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Title

Compelled to Interact: Forensic community mental health nurses and service users relationships.

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COMPELLED TO INTERACT: Forensic community mental health nurses and service users’ relationships.

ABSTRACT

This is the first of two papers reporting community forensic mental health nurses’ experiences of Restriction Orders and Supervised Discharge mechanisms. Service user/nurse relationships and risk are addressed in this initial paper. A mixed method/approach was used. A piloted 15-item questionnaire sought quantitative and qualitative data from 122 nurses throughout England and Wales. Returns amounted to 57. Limitations applying to gaining qualitative data via written questionnaire are overtly acknowledged. Quantitative data were analysed using SPSS. Content analysis and reflexive appraisal of qualitative data led to production of critically appraised conclusions. Findings are illustrative of complexity. Increased understanding of relevant issues, rather than definitive conclusions, is claimed as an outcome. Reductionist approaches are insufficient in illustrating relevant complexities; nurses offer considered, contextualised responses; diametrically opposed opinions exist about the value of interpersonal relationships and balances between care, control and risk assessment.

KEYWORDS: Forensic, community mental health nursing, compulsion, relationships, risk, mixed mode research.
INTRODUCTION
This paper provides an analysis of experiences and perceptions of forensic community mental health nurses (FCMHNs) in terms of the effects of compulsion upon relationships with service users. Control in the community has a diverse legal and social history. Mandatory powers apply to those patients convicted of serious offences and 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 with restrictions placed on where they might live and what treatment they must accept. FCMHNs contribute to the care and supervision of these patients and as a group, the numbers of these specialist nurses is increasing (Brooker and White 1997). FCMHNs care for patients both inside and outside secure environments, with the emphasis of their work focusing on assessment and management of potential risk (Evans 1996).

The Mental Health (Patients in the Community) Act 1995 came into effect in April 1996. This allows patients subject to detention in hospital for a mental disorder, to be discharged on conditions. Conditions may include for example attendance for treatment, education or training. Patients may also be required to provide access to their accommodation to their supervisor, for assessment and treatment purposes. The patient is assigned a supervisor on discharge, often a Community Mental Health Nurse (CMHN). Patients who refuse treatment while subject to Section 25 will have their care programme reviewed and may be reassessed for admission to hospital. The potential effects upon interpersonal (professional) relationships are broad, yet may be better understood by considering practitioner perceptions.
BACKGROUND LITERATURE

Literature describing mental health nurses’ views of compulsory community treatment and effects upon relationships is scarce. Coyne (1999) includes relevant overseas (non-UK) research as background to a small qualitative study that identifies significant reservations about the value or impact of compulsory treatment. Godin and Scanlon (1997 p.83) provide an exceptional account. They indicate similarity of perception by nurses and users, of power in relationships; examples of “seemingly irreconcilable positions” in which nurses adopt compromises; and differences between therapeutic and professional positions. Jones et al (1999) present some evidence that nurses recognise the need to involve users more and, that decision making with users, requires exploration of alternatives involving tensions between care and compulsion. In a study of European literature Clark and Bowers (2000) illustrate the relevance of social, ethnic and gender issues and suggest that CMHNs might learn much about maintaining good relationships (with users) from approved social workers. Franklin et al (2000) studied psychiatrists’ experiences but mainly in respect of medication compliance, service engagement and patient monitoring. This study was criticised by Burns (2000) who highlights the conflict between supervision and treatment.

FCMHNs have an important role in monitoring conditionally discharged patients, who have been described as being largely synonymous with the seriously mentally ill (SMI) (Shepherd 1993). These are likely to attract most attention when government completes its review of the Mental Health Act, including as it does the possibility of including nurses formally for the first time in the detention process.
METHODOLOGY

Combinations of approaches, rather than a discrete, preferred method was prompted by the following research questions:

- How do FCMHNs perceive issues in relation to the development and maintenance of therapeutic relationships with their patients?
- What is FCMHNs experience in relation to recall of these patients to hospital?
- Do FCMHNs believe that powers of compulsory treatment such as restriction orders have a role in managing any risk (self-harm, self-neglect and harm to others) that these patients may present?

The ‘quantitative-qualitative’ debate abounds in nursing (Carr 1994, Johnson 1999, Cushing 1994, Holmes 1990). Our position is that particular philosophies have strengths and weaknesses that apply contextually. This research sought quantifiable and qualitative data that would help inform clinicians, other researchers/educators and policy makers. We did not set out to capture ‘lived experience’ but brief textual representation of views/opinions as well as quantitative responses that we could use to supplement or modify our developing understanding. We were keen to contribute to the ‘continuing conversation’ cited by Paley (1998 p. 823). Extensive reading and reflexive discussions raised three significant issues for us. First, our shared understanding of what counts as ‘evidence’. We attribute value to ‘everyday experiences’ even though as Clarke (1999 p. 271) states: “Everyday experience is difficult to gauge in formal terms: untidy, volatile and unpredictable, it is hardly the stuff of which ‘scientific’ reports are made”. Second, we support Edwards’ (1999) reservations that nursing is a ‘science’. Illness and health have experiential, subjective components and improvement due to nursing relies in part on the user’s perceptions. Third, complexity is ever-present, as illustrated by Barker et al (1999 p. 274) who describe socio-political pressures leading
to paternalistic modes for nurses, especially in relation to compliance and compulsion –
one outcome of the ‘moral panic’ in the community.

In summary, we sought to be “critically subjective” (Johnson 1999 p.70) to ‘make
sense’ without falling into the trap of making illegitimate claims in respect of
methodology, validity or conclusions. We chose methodological pluralism, searching
for warranted assertions rather than truth.

**Study design and Data Analysis**

FCMHNs in England and Wales were surveyed using 15-item postal questionnaires.
Demographic details and opinions were sought, in relation to experiences of working
with service users involved with restriction orders. The questionnaire was designed
specifically for this study as no similar work has been carried out previously.
Responses were quantified using a 5-point likert scale and SPSS (Norusis 1993) was
used to assist analysis. Questions were formed and grouped to reflect current themes
and concerns evident from the literature on compulsory community treatment.
Specifically, these dealt with issues of establishing and maintaining therapeutic
relationships, risk management, involvement in decision making, compliance, policy
development and nurses views of service user perceptions (of compulsory community
powers). The terms ‘service user’, ‘user’ and ‘patient’ are used synonymously to
indicate an individual in receipt of health care. In some cases individual respondents
have used the term ‘client’ in the same context. The instrument’s format constituted a
degree of pre-emptive coding, in respect of its sections. An opportunity for more
detailed (qualitative) information was provided by a comments box in each question. This provided a qualitative element to the instrument, albeit in a minimal capacity. Thematic content analysis was applied to these data. Responses were coded and categorised in a first round of analysis. These categories were reduced during second and third rounds when saturation was reached. All measures were piloted on a convenience sample (n=13) of local Community Mental Health Nurses who did not form part of the main study sample. Respondents to the pilot study were informed of its purpose and asked to comment on the comprehensibility and wording of the questions as well as relevance to community mental health nursing practice. Some minor changes to the wording of items were incorporated as a result of this process.

We tried to operate in keeping with the ethos outlined by Cutliffe and Goward (2000 p591) in order to make our actions and decisions overt and explicit (and therefore open to judgement re validity). This methodological trail, the representativeness of respondents, examples of participants’ own words and our own ‘Aha’ sessions (our discussions and reflections) are included for these reasons. Denzin’s ideas (1996, cited in Koch and Harrington 1998) were very helpful in our writing. These included acknowledging facts as social constructions, allowing literary and autobiographical elements to co-exist and that disparate, multiple author views are useful. Figure 1 illustrates examples of our separate reflexive diary entries, which were subsequently shared.
All data were subject to extensive reading and appraisal, beginning the process of identifying saturated categories. Figure 2 illustrates the analysis and saturation process relevant to each section of the instrument. In respect of ‘Relationships’ and ‘Risk’ a first analysis round established broad themes that adopted terminology used by respondents as categories, with specific words in textual replies determining categorisation and subsequent saturation. Both researchers (independently and jointly) refined the categories on the basis of meaning rather than specified word presence (Stage 2). So, for example, the response category ‘depends’ was accommodated in ‘context’ on the basis of similarity of meaning even though precise words used may have differed. Finally, (Stage 3) data and category saturation were revisited and re-appraised. This confirmed the finalised categories of textual responses and is consistent with notions of researcher reflexivity (Parahoo 1997: 292, Roe and Webb 1998: 48).

Sample

The total sample was 122, all either FCMHNs in 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 details of which were accessed through personal contact at a forum meeting. In most cases these two groups are synonymous although some FCMHNs are not included in the Forensic Services Directory and others do not attend the FCMHN forum. In all cases the
respondents are Registered Mental Nurses (RMNs) who work in community settings with a specific forensic brief.

**Ethical Issues**

Ethics committee approval was gained locally. There was no compulsion to respond and anonymity and confidentiality applied to responses and workplace locations. There were no cost implications for respondents who were also offered a summary copy of the final report.

**FINDINGS**

Of 122 questionnaires distributed, 57 were returned, a response rate of 47%. Telephone follow-up of non-responders resulted in no further responses. Three respondents returned uncompleted questionnaires that were discarded, leaving 54 subject to analysis. This paper reports on the findings relevant to relationship issues. While a number of constructs examined in this study overlap, for example issues of power and control are important in respect of relationships, for reasons of space they are reported elsewhere (Coffey and Jenkins submitted). Figure 3 illustrates respondents’ demographic details.

**FIGURE 3 HERE**

**Beginning, developing and ending relationships**

Generally, FCMHNs felt that the use of restriction orders made no differences to their;
1. engagement with patients (n=30, 55.6%)
2. ongoing relationships with patients (n=28, 51.8%),
3. ending relationships with patients (n=30, 55.6%).

However 46.3%(n=25) considered that restriction orders involving recall of a patient did impact upon re-establishing relationships with their patient. A significant minority recorded “neutral” responses, seemingly unsure of the effect of restriction orders upon;

1. engagement with patients (n=9, 16.7%)
2. ongoing relationships with patients (n=9, 16.7%)
3. recall and re-establishing relationships (n=18, 33.3%)
4. ending relationships with patients (n=15, 28.3%)

A further group disagreed with the majority view feeling that restriction orders did make a difference to

1. engagement with patients (n=15, 27.8%)
2. ongoing relationships with patients (n=17, 31.5%),
3. ending relationships with patients (n=8, 15.1%).

These findings are presented in Table 1.

Qualitative data illustrated complexity, indicative of the importance of context and the ambiguous nature of forensic mental health nursing. There seems to be a compelling onus upon individual nurses to invest effort and energy in a personal sense, if professional standards are to be maintained. (Verbatim quotes are italicised).
Duration (of relationship) is relevant, benefits being evident through early relationship formation when the user is in a residential unit prior to community care. “Undoubtedly, issues relating to restriction orders arise as the relationship develops and trust is developed”. Communicating a collaborative, co-operative ethos is demanding in such circumstances. “Generally, my ongoing relationship with clients is good, but because of the above [Restriction Orders] I feel it must have a bearing on the clients”. Some respondents indicated that compulsion makes no difference to their relationships with users though particular circumstances are thought to determine all aspects of relationship development. “Depends on circumstances”……”Depends on strength of relationship”. Responses constitute an apparent reluctance to adopt generalised prescriptions.

Data indicate a perception of ‘insurance’ that relates to persuading users to accept help, either as medication, contact or proffered suggestions. “They are more likely to see me as an authority figure…more likely to comply with suggestions, take medication”. Other responses suggest a positive stance. “Can help to keep the client engaged with services... who might otherwise refuse input”. To maintain or re-establish the relationship, particularly post-recall or failed review, requires effort. “Clients will often view this as punitive, much energy is required to fill this gap”. The absence of choice is seen almost as a ‘fait a compli’ which has little or no relevance to the relationship. “Makes very little difference, acknowledge that I can exert influence but continue to work as co-operatively as possible”.

**TABLE 1 HERE**
Compulsion and risks of self harm, self neglect and harm to others

62.9% (n=34) disagreed that “Compulsory powers such as restriction orders are helpful in managing self-harm by services users” although a further 29.6% (n=16) neither agreed nor disagreed. 51.8% (n=28) felt that compulsory powers were helpful in managing self-neglect by service users while a further 24.1% (n=13) could not decide.

A majority (n=45, 84.9%) felt that compulsory powers were helpful in managing harmful behaviour to others by service users. A further group of nurses (n=5, 5.9%) gave a neutral response to this question while 3 (5.6%) disagreed about the helpfulness of compulsory powers in this respect.

These findings are detailed in Table 1.

Qualitative responses again pointed to ‘insurance’ or ‘safety’ in terms of maintaining contact, dealing with neglect, promoting intervention sooner rather than later and reducing harm to others. “Having the power to maintain contact can lead to early intervention”. A group of responses refer to the use of compulsion as a means to prompt engagement/involvement of other agencies and services in the user’s interests. “Restriction Orders highlight clients’ needs to our and other services, give you a clear reason to engage people”.

The qualifier ‘depends’ was repeatedly applied to the user’s mental state. Compulsion is only justified when the mental state is thought likely to produce harm. “Service users will self harm if they are on a Restriction Order or not”. Additionally, a neutral stance
is described, “Anyone with such a lack of self regard is unlikely to pay much attention to compulsory powers except as an after thought after the event.”

Good team-working and helpful relationships are seen as more effective means of reducing self-harm than resort to legal process. “Good care planning and therapeutic intervention is far more important”……."Good team-working and nursing practice would be more helpful than restriction orders”. Compulsory powers are generally perceived as “a necessary evil” and indiscriminate use of compulsory powers is regarded as poor practice. Good practice, in the form of thoughtful approaches to using compulsory powers is dependent upon effective team-working and relationships.

Completely dependable arrangements guaranteeing circumstances in every instance are not possible. Risk should be reduced through application of law though this must be balanced against civil liberties and rights. The tensions between risk, harm and autonomy are considerable. “Provides firm boundaries within a legal framework in which the aftercare team can intervene if self-neglect is evident, however, some clients choose chaotic lives mainly related to substance misuse which consequently affects their care”. Difficulty in balancing rights and responsibilities are evident. “Very difficult to manage/change individuals’ standards, may not be part of mental health problem”.

LIMITATIONS OF STUDY

The study was undertaken within the constraints of the researchers’ workloads that prevented selection of relatively expensive methods such as individual or focus group
interviews. The questionnaire was chosen as an instrument because of our wish to capture views of a widespread group as economically as possible. Wording of some questions may have led to different interpretation although we are somewhat reassured by the consistent fashion in which subjects responded to individual questions. Limits applying to the particular methods used and data analysis are quite well documented and include for example to limitations on the generalisability of findings and qualitative data was provided in the form of relatively short statements.

DISCUSSION
The discussion which follows uses selected additional quotes to illustrate further some of the emerging themes reported above.

Demographic information
Respondents are generally, an experienced group of staff. Most have been in nursing more than 10 years and the majority are graded at G or above. The percentage of nurses in the grades ‘G’ and above, the number of years in nursing and years in current post is similar to a previous study of FCMHNs (Coffey 2000). This current sample included more men (64%) than women (36%) which differs to Coffey’s (2000) study. Most respondents (85%) had at least one patient on their caseload subject to Section 41 of the Mental Health Act (MHA 1983) and therefore have experience of this type of compulsion. As a group they did not have much experience of supervising patients on Section 25 (MHA 1983). This section of the MHA however has very little direct power or sanction upon the mentally ill and contrasts sharply with that of the restriction order.
As such the application of Section 25 will be restricted to those patients not already on a restriction order and of whom there are significant concerns. This may be a relatively small subset of the forensic patient population, a fact reflected in the low numbers of these patients on FCMHN caseloads.

**Relationships**

Quality of relationship has direct impact upon the achievement of positive outcomes for service users (Frank and Gunderson 1990). More than 50% of respondents perceive restriction orders as having little impact upon developing relationships, rather than a positive or negative impact. Yet many of these responses were ‘qualified’ by textual comments such as “Although I try to work together with service users to arrange community care and relationship building there is always the compulsory element to the care built in with the order which acts as the spectre at the feast”. A substantial minority (just under half) were either unsure about this or felt that the order did impact upon relationship development. Trust and effective communication are highly valued and seen as benefiting from contact with service users while still inpatients in secure services, corroborating Evans’ (1996) view. Negative effects of compulsion are partially countered by early contact, though it is possible that some nurses are not making explicit to their patients the implications of the restriction order for fear of impeding the development of the relationship or promoting examples of what Mason (2000) terms ‘protest behaviour’. This may be justified as a pragmatic approach to ensuring the compliance of the patient once discharged from hospital, but it could also be interpreted by the patient as at best paternalistic and at worst, a betrayal. If the
relationship is regarded in high esteem, then using it as a basis for limiting negative anticipated reactions is improper, perhaps deceitful. Contrasts are evident between this type of non-disclosure and acting in line with principles of trust, fairness, equity and respect – all fundamental to the therapeutic relationship. Evoking the ‘best interests of the patient’ clause may serve to buffer nurses who respond paternalistically when faced with difficult circumstances, effectively avoiding conflict with the service user. Alternative, more honest responses might involve risk taking by nurses (risking the relationship itself) and would demand more mutually respectful (and adult oriented) interactions. Mason (2000 p.273-274) offers some illuminating principles relevant to practising more ethically in these types of situations that involve nurses viewing the user’s position as that of ‘medical hostage’. Honest negotiation or “normative bargaining” can then take place, designed to promote a genuinely co-operative relationship and to diminish/eradicate coercion.

“We can move the paradigm of coercion towards a more equitable negotiation strategy…… an opportunity for a win-win situation to develop .... a face-saving device for all...”

(Mason 2000 p.275)

For some respondents, awareness of potential impact of restriction orders upon the establishment of a therapeutic relationship is crucial, whilst for others it less so because of the safeguard of legal sanction if the service user does not engage. This acknowledgement of the benefits of power to the system is seen by extension, to benefit the service user. For example, “But, Section 41 can help to keep client engaged with services who might otherwise refuse input”. This constitutes an alternative view of
therapeutic relationships, which values a commitment (compelled or otherwise) to the maintenance of contact, above the freedom of choice to participate.

Differing views on the impact of compulsion on the formative stages of relationship building are evident, though less so in relation to the effects of recall to hospital. Neutral responses are perplexing in that approximately 20% of conditionally discharged patients are recalled to hospital (see for example, Kershaw et al 1997) therefore FCMHNs should have some experience of this group. It would seem that FCMHNs should access learning opportunities as presented in practice to both broaden and enhance their experiential knowledge. To this end formal guided reflection may offer FCMHNs the opportunity to learn from and build upon practice.

Complexity and context are important factors with much use of the word “depends”. For example, “Depends how recall is handled and circumstances surrounding this. Liaison between us is continued even if patient is recalled”. Some respondents were categoric in their assertions that recall has not had any effect upon re-establishing relationships with their clients; “I have experienced several recalls and found this situation does not interfere with therapeutic relationships”. Why this should be is debatable but may be a function of the value placed upon their ability to establish relationships with difficult clients. Though difficulties are recognised, confidence that they could be overcome is apparent; for example “I am known to my patients and this helps when re-establishing relationships”. This may be reflective of the experience of a group of nurses who are used to dealing with difficult situations and maintaining
relationships with service users with whom mainstream services have been unable to engage. It may also reflect a pragmatic outlook on the part of the nurses that patients who are recalled will have to re-establish relationships with them.

Risk

Use of compulsory powers in the community to manage harm to others has been debated extensively (Dunn 1991, Fulop 1995). Concerns include enforcing treatment and the potential prophylactic effects of being placed on such an order. It is this potential for preventing harm which motivates imperatives such as compulsory treatment as well as mobilising opinion on the level of control being placed on vulnerable members of society. Respondents saw no benefit in using compulsory treatment orders to assist in the management of self-harming behaviour; for example, “Feel it makes no difference”, “In my experience I have seen no evidence that restriction orders are helpful in this way”. This contrasts with recent policy imperatives seeking to include such persons on supervision registers (DoH 1994) and supervised discharge orders (DoH 1995). Nurses see little practical benefit of using compulsory treatment in self-harming cases and would adopt alternatives; for example, “If a service user is experiencing a crisis, a short term respite period can be negotiated, rather than recall”. However, this may reflect the experience of these nurses as patients are more likely to be placed on restriction orders due to concerns about harm to others. FCMHNs have caseloads that are disproportionately loaded in the direction of concerns about harm towards others; “This has not been my experience, although self harm has not been a prominent feature of [patients] I have been involved
with”. Obviously, those who risk harm to others may also present a risk to themselves. Other responses are overtly positive for example, “…Section 41 helps to maintain ongoing contact, review, medication regime etc”. Some responses distanced nurses from responsibility for the actions of the service user, examples included, “Managing self-harm should be the client's responsibility” and “I cannot be with them 24 hours a day”. Compulsion is deemed helpful in managing self-neglect, compulsion acting as a lever in securing services and resources; “Positively framed coercion serves as a motivator and allows service providers to step in and do for if necessary for a time”.

Compulsory powers have most to offer when caring for service users who are at risk of harming others. The benefit seems to derive partially from the ability to act quickly in situations where there are concerns about risk. This contrasts with the experience of using civil sections of the Mental Health Act, where professionals are compelled to wait until the patient’s condition has deteriorated significantly to the extent that they become detaineable. As a professional group therefore it would seem that FCMHNs on the whole are ambivalent about the benefits of compulsory community care while acknowledging specific positive applications of such powers. It may be that at the present time this group are unwillingly to shoulder the professional responsibility of using compulsory treatment to manage risk. Alternatively they may see this as a limited strategy for successfully dealing with risky behaviour.

SUMMARY OF FINDINGS AND CONCLUSIONS
We recognise that our interpretations are influenced by value judgements about what we see as “good” practice and by extension, its corollary. By this we mean that FCMHNs who value and use interpersonal skills and work collaboratively with service users may be seen as practice exemplars. Sharing these types of exemplars would benefit practice and the knowledge base of forensic community mental health nursing. We claim that (excepting demographic details) categoric answers are insufficient in illustrating complexities. We may also be charged with expounding a naïve realism, in that we give weight to our interpretation of the responses and these have not been member checked.

FCMHNs work with people with complex needs. Most respond with proportionate complexity and sophistication. Respondents demonstrated the ability to analyse challenging situations and evolve practice responses which service users could benefit from. Nurses do not appear to merely react to events that are presented in practice, but offer considered responses that acknowledge the broader contextual nature of forensic work. These responses are indicative of a knowledgeable workforce capable of high level thinking. Complexity contributes to difficulty in describing clearly and simply what it is that FCMHNs do. Although efforts have been made to define and develop competencies for forensic nurses (Kirby and McGuire 1997) it may be that this type of work will defy such reductionism as implausible (perhaps amounting to an unnecessary burden of distraction), given the need to work flexibly and creatively with service users.
Context is important in deciding upon the relative risk that any individual may present (Vinestock 1996). This message (avoiding ‘standardised solutions’) shines like a beacon from the responses. FCMHNs have awareness of expectations that exist in respect of risk assessment and the difficulty in reconciling these with the reality of practice. That risk assessment will eliminate entirely, all risk, is a burdensome weight to carry and is unlikely to be achievable in real terms (Grounds 1995).

There remains an inherent faith in the value of the nurse-patient relationship. This is unsurprising given that the focus of mental health nursing has been based upon the primacy of relationships (Peplau 1988). Nurses perceive that the relationship creates conditions for therapeutic outcomes and that this may be of more value in the longer term than any compulsory powers. Even if this is accepted, it seems (somewhat paradoxically) that nurses also hold a pragmatic belief in the value of having recourse to formal powers, should they become necessary.

The education and preparation of FCMHNs should include an examination of the likely effects upon therapeutic relationships of the use of compulsory powers. This would be usefully informed by research that explored the perspective and lived experience of service users living in the community subject to restriction. This research knowledge is necessary to reconcile what nurses saying they are doing with how service users experience this part of the care-giving process.
The viewpoint of some, that compulsory powers made no difference to their relationships with service users was surprising. This highlights a potential area for research. A qualitative study of the lived experience of service users on restriction order, living in the community, might provide a wealth of information on perceptions of relationships. Additionally, an ethnography of the practice of FCMHNs and their interactions with service users would illuminate how difficulties related to compulsion are experienced and managed. Education and preparation of FCMHNs for practice should deal overtly with the likely influence of compulsory powers upon the development of relationships with service users.

Acknowledgements

We would like to thank our colleague Rob Grey for his assistance in independently verifying our interpretation of the responses to this study.
REFERENCES


Figure 1: An example of diary extracts

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<thead>
<tr>
<th>11/05/00 - MC</th>
<th>11/05/00 - EJ</th>
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</thead>
<tbody>
<tr>
<td>Qualitative bit. Some concerns. Should we include this as we have done or (and) should we have a separate section which looks at emerging themes from the qualitative responses. I wonder whether we are confusing our analysis by saying we are doing content analysis but still grouping responses and the categories we have previously decided before completing the content analysis.</td>
<td>Categories formed initially – prior to questionnaire formulation, so outcomes not too surprising. BUT, context is crucial. Nurses thinking critically, in sophisticated ways. (Some are NOT – they are rule bound, concrete thinkers). Methodology = pluralist, mixed. The variation (and complexity) of responses are indicative of validity? I think!</td>
</tr>
</tbody>
</table>
Figure 2: Reflexive appraisal and analysis, coding and categorisation

QUESTIONS CATEGORIES and STAGES OF ANALYSIS

Independent & joint reflexive appraisal, challenge and decision making

<table>
<thead>
<tr>
<th>STAGE 1</th>
<th>STAGE 2</th>
<th>STAGE 3</th>
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<td><strong>Importance</strong></td>
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<td>Depends</td>
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<td><strong>Insurance</strong></td>
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<td><strong>Insurance</strong></td>
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<td>Safety</td>
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<td>Not relevant</td>
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<td>Relationship and Teamwork</td>
<td><strong>Relationships and Teamwork</strong></td>
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<td>Rights and responsibilities</td>
<td><strong>Rights &amp; responsibilities</strong></td>
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**Figure 3: Demographic details**

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<tr>
<th>Age: One respondent did not answer.</th>
<th>Gender: One respondent did not answer.</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29 years – 1.9% (n=1)</td>
<td>Male - 64% (n=34)</td>
</tr>
<tr>
<td>30-39 years - 60.4% (n=32)</td>
<td>Female - 36% (n=19)</td>
</tr>
<tr>
<td>40-49 years - 31.5% (n=17)</td>
<td></td>
</tr>
<tr>
<td>50-59 years – 5.7% (n=3)</td>
<td></td>
</tr>
</tbody>
</table>

**Caseload:**

<table>
<thead>
<tr>
<th>Patients subject to Section 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>70.4% (n=38) had no patients subject to Section 25</td>
</tr>
<tr>
<td>11.1% (n=6) had 1 patient subject to Section 25</td>
</tr>
<tr>
<td>13% (n=7) had 2 patients subject Section 25</td>
</tr>
<tr>
<td>1.9% (n=1) had 3 patients subject to Section 25</td>
</tr>
<tr>
<td>1.9% (n=1) had 5 patients subject to Section 25</td>
</tr>
<tr>
<td>1.9% (n=1) had 11 patients subject Section 25</td>
</tr>
</tbody>
</table>

**Restricted (Section 41) patients**

<table>
<thead>
<tr>
<th>Restricted (Section 41) patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.8% (n=8) had no restricted patients</td>
</tr>
<tr>
<td>50% (n=27) had between 1 and 4 restricted patients</td>
</tr>
<tr>
<td>29.7% (n=16) had between 5 and 9 restricted patients</td>
</tr>
<tr>
<td>5.7% (n=3) had between 10 and 12 restricted patients</td>
</tr>
</tbody>
</table>

**Grade:** Two respondents did not answer.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>E</td>
<td>5.8% (n=3)</td>
</tr>
<tr>
<td>F</td>
<td>5.8% (n=3)</td>
</tr>
<tr>
<td>G</td>
<td>59.6% (n=31)</td>
</tr>
<tr>
<td>H</td>
<td>26.9% (n=14)</td>
</tr>
<tr>
<td>I</td>
<td>1.9% (n=1)</td>
</tr>
</tbody>
</table>

**Experience:**

<table>
<thead>
<tr>
<th>Experience:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Years in nursing</td>
</tr>
<tr>
<td>06-10 years - 11.1% (n=6)</td>
</tr>
<tr>
<td>11-25 years - 87% (n=47)</td>
</tr>
<tr>
<td>&gt; 25 years - 1.9% (n=1)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years in present job</th>
</tr>
</thead>
<tbody>
<tr>
<td>01-05 years - 70.4% (n=38)</td>
</tr>
<tr>
<td>06-10 years - 22.2% (n=12)</td>
</tr>
<tr>
<td>11-15 years - 7.4% (n=4)</td>
</tr>
</tbody>
</table>