, A.G., Velasquez, M.M., von Sternberg, K. & Carvajal, R. (2003). Jail as important but constrained venues for addressing women's health. *Family & Community Health, 26*(2), 157-168.

Murtha R. (1975). It started with a director of nursing. *American Journal of Nursing 75*(3), 412-22.

National Institute of Corrections (NIC). (2011). *Jail Design Guide*. U.S. Department of Justice. https://nicic.gov/jail-design-guide

Nolan, G. & Walsh, E. (2012). Caring in prison: The intersubjective web of professional relationships. *Journal of Forensic Nursing, 8*(4), 163-169.

Norman, A. (1999). Prison health care: what is it that makes prison nursing unique? *British Journal of Nursing, 8*(15), 1032-1033.

Norman, A. & Parrish, A. (1999). Prison health care: Work environment and the nursing role. *British Journal of Nursing, 8*(10), 653-656.

Norman, A. & Parrish, A. (2000). Prison health care. *Nursing Management, 7*(8), 26-29.

Nurse, J., Woodcock, P. & Ormsby, J. (2003). Influence of environmental factors on mental health within prisons: Focus group study. *British Medical Journal, 327*(7413), 480-483.

Ogilvie, L. D., Burgess-Pinto, E., & Caufield, C. (2008). Challenges and approaches to newcomer health research. *Journal of Transcultural Nursing, 19*(1), 64-73.

Ogilvie, L., Higginbottom, G., Burgess-Pinto, E., & Murray, C. (2013). Fostering excellence: Development of a course to prepare graduate students for research on migration and health. *Nursing Inquiry, 20*(3), 211-222.

Oliffe, J. (2005). Why not ethnography? *Urology Nursing, 25*(5), 395-399.

Olson, K. (2011). *Essentials of qualitative interviewing.* Left Coast Press.

Ontario Government Agency History. (n.d.). *Ontario inspector of asylums, prisons and public charities.* Archives of Ontario http://ao.minisisinc.com/scripts/mwimain.dll/144/ARCH_AUTHORITY/AUTH_DESC_DET_REP/SISN%204811?SESSIONSEARCH

Onwuegbuzie, A.J. & Leech, N.L. (2007). A call for qualitative power analysis. *Quality & Quantity, 41*, 105-121.

O'Reilley, M. & Parker, N. (2013). 'Unsatisfactory saturation:' A critical exploration of the notion of saturated sample sizes in qualitative research. *Qualitative Research13*(2), 190-197.

Papps, E. & Ramsden, I. (1996). Cultural safety in nursing: the New Zealand experience. *International Journal for Quality in Health Care, 8*(5), 491-497.

Parker, R. (2010). Australia's aboriginal population and mental health. *Journal of Nervous & Mental Disease, 198*(1), 3-7.

Parsons, M.L. & Warner-Robbins, C. (2002). Factors that support women's successful transition to the community following jail/prison. *Health Care for Women International, 23*(1), 6-18.

Pauly, B., McCall, J., Browne, A. J., Parker, J. & Mollison, A. (2015). Toward Cultural Safety: Nurse and patient perceptions of illicit substance use in a hospitalized setting. *Advances in Nursing Science, 38*(2), 121-135.

Peden, A.R. (1993). Recovering in depressed women: Research with Peplau's theory. *Nursing Science Quarterly, 6*(3), 140-146.

Penitentiary Museum. (2020). *Historical information: Interesting facts.* https://www.penitentiarymuseum.ca/history/interesting-facts/

Peplau, H.E. (1965). The heart of nursing: Interpersonal relations. *Canadian Nurse, 61*(4), 273-275.

Peplau, H.E. (1988). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing.* Palgrave MacMillan (Original work published 1952, G. P. Putnam's Sons.).

Peplau, H.E. (1992). Interpersonal relations: A theoretical framework for application in nursing practice. *Nursing Science Quarterly 5*(1), 13-18.

Peplau, H.E. (1997) Peplau's theory of interpersonal relations. *Nursing Science Quarterly, 10*(4), 162-167.

Perron, A. & Holmes, D. (2011). Constructing mentally ill inmates: Nurses' discursive practices in corrections. *Nursing Inquiry, 18*(3), 191-204.

Perry, J., Bennett, C. & Lapworth, T. (2010a). Nursing in prisons: Developing the specialty of offender health care. *Nursing Standard, 24*(39), 35-40.

Perry, J., Bennett, C. & Lapworth, T. (2010b). Management of long-term conditions in a prison setting. *Nursing Standard, 24*(42), 35-40.

Peternelj-Taylor, C. (2004). An exploration of othering in forensic psychiatric and correctional nursing. *Canadian Journal of Nursing research, 36*(4),130-146.

Peternelj-Taylor, C. (2008). Chapter 33: Forensic psychiatric and mental health nursing. In W. Austin & M.A. Boyd (Eds.) *Psychiatric Nursing for Canadian Practice*, (pp. 791-804). Lippincott Williams & Wilkins.

Peternelj-Taylor, C. & Yonge, O. (2003). Exploring boundaries in the nurse-client relationship: Professional roles and responsibilities. *Perspectives in Psychiatric Care, (39)*2, 55-66.

Pettman, H., Loft, N. & Terry, R. (2019). We deal with grey: Exploring professional boundary development in a forensic inpatient service. *Journal of Forensic Nursing, 16*(2), 118-125.

Piat, M. (1992). Deinstitutionalization of the mentally ill: Theory, Policy, and Practice. *Canadian Social Work Review, 9*(2), 201-213.

Pink, J.E. & Perrier, D.C. (2003). Glossary of frequently used legal terms in the criminal justice system. In J.E. Pink & D.C. Perrier (Eds.) *From Crime to Punishment* (5th ed., pp. 639-645). Tomson Carswell.

Philip, R.K. (2020). Word cloud analysis and single word summariasation as a new paediatric educational tool: Results of a neonatal application. *Journal of Paediatrics and Child Health, 56*, 873-877.

Plugge, E., Douglas, N. & Fitzpatrick, R. (2008). Patients, prisoners, or people? Women's prisoners' experiences of primary care in prison: a qualitative study. *British Journal*

of General Practice, 58(554), e1-e8.

Polaschek, N.R. (1998). Cultural safety: A new concept in nursing people of different ethnicities. *Journal of Advanced Nursing, 27*(3), 452-457. https://doi.org/10.1046/j.1365-2648.1998.00547.x.

Porter, L. & Calverley, D. (2011). *Trends in the use of remand in Canada*. Statistics Canada. https://www.publicsafety.gc.ca/lbrr/archives/jrst11440-eng.pdf

Protzel, M.S. (1972). Nursing behind bars. *The American Journal of Nursing, 72*(3), 505-508.

Ptak A. (1975). Replacing pill pushing with nursing. *American Journal of Nursing 75*(3), 427-28.

Ramsden, I. (2002). *Cultural safety and nursing education in Aotearoa and Te Waipounamu* [Unpublished doctoral dissertation]. Victoria University of Wellington.

Ramsden, I. & Spoonley, P. (1994). The cultural safety debate in nursing education in Aotearoa. *New Zealand Annual Review of Education, 3*, 161-174.

Raphael, D. (2004). Introduction to the social determinants of health. In D. Raphael (Ed.) *Social Determinants of Health: Canadian Perspectives* (pp.1-18). Canadian Scholars Press.

Raphael, D., Bryant, T., Mikkonen, J. and Raphael, A. (2020). *Social Determinants of Health: The Canadian Facts*. Ontario Tech University Faculty of Health Sciences and Toronto: York University School of Health Policy and Management. https://thecanadianfacts.org/The_Canadian_Facts-2nd_ed.pdf

Raphael, S. & Stoll, M.A. (2013). Assessing the contribution of deinstitutionalization of the metally ill to growth in the U.S. incarceration rate. *The Journal of Legal Studies, 42*(1), 187-222.

Reed, P.G. (1996). Transforming practice knowledge into nursing knowledge: A revisionist

analysis of Peplau. *Journal of Nursing Scholarship 28*(1), 29-33.

Reeves, C. (2014). Nursing in prison. In E. Walsh & A. Norman (Eds.), *Nursing in criminal justice services* (pp 55-70). M & K Publishing.

Reimer, G.R. (2007). Transforming correctional health care through advanced correctional nursing education. *Journal of Correctional Health Care, 13*(3), 163-169.

Reis, M.D., Rempel, G.R., Scott, S.D., Brady-Fryer, B.A. & Van Aerde, J. (2010). Developing nurse/parent relationships in the NICU through negotiated partnership. *Journal of Obstetric, Gynecologic, and Neonatal Nursing, 36*(6), 675-683. htpps://doi.org/10.1111/j.1552-6909.2010.01189.x

Reviere, R. & Young, V.D. (2004). Aging behind bars: Health care for older female inmates. *Journal of Women & Aging, 16*(1/2), 55-69.

Richards, L. & Morse, J. (2013). *ReadMe First for a User's Guide to Qualitative Methods* (3rd ed.). Sage.

Rimm-Kaufman, S. E., Pianta, R. C., Cox, M. J., & Bradley, R. H. (2003). Teacher-rated family involvement and children's social and academic outcomes in kindergarten. *Early Education and Development*, *14*, 179-198.

Saik, B. (2020). A correctional facility nurse describes what it's like to work on the 'inside.' *Canadian Nurse, 116*(11). https://www.canadian-nurse.com/dev-cn-en/blogs/cn-content/2020/11/02/a-correctional-facility-nurse-describes

Salt, R. J., Costantino, M. E., Dotson, E. L., & Paper, B. M. (2017). "You are not alone" strategies for addressing mental health and health promotion with a refugee women's sewing group. *Issues in Mental Health Nursing, 38*(4), 337-343.

Sasso, L., Delogu, B., Carrozzino, R., Aleo, G. & Bagnasco, A. (2018). Ethical issues of prison nursing: A qualitative study in Northern Italy. *Nursing Ethics, 25*(3), 393-409.

Saunders, B., Sim, J., Kingston, T., Baker, S., Waterfield, J., Bartlam, B., . . . Jinks, C. (2017). Saturation in qualitative research: Exploring its conceptualization and operationalization. *Quality & Quantity, 52*, 1893.

Savage, J. (2000). Ethnography and health care. *British Medical Journal, 321*(7273), 1400-1402.

Savage, L. (2019). *Juristat: Female offenders in Canada, 2017*. Statistics Canada.

Schafer, P. & Peternelj-Taylor, C. (2003). Therapeutic relationships and boundary maintenance: The perspective of forensic patients enrolled in a treatment program for violent offenders. *Issues in Mental Health Nursing, 24*, (6-7), 605-625.

Schoenly, L. (2013). Context of correctional nursing. In L. Schoenly & C.M. Knox (Eds.) *Essentials of correctional nursing* (pp. 1- 18). Springer Publishing Company.

Schonbrun, Y.C., Johnson, J.E., Anderson, B.J., Caviness, C. & Stein, M.D. (2017). Hazardously drinking jailed women: Post-release perceived needs and risk of reincarceration. *International Journal of Offender Therapy and Comparative Criminology, 61*(16), 1819-1832.

Sealy, P.A. (2012). The impact of the process of deinstitutionalization of mental health services in Canada: An increase in accessing of health professionals for mental health concerns. *Social Work in Public Health, 27*(3), 229-237.

Sealy, P.A. & Whitehead, P. C. (2004). Forty years of deinstitutionalization of psychiatric services in Canada: An empirical assessment. *Canadian Journal of Psychiatry, 49*(4), 249-257.

Sered, S.S. & Norton-Hawk, M. (2019). Women on the institutional circuit: A 9-year qualitative study. *Journal of Correctional Health Care, 25*(1), 25-36. htpps://doi.org/10.1177/1078345818819811

Serpell, Z. N., & Mashburn, A. J. (2012). Family-school connectedness and children's early social development. *Social Development*, *21*, 21-46. htpps://doi.org/10.1111/j.1467-9507.2011.00623.x

Shade, K., Kools, S., Weiss, S.J. & Pinderhughes, H. (2011). A conceptual model of incarcerated adolescent fatherhood: Adolescent identity development and the concept of intersectionality. *Journal of Child and Adolescent Psychiatric Nursing, 24,* 98-104.

Shelton, D. (2009). Forensic nursing in secure environments. *Journal of Forensic Nursing, 5*(3), 131-142.

Shelton, D., Maruca, A.T. & Wright, R. (2020). Nursing in the American justice system. *Archives of Psychiatric Nursing, 34*(5), 304-309.

Simon, L., Beckman, D., Stone, M., Williams, R., Cohen, M. & Tobey, M. (2020). Clinician experiences of care provision in the correctional setting: A scoping review. *Journal of Correctional Health Care, 26*(4), 301-314. https://doi.org/10.1177/1078345820953154

Simon, M., Salamat, K. & Gustavson, K. (2020). Improving care at correctional facilities: Listening, learning and creating change from a patient care quality office. *Nursing Leadership, 33*(1), 52-58.

Smith, A.D. (2021, December 26). *Splitting: It's not just for borderline personality*. Psychology Today. https://www.psychologytoday.com/ca/blog/and-running/202112/splitting-it-s-not-just-borderline-personality

Smith, E. (2010). Care versus custody: Nursing in the prison service. *Practice Nurse, 40*(7), 33-35.

Smith, S. (2005). Stepping through the looking glass: Professional autonomy in correctional nursing. *Corrections Today, (February)*, 54-56, 70.

Smith, S. (2021). Addressing moral distress in correctional nursing: A call to action. *Journal of Correctional Health Care, 27*(2), 75-80.

Smye, V., & Browne, A. J. (2002). 'Cultural safety' and the analysis of health policy affecting aboriginal people. *Nurse Researcher, 9*(3), 42-56.

Smye, V., Rameka, M., & Willis, E. (2006). Indigenous health care: Advances in nursing practice. *Contemporary Nurse, 22*(2), 142-154.

Solell, P. & Smith, K. (2019). 'If we truly cared': Understanding barriers to person-centred nursing in correctional facilities. *International Practice Development Journal, 9*(2), 7. htpps://doi.org/10.19043/ipdj.92.007

Spagnolo, J. (2014). Improving first-line mental health services in Canada: Addressing two challenges caused by the deinstitutionalization movement. *Healthcare Quarterly, 17*(4), 41-45.

Spiers, J. A. & Wood, A. (2010). Building a therapeutic alliance in brief therapy: The experience of community mental health nurses. *Archives of Psychiatric Nursing, 24*(6), 373-386.

Stein-Parbury, J. & Liaschenko, J. (2007). Understanding collaboration between nurses and physicians as knowledge at work. *American Journal of Critical Care, 16*(5), 470-477.

Stepaniuk B.A. (1981). Nursing in juvenile corrections. *American Journal of Nursing 81*(4), 742-43.

Stephenson, A.L. & Bell, N. (2019). Finding meaningful work in difficult circumstances: A study of prison healthcare workers. *Health Services Management Research, 32*(2), 69-77.

Stevens, R. (1993). When your clients are in jail. *Nursing Forum, 28*(4), 5-8.

Suarez, A. (2021). "I wish I could hold your hand": Inconsistent interactions between pregnant women and prison officers. *Journal of Correctional Health Care, 27*(1), 23-29. https://doi.org/10.1089/jchc.19.06.0048

Sun, S., Crooks, N., Kemnitz, R. & Westergaard, R. P. (2018). Re-entry experiences of Black men living with HIV/AIDS after release from prison: Intersectionality and implications for care. *Social Science & Medicine, 211*, 78-86.

Talaga, T. (2017). *Seven Fallen Feathers: Racism, Death, and Hard Truths in a Northern City.* House of Anansi Press.

Terblanche, L. & Reimer-Kirkham, S. (2020). Nursing leadership implications for clinical placements in corrections. *Nursing Leadership, 33*(1), 35-51.

The Canadian Encyclopedia. (2022a). *Rupert's Land*. https://www.thecanadianencyclopedia.ca/en/article/ruperts-land

The Canadian Encyclopedia. (2022b). *Treaty 6.* https://www.thecanadianencyclopedia.ca/en/article/treaty-6

Thistle, J. (2019). *From the Ashes*. Simon & Schuster.

Thomas, K., Wilson, J.L., Bedell, P. & Morse, D.S. (2019). "They didn't give up on me": A women's transitions clinic from the perspective of re-entering women. *Addiction Science & Clinical Practice, 14*(1), 12. https://doi.org/10.1186/s13722-019-0142-8

Torrey, E.F., Zdanowicz, M.T., Kennard, A.D., Lamb, H.R., Eslinger, D.F. Biasotti, M.C. & Fuller, D.A. (2014). *The treatment of persons with mental illness in prisons and jails: A state survey.* The Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/storage/documents/treatment-behind-bars/treatment-behind-bars.pdf

Tripodi, S., Pettus-Davis, C., Bender, K., Fitzgerald, M., Renn, T. & Kennedy, S. (2019). Pathways to recidivism for women released from prison: A mediated model of abuse, mental health issues, and substance use. *Criminal Justice and Behaviour, 46*(9), 1219-1236.

Truth and Reconciliation Commission of Canada (2015). *Truth and reconciliation commission of Canada: Calls to Action*. Author. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

Tyler, N., Miles, H.L., Karadag, B. & Rogers, G. (2019). An updated picture of the mental health needs of male and female prisoners in the UK: Prevalence, comorbidity, and gender differences. *Social Psychiatry and Psychiatric Epidemiology*, *54,* 1143-1152.

United Nations (n.d.). *Indigenous peoples, Indigenous voices*. Author. https://www.un.org/esa/socdev/unpfii/documents/5session_factsheet1.pdf

United Nations (1948). *Universal declaration of human rights*. Author. https://www.un.org/en/about-us/universal-declaration-of-human-rights

United Nations Office on Drugs and Crime (UNODC) (2015). *The United Nations standard minimum rules for the treatment of prisoners: The Nelson Mandela rules.* Author. https://documents-dds-ny.un.org/doc/UNDOC/GEN/N15/443/41/PDF/N1544341.pdf?OpenElement

Urbanoski, k., Pauly, B., Inglis, D., Cameron, F., Haddard, T., Phillips, J., Phillips, P., Rosen, C., Schlotter, G., Hartney, E. & Wallace, B. (2020). Defining culturally safe primary care for people who use substances: A participatory concept mapping study. *BMC Health Services Research, 20*(1), 1060.

Veal, C. (2001). Clinical challenges that face nurses working in a correctional setting. *Contemporary Nurse, 10*(3-4), 228-233.

Vermette, K. (2021). *The Strangers.* Penguin Random House.

Wagenfeld, A. & Winterbottom, D. (2021). Coping on the inside: Design for therapeutic incarceration interventions – A case study. *Work, 68*(1), 97-106. htpps://doi.org/10.3233/WOR-203360.

Wakefield, J. (2018, June 24). Correctional officer turned nurse shines a light on pregnancy, women's health in Alberta jails. *Edmonton Journal.*

Walker, J.L. (2012). The use of saturation in qualitative research. *Canadian Journal of Cardiovascular Nursing, 22*(2), 37-41.

Walmsley, R. (2017). World Pre-trial/Remand Imprisonment List (3rd ed.). *International Centre for Prison Studies.* http://www.prisonstudies.org/sites/default/files/resources/downloads/wptril_3rd_edition.pdf

Wall, S. (2015). Focused ethnography: A methodological adaption for social research in emerging contexts. *Forum: Qualitative Sozialforschung / Forum: Qualitative Social Research, 16*(1), Art.1.

Walsh, E. (2008). The emotional labour of nurses working in her Majesty's (HM) prison service. *Journal of Forensic Nursing, 5*(3), 143-152.

Walsh E. & Freshwater, D. (2009). The mental well-being of prison nurses in England and Wales. *Journal of Research in Nursing, 14*(6), 553-564.

Webkamigad, S., Cote-Meek, S., Pianosi, B & Jacklin, K. (2020). Exploring the appropriateness of culturally safe dementia information with Indigenous people in an urban northern Ontario community. *Canadian Journal on Aging, 39*(2), 235-246.

Webkamigad, S., Warry, W., Blind, M. & Jacklin, K. (2020). An approach to improve dementia health literacy in Indigenous communities. *Journal of Cross-Cultural Gerontology, 35*(1), 69-83.

Weiskopf, C.S. (2005). Nurses' experience of caring for inmate patients. *Journal of Advanced Nursing, 49*(4), 336-343.

Whitson,, D., Wall, k. & Gannon, D.C. (2021). Alberta: From rags to riches to roulette. In D. Saint-Pierre & M. Gattinger (Eds.), Cultural Policy: Origins, evolution, and implementation in Canada's provinces and territories (pp. 439-479). University of Ottawa Press.

Williams, T. & Heavey, E. (2014). How to meet the challenges of correctional nursing. *Nursing 2014, 44*(1), 51-54.

Willmott, Y. (1997). Prison nursing: The tension between custody and caring. *British Journal of Nursing, 6*(6), 333-336.

Wilson, D., & Neville, S. (2009). Culturally safe research with vulnerable populations. *Contemporary Nurse, 33*(1), 69-79.

Winstead-Fry P. (1975). Mental health nursing of inmates. *American Journal of Nursing 75*(3), 425-26.

Wirmando, Astari, A.M. & Yuliatun, L. (2022). Caring for criminals. *International Journal of Caring Sciences, 14*(2), 1034-1044.

World Health Organization (WHO). (2009). *Women's health in prison: Correcting gender inequity in prison health.* World Health Organization Regional Office for Europe. http://www.euro.who.int/__data/assets/pdf_file/0004/76513/E92347.pdf

World Health Organization (WHO). (2010). *A conceptual framework for action on the social determinants of health: Social determinants of health discussion paper 2: Debates, policy & practice, case* studies. Author. https://www.who.int/publications/i/item/9789241500852

World Health Organization (WHO). (2018 March 30). *Mental health: Strengthening our response.* Author. https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response

World Health Organization (WHO). (2019 November 28). *Mental disorders.* Author. https://www.who.int/news-room/fact-sheets/detail/mental-disorders

Young, D.S. (2000). Women's perceptions of health care in prison. *Health Care for Women International, 21*(3), 219-234. htpps://doi.org/10.1080/073993300245276

Appendix A: Correctional Facilities that House Women in Canada

Facility	Type & Jurisdiction	Location	Sex
Algoma Treatment and Remand Centre	Provincial Remand	Ontario	Men & Women
Alouette Correctional Centre for Women	Provincial Sentenced	British Columbia	Women
Amos Detention Centre	Provincial Remand & Sentenced	Quebec	Men & Women
Calgary Remand Centre	Provincial Remand	Alberta	Men & Women
Central Nova Scotia Correctional Facility	Provincial Remand & Sentenced	Nova Scotia	Men & Women
Corner Brook Lock-up	Provincial Remand	Newfoundland	Men & Women
Edmonton Institution for Women	Federal Sentenced	Alberta	Women
Edmonton Remand Centre	Provincial Remand	Alberta	Men & Women
Elgin-Middlesex Detention Centre	Provincial Remand	Ontario	Men & Women
Fraser Valley Institute for Women	Federal Sentenced	British Columbia	Women
Fort Saskatchewan Correctional Centre	Provincial Sentenced	Alberta	Men & Women
Fort Smith Correctional Complex	Provincial Remand & Sentenced	Northwest Territories	Men & Women
Grand Valley Institution for Women	Federal Sentenced	Ontario	Women
Joliette Institution for Women	Federal Sentenced	Quebec	Women
Kenora Jail	Provincial Remand	Ontario	Men & Women
LeClerc Detention Centre	Provincial Remand & Sentenced	Quebec	Men & Women
Lethbridge Correctional Centre	Provincial Remand & Sentenced	Alberta	Men & Women
Nanaimo Correctional Centre	Provincial Sentenced	British Columbia	Men & Women
New Brunswick Women's Correctional Centre	Provincial Sentenced	New Brunswick	Women
Newfoundland and Labrador Correctional Centre for Women	Provincial Sentenced	Newfoundland	Women
Niagara Detention Centre	Provincial Remand	Ontario	Men & Women
Facility	**Type & Jurisdiction**	**Location**	**Sex**
North Bay Jail	Provincial Remand	Ontario	Men & Women
Nova Institution for Women	Federal Sentenced	Nova Scotia	Women
Nunavut Women's Correctional Centre	Provincial Remand & Sentenced	Nunavut	Women

Okimaw Ohci Healing Lodge	Federal Sentenced	Saskatchewan	Women
Orsainville Detention Centre	Provincial Remand	Quebec	Men & Women
Ottawa-Carleton Detention Centre	Provincial Remand	Ontario	Men & Women
Pine Grove Correctional Centre	Provincial Sentenced	Saskatchewan	Women
Provincial Correctional Centre	Provincial Sentenced	Prince Edward Island	Men & Women
Quinte Detention Centre	Provincial Remand	Ontario	Men & Women
Red Deer Remand Center	Provincial Remand	Alberta	Men & Women
Saint John Regional Correctional Centre	Provincial Remand & Sentenced	New Brunswick	Men & Women
Saint-Jerome Detention Centre	Provincial Remand & Sentenced	Quebec	Men & Women
Sarnia Jail	Provincial Remand	Ontario	Men & Women
Saskatoon Community Training Residence for Women	Provincial Sentenced	Saskatchewan	Women
Saskatoon Correctional Centre	Provincial Remand & Sentenced	Saskatchewan	Men & Women
St. John's City Lock-up	Provincial Remand	Newfoundland	Men & Women
Sudbury Jail	Provincial Remand	Ontario	Men & Women
Tanguay Detention Centre	Provincial Remand	Quebec	Women
Territorial Women Correctional Centre	Provincial Sentenced	Northwest Territories	Women
The Pas Correctional Facility	Provincial Sentenced	Manitoba	Men & Women
Vanier Centre for Women	Provincial Sentenced	Ontario	Women
Whitehorse Correctional Centre	Provincial Remand & Sentenced	Yukon	Men & Women
Winnipeg Remand Centre	Provincial Remand	Manitoba	Men & Women
Women's Correctional Centre	Provincial Sentenced	Manitoba	Women

Appendix B: Study Poster

Participate in a Study

WHAT IS THE EXPERIENCE OF CORRECTIONAL NURSES CARING FOR INCARCERATED WOMEN?

If you currently work in corrections or have ever worked in corrections, I want to hear about your experience.

I am a PhD student at the University of Alberta, Faculty of Nursing. My research aims to better understand the correctional nurse-patient relationship.

To be eligible to participate in this study, you must:
1. Be a Registered Nurse, Registered Psychiatric Nurse, Licenced Practical Nurse or Nurse Practitioner;
2. Be over the age of 18, speak and understand English, and have the capacity to consent to participate in the study;
3. Currently work in or have ever worked in a Canadian correctional facility;
4. Currently work with or have ever worked with incarcerated women in Canada;
5. Be willing to talk about your experiences.

Interviews will take place virtually at your convenience and last approximately 1 hour. You will receive a $10 coffee card for your time.

To learn more, please contact:
Cybele Angel, RN, MA
PhD Candidate, Faculty of Nursing, University of Alberta
Email: cangel@ulberta.ca

Appendix C: Email Template

Hello,

My name is Cybele Angel. I am a PhD Candidate in Nursing at the University of Alberta. My area of research is correctional nurses working with women who are incarcerated. I will be studying the nurse-patient relationship.

I am writing to ask if it would be possible to recruit participants through your organization. I would like to send a recruitment poster with an email request to your membership. This would have the details to contact me.

The template for the email request is below. If you have any questions regarding this request, please let me know.

Cybele Angel RN BScN MA CPMHN(C)
PhD Candidate
Faculty of Nursing
University of Alberta

Email for potential participants:

Subject line for the email: Invitation to participate in a research project

Content:

Hello,

I am a PhD student in Nursing at the University of Alberta conducting research on correctional nurses working with women who are incarcerated. I am recruiting correctional nurses to participate in an individual interview about your experience.

Attached is a recruitment poster with the study and participation information.

Thank you,

Cybele Angel RN BScN MA CPMHN(C)
PhD Candidate
Faculty of Nursing
University of Alberta
cangel@ualberta.ca

Appendix D: Interview Guide

INTERVIEW GUIDE:
Individual Semi-structured Interview
PhD research project – A Focused Ethnography of Correctional Nurses Who Care for Incarcerated Women with Mental Health Concerns in Canada

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Office use only:
Interview location:

Interviewer: _____

Interview start time: _____ Interview end time: _____

Date of Interview: _____

INTRODUCTION:

- Thank you again for agreeing to participate in this study. Your opinions are very important to me. I'd like to understand your experiences working with incarcerated women.

- Your information will be kept confidential. As well, the information you share will NOT be identifiable.

- As a reminder, you do not need to answer any questions that make you feel uncomfortable.

- Please remember, there are no right or wrong answers, so please be open and say what comes to your mind.

- As we talked about in the consent form, I will record this interview so that I can make sure I have everything you tell me during the interview.

- This interview will take approximately one hour.

- Remember, your name will not be used on the recording and we ask if you mention any other people, please don't use their names either.

- Also, remember that you can end the interview at any time.

- Do you have any questions before we begin?

BEGIN RECORDING:

Today's date is: _____/____/_____ and I am with Study ID #'s _____.

Background

Let's begin with some background information.

1. What is your professional registration?
2. Can you tell me how long you have been practicing nursing?
3. How long have you practiced in corrections?
4. What kind of correctional facilities have you work in?
    a. How long at each facility?
    b. What has been your history working with incarcerated women?
5. What led you to work in corrections?

Nurse – patient relationships

1. Thinking about your experience working with incarcerated women:
    a. Can you tell me about a typical day?
    b. Can you tell me about a typical interaction?
2. Thinking about your experiences with incarcerated women, can you tell me about a time where you had a positive interaction, or you witnessed a positive interaction?
3. Thinking about your experiences with incarcerated women, can you tell me about a time where you had a poor interaction, or witnessed a poor interaction?
4. How would you describe nurse-patient relationships in a correctional facility?

5. Thinking about your experiences with incarcerated women:
    a. Can you tell me how you define mental health concerns / issues?

    b. Can you tell me about your experiences with women that have a mental health concern / issue? *Prompt: these can be women with any kind of diagnosed or self-reported mental disorder (depression, anxiety, personality disorders, bipolar disorders or schizophrenia as a few examples).*

6. Thinking about your experiences providing heath or mental health care to incarcerated women, can you tell me if it is customary for officers to be present? Can you tell me about these interactions?

    a. How does the presence of an officer impact your patient care?

    b. How does the presence of an officer impact the nurse-patient relationship?

Core Correctional Nursing Values

1. When you think of your work as a correctional nurse, how would you define correctional nursing practice?

2. What do you think are the core nursing values in correctional nursing?

3. Thinking about your work as a correctional nurse, what do you think your impact is on the mental health and well-being of incarcerated women?

Support for Correctional Nurses

1. Thinking about your work as a correctional nurse, what supports do you have in place that positively impact your nurse-patient relationship?

2. Thinking about your work as a correctional nurse, what supports would you like to see in place that could improve your nurse-patient relationship?

Cultural Safety

Part of my research is around the concept of Cultural Safety and correctional healthcare.

1. Are you familiar with the concept "Cultural Safety"? If so, what does it mean to you?

2. Part of Cultural Safety is the idea that the nurse is a carrier of his/her own culture. How do you identify with your culture?

3. Do you think your culture has an impact on your nurse-patient relationships?

CLOSING: We're almost at the end of our time together. Just a few last questions…

- Is there anything else we should know about **any of** these issues we've talked about?
- Is there something I forgot to ask you?
- Do you have any comments to share with us about this interview or this study?

TURN OFF RECORDER NOW.

Interviewer Notes (use other side if necessary):

Appendix E: Information Letter Consent Form

Level 3 Edmonton Clinic health Academy
11405 – 87 Ave
Edmonton Alberta, Canada, T6G 1C9
Tel : 1-888-492-8089
Fax : 780=492- 2551
www.nursing.ualberta.ca

Information Sheet

TITLE OF RESEARCH STUDY:
A Focused Ethnography of Correctional Nurses Who Care for Incarcerated Women with Mental Health Concerns in Canada

RESEARCH TEAM:

Principal Investigator:
Cybele Angel
PhD Candidate, Faculty of Nursing
Level 5 ECHA, University of Alberta
cangel@ualberta.ca

Supervisor:
Dr. Tanya Park
Associate Professor, Faculty of Nursing
Level 5 ECHA, University of Alberta
tanya.park@ualberta.ca

Supervisory Committee members:
Dr. Margot Jackson
Assistant Professor, Faculty of Nursing
Level 5 ECHA, University of Alberta
margotj@ualberta.ca

Dr Kathleen Hegadoren
Faculty of Nursing
University of Alberta
Kathy.hegadoren@ualberta.ca

You are being asked to take part in a study. Before agreeing to participate, it is important that you read and understand this information and consent form. This form provides the information you need in order to make an informed decision about whether or not you wish to participate in this study. The following information describes the background, purpose, procedures, benefits and risks. It also describes your right to refuse to participate or withdraw from the study at any time. Should you have any questions while reading this form or after

reading this form, please ask the researcher whose contact information is listed above. Make sure all your questions have been answered to your satisfaction before signing this document or giving your verbal consent.

Background and Purpose
Incarcerated women with mental health disorders are disproportionally burdened in the corrections healthcare system. Once inside a correctional facility it is nursing staff that have the closest contact with these women. The nurse-patient relationship may mitigate the health burdens these patients face. The aim of this study is to shed light on this relationship, to understand the nurses' experiences in caring for incarcerated women with mental health disorders. By uncovering what it means to live and work as a correctional nurse, the health experience of incarcerated women may be changed for the better.

Procedure
You are invited to participate in one interview with the researcher (Cybele Angel). The interview will take approximately 60 minutes and will take place virtually via Zoom at a time that is convenient for you.

During the interview, you will be asked to discuss your experience working with incarcerated women. The interview will be audio / video recorded and notes will be taken during the interview by the researcher. All recordings will be kept confidential and only be listened to by the researcher and her supervisor. Your name and anything you say that could identify you will be removed before sharing the transcription with other research team members for analysis. The transcription will not be shared with anyone outside of the research team.

Potential Benefits
There may be no direct benefits from participation in this study. However, this research will lead to a better understanding of the correctional nursing experience, and more specifically how the nurse-patient relationship is constructed. The goal of exploring the nurses' experiences with this specific patient population is to inform and improve correctional nursing practice.

Potential Risks
There are no direct long or short-term risks anticipated as a result of participating in this study. The only potential risk may include emotional distress. In the unlikely situation where you become upset the researcher will ask you if you would prefer to stop your participation in this study. If needed, assistance with referral to counselling will be provided.

Financial Compensation
You will receive a $10 coffee card as compensation for your participation in this study.

Confidentiality
The information obtained during the interview will be kept confidential and will not be available to anyone except the researcher team members, and members of the Ethics Review Board will have access to the study data. All information obtained in this study will be used for research purpose only. The information obtained during the interview will be kept in a secure and confidential data repository for a period of 5 years after the study is completed and will then be destroyed. Consent forms will be kept in a separate secure and confidential data repository for the same period of time and will then also be destroyed.

The findings of this study will be used in presentations and publications. Direct quotes from the interview may be used in reports, presentations and/or publications, but no identifying information (including your name) will be provided with these quotes. Pseudonyms will be used in research reports or publications.

Voluntary participation
Your participation in the study is voluntary. You are free to refuse to answer any questions, refuse to take part in the study or to withdraw from the study at any time without giving any reason. If you choose to withdraw from this study, your data will be removed and destroyed from the database. However, the last day to withdraw your interview once completed will be seven days after your interview as the answers will be integrated and impossible to remove after this point.

You will receive the $10.00 gift card even if you decide to withdraw from the study during the interview or if you decide to withdraw your interview from the study within one week of completing the interview.

Future use of the study
The findings of the study shall be presented at the conferences and with the hope of publishing in peer-reviewed journals.

Further information
If you have any further questions regarding this study, please do not hesitate to contact Cybele Angel at cangel@ualberta.ca. The plan for this study has been reviewed for its adherence to ethical guidelines by the Health Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at +1 (780) 492-2615. This office has no direct involvement with this study.

Please keep a copy of this letter for reference.

Level 3 Edmonton Clinic health Academy
11405 – 87 Ave
Edmonton Alberta, Canada, T6G 1C9
Tel : 1-888-492-8089
Fax : 780=492- 2551
www.nursing.ualberta.ca

Consent form for Individual Interview

TITLE OF RESEARCH STUDY:
A Focused Ethnography of Correctional Nurses Who Care for Incarcerated Women with Mental Health Concerns in Canada

RESEARCH TEAM:

Principal Investigator:
Cybele Angel
PhD student, Faculty of Nursing
Level 5 ECHA, University of Alberta
cangel@ualberta.ca

Supervisor:
Dr. Tanya Park
Associate Professor, Faculty of Nursing
Level 5 ECHA, University of Alberta
tanya.park@ualberta.ca

Do you understand that you have been asked to participate in a research study?	Yes	No
Have you read and received a copy of the attached Information Sheet?	Yes	No
Do you understand the benefits and risks involved in taking part in this research study?	Yes	No
Have you had an opportunity to ask questions and discuss this study?	Yes	No
Do you understand that you are free to refuse to participate or that can withdraw from the study at any time? You do not have to give a reason.	Yes	No
Do you consent to be interviewed?		
Do you consent to be audio / video taped?	Yes	No
Has the issue of confidentiality been explained to you?	Yes	No

This study was explained to me by: _____

I, _____ agree to participate in this study.

_____ _____
Signature of Research Participant Date

_____
Printed Name

I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate.

_____ _____
Signature of Investigator or Designee Date

Appendix F: Ethics Approval

Notification of Approval

Date:	June 1, 2021
Study ID:	Pro00110611
Principal Investigator:	Cybele Angel
Study Supervisor:	Tanya Park
Study Title:	A Focused Ethnography of Correctional Nurses Who Care for Incarcerated Women with Mental Health Concerns in Canada
Approval Expiry Date:	May 31, 2022

Thank you for submitting the above study to the Research Ethics Board 1. Your application has been reviewed and approved on behalf of the committee.

Approved Documents:

Recruitment Materials

Email template, Version 1, May 30, 2021

Recruitment Poster Clean Copy, Version 2, May 30, 2021

Consent Forms

Consent form clean copy, Version 2, May 30, 2021

Information Sheet Clean copy, Version 2, May 30, 2021

Questionnaires, Cover Letters, Surveys, Tests, Interview Scripts, etc.

Interview Guide Clean Copy, Version 1, May 30, 2021

Any proposed changes to the study must be submitted to the REB for approval prior to implementation. A renewal report must be submitted next year prior to the expiry of this approval if your study still requires ethics approval. If you do not renew on or before the renewal expiry date, you will have to re-submit an ethics application.

Approval by the Research Ethics Board does not encompass authorization to access the staff, students, facilities or resources of local institutions for the purposes of the research.

Approval by the Research Ethics Board does not encompass authorization to recruit and/or interact with human participants at this time. Researchers still require operational approval as applicable (e.g., AHS, Covenant Health, ECSD, etc.), and where in-person interactions are proposed, institutional and operational requirements outlined in the Resumption of Human Participant Research - June 24, 2020, must be met.

Sincerely,

Carol Boliek, Ph.D.
Associate Chair, Research Ethics Board 1

Note: This correspondence includes an electronic signature (validation and approval via an online system).