FORENSIC NURSING: A REVIEW OF THE LITERATURE

John Doyle, RN, BA(DipEd), is a lecturer in nursing at the University of Western Sydney, Macarthur, Sydney, Australia

Accepted for publication July 2000

Key Words: literature review, forensic nursing, prison nursing

ABSTRACT

A review of the nursing literature reveals that forensic nursing is an emergent specialty area of practice that has undergone substantive role development in recent years. Forensic nurses have not only begun to write about the challenging and distinctive nature of their practice and their unique practice arrangements, but have commenced a concerted call to action for greater recognition within the nursing profession and correction and criminal justice system. The literature reveals an increasing demand for forensic nursing skills in a range of community and hospital based clinical settings. The problematic nature of caring for forensic clients in both correctional and less restrictive contexts of care remains a salient feature of forensic nurses' accounts of their practice.

INTRODUCTION

There is evidence in the published literature to suggest that forensic nursing is an emergent specialty area of practice which has undergone substantive role development in recent years.

The care nurses give in prisons and forensic institutions remains largely hidden from the public by the very nature of the places in which it is carried out. As correctional and criminal justice systems are often impervious to the reforms occurring in society, collectively forensic nurses have remained to some degree isolated from the mainstream of the nursing profession. However, they are gaining increasing international recognition for the challenging and distinctive nature of their practice and their unique practice arrangements (Peternelj-Taylor and Johnson 1995). In the past decade forensic nurses have not only begun to write about their practice more frequently (Peternelj-Taylor and Johnson 1996) but have commenced a concerted call to action for not only recognition within the nursing profession itself but a greater say in the ideological priorities of the organised provision of health care within society's correction and criminal justice system (Lego 1995). This article seeks to review the literature of a highly specialised and distinctive occupational cohort who deliver nursing care at those very points where society's intentions towards its criminal and offender elements are made known.

The challenge of caring for those persons who have committed offences against the law and whose treatment needs are met in prison, correctional or other secure settings has been hailed as one of the 'most exciting developments confronting the nursing profession this decade' (Peternelj-Taylor and Johnson 1995 p.12). The problems associated with the provision of quality nursing care to incarcerated offender and forensic populations have been identified as diverse, complex and pressing (Maeve 1997; Niskala 1987). Australia, like most developed nations, is experiencing a crisis of confidence in its ability and its willingness to either punish or to rehabilitate its criminal offenders. Decades of economic stringency, rapid social change and generational unemployment have been identified internationally as

resulting in the disproportionate over-representation of minority, disadvantaged and marginalised groups in the industrialised world's rapidly growing prison population (Lego 1995). The worldwide demand for the provision of specialised health care to increasingly diverse and expanding forensic inpatient populations in both hospitals and prisons has created 'a new and challenging frontier for the nursing profession' (Peternelj-Taylor and Johnson 1996 p.23).

The term 'forensic' however, when applied to nursing and to health related matters generally, is used with considerable latitude and in a wide range of diagnostic, clinical and medico-legal contexts. Before exploring the literature of this specialised area of nursing practice it is essential to identify what the descriptor 'forensic' implies when applied to nursing, and how such varied and seemingly divergent groups of nurses use it to describe their practice.

Forensic nursing defined

Statutory definitions not withstanding, the term 'forensic' implies the link between anything medical or health related and the law, particularly criminal law and the science of criminology. Within nursing literature, 'forensic' is a rubric which describes the delivery of nursing care to persons who have been remanded or convicted of crimes; who have committed offences against the law and have been found to be 'not guilty' by virtue of their suffering a mental illness, or have been the victims of crime, neglect or abuse (Peternelj-Taylor and Hufft 1997). Known also a 'correctional', 'corrections' or 'prison' nursing (Hennakem 1993; Paskalis 1993; Carmody 1988), forensic nursing care is delivered in a diversity of practice settings including prison hospitals and infirmaries secure or specialised units of public psychiatric hospitals,' regional secure units', and purpose-built 'forensic hospitals'. Some forensic nurses are based in police watch-houses, locked units of general hospitals or undertake the supervision of paroled offenders in the community. Other forensic nurses have very little professional contact with offenders, working with the victims of crime and their families in detecting, documenting and reporting evidence of crimes against the person (Lynch 1993; Birk 1992). Internationally, forensic nurses have been identified as a distinctive occupational group who 'integrate nursing philosophy and practice within a socio-cultural context that includes the criminal justice system' (Peternelj-Taylor and Johnson 1996 p.18). Birk (1992) asserts that forensic nurses practice 'anywhere the worlds of law and medicine collide' (p.7). In Australia the nature of forensic nursing practice and practice arrangements have been defined in terms of both the distinctive presentation of morbidity encountered in institutional forensic populations (Paskalis 1993; Carmody 1988) and the unique environmental influences of the forensic treatment milieu itself (Hennakem 1993). However, some commentators report that the devolution of the duty of care to mentally ill offenders to mainstream health service providers, and changes in mental health legislation has resulted in more Australian forensic nurses practising outside purely custodial or secure settings (Paskalis 1993).

While some authors have been forthright in claiming forensic nursing as a new sub-specialty of advanced psychiatric mental health nursing (Dunn et al 1996), others have emphasised its medical, surgical, primary health care and domiciliary nursing functions (Maeve 1997; Burrow 1993; Gulotta 1987; Niskala 1986; Lehman 1983). The literature reveals that the role development and professional 'consolidation' (Paskalis 1993 p.1) achieved by forensic nurses, within both the public health and correctional and criminal justice systems have served as a basis from which to expand their practice from purely custodial or institutional settings to less restrictive community-based contexts of care. Similarly, United States and Canadian forensic nurses have pushed the boundaries of their practice outward to construct independent practitioner roles in the detective and investigative functions of criminal justice, policing, accident, insurance and workers' compensation fields (Lynch 1993). Birk (1992) reports the development of forensic nursing roles in such diverse practice areas as accident and emergency and child care to collect photographic and material evidence from patients with signs or behaviours which might identify them as victims of crime or abuse. The highly specialised roles of forensic nurse coroner, death investigator, legal nurse consultant and even nurse attorney are also identified in the literature of forensic nursing (Dunn et al 1996; Lynch 1993).

An increasing demand for forensic nursing skills

A strong theme of the literature is that of an increasing demand for forensic nursing skills and experience by both publicly funded and private sector health service providers, correctional and criminal justice agencies (Maeve 1997; Peternelj-Taylor and Hufft 1996). Birk (1992) also reports a demand by hospitals for 'forensically educated nurses' (p.9) to identify, report and implement specialised interventions in cases involving sexual assault, child abuse, domestic violence, violent crime and addiction. While some nursing commentators (Lego 1995; Peternelj-Taylor and Johnson 1995) concede that this phenomenon is demand-driven, there has been no consensus reached in terms of its causes. Peternelj-Taylor and Johnson (1996) verify that 'the evolution of this specialty within nursing has seen forensic nurses providing the same standard of health care as to the community at large' (p.23). Most authors hold divergent views as to how this has occurred. However, the increasing demand for forensic nursing skills has been incrementally

linked to social and political changes in the way in which society's intentions towards its criminal elements are delivered (Drake 1998; Maeve 1997; Paskalis 1993; Maeve 1997). A hardening of community attitudes towards crime and punishment issues (Maeve 1997), the introduction of 'truth in sentencing' legislation (Lego 1995) and a willingness on behalf of the judiciary to hand down harsher prison sentences (Drake 1998; Osborne 1995) have all been identified as precipitating a crisis of overcrowding in the prisons of most developed nations. There is also a tendency to move away from the rehabilitation ideal in favour of a desire to punish or simply incapacitate the imprisoned offender as part of broader ideological changes in correctional and criminal justice philosophy. This has been cited by nursing commentators as fuelling the rapid expansion of prison building programs to accommodate the exponential growth in prison inmate numbers (Lego 1995; Paskalis 1993; Carmody 1988).

There is a strong conviction in the nursing literature that the ongoing responsibility of governments to meet their international treaty obligations to provide equitable and accessible standards of health care to prisoners has ensured a growing need for better correctional health services. An essential component has been identified as an incremental demand for specialised forensic nursing skills. This has been recognised as an essential requisite in meeting the health care needs of an incarcerated offender population which is elemental in its representation of those groups in society which are increasingly identified as the victims of social inequity and economic causation (Maeve 1997; Osborne 1995; Jenkins 1993).

The rising demand for forensic nursing skills has also been directly attributed to the disproportionate representation of the consumers of traditional mental health services in the correction and criminal justice system (Lego 1995; Caplan 1993; Hennakem 1993; Bernier 1991). For some commentators, as psychiatric hospitals have closed, prisons have simply taken their place as a repository for the mentally disturbed (Lego 1995; Paskalis 1993). Australian authors (Hennakem 1993; Paskalis 1993; Carmody 1988), while acknowledging the implications of this trend for nurses, are quick to point out that no direct correlation has been established in this country between the de-institutionalisation of the long-term mentally ill and their incarceration rates in the nation's prisons. Others, however, have been more forthright in their condemnation of de-institutionalisation as a policy when arbitrarily applied by governments. The Canadian Nurses Association (1995) has labelled the over-representation of the mentally ill in incarcerated inmate populations as 'the criminalisation of the mentally ill' (p.8). While the long-term verdict of nurses on the policy of de-institutionalisation is not yet in, United States nursing authors have been emphatic in identifying prisons as 'becoming the 1990s' state psychiatric hospitals' (Lego 1995 p.174). Other nursing commentators have been quick to juxtapose the outcomes of de-institutionalisation of the long-term mentally ill and the decreased tolerance of society towards crime and deviant behaviour; an ethos resulting in the political expediency of harsher punishments, more prisons and subsequently more need for forensic nursing skills (Dunn et al 1996; Osborne 1995; Burrow 1993; Scales et al 1993).

By contrast, Peternelj-Taylor and Johnson (1996) view the rise of forensic nursing as having 'evolved as a consequence of increased violence, a major public health problem in North America' (p.23). Dunn et al (1996) have identified a national trend towards criminal justice issues in United States jurisdictions which has led nurses to increasing contact with forensic patients. The United States', having the highest incarceration rate in the world, currently has 1.6 million of its citizens in prisons or correctional institutions (Maeve 1997). Lego (1995) points to a range of other factors which have increased demand for forensic nursing services including racial bias in sentencing, mandatory incarceration for drug-related offences and the nature of maximum security prisons which have transformed death row into the 'back wards' (p.173) of the new millennium. In an Australian context of practice, increasing homelessness and incarceration rates of the long-term mentally ill have also resulted in an increasing demand for nurses with forensic experience.

A conviction of specialisation and a sense of 'uniqueness'

The literature of forensic nursing reveals two recurrent and interdependent themes; a conviction on the part of forensic nurses that their practice is highly specialised and a sense of 'uniqueness' in relation to its distinctive nature. In the early 1980s Lehman (1983) described the Canadian prison nursing experience as 'unique' (p.38), a view predicated on the duality of security considerations and the 'obscure' (p.38) locus of practice. Gulotta (1987) identifies a 'unique role' for nurses emerging internationally in the correctional setting (p.3). Scales et al (1993) go so far as to identify the existence among nurses who work in the whole criminal justice continuum of 'a palpable sense that their practice is unique' (p.40). The 'uniqueness' of forensic nursing practice is also verified by other commentators (Burrow 1993; Hennakem 1993; Fontes 1991; Felton et al. 1987; Niskala 1986), Hennekam (1993, p.1) describes prison nursing care as delivered in a 'unique situation'.

In the literature this notion of the uniqueness of forensic nursing practice is based on a number of distinguishing factors. These include the distinctive clinical presentation of health breakdown in the forensic

environment (Petryshen 1991), the high prevalence of certain types of morbidity in forensic populations (Hufft and Fawkes 1994) and the omnipresence of uniformed custodial staff and their ethos of correction in the practice setting.

The notion of specialisation is also strongly evident throughout the published accounts of forensic nursing. In the 1980s Niskala (1986) identified nursing practice in forensic settings as requiring 'specialised skills', (p.410) while Abeyta-Phelps (1983) concedes prison nursing practice as having 'challenged and expanded her clinical skills audit' (p.48). Having initiated the debate in an Australian context of practice over a decade ago, Carmody (1988) identified forensic nursing as 'a postgraduate specialty that nursing professionals in other parts of the world aspire to as a means to excellence' (p.1). The conviction of specialisation is broadly based on a widely-held view that forensic nurses call upon a specialised body of nursing knowledge that reflects the distinctive nature of their practice arrangements. Carmody (1988) asserts that the interface of nursing science and the criminological aspects of forensic practice produces a 'unique body of knowledge' (p.3). Specifically, Lynch (1993) maintains that forensic nursing 'constructs its own theoretical models in terms of its inter-relationships with other disciplinary bodies of knowledge including law, criminology and corrections' (p.1) while Brown (1992) delineates forensic nursing skills as distinct from nursing's 'common body of knowledge' (p.90). Paskalis (1993) identifies the need for forensic nurses to have, at the very least, a conceptual understanding of the complex relationship between morbidity, criminality and inpatient behaviour to survive professionally in the forensic setting. Dunn et al (1996) identify forensic nurses as having both the knowledge and skills to ensure balance in the treatment of offenders, and to 'create bridges between the health and criminal justice systems which are sometimes at odds' (p.372).

The forensic nursing literature also alludes to skills and procedures which are distinctly unfamiliar to nurses practicing outside the criminal justice system. These include determining competence to stand trial (Dunn et al 1996); pre-release, pre-sentencing and parole reports (Paskalis 1993); and a range of security functions including preventing contraband substances from entering the practice setting (Burrow 1993). While the literature does not offer any detailed descriptions of these forensic nursing functions, they are indicative of the specialised tasks associated with practice in correctional and secure settings.

Published accounts of forensic nursing practice are also significant in their commentary on the identifiable personal qualities required of forensic nurses. Dopson (1988) testifies that 'it takes special qualities to wear the prison service uniform in very secure conditions' (p.37). Day (1983) calls for 'special qualities to deal with the unique environment of the correctional institution' (p.35) and Abeyta-Phelps (1983) for no less than 'a special mental attitude, fortitude and understanding' (p.48). Peternelj-Taylor and Johnson (1995) identify nurses who, through their own volition, practice within the correctional environment as professionals who 'dare to be challenged' (p.17). Lego (1995) indicates that 'it would not be possible for a nurse to practice in the forensic setting without a thorough understanding of shame, guilt, frustration, rage and narcissism' (p.173). A high degree of autonomy in clinical judgment, a genuine concern for the welfare of offenders and clarity of personal and professional goals are also cited as inducing nurses to practice in forensic settings. (Drake 1998; Maeve 1997; Caplan 1993; Macdonald and Grogan 1991).

Recognition, emergence and role development

The nursing literature of the last two decades reveals a process of gradual but definitive change in the manner in which forensic nurses not only view the nature of their practice, but also their position within the correctional and criminal justice continuum. The nursing literature of the 1980's reports forensic nurses generally protesting the under-development of their role and the general lack of recognition accorded them, both within prison systems and by the nursing profession itself (Bernier 1991; Gulotta 1987; Niskala 1986; Alexander-Rodriguez 1983; Day 1983). Carmody's (1988) use of the colourful Australian metaphor in alluding to forensic nursing as the 'dag' on the sheep of public health care exemplifies the protest of this group of nurses at the impoverished status their practice had been conventionally accorded.

More recently these sentiments have galvanised the beginnings of a call to action by forensic nurses for not only greater recognition of their specialised role, but a greater say in the operational priorities of the correction and criminal justice system. Brown (1992) described forensic nurses as an occupational group 'requiring role development', calling on them to 'enhance the specialist concept and improve their profile' (p.90). Burrow (1993) cites the 'Official Secrets Act' type provisions of many governments as having 'prevented a more liberal and comprehensive discourse of professional nursing matters in this field' (p.39) but predicts the emergence of forensic nursing as a recognised specialty with their gradual abolition. While conceding that historically the role of nurses in prisons was limited, Fraser (1994) has demanded Canadian forensic nurses have a greater recognition for the consistency of their contribution to the health care and rehabilitation of incarcerated offenders and, indirectly, the welfare of the community itself. Drake (1998) makes the salient point that although historically forensic nurses have always cared for 'under served populations' (p.41), the

rapid growth of imprisoned populations and their need for specialised care justifies a greater recognition of the role of forensic nurses by the nursing profession itself.

The problematic nature of prison forensic nursing practice and practice arrangements

A significant preoccupation in the published literature of forensic nursing is the problematic aspect of the provision of quality nursing care in practice environments that are both distinctive and challenging. In an Australian context of practice, Carmody (1988) identifies problems in forensic clinical and administrative areas as 'peculiar to a correctional environment' (p.2), but does not elaborate. In identifying the often paradoxical nature of the oral and experiential traditions of prison forensic nursing, Maeve (1997) indicts the 'distorting and perverting effect prison systems have on the practice of nursing' (p. 495), going so far as to identify caring, the definitive core phenomenon of nursing as 'expressly denied' (p.507) in prison nursing practice.

The prison forensic practice environment itself is variously described in epithets ranging from 'perverse' (Maeve 1997 p.1), 'deprived and hostile' (Peternelj-Taylor and Johnson 1995 p.1), to 'Orwellian' (Paskalis 1993 p.1). It is of some concern that authors identify it as a place where violence and manipulation are inherent, and where failure to muster the 'ability to endure and triumph' is for the nurse 'to fall by the wayside as a victim, or to become an accomplice' (Peternelj-Taylor and Johnson 1995 p.13).

The concerns of prison-based forensic nurses expressed in the literature centre upon a number of salient themes. These include the often isolated nature of forensic nursing practice; the pathogenic influences of the forensic environment on client behaviour and the quality of nurse patient relationships; the stigma of caring for society's failures, and the sense of isolation associated with working in custodial institutions. The other singular most pervasive theme in the literature of forensic nursing is the intrusion of the operational priorities associated with the ethos of correction and criminal justice and its impact upon the therapeutic goals of nursing and nursing practice values (Maeve 1997; Burrow 1993; Hennakem 1993; Paskalis 1993). For most nursing commentators this has resulted from a historical legacy of dual administrative responsibility shared by criminal justice agencies and health service providers in prison systems, and the subsequent presence of custodial officers in the forensic treatment setting (Maeve 1997; Peternelj-Taylor and Hufft 1997; Carmody 1988).

Forensic nursing and the legacy of history

The literature is emphatic in its conclusion that the continued presence and historic role of forensic nursing within the correctional and criminal justice system is the product of the evolution of prison medical services, as societies attempt to prevent outbreaks of infectious disease in its incarcerated offender populations. Carmody (1988) and Drake (1998) insist that nursing as a profession has not simply moved into and found a place for itself in prisons, but has become an integral part of the administration of correction and criminal justice within the prison system. Paskalis (1993) maintains that the provision of forensic nursing care to incarcerated offenders began inside the prison and essentially remains there. This has resulted in practice environments where uniformed prison officers, security or custodial staff are omnipresent. For some authors (Maeve 1997; Hennakem 1993; Paskalis 1993) it has also resulted in practice arrangements where nursing decisions and professional accountability are subordinate to the operationalised priorities of correctional administration.

A recurrent theme of the published literature is the loss of ownership of their practice by forensic nurses. Paskalis (1993) views prison-based forensic nurses having to constantly endure the ideological intrusion of the ethos of correction and criminal justice upon their practice values. For Maeve (1997), nursing in prisons is at best a perpetually negotiated compromise in order to mitigate or accommodate the philosophical priorities of correctional services: compliance, segregation, security, discipline, acquiescence, regulation and order. The literature cites some very poignant examples of these instances. Hennakem (1993) reports of prison officers being able to prioritise or 'cull' patients' requests for heath care treatment, and nurses compromising their practice routines by having no alternative but to dispense medication through a trapdoor without visibly seeing the patient; any physical contact with patients being at the discretion of custodial staff. Other nurses report being continually subject to requests from prison officers to administer psychotropic and other sedative medications to prisoners for aggressive or antisocial behaviour in the absence of mental illness.

Forensic nurses writing about their practice (Keaveny and Zauszniewski 1999; Maeve 1997; Peternelj-Taylor and Johnson 1995) express the conviction that the attitudes and actions of custodial staff often reflect an arbitrary view of prisoners as incorrigible and recidivist. This negative attitude of prison officers circumscribes any constructive engagement by nurses with their prisoner patients, and can lead to prison officers questioning the validity of any nursing intervention which they view as going beyond that of the simply deterrent or punitive. Authors (Drake 1998; Maeve 1997; Paskalis 1993) also report that nurses are constantly exposed to the negative and often critical rhetoric of prison officers. The expressed attitudes of custodial officers to prisoner inpatients often reflects a despairing or frustrated sense of cynicism; an ad hoc amalgam of reformist, punitive or antithetical views (Paskalis 1993). Carmody (1988) maintains that prisoners are simply labelled by custodial officers as deceitful and

delinquent by nature; their incarceration itself being a validation of this view. The failure of prisoner inpatients to respond to nursing interventions is deemed by prison officers as indicative of a form of ingratitude. In the same way, a prisoner patient's relapse or recurrent illness is seen as recidivism or re-offending (Maeve 1997). Additionally, any form of psychiatric symptom shown by a prisoner attracts a derogative label of mental illness from prison officers. Nurse authors attest that this attaches considerable stigma to the mentally ill offender within the prisoner subculture and ensures a degree of ostracism from peers: an additional source of prejudice which nurses must attempt to ameliorate (Lego 1995; Bernier 1991).

While some commentators (Maeve 1997; Hennakem 1993; Galindez 1990) go so far as to advocate an organisational disengagement of prison nursing services from corrective services administrative control, others continue to insist that the dually administered prison treatment setting is still capable of furnishing the tangible means to achieve therapeutic outcomes to nursing interventions (Burrow 1993). Drake (1998) reports feeling 'secure' in the presence of custodial officers, seeing their presence in the practice setting as maintaining both 'structure and order' (p. 46). Carmody (1988) goes so far as to suggest that the presence of custodial staff in the forensic nursing practice environment generates instances where uniformed officers can provide positive role modelling and therapeutic interactions which complement and support nursing interventions.

Calls for a reconstruction, or at least some form of re-negotiation, of practice arrangements are part of a wider demand in the literature for forensic nurses to play a greater role in bringing about much-needed reform in the criminal justice system (Osborne 1995; Abeyta-Phelps 1983). While Lego (1995) asserts that forensic nurses 'bring humanity and reason to forensic settings' (p.173), Carmody (1988) testifies to an 'unshakeable belief that nurses can be instrumental in bringing about reform in correctional health care' (p.2).

A challenging client population

The published forensic nursing research reveals that forensic inpatient populations have distinctive characteristics that impact on the treatment environment and on the provision of nursing care (Keaveny and Zauszniewski 1999; Caplan 1993; Paskalis, 1993; Abeyta-Phelps 1983).

The evidence strongly suggests that despite the fact that prisoner inpatient populations are comprised predominantly of young males and females under the age of forty, morbidity and mortality in terms of chronic lifestyle diseases and mental illness are significantly higher than in non-prison populations (Maeve 1997; Paskalis 1993; Petryshen 1991). While many persons enter custody with a history of psychiatric disturbance, nursing authors report that others experience their first episode of mental illness in prison (Caplan 1993; Carmody 1988; Hennakem 1993; Paskalis 1993; Carmody 1988; Abeyta-Phelps 1983).

From the nursing literature it would seem that a significant proportion of offender inpatients display behaviours associated with severe personality disorder, depression and psychotic type illness (Drake 1998; Maeve 1997; Peternelj-Taylor and Johnston 1996). Nursing commentators also report that within forensic inpatient populations drug and alcohol dependency are almost pandemic, with many clients requiring detoxification upon entry to prison and continuing to abuse mood-altering substances while incarcerated (Drake 1998; Paskalis 1993; Carmody 1988). Forensic nurses (Maeve 1997; Brown 1992; Petryshen 1991) report that in the overcrowded, less than optimal conditions of the prison, inpatient behaviours can present a range of professional challenges. Examples cited include constant harassment of nursing staff by prisoners for sedatives or analgesia for complaints of headache, anxiety, depression insomnia or other somatic distress. This often occurs in a climate of stress, tension and exasperation.

Authors also concede that failure to respond in a salutary fashion to inpatients' vague, generalised or poorly-defined complaints of somatic distress can lead patients to perceive nurses' clinical judgements as partisan and aligned with the punitive responses of the custodial staff (Maeve 1997; Paskalis 1993).

The 'isolation' of forensic nursing

A persistent theme in the literature of forensic nursing is that of 'isolation'. Paskalis (1993) reminds us that prisons are built for both geographical and symbolic isolation and Wilton (1992) identifies prison forensic nurses as 'physically isolated, either in their location within the gaol or remote locations which are on occasions completely inaccessible' (p.50). As Carmody (1988) points out, society neither wishes to see nor necessarily hear from those it employs to care for its offender elements 'out of sight and out of mind'. Despite being in a crowded and highly structured environment where all movement is regulated and every activity scrutinised, a number of authors testify to personal sense of isolation attached to forensic nursing practice (Burrow 1993; Hennakem 1993; Brown 1992). Some commentators have identified that they feel subject to the same restrictions as their patients, citing the use of locked perimeters, watchtowers, monitors and the artifice and technology of surveillance as compounding a sense of diminution and isolation (Drake 1998; Maeve 1997). Others link this very feeling of isolation in a crowded workplace with a sense of personal powerlessness in the face of a monolithic and impersonal criminal justice system embodied in the architecture and design on the prison practice setting (Paskalis 1993; Hennakem 1993).

Forensic nursing authors have also described themselves as isolated both socially and professionally because of the 'hidden' (Carmody 1988, p.1) nature of their practice, citing that society only wants those it pays to deal with its problematic elements to develop further techniques to treat and contain them. The theme of isolation is further pursued by Brown (1992) in terms of the historical insularity of forensic nursing, traditionally delivered within the closed , secure and indeed secretive world of the prison or institution and 'outside the mainstream of the nursing profession' (p.1).

Prison sub-culture and the unique influences of the correctional milieu

The nursing literature reveals that while some prisoners adapt reasonably well to the rigours of incarceration, others suffer tangibly or struggle visibly with their adjustment to the correctional environment (Keaveny and Zausniewski 1999; Bernier 1991). A confounding element of the forensic nursing practice environment is the omnipresence of a powerful, all-subsuming prison subculture with its own nihilistic values, distinguishing roles and secretive codes of behaviour (Burrow 1993; Paskalis 1993; Carmody 1988).

The literature reveals that much of the antipathy directed toward nurses by prisoners results from measures to maintain status within the prisoner sub-culture (Drake 1998; Paskalis 1993; Carmody 1988). Forensic nurse authors (Peternelj-Taylor and Johnston 1996; Burrow 1993; Phillips 1983) complain that regardless of the level of commitment, concern and professionalism shown; a proportion of clients remain uncooperative, unconcerned or subversive with treatment goals. For Paskalis (1993), inpatients' awareness of the limited capacity of the prison system to respond to their antipathy or passivity leads them to perceive nurses as vulnerable, visible and convenient representations of authority as embodied in the criminal justice system.

Similarly, the literature reveals that nurses' counselling or psychotherapy interventions are often identified by forensic clients as 'brainwashing' (Carmody 1988, p.3). It is evident that despite good will and professionalism, many offender inpatients view cooperation, self care and initiative in meeting nursing treatment goals as a form of collaboration with a system of enforced oppression. For some authors (Paskalis 1993; Carmody 1988) the propensity for prisoners to deem any form of nursing intervention as conspiring against the dignity of the individual, results in nursing interventions being disputed as either hypocritical palliatives or measures of repressive control.

CONCLUSION

The literature of forensic nursing is distinguished by a number of recurrent themes including a strongly held conviction that its practice is both unique and highly specialised. Many forensic nurse authors feel that their role within the criminal justice system deserves, and is now gaining, a greater degree of recognition by the nursing profession as an emergent specialty area of practice. These views are predicated upon the distinctive nature of forensic nursing practice and practice arrangements. It is evident from an exploration of the literature that forensic nurses have expanded the limits of their roles to make a professional contribution at many points on the criminal justice rehabilitation continuum, both in institutions and in the community.

A preoccupation in the literature remains the problematic aspects of delivering quality nursing care to incarcerated offender and forensic populations. Salient issues of concern identified by forensic nurse commentators include the isolation felt by many forensic nurses, the presence of custodial staff in the prison treatment setting, and the influences of the inpatient subculture and other forensic milieu factors upon nursing practice. Although this area of nursing has attracted only scant research attention to date, the diversity and professional challenges of forensic nursing practice revealed in the literature would seem to offer many interesting opportunities for future nursing research.

REFERENCES

Abeyta-Phelps, M. 1983. Health care in a correctional setting: A nurse practitioner's perspective. *Journal of Prison and Jail Health*. 12(1):38-42.

Alexander- Rodriguez, T. 1983. Prison health: A role for professional nursing. *Nursing Outlook*. 31:115-118

Bernier, S. 1991. Mental health issues and nursing in corrections. In McFarland, D. and Thomas, M. (eds.), *Psychiatric mental health nursing*. Philadelphia: Lippincott.

Birk, S. 1992. Emerging specialties expand opportunities. *American Nurse*. 24(9):7,9,24.

Brown, T. 1992. Forensic and corrections nursing. *Proceedings of the 1st National Corrections Health Care Conference*. Sydney: NSW Prison Medical Service.

Burrow, S. 1993. Inside the prison walls: Forensic nursing. *Nursing Times*. 89(37):45-48.

Canadian Nurses Association. 1995. *Mental health care reform: A priority for nurses*. Toronto: Canadian Nurses Association.

Caplan, C. A. 1993. Nursing staff and pre-occupations in a maximum-security forensic hospital. *Archives of Psychiatric Nursing*. 7(1):23-29.

Carmody, J. 1988. Correctional health nursing. In ACMHN (Ed.) *Bedlam, bicentennial and beyond*. Sydney: ACMHN (Inc.).

Day, R. A. 1983. The challenge: Health care vs security. *Canadian Nurse*. 79(7):34-46.

Dopson, L. 1988. Beds behind bars. *Nursing Times*. 84(19):35-37.

Dunn, A., Selzer, J. and Tomko, P. 1996. Designing a forensic program. In Lego S. (Ed.). *Psychiatric nursing: A comprehensive reference*. Philadelphia: Lippincott.

Drake, V. K. 1998. Process, perils and pitfalls of research in prison. *Issues in Mental Health Nursing.* 19:41-52.

Felton, G., Parsons, M. and Satterfield, P. 1987. Correctional facilities: A viable community health practice site for students. *Journal of Community Health Nursing* 4: 111-115.

Fontes, H. 1991. Prisons: Logical, innovative, clinical nursing laboratories. *Nursing and Health Care.* 12:300-303.

Fraser, L. 1994. Correctional service of Canada nurses: A special breed. *Let's Talk.* 8(6):20-21.

Galindez, E. 1990. An orientation model for correctional health nursing. *Journal of Nursing Staff Development.* 6:225-228.

Gulotta, K. C. 1987. Factors affecting nursing practice in a correctional setting. *Journal of Prison and Jail Health.* 6(1):13-22.

Hennakem, P. 1993. Occupational health issues facing nurses in South Australian prisons. *Proceedings of the 5th World Conference on Prison Health Care.* Brisbane: Conference Solutions Pty. Ltd.

Hufft, A. and Fawkes, L. 1994. Federal inmates: A unique psychiatric nursing challenge. *Nursing Clinics of North America.* 29:35-42.

Jenkins, M. 1993. Moving health care into the 20th century and towards the future: H.M. Prison Health Care Centre, Leeds. Proceedings of the 5th World Conference on Prison Health Care. Brisbane: Conference Solutions Pty Ltd.

Keaveny, M. E. and Zauszniewski, J. A. 1999. Life events and psychological well being in women sentenced to prison. *Issues in Mental Health Nursing.* 20:73-89.

Lego, S. 1995. Book review: Live from death row. *Journal of the American Psychiatric Nurses' Association.* 1:171-174.

Lehmann, A. 1983. Nursing's last frontier: Our Canadian prisons. *Canadian Nurse.* 79(7):37-39.

Lynch, V. 1993. Forensic aspects of health care: New roles, new responsibilities. *Journal of Psychosocial Nursing and Mental Health Services.* 31(11):5-6.

Macdonald, E. and Grogan, E. R. 1991. Personal accounts of satisfying and unsatisfying nursing experiences as a needs assessment strategy. *Journal of Continuing Education in Nursing.* 22:11-15.

Maeve, M. K. 1997. Nursing practice with incarcerated women: Caring for mandated alienation. *Issues in Mental Health Nursing.* 18:495-510.

Niskala, H. 1986. Competencies and skills required by nurses working in forensic settings. *Western Journal of Nursing Research.* 8(4):400-413.

Osborne, O. H. 1995. Jailed mothers: Further explorations in public sector nursing. *Journal of Psychosocial Nursing.* 33(8):23-28.

Paskalis, P. 1993. Prisoners as patients: International perspectives in correctional and forensic nursing. *Proceedings of the 5th World Conference on Prison Health Care.* Brisbane: Conference Solutions Pty. Ltd.

Peternelj-Taylor, C. and Hufft, A. 1997. Forensic nursing. In Johnson B. S. (Ed.). *Psychiatric mental health nursing: Adaptation and growth.* Philadelphia: Lipppincott.

Peternelj-Taylor, C. and Johnson, R. 1995. Serving time: Psychiatric mental health nursing in corrections. *Journal of Psychosocial Nursing and Mental Health Services.* 33(8):12-19.

Peternelj-Taylor, C. and Johnson, R. 1996. Custody and caring: Clinical placement of student nurses in a forensic setting. *Perspectives in Psychiatric Care.* 32(4):23-29.

Petryshen, P. 1991. Nursing the mentally disordered offender. *The Canadian Nurse.* 77(6):26-28.

Scales, C., Mitchell, J. and Smith, R. 1993. Survey report on forensic nursing. *Journal of Psychosocial Nursing and Mental Health Services.* (11):39-44.

Wilton, N. 1992. Report of the New South Wales Prison Service Review Committee, NSW Department of Health.