Nurses Leading Care in Custody Suite Environments: A Qualitative Study from Scotland

John Hurley, PhD1, Paul Linsley, MSc2, Martin Elvins, PhD3, and Martyn Jones, PhD3

ABSTRACT
This paper outlines the qualitative findings of a recent multimethod study exploring the impact of nurses assuming leadership roles in delivering primary health care to detainees within police custody suites in Scotland. The full multimethod study was conducted within a framework of realistic evaluation with key findings indicating that the nurse-led model of service delivery offers positive outcomes for all key stakeholders. Findings from the qualitative component of the study showed that the quality of clinical care for detainees improved, policing concerns for detainee safety were mitigated, and forensic medical examiners were able to expand their specialist roles. Key supporting mechanisms in achieving these outcomes included generating collaborative practices, enacting clinical leadership, and providing a forensic nursing educational program to empower nurses to generate service provision and grow professional autonomy.

KEY WORDS: clinical leadership; custody suites; realistic evaluation

The problem of providing sustainable evidence-based primary health interventions into police custody suite environments has received minimal research within the United Kingdom, generally, and Scotland, more specifically. This is despite the comparative inequalities of detainees’ health service provision and the demands on police law enforcement resources to respond to those health needs. Typically, a detainee is a person who has been charged by police with an offense or who is being interviewed by police. Detainees have very short stays in the custody suites before their initial court proceedings or are released after questioning. What is recognized is that detainee populations have higher levels of mental health problems and substance misuse than the general populations and that their vulnerabilities are consequently greater (Cummins, 2007). Such vulnerabilities will include episodes of self-harming behaviors within police custody suites with the most common therapeutic response being an increase in levels of observation. The custody suite environments are identified as being highly challenging for staff, and that specific training in managing such behaviors is often absent (Cummins, 2008). Detainee populations also have high levels of comorbidity with wide-ranging physical health conditions including communicable diseases (Watson, Simpson, & Hostick, 2003). They are also likely to have low levels of treatment concordance and restricted access to prescribed medications and, as indicated by Payne-James et al. (2010), are not receiving appropriate care, hence represent a risk to themselves and those around them.

A major driver for evaluating alternate approaches to delivering health care into police custody suites emerged from policing policy rather than recognition of the relative vacuum of available research. The Police Bureaucracy Taskforce (2003) identified the necessity to modernize clinical and forensic services into police custody suites. This modernization sought to address forensic medical examiner (FME) shortages as well as to promote equivalence in healthcare delivery to police detainees with those in other custodial settings, where multidisciplinary care is...
The policy initiatives and consequent joint working between health and policing stakeholders culminated in the establishment of a pilot primary healthcare service within the Tayside police custody suites in Scotland. The setting up of this pilot took cognizance of the limited evidence on possible care delivery models that could be used to provide health care to detainees. Collaborative nursing and medical models were identified as offering increased responsiveness to traditional forensic medical officer services (Bond, Kingston, & Neville, 2007), whereas commercial outsourcing appeared more expensive than the traditional forensic medical officer services (Payne-James, Anderson, Green, & Johnston, 2009). It is worth noting that the preexisting model to the Tayside custody suites was a commercial-based medical officer service that had been in place for some years. A key factor influencing the ultimate choice of service design was that the health-focused report by HMICS (2008b) identified that 85% of FME work was focused toward therapeutic rather than forensic activities, indicating that considerable scope for that aspect of the study. The interview-based study on detainee’s experiences of the Tayside pilot will be reported on elsewhere. The interview-based study on detainee experiences of the Tayside pilot will be reported on elsewhere.

The study on the norm. Her Majesty’s Inspectorate of Constabulary for Scotland (HMICS, 2008a) report on custody facilities also forwarded that a multiagency review of custody suite healthcare delivery should be undertaken. A separate report focusing solely on health services to detainees was also produced by HMICS (2008b). This report highlights the difficulties associated with recruiting and retaining sufficient medical officers to carry out the dual roles of providing both forensic and health services. The report also confirms that the policing forces in Scotland view the National Health Service (NHS) as the best partner to deliver health services and that by doing so will help police achieve the key requirements from commitments arising from the Police Bureaucracy Taskforce (2003).

### The Pilot Service

The Scottish Police services agreed in 2009 to fund an independent research-based evaluation of a new primary care health service being delivered directly from Tayside police custody suite environments. This new service ran for an initial 3-year period and is currently acting as a pilot site for a potential role out across other locations in the United Kingdom.

### Ethics

Ethical clearance was sought and obtained for the study from the Tayside Committee on Medical Research Ethics. However, given the vulnerable position of detainees within the police custody suites, the ethics committee requested and eventually granted a separate ethical clearance for that aspect of the study. The interview-based study on detainee’s experiences of the Tayside pilot will be reported on elsewhere.

### Methodology

The principles of experimental design are fairly well established in evaluation research (Bryman, 2008), but other approaches have emerged in recent years. One such approach, that of realistic evaluation (Pawson & Tilley, 1997), was used as the framework for this study. Realistic evaluation was developed by Pawson and Tilley (1997) and is based on the philosophy of critical realism. Critical realism holds that “we will only be
able to understand—and so change—the social world if we identify the structures at work that generate those events and discourses” (Bhaskar, 1989, p. 2). As such, critical realism acknowledges that the world is an open system, played out by different people, in different settings, subject to different circumstances, at different times. Critical realists accept that the categories they employ to understand reality are likely to be provisional and that there is a distinction between the objects of their enquires and the terms used to describe, account for, and understand them (Bryman, 2008).

In keeping with this philosophy, the aim of realistic evaluation is to produce even more detailed answers to the question of why an initiative “works, for whom and in what circumstances” (Pawson & Tilley, 1997). In realistic evaluation, this is expressed by the development of contexts, mechanisms, and outcomes, collectively known as context–mechanisms–outcome configurations (CMOs). Put simply, the outcome of an intervention is the result of generative mechanisms (factors that inhibit or promote the intervention) and the context in which the intervention is introduced and played out. In this way, effectiveness of the program is apprehended with an explanation of why the outcomes developed as they did and how the program was able to react to the other underlying mechanisms and in what contexts. Furthermore, “the aim is not to cover a phenomenon under a generalisation but to identify a factor responsible for it, that helped produce it, or at least facilitate, it” (Lawson, 1998, p. 156). As such, realistic evaluation is method-neutral, equally suited to either quantitative methods, qualitative methods, or both. As Pawson and Tilley (1989) noted, contemporary sociological research is essentially pluralistic; researchers often combine quantitative and qualitative research methods within the same study.

Within this study realistic evaluation required the research team to logically propose three hypothesis-generating questions:

1. What changes and/or outcomes will be brought about by instigating primary healthcare services into the police cells of Tayside?
2. What contexts impinge on this?
3. What mechanisms (social, cultural, or others) would enable these changes, and which may disable the new healthcare service?

### Study Design

This study formed part of a broader Scottish Government funded project exploring the effectiveness of providing a nurse-led primary healthcare service in the police cells of three Scottish police stations. The study design tested the key questions of what has worked for all stakeholders of the new pilot service and why has it worked? Quantitative data on collaborative working and policing qualitative data were used within the overall evaluation of the pilot and are reported on as part of the larger study (Elvins et al., 2012).

#### Data Collection

Qualitative data were collected by initially conducting individual interviews and then running focus groups. The interviews were undertaken with both the nurse manager of the service and with all the nurses involved in the scheme. Interviews were held in the participants’ practice setting and lasted between 40 minutes to an hour. It was anticipated that this would allow participants to express feelings and views about the new service that they may not have felt able to in the presence of others as part of the focus groups (Grove & Burns, 2008). The interview schedule sought to explore key service areas as highlighted in the memorandum of agreement and stated aspiration goals for the service. Such questions sought participants’ experiences and understandings toward the efficacy of the service, impact on detainee health, and collaborating with other stakeholders, reflecting a direct phenomenological approach to interviewing (Titchen & Hobson, 2005). This, along with the focus groups described below, was the main method of data collection.

A series of focus groups for 28 participants was held over the course of the 2 years consisting of nurse-only groups and mixed-staff groups between the nurses, police, and security personnel. Focus-group size ranged from 4 to 13, and they were run concurrently with the individual interviews described above to allow team members to discuss issues collectively, generate new topics, and explore emerging themes. The groups were again held within the participants’ place of work and lasted between 60 and 90 minutes. The focus-group data reported on in this paper focused on health rather than policing aspects of the overarching study and sought both negative and confirming data examples to the interview data as well as identifying new and emerging experiences of the pilot.

Both the interviews and focus groups were audio-recorded with the consent of participants. All the recordings were transcribed verbatim and checked for accuracy, and participant information was removed. After the initial reading of the transcripts, notes were made regarding issues emerging from the data. Individual participants were given codes to track their involvement across different aspects of the study.

#### Data Analysis

Qualitative data analysis from health staff interviews took place in two phases from 2010 to 2011 and explored
data collected from an interview-led study of 22 healthcare professionals constituting 13 nurses, 6 medical officers, and a pharmacist, as well as 2 professionals from non-government-aligned health agencies. The analysis of the focus-group data was an iterative process including categorization of data, analysis of themes, and refinement of the thematic analysis through writing and engaging with the literature (Grove & Burns, 2008). According to Pope, Ziebland, and Mays (2000), analytical categories “may be derived inductively—that is, obtained gradually from the data—or used deductively, either at the beginning or part way through the analysis as a way of approaching the data” (p. 114). The coding of data and the development of themes were undertaken by the three researchers involved in this part of the study. This group researcher process, it is argued here, enhanced the credibility of the themes generated, as individual interpretations were modified by a consensus process. The dependability of the resulting group interpretation was supported through a discussion as part of the project steering group meetings (Patton, 2002).

Key Findings

Theme 1: Comparative Improvements
Participants constructed a picture of the pilot service as being more effective in meeting detainee multifaceted health needs, better connection to outside services, and a safer service from the perspective of all stakeholders. All stakeholder groups were identified as gaining from the new model of service delivery when contrasted against the previous system. Key components of this theme include the following:

1. More appropriate and safer care
   Participant health staff created a powerful picture that the detainees were the primary beneficiaries of the new pilot and that through having an expanded range of health services within the cells, as well as care being tightly integrated with community and hospital-based services, detainees gained most from the new model of service delivery. A key feature of participants’ perceptions and experiences of the pilot contrasted against the previous model: Detainees received care appropriate to need, with health care being informed by information systems and processes connected to wider 24/7 NHS services.

   (Nurse) The same amount of DFs (Dihydrocodeine) and Diazepam could have been prescribed to every single person who claimed they had a drug problem without checking an opiate withdrawal scale, without checking whether that person was already on Methadone, when was the last time they had their Methadone, do they require symptomatic relief, you know, none of that was done.

   Enhanced safety was understood to have been created through nurses responding quickly to health need up to but not exceeding their level of expertise, through instant (in the case of the main Dundee site at least) response to health interventions or advice requests from police, through having mental health expertise within the holding cells, and through having systemic policies focusing on clinical governance and risk minimization.

   (Nurse) We had an old guy in yesterday, he was 78; he was just lovely and, and he’s on loads of heart medication and if we hadn’t been here, we wouldn’t have managed to get to his house to get it. He had angina and we made his health better.

2. Improved forensic examining
   With nurses assuming clinical leadership of detainee health needs, the forensic pathologists were able to expand their roles within their area of expertise. In addition, as the nurses received forensic-specific training and education, they assumed new responsibilities such as fitness to release examinations over the life of the pilot, which in turn released the FMEs to focus on more complex aspects of forensic examining and reporting. The FME staff at the University of Dundee were able to provide significantly more detailed reporting into legal cases of nonlethal nature, rather than providing detailed forensic reports for deaths alone. This expansion of forensic reporting capacity includes a greater opportunity to conduct more in-depth and complex investigations and to deliver the forensic education of general practitioners and nursing staff.

   (FME) The training and the expertise of full time staff of this (Forensic Medicine) department is of course rather in the field of forensic science, forensic medicine and description and assessment of injuries and so on, so we would hope that the quality of the reports that the police and the procurator fiscal get about the truly forensic part of our work would have improved.

3. Gains for nurses
   The primary gain for the nursing staff in the pilot was that of assuming front-line responsibility for running the health service. The pilot is a distinctive nurse-led service that places nurses into professional roles with high levels of autonomous decision making. Consequently, nursing
staff hold direct power to shape the service. Through enacting professional roles underpinned by autonomy, responsibility, and power, the nurses are generating new and arguably more esteemed professional identities.

4. Gains for police

Health staff constructed a picture of benefit for police staff because of the new pilot service. While acknowledging that the Sergeants maintained final decision-making power on all aspects of detainee welfare, the health staff reported that enhanced responsiveness to health needs, immediate access to healthcare knowledge, and better health care being delivered to detainees benefited policing staff.

(Doctor) Not like the doctors. So we go there just to see patients and come back, so we don’t have time to have a chat with them, to connect with them. But the nurses are there, they know everybody practically in the police station, so they are having a very good relationship with police…… the police have the confidence in them.

2. Community follow-up and reoffending

Participants identified that, because of the nature of the pilot service, there are limited opportunities for direct follow-up on care initiated within the cells. In addition, because of the brief intervening nature of offering health care and harm prevention education to the detainees, there was little perceived positive impact on reoffending rates achieved by the new service.

Theme 3: Enabling CMOs

The following themes represent key pilot service CMOs, which would need to be successfully replicated elsewhere. It is important to understand these themes as being interconnected and interdependent, rather than as stand-alone successful characteristics of the pilot. Arguably, all must be in place to allow individual-themed features to function with the probable outcome of picking individual features being a less effective service.

1. Collaborative working

Within this theme are the capabilities and behaviors that constructed the possibilities for collaboration, particularly between nurses and police to occur. Through having shared outcomes, working together on individual cases, and having clarity of each other’s roles and responsibilities seemingly contributed to collaborative behaviors. Having empathy is in effect seeing emergent issues from policing views, being open to new experiences such as working with police, and being able to cope with the emotionally charged environment of the holding cells where the primary capabilities supported collaboration between nurses and police.

(Nurse) If we’re tied up for whatever reason dealing with people in Dundee and Perth say we need someone here now we have triaged that appropriately; we say to Perth or Arbroath, look you’ll just have to wait, we’re dealing with something here. But from their point of view when they’ve got people climbing the walls and screaming out for a nurse now, you know, it must be difficult for them.

2. Staff knowledge and values

The recruitment of health staff appears to be a vital aspect contributing to service efficacy as well as their subsequent ongoing forensic education. These staff capabilities can be understood within three broad capability areas of intrapersonal capabilities such as self-awareness, interpersonal capabilities such as advanced empathy, communication skills, and finally professional capabilities inclusive of specialized clinical expertise. Key areas of specialized expertise included diabetes, mental health and addictions, as well as cardiac surgery, neurosurgery, pediatrics, and finally minor injuries. The forensic education the nurses received enhanced existing core capabilities that they entered the service with, consequently minimizing organizational risk while supporting nurses’ role expansion.
There are certain core competencies we expect them to come with. We expect them to understand the needs of the prisoner and to be able to clinically assess them. We expect them to understand drug and alcohol withdrawal, the common phenomena. We expect them to be competent at that and we test their competence.

3. Being the NHS onsite

A fundamental aspect of nurses being able to forge effective therapeutic encounters with detainees was being separate from the police, in effect being the NHS, a brand name that holds an intrinsic level of trust. Communicating this separateness verbally, through behaviors and through having a separate physical space within the cells, all contributed to the pilot service being experienced as an onsite NHS service, rather than a police-sponsored service. This promoted trust from detainees that they could receive health input unrelated to their alleged offenses, communicate concerns without impacting on court hearing, and seek advice that was entirely health focused.

(Nurse) We have to remind ourselves of is that we don’t—we’re not part of the police and I think it’s even more important for the nurses who are physically present within the police building and surrounded by 90% police staff that we’re not part of the police, that we’re NHS.

4. Nurses leading the service

Another key feature of the service being identified as being effective is that it is a nurse-led service, rather than a medical or police-led service. Because nurses lead the service, they are able to shape the service to meet the needs of the detainees, as well as their responses to their needs. Nurses had a sense of ownership of the service, which in turn acted to enhance leadership within the clinical level.

Discussion

The emergent picture from this qualitative study was that this nurse-led service generated benefits experienced by all major stakeholders of the pilot. The trustworthiness of these findings was enhanced through the activity data of the service, which was collected as part of the overall study. FME occasions of service to the custody suites decreased from around 4,800 service occasions per annum prepilot to nearly 895 service opportunities per annum postpilot, indicating an 80% decrease in the number of occasions of service provided to detainees. This reduction in service occasions was complemented by a 60% increase in the number of occasions each occasion comprised, indicating a shift towards more comprehensive and intensive rounds of care for each detainee.

Increased investment into detainee health care within custody suite environments.

A key purpose to realistic evaluation studies is to gain understanding of how a new program functions as well as why it functions the way it does (Pawson & Tilley, 1997). As evident within the qualitative data and the audit activity data, a key process to the functioning of the pilot from a health perspective was nursing leadership. However, adding the wider perspective of policing into the study also showed that collaboration between police and nursing underpinned the operation of the pilot. Indeed, the successful assumption of leadership appropriate to duty of care resulted in a form of collaborative leadership whereby nurses and police respectively led on health and justice. By relating and building services around the detainee, it provides a means of reducing duplication and cost while targeting the essential components of care, consequently providing a service that the patient needs at the time required. Achieving a balance across these elements implies processes of active management where the nurses, along with other professionals and service managers, look to achieve the highest standard of care possible in what are often socially constructed and defined ways of working. Partnership working of the kind reported in this study is important in fostering a sense of ownership and collective responsibility that actively involves and reflects the views and needs of detainees, staff, and the wider community.

Historically, nursing leadership has been driven by authoritarian and transactional leadership approaches, often dominated or at least influenced by managerial models rather than genuine leadership approaches (Stanley & Sherratt, 2010). In addition, nursing historically and arguably continues to be understood as a profession that is passive, awaiting the direction of other disciplines (Hurley et al., 2012). This pilot highlights the immense benefit of releasing nurses not only from its own shackles of internally driven leadership dilemmas but also of the medical profession empowering and then handing nurses the clinical leadership role. This model of clinical leadership is gaining increasing attention within the nursing profession with improved clinical outcomes being shown against traditional models of nursing leadership (Stanley, 2011). This enables a proactive and autonomous style of nursing that is arguably more closely situated to the context of the patient than could be provided for by other health disciplines. Evidence of clinical leadership is apparent in the sheer diversity of nurse capability within the custody suites. The nursing staff consultations included undertaking global health assessments, pain assessments, and head injury assessments, as well as diabetic consultations and interventions, wound dressings, and suicide/mental health assessments. Leadership within these clinical scenarios
rests within the capability of the nurse, enhanced through formal postgraduate education and clinical experience (Linsley et al., 2011). However, this comes with a caveat that nurses need to able to articulate what they do, what they bring to “the table,” and perhaps, most importantly, the difference that they make.

**Recommendations**

As the pilot is progressively rolled out, the need for further evaluative studies is highlighted. An interesting area for exploration in future studies will be to look at how service providers empower nurses to take on this new role. Kanter (1993) has already provided us with the components of organizational empowerment, which are as follows:

1. the ability to advance in a current role or the opportunity to be involved in activities beyond the current scope of practice,
2. access to information that allows staff to fulfill role expectations and understanding of the proper source from which to obtain correct information,
3. knowledge of job expectations and support in fulfilling them, and
4. ability to obtain resources required to accomplish tasks.

These components could be incorporated into CMO configurations for use in the evaluation of the service as it is taken forward.

**Limitations**

The findings from this qualitative study illuminate the issues surrounding nursing care delivered in a specific setting as part of changes to healthcare provision in Scotland and need to be considered in reference to similar changes in health policy by the other countries within the United Kingdom, as our findings may be relevant in these contexts. However, the findings should be translated internationally with care.

**Acknowledgment**

We offer sincere thanks to the Association of Chief Police Officers in Scotland (ACPOS) for funding this 2-year-long research project.

**References**


