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"If it wasn't for ethics, I wouldn't go near him": An Interpretative Phenomenological Analysis of caring for patient-prisoners in Kenya - A Pilot Study

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"If it wasn't for ethics, I wouldn't go near him": An Interpretative Phenomenological Analysis of caring for patient-prisoners in Kenya - A Pilot Study

Those caring for patient-prisoners experience distinct challenges that may impede effective treatment. Previous studies have investigated these issues from the perspective of forensic or correctional nurses, yet overlooked the lived experiences of nurses based in public health hospitals caring for patient-prisoners. In this study, semi-structured interviews were conducted with five nurses caring for patient-prisoners in public hospitals in Kenya. Interviews were analysed using interpretative phenomenological analysis. Four superordinate themes were identified; fear of patient- prisoner, time constraint, labelling, and optimism on recidivism. The fear of patient -prisoner theme included two sub-themes, perceived dangerousness and communication hindrance. The time constraint theme included three sub-themes, workload, short hospital stay, and task oriented system. The labelling theme contained the loss of individual identity and representative of a group sub-themes. Optimism on recidivism involved two sub-themes, reformation and rebuilding one's life. Future research should investigate the extent to which these impact on the patient-prisoner experience.

Keywords: *interpretative phenomenological analysis; nursing; offenders; patient care; prisoners*

Introduction

Approximately ten million adults are incarcerated globally (Walmsley, 2009) and research indicates that prisoners experience poorer physical and mental health than those in the general population (Butler et al. 2006; Fazel, Hayes, Bartellas, Clerici, & Trestman, 2016). This pattern is predicted to continue as the number of older men and women in custody increases (Williams, Stern, Mellow, Safer, & Greifinger, 2012). A range of factors may contribute to poor prisoner health (Douglas, Plugge, & Fitzpatrick, 2009) including prior trauma (Tripodi & Pettus-Davis, 2013), risky behaviour (e.g., substance use, Fazel, Bains, & Doll, 2006), and environmental factors (e.g., overcrowding or isolation, Nurse, Woodcock, & Ormsby, 2003; Warmsley, 2005). It is therefore important to consider the health care treatment delivered to patient-prisoners, particularly as these individuals have less control over their healthcare provider than members of the general population. Indeed initial research indicates that prisoners report low satisfaction with the health services received in custody (Bjorngaard, Rustad, & Kjelsberg, 2009).

Caring for patient-prisoners presents a distinct challenge, hence nurses frequently report difficulties providing care in a prison environment (Weiskopf, 2005). In part, these difficulties reflect the need to both maintain security and provide effective patient care (Mason, 2002; Weiskopf, 2005). The custody-care tension is consistently identified as problematic by healthcare workers based in prison settings (Maroney, 2005; Powell, Harris, Condon, & Kemple, 2010). For example, forensic nurses (i.e., those delivering nursing care in a custodial setting) report that correctional officers do not understand the requirements of patient care and their presence during treatment impedes treatment (Weiskopf, 2005). This may create tension between health care professionals and correctional officers (Alexander-Rodriguez, 1983). Particular issues result when communication that would typically be held in private become more public when treating prisoners (Flanagan & Flanagan, 2001).

Furthermore, practices such as preventing nurses from revealing personal information may hinder the formation of a therapeutic relationship or delivery of effective treatment (Weiskopf, 2005) and prison officers may signal their disapproval if nurses are perceived to be too friendly with prisoners (Flanagan & Flanagan, 2001).

Additional issues may arise from the patient-prisoner status. Patient-prisoners may prompt a range of reactions including fear and disgust (Jacob, Gagnon, & Holmes, 2009) and in forensic settings, nurses may use depersonalising language to describe their patients (Peternelj-Taylor, 2004) which serves to 'other' (i.e., separate and devalue) the patient. The process of othering negatively impacts on the therapeutic relationship and treatment provided (Corley & Goren, 1998). Patient-prisoners appear aware of the differential treatment they receive and female prisoners have reported receiving non-empathetic treatment. For example being treated as if they are undeserving of care (Young, 2000). As described by one prisoner "*My own personal opinion is they take these people who come in and they lump everybody in the same category and they say okay, they're a drug addict, they're street people, they're whatever they are, they're all lumped in one. So when I get to you, I'll get to you*" (Young, 2000, p228). This treatment may reflect a range of issues including fear, perceptions that patient-prisoners are manipulating healthcare professionals for personal gain, and over-representation of stigmatised groups in the prison population (Foster, Bell, & Jayasinghe, 2013; Maroney, 2005).

To investigate these issues, researchers have typically focused on the experiences of forensic or correctional nurses based in secure settings (e.g., Caplan, 1993). There is, however, a paucity of research investigating the experiences of nurses based in public health hospitals who are required to treat patient-prisoners taken to the hospital. These individuals may be less prepared than forensic nurses to treat patient-prisoners. Therefore, the present study investigates the experiences of nurses based in Kenyan public hospitals who deliver

care to patient-prisoners. Understanding the lived experiences of nurses delivering care may provide important information about the treatment of patients and the nurse-patient relationship and hence inform practice. Interpretative phenomenological analysis was utilized, a methodology that has previously been employed to understand the lived experiences of those delivering care and patients (e.g., Brewer & Tidy, 2016; Maguire, Stoddart, Flowers, McPhelim, & Kearney, 2014; Talbot & Brewer, 2016).

Method

Participants

Five nurses aged 26-50 years old were recruited through online purposive sampling. The sample size is consistent with recommendations for Interpretative Phenomenological Analysis (Creswell, 1998) and was guided by the amount of informational power (e.g., quality of the dialogue) produced by the data (Malterud, Siersma, & Guassora, 2016). All participants were qualified registered nurses based in Kenyan public hospitals with direct experience caring for patient-prisoners. Participant characteristics are shown in Table 1.

Interview Procedure and Data Analysis

Individual semi-structured interviews were conducted via WhatsApp or Skype. The use of digital technologies allowed recruitment of nurses from non-WEIRD (Western, Educated, Industrialised, Rich, Democratic) populations (Henrich, Heine, & Norenzayan, 2010) while retaining the synchronicity of a traditional face to face interview. Digital technologies are also more convenient for participants and can accommodate those unable to attend an interview in-person (Deakin & Wakefield, 2014; Lo Iacono, Symonds, & Brown, 2016). The use of digital technologies had no adverse impact on the interview. The interview schedule was developed following appropriate guidelines (Pietkiewicz & Smith, 2014; Smith, 1995) and encouraged participants to reflect on their experiences caring for patient-prisoners. Example questions included "Tell me how you felt when you were at the prisoner's bedside". Each interview lasted for 25-35 minutes. The interview procedure was consistent with interpretative phenomenological analysis and focused on the manner in which individuals make sense of their lived experience (Smith, Flowers, & Larkin, 2009).

Interviews were recorded and transcribed verbatim. Identifying details were removed at the point of transcription and pseudonyms were used to preserve participant anonymity. All participants consented to the publication of direct, anonymised, quotations. Interpretative

phenomenological analysis provides researchers with a position and protocol for the analysis of qualitative data. The researcher adopted a double hermeneutic process in order to understand each participants' experience and the manner in which the individual makes sense of that experience (Smith, Flowers, & Larkin, 2009). Transcripts were read and re-read, making notations of items that were significant. The researcher's focus was on content (what was said), language (metaphors, pauses, repetitions), context, and initial interpretative comments. Connections between emerging themes were then identified, grouped according to conceptual similarities, and each cluster was given a descriptive label. Guidelines proposed by Smith, Flowers, and Larkin (2009) were followed throughout the data collection and analytic process.

Results

Four superordinate themes were identified; fear of the patient-prisoner, time constraint, labelling, and optimism about desistance. The fear of the patient-prisoner theme contained two sub-themes; perceived dangerousness and communication hindrance. As shown in Table 2, the time constraint theme contained the workload, short hospital stay, and task oriented system sub-themes. The labelling theme contained the loss of individual identity and representative of a group sub-themes. The optimism on recidivism theme contained two sub-themes; reformation and rebuilding a life.

Fear of the Patient-Prisoner

Perceived Dangerousness: All participants expressed fear of patient-prisoners. This largely reflected a fear of the unknown based on visual cues such as the patient being chained to the bed and the presence of prison officers, which were interpreted as an indication of patient-prisoner dangerousness.

"*He was soft spoken, you know… the dangerous type, though I talked with him on several occasions, I was scared of him, he was chained to the bed on one hand and the opposite leg*" (June)

"*You cannot trust these people, he could have been marking us to attack us in future…he made me uncomfortable… If it wasn't for ethics, I wouldn't go near him…*" (Beth)

Communication Hindrance: All nurses commented that effective communication with the patient-prisoner would help them to understand their patient and reduce fear. The presence of prison officers, shortage of time, and patients' unwillingness to talk, were each believed to hinder effective communication.

"*I wanted to have a one-on-one talk with the patient, but the prison officer was always present, I planned to explain to him first, but I didn't get the opportunity, the patient was discharged*" (Asha)

"*I just talked the usual…how was your night...here is your medication… the prison officer was making it impossible to communicate because they were getting into the patient room every time health worker would approach it… they were listening to our conversations*" (June)

Time Constraint

  Workload: Participants commented on their workload and the extent to which this impacted on their ability to care for the patient-prisoner and their ability to develop a rapport. "*I only get time to talk to the patient during procedures and as you know, there's not much to discuss because other people including other patients near you who would distract us*" (Beth) "*We no longer have time to talk with a patient because of staff shortage, the wards were normally full but no additional staff. This used to leave me exhausted*" (Dave)

  Short Hospital Stay: Patients also reported that patient-prisoners were discharged very quickly, with medical care continued at the prison facilities. This limited opportunities for nurses to interact with the patient-prisoner.

"*One week is not enough to gain trust from a patient who feels like the whole world is against him, my patient was discharged just when we had started to feel comfortable being around him*" (Asha)

 "*I don't know whether its prison rules, or the hospital's that require these patients to be referred back within days unless the doctors recommended an extended stay, Its sad we don't get to hand over the patient for continuity of care*" (June)

  Task Oriented System: Participants perceived the Kenyan health system to be extremely task oriented and target driven. Recent developments have resulted in greater management and accountability; as a consequence some services such as counselling are not valued and are frequently dismissed.

"Performance contract requires proof of work done, in most cases a photo as you carry on the tasks, how would I present a photograph sitting at the patient bed side? This situation need to be remedied for the patients, wellbeing" (Dave)

"I believe patients are suffering emotionally and it will get worse because no nurses have been recruited, management does not understand holistic care. Counselling is no longer part of the nursing roles" (Violet)

Labelling

Loss of Individual Identity: Most participants reported that it is a common practice among staff and patients to refer to a prisoner-patient by their situation or status. Even when prisoner-patients insisted that they be called by their names they were referred to as prisoners. *"I find myself referring to him as prisoner and it is very natural, though I have never addressed him directly. I don't think I have ever asked him his name"* (Beth)

"I address every patient by name, but I forget always the name is not hard, but I just forget. I consider him be of a category …it's that I could not utter the name" (Asha)

Representative of a Group: Nurses viewed patient-prisoners in the wider context of other offenders and there was frequent reference to prisoners as "these people".

"Maybe it's because he has prison uniform, I think of the prisoners when I see him, how some torture their victims and how others harm helpless children. I know it sounds irrational, but it is hard to isolate one offender from the rest" (Violet)

"At first, when I found the prisoner in the ward, I wondered why he deserved help, yet they show no mercy when they attack despite one's pleas. To me, he was just like those who came to my house and robbed me, there was no difference, he must have hurt someone else" (Dave)

Optimism on Recidivism

Reformation: All participants were optimistic that patient-prisoners could reform and not re-offend.

"*I wished I could talk to him and encourage him to reform. Everyone can change, a prisoner needs understanding as they try to cope with the consequences of their actions*" (Beth).

"*I wondered whether he would be willing to leave crime…he could reform if he wanted, others have reformed and are living normal lives, … he would need help to integrate back into society then the rest would fall in place*" (Asha)

Rebuilding a Life: Nurses also expressed a desire to help the patient-prisoner make this change; further most recommended the involvement of a priest, family members, or counsellor to help the patient-prisoner develop a positive attitude towards life.

"*We should also be involved in helping the patient reform, everyone who came across this man should help him see the meaning of life, in prison he only relates with fellow prisoners, but we can give him hope*" (Dave)

"*For the time he was in the ward, I believed it was a chance to make my contribution towards his reformation, I wished he could be allowed visitation from a family member and a spiritual leader*" (Violet)

Discussion

In the present study, interviews were conducted and subject to interpretative phenomenological analysis. Four superordinate themes were identified; fear of patient-prisoner, time constraint, labelling, and optimism on recidivism.

Nurses were fearful of the patient-prisoners under their care. Previous research suggests that lay people and forensic psychiatric nurses make similar judgments with respect to perceived dangerousness (Jackson, 1988). Hence, the inaccurate beliefs about offenders which are common in the general population are also likely to impact on nurses (Levenson, Brannon, Fortney, & Baker, 2007). Factors impacting on perceived dangerousness include the nature of the offence and victim (Wood & Francis, 2007) though providing information about the environmental factors which contribute to offending may reduce perceived dangerousness (Quinsey & Cyr, 1986). Additional training may also be beneficial, increasing nurses' confidence that they can identify and manage risk. Nurses reported that visual cues such as the use of restraints and the presence of prison officers increased perceptions of patient-prisoner dangerousness. Caring for offenders requires both maintenance of security and the provision of specialist care (Weiskopf, 2005). Future research may review current practice and the level of security provided.

Effective communication between nurses and patients is essential, with communication influencing a range of important outcomes such as recovery rates, patient satisfaction, and adherence to treatment (e.g., Boissy, et al. 2016; Kelley, Kraft-Todd, Schapira, Kossowsky, & Reiss, 2014). Furthermore, communication issues contribute to treatment error (Sutcliffe, Lewton, & Rosenthal, 2004). Communication between nurses and the patient-prisoners in their care was problematic and may pose a threat to effective care. Consistent with previous research, communication was hindered by practical considerations such as a high workload and lack of time (Anoosheh, Zarkhah, Faghihzadeh, & Vaismoradi,

2009). In addition, factors specific to the treatment of offenders were identified such as the presence of prison officers. Prison officers represent authority and patient-prisoners may be unwilling to disclose important information in their presence, potentially leading to inappropriate treatment or deterioration of patient wellbeing. This is particularly likely if the prisoner is required to disclose stigmatising conditions or behaviour (e.g., substance abuse) that would result in punishment. Future research should further investigate this element of current practice and strategies to improve communication with patient-prisoners.

A substantial and increasing workload was problematic for all participants. This led participants to focus on the most essential tasks, provided minimal opportunities for engaging with patient-prisoners, and appeared to impact on nurse wellbeing, with participants commenting that they were "exhausted" by their role. This is consistent with previous research identifying the time pressures experienced by forensic nurses (Flanagan & Flanagan, 2001) and the negative impact of workload on nurse wellbeing and patient care (Sheward, Hunt, Hagen, Macleod, & Ball, 2005). This reflects a range of factors, such as an ageing population and an increase in chronic health conditions which heightens demand for health care workers. Future research is required to establish the impact of this issue on patient-prisoners both with regard to acute care and more generalised health care and health promotion.

Compared to non-offenders, patient-prisoners are admitted to the hospital for a relatively short period of time. The priority is to diagnose, treat, and stabilise the patient sufficiently to allow treatment on return to the prison. This limits opportunities for nurses to interact with patient-prisoners and to develop trust. Though the nurse must complete a series of complex technical tasks (e.g., monitoring health measures, administering medication), they must also establish a caring and supportive environment. This is more difficult when the patient-prisoner is resident for a short time only. The task oriented healthcare system was also

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perceived to contribute to difficulties treating patient-prisoners. This appears to be a global issue (Care Quality Commission, 2011), leading to lower nurse autonomy and poorer nurse-patient interactions (Dhondea, 1995). In particular, this approach may result in patients perceiving themselves to be "just another patient", perhaps even more pertinent for patient-prisoners who are often treated as a particular category of patient rather than as an individual.

It appears to be common practice, at least amongst those interviewed, to refer to patient-prisoners as a prisoner or by their offence. This labelling occurred even when patient-prisoners requested that their names be used. Findings are consistent with previous research reporting that forensic nurses working with substance misusing patients displayed stereotyping and moralism which negatively impact on the care provided (Adjorlolo, Abdul-Nasiru, Chan, & Bambi, 2018; Foster & Onyeukwu, 2003). As recommended by Neil (2012), health care practitioners working with offender populations should remember that those they care for are patients first and prisoners second. In addition, nurses perceived patient-prisoners as representatives of all offenders and qualitatively different from non-offenders. They did, however, find it difficult to explain how patient-prisoners differed, instead providing general comments based on the offense such as "no normal person can commit a crime". Future research should seek to establish the extent to which patient-prisoners are aware of such labelling as such stereotyping and perceived stigma can impact on subsequent behaviour and wellbeing (Moore, Stuewig, & Tangney, 2013).

Despite the 'othering' behaviour targeted at patient-prisoners, nurses reported that it was possible for offenders to cease criminal activity. They reported that support from the family or religious community would be particularly beneficial, consistent with previous reports that desistance is both a personal and social process requiring community-level and broader social and political commitment to ex-prisoner reintegration. The support for reformation reported by participants was not consistent with previous research identifying

low levels of community support for offender community reintegration (Hardcastle, Bartholomew, & Graffam, 2011). A range of factors impact on attitudes towards ex-offenders including prior interpersonal contact (Rade, Desmarais, & Mitchell, 2016), therefore increased support for reformation amongst nurses may reflect direct experience with patient-prisoners.

The current study employed interviews and interpretative phenomenological analysis to obtain a detailed understanding of nurses' lived experience caring for patient-prisoners. The subject has typically been examined in Western custodial settings, though important differences separate Kenyan and Western health care systems such as the loss of trained professionals to Western countries (Kirigia, Gbary, Muthuri, Nyoni, & Seddoh, 2006; Wamai, 2009) and extrapolation from one context to another is inappropriate. Data were of course collected from a small sample (characteristic of qualitative research) and further research is required to determine whether these experiences are representative of the wider nursing community and those factors which influence nurses' perceptions of patient-prisoners. Subsequent studies should also investigate the impact of caring for patient-prisoners on job satisfaction, wellbeing, and retention. Previous research has identified the impact of specific elements of the nursing role on staff wellbeing such as effective leadership and changes to the work environment (Laschinger, Finegan, & Wilk, 2011; Verhaeghe, Vlerick, Gemmel, Maele, & Backer, 2006). Finally, future studies should explore interactions between nurses and patient-prisoners from the patient-prisoner perspective and employ objective patient outcome measures. Though the nurses interviewed attempted to provide high quality medical care, restricted communication, difficulties developing a rapport, and the need to return patient-prisoners to a secure environment may compromise patient care.

To conclude, the present study builds upon previous research investigating patient-prisoner care in Western custodial settings. Nurses employed in Kenyan public hospitals

identified a number of issues which negatively impacted on their care of patient-prisoners. In particular, nurses were often fearful of the patient-prisoner and this fear was exacerbated by visible cues to their prisoner status. Managers should discuss the appropriate identification and management of risk with their employees to address undue anxiety. Further, interventions should be implemented to enhance communication between nurses and patient-prisoners. For example, labelling of patient-prisoners by offense rather than name should be discouraged and the impact of monitoring from prison officers should be investigated.

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Table 1: Participant Characteristics

Participant	Sex	Age (years)	Role	Years in Current Position	Department
June	Female	26	Staff Nurse	12 months	Surgical
Dave	Male	27	Staff Nurse	18 months	Maternity
Asha	Female	49	Lecturer	10 years	Training
Violet	Female	38	Senior Nurse	7 years	ICU
Beth	Female	50	Matron	10 years	Medical

Table 2: Superordinate and Sub-Themes

Superordinate Theme	Sub-Theme
Fear of Patient-Prisoner	Perceived Dangerousness
	Communication Hindrance
Time Constraint	Workload
	Short Hospital Stay
	Task Oriented System
Labelling	Loss of Individual Identity
	Representative of a Group
Optimism on Recidivism	Reformation
	Rebuilding a Life