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Title

Power and Control: forensic community mental health nurses perceptions of team-working, legal sanction and compliance

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POWER AND CONTROL: forensic community mental health nurses perceptions of team-working, legal sanction and compliance

ABSTRACT

This is the second of two papers reporting on a descriptive mixed methods study of community forensic mental health nurses' experiences of Restriction Orders and Supervised Discharge mechanisms. Forensic community mental health nurses (FCMHNs) have a body of experience of working with mentally disordered offenders in the community. A number of these patients will be subject to conditions on discharge. This in effect acts as compulsory community treatment with the sanction of recall to hospital. This paper examines nurses perceptions of team-working, legal powers and their effects upon compliance. Findings include that FCMHNs express general satisfaction with their input to decision-making but some concerns were raised which challenge the ethic of team-working. Respondents were broadly in favour of increased professional responsibility although this may be related to a quest for status. A pragmatic if equivocal support for the use of compulsion in community mental health care was also expressed.

KEYWORDS: Forensic, mental health, community, compulsion, power, control, quantitative, qualitative.

INTRODUCTION

Forensic community mental health nursing (FCMHN) is an expanding field of practice within the sub-speciality of forensic nursing (Brooker and White 1997). These nurses have established a body of experience in the community treatment and supervision of mentally disordered offenders that has not previously been investigated. These experiences include the establishment and assertion of their roles in new arenas and the potential impact of compulsory care upon patient outcomes. They may also have formed professional opinions in relation to the suitability of extending similar powers to non-offending patients and of the usefulness of these powers being in the hands of community mental health nurses.

A substantial proportion of mentally disordered offenders are subject to restrictions and possible recall to hospital should they fail to comply with the conditions imposed upon them (Kershaw et al 1997). This has the effect of being a compulsory community treatment order although with notable exceptions to those advocated elsewhere (RCP1987). There have been some concerns expressed in the literature as to the impact of negative staff attitudes to formal powers in the community (Miller and Fiddleman 1984; Hiday and Scheid-Cook 1987). With the current Mental Health Act under review it would seem an opportune time to access experiences and opinions of this group of mental health nurses working with patients who are in effect subject to compulsory community treatment.

BACKGROUND LITERATURE

Mentally disordered offenders convicted of serious offences can be placed on restriction orders under Section 41 of the Mental Health Act 1983. These patients frequently return to live in the community on conditional discharge compelling them to live where directed and accept certain treatments. FCMHNs contribute to the care and supervision of these patients. FCMHNs have to engage, initiate and maintain therapeutic relationships with their patients who may in some instances be resentful of the level of control and compulsion they are subject to. Forensic nurses working in secure settings are frequently challenged in their work to strike a balance between

care and control (Burrow 1991; Clarke 1996) yet there is little research into how their community colleagues achieve such a balance.

The exercise of power over those who use services may not be readily recognised by professionals. Hugman (1991) notes that the professions, while recognising power relations within their professional structures often fail to acknowledge this dynamic in interactions with their client group. Hugman (1991) notes that the exercise of power is an inherent element of the claims by professionals for greater autonomy. As such Godin and Scanlon (1997) assert that psychiatrist's calls for community treatment orders is an assertion of biomedical authority presumably with the altruistic goal of promoting mental well being. The exercising of power with its negative elements of coercion and control would seem to many nurses to be anathema to the act of caring. However for mental health nurses this is a feature of their work and there is a growing recognition that the nettle of formalising these powers may well have to be grasped by the profession (Godin and Scanlon 1997). Indeed the White Paper '*Reforming the Mental Health Act*' (DoH 2000) suggests that a formal role exists for other "suitably trained mental health professional(s)" (p.5) in place of a social worker to participate in compulsory admission to hospital. There persists however a tension between the exercising of power and control over the mentally ill and the apparent unease which community mental health nurses experience in employing these powers. This appears in stark contrast to the struggle for professional power and autonomy that so often accompanies the drive for professionalism and which is illustrated by nurses in Godin and Scanlon's (1997) study.

This battle for professionalism is being fought within the context of clinical teams in which consultant psychiatrists (as Responsible Medical Officers) and social workers (as Social Supervisors) hold all the cards in terms of status both in their ultimate decision-making authority and in their overt recognition by the Home Office. The success or otherwise of FCMHNs in fitting into this context may have important consequences for the successful community supervision and treatment of mentally disordered offenders and for the extension of other forms

of compulsory community treatment. There is no current research evidence on the lived experience of FCMHNs in the UK and descriptions of their work are limited by this paucity.

There have been few previous studies of community mental health nurses (CMHNs) attitudes to compulsory care in the community. Burns et al (1995) surveyed community mental health staff on their responses to a number of compulsory community treatment options. The study had a 63% response rate among CMHNs of which 25% were prepared to use such powers without reservations. CMHNs were concerned that use of these powers would cause patients to avoid contact with services, damage the therapeutic relationship and lead to an abuse of civil liberties. Burns et al (1995) argue that CMHNs were reluctant to support these new powers on the basis that they would shoulder the bulk of the supervision and may be expected to discharge a decision they had opposed.

Historically proposals for compulsory community treatment orders have emphasised the benefits for improved compliance (RCP 1987 and 1993). Compliance in this context often relates solely to medication although its application can be broadened to include accommodation, day-care services and outpatient appointments as evidenced in the Mental Health (Patients in the Community) Act 1995. Patients on restriction orders may be subject to similar conditions and FCMHNs are often charged with ensuring compliance. There is no evidence to date that details FCMHNs experience of this part of their work and whether they see compulsion as a useful aid to compliance. Given the recent impetus to review the Mental Health Act 1983 and the White Paper's emphasis on compulsion and control (DoH 2000) it would be informing to have FCMHNs views of their experience in this regard.

FCMHNs are operating in an arena in which the control and supervision function would seem explicit in that patients may be very aware of the likely sanctions incurred for example, by a default in treatment. As such it is possible that FCMHNs like their multi-disciplinary colleagues may have developed a philosophy of care which enables them to reconcile

concerns about the use of coercion, power and control while sustaining therapeutic engagement.

RESEARCH QUESTIONS

- What formal input do FCMHNs offer to the decision-making and review process in terms of the restriction order?
- How do FCMHNs address issues of power and control with their patients?
- Do FCMHNs see potential benefits in extending similar powers to cover non-offending patients?
- Would FCMHNs like extended powers themselves?

METHODOLOGY

FCMHNs in England and Wales were surveyed using 15-item postal questionnaires specially designed for this study. Demographic details and opinions were sought, in relation to experiences of working with service users involved with restriction orders.

Study design and Data Analysis

This second paper reports on our findings in relation to forensic community mental health nurses perceptions of involvement in decision making, legal sanction and compliance.

Study design, data analysis, research methodology and its limitations are detailed elsewhere (Jenkins and Coffey submitted) and are further discussed in Coffey and Jenkins (2001).

Sample

The total sample surveyed was 122. All were either FCMHNs attached to NHS Medium Secure Units in England and Wales as identified in the Forensic Services Directory (Rampton Health Authority 1997) or members of the Royal College of Nursing FCMHN forum. In all cases the respondents are Registered Mental Nurses (RMNs) who work in community settings with a specific forensic focus.

Ethical Issues

Ethical approval was gained locally and usual, acceptable practices determining study construction, contact with potential and actual respondents and data management were adhered to. There was no compulsion to respond or participate. Anonymity and confidentiality was assured and no identification of individuals or services is known to anyone beyond the researchers immediately involved in the research. There were no cost implications for respondents and the only incentive offered was a summary copy of the final report.

FINDINGS

Response rates, demographic details of respondents and findings related to nurse/patient relationships are reported elsewhere (Jenkins and Coffey submitted). Responses to the quantitative elements of this portion of the study are presented in Table 1.

TABLE 1 HERE

Input to care and decision-making

To gain a flavour of FCMHNs experiences of team-working in relation to working with service users on restriction orders, questions were posed which sought views on input to decision-making and review of care.

A majority of respondents (57.7% n=30) felt that they had satisfactory formal input to decision-making in relation to the restriction order although 19.2% (n=10) disagreed or strongly disagreed. 80% (n=43) either agreed or strongly agreed with the statement “As a FCMHN my formal input to the review process in terms of the restriction order is satisfactory”, 7.6% (n=4) disagreed or strongly disagreed with this statement and a further 9.6% (n=5) offered a neutral response.

Qualitative analysis identified the following themes (verbatim quotes are italicised) relating to decision-making processes:

Teamwork /Politics/Medical power

These were treated originally as separate categories of response but have been included as a single category on the basis of their interrelationship and overlap. Involvement and contribution to decision making is generally perceived positively by respondents. Although a formal (statutory) mandate for CMHN inclusion is not a requirement, multi-disciplinary teams (MDT) may consider all members' contributions with the aim of improving comprehensiveness and quality of assessments.

Examples of responses included

“Working in a multi-professional team, my views are accepted equally with those of the SW [Social Worker] and RMO [Responsible Medical Officer] whilst decisions affecting patient care are the responsibility in law of the SW and RMO, my nursing perspective is valued”

“If multi-disciplinary team works effectively all members have a voice/opinion which is fundamental to effective care planning”

and

“Because I'm usually the most frequent contact for the patient my professional credibility with RMO is what determines the level and nature of consideration given to my input to reviews”

Alternative disparate responses are also evident. These indicate medical power as being the main driver of decision-making. Examples of responses include

“Medical power often drives planning”, and

“There is a disparity in the level of satisfaction vis a vis my input - this varies with RMOs”.

Reticence

Responses express reservations, mainly in relation to input to the decision making process but also in regard to the role of the FCMHN. Specifically, disquiet is expressed at the lack of formal input in terms of the nurse's extensive knowledge of and contact with, the service user. Examples of responses include

“ Service not well organised. Reviews haphazard, tends to be RMO, SS [social services] and others, FCMHN not routinely invited in community cases”,

“FCMHN does not provide reports to tribunals or home office, although our views are passed on via outpatient reviews, however, FCMHNs usually have the most contact with users in the community”, and

“As part of MDT I have as much input as I wish but its rather insulting that the FCMHN has no formal input to home office...”

Compliance and treatment

To ascertain whether the use of restriction orders had influence upon the interaction between FCMHN and patient, respondents were asked to note their agreement or otherwise to the statement “Nurses should not negotiate treatment options with service users who are on restriction orders”. The vast majority of respondents (n=47, 87%) disagreed or strongly disagreed with this statement although 5 (9.3%) agreed with the statement and 2 (3.7%) gave a neutral response.

FCMHNs remained ambivalent as to the benefits of compulsory powers in facilitating positive therapeutic outcomes. 41.5% (n=22) felt that compulsory powers facilitated positive

therapeutic outcomes although the majority (49.1% n=26) were undecided in either direction while 9.4% (n=5) disagreed with the statement.

Opinions on the value of using compulsory powers to enhance compliance on a range of indicators were sought. The majority agreed (62.3% n=33) or strongly agreed (26.4%, n=14) that compulsory powers enhanced service user compliance with medication (total in agreement 88.7%, n=47).

Support for the statement “Compulsory powers enhance service user compliance with day-care services” was less emphatic but remained in the same direction with 43.4% (n=23) agreeing and 7.5% (n=4) strongly agreeing (total in agreement 50.9%, n=27). However 37.7% (n=20) remained neutral about the effectiveness of compulsory power in this respect.

The majority of this sample supported the statement “Compulsory powers enhance service user compliance with attendance at outpatients” with 56.6% (n=30) agreeing and 22.6% (n=12) strongly agreeing (total in agreement 79.2%, n=42). Some respondents were undecided on the benefits of compulsory treatment in respect of outpatient care (15.1% n=8).

A majority (58.5% n=31) agreed with the statement “Compulsory powers enhance service user compliance with supported accommodation” and a further 24.5% (n=13) strongly agreeing. 15.1% (n=8) were undecided.

Overall, compulsory powers are perceived by respondents as being effective for a range of issues. Qualitative analysis identified the following themes relating to compliance:

Negotiation

Negotiation is perceived as an important aspect of the CMHN’s role and function. Without negotiation between nurse and user, irrespective of legal status, serious shortcomings are likely. These amount to simply controlling users, leading (for example) to frustration and other negative feelings with relevant consequences. Examples of responses include

“I feel that negotiation is always available, there is no point imposing treatment options, they are doomed to fail”,

“All patients in my view have a right to be informed of treatment options in order for them to be equipped to negotiate their care with RMO and SW”, and

“Care should be holistic, some patients have less options than others re treatment but generally patients should have some input into decisions that make major differences to their lives, if there is no room for negotiations the approach is too controlling leaving patients frustrated, and angry”,

Context

Individual circumstances play a part in compliance. Examples of responses include,

“It depends on the conditions of discharge and also how the patient views team and restriction order”,

and

“Depends on the individual and his or her understanding and what it means to them to be on compulsory powers”.

Values

Initially, separate, distinct value categories (positive and negative) were identified. Later rounds of analysis involved combining these with an identified ‘Empowerment’ category.

Both positive and negative values were expressed, in relation to compulsion being enhancing in regard to compliance. Compulsion may be perceived as empowering, in the sense of making explicit the needs of users and the responsibilities of providers. Examples of responses include

“Such orders empower the service user and health and social services to both accept treatment, supervision and provide”,

“... ensures that the user is given active service and not allowed to disappear”,

“... it restricts the therapeutic alliance”,

Caveats

The complexity of compliance with any form of treatment or help is reported. Respondents seem to note that there is no one template to be applied in all situations and that there are important fundamentals to be considered in the first instance. Examples of responses include,

“Secondary to good relationships between patient and carers”,

and

“There are some people who will still not comply despite the best plans”.

Policy development

FCMHNs were asked to rate their level of agreement to the statement “It would be beneficial to extend similar powers (as restriction orders) to non-offending patients”. There was equivocal support for this with 38.4% (n=20) agreeing or strongly agreeing, 32.7% (n=17) undecided and 28.8% (n=15) disagreeing.

There was little outright support for extended powers to be given to FCMHNs, 30.1% (n=14) agreeing or strongly agreeing that “FCMHNs should have extended powers under the Mental Health Act” while 37.7% (n=20) were undecided and 32.1% (n=17) disagreed or strongly disagreed.

Qualitative analysis identified the following themes relating to policy development:

Yes and No

Initial categories of ‘Ambivalence’ and ‘Depends’ were merged with ‘Yes and No’. A broad range of differing responses suggest a variety of views on extending powers. Examples include *“Possibly”, “Only in some cases”* and *“This depends on the risk that the service user poses to self or others”*. Some views are clinically oriented, such as enabling particular approaches with some individuals whilst others are professionally oriented, claiming that extended powers would make nurses as powerful as social workers.

The strongest terms are related to negative perceptions of extending compulsory community powers to non-offending patients – where language such as ‘*coercion*’ and ‘*destroy*’ is used. Examples of responses included,

“I feel that FCMHNs should take on social supervision now (training required). It does not make sense to involve someone who does not know the patient. Key-workers RMNs, OTs etc. should take on ASW type powers”,

“It would destroy the therapeutic alliance”, and

“Strongly disagree - coercion is not a good basis for a care plan and can be detrimental to a relationship”

Rights

Reservations are expressed in respect of the individual, service providers and society generally. Examples of responses include,

” Very beneficial to the service providers and perhaps in very few cases to society generally, and in some cases to service users but at the cost of a serious erosion of basic rights, liberty and criminalisation of mental illness”,

“Such powers should be reserved to those who have proved their dangerousness”,

and

“Not unless further training and support is given, this would change the nature of nursing and the balance of security/therapy”,

Caveats

Some responses indicate a lack of need, sufficiency and inappropriate use of current powers.

There are also examples of questions raised by respondents including,

“Why does what we already have not work?...Maybe we don't use the Act fully”.

There is a sense in which the current practice fails to make use of current legislation.

“Section 117 after care should be seen as good practice regardless”.

Some respondents suggested that extended powers should be reserved for specific groups of patients.

“Except prolonged non-compliance with prescribed treatment in enduring mental illness where the users may be at risk themselves or to others”.

DISCUSSION

The written responses of nurses in our study is illustrative of the considerable complexity, the importance of context and the ambiguous nature of forensic community mental health nursing. Indeed it may reflect the nature of mental health nursing as a whole that is not opting for a panacea but rather treating individuals in individual ways. There seems to be a compelling onus upon the individual nurse to invest effort and energy in a personal sense, if these professional standards are to be maintained.

FCMHNs in our study appear satisfied with the level of input they enjoy in respect to decisions made about restriction orders when questioned using the quantitative format. This however masks real concerns and many took the opportunity provided to express opinions that paint a more complex picture.

FCMHNs have no formal (legal) role to play in decisions about the imposition of restriction orders, discharge or recall of those on restriction. However as part of the team caring for these patients they have a role to play in making informed judgements with other team members about the viability of community placement of restricted patients. Where the use of a supervised discharge order is being considered the FCMHN who will often act as the supervisor and must agree with the content of the order. It is the collaborative nature of multidisciplinary working which is at the heart of comprehensive community care. This collaborativeness would seem to be crucial in the follow-up and co-ordination of care of forensic patients in the community. It is with this principle in mind that we posed questions about the involvement of FCMHNs in the decision making process with particular reference to decision-making and review of care.

There was support for the idea of collaborative working within the multi-disciplinary team. This probably reflects nurses experience of meeting the complex needs of mentally disordered offenders in the community. There was also acknowledgement of the relative powers that exist within teams. More specifically this referred to the power of the consultant to allow collaborativeness and team working.

Some respondents reported attitudes which are of concern, in relation to teams in which they work for example “*Especially with regard to individuals I have previously nursed [FCMHN] opinion is not always sought*”. This example is worrying given the complexity of care of many forensic patients in the community where it would seem appropriate to have the views of all team members in care decisions. FCMHNs within this study expressed some concerns

in regard to their input to the review process. It is incredulous that circumstances arise in practice which exclude FCMHNs from these processes in an age when we have become accustomed to inadequacies of community care often being linked to failures in communication (Prins 1994). It is essential that FCMHNs use all opportunities to assert themselves in practice to ensure their involvement in the review processes of service users with whom they have direct contact.

There was also a sense within these responses that FCMHNs as a professional group felt devalued and wanted more status and recognition of their input into the care of forensic patients in the community. This yearning for more status may even extend to FCMHNs giving formal professional opinion and input to decisions to impose an order at the outset. This can be rationalised in the context of the growing experience and confidence of these practitioners in providing community support and supervision to mentally disordered offenders. As their expertise develops these practitioners may expect to be consulted about decisions of care over which they will have jurisdiction. It may be that they will require some preparation for these extra responsibilities and this would seem appropriately placed within a MDT educational programme.

We posed a number of questions about compliance and the role of the FCMHN with the intention of elucidating the approach which these nurses adopt when working with patients subject to significant levels of compulsion. We first posed a question about negotiation which is an important element in developing collaborative relationships (Beck 1989). It is clear that despite the element of compulsion inherent within these relationships negotiation with users is regarded as being of crucial value and importance in FCMHN's work. Coercion is afforded proportionate negative value. This is qualified however, by reference to contexts in which users 'reject' the advice of professionals.

The language of *'user attitudes'* and *'user's views of the team'* suggests a 'take it or leave it' position on the part of some nurses. This, in turn, could be indicative of some abdication of therapeutic input (as characterised by promoting increased self-reliance) and an encouragement to conform (characterised by users following nurses' directives unquestioningly). Tensions exist between striving to be therapeutic and concurrently monitoring or policing. Measuring the effects of compliance in terms of easily quantifiable targets or outcomes may be relatively straightforward but in respect of the users experience of service provision and quality it is much more difficult. The following verbatim quote is illustrative of one respondents awareness of differences between user and professional/service perspectives; *"Positive outcomes from service perspective frequently. Positive outcomes from patients perspectives sometimes"*. Those aspects of compliance that are easily measurable, such as attendance or taking medication may reflect an 'organisational' or 'policy' agenda whilst other, more difficult to measure outcomes, such as feeling better supported, are those faced by individual practitioners with users. These are substantively different. It appears that FCMHNs recognise that there are substantial limitations to the imposition of compulsion in community mental health care and that organisations and systems are better served than individuals in receipt of care. Despite this there appears in the quantitative responses to be a pragmatic acceptance of the role of compulsion within forensic mental health care. FCMHNs while still a relatively fledgling group may already be carving out an identity as critical participants in the provision of community care to mentally disordered offenders. While this may be frowned upon by policy makers and senior management it ensures that service users have some hope of receiving care which has been subject to some scrutiny. The impact upon FCMHNs in terms of the pressure that is likely to be brought to bear upon dissenters may however be seen in increased occupational stress for this group.

Ambivalence and the broadest spectrum of views were evident in responses to questions on the potential extension of formal powers. Clear support exists for an increase in the professional autonomy of FCMHNs but this is accompanied by two concerns. Firstly,

negative impacts of extending powers are acknowledged. This might be indicative of a professional concern; that avoiding the status of having compulsory power will facilitate the maintenance of ‘friendliness’ between nurses and users. Conversely, it might illustrate an alternative perspective of nurses’ perceived status and power or even a degree of fence sitting. Secondly, current powers are seen as perfectly adequate but are used ineffectively. Aftercare should comprise good practice in its own right, independent of compulsory powers. It is perhaps worthy of note that none of our respondents highlighted lack of resources which have figured in other research on compulsory powers (Godin and Scanlon 1997) and have prompted comment and concern from service users (MIND 1995) and professionals (Eastman 1994). This may be explained by the statutory priority given to patients subject to Section 117 of the Mental Health Act 1983 which ensures that appropriate funding is provided for their care. In essence it would seem that these nurses do not feel that there is a need for FCMHNs to adopt the use of formal powers and seem content to influence this process from the sidelines. It may be however that FCMHNs have already succumbed to what Morrall (1998) suggests is the dominance of consultant psychiatrists and biomedicine. Clarke (1999 p.139) however urges caution here and argues that *“it is not about the correctness of biomedical constructs, it is about nurses aligning themselves with these such that...[they]...lead to a culture of inevitability and pessimism in the way that patients are related to”*.

FCMHNs appear to acknowledge the gravity of issues of community compulsion particularly in respect of civil liberties and the capability to suspend people’s lives. There is clear recognition that this duty must be discharged equitably. If compulsion is used it must be on the basis of reciprocity or else compulsion assumes its own inherent utility, devoid of any therapeutic content or process.

Perhaps these power-oriented contentions and their complexity can be better understood via reference to notions of ‘caring for’ (traditional and paternalistic) and ‘caring with’ (facilitative and therapeutic) users as discussed by Barker et al (1999 p.279). “...what nurses ‘need’ to do – at any one time – is a function of various contextual factors, not least the legal and

professional expectation that nurses will keep people in their care safe...If the nurse is to avoid stifling the person, perhaps (s)he needs to straddle 'reckless trust' and 'over-professional caution'". That no clear demarcation of responses were found seems indicative that FCMHNs are thinking carefully and seriously about the tensions between power and therapeutic role issues. Unambiguous situations or criteria might be exceptional rather than usual and this presents yet another instance of FCMHNs needing to carry considerable toleration of uncertainty.

CONCLUSIONS

FCMHNs experience of power largely mirrors the experience of service users in that much of what they do is directed or orchestrated by others. Experiences of power seem to exist in at least two relationship dimensions namely those with service users and those with colleagues. In this latter respect a tension appears to exist in some cases between some FCMHNs and their medical colleagues as evidenced in their involvement in the review and decision-making processes of care.

There is some qualified support for the use of compulsion in community mental health care. This is indicative of a considered and critical approach to providing quality mental health care. There are some nurses in our study who remain ambivalent towards compulsion of any sort in mental health nursing and perceive benefit from their lack of formal powers. These nurses may however be challenged in the future to articulate their case in the light of likely legislative changes.

The establishment of a professional identity for FCMHNs is far from complete. For these nurses the struggle for attainment of professional credibility is demonstrable within the clinical teams in which they work. For some there is clear recognition of the front-line role they play in the delivery of community care to forensic patients while for others this struggle continues. Some nurses in our study seem to see the realisation of the professional nirvana they seek in the

attainment of significant new formal powers and a recognition of their role in decisions on and reviews of, restriction orders.

It is recognised that although not legally required it would be in the true spirit of multi-disciplinary working if FCMHNs as front-line community workers were involved in the decision-making and review process of restriction orders. As the discipline who will have most contact with the service users and who is the main link between them and mental health services it would seem appropriate that this input be formalised.

It would seem that FCMHNs may have developed a pragmatic ethos of care which allows them to balance dichotomies and accept complexities related to power and control while sustaining therapeutic engagement. These qualities would appear to be essential components of successful and ongoing engagement with mentally disordered offenders living in the community. Research which further elucidates these qualities may be useful in facilitating the preparation and education of future entrants to forensic community mental health nursing services.

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REFERENCES

- Barker, P., Jackson, S. and Stevenson, C. 1999. What are psychiatric nurses needed for? Developing a theory of essential nursing practice. **Journal of Psychiatric and Mental Health Nursing**. 6: 274-82.
- Beck A.T. 1989. **Cognitive Therapy and the Emotional Disorders**. London. Penguin.
- Burns T., Goddard K. and Bale R. 1995. Community supervision orders for the mentally ill: Mental health professionals' attitudes. **Journal of Mental Health**. 4: 301-308.
- Brooker C. & White E. 1997. **The Fourth Quinquennial National Community Mental Health Nursing Census of England and Wales**. The University of Manchester and Keele University, Manchester.
- Burrow, S. 1991. The Special Hospital Nurse and the dilemma of therapeutic custody. **Journal of Advances in Nursing and Health Care**. 1(3): 21-38.
- Clarke, L. 1996. Participant observation in a secure unit: care, conflict and control. **NT Research**. 1(6): 431-41.
- Clarke, L. 1999. **Challenging Ideas in Psychiatric Nursing**. Routledge. London.
- Coffey, M. and Jenkins, E. 2001. **Compelled To Act: Forensic Community Mental Health Nurses' experiences of compulsory community care**. Swansea. School of Health Science. University of Wales Swansea.
- Department of Health. 2000. **Reforming the Mental Health Act**. Norwich. The Stationary Office.
- Eastman N. 1994. Mental Health Law: civil liberties and the principle of reciprocity. **British Medical Journal**. 308: 43-5.
- Godin, P. and Scanlon, R. 1997. Supervision and control: A community psychiatric nursing perspective. **Journal of Mental Health**. 6(1): 75-84

Hiday V.A. and Scheid-Cook T. 1987. The North Carolina experience in outpatient commitment: a critical appraisal. **International Journal of Law and Psychiatry**, **10**: 215-232.

Hugman R. 1991. **Power in the Caring Professions**. London. MacMillan.

Jenkins, E. and Coffey, M. (submitted) **Compelled to Interact: Forensic community mental health nurses and service users**.

Kershaw, C and Dowdeswell, P and Goodman, J. (1997) **Restricted Patients – Reconversions & recalls by the end of 1995: England & Wales**. Home Office Statistical Bulletin **1/97**. London. Home Office.

Miller R. and Fiddleman P. 1984. Outpatient Commitment: treatment in the least restrictive environment? **Hospital and Community Psychiatry**, **35**(2): 147-51.

MIND. 1995. **Care Not Coercion**. London. MIND Publications.

Morrall P. 1998. **Mental Health Nursing and Social Control**. Whurr Publishers. London.

Prins, H. 1994. "All tragedy is the failure of communication" - the sad saga of Christopher Clunis (editorial). **Medicine, Science and Law**. **34**(4): 277-278.

Rampton Hospital Authority. 1997. **The Forensic Directory: National Health Service and Private Forensic Psychiatric Facilities in England, Scotland, Wales and Northern Ireland** (2nd Edition). Rampton Hospital Authority. Nottinghamshire.

Royal College of Psychiatrists. 1987. **Community Treatment Orders**. London. Royal College of Psychiatrists.

Royal College of Psychiatrists. 1993. **Community Supervision Orders**. London. Royal College of Psychiatrists.