An Interpretative Phenomenological Analysis of the Experience of the Therapeutic Relationship between Service Users and Staff after Physical Restraint in a Secure Mental Health Service

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Restrictive interventions, such as physical restraint, should be a last resort for managing imminent risk. There has been growing recognition of the harmful effects of them, for both staff and service users. Limited research has considered the impact of physical restraint on the therapeutic relationship between staff and service users. The aim of this research was to address this gap in the literature and explore both service user and staff perspectives of the therapeutic relationship after physical restraint, in a UK-based service that provides low and medium secure care for adults. Ten semi-structured interviews were conducted with five service users and five staff members. All participants had been involved in at least one incident of physical restraint. Interpretative Phenomenological Analysis was used to analyse the data. Three master themes emerged from the service user experiences: emotional impact; changes to the therapeutic relationship; and appraisal of the necessity of physical restraint. A further three master themes were produced from the staff member experiences: emotional response; balancing professional roles and responsibilities within the relationship; and moving forward with the therapeutic relationship after physical restraint. Findings support the need to continue to reduce restrictive interventions including physical restraint in secure mental health services and consider the impact upon those involved, both emotionally and relationally. Contemporary approaches to reducing power imbalances between staff and services users, as well as those that would reduce the likelihood of (re)traumatising service users, are also recommended.

Keywords: Restrictive interventions; coercion; physical restraint; therapeutic relationship; secure services; IPA

Introduction

Restrictive practices refer to interventions used by staff to restrict a person's movement, liberty and/or freedom (Department of Health, 2014). The terms 'restrictive practices' and 'restrictive interventions' have often been used interchangeably in the literature, but Hui (2017) makes a distinction between them: 'Restrictive interventions' describes measures that intend to control/contain service users beyond the daily norms of their environment and include physical/mechanical/chemical restraint, seclusion, and segregation. 'Restrictive practices' is an overarching term used to refer to the broader context of confinement, including the ward environment, dynamics, atmosphere, and routines, which also includes restrictive interventions. As the focus of the current study was on physical restraint, the term restrictive interventions instead of restrictive practices will be used henceforth.

Restrictive interventions can be used as a last resort to manage imminent risk. Whilst mental health legislation permits the use of restrictive interventions, such as seclusion and restraint, in a range of contexts internationally, these approaches have been associated with harmful unintended consequences for the people who experience them. These include physical injury, deterioration of mental health (including the onset of post-traumatic stress disorder), increased length of stay in hospital (Chieze et al., 2019) and in some instances, death (Duxbury et al., 2011; Weiss et al., 1998). Restrictiveness was experienced as violating the autonomy, sense of self and personhood of people who use secure mental health services, and some reported feelings of insignificance, degradation, humiliation, and sadness (Tomlin et al., 2020). Lawrence et al. (2021) supported these findings whereby restrictive interventions were found to have a detrimental impact on the wellbeing of most service users in adult secure services as well as the staff who use them.

When considering physical restraint specifically, Duxbury et al. (2019) reported that this type of intervention is associated with discomfort and physical injury, for both staff and

service users, trauma, and problems such as psychological strain, stress, lack of confidence and prolonged staff sickness. The authors therefore argued the need to focus on and reduce the use of physical restraint. This is in keeping with increased government, legislative, academic, and clinical efforts to reduce the use of physical restraint and restrictive interventions in recent years (Department of Health, 2014; Royal College of Psychiatrists, 2019; Welsh Government, 2021) but progress has been slow and restrictive interventions remain a prevalent issue internationally (CQC, 2020; Sashidharan, et al., 2019). For example, Flammer et al. (2020) found that of all of the cases treated in 2017 across the eight forensic units included in their study, 22.6% were subjected to seclusion.

Despite the use of physical restraint in secure mental health services, little research has been undertaken to specifically consider the potential impact of this intervention upon the therapeutic relationship between staff and service users in this particular context. The therapeutic relationship has been defined as the relationship between service users and clinicians that is the primary component of all health care interactions that facilitate the development of positive experiences between staff and service users (Kornhaber et al., 2016). Many individuals who use secure mental health services are detained involuntary under mental health legislation. Being subject to such restrictions can negatively impact the ability for service users to develop therapeutic relationships with clinicians (Roche et al., 2014). It is therefore important to consider factors and interventions that could exacerbate this problem, due to the significant impact that the therapeutic relationship has upon both short and long-term outcomes for service users (McCabe & Priebe, 2004). The therapeutic relationship has been recognized as one of the most consistent effective predictors of treatment outcome (Priebe & McCabe, 2008) including service engagement, medication adherence and service satisfaction (Roche et al., 2014). Not only has the therapeutic relationship been associated with better treatment outcomes, a positive association has also been found between the

therapeutic relationship and quality of life within a mental health context (McCabe et al., 1999). A study which looked at service user experiences of their hospital admission identified that the therapeutic relationship was valued as one of the most important aspects of their care (Gilburt et al., 2008). A good therapeutic relationship has also been shown to protect against the harmful effects associated with restrictive interventions for people who use secure mental health services (Askew et al., 2020; Tingleff et al., 2019). Therefore, problems within therapeutic relationships have the potential to impact on service user progress and response to their care and treatment. Due to the significance of the therapeutic relationship, it is important then to understand the impact that physical restraint can have on the development and maintenance of this relationship, particularly when considering that restrictive interventions such as physical restraint have been described as common in secure settings (Vollm & Nedopil, 2016)..

The aim of the current study was to address this gap in the literature and explore and compare service user and staff experiences of the therapeutic relationship within a secure mental health service, after physical restraint had been used. Limited studies have explored secure service user experiences of physical restraint and only one explored the therapeutic relationship specifically (Knowles et al., 2015). These authors found that there were greater barriers to creating or maintaining therapeutic relationships with staff involved in restraining them, particularly when the restraint was perceived to be unjust. We believed that by considering the perspectives of both service users and staff (separately) we could develop upon the findings of Knowles et al. (2015) as it would allow for the exploration of how physical restraint impacted on the therapeutic relationship from the perspectives of the two groups that differed based on the level of power held during such experiences. It was intended that this approach to the analysis would develop an understanding of ways in which the experience of the therapeutic relationship after a physical restraint was similar between

these two groups, but also allow for an appreciation of potential differences. The specific focus on secure mental health services is warranted because restrictive interventions have been seen as an integral part of forensic psychiatry (Völlm & Nedopil, 2016) and are used more frequently there than in general adult settings (Flammer et al., 2020).

Method

Design

As the study was concerned with the lived experiences of service users and staff, a qualitative design was used to address the aims of the research. Interpretative Phenomenological Analysis (IPA; Smith et al., 1999) was deemed suitable and used to analyse ten semi-structured interviews. IPA was chosen as it allows for personal meaning of experiences to be explored. Individual narratives could be appreciated and illustrated, whilst also allowing for comparisons and contrasts between individual experiences. As the experience of the therapeutic relationship after physical restraint was the focus of the research, not an account of a specific physical restraint, unpaired interviews were conducted.

Research Site

The research took place in a secure hospital in the UK, which provides low and medium secure care for adult men and women predominantly of working age (18-65 years old). The site consisted of 110 beds split across six wards. Three wards provided care in conditions of medium security and three in low security. Each ward had its own Intensive Care Suite (seclusion room). One of the medium secure wards provided care to women and consisted of 16 beds. The remaining beds were for male service users. White British was the predominant ethnic backgrounds of service users and staff at the time of the research. All service users were detained under the Mental Health Act (1983/2007).

Recruitment

Convenience sampling was used where service user participants who met the inclusion criteria were identified by the Multi-Disciplinary-Teams (MDTs) and given a participant information sheet. MDTs consisted of a Consultant Psychiatrist, Psychologist, Social Worker, Occupational Therapist, and nursing staff and met on a weekly basis to review the care of service users. Potential staff participants were identified by a Ward Manager and were then approached by one of the authors to ask if they would be willing to meet with the first author to discuss participation in the study. All participants were asked to complete a consent to be contacted form if they did agree. These initial meetings then enabled the researcher to determine if potential participants met the inclusion criteria. Most individuals approached agreed to take part in the study other than one service user who initially consented to take part but later withdrew his consent. A reason for this was not asked for, nor provided. No one volunteered to take part and all the final participants had been approached. Prior to the interviews, the nurse responsible for running the ward at the time assessed service user participant risk and capacity to provide consent at that time and decided with the service user whether it was appropriate for them to meet the researcher.

Participants

Service user and staff inclusion criteria are outlined in Table 1.

[Table 1 near here]

Following the recruitment process, a total of 10 people participated in the research. This was deemed to be an appropriate sample size based on the study design and analytic strategy (Smith et al., 1999). Five were service users and five were staff members. Of the five service

user participants, two were male and three were female. The range of time that the service users had been cared for at the research site was between 11 months to 5.5 years (mean = 3 years).

Of the five staff member participants, two were male and three were female. Three of the staff members were qualified nurses and two were healthcare workers. Nine participants agreed for their age and ethnicity to be included in the study. The age range of these participants was 20-49 years (mean = 31) and all participants, both staff and service users were white British.

The Interview

A semi-structured interview was developed to elicit participants' experiences of the therapeutic relationship after physical restraint. The questions were refined following feedback from service users and staff at the site's service user representatives meeting. As well as service user representatives, the Hospital Director, Lead Nurse, and an Independent Advocate were present at this meeting. Attendees were asked for their perspectives about the research proposal, participant information sheets and consent forms. Initial ideas about themes that could be explored in the interviews were also discussed. These suggestions helped design the research materials. The interview schedule consisted of an interview guide of a small number of open ended questions, which began with more general questions to more specific and personal questions. This was recommended as it allowed rapport to be built throughout the interview (Willig, 2008). As the questions were open ended, this allowed the author to explore the responses in more detail (Brown & Lloyd, 2001). The interview aimed to be inductive in that the questions were not based on a pre-existing theory, rather, the researcher aimed to be guided by the participants' accounts to create a narrative of their experiences.

Interviews with both service users and staff were conducted for up to one hour. All interviews were audio recorded. The first author conducted all the interviews between January and March 2017. All interviews took place in a private room off the main part of the wards. At the beginning of the interview the researcher reminded the participants of their right to withdraw, confidentiality and what their data would be used for and how it would be stored. Afterwards, all participants were provided with a debriefing information sheet and offered an opportunity to ask any questions about the research. Each interview was manually transcribed by the first author within two days of the interview having taken place. They were anonymised for confidentiality purposes. Once transcription had taken place, audio recordings were deleted.

Analytic Strategy

The six-stage process of IPA was followed as described by Smith et al. (2009). IPA aims to achieve exploration of participants' meaning of their experiences (Pietkiewicz & Smith, 2012). Each interview transcript was read and analysed individually by the first author. In line with the principles of triangulation, two of the co-authors separately analysed proportions of the data to compare to the first author's analysis (Carter et al., 2014; Reid et al., 2005). Whilst it is understood that there is no single interpretation of the data, no significant differences were found. Ahern's (1999) reflexive bracketing advice was followed to enhance validity and minimize bias. The first author met regularly with other authors, where reflection on the coding of the data and the emergent themes was encouraged. The first author kept a reflective diary to reflect on thoughts, feelings and preconceptions which arose throughout the research process. The first author had previously worked within a secure hospital environment and had worked alongside patients and staff who had been involved in physical restraint. The author used supervision throughout the analysis to reflect upon their

prior training, such as trauma-informed and attachment based approaches, as well as approaches to reducing restrictive interventions, which could have impacted upon the interpretation of the data.

In line with the aims of the study, staff and service user data were analysed separately. This was because we believed the experiences of the two groups to differ significantly based on the power differential between them. Numerous themes emerged from the transcripts and these were compiled to create organized into master themes and subthemes (see Tables 2 & 3). Theme criteria were determined by their relevance to the aims of the research and the depth of interview data which supported them.

Ethics

The research was reviewed and approved by the relevant health service ethics committee and the research site's local research committee.

Results

Three master themes were identified relating to service user experiences of the therapeutic relationship after physical restraint (Table 2). A further three master themes were produced from the staff data (Table 3). Each master theme includes additional subthemes. Interview quotations are presented with gender neutral pseudonyms, to protect the anonymity of the participants.

[Table 2 near here]

Service User Master Theme One: Emotional Impact

A key experience of service users was the emotional impact following a physical restraint and how this impacted on their therapeutic relationship with staff. This theme consists of two subthemes: distress and disempowerment and staff detachment and denial of emotional impact.

Distress and Disempowerment

Three participants shared the fear that they experienced in relation to staff after the physical restraint.

> *Well I wouldn't go as far as say panicked, but for want of a better word, panicked, and fought back…I'd be more cautious around them. I was more on edge whenever they were around me.* (Alex)
>
> *I was scared, absolutely petrified…Because he had scared me so much, the whole team had kind of thing…I mean I was literally having panic attacks…and I felt dread, I felt sick, I felt every single emotion that I possibly could. Total fear. I didn't feel safe there at all.* (Joey)
>
> *I'm praying for her not to be in ward round.* (Billie)

The accounts suggest that the experience of a restraint had lasting distressing emotional consequences after the restraint, which could impact the therapeutic relationship.

Within the service users' narratives, their experiences of a dependent relationship was evident.

> *So I have to have some sort of relationship with him whether I want it or not. That's beside the point.* (Alex)
>
> *I guess it's just difficult because you have to work with the staff on a day to day basis.* (Billie)

This dependent relationship was complicated further when service users had been involved in physical restraint with those providing their care, particularly if this had been a distressing experience or it had been perceived as disproportionate or unnecessary.

I didn't trust the staff and it caused such a breakdown in the relationship… made me question whether or not I could trust them. (Joey)

Then I struggled with them staff, I can't trust them, can't work with them… If you don't trust them, you can't have a relationship with them. (Charlie)

A sense of disempowerment was evident in most of the service users' narratives, leaving feelings of helplessness and anger and a desire to regain power.

We can't do anything about it. (Billie)

You just thinking all you want to do it prove you're bigger than me because you've got the set of keys… You're nothing and I'll prove to you you're nothing. And you just want to fight back. (Alex)

It felt like I was battling a big wall on my own. (Joey)

Joey emphasised that if physical restraint is used disproportionately, the disempowerment can lead to a feeling of being abused. They described a staff member who led the restraint in a previous service as an *"abuser"* clearly articulating the significant impact restraint can have emotionally and relationally.

Staff Detachment and Denial of Emotional Impact

Four participants reflected on the emotional response of the staff who restrained them.

He came across as blank. Like he'd detached himself from it. Like he had no emotions. (Joey)

It didn't bother them [staff]. (Charlie)

Whereas service users experienced elevated levels of emotional distress after restraint, the above quotes suggest that from the perspective of the service users, staff *"detached"* and cut themselves off from the incidents.

Alex offered an explanation as to why they believed that staff did not show an emotional response.

As staff you're not allowed to have personal feelings about the job… you're told when you walk into the job you're not allowed to have personal feelings about it. You're told leave your personal feelings at the door. (Alex)

I just feel like obviously staff are being professional so they're not going to say I don't like you. So they're like oh don't worry about it. And you can just tell they're bloody angry like. (Billie)

Alex was of the view that the reaction observed from staff was due to their training and rules that they are expected to follow.

I still feel like they've got a problem with me. But they say oh no it's alright. There's underlying issues like…. I'm not being paranoid, I'm not stupid, I know when someone's got a problem with me. (Billie)

Billie's account suggests that the reaction of the staff and their aim to be *"professional"* was a source of further frustration and they would have preferred staff to be more open about their

own emotional experiences. Billie was also of the view that these processes contributed to the further breakdown of the therapeutic relationship.

Service User Master Theme Two: Changes to the Therapeutic Relationship

Participants reflected on how their therapeutic relationship with staff changed following restraint. Within this master theme, three subthemes emerged: re-evaluation of the therapeutic relationship, disengagement from the therapeutic relationship and engagement and repair of the therapeutic relationship.

Re-evaluation of the Therapeutic Relationship

A process of re-evaluating their relationship with the staff members that restrained them was apparent for most participants.

It [the relationship] broke down. [I] Didn't want to be around them [staff] at all. (Charlie)

There's not enough time in the world to heal what she's done. (Alex)

Most participants described a deterioration in their relationship with staff following restraint, to the point of not wanting to be around them nor believing the relationship could be repaired.

In contrast, Leigh believed the therapeutic relationship remained unchanged.

I'll let them get on with what they need to do and they let me on with what I've got to do…Just be normal with them. (Leigh)

It is noteworthy that Leigh described only engaging with staff to get immediate needs met prior to the restraint. Leigh may have also have perceived the relationship differently, as they stated that they intentionally chose to behave in a way to initiate the restraint.

I kind of wanted to be kept in ICS [Intensive Care Suite] so I went for a couple of staff members. (Leigh)

Most participants talked about finding it difficult to trust staff after restraint.

Then I struggled with them staff, I can't trust them, can't work with them. (Charlie)

I didn't trust the staff and it caused such a breakdown in the relationship. (Joey)

Seeing as he's got a very important role with me, I wouldn't say trust him. But to some degree I have to trust him. (Alex)

Disengagement from the Therapeutic Relationship

Following the physical restraint, four participants shared incidents when they either wanted to or had disengaged from staff members who had restrained them.

I was, leave me fucking alone…I wouldn't speak to them for ages and ages…I don't speak to them now. (Charlie)

I don't want a relationship with her…I'm going to stay away from them, because I don't like them…I'd avoid her at every cost…I did kind of cut off and didn't want anything to do with the staff that restrained me. (Alex)

Joey, who resorted to aggressive methods to ensure the disengagement of their relationships with staff: *"I will throw the tv [television]…I will slash you with a piece of glass",* described how this was triggered by feeling fearful of staff after the restraint. It was clear that due to this, Joey felt unable to seek care and support from staff.

I didn't want to seek help because I was scared…I wouldn't go up the corridor to go and get my meds. (Joey)

Whilst Charlie and Alex disengaged from staff, Joey gave the sense of disengaging from the wider staff team because in their view, they *"sided"* with one of the staff members involved in the restraint. It was apparent that these relational dynamics following the physical restraint were a factor that perpetuated Joey's distress.

> *I was self-harming and they were coming in, which is obviously bringing them in, but I was self-harming because I was stressed with them. So it was a vicious loop.* (Joey).

Engagement and Repair of the Therapeutic Relationship

Despite the negative consequences of experiencing a restraint, three participants discussed instances where it had been possible to approach and engage with staff members who had restrained them.

> *It was as if she was purposefully trying to make things go back to the way things were. Which I think went a long way to helping me change my attitude more quickly.* (Alex)
>
> *She explained why she reacted in the way that she did. And we were both able to see each other's point of view.* (Joey)

Staff approaching and engaging with Alex and Joey helped them to re-appraise and re-engage with the therapeutic relationship. Sharing each other's perspectives seemed to help Joey with this process. Similarly, Leigh reflected on the benefits of service users and staff approaching each other after the physical restraint, to repair the relationship between them. They spoke about benefitting from an opportunity to *"just clear the air"*.

Joey discussed an incident in which they felt that staff adjusted their approach and used the least restrictive measure possible.

He was like, 'don't worry about restraining her, put hold on her, but don't fully restrain her to the ground'. And I was like 'Thank you'. It made me think, they're listening to me here…They were very very good, they were kind. (Joey)

Joey's account suggests that even something as restrictive and distressing as a physical restraint can be done in a manner that can preserve the therapeutic relationship and help service users feel listened to.

Service User Master Theme Three: Appraisal of the Necessity of Restraint

Participants demonstrated a process of appraising the necessity of the restraint with different perceptions of this influenced the magnitude of the rupture to the therapeutic relationship. Within this theme, two subthemes emerged: acceptance levels of restraint and factors influencing acceptability.

Acceptance Levels of Restraint

All participants reflected on whether they deemed the restraint they were involved in to have been acceptable/necessary.

People in your team shouldn't be restraining you. Not unless they have to…Try and understand why they have to do it as part of their job. (Charlie)

She should never have done it…As far as I'm concerned, it shouldn't have happened…She was just in the wrong place at the wrong time. She was just doing her job. (Alex)

Sometimes I think oh I could bloody kill them and then other times I think they're just doing their job. (Billie)

The above quotes indicate that three of the participants were conflicted in their views about the acceptability of physical restraint reflecting a level of ambivalence. Sometimes this contrast was stark, where on the one hand Billie would like to *"bloody kill them"*, yet on the other, they are *"just"* doing their job. This accentuates the contrast between the distressing emotional response to being physically restrained and the cognitive understanding of why this may have happened.

Whereas Charlie, Alex and Billie fluctuated in their views on the acceptability of the restraint, the remaining two participants remained consistent in their opposing views.

> *I just took it as it came really. I just had to be restrained at the time and that was that…I needed to be held down, I went to attack them.* (Leigh)
>
> *It's not meant to happen, when they're authority looking after you that's not meant to happen. It was totally wrong.* (Joey)

The differing views on the acceptability of physical restraint reflects the individual experiences of each of the service users and the individual nature in which they made sense of the events. It seemed that where service users were more accepting or understanding of why restraint was needed, they were more open to working with staff and repairing the therapeutic relationship. The contrast in the responses provided by Leigh and Joey support this.

Factors Influencing Acceptability

Participants' narratives revealed factors that influenced the perception as to whether restraint was an acceptable and necessary measure.

Assistance should only ever be called if every other means has been exhausted: if you've tried to talk a person down; if you've tried to walk a patient into ICS without putting hands on them. (Alex)

They should try and verbally de-escalate you and give you quite a lot of time ... Some staff would talk to me and other staff would be like 'assistance, assistance!' And I was like oh my god that's ridiculous. (Billie)

Alex and Billie referred to how quickly they perceived staff to have chosen to use physical restraint. This was supported by Joey who talked about how staff *"rushed in"* to restrain them in *"the heat of the moment"*. Participants' narratives suggested they believed staff had acted disproportionately when initiating physical restraints and they suggested other strategies that could have been attempted. Participants could consider physical restraint as being necessary but only if it was proportionate to the risk and as a last resort when all other options have been attempted first.

[Table 3 near here]

Staff Master Theme One: Emotional Response

Staff considered the emotional impact that the restraint had upon them and how this affected the therapeutic relationship. This master theme consists of two subthemes: emotional impact; and coping with the emotional impact.

Emotional Impact

Three participants acknowledged the emotional impact following the physical restraint.

I just felt like I was going to pass out…I was terrified. I was like oh my god. I just didn't know what to do. (Taylor)

I was very anxious that I could possibly start him escalating again. I was embarrassed for him…so you're very worried on how he would react to you. (Jesse)

There was a lot of fear around her, a lot of fear…People were afraid to go close to her... some of them were angry and upset with her. (Frankie)

The language used suggests that anxiety was a common emotional response. Frankie also suggested that anger was also felt by staff, which was supported by Jesse who stated *"you sort of feel a bit of anger".*

It was indicated that the emotional experiences of staff had the potential to impact the relationships with service users.

I just felt scared of what he might say or scared about how he might react. (Taylor)

I was anxious that I would start him off again. And also embarrassment on his behalf, because he knows that I've seen him like that… It's difficult, because you get quite angry that it really didn't need to get that far. (Jesse)

This was partly due to consideration of the service user's emotional response and anticipation of how they may then react, but also due to their own emotional response regarding both the service user and what had led to the incident. Anger was expressed by Jesse, not in relation to the service user, but due to feeling that the situation could have been deescalated sooner to avoid restraint.

In contrast to the above quotes, some staff denied any emotional impact following restraints.

I didn't feel the fear. (Frankie)

Honestly, it doesn't affect me in the slightest. (Jamie)

Somehow you have to sort of distance yourself from them feelings. (Ashley)

It is unclear whether the physical restraint did not evoke such strong emotional experiences for some staff, or there is some minimization/denial of the emotional impact of engaging with a restraint. Ashley's quote gives a sense of detachment, possibly as a way of coping with a distressing experience. This will be the focus of the next sub-theme.

Coping with the Emotional Impact

Participants discussed ways of coping with the restraints that they had been involved in.

You've just got to let it go, straight through and not take anything to heart… You can't sort of take it personally. (Jamie)

What's the point in me being angry, with someone who's unwell and not realizing what she was doing? (Frankie)

It's easier I think to deal with things when you know it's not against you and it's their problems...how I deal with it is the fact that I don't take it personally. (Ashley)

The idea that the incident that led to the restraint was not personal or intentional seemed to be helpful for staff to make sense of the incidents and protect themselves from the emotional impact. Taylor talked about a similar strategy that she drew upon.

I couldn't believe it. It didn't seem real like it had actually happened, but yeah in work I didn't think about it to be honest. (Taylor)

Whilst similar, compared to the perspective taking voiced by the above staff, Taylor's account is more suggestive of avoidance of the emotional consequences of the restraint as indicated by the repetition of *"I didn't think about it".* This could be problematic in terms of the therapeutic relationship as it suggests the possibility of avoiding the service user as a way of avoiding the emotional consequences.

One of the staff members described utilising their relationship with colleagues to reflect, which helped them to regulate their emotions, to avoid such impacting on their relationship with the service user.

> *Me personally, I just need five minutes out…Talk to your peers, you know I get on quite well with my colleagues and I am able to talk openly with them…we are able to talk about them professionally and not hold grudges.* (Jesse)

Staff Master Theme Two: Balancing Professional Roles and Responsibilities within the Relationship

Staff shared that they have conflicting professional roles and responsibilities within their therapeutic relationships with service users. This master theme consists of these two dual roles and therefore two subthemes: risk management and safety; and the supportive role.

Risk Management and Safety

Staff shared that they had to prioritize management of the immediate risk to ensure safety of everyone involved.

> *Trying to make sure everyone was fine. I managed to get everything under control… I had to make sure the patient was safe, I had to make sure my staff was safe. I had to ensure the police and ambulance crew on site were safe as well.* (Frankie)

I don't care because I know that I'm protecting myself, protecting the patients and protecting the ward…because I know I've done the right thing. I don't mind if they don't like me anymore. (Taylor)

We had to break everything that we had built initially just to make sure that he was safe…That's when it gets difficult when you've got to do a restraint because you flashback all the things you've put into the relationship, all the things that we've spoken about. (Jesse)

Taylor and Jesse acknowledge that prioritization of risk management can have a negative impact on the therapeutic relationship with service users. Jesse went on to describe this as a *"moral issue for a member of staff"* and stated that *"you question yourself a lot"* when involved in a restraint.

Supportive Role

As well as the management of risk, three participants talked about providing support for the service users after the restraint.

From when something has happened and you deal with it, it should not distract from your main aim to be the support for their recovery journey. (Frankie)

I think it's important that we don't give up on them and that is when they start to trust certain members of staff and that's a really important part. (Ashley)

When I came back, I felt like I needed to go see him. (Taylor)

These narratives suggest that despite the difficulty of the situations they had experienced, staff did not lose sight of their role in supporting service users nor of the importance of repairing the therapeutic relationship. Their role in managing risk and supporting service

users seemed a difficult balance to strike for staff and they spoke of needing support to help with this.

> *It is good for people who have experience to pass some of their knowledge to the staff and share that. Probably have things like reflective practice to talk things through. The opportunity to vent how we're feeling.* (Frankie)
>
> *Supervision is a massive part and sometimes we don't get as much as we need.* (Jesse)
>
> *Through my debriefing, I did explain this recovery journey thing, that we have got to try and work with her and try and get to the bottom of that behaviour…Because she could potentially be losing out with staff members not interacting with her.* (Ashley)

It was the view of the staff that supportive forums would help them maintain their therapeutic relationships and provide support for service users when restraints have been used.

Staff Master Theme Three: Moving Forward with the Therapeutic Relationship after Physical Restraint

Staff shared a process of moving forward in their relationships with service users after the experience of the physical restraint. This master theme consists of two subthemes: rupture and repair of the therapeutic relationship; and understanding the service user as a mechanism for repair.

Rupture and Repair of the Therapeutic Relationship

Staff described that despite the rupture in the therapeutic relationship following restraint, it was possible to repair this.

I think our relationship was, although it was knocked, you could see there was a significant knock there and some of the hard work had been unpicked, it wasn't completely ruined. There was something there to build on again. (Jesse)

It wasn't where it was before, it was never going to be there, but it was it was a good therapeutic relationship in the end. (Taylor)

Both Jesse and Taylor expressed that through continued engagement and investment in the therapeutic relationship, reparation was possible. This then enabled the staff team to help the service users work towards their goals, for example when Jesse supported a service user in their goals towards improving their personal care, she shared that *"the progressive steps and successes have been noted".*

A final quote from Taylor serves as a reminder of the dilemma that staff face when working with individuals who are at risk of harming themselves and/or others.

You do need to build that basic relationship with someone, but how can you do that when you've got to constantly restrain them. They're not going to accept you. (Taylor)

Understanding the Service User as a Mechanism for Repair

Each of the staff members shared that they went through a process of attempting to understand what had led to the restraint.

Ensure that you're not brittle towards them because this man in particular was mentally unwell at that point. (Jesse)

They're not well at that time. You can't sort of hold a grudge against a patient. (Jamie)

But that went to show to me that she really was unwell. (Frankie)

Three participants made attributions about how *"well"* the service user was at the time. Viewing the service users as 'unwell' helped them process the incident in a manner that did not damage the therapeutic relationship and enabled them to remain motivated to support the service user. Jamie took this a step further and discussed other service user factors that could have contributed to the restraint.

> *Even staff that are on the ward working with the patients regular, they forget the difficulties they've had through their upbringing. And sometimes it's just reminding them that you know this person hasn't had the same upbringing you have.* (Jamie)

Jamie drew upon his knowledge of the service user's childhood experiences to make sense of how the incident occurred. Through this understanding, Jamie was able to empathize, contextualize the incident that had led to the restraint and remain curious about what needs the service user has, despite the occurrence of such an incident. Jamie's statement of *"reminding them"* suggests that he recognized the potential of this perspective for other staff members in terms of maintaining a therapeutic relationship.

Discussion

The aim of the current study was to explore service user and staff experiences of the therapeutic relationship within a secure mental health service, after a specific type of restrictive intervention had been used, namely physical restraint. The perspectives of both service users and staff were considered to allow for the comparison of how physical restraint impacted on the therapeutic relationship from the perspectives of two groups that differed based on the level of power held during such experiences. This section will focus on the implications of the results reported and compare the experiences of the two groups.

Service users gave powerful accounts of the disempowerment and distress they experienced because of being physically restrained. This is in keeping with previous research related to people's experiences of physical restraint and restrictive practices more broadly (e.g. Askew et al., 2020; Hui, 2017; Knowles et al., 2015). Powerlessness and overwhelming dysregulated emotional experiences can contribute to the development and maintenance of severe mental health problems (Bentall et al., 2012; Bradley et al., 2011; Johnstone & Boyle, 2018). With this in mind, through the use of interventions such as physical restraint, secure mental health services are at risk of unintentionally compounding the very problems that they aim to address: a phenomenon referred to as iatrogenic harm (Bateman & Fonagy, 2006). This is particularly salient when considering that restrictive interventions have been described as an integral feature of mental health services (Albrecht, 2016; Völlm & Nedopil, 2016). Our findings support the need to continue to reduce restrictive interventions including physical restraint in secure mental health services and consider the impact upon those involved, both emotionally and relationally. Numerous interventions and initiatives that aim to reduce restrictive interventions exist, including the Six Core Strategies (6CS; Huckshorn, 2004) and Safewards (Bowers, 2014). Such approaches have been found to be effective in reducing both challenging behaviours and restrictive interventions in some settings (Bowers et al., 2015; Duxbury et al., 2019) but have been applied to a lesser extent and with variable success in secure mental health services (Price et al., 2016). We recommend that clinicians and academics continue to develop, apply, and evaluate such approaches in secure services. The recent study by Maguire et al. (2022) that aimed to develop an addition to the Safewards model for forensic mental health services is encouraging.

Staff voiced similar experiences of distress as a result of restraint and reported a conflict in striking a balance between risk management and the provision of care and support for service users. This is again in keeping with previous studies on the topic where staff reported

distress, a sense of unease and even trauma in the context of implementing restrictive interventions (Gustafsson & Salzmann-Erikson, 2016; Holmes et al., 2015). It is important that staff working in secure services are supported to manage their emotional wellbeing. If this is not achieved, emotional experiences such as those described by participants in the current study could potentially lead to a reduction in the capacity for staff members to experience a compassionate motivation to support service users (Lucre & Taylor, 2020) which could impact both them and their relationships with service users. Some have found that threat-based emotional experiences in staff, such as anger and fear, have been associated with increased restrictive intervention use (Bowers, 2007). This has obvious implications for the therapeutic relationship as well as reducing restrictive interventions in secure settings.

Whilst there were similarities between the accounts provided by staff and service users in terms of the emotionally distressing experience of a physical restraint, there were also key differences. There was a greater focus and emphasis on the emotional distress experienced by the service users, compared to staff. This may be explained by staff being able to provide a justification for the restraint (due to the need to manage risk and safety) which could have helped to protect them against the distress. Such justification and reasoning of restrictive interventions by staff has been highlighted as a protective factor previously (Gustafsson & Salzmann-Erikson, 2016). Care should be warranted to ensure that such cognitive strategies do not become protective for staff but to the detriment of service users. In a previous study, staff referred to restrictive interventions as a 'necessary evil' (Hui, 2016). Whilst this may be protective for them in terms of experiences of guilt/unease because of using such practices, these attitudes may increase staff resistance to approaches that reduce restrictive interventions.

Service users on the other hand were often of the view that there had been many occasions where the use of restraint was unjustified. There was a clear emphasis on powerlessness

when considering the service user data and for obvious reasons, an absence of such captured in the accounts provided by staff. This may suggest that there are different psychological mechanisms that lead to restraint associated distress experienced between the two groups. Powerlessness and being controlled seemed to be what mostly contributed to the distress of the service users, whereas staff distress seemed more often related to threats to their safety. This is an important consideration as it points to differences in the way in which services can support staff and service users to reduce the level of distress caused by incidents involving physical restraint which would in turn help to preserve the therapeutic relationship. Staff may benefit more from being supported to develop skills to manage/reduce threat-based emotional experiences and instil a sense of inner safeness (e.g. Compassion Focused Staff Support; Lucre & Taylor, 2020). Service users however, may benefit from collaborative approaches to providing care which promote autonomy, independence and responsibility that move away from imbalances in power. These are associated with positive effects and improved outcomes for service users (Cartwright et al., 2021a; Prytherch et al., 2020). As are approaches that aim to ensure service users feel fairly treated (such as Procedural Justice; Fitzalan-Howard & Wakeling, 2020; 2021). Bergk et al. (2011) suggested that collaboration and offering choice and as well as helping service users to feel in control can reduce perceptions of the restrictiveness of an intervention and reduce feelings of helplessness. These points are supported by our findings where for example, one service user described how they had found it helpful for staff to be flexible and responsive with them during a restraint and use the least restrictive techniques. Thus we recommend that collaboration with service users and flexibility of approach is made a priority during physical restraints.

Both parties discussed how the restraint and the emotional distress experienced had impacted their therapeutic relationships, often in a detrimental way. Numerous service users described a sense of re-evaluating their relationships with staff who had restrained them

which could lead to them disengaging from the relationship. Our findings support those reported by Knowles et al. (2015), who identified that there were greater barriers to creating or maintaining therapeutic relationships with staff involved in restraining service users. This view was emphasised less by staff, likely due to them being unable to actively disengage from the relationships with service users due to the requirements of their job role. It is imperative that future academic and clinical efforts are focused not only on reducing restraint but also on preserving the therapeutic relationship between staff and service users when restraint use has been absolutely necessary. Even if the staff did not disengage from service users, a 'forced' or disingenuous therapeutic relationship would be unlikely to be helpful. Positively, both staff and service users in the current study discussed the possibility of repairing the therapeutic relationship after a physical restraint. This was possible when both parties felt supported to make sense of the experience, address the emotional impact, and continued to work together and invest in the therapeutic relationship and service user's goals. These findings have implications for practice whereby services should aim to address these areas to enable the timely and effective repair of therapeutic relationships when physical restraint has been used.

Both groups discussed how they coped with and processed the restraint. In both groups, for some, this involved avoidance, including not thinking about the incident, removing themselves from the environment and avoiding the other person involved in the restraint. This is problematic as avoidant coping has been identified as a factor that perpetuates emotional distress across a range of contexts (e.g. Ambrus et al., 2020; Thompson et al., 2018) and has implications for barriers to the repairing of the therapeutic relationship. One service user described how in the context of feeling powerless and fearful, they escalated to the point of serious aggression to maintain their distance from staff. Service user participants described how they noticed when staff emotionally detached and distanced themselves from

them following a physical restraint, which for one service user perpetuated their feelings of anger and disengagement from the therapeutic relationship. Staff noticed a similar process in the service users and commented on how it was difficult to maintain a relationship because of such. Service users reported that they would have found it beneficial for staff to be honest with them and express how the experience of the physical restraint made them feel. This is in contrast with the more professional, detached aspects of the accounts provided by the staff in terms of needing to manage risk and safety as a justification for the intervention, which service users experienced as invalidating of their distress. Previous research has found that safe and professionally executed transparency and self-disclosure can aid with the development of the therapeutic relationship (Davidson, 2020). Others have found that service users believed that effective communication with staff would have protected against the harmful effects of the restrictive interventions they experienced (Tingleff et al., 2019). Our findings support these assertions and highlight the importance of transparent communication and collaboration between service users and staff when restrictive interventions have been unavoidable, including the acknowledgement that experiences of restraint have also been emotionally difficult for the staff involved.

Participants shared a process of perspective taking and consideration of how proportionate and necessary the restraint was. For some, their appraisal of the event protected them from the emotional impact of the incidents. This is in keeping with previous studies that found that the ways in which participants made sense of the use of restrictive interventions protected against the emotional consequences of them (Gustafsson & Salzmann-Erikson, 2016). Appropriate interventions to address this may differ in nature between service users and staff. Lawrence et al. (2021) recommended that post restrictive intervention reviews may offer a good opportunity to support the way in which service users process and make sense of restrictive interventions to protect against the emotional impact of them and to restore the

therapeutic relationship when such practices are used as a last resort. For staff, such support may be provided in the form of supervision, reflective practice and debriefs following incidents and the use of restrictive interventions. These were identified by staff participants in the current study as being methods that would help them to maintain therapeutic relationships with service users after a physical restraint. Such approaches are helpful for staff wellbeing (Burrows et al., 2019) and may help staff to understand service user presentations from a trauma-informed, psychological formulation-based perspective. Whilst supervision and reflective practice are already well recognized as being an important part to secure hospital practice, we emphasize the necessity of them in the context of reducing restrictive intervention and contributing to the development and maintenance of strong therapeutic relationships.

Limitations

Participants were selected based upon prior involvement in a physical restraint; it was not a requirement that service users and staff had been involved in the same incident. Paired interviews of participants who were involved in the same physical restraint could further the exploration of the therapeutic relationship through interpretation of the interactions between them. The small number of participants were recruited and were either detained at or worked at the same independent sector secure hospital in the UK, with limited ethnic diversity. This is a limitation as research has found that people from black and ethnic minority groups are disproportionately subjected to restrictive interventions compared to white service users (Payne-Gill et al., 2021). A more racially diverse sample may have produced different findings. This has implications for the applicability of our findings. Similarly, differences have been found in the way in which men and women experience restrictive interventions

(Scholes et al., 2022). Thus, presenting the findings in a gender neutral way is another limitation of the study for the same reasons.

Information regarding when the physical restraint had occurred was not recorded. Therefore, it is difficult to comment upon whether the experience of the therapeutic relationship differs depending upon when the individuals reflect upon this and whether this perception changes over time.

Conclusion and Recommendations

Physical restraint is a restrictive intervention that can result in emotional distress for the people who implement them as well as those who experience them. As well as this, physical restraints can rupture the therapeutic relationship between staff and service users in secure services. This is problematic, not least because some have described the therapeutic relationship as being at the core of good mental health care. Based on our findings, it is recommended that secure services continue their efforts to reduce physical restraint use and restrictive interventions more broadly but also support service users and staff when such practices have been used a last resort, to protect against the emotional consequences of these measures and to preserve the therapeutic relationship. To achieve this, it is recommended that services work towards transparent communication, collaboration and flexibility between staff and service users as well as opportunities for both service users and staff to reflect after incidents of physical restraint. It is also recommended that staff receive ongoing support in the form of peer support, supervision, reflective practice and debriefs to help manage their emotional wellbeing, understand the needs of the service users from a trauma-informed perspective and make sense of physical restraints when they occur. Whilst the importance of these recommendations has already been acknowledged, to date, little research has considered them in the context of restrictive interventions nor as part of reducing restrictive

intervention initiatives in secure services. Our findings and recommendations are consistent with, and point to the need for, secure services to adopt contemporary approaches to reducing power imbalances between staff and services users, as well as those that would reduce the likelihood of (re)traumatising service users. Ongoing support with the repairing of the therapeutic relationship when ruptures have occurred is also required. Principles of Procedural Justice, Safewards, and trauma informed approaches have been applied on a limited basis in UK secure mental health services to date, but have all been recognised as having potential benefits in these areas for such services (Cartwright et al., 2021b; Maguire et al., 2022; Simpson et al., 2020). Based on our findings we recommend that secure service providers and future research should aim to explore these approaches further.

Disclosure Statement

There are no interests to declare.

REFERENCES

Ahern, K. J. (1999). Ten tips for reflexive bracketing. *Qualitative health research*, *9*(3), 407-411.

Albrecht, H-J. (2016). Legal Aspects of the Use of Coercive Measures in Psychiatry. In B. Völlm & N. Nedopil (Eds.), *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges* (pp. 31-49). Cham: Springer.

Ambrus, L., Sunnqvist, C., Asp, M., Westling, S., & Westrin, Å. (2020). Coping and suicide risk in high risk psychiatric patients. *Journal of Mental Health*, *29*(1), 27-32.

Askew, L., Fisher, P., & Beazley, P. (2020). Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective. *Journal of Psychiatric and Mental Health Nursing*, *27*(3), 272-280.

Bateman, A. & Fonagy, P. (2006). *Mentalization Based Treatment: A Practical Guide*. Oxford: Oxford University Press.

Bentall, R. P., Wickham, S., Shevlin, M., & Varese, F. (2012). Do specific early-life adversities lead to specific symptoms of psychosis? A study from the 2007 the Adult Psychiatric Morbidity Survey. *Schizophrenia bulletin*, *38*(4), 734-740.

Bergk, J., Einsiedler, B., Flammer, E., & Steinert, T. (2011). A randomized controlled comparison of seclusion and mechanical restraint in inpatient settings. *Psychiatric services*, *62*(11), 1310-1317.

Bowers, L. (2014). Safewards: A new model of conflict and containment on psychiatric wards. *Journal of psychiatric and mental health nursing*, *21*(6), 499-508.

Bowers, L., Alexander, J., Simpson, A., Ryan, C., & Carr-Walker, P. (2007). Student psychiatric nurses' approval of containment measures: relationship to perception of aggression and attitudes to personality disorder. *International journal of nursing studies*, *44*(3), 349-356.

Bowers, L., James, K., Quirk, A., Simpson, A., Stewart, D., & Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: The Safewards cluster randomised controlled trial. *International journal of nursing studies*, *52*(9), 1412-1422.

Bradley, B., DeFife, J. A., Guarnaccia, C., Phifer, M. J., Fani, M. N., Ressler, K. J., & Westen, D. (2011). Emotion dysregulation and negative affect: association with psychiatric symptoms. *The Journal of clinical psychiatry*, *72*(5), 685.

Brown, C. & Lloyd, K. (2001). Qualitative methods in psychiatric research. *Advances in Psychiatric Treatment*, 7, 350-356.

Burrows, A., Warner, C., & Keville, S. (2019). A qualitative evaluation of reflective practice groups on acute adult mental health inpatient units. *Clinical Psychology Forum, 321*, 23-27.

Cartwright, J., Lawrence, D., & Hartwright, C. (2021a). Improving Psychological Interventions from the Perspective of Forensic Mental Health Service Users: A Meta-synthesis. *Journal of Forensic Psychology Research and Practice*. 10.1080/24732850.2021.1945838

Cartwright, J., Lawrence, D., & Hartwright, C. (2021b). Linking the past and the present: service users' perspectives of how adverse experiences relate to their admission to forensic mental health services. *The Journal of Forensic Practice*. 10.1108/JFP-05-2021-0029

Care Quality Commission. (2020). *Out of sight – who cares? A review of restraint, seclusion and segregation for autistic people, and people with a learning disability and/or mental health condition*. Newcastle Upon Tyne: Care Quality Commission.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. J. (2014). The use of triangulation in qualitative research. *Oncology nursing forum*, *41*(5), 545-547.

Chieze, M., Hurst, S., Sentissi, O., & Kaiser, S. (2019). Effects of Seclusion and Restraint in Adult Psychiatry: A Systematic Review. *Frontiers in psychiatry*, *10*, 491.

Davidson, S. (2020). Self-disclosure as a therapeutic tool. In W. Curvis (Ed.), *Professional Issues in Clinical Psychology: Developing a Professional Identity through Training and Beyond*. Oxon: Routledge.

Department of Health. (2014). Positive and Proactive Care: Reducing the need for restrictive interventions. London: Department of Health.

Duxbury, J., Aiken, F., & Dale, C. (2011). Deaths in custody: The role of restraint. *Journal of Learning Disabilities and Offending Behavior*, *2*(4), 178-189.

Duxbury, J., Baker, J., Downe, S., Jones, F., Greenwood, P., Thygesen, H., ... & Whittington, R. (2019). Minimising the use of physical restraint in acute mental health services: The outcome of a restraint reduction programme ('REsTRAIN YOURSELF'). *International journal of nursing studies*, *95*, 40-48.

Fitzalan Howard, F., & Wakeling, H. (2020). People in Prisons' Perceptions of Procedural Justice in England and Wales. *Criminal Justice and Behavior*, *47*(12), 1654-1676.

Fitzalan Howard, F., & Wakeling, H. (2021). Evaluating the impact of 'rehabilitative adjudications' in four English prisons. *Psychology, Crime & Law*, https://doi.org/10.1080/1068316X.2021.1876050

Flammer, E., Frank, U., & Steinert, T. (2020). Freedom restrictive coercive measures in forensic psychiatry. *Frontiers in psychiatry*, *11*, 146. https://doi.org/10.3389%2Ffpsyt.2020.00146

Gilburt, H., Rose, D. & Slade, M. (2008). The importance of relationships in mental health care: a qualitative study of service users' experiences of psychiatric hospital admission in the UK. *BMC Health Services Research*, 8, 1-12.

Gustafsson, N., & Salzmann-Erikson, M. (2016). Effect of complex working conditions on nurses who exert coercive measures in forensic psychiatric care. *Journal of psychosocial nursing and mental health services*, *54*(9), 37-43.

Holmes, D., Murray, S. J., & Knack, N. (2015). Experiencing seclusion in a forensic psychiatric setting: A phenomenological study. *Journal of forensic nursing*, *11*(4), 200-213.

Huckshorn, K. A. (2004). Reducing seclusion & restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial Nursing and Mental Health Services*, *42*(9), 22-33.

Hui, A. (2016). Mental Health Workers' Experiences of Using Coercive Measures: "You can't tell people who don't understand". In B. Völlm & N. Nedopil (Eds.), *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges* (pp. 241-255). Cham: Springer.

Hui, A. (2017). Least restrictive practices: An evaluation of patient experiences. Retrieved from http://eprints.nottingham.ac.uk/48816/1/Least%20Restrictive%20Practices%20Evaluation%20-%20Final%20Report%20AH%2020.12.17.pdf

Johnstone, L., & Boyle, M. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* Leicester: British Psychological Society.

Kornhaber, R., Walsh, K., Duff, J., & Walker, K. (2016). Enhancing adult therapeutic interpersonal relationships in the acute health care setting: an integrative review. *Journal of multidisciplinary healthcare*, *9,* 537-546.

Knowles, S. F., Hearne, J., & Smith, I. (2015). Physical restraint and the therapeutic relationship. *The Journal of Forensic Psychiatry & Psychology*, *26*(4), 461-475.

Lawrence, D., Bagshaw, R., Stubbings, D., & Watt, A. (2021). Restrictive Practices in Adult Secure Mental Health Services: A Scoping Review. *International Journal of Forensic Mental Health*, 1-21.

Lucre, K., & Taylor, J. (2020). Compati| To Suffer with: Compassion Focused Staff Support as an Antidote to the Cost of Caring in Forensic Services. In H. Swaby, B. Winder, R. Lievesley, K. Hocken, N. Blagden, & P. Banyard (Eds.), *Sexual Crime and Trauma* (pp. 143-174). Cham: Palgrave Macmillan.

Maguire, T., Ryan, J., Fullam, R., & McKenna, B. (2022). Safewards Secure: A Delphi study to develop an addition to the Safewards model for forensic mental health services. *Journal of Psychiatric and Mental Health Nursing, 29,* 418-429.

McCabe R. & Priebe, S. (2004). The therapeutic relationship in the treatment of severe mental illness: A review of methods and findings. *International Journal of Social Psychiatry*, *50*(2) 115-128.

McCabe, R., Roder-Wanner, U.U., Hoffmann, K. & Priebe, S. (1999). Therapeutic relationships and quality of life: Association of two subjective constructs in schizophrenia patients. *International Journal of Social Psychiatry*, 45, 276-283.

Payne-Gill, J., Whitfield, C., & Beck, A. (2021). The relationship between ethnic background and the use of restrictive practices to manage incidents of violence or aggression in psychiatric inpatient settings. *International journal of mental health nursing*, *30*(5), 1221-1233.

Pietkiewicz, I. & Smith, J.A. (2012). A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology. *Psychological Journal*, *18*(2), 361-369.

Price, O., Burbery, P., Leonard, S. J., & Doyle, M. (2016). Evaluation of Safewards in forensic mental health. *Mental Health Practice*, *19*(8).

Priebe, S. & McCabe, R. (2008). Therapeutic relationships in psychiatry: the basis of therapy or therapy in itself? *International Review of Psychiatry*, *20*, 521-526.

Prytherch, H., Cooke, A., & Marsh, I. (2020). Coercion or collaboration: service-user experiences of risk management in hospital and a trauma-informed crisis house. *Psychosis*, *13*(2), 1-12.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(1), 20-23.

Roche, E., Madigan, K., Lyne, J. P., Feeney, L. & O' Donoghue, B. (2014). The therapeutic relationship after psychiatric admission. *Journal of Nervous and Mental Disease*, 202(3), 186-192.

Royal College of Psychiatrists. (2019). *Reducing Restrictive Practice program.* Retrieved from https://www.rcpsych.ac.uk/improving-care/nccmh/reducing-restrictive-practice

Sashidharan, S. P., Mezzina, R., & Puras, D. (2019). Reducing coercion in mental healthcare. *Epidemiology and psychiatric sciences*, *28*(6), 605-612.

Scholes, A., Price, O., & Berry, K. (2022). Women's experiences of restrictive interventions within inpatient mental health services: A qualitative investigation. *International Journal of Mental Health Nursing*, *31*(2), 379-389.

Simpson, A. I., Boldt, I., Penney, S., Jones, R., Kidd, S., Nakhost, A., & Wilkie, T. (2020). Perceptions of procedural justice and coercion among forensic psychiatric patients: a study protocol for a prospective, mixed-methods investigation. *BMC psychiatry*, *20*(1), 1-10.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis. Theory, Method and Research.* London: Sage Publications.

Smith, J. A., Jarman, M. & Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray & K. Chamberlain (Eds.), *Qualitative health psychology* (pp. 218–240). London: Sage Publications.

Thompson, N. J., Fiorillo, D., Rothbaum, B. O., Ressler, K. J., & Michopoulos, V. (2018). Coping strategies as mediators in relation to resilience and posttraumatic stress disorder. *Journal of Affective Disorders*, *225*, 153-159.

Tingleff, E. B., Hounsgaard, L., Bradley, S. K., & Gildberg, F. A. (2019). Forensic psychiatric patients' perceptions of situations associated with mechanical restraint: A qualitative interview study. International Journal of Mental Health Nursing, 28(2), 468–479.

Tomlin, J., Egan, V., Bartlett, P., & Völlm, B. (2020). What do patients find restrictive about forensic mental health services? A qualitative study. *International Journal of Forensic Mental Health*, *19*(1), 44-56.

Völlm, B., & Nedopil, N. (2016). Introduction. In B. Völlm & N. Nedopil (Eds.), *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges* (pp. 1-9). Cham: Springer.

Weiss, E. M., Altimari, D., Blint, D. F., & Megan, K. (1998). Deadly restraint: A nationwide pattern of death. *Hartford Courant*, *1*, 1-16.

Welsh Government. (2021). *Reducing Restrictive Practices Framework: A framework to promote measures and practice that will lead to the reduction of restrictive practices in childcare, education, health and social care settings for people of all ages.* Retrieved from https://gov.wales/sites/default/files/publications/2021-07/reducing-restrictive-practices-framework.pdf

Willig, C. (2008). *Introducing qualitative research in psychology* (2nd ed.). Berkshire: Open University Press.