Professional Education for Correctional Nurses
A Community-Based Partnership Model

A dvanced education in correctional health nursing is urgently needed to shift the professional isolation of practice behind bars to a seamless community-based health service with links of multifaceted health and judicial programs. Such a shift requires knowledge, leadership, and competence in managing the health of a highly vulnerable population—the correctional population—who are locked within a medicolegal system.

Also referred to as the forensic population, this group is affiliated with crime or violence, as either perpetrator or victim. Their health needs are complex, even more intensified in an incarcerated environment that has become overcrowded, fiscally constrained, and resource poor.

Overview

With almost 4 million adults on probation or parole, and more than 5.5 million people—2.8% of the U.S. adult population—under some form of correctional supervision, including those held in local jails and state and federal prisons (U.S. Department of Justice, 1997a), correctional health services represent a substantial segment of the nation’s health care. Despite strong evidence suggesting that inmates experience a higher rate of disease and disability than the general population (Hammett, 1998; Jordan, Schlenger, Fairbank, & Caddell, 1996; Levy, 1997), a broad-based understanding of health-related issues surrounding crime, including health risks and needs of the offenders, victims of crime, and their families is lacking. With few exceptions, neither medical nor nursing schools have made a solid commitment to curricular adjustments in the study and research of crime and health. Medical and nursing textbooks generally do not include correctional health issues and discussion related to medicolegal systems.

Nursing is the backbone of correctional health within the institutions, and provides the major component of health services. Yet, correctional nursing has gotten limited, if any, professional recognition or formalized education as a clinical specialty. This professional isolation may stem from a deeply rooted punitive sentiment toward prisoners within society, which also prevails within the health care community.

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September 1999
Public and private health sectors in the community and correctional health systems are disconnected from each other with the exception, perhaps, of mental health. But the correctional population migrates through all systems, within and outside institutions. As the current trend of advanced nursing education and practice expands to adjust to the national health care reform, nurse educators should prepare correctional nurse specialists and competent leaders to build bridges between the systems.

Interagency collaboration is no longer a managed care concept; it has become a reality for independent health care agencies to survive the cost-containment pressures of health care reform.

Preparing professional education for correctional nursing is not all about curriculum development. Rather, it should bring a better understanding of what it means to practice nursing in a correctional facility and the forces affecting the system. Students must be educated about clients cared for under a judicial system: the life the inmates bring with them to prison, the life they left behind—and to which they will return—and their families, friends, and community. Most importantly, students should learn to accept and adopt a concept of health that is amenable within the context of crime.

Nurse educators, nurse scientists, and community nurse leaders have not collaborated with nurses who practice in prison. Nor have nurses within the correctional system asserted their professional identity.

The realization of a serious knowledge gap about this significant segment of our population at risk, nearly 4 million, is the stimulus for further discussions and dialogue on how to strengthen correctional health nursing through education, so we may assume leadership in managing the forensic population in our communities.

A decade of changing trends

Two decades ago, public health professionals described crime as a social disorder within an interrelated mesh of social factors, which played augmenting roles in the state of health or illness of individuals, families, and communities (Hanlon & Pickett, 1979). In other words, crime is a disconnect from community norms and values, and robs the community of its vitality and health.

Not too long ago, the Surgeon General identified crime as a major public health problem of epidemic proportions (Robinson, 1996). Apparently, the era of correctional health isolation is ending, and the door has opened to expand the scope of practice to the community.
Population growth

During the past decade, correctional facilities have become overwhelmed by the growing inmate population and its increasingly complex health needs associated not only with substance abuse and addictions, but with an overall marginal lifestyle.

The rate of the prison population alone has nearly doubled, from about 228 per 100,000 population in 1987 to about 449 per 100,000 in 1997. The average yearly increase is nearly 3%, from 600,000 in 1988 to more than 1.7 million in 1998, which is close to 1% of the national population. These figures do not include all incarcerated populations (U.S. Department of Justice, 1998a).

Changing laws

This phenomenal growth trend bleeds the system of its already scarce resources, which could barely meet the minimum needs of its inmate population a decade ago. Alcohol- and drug-related crimes of epidemic proportions, and changes in sentencing laws explain the continuing upward spiral. About three quarters of all prisoners can be characterized as involved with alcohol or drug abuse in the time leading up to their arrest (U.S. Department of Justice, 1998b).

The law, "three strikes and you are out," brought stiffer sentences for substance abuse violations.

The Violent Offender Incarceration/Truth-in-Sentencing (VOI/TIS) law requires violent offenders to serve at least 85% of their prison sentence before being eligible for release. In addition, amendments to the laws offer grant incentives for the states to reinstate the laws. Consequently, prisoners are spending more time behind bars and release rates have dropped (37 per 100 state prisoners in 1990 to 31 per 100 in 1996), while the prison populations nationwide continue to grow (Ditton & Wilson, 1999).

Health profile and service needs

The health services needs of the incarcerated population are multifaceted, complex, and often acute, especially when entering the institution. Most come with a background of minority status, limited education, poverty, and unemployment. They grew up in dysfunctional families in an environment of crime-related activities, misuse or abuse of substances, abuse and neglect, and often homelessness (ACA, 1990). Associated with such backgrounds are high-risk behaviors, unhealthy lifestyles, nutritional deficiencies, and personal neglect. Often, inmates have had no health care prior to their incarceration. It is not surprising that their overall health is compromised, often severely.

Compared with the general U.S. population, infectious diseases and chronic medical problems among prisoners is far more prevalent, especially HIV or AIDS, sexually transmitted diseases (STDs), and Mycobacterium tuberculosis (TB) (Hammett, 1998).

Rates of psychiatric disorders and psychological distress associated with exposure to traumatic events are high. An older population afflicted with chronic disease, disability, and terminal illness has increased (Hammett, 1998; Jordan, Schlenger, Fairbank & Caddell, 1996; Levy, 1997; Peterelji-Taylor, 1998). Health service utilization rates are five to six times higher than the rates in the community (Anno, 1997; Goldkuhle, 1995).

Upon initial incarceration, effects of withdrawal from alcohol and drug misuse, mental and emotional shock may be present. Malnourishment—many have not eaten properly for a long time, if at all—may be present. In female populations, high-risk pregnancies due to lack of or neglect of prenatal care, and effects of often longstanding or recent acute traumatic stress, such as severe abuse of any type, injury, prostitution are acute situations confronting nurses (ACA, 1990; Goldkuhle, 1995). The circumstances become even more critical with high arrest rates and overcrowded conditions combined with an overextended staff, minimum support, and few financial resources to provide for health needs of the inmates.

The Forensic Population in the Community

The Chair of the National Commission on Correctional Health Care (NCCHC), Charles A. Meyer, Jr., MD, CCHP-A, recently acknowledged:

It is vital that prisoners receive proper health care while they are incarcerated, and this has a direct effect on the community at-large once they are released. Without proper health care and education before they are released and linkage programs once they are released, these individuals can pose a great health risk to the public (Vitucci, 1998 p. 18).

Most inmates have lived on the margins of the community, and are likely to return, often under some type of judicial supervision (parole or probation). As stated earlier, almost 4 million people are under such supervision. Most have limited, fragmented, or no access to appropriate follow-up care. Many cannot pay for needed services. If care is offered, it usually is short term. Connected with the correctional population is a "hidden" population in the community: the family members, children, and friends. They are not directly accounted for and hardly discussed among health service providers.
Yet, they are linked to the total health profile of the correctional population and together make up the forensic population.

They draw large health risk and vulnerability circles around each offender's life with problems mostly related to misuse of substances, violence, abuse, and neglect. Because nearly 94% of the offender population are men (U.S. Department of Justice, 1996), most of the offenders’ family members or affiliates are women and children.

In 1994, women were about two thirds as likely as men to be victims of violence, compared with statistics from 20 years ago when women accounted for less than 50% of that of men (U.S. Department of Justice, 1996). Among the estimated 1.4 million emergency-department patients treated in 1994 for nonfatal injuries, 94% were injured during an assault including rape or sexual attacks. Some 77% knew the perpetrator as a relative, friend, or acquaintance (U.S. Department of Justice, 1997b).

Many children of the offending adult population are vulnerable to failure to thrive, permanent health and developmental damage, and a continuing crime cycle. Emotional and cognitive problems related to family deprivation hinder healthy psychological, social, and intellectual adjustment (Aloschler & Armstrong, 1996).

Finally, we must be aware that discharge planning is as necessary in the correctional facilities as it is in any hospital or other health care facility. Ideally, the planning would be family-focused in linking appropriate health and social resources in connection with the judicial system.

**Collaborative service attempts**

Prisons have begun to realize that they cannot absorb the entire health management of the inmates. Integration into the broader health care community has been suggested (Drees, 1994) and signs of collaborative efforts with some public health agencies are being reported (Conklin, Lincoln, & Flanigan, 1998; Hammett, 1998).

A 1997 nationwide survey, conducted by the National Institute of Justice (NIJ)/Center for Disease Control and Prevention (CDC), examined the extent and nature of public health-corrections collaboration in the prevention and treatment of HIV or AIDS, STDs, and TB. This is the only national evaluation report on diverse interagency collaboration developments to look at administration and infrastructure, policy development, and service delivery.

Results revealed some collaborative ventures with public health agencies related to disease surveillance, staff training, legislation and policy development, and education programs. Two model sites emerged, Rhode Island and New York State, which had instituted comprehensive follow up, continuity of treatment interventions, and social support when inmates returned to the community. They became permeable to the community in service interventions and resource sharing, which made the transitions for the inmates easier upon returning to the community.

Effects were seen in decreased morbidity in STDs, improved case finding, continuity of treatment, and social support. Aside from the model programs, discharge planning and continuity of medical services from correctional facilities to the community were otherwise most inadequate across services. It was stated that, although public health and correctional agencies have complementary missions in the health and safety of the larger community, the difficulty in overcoming respective differences in perspectives, philosophies, and priorities remain strong barriers to collaboration (Hammett, 1998).

Another collaborative program, which focused on HIV-seropositive patients at Hampton County Correctional Center (HCCC), expanded its service approach to include problems related to chronic illness or biopathology. Results indicated a reduced recidivism rate of 46% versus 72% among the general offender population. The authors state that "offenders who are involved with their health care may view themselves more positively and be less inclined to engage in criminal or unhealthy behaviors when they return to the community" (Conklin et al., 1998, p. 1250). Though empirical evidence must show that health care involvement may contribute to a decline in recidivism, the fact that health care providers have begun to link health behavior with criminal behavior is promising.

As the few documented collaborative attempts are most promising, they strongly signal an urgent need for correctional nursing to get involved, expand their role, and join the pioneering of community-based collaborations.

So far, as reported, initiatives were driven by the medical profession. Nursing is not mentioned nor are any beginning discussions on the subject found in the nursing literature. The opportunity is now to partner with medical providers, community nursing, and other services to manage the health of this population. In addition, outcome studies are urgently needed to be incorporated up-front with developments of service collaborations.

Nursing, the provider of care and the specialist in health and wellness management, is the legitimate profession to manage the health of this population. For this to happen, nursing education must commit to curriculum adjustments to prepare for the needed leadership in practice and research.
Role Development

Working with inmates offers opportunities for health care providers to apply principles to improve the health of prisoners and at least to minimize community health risks. Helping inmates deal with adverse social pressures, addiction, and health risk behaviors under controlled incarceration conditions, can contribute to crime prevention. “Doing time could improve nutrition, reduce consumption of tobacco, drugs, and alcohol” (Levy, 1997, p. 1403), while also providing remedial health education programs tailored to specific health needs.

For correctional health to be effective, consensus must be reached about a definition of health so that more uniform, realistic goals could be established within the forensic context; goals that would enable health promotion program planning accordingly.

A full discussion is beyond the scope of this article, but the intent is to stimulate the process. Health for an incarcerated person cannot mean the same as for a free person. Health, defined by the United Nations (1968) as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Roy & Andrews, 1991, p. 19), may not be appropriate for incarcerated offenders.

Health viewed as a “state and a process of being and becoming an integrated and whole person and the lack of integration represents lack of health” (Roy, 1984 p. 24) is a workable definition. Sensitive to adverse life conditions, including incarceration, it is a process of healthy adaptation.

Building a Foundation for Professional Education

Currently, the scope of correctional health nursing practice in most jurisdictions remains custodial and narrowly focused on institutional care. Though it may vary among institutions, as some are more progressive in trying to adapt to managed care concepts in alignment with the national health care trend, the emphasis continues to be on infection control, episodic care, response to acute health needs, and illness treatment as required by law. Thus, medical-surgical nursing, emergency nursing, and mental health nursing are the knowledge and competence focus.

We can assume that at some point in an inmate’s life, he or she was considered healthy. From the background histories, we can also assume that at some point in that person’s life, some type of trauma event(s) occurred: physical, biological, emotional, psychological, social, spiritual, or other unknown factors that led to behavior(s) of disconnect from community norms and values.

Then, the health-trauma cycle opened and the crime disease process began. For some, that process eventually leads to incarceration or involuntary confinement. For others, either healing occurs without incarceration or crime becomes a way of life that may eventually destroy self, others, or health of the community. Thus, the aim of correctional health is to close the health-trauma cycle by restoring the inmate’s health to a state and a process of being, and the inmate to an integrated and whole person within the community.

To fulfill that purpose, the crime pathogen, therefore, ought be attacked by seamless and interconnected multifaceted interventions within and outside the institution.

When health is defined in a context of crime and forensic issues, and when community and medical interventions are realized as one aspect of a much broader public health approach, then the scope of advanced correctional health nursing practice becomes clearer. That understanding is the foundation of an educational and community-based practice framework.

The roles of correctional health, community health, and forensic nursing provide a wealth of knowledge expertise to draw from for the development of a sound curriculum base in advanced correctional health education.

Community health nursing

A community health nursing (CHN) role readily blends into correctional health. CHN is an umbrella term for all nurses who work in the community, including those who have formal preparation in public health nursing. Although the overriding goal of public health nursing is to improve the health of the community by identifying subgroups at high risk or illness, disability, or premature death, CHN is a synthesis of nursing practice and public health practice applied to promoting and preserving the health of populations.
Although the CHN practice is general and comprehensive with a dominant responsibility to the population as a whole, interventions may be directed to individuals, families, or groups. The heart of CHN is primary prevention of illness and promotion and protection of health (American Nurses Association, 1980; American Public Health Association, 1980).

Specifically, the CHN
- represents and negotiates exchanges between community members and multidisciplinary team members to effect a health care plan;
- coordinates the assessment, planning, implementation and evaluation processes, and creates alliances for the improved health of the community;
- serves as communication link; and
- facilitates transitions between systems of care (Smith & Maurer, 1995).

The forensic aspect of crime and judicial involvement, however, brings a perspective to community health for which CHNs are not prepared. Aside from a medicolegal knowledge competence, the often strict safety rules, restrictions, and structured living arrangements must be followed in correctional facilities or in parole agreements in the community. These restrictions affect the family’s needs and supportive resources, and require special knowledge and skills to accurately assess their overriding health needs and service requirements.

**Forensic nursing**

Forensic nursing (FN) represents an alliance of nurses as health care providers with law enforcement and the forensic sciences. It is a rapidly evolving, new advanced practice role which focuses on meeting the needs of victims and perpetrators of violent crime. The FN model applies clinical and scientific nursing knowledge to the delivery of care for victims of physiological and psychological trauma, criminal and interpersonal violence, evaluation and treatment of perpetrators, and the families of both (Lynch, 1993).

The FN curriculum is built on forensic science and criminalistic techniques in advanced nursing practice, including psychosocial dimensions of forensic interventions, crime scene preservation, and injury and death investigation. The strength of the advanced education lies in a medicolegal knowledge and competence building in the forensic aspects of public health, for instance, violence, abuse, and sexual assault, but lacks a comprehensive community health management component.

A lack of education may be the key barrier to overcome perceptions and isolation.

**Educational Goals**

As indicated earlier, correctional nursing, recognized as one dimension of forensic nursing, is still evolving in curriculum development. As such, given the trend in correctional health services today, and the emerging collaborative intervention initiatives, the time is right to design a curriculum base for professional education to prepare leaders in managing the health and wellness of the forensic population.

A three-part educational foundation is being proposed:
- a core curriculum in advanced nursing practice, with emphasis on public health approach in primary care and community health nursing;
- a specialty track in clinical forensic nursing with emphasis on a medicolegal, family-focused trauma/violence, victims/perpetrator, surveillance/investigation, criminal justice/psychopathology; and
- research with emphasis on operational program and outcome evaluations.

The educational foundation will enable the correctional health nurse to assume leadership in:
- multidisciplinary case management, interfacing with the forensic population (correctional and family), judicial system, and health services (medical, mental, social, and other resources) between institution and community;
- development of roles in various practice areas within the medicolegal system, policies, and standards of practice, and a practice framework; and
- research, such as operational or program evaluation and development of outcome measures relating to healthful adaptation to institutional and community life, health informatics, and surveillance or data management to track service effectiveness.

**Conclusion**

A timely opportunity exists to strengthen correctional health nursing to assume leadership in managing the health and wellness of a highly vulnerable and neglected population in our communities: the forensic population within the judicial system. Advanced, professional education is the key to shift the correctional health nursing role from isolated practice behind bars to a seamless community-based managed care approach.

From a public health perspective, the state of health or illness of the correctional population that is affected by the social disorder or disease of crime, reflects the state of health or illness of the community of which they are a part. Efforts to enhance the health of this high-risk group also can contribute to crime prevention by helping them deal with adverse social pressures, addiction, and health risk behaviors. Overcoming the complex health effects of crime requires a comprehensive commitment among health, social sciences, and judicial disciplines to collaborate services and information exchange. For collaborative initiatives to sustain, a practice framework is needed to coordinate and
KEY POINTS

- Advanced, professional education is the key to shift the correctional health nursing role from isolated practice behind bars to a seamless community-based, managed-care approach.

- From a public health perspective, the state of health or illness of the correctional population reflects the state of health or illness of the community of which they are a part.

- The aim of correctional health is to close the health-trauma cycle and to restore the inmate’s health to a state and a process of being, and the inmate to an integrated and whole person within the community.

manage seamless community-based health interventions from prison to community and to overcome barriers.

Generally, health professionals are not educated in areas of criminal justice, pathologies, or behaviors related to crime, violence, and victimization, including health risks and needs of the offenders, victims, and their families. As such, deep-rooted social punitive perceptions persist over a better understanding of this population.

This lack of education may be the key barrier to overcome perceptions and isolation. It is a challenging time for nursing to not let the barriers overwhelm the opportunity to take charge of correctional health and be a participant in building healthier communities for the new millennium.

References


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