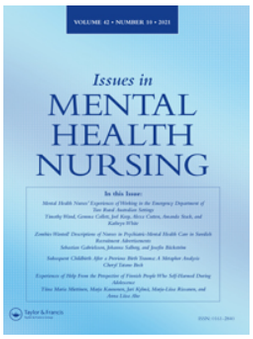

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Exploring the Experiences of Male Forensic Inpatients' Relationships With Staff Within Low, Medium and High Security Mental Health Settings

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ABSTRACT

Therapeutic relationships within psychiatric settings are highlighted as important throughout the literature. However, research from the forensic inpatient perspective is limited. We address this gap by exploring the patient-staff relationships within forensic mental health inpatient services, from the patient's perspective. Thirty adult male forensic inpatients were interviewed about their experiences on the ward and their interactions with staff. Our analysis examines inpatients experiences of respectful and reciprocal relationships, relationships that empower, a disinterest in their patients' and authoritarian relationships. This study concludes by highlighting the need to prioritise the development of reciprocal relationships within forensic services.

Introduction

Forensic inpatient mental health services provide care to individuals who are detained involuntarily under the Mental Health Act (1983) having been charged with criminal offences. They are remanded within these services for assessment and/or treatment as they are seen to pose a threat to themselves and/or to the community (Maguire et al., 2012). These services are tasked with balancing the provision of a therapeutic environment alongside protecting the individual, other inpatients, staff and the community (Brunt & Rask, 2005), as the individuals typically present with challenging behaviours, including violence and aggression (Völlm et al., 2018).

The number of forensic inpatients within England and Wales is increasing, with reports of medium secure units (MSU) rising from 2,500 forensic inpatients in 1997 to 3,723 in 2007 (Rutherford & Duggan, 2008). More recently, 7,718 beds were commissioned across low, medium and high secure units in 2015 (NHS England, 2015). Forensic patients are likely to stay much longer than those in general psychiatric care, with 23.5% in high secure and 18.1% in medium secure identified as long stay[1] patients (Hare Duke et al., 2018). These services are estimated to cost approximately 1% of the NHS health budget and 10% of the mental health budget (Rutherford & Duggan, 2008; Walker et al., 2012) and are therefore high cost, low volume services (Mottershead et al., 2020).

The importance of the development of therapeutic relationships between patients and staff is widely acknowledged throughout the literature (e.g. Johansson & Eklund, 2003) and accepted within clinical practice across settings. The act of engaging meaningfully with patients, something central to a good therapeutic relationship, permeates the principles of the nursing profession (Royal College of Nursing, 2010) and therefore may be considered a fundamental aspect when providing care. It is argued that the therapeutic relationship has the greatest impact on treatment outcomes for mental health difficulties, above and beyond the specific models or intervention used (Martin et al., 2000; Messer & Wampold, 2002; Priebe & McCabe, 2006). In addition, the therapeutic alliance between patients and staff is stated within the Best Practice Guidelines in Medium Secure Units (Jobbins et al., 2007) as being at the centre of high-quality care within secure settings. Hui et al. (2013) reported that when participants were asked about their experiences of psychiatric hospitals their responses largely centred around the people they had encountered, and the relationships developed.

With forensic settings being described as restrictive, controlling and coercive environments (Hui et al., 2013), the development of positive patient-staff relationships may be understandably challenging. Staff working in these settings are faced with the complexity of providing a caring, supportive atmosphere for patients who are being taken care of against their will (Selvin et al., 2016) and undertaking compulsory actions in an attempt to improve their health and quality of life (Hörberg et al., 2012). The ability to fulfil this conflicting role has been questioned, as the responsibilities relating to security (including implementation of physical restraint) and working therapeutically may be seen as incompatible (Knowles et al., 2015).

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[1]Long-stay defined as a stay of more than 10 years in HSU, 5 years in MSU or 15 years in a mix of high and medium secure settings.

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In addition, forensic mental health services have historically been professionally driven and decision making has been led by clinicians (Livingston et al., 2012). However, patients are no longer seen simply as passive recipients of healthcare and there has been a shift in recognising the importance of patients as evaluators of the services they use (Carlin et al., 2005) with the UK Department of Health (2002) guidance stating treatment should be guided by patient goals and experiences. Coffey (2006) highlights the necessity of researching the views of forensic mental health patients, as they are a marginalised and stigmatised group and their perspective is required in order to enable development of care within forensic services. In recent years there has been a surge in researchers giving voice to the forensic patient by presenting their perspectives and experiences (e.g. Clarke et al., 2016).

However, a focus on the inpatients' perspective of patient-staff relationships within forensic mental health settings, compared to other areas of care and compared to the staff's perspective, is still lacking. For example, Gildberg et al. (2010) review into what characterises staff interaction with inpatients within forensic mental health settings concludes with the suggestion that there is a need for further research into patient-staff relationships from the perspective of the patients. Additionally, whilst Kumpula and Ekstrand (2013) and Marshall and Adams (2018) explore patient-staff relationships in a forensic setting, they were only concerned with the views of staff.

Of the studies which do present a forensic inpatient perspective, where the patient-staff relationship is raised by participants and therefore presented within the analysis, this is not the primary focus of many of the papers. For example, the main objectives were to explore experiences of care more generally (Askola et al., 2018; Hörberg et al., 2012), rehabilitation and recovery (Barnao et al., 2015; Livingston et al., 2013), satisfaction with services (Bressington et al., 2011), de-escalation of conflict behaviours (Goodman et al., 2020) and restraint (Knowles et al., 2015). Although these studies each comment on patient-staff relationships, a more in-depth exploration is required to provide additional information relating to these experiences to aid in nursing care meeting patient needs and to improve the quality of care, a need highlighted within Hörberg et al. (2012).

The few studies where the focus of the research is to assess therapeutic relationships and social interactions between patients and staff primarily use quantitative measures (e.g. Höfer et al., 2015; MacInnes et al., 2014; Rask & Brunt, 2006). Schafer and Peternelj-Taylor (2003) explored patient-staff relationships in more depth, interviewing individuals within the Canadian criminal justice system who were voluntarily enrolled within an intensive treatment programme. Their focus was on the development of, and boundaries within therapeutic relationships and concluded that the therapeutic relationship is dynamic, for example being influenced by the physical presence of the primary therapists, whether patients feel heard or objectified etc. Additionally, they highlight the context of the relationship as being influential. This is particularly important when considering the participants were voluntary patients and could withdraw from the treatment programme if they chose and would subsequently return to their original institutions.

Therefore, the current research contributes to this body of knowledge by exploring relationships between patient and staff, within UK forensic mental health wards, where the inpatients do not have this choice about residing within the units. An exploration of these relationships not only offers a contribution to the existing literature but will also explore the clinical and practical implications of patient staff relationships. This will enable services to gain more insight into how they can achieve the balance between care and security, benefitting patient mental health and service outcomes. Therefore, to address this gap in the knowledge base, this study asks the following research question: What are inpatients' experiences of relationships with staff within forensic mental health settings?

Materials and methods

Design

The epistemological position of this study was primarily a critical realist approach where "language is understood as constructing social realities" (Sims-Schouten et al., 2007, p. 102). This approach "combines constructionist and realist positions to argue that while meaning is made in interaction, non-discursive elements also impact on that meaning" (Sims-Schouten et al., 2007, p. 102), for example, the physical space of the forensic setting. This approach provides the current study with "an alternative both to naïve versions of realism and to totalizing versions of relativism" to explore the ways in which inpatients understand and construct the experiences through language whilst also offering a concern to the materiality of such experiences (Sims-Schouten et al., 2007, p. 103).

A qualitative design was utilised to explore inpatients' experiences of relationships with staff within forensic mental health settings. The semi-structured interviews were guided by a schedule focussed around four areas (general experiences, experiences of restrictive practices, experiences of seeing restrictive practices, relationships on the ward) with several prompts to provide an opportunity for patients to share their experiences of life in a secure unit and allow for more of an insight into the participants' views (Kelley et al., 2003). The interviews were part of a larger mixed methods study. However, for the purpose of this project, the focus will be on the qualitative data collected as this data was specifically focussing on the lived experiences of the inpatients.

Participants

Setting

Participants were recruited from one high secure (HSU), one medium secure (MSU) and one low secure hospital (LSU), across two NHS trusts, within the United Kingdom. All participants were adult (18+) males detained within forensic settings, which provide assessment, intervention, support and rehabilitation, under the Mental Health Act (1983). Data was collected between November 2019 and March 2020.

Sample

Across the hospitals, 28 wards were initially contacted, with a total population of 404 patients, 30 participants were recruited from 12 wards (HSU n = 18, MSU n = 6, LSU n = 6). All participants were male, aged 23 to 61, with a mean of 41.6 years (SD = 12.1 years). Participants' length of stay on the current ward ranged from 2 months to 297 months (24.75 years) and overall continuous length of stay within forensic mental health services ranged from 6 months to 420 months (35 years). Many patients had comorbid diagnoses, with the most common diagnosis being paranoid schizophrenia (n = 21, 70% of the sample) (ICD-11, World Health Organization, 2018). The sample within this study is similar to the general population of service users within forensic mental health services in the UK (Harty et al., 2004; Völlm et al., 2018) in terms of mean age, ethnicity, diagnoses and index offences (Table 1).

Research ethics

The study was then approved by an NHS Research Ethics Committee (REC) (Harrow – 19/LO/0772) and additional approvals were received from the local Trust's Research and Development departments.

Method of analysis

In line with the ontological and epistemological approach highlighted above, interviews were transcribed verbatim by the researchers and analysed using reflexive thematic analysis (TA) (Braun et al., 2019; Braun & Clarke, 2019). This approach was chosen due to the relative lack of research exploring the experiences of forensic inpatients' relationships with staff (Joffe & Yardley, 2004). In addition, reflexive TA was chosen as it can be flexibly used to address questions related to experiences and views and can be used with larger data sets, rather than focussing on the idiographic experiences of individuals (as in Interpretative Phenomenological Analysis) (Eatough & Smith, 2008). Reflexive TA requires "deep and prolonged data immersion" (Braun & Clarke, 2019, p. 591) and encourages a systematic approach to coding and theme development, whilst also emphasising the need to be fluid and recursive in the process and therefore builds upon the initial six phase process described within Braun and Clarke (2006).

Braun and Clarke (2019) highlight the need for continual questioning of the assumptions being made throughout the interpretation and coding and furthermore, reflective and thoughtful engagement with the data is thought to be essential. This approach acknowledges the active interpretative work of the researchers as being key in generating themes and therefore we do not suggest our findings represent a definitive account of the data. Yardley (2000) and Braun and Clarke (2006) guidelines for assessing rigour were utilised, to enhance the credibility of the analysis. This process included the constant reflection from both authors with regards to the ways our personal experiences may have influenced the analysis, as is unavoidable with qualitative research. In line with recent publications utilising Thematic Analysis the following results are presented and discussed in relation to the existing literature to enrich the analytic depth of our findings (e.g. Clarke & Braun, 2019; Hayfield et al., 2019; Le Grice & Braun, 2017).

Results and discussion

Respectful and reciprocal relationships between patients and staff

Throughout the interviews, patients commented at length on the respectful, supportive and caring staff within the hospitals. As the following participants comment:

> The staff are fantastic … I haven't got anything bad to say about any of the staff at all … They are very supportive and quite knowledgeable and very sociable and very respectful. And you couldn't really ask for much more than that. (Ben, HSU)

> All the team, the whole team, from the doctor down to domestics. They've all supported me in times where I've been unwell or uncooperative. (James, LSU)

In the two extracts above these participants highlight how staff support is embedded in their experiences of care, something that is argued to be of central importance within forensic care (e.g. Barnao et al., 2015). Whilst other research (e.g. Tomlin et al., 2018) has found patients suggesting that support is not always present or believing more could be done to support their needs, the above extracts highlight the ways in which the participants feel the staff they have encountered are "supportive", "knowledgeable", "sociable", and "respectful" even in situations whereby the patient felt they were "unwell or uncooperative". This kind of relationship may provide patients with a sense of acceptance and companionship which they may not have previously experienced (Turton et al., 2011) and may be particularly important when opportunities for relationships outside of hospital are limited (Mezey et al., 2010).

These positive relationships through the "support" and "respect" offered appeared to make a difference to the patients who perceived staff as taking an active role in this process, with the staff's intentions of creating a reasonable environment for patients, in a place which could easily be intolerable. Such positive therapeutic relationships have been found to influence overall satisfaction with forensic services (Bressington et al., 2011; Coffey, 2006) and predict favourable outcomes for patients both short and long term (Hamrin et al., 2009; Meehan et al., 2006).

Considering the patients' needs in this way seemed to be viewed as staff going beyond just doing a job. As the following participant notes:

> It's like they realise that this is a bad experience for us and no one wants to be in a mental health hospital … So, it's like they try and make it as easy as possible for us … Just like friendly banter, ask us how we are doing, checking on us … .I think they just try and make it as pleasant an experience as it can be … . It's just how they relate to you and how they talk to you and how they deal with what you need. (Steve, MSU)

Table 1. Participants.

Participant	Age bracket	Ethnicity	Index Offence Group	Clinical diagnoses	Unit type	Length of stay in hospital	Length of stay on ward
Ross	30–34	White British	Arson and criminal damage	Paranoid Schizophrenia and Autism Spectrum Disorder	HSU	61–66 months	13–18 months
Harrison	45–49	White British	Arson and criminal damage	Antisocial Personality Disorder, Emotionally Unstable Personality Disorder, Narcissistic Personality Disorder	HSU	43–48 months	31–36 months
Callum	30–34	White Irish	Violence against another person	Autism Spectrum Disorder, Emotionally Unstable Personality Disorder, Antisocial Personality Disorder	HSU	25–30 months	13–18 months
Toby	50–54	White British	Violence against another person	Paranoid Schizophrenia, Emotionally Unstable Personality Disorder	HSU	73+ months	73+ months
Nick	45–49	White British	Sexual offences	Avoidant Personality Disorder and Antisocial Personality Disorder	HSU	73+ months	25–30 months
Sam	45–49	Black British	Sexual offences	Schizotypal Personality Disorder, Antisocial Personality Disorder and Narcissistic Personality Disorder	HSU	31–36 months	25–30 months
Stuart	45–49	White British	Violence against another person	Antisocial Personality Disorder and Emotionally Unstable Personality Disorder	HSU	73+ months	73+ months
Duncan	45–49	White British	Violence against another person	Paranoid Schizophrenia, Emotionally Unstable Personality Disorder, Avoidant Personality Disorder, Histrionic Personality Disorder, Antisocial Personality Disorder, Bipolar Affective Disorder (Type 1)	HSU	55–60 months	49–54 months
Roger	30–34	Black British	Violence against another person and sexual offences	Paranoid Schizophrenia, Antisocial Personality Disorder	HSU	55–60 months	13–18 months
Edward	20–24	Black British	Robbery	Paranoid Schizophrenia	HSU	43–48 months	43–48 months
Ben	50–54	White British	Violence against another person and sexual offences	Paranoid Schizophrenia and Autism Spectrum Disorder	HSU	73+ months	73+ months
Phil	25–29	White-other	Violence against another person	Schizoaffective Disorder	HSU	13–18 months	13–18 months
Chris	25–29	White British	Violence against another person	Paranoid Schizophrenia	HSU	25–30 months	25–30 months
Joseph	25–29	White British	Sexual offences	Emotionally Unstable Personality Disorder and Antisocial Personality Disorder	HSU	1–6 months	1–6 months
Kyle	50–54	White British	Violence against another person	Emotionally Unstable Personality Disorder, Antisocial Personality Disorder	HSU	73+ months	7–12 months
Mason	30–34	African	Violence against another person	Paranoid Schizophrenia	HSU	31–36 months	1–6 months
Alex	30–34	Mixed-White and Black Caribbean	Violence against another person	Paranoid Schizophrenia	HSU	13–18 months	13–18 months
Adam	30–34	Asian British	Violence against another person	Paranoid Schizophrenia	HSU	7–12 months	7–12 months
James	60–64	White British	Missing data	Antisocial Personality Disorder, Paranoid Schizophrenia	LSU	73+ months	67–72 months
Max	60–64	White British	Sexual offences	Mixed Anxiety and Depressive Disorder,	LSU	73+ months	25–30 months

(*continued*)

Table 1. Continued.

Participant	Age bracket	Ethnicity	Index Offence Group	Clinical diagnoses	Unit type	Length of stay in hospital	Length of stay on ward
				Paranoid Schizophrenia			
Marcus	60–64	White British	Violence against another person	Emotionally Unstable Personality Disorder	LSU	73+ months	7–12 months
Declan	30–34	White British	Violence against another person	Paranoid Schizophrenia	LSU	55–60 months	7–12 months
Reece	45–49	White British	Arson and criminal damage	Paranoid Schizophrenia	LSU	73+ months	13–18 months
Graham	25–29	White British	Arson and criminal damage	Paranoid Schizophrenia	MSU	37–42 months	1–6 months
Mitchell	45–49	Black British Caribbean	Violence against another person	Paranoid Schizophrenia	MSU	1–6 months	7–12 months
Tom	30–34	White British	Violence against another person	Paranoid Schizophrenia	MSU	73+ months	13–18 months
Jaden	55–59	Black British	Violence against another person	Paranoid Schizophrenia and Schizoaffective Disorder	MSU	73+ months	7–12 months
Steve	25–29	Black British	Robbery	Paranoid Schizophrenia	MSU	25–30 months	13–18 months
Daniel	50–54	Black British	Arson and criminal damage	Paranoid Schizophrenia	MSU	73+ months	1–6 months
Matt	50–54	Black British	Violence against another person	Paranoid Schizophrenia	MSU	73+ months	1–6 months

Here the participant documents the ways in which interactions between staff and patients were experienced by patients to be genuine attempts by the staff to turn what they see as essentially a "bad experience" into something more positive. The positive therapeutic relationship has been shown to be important to patients and nurses alike (Holmes et al., 2015) and is developed due to staff wanting to understand more about the patients from their perspective and understanding their experiences by encountering their life-world (Hörberg et al., 2012). To facilitate this type of a relationship it has been suggested that there is a need for the staff member to treat the patient with empathy (Bowen & Mason, 2012), respect and understanding (Barnao et al., 2015) all of which can be understood as being central to the participant's account in relation to the staff "realise[ing] that this is a bad experience for us and no one wants to be in a mental health hospital". However, it isn't just a position of support and empathy that this participant understands as being important, rather through reference to "friendly banter" and staff asking "how we are doing" he highlights the informal, friendly interactions patients had with staff that helped develop trust, showing staff to not have an ulterior motive or agenda when speaking with them. Staff were described as making an effort to start a conversation with the patient on a topic the patient is willing to engage with.

Despite this opportunism and pragmatism being considered by some nurses as simply part of the psychiatric nursing role (Chiovitti, 2008), it seems for the patients within these forensic hospitals, that these actions speak volumes. As the following participant comments:

> Most of the conversation is a load of shit, but that doesn't matter. You were having a conversation, you were engaging. You won't even remember half of that conversation, but it is about that human interaction, that human contact. (Joseph, HSU)

In this extract the participant describes a simple "human interaction", highlighting the importance of "human contact" in a place which may otherwise feel very lonely. Within forensic settings the power dynamics between patient and staff are often evident, but the use of the phrase "human interaction" suggests the patient may have experienced this as a time when he felt equal to the staff member on a "human" level and that this was appreciated (Walsh & Boyle, 2009). This participant also emphasises that the content of the conversation "doesn't matter" and it is simply the engaging in a conversation with staff which is desired, corroborating previous findings of the significance for psychiatric patients in staff being "genuine" human beings (Pejlert et al., 1995).

Patients shared that staff were not necessarily interchangeable when it came to this close therapeutic relationship, with one participant describing the ward environment as a "microcosm of society" (Kyle, HSU), explaining that not everyone gets on, but from their experience all patients have developed a special relationship with at least one member of staff. However, many participants had been within forensic services for several years and had experienced a variety of relationships with staff. Within acute psychiatric inpatient settings coercion has been shown to undermine the development of therapeutic relationships (Gilburt et al., 2008) and participants' accounts in this study corroborated with this, whilst also describing their experiences throughout the years of staff's abusive behaviour towards them. Participants highlighted the positive changes in recent years, with one participant commenting:

> It has come a long way. It is more patient centred … I think staff are taking patients more seriously … I think the staff are trying harder than they ever have done before. In the 90s it was really dire. It was all, staff were quite intimidating and bullied a lot of people … but now, as I said, they are getting much more, developing a bit more, what's the word … feeling towards people. I think so yeah, and it is more passionate. Not passionate, compassionate. (Marcus, LSU)

Here the participant presents what they deem to be a positive shift from some of the abusive approaches such as bullying and intimidation and general "bad habits" utilised 30 years ago and highlights the importance of person-centred care (Barnao et al., 2015). This extract also notes the staff "taking patients more seriously", "trying harder" and having more compassion towards patients. Lammie et al. (2010) reported a correlation between age and reduced stigma which they proposed may indicate experience of working in forensic settings reduces stigma, however it is worth considering whether a societal change in understanding of mental health difficulties and policies surrounding this may have impacted the types of individuals who now apply for jobs within forensic settings. Staff taking an interest in the person behind the illness and/or crime has been documented previously (Kumpula & Ekstrand, 2013) and the impact this had on patients' belief in themselves and their ability to have a life after the unit was acknowledged by some participants:

> My primary nurse … she is a very … optimistic about the future, about my plans, she thinks I can do everything I want to do. She encourages me and makes me feel better about myself. (Daniel, MSU)

> Staff want the best … it makes you feel better that there are people that want to help you get back on your feet. (Tom, MSU)

These extracts display the shared belief amongst participants that staff really did "want the best" for each patient. Staff were described as being "optimistic about the future" and encouraging and supportive of patients achieving their goals and progressing in their recovery, which in turn patients responded well to (Harker-Longton & Fish, 2002; Ruef & Turnbull, 2002). Having these supportive alliances with staff is understandably valued by forensic inpatients (Tapp et al., 2013) and of particular importance is the role of a primary nurse (Askola et al., 2018), with these trusting and compassionate relationships thought to be vital in terms of patient recovery (Drennan & Wooldridge, 2014).

Working with and empowering patients within a restrictive environment

Whilst patients acknowledged that residing within a restrictive environment had understandable implications limiting their freedoms, bringing about many frustrations (particularly for those within the HSU where restrictions are most severe), they also recognised how these frustrations were reduced and their quality of life improved within the units when staff appeared to be working with them, rather than against them. This included staff allowing them some control and responsibility, as well as helping the patients to develop skills which would be beneficial not only in their current context, but for life outside of the unit. As one participant comments:

> There are rules obviously, but they apply them sensibly. (Max, LSU)

This extract refers to the staff's use of initiative and clinical judgement in relation to the rules on the unit, rather than blanket restrictions or overly controlling procedures which were perceived by many participants as unnecessary and over the top. The impact of strict blanket rules was described as leaving them feeling like a child, as reported by To et al. (2015) and Wright et al. (2014). Whereas staff "applying [rules] sensibly" allowed for some autonomy in an otherwise restrictive environment. This sense of flexibility was appreciated throughout participants accounts, particularly in relation to crisis situations. Working collaboratively with patients was described as being particularly helpful, but only possible if the staff member knew the patient well.

The extracts below describe examples of how staff have worked with the patient to recognise early warning signs and to come up with a solution to manage the patient's distress in a way which allows the patient to remain in control, with access to support from staff, rather than them being taken to seclusion, which in forensic services is often the course of action:

> I have got it care planned where if my heads not in the right space and I'm losing my head a bit … I can seclude myself to my room … and I listen to my music or watch TV and then once I have calmed down my seclusion will get terminated … That is very different to being put out in the seclusion room where you have got nothing … .One night I secluded myself, one night I told them to seclude me, because I was losing my head, so I said to them, like seclude me I am going behind my door and the next day I had CTM and I went in CTM and I just suggesting like having it as a plan when I am like losing my head. Maybe there are not staff around for me to communicate, or maybe I am not in the right head space to communicate, to then seclude myself. It prevents me from doing anything silly. And then my consultant and the team in the CTM just agreed it would be a good idea. The ward manager and that agreed it would be a good idea so it went in there. (Joseph, HSU)

> So when I get wound up, talk to me and get me into my room, don't put me in seclusion. Because once I go to seclusion, it might only be for a few hours from their end but it becomes a massive thing to me. I become more agitated, they are more agitated and don't want to open the door because they are worried I will kick off. They have had experience of it … when I started kicking off or shouting off or mouthing off or whatever, they walked me back to my room and it broke the cycle of going from anger straight to seclusion. So when I did get angry and went straight to my room, I was more likely to take my PRN. PRN calms me down, I sit down. They bring me a cup of tea, "what's wrong, talk to me". (Kyle, HSU)

These participants' accounts describe "losing their head" and being "wound up" as well as being "agitated" and previously "kicking off". The understandable frustration and justifiable anger (Towl & Crighton, 1996) patients experience within forensic settings can lead to an increase in aggression and violence if the patient is ill-equipped with coping strategies to manage these difficult emotions (Knowles et al.,

2015). These participants describe the coping skills they have discovered and developed, with the help of staff. One participant describes needing space, surrounded by his possessions, where he can listen to music or watch TV. The other describes the availability of staff to speak with him and explore what is going on as being helpful, which supports Maguire et al. (2014) and Griffith et al. (2013) findings. Additionally, he shares being offered Pro Re Nata (PRN) medication and also being brought a cup of tea as helpful. They both note that being in their own rooms is more beneficial than being in the designated seclusion room and that the strategies utilised have helped them to calm down, preventing escalation of the distress and possible violent acts. This preference of calming down within their own space corroborated previous findings (Fish & Culshaw, 2005; Hall & Deb, 2008).

These individualised approaches for managing distress being captured within their care plans allow for all nursing staff to be informed about the best way of supporting each patient in times of distress or crisis, which is invaluable for de-escalation and is in line with professional beliefs worldwide of the need to reduce controlling strategies (Huckshorn, 2007; Jonker et al., 2008; National Institute for Clinical Excellence, 2005). This may also help to preserve therapeutic relationships in the event of violence or aggression, as the staff's response has been planned in advance, in collaboration with the patient (Holmes et al., 2015). However, prior to this being officially recorded within their care plan it requires staff being willing and open to working alongside the patient in exploring what was happening for the individual and what they find to be most helpful, for it to then be agreed by the team. Psychiatric patients' desire to talk about incidents of aggression, explore their feelings and motivations for actions has been previously documented within a systematic review by Gudde et al. (2015). This requires the patient to be engaged in dialogue about their care and to be heard by professionals in these discussions (Livingston et al., 2012; Selvin et al., 2016).

This approach recognises that patients know what is best for them as they are the experts in their own lives and these needs will differ between patients and is thereby more person-centred (Goodman et al., 2020; Tapp et al., 2013). This again goes some way to balancing the power dynamic between patient and staff and this sharing of power can help to strengthen the therapeutic relationship (Warne & McAndrew, 2007). The patient is required to recognise their distress and a need to address this and then, that they are able to take some control over this, whilst knowing that the staff is there to provide them with the identified necessary support. This has benefits for the patient, other patients and staff on the ward at that time. It also provides opportunities for the patient to develop skills in self-soothing and/or seeking support from others. This can be practised within the hospital, but will also be beneficial for life outside of the hospital. These opportunities for patients to take responsibility for and influence their own recovery as described by the current study's participants is often lacking within forensic care settings (Marklund et al., 2020).

Accounts also described ways that staff could empower patients to have some choice and control over their lives more generally on a day-to-day basis. This need for empowerment in a restrictive environment has previously been highlighted as important by Marklund et al. (2020) and within a recent review by Doyle et al. (2017). As the following participant comments:

> Sometimes we have a member of staff where they ask you, for example in the morning time, plan of the day, what would you like to do. So that helps. You say OK I want a phone call or something. So they are encouraging the patients to, to plan their day. Sometimes, not always, but some days, sometimes they do that. Which is good. (Adam, HSU)

This participant gives the example of staff "encouraging the patients to plan their day" to ensure it involves things they wish it to, like "a phone call". Although there may be patient requests which are unable to be facilitated due to the restrictive environment, such as leave which has not yet been granted, this still allows patients to consider what they would like to do with their day and communicate this to staff, so that staff can work with the patients to assist in this being achieved. Barnao et al. (2015) describe this person-centred approach as the individual being 'centre stage', where staff understand what matters to the patient, support their interests and help action their wishes, which can evoke a patient's hope for the future.

The essence of the above extracts supports previous findings by Tapp et al. (2013) who report collaboration in care between patient and professional to be essential and staff who are encouraging of this are valued by inpatients (Marklund et al., 2020; Wood & Alsawy, 2016) and results in better outcomes (Resnick & Rosenheck, 2008; Sidani, 2008). Despite this recognised importance, Lundqvist and Schröder (2015) report patients in forensic care are often not satisfied with the opportunities provided for them to participate in discussion or collaborate in their own care.

Keeping themselves to themselves, a disinterest in their patients

Although spoken about less than the positive relationships with staff, participants did voice their frustrations at staff sometimes appearing disinterested in engaging with patients. There was a shared belief amongst participants that some staff would only spend time with patients when it was considered absolutely necessary for them to do so. This often related to staff being more interested in engaging with each other than patients, as the following participants comment:

> I have had it before when I have been sat in the day area for 3-4 hours and no one starts approaching me. That is not uncommon, but it is dependent on the staff team and it is dependent on the staff that are on shift … Like you could probably sit in the day area for a couple of hours and the staff wouldn't speak to you. And they would happily sit there and talk amongst themselves and have conversations amongst themselves. Not all staff, but it does happen. (Joseph, HSU)

> I find that some staff are not really engaging … But I would rather they was. Because I like to talk. When I say I like to talk

> I like to talk about real things, like real life. And if we are speaking about real life then I am ready to be awake, I don't need to be in my bed coz of that, I would be having a good conversation with someone. But if I find that it's a dreary reality and I just see staff talking to themselves, I mean amongst themselves, and I can't really fit into that. Then I find that's a problem. You know? I would rather that staff was more engaging. (Alex, HSU)

In these extracts one participant describes a time where he "sat in the day area for 3-4 hours" without a member of staff interacting with him. In this extract he suggests that this lack of engagement is not due to the staff being physically unavailable but that "they would happily sit there and talk amongst themselves", inferring there is a distinct lack of interest in engaging with patients, but that this is "not all staff". The second participant also refers to "some staff" rather than all staff when discussing the lack of engagement but is clear that he would prefer staff to make more of an effort to "talk about real things" with him. He implies that "a good conversation" with staff would be motivation to get out of bed and also comments on staff seeming more interested in their conversations with each other rather than patients. He describes this as "a problem", which has been reported by patients previously by Marklund et al. (2020).

Staff time and attention has been reported as valuable (Bonner et al., 2002) and the above examples present missed opportunities by staff to engage patients. This disinterest is then disruptive to the therapeutic relationship and patient motivation (Nijdam-Jones et al., 2015; Olsson et al., 2015; Sainsbury et al., 2004). Many participants acknowledged that there were times when staff were busy writing notes or undertaking other tasks which required prioritising and so were unable to engage with patients on the ward. However, these obstacles may be interpreted by patients as staff intentionally avoiding time with them (Gilburt et al., 2008) due to their lack of interest. The above accounts describe a physical presence of staff, but a lack of interest to engage with patients around them.

This passivity from staff may have been interpreted as uncaring. This may understandably lead to patients questioning staff intentions and desire to work in such a role, and their commitment to providing care (Stenhouse, 2011) which may cause frustration. Previous studies have reported that patients experienced staff as disengaged, without genuine interest in patients and just taking the job to earn a living (Benson et al., 2003; Carlsson et al., 2006; Nijdam-Jones et al., 2015). Forensic inpatients have previously been described as just "killing time" (Farnworth et al., 2004; O'Connell et al., 2010) and with longing for authentic personal interactions being triggers for violent encounters (Carlsson et al., 2006), meaningful interactions with staff are incredibly important.

A more concerning example was provided about a time when a patient was distressed and was not approached by staff. This participant said:

> You could see on my face that I'm really upset, you can see that I'm scared and not one staff, after hours of sitting down would come up to me and say you alright, you look like you need someone to talk to and stuff like that. (Tom, MSU)

In this extract the participant describes being visibly "really upset" and "scared", hoping for a member of staff to check in with him, but he was not approached or offered support. It is unclear as to whether staff recognised his distress and ignored this, whether "after hours of sitting down" he had no contact with staff at all, or whether staff saw him and did not realise he was distressed. Either way, this presents a situation where staff may not be paying enough attention to their patients and may be perceived as lacking understanding of their patients' problems. Staff's disinterest could be detrimental to patient wellbeing and this, as well as patients feeling ignored by staff, has been reported as a potential trigger for aggressive behaviour (Bonner et al., 2002; Clarkson et al., 2009; Meehan et al., 2006; Olsson et al., 2015). It also may lead to patients withdrawing from relationships with staff who do not see their suffering or try to understand their lifeworld (Hörberg et al., 2012).

Authoritarian relationships and the perceived over exertion of power

Some participants described ways in which some staff would exacerbate the power imbalance present within these restrictive environments with their authoritarian approach. An approach utilised by staff which has been documented many times within the literature (e.g. Tomlin et al., 2018). Across accounts within the current study there was a shared belief that this approach was not utilised by the majority of staff, but by a few who possibly had a "chip on their shoulder" (Knowles et al., 2015, p. 469). These participants commented:

> Sometimes they exercise their powers in a different way. Meaning they know they are the authority and they take it out on patients. Not all the staff, just one or two. They will pinpoint one person and make his life a misery. (Daniel, MSU)

> You get threatened with seclusion … like well we'll put you in seclusion … we'll take this away if you, well take that away if you keep acting like that. (Stuart, HSU)

These extracts highlight the use of staff's "authority" to "threaten" patients with seclusion or removing privileges in order to control a patient's behaviour. One participant describes how staff "exercise their powers" and "take it out on patients", which implies a release of aggression in some form. He shares this can be targeted specifically at one person, making their "life a misery", which corroborates Mottershead et al. (2020) reports of bullying. This use of threats, coercion and misuse of power is reported throughout the literature (Gilburt et al., 2008; Knowles et al., 2015; Lilja & Hellzén, 2008; Meehan et al., 2004; Sequeira & Halstead, 2002) with Hörberg et al. (2012) suggesting this is part of daily life as a forensic inpatient, characterised by fear of punishment and can lead to a sense of mistrust towards staff (Gilburt et al., 2008). These actions from staff appear to be intended to remind patients who is in charge and evident staff's power (Olsson et al., 2015). Despite working within a hospital and therefore therapeutic setting, staff's behaviours at the times described above correspond with Morrison's

(1990) report of a culture of toughness, where a police-like role is adopted. This is supported by Goodman et al. (2020) who argues that staff assert their dominance, utilising coercive measures, rather than using other de-escalating techniques and this use of power to manage challenging situations frustrates patients.

The experience of staff being overly dominant, and potentially abusing their power in a structure of unbalanced power relationships was experienced through actual and symbolic acts. As the following participant comments:

> They think just because I'm a patient and just because they've got a set of keys automatically, in their mind, to them, I've got no insight, they can't mentally penetrate my character they can't see how I am they can't see who themselves are. They've got the keys, I'm the patient, they're clever, I'm stupid and I think that's what they assume … A lot of the staff are good you know and it's just yeah certain members of staff. The older generation … the old school staff, people round here call them the old school, oh your old school, you know, don't like you your old school. They've got an attitude towards patients. I've said to members of staff, younger members, I can't wait until men, mainly men in their 50s and 60s retire and go away and we have new people in their 20s and 30s working here just freshen the place up and be like modern and you know. Psychiatry is an archaic thing. It's got it roots in really bad behaviour, bad treatment of people. Lobotomies, dunking people in water and things like that. Injecting them with convulsants, all that shit. That's what this used to be all about behaving to people like that so like when these 60-year-old men working in here, when they were 20s and 30s, patients didn't get treated very kindly and they're still working in here, those men are still working in here and they think like, they're just men and there's competition, like some man thing going on where like they've got to be up here and we've got to be down there, they've got to put us down. (Toby, HSU)

Perlin (1991) describes the forensic relationship as an unbalanced one, by its very nature and this appears evident here. This participant states "they've got keys", which is a constant, visual and symbolic reminder of this power imbalance and he continues that this "automatically" means he has "no insight" and as the patient he is assumed to be "stupid" and staff are assumed to be "clever". When patients are seen as lacking insight, there can be an assumption that they need to be controlled, which can give rise to paternalistic behaviours by staff (Gildberg et al., 2010). This is in line with existing literature highlighting the patient-staff power divide, which nurses within forensic settings are reported to be acutely aware of (Holmes & Jacob, 2012). However, a recent study by Mottershead et al. (2020) reports patients feel subordinate, whereas this participant implies this is staff's perception of patients, rather than his own, supporting findings from a recent review that staff see themselves as higher-status (Tomlin et al., 2018).

The dynamic described within this extract has been previously framed as 'us vs them' within the literature (Barsky & West, 2007; Brunt & Rask, 2005; Dickens et al., 2005; Hörberg et al., 2012; Knowles et al., 2015; Larkin et al., 2009; Tomlin et al., 2020). This is thought to be more likely when patients are viewed in terms of their risk or illness, thereby accentuating the differences between the two groups (Barnao et al., 2015). This participant also states his hopes for when the older staff members retire who "put us down". He seems hopeful that there will be a shift in the care offered, with new younger members of staff "freshen[ing] the place up". He also uses the term "modern". This may refer to the change in societal views in the younger generations and the related reduced stigma for forensic inpatients, as well as the perception that newer staff will be informed by contemporary approaches to providing care within these settings (Barnao et al., 2015). His account supports Marklund et al. (2020) report that individuals utilising authoritarian and confrontational approaches are unsuitable for roles within forensic mental health care settings.

Conclusions

This research aimed to explore the patient-staff relationships within forensic mental health inpatient services, from the patient's perspective. The analysis suggests that where inpatients experience something akin to a positive therapeutic relationship they suggest staff needed to be respectful towards them and genuinely care, seeing them as individuals, rather than as a collective group who needed to be controlled. Further to this, the analysis suggests inpatients value staff understanding their individual needs, as well as collaboratively working with them, aiding them in finding their way through the forensic system, allowing them some control over decisions when possible. Additionally, the analysis suggests staff's seeming disinterest in getting to know the patients (choosing instead to engage with other staff members), as well as an authoritarian approach (which emphasised and exacerbated the power imbalance between the two groups) may act as barriers to the development of positive therapeutic relationships. These findings support the ideas surrounding the hindering or promotion of a therapeutic relationship presented within Schafer and Peternelj-Taylor (2003).

Participant accounts within the present study appeared more consistently positive than in previous research where "pockets of good care" which could be temporary, and irregular have been described (Hörberg et al., 2012, p. 745). Despite the noted problematic attitudes of some, staff were mostly described as positive, corroborating findings by Lammie et al. (2010) who investigated this from the staff perspective. The participants within this study appeared primarily satisfied with their patient-staff interactions, supporting findings within general psychiatric inpatient units (Molin et al., 2020).

As previously described, the majority of research within forensic mental health settings is conducted with staff as participants, including looking at the patient-staff relationship (e.g. Marshall & Adams, 2018). Studies which have focussed on the patient's experience, have commented on such relationships but focus on other aspects such as recovery or experience of care more generally (Askola et al., 2018; Hörberg et al., 2012) and restraint (Knowles et al., 2015). Therefore, the current study adds to the existing literature by specifically exploring patient-staff relationships from the

patient perspective, across low, medium and high secure forensic mental health settings.

Clinical implications and future research

Participants' accounts would suggest that when recruiting staff to forensic mental health settings it is of key importance to ensure potential staff have a genuine interest in engaging with patients in a meaningful way and a desire to listen, understand and work with patients, rather than seeing patients as purely ill, risky and needing to be controlled. Specific training about the importance of collaborative working with patients and the importance of maintaining the therapeutic relationship may also be helpful. However, this training is likely only to be beneficial to the right type of staff, as characteristics such as kindness and friendliness are more likely to be inherent rather than established from training (Cleary et al., 2012) and therefore the responsibility for providing a caring environment is placed on both the individual staff member and the care organisation (Hörberg et al., 2012). There also may need to be more consideration from services about the necessity of regular protected time for all staff to spend with patients without set agendas or clinical tasks, but as time dedicated to developing and strengthening the therapeutic relationship by getting to know their patients. This greater understanding of the individual may help also strengthen case formulation within teams which can help guide decision making (Hart et al., 2011).

Despite the development of the therapeutic relationship being of great importance, staffing levels within forensic services are often based on security concerns, as providers tend to prioritise safety and security rather than other caring needs (Hinsby & Baker, 2004). An evaluation of staffing levels in relation to the wards' ability to consistently provide person-centred care may be beneficial as it may highlight a need for new policy guidance relating to increased staffing levels. As the therapeutic relationship has shown to be important in the effective management of violence and aggression (Goodman et al., 2020) and recovery within forensic settings (Marshall & Adams, 2018) and more generally across mental health care (Hartley et al., 2020) responding to patient needs in ensuring adequate staffing (both in numbers and staff characteristics) may help to ensure person-centred care and promote individual recovery. As forensic inpatients typically reside within the secure environment for much longer than within general psychiatric settings there are many opportunities for these positive relationships to develop, which have the potential to positively impact a patient's quality of life and progression through services (Knowles et al., 2015).

The current study explored male participants' experiences, but as previously stated, forensic inpatient services also provide support to females, with Harty et al. (2012) reporting there are 1,625 women's secure beds within England and Wales. It has been previously acknowledged that there are gender differences when it comes to needs within forensic services (Bartlett, 2004) and as it has been suggested that men and women experience relationships differently (Felton, 1986; Umberson et al., 1996), future research might explore whether female forensic inpatients have similar experiences and perspectives to the findings presented within this paper.

Additionally, the participants were recruited across hospital sites (low, medium and secure settings) and similar themes were found throughout participant accounts, irrespective of security level. Askola et al. (2018) investigated forensic psychiatric patients' perspectives on their care in Finland and report progression in relationships with staff as patients stay in forensic settings. Exploration into this would be beneficial to investigate whether this occurs with the UK forensic mental health system, the impact of this and also the factors which may be influential. For example, does this relate to patient's increased understanding of the system and the care provided over time? Or increased time aid the development of these relationships? Or does having less enforced restrictions as patients progress through the system place less tension on these relationships? Or are members of staff with perceived different characteristics being drawn to work in different levels of security? A further suggestion for future research might also be to explore forensic inpatient relationships with their peers and the impact of these relationships on their experience of living on the ward more generally.

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