



ORIGINAL ARTICLE

Nurses' and patient' descriptions about forms of power in pro re nata medication participation in forensic psychiatric care: A qualitative secondary analysis

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Funding information

Turun Yliopisto; Turun Yliopistosäätiö

Abstract

Despite there being an emphasis on patient participation in their own care, it has been a challenge in pro re nata (PRN, as the circumstance arises) medication in forensic psychiatric care. The power imbalance in treatment relationships can be a barrier to patient participation and should therefore be further explored. This qualitative descriptive study aimed to explore the aspect of power in the descriptions of patients and nurses interviewed in a Finnish forensic psychiatric hospital about patient participation in PRN. A qualitative secondary analysis was conducted through the semi-structured interviews of the patients ($n = 34$) and nurses ($n = 19$). The data were analysed with deductive content analysis. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines were used to ensure comprehensive reporting. The findings revealed that patients and health professionals may have conflicting goals in PRN and that they both use power to try to achieve them. Power in PRN was described in different forms, including authority, force, manipulation and persuasion. Based on our results, the power that health professionals have in PRN medication is particularly based on their legitimate authority and the hierarchical structures of the hospital environment. Patients also hold power in the dynamics of PRN medication care, but their position as a power holder can vary individually and situationally. Recognizing different forms of power and supporting patients with a decreased capacity for decision-making is essential for promoting high-quality and patient-centred forensic psychiatric nursing.

KEYWORDS

forensic mental health nursing, interview, patient-centred care, power, pro re nata medication

INTRODUCTION

Pro re nata (PRN), referring to as-needed, unscheduled drugs administered for acute symptoms (Mardani et al., 2022), is part of holistic forensic psychiatric care for persons with severe and enduring mental health challenges (Howner et al., 2019). The aim of PRN is to promote symptom management and rehabilitation so that patients can live more independently (Selvin et al., 2021). PRN is commonly used in forensic inpatient care (Haw & Wolstencroft, 2014; Hipp et al., 2020). One study

found that all but one of 67 patients had PRN events and a quarter of patients used PRN more than half of the days in a 1-year period (Hipp et al., 2020). In another study, PRN medication was used 135 times in a pre-intervention phase (2 months) for 17 patients (Maguire et al., 2019). PRN regimens are prescribed by physicians and administered by nurses based on patients' physical or psychiatric medication needs (Mardani et al., 2022).

Patients in patient-centred forensic psychiatric care (Nicholls & Goossens, 2017) should participate in shared decision-making with health professionals in

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the prescription, administration and evaluation of their PRN medication care (Baker et al., 2007). Patient participation is emphasized as a principle of high-quality care (OECD, 2017; WHO, 2018). It is based on the right of patients to make their own choices and to be actively involved in making decisions concerning them (Lindberg et al., 2019; UN, 2007). Furthermore, patient participation has been found to have positive impacts on clinical care, treatment outcomes (Huang et al., 2020) and patient empowerment (Castro et al., 2016). However, forensic psychiatric patients (Perlin, 2016), as well as other people with mental health illnesses (WHO, 2018), have been recognized as a vulnerable group in the matter of violations of fundamental human rights.

Due to the severe and persistent mental health illnesses of forensic psychiatric patients, and the risk of violence, they are treated against their will and care often is restrictive in nature (Johansson & Holmes, 2022). In this context, achieving patient participation has been challenging, particularly due to patients' decreased mental capacity (Markham, 2020; Selvin et al., 2021) as well as power imbalances between patients and health professionals (Haines et al., 2018). Previous studies have explored patient participation in PRN medication care (Hipp et al., 2018). However, we were unable to find a study focusing on power related to patient participation in PRN. Our paper targets this unresearched issue.

BACKGROUND

Patient participation refers to equal partnership and collaboration between patients and healthcare providers (Thórarinsdóttir & Kristjánsson, 2014). Patient participation includes balancing the patient's power with that of professionals, based on their expertise and responsibilities (Castro et al., 2016). The decision-making process is central to power in psychiatric care, and it traditionally takes paternalistic forms, where the expertise of mental

health professionals is emphasized over the lived experience of the patient (Verbeke et al., 2019).

Having power refers to one's capacity to produce intended and foreseen effects on others (Wrong, 2002). In the field of nursing, this involves the power of a patient to influence the behaviour of health professionals to support the patient's intentions, and vice versa. In previous mental health studies, power has been found to be exercised over patients through different forms of coercion (Hawsawi et al., 2020; Paradis-Gagné et al., 2021). In the forensic context, patients (Söderberg et al., 2022) and health professionals (Magnusson et al., 2020) have indicated that patients have limited possibilities to participate in decision-making and that the professionals hold the power in patient care. Patients have perceived that their individual needs are ignored or opposed to and that they therefore must adapt to a predetermined care plan (Marklund et al., 2020). On the contrary, when patients perceive coercion, they may try to resist (Simms-Sawyers et al., 2020), and in situations in which they feel powerless, such as when being secluded, they may seek out power (Askew et al., 2020).

Power in forensic psychiatric care has been discussed philosophically (Holmes, 2002; Hörberg & Dahlberg, 2015; Johansson & Holmes, 2022), and it has been recognized as an important phenomenon in forensic psychiatric care (Hörberg & Dahlberg, 2015); still, knowledge on how it is executed in daily practices in this context is lacking. Health professionals should be aware of how power can be framed in their relationships with patients. Thus, the ultimate goal of our study was to recognize and denominate forms of power in the context of PRN in forensic psychiatric care. As a theoretical framework, we used a typology by Wrong (2002) that includes forms in which power can be based and used in social relations between individual or collective actors: authority (divided into five subtypes), force, manipulation and persuasion (Table 1).

In this paper, we explore how patients and nurses in the context of PRN in a forensic psychiatric hospital depicted their perceptions of power during interviews

TABLE 1 Forms of power by Wrong (2002) used as a theoretical framework in the deductive analysis.

Form of power	Description
Authority	
Coercive authority	A person complies with a power holder because they are convinced that the power holder is capable and willing to use force
Authority by inducement	Refers to situations in which adherence is based on rewards and positive consequences
Legitimate authority	Based on a person's perceived status with the acknowledged right to command and an obligation to obey; it also refers to the norms of the larger collectivity
Competent authority	People obey the power holder out of belief in the authority's superior competence to know what is best for them
Personal authority	A power subject desires to obey and serve the power holder due to the power subject's personal qualities
Force	Typically refers to physical violence and restrictions of freedom; can also be based on psychological violence
Manipulation	A power subject is uninformed of the power holder's intention, and there is a deliberate effort to influence the subject's response
Persuasion	Refers to presenting arguments, appeals, or exhortations to achieve a desired result, and the power subject has a choice of whether or not to accept the persuasion to affect their behaviour



with them. Our research questions were: (1) What kind of contents are described representing different forms of power? and (2) How were the forms of power distributed?

METHODS

Design

This was a secondary analysis (Heaton, 2008) of patient and nurse interviews held in a forensic psychiatric hospital in Finland in Autumn 2019. The earlier study focused on patient participation in PRN (Hipp & Kangasniemi, 2022), and during this analysis, we recognized that there was rich description of power in relation to PRN decisions. So, we found it important to conduct a secondary analysis from the viewpoint of power. The secondary analysis enabled production of new knowledge by using existing data (Doolan & Froelicher, 2009). This method allowed us to re-analyse data so that we could make previously unpublished results visible by generating a new research question (Heaton, 2008). We chose deductive analysis because there is earlier theoretical knowledge on power (Wrong, 2002) that could be used as a coding scheme to ensure a thorough perspective of the phenomenon of power (Elo et al., 2014). We used the consolidated criteria for reporting qualitative studies (COREQ) for reporting the study (Tong et al., 2007).

Research environment

The data were collected in a state-run forensic psychiatric hospital with 284 beds for adults (Niuvanniemi Hospital, n.d.). All patients in the hospital had been involuntarily admitted, and they included (i) forensic patients (46%), (ii) patients who were considered too dangerous or difficult to be treated in municipal hospitals (44%) and (iii) patients for a court-ordered mental state examination (10%).

Recruitment and participants

We used purposeful sampling to recruit participants. The patients were eligible if they were Finnish-speaking adults, charted for any PRN medication during their admission (based on self-report) and capable of giving voluntary informed consent. Nurses were eligible if they executed the planning and/or administration of patients' PRN treatments.

Patients were recruited at meetings on the units ($n=13$) by one researcher (KH). A total of 37 patients enrolled. Two were excluded because of a physician's assessment that they were incapable of providing informed consent due to their current mental health, and one patient retracted their participation before the interview.

Nurses were recruited with distributed information letters, and in meetings organized by the researcher and a head nurse. Altogether, 28 nurses enrolled, of which 19 participated in the interview; nine were unable to participate when the interview was arranged, mostly due to an acute situation in the unit.

Data collection

The data were collected in semi-structured interviews by the researcher (KH). The interview guide was developed based on previous knowledge and consisted of three themes: patients' knowledge on PRN, patient participation in the planning of PRN medication, and decision-making in PRN events. The questions did not focus on a particular health professional group and the interviewees could freely describe their perceptions of the roles of different stakeholder groups in PRN.

We carried out individual interviews with patients in their units in a separate room. Due to hospital security protocol, a health professional was present but did not participate in the conversations. The patient interviews lasted 9–39 minutes. The nurse interviews were held in groups of two to four participants from different units. These interviews lasted 57–80 minutes. We had made the decision to interview all the enrolled participants. After that, the researcher evaluated that the data were sufficient to answer the research questions of the original study. In this secondary analysis, saturation was appraised focusing on the analysis (Saunders et al., 2018), that is whether there was enough data to describe power within a chosen theoretical framework, and saturation was achieved.

Analysis

Transcribed interviews produced a total of 412 pages (single-spaced, Times New Roman). We applied deductive content analysis (Elo et al., 2014) and qualitative quantification with Wrong's (2002) forms of power as an analytical framework. First, we read the data several times to get an overview of the content. Second, we extracted data according to Wrong's (2002) classification into eight forms: coercive authority, authority by inducement, legitimate authority, competent authority, personal authority, force, manipulation and persuasion. During the extraction, we identified all meaning units (quotes) that expressed some form or characteristics of power, as Wrong (2002) has described them (Table 1).

Third, we coded all of the quotes, grouped them and abstracted them again into the sub-categories in Wrong's (2002) taxonomy. Fourth, qualitative quantification was used to express the number of quotes among the forms of power and their division between patients and nurses, to gain knowledge about what kind of forms



of power participant groups identified. The analysis was carried out in collaboration with two researchers (KH and TL) and finalized within the research group. We used QSR International's NVivo 20 software to manage data and assist in the data analysis.

FINDINGS

In total, 34 patients and 19 nurses participated in our study. Most of the patients were male (85%, $n=29/34$), and their age ranged from 22 to 64 years (mean 40). They had been at this hospital for 5 months to 30 years (mean 7 years). The most common self-reported main diagnosis was schizophrenia (68%, $n=23/34$) followed by schizoaffective disorder (18%, $n=6/34$). Most of the nurses ($n=19$) were female (84%, $n=16/19$), and their average age was 41 years. They had worked at the hospital from one to 24 years (mean 10).

Altogether, 423 quotes were extracted as they expressed the forms of power (Wrong, 2002) in PRN participation. Approximately half of them were from patients ($n=205$) and the other half from nurses ($n=218$). The most common form of power among both groups was legitimate authority ($n=208$), and less common was authority by inducement ($n=4$). Examples of the quotes are presented in Table 2.

Legitimate authority

Legitimate authority was the most common ($n=208$ quotes) form of power in PRN participation. It frequently referred to the *authority based on professionals' legitimate power*. Both patients and nurses described that, based on their legitimate position, physicians have the unilateral power to prescribe PRN, sometimes without hearing from the patients. Patients felt that they had to consent physicians' decisions, despite their possible disagreeing views. In addition, nurses were described to have the legitimate power to administer PRN because only they have access to the medication.

Power structures in professionals' legitimate power meant that physicians held the highest legitimate authority and power, which convinced the patients in PRN care. The nurses followed physicians' orders and felt that they were not considered in the decisions made regarding patients' PRN care.

Authority based on patient's legitimate power in PRN referred to patients' rights and autonomy to decide for themselves when they use as-needed medication, both by requesting PRN and refusing PRN offered by nurses. Because the nurses agreed that patients have autonomy, the nurses felt obligated to administer medication when patients requested it, even when the nurses questioned the need for it. The nurses expressed that the legitimate power of patients has increased over

time and that their requests are sometimes even too easily fulfilled.

The legitimate authority of patients was illustrated in relation to *patients' role and status in decision-making*. The patients had sometimes experienced health professionals highlighting their superiority and reminding patients of their 'lower' status. Nurses suggested that the perceived role of patients as power subjects could be due to their mental illnesses. From the nurses' viewpoint, patients can adapt a passive role because of their previous experiences of being rejected by nurses. The patients felt that they were expected to not be too independent and active in their care.

The interviewees described that, when being hospitalized, patients had to settle for *house rules in decision-making*. This was especially discussed in relation to the hospital policy to avoid the use of benzodiazepines. According to the interviewees, some of the patients strongly disagreed with this policy. Patients also suggested that PRN was prescribed similarly for all patients, and that they were powerless subjects of this policy. Similarly, the nurses found that standard medication care was commonly used with all patients. Furthermore, nurses described how they had to adopt the PRN practices of the unit even when they found them questionable.

Persuasion

Persuasion was the second most found ($n=75$ quotes) form of power in PRN participation, mostly described from the nurses' viewpoint. Both nurses and patients used *medical arguments* to influence PRN decisions. Patients suggested that health professionals could deliberately highlight the pros and withhold negative information. Nurses described that they used medical arguments to motivate drug-avoidant patients to use medication, verbalize patients' conditions and explain how PRN could help ease patients' distress. However, both patients and nurses said that nurses tried to mitigate patients' PRN use with drug-seeking behaviour. The patients' medical arguments could include explaining their needs for medication. The patients had also sought out literature on medication and used that information to argue for their preferences. The nurses suggested that patients could exaggerate their symptoms and advise peers on how to persuade the physician to make the desired PRN prescription. Nurses had noticed that patients' medication knowledge could be erroneous, or that they had sought only one-sided evidence.

Nurses described that they used *sweet-talk* as a form of persuasion when they were encouraging patients to take PRN. In doing so, they tried to sound empathetic and find out patients' individual preferences to support adherence.

**TABLE 2** Categories and examples of quotes describing forms of power.

Main categories (ref. total; patients/nurses)	Sub-categories (ref. total; patients/nurses) examples of quotes from patients (P) and nurses (N)
Legitimate authority (<i>n</i> =208; 122/86)	<p>Authority based on professionals' legitimate power (<i>n</i>=88; 56/32)</p> <ul style="list-style-type: none"> • Actually, I don't have any medication that I would want myself, they are all prescribed just like that—like having no power of my own to say anything in medication. (P2) • That nurse who is responsible for medication and has the key to the medicine cabinet (decides whether the medication is administered or not). (P17) • Well, the nurse has the key to the cabinet, the patient is not able to forcibly take it. (N1) <p>Power structures in professionals' legitimate authority (<i>n</i>=16; 2/14)</p> <ul style="list-style-type: none"> • A physician of the unit or a head physician decides the medication, and nurses don't and cannot decide, but they can give those drugs that a physician has ordered, but nurses cannot prescribe them. (P31) • Sometimes it feels like it's enough if a doctor just comes and asks something like 'what is your current health', and it might be that the patient is suddenly willing to take that medication. It is because of the physician's authority. (N18) • It is always a physician who assesses the need for medication, it is specifically a physician, not a patient or a nurse. (N3) <p>Authority based on patient's legitimate power (<i>n</i>=46; 22/24)</p> <ul style="list-style-type: none"> • It is my decision whether or not I take medication. (P8) • I don't have any proof if the patient says that 'I have a bad mental condition', it is legally really difficult, like how could I justify that I refuse to give you this as-needed medication if someone is saying that they are in bad condition? (N1) • Considering this participation issue, nowadays their (the patients') wishes are quite largely answered. Like if they want an as-needed medication for something, they are also getting it. (N6) <p>Patient's role and status in decision-making (<i>n</i>=15; 12/3)</p> <ul style="list-style-type: none"> • Well, the doctor wanted to highlight his authority to that guy when he didn't quite understand the physician's status. (P11) • And then they blame me for being self-determined when it comes to medicines. (P1) • The patients who have been in care in this hospital for a long time, it is maybe in our culture some kind of atmosphere that everyone maybe does not have the courage to ask what as-needed medication they have, if there is not a really trustable nurse on a shift. It is also our nurses' own fault, we can sometimes say that 'you don't need to know that' if we, for example, currently have no time to check the list or something. And when you get rejected enough times, it just results in a kind of 'do I dare'. (N19) <p>House rules in decision-making (<i>n</i>=46; 30/16)</p> <ul style="list-style-type: none"> • I think that those as-needed drugs should be prescribed when you are really in such bad shape that you need those benzodiazepines. They should be prescribed rather than thinking that 'oh, they cannot be given because you would be drunk'. (P16) • Mostly, all these places are following the same protocol with as-needed drugs. (P19) • And it probably is just the way that the working team is used to doing, for example, I think that we are giving (PRNs) more easily than in some other units—it is like, when others are always giving it, why shouldn't I. (N18)
Persuasion (<i>n</i> =75; 26/49)	<p>Medical arguments (<i>n</i>=58; 22/36)</p> <ul style="list-style-type: none"> • I appeal to those symptoms that the physician has prescribed the pill for. (P11) • We always provide arguments like 'your condition and situation is what it is now and we would like to ease it with medication' but sometimes the patient does not admit it. (N5) • Many times a patient comes to argue that they have sought information about a particular medication, and then you have to question it like 'where you have learned this'. Their information-seeking is quite purposeful really. (N16) <p>Sweet-talk (<i>n</i>=4; 0/4)</p> <ul style="list-style-type: none"> • When it is like 'nothing helps this condition' when a patient is, for example, really anxious, the conversation goes like 'well, banging your head against the wall is barely helping and soon you will have a headache too, so if you would still try this'. We try to use discussion. (N17) • We propose something like 'what would be helpful for you, how could I help you'. (N18) <p>Pushing (<i>n</i>=7; 2/5)</p> <ul style="list-style-type: none"> • I have disagreed, like I don't want it now, and they have tried to push it. (P27) • With some patients, you have to persuade, like sit there sometimes even half an hour, but I agree that they usually accept it. (N9) <p>Exhaustive persuasion (<i>n</i>=6; 2/4)</p> <ul style="list-style-type: none"> • I have made it clear that I am not at all interested in talking about it anymore, that I have talked and talked about it for 10 years already and it will not change anything. But even if I'm not interested, somehow the discussion always goes to medication and, again, we are talking about it. (P8) • You just give it (PRN) because you know that if you don't, the patient is kind of walking behind you all day until they get it. (N2)

(Continues)



TABLE 2 (Continued)

Main categories (ref. total; patients/nurses)	Sub-categories (ref. total; patients/nurses) examples of quotes from patients (P) and nurses (N)
Competent authority (<i>n</i> =46; 24/22)	<p>Authority based on professional competence (<i>n</i>=30; 17/13)</p> <ul style="list-style-type: none"> • The problem is mostly that patients usually have lack of information about these things—and physicians know better as they have seen patients who have tried different medications and thus know what affects they have. (P30) • Despite feeling that I don't need medication, it can still be that I really need them, and then the nurses who know me can offer them to me. (P34) • There are patients who have no idea even why they are here and that they have some illness that requires medication, or they do not recognize their inconvenience even if it can be seen from the outside, and in that situation, it is more the nurses' responsibility. (N7) <p>Authority based on patients' lived experience competence (<i>n</i>=16; 7/9)</p> <ul style="list-style-type: none"> • From all of this I have kind of learned and I know what helps and what doesn't—like experienced that but still it is a fact that you cannot just decide and list that 'I want this and this medicine', it is quite wild thinking like that. (P3) • For example a headache, it is so subjective, it is hard to say from outside that your head is not aching, thus we usually give a painkiller. (N19)
Force (<i>n</i> =43; 12/31)	<p>Violence (including verbal abuse, passive-aggressive behaviour, creating pressure, and physical violence) (<i>n</i>=35; 9/26)</p> <ul style="list-style-type: none"> • I can start to yell and rage, and in the worst case I can also cuss them out. (P31) • I refused to talk to that physician if I didn't get Temesta or Xanor [benzodiazepine brand names]. (P12) • You get out of that situation when you take that medicine. (P27) • Once (when I didn't get PRN that I requested) I threw a chair and was secluded—it was to demonstrate how bad I was feeling, I just couldn't figure out any other solution there. (P7) • It can also be just attention seeking, like 'okay, I didn't get it, so I'll whine and protest here a little bit'. (N8) • When we try to cut it and motivate them not to take it (PRN), they are totally ending the cooperation—for example, they don't tell the reason or discuss and reflect on that with a nurse, they are not willing to interact, they just appeal to their subjective experience and say that we have to give that medicine. (N3) • Someone is in extremely bad psychiatric condition and then staff say, 'you should take this' and then a big gang gathers, starting with the physician. And there is only one patient. The patient's experience can be that the medicine was almost forced on them, even if they finally took it themselves. (N1) • Only about 2 weeks ago when one patient attacked for just that reason that the as-needed medicine had been changed, discontinued—so, a violence event. (N13) <p>Restrictions in care (<i>n</i>=8; 3/5)</p> <ul style="list-style-type: none"> • When you are in a seclusion room and they (nurses) decline to bring it (PRN), you are unable to go and get it—if you push that button and they say that you are not getting the medicine, you can't do anything, then you just need to be without it. (P16) • In the worst case, if a patient refuses to take the medicine and refuses cooperation, they are transferred to a seclusion unit or room. (N14) • Some are happy to accept it (PRN), and with others there is no way, and then we sometimes must proceed to a forced injection. (N5)
Coercive authority (<i>n</i> =32; 8/24)	<p>Fear of coercive methods and delayed progress in care pathway (<i>n</i>=11; 6/5)</p> <ul style="list-style-type: none"> • When they offered as-needed, I had the feeling that I will be secluded if I don't accept it, even if they never said so. (P1) • Sometimes I just took it without opposing, because it is known that if you refuse the offered medication here, I have understood that it is not seen as good and you might end up getting rebuked by a physician—and it is never a good thing if you need to be rebuked by a physician due to some bad thing. You can lose your freedoms. (P5) • In our hospital, it is always that thing that this is forced treatment and many things go like that physician evaluates a patient's health and if they are capable to something, for example to go outside with a nurse or to move with peers in the hospital area, the physician has like, I don't know the right word, but kind of a big authority to make decisions. Thus, patients might hesitate to talk to a physician because they are afraid to lose the benefits they have earned. (N10) <p>Fear of negative impact on therapeutic relationship (<i>n</i>=6; 2/4)</p> <ul style="list-style-type: none"> • I have understood that you can refuse them (PRNs), but I don't know what the point is, because then you are just getting kind of disreputable here. (P30) • It can have long-lasting effects on the connection with the patient if you basically show the patient that you don't believe them. (N3) <p>Fear of patient filling a complaint (<i>n</i>=5; 0/5)</p> <ul style="list-style-type: none"> • Our patients are well aware of their rights and they really make a lot of complaints. (N14) <p>Fear of violence (<i>n</i>=10; 0/10)</p> <ul style="list-style-type: none"> • Sometimes you can see from a patient's face that it's not a good time to ask and then you just give that medicine and discuss later. (N4) • The patient is maybe not acutely violent there, but their background is such that you prefer giving the as-needed rather than seeing where it goes this time. (N19)



TABLE 2 (Continued)

Main categories (ref. total; patients/nurses)	Sub-categories (ref. total; patients/nurses) examples of quotes from patients (P) and nurses (N)
Personal authority (n=10; 6/4)	Authority based on personal characteristics of patients (n=3; 2/1) <ul style="list-style-type: none"> • (I am involved in decision-making) because they know me and my things, and I am a good patient, like with me things go without problems or rulebreaking—I am in the positive extremity, and there are also lot of patients in the negative extremity who the physician cannot trust at all. (P1) • I don't know how much patients can influence it themselves, surely someone strong-minded is able to influence—it is a difficult patient—in quotation marks. Like someone who holds their ground, their own wish. (N16)
	Authority based on personal characteristics of professionals (n=7; 4/3) <ul style="list-style-type: none"> • The current physician in our unit is the best physician in this hospital, they are easy to get along with and they somewhat understand. (P8) • Then we negotiate, if it (PRN) is really urgently needed, and we choose the person who gets along best with the patient in that moment to be the negotiator. (N13)
Manipulation (n=5; 4/1)	Not telling why PRN was offered (n=3; 3/0) <ul style="list-style-type: none"> • It was really some trivial situation, I went to ask something, and after that, the nurse said that 'take one extra medicine', and I was like 'why?' and the nurse was 'just take it', and I was like 'sure, okay'. (P25)
	Not telling medication is PRN (n=2; 1/1) <ul style="list-style-type: none"> • They don't say that this is as-needed, they just give it. (P9) • We had one secluded patient in really bad health, and it might be that we seldom asked whether they wanted to take the medicine but we just brought it and said that 'here is medicine for you'—it is like that when, being really unwell, they are unable to say that they can take it. (N18)
Authority by inducement (n=4; 3/1)	Freedoms in care as inducement (n=3; 3/0) <ul style="list-style-type: none"> • It is quite important when thinking about self-care that you take care of yourself, and when you have a need for medication, it is good to take it—after all, the aim of this treatment is that 1 day you will live independently in society. (P26)
	Better cooperation as inducement (n=1; 0/1) <ul style="list-style-type: none"> • Maybe it enhances the cooperation and adherence in care when patients' needs are heard. (N6)

When the nurses found PRN to be inevitable, they used *pushing* to persuade patients to take medication. Nurses tried to convince the patients of the need for medication. If the patients did not recognize the need themselves, they could experience the nurses' offers of PRN as enforcing and imposing. However, unlike the use of force, the patients did not have a sense of obligation to comply. According to the nurses, patients could also use pushing when one nurse was denying their PRN requests by claiming that another nurse had previously complied.

Nurses described that patients used *exhaustive persuasion* in order to get PRN: Some patients did not accept a denial of their request but kept on demanding PRN. One patient described how nurses and physicians had used exhaustive persuasion to try to reduce his medication avoidance.

Competent authority

Competent authority (n=46 quotes) referred to professional's authority based on their competencies and a patient's authority based on the competence gained through their lived experience. The patients commonly described that health professionals' *authority based on professional competence* in PRN created a basis for their

trust in physicians' and nurses' competencies in medication care. Some patients excluded themselves from decision-making because they assumed professionals to have superior competence. Physicians' competent authority was associated with paternalistic culture, a context in which the competency of physicians is considered self-evident and questioning their decisions is challenging.

The interviewees also described *authority based on patients' lived experience competence*. Nurses described that patients were unquestionably competent to evaluate their needs for PRN because of their subjective experience of particular symptoms. Also, some patients valued their lived experience in the planning of their PRN care and hoped that they would be prescribed PRNs that they had found useful. However, both the patients and the nurses suggested that patients' competency varies and is associated with their health status.

Force

In total, 43 quotes referred to force, including descriptions of violence and restrictions in care. Descriptions of *violence* referred mostly to psychological violence, particularly verbal abuse by patients. Patients used violence to influence their PRN administration: Patients



described that they could be verbally abusive if their wishes for PRN were not fulfilled. Similarly, nurses described that patients had sometimes gotten angry and expressed indignation over denied PRN requests.

The patients had also displayed power in the form of passive-aggressive behaviour by ceasing to cooperate with or refusing to talk to physicians or nurses who had declined their wishes for PRN. Similarly, the nurses expressed that PRN denials could lead to failed cooperation. One description that demonstrated a nurse's passive-aggressive behaviour involved denying PRN for self-inflicted symptoms so that the patient would learn through suffering the consequences.

From the patients' point of view, force could also be used to create a pressure to take medication. The nurses indicated that they did not actually force patients to take PRN, but patients might feel pressured to accept PRN offered. The nurses also described the pressure instigated by patients. Nurses suggested that it could be easiest for everyone if health professionals accommodate patients' medication wishes instead of questioning them or arguing.

The nurses described that, in the worst cases, disagreements related to PRN medication had led to patients being physically violent. The violence had been a response to not being prescribed or administered a desired PRN but also a reaction of disappointment in not being informed about changes in medication prescriptions. Patients had also threatened physical violence if they were to not receive the PRN they were asking for. Only one patient described using physical violence.

Force was also related to *restrictions in care*. Patients described limited power in the restricted environment of forensic psychiatric care. According to the patients, the health professionals could revoke a transfer to a more open unit if a patient expressed needs for psychotropic PRN. Also, being secluded limited patients' opportunities to get PRN. Nurses discussed about how patients' refusals of PRN could result in restrictions, such as seclusion and forced medication, but that these restrictions were based on a patient's worsened condition, not the refusal itself.

Coercive authority

Coercive authority ($n=32$ quotes) referred to patients' behaviour based on the fear of negative consequences. Coercive authority was described in relation to patients' *fear of coercion and delayed progress in care pathways*. Patients explained that they had accepted PRN that had been offered because they were afraid that refusing it could result in seclusion or forced medication. The patients said that resisting health professionals could lead to longer hospitalization periods; thus, they found it more beneficial to comply. They also indicated that refusing medication could result in losing freedoms in

care. The nurses had noticed that patients might have hesitated in expressing needs for PRN because it could be interpreted as an indicator of a worsening condition and a requirement for more intensive care.

Coercive authority was also based on a *fear of negative impact on the therapeutic relationship*. Both patients and nurses felt that expressing disagreeing views in PRN events could affect their reputation. Patients were worried about being seen as 'a difficult patient' if they refused PRN. Similarly, nurses indicated that denying patients' PRN requests could have a negative impact on patient–nurse relationships.

The nurses indicated that patients were keen to write official complaints if they were refused PRN medication when they desired it. Therefore, nurses sometimes had the *fear of a patient filling a complaint*.

Patients used coercive authority based on the nurses' *fear of violence*. The nurses' PRN decision-making commonly included evaluating the risk of physical violence. The nurses were aware of the aggressive tendencies of this patient group, and they avoided the risk of violence by administering PRN rather than impugning patients' requests.

Personal authority

Personal authority ($n=10$ quotes) in PRN participation came up in the interviews in relation to authority based on personal characteristics of patients and personal characteristics of professionals. Patients and nurses had divergent views on *authority based on personal characteristics of patients*. One patient suggested that physicians have favourite patients, those they consider loyal and trustable, who they involve in PRN decisions. According to nurses, however, those who are strong-minded, determined and capable enough have more power when cooperating with physicians.

Both patients and nurses described that some health professionals have more *authority based the professional's personal characteristics*. The patients valued nurses and physicians who were knowable, humane, but also casual and humorous enough. The nurses expressed that health professionals favoured by certain patients could be used to convince them in challenging situations. The nurses also indicated that some professionals were more powerful because they were strict enough.

Manipulation

Manipulation brought up in the interviews ($n=5$ quotes) referred to when nurses would withhold the reasons for offering PRN, and to when they did not disclose that the medication was PRN. The patients described situations in which they were encouraged to take PRN but *were not told why PRN was being offered*. Patients had accepted the PRN even if they did not understand the need for it.



Another form of manipulation was that patients were *not told that medication was PRN*. According to the nurses, this is done if a patient is too unwell to make decisions about PRN.

Authority by inducement

In our data, authority by inducement ($n=4$ quotes) referred to the form of power in PRN participation where patients expected freedoms in care, or better patient-staff cooperation, as positive consequences of adherence. *Freedoms in care as inducement* was described by patients who told that accepting the medication care as recommended by health professionals was one key to freedoms in care, and finally being discharged from the hospital. From the nurses' viewpoint, authority by inducement was described in one quote as *better cooperation as inducement*. The nurse suggested that accepting patients' PRN requests was part of a patient-centred approach that supports patients' adherence and patient-staff cooperation.

DISCUSSION

Our findings show that patient participation in PRN in a forensic psychiatric hospital contained all eight forms of power as categorized by Wrong (2002). The results show that patients and health professionals may have conflicting goals in PRN and use different forms of power to achieve them. Furthermore, our results reflect the power dynamics associated with the hierarchies of nurses and physicians, in line with an earlier study by Haines et al. (2018) who found that nurses have an overarching view of patients but that is the physicians who are usually the ones making the decisions that nurses follow, even if they disagreed them. Our results highlight the multidimensional nature of power, including aspects that often go unrecognized. This enriches the literature on power in psychiatric nursing, which has previously focused on restrictions and patients' limited possibilities to make decisions in their care (Farrelly et al., 2016).

The power of the health professionals was most commonly legitimate power linked to their profession and role in the hospital. The other forms of power used by health professionals can be seen as linked to their legitimized position and mandates. Their competent authority was largely based on their profession, and they were the ones making decisions about restrictions and freedoms, which was a reason for patients to obey. One worrying finding was that some patients considered themselves powerless in their care due to health professionals' legitimate power and the hospital's house rules. Similarly, Pelto-Piri et al. (2019) illustrated that forensic patients felt powerless in relation

to professionals: patients felt that nurses could not be disturbed with questions or concerns or the patients would experience negative consequences. This reflects the constancy of patriarchal culture in forensic psychiatric care where patients may adopt passive roles (Livingston et al., 2012). Implementing a corrective and disciplinary approach in this vulnerable patient group jeopardizes the ethical care that includes promoting patient participation (Magnusson et al., 2020). It is indeed a challenge to create a treatment environment that supports forensic psychiatric patients' empowerment in their own care, as the care is coercive and patients are treated involuntarily (Selvin et al., 2019). However, creating an accepting and trustful treatment relationship should be a target as it is pivotal to treatment adherence and rehabilitation (Askola et al., 2022).

Our findings reveal a contrasting power balance between health professionals and patients. Patients and nurses alike described the legitimate power of patients and how they have the last word on PRN decisions. This contradicts an earlier study in which patients described that professionals held the power over them in PRN (Cleary et al., 2012). Our result may reflect a change in the role of patients due to a strong emphasis put on patient participation and autonomy in the last decades (OECD, 2017; WHO, 2018), including in forensic psychiatric care (Nicholls & Goossens, 2017). With regard to PRN medications, autonomy to make decisions can, however, decrease the safety of the wards. Unwillingness to accept PRN medications has been found to be a risk factor for violence (Radisic & Kolla, 2019). Thus, finding a power balance that factors in both safety and patient rights is crucial.

Our results suggest that, whereas the power of health professionals was constant, patients' power seemed to be situational and varied based on their personal characteristics or habits, as well as on their functional status. Patients needed to 'take the power', but they also had opportunities to assign it to the health professionals. Surrendering power from professionals to patients is an essential part of patient participation (Sahlsten et al., 2008). It has been suggested that all patients in forensic psychiatric care are not willing to take responsibility and control their care (Magnusson et al., 2020; Selvin et al., 2016, 2021). Our results confirm previous knowledge that there is still a need to discover means to support patient involvement in decision-making (Marklund et al., 2020; Selvin et al., 2021; Söderberg et al., 2022). From the viewpoint of health professionals, power is linked to their ethical responsibility to assess each patient's capability to make decisions and to give them a possibility of shared (Huang et al., 2020) or supported decision-making (Jeste et al., 2018). Noteworthy, in situations when a patient is incapable of identifying their own best interest, the patient can interpret nurses' actions either as a use of power or as valuable caretaking.



Limitations

The interview data collected in previous research included unique content related to power. Therefore, we considered the data to be adequate for secondary analysis (Tate & Happ, 2018). Secondary analysis also reduces research waste by maximizing the use of existing data (Tate & Happ, 2018). However, interviews with a more distinct focus on power could have yielded more in-depth views. The credibility of the conclusions could have been improved by confirming them with the study participants (Lincoln & Guba, 1986). Credibility was strengthened, however, by the same researcher carrying out the interviews, participating in the analysis and the reporting of the study. The conclusions were also made valid by including two researchers with clinical expertise (Tate & Happ, 2018) in psychiatric inpatient care. The limitations regarding the data collection and transferability of the findings are reported in the earlier publication of the data (Hipp & Kangasniemi, 2022).

The theoretical framework used in the deductive analysis is a general framework of power and not specific to psychiatric care. Therefore, the researchers who conducted the analysis have made interpretations regarding how forms of power are described in our data. Quotations are used to represent how these interpretations illustrate the categories (Elo et al., 2014). The content of categories is partially overlapping, reflecting the multidimensional nature of power in forensic psychiatric care. The findings reflect power in PRN medication in the Finnish forensic psychiatric inpatient setting. As the culture of care can vary between hospitals and countries (Rapisarda & Miglioretti, 2019), the transferability of these findings to other settings should be considered with caution.

CONCLUSION

Patient participation in PRN in forensic psychiatric care incorporates multidimensional forms of power between patients and health professionals. Power is used by both patients and health professionals to influence each other's behaviour to achieve goals in PRN medication. It is crucial in patient-centred care that patients' preferences are considered in PRN medication. This includes sharing power in decision-making. However, balancing the power between patients and health professionals should always serve the patient's best interest. In the future, there could be a need for an instrument to measure patients' individual experiences of forms of power.

RELEVANCE FOR CLINICAL PRACTICE

Our study highlights the sometimes conflicting goals of health professionals and patients in PRN medication

and the different forms of power used to achieve them. Ensuring balanced power that considers both safety and patient rights is essential. Having clear mutual expectations could be one solution for decreasing unwritten house rules, including those related to medication therapy practices. The findings of this study indicate that different forms of support for patients with a decreased capacity for decision-making are warranted in forensic psychiatric settings.

AUTHOR CONTRIBUTIONS

All persons who meet authorship criteria are listed as authors, and all authors certify that they have participated sufficiently in the work to take public responsibility for the content.

ACKNOWLEDGEMENTS

We thank the patients and registered nurses for sharing their experiences, and the staff members for their contributions to recruitment and data collection.

FUNDING INFORMATION

The work during data collection was supported by the Turku University Foundation and the Department of Nursing Science at the University of Turku.

CONFLICT OF INTEREST STATEMENT

The authors have no conflicts of interest to declare.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ETHICS STATEMENT

The study was approved by the Committee on Research Ethics of the University of Eastern Finland and the hospital board. All participants provided written informed consent after an adequate time for decision-making had passed.

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How to cite this article: Hipp, K., Kangasniemi, M., Varpula, J. & Lantta, T. (2023) Nurses' and patient' descriptions about forms of power in pro re nata medication participation in forensic psychiatric care: A qualitative secondary analysis. *International Journal of Mental Health Nursing*, 00, 1–12. Available from: <https://doi.org/10.1111/inm.13219>