Forensic mental health nurses' experiences of rebuilding the therapeutic relationship after an episode of physical restraint in forensic services in Ireland: A qualitative study

Received: 16 June 2022 | Accepted: 13 May 2023

DOI: 10.1111/inm.13176

International Journal of Mental Health Nursing

ORIGINAL ARTICLE

Forensic mental health nurses' experiences of rebuilding the therapeutic relationship after an episode of physical restraint in forensic services in Ireland: A qualitative study

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Abstract

Few studies have explored how forensic mental health nurses can rebuild the therapeutic relationship following an episode of physical restraint in the acute forensic setting. In this study, we aimed to redress this gap in the literature by exploring with forensic mental health nurses the factors that enable or hinder the rebuilding of the therapeutic relationship following an episode of physical restraint. A qualitative study design was used to capture participants' experiences, views and perceptions of the therapeutic relationship following an episode of physical restraint in the acute forensic setting. Data were collected through individual interviews with forensic mental health nurses ($n=10$) working in an acute forensic setting. Interviews were audio recorded, and transcribed verbatim and accounts were analysed using thematic analysis. Four themes were identified: 'Building a Recovery Focused Therapeutic Relationship'; 'Authoritarian Role'; 'Inevitable Imbalance'; 'Rebuilding the Therapeutic Relationship'; plus two sub-themes 'Facilitators to rebuilding' and 'Barriers to rebuilding'. Findings suggest that an inevitable imbalance exists in building a recovery-focused therapeutic relationship and at times, is hindered by the authoritarian role of the forensic mental health nurse. Recommendations for changes in clinical practice and in upcoming policies should incorporate a dedicated debrief room and protected time for staff to debrief effectively following restraint. Routine post-restraint-focused clinical supervision would also be beneficial to mental health nursing staff.

KEYWORDS

acute forensic services, forensic mental health nursing, physical restraint, qualitative research, thematic analysis, therapeutic relationship

INTRODUCTION

Nurse patient therapeutic engagement is central to mental health nursing practice (Peplau, 1952) and can broadly be described as the use of verbal and non-verbal interchange to improve a person's mental health (Cormack, 1976; Evans, 2016). Lack of high-quality engagement in mental health in patient settings, specifically forensic settings is strongly associated with increased rates of self-harm, violence, aggression and poor experiences of in-patient care (Papadopoulos et al., 2012; Tomlin et al., 2020; Wykes et al., 2018). Effective therapeutic engagement supports building and maintaining a therapeutic relationship between forensic mental health nurses (FMHNs) and patients (McAllister et al., 2021). This therapeutic relationship has been conceptualized over time as being a central interpersonal process, and central to person-centred, recovery-focused care, which arguably has a meaningful impact on treatment outcomes (Duncan et al., 2010; Hartley et al., 2020;

Kane, 2015; Priebe & Mccabe, 2008). For the purposes of this study, the authors view the therapeutic relationship as an ongoing interpersonal process. This process requires collaboration by both parties along with skilled application on the part of the FMHN in support of recovery and improved outcomes for the patient. While the development of the therapeutic relationship plays a vital role in all mental health care provision, building and maintaining the therapeutic relationship in forensic settings following physical restraint poses a unique challenge for FMHNs (Goodman et al., 2020; Hartley et al., 2020; Marshall & Adams, 2018).

The use of physical restraint on people with mental health problems is one of the most controversial and criticized forms of restrictive practice. Studies indicate that the use of physical restraint has a negative impact on outcomes for people with mental health problems, and has traumatizing effects on patients, their careers and staff (Duxbury et al., 2019; Equality and Human Rights Commission, 2019; Goulet et al., 2017; Haines-Delmont et al., 2022; Lee et al., 2021; Riahi et al., 2016; Rose et al., 2017). Despite the growing evidence and introduction of policies aimed at reducing the use of restraint, the use of physical restraint on people with mental health problems is still a common feature in inpatient mental health services (Maguire et al., 2020; Power et al., 2020; Riley, 2018; Thomann et al., 2021). In this study, physical restraint is defined as the use of physical force (by one or more persons) that restricts and prevents the patient's freedom of movement or normal access to his/her body when they pose an immediate threat of serious harm to self or others (Mental Health Commission, 2009). The literature repeatedly points to the need to find alternatives to the use of physical restraint in mental health hospital settings because of the negative impact on both patients and FMHNs (Aguilera-Serrano et al., 2018).

BACKGROUND

Mental health staff strive to work within a negotiation framework regarding care, treatment options and decisions (Care Services Improvement Partnership, Social Care Institute for Excellence (Great Britain)) and Royal College of Psychiatrists (2007). Staff attitudes and a belief in the person's potential to participate actively in their own care and recovery from their experience are key to the development of supportive therapeutic relationships and the delivery of a recovery-oriented service (Oates et al., 2017). The therapeutic relationship is one that is based on the individual patient's needs, which requires the nurse to utilize knowledge and skills to collaboratively interact with the patient to gain a positive outcome of care. The relationship itself is based on the premise of engagement which can be more difficult to obtain in a forensic setting as opposed to a generic mental health facility, due to the high levels of security. The role of the FMHN has led to many debates due to the conflicts between the security and therapeutic aspects of their role (Lee et al., 2021; Ye et al., 2019). Physical restraint is an authoritarian, security-focused element of the role of the FMHN which can negatively impact on their ability to work therapeutically with patients. Some of the ways patients find to cope with their experiences of restraint could also be seen as distancing themselves from staff (Knowles et al., 2015). A quantitative study carried out in a forensic service in Ireland found that 97% of FMHNs believed that while forming a strong therapeutic relationship was important, the need to maintain a safe and secure environment was their key priority (Timmons, 2010). Similar findings were reported by Tomlin et al. (2020) and Markham (2021) where forensic mental health services place favour on the concept of the managed patient rather than having regard for patient agency or autonomy.

Forensic settings internationally have been described as restrictive, coercive and controlling environments (Hui et al., 2013). Clinical staff in these settings face the difficult task of creating a caring, supportive environment for patients who are being treated against their will (Selvin et al., 2016). The challenge in all mental health settings of working therapeutically while implementing physical restraint has been noted in the literature (Knowles et al., 2015). The enhanced responsibilities relating to security in forensic settings, increase the challenge with restrictive interventions such as physical restraint entailing a loss of dignity, autonomy and self-determination on the part of the patient (Kennedy et al., 2020). In most jurisdictions, physical restraint is permissible when authorized in accordance with law, when proportionate to the need to prevent violence, when minimized in duration and when deployed where all other measures have failed (Council of Europe, 2017). The Council of Europe (2017) recently issued revised standards on means of restraint and they did not propose blanket bans on restrictive or intrusive intervention. Instead, the standards acknowledge that a range of such interventions are used in accordance with professional skill and individual circumstances, with many variations between jurisdictions, and that skilled clinicians typically employ a range of interventions such as seclusion, manual restraint, mechanical restraint and rapid tranquillisation. Such interventions are permissible if used as a last resort, proportionate, least restrictive and in accordance with the law.

Whilst the rates of physical restraint on mental health inpatients differ globally from one country to another, studies show that this has increased in the last decade ranging from 3.8% to 51.3% (Beghi et al., 2013; Maguire et al., 2020; Staggs, 2015). Forensic mental health services have higher rates, duration and frequency of restrictive practices including physical restraint (Maguire et al., 2020). In the Republic of Ireland, the Mental Health Commission (MHC, 2021) reported there were

5830 episodes of restrictive practices reported in 2020, with 1880 people being secluded and/or restrained during that time. These figures include 317 episodes of physical restraint recorded in a forensic mental health hospital in Ireland in 2020, a sharp increase of 13.62% from 2019's figure of 279 (MHC, 2021). This increase is despite the introduction of the Restraint Reduction Strategy in 2014 and the 'Sharing the Vision' (DOH, 2020) mental health policy to reduce the use of restraint. Recent figures in England indicate a 50% increase from 2016 to 2017 and more than 70% from 2017 to 2019 (Abbott & Clifton, 2020; NHS Digital, 2018).

Although there have been national and international studies on therapeutic relationships from a mainstream mental health standpoint (Douglas et al., 2022; Lee et al., 2021; McAllister et al., 2021; Tomlin et al., 2020; Ye et al., 2019), there is a dearth of literature involving FMHNs perspectives on how therapeutic relationships can be rebuilt following an episode of physical restraint in an acute forensic setting. The continued high incidence of physical restraint used in these settings, along with the evidence that physical restraint is viewed as coercive by service users and seen to undermine the therapeutic relationship by FMHNs (Lawrence et al., 2022) makes the need for greater understanding of FMHNs therapeutic relationship building experience following physical restraint timely. This study, therefore, addresses some of the gaps in the evidence by reporting on a study that aimed to explore mental health nurse's experiences of rebuilding a therapeutic relationship with patients following an episode of physical restraint in an acute forensic setting.

METHODS

Study design

To address this study's aim, a qualitative study design using a reflexive thematic analysis guided by Braun and Clarke's framework (Braun & Clarke, 2006, 2021) was used to capture participants' experiences, views and perceptions of rebuilding the therapeutic relationship following a physical restraint in an acute forensic setting. The research is reported in accordance with the consolidated criteria for reporting qualitative research (COREQ) 32-item checklist (Tong et al., 2007).

Ethical approval was obtained from the local Nursing Research Ethics Committee, National Forensic Mental Health Service on 3 December 2021 (Project reference number: 2021_004). Each participant was provided with written information about the purpose of the study, and their rights were explained in relation to confidentiality and the voluntary nature of participation. All potential participants were informed that they were free to participate, refuse or withdraw at any time, and their signed consent was obtained prior to being interviewed.

Data collection

Participants were recruited from one Forensic Mental Health Service in Ireland and were open to all FMHNs. A self-selected convenience sample was recruited, consisting of registered FMHNs working in forensic hospital wards within the Forensic Mental Health Service in Ireland, using the following eligibility criteria: (i) at least 12 months' forensic setting experience, and (ii) prior experience of physical restraint. A Participant Information Leaflet (PIL) was distributed to ward managers through a variety of methods (poster, email and verbal) within the service. Participant recruitment was conducted over a 3-month period from December 2021 to February 2022. Data collection ended when the researchers were sufficiently confident of the informational redundancy or saturation in the data (Lincoln & Guba, 1985). The lead author screened participants who expressed an interest in participating against the eligibility criteria, and if they were eligible obtained formal written consent from willing participants via email. All willing participants who met the eligibility criteria were interviewed.

Data were collected through semi-structured, in depth, face-to-face interviews guided by an interview schedule (Table 1). All interviews were audio-recorded. The interview schedule was developed by the research team to guide data collection on participant's views of the factors they believed enabled or hindered the rebuilding of the therapeutic relationship following an episode of physical restraint. This schedule was used flexibly, with a combination of open-ended questions and follow-up probes to facilitate exploration of participants' own personal experiences. It was then piloted with two FMHNs with extensive experience in qualitative research and not involved in the study, resulting in only minor adjustments to the flow and order of the questions. Due to Covid-19 restrictions, all interviews were conducted via Microsoft Teams, anonymised and transcribed verbatim by the interviewer (lead author) who also kept a reflective diary and field notes during and after interviews, aiding the analytic process. None of the participants indicated any distress during or following the interviews. The median interview duration was 40 min (range 25–54 min). A total of 397 min of interview material was collected. Participants were informed that they could review their interview transcript if they so wished, but no participant took up the offer.

Participants' demographic information was obtained through a questionnaire. The quality of the nurse–patient therapeutic relationship from the nurse's perspective was also obtained through The Therapeutic Relationship Assessment Scale–Nurse (TRAS-Nurse; Coelho et al., 2021). This scale was administered to all participants prior to the interview. The TRAS-Nurse is a self-report measure which was developed from a nurse's perspective that assesses the quality of the therapeutic relationship between the nurse and the patient on a

TABLE 1 Interview schedule.

The therapeutic relationship and physical restraint
1. What is your understanding of the therapeutic relationship?
2. How much time would you say you typically spend per shift working on the therapeutic relationship with patients?
3. Would you like to be able to spend more time?
4. What is stopping you from spending more time?
5. Are you experienced with being involved in physical restraints of patients with whom you have built therapeutic relationship?
6. Do you view rebuilding the therapeutic relationship as a priority following physical restraints?
7. Do you believe that being involved in physical restraints hinders the development of the therapeutic relationship? Please give example?
8. What are some of the typical reactions from patients following episodes of physical restraints in the acute forensic setting (AFS)?
9. How do you think the therapeutic relationship typically impacted for both the patient and the nurse following physical restraints?
Strategies and Skills adopted in rebuilding the therapeutic relationship following physical restraint
1. How long would you say it takes on average to rebuild the therapeutic relationship following an episode of physical restraints?
2. How confident are you in your ability to rebuild the therapeutic relationship following physical restraints on a scale of 1 to 10?
3. Can you describe an example of rebuilding the therapeutic relationship following physical restraints from your experience in the AFS that went well? What strategies/skills/interventions were used?
4. In all of your experience in this setting, which strategies/skills/interventions have you found to be most beneficial?
5. Where did you acquire these skills?
6. What are the barriers/facilitators to rebuilding the therapeutic relationship following physical restraints in the AFS?
7. Can you describe a typical debrief with a patient following physical restraints? Is the debrief a priority? If so why?
8. In episodes of physical restraint where the patient has a history of trauma, is the therapeutic relationship more likely to be negatively impacted following these episodes? Is it more difficult to re-engage?
9. Do you adjust your strategy in cases where the patient has a history of trauma? Please give example – before/during/after?
Training and support
1. Did your professional training prepare you adequately for this role? If yes/no how?
2. In your view, what support is needed for mental health nurse's to further develop their ability to rebuild the therapeutic relationship following episodes of physical restraint in the AFS?
3. What can forensic services do to help and support you in your role?
4. What is the impact of being involved in physical restraint on you personally/professionally?
5. Is there anything else that you would like to add that you think is important about your experience and/or needs?
Is there anything else you would like to add and say?
Thank you for participating in this study.

five-point Likert scale. The TRAS-Nurse has 25 items and can be used as a one-factor structure (min score of 25 and a max of 125) and demonstrated good reliability and internal consistency (Cronbach's alpha 0.93). For the purpose of this study, we used the mean score on the one factor to assess the quality of the nurse–patient therapeutic relationship from the nurse's perspective.

Data analysis

All transcribed interviews were anonymised and imported into NVivo qualitative data analysis software (Version 12.1; QSR 2018) for data management purposes and were stored in a password-protected database to perform the qualitative analysis procedure. Reflexive thematic analysis was used to identify and generate the themes. This was appropriate for exploring patterns in narratives and describing thoughts and experiences (Braun & Clarke, 2006). The analysis method followed Braun and Clarke's (2006) six-step process of thematic analysis and this analytical process is illustrated in Figure 1. Anonymity was assured by using code numbers instead of participants names. The initial analysis was performed by the lead author, transcripts were subjected to line-by-line interrogation, and codes were generated inductively and were collated to identify patterns across the data. Transcripts were initially coded according to the explicit content of the participant's response to questions. During this process, initial codes were grouped into coherent themes based upon their emerging congruence with other codes. These themes were then clustered to form larger categories which were reviewed and revised through discussion between the three authors. Participant' quotes were then selected to illustrate the themes and sub-themes in the results section. To enhance rigour, the other two authors (AG and AH) who have extensive experience in conducting qualitative research, critically examined the transcripts with preliminary coding, original notes, theme tables, and the process of theme development and independently coded 50% of the transcripts. All authors engaged in extensive debate on, and critique of, each other's dataset interpretations and reviewed each stage, with any disagreements discussed until consensus was reached.

Rigour

This study applied "the Four-Dimensions Criteria" (credibility, dependability, confirmability and transferability) for assuring the rigour of qualitative research proposed by Lincoln and Guba (1985). To ensure the analysis was sufficiently rigorous and minimized the potential for bias, the research team conducted a pilot test of the interview schedule. Reflexivity is a key component of Braun and Clarke's approach to thematic analysis (Braun & Clarke, 2021) and increasingly is regarded as a marker of quality in qualitative evidence. All three authors recorded presuppositions about this study topic in advance of data collection, and the lead

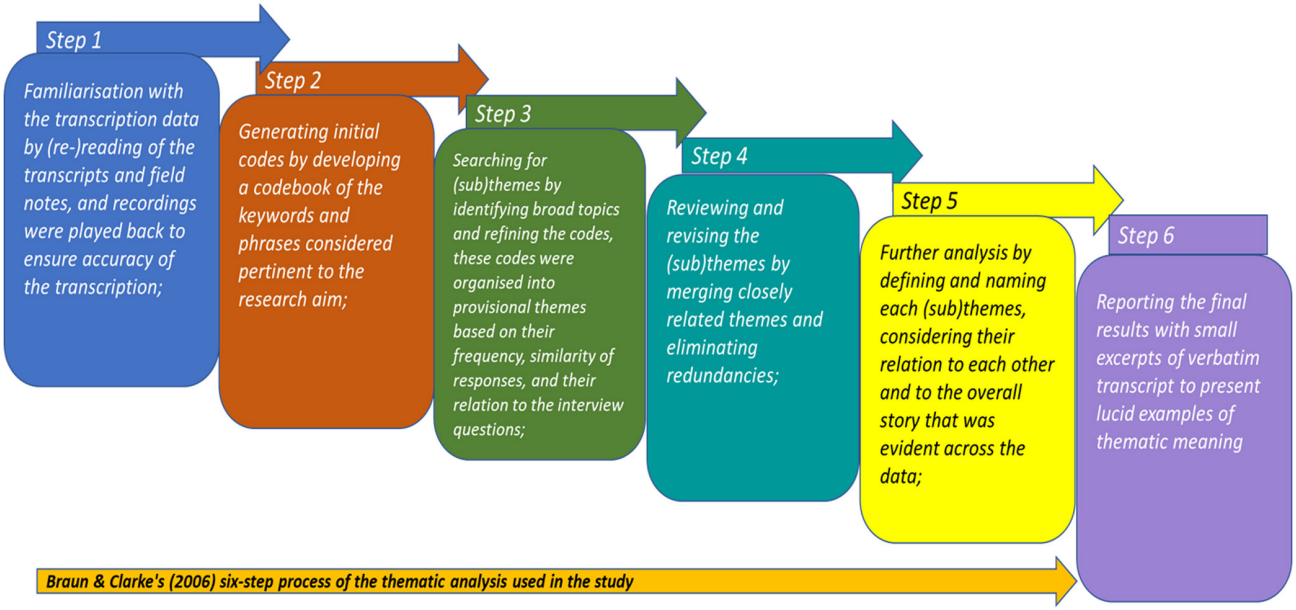

FIGURE 1 Analytical process.

author kept a reflexive diary and field notes during and after interviews including recorded memos on the development of themes and the influences on same. The use of verbatim transcriptions to ensure data accuracy, application of a thematic analysis described in the data analysis section, maintenance of an audit trail to demonstrate how themes emerged from the data, and intercoder agreement within the research team, all ensured a high level of consistency, credibility, dependability, confirmability and transferability of the results. Descriptions of the setting in which the study was undertaken and participant characteristics allow others to consider the transferability of the study's findings and their implications for local practice.

RESULTS

Participant's characteristics

Ten participants (three females and seven males) were interviewed from two units in one Forensic Mental Health Service in Ireland ($n=10$). Participants' demographic details are presented in Table 2. Participants were aged 24–49 years (mean age was 36.6). The majority of the sample identified as White Irish ($n=8$, 80%), Asian Filipino ($n=1$, 10%) and Black African ($n=1$, 10%). All participants were registered mental health nurses with the Nursing and Midwifery Board of Ireland (NMBI). Participants were educated to degree level ($n=8$, 80%) and masters degree ($n=2$, 20%). The average number of years in nursing clinical practice ranged from 2 to 20 years (mean years 6.3 years), and reported working in the acute forensic ranged from 1 to 5 years (mean years 2.8 years). The Relative Importance Index on the TRAS-Nurse prior to the interview was calculated, (mean score 40.70, standard deviation 12.71; see Table 2). The mean score of the 25 items was calculated and grouped as follows: mean scores from 1.00 to 1.80 were allocated to "Strongly disagree", 1.81 to 2.60

TABLE 2 Sample demographics characteristic.

Registered mental health nurses (RMN) characteristics ($n=10$)	
Age in years, mean (SD)	
Age range 24–49 years	36.6 (7.71)
Gender, *n* (%)	
Female	$n=3$ (30%)
Male	$n=7$ (70%)
Ethnicity, *n* (%)	
White Irish	$n=8$ (80%)
Asian Filipino	$n=1$ (10%)
Black African	$n=1$ (10%)
Professional role, *n* (%)	
RMN registered on Nursing and Midwifery Board of Ireland (NMBI)	$n=10$ (100%)
Educational attainment, *n* (%)	
Educated to Degree (BSc)	$n=8$ (80%)
Educated to Masters (MSc)	$n=2$ (20%)
Years in Role as RMN, mean (SD)	
Range 2–20 years	6.30 (5.59)
Years in role as RMN in acute forensic setting, mean (SD)	
Range 1–5 years	2.8 (1.08)
Perceived quality of the therapeutic relationship[a], mean (SD)	40.7 (12.71)

[a]Therapeutic Relationship Assessment Scale – Nurse (TRAS – Nurse), categorisation based on the Relative Importance Index.

to "Somewhat disagree", 2.61 to 3.40 to "Neither agree nor disagree", 3:41 to 4:20 to "Somewhat agree", 4:21 to 5:00 to "strongly agree". All participants indicated that they pay attention to establishing a successful therapeutic relationship with their patients.

Main findings

Four themes and two sub-themes emerged from participant data: (1) Building a Recovery Focused Therapeutic Relationship; (2) Authoritarian Role; (3) Inevitable Imbalance (4) Rebuilding Therapeutic Relationships, sub-themes (4a) Facilitators to rebuilding and (4b) Barriers to rebuilding, (see Figure 2). The relationship between the themes and sub-themes is illustrated in Figure 2: The Relationship Cycle. This illustration represents the constantly changing nature of building therapeutic relationships within the context of the forensic setting. The sub-themes (4a) Facilitators to rebuilding and (4b) Barriers to rebuilding together explain the interplay of factors, and account for the fourth theme of Rebuilding Therapeutic Relationships. Each theme and subtheme is supported by exemplar quotations from participants and is presented in the narrative below. Illustrative quotations for each theme and sub-theme are shown in Table 3.

1. Building a recovery focused therapeutic relationship

Data indicated that participants were all clear of the importance of developing a therapeutic relationship. The data (Table 3) supports the view that this is a fundamental component of mental health nursing. Participants also viewed the therapeutic relationship as a key component of recovery-orientated care, but noted the day-to-day challenge of building and crucially maintaining a therapeutic relationship in the acute forensic setting. It was noted that patients often found it hard to differentiate between the recovery-focused therapeutic relationship-building role of the FMHN and the safety focused, at times authoritarian role, which was viewed as having similarities to that of prison officers

> So look, there can be resistance to it and there can be resistance to it from… both staff and both patients. Sometimes maybe the patient mightn't want to build their relationship and might want to kind of be a bit adversarial towards staff, which we don't really want. We want to have a positive interaction with patients.
>
> [P1]

Given the challenge in establishing and maintaining therapeutic relationships within forensic settings it is not surprising that the participants indicated that large proportions of their working day, during 13-h shifts, were committed to recovery-focused therapeutic relationship building, with participants citing between 2 and 13 h spent on this endeavour in any given shift. Along with this ongoing effort to build and maintain therapeutic relationships, participants noted that they were taken away from therapeutic contact by administrative duties in addition to the previously noted safety-focused and authoritarian activities. These barriers to spending therapeutic time

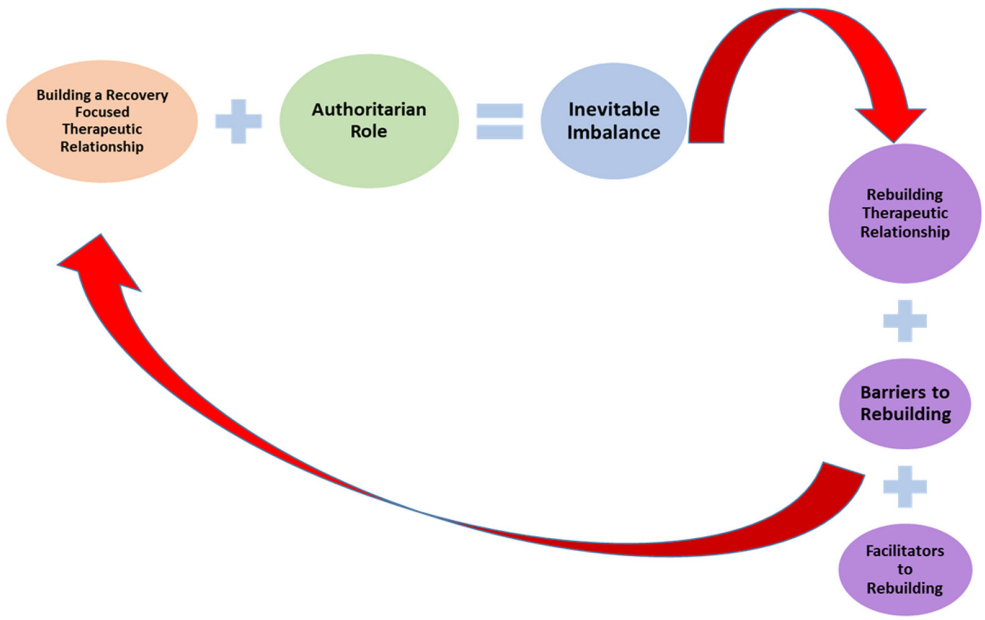

FIGURE 2 Four themes and two main sub-themes emerged from participant data.

TABLE 3 Illustrative quotations presented by theme and sub-theme.

Theme	Illustrative quotation
1. Building a recovery focused therapeutic relationship	1.1 – 'so I think one of the first things that we do you know, taking the handcuffs off the prisoner at the gate and then then they become a patient' [P1]
	1.2 – 'it still can take them a little while to kind of come to terms and understand the difference between a nurse and a prison officer, so it does take a wee bit of time to build up that relationship' [P9]
	1.3 – 'It's the core part of our nursing role, really. Uh, it's for person centred care and recovery approach, and so that means, like in collaboration with your patient… to achieve like positive outcomes for their mental health. So we kinda like agree on goals and tasks and set boundaries with our patients' [P5]
2. Authoritarian role	2.1 – 'when a restraint episode happens, usually you, see responders coming from other units as well and with all those people the priority during that time is to make sure that, uh, we contain the situation but uh security and safety is prioritised over anything else' [P8]
	2.2 – 'I suppose a show of numbers (when nurses from other units also respond to an alarm going off) as well … that could be seen as a barrier… um again a patient might perceive it as threatening. For us obviously it's a good thing but for the patient… they could perceive it as very very different'. [P5]
3. Inevitable imbalance	3.1 – 'Could they see it as a as a power imbalance, do you know what I mean, as I said they do feel powerless maybe, the patient' [P2]
	3.2 – You would be you would be more cautious about the patient afterwards (after restraint … you could be maybe very hesitant to put yourself in a position where you could think, well, if this happened again, I could get hurt very, very quickly. You would be more security conscious to yourself' [P10]
	3.3 – 'She felt powerless (following restraint). Like she couldn't do what she wanted to do, that we prevented her from doing that. So that kind of affected the power balance in the relationship. Kind of she felt like you almost you became almost an authoritarian figure within the relationship, right? Yeah, absolutely yeah, like we weren't on middle ground anymore. You know there wasn't equal power within the relationship' [P4]
4. Rebuilding the therapeutic relationship	4.1 – 'Yeah, I think time, time is a really important one you know there's no point there's no point jumping straight on seclusion trying to interact with someone trying to say oh look I forgive you I forgive this like you have to give it time. Let them settle down, let you settle down and uhm yeah, time's really important thing there just for building therapeutic relation' [P7]
	4.2 – 'And then once I went in and broke the ice kinda and left in a day or two just spoke to him in through the door…And yeah, I think just showing him there was just showing that I cared the next day. i didn't really engage too much and then spoke to him. Then when everything is settled three or four days later, and yeah, that was it. But just the body language uhm, when I went in just show him like you know I was open and good communication skills clear and you know just kind of bit of compassion in the voice'. [P6]
Sub-theme	4.3(a) – 'As I said, yeah, like I said we, we do have kind of quiet time and as I said there are times when we would ask the patient to do they want to it to spend time in one of the small yards to vent if they want. So that that can kind of that can definitely facilitate there not being a physical restraint again' [P2]
	4.3(b) – Yeah, yeah, it probably comes back to the staff member as I said good communication and again go with trust and respect and as I said put it back on the patient to say right what, what, what can we do differently to steady relationship. [P3]
4(a) Facilitators to rebuilding	4.4(a) – 'if some of your colleagues got hurt or maybe badly physically or verbally abused in it, you know, you could you could be very annoyed over that as well.
	Yeah but I suppose for the impact on the therapeutic relationship for the nurse like what uhm from the nurses point of view, how is the therapeutic relationship impacted following a physical restraint?' [P9]
4(b) Barriers to rebuilding	4.4(b) – 'If you have been involved in restraint with somebody who has a history of trauma, did you find it more difficult to reengage than somebody who didn't? Yeah because that person is kind of far more mistrusting of you after. Uhm instead of you know the people that may not have experienced trauma like that, uhm it'll be easier to kind of build up the trust back again and but finding out people that have experienced trauma like that's a significant barrier.' [P3]
	4.4(c) – 'I mean as I said earlier on we don't we don't probably spend enough time with our with our patients uhm other things are maybe uhm you know as I said we have to maintain a safe environment. [P10]

with patients ranged from administration, documentation, security duties, training, liaising with other professionals and audits. Other duties which limited therapeutic time include medication administration, vital sign monitoring, patient escorts and mealtime supervision. Acting up into ward management roles and lack of private therapeutic spaces could also impact the amount of time spent.

2. Authoritarian role

All participants in the study had experience of rebuilding therapeutic relationships after episodes of physical restraint. In explaining the influence of the Authoritarian Role theme the participants noted that while maintaining a therapeutic relationship was important, restraint was often a consequence of maintaining a

secure environment, and prioritizing safety resulted in adopting the authoritarian role

> the priority at all times in the forensic setting is relational security, therapeutic security. With, the cohorts were dealing with making sure everyone is safe and then. Everything else comes after that.
>
> [P2]

Rebuilding the therapeutic relationship post-restraint was viewed as the next priority following safe conclusion of physical restraint. The participants were also clear that undertaking physical restraint with patients impacted on the therapeutic relationship and created a power imbalance affecting trust between FMHN and patients. Staff noted that along with the impact of physical restraint on patients they themselves are subject to assault, threat and verbal abuse, with resultant emotional impact for both groups. Participants noted that the emotional impact on staff also impacted on their ability to work therapeutically. Staff noted that they believed patients would also note changes in FMHNs, viewing staff as more authoritarian. This had the potential to result in patients becoming more withdrawn, hesitant and less likely to engage therapeutically following physical restraint.

3. Inevitable imbalance

The theme Inevitable Imbalance explains how the interaction of Building a Recovery-Focused Therapeutic Relationship and Authoritarian Role result in an ongoing change in the nature of therapeutic relationships. Table 3 shows how the FMHNs identified a range of reactions and consequences following physical restraint. While physical restrain is at times a necessary safety component of the FMHN role, inevitably resulting in an imbalance of power which may manifest in the therapeutic relationship. With patients experiencing a range of responses such as anger, a sense of injustice and the potential for further aggression and threatening behaviour. Typically, these responses would undermine the therapeutic relationship for both the patient and the FMHN

> And I found like in my experience of the restraints that I have been involved in on unit one that it's the trust that's a huge issue, like and especially from a security point of view as a staff nurse in in that unit. Like, really, like learning how to trust the patient again
>
> [P4]

Participants noted that trust, as key element of the therapeutic relationship could break down, negatively impacting the relationship. Participants noted that trust was undermined in response to patients feeling a notable shift in the power balance resulting in feelings of powerlessness. Similarly, FMHN noted heightened awareness of the level of risk the patient poses along with the potential for further violence. Consequently, the FMHN can become more aware of their own safety and the safety of others which in turn impacts on communication style, content and body language with potentially negative impacts on therapeutic relationship building. What participants did not view as inevitable was the impact upon the therapeutic relationship. Participants spoke of ongoing efforts to rebuild therapeutic relationships, being influenced by a range of barriers and facilitators, discussed in the fourth theme Rebuilding the Therapeutic Relationships.

4. Rebuilding therapeutic relationships

Facilitators towards rebuilding the therapeutic relationship include; skilled communication, and effective debrief. Participants noted that skills including effective communication were most commonly acquired through observing senior staff and other staff members in the workplace

> I suppose like that rebuilding on the relationship starts going it straight away after restraint with the debrief and kind of procedures and making sure that the patient understands why you had to do what you did
>
> [P3]

Many participants also noted acquiring skills through their nursing education, through reflecting on their professional experience and through reading patient notes to allow effective engagement. Participants also indicated that there was inevitably a time period required to re-build the therapeutic relationship. Responses ranged from 24 h to 1 month or longer with most participants feeling rebuilding would take over a week. Participants themselves noted this variation, basing it in a range of factors including the relationship prior to restraint and the severity of the incident:

> It's different for every patient like I know one patient. For example, went into seclusion that morning a Saturday morning and he was out again that evening had settled down and things were back to square one and he admitted he just blew up … the trust was still there. That way he knew that it was as he was having an off day and that was it. So for him it was probably about 6 hours and then for other people I could I'd say if there's a serious assault or it could be two to three months.
>
> It's it's, it's hard to quantify [P7]

While clearly challenging, most participants felt this could be achieved in time, given the presence of facilitators as outlined in the next section.

4(a) Facilitators to rebuilding

Facilitators included staff possessing good communication skills, non-judgemental attitudes and having a consistent staff group in a given setting. Effective debrief was also seen as an important intervention to understand feelings, identify triggers and inform future care. Of note communication skills were also seen as key to effective debrief, similarly debrief was seen as bolstering staffs' ability to not take threats and abuse personally. As part of debrief a strategy of simply checking if the patient needed anything—tea/coffee/shower/phone call and facilitating this where possible was also seen as useful. The nature of debrief following physical intervention was noted as an important facilitator, where effectively undertaken it was felt to be important for staff and patients to gain an understanding of what happened and why. Crucially this would include a discussion between staff and patient to talk through the events that led to physical intervention.

Debrief is also seen as being effective in reducing the incidence of repeat restraint. It also helps to ensure the patient understands why physical restraint was necessary, while offering an opportunity to begin to rebuild the therapeutic relationship by looking at the triggers that led to the incident and to developing strategies to prevent a reoccurrence in future. The data also indicate that balancing the need for debrief against giving the patient time and space following physical restraint was very important in order for emotions to settle. Some participants also noted the potential benefits of making formal time and space for debrief and using a standardized debrief tool or approach in ensuring that this remains a facilitator for rebuilding the therapeutic relationship

> So a debrief room there could be learning opportunity to… I, I think a debrief room, where just the initial people. Yes, yeah and then given space and time to debrief properly and strategize for future restraint. Yeah.
>
> [P6]

Undergraduate and subsequent training was identified as something that could overcome barriers, acting as a facilitator for building and rebuilding therapeutic relationships. Participants had mixed views on the degree to which their training prepared them, with some feeling it was adequate others less so. Of note theoretical training was seen as less valuable than experience and observing senior staff in the clinical area. Unsurprisingly training in the prevention and management of violence and aggression was viewed as helpful. While experiential learning was clearly prioritized, it should be noted that the majority of participants took the view that training should incorporate role plays on rebuilding the therapeutic relationship following a physical restraint

> Certainly, we still have times where you play the role of a patient and that and it's kind of some bit of an insight as to what it's like to be restrained.
>
> [P4]

Participants also felt that formal training from senior staff would be beneficial along with allocating more time to debrief, routine physical restraint-focused clinical supervision and a policy of staff being given the opportunity of going off shift if assaulted during physical restraint. Participants noted the need to adjust strategy in cases where the patient has a history of trauma. Agreeing that strategies such as not using a staff member who resembles a perpetrator of any abuse or trauma where physical restraint may be common. Using staff of the same sex as the patient where possible, especially where a person of opposite sex was involved in any past abuse. Having regular staff on the unit is also viewed as helpful as staff involved in physical restraint should be aware of the patient's history of trauma and aware of any triggers which may exacerbate the situation. Ideally, care planning for potential physical restraint should be planned in co-production with patient preferences taken into account in order to avoid re-traumatisation.

As noted, effective communication was viewed as the key facilitator. Participants indicated this skill underpins FMHNs decision-making; how best to allow the patient space and time to communicate also supports effective debriefing. Reflection skills were also seen as beneficial along with being proactive in spending as much time as possible with patients in order to build strong therapeutic relationships. This last point touches on the view that developing a strong therapeutic relationship prior to any physical restraint is beneficial when rebuilding the therapeutic relationship afterwards.

4(b) Barriers to rebuilding

Common barriers were seen to be; poor mental health and positive symptoms relating to psychosis amongst patients, non-regular staff on the unit, poor staff attitudes and language barriers. Also, the 'show of numbers' that occurs when staff from other units also respond to a staff alarm going off was viewed as a barrier as patients can view that as threatening. As noted, given the incidence of past history of trauma amongst this patient group, it is noted that physical restraint is potentially likely to negatively impact this group. Most participants viewed physical restraint as a traumatic event for patients, noting it can trigger memories of past traumas and re-traumatisation can occur. Participants noted that negative emotions are involved and these patients can find physical restraint very stressful. While participants noted that past history of trauma is of itself a barrier to rebuilding the therapeutic relationship it is noteworthy that participants recognized this and considered mitigating factors. There

was acknowledgement that the timescale to rebuild the therapeutic relationship is longer with these patients as they can become more mistrusting of staff involved:

> The staff members attitude, uh… During the whole episode… plays a very important role… because being patronising to patients where patients lack autonomy and where they feel like they are always only on the receiving end and the member of staff, they know it all and they know what is right for the patients and the patients are…. That attitude… I think it costs a lot of friction and it hinders the development of therapeutic relationship
>
> [P8]

DISCUSSION

Analysis of the themes presented in this study shows that building and maintaining a recovery-focused therapeutic relationship is a constantly evolving process. The analysis indicates that while FMHNs value the development of these therapeutic relationships, they also recognize the negative impact of physical restraint upon those therapeutic relationships.

The themes Authoritarian Role and Inevitable Imbalance provide similar insight to studies by McKeown et al. (2019) and Riahi et al. (2016) which note the complexities present when trying to justify the use of physical restraint, account for FMHNs motivation for its use and ultimately account for the negative impacts. The evidence suggests that rather than maintaining safety restrictive practices and coercive staff behaviour undermine therapeutic relationships (Thibaut et al., 2019). The sub-theme Facilitators to Rebuilding notes the importance of skilled approaches and interventions, specifically verbal de-escalation, which is highlighted as the main strategy for avoiding physical restraint. These findings are found in other studies that note FMHNs and patients value effective de-escalation, noting the positive impact on therapeutic relationships and institutions more broadly (Kuivalainen et al., 2017; Price et al., 2018).

The findings of this study also mirror contemporary literature that notes that forensic settings require high staff-to-patient ratios and specialist therapeutic and security-focused skills for the prevention and management of violence and aggression (Power et al., 2020; Rose et al., 2017). FMHNs require skills in dynamic risk assessment, de-escalation and the proportionate skilled use of restrictive and intrusive interventions (Kennedy et al., 2020; Markham, 2021). Studies by Duxbury et al. (2019) and Haines-Delmont et al. (2022) indicate the need to reflect critically on the interplay of practices, procedures and policies in forensic care settings given the negative outcomes resulting from restrictive measures. The theme Rebuilding a Therapeutic Relationship provides similar understanding of the interplay of barriers and facilitators to rebuilding therapeutic relationships following physical restraint. Given that forensic inpatients are typically placed in a secure environment for far longer than patients in standard mental health facilities, the themes presented in this study add to an understanding that there are clear opportunities for strong therapeutic relationships to form. Where FMHNs are supported with resources and training to take the opportunity to constantly rebuild the therapeutic relationship, such relationships have the potential to improve a patient's quality of life and also aid their progress on the path to recovery (Knowles et al., 2015; Tomlin et al., 2020).

This discussion reflects participants understanding that involvement in physical restraint has a profound personal and professional impact on FMHNs. This impact having the potential to create a barrier to effective rebuilding of the therapeutic relationship post-physical restraint. The participants noted the emotional discomfort experienced, leading to rumination over decisions made and subsequent actions. While seen as a final option the potential for participation in physical restraint to also be an opportunity for experiential learning was referred to in the data; with training, effective debrief and positive role modelling from senior staff viewed as the main factors supporting positive outcomes. The themes illustrate an ongoing process, by which the Recovery Focused Therapeutic Relationship is constantly challenged, altered and revisited in response to the application of building and rebuilding the therapeutic relationship and the authoritarian role in forensic settings.

Strengths and limitations

This study explored FMHNs experiences of rebuilding the therapeutic relationship following an episode of physical restraint in the acute forensic setting. The findings of this study are limited by all data collection taking place within only two wards in a single Irish forensic hospital. The experiences of FMHNs ($n=10$) in this study may not reflect FMHNs from different health care systems and settings, but the findings do show synergies with and add to the findings in similar studies in forensic settings (Knowles et al., 2015; Kuivalainen et al., 2017).

CONCLUSION

This study reported on FMHNs experiences of rebuilding the therapeutic relationship following an episode of physical restraint in the acute forensic setting.

Knowledge in this area has been enhanced by developing a better understanding of how inevitable imbalance exists between maintaining a recovery-focused therapeutic relationship and the safety-focused authoritarian role of the FMHN including restraint. The negative features can be mitigated by FMHNS awareness of, commitment to and capacity for maintaining therapeutic relationships in the acute forensic settings. The ability of FMHNs to achieve this being influenced by a range of barriers and facilitators.

RELEVANCE FOR CLINICAL PRACTICE

Recommendations for changes in clinical practice include ensuring experiential training for forensic FMHN involved in rebuilding therapeutic relationships post-physical restraint. The training should incorporate role plays and be delivered by senior staff. Upcoming reviews of the policy on physical restraint should incorporate a dedicated debrief room and protected time for staff to debrief effectively following restraint. Routine post-restraint-focused clinical supervision would also be beneficial to mental health nursing staff.

AUTHOR CONTRIBUTIONS

All authors listed meet the authorship criteria, the latest guidelines of the International Committee of Medical Journal Editors. All authors are in agreement with the manuscript. JM and AMG designed the study with initial design input from AH. AH made substantial contributions to conceptualisation, methodology, formal analysis and manuscript writing. JM was responsible for recruitment, and data collection and had full access to all the data in the study. JM and AMG were responsible for data analysis, drafting and critical revisions of the manuscript. AMG takes responsibility for the integrity of the data in the study and the accuracy of the data analysis. All authors contributed to the write-up.

ACKNOWLEDGEMENTS

The authors would like to thank all those who participated in the study, the National Forensic Mental Health Service and the Health Service Executive. The authors would like to thank Joana Coelho for giving us permission to use the Therapeutic Relationship Assessment Scale-Nurse (TRAS-N) for this study. We also wish to acknowledge Trevor Murrells our colleague at King College London for providing his guidance and expertise in the statistical analysis of the TRAS-N. Open access funding provided by IReL.

FUNDING INFORMATION

None.

CONFLICT OF INTEREST STATEMENT

None declared.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

ETHICAL APPROVAL

Ethical approval was obtained from the Nursing Research Ethics Committee – National Forensic Mental Health Service on 3rd December 2021 (Project reference number: 2021_004).

PATIENT CONSENT

Patient consent for publication statement (if relevant) – Not applicable.

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How to cite this article: Moyles, J., Hunter, A. & Grealish, A. (2023) Forensic mental health nurses' experiences of rebuilding the therapeutic relationship after an episode of physical restraint in forensic services in Ireland: A qualitative study. *International Journal of Mental Health Nursing*, 00, 1–13. Available from: https://doi.org/10.1111/inm.13176