Measuring Experiences of Restrictiveness in Forensic Psychiatric Care: Developing a Questionnaire

Jack Tomlin

LL.B, LL.M (Cum Laude)

Thesis Submitted to the University of Nottingham for the Degree of Doctor of Philosophy

May 2019

Table of Contents

LIST OF FIGURES **5**

LIST OF TABLES **6**

ABBREVIATIONS **8**

LIST OF SYMBOLS **10**

ACKNOWLEDGMENTS **12**

ABSTRACT **15**

CHAPTER 1 INTRODUCTION **17**

1.1 SUMMARY 18
1.2 INTRODUCTION 19
1.3 FORENSIC PSYCHIATRY IN ENGLAND AND WALES 21
1.4 RATIONALE AND AIMS OF PROJECT 31
1.5 STRUCTURE OF THE THESIS 35
1.6 A NOTE ON TERMINOLOGY 38

CHAPTER 2 THEORETICAL FRAMEWORK **39**

2.1 SUMMARY 40
2.2 AUTONOMY IN MENTAL HEALTH 41
2.3 RISK AND FORENSIC CARE 46
2.4 FORENSIC HOSPITALS AS TOTAL INSTITUTIONS 51
2.5 CONCEPTUAL CLARITY: DISTINGUISHING RESTRICTIVENESS 59
2.6 'LEAST RESTRICTIVE ALTERNATIVE' IN GENERAL PSYCHIATRY 67
2.7 CONCLUSION 68

CHAPTER 3 LITERATURE REVIEW AND CONCEPT ANALYSIS **70**

3.1 SUMMARY 71
3.2 DEFINING 'LEAST RESTRICTIVE' 72
3.3 AIMS AND RATIONALE 75
3.4 MATERIAL AND METHODS 76
3.5 RESULTS 79

3.6 Discussion 117
3.7 Situating this Study within Trends in the Literature 120
3.8 Limitations 121
3.9 Conclusion 122

CHAPTER 4 METHODOLOGY 124

4.1 Summary 125
4.2 Philosophical Underpinnings 127
4.3 Mixed Methodology 132
4.4 Methods 138
4.5 Qualitative Phase 138
4.6 Generation of the FRQ Items and Face Validity 150
4.7 Quantitative Phase 151
4.8 Data Collection and Sampling 166
4.9 Researcher Biography and Reflexivity 172
4.10 Research Ethics and Setting 173
4.11 Conclusion 178

CHAPTER 5 QUALITATIVE INTERVIEWS 180

5.1 Summary 181
5.2 Introduction 181
5.3 Participants' Demographic, Clinical and Legal Profiles 184
5.4 Results 188
5.5 Discussion 241
5.6 Summary 253
5.7 Conclusion 254

CHAPTER 6 DEVELOPING THE FRQ 255

6.1 Summary 256
6.2 Methods 256
6.3 Developing Items for the Pilot FRQ 257
6.4 Expert Assessment of Face Validity 264
6.5 Results 268
6.6 The Pilot FRQ 277

6.7 Conclusion 278

CHAPTER 7 PSYCHOMETRIC PROPERTIES OF THE FRQ.....280

7.1 Summary 281
7.2 Introduction..... 281
7.3 Methods 283
7.4 Hypotheses..... 286
7.5 Results 288
7.6 The Final FRQ 313
7.7 Conclusion 314

CHAPTER 8 DISCUSSION.....316

8.1 Summary 317
8.2 The Psychometric Properties of the FRQ 319
8.3 Factor Analysis and Restrictiveness as Subjective Experience . 320
8.4 Restrictiveness and its Relationship to Other Concepts 323
8.5 Recent Adverse Events and Restrictiveness 331
8.6 Restrictiveness across Demographic, Clinical, and Legal Profiles 333
8.7 Key Knowledge Claims..... 343
8.8 Limitations of the Present Study 346
8.9 Distinguishing Restrictiveness and the FRQ 351
8.10 Novel Contributions of the Present Study 352
8.11 Implications for Practice 354
8.12 Impact of the Study and Future Projects 356
8.13 Conclusion..... 359

REFERENCES.....361

APPENDICES.....383

List of Figures

Figure 2-1 The Model of Penal Consciousness (Sexton, 2016)..... 66

Figure 4-1 Study Outline Logic Mode..... 134

Figure 4-2 Questionnaire Development Protocol (Adcock & Collier, 2001) 137

Figure 4-3 Procedure for EFA from: Furr (2011) 158

Figure 5-1. Model of Restrictiveness 190

Figure 7-1 Scree plot of Parallel Analysis and PAF Factors..... 292

Figure 7-2 Histogram of FRQ total scores 298

Figure 7-3 Histogram of EssenCES total scores..... 298

Figure 7-4 Histogram of FQL-SV total scores..... 299

Figure 7-5. Scatter plot of correlation between the FRQ and EssenCES 300

Figure 7-6. Scatter plot of correlation between the FRQ and FQL-SV ... 301

Figure 7-7. Scatter plot of correlation between the EssenCES and FQL-SV 301

List of Tables

Table 3-1 Literature Review Inclusion and Exclusion Criteria 78

Table 3-2. List of Papers included in Literature Review 81

Table 3-3 Depiction of Themes Found in Literature Review..... 88

Table 4-1. Attributes of Qualitative Interviewing (Kvale, 2008)..... 140

Table 4-2 Inclusion and Exclusion Criteria 167

Table 5-1. Profiles of Interview Participants 186

Table 5-2 Most Widely Occurring Basic Themes 188

Table 6-1. Heuristic for Retaining, Amending or Removing FRQ Items . 266

Table 6-2. Profiles of Expert Participants 267

Table 6-3. Results of Expert Panel Feedback 271

Table 7-1 MCAR Scores for FRQ, EssenCES and FQL-SV..... 284

Table 7-2. Demographic, Clinical and Legal Profiles of Participants..... 288

Table 7-3. Initial Observed and PA Eigenvalues with Variance Explained (N=221) 292

Table 7-4. Items, Factor Loadings and Uniqueness Scores for the Unidimensional FRQ 295

Table 7-5 Internal Consistency of 15-Item FRQ (N=221) 296

Table 7-6 Total scores for the FRQ, EssenCES and FQL-SV..... 297

Table 7-7 Correlations between FRQ, EssenCES (and Domains) and FQL-SV 300

Table 7-8 Independent t-tests for FRQ, EssenCES and FQL-SV total scores between individuals experiencing adverse event and those not..... 304

Table 7-9 FRQ Scores by Ethnicity 306

Table 7-10 FRQ Scores by Security 307

Table 7-11 FRQ Scores by MHA Section..... 307

Table 7-12 FRQ Scores by Diagnosis 309
Table 7-13 FRQ Scores by Index Offence 310
Table 7-14 Interpreting FRQ Scores: a Preliminary Range 314
Table 8-1 Key Knowledge Claims of the Project 344

Abbreviations

ANOVA	Analysis of Variance
Art.	Article
BAME	Black and Minority Ethnic
CES	Coercion Experience Scale
CITC	Corrected Item-Total Correlations
CPA	Care Programme Approach
CPT	Committee on the Prevention of Torture and Inhuman and Degrading Treatment
CQC	Care Quality Commission
DoH	Department of Health
DSPD	Dangerous and Severely Personality Disordered
ECHR	European Convention on Human Rights and Fundamental Freedoms
ECtHR	European Court of Human Rights
EFA	Exploratory Factor Analysis
EssenCES	Essen Climate Schema
FQL-SV	Forensic Quality of Life – Short Version
FRQ	Forensic Restrictiveness Questionnaire
GLM	Good Lives Model of Offender Rehabilitation
HRA	Health Research Authority
IPP	Imprisonment for Public Protection
LoS	Length of Stay
LTS	Long Term Segregation
MDT	Multi-Disciplinary Team
MI	Mental Illness
MMR	Mixed-Methods Research
MoJ	Ministry of Justice
NHS	National Health Service
NICE	National Institute for Clinical Excellence

NPM	National Preventive Mechanism
OPCAT	Optional Protocol to the Convention Against Torture
PAF	Principle Axis Factoring
PD	Personality Disorder
QoL	Quality of Life
RC	Responsible Clinician
REC	Research Ethics Committee
SDT	Self-Determination Theory
TI	Total Institution
TNA	Thematic Network Analysis
YOI	Young Offender Institute

List of Symbols

α	Cronbach's Alpha
χ^2	Chi-square
η_p^2	Partial Eta Squared
§	Section
§§	Sections
ρ	Spearman's RHO

Research Dissemination

Conferences

2019	Toronto, Canada.	Ontario Shores Centre for Mental Health Sciences Annual Conference. Paper 'The Restrictiveness of Forensic Care: Measuring Patient Experience'
2018	Liverpool, U.K.	Paper 'The Restrictiveness of Forensic Care: Exploring Patient Experience'
2018	Cairo, Egypt.	LIFE Project Conference. Paper Forensic Patients and Late Modern Social Control; Paper Restrictiveness of Forensic Psychiatry: Patient Experience
2018	Antwerp, Belgium.	IAFMHS Annual Conference. Paper 'The Restrictiveness of Forensic Care: Exploring Patient Experience'
2018	Nottingham, U.K.	Royal College of Psychiatrists Forensic Section Annual Conference. Paper 'The Restrictiveness of Forensic Care: Exploring Patient Experience'
2018	Nottingham, U.K.	Mental Disability Law Conference. Paper 'The Restrictiveness of Forensic Care: Exploring Patient Experience'
2017	Nottingham, U.K.	CJRC East Midlands Postgraduate Conference. Paper 'The Restrictiveness of Forensic Psychiatric Care: A Concept Analysis'
2017	Brighton, U.K.	Sussex CRC Annual Graduate Conference. Paper 'Criminal Responsibility and Mental Illness: Are the Two Mutually Exclusive?'
2016	Nottingham, U.K.	Inaugural U.K. Mental Health Law Conference. Paper 'Conceptualizing Restrictiveness in Forensic Care: Tentative Findings from the Literature'
2016	Bath, U.K.	ESRC NCRM Research Methods. Poster 'Policies and care pathways in forensic-psychiatric care: Patient experience in two European countries'
2016	Nottingham, U.K.	IMH, 10 Year Anniversary. Poster 'Policies and care pathways in forensic-psychiatric care: Patient experience in two European countries'
2016	Helsinki, Finland.	Modern forensic in-patient facility design standards. Paper 'Conceptualizing Restrictiveness in Forensic Care'
2015	Warwick, U.K.	Long Stay in Forensic Psychiatric Services Training School.

Published Articles

Tomlin, J., Bartlett, P., & Völlm, B. (2018). Experiences of restrictiveness in forensic psychiatric care: Systematic review and concept analysis. *International Journal of Law and Psychiatry*, 57, 31–41

Tomlin J. (2019): Not Guilty by Reason of Insanity and the Recovery Paradigm: Are they compatible? *Journal of Recovery in Mental Health*. Vol. 2 No. 2/3 Winter/Spring

Tomlin, J., Egan, V., Bartlett, P., & Völlm, B. (2019). What Do Patients Find Restrictive About Forensic Mental Health Services? A Qualitative Study. *International Journal of Forensic Mental Health*, 1-13.

Articles under Review

Tomlin, J., Völlm, B., Furtado, V., Egan, V. & Bartlett, P. (2019/20).The Forensic Restrictiveness Questionnaire: Development, Validation and Revision. *Frontiers in psychiatry*. UNDER REVIEW

Tomlin, J., Bartlett, P., Völlm, B., Furtado, V. & Egan, V. (2019/20) Restrictiveness in forensic mental health: do demographic, clinical and legal characteristics matter? IN DRAFT

Blog Posts

Tomlin, J. (2016). Restrictiveness in long-term forensic psychiatric care: Report of a STSM in the Netherlands. Long-Term Forensic Psychiatric Care. COST ACTION: IS1302.

Invited Speaker Roles

Centre for Human Rights and Mental Health, Nottingham, U.K. *Interviewing forensic patients.* January, 2019.

Economic and Social Research Council, Nottingham, U.K. *Recruiting Participants in forensic psychiatric settings*. April, 2019.

Acknowledgments

I would foremost like to express my sincere gratitude to the Economic and Social Research Council. The ESRC funded my project and helped me develop the skills to become a researcher. This was my first empirical project and would have looked very different had I not received the training I have.

I also wish to thank the NIHR Clinical Research Network, staff based at all the participating sites, the participants involved and anyone else who helped along the way. My list of thanks extend to my internal and external examiners, anonymous peer reviewers, and everyone who critiqued my work and sharpened me as a researcher.

Some of the most significant support I have received comes from the friends I have made during my stay in Nottingham. Some of these, but not all, include: Yuwu, Stephy, Clare, Aaron, Emma, Emily, Jon, Ben, Matt, Cerys, Alessio, Aline, Harleen, Shaz, Joey, Iti and Steph. Thank you all.

I would not have completed this project were it not for my supervisors. Prof. Peter Bartlett, Prof. Birgit Völlm and Dr. Vincent Egan. Their unwavering support and insight taught me that academia does not have to be the high-stress, publish or perish, competitive environment it is so often painted as. It can be fun, too.

Finally, to my mother, father and brother who have supported me always; and to Emma, who will support me always.

For Faye,

You will probably never read this. And that's OK.

Your loving uncle.

Abstract

Forensic psychiatric care is often practiced in closed institutions. These highly regulated, secure and proscriptive environments can reduce autonomy, self-expression and personhood. Taken together these settings can feel restrictive as patients' active participation in clinical, organizational, community and personal life-worlds are curtailed.

Consequences of restrictive experiences have not been explored empirically. This study aimed to develop a psychometrically-valid measure of experiences of restrictiveness. This thesis presents the conceptualization, development and validation of the Forensic Restrictiveness Questionnaire (FRQ).

This project had a Mixed Methods Methodology. Semi-structured, qualitative interviews were conducted with 18 residents in low, medium and high secure hospitals in England. These explored patients' experiences of restrictiveness and were analysed thematically. The findings informed the conceptualization of the FRQ items. A pool of 65 items was sent to a panel of five experts in the field of forensic psychiatry for an assessment of face validity.

A revised 58-item FRQ was piloted with N=230 patients. The dimensionality of the FRQ was tested using Exploratory Factor Analysis. Internal consistency was investigated. Ward climate and quality of life questionnaires were completed by participants as indicators of convergent validity. Data were collected on participants' demographic, clinical and legal profiles to analyse variances in FRQ scores.

The qualitative analysis showed respondents described restrictiveness in five key ways. Patients' narratives help us understand: 1) the antecedent conditions to restrictive phenomena; 2) restrictive phenomena themselves; 3) how these are enacted in secure settings, 4) how these phenomena were subjectively experienced by residents; and 5) the consequences of these phenomena as expressed by residents.

The quantitative phase indicated that the FRQ has good psychometric properties. Factor Analysis revealed a unidimensional structure, indicating a single latent construct. Convergent validity was confirmed as restrictiveness was significantly negatively correlated with quality of life and ward climate. Internal consistency was demonstrated. Analysis of variance suggested individuals with a diagnosis of personality disorder scored significantly higher on the FRQ than peers with a mental illness diagnosis.

The data indicate that the final 15-item FRQ is a valid and internally reliable unidimensional measure. The correlations between restrictiveness and quality of life and ward atmosphere suggest these constructs are strongly linked. Any interventions concerning quality of care and living conditions must therefore recognise and address experiences of restrictiveness. The FRQ offers a novel and simple measure of an important phenomenon in forensic settings and has clinical and scientific implications.

Chapter 1
Introduction

1.1 Summary

This thesis is about the 'restrictiveness' of secure forensic psychiatric care. It was concerned with capturing subjective patient experiences of restrictiveness and synthesizing these into a valid definition. This definition was used to develop the Forensic Restrictiveness Questionnaire (FRQ). The FRQ allows us to measure these subjective experiences to see how restrictiveness changes over time; differs between patient groups or hospitals; and predicts recovery outcomes. Data collected from patient interviews and the FRQ help us to better understand the effects secure hospitals have upon their residents as they negotiate a complex journey of recovery and growth in conditions of deprived liberty.

The nexus between freedom and restrictiveness can be described as a 'penumbra' – the fuzzy outline of a shadow. This metaphor is adopted to describe the obfuscated space that exists between providing the level of restrictiveness needed to safely maintain a therapeutic milieu for each patient but also facilitate conditions that provide the maximum autonomy suitable to enable personal growth and respect human dignity. Forensic psychiatry's dual aims of treatment and reducing recidivism and harm are jeopardized when the restrictiveness of the setting exceeds that necessary to safely provide care – when the telos of care becomes carceral and notions of risk are excessive. The aim of this project is to add clarity to this penumbra by exploring and measuring patient experience.

1.2 Introduction

Forensic psychiatry is a subspecialty of clinical psychiatry (Sugarman & Dickens, 2015). As a discipline it aims to both treat patients suffering from a mental disorder who have committed an offence and protect that individual and the public from future harm. It therefore involves agents, regulation, and institutions of both the healthcare and criminal justice systems (Sugarman & Dickens, 2015). Patients need a suitable environment to recover and address criminogenic needs free from stigmatization and victimization. In turn the public expects protection from preventable harms (Urheim, Rypdal, Palmstierna, & Mykletun, 2011). The environment within which this care is provided is often therapeutically driven, yet risk-averse and highly secure. These two prerogatives pose significant challenges to staff when delivering care and necessitate a finely-balanced weighting of operational objectives (Cashin, Newman, Eason, Thorpe, & O'Discoll, 2010).

In attempting to provide treatment and manage risk, forensic psychiatry operates within prevention and protection models of liberty deprivation (Slobogin & Fondacaro, 2000). The prevention model presupposes that individuals may cause future harm to themselves or others and is not concerned with ascribing blame for past harm. It aims to prevent future harms through intervention and incapacitation. The protective model aims to *'assure autonomous conduct'* by restoring decision-making faculties to those deemed to lack capacity (Slobogin & Fondacaro, 2000: 506).

The rationales behind these approaches are important for this thesis. In both models, individuals are deprived of their liberty but for beneficent purposes – in the former the prevention of harm and in the latter the restoration of autonomy. These assumptions – that harm is undesirable and autonomy desirable – underpin a fundamental ethical tension in the practice of forensic psychiatry (Adshead, 2000).

This introduction chapter describes macro-level features of the forensic care system in England and Wales that are helpful in understanding why patients might find forensic settings restrictive. It describes the forensic system of England and Wales; the patient population; legal and human rights frameworks; and clinical best-practice guidelines. Features of forensic care that are helpful in developing an understanding of the 'restrictiveness' of secure hospitals are focused on. Finally, the rationale, aims and structure of this doctoral thesis are discussed.

The definition of restrictiveness evolves over this study from a broad conceptualization to workable operationalization, and finally a measurable set of questionnaire items. To preface this thesis, a broad conceptualization of restrictiveness is given:

> ***Definition One.*** *The restrictiveness of secure forensic care refers to any externally-derived (intended or unintended) negation of residents' autonomy that is against their will.*

1.3 Forensic Psychiatry in England and Wales

The current study investigates patients residing in secure hospitals in England. Thus, this section describes the characteristics of the forensic system and population of the jurisdiction of England and Wales.

1.3.1 Diagnoses, Beds, Length of Stay and Costs

In England and Wales forensic care is provided across penal, secure hospital, and out-patient settings. The NHS commissions approximately 7718 secure hospital beds across England and Wales annually and therefore serves a significant proportion of the mentally disordered offender (MDO) population (NHS England, 2015). There are approximately 795, 3192 and 3731 patients in high, medium and low secure care respectively (NHS England, 2015). The number of forensic beds in England and Wales have risen steadily over the preceding decades despite general psychiatric beds decreasing (Chow & Priebe, 2016).

Security levels are stratified to manage different levels of patient risk (Kennedy, 2002). High secure hospitals provide care at a level equivalent to maximum security prisons rated category 'A' or 'B'. Individuals in high secure settings must "*[…] require treatment under conditions of high security on account of their dangerous, violent or criminal propensities"* (§4 National Health Service Act 2006); and this risk must be *'[…] grave and immediate'* (NHS England, 2018b: 2). Medium secure settings provide care for patients that '*[…] present a serious risk of harm to others and whose escape from hospital must be prevented'* (NHS England, 2018b: 2). Low

secure services aim to treat patients that cannot safely be treated in open units and pose a significant risk of harm (NHS England, 2018a).

Forensic services are 'high cost, low volume' with high secure beds varying in cost from £271,560 to £357,335 per annum (Centre for Mental Health, 2013). Average medium and low secure beds costs £175,000 and £150,000 respectively (Centre for Mental Health, 2013). The total forensic budget (£1.2 billion) amounts to approximately 20% of the NHS mental health budget or 1% of the entire NHS budget (Centre for Mental Health, 2013).

Length of stay in secure care varies considerably. Indeed, a significant number of forensic patients are 'long-stayers': 24% of high secure and 17% of medium secure patients remain in high or medium secure settings for more than ten and five years respectively (Hare Duke, Furtado, Guo, & Völlm, 2018). The average length of stay in high secure care is 8 years; of those staying over 10 years, 3% have stayed over 20 years (Hare Duke, Furtado, Guo, Völlm, et al., 2018). In medium secure care, estimated averages vary from 2-5 years. However, accurate figures are elusive as patient notes often do not contain records of previous hospitalizations in other NHS Trusts.

Patient diagnoses are heterogenous. Psychotic disorders are the most prevalent diagnosis (approx. 60%), followed by personality disorders (approx. 20-45%) (Harty et al., 2004; Reed, 1997); however, most patients often receive dual (or more) diagnoses. Patients will also be admitted with comorbid substance abuse disorders; learning disabilities and neurodevelopmental disorders; affective disorders; and organic disorders

(NHS England, 2018a). These are diagnosed in accordance with ICD-10 categories. Individuals in secure care are often difficult to treat and present complex, sometimes treatment-resistant, symptomatology.

Treatment takes a biopsychosocial approach and there is a shift towards recovery principles (Mann, Matias, & Allen, 2014; Simpson & Penney, 2011, 2018). Care plans typically consist of various forms of cognitive therapies including cognitive behavioural therapy, dialectic behaviour therapy, cognitive analytic therapy, and schema therapy. Alongside these, programmes are offered for managing violence, aggression and substance misuse. Psychosocial therapies, psychoeducation, group activities and occupational therapies are also offered. The provision of these will vary between patients depending on their presentation, willingness to engage, relevance to criminogenic factors, and stage of care pathway. These will also vary according to hospital and the resources available.

There is an increasing adoption of patient-centred care tools to promote patient involvement in their recovery (NHS England, 2018a, 2018b). These include the DUNDRUM toolkit and the SAPROF protective risk factor measure, which have self-report components and are being adopted at some English sites. Efforts to reduce restrictive practices and promote relational security such as the Safewards model are being embraced by some centres (see also the Mental Health Safety Improvement Programme

to Reduce Restrictive Practices[1]). Further, medications aimed at alleviating symptoms of psychosis, anxiety, depression and somatic conditions including obesity and metabolic syndrome also feature in patient care plans (Long & Shine, 2015).

Studies reporting demographic data suggest approximately 80-85% of patients are male (Harty et al., 2004; Reed, 1997). Fewer female patients has led to a dearth of dedicated women's services (Thomson, Bogue, Humphreys, & Johnstone, 2001). Black and Minority Ethnic (BAME) individuals are overrepresented in the mental health system generally (The Mental Health Taskforce, 2016; Wessely, 2018); and a study of Special Hospital (now high secure) patients (N=1255) reported BAME individuals comprised roughly 18% of their sample[2] (Harty et al., 2004). The same study reported the majority of patients were single (approximately 70%) and were on average 40 years old (S.D.=11.2).

In summary, forensic services offer care to a heterogenous population. Patients' demographic, clinical and legal profiles can differ considerably. This has consequence on the possibilities to provide appropriate care, patients' willingness to engage in treatment, their experiences of the care setting, and interactions with staff and one another. It is likely that patients

[1] This is a collaboration between NHS Improvement (NHSI) the Care Quality Commission (CQC). This programme aims to reduce seclusion, restraint and rapid tranquilizations by 33% on participating wards.

[2] The closest United Kingdom census in 2001 found that BAME individuals made up 9% of the total U.K population (Office for National Statistics, 2012).

have experienced complex social and mental health problems and will require care for lengthy periods.

1.3.2 Legal, Human Rights and Clinical Care Provisions Relevant to Restrictiveness

Forensic patients are *de facto* and *de jure* deprived of their liberty. This section outlines the legal frameworks of England and Wales that place individuals within secure hospitals. It further details some of the relevant human rights instruments the U.K. is a signatory to. In particular it describes pertinent legislation within the Mental Health Act 1983 (as amended); the European Convention on Human Rights and Fundamental Freedoms; and briefly highlights the role of the European Committee on the Prevention of Torture and Inhuman and Degrading Treatment (CPT). Subsequent to this, relevant national best practice guidelines are described.

1.3.2.1 The Mental Health Act, 1983 (as amended)

Individuals residing within secure hospitals do so involuntarily. They are detained under the Mental Health Act 1983 (as amended). This Act allows for the involuntary detention of individuals under prescribed conditions. Patients are placed within forensic care primarily through sections 3, 37 and 47 of the Mental Health Act (1983), although other sections are used.

Section 3 is a civil commitment. This mandates the care of someone who poses a significant risk of harm to themselves or others that necessitates secure care, but who has not committed an offence. Section 37 is a 'hospital order' ordered by a Magistrates or Crown Court following the conviction for an offence and on the recommendation of two registered (forensic) medical

practitioners. Section 47, a 'prison transfer', might be ordered when an individual in a custodial setting presents with a mental disorder of sufficient gravity to warrant treatment in secure conditions. Those on a prison transfer may return to prison for the remainder of their sentence or continue on a care pathway through forensic services towards the community. A series of other sections concern civil assessment, forensic assessment, and individuals found unfit to plead.

These have an undefined temporality and are subject to review by the Mental Health Review Tribunal or following an appeal lodged by a patient. The tribunals listen to the views of the patient with reference to the advice of the patients' care team headed by their Responsible Clinician (RC).

Residents that present with an especially high risk of harm to themselves or others, of absconding, or have garnered media attention may have a 'restriction order' added to their section. This can be ordered by a Crown Court and is stipulated in section 41 MHA 1983 for hospital orders or section 49 MHA 1983 for prison transfers. This restriction order places extra limitations on patients' care pathways; for instance, discharges, hospital transfers, and grounds access need to be approved by the Ministry of Justice (MoJ) as well as the patient's care team.

1.3.2.2 The Council of Europe, ECHR and CPT

Various international human rights instruments shape the conditions of secure hospitals. Failure to adhere to these pose significant moral and legal concerns and may lead patients to experience feelings of unfairness, restrictiveness and degradation. For instance, the U.K. is a signatory to the

European Convention on Human Rights and Fundamental Freedoms (1950) (ECHR). Thus, it has an obligation to ensure citizens' right to life (art. 2 ECHR), and to a private and family life (art. 8 ECHR); to prohibit the use of torture or inhuman or degrading treatment (art. 3 ECHR); and to not enact unjustified deprivation of liberty (art. 5 ECHR).

These provisions intend to safeguard individuals from arbitrary, disproportionate and unjustified detention; facilitate patient individuality and expression; and maximize the exercise of agency in patients' private lives. In doing so these rights are the fundamental principles that underpin services characterised by humane and dignified practices and conditions. In Recommendation REC(2004)10 the Council of Europe makes plain that these rights should not be abrogated on the grounds of an individual's mental illness (Council of Europe, 2004: art. 4). It further provides that patients should receive care in the least restrictive environment possible (art. 8). This environment should:

> *'[…] provide each such person, taking into account his or her state of health and the need to protect the safety of others, with an environment and living conditions as close as possible to those of persons of similar age, gender and culture in the community. (Council of Europe, 2004: art. 9).*

The Council of Europe prescribes certain standards that psychiatric institutions must meet (Council of Europe, 1998). The involuntary placement in psychiatric establishments standards details requirements for adequate space, lighting, heating, and ventilation; appropriate decoration,

furniture, personal belongings, and visual stimulation; adequate sanitary facilities, food and personal clothing (Council of Europe, 1998: §§34-36). Patients should have individualized care plans with medication and therapy appropriate to their diagnosis. Staffing numbers and levels of training should be sufficient and restraint and seclusion used only when clearly defined in policy and necessary in that moment (§§37-50 Psychiatric Establishments CPT Standards).

The European Convention on the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (1987), of which the U.K. is a signatory, further enshrines the right of individuals not to suffer degrading treatment. This instrument provides for a committee to oversee compliance with the convention and make recommendations following institutional visits. These visits include forensic hospitals. The Committee on the Prevention of Torture (CPT) inspects five domains including patients' living conditions, treatments offered, staff, the use of restraint and seclusion, and legal safeguards. Recommendations carry political weight and member states typically respond in some manner to comments made by the CPT.

Of relevance for this thesis is a recent CPT report compiled after visiting institutions in the U.K. In this report, the CPT admonished the U.K. for the use of Long Term Segregation (LTS) at Ashworth and Broadmoor high secure hospitals (Council of Europe, 2018a). The report described several patients that had been placed within LTS for years with minimal meaningful activity and in some cases no opportunity to integrate onto their ward. The CPT stated that *"[…] in certain cases, the impact of LTS on patients amounts*

to inhuman and degrading treatment and that steps should be taken as a matter of urgency to review its use" (p. 81).

The U.K. is a member of the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984), which also enshrines individuals' right to be treated with dignity. This applies to in-patient care settings. An optional protocol (OPCAT) adopted in 2002 established a subcommittee to visit centres of detention and oversee National Preventive Mechanisms (NPM). These NPMs are charged with visiting centres with the aim of preventing torture and inhuman or degrading treatment similarly to the CPT.

1.3.2.3 National Policy and Best Practice Guidelines

In England and Wales various mechanisms aim to promote safe, clinical care. These include government policy; the National Institute for Health and Care Excellence (NICE) guidelines; Care Quality Commission (CQC) guidelines, investigations and subsequent reports on all institutions delivering healthcare; the Mental Health Act (1983) Code of Practice; the Department of Health; NHS Trust- and nation-wide initiatives such the CEQUIN MH3 on reducing restrictive practices in low and medium secure settings. Examples of these that are relevant for this thesis are described below.

The Department of Health asserts that high secure forensic care services "[…] should aim to meet individual needs and those of specific groups of patients […] to consider how recovery and reduction of risk can be best achieved" (Department of Health, 2010a: 1). It asserts forensic care should

be provided in a setting distinct from prison, aiming to integrate community interaction as individuals progress down levels of security (Department of Health, 2010a, 2011).

According to the Mental Health Act 1983 Code of Practice, involuntary hospitalization should be for the shortest period necessary and in the least restrictive hospital setting (DoH, 2015). The 'least restrictive' requirement is ubiquitous in mental health guidelines and parliamentary recommendations (Care Quality Commission, 2018; DoH, 2015; JCPMH, 2013; NHS England, 2018a, 2018b; NICE, 2011; The Mental Health Taskforce, 2016; Wessely, 2018).

The Code of Practice also states that any restrictions on patients should be the minimum necessary to provide care that is safe and regards patient rights and freedom of action. Patient-centred care should be prioritized, with blanket restrictions prohibited unless justified for that particular setting and necessary for safety and security (DoH, 2015).

NICE stipulates that any individual in hospital for mental health issues should be afforded access to meaningful activities that are culturally appropriate and also offered outside of a typical 9-5 working week (NICE, 2011: Quality Standard 13). It further stipulates that coercive measures including: control, restraint and compulsory treatment should not be used, unless effected competently, safely, with minimum force and where a last resort (NICE, 2011: Quality Standard 14).

The NHS has initiated a payment-incentive scheme to reduce restrictive practices in adult low and medium secure care settings (NHS England,

2017). The scheme rewards providers in the *"[…] development, implementation and evaluation of a framework for the reduction of restrictive practices […] in order to improve service user experience whilst maintaining safe service"* (NHS England, 2017: 1). Importantly, the scheme identifies restrictive aspects of care including: patients' liberty; grounds and kitchen access; use of telephones and mail; visitations; access to money and the internet; R18 materials; and bedroom and personal searches.

In summary, there exists a national and international framework of legal, clinical, and human rights guidelines that forensic services must operate within. This framework makes it incumbent upon secure hospitals to offer treatment in the least restrictive environment; maximize patient autonomy; ensure appropriate treatment and recovery conditions; provide legal safeguards; and minimize the use of coercive measures.

1.4 Rationale and Aims of Project

This chapter has thus far described several macro-level features of forensic care relevant for researching experiences of restrictiveness. Patient autonomy is explicit in contemporary frameworks of mental health. Discussing restrictions in forensic care is salient given the total nature of most secure settings and the consequences this can have on residents. To achieve the dual aims of treatment and harm reduction, forensic services must balance a secure environment and an autonomy-promoting therapeutic milieu (Adshead, 2000). Exploring how patients experience the restrictiveness of their care is thus crucial to our understanding of the iatrogenic effects of living in forensic settings.

Studies acknowledge the *de facto* and *de jure* restrictions upon forensic patients, but little systematic research has been conducted to bring these together from a patient perspective. Research has described characteristics of Total Institutions, coercion and coercive measures, repression in Young Offender Institutes, and the pains of imprisonment; but a more holistic framework for understanding restrictions on autonomy, self, and personhood; intended or unintended, within forensic hospitals from a patient perspective is wanting.

Given that a significant number of individuals are deprived of their liberty in secure hospitals in England and Wales for extended periods of time at significant financial cost to the state; it is important research continues to describe the conditions of this care, and the effects of secure confinement on recovery outcomes is measured. Exploring patient perceptions of restrictiveness will better our understanding of the iatrogenic effects of liberty deprivation and give voice to a highly marginalized and ostracised population.

Many forensic patients led isolated lives prior to arriving in hospital, experiencing high levels of social exclusion and stigma (Coid, Kahtan, Cook, Gault, & Jarman, 2001; Mezey, Youngman, Kretzschmar, & White, 2016). Many have also spent periods of time in institutional settings without meaningful social bonds. These experiences have been associated with poor mental health outcomes (Caldas-Almeida, Mateus, & Gina, 2016; Kawachi & Berkman, 2001), and criminal offending (Chambliss, 1973; Hirschi, 1969; Mbuba, 2012). It is problematic that the forensic system might calcify these

conditions in more total ways; leading to greater isolation, social exclusion and stigma, and institutionalization.

Consequently, a clear operationalization of restrictiveness is needed. This should facilitate better understanding of patient experience and the antecedents and consequences associated with these experiences. A measurable definition that reifies subjective experiences of restrictiveness will help fill gaps in our knowledge.

Some unanswered questions include: do patients find elements of care restrictive; how significant are identified restrictions for patients; do patients experience restrictions similarly to each other; do they describe changes to their sense of self; are there meaningful differences between groups of individuals given their demographic, clinical and legal profiles; does the presence of a recent adverse event shape perceptions of restrictiveness; and do these experiences correlate with indicators of recovery such as quality of life (QoL) and ward atmosphere?

In effort to bring us closer to answering these questions the present study prioritizes the narratives and experiences of patients. In doing so, it responds to calls for further patient involvement in research (Coffey, 2006). Indeed Markham (2018) writes: *"[k]nowledge about the experiences of forensic psychiatric patients is sparse, therefore, clinical care cannot sufficiently be adjusted to the needs of these patients"* (p.26). Further, Horvath and colleagues (2018) highlight that:

> *"[o]btaining narrative accounts and getting an insight into personal front row experiences, especially narratives of those patients living*

under regimented conditions, may enable a better responding to the needs of patients within the forensic mental health services and prospective outcomes" (p.4).

To capture patient experience and generate a valid and reliable measure of restrictiveness this project adopted a mixed methods research methodology (Creswell & Clark, 2007; Teddlie & Tashakkori, 2009). The result of this inquiry was the Forensic Restrictiveness Questionnaire (FRQ). The FRQ is a 15-item self-report instrument derived from patient experience. The FRQ captures the subjectivity inherent in patients' descriptions of restrictiveness and offers a tool for both academic and clinical use. The FRQ is an important tool for provoking dialogue between staff and patients and directing changes in care plans to promote autonomy or explain restrictions.

This doctoral project had the following purpose and objectives:

Purpose

1. The purpose of this project is to understand if, what and how patients experience elements of secure forensic psychiatric care as restrictive.

Primary Objective

1. The objective of this project is to generate a questionnaire to measure subjective experiences of restrictiveness in secure forensic psychiatric care.

Secondary Objectives

1. To explore and operationalize patients' experiences of restrictiveness in secure forensic psychiatric care settings.

2. To develop a preliminary questionnaire to measure patients' subjective experiences of restrictiveness in secure forensic psychiatric care.
3. To assess the psychometric properties of a piloted questionnaire developed to measure patients' subjective experiences of restrictiveness in secure forensic psychiatric care.

1.5 Structure of the Thesis

Chapter One. Introduction

This chapter introduced the project, its rational and aims; and described macro-level aspects of the forensic system in England pertinent to an exploration of restrictiveness. It was proposed that individual autonomy is crucial in contemporary mental health approaches, yet this is significantly curtailed in forensic psychiatric settings. Understanding and measuring this restrictiveness was identified as the aim of this project.

Chapter Two. Theoretical Framework

Chapter two highlights the competing prerogatives of managing risk and maximising patient autonomy. Forensic settings are described as 'Total Institutions'; features of which have relevance for studying restrictiveness. Individual experiences of coercion, repression, and imprisonment are drawn upon to distinguish restrictiveness from similar subjective phenomena.

Chapter Three. Literature Review and Concept Analysis

No holistic definition of patients' experiences of restrictiveness exists in the literature. This chapter thus describes a literature review conducted to

identify aspects of care that reduce patient autonomy. These were synthesized using a concept analysis framework to conceptualize restrictiveness. This conceptualization informs the content of the qualitative interviews reported in chapter five. Literature considering forensic hospitals was selected to limit the scope of the review and ensure the FRQ is context specific.

Chapter Four. Methodology

Chapter four describes the mixed methods methodology used to answer the study's aims. The philosophical underpinnings and rationale for qualitative and quantitative methods is described. These are situated within a framework for developing and validating psychometric questionnaires. The methods for data collection and analysis are described alongside issues of researcher reflexivity, data protection and obtaining informed consent.

Chapter Five. Qualitative Interviews

This chapter reports the findings of 18 interviews with patients in low, medium and high secure settings. Resident narratives of restrictiveness were subjective and meaningful. A model derived from the data helps us understand 1) why elements of care might be restrictive; 2) what phenomena are frequently discussed as restrictive; 3) how these phenomena are enacted in an intended or unintended manner; 4) subjective experience of the severity and salience of these; and 5) the consequences restrictiveness might have for individuals.

Chapter Six. Developing the FRQ

Chapter six reports on the process of developing a pool of items for the FRQ. Eighty items were generated from the qualitative data presented in chapter five. The face validity of these were reviewed by colleagues and a panel of experts in forensic psychiatry. Consequently, 58 items were selected for the pilot FRQ.

Chapter Seven. Psychometric Properties of the FRQ

This chapter describes the process of piloting and assessing the psychometric properties of the FRQ. This was a national, multisite study involving 16 NHS Trusts and 230 patients. The dimensionality of the FRQ was tested using Principle Axis Factor Analysis (PAF) and parallel analysis. Internal consistency was explored with Cronbach's α. Ward climate (EssenCES) and quality of life (FQL-SV) questionnaires were completed by participants as indicators of convergent validity. The relationship between FRQ scores and both recent adverse events and demographic, clinical and legal profiles are reported.

Chapter Eight. Discussion

This final chapter situates the results described in chapter seven in current literature, with particular attention to the relationship between the FRQ and both ward atmosphere and quality of life. It identifies the key knowledge claims of this thesis, its limitations, anticipated clinical and research uses of the FRQ, and actual and potential future research projects.

1.6 A Note on Terminology

Respondents in this study are referred to interchangeably as patients, residents, individuals, respondents, and participants. This is because there is no universally accepted label that individuals in mental health settings wish to adopt (e.g. Staves (2016)). I do not use the term 'service user' as I think it denotes a commercial relationship that is problematic. However, where individuals self-identified as service users then this was respected and written as such.

The term 'mental illness' refers to ICD-10 200-290 diagnoses. The term 'mental disorder' is used to refer to the range of diagnoses represented with secure settings; encompassing a diagnosis of schizophrenia, personality disorder and otherwise.

Chapter 2
Theoretical Framework

2.1 Summary

The present chapter aims to describe the theoretical underpinnings that informed the conceptualization of restrictiveness for this study. This is accomplished in three parts. First, the penumbra between providing the level of restrictiveness and risk management needed to safely maintain a therapeutic milieu but also facilitate conditions that promote maximum individual autonomy is addressed. Individual autonomy is described and situated within contemporary models of mental health care including: the Good Lives Model of Offender Rehabilitation, Self-Determination Theory, and the Recovery paradigm. Subsequent to this, the role that risk assessment and management plays in secure care is discussed. It is argued that risk prevention strategies are a dominant factor in shaping the restrictiveness of forensic hospitals.

Second, to better frame patient experiences of restrictiveness and contextualise this within a larger academic literature, work exploring features of other Total Institutions[3] is presented. This literature is engaged to better understand Total Institutions as social spaces and draw parallels with forensic settings. Particular attention is paid to describing Total Institutions as a theoretical construct; how procedures operating with Total

[3] The concept of the Total Institution (Goffman, 1961) is discussed in more detail subsequently, however the term includes in-patient psychiatric settings, elderly care homes, prisons, military barracks, monasteries, boarding schools and other social spaces that are enclosed and separated from wider society to a large extent.

Institutions shape the identities of their residents; and how power and control are mobilized within these spaces. Thus, this section presents a meso-level perspective on secure settings that builds on the macro-level description offered in chapter one.

Third, individual experiences of general psychiatric, penal, and young offender institutes are described. This section draws on concepts that are conceptually similar to restrictiveness in forensic settings, including: coercion in psychiatric settings, repression in Young Offender Institutes, and punishment within penal settings. These helped inform the way restrictiveness was thought of and conceptualized in the present study and distinguish it theoretically. This section offers a micro-level perspective on experiences of Total Institutions, building on the meso-level description preceding it.

2.2 Autonomy in Mental Health

The previous chapter highlights an explicit intention in mental health services to preserve patient autonomy as much as possible. This is clear in efforts to reduce restrictive practices, provide care in the least restrictive environment, and legal safeguards on liberty deprivation. In this regard, autonomy is normative value woven into much mental health provision. This reflects contemporary Western values. Besides providing the groundwork for much humanist and enlightenment thinking (Pagden, 2013); notions of autonomy and self-determination are present in foundational legal texts (e.g. the United Nations Universal Declaration on Human Rights (1948); the European Convention on Fundamental Freedoms and Human Rights (1950);

the Bill of Rights of the United States of America (1791); the French Declaration of the Rights of Man and the Citizen (1789), and so forth.

Contemporary models of mental health and offender rehabilitation embrace these notions of individual autonomy. They incorporate concepts such as autonomy, empowerment and self-determination; seeing these as crucial in achieving positive outcomes. These include the Good Lives Model of Offender Rehabilitation (Ward & Brown, 2004), Self-Determination Theory (Deci & Ryan, 2008), and the Recovery Paradigm (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Simpson & Penney, 2018). The role autonomy plays in these models is described in the following paragraphs.

2.2.1 The Good Lives Model of Offender Rehabilitation

The Good Lives Model of Offender Rehabilitation (GLM) is a conceptual model with empirical support that has been applied in both forensic and penal settings (Barnao, Ward, & Robertson, 2016; Bouman, 2009; Ward & Brown, 2004). The GLM proposes that rehabilitative interventions should not focus solely on risk-reduction strategies but should also aim to promote an individuals' abilities, strengths, personal interests, and opportunities to live a good life. This good life is characterized by the fulfilment of fundamental human goods, the attainment of which has been positively associated with well-being (Ward & Brown, 2004).

The GLM proposes that there are nine 'fundamental human goods. One of these, 'Excellence in agency', concerns autonomy and self-directedness. These are thought of as inimical to individuals living a good life. The model

supposes that it is the frustration of an individual's ability to realize these valued fundamental goods that is criminogenic.

Within a GLM framework, Bouman and colleagues (2009) explored the association between subjective well-being as an indicator of life fulfilment and recidivism in forensic outpatients diagnosed with a personality disorder (PD). The authors found that satisfaction with health and life fulfilment (of which self-directedness is an indicator) had a mediating effect on short-term self-reported deviant behaviour when controlling for risk-levels, and a buffering effect on long-term official reoffending behaviour (Bouman et al., 2009).

2.2.2 Self-Determination Theory

Self-determination theory (SDT) asserts that autonomy and the degree to which it is exercised by an individual is key to achieving effective functioning and psychological health (Deci & Ryan, 2008). SDT proposes that such functioning and health are predicted by basic and universal psychological needs. These needs are: competency, autonomy and relatedness. The degree to which these are thwarted or realized in different environments results in a typology of motivations or 'causality orientations'.

An autonomous orientation sees the satisfaction of an individual's competency, autonomy and relatedness in different contexts. A meta-analysis of studies exploring the relationship between domains of SDT and mental health outcomes was conducted (Ng et al., 2012). The analysis of 184 data sets found that domains of the SDT model, i.e. measures of

competency, autonomy and relatedness, were positivity associated with outcome measures of mental and physical health.

The autonomous orientation directs individuals towards affiliation, generativity and personal development. Alternatively, 'controlled' and 'impersonal' orientations consist of a partial or total absence of these three universal psychological needs and is associated with rigid functionality, diminished well-being, poor functioning, and self-derogation (Deci & Ryan, 2008).

2.2.3 The Recovery Paradigm

Forensic psychiatric care is increasingly adopting principles of the recovery movement (Drennan et al., 2014; Mann et al., 2014; Simpson & Penney, 2018). Recovery is a process of living with and through mental disorder. Recovery is typically defined as an inherently subjective experience (Leamy et al., 2011). It may be considered a journey or an end-point. Anthony (1993) defines recovery as *"[…] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles […] and a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness"* (p. 527).

Empowerment features in multiple accounts of recovery (Leamy et al., 2011). Conceptualizations emphasize that individuals should play a role in planning their care, daily life, and take responsibility for their actions. This empowerment is contingent on a notion of autonomy and the ability to act as an independent agent (Jacobson & Greenley, 2001). In doing so, individuals utilize knowledge and self-confidence when given the

opportunity to make meaningful choices in life. These choices rely on a willingness to take risks and to step out of safe routines that necessitate a concomitant responsibility over one's actions. The recovery paradigm therefore presupposes that individuals with mental disorders ought take responsibility for, and through empowerment, self-determine their actions (Leamy et al., 2011).

Studies highlight that implementing recovery principles in forensic settings can be problematic, however. A literature review of qualitative studies investigating forensic patients' experiences of recovery identified five themes: connectedness, sense of self, coming to terms with the past, freedom, hope, and health and intervention (Clarke, Lumbard, Sambrook, & Kerr, 2016). These mirror recovery models in non-forensic settings; but suggest the addition of concerns idiosyncratic to forensic settings. These include acknowledging criminal actions and criminogenic factors, and negotiating restrictions on developing ones' self and exercising autonomy in secure environments.

Autonomy, self-determination and living a good and meaningful life are values that reflect broader paradigm shifts in the provision of mental health care. These shifts have their roots in various social, political and economic reforms of the 1950s and 60s (Pouncey & Lukens, 2013). It became less common to consider that the treatment of individuals with serious mental disorders was best provided in large psychiatric asylums cut off from society (Goffman, 1961; Chow and Priebe, 2013). Instead, there were movements to empower patients, and provide care as close to the individual's home setting as possible in the least restrictive manner.

To summarize, the GLM, SDT and Recovery paradigm are contemporary mental health models that highlight the importance autonomy is perceived to hold in achieving a good life; reducing recidivism and risk; increasing positive mental health outcomes; fostering decision-making capacities; and furthering patient integration into the community. Restrictions on patient autonomy are worth exploring in this project given the normative, positive and protective role individual autonomy plays in mental health recovery. Thus, these propositions are a key rationale for studying and measuring the restrictiveness of secure care from patients' perspectives.

2.3 Risk and Forensic Care

Forensic settings aim to provide a level of security that minimize risk but maintain a therapeutic milieu. Risk assessment and management are consequently dominant aspects of secure care. Risk is the possibility of something adverse happening; it is *"[…]the product of the probability of a harm occurring and the extent or magnitude of the resulting loss"* (Markham, 2018: 18). The degree to which patients are considered risky shapes the conditions, particularly the restrictiveness, of their treatment. This section describes the predominance of risk management in secure care; patient-specific and cultural explanations for this; problems with measuring risk; and the implications risk management can have for the restrictiveness of care.

Risk management is present in all features of secure care. Foremost, patients are mapped into low, medium or high secure hospitals due to their assessed riskiness (Kennedy, 2002). Risk thus provides the *raison d'etre*

for the structure of the secure system and directs the placement of patients. The primacy of risk can be seen in the legally mandated use of risk assessment instruments when approving leave, grounds access, and food brought in by family visits (High Security Directions, 2013).

Risk is further embedded in guidelines for the design of secure built-environments, including the most appropriate paint-types and plant varieties (Department of Health, 2010a, 2011; Seppänen, Törmänen, Shaw, & Kennedy, 2018); staff induction trainings that stress the dangerousness of the patient population prior to providing breakaway and self-defence training (field note, 2016); and the enacting of 'blanket rules' to prevent individuals from engaging in past harms committed by other patients (CQC, 2017). As noted by a clinical staff member in Dein and colleagues (2016) *"[…] everything in this unit [MSU] is risk based […]"* (p.19).

There are two explanations for the prominence of risk management processes. The first concerns the patient population. A precondition for placement within secure care is that an individual has committed a criminal act or is considered to pose a significant risk to themselves or others (NHS England, 2018a). Indeed, §4 of the National Health Service Act 2006 stipulates that for admission into high secure care, patients must have *"[…] dangerous, violent or criminal propensities"* (§4 National Health Service Act 2006).

The probability of self-harm or aggression is heightened in forensic populations. Forensic patients are more likely to self-harm than the general

population and approximately 30% of all offenders have committed some form of self-harm during their incarceration (Jeglic, Vanderhoff, & Donovick, 2005). These behaviours have been attributed to features of secure settings and the psychopathology of patients. Reasons for self-harm in forensic patients include depression and suicidal intent, manipulation of the environment, the regulation of emotions, and as a response to psychosis (Jeglic et al., 2005).

Aggressive and socially disruptive behaviours occur in mental health settings (NICE, 2015). Such behaviours include verbal and physical threats and aggression that may lead to serious injury or death. Past history of violence, psychopathy, individual psychopathology, situational triggers, and the restrictiveness of secure environments have been identified as predictors of aggression (Hill, Rogers, & Bickford, 1996). Psychosis, when coupled with substance misuse, has been associated with violence and violent offending (Fazel, Gulati, Linsell, Geddes, & Grann, 2009). Aggressive behaviours are detrimental to ward atmosphere, patient recovery and the well-being of staff (NICE, 2015). Forensic settings are likely to experience high levels of aggression given the complex mental health needs of most patients and their (criminogenic) history of harmful behaviour.

The second explanation for the salience of risk management is socio-cultural. The prediction and management of harms has been cited by some as a feature of Late Modern societies (Beck, 1992; Garland, 2001; Rose, 1998). Social theorists have argued that new modalities of social control have emerged that aim to model riskiness and exclude risky groups (Feeley & Simon, 1992). These approaches are actuarial in nature and have

developed to contain a constellation of risks unique to the 20th and 21st centuries (Beck, 1992).

Examples of this include the use of preventive detention for sexual offenders (Simon, 1998); Anti-Social Behavioural Disorders that exclude individuals from certain geographical spaces (Lewis, Crawford, & Traynor, 2016); the Dangerous and Severe Personality Disorder programme (Rutherford, 2006); the emergence of the Imprisonment for Public Protection (IPP) sentence (these are no longer issued; however, some inmates still reside in prisons given the imposition of an IPP sentence issued prior to its discontinuation); ubiquitous use of the HCR-20 in forensic settings to measure risk; and the emergence of Artificial Intelligence probabilistic tools to assist in sentencing convicted individuals.

Custodial sentences further illustrate the trend towards excluding groups of individuals considered risky. In England crime rates have been decreasing since the mid-90s; however, the prison population has increased from approximately 35,000 to 82,698[4] over the same time period (The Prison Reform Trust, 2018). Such a trend suggests a socio-cultural tendency towards the incarceration of deviant groups (Garland, 2001; Goshe, 2017).

Risk management leads to restrictive practices. Relational, procedural and physical security protocols are enacted to contain risk (Department of Health, 2010b). These security measures can reduce patient autonomy. High fences are built to prevent unauthorized exit or entry into secure

[4] As of 20th July 2018 (The Prison Reform Trust, 2018).

spaces (Seppänen et al., 2018); routine searches are conducted on patients' rooms and bodies (CQC, 2017); residents are frequently observed (Holmes & Murray, 2011); and so forth. The cumulative effect of risk-reducing security measures reduces patient autonomy and self-determination. Oftentimes these measures are clinically necessary; however, accurate risk is difficult to calculate.

Risk assessment and management has traditionally embraced actuarial tools with a positivist epistemology, focusing on static historical variables predicting aggression. Recent approaches are more nuanced and consider static and dynamic risk factors alongside protective factors and clinical judgement (de Vries Robbé, 2014; Hannah-Moffat, 2005). However, efforts to establish sufficiently reliable indicators of future harm are not perfect (Buchanan, 2013).

No single method or instrument exists that accurately predicts harm; indeed, "*[r]isk thinking tames chance, fate and uncertainty by a paradoxical move*" (Nikolas Rose, 1998: 180). Accordingly, where the management of risk leads to restrictive practices, this opens the possibility of individuals being subject to inappropriate levels of restriction. Studies have historically demonstrated that a significant number of forensic patients have been placed at inappropriately high levels of security. Harty and colleagues (2004) found that 40% of high secure residents surveyed were suitable for transfer to conditions of lower security.

In summary, risk is important for understanding the restrictiveness of secure care for three reasons. First, a patient's perceived riskiness, a

perception epistemic and naturally subject to miscalculation (Buchanan, 2013), will play a role in deciding which context to place him/her in. Increased levels of security are more restrictive and 'total'. Second, a culture of risk aversion that exists within forensic settings colours service provision (Markham, 2018). A focus on risk can lead to an emphasis on security over therapeutic interventions and reflective organizational thinking (Mann et al., 2014). Third, a risk-averse culture conflicts with models of mental health care including the Good Lives Model, Self-Determination Theory and the Recovery Paradigm that embrace patient autonomy, empowerment, positive risk-taking, and participation in treatment (Mann et al., 2014; Simpson & Penney, 2018; Ward & Brown, 2004).

2.4 Forensic Hospitals as Total Institutions

In the present section of this chapter meso-level features of secure settings are explored. As the focus of this thesis is secure in-patient settings, accounts of analogous institutions are chosen to guide the exploration of restrictiveness. Erving Goffman's (1961) work on Total Institutions provides the conceptual frame for this discussion. It is argued that in forensic hospitals, a type of Total Institution, processes of depersonalization and regimes of control can restrict patients' sense of self and ability to self-determine – constituent elements of the GLM, SDT and the Recovery paradigm.

The 'ideal-type' Total Institution offers a helpful lens to understand three important elements of secure settings that are relevant for this thesis. First,

Goffman (1961) offers a cogent description of Total Institutions that helps us understand what forensic hospitals are like; second, organizational features of Total Institutions shape the identity of residents in ways that have important consequences on patients' identities; and third, power and control over residents in Total Institutions is encompassing; thus, understanding these structures helps makes sense of patients' experiences of restrictiveness. For rich ethnographic contributions, this section draws on literature exploring general psychiatric in-patient facilities, elderly care homes and prisons.

2.4.1 Total Institutions

Total Institutions are defined as "[…] a place of residence and work where a large number of situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life" (Goffman, 1961:11). Forensic care settings are often large, enclosed spaces with secure perimeter fencing, and high levels of security wherein visits are regulated. Inhabitants may not be afforded leave, might have legal restrictions placed upon them, and lose contact with the outside world for indefinite periods of time. Indeed, forensic patients' lives may be significantly (if not fully) encapsulated within the hospital.

There are four central features of the Total Institution. First, all aspects of life are conducted in the same place under the same authority; second, each phase of life and activity is conducted amongst others doing the same; third, activities and phases of life are tightly regimented and scheduled under a system of imposed rules from single authority; and finally, all these

are brought together under a single plan to fulfil the aims of the institution (Goffman, 1961). These attributes thus shape the nature of interactions, activities and personal pathways experienced by patients within forensic hospitals.

It has been argued that the Total Institution are not entirely 'Total'. Critical structuralist accounts argue that such institutions represent techniques of social control. They argue that so-called Total Institutions reproduce in the minutiae of residents' lives technologies of discipline, control and reform that reflect wider social control efforts (Foucault, 1977; Holmes & Murray, 2011; Wacquant, 2010). In this sense these spaces are not distinct from society, but rather institutions enacting wider social structures. For reasons of space, these arguments are not discussed further in this thesis.

2.4.2 Processual Features of Total Institutions

Residents of Total Institutions experience processes that change them. Goffman writes:

> *"In our society […] a formal instrumental organization does not merely use the activity of its members. The organization also delineates what are considered to be officially appropriate standards of welfare, joint values, incentives, and penalties. These conceptions expand a mere participation contract into a definition of the participant's nature or social being" (Goffman, 1961:164).*

To this end, the admitted individual is smoothed over; their unique qualities and traits shorn away by the institution. Elements of one's life and pre-existing notions of self can be lost or taken away systematically. Hobbies,

habits, personal belongings, community roles, occupations, social networks and daily routines can be lessened or precluded entirely. In more debasing regimes the admitted are given uniform clothing, haircuts, identity numbers, and are finger-printed and showered upon entry marking a severing of previous social roles (Goffman, 1961).

According to Goffman (1961) an individual entering a Total Institution such as a psychiatric hospital, prison, or monastery will undergo a 'mortification of the self'. Through a series of punishments and rewards for behaviour within the institution, the loss of previous support structures, an absence of activities to engage in, and (for some) complete isolation from the external world, a patient's identity is re-formed (Goffman, 1961; Chow & Priebe, 2013). In Goffman's formulation, the reformed self is constituted of those actions, interactions, thoughts and beliefs deemed desirable by the institution.

The consequences to these processes of depersonalization and mortification were also discussed by Russell Barton who developed the dated diagnostic, 'Institutional Neurosis' (Jones & Fowles, 1984). For Barton, institutional neurosis was a diagnosable condition, amenable to treatment. Barton identified seven 'causes' underlying institutional neurosis including a regime of enforced idleness; the bossiness of medical staff; the loss of personal friends, possessions and events; prescribed drugs; ward atmosphere; and the loss of future prospects (Jones & Fowles, 1984).

These 'causes' would manifest in a symptomatology wherein patients were apathetic; lack initiative; lose their interest in the outside world and future

events; become submissive and resigned; and experience deteriorating personal habits and standards. Barton even proposed that patients suffering from institutional neurosis might develop a particular gait and stance.

This loss and reconstitution of self has also been discussed in elderly care homes. Peter Townsend described a similar process in which elderly patients led dull, isolated lives and felt lonely with 'stoic resignation' (Jones & Fowles, 1984). Individuals would undergo a process of 'depersonalization'. Townsend writes of the residents that:

> *"[t]heir mobility is restricted, and they have little access to general society. […] They are subtly oriented towards a system in which they submit to orderly routine, lack creative occupation, and cannot exercise much self-determination […] the result for the individual seems fairly often to be a gradual process of depersonalization" (Townsend, 1962 quoted in Jones & Fowles, 1984).*

Contemporary literature describes the institutionalizing effects of such settings. According to Chow and Priebe (2013), institutionalization – the long-term effects of an institution upon a resident – is born of four characteristics: the bricks and mortar of the institution; the policy and legal frameworks regulating care; clinical responsibility and paternalism in clinician-patient relationships; and patient's adaptive behaviour to institutionalized care (Chow & Priebe, 2013). The process of institutionalization is therefore the result of multiple features of the institution and can have restricting and detrimental effects upon residents.

In summary, processual features of Total Institutions are such that residents' lives may be significantly shaped by the setting. The features of secure environments, isolation from wider social interaction, durations of stay, and the clinical and relational aspects therein are likely to shape the identity of forensic patients. The total and routinized nature of these sites are further likely to curtail residents' ability to self-determine.

2.4.3 Power and Control in Total Institutions

When enforcing risk management strategies and implementing legal sections of the Mental Health Act 1983, forensic hospitals enact power over patients. Risk management techniques, treatment regimens, and procedural and relational aspects of daily life in secure hospitals thus control residents, limiting autonomy for reasons beneficent or elsewise. This section explores what this control looks like, and how power can be experienced by residents.

Asylums have been criticised as sites for controlling the mad, the bad and the underclass (Rose, 1998). Recently Seppänen and colleagues (2018) wrote that *"[…] the development of psychiatric institutions has been characterised as coercive, confining and their buildings as the embodiment of discipline and control, the exercise of power over the socially deviant"* (p.2).

Power in Total Institutions has been described in myriad ways: soft, covert, overt, coercive, hard, physical, relational and procedural (Bergk, Flammer, & Steinert, 2010; Crewe, 2007, 2011; Crewe, Liebling, & Hulley, 2014; Foucault, 1977; Holmes & Murray, 2011). It is directed at staff, visitors and

residents and may be met with passive acceptance, ambivalence, gentle resistance or explicit contestation (Crewe, 2007; Goffman, 1961; Rubin, 2016). This section describes how power emanating from the institution is mobilized downwards towards residents.

Foucault (1977) proposed that the management of social deviants over the 18th and 19th Centuries underwent a transition in which punishment for deviant behaviour once public, barbaric, expressive and indicative of monarchical power was replaced by a subtler, smoother and more insidious 'disciplining'. This aimed to orient individuals into certain frames or ways of being and doing. Boarding schools, barracks and prisons used routine and habit to shape and mould the soul rather than the body.

Foucault (1977) drew on Jeremy Bentham's 'panopticon'; a circular prison wherein cells are situated, centrifuge-like, around an observation tower. Unique to the panopticon is the ability of those staff inside the observation tower to watch all inmates without being seen by those same inmates. In Foucault's eye's this was Modern social control writ-large. Inmates would be uncertain whether the gaze of staff might reach their cell at a particular moment and self-discipline themselves so as to avoid possible sanction. No overt power was needed to discipline the inmate into conforming to the institution's aims (Holmes & Murray, 2011; Shearing & Stenning, 1997).

This 'governmentality', is drawn upon in contemporary penal and TI literature (Crewe, 2007, 2011; Scott, 2010). Crewe (2007) describes the Late Modern prison as one in which power is opaque, bureaucratic and distant, operating through incentive schemes and expert knowledge. Power

is not primarily coercive, violent or economic; rather it lies in the production of normative consent and legitimacy held towards the aims of the prison and its regime. Autonomy is limited and choices are directed, nudging inmates into certain behaviours. Scott (2010) describes self-regulation in modern Total Institutions thusly: *"[t]he disciplinary gaze is not merely transmitted but reticulated: dispersed and refracted through an agentic network"* (Scott, 2010: 221).

Crewe and colleagues (2007; 2011) explored inmates' experiences of power in prisons in England. Respondents found this Late Modern variant of control confusing, oppressive and distal. Staff 'on the ground' were seen to embody the power of the institution but not represent it. 'Expert' staff with particular skillsets – managers, psychologists, parole boards – were conversely described as repressive, extensive and increasingly powerful. This power had no discernible base against which to protest and expected behaviours were not always apparent.

Inmates disliked the bureaucratic tendencies of the institution. Such opaque control delegitimized the penal regime (Crewe, 2007). Sexton (2016) reports that illogical penal strictures worsened inmates experience of punishment. Where perceived as illegitimate or illogical, penal regimes are at higher risk of inmate resistance and rebellion (Rubin, 2016). Inmates spoke of playing the carceral system and conforming simply to avoid stagnation. For residents, this formal rationality was *"[…] in conflict with genuine concerns to rehabilitate, and meaningful assessments of truth and risk"* (Crewe, 2007: 264).

The above suggests that power and control operating within Total Institutions is not the simple enactment of coercive measures, regulation or prohibitive security. The involuntary and indefinite nature of forensic care; competing care and custodial prerogatives; and conditions of high security crystalize into unique modalities of power (Cashin et al., 2010; Holmes, 2005; Holmes & Murray, 2011; Horberg, Sjogren, & Dahlberg, 2012). The restrictiveness of forensic care has a dialectic relationship with autonomy; one mediated to some extent by the power and control maintained in the setting. Therefore, exploring power structures in Total Institutions helps us to understand in what forms restrictiveness manifests.

In summary, forensic hospitals can be characterised as a form of Total Institution. Patients' experiences of the restrictiveness of the setting are born of and shaped by the meso-level environment. Key to understanding this environment is Goffman's (1961) description of Total Institutions. Applying the Total Institution frame to forensic settings sheds light on how patients, particularly their sense of self, might be reformed; and how the unique modalities of power enacted in Total Institutions contribute to this. Processes of depersonalization and obscure regimes of control can obfuscate patients' sense of self and ability to self-determine – constituent elements of the GLM, SDT and the Recovery paradigm.

2.5 Conceptual Clarity: Distinguishing Restrictiveness

This thesis has identified some macro- and meso-level traits of the forensic system in England. Space was dedicated to secure sites as Total

Institutions, and the interplay between risk management and individual autonomy. Presently this chapter addresses micro-level considerations. Specifically, this section identifies constructs that describe individual-level experiences that are similar to restrictiveness. This discussion aims to situate subjective experiences of restrictiveness within a conceptual network by focusing on: coercion in psychiatric settings, repression in Young Offender Institutes (YOI), and punishment in penal settings.

2.5.1 Coercion

Coercion, typically understood, presents serious ethical and clinical challenges. Coercion and coercive measures might be enacted in the best interests of the targeted person or for the protection of others around that person (Soininen, Kontio, Joffe, & Putkonen, 2016). Coercion might further be used for discipline, order or preventing escape (Albrecht, 2016). In either case, evidence for the effectiveness of coercive interventions in psychiatry is sparse (Ewington, 2016). This is in large part due to the ethical issues of randomizing potentially harmful measures (Elcock & Lewis, 2016).

Research on the consequences of coercion is also hindered by issues of definition. Coercion is variously operationalized as: a discrete list of interventions such as: restraint, seclusion and forced medication (Bergk et al., 2010; Hui, Middleton, & Vollm, 2013; Kallert et al., 2005); the process of involuntary hospitalization (Gardner, Hoge, & Bennett, 1993; Høyer et al., 2002); threats, pressure or the absence of choice (Szmukler, 2015). Distinctions have been made between objective and perceived coercion (Bergk et al., 2010; Kjellin, Høyer, Engberg, Kaltiala-Heino, &

Sigurjónsdóttir, 2006). Defining coercion is also complicated by claims that the manner in which coercion exists within an institution is cultural and idiosyncratic (Cope & Encandela, 1998; Ewington, 2016; Urheim et al., 2011). However, these definitions typically share in common the requirement of an action; that the coercion is intended by others and restricts the autonomy of the coerced (Newton-Howes & Banks, 2014).

Coercive measures have predominantly been linked to negative consequences for patients. Coercion can lead patients to feel there was a violation of their human rights, disrespected, not heard by clinicians, and dehumanized (Newton-Howes & Banks, 2014). Patients that have experienced perceived coercion are less likely to consider staff as helpful; hindering the development of positive therapeutic relationships (Cope & Encandela, 1998). Kontio et al. (2012) found coercive measures undermined satisfaction in care, treatment adherence, and violated patient autonomy. When subject to coercive measures patients experienced negative emotions, a lack of communication, unmet basic needs, reduced access to activities, and insufficient information from staff.

It will become apparent over the course of this thesis that aspects of coercion – where defined as an action deliberately enacted by one party over another – are relevant for the operationalization of restrictiveness. Indeed, coercive measures constitute some of the most severe curtailments of autonomy in psychiatric settings. However, drawing on data collected in patient interviews restrictiveness will be operationalized to include intended and unintended restrictions experienced by patients. This point is developed in chapter five.

2.5.2 Repression

Repression expands the concept of coercive measures and coercion. De Valk et al. (2017) explored youths' experiences of repression in Dutch open, secure, and forensic Young Offender Institutes. Repression was defined as:

> *"[…] a series of transactional processes between youth, authority figures, and the organizational approach and structure, characterized by an authority figure intentionally acting in a way that harms the youth, or by an authority figure, unlawfully or arbitrarily depriving the youth of liberty or autonomy, fuelled by institutionalization and intrapersonal processes in authority figures (fear, rationalization, lack of empathy, dehumanization), mediated by interpersonal processes (socialization and identification)" (de Valk et al., 2016: 14).*

The authors found experiences to be characterized by perceived abuses of staff power; a lack of agency in decision-making; confusing or arbitrary rules; dehumanizing care; and an acceptance or resignation to this repression as *"[i]t is just the way it is"* (de Valk et al., 2017: 16). They assert that repression threatens the basic psychological needs identified in Self-Determination Theory (De Valk, Kuiper, Van Der Helm, Maas, & Stams, 2018).

Repression differs from restrictiveness in two ways. First, the latter is broader in that patients in the present study described some restrictions that are not enacted by authority figures. Indeed, other patients, public perceptions, and systemic features of forensic care coalesced into restrictive experiences for some residents.

Second, repression was defined as the negation of liberty and autonomy. For the concept of restrictiveness this is broader, encompassing: autonomy, self, and personhood. These variables extend the range of detrimental effects of restrictiveness beyond one's autonomy of movement, choice, and capacity, to include one's identity and humanity. This is discussed further throughout the thesis.

2.5.3 The Pains of Imprisonment

The penal literature offers conceptual frameworks for understanding how inmates subjectively perceive punishment. Two recent contributions are outlined here: the pains of imprisonment as depth, weight and tightness (Crewe, 2011; Crewe et al., 2014); and the model of penal consciousness (Sexton, 2015).

Crewe (2011) proposes that the pains of imprisonment can be conceptualized as the depth, weight and tightness of carceral life. The depth of imprisonment experienced by an inmate concerns the distance they have until freedom and autonomy outside. The weight of imprisonment is the extent to which relationships with staff and other prisoners; the expression of rights and privileges; the material standards and conditions of the prison; and the quality of life experienced therein are enabled or precluded by the prison regime and subsequent psychological burden these carry (Crewe et al., 2014).

Tightness is the way in which control is expressed, given life, and experienced by the inmate. The tightness of this control is the extent to which forms of control play on the inmate. Tightness asks to what extent

control *"[…] wraps [inmates] up, smother[s] them and incite[s] them to conduct themselves in particular ways"* (Crewe, 2011: 522).

These ideas can help us understand the way in which restrictiveness might be experienced in forensic settings. Depth may concern the actual distance a patient is from release into the community, supported care, or progressing through the forensic care system to lower levels of security. It could be the expression of one's length of stay, legal frameworks or level of security that direct this time period. Weight could concern the extent to which forensic patients may feel burdened by their care setting. If a patient feels restricted by a range of controlling and coercive elements of their care, or by perceived systemic injustices, then their experiences of autonomy, choice and expression might be commensurately affected.

Tightness might express the manner through which the restrictive elements of care are implemented; referencing the degree to which restrictive elements are constructed, implemented and enacted toward patients. Tight restrictions might refer to strictly enforced rules on the conditions in which patients may eat, drink, or go on leave. Loose restrictions may include the implicit enforcement of staff attitudes that preclude sexual intimacy between patients. Conceiving of restrictiveness in such a way, i.e. the depth, weight and tightness experienced in forensic care suggests such experiences are likely subjective, nuanced, and complex.

2.5.4 The Model of Penal Consciousness

The Model of Penal Consciousness is drawn on in this thesis to frame patients' subjective experiences of restrictiveness. It will be revisited in

chapter five. Sexton (2015) proposes that the extent to which a prison inmate feels punished is a product of the degree to which a concrete referent is interpreted as a symbolic punishment.

A concrete referent might be the denial of a cup of coffee or the forced shaving of one's hair. A symbolic punishment would be the degree to which an inmate considers this to affect their autonomy, self or personhood. Autonomy refers to an individual's self-determination and the range of choices available to them. 'Self' concerns one's individual characteristics and unique traits. It refers to those identifiers that make individuals so uniquely 'them'. Personhood captures one's existence and status as a rights-bearing human being. Negations of personhood deny individuals of their humanity, defining them alternatively as animals, cogs, numbers or something less than human.

An inmate might experience the forced head shaving as more severe if they felt this reduced their ability to express their 'self' and exercise autonomy of choice; and the precluded cup of coffee as less so if this affected autonomy of choice only. This experience will have increased salience if it was unanticipated by the inmate. If inmates expect the presence or severity of a symbolic punishment, then this will have less salience than an unanticipated one. The greater the severity and salience, the more the punishing experience. This is depicted in Figure 2-1.

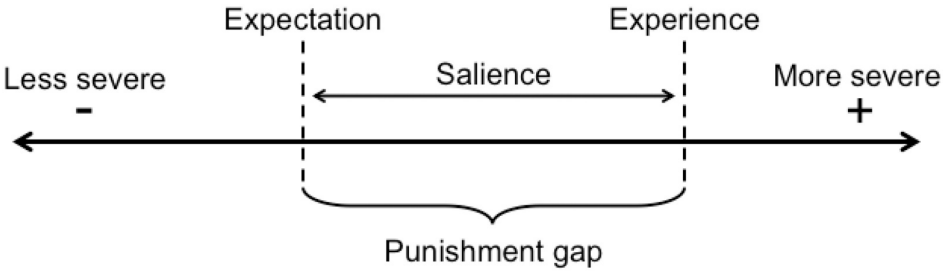


Figure 2-1 The Model of Penal Consciousness (Sexton, 2016)

Applying this to restrictiveness in forensic settings, elements of care (concrete referents) may be considered more restrictive the greater they are perceived to have infringed upon oneself symbolically. Felt as restricting one's self or personhood, certain aspects of forensic care may feature more prominently in residents' accounts of restrictiveness than those perceived to restrict autonomy only. Familiarity with secure services would, according to Sextons' (2015) model, have consequences on how restrictiveness is experienced; the longer patients are in secure care, the more familiar they are with the setting. Consequently, the expectation-reality gap might be smaller for these individuals leading to lower salience.

In summary, there exists the need to further explore restrictive experiences of secure care. Studies in coercion, repression and imprisonment have demonstrated that a range of negative consequences can follow. Defining and measuring restrictiveness specific to forensic settings from patients' perspectives will draw on and expand our understanding of life in Total Institutions. Exploring aspects of the forensic system that are not captured by the above constructs is thus an aim of this study

2.6 'Least Restrictive Alternative' in General Psychiatry

General psychiatry has long been concerned with providing care in the least restrictive environment (Appelbaum, 1999). Since the 50s and 60s there have been efforts to locate patients close to their communities and reduce the number of residents in in-patients settings (Pouncey & Lukens, 2013). This is evidenced in the deinstitutionalization movement seen in many European and North American states. For instance, following a large social movement including politicians, academics and medical professionals, the passage of the 'Basaglia law' in Italy in 1978 saw the steady closure of its general psychiatric asylums (Carabellese & Felthous, 2016; Fioritti, 2018).

At a similar time in the U.S, 'least restrictive alternative' was a mechanism used in courts to advocate moving patients into community settings (Appelbaum, 1999). A rationale for 'least restrictive alternative' was summarized in U.S Supreme Court case *Olmstead* majority opinion by Justice Ruth Bader Ginsberg, that placement in institutions '*perpetuates unwarranted assumptions that persons so isolated are incapable or unworthy of participating in community life*,' and '*severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment*' (*Olmstead v. L.C.*, 1999 WL 407380 (1999)).

In the U.K, the meaning 'least restriction' has in general psychiatry has evolved in recent years (Ranjit, 2016). Current guidance on providing care in the least restrictive environment comes from the Mental Health Act Code

of Practice (2015). This Code implies that detention under the MHA 1983 is per se restrictive and only used where voluntary treatment or treatment offered through other legal mechanisms are not appropriate (Ranjit, 2016). It stipulates: '*Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained'* (Mental Health Act Code of Practice, 2015: 23)

The reasons for this move towards providing care in minimally restrictive environments include broader shifts recognizing individuals with mental illness as social actors with equal rights to social participation. Parallel developments emerged in relation to other socially isolated groups or minorities (Pouncey & Lukens, 2013). Service user and recovery movements drove these shifts alongside increasing recognition within psychiatric care settings that large asylums might be detrimental for some patients' outcomes and that advances in psychopharmaceuticals that helped equip people to manage psychotic symptoms closer to home.

Cognizant of the wider debates regarding least restriction in general psychiatry, this thesis proceeds concerned only with the concept as understood within a forensic context. This is to ensure a clear focus for the thesis and maintain fidelity to forensic settings for the purposes of developing a measure of restrictiveness in forensic contexts only.

2.7 Conclusion

This chapter has presented the theoretical framework that underpinned the present study. The dual prerogatives of individual autonomy and risk

management were described and located within contemporary models of mental health care and offender rehabilitation. Meso-level aspects and micro-level experiences of Total Institutions relevant for conceptualizing restrictiveness in the present study were then identified. The following chapter builds on these accounts of Total Institutions by focusing solely on forensic hospitals. It describes a systematic literature review conducted to identify aspects of care considered to be restrictive.

Chapter 3
Literature Review and Concept Analysis

3.1 Summary

The previous chapter gave an overview of aspects of Total Institutions. This helped develop an emerging understanding of how restrictiveness may be conceptualized within forensic settings. Relationships, processes, and power dynamics were described in penal and general psychiatric settings. This overview was intended to inform the systematic literature review and concept analysis in the present chapter.

This review helped to conceptualize restrictiveness within forensic settings only. The purpose of the literature review was to aid in the development of the methodology of this project, further define a preliminary conceptualization of restrictiveness, and inform the development of questions asked within qualitative interviews. The review also aimed to situate the thesis within trends in the forensic literature and identify relevant knowledge gaps.

The structure of this chapter is as follows. The concept of 'least restrictive' is explored. It is argued that this maxim does not have a shared definition, and the plurality of definitions typically have not drawn on patient perspectives. This is followed by the aims and methodology of the present review. The results of the review are described thematically. These findings are then discussed, linked to literature identified in chapter two, and used to situate the present thesis. This chapter is a revised and updated version of Tomlin, Bartlett, and Völlm (2018).

3.2 Defining 'Least Restrictive'

The Mental Health Act (1983) Code of Practice stipulates that care should be provided where in the least restrictive manner or setting (DoH, 2015). This principle is now ubiquitous in mental health care policy (JCPMH, 2013; The Mental Health Taskforce, 2016). The prioritization of conditions of least restriction and promoting autonomy is embedded in recent models of mental health such as the Good Live Model and the recovery paradigm (Leamy et al., 2011; Ward & Brown, 2004). In forensic services, the least restrictive alternative clashes with conditions of high security and detention (Pouncey & Lukens, 2013). Thus, 'least restrictive' in forensic settings led to the development of the restrictive practice pyramid (Ewington, 2016); and the preference for relational over physical and procedural security (Department of Health, 2010b). These developments encourage the use of talking and interpersonal leverage to assist in supporting patients through acute moments that may lead to harm, rather than using restraint, seclusion, or forced medication.

The least restrictive maxim is present internationally. For instance, Salize et al. (2002) found that of the fifteen EU member states they investigated, thirteen codified the notion of 'less restrictive' facilities or medication into law. Law in thirteen states underlined involuntary admission and treatment as an 'ultima ratio'. 'Least restrictive' was commonly considered as a general philosophy of 'paramount importance' (Salize, Dreßing, & Peitz, 2002).

The requirement to provide mental health care in the least restrictive setting is also present in North America. In Canada the Ontario Court of Appeal has held that when considering the disposition of not criminally responsible (NCR) patients, the Ontario Review Board's decision must be 'necessary and appropriate in the circumstances', with consideration of the 'least onerous and least restrictive' disposition (Osawe (Re), 2015 ONCA 280).

The U.S. Supreme Court in *Olmstead* held that where conditions are met, states are required to transfer general psychiatric residents from institutional settings to community care. These conditions include whether transfer is clinically appropriate; can be reasonably accommodated; is not opposed by the resident concerned; and having consideration for state's resources and other residents' needs (Olmstead V. L. C. (98-536) 527 U.S. 581 (1999)). Thus, an expectation exists internationally that mental health care be provided in a way that is minimally restrictive.

In England, least restrictive practices (LRPs) typically refers to alternative interventions taken by staff in moments of patient crisis or aggression (Elcock & Lewis, 2016). However, it not apparent that restraint, seclusion, and forced medication are the only aspects of secure care that patients might describe as restrictive. A recent study qualitatively explored patients' experiences of LRPs in an English medium secure unit. Sustere and Tarpey (2019) asked residents whether LRPs increased autonomy and recovery.

The authors found that participants felt LRPs led to more positive risk-taking, greater levels of responsibility, and less judgement from staff (Sustere & Tarpey, 2019). They reported that patients and staff had

different definitions of LRPs and there was a lack of transparency around the use of LRPs. When asked how LRPs affected their lives on the ward, residents identified restrictions on social interactions, which made them feel isolated; and restrictions on their ability to take control over aspects of their care, particularly in relation to risk management. Residents also described wanting more leave to go to the cinema or having their own room keys. Respondents therefore had a broader understanding of LRPs and phenomena that would restrict autonomy than restraint, seclusion, and forced medication.

Another recent study investigated least restrictive practices from a patient perspective. Hui (2017) interviewed 28 patients residing within a high secure hospital in England. She distinguishes between restrictive interventions as *"[…] measures that intend to control or contain patients beyond the daily norms of their hospital environment. These include the uses of physical restraint, mechanical restraint, chemical restraint (rapid tranquillisation), seclusion and segregation"*; and restrictive practices, which *"[…] relate to the broader context of confinement, notably, the physical ward environment, ward dynamics, atmosphere and routines. These may also include and be influenced by the hospital rules, regulations and cultures, notably; the physical, procedural and relational security measures that occur within a high security hospital"* (p. 1).

Hui (2017) reports that restrictive interventions were experienced by patients as humiliating, fear-provoking, degrading, inhumane, anxiety-provoking, and detrimental to dignity. Residents described restrictive practices as encompassing close confinement with others, a lack of private

space, and few personal belongings. They expressed feeling frustrated by confusing or unfair rules and regulations. They suggested the environment promoted dependence on others and described feeling physically and mentally confined. Hui's (2017) definition of restrictive practices, explicated here by patient experience, mirrors participant's understandings of LRPs in the study by Sustere and Tarpey (2019). Thus, there appears a disconnect between patient and policy understandings of least restrictive practices.

3.3 Aims and Rationale

Recent efforts have been made to investigate patients' experiences of restrictive practices in high and medium secure settings (Hui, 2017; Sustere & Tarpey, 2019). Patient narratives extend beyond least restrictive measures understood as restraint, seclusion, and forced medication, to encompass wider features of secure care. However, the operationalization of a broader understanding of restrictiveness in forensic care derived from patient experience, inclusive of low secure settings, is under-researched. Indeed, *"[t]he notion of 'least restrictive practices' however, is not clearly defined"* (Ada Hui, 2017: 1). With a better understanding of this phenomenon we can explore the effects that restrictiveness can have on residents' recovery.

The present review aims to synthesize the defining attributes of a concept of 'restrictiveness' across forensic psychiatric care settings of all security levels. This chapter presents a literature review and concept analysis of empirical and policy literature that addresses restrictive features of secure care as described by residents, staff and academic commentators.

3.4 Material and Methods

3.4.1 Concept Analysis

This review is a qualitative concept analysis (Booth, Sutton, & Papaioannou, 2012). A concept is a mental construction attempting to *"[…] order environmental stimuli in a meaningful way"* consisting of *"[…] categories of information that contain defining attributes"* of certain social phenomena under investigation (Walker & Avant, 2011: 157).

Chow and Priebe (2013) propose:

> *"[u]nlike a standard systematic review, the aim of a conceptual review is not to review all literature but to search widely using various databases and sources; building in safety nets to minimize potential biases […] and incorporating some overlap in the various stages of the review process so that the precise direction of the review can be clarified" (p. 2).*

Walker and Avant (2011) state that concept analysis requires researchers to identify several features of the concept being studied. This review therefore identified 1) antecedent conditions to; 2) characteristic attributes of; 3) consequences of; and 4) 'deviant' cases of the concept of restrictiveness. This helps delimit a conceptual definition of restrictiveness and place it within a chronological order by investigating what phenomena may precede and result from it.

The categories identified by Walker and Avant (2011) were used to guide the presentation of the thematic analysis. These included the antecedents, characteristic attributes, consequences and deviant cases of restrictiveness.

Thematic analysis was conducted in accordance with the procedure outlined by Braun and Clarke (2006) and the superordinate and subordinate themes were placed within these four categories. Thus, the categories frame the presentation of the thematic analysis and the derived themes.

3.4.2 Search Strategy

The terms 'forensic', 'psychiatry', 'mental disorder', 'restrict', 'autonomy', and 'freedom'; and respective synonyms/antonyms were inserted in PsychINFO, Medline, EMBASE, Westlaw, PubMed, the Cochrane Library, Google Scholar and Google Search. A full list of search terms can be found in Appendix A. No geographical limit was specified, and sources published prior to April 2016 were included. Papers were included if written in the English language, had qualitative or quantitative empirical or policy content, were set in secure forensic facilities and included residents over 18 years old with any clinical diagnoses. Consistent with the concept analysis method, a wide range of sources was sought; however, these were limited to forensic hospitals to ensure fidelity to context, which is an important consideration in questionnaire development.

Documents needed to address restrictive elements of secure forensic care in a non-cursory way. This meant that at least a paragraph or sub-heading addressed a potentially restrictive element of care. Restrictiveness was initially conceptualized *any externally-derived (intended or unintended) negation of residents' autonomy that is against their will*. Papers were excluded if they were opinion pieces or book reviews; focused on staff experiences of coercive measures; set in prisons, general, or out-patient

care settings; or not in the English language. A full list of inclusion/exclusion criteria can be found in Table 3-1.

Table 3-1 Literature Review Inclusion and Exclusion Criteria

Inclusion Criteria	Exclusion Criteria
• Relate to research question • Empirical studies (qualitative or quantitative) • Conceptual pieces • Set in high, medium or low forensic secure in-patient setting • Any diagnosis • Patients >18 years • Papers were included if they had some empirical perspective of patients or staff, or data collected about patients relating to the concept of restrictiveness • Papers that did look at settings outside secure forensic care were included if they also addressed secure forensic care (e.g. a study comparing hospitals and prisons)	• Opinion pieces • Reviews of books • Prisons, general psychiatric, and out-patient settings • Papers that do not include a section with some substantive discussion of restrictive elements of care • Patients <18 years

3.4.3 Data Analysis and Synthesis

The method used to identify and synthesize features of restrictiveness was an inductive and deductive version of thematic analysis, which *"[…] involves identifying, analysing and reporting patterns (themes) within data […] minimally organiz[ing] and describ[ing] your data set in (rich) detail"* (Braun & Clarke, 2006). Coding was undertaken in the NVivo v.11 software package. As the analysis progressed and an emerging thematic framework could be discerned a deductive heuristic was incorporated (Fereday & Muir-Cochrane, 2006). Combining inductive and deductive approaches therefore provided a richer and more rigorous thematic framework to inform the

concept analysis. Themes were generated by myself and discussed with supervisors to strengthen the analytic validity of the results (Kvale, 2008).

3.4.4 Update to Literature Review

The results of this review were updated on the 28th January 2019. This timeframe commenced where the previous literature review stopped – 25th March 2016. The update utilized the same search strategy detailed above with the exception that only the first 150 instead of 300 results from Google Scholar and Google Search were scanned. The purpose of this update was to introduce new material into the deductive framework developed in the initial literature review. Articles that introduced results not incorporated into the initial literature review or disputed its findings were welcomed. The results section of this chapter presents the findings for both the original and updated review together.

3.5 Results

In the initial review conducted on 25th, March 2016 a total of 12,821 records were identified in database searches and a further 152 in Google Search and Scholar after hand-searching the first 300 results in each. After duplicates were removed, 8275 records were scanned for relevance. Ninety records were assessed for eligibility in light of the inclusion/exclusion criteria and 50 sources were included in the review. A PRISMA diagram of this process is illustrated in Appendix B. Articles originated from the U.K. (62%), Canada (10%), Sweden (10%), the United States (4%), Australia and New Zealand (4%) and five other European nations (10%). Three of the documents from the U.K. were Department of Health guidelines.

In the updated review conducted on January 28th, 2019 of a total of 1,131 records were identified in database searches and a further 23 in Google Search and Scholar after hand-searching the first 150 results in each. After duplicates were removed, 921 records were scanned for relevance. Fifty-three records were assessed for eligibility in light of the inclusion/exclusion criteria and 23 sources were included in the review. A PRISMA diagram of this process is illustrated in Appendix C. Articles originated from the U.K. (61%), Germany (13%), and one paper each from Canada, Finland, the U.S., Denmark, Australia, and an EU multi-site project. One U.K. document was a Care Quality Commission (CQC) guideline on reducing blanket bans. A full list of the 73 sources included in this review can be found in Table 3-2.

Seventeen subordinate themes developed throughout the analysis with six superordinate themes. The six superordinate themes reflect the four elements of the concept analysis method: antecedent conditions, characteristic attributes, consequences, and deviant cases. However, characteristic attributes is divided into three levels of restrictive phenomena and thus represented three superordinate themes instead of one. This is illustrated in Table 3-3.

Table 3-2. List of Papers included in Literature Review

	First Search – Until 25th March 2016	Place
1.	Barr, W., Brown, A., Quinn, B., McFarlane, J., McCabe, R., & Whittington, R. (2013). How effective is high-support community-based step-down housing for women in secure mental health care? A quasi-experimental pilot study. J Psychiatr Ment Health Nurs, 20(1), 41-49.	U.K.
2.	Becker, M., Love, C. C., & Hunter, M. E. (1997). Intractability is relative: Behaviour therapy in the elimination of violence in psychotic forensic patients. Legal and Criminological Psychology, 2(Part 1), 89-101	US
3.	Brown, A. P., Fishbein, D. J., & Fisher, W. H. (2001). "Titicut follow-up": Successful transfer of assaultive patient from a high security facility to a less restrictive setting. Administration and policy in mental health, 29(1), 67-79	US
4.	Brunt, D., & Rask, M. (2005). Patient and staff perceptions of the ward atmosphere in a Swedish maximum-security forensic psychiatric hospital. Journal of Forensic Psychiatry & Psychology, 16(2), 263-276.	SWE
5.	Craik, C., Bryant, W., Ryan, A., Barclay, S., Brooke, N., Mason, A., & Russell, P. (2010). A qualitative study of service user experiences of occupation in forensic mental health. Aust Occup Ther J, 57(5), 339-344.	U.K.
6.	Daffern, M. (2013). The impact of interpersonal style on aggression, therapeutic alliance and treatment non-completion in patients admitted to hospital for psychiatric treatment. Australian and New Zealand Journal of Psychiatry, 47, 18.	U.K.
7.	Davies, J. P., Heyman, B., Godin, P. M., Shaw, M. P., & Reynolds, L. (2006). The problems of offenders with mental disorders: a plurality of perspectives within a single mental health care organisation. Soc Sci Med, 63(4), 1097-1108.	U.K.
8.	Dein, K. E., Williams, P. S., Volkonskaia, I., Kanyeredzi, A., Reavey, P., & Leavey, G. (2016). Examining professionals' perspectives on sexuality for service users of a forensic psychiatry unit. Int J Law Psychiatry, 44, 15-23.	U.K.
9.	Dickens, G., Stubbs, J., Popham, R., & Haw, C. (2005). Smoking in a forensic psychiatric service: a survey of inpatients' views. Journal of Psychiatric and Mental Health Nursing, 12(6), 672-678.	U.K.
10.	Enser, J., & MacInnes, D. (1999). The relationship between building design and escapes from secure units. The Journal of the Royal Society for the Promotion of Health, 119(3), 170-174.	U.K.
11.	Ferrito, M., Vetere, A., Adshead, G., & Moore, E. (2012). Life after homicide: Accounts of recovery and redemption of offender patients in a high security hospital - a qualitative study. Journal of Forensic Psychiatry and Psychology, 23(3), 327-344.	U.K.

12.	Haw, C., Stubbs, J., Bickle, A., & Stewart, I. (2011). Coercive treatments in forensic psychiatry: A study of patients' experiences and preferences. Journal of Forensic Psychiatry & Psychology, 22(4), 564-585.	U.K.
13.	Holmes, D. (2005). Governing the captives: forensic psychiatric nursing in corrections. Perspect Psychiatr Care, 41(1), 3-13.	CA
14.	Holmes, D., & Murray, S. J. (2011). Civilizing the 'Barbarian': a critical analysis of behaviour modification programmes in forensic psychiatry settings. J Nurs Manag, 19(3), 293-301.	CA
15.	Horberg, U., Sjogren, R. & Dahlberg, K. (2012). To be Strategically Struggling against Resignation: The Lived Experience of Being Cared for in Forensic Psychiatric Care. Issues in Mental Health Nursing, 33(11), 743–751	SWE
16.	Ireland, C. A., Halpin, L., & Sullivan, C. (2014). Critical incidents in a forensic psychiatric population: An exploratory study of motivational factors. Journal of Forensic Psychiatry & Psychology, 25(6), 714-732.	U.K.
17.	Larkin, M., Clifton, E., & de Visser, R. (2009). Making sense of 'consent' in a constrained environment. Int J Law Psychiatry, 32(3), 176-183.	U.K.
18.	MacInnes, D., Beer, D., Keeble, P., Rees, D., & Reid, L. (2010). The development of a tool to measure service user satisfaction with in-patient forensic services: The Forensic Satisfaction Scale. Journal of mental health (Abingdon, England), 19(3), 272-281.	U.K.
19.	Mat, A., Hoare, T., McCarran, P., Kennedy, H. G., & O'Shea, D. (2014). The prevalence of obesity and metabolic syndrome among inpatients at a forensic psychiatric hospital in the Republic of Ireland. Irish Journal of Medical Science, 1), S461.	IRE
20.	Mathias, K., & Hirdes, J. P. (2015). Gender differences in the rate of restriction to room among Ontario forensic patients. Healthc Manage Forum, 28(4), 157-162.	CA
21.	McKeown, M., Jones, F., Wright, K., Spandler, H., Wright, J., Fletcher, H., & Turton, W. (2014). It's the talk: a study of involvement initiatives in secure mental health settings. Health Expect. 19. 570-579	U.K.
22.	Mercer, D., & Perkins, L. (2014). Theorising sexual media and sexual violence in a forensic setting: men's talk about pornography and offending. Int J Law Psychiatry, 37(2), 174-182.	U.K.
23.	Mezey, G. C., Kavuma, M., Turton, P., Demetriou, A., & Wright, C. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. Journal of Forensic Psychiatry & Psychology, 21(5), 683-696.	U.K.
24.	Mohan, D., Jamieson, E., & Taylor, P. J. (2001). The use of trial leave for restricted special hospital patients. Crim Behav Ment Health, 11(1), 55-62.	U.K.

25. Mohan, D., Murray, K., Steed, P., & Mullee, M. A. (1998). Mental health review tribunal decisions in restricted hospital order cases at one medium secure unit, 1992-1996. Criminal Behaviour and Mental Health, 8(1), 57-65. U.K.

26. O' Sullivan, M., Boulter, S., & Black, G. (2013). Lived experiences of recalled mentally disordered offenders with dual diagnosis: A qualitative phenomenological study. Journal of Forensic Psychiatry & Psychology, 24(3), 403-420. U.K.

27. O'Connell, M., Farnworth, L., & Hanson, E. C. (2010). Time use in forensic psychiatry: A naturalistic inquiry into two forensic patients in Australia. The International Journal of Forensic Mental Health, 9(2), 101-109. AUS

28. Oakley, C., Mason, F., Delmage, E., & Exworthy, T. (2013). A right to be fat? A survey of weight management in medium secure units. Journal of Forensic Psychiatry & Psychology, 24(2), 205-214. U.K.

29. Parrott, F. R. (2005). 'It's Not Forever': The Material Culture of Hope. Journal of Material Culture, 10(3), 245-262. U.K.

30. Parrott, F. R. (2010). 'Real relationships': sociable interaction, material culture and imprisonment in a secure psychiatric unit. Cult Med Psychiatry, 34(4), 555-570. U.K.

31. Parrott, F. R., Macinnes, D. L., & Parrott, J. (2015). Mental illness and parenthood: being a parent in secure psychiatric care. Crim Behav Ment Health, 25(4), 258-272. U.K.

32. Phillips, C., Burnard, P., & Morrison, P. (1996). Quality in provision of forensic psychiatric services: room for improvement. Int J Health Care Qual Assur, 9(6), 26-32. U.K. + AUS

33. Pulsford, D., Crumpton, A., Baker, A., Wilkins, T., Wright, K., & Duxbury, J. (2013). Aggression in a high secure hospital: staff and patient attitudes. J Psychiatr Ment Health Nurs, 20(4), 296-304. U.K.

34. Prebble, K., Kidd, J., O'Brien, A., Carlyle, D., McKenna, B., Crowe, M., Gooder, C. (2011). Implementing and maintaining nurse-led healthy living programs in forensic inpatient settings: an illustrative case study. J Am Psychiatr Nurses Assoc, 17(2), 127-138. NZ

35. Quinn, C., & Happell, B. (2015). Consumer sexual relationships in a forensic mental health hospital: perceptions of nurses and consumers. Int J Ment Health Nurs, 24(2), 121-129. AUS

36. Repo-Tiihonen, E., Vuorio, O., Koivisto, H., Paavola, P., & Hakola, P. (2004). Opinions About Treatment Modalities Among Patients Involuntarily Committed to a Forensic Psychiatric Hospital in Finland. Journal of Offender Rehabilitation, 38(3), 81-95. FIN

37. Ros, N., Van der Helm, P., Wissink, I., Stams, G. J., & Schaftenaar, P. (2013). Institutional climate and aggression in a secure psychiatric setting. Journal of Forensic Psychiatry and Psychology, 24(6), 713-727. NL

38. Ruane, J., & Hayter, M. (2008). Nurses' attitudes towards sexual relationships between patients in high security psychiatric hospitals in England: an exploratory qualitative study. Int J Nurs Stud, 45(12), 1731-1741. U.K.

39. Simpson, A. I. F., Penney, S. R., Fernane, S., & Wilkie, T. (2015). The impact of structured decision making on absconding by forensic psychiatric patients: Results from an A-B design study. BMC Psychiatry, 15 (1): 1-13 CA

40. Stubner, S., Gros, G., & Nedopil, N. (2006). Inpatient risk management with mentally ill offenders: Results of a survey on clinical decision-making about easing restrictions. Criminal Behaviour and Mental Health, 16(2), 111-123. DE

41. Thomson, L. D., Bogue, J. P., Humphreys, M. S., & Johnstone, E. C. (2001). A survey of female patients in high security psychiatric care in Scotland. Crim Behav Ment Health, 11(2), 86-93. U.K.

42. To, W. T., Vanheule, S., De Smet, S., & Vandevelde, S. (2015). The Treatment Perspectives of Mentally Ill Offenders in Medium- and High-Secure Forensic Settings in Flanders. Int J Offender Ther Comp Criminol, 59(14), 1605-1622. BE

43. Urheim, R., Rypdal, K., Palmstierna, T., & Mykletun, A. (2011). Patient autonomy versus risk management: A case study of change in a high security forensic psychiatric ward. The International Journal of Forensic Mental Health, 10(1), 41-51. SWE + NOR

44. Vernham, Z., Tapp, J., & Moore, E. (2015). Observer Ratings of Interpersonal Behavior as Predictors of Aggression and Self-Harm in a High-Security Sample of Male Forensic Inpatients. J Interpers Violence. Vol. 31(9): 1597 –1617 U.K.

45. Vincze, M., Fredriksson, L., & Wiklund Gustin, L. (2015). To do good might hurt bad: exploring nurses' understanding and approach to suffering in forensic psychiatric settings. Int J Ment Health Nurs, 24(2), 149-157. SWE + NOR

46. Whitehead, E., & Mason, T. (2006). Assessment of risk and special observations in mental health practice: a comparison of forensic and non-forensic settings. Int J Ment Health Nurs, 15(4), 235-241. U.K.

47. Wilkie, T., Penney, S. R., Fernane, S., & Simpson, A. I. F. (2014). Characteristics and motivations of absconders from forensic mental health services: a case-control study. BMC Psychiatry, 14(1), 1-13. CA

48. DoH (2010a). High secure building design guide: Overarching principles for Ashworth, Broadmoor, Rampton Hospitals. 30 Nov 2010. Last accessed on 01/02/17 https://www.gov.U.K./government/uploads/system/uploads/attachment_data/file/215865/dh_122964.pdf U.K.

49. DoH (2010b). See, Think, Act: Your Guide to Relational Security. Last accessed on 01/02/17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/320249/See_Think_Act_2010.pdf U.K.

50. DoH (2011). Environmental Design Guide: Adult Medium Secure Services. 06 Apr 2011. Last accessed on 01/02/17 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215623/dh_126177.pdf U.K.

51.	Adshead, G., & Davies, T. (2016). Wise restraints: Ethical issues in the coercion of forensic patients. The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges	U.K.
52.	Albrecht, H. J. (2016). Legal aspects of the use of coercive measures in psychiatry. The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges, 31–48. https://	DE
53.	Bowser, A., Link, W., Dickson, M., Collier, L., & Donovan-Hall, M. K. (2018). A Qualitative Study Exploring the Causes of Boredom for Men with a Psychosis in a Forensic Setting. Occupational Therapy i	U.K.
54.	Capone, G., Braham, L., Schroder, T., & Moghaddam, N. (2017). Perceptions of therapeutic principles in a therapeutic community. Therapeutic Communities, 38(2), 60–78. https://doi.org/10.1108/TC-02-2017-0009	U.K.
55.	Clarke, C., Lumbard, D., Sambrook, S., Kerr, (2016). What does recovery mean to a forensic mental health patient? A systematic review and narrative synthesis of the qualitative literature. Journal of Forensic Psychiatry and Psychology, 27(1), 38–54. https://doi.org/http://dx.doi.org/10.1080/14789949.2015.1102311	U.K.
56.	CQC. (2017). Brief guide: the use of 'blanket restrictions' in mental health wards. Retrieved from https://www.cqc.org.uk/sites/default/files/20170109_briefguide-blanket-restrictions.pdf	U.K.
57.	Elcock, S., & Lewis, J. (2016). Mechanical restraint: Legal, ethical and clinical issues. The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges., 315–3	U.K.
58.	Ewington, J. (2016). Best practices for reducing the use of coercive measures. The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges. 285–314.	U.K.
59.	Horvath, J., Steinert, T., & Jaeger, S. (2018). Antipsychotic treatment of psychotic disorders in forensic psychiatry: Patients' perception of coercion and its predictors. International Journal of Law and Psychiatry, 57, 113–121. https://doi.org/http://dx.doi.org/10.1016/j.ijlp.2018.02.004	DE
60.	Livingston, J. D., Crocker, A. G., Nicholls, T. L., & Seto, M. C. (2016). Forensic mental health tribunals: A qualitative study of participants' experiences and views. Psychology, Public Policy, and Law, 22(2), 173–184. https://doi.org/http://dx.doi.org/10.1037/law0000084	CA
61.	MacCall, C. A. (2017). Drug testing in forensic mental health settings. Addiction, 112(4), 729–730. https://doi.org/http://dx.doi.org/10.1111/add.13727	U.K.
62.	Markham, S. (2018). Red-teaming the panopticon* (mobilising adaptive change in secure and forensic settings). Journal of Forensic Psychiatry and Psychology, 29(1), 16–36. https://doi.org/http://dx.doi.org/10.1080/14789949.2017.1335761	U.K.

63.	Murphy, P., Potter, L., Tully, J., Hearn, D., Fahy, T., & McCrone, P. (2017). A cost comparison study of using global positioning system technology (electronic monitoring) in a medium secure forensic psychiatric service. Journal of Forensic Psychiatry and Psychology, 28(1), 57–69. https://doi.org/10.1080/14789949.2016.1261172	U.K.
64.	Quinn, C., & Happell, B. (2016). Supporting the Sexual Intimacy Needs of Patients in a Longer Stay Inpatient Forensic Setting. Perspectives in Psychiatric Care, 52(4), 239–247. https://doi.org/10.1111/ppc.12123	AUS
65.	Reavey, P., Brown, S. D., Kanyeredzi, A., McGrath, L., & Tucker, I. (2019). Agents and spectres: Life-space on a medium secure forensic psychiatric unit. Social Science and Medicine, 220(June 2018), 273–282. https://doi.org/10.1016/j.socscimed.2018.11.012	U.K.
66.	Rees, G., & Reed, J. (2016). Patients or prisoners? Time to reconsider the voting rights of mentally disordered offenders. BJPsych, 169–172. https://doi.org/10.1192/pb.bp.115.050781	U.K.
67.	Seppänen, A., Törmänen, I., Shaw, C., & Kennedy, H. (2018). Modern forensic psychiatric hospital design: Clinical, legal and structural aspects. International Journal of Mental Health Systems	EU
68.	Soininen, P., Kontio, R., Joffe, G., & Putkonen, H. (2016). Patient experience of coercive measures. The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges.	FIN
69.	Steinau, S., Brackmann, N., Sternemann, U., Biller-Andorno, N., & Habermeyer, E. (2018). Conflicting Priorities Between Risk Management and Treatment of Schizophrenia in Swiss Forensic Services—A Case Report. Frontiers in Psychiatry, 9(December), 1–5. https://doi.org/10.3389/fpsyt.2018.00680	DE
70.	Tingleff, E. B., Hounsgaard, L., Bradley, S. K., & Gildberg, F. A. (2018). Forensic psychiatric patients' perceptions of situations associated with mechanical restraint: A qualitative interview study. International Journal of Mental Health Nursing. https://doi.org/10.1111/inm.12549	DEN
71.	Tiwana, R., McDonald, S., & Vollm, B. (2016). Policies on sexual expression in forensic psychiatric settings in different European countries. Int J Ment Health Syst, 10, 5. https://doi.org/10.1186/s13033-016-0037-y	U.K.
72.	Völlm, B., Bartlett, P., & McDonald, R. (2016). Ethical issues of long-term forensic psychiatric care. Ethics, Medicine and Public Health, 2(1), 36–44. https://doi.org/10.1016/j.jemep.2016.01.005	U.K.
73.	Warburton, K. D. (2016). A new standard of care for forensic mental health treatment: Prioritizing forensic intervention. Violence in Psychiatry. 252–257. Retrieved from http://ovidsp.ovid.com/ovidwe	US

Over 600 codes were generated; the ten most widely coded are listed in Appendix D. The largest superordinate theme, Restrictive phenomena, consisted of clusters of elements of the forensic setting that residents, staff, or commentators identified that were considered to negate resident autonomy against their will. Restrictive phenomena fell into the superordinate themes: individual, institutional and systemic.

A fourth superordinate theme was identified as the antecedent conditions of the forensic setting. This comprised the subthemes of the purpose, or telos, of the forensic care system; and the extent to which residents are considered risky by those working in forensic care. The fifth superordinate theme described the consequences of restrictive elements of care. The sixth superordinate theme outlined examples of deviant-cases – those elements of care identified as restrictive by some but not by others. These themes are now described in turn. Examples that capture the essence of each theme as constructed during the coding process are given.

3.5.1 Individual-Level Phenomena

3.5.1.1 Relational

Relationships within secure care settings were salient in the literature. This was in large part due the amount of time patients spent in a single space with a limited number of possible interactions (Adshead & Davies, 2016). Reavey and colleagues (2019) report a study of patients' 'life-worlds' and conclude that the relational spaces occupied by forensic patients are curtailed, limiting residents' sense of self, growth, and recovery. The literature identifies four 'types' of relationships present in the forensic care

settings that patients experienced as restrictive or restricted: patient to patient, staff to patient, staff to staff, and patient to outside world.

Table 3-3 Depiction of Themes Found in Literature Review

Concept Analysis Features	Superordinate themes	Subthemes
Antecedent Conditions	Antecedent Conditions to Restrictiveness	Telos of Forensic Care Perceived or Actual Risk
Restrictive Phenomena (Characteristic Elements)	Individual Phenomena	Relational Food, Drink and Drugs Personal Belongings Communication and Expression Personal Choice Pathologization and Labelling
	Institutional Phenomena	Built Environment Activities Institutional Resources The Culture of the Setting Coercive Measures Security
	Systemic Phenomena	Legal Policy Temporal
Consequences	Consequences to restrictiveness	A range of negative emotional and behavioural outcomes
Deviant Cases	Deviant Cases from Restrictiveness	Examples of phenomena that residents described as not restrictive, yet were described by others as restrictive

3.5.1.1.1 Patient to patient

Patients felt other patients might restrict their autonomy on the ward. For instance, a patient explained that "[w]e have a thing in the yard called schizo corner where all of us schizophrenics [get] together. We have two groups, we all sit in one corner and all the normalies sit in the other ...

mostly we just sit there and think, talk to our voices telepathically … whereas the normal ones want to bash you and hit you … they were just psychopaths and criminals and druggies and that they used to be pretty nasty towards me" (O'Connell, Farnworth, & Hanson, 2010: 106). This example demonstrates how patients may feel less inclined to visit a certain space depending on who was there.

Patients were also reluctant to move around the ward where the presence of others made the setting feel stressful, noisy or chaotic. This was more likely when the patient group was large in size (To, Vanheule, De Smet, & Vandevelde, 2015). Patient interaction in these conditions led to aggressive or risky incidents, and necessitated greater staff supervision (Becker, Love, & Hunter, 1997; Urheim et al., 2011). Patients sometimes chose to stay in their rooms to avoid these conditions.

At time patients discouraged progression through each other's pathways. A patient in the study by McKeown and colleagues (2014) reported being negatively affected by feedback he received from fellow patients. They stated *"[i]t can feel like you are wasting your time. ... I had to listen to a lot of negativity during the pilot from other service users ... you know, 'what the fuck is this for'. ... It does get you down. I'm trying to help them you know"* (p. 574).

Inter-patient relationships were restricted or banned. Urheim et al. (2011) reported instances where residents were not allowed in the same room unsupervised by staff. Most of the identified literature reported that forensic settings prohibited sexual contact between patients (Dein et al., 2016;

Mercer & Perkins, 2014; Quinn & Happell, 2015; Chris Quinn & Happell, 2016; Ruane & Hayter, 2008; Tiwana, McDonald, & Vollm, 2016). This was largely predicated on the perceived risks of harm, pregnancy, exploitation, and detrimental therapeutic impacts, particularly for sexual offenders, despite there being *"[…] no evidence that the prohibition of sexual contact on psychiatric wards will improve the safety of inpatients"* (Dein et al., 2016: 16). Thus, interactions between patients were restricted by organizational rules on relationships and by living with a diverse group of individuals in a single space.

3.5.1.1.2 Staff to Patient

Staff were be seen by patients as paternalistic. Staff were described as key-holders, lacking in empathy, insensitive, disempowering, forceful, abusive, prone to over-reaction and of a higher-status (Davies, Heyman, Godin, Shaw, & Reynolds, 2006; Haw & Stubbs, 2011; Holmes, 2005; M Larkin, Clifton, & de Visser, 2009; McKeown et al., 2014; O' Sullivan, Boulter, & Black, 2013; Whitehead & Mason, 2006). This dynamic was sometimes described as 'us vs them' and 'stereotypical' (Brunt & Rask, 2005; G Dickens, Stubbs, Popham, & Haw, 2005).

Conflict arose due to these power struggles. This was fuelled by what patients felt as unfair restrictions, disrespect, or a sense of being tested (Capone, Braham, Schroder, & Moghaddam, 2017; Urheim et al., 2011). *"I felt that the staff were trying to antagonize me, to make me try and fight them back or to trap me"* (Ferrito et al., 2012: 338).

These dynamics hindered patient autonomy. One patient felt he had to beg staff to get anything on the ward; others that they had to demand attention in some way (Ireland, Halpin, & Sullivan, 2014; To et al., 2015). Using metaphor, a patient recalls how staff disempowered him, *"[i]t's like I knitted up a jumper … and [the team] helped me knit the jumper. And … say 'didn't you do well, ahh look at the design on it, isn't it lovely'. And then I went out and put the jumper on and people looked at me and said 'God do you see his jumper, he looks the part in his jumper', and then [the team] start grabbing hold of the jumper and start pulling it"* (O' Sullivan et al., 2013: 410). Patients were reliant on staff to validate stages in their recovery and enact choices on the ward.

Staff attitudes were identified as restrictive. These were described as authoritarian, conservative, and enforcing conformity (Dein et al., 2016; Holmes, 2005). It was predominantly staff attitudes that prohibited sexual intimacy between patients, more so than hospital policy (Mercer & Perkins, 2014; Chris Quinn & Happell, 2016; Ruane & Hayter, 2008). Dein et al. (2016) note that *"[a]s a result of there being no clear policy on the matter of patient sexuality, it was apparent that many professionals used their personal judgment to reach decisions on whether to allow patients to engage in sexual activity"* (p. 17). These attitudes were described as inappropriate or discriminatory (Dein et al., 2016). Staff attitudes thus contribute to shaping the permissiveness or restrictiveness of the setting.

3.5.1.1.3 Staff to Staff

Interaction amongst staff played a role in constructing ward atmosphere; institutional policies, both written and spoken; and affecting the provision

of care. Sometimes this was in a restrictive manner. Such interaction can serve to reinforce attitudes and practices, preserving recalcitrance to organizational change (Völlm, Bartlett, & McDonald, 2016). A nurse reported that *"[…] in the staff room and when you go out for a pint and it goes to a different level then because of course we're off duty… we're not on stage at any level and then they're talked about as being sick… horrible… perverted… should never get out… throw away the key"* (Mercer & Perkins, 2014: 177).

A lack of coordination amongst staff can be restrictive for patients as they may fall through procedural gaps. Urheim et al. (2008) found that in the first decade of a new forensic unit, there was no treatment coordination between ward management and treatment staff. Mohan and colleagues (2001) discussed the division of labour and responsibility when granting trial leave to less-secure settings. They highlight a disconnect between the referring psychiatrist responsible in law, and the receiving clinical team responsible in practice. These gaps impede patients' progression through their pathways.

3.5.1.1.4 Patient to Outside World

Patients' interactions with the outside world can be limited. Interactions manifest in several ways including: receiving visitors; taking periods of leave; using the radio and other media; and *aid memoires* such as clothing, or photographs of loved ones (Bowser, Link, Dickson, Collier, & Donovan-Hall, 2018; Parrott, 2005). Indeed, Reavey and colleagues (2019) note "*[…] that the psychological limits of the life of the forensic patient extend far beyond the immediate secure setting in which they are detained*" (p. 274).

Visits are highly regulated. Restrictions on visitors include who, when, and at what time family or friends outside the hospital may visit, and what they may bring with them. Visitors are typically banned from ward areas and patient rooms (Urheim et al., 2011). Law in England and Wales stipulates that in high secure sites visitors may only bring food with them when permission is granted by the patient's responsible clinician in consultation with the patient's clinical team and the medical director (§12(5)(a) High Secure Directions (2013)). Patients may be precluded private time with their partners: *"[p]eople coming in to see their partners and they're not allowed to touch them, or kiss them, or anything, and that's frustrating... You can't touch or anything, it's terrible. It's terrible",* expressed one patient (Quinn & Happell, 2015: 126). Receiving visitors is therefore contingent on following strict procedure.

There are limitations on the circumstances for visiting children. Patients describe these limitations as difficult. It may be that an individual can see his/her child only after a successful assessment of risk (Parrott, Macinnes, & Parrott, 2015). Parrott et al. (2015) writes that *"[o]ne mother felt it was unfair that she had seen her children immediately in prison but had to wait weeks for permission after transfer to the unit"* (p. 266). Regulation on seeing one's children were here experienced as a restriction on a legitimate process experienced elsewhere (in prison).

Having access to media that connected patients to the outside world was highlighted as important. This included phone calls, letters, and emails. However, much private communication is restricted. In high secure hospitals phone calls and letters are subject to regulation detailing

conditions of use, antecedent risk assessment, and monitoring (High Secure Directions, 2013).

Interactions with local communities are restricted in secure care. This can be due to public perceptions of forensic patients; their assessed risk-levels; or patients' personal apprehensions. Indeed, one patient remarked that *"it might be a bit of culture shock going back into the community you know, after being in here wrapped up in cotton wool in this place and then going back into err somewhere so fast and busy"* (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010: 690). This example speaks to the institutionalizing effects of secure care and the consequences this can have on reintegration into the community.

3.5.1.2 Food, Drink and Drugs

The literature identifies various consumable goods that patients may be restricted access to. These include: tea, coffee, smoking, food, and illicit drugs. Oakley et al. (2013) found in a study of medium secure units in England, that two-thirds of participating centres restricted access to caffeine. Völlm and colleagues (2016) reported some patients found making their own hot drinks to be 'a leap'. Hot drinks were restricted in other sites leading some patients to feel trusted if they could make their own (Clarke et al., 2016). Food captured the tension between patients' autonomy to choose what they consume and clinical teams' prerogative to encourage healthy life decisions (Oakley, Mason, Delmage, & Exworthy, 2013). Choice of everyday consumables is restricted, and access can be incorporated into a system of rewards for desired patient behaviour.

Certain hospitals prohibit smoking for patients (Bowser et al., 2018; Ruane & Hayter, 2008; To et al., 2015). Alcohol is prohibited (Davies et al., 2006; Oakley et al., 2013; Repo-Tiihonen, Vuorio, Koivisto, Paavola, & Hakola, 2004). Drugs and alcohol tests are conducted in England and Wales (High Secure Directions, 2013). A study by MacCall (2017) reported that simply offering patients a choice between urine or oral fluid testing instead of enforcing the former made a significant difference for patients and preserved dignity. Thus, the manner in which restrictions are imposed matters for patients.

3.5.1.3 Personal Belongings

The number and type of personal belongings patients may possess is limited. Belongings may serve practical use, contain memories, or provide excitement in the face of boredom. The degree to which personal belongings are restricted varies across institutions and levels of security, but is often the result of risk-reducing security policy (Brown, Fishbein, & Fisher, 2001; Parrott, 2010). Regulations list those items patients may keep (CQC, 2017). Such restricted items include: gym and weight equipment, televisions, number of CDs, photographs, pens, or pornography (CQC, 2017; Department of Health, 2011).

Patients may keep certain posters, gifts, and family-related objects such as photographs and drawings as tangible evidence of a connection to the outside world, parenthood, and external relationships (Parrott, 2005; Parrott et al., 2015). These decorations can foster autonomy by nurturing a sense of ownership over one's space (Reavey et al., 2019; Seppänen et

al., 2018). Ownership of personal belongings provides moments to exercise ownership over one's setting and connect to life before the institution.

3.5.1.4 Communication and Expression

Patients frequently expressed frustration at a lack of communication and information provided by staff. This was felt most acutely during coercive measures wherein patients did not understand why they were being secluded, restrained, or injected intra-muscular medication (Haw, Stubbs, Bickle, & Stewart, 2011; Repo-Tiihonen et al., 2004; Soininen et al., 2016). *"You can't be heard, you can't communicate"*, one patient reflected on being in seclusion (Haw et al., 2011: 575). Patients described the importance of being listened to, *"[s]taff could help me in this place a lot more. When someone in my family dies, they could sit down and talk to me about it"* (Davies et al., 2006: 1104).

A feeling of not being heard resulted in some patients engaging in critical incidents, barricading a room, or escaping to the hospital roof. Patients stated, "*[…] sometimes it's just got to be done for people to listen*", and "*[…] people take you seriously for once"* (Ireland et al., 2014: 721). Feeling unheard during coercive interventions led some patients to enact 'overt protests' until they became silent, feeling disempowered, and helpless (Tingleff, Hounsgaard, Bradley, & Gildberg, 2018). Patients saw value in the process of communication, not just the outcomes of these *conversations "[y]ou don't always get what you ask for. All I am after is a proper explanation and the chance to put my view across"* (McKeown et al., 2014: 575). Communication, and consequently self-expression, were limited for

residents where staff were unavailable or unwilling to listen and provide information.

3.5.1.5 Personal Choice

Secure hospitals reduce the opportunities for making choices (Markham, 2018). Clarke and colleagues (2016) described forensic settings as permitting *optimal* choice-making instead of *maximal* choice-making. The physical space, legal regulations, and hospital rules reduced the number and type of decisions patients can make (Bowser et al., 2018; Mezey et al., 2010). For instance, Seppänen et al. (2018) highlight the potential positive mental health effects that exercising choice as to the decorations, furnishings, and art present on a unit can have. MacCall (2017) reports that offering patient's choice over the method of drug testing led to a marked change in testing modalities over time. The rigid structure of a forensic hospital was felt by some patients as offering less daily choice than prison settings (To et al., 2015). When choice-making is curtailed where not in patients' best interest this can be damaging to their recovery (Clarke et al., 2016).

The ability to shape both day-to-day and long-term decisions is curtailed in secure settings. For instance, To et al. (2015) report a patient's experience of cooking: *"[t]here are too many rules, e.g., if you want to cook something, you cannot cook whenever you want. You can only cook between 4 and 5 p.m., later than that it is not possible"* (p. 1611). Decisions concerning progression through one's pathway are also removed from patients. Exploring patient's experiences of review board meetings in Ontario,

Canada, Livingston and colleagues (2016) found that patients felt decisions to prolong treatment were taken out of their hands. In these examples, patients felt removed from both mundane and significant decisions.

3.5.1.6 Pathologization and Labelling

Pathologizing behaviour restricted patients' self-expression and identity. Having a diagnosis of a particular disorder and being present in a secure unit was felt by some as a means of classification. Patients expressed feeling labelled as deviant from social norms (Clarke et al., 2016; O' Sullivan et al., 2013). After hearing of the death of a friend, a patient named Noel recounts becoming frustrated at not being able to visit a shop to collect his clothes and subsequently "*smashed up*" the ward because he didn't want to receive an intra-muscular injection to become calm (Davies et al., 2006: 1105). The authors wrote that *"[t]he staff reaction is portrayed as controlling through force, presumably because they viewed his initial response as a sign of mental disorder and/or criminogenicity"* (Davies et al., 2006: 1105).

Perceptions of criminogenicity were also present in a Swiss case study. Steinau et al. (2018) report that a patient with schizophrenia was kept in secure settings for 30 years in part due to his index offence, despite his risk profile changing considerably over this time period. This was echoed in third example in Canada. Forensic mental health professionals were interviewed regarding patients' chances of successful review board applications. One interviewee noted that *"[…] the index offence, unfortunately, will always come back to haunt the client"* (Livingston, Crocker, Nicholls, & Seto, 2016:

180). This identification as a mentally ill offender was described by residents as a barrier to recovery (Clarke et al., 2016).

Everyday behaviours were seen through a pathologizing lens. Larkin et al. (2009) report an incident of patient aggression wherein the patient felt his doctor initially perceived this outburst as anger, but later labelled this as persecutory delusion. The patient felt this legitimate human emotion was reinterpreted as mental disorder. Intimate relationships were pathologized in sexual offenders, rather than being seen as normal human behaviour making such interaction less likely for this patient group (Mercer & Perkins, 2014; Quinn & Happell, 2015; Ruane & Hayter, 2008).

Patients expressed that medical notes recorded only pejorative behaviours, and it was only these events that would be referred to in the future when their detention was reviewed (Livingston et al., 2016). Patients interpreted a wide range of actions taken against them as pathologizing, based on improper conceptions of who they are. This they described as diminutive of their self and identity.

3.5.2 Institutional-Level Phenomena

Forensic care hospitals are often characterized by their oppressive physicality and prison-like appearance. However, the literature identified aspects of the institutional setting stretching beyond the bricks and mortar of the buildings to include the range and meaningfulness of activities available to patients; the hospital culture and its resources; the mode of therapeutic care provided; and the range of security measures employed.

3.5.2.1 Built Environment

The built environment physically and symbolically restricted patients. A healthy living programme at a New Zealand secure unit was disrupted by a lack of space; this restricted patients' participation and opportunities for meaningful exercise (Prebble et al., 2011). Too little space can lead patients to feeling overcrowded: *"[i]f you feel really cramped… it affects the atmosphere, it affects the stress between individuals"*. (Mezey et al., 2010: 691). Capone and colleagues (2017) proposed that although movement around secure sites is indeed limited; patients in a high secure learning disability directorate were encouraged to exercise autonomy in choosing where to go within this limited space.

A totality and punitiveness is captured in the physicality of secure settings. Holmes & Murray (2011) assert that the total nature of the forensic institute is symbolized by its architectural barrier to the outside world; with *"[…] locked doors, high walls, barbed wire, cliffs and water, open terrain and so forth"* (p. 691). Parrot (2005) reports that a secure unit aimed to achieve a sense of domesticity, but an 'institutional version' wherein *"[…] perimeter security, windows that barely open, panic alarms and double-locked entrance and exit doors are featured alongside garden landscaping"* (p. 249). The presence of locked doors not only physically restricted patients, but also reinforced staff-patient roles and hierarchy (Vincze, Fredriksson, & Wiklund Gustin, 2015).

Some patients were hesitant to bring children to the secure centre. For instance: *"[i]t looks like a jail with the locks and doors"* (Parrott et al., 2015: 265). 'Prison' was a recurring motif throughout the literature, and rooms

were sometimes referred to as 'cells' or 'cage-like' (Enser & MacInnes, 1999; Holmes, 2005; O'Connell et al., 2010). Indeed, patients often felt locked up, reporting *"[b]eing dragged away and put in a room on my own and locked in"* (Haw et al., 2011: 571). To normalise forensic hospitals, Seppänen et al. (2018) suggeste locating low and medium secure settings within urban areas to promote community engagement and minimise social isolation. The built space thus demarcated a site distinct from other areas of a community.

Patients have little privacy on their wards. Parrot (2005) and Holmes and Murray (2011) assert that the layout of the secure unit facilitates continuous observation. In one study, staff referred to the nursing station as the 'roundhouse' (O'Connell et al., 2010). Continuous observation may encourage patients to act in institutionally-prescribed ways at all times, limiting individual autonomy.

3.5.2.2 Activities

The literature lists a wide range of activities that are prohibited or restricted. This left some patients feeling bored (Bowser et al., 2018). *"If I have to have a big gripe about this place it's that you're left to your own devices to get bored and it's a terrible thing, boredom"* (Phillips et al., 1996: 29).

Leave or grounds access can be precluded or highly restricted in patients' care plans. The High Secure Directions (2013) of England and Wales stipulate in §36(1) that individuals are not permitted access to the hospital grounds unless recommended by their clinical team and approved by the site's grounds access committee or medical director. One NHS Trust

introduced GPS monitoring for patients on leave (Murphy et al., 2017). This has been associated with fewer leave violations, but raises questions of surveillance and ethics.

Most patients interviewed by Phillips et al. (1996) in a medium secure unit wanted more time outside, either on escorted or unescorted leave: *"I would like to be able to read a book in the open air on a warm day"* a patient noted (p. 29). Leave can be important for patients to reconnect with their relationships outside the hospital and maintain a previous lifestyle (Parrott, 2010). Not being able to go 'bushwalking', a patient described prison as an *"iron cage"*, and his special mental health unit as a *"golden cage … it's better, but it's still a cage"* (O'Connell et al., 2010: 105). Patients may have few opportunities to leave secure sites and consequently feel imprisoned.

3.5.2.3 Institutional Resources

Forensic care settings are organizations operating to budgets, employing human beings, and trying to fulfil multiple stakeholder aims. Certain constraints affect the running of these settings, such as available finances and bed-occupancy rates.

Limited staff numbers and training reduced the range of activities residents could engage in. Access to occupational therapies and meaningful activities have been reduced or cancelled for these reasons (Bowser et al., 2018; Craik et al., 2010; Prebble et al., 2011). This is especially problematic when patients engage in 'critical incidents' soaking up staff resources (Ireland et al., 2014). One individual commented that a lack of staffing on their rehabilitation unit meant patients were not able to be enjoy periods of leave

"[t]here's not enough staff on – especially in the rehabilitation ward, to get all the patients out on their various paroles and it's a frustrating thing" (Phillips et al., 1996: 29). Ewington (2016) further reported that low staffing, poor training, and staff gender imbalances can lead to increased use of coercive measures.

On the availability of funding for a healthy living programme, a health professional remarked that "[w]e had a recreational officer, who has helped quite a lot… [but she left] at the start of this year and they told us they're not replacing her… I suppose it's a funding issue but it's really sad because now we've got one that's sort of spread around all the wards and she can only offer us so much time" (Prebble et al., 2011: 131). Thus, understaffing is associated with less meaningful patient engagement on the ward.

A limited number of beds restrict patients' movement through secure services. Indeed, Whitehead and Mason (2006) write that *"[…] in reality the transfer of patients can be difficult, time-consuming, and 'politically' motivated"* (p. 236). Commissioning bodies have promoted funding schemes that as a consequence save money but place patients in inappropriate settings (Phillips et al., 1996). Patients have been found ready to move into community services by review boards but are held in secure settings waiting for spaces to become available (Livingston et al., 2016). Progression to more appropriate, less restrictive conditions is therefore contingent on beds being available.

3.5.2.4 The Culture of the Setting

The culture of a forensic unit plays a crucial role in enforcing restrictive measures. Secure settings were criticized for being conservative, oppressive, paternalistic, security-prioritizing, institutionalizing, and introverted (Brunt & Rask, 2005; Dein et al., 2016; Ireland et al., 2014; McKeown et al., 2014; Mercer & Perkins, 2014). Urheim et al. (2011) write that culture is significant in defining attitudes towards: discipline; punishment; coercion; the levels of autonomy given to patients; structured activity; rules; procedures; and desirable behaviour more generally. Prebble et al. (2011) highlighted the difficulties of starting a healthy living programme in a unit with *"[…] deeply entrenched attitudes, routines, and processes"* (p. 135). The culture of a unit is a powerful variable in shaping what restrictions are enacted.

The maintenance of rigid cultures can be detrimental for patient autonomy. Nursing staff can adjust to the demands of their hospital culture instead of their patients' individual needs (Vincze et al., 2005). This can subject the patient to the will of others, rather than empowering him/herself to *'[…] ascribe meaning to his/her own life'* with the help of staff (Vincze et al., 2005: 154). Enforcing structure and activity was appreciated by some patients as it provides activity and engagement. However, the rigidity of this was also perceived as being too routine, structured, and sometimes detrimental to patients' sense of control (To et al., 2015).

Ward culture was identified in some sites as 'gendered'. This was primarily masculine (Dein et al., 2016; Mercer & Perkins, 2014). In this masculinized culture, patients were less likely to receive more maternal, feminine modes

of care as masculine culture dominated. Some patients may feel prohibited from expressing themselves in ways considered more feminine for fear of being excluded from social interactions (Mercer & Perkins, 2014). Such culture can restrict residents' self-expression particularly if this expression concerns sexuality and gender identity.

3.5.2.5 Coercive Measures

Coercive measures appeared frequently in the literature and are problematic for patient autonomy. Narrowly defined, coercive measures include forced medication, restraint, and seclusion (Elcock & Lewis, 2016; Ewington, 2016; Hui et al., 2013). Other studies broadened this to include admission processes and 'soft coercion' (Adshead & Davies, 2016; Brink & Goossens, 2016). They represent a significant curtailment of patients' autonomy; and the Committee for the Prevention of Torture has raised repeated concerns over solitary confinement, restraints and forced medication, which may amount to inhuman and degrading treatment (Albrecht, 2016).

Medication was seen by some patients as restrictive. This was in relation to its effects or forced application (Horvath et al., 2018). Medication, particularly anti-psychotics, can restrict patient engagement in activities and can lead to weight gain (Mat, Hoare, McCarran, Kennedy, & O'Shea, 2014; Oakley et al., 2013; Parrott, 2005). Medication was used as a 'plan B' when staff were not able or willing to keep patients engaged in activity (Davies et al., 2006). Medication that could only be administered orally was seen as advantageous by a patent named Andrew, as he felt staff could not

"[…] squeeze it in between your teeth" (Larkin et al., 2009: 179). Medication effects limited resident engagement in activities and its forced application was experienced as a violation of personal choice.

Seclusion and restraint can undermine trust and working alliance built between staff and patients. They can lead to feeling fear, humiliation, loss of dignity, past abuses, and powerlessness (Elcock & Lewis, 2016; Haw et al., 2011; Vincze et al., 2015). Coercion can therefore influence the manner in which patients are willing to engage in care, can precipitate aggression from patients and on rare occasion lead to loss of life (Daffern, 2013; Tingleff et al., 2018; Whitehead & Mason, 2006). Restraint and seclusion can thus restrict physical movement and hinder therapeutic outcomes.

3.5.2.6 Security

Security measures shape much of the restrictiveness of secure settings. A nurse in the study by McKeown et al. (2014) stated, *"[o]n my ward it is safety and security first, involvement and anything else come second to this"* (p. 573). This is echoed in Craik et al.'s (2010) study of occupational therapies in secure care. One participant remarked, *"I think the major problem with the OT department is… they will do everything they possibly can in the security allowance… You can't have knives and tools out all the time unless you've got staff with a radio there"* (p. 342).

Security measures are enacted to mitigate risk. Urheim et al. (2011) note that static conceptions of risk encouraged procedural and physical security instead of relational security. These methods of security can be detrimental to therapeutic relationships. They can *"[…] constrain full realization of*

involvement goals" (McKeown et al., 2014). Repo-Tiihonen et al. (2004) thus argue that involuntary care *"[…] should not be used to restrict patients more than necessary for reasons of safety"* (p. 83). Security can therefore take priority over or shape various therapeutic initiatives and restrict patient engagement.

3.5.3 Systemic-Level Phenomena

The literature discusses the legal and policy frameworks within which forensic care settings operate. These have consequence on how residents move through secure care and how much time they spend in it. Patients describe playing the system and just doing what needs to be done to progress. Nurses in Vincze et al.'s (2015) study asserted that *"[…] patients did not have any other alternatives than to adjust to the regulations or act out frustration and agony, thus contributing to a downward spiral of suffering and restrictions"* (p. 152). These examples suggest the 'system' of forensic care can exist detached from patients' individual recovery journeys.

3.5.3.1 Legal

A patient's legal status can curtail his/her autonomy beyond involuntary admission. An example of this is being detained on a restriction order (§§37/41 or 47/49) under the Mental Health Act 1983. Such a restriction order can affect the available choices patients have for exercise (Oakley et al., 2013). The number of restriction orders has increased in recent decades (Markham, 2018).

Detention under the MHA (1983) was seen as coercive by patients (Daffern et al., 2010). Mezey et al. (2010) report a patient recounting "I can't have total control over my life because of the section I'm on and you know what one of the nurses said to me the other day, he said 'the Home Office owns you' – he said you can't do whatever you want because they will just recall you to hospital you know. I have to abide by the restrictions. I can't do anything about it" (p. 693). Legal sections can thus limit leave, discharge, grounds access, and exercise.

Review tribunals play a significant role in a patient pathways. A study of the Ontario Review Board demonstrated that patients typically found the experience helpful and respectful but also had feelings of being stuck, surprised by outcomes, and constrained (Livingston et al., 2016). These constraints included minimal involvement in the process, lack of voice, being given confusing information, and not being seen as a 'credible' spokesperson.

The legal framework directing the provision of forensic care was seen by some commentators as bureaucratic. This included conceptualizing patients as objects to be managed. Larkin et al. (2009) write that patients were either unaware of the bureaucracy and legislation directing their care or saw these as *"[…] obstacles to understanding and agency"* (p. 180). Brown et al. (2001) write that in Massachusetts, legislative processes were concerned with static, legalistic considerations of risk over a clinical perspective accounting for *an "[…] interactive, dynamic view of assaultive behaviour"* (p. 77). Judicial processes were thus described as detached from clinical reality.

Some patients receive significant media attention. Certain decisions, particularly relating to the release or granting of leave for high-profile patients, may therefore be restricted for political reasons (Whitehead & Mason, 2006). This can hinder a patients' progression from secure care and deepen internal perceptions of oneself as a deviant other.

Some forensic patients are disenfranchised. The rights of patients to vote in public elections is taken away following conviction for a criminal offence (Rees & Reed, 2016). This ban persists despite a ruling from the ECtHR on its illegality in 2005 (Rees & Reed, 2016). This restricts a significant part of citizenship in social life.

3.5.3.2 Policy

Institutional policies can also restrict patients' engagement in care. Such policies highlighted in the literature include: the banning or limiting of patients trading goods within a medium-secure unit (Parrott, 2010); smoking (Dickens et al., 2005); sexual expression between patients and with visitors (Mercer & Perkins, 2014); access to media such as computers, video games consoles and telephones (§23 High Secure Directions, 2013); articles of clothing (Brown et al., 2001; Holmes, 2005); the type, number and volume of patient belongings (CQC, 2017; §21 High Secure Directions, 2013); access to bedrooms and keys (To et al., 2015); seclusion and restraint (Elcock & Lewis, 2016; Ewington, 2016; Repo-Tiihonen et al., 2004; Soininen et al., 2016); room, locker and rub-down searches (Capone et al., 2017); and permission to open a fridge earlier than scheduled in the course of a healthy living programme (Prebble et al., 2011).

Certain restrictions are necessary given the context of an individual's care plan. However, current institutional policy is unequivocal in discouraging so-called blanket bans or policies (CQC, 2017). Blanket bans are*: "[r]ules or policies that restrict a patient's liberty and other rights, which are routinely applied to all patients, or to classes of patients, or within a service, without individual risk assessments to justify their application"* (CQC, 2017: 1).

Mercer et al. (2014) described a tension that arose on a ward when balancing a blanket ban on sexual relationships and risk reduction in individualized care. A health professional struggled to reconcile balancing the unit protocols considering risk in secure care with promoting autonomy in patients participating in a healthy living programme, *"we're working from a locked environment here, you know, how do we work around that aspect? Can we actually let these people go out the door and go and do their shopping?"* (Prebble et al., 2011: 135). Blanket bans can reduce patient autonomy in an arbitrary manner and staff struggle to enact fair bans that account for patient individuality.

To et al. (2015) found that ward rules were enforced to provide structure to the patients' day, security and for organizational practicalities but were *"[…] obstructive to the participant's feeling of control"* (p. 1611). The authors report patients experiencing ward rules and restrictions as *"[…] stressful, childlike, too strict, too rigid, and not adjusted to the individual needs of each person"* (p. 1611). Strict adherence to ward rules resulted in power struggles between patients and staff; and more lenient and creative approaches that sought to use communicative skills over zero-tolerance ideals (Urheim et al., 2011). In a study on policies concerning sexual

expression patients had minimal say in designing institutional rules; across fourteen European countries, only Switzerland involved patients in the design of these policies (Tiwana et al., 2016). These policies are experienced by patients as wide ranging, unfair, and detached.

3.5.3.3 Temporal

Time featured as an element of the systemic constraints in secure care. This was discussed in relation to patients' lengths of stay. Duration of stay was described as dictated by staff, unfair, and exceeding the proscribed time mandated for their offence (Craik et al., 2010; Völlm et al., 2016). Length of stay can be indefinite, *"[a]n offender gets a sentence and knows when he is a free man again. An interned mentally ill offender has to wait and does not know when it ends and that is making me crazy, you do not have an idea when it ends"* (To et al., 2015: 1613). Another patient remarked that *"[i]f I had been charged regularly, I would've been out after 2 or 3 months; instead, I've been in here [the forensic hospital] for 4 years"* (Livingston et al., 2016: 180). Thus length of stay was felt by some as unjust, keeping them in secure care for an underserved period.

Residents struggled with this indeterminacy. It was considered by some as "*unbearable*" (Wilkie, Penney, Fernane, & Simpson, 2014: 3). Others report that patients lose hope and give up on attempting to be discharged (Livingston et al., 2016). Markham (2017) writes that long-term care can lead to *"[…] iatrogenic exacerbation of the mental disorder, abuse by staff, patients and stigmatisation"* (p. 22). Length of stay was negatively associated with levels of hope by some.

3.5.4 Antecedent Conditions to Restrictive Phenomena

Underpinning each of the restrictive elements described at individual-, institutional-, and systemic-levels are the ways in which they are enacted. This praxis is moderated by two antecedent conditions; the telos of the forensic care system and the perceived level of risk that residents pose to themselves or others.

3.5.4.1 Telos of Forensic Care: Care v Custody

The telos of the forensic care setting may be caring, aiming to treat and prevent future recidivism; or custodial, acting as agents of criminal justice (Markham, 2018). Holmes & Murray (2011) described this as the *"[…] tensions that arise when therapeutic ideals operate within the punitive setting of a prison, when care comes face to face with incarceration"* (p. 294). Brunt & Rask (2005) highlight an inbuilt conflict between *"[...] the role of maintaining a therapeutic environment in order to facilitate the improvement of the mental health of the patients on the one hand, and security, detention and protecting society on the other"* (p. 264). The nature of praxis changes as staff are responsible for security and control alongside care.

Punitive attitudes can colour service provision. One participant in the study by Ruane et al. (2008) noted of residents that "[t]hey should be having a miserable time. That's not a therapeutic attitude I know, and it doesn't really work very well but I do feel it from time to time" (p. 1737). The authors found staff thought residents were underserving of certain

privileges given their offending history. One resident expressed that their unit was "[…] becoming very much a prison, more than a prison" (Craik et al., 2010: 341).

Warburton (2016) described secure hospitals as dangerous, punitive and controlling. Tiwana and colleagues (2016) felt that bans on sexual intimacy between patients in England was in part due to punitive public attitudes permeating the clinical setting. The Swiss case study of an individual with schizophrenia who had been detained in prison and forensic settings for 30 years reported that the prolonged detention was more for punitive reasons than risk management given the progression of the mental illness (Steinau et al., 2018). Punitiveness can seep into care, colouring reactions to patient behaviour and demoting patient treatment and engagement for restriction and custody.

3.5.4.2 Perceived or Actual Risk of Residents

The notion of risk management is ubiquitous in secure care. Risk is considered the possibility of an individual engaging in abusive, harmful or antisocial behaviours to others or themselves (Markham, 2018). Forensic populations are perceived as being a particularly risky group to society (Wilkie et al., 2014).

Few aspects of forensic psychiatric life avoid risk assessment. Holmes (2005) observed on ward rounds that resident rooms would be searched for suspicious objects that could be used as weapons or to manufacture drugs or fruit that may be used for brewing alcohol. Similarly, in designing medium secure services, the U.K. Department of Health advices that

"[p]lants that could be used as a climbing aid, for fermenting or as a weapon (including blowpipes) should not be used" (DoH, 2011: 25). For a period of time, weight lifting was not permitted in a Norwegian secure unit as it was considered a risk-increasing activity (Urheim et al., 2011).

Risk management strategies may restrict residents' engagement in therapy and group activities, or place them in isolation and seclusion (Mathias & Hirdes, 2015; McKeown et al., 2014). Indeed, Adshead and Davies (2016) wrote that *"[…] secure services remove agency from forensic patients in the name of risk reduction"* (p.81). Concerns to manage risk inhibits the provision of services and activities and increases security measures (Markham, 2018; Völlm et al., 2016). Risk management can restrict individual autonomy and affect outcomes.

Commentators point out an inauthenticity in trying to correct and control the risky behaviour of individuals in secure care. Holmes & Murray (2011) write that *"[a]ny autonomy the forensic psychiatry patient does experience is a false autonomy, as it is clear that his submission to institutional order is total"* (p. 299). The authors propose that any intervention that aims to teach socially acceptable behaviour rather inscribes behaviours that are consistent with the aims of the institution.

3.5.5 Consequences

The elements of care described above were identified as having various adverse effects upon residents. Residents subjected to overly restrictive settings can experience difficulties in (re)developing and expressing a sense of 'self' (Horberg et al., 2012; O' Sullivan et al., 2013; Parrott, 2010);

building relationships with staff and others (Vincze et al., 2015); and engaging in meaningful activity that develops occupational, social and creative skillsets crucial for recovery (Craik et al., 2010; Repo-Tiihonen et al., 2004).

These difficulties can lead to individuals becoming institutionalized, bored, hopeless, lonely, or lethargic (Bowser et al., 2018). Patients described that this boredom increased psychotic symptoms (Bowser et al., 2018). They may lose trust in their care (MacInnes, et al, 2010; Mezey et al., 2010); give up hope of developing intimate and social relationships (Quinn & Happell, 2015; Ruane et al., 2008); or come to see future integration into wider society as futile.

Residents may develop serious metabolic health issues eating through boredom (Mat et al., 2014); or engage in critical incidents to kill time and achieve a sense of control or space (Ireland et al., 2014; Wilkie et al., 2014). Residents may see their situation as fixed and determined, left feeling resigned, lacking control, and consequently existing in a state of "not-living" (Horberg et al., 2012: 747). Thus the literature identifies several adverse consequences as associated with overly restrictive settings.

3.5.6 Deviant Cases

Phenomena described as restrictive by some were not experienced as such by others. For instance, certain residents appreciated being on mixed wards with a heterogenous patient group. A female resident preferred being on a mixed-gender ward as in her words it *"[s]tops the bitching"* (MacInnes et al., 2010: 275). Many residents appreciated their interactions with staff and

the relationships they built together; finding staff caring, helpful, and polite (Haw et al., 2011; Phillips et al., 1996). One resident described his previous ward as a *"[…] nice environment, the staff were engaged and they had time to listen to me"* (Ferrito et al., 2012: 338). Thus instances are identified where residents developed meaningful relationships, felt listened to, and were able to express themselves.

Coercive measures were sometimes appreciated by residents. These were justified by staff to avoid harm, proposing that coerced treatment is beneficial in the long-run (Daffern, 2013; Haw et al., 2011; Vincze et al., 2015). Indeed, some patients report feeling safer or calmer as a result of being restrained or secluded (Soininen et al., 2016). Haw et al. (2011) report a resident remarking: *"[s]ometimes it's nice to be on your own and not to have people around when you are feeling upset"* (Haw et al., 2011: 572).

Features of the secure setting that are physically restrictive for some were beneficial for others. Some individuals chose to see the high levels of security as protection from the outside world, *"[…] tend[ing] to feel that locked doors and security of the unit were for their benefit, to protect and shield them from a hostile and uncomprehending public, as much as for the protection of the public"* (Mezey et al., 2010: 689-690).

Residents adapted to restrictions and utilized these to their benefit. In one forensic setting that observed visits from children, constant observation by staff provided parents with an opportunity to prove to clinicians how well they could interact with their children (Parrot, 2015). In another example,

the legal framework governing forensic care was used as a tool by one resident to prevent perceived mistreatment from staff: *"I've got me own Mental Health Act manual, the Richard Jones one, sixth edition"* *"'I'll go and check it out, and if necessary I'll write it out for them"* (Larkin et al., 2009: 181). The above examples suggest phenomena described by some residents are not experienced as such by others.

3.6 Discussion

This review aimed to conceptualize the restrictiveness of forensic psychiatric care by identifying 1) antecedent conditions to; 2) characteristic attributes of; 3) consequences of: and 4) 'deviant' cases of the concept of restrictiveness. In doing so it highlighted many aspects of care that can be considered restrictive either by residents themselves, staff or academic commentators. The results are heterogeneous, operating in and across individual, institutional and systemic levels of care. These phenomena are enacted in ways reflective of the purpose of the forensic system and the perceived riskiness of patients. What may be restrictive for one resident may not be felt as so by another. These restrictions negatively affect resident autonomy. Sometimes this is justified given the clinical needs of the residents, other times not.

The results of this review build on residents' accounts of repression in Dutch YOIs (de Valk et al., 2017), and adult forensic patients in medium and high secure hospitals in England (Hui, 2017; Sustere & Tarpey, 2019). Restrictiveness was found to operate on a series of different levels as a

complex interplay between staff and residents, enforced or mitigated by staff attitudes and institutional practices.

This is an important parallel as qualitative work by de Valk and colleagues (2017) found repression was characterised by abuse of staff power, reduced personal autonomy, arbitrary and contradictory rules, feelings of dehumanization and ultimately resigned to accepting repression as 'just the way it is'. Hui (2017) also reported patients' accounts of the negative consequences of restrictions. These included a lack of hope, feelings of degradation, traumatization and re-traumatization following coercive measures, and a loss of dignity. In that study, residents described a sense of being mentally and physically confined.

In forensic care, there must be a reflexivity by staff and policy-makers between the level of restrictiveness and security needed to safely provide care in a therapeutic milieu and enabling the maximum amount of resident autonomy possible. Horberg et al. (2012) assert that current ward cultures and environments need to be *"[…] clarified, questioned, and examined"* (p. 750). Markham (2018) highlights the inherent contradictions in assessing risk in secure settings as the inductive prevention paradox. She asserts that praxis that relies too heavily on risk management is detrimental to residents' will, autonomy, freedom, choice, and responsibility. She subsequently advocates a red-teaming approach to uncover the rational, political, and cultural biases that underpin much of the restrictiveness of secure hospitals.

Such a critical reflexivity must consider each resident and setting individually on a day-to-day basis. The conceptual analysis undertaken in this review outlines potentially restrictive elements of care on individual, institutional and systemic levels. It therefore gives a useful heuristic to start this reflexivity and question more deeply how the telos of forensic care and aversion to risk shapes the restrictiveness of the setting for each resident differently.

This review builds on the literature introduced in chapter two of this thesis. Chapter two described features of Total Institutions, with particular focus on processes and power structures within them; it also discussed competing notions of risk and autonomy. These concepts were present within this review. Risk was identified as an important antecedent to the enactment of restrictive phenomena in §3.5.4.2. The effects secure settings have on autonomy, particularly patients' ability to exercise choice, was described in §3.5.1.5.

The restrictions on patients' ability to express themselves to staff were identified in §3.5.1.4 and experiences of pathologized behaviour discussed in §3.5.1.6 resonate with Goffman's (1961) 'mortification of the self'. Patients' descriptions of feeling stuck within care, attempting to 'play the system' and demonstrate favoured behaviours echo Foucault's (1977) concept of 'governmentality' and a form of autonomy experienced in Late Modern penal settings as limited and directed (Crewe, 2007; Scott, 2010). This review identifies these concepts within forensic settings.

The review provided a conceptualization of restrictiveness derived from forensic mental health literature. It identified specific features of care that the literature identifies as restrictive and posits some antecedents and consequences of these. This conceptualization offers a broad definition of restrictiveness required in stage one of the protocol for developing, validating and revising a questionnaire[5] (Adcock & Collier, 2001). This conceptualization and grouping of themes presented in Table 3-3 were used to develop the questions asked in the qualitative phase of this study. Reflecting on the initial definition of restrictiveness presented in chapter one, this is revised in light of the literature review.

> ***Definition Two.*** *The restrictiveness of secure forensic care refers to any externally-derived (intended or unintended) negation of residents' autonomy experienced as such by that resident. These restrictions exist on individual, institutional, and systemic levels and are likely born of risk management techniques or custodial attitudes.*

3.7 Situating this Study within Trends in the Literature

It is possible to identify several tends in the literature included in this review. These reflect and pre-empt changes in forensic mental health praxis. The broad thrust of this is reconfiguring service provision towards holistic treatment approaches focused on all aspects of residents' lives. These changes are best captured by the Good Lives Model and recovery

[5] This is described in detail in chapter four.

paradigm. Both permeate the literature from the late 2000's and emphasise patient autonomy, empowerment, involvement in care, personal strengths, protective factors, skills, and living a meaningful or good life. They are also reflective of changes pursued by the UN Convention on the Rights of Persons with Disabilities.

The present doctoral study fits within these general trends. The study aims to further our understanding of the restrictiveness of secure settings by developing a definition broader than that typically understood by least restrictive practices and coercive measures. It does so by locating this definition in patient experience; the operationalization of least restrictive practices so-understood in England took a top-down approach and thus is not comprehensive. Restrictiveness in this study considers a wide range of phenomena and consequences on domains of patients' lives.

Further, by developing a measure of restrictiveness, this study adds depth to models that explore associations between aspects of residents' lives that have been identified as crucial to positive outcomes by the recovery paradigm and the GLM. These include quality of life and ward atmosphere. Thus, a measure of restrictiveness will help us understand the effects of secure care on residents within a broader conceptualization of patient well-being.

3.8 Limitations

There are several limitations to this chapter. First, the conceptualization drew on subjective interpretation. This therefore needs to be subject to empirical testing. Second, the sources included in this review were

extensive but not comprehensive. The 73 sources were drawn from psychological, mental health, legal, nursing, and governmental documentation in the English language. An inclusion criterion was that literature 'needed to address restrictive elements of secure forensic care in a non-cursory way'. This was a subjective interpretation and could have been assessed differently by a different researcher. Thus, more and different literature could have been included. However, it was felt 73 sources was sufficient for the purposes of this review and consistent with the concept analysis method (Walker & Avant, 2011).

Third, it should be acknowledged that this review combined the perspectives of residents, staff, and academic commentators. This approach was undertaken to help inform an initial, broad conceptualization of restrictiveness and introduce into discussion elements of care identified by a broad range of actors. This review should be seen as a springboard from which questions were generated to probe more deeply with patients.

3.9 Conclusion

This review collated restrictive phenomena within secure settings. This review scoped out how wide a concept of restrictiveness can be and offered a useful heuristic to guide the development of interview questions. This review highlighted that although there has been an increasing focus on coercive measures and restrictive practices in recent years there is a gap in the literature describing the restrictiveness of secure care in a holistic way from patients' perspectives.

Chapter 4
Methodology

4.1 Summary

The methodology of this project was chosen as it was most appropriate to answering the study's research aims. Ensuring alignment between research question and methodology is a necessary precondition for good research (Silverman, 2015). Therefore, these aims are repeated here:

Purpose

1. The purpose of this project is to understand if, what and how patients experience elements of secure forensic psychiatric care as restrictive.

Primary Objective

1. The objective of this project is to generate a questionnaire to measure subjective experiences of restrictiveness in secure forensic psychiatric care.

Secondary Objectives

1. To explore and operationalize patients' experiences of restrictiveness in secure forensic psychiatric care settings.
2. To develop a preliminary questionnaire to measure patients' subjective experiences of restrictiveness in secure forensic psychiatric care.
3. To assess the psychometric properties of a piloted questionnaire developed to measure patients' subjective experiences of restrictiveness in secure forensic psychiatric care.

This chapter outlines the research design adopted to achieve these aims. It describes the philosophical and methodological frameworks that guided data collection and analysis. To frame the project's overarching research design, Greene's (2006) four domains for conducting rigorous research is used. These are: 1) philosophical assumptions and stances; 2) inquiry logistics; 3) guidelines for practice; and 4) socio-political commitments in science.

The philosophical assumptions adopted in this study refer to a dualist ontology and an interpretivist epistemology. It is proposed that these are helpful to explore forensic patients' subjective experiences of restrictiveness. Inquiry logistics refers to the project's Mixed Methods Methodology situated in a framework for developing, validating and revising the FRQ. Guidelines for practice discusses methods of data collection and analysis. The socio-political commitments of the researcher are addressed as my own researcher reflexivity. Finally, the context of the project, gaining access, and ethical considerations are described.

Greene (2006) proposes that social inquiry gains credibility when each of these domains "[…] act in concert with one another, when their interlocking connections are smooth and well oiled, when overall presentation is strong, coherent, well-articulated and thus persuasive" (p. 94).

4.2 Philosophical Underpinnings

4.2.1 Introduction

Identifying the philosophical groundings of social scientific research is called 'foundationalism' (Hughes & Sharrock, 1997). Foundationalism proposes that to be confident in products of social inquiry, researchers need to demonstrate that their work rests on:

> *"[S]ound foundations… from which our beliefs may be logically deduced, so retaining the truth value of the foundational premises from which they follow, and in terms of which our methods of forming further ideas about the world and investigating it can be licensed" (Hughes & Sharrock, 1997: 4-5).*

Inquiries of the social sciences – human action, interaction, reaction, belief, attitude, culture, experience – are constructed in innumerable and situated ways by reflexive actors (Benton & Craib, 2010). Human actors exploring social phenomena inescapably shape and are shaped by that social phenomenon (Ritzer & Stepnisky, 2017). This constitutes a 'double hermeneutic' as researchers interpret the actions and meanings of others which are in turn shaped by others' actions and inferred meanings, including that of the researcher him/herself (Blaikie, 2007).

The nature of the 'thing studied' in this project – patients' experiences of restrictiveness in secure forensic settings – therefore needs to be couched in an understanding of social scientific inquiry that treats knowledge as dependent on experience, interpretation and context. This project aims to explore qualitatively and infer quantitatively experiences of restrictiveness

as expressed by patients themselves. In accordance with the principle of 'foundationalism' described above, the ontological and epistemological positions adopted for this project are outlined.

4.2.2 Ontological Position

Ontology asks the question, 'what kinds of things are there in the world?' (Benton & Craib, 2010; Denzin & Lincoln, 2013). There are three key ways to respond to this: materialism, idealism and dualism (Benton & Craib, 2010). Materialists propose that the world exists as a real and tangible entity independent of human perception and experience (Blaikie, 2007). This discrete reality is accessible to us through our senses and therefore underpins much positivist research. Idealists contrastingly take a solipsistic or Cartesian approach (Blaikie, 2007). Proponents assert that the world cannot exist as a separate entity, or if it does, that we are never truly capable of knowing this world (Benton & Craib, 2010).

Dualism encompasses elements of both. Proponents do not refute that there is a 'world out there' yet reject a purely solipsistic account. Dualism, or constructivism[6], offers helpful insights into what constitutes knowledge in the social sciences. This is because human beings construct and interpret the world around them given psychological and sociological context (Hughes & Sharrock, 1997). In the words of Alfred Schutz:

[6] The term 'constructivism' is more common in the literature and will be used in this thesis.

'Social reality consists of the "cultural objects and social institutions into which we are all born, within which we have to find our bearings, and with which we have to come to terms. From the outside, we, the actors on the social scene, experience the world we live in as a world both of nature and of culture, not as private but an intersubjective one […]" (Schutz, 1962:236, quoted in Blaikie, 2007).

This project adopts a constructivist ontology to help guide and enrich the research conduct and analysis as forensic care settings are unique social, organizational and cultural contexts. The experiences of patients residing in secure care are shaped by their understandings, interpretations and interactions with other patients, staff, rules, activities around them, and by their interactions with myself as researcher.

4.2.3 Epistemological Position

Epistemology asks: 'how can we understand anything about the world?' (Benton & Craib, 2010; Hughes & Sharrock, 1997). Epistemological positions can be divided into positivist and interpretivist groupings (Hughes & Sharrock, 1997). Positivism assumes a materialist ontology and through the empirical collection of data and hypothesis-testing generates causal or explanatory statements about the world, often in a quantitative format (Chalmers, 2013). Positivist methods are used frequently in social research as they can capture large-scale social phenomena and explore complex causal relationships (Cook & Campbell, 1979).

Interpretivism proposes that individuals' understandings of reality are constructed and subjective. Social scientific research consequently involves

interpretation in understanding social action, motivation and meaning (Blaikie, 2007, 2010). Interpretivists ask: 'how is it possible to form objective concepts and objectively verifiable theory of subjective meaning structures?' (Blaikie, 2007). An interpretivist position was taken in this thesis as the project sought to explore patient experience; an aspect of their social reality that must be understood through the communication of their subjective understandings.

Two interpretivist contributions were drawn on to aid the analysis of patients' experiences of restrictiveness. These include socially-constructed 'typifications' used by social actors described by Alfred Schutz (1953); and the role social structures play in subjective experience described by Anthony Giddens.

Schutz sought to explain how actors communicate intersubjectivity. For him, the social world:

> *"[…] has a particular meaning and relevance structure for the human beings living, thinking and acting therein. They have preselected and preinterpreted this world by a series of common sense constructs of the reality of daily life, and it is these thought objects which determine their behaviour, define the goal of their action, the means available for attaining them – in brief, which help them to find their bearings within their natural and socio-cultural environment and come to terms with it." (Schutz, 1962: 305, quoted in Blaikie, 2007).*

Schutz proposed that individuals' motivations are shaped by socially constructed 'typifications'. Typifications are common sense constructs

drawn upon by actors in everyday life, held in common and passed on to others, reflected upon, and reinterpreted (Schutz, 1953). Biographical and situational characteristics shape mutually held constructs so that actors can communicate intersubjectively. Individuals then interact, drawing on these meanings, reshaping and co-constructing new typifications together. These typifications denote a way of seeing the world that is socially constructed.

Anthony Giddens felt that much interpretivist work focused on individual-level explanations for social action, neglecting larger structural features. For Giddens, social actors are historically located; they both produce and are produced by their society in time and space (Blaikie, 2007). Actors draw upon resources and the conditions of their world implicitly; they are not cognisant of all the complexities of the social world they interact with and reproduce. Individuals play a role in shaping social structures that in turn shape them. Giddens calls this phenomenon the 'duality of structure'.

Indeed, "[b]y the duality of structure I mean that social structures are both constituted by human agency, and yet at the same time are the very medium of this constitution" (Giddens 1976:121 quoted in Blaikie, 2007). Giddens encourages us to recognise the structural features of the social reality of the actors under study in social scientific research. This is especially salient in forensic settings as patients are situated within 'total' structures including the hospital itself, the regulations operating therein, the legal frameworks directing their care, discourses surrounding the provision of mental health care, and broader social structures that designate MDOs as social deviants.

It is argued in this thesis that given the nature of forensic settings; biographic, interactional, institutional, and systemic features of care are produced and reproduced by the actors within them. Patients shape the structures of forensic care – ward climate, attitudes of staff and other patients, best practice guidelines derived from patient experience, public and political opinion and so forth – and are in turn shaped by these.

These features become typifications for patients as they are experienced every day and co-constructed. Patients have shared understandings of their care settings and build expectations around these. Patient experiences are born of and subsequently shape these typifications and structures. Thus, the data collected in this study was communicated with regard to and through these phenomena. In light of this, data collection and analysis were conducted cognisant of the socially-constructed nature of patient experience. Each participants' experience was captured as a unique narrative but seen as a lens through which broader socially-constructed knowledge claims could be derived.

4.3 Mixed Methodology

Greene's (2006) second domain for conducting rigorous research refers to inquiry logistics or overarching study methodology. This section describes the Mixed Methods Research (MMR) design of this study and the framework adopted to guide the development, validation and revision of the FRQ. MMR is defined as *"[…] a research design (or methodology) in which the researcher collects, analyses, and mixes (integrates or connects) both quantitative and qualitative data in a single study or a multiphase program*

of inquiry" (Creswell quoted in Johnson, Onwuegbuzie, & Turner, 2007: 119). MMR was chosen as it offers an in-depth approach to operationalizing a concept in the development of a questionnaire grounded in empirical data (Cooper, 2018).

The study comprised four phases. First, a literature review was conducted to conceptualize restrictiveness and inform the topic guide used in phase two. Second, semi-structured interviews were conducted with 18 patients in low, medium and high secure hospitals. The purpose of these interviews was to inductively generate data on respondents' experiences of the restrictiveness of their care. The results of the thematic analysis conducted on this data were used to inform the generation of a pool of questionnaire items in the third phase of the study. This phase also involved an assessment of face validity by a panel of five experts in the field of forensic psychiatry. In the fourth phase, 230 patients across 16 NHS Trusts piloted the FRQ and its psychometric properties were explored. A logic model of the study design is presented in Figure 4-1.

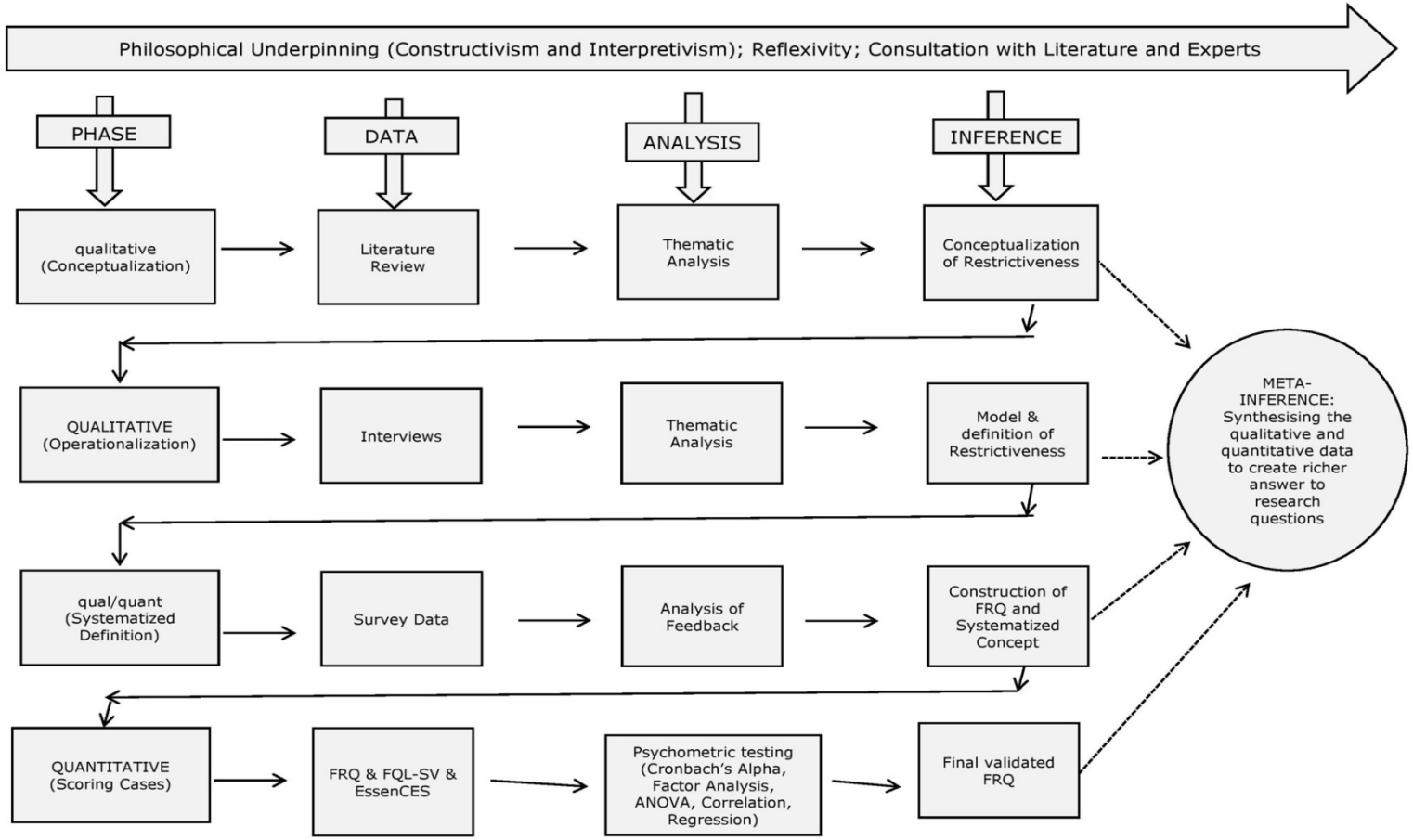


Figure 4-1 Study Outline Logic Mode

This project had a sequential 'qual->Qual->qual/quant->Quant' (Teddlie & Tashakkori, 2009) or 'Exploratory' (Creswell & Clark, 2007) design. The qualitative data from the literature review (small 'q' as it was not the primary qualitative dataset) and interviews (large 'Q' as it was the primary qualitative dataset) were collected to explore how participants experienced the restrictiveness of their care. These data informed the development of pilot FRQ items (qual/quant as the face validity survey used in this phase mixed data types). Finally, the piloting of the FRQ built on the preceding phases with a larger sample, using quantitative methods (hence large 'Q' as this was the main quantitative phase).

In making this shift (qualitative to quantitative) the research was conducted at an idiographic before passing on to a nomothetic level. This is recommended practice for questionnaire development as it grounds the instrument in rich data on patient experience (Adcock & Collier, 2001; Creswell & Clark, 2007; Luyt, 2012; Teddlie & Tashakkori, 2009). This heuristic shift has been used in the development of similar questionnaires including the Forensic Satisfaction Scale (MacInnes, Beer, Keeble, Rees, & Reid, 2010), the Forensic In-Patient Quality of Life Profile (Vorstenbosch, Bouman, Braun, & Bulten, 2014) and EssenCES Ward Climate scale (Schalast, Redies, Collins, Stacey, & Howells, 2008). This enables group-level inferences to be made.

4.3.1 A Framework for Developing, Validating and Revising the Questionnaire

To guide the design, validation and revision of the questionnaire Adcock & Collier's (2001) framework, developed within an MMR paradigm by Luyt (2012), for questionnaire development was used. This is depicted in Figure 4-2.

The questionnaire development comprised three interconnected stages. In the first stage, 'measurement development', a 'background concept' was defined and conceptualized into a 'systematized concept'. The former concept is broad and encompassing, defined as *"[…] broad constellations of meanings and understandings associated with a given concept"* (Adcock & Collier, 2001:531). The systemized concept is a specified definition of the concept of restrictiveness. This is empirically-driven and particular enough to provide common understanding across researchers and disciplines.

The systematized concept was then operationalized into a pool of 'items' that captured the essence of restrictiveness as a latent construct (Raykov & Marcoulides, 2011). These items were questions on the FRQ that respondents had to act upon. When responding to the items participants situate themselves somewhere in relation to the systematized construct of restrictiveness (Adcock & Collier, 2001; Cooper, 2018; Luyt, 2012; Streiner & Norman, 2008). Conceptualization and operationalization took place in the literature review, interview, and face validity phases of this study, i.e the 'qual', 'Qual' and 'qual/quant' phases of the MMR design.

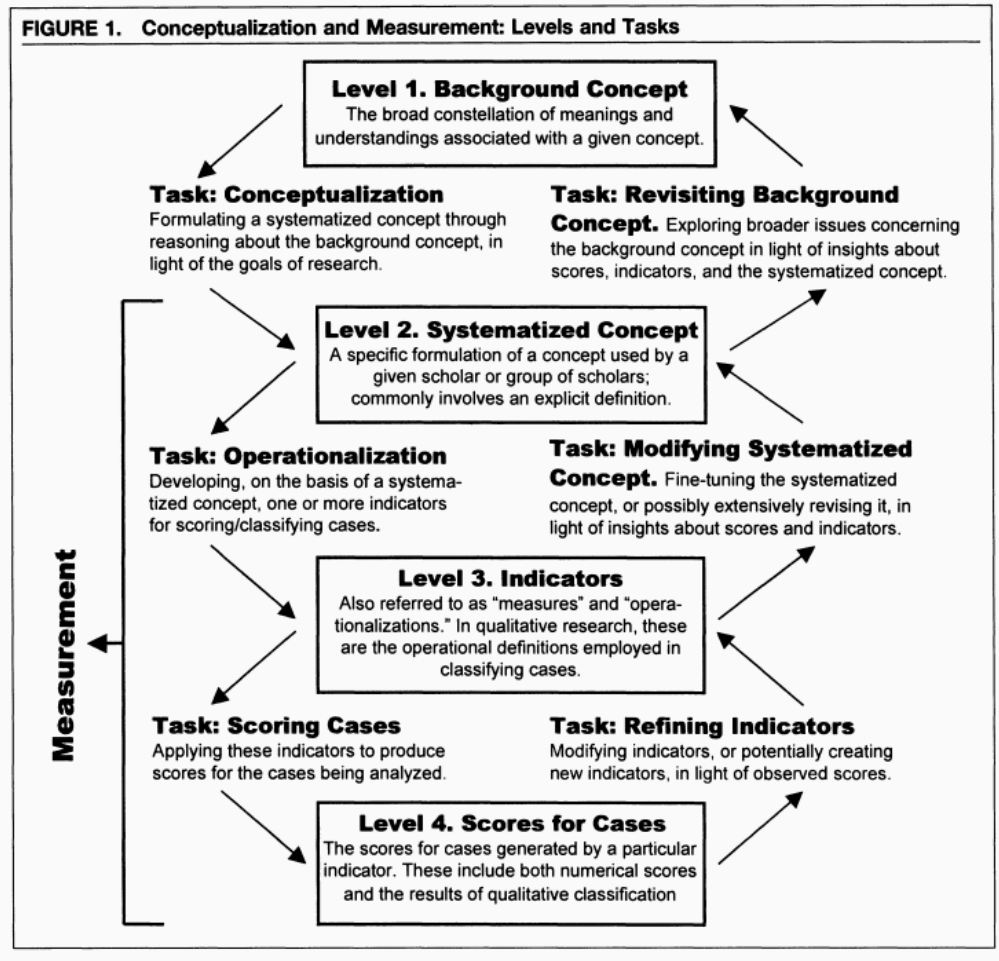


Figure 4-2 Questionnaire Development Protocol (Adcock & Collier, 2001)

The second stage concerns the validation of the psychometric properties of the questionnaire. This consists of a series of statistical tests that explore the construct validity of the measure. These included the dimensionality of the construct, the internal consistency of the scale, and its convergent validity (Cooper, 2018; Hinkin, 1998; Raykov & Marcoulides, 2011; Streiner & Norman, 2008).

Finally, the questionnaire was revised in light of the piloting phase and psychometric properties (Adcock, 2001; Luyt, 2012). This final stage provided a moment to reference the data collected in the previous phases

to ensure fidelity to participant experience. These stages were cyclical, meaning that the empirical data collected during piloting were important in reformulating items in the instrument which necessitated a rethinking of the systemized concept (Adcock, 2001).

4.4 Methods

Greene's (2006) third domain for conducting rigorous research refers to guidelines for practice. It includes the specific methods used to answer the research aims. The first stage of Adcock & Collier's (2001) framework for questionnaire development describes the process for generating a systematized concept of restrictiveness and operationalizing this into the FRQ items. This was guided by literature and an inductive process of empirical work. This section describes the method of qualitative interviewing used to explore patients' experiences of restrictiveness.

4.5 Qualitative Phase

Focus groups were chosen as the preferred method to collect patient experiences of restrictiveness. However, following two mini-focus groups with five participants, this method was replaced by individual interviews. This change was made given difficulties in aligning patient schedules and attrition rates. It was felt individual interviews were consistent with the study's aims and easier to facilitate.

Interviews are a qualitative form of social inquiry and constituted the 'Qual' phase of the study's 'qual->Qual->qual/quant->Quant' MMR project design (Teddlie & Tashakkori, 2009). In this section interviewing as a method is

discussed. It addresses how interviews generate socially constructed data; the semi-structured nature of these interviews; and the method of data analysis.

4.5.1 Qualitative Interviewing

Interviewing is a form of qualitative inquiry (Kvale, 2008). Qualitative methods involve "[…] the systematic collection, organization, and interpretation of textual material derived from talk or observation. [They are] used in the exploration of meanings of social phenomena as experienced by individuals themselves" (Malterud, 2001: 483). Interviewing as a method is commonly used for data collection in the social sciences as it can facilitate in-depth exploration of participant experience, belief and emotion; break down or mitigate a power imbalance between researcher and subject; and give voice to individuals that may have no other platform for expression (Affleck, Glass, & Macdonald, 2013; Mason, 2002; Silverman, 2015).

Interviews have been described as professional interactions or conversations with a purpose (Kvale, 2008). Interviewers utilize a *"…careful questioning and listening approach with the purpose of obtaining thoroughly tested knowledge"* (Kvale, 2008: 7). Interviewing in an academic context aims to generate data that is valid and reliable. Assessing the validity and reliability of interview data is discussed later in section 4.5.4.2.

Kvale (2008) asserts that there are twelve features of qualitative interviewing that researchers must consider and incorporate. These are summarized in Table 4-1.

Table 4-1. Attributes of Qualitative Interviewing (Kvale, 2008)

Feature	Description
Life Worlds	Interviews aim to explore life worlds, one's everyday lived experience as expressed in one's own words
Meaning	Interviewers aim to perceiving in this the meaning of central themes, interpreting what and how something is said
Qualitative	The interview is distinctively qualitative with rich and nuanced data and not numerically driven
Describe	It is the task of the interpreter to accurately describe how interviewees experience, feel and act
Specific examples	The interviewer must use specific examples to illustrate this and develop concrete understandings
Qualified naïveté	The interviewer employs a qualified naïveté wherein they are open to unexpected phenomena, are critical of their own views
Focused	The interviewer must be sufficiently focused to maintain the overall purpose of the research project and themes and dimensions of interest
Ambiguous	Interviewers must remain ambiguous throughout the process, allowing themselves to clarify uncertainties which will inevitably arise
Change	Both the interviewer and interviewee's potential to change mind-sets and understandings as the conversation with a purpose unfolds
Sensitive	The interviewer must be sensitive to the needs of the interviewee, reflecting on what the questions asked demand of them being conscientious not forceful or leading
Interactive	The interview is an interactive phenomenon in which knowledge is co-constructed produced in tandem
Positive	The experience should be positive, both in tone and productivity

Each of these were born in mind throughout the process of conducting mini-focus groups and interviews. Interviewing allowed patients to express in their own words the presence and salience of the restrictiveness of their care setting on their life world.

4.5.2 Semi-Structured Interviewing

The data generated within the mini-focus groups and interviews were socially-constructed. The ontological character of the data are shaped by

the type of interview conducted. A key factor in this process is the structure of the interview: unstructured, structured or semi-structured (Silverman, 2015).

The mini-focus groups and interviews held in this study were semi-structured. Semi-structured interviews maintain some overall structure but permit deviation and interviewee-led foci where still conceptually helpful in answering the study's aims (Silverman, 2015). This helps provide some consistency across interviews allowing for the generation of trends or generalizability, but also gives space to participants to discuss what is salient to them (Kvale, 2008).

Unstructured and semi-structured interviews assume an idealist or dualist ontology with a interpretivist epistemology. Indeed, *"[…] accounts are not simply representations of the world; they are part of the world they describe"* (Hammersley & Atkinson, 1995: 107, quoted in Silverman, 2015).

It was appropriate to use a semi-structured style of questioning in the mini-focus groups and interviews as the concept of restrictiveness was developed inductively. There was no precise theoretical framework in the literature to guide the questions asked and the project's research aims were to explore how patients experienced the restrictiveness of their care setting – they therefore needed some space within the mini-focus groups and interviews to communicate this.

4.5.3 Focus Groups

The following briefly discusses characteristics of focus groups as two mini-focus groups were conducted with N=5 participants. A focus group is *"…a*

particular type of group interview where the moderator (or researcher/evaluator) asks a set of targeted questions designed to elicit collective views about a specific topic" (Ryan, Gandha, Culbertson, & Carlson, 2014: 2, quoted in Silverman, 2015). A handful of set questions shaped and directed discussion but were sufficiently pliant to allow *"[…]participants [to] share and respond to comments, ideas and perceptions"* generated amongst themselves (Litosseliti, 2003: 1).

The data generated in focus groups were therefore highly contingent on those present on the day, the group dynamic, their orientations and politics. This implies that the data is constructed by that group in that context (Barbour, 2008). However, focus groups have been identified as a helpful technique to employ in the exploratory stages of a research project (Kvale, 2008; Litosseliti, 2003).

4.5.4 Qualitative Data Analysis

In this section, the method of data analysis is described and justified in light of the projects' aims and philosophical underpinnings. Qualitative analysis techniques aim to interpret data to generate valid and reliable findings concerning social phenomena (Malterud, 2001). Thematic Analysis, drawing on the Thematic Network Analysis variant outlined by Attride-Stirling (2001), was chosen as the method of qualitative data analysis and is described below.

4.5.4.1 Thematic Network Analysis

Thematic Network Analysis (TNA) is a specific type of Thematic Analysis (Attride-Stirling, 2001). Thematic Analysis is a qualitative form of data

analysis defined as a *"[…] method for identifying, analysing and reporting patterns (themes) within data. It minimally organizes and describes your data set in (rich) detail"* (Braun & Clarke, 2006: 79). TNA is a useful variant of Thematic Analysis as it offers a framework for deriving different levels of themes. This framework is based on Toulmin's Argumentation Theory and groups themes into basic, organizing and global themes.

Argumentation Theory attempts to define and elaborate upon formal and typical elements of a negotiation discourse with the aim of identifying explicit statements and implicit meanings (Attride-Stirling, 2001). It therefore breaks an argument into three parts: evidence or data with which one constructs a warrant; warrants that constitute the premises of a claim; and claims which are conclusion of an argument.

Thus, in TNA basic themes are composed of empirical data; organizing themes group these together and constitute one's warrants; and global themes bring together several organizing themes, or claims, to form an overarching conclusion embedded in empirical data.

TNA proceeds as an inductive process allowing the data to guide the analysis. However, the method is not entirely theory-independent for two reasons. First, philosophers of science highlight that empirical observation of knowledge claims cannot exist *a priori* to theory as some degree of theory must have informed one's research aims, how the research was conducted, and how it was observed and communicated (Blaikie, 2007; Chalmers, 2013).

Second, the conceptual framework developed in the literature review presented in chapter three provided a guide that was referenced deductively in the analysis and used within the mini-focus groups and interviews. As the analysis developed and organizing and global themes emerged, the process moved from data-driven and inductive to abductive whereupon data was considered in light of emerging themes and vice-versa. Developing themes in this way is recommended in the Thematic Analysis literature (Attride-Stirling, 2001; Braun & Clarke, 2006; Fereday & Muir-Cochrane, 2006).

Given that TNA requires those employing the method to explore and retrieve distinct themes operating at different levels within the data the technique is inherently interpretivist. Indeed, *"[a]nalysis of qualitative material is a necessarily subjective process capitalizing on the researchers' appreciation of the enormity, contingency and fragility of signification"* (Attride-Stirling, 2001: 402-403). This subjectivity is in line with the interpretivist epistemology underpinning this research project. It proceeds on the assumption that knowledge is co-constructed by individuals as the participants' life worlds as understood and expressed in the mini-focus groups and interviews are then synthesized and interpreted by the researcher.

Themes were generated using NVivo version 14 software. TNA requires six steps: first, the empirical data were coded line-by-line; second, these codes were grouped together in lower level themes; third, these lower level themes were arranged into networks of basic, organizing and global themes; fourth, these networks were then explored in detail and described

explicitly; fifth, these networks were then summarized and presented before finally being interpreted in light of the research aims and theory (Attride-Stirling, 2001).

4.5.4.2 Quality in Qualitative Research

There is debate in academic literature on how to assess the value of qualitative research, particularly when situated within a mixed methods project (Bryman, 2003; Kvale, 2008; Onwuegbuzie, 2012; Teddlie & Tashakkori, 2009). This questions whether or not it is desirable or possible to use quantitative measures of quality such as internal and external validity, construct validity, and reliability. Some scholars argue for a unique phraseology that reflects the subjective and interpretative nature of qualitative data; preferring transferability, dependability, trustworthiness and credibility (Bryman, 2003; Denzin & Lincoln, 2013; Kvale, 2008; Onwuegbuzie, 2012).

This thesis adopts Kvale's (2008) framework for assessing quality in qualitative research. This framework uses positivist terminology but applies this to qualitative research designs. The following sections describe how objectivity, reliability, validity and generalizability were sought in this project.

4.5.4.2.1 Objectivity

Given the implications that theoretical underpinnings have on qualitative research and the subjective, interpretivist nature of constructivist paradigms researchers need to be transparent (Denzin & Lincoln, 2013; Malterud, 2001). Indeed, researchers are *"[…] bound within a net of*

epistemological and ontological premises which – regardless of ultimate truth or falsity – become partially self-validating" (Bateson, 1972: 314 quoted in Denzin & Lincoln, 2013).

Strengthening objectivity in the process of collecting and analysing interview data helps remove bias from an interpretivist paradigm as much as possible. Interpretation is part of qualitative research; bias is undesirable. Objectivity is strong where consistent with philosophical assumptions that guide the research. Kvale (2008) distinguishes five types of objectivity.

Objectivity as freedom from bias involves the systematic collection and cross-checking of verifiable interview data and analysis to minimise distortion, bias or prejudice in interpretation. *Objectivity as intersubjective knowledge* asserts that knowledge is co-constructed between interviewer and interviewee(s). *Objectivity of analysis as dialogic intersubjectivity* presupposes agreement through rational discourse and reciprocal criticism between those interpreting a phenomenon.

Objectivity as being adequate to the object investigated assumes that the interviewee(s) are objects that can talk and this talk represents its own ontological reality that must be faithfully reproduced by researchers. *Objectivity as allowing the object to object* is achieved when interviewee(s) are given the opportunity to object to what is being said. Criticism from the interviewee is therefore said to be a significant form of objectivity as the interviewer, or interpreter, is constantly corrected for any misinterpretations by the interviewee(s).

Given that this project assumes a constructivist ontology and interpretivist epistemology, objectivity is best conceived of as objectivity as intersubjective knowledge assessed dialogically. This was appropriate for the mini-focus group and interview data as participants expressed their life worlds and reflected upon the concept of restrictiveness in dialogue that constructed their understanding of the phenomenon. This data was then subject to interpretation by myself in tandem with my supervisors in a further act of intersubjective dialogue aiming to increase objectivity as freedom from bias.

Themes across the data constructed with Thematic Network Analysis strengthened objectivity through this interpersonal dialogue. Therefore, objectivity as intersubjective knowledge was sought in this project through the dialectic nature of the mini-focus groups and interviews and discussions with supervisors. Objectivity as being adequate to the object investigated was sought by audio-recording and transcribing verbatim each mini-focus group and interview by hand.

4.5.4.2.2 Strength (Reliability and Validity)

Kvale (2008) suggests that there are three means through which we can assess the strength of qualitative research: reliability, validity and generalizability.

Reliability is described as the consistency and trustworthiness of research findings (Denzin & Lincoln, 2013). It asks whether findings are reproducible across researchers and within interviews conducted at different times. Reliability needs to be ensured inside and outside the interview. The former

suggests that respondents answer interview questions in a similar way if interviewed by different people. Although deviations will exist in responses, reliability can be sought by checking for details, asking follow-up questions, and exploring examples with participants. The latter requires consistency in transcript interpretation, identifying the same conclusions or themes across coders.

Validity refers to the correctness or strength of an argument the researcher presents; whether it is well-grounded, sound and justifiable. It refers to: *"[…] the extent to which our observations indeed reflect the phenomena or variables of interest to us"* (Pervin, 1984: 48, quoted in Kvale, 2008). Validity drops concern for absolute truth and aims toward strong knowledge claims that are falsifiable. The more attempts at refutation withstood, the stronger the research validity (Benton & Craib, 2010; Chalmers, 2013).

Two approaches to validating interview knowledge claims outlined by Kvale (2008) are utilized in this project. First, *validity as quality of craftsmanship* is an on-going endeavour. It is the continuous exercise of best practice in research conduct, spanning the project's conception, practice and conclusion. Interviewers should critically examine the project's assumptions and conclusions for falsifications by checking for representativeness, researcher effects, triangulation and deviant cases. The researcher also needs to ensure methodological fidelity and be cognisant of theoretical implications of each stage of the research project.

In this project I conferred regularly with academic advisors, published, and presented at conferences for peer scrutiny. Methodological fidelity was

maintained as the research protocol was constantly referenced to ensure compliance. Transparency was ensured by presenting the project's methodology in depth in this chapter, maintaining a participant recruitment and data collection journal and providing excerpts of empirical data (see chapter five). Theoretical implications were considered at each stage of the project (e.g. shifting from focus groups to individual interviews).

Second, valid knowledge claims should be *reflective of the discursive turn* in that knowledge claims ought to have communicative validity. Communicative validity maintains that observation and interpretation must acknowledge the unique discourse utilized by the social group studied. Research must therefore present data and findings contextualized in participants' historical and social setting.

Communicative validity was sought by providing verbatim excerpts from interviews and prioritizing participants' voices in the construction of the FRQ. These experiences were given more weight than the data collected in the literature review and the assessment of face validity. FRQ items were phrased as closely as possible to participants' talk.

4.5.4.2.3 Generalizability

Finally, qualitative data produced in mini-focus groups and interviews may also be generalizable (Silverman, 2015). Generalizability can be assessed analytically in qualitative research (Kvale, 2008). Analytical validity consists of reasoned judgement about the extent to which findings from one study can be used as a guide to what might occur in another situation.

Thus, 18 individuals from different hospitals, levels of security, genders, and diagnoses participated to capture a heterogeneous range of experiences and increase the generalizability of findings. The idiographic-level data collected in these interviews was used in this project to inform the FRQ which sought knowledge claims at a nomothetic level. The FRQ is therefore predicated on the possibility that qualitative data is generalizable. Indeed, as the psychometric analysis of the FRQ data presented in chapter seven attests, it is a valid measure of restrictiveness drawn directly from patient experience across England.

4.6 Generation of the FRQ Items and Face Validity

This chapter has thus far described the methods employed for the 'qual' and 'Qual' phases (literature review, mini-focus groups and interviews) of the 'qual->Qual->qual/quant->Quant' MMR design. These phases fall within stage one of three of the framework for developing, validating and revising a questionnaire as described by Adcock (2001) and revised by Luyt (2012). Stage one focused on conceptualizing the phenomenon of restrictiveness in secure care before operationalizing a systematized definition of the concept that was grounded in the empirical data collected in the mini-focus groups and interviews, supported by the literature review. The following section briefly describes the processes of item generation and assessing their face validity. A more detailed discussion of this process is provided in chapter six.

A pool of 80 items that were hypothesized to indicate the latent construct of restrictiveness was compiled. These items were derived from the

literature, mini-focus group and interview data, grounding them in patients' experience. The items were *"[…] chosen so as to sample all possible contents which might comprise the putative trait [restrictiveness] according to all known alternative theories of the trait"* (Loevinger, 1957: 659, quoted in Streiner & Norman, 2008). To embed participants' experiences and to be discursively familiar to them, some items were developed from the focus group and interview data using direct quotes where appropriate.

These items were sent to a panel of five experts in the field of forensic psychiatry for an assessment of face validity. Feedback was requested in the form of a survey. Responses fell into three sections. Participants were asked to indicate on each item to what extent they felt it helps capture the concept of restrictiveness; and to what extent each item was likely to be understood by the target population. A three-point Likert scale with the responses 'Totally', 'A little' and 'Not at all', was used to capture this feedback quantitatively. Space was also provided for experts to reflect on the items qualitatively.

This phase influenced the addition, removal or alteration of some items prior to piloting it with the target population in phase four. The methods used for phase four are described in the following section.

4.7 Quantitative Phase

The quantitative phase of the thesis involved the validation of the psychometric properties of the FRQ. This constitutes the 'Quant' of the study's 'qual->Qual->qual/quant->Quant' MMR design. This phase also marks the transition into stages two and three of Adcock & Collier's (2001)

framework to assess the psychometric properties of the FRQ after it was piloted with a sample of the target population, and its revision in light of this.

Assessing the psychometric properties of any questionnaire is a crucial part of its construction, particularly if it is to have clinical use and consequence (Streiner & Norman, 2008). A series of statistical techniques were used to explore the psychometric properties of the FRQ to assess its reliability and validity (Cooper, 2018; DeVellis, 2016). In this chapter section, reliability and validity are defined, and the statistical methods and parameters used to investigate these described.

4.7.1 Reliability and Validity

Contemporary literature suggests that neither reliability nor validity are end-points that a questionnaire may achieve (Messick, 1995). Instead, they are processes followed to attest to the inferential strength of a questionnaire given the context in which it was produced and completed. Questionnaires that aim to measure particular latent constructs are unable to do so directly – hence the 'latent' nature of the construct – and must use proxy observations, or items on scales, to do so.

Questionnaires can only be said to 'measure' what respondents understood and wrote down when completing the questionnaire (Raykov & Marcoulides, 2011). This is measurement by fiat (Coombs, 1964; Cooper, 2018). Thus, items hypothesized to be reflective of the latent construct of interest will inevitably fall short of capturing it in its entirety (Raykov & Marcoulides, 2011).

In light of this, scholars aim to assert that their questionnaire is a strong measure of the construct and that it produces consistent results when making inferences about individuals given their scores. Reliability and validity are better seen as processes of strengthening or refuting the strength of a measure in particular contexts; rather than an attainable end-point (Cooper, 2018; Streiner & Norman, 2008). Important in this process is acknowledging the context in which the questionnaire was completed and restricting claims of reliability and validity to reflect where, when, and by whom the questionnaire was completed.

4.7.1.1 Reliability

"Reliability is a fundamental way to reflect the amount of error, both random and systematic, inherent in any measure" (Streiner & Norman, 2008: 167). It is the interaction between those completing the questionnaire, the questionnaire itself, and the setting in which it was completed.

Error in measurement can result systematically as some manifest error within the questionnaire, i.e. the items of the questionnaire reflect a different construct of interest; are phrased poorly; or encourage participants to answer in a skewed way (Cooper, 2018). Error can also occur randomly where participants feel tired; respond without contemplation; accidentally tick the wrong box, and so forth. Measures of reliability can therefore indicate the extent to which the variation in the results of the questionnaire reflect variation in the true scores of the target population. Reliability can be understood as a coefficient expressed as: subject

variability / (subject variability + measurement error) (DeVellis, 2016; Streiner & Norman, 2008).

Reliability can be explored in several ways, including test-retest, inter-rater reliability or by internal consistency assessments (DeVellis, 2016; Hinkin, 1998; Streiner & Norman, 2008). Only internal consistency was explored in this study. It is typically presented as a measure of reliability in academic literature although it does not provide a reliability coefficient as the other two would (Streiner & Norman, 2008). It does however provide an indication of the reliability of a scale, as internal consistency tells us to what extent the scale is measuring the same thing across items. Test-retest reliability was not conducted due to time constraints and inter-rater reliability was not sought as the FRQ is self-report.

4.7.1.2 Validity

Reliability is a necessary but not sufficient precondition in establishing of the usefulness of a scale (Streiner & Norman, 2008). Scales can score highly on a measure of reliability but consistently measure a different concept than that of interest. Thus, it is crucial to assess the validity of a measure. Validity traditionally referred to a triumvirate of measurements; content, criterion, and convergent-divergent validity (Streiner & Norman, 2008). Recent developments in psychometric testing assert that a broader process of hypothesis-testing that incorporates traditional elements of validity offers a stronger approach to scale validation (Cooper, 2018). This understanding of construct validity approach draws heavily off the work of Messick (1995).

Furr (2013) describes this. He highlights four types of construct validity evidence: scale content (content validity), internal structure (dimensionality), associations amongst scores and other variables (convergent/divergent validity), and response processes. The fourth of these was not assessed in this study as the participants' actions were not observed; data were only collected on their questionnaire scores.

Content validation refers to the extent to which an instrument is representative of the concept it is intended to measure (Messick, 1995; Streiner & Norman, 2008). Assessing this representativeness is not statistical; it is theoretical and was investigated in this project through expert opinion, empirical data, and literature to help strengthen claims of content validity. Participants were further asked to express thoughts on the pilot FRQ whilst completing the questionnaire.

The dimensionality of the FRQ was explored with Exploratory Factor Analysis (EFA). The dimensional structure of the FRQ was hypothesised given the themes derived from the qualitative interviews reported in chapter five. Convergent validity was explored by placing the FRQ within a nomological network. The hypothesised nomological network in the present study included measures of ward atmosphere and quality of life (QoL).

Evidence of hypothesised associations amongst scores was explored in several ways. Differences on FRQ scores across individuals on their demographic, clinical and legal profiles were investigated. Further, differences on FRQ scores between respondents that had experienced a recent adverse event and those that had not were inspected.

Taken together, these approaches offer evidence to support or refute the contention that a questionnaire validly measures the latent construct its authors purport it to (Furr, 2011; Streiner & Norman, 2008). The specific statistical methods used to investigate the reliability and validity of the pilot FRQ are described in the following section.

4.7.2 Quantitative Data Analysis

4.7.2.1 Initial item reduction

STATA v.14 and IBM SPSS v.24 were used to run the statistical analyses. Significance levels were set to p=<0.05, two-tailed. Prior to exploring reliability and validity, items on the FRQ were scanned for exclusion from the analysis. Reducing the total number of items was important given the ratio of items (56) to sample (N=221). Five criteria were used for item removal. 1) Items that correlated very highly (Spearman's ρ=>0.7) with other items suggesting their inclusion added little discriminatory power; 2) items that correlated highly (Spearman's ρ=>0.6) with other items were removed if it was felt one was qualitatively redundant; 3) items with high 'ceiling effects', where >50% of responses fell on a single item and >80% were for agree or disagree (including the 'Not Applicable' option'); 4) items that had Corrected Item-Total Correlation (CITC) scores <0.3; and 5) items that upon reflection were not representative of restrictiveness presented in chapter five were removed.

4.7.2.2 Exploratory Factor Analysis

A measure of the construct validity of a measure is how well the empirical data support the hypothesized latent factorial structure of the scale (Hinkin,

1998). Exploratory Factor Analysis was undertaken to explore the underlying structure of the FRQ and to remove items that were not placing well within any of the identified factors.

Exploratory Factor Analysis was chosen to explore the dimensionality of the FRQ. The process for conducting EFA follows the recommendations of Furr (2011) depicted in Figure 4-3. EFA is an iterative, theory-driven approach that groups together variables that are hypothesized to reflect respondents' scores on a latent variable (Costello & Osborne, 2005; Dancey & Reidy, 2014; Fabrigar, Wegener, MacCallum, & Strahan, 1999; Furr, 2011).

4.7.2.2.1 Suitability of data for EFA

The Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy was calculated to investigate whether variance across FRQ items was influenced by underlying factors (Cooper, 2018). KMO scores >0.7 suggest data are influenced by underlying factors (Cooper, 2018). Bartlett's Test of Sphericity was used to explore whether the overall item correlation matrix was meaningfully different from an identity matrix, indicating the data would be suitable for Factor Analysis (Cooper, 2018; Tabachnick & Fidell, 2013). Significance values $p<.05$ would suggest this. Bartlett's test is suitable for samples with a participant to item ratio of 5:1 or less (Tabachnick & Fidell, 2013).

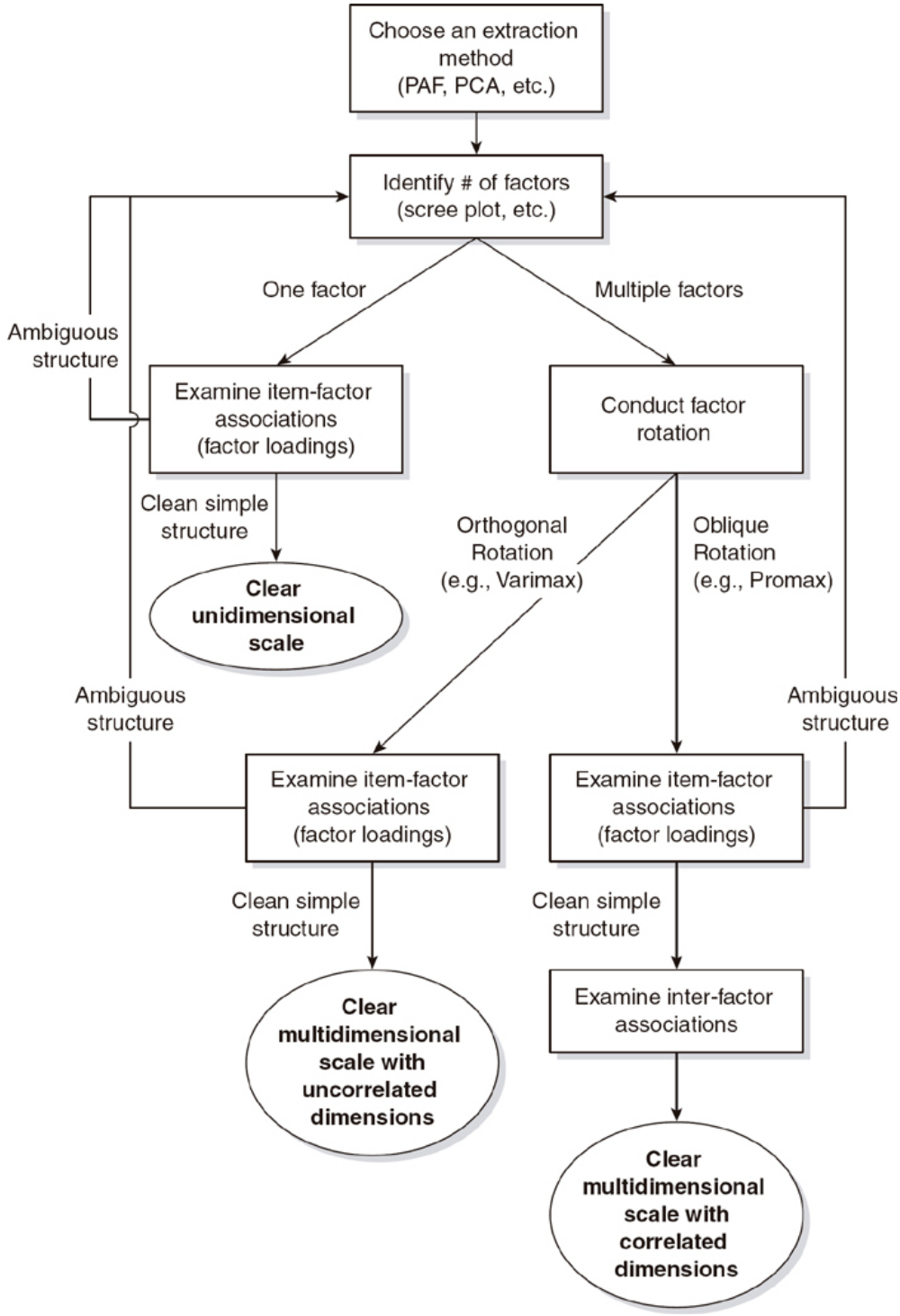


Figure 4-3 Procedure for EFA from: Furr (2011)

4.7.2.2.2 Factor Extraction

Factors were extracted using Principle-Axis Factoring (PAF). PAF was preferable to Principle Components Analysis (PCA) as the latter seeks only to reduce data structures and in doing so does not consider data to reflect latent variables (Costello & Osborne, 2005; Furr, 2011). As the data were hypothesized to be influenced by 'restrictiveness', PAF was chosen. PAF is suitable for non-parametric data, and therefore a necessary choice given the FRQ data were not normally distributed (Costello & Osborne, 2005).

4.7.2.2.3 Factor Retention

The decision to retain factors was based on several criteria: the Kaiser-Criterion rule of Eigenvalues >1.0; scree plot analysis; and parallel analysis. Eigenvalues >1.0 is an often-used heuristic for factor retention. However, the Kaiser-Criterion rule is subject to criticism for inaccuracy in the literature (Costello & Osborne, 2005; Fabrigar et al., 1999). It was therefore interpreted with caution. Scree plots were scanned and factors above a discernible curve were considered for retention (Furr, 2011). Parallel analysis based on the Monte-Carlo simulation technique was used with 10,000 repetitions. Observed factors with Eigenvalues greater than those generated in the parallel analysis were considered for retention.

4.7.2.2.4 Factor Rotation

Oblique, promax rotation was chosen to clarify resulting factors. Rotation aims to simplify data structure, making factors more interpretable (Costello & Osborne, 2005; Furr, 2011). Oblique rotation was chosen over orthogonal as it was hypothesized extracted factors would correlate. This is best practice in social science data (Costello & Osborne, 2005).

4.7.2.2.5 Item Loadings

Items were removed if they failed to load onto a factor meaningfully. Items with factor loadings <0.3 were considered weakly associated and were removed (Dancey & Reidy, 2014; Fabrigar et al., 1999; Furr, 2011). Items were removed if they cross-loaded >0.3 onto two or more factors.

4.7.2.2.6 Iterative Process

As EFA is an iterative process, numerous models with different factorial solutions were computed before the most meaningful structure, guided by hypothesis and theory, was arrived at.

4.7.2.3 Measure of Reliability

4.7.2.3.1 Internal consistency

Internal consistency is considered a measure of reliability and was explored in this study (Furr, 2011). Internal consistency explores to what extent all items within the scale correlate with each other. Cronbach's Alpha (α) provides a statistic on the internal consistency of the scale as a whole. An α >0.7 was considered the minimum for a satisfactory score of internal reliability (Hinkin, 1998).

The Corrected Item-Total Correlation (CITC) score provided a correlation coefficient between each item and all others on the scale except itself. Items with CITC scores <0.3 were considered low and were hypothesized not to measure the latent construct of restrictiveness. Items were removed if they had a CITC score <0.3.

4.7.2.4 Measures of Convergent validity

Convergent validity explored the extent to which restrictiveness as captured by the pilot FRQ correlated in a hypothesised fashion with quality of life and ward climate. Spearman's RHO was used as the FRQ and FQL-SV data were not normally distributed (Dancey & Reidy, 2014).

4.7.2.4.1 EssenCES patient-version

Ward Climate was measured with the EssenCES patient-version (Schalast et al., 2008). This scale was initially designed in German and subsequently translated into English. The scale is composed of 15 items across three domains. The domains comprise therapeutic hold (TH), experienced safety (ES) and patient cohesion (PC).

It has shown strong psychometric properties (Schalast et al., 2008). Principle Components Analysis revealed the above domains, indicating good content validity. Internal consistency was demonstrated for each domain (α= 0.87, 0.79 and .80 for TH, ES and PC respectively). Significant positive correlations with three other measures of ward milieu suggested suitable convergent validity (Schalast et al., 2008). EssenCES has been validated in an English secure setting (Milsom, Freestone, Duller, Bouman, & Taylor, 2014).

4.7.2.4.2 Forensic Quality of Life-Short Version (FQL-SV)

Quality of life was measured with the short version of the Forensic Quality of Life Profile (Schel, Bouman, Vorstenbosch, & Bulten, 2017; Vorstenbosch et al., 2014). This scale was developed in The Netherlands and translated into English. The FQL-SV is comprised of 20 items. It asks patients about a

range of topics including leave, safety, food, personal hygiene, sexuality and relationships with other residents.

It has demonstrated good psychometric properties in a Dutch sample (Schel et al., 2017). Internal consistency was good (α =.79). Convergent validity was demonstrated as the FQL-SV correlated significantly with the World Health Organization's WHOQOL-Bref QoL measure, and the EssenCES measure of ward climate. The FRQ-SV total score correlated significantly with the three domains of the EssenCES; and the WHOQOL-Bref domains 'psychological health' and 'environment'. It did not correlate significantly with the domains 'physical health' or 'social relations' of the WHOQOL-Bref. It's parent instrument, the FQL long version, has also demonstrated good psychometric properties (Vorstenbosch et al., 2014).

4.7.2.5 Recent Occurrence of Adverse Events

An independent samples t-test was conducted to explore whether total FRQ scores were significantly different between individuals stipulating that they had experienced something hard, difficult or hurtful within the week prior to completing the FRQ and those not stipulating this. Independent samples t-tests assume that data are normally distributed, the groups are independent, and there is homogeneity of variance between groups (Dancey & Reidy, 2014). The first assumptions was investigated with the Shapiro-Wilk statistic (Dancey & Reidy, 2014). The second assumption was assessed by inspecting the data. The third assumption was investigated with Levine's Test of Equal Variance (Acock, 2008). Where this assumption

was not met, the Welch-Satterthwaite adjustment was used (Ruxton, 2006).

Bootstrapping was performed to help interpretation of inferential results where the data were non-parametric. Bootstrapping with SPSS's bias corrected accelerated function was conducted on all analyses of mean differences. Bootstrapping provides an alternative way of estimating population parameters (Hinton, Brownlow, & McMurray, 2014). Bootstrapped 95% C.I of mean differences between groups are reported to give a more reliable indication of mean differences at the population level given the non-normal distribution of some the data in the present study.

Non-parametric alternatives are recommended where data are extremely skewed with a small sample size (Dancey & Reidy, 2014). This was not the case in the present study so an independent samples t-test conducted with bootstrapping. The effect size of the difference between groups was calculated using Cohen's *d*. Effect sizes of 0.2 were considered small, 0.5 moderate, and 0.8 large (Cohen, 1988).

4.7.2.6 Legal, clinical and demographic profiles

Data on participants' legal, clinical and demographic profiles were collected. These data provided a descriptive account of patients involved in the study and allowed analysis of significant differences between groups. Data were collected on age, gender, ethnicity, mental health diagnosis, index offence (if applicable), Mental Health Act (1983) section, and length of stay in current hospital.

One-way, between group ANOVAs were conducted to investigate group differences on FRQ scores where there were three or more groups. ANOVAs are suitable for comparing the means of interval-level outcome variables across categorical groups (Acock, 2008). ANOVAs carry several assumptions: 1) the scores on the dependent variable are normally distributed; 2) the groups are independent of each other; 3) there are no significant outliers; 4) there is homogeneity of variance between groups; 5) and the dependent variable is at least interval level (Acock, 2008; Dancey & Reidy, 2014).

The first assumption was investigated with the Shapiro-Wilk statistic (Dancey & Reidy, 2014). ANOVAs were conducted where this assumption was violated if most of the other assumptions held as ANOVAs are robust to deviations from this assumption (Shingala & Rajyaguru, 2015). Bootstrapping was also performed to help interpretation of inferential results where the data were non-parametric. Bootstrapping with SPSS's bias corrected accelerated function was conducted on all analyses of mean differences as with the independent samples t-test.

The second assumption was assessed by inspecting the data. The third assumption was assessed graphically with box and whisker plots. The fourth assumption was investigated with Levine's Test of Equal Variance (Acock, 2008). The final assumption was assessed by inspecting the data.

Partial eta^2 (η_p^2) was calculated as a measure of effect size where significant differences in variance were found. η_p^2 demonstrated how much variance in FRQ scores was accounted for by the demographic, legal or clinical

grouping. The Tukey HSD *post hoc* test was employed to investigate the significance of differences between specific groups where equality of variance was found (Dancey & Reidy, 2014). Tukey HSD is conservative and suitable where samples sizes differ between groups (Hilton & Armstrong, 2006). The Games-Howell multiple comparisons *post hoc* test was employed to investigate the significance of differences between specific groups where equality of variance was not found (Games & Howell, 1976; Hilton & Armstrong, 2006; Shingala & Rajyaguru, 2015).

Independent samples t-tests were conducted to investigate the difference in mean FRQ scores between two groups. Bootstrapping with SPSS's bias corrected acceleration function with 1000 samples was conducted. The assumptions and procedures for conducting an independent samples t-test were described in §4.7.2.5 and will not be repeated. Effect sizes were calculated with Cohen's *d*; 0.2 was considered small, 0.5 moderate, and 0.8 large (Cohen, 1988).

All ANOVAs and t-tests were conducted within the IBM SPSS statistical package v.24 to make use of the Bootstrapping technique.

The relationships between age and FRQ score, and length of stay at current institution and FRQ score were explored using Spearman's RHO. Spearman's RHO is a suitable non-parametric measure of association to use where data are not normally distributed (Dancey & Reidy, 2014). Age was measured in years; length of stay at current institution was measured in months and are thus both continuous-level data.

In summary, the above psychometric methods were undertaken to explore the reliability and construct validity of the FRQ in the context of the present study. Revisions to the FRQ were made in light of this and participant feedback.

4.8 Data Collection and Sampling

The following section describes the process for sampling and recruiting participants for the qualitative interviews and the piloting of the 58-item FRQ. The process for recruiting the panel of experts described in §4.6 is outlined in chapter six.

4.8.1 Sampling Method and Inclusion/Exclusion Criteria

The process for sampling was the same for both qualitative and quantitative phases of the study, therefore this is presented together. The sampling frame comprised the forensic inpatient population. This population is described in section 1.3.1 of this thesis. Individuals with a diagnosis of a learning disability were excluded from the study given the lack of expertise to address the needs of this group. Patients that were being secluded or restrained at the time of recruitment were also excluded. This was due to restrictions imposed by clinical staff, concerns not to exacerbate poor mental health, and lack of ethical approval. Patients needed capacity to consent and willingness to participate.

Sampling proceeded as non-probabilistic, accessible and purposive (Creswell & Clark, 2007; Lynn, 2016; Silverman, 2015). This was because

patients could not be randomly chosen as they needed to have capacity to consent and be willing to participate. Many individuals were not interested in the research. Participants' accessibility was limited to those NHS Trusts that had agreed to participate in the project with whom appropriate self-defence, good clinical practice training had been undertaken by the researcher(s); and were within the resource limits of this project. The number of participating Trusts was capped to ensure the project could be managed remotely from Nottingham.

A purposive sampling design was followed to mitigate these limitations and seek a representative selection of voices. Individuals with a range of diagnoses; levels of security; genders; and ethnicities were approached. Thus, low, medium and high secure hospitals were involved; different wards that provide care for specific diagnoses and genders were approached; and patients were encouraged to participate if they were of black or minority ethnicity. Further data were collected on patients' length of stay at current institution, Mental Health Act (1983) section, and index offence. A summary of the inclusion and exclusion criteria are presented in Table 4-2.

Table 4-2 Inclusion and Exclusion Criteria

Inclusion Criteria	**Exclusion Criteria**
• Sufficient grasp of English language (with use of translator if requested) • Capacity to consent • Primary diagnosis of Mental Illness, Personality Disorder or 'Other' (defined in Chapter seven)	• Too unwell to participate (asserted by individual or staff) • Primary diagnosis of a Learning Disability • Lacked Capacity to consent

4.8.2 Sample Size

The target sample size for the qualitative study was N=30 focus group participants (Barbour, 2008; Litosseliti, 2003). However, this changed as the focus groups method was replaced by individual interviews[7]. Creswell and Clark (2007) write that instead of selecting large numbers of respondents, studies should identify a small number of individuals that will provide in-depth, personal experiences of the phenomenon of interest. They propose that the sample size should reflect the study methodology and permit rich analysis.

Subsequently, this target was revised to N=20. This target was set to balance maximising reliability, validity, and transferability when interpreting the data (Kvale, 2008; Malterud, 2001); and the time constraints of the project. It was felt that N=20 was large enough to satisfy the demographic and clinical representativeness sought in the sample and approach data saturation (Ness & Fusch, 2015). This target was also considered suitable in light of the method of data analysis: Thematic Analysis. Thematic Analysis utilizes a smaller 'N' than quantitative methods but larger than phenomenologically-informed qualitative approaches, such as Interpretative Phenomenological Analysis (Braun & Clarke, 2006; Larkin, Watts, & Clifton, 2006).

The target for the quantitative phase was N=200. This target was set for several reasons: with reference to the literature on conducting Exploratory

[7] Reasons for this were explained in §4.5.

Factor Analysis (EFA) for psychometric assessment; the study design and aims; comparison to other questionnaires developed in forensic hospitals; the target population; and given the time constraints of the project.

The literature gives different estimates for appropriate sample sizes when conducting EFA. Ideal sample sizes have been identified at the 10:1 ratio or a total of N=200 (Hinkin, 1998). A review of studies published in PsychINFO over a two-year period that conducted EFA found participant to questionnaire item ratios below 5:1 comprised 40.5% of the included studies (Costello & Osborne, 2005). Some recent developments in EFA suggest it is possible to conduct with samples as small as N=50 (Jung & Lee, 2011).

Fabrigar and colleagues (1999) propose that depending on the nature of the collected data adequate absolute sample sizes can range from N=100 to N=400 or N=800. The nature of the data depends on to what extent items load onto factors; item communalities; number of items; whether items cross-load on factors; the number of factors extracted; as well as the sample size (Costello & Osborne, 2005; Fabrigar et al., 1999; MacCallum, Widaman, Zhang, & Hong, 1999).

The number of participants included for validating scales and conducting EFA in forensic settings varies. This is in part due to the clinical characteristics of patients, the target population size, and security measures affecting access to patients.

The Forensic Satisfaction Scale had a sample of N=63 patients to assess the psychometric properties of a 96 item scale in the U.K. (MacInnes et al.,

2010). The 15-item EssenCES ward climate measure was assessed with a sample of N=327 from 46 wards in Germany (Schalast et al., 2008). The Forensic inpatient Quality of Life questionnaire (FQL) authors recruited N=98 unique participants to complete the questionnaire at three different time-points (N=53, 50 and 60 patients respectively) to assess the properties of the 114 subjective items in the Netherlands (Vorstenbosch et al., 2014). The authors of the Coercion Experiences Scale (CES) conducted EFA on 41 items with a sample size of N=102 (Bergk et al., 2010).

Given the exploratory nature of this study; that the FRQ sought to measure a single construct; the target population; comparable measures developed in secure settings; and with reference to the literature on conducting EFA a target of N=200 was set.

4.8.3 Sites

Data for the qualitative phase were collected within one NHS Trust in the East Midlands. Data collection took place across three low, medium and high secure hospitals. These sites were chosen to ensure residents in all security levels of care were represented. The low and medium secure sites primarily treat male, mentally ill MDOs and civilly-detained patients. There is one female ward at the low secure site. The high secure site offers treatment for male and female personality disordered and mentally ill MDOs. Qualitative data were collected by myself.

The quantitative data were collected from 16 NHS Trusts across England. In the leading NHS Trust, data were collected by a colleague and myself. When it became apparent the target N=200 would not be reached in this

site, the study was placed on the Clinical Research Network (CRN)[8]. Thus, 15 Trusts were added to the project. Each Trust needed ethical and local NHS approvals, and to appoint local Principle Investigators (PI) and Chief Study Officers (CSO). The 15 NHS Trusts followed the same protocol, inclusion and exclusion criteria, ethical procedures, and data management plans developed for the lead Trust. These Trusts are spread around the country, adding to the representativeness of secure services. Trusts set their own targets which ranged from N=4 to N=40. Data and consent forms were securely communicated to myself for storage and analysis.

4.8.4 Process of Recruitment

To gain access to the participating sites approvals were obtained from national ethical bodies; self-defence training was undertaken; and the permission of Ward Managers, Clinical Directors and Responsible Clinicians sought. Access also required NHS training in information governance and good clinical practice.

To recruit participants, I spent time getting to know those residing and working in the hospitals involved in the project. Initially I presented the research to members of staff at two sites (one of which chose not to participate in the project); met with the clinical director of a third site; and communicated with a fourth clinical director over email to gain their assent to conduct the study.

[8] For more information on the CRN, please visit: https://www.nihr.ac.uk/nihr-in-your-area/local-clinical-research-networks.htm

The project was then presented at ward community meetings to both patients and staff. Interested patients could approach myself directly or by indicating their interest to staff with whom I liaised. Patients were given information sheets and the project was explained to them. Patients' Responsible Clinicians were approached to ascertain if they believed the patient should not participate for any reason. Patients were given at least 24 hours to reconsider participation before a meeting was set. In this meeting participants signed consent forms and participated in an interview or completed three questionnaires. Demographic data were obtained through patients notes stored electronically. Data were securely transported and stored in accordance with ethical approvals.

4.9 Researcher Biography and Reflexivity

Greene's (2006) fourth domain for conducting rigorous research describes the researchers' socio-political commitments. All social actors are endowed with their own biographies, socio-political commitments and limited understanding of the world around them (Denzin & Lincoln, 2008; Malterud, 2001; Onwuegbuzie, 2012). It is important therefore to make explicit researchers' own biographies and commitments as these features are likely to colour the conduct and interpretation of their research projects (Koch & Harrington, 1998; Malterud, 2001).

I am a male in my mid-twenties, of white European and middle-class background. I do not have a history of mental disorder and no individual close to me has lived with such a disorder experienced by forensic patients. I have a legal and criminological background rather than a clinical one. I do

not work for the NHS. This placed me in the position of 'outsider' (Silverman, 2015) both from a patient and staff perspective. This brought with it a lack of routine knowledge about the details of everyday life on a forensic care ward but permitted a different perspective on the role forensic care plays or is intended to play in a criminological context.

To maintain reflexivity throughout the project I kept a recruitment and data collection journal, regularly convened to discuss progress with my supervisors, took notes on evolving thoughts and constantly questioned the aims and conduct of the project. For instance, was the project about restrictiveness or autonomy? Is a criminological perspective beneficial if the questionnaire is to have clinical implications? Am I neglecting the perspectives of staff? Are explanations too idiographic, neglecting macro-level features of secure care? By entering the project aiming to explore 'restrictiveness', am I already biasing the research? The purpose of reflexivity in research is to ask these questions, and be cognisant of the role they may play in shaping the project (Koch & Harrington, 1998).

4.10 Research Ethics and Setting

This project was conducted in accordance with ethical principles. Ethics in research refers to the manner in which harms are minimized and goods resulting from the research are maximized (Orb, Eisenhauer, & Wynaden, 2001). Both researcher and participant should not be psychologically, socially or physiologically affected adversely. In this project efforts were made to ensure participants did not leave interviews feeling distressed; private information would not be handled negligently; and patients'

treatment pathways were not affected. This section identifies several ethical risks associated with this project and how they were addressed discussed in light of the unique peculiarities the forensic setting brings.

Features of secure hospitals pose challenges for conducting rigorous and ethical research. Involuntary care, liberty deprivation, mental disorder, levels of risky behaviour, past criminal actions, and isolation from wider social interactions make forensic patients a unique and complex social population.

The experiences of living in secure settings as a mentally disordered offender brings a unique epistemic standpoint little understood by individuals who do not interact with aspects of the forensic system (Coffey, 2006). Highlighting such experiences colours social debate on the topic of mental health care and can help widen society's gaze on the conditions in which individuals are deprived of their liberty.

4.10.1 Principles Underpinning Ethical Research

A framework identified in the literature was used to mitigate any potential harm or ethical misconduct. The specific measures taken were guided by three principles of ethical research identified by Orb and colleagues (2001): autonomy, beneficence and justice. These are described in turn.

Autonomy refers to a participant's ability to freely choose to engage in a project. Individuals were not forced, tricked or coerced into participation. This necessitated more than eliciting a simple "yes, I wish to be involved" answer. To make a more strongly autonomous decision to participate interested individuals were given a detailed account of what the project

involves, its aims, and potential harms, and benefits, before they gave informed consent. Participants were able to withdraw consent if they wished to do so (Moore & Miller, 1999).

Beneficence concerns the act of doing good and preventing harm (Orb et al., 2001). Throughout the research project it was asked whether the following step or action would engender harm or good for participants. This was a reflexive process wherein the overarching aims of the project to achieve some good were constantly balanced alongside an assessment of participants' subjective experience. It was concluded that no harm would occur to participants during the interviews, face validity and questionnaire phases.

Inside the mini-focus groups and interviews, discussion of the restrictiveness of the secure unit had the potential to bring some participants to recall aspects of life not experienced in these settings, i.e. contact with friends and family, travel, past institutionalization etc. To ensure the discussion did not become too upsetting for any individual, I judged the tone of the conversation and prepared questions to change the topic under discussion if necessary; and debriefed with patients before leaving the ward.

Justice requires that researchers do not exploit participants, that they respect their rights and wishes (Orb et al., 2001). Interaction must be fair and perceived as so by participants. This was assessed by whether or not respondents continued to participate and consent (Moore & Miller, 1999). The principle of justice asks that marginalized or vulnerable groups be given

a voice and effort be made to include them in research projects (Silverman, 2015). Patients were sought out in this study deliberately to capture these marginalized narratives.

4.10.2 Risks Involved in the Project

The above principles of autonomy, beneficence and justice underpinned the ethical risks and conundrums that affected this research project. Silverman (2015) highlights several risks to ethical research that were relevant for this project.

Power Asymmetry. Researchers annexed to a University carry with them the weight of the University when they interact with members of the public. For some research participants, researchers can be felt to be clever individuals who may judge them. The researcher also directs many of the activities. This has the potential to create a power imbalance. It was stressed that I was a student undertaking research into patient experiences and that what they had to say was key. This prioritizing of patient experience served to redress some of the power asymmetry. Much time was spent simply being on the wards to answer any questions regarding the project and build a rapport.

Exploitation and Deception. Forensic populations are considered vulnerable; not simply given any mental disorder they may be experiencing but also due to their medication effects, legal restraints and liberty deprivation. To ensure that exploitation did not occur accidentally, several steps were taken. Participants were given a Participant Information Sheet and 24 hours to consider their participation. Subsequent to this were asked if they

consented to the project and their capacity to give written informed consent was assessed.

Anonymity and Confidentiality. Participant anonymity and the confidentiality of data was considered in detail throughout the project. A data protection plan developed with NHS Trust Research and Development was followed. Patients and hospitals were anonymized or pseudonymized. No names are reported in study reports. All participants were told that any matter discussed during the course of the project would be confidential and the information would not be shared in any identifiable way with members of staff. All paper study documents transported in secure envelopes and stored in a locked file cabinet. Electronic data and information were stored on a password-protected encrypted partition of my computer's hard-drive.

Vulnerable Groups. Forensic patients can be seen as a 'doubly vulnerable' population. Quoting (Silva, 1995: 15), Moore and Miller (1999) describe vulnerable groups as those who experience *"[…] diminished autonomy due to physiological/psychological factors or status inequalities"* and consequently lack the ability to make personal life decisions, maintain independence or self-determine.

Safeguards were undertaken throughout the project in light of these vulnerabilities. For instance, patients were never told what to do, at what moment in time and where. Any activity undertaken for the project was discussed with patients' multidisciplinary teams and care was taken to ensure patients' schedules were not affected. Patients were therefore centrally involved in all steps of the research process they participated in.

Each participants' RC was asked if they felt there was any reason why the patient should not or would not be able to participate in the project.

4.10.3 Gaining Research Governance and Ethical Approval

Ethical approval was obtained from four bodies: The University of Nottingham, the Health Research Authority (HRA), a Research Ethics Committee (REC); and the Nottinghamshire Healthcare NHS Foundation Trust Research and Development department (R&D).

The protocol developed for this project was subject to scrutiny from the University of Nottingham's Sponsorship team and NHS Trust R&D to ensure compliance with these guidelines before it was submitted to the HRA and REC. University Sponsorship was granted on 04/04/2017 (see Appendix H).

This project was submitted to the HRA and REC for approval on 05/04/2017. After minor amendments were made REC approval was received on 21/06/2017 and HRA approval was received on 22/06/2017. Letters of approval are presented in Appendix F and G respectively. Final approval from the NHS Trust R&D department was received on 28/06/17.

4.11 Conclusion

This chapter has presented the mixed methods research design employed in this study. It described the study's research aims and the 1) philosophical assumptions and stances; 2) inquiry logistics; 3) guidelines for practice; and 4) socio-political commitments that were drawn upon to answer these aims. The following chapter presents the first empirical phase of this

project; semi-structured qualitative interviews conducted with 18 patients in low, medium and high secure hospitals.

Chapter 5
Qualitative Interviews

5.1 Summary

The previous Chapters have presented the aims, methodology and literature review underpinning this study. The current chapter describes the results of qualitative interviews with 18 residents in low, medium, and high secure settings. This phase sought to elucidate elements of care found to be restrictive. These experiences informed the development of the FRQ items. The analysis in this chapter further conceptualized 'restrictiveness' beyond the literature review in chapter three. This chapter presents the 'Qual' phase of the study's Mixed Methods 'qual->Qual->quant/qual->Quant' design (Teddlie & Tashakkori, 2009). It falls within the conceptualization stage outlined in Adcock and Collier's (2001) framework for developing and validating a psychometric questionnaire. The analysis attempts to fill a gap in our knowledge regarding why, what, how, and with what consequence do residents experience parts of secure care as restrictive. A Model of Restrictiveness is derived from the data.

5.2 Introduction

The qualitative data discussed in this chapter were derived from individual interviews and mini-focus groups (Barbour, 2008; Kvale, 2008). These interviews sought to explore:

1. What elements of secure forensic psychiatric care residents experienced as restrictive
2. How, psychologically, they experienced these phenomena
3. What consequences of restrictive phenomena residents identified

Semi-structured interviews were conducted with eighteen individuals residing within low, medium and high secure forensic hospital in the U.K. The interview question guide can be found in Appendix E. The methodological underpinnings and rationales for these interviews were discussed in chapter four. Respondents were asked a range of questions relevant to the research aims and the discussions were audio-recorded, transcribed and analysed using Thematic Network Analysis (Attride-Stirling, 2001).

The results present restrictiveness as a complex, subjective experience. Many common themes were found yet myriad phenomena were described as restrictive. The analysis of this data aimed to synthesize and reduce complex resident experience into a helpful analytic framework to make sense of restrictiveness. Consequently, this chapter discusses a Model of Restrictiveness and presents its attributes in turn. These attributes are presented as global, organizing, and basic themes in line with the terminology of the TNA method of data analysis.

The analysis suggested that to best understand subjective experiences of restrictiveness five key global themes need to be considered. This is depicted in Figure 5-1. The derived model helps us understand 1) why elements of care might be restrictive; 2) what phenomena are frequently discussed as restrictive; 3) how these phenomena are enacted in an intended or unintended manner; 4) subjective experience of the severity and salience of these; and 5) the consequences restrictiveness might have for individuals. Each of these themes maps onto empirical data and were used to derive items on the FRQ. The Model of Restrictiveness offers a

systematized concept of restrictiveness. This systematized concept is drawn on in step two of Adcock and Collier's (2001) framework to generate a pool of items that capture the latent construct of restrictiveness.

A section has been included in the results that highlights instances where participants did not experience phenomena as restrictive. This is important as restrictiveness was not universal and experienced by all forensic patients all the time. Indeed, many communicated positive experiences of care. These 'deviant cases' were not the focus of investigation in this study; however, it is helpful to note the empirical and conceptual bounds of the concept of restrictiveness by identifying where it was not present, and to highlight instances of good practice. These examples provided support for the proposition made in this study that restrictiveness is subjective.

The participants' demographic, clinical and legal profiles are described. The results are then presented in thematic order. This chapter presents the results of the TNA in six sections. The first five describe the five global themes identified inductively from the in the TNA. As the analysis developed it became apparent that emerging themes overlapped with the concept analysis categories (Walker & Avant, 2011) and qualitative themes (Braun & Clarke, 2006) described in the literature review. This overlap is discussed in detail in section 5.5.7 of this chapter. The sixth section describes 'deviant cases' to restrictiveness. This section was taken from the concept analysis categories identified by Walker and Avant (2011). Accordingly, the excerpts described in this section are deductive. A discussion closes the chapter, reflecting on the findings and situating these in the wider literature.

A few points on grammar. Ellipses denote a lengthy pause in participants' speech e.g. '…'. Ellipses in square parentheses indicate text has been removed by the author e.g. *'[…]'*. Words in square parentheses have been inserted by the author to add meaning e.g. '[staff]'. '*Sic*' implies a word or series of words were unclear and were replaced by words that sound like what the interviewee was trying to say e.g. *'you get (to pick sic) things off the canteen'*. Apostrophes indicate participants are quoting other people or themselves e.g. *[…] and they'd be like, 'yea but [participant name] they were cunts, used to just attack you for nothing'.* A hyphen mid-way through a word suggests the speaker was interrupted or did not finish the word e.g. '*[…] trainers, boots, toilet ro-, basically whatever […]*.

5.3 Participants' Demographic, Clinical and Legal Profiles

Individual interviews (n=13) and two mini-focus groups (n=5) were conducted between October 2017 and January 2018. All participants resided within low (n=6), medium (n=2), or high (n=10) secure forensic NHS hospitals in England. The majority (n=14) were given a primary diagnosis of mental illness, predominantly paranoid schizophrenia. Four were diagnosed with a personality disorder. Ages ranged from 30 to 64 (Mean=44). Two participants were female. Only two individuals were not White British. The primary MHA 1983 section was a Hospital Order with Restrictions §37/41 (n=10), followed by a Prison Transfer with Restrictions §47/49 (n=4), and a Civil Section §3 (n=4). Index offences included offences against the person (n=9), sexual offences (n=3), and arson (n=2).

Interviews lasted 18 to 106 minutes (mean=48 minutes). A full summary of these is depicted in Table 5-1. All interviews were audio recorded and transcribed verbatim.

Table 5-1. Profiles of Interview Participants

Study Data		**Demographic**			**Legal**		**Clinical**			
ID	*Time (mins)*	*Age*	*Sex*	*Ethnicity*	*MHA Section*	*Index Offence*	*Security*	*LoS (months)*	*Diagnosis*	
1 (FG)	N/A	30	M	W/B	47/49	Murder	High	63	F200 Schizophrenia	Paranoid
2 (FG)		44	M	W/B	37/41	GBH x2; Having a bladed article	High	8	F200 Schizophrenia	Paranoid
3 (FG)		25	M	W/B	37/41	Sending indecent/offensive images; Affray; AOABH x3; Assault by beating; Escape from lawful custody; Criminal damage	High	12	F200 Schizophrenia	Paranoid
4	106:38	46	M	W/B	37/41	Rape	High	~ 48	F60 Antisocial PD; F60 Borderline PD	
5	33:22	52	M	W/B	3	N/A	Low	5	F200; F602 Dissocial PD; F171	
6	19:27	44	M	W/B	3	N/A	Low	3	F259 Schizoaffective Unspecified; F171	
7 (FG)	56:30	41	M	W/B	37/41	Wounding; Possession of a bladed article	Medium	10	F250 Schizoaffective disorder; F200 Paranoid Schizophrenia	
8 (FG)	56:30	40	M	Other (Persian)	37/41	Attempted murder; GBH	Medium	54	F200 Schizophrenia	Paranoid
9	39:25	44	M	W/B	3	N/A	Low	55	F200 Paranoid Schizophrenia; F171	

10	72:48	44	M	W/B	37/41	Indecent assault on 12 year old; Indecent assault on adult	High	136	F600 Paranoid PD; F60 Borderline PD; F60 Antisocial PD; Suspected F606 Avoidant PD
11	20:00	49	M	W/B	37/41 (CPIA)	Attempted murder; Wounding	Low	36	F20 Paranoid Schizophrenia
12	71:14	52	M	W/B	47/49	Arson	High	66	F60 Borderline PD; F606 Avoidant PD
13	71:45	40	M	W/B	37/49	Wounding	High	42	F200 Paranoid Schizophrenia
14	35:06	55	M	W/B	37/41	GBH with Intent	High	111	F200 Paranoid Schizophrenia
15	48:33	54	M	W/B	47/49	Murder	High	117	F200 Paranoid Schizophrenia
16	18:19	33	M	W/B	47/49	Arson with intent to endanger life; Arson being reckless as to whether life was endangered	High	48	F200 Paranoid Schizophrenia
17	45:31	64	F	W/B	3	N/A	Low	4	F313 Bipolar Affective; F603 Emotionally Unstable PD
18	37:10	41	F	Asian	37/41 CPIA	GBH with Intent	Low	5	F323 Severe Depression with Psychotic Symptoms

Note. FG, Focus Group. PD, Personality Disorder. F171 'Mental or physical disorder due to use of tobacco' not repeated to save space. GBH, Grievous Bodily Harm. AOABH, Assault Occasioning Actual Bodily Harm

5.4 Results

Interview data were organized into twenty-one organizing themes and five global themes. Some basic themes were situated across several Organizing themes. These themes were not hierarchical and did overlap. For instance, 'Security' fell within the Organizing themes: 'The Purpose of Forensic Psychiatric Care' and 'Visible, Routine and Coercive' as it had relevance for both the purpose of the secure setting and how power is enacted inside the hospital. In total 287 basic themes were identified in the data. The twenty-five most widely referenced basic themes are presented in Table 5-2. Coding was undertaken by myself and discussed with my supervisors.

What became clear in the analysis of the data is that respondents did not simply list a range of phenomena they found restrictive. They articulated a narrative in which restrictiveness is something complex and interacting with a deeply subjective quality. Reasons were given for why they felt care was at times restrictive. Arguments were proffered justifying or delegitimizing restrictions. The analysis revealed five global themes that help explain this.

These are: 1) the antecedent conditions to restrictive phenomena; 2) restrictive phenomena themselves; 3) the enactment of these, either intended or unintended; 4) how these phenomena were psychologically experienced by residents; and 5) the consequences of these phenomena as expressed by residents. The model helps us understand why the same restrictive elements of care might be experienced in myriad ways by different residents.

Table 5-2 Most Widely Occurring Basic Themes

Basic Theme	No. of Interviews Appearing in	No. of times coded across Interviews
Length of Stay	14	42
Family contact	14	40
Other patients	14	63
Information	12	29
Activities	12	42
Restrictive	12	32
Prison	11	44
Leave	11	41
Outside World	11	23
Reflexivity	11	43
Punishment	10	16
Staff Numbers	10	19
Rules	10	16
Medication	10	31
Slow speed for action	10	25
Therapy	10	31
Hot drinks	10	15
Personal Belongings	10	22
Progression in Pathway	10	34
Mental Health	9	19
Routine and Structure	9	18
Off-ward	9	15
Interaction with Staff	9	16
Locked doors	8	11
Risk	8	19

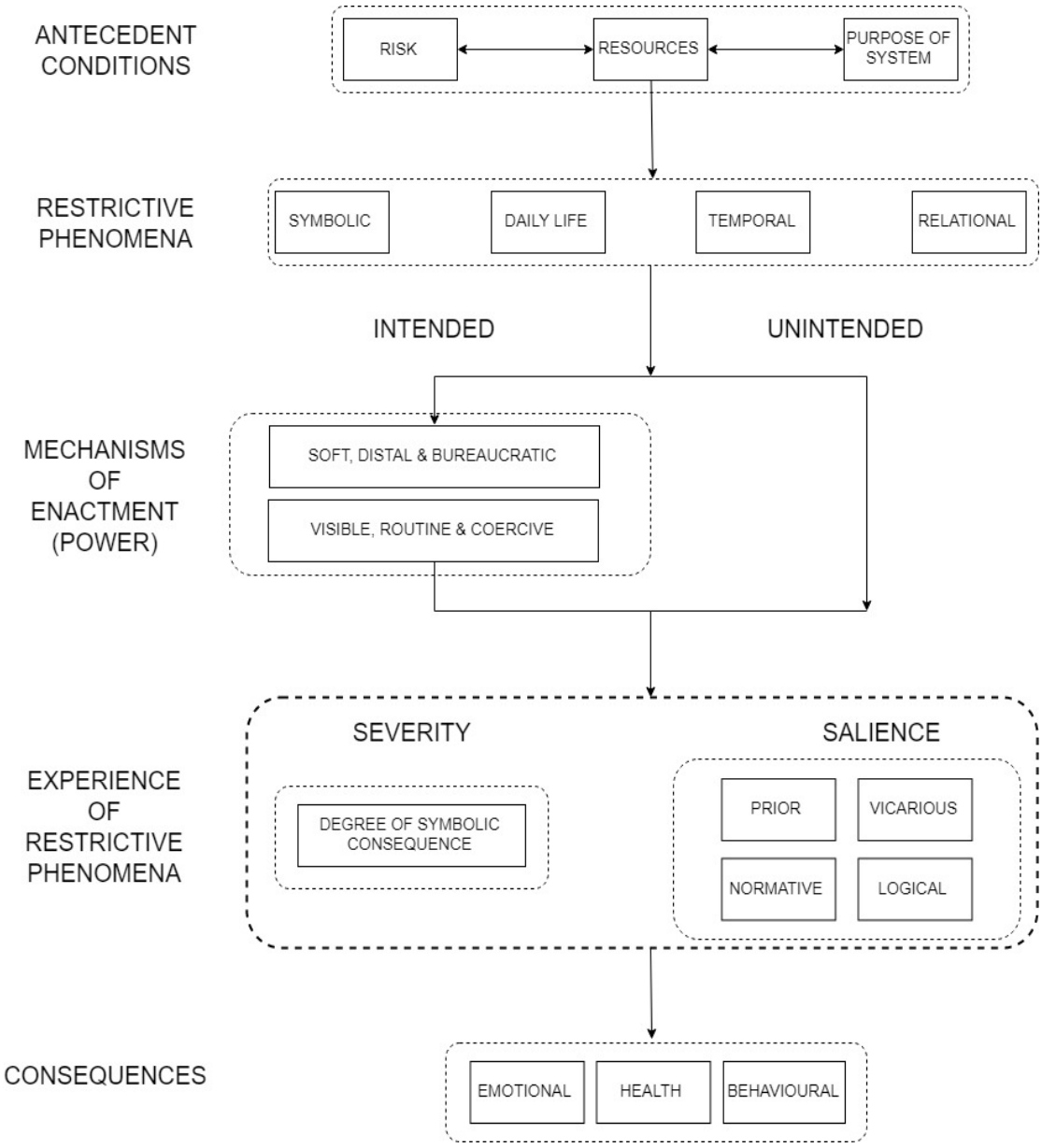


Figure 5-1. Model of Restrictiveness

5.4.1 Antecedent Conditions to Restrictive Phenomena

This global theme consisted of three organizing themes; 1) risk, 2) resources, and 3) the purpose of the forensic psychiatric system. It highlighted through residents' perspectives the reasons why restrictive phenomena exist in the first place. Acknowledged in much of the

respondents' talk were the two antecedent factors also found in the literature review – an institutional culture of risk aversion and the purpose of forensic services, leading to whether the setting was perceived by stakeholders as caring or custodial. The data also demonstrated a third antecedent: a ubiquitous lack of resources, staffing and staff training which participants felt limited their engagement in, for example, named nurse sessions, meaningful activities or access to fresh air. This also reflects literature identified in chapter three.

5.4.1.1 Risk

The management of risky behaviours to avoid harm such as aggression, bullying or self-harm was frequently given as a justification for the restrictiveness of secure settings. This was sometimes offered as a legitimate justification wherein patients felt restrictions were needed for their own safety but also as an illegitimate one. Concerns over risk led to certain items and activities being prohibited and thus limited residents' scope for agency. Risk management was felt to stretch beyond that necessary to provide a safe therapeutic milieu. It was described as omniscient as if woven into the fabric of the hospital.

> *P12 – There's no other word for it. Risk is priority in this place. Absolute priority. If there's a risk of this happening or a risk of that happening, you know everything's taken into account.*

Risk management precluded resident participation in activities and possession of belongings. Occupational therapies, mixed-gendered events, solo use of toilet areas, reading books on philosophically-inspired karate, or certain personal belongings were some examples of life restricted on risk grounds. For instance:

P17 – You're not allowed to have perfume bottles, that has to be put in the sharps cupboard because of the risk of glass being broken and people cutting themselves erm, you're not allowed sprays, any aerosols, they have to be kept as well out of your room.

The management of risk was primarily provided through security teams. Security was described as '*…overbearing'* (P2), '*intense'* (P4) and '*…a force of their own…*' (P12). Residents discussed asking for items, changes to care plans or for opportunities to engage in activities. In response clinical staff, even when hoping to facilitate these requests, might respond negatively as security services would not approve. This affected therapeutic relationships and trust. Describing not being allowed to visit the toilet on his own, even when on horticulture, an area he felt very trusted, one respondent stated:

P12 – And I know it's not down to the staff, its, you know it is down to the security, I mean they give the final say, 'well that's it, this stops now', and staff have to do it, I mean its inconvenient for them as well but, it, it, it's just that that little bit of freedom, that little bit of element of trust is gone.

5.4.1.2 The Purpose of Forensic Psychiatric Care

This organizing theme refers to a well-known tension that exists in forensic psychiatric practice. Straddling both healthcare and criminal justice systems, forensic care is sometimes caught between caring and custodial attitudes, practices, and goals. The degree to which care was experienced by residents to be restrictive was to some extent contingent on whether they felt care or custody, and their accompanying ideological commitments, prevailed. Residents suggested the former permitted a more therapeutic and open environment, whereas the latter was more restrictive and punitive.

Respondents identified several aspects of life that made secure care feel oftentimes custodial. This sentiment, represented in media and public perceptions, suggested forensic services aimed to contain risky offenders. This was felt to make life inside more restrictive as secure hospitals were painted as dangerous madhouses. In the following excerpt a resident felt media portrayals of a high secure hospital prevented visits from family:

> *P1 – Yea, [hospital name] got a pretty bad press out there, you know, that's why I struggle with like getting my nieces and my nephews up here to visit me because obviously social workers see 'oh, he's in [hospital name]', you know, and you know er one social worker, you know she said it's not the environment that a child should come and visit, which is, it's a hospital … you know, it's a high secure hospital but it's still a hospital that's supposed to help people.*

This tension over aims was also reflected in experiences of staff attitudes and levels of security. These led some patients to feel as if hospital was less desirable and more restrictive than prison. Prison was felt to offer more autonomy to some. This was in part due to the routinized and highly structured forensic setting.

> *P3 – To be honest I prefer prison because you can smoke, you have a kettle in your room, so you can make a tea and hot drinks whenever you want, you get (to pick sic) things off the canteen (for sic), things that you can't get here, again, cigarettes is the main thing for me, that I miss. urm, you can go to work, I used to work at laundry, used to get paid to do that, used to enjoy my work, erm, and visits where you get food during visits and it's a bit, I think you get a bit longer in visits, it was just er, a bit freer I suppose.*

The punitive aspects expressed by residents were also discussed in frustration felt over being detained in secure care for a period of time longer than their prison sentence (P1, P10, P12), the long term stigma associated

with being an MDO (P1, P2, P4, P14, P18), rooms described as cells locked over-night, feeling punished given the constraints of the setting (P17), and the number of locked doors (P18).

A clear illustration of this lies in a civil sectioned patient's feelings about the protocol for being taken out of hospital grounds in handcuffs.

> *P10 – They won't let me go to the dentist unless I wear handcuffs*
>
> *Int – Really?*
>
> *P10 – Yea, but I'm a section 3 so there's no way I'm gonna wear handcuffs to go to the dentist*
>
> *Int – Yup, that's because you feel that you shouldn't, because you're section 3?*
>
> *P10 – Yea, I'm not a prisoner or something I'm a section 3 yea.*

5.4.1.3 Institutional Resources

Respondents felt that certain aspects of life not precluded by risk concerns were restricted by a lack of organizational resources. These included poor staff training, limited beds in less-restrictive settings slowing one's progression, but most pressingly a shortage of staff. This latter point was ubiquitous and no resident expressed that there was a sufficient number of staff on their ward. The consequence of staff shortages included not being able to get a hot drink made (P10), having fresh air trips cancelled as staff could not escort patients off-ward (P10), asking staff to do things on their behalf (P11); attending horticulture, cooking, or other OT activities (P12, P18, P7, P9); having a limited number of communal rooms open at one time (P15); cancelled visits (P18); being confined to bedrooms for easier observation (P4); and accessing personal belongings in locked cabinets (P9).

When activities were held, these were experienced by some patients as pointless or just for wasting time. This was sometimes ascribed to poor staff training.

> *P7 – To be fair like they're trying to teach us woodwork when they haven't got no one to teach us woodwork.*

And:

> *Int – What about the other activities that you can get involved with here at [Hospital]?*
>
> *P7 – Menial tasks, menial tasks like, the OTs, you know what I mean, I don't think they're qualified in anything like to be fair.*

The above antecedents not only generate or shape the restrictive phenomena experienced by residents, but they provide material for legitimizing or delegitimizing them. The degree to which phenomena are experienced as restrictive is contingent on residents' rationalization of them; their logical and normative underpinnings. 'Why' restrictions are in place plays a large role in this internalizing and is discussed further in the section 'Experiences of Restrictive Phenomena' (§5.4.4).

5.4.2 Restrictive Phenomena

Many phenomena were experienced as restrictive. Individuals identified prohibitions on smoking, leave, the number and types of personal belongings allowed, interaction with staff and other patients, tribunal decision-making processes, and a lack of information about their care.

However, a broader notion of restrictiveness was also described, one in which these phenomena mesh together and situate respondents within a network of restrictive experiences. The nature of these restrictive experiences ranged from the day to day – the built environment or the

range of available activities; the relational – interactions with other patients, staff, and family outside; the symbolic – being given a diagnosis that was felt to enable their being managed as a cog in a machine, shorn of identity and complexity; and the temporal – individuals' lengths of stay and progression through care pathways.

5.4.2.1 Daily Life

Phenomena of daily life are those elements of forensic care that carry some felt presence on a day to day basis. This organizing theme includes the built environment, the number and types of possessions and consumable goods permitted on-ward, and the range of activities available to residents. In different ways these restricted residents' autonomy of movement and their ability to develop social and occupational skills.

5.4.2.1.1 Built Environment

The built environment was described as having too many locked doors, which was felt especially difficult if residents wanted to go out for fresh air or for off-ward activities.

> *Int – How do you find the built environment here, so the colours, the pictures on the walls, the furniture, the doors these sorts of things?*
>
> *P18 – er, everything is ok apart from doors, I feel there are too many … there are too many locked doors still for people to go out and things, even to get fresh air there are two locked doors.*

The setting was felt by one resident as '*close'*, making him feel nervous (P13), and by another as '*claustrophobic*' (P3). A third stated he felt like he was '*[…] shoved in a, maybe not one room, but a few rooms, two or three rooms and that's our life*' (P2).

Some residents disliked the ward they were on, only finding their room agreeable. However, this was not universal. One remarked that his room was 'seclusion' and described it as a cell with few personal belongings (P15). Another participant felt locked in a cupboard:

> *P17 – Well personally I think everybody should be given off-ward access. I don't think being locked in a room all day and in a cupboard, quite frankly I think to say to them, 'would you do that to your mother or your sister or your wife'?*

5.4.2.1.2 Personal Belongings and Consumable Goods

The number and types of personal belongings and consumable goods permitted on secure setting was limited for participants. Some found this confusing or frustrating, and limited their ability to direct their day themselves. Those belongings and goods banned identified by participants included alcohol (P9), a Dictaphone (P10), pets (P7, P15), opposite gender clothing and wizards robes (P15), religious clothing (P16), shoelaces (P8), modern games consoles with internet connectivity removed (P3), and internet access (P1, P2, P12, P15, P17, P5, P9).

Other belongings and goods were not prohibited but regulated such as music downloads or internet time. This regulation was described as nonsensical and arbitrary.

> *P12 – So you can't have your pictures on the walls, you can only have four in your room. I'm not allowed, I'm not allowed me own bedding, my own duvet cover or anything like that it has to be hospital supplied. Not allowed me own carpet, its carpeted anyway but I'm not allowed a rug, it's just, it's just little things that make, that'd make my room more homely, more you know.*

Certain belongings were permitted but only under strict hospital control.

P9 – […] for example you want to use some deodorant, it's a spray deodorant so its kept in the office because you can use deodorant to get high, can't you, with the gases inside and stuff like that, so erm, that's hidden, and if you want to use it, if you knock on the staff door, now the staff might be busy, some of them say not right now some, you can actually get to a situation where you can wait half an hour for something you want.

5.4.2.1.3 Activities

Activities were mainly discussed as being inaccessible or lacking meaning. This was restrictive for participants as the absence of such activities mitigated their autonomy of movement, skill-development, and self-expression. Most of these activities were held off-ward and were supposed to be conducted by trained occupational therapy staff. As described previously a lack of resources was often given as the reason why activities were cancelled or hosted by poorly trained staff.

Respondents felt they were deprived opportunities to increase occupational or social skills.

P4 – I think I should be allowed out for leave I think I should go to college, I think I should be able to go to, to, er, outside gym, I should be able to go to erm, libraries and stuff like that, I think should be, I should get leave

Another individual felt the hospital did not provide the facilities to enable self-learning.

P9 – But yea as I say for education-wise, I'd like to educate myself in webpages to do more webpage design

Int – So, ideally you'd like to be able to develop some of these skills here?

P9 – Yes

Int – er, but you're unable to now because there's no access to the internet?

P9 – That's correct, yea.

Some respondents expressed a preference for prison as they facilitated paid work not permitted in secure settings. Having the opportunity to work would, in the eyes of one respondent, feel as if '*[…] we've achieved something every day, we can lay back down on our beds at night and feel we've you know, achieve something*' (P2). For another interviewee, voluntary work outside the hospital or manning a free beauty clinic set up inside the hospital would achieve a similar sense of satisfaction (P17).

5.4.2.2 Relational

Relationships and interactions with others were highly salient in the data. Respondents described peers and staff acting in ways that restricted their autonomy or self-expression. The data also highlighted curtailed opportunities to develop meaningful or intimate relationships with people inside or outside the hospital.

5.4.2.2.1 Staff

Relationships with staff were described as an 'Us v Them' dynamic. This had negative consequences for therapeutic relationships, ward atmosphere, and trust. Relationships with staff are especially salient in secure care as staff act as gatekeepers. They play a role in residents accessing certain belongings and progressing through their pathway. For one respondent staff deliberately made life difficult:

Int – What do you think about ward rounds?

P5 – Yea, I think it's a waste of time, if they're not gonna give you leave there's no point going

Int – mm, is that the only purpose for ward rounds? Leave?

P5 – Well just to give you things, but them don't give you anything so there's no point going

Int – And why do you think they don't give you things?

P5 – 'Cos they're horrible, ha.

The division between staff and residents was felt by some to be enforced by staff themselves.

P4 – I think that is equal [staff are equally] responsible for the divide that is created in these environments in my opin-, I know it's only my opinion but in my opinion it is definitely equally responsible for that division that is created for us and them, because the staff entrench it … as well as the patients.

The division described manifest in staff attitudes. Staff were described as difficult and self-defensive (P10), lazy (P15), disrespectful and inappropriate (P4). Some were seen as key-turners only present to earn a wage (P4). Although respondents acknowledged that things had gotten better over time, staff attitudes could still be custodial or abusive. For one respondent, this was illustrated by many nursing staff's continued membership of the Prison Officers Union (P15). Another recounts an interaction with staff:

P4 – A lot of the people [staff] that talk about how they used to be in the olden days, but staff are still there, how they used to treat patients and think its ok to sit and talk about that, in a free [way]

Int - mm

P4 – [speaking as a staff member] 'oh yea we used to fucking, make em stand with [their] fucking noses against the wall … and I'm like, I knew this, 'well don't you think that that's abusive?' And they'd be like, 'yea but [participant name] they were cunts, used to just attack

you for nothing'. 'Well that's cos they're mentally ill'. 'No, they were just mean, horrible cunts'.

The difficulties expressed by respondents were exacerbated by their reliance on staff. Residents' ability to access belongings, move around the ward, and participate in activities was contingent on staff.

P12 – And there are other members of staff where ah, there's no good in asking them, no good asking that one cos he, you know you might be chasing them up all day long, 'have you done that yet? Have you done that yet?'

5.4.2.2.2 Other Residents

This was one of the most frequently discussed topics. Other residents were felt to restrict respondents in where they could go on the ward; monopolizing resources on the ward, generating unfair rules in response to adverse behaviour, and jeopardising their progression out of care.

Respondents didn't like sharing a similar space with others who had committed serious index offences, were much younger than themselves, or were severely mentally unwell. They felt this put them in danger, experiencing other residents as bullies and having to alter their daily routine around them.

P12 – You know like if you're erm, if you're in, if you're in the day room watching TV and you're mindful that there's someone behind you whose, whose quite paranoid you know I have to be careful not to lean over and whisper to the person I'm talking to.

And:

P13 – Like when you get personality disorder that they're very manipulative, they'll walk onto a ward and they'll gridlock the ward erm, with their mind, so they'll know that he's got a vulnerability there, he's got a vulnerability there, he's got a vulnerability there,

he's got a vulnerability there and they'll, they'll lay out their territory by working them vulnerabilities against each individual patient sometimes and even do it with staff … bullying, you know what I mean?

This would limit where residents went and what they did on the ward:

P14 – I operate on a policy of avoidance and I'll let you even, and because you've got your recorder on, it's the best policy to operate in a mental hospital. Avoidance

Int – mm and what does avoidance encompass?

P14 – It just means if somebody's in the day area that you don't like, you go in the dining room, if someone's in the dining room you don't like, you go in the day room.

The same respondent was so concerned by the threat of harm from residents on other wards, he chose not to leave his ward despite this having negative consequences on his progression out the hospital. Other residents' concerns were driven by psychotic paranoia but nonetheless carried weight for them as they sought to avoid 'Himmler' (P15) and others with mind controlling powers.

A cumulative effect of these interactions was an atmosphere described as '*intense'* and '*unpredictable'* (P11), '*tense'* (P12), '*terrible'* (P14) and '*non-therapeutic'* (P17). It also meant staff attention and resources were felt to be unfairly distributed to those patients most unwell, aggressive or needy, with quiet, passive residents left to wait longer for help or to gain access to certain spaces.

5.4.2.2.3 Other Meaningful Relationships: Family, Friends and Sexual Intimacy

Association with family and friends outside secure hospitals was often experienced as limited. These encompassed: phone calls, letters, visits, and

leave. Contact with children was identified as especially restricted. Participant ten describes his experiences of trying to contact his nephew:

> *P1 – So erm, yea I mean the big thing, I guess for me is sort of family contact, and what I've found really is I've wanted to see my erm, my nephew. And erm, I had to erm, go through an accreditation process. And erm, it got refused, and then I had to appeal it and it took me a year just to see my nephew.*

His account was not unique. Impediments to contact meant many felt estranged from family.

> *P10 – Now, my sister has a 12 year old daughter ok? Now, she wasn't born when I was locked up. Ok? So she's never met me, but I ring my sister every night. Every night. Ok? When my sister's on the phone to me, [daughter's name] her daughter, has to be quiet. Because if these [gesticulates to ward] heard her talking, they might think, as they have done previously, she was talking to me because they can hear when we've had a conversation.*

Contact with friends was also described as limited. The lengthy accreditation process to admit visitors or the hospital's geographic distance from their hometown were cited as some reasons for this. Respondents felt this could be rectified with access to the internet. However, internet was banned at high secure hospitals and access to social media was restricted at a low secure site. Another option for increasing family contact was greater amounts of leave either escorted or unescorted. For one high secure patient this was not possible, and he describes that he has '*[…] never been able to visit the erm the, the grave plot of my dad and my two sisters and my grandmother, they're all buried in the same plot*' (P12).

Sexual interaction and intimacy were highlighted by two participants as banned. This ban pertained to sexual expression with other residents, staff,

and individuals outside the hospital. One respondent felt that although he didn't want sexual intercourse, he felt others should be allowed, especially given in his eyes this occurred openly in prison (P15). He reflected that this ban was justified for some vulnerable patients but not all. Another participant felt unable to develop a meaningful intimate relationship whilst inside this hospital and that time for this was pressing.

> *P14 – I want, I want a wife, that's all I want. I want to get out there and find myself a wife and start a family. I'm 55 and times getting short for that sort of thing.*

5.4.2.3 Symbolic Phenomena

Restrictive phenomena operated in a symbolic fashion. These phenomena were described as sometimes having a material element but resonated as a more abstract restrictiveness with consequences likely to affect residents' sense of self and personhood. These symbolic restrictions included feeling like 1) an object to be managed rather than a unique, biographical individual; 2) as given a reshaped identity as an excluded 'other'; and 3) as voiceless, denied agency in both hospital and wider social citizenship.

5.4.2.3.1 Objectification and Pathologization

Some respondents disagreed with their care team's assessment of their mental ill-health and continued treatment. Several residents felt they were well enough to move on, with one describing his frustration at being told:

> *P1 – "You're unwell' you know, 'there's something wrong with you', 'you need help' kinda thing,* you *know. Me I've, I've just left, I've got left alone I just crack on with the stuff that I've gotta do'.*

This led to dissatisfaction with treatment, feeling stuck in care.

P15 – I'm not mentally ill. I have been spiritually hyper … we've gone through it all, and that has happened, and I wish to god they hadn't pumped drugs into me, I wish to god they hadn't.

One respondent felt that an incorrect diagnosis meant he was subject to therapies that were not applicable to his recovery.

P10 – You know how in here they have your PRP your ORP your SOTP etc. They are what I call preformulated therapy ok, and they are very pigeon-hole type therapies where the point is that you have a risk, a particular type of offence, so therefore you fit into this box and because you fit into this box then you need to give us this, this, this and this explain[ation] but then if you can't give them that explanation then then you're being avoidant. You're refusing to engage or in denial. There's always a reason why you're not doing what you're doing.

Another respondent found *not* being given a certain label, in his case a diagnosis of depression, restricted his access to appropriate support.

P13 – If I'[d] have had the knowledge then that I have now I'd have made a challenge what that doctor was saying to me then when he said to me, 'you can't have it [medication] because you don't show any signs of being clinically depressed'. I'd have said, 'well in actual fact, that's just a word that umbrellas a group of people that come under that spectrum, like schizophrenia'.

Once assumed into the role of a patient to be managed, this was felt compounded and reinforced by some respondents. This was most evident in respondents' talk about patient notes. They felt staff only wrote examples of adverse behaviour or negative symptoms of their mental health.

P17 – I sometimes, cos I find that this place is non-therapeutic … so sometimes I tend to go to my room and stay in my room a lot and then that gets in to, put down in the notes that she stays in her room and she's not … doing much and mixing or whatever.

These notes were then used as evidence of a lack of progression or recovery and shaped an incontrovertible narrative about the individual. This narrative further pathologized residents, limiting the total range of information their responsible clinicians, amongst others, could read and draw upon when making decisions about care. These notes were felt to immortalize adverse behaviour without context. In the following excerpt participant 10 recalls swearing in a Care Programme Approach meeting.

> *P10 – So, you know I didn't just walk up to him [RC] and go 'oi you, fuck off'. I was in the middle of a ward round, I'd had an half hour conversation with him, with 15 'I don't remember that's'. Oh d'you know, fuck off, I can't be ass-ed. I just got up and walked out. And I, that's still documented, that's still mentioned […] in CPA reports, it's still mentioned in tribunal reports because it was an act of aggression in his view, it wasn't in my view.*

5.4.2.3.2 Citizenship

The above left some residents aiming to simply play the system, eschewing the hope of individualised recovery. Feeling objectified or denied patient-centred care was expressed by respondents as voicelessness. This disempowerment was evidenced in the degree to which residents felt they could act with agency in life inside and outside the hospital, exercising active citizenship in these areas.

Residents felt excluded from their care pathway. This was in part because they felt a significant restriction on information flows. This refers to the extent to which residents were given comprehensible information they understood and could respond to. For one individual ward rounds were confusing as too many people were presenting information at the same time (P11). Others were confused about their MHA (1983) section, their

continued care, what therapies were available, why certain activities were cancelled and why certain restrictions existed. For instance:

> *P13 – Yea erm, I'm on section 47/49, I don't, I should understand fully the restriction, the restrictions, I know that I'm, one of them's a transfer from prison to hospital … and the other one is the restrictions of what I'm entitled to and what I'm allowed to do while I'm here, but I aint quiet sure which is which, the 37, the er 47 or the 49.*

And:

> *Int – mm why don't they want you to wear your wizards' robes?*
>
> *P15 – I'm not quite sure.*

The following excerpt on MDT meetings reflects residents' sentiment that they are sometimes not given a voice.

> *P18 – Sometimes the decisions are bombarded on you, not bombarded but they are thrown upon you theyre, you're not involved so much in the decision-making. They don't listen to you as such as a patient, they make their own decisions then, then you are given, 'that this is what we've decided for you'.*

This voicelessness was described by individuals in relation to appealing their stay, involvement in care plans, altering things on the ward like activities, participating inside therapy sessions, submitting complaints of ill-treatment within the hospital or to the CQC, and being able to express oneself more broadly.

> *Int – It's really important when we are trying to get better to be able to express ourselves, our own individual person…*
>
> *P5 – uh huh*

Int - …so the things we're interested in, our hobbies, erm the things that we find funny, you know, us as a human being, do you think that you can adequately express yourself whilst you're here?

P5 – No I don't think so no

Int – Why not?

P5 – No one listens to you so.

On describing his experiences of challenging his current stay, P14 recounted:

P14 – I've spoke to all sorts of people and written all sorts of letters but no progress

Int – mm. Can I ask who you've spoken to?

P14 – All sorts of people

Int – Sure. Including the CQC?

P14 – Yes I've spoken to them

Int – Yep and what what's the response? What's the feedback?

P14 – I get no progress wherever I go.

Respondents also expressed concern about whether they would be given a fair hearing if they complained or appealed (P17). One gentleman said he felt he would be punished by the hospital (P15), and others that review tribunals only listen to doctors (P5, P14).

These examples of restricted agency indicate a cumulative effect of weakening respondents' citizenship or engagement in the hospital setting. This was further exacerbated when respondents felt they were restricted interaction with the world outside the hospital. Residents described being denied interaction with family members and friends (P1, P10), being kept abreast of current events (P1, P2), and opportunities to develop skills necessary to integrate into life after care. This latter point was often

discussed in relation to emerging and developing technologies in general (P14); and smartphones (P12), computers (P17) and the internet (P12) more specifically.

5.4.2.3.3 Otherness

Some residents felt stigmatized, existing as an othered group in society (P1, P2, P4, P14, P18). P2 felt the wider public saw him and other patients as '*mad axe men'*. Another felt he was considered a '*rogue'* (P6). This stigma was strongest for high secure patients.

> *P1 – but yea, being here it's sort of, you know it's gonna stay with me for the rest of my life, you know erm, like I say there's only three of these hospitals in the country in't there?*

This was largely born of their status as an MDO but furthered by their inability to engage meaningfully in hospital or wider social interactions and discourses.

> *P14 – I'll tell you this, when you become [a] mental patient, nobody wants to know you.*

This stigma was anticipated to carry through until release into the community and restrict opportunities to find work, get insurance, and establish new social bonds. In explaining this frustration, one resident remarked:

> *P4 – Actually I'm not gonna, you don't have to lock up all your fucking daughters, actually I'm not a rapist, actually I'm not gonna go out and take drugs and damage the fucking area that I'm in and become … a one man crime wave and it's just not about mental health it's just not about you know, it's just not about a crime, or it's just not about one crime or … a specific set of crimes, it's about the whole thing isn't it? There's a lot, I carry a lot of stigma with me.*

In foreseeing this and lamenting other aspects of their current life, respondents expressed a desire for a normal life. Respondents felt '*…singled out different[ly] from the norm…*' (P17), described a visit to the hospital shop as '*…kind of normal in a way…*' (P9), and feeling that they are '*…not in the real world, because things aren't like that in the real world'* (P17). Participant six felt that for him, leave was an opportunity to go somewhere, have a drink and talk to strangers who do not know his current situation.

The above organizing theme provides support for an understanding of restrictiveness as something that has consequence for residents beyond the immediacy of the physical setting, relationships, or coercive medication. They demonstrate how aspects of forensic care can restrict self-expression, identity, and one's status as a human being.

5.4.2.4 Temporal Phenomena

A temporality was described that residents felt placed them within in a unique space-time. Lengths of stay, the slowness of life, and residents' progressions through their pathways were described.

5.4.2.4.1 Length of Stay

Respondents struggled with the indefinite length of stay. These were felt as especially restrictive where their current stay had exceeded a prison sentence. One respondent felt he had served his sentence many times over (P15), and another highlighted that he is seventeen years over his five-year tariff (P12). This frustration reflected normative assessments of fairness in relation to the seriousness of one's index offence:

> *P1 – I know I'm not a doctor or anything like that but this place does sort of hold on to people who've not committed very serious index*

offences, for, a lot longer than, how, how long they would stay in prison if they've got convicted and had a prison sentence.

Such lengths of stay meant some felt '*stuck'* and '*bed-locked'* (P10), seeing this as a form of punishment (P18). These feelings were made worse where participants felt disconnected from processes controlling their length of stay, unable to meet their care team or the Ministry of Justice's (MoJ) requirements for demonstrating progress.

P10 – But, irrespective of whether that 7 years become[s] 17 years or 70 yea? I'm still not gonna do what they want. Because I can't, but they won't accept my views and my opinions because my views and opinions are different.

Due to this, respondents expressed a preference for prison even where they felt their quality of life would be worse as there would be a defined period of incarceration (P3). Residents' lengths of stay therefore reflected one of the most restrictive elements of their care. Time spent in secure care reflects the time exposed to restrictive phenomena and time not spent in the community.

5.4.2.4.2 The Slowness of Time

Participants felt life in secure care progressed very slowly. Respondents would refer to '[hospital name]-time', which existed on a different linear plain than normal time. This was felt on a day to day basis with simple requests for goods or help from staff (P12, P9).

Int – Are they [staff] helpful when they are here?

P17 – Up to a point, but everything's very slow, very slow. Erm, its like you go to the office to ask a member of staff something and then they say 'oh just a minute they're busy'.

The hospital as an institution was described as slow. One respondent felt he had to wait *'weeks and weeks'* to buy something (P16). A second interviewee described requesting a laptop to connect to the internet:

> *P9 – Things move very slowly sometimes*
>
> *Int – When you say things move slowly…*
>
> *P9 – Decisions to be made if, if for example, if the patients were allowed access to the internet or not and debates gone on for years and years and years and still there's nothing. Where is it? Come on, you know.*

Gaining other things within the hospital such as leave (P6) and being added to OT sessions (P10) was discussed as being slow. One participant felt this was institutionalizing as this did not reflect the pace of life outside the hospital (P17) and another that it left her bored and depressed (P18).

Residents also expressed systems beyond the immediate hospital moved slowly. The MoJ was singled out for being particularly slow with processing approvals for leave or transfers to other hospitals (P4, P7, P8). This left residents disempowered and denied information or agency in both menial and significant aspects of their life.

5.4.2.4.3 Prospects: Looking to Integration

Respondents often looked to the future and discussed the consequences of their care on their future prospects. This section considers the practicalities of integrating into the community and how respondents anticipated a restricted social citizenship.

Respondents felt they were not being given training to develop necessary skills for the outside world (P18, P5). This would limit job prospects with participant eighteen feeling that she would have to justify her absence from

the job market to employers. Another felt she needed support finding accommodation but was not receiving this (P17). This sentiment is illustrated in the excerpt below:

> *P14 – I suppose I'll have a really hard job getting a job after 20 years on a hospital order, but I'm gonna look for a job and hopefully there will be a network in place to help us*
>
> *Int – mm do you think that you would, why would it be difficult for you to get a job, for what reasons?*
>
> *P14 – After I committed my offence and done 20 years for it, it's going to be difficult to get a job.*

Being transferred from prison presented another respondent with different concerns. He felt that the threat of a return to prison loomed overhead and could disrupt his arrival in the community via the healthcare system, making pointless his time spent in secure care.

> *P12 – So at the back of me mind I'm thinking, 'yea, I'm doing well', I'm being referred to an RSU actually in a couple of weeks, but at the back of me mind I'm stilling thinking, 'I could still end up going back to prison', and if that happens I'm going to be thinking, 'what on earth was all this about?'*

Respondents therefore wanted their time in secure care to count out in the community. This gave them a sense of optimism. Where this was denied to patients through a lack of skills training, support finding accommodation or a possible transfer back to prison, residents expressed a pointlessness and frustration that the forensic system that was supposed to enable their integration back into the community might have the opposite effect. This restrictiveness is not immediate. Rather it follows the forensic patient beyond the confines of their care.

5.4.3 Mechanisms of Enactment

Restrictive phenomena were both intended and unintended. This aspect of the Model of Restrictiveness attempts to explore in what ways restrictive phenomena are enacted. It primarily focuses on those that are intended, as the manner in which restrictiveness is enacted is important for our understanding of what residents find restrictive and how they experience this. In this section the mechanisms through which restrictive phenomena are enacted are discussed.

5.4.3.1 Unintended Enactment

Unintended restrictions reflect a situation in which experiences of restrictiveness recounted by residents cannot be easily attributed to the hospital or the wider forensic psychiatric system. For instance, a relative did not wish to travel the requisite distance to visit a participant in hospital. This individual found this restrictive as he could not interact with his family member. This was indeed a restrictive experience for him, but not one the hospital could do much about. Further, one participant found having female members of staff restricted him as he felt secure care was '*…a man's world*' and he wouldn't be able to watch pornography due to their presence (P6). Little could reasonably be done to mitigate this experience bar employing only male staff.

Some restrictions were self-imposed. For instance, participant nine was encouraged to take leave but chose not to.

> *Int – mm, so did you say that you are able to go to this gamers, er, museum if-*
>
> *P9 – Well I'm not able at the moment but they want me to go*

Int – Ok

P9 – Because they think I'm well enough but I don't, but erm, but erm, but yea I'm allowed to go if I want

Int – Ok but you've decided that you don't want to go yet?

P9 – Yes, that's correct.

5.4.3.2 Intended Enactment

Conversely, intended restrictions were enacted in specific ways respondents found restrictive. Intentional restrictions accounted for most experiences as many aspects of life in secure hospitals are regulated or enacted by staff, regulation, or other residents. Revealing in this data are the complex ways in which mechanisms of power and control enact restrictive phenomena.

By definition, restrictive phenomena were not wanted by residents. Therefore, these were enacted with a degree of coercion and power. This was described in different ways in the data and the exercise of this power can be presented on a continuum. At one end, power was soft, hidden and distal appearing not to be outwardly coercive, but which nonetheless had a significant degree of influence over the lives of residents. Further along the continuum the data presented more visible forms of power including: culture, staff and peer behaviours, and rules and regulations of secure care. Beyond these, some examples of the most coercive and overt measures are identified including forced medication and seclusion.

5.4.3.2.1 Soft, Distal and Bureaucratic

This basic theme centres around respondents' experience of power in secure care as something hidden, inaccessible, and intractable. Existing in this way, power made certain aspects of life impossible to negotiate and left

respondents confused and powerless. This was best illustrated through respondents' depictions of security.

> *P12 – But yea I mean they're a law unto themselves, security for some reason they're just so… you just don't know where you stand when it comes to security… They [nursing staff] say 'oh you can't do that anymore', 'well, why?' It's, 'security said it's become an issue and it's been stopped, you can't do it, you can't do that anymore', and I say 'why?', 'it's a security issue'.*

Respondents asserted that decisions were taken out of their spheres of influence. The hospital and MoJ operated in a hidden space described as overly bureaucratic. Power therefore operated at a distance, unassailable.

> *Int – Do you feel confident that's there's a solid date that you'll get out and move on or-*
>
> *P7 – No*
>
> *Int – No?*
>
> *P7 – I think, I think because the way things are with the, with, it seems like everything is like a game like, you know what I mean like the ministry, the MoJ, there's a delay there, there's a delay there, there's a delay here, like you*[9] *say its waiting for bureaucracy to pull their finger out and the bureaucracy is too much.*

Note that although it is not the entire MoJ working on their individual case, the respondent describes it as such, emphasising a perception of the MoJ as a single hegemonic power.

Power also operated softly within secure care. It was discussed by respondents as operating through a punishment and reward system. This system rewarded institutionally desirable behaviour but restricted privileges

[9] A figurative 'you', meaning: 'one says'.

and the progression of those in discordance with these aims. Describing leave in such a system:

> *P9 – First of all escorted and then unescorted and you can graduate into different levels until you can go every day and then you're nearly ready to be discharged.*

Although several patients advocated this, even promoting a more prominent rewards-based system; some found it unnavigable, restricting their progression. Others felt they were unable to fulfil the desires of the hospital to act in a particular way and struggled to foresee progression. One respondent was unable to engage in this incentivized system as he disagreed with his care teams' perception of his mental ill-health.

> *P14 – Since January 2015 I haven't had an incident or episode of depression which is what I used to get prior to January 2015. I've been a well man and that should be recognised and I should have been released before now.*
>
> *Int – And you say that these changes, and the fact that you're better now are not being recognised?*
>
> *P14 – No.*

A soft form of power, one experienced as frustrating and restrictive by respondents was the frequency and invasiveness of observation or 'obs'. Observation, emblematic of surveillance more broadly, was described as constant and persistent (P1).

> *P12 – Everywhere you go you're being watched, even when you're in your room, every half hour, you know the, you know the curtain on your door will open and somebody will be looking in and the light will come on if they can't see ya, that's every half hour.*

Participant 15 felt that the hospital recorded everything; P12 that patients observe each other; and P9 recalled that a nurse was always present in

common areas to watch over these spaces. This ever-present gaze left residents feeling untrusted. P12 felt that when he had visitors from outside the hospital his speech was censured by observing staff:

> *P12 – I just feel like a member of staff will be sat over my shoulder, '[participant name], you can't talk about that' and I think 'oh f-, sorry', and then '[participant name], you can't talk about that' and it would be like every 5 minutes with me, so, I've been reluctant to erm have one [a volunteer] come in to be honest with ya.*

5.4.3.2.2 Visible, Routine and Coercive

Respondents described mechanisms of power that shaped the enactment of restrictive phenomena in more obvious and tangible ways. This basic theme discusses how security, routine, regulation, and coercive measures were felt by residents.

Security represents one of the most significant forms of power in secure care. This is largely due to assumptions and understandings about what forensic psychiatry is for and how best to prevent real or perceived harm from occurring. The distal and intractable side to security is described above. More visible manifestations of this described by participants included room searches, limitations on visitors, walls, locked doors, restricted phone calls, locked cupboards and doors, and so forth. Respondent two felt given the extent to which security concerns shaped daily life it became the dominant force and rationale for secure hospitals.

> *P2 – It's from that standpoint [security] that they make all the rules, and so, things will get done on the grounds of security rather than the benefit of the patient, whereas, if they lowered the security and allowed er, you know, people out into the gardens so to speak to do gardening … people would benefit so much more.*

Residents also expressed a dislike for the highly routinized environment. This was felt to limit autonomy of movement and choice when structuring one's day. This had the effect of leaving participant two frustrated at the absence of spontaneity. For him, this represented a loss of normality.

> *P2 – Because mostly, you get up and do something when you, when you feel compelled to do it at the time, spontaneously, and I just feel all that's gone.*

Routine also restricted access to certain activities or particular spaces. Routine was described as affecting residents' ability to choose when they went out for leave (P11), shaved (P12), used perfume (P17), went to bed under night-time confinement (P5, P10, P11, P14), and ate dinner (P10). Respondent fourteen describes how he experienced the consequence of this routine as diminutive of his individuality.

> *Int – Ok, do you feel treated as an individual here?*
>
> *P14 – The answer to that is sometimes*
>
> *Int – Sometimes?*
>
> *P14 – Sometimes you can be treated as an individual, such as when they give you medication and sometimes you're just another brick in the wall such as when you're herded into the dining room for meal times.*

Respondents described certain rules as restrictive. Rules concerned what items were prohibited; and where, when, and with whom residents could do certain things. Respondents felt that there were too many rules and regulations and that these were too strict (P3) or stupid (P5). One resident felt although spiritually free he was physically bound by hospital rules (P15). Rules were seen to be unnegotiable and attempts to change them fruitless (P10). For instance:

P12 – Nowhere in the hospital can you go into your room and have a shave unsupervised, it, it, its policy, that's all it is.

Blanket bans were highlighted by residents as especially restrictive. These bans pertained to the preclusion of an activity or item applied to all residents without discrimination. Participants felt blanket bans were unfair as they were enacted due to the past actions of others (P1), the actions of a patient on another ward (P10, P12, P18), or because they were necessary for others, yet were not necessary for themselves (P4, P12). It was felt blanket bans shouldn't be enforced on those who have shown responsibility.

P10 – So rather that saying, well actually this patients had this item in his possession or her possession for 16 years and has never ever done anything other than use it for its intended purpose erm, it doesn't matter because somebody else didn't, so therefore you have to lose it in order to prevent you from doing what it was they did, er and that may lose that individualism.

Blanket bans were considered an inevitable and unnegotiable part of life in secure care (P12) and were experienced as '*[…] patronizing, it feels kind of like untrusting*' (P4).

Coercive measures, typically defined, were not discussed at length in the interviews. This is because patients' experiences of coercive measures are well documented (Bergk et al., 2010; Brunt & Rask, 2005; Daffern, 2013; Haw et al., 2011; Hui et al., 2013; Kallert et al., 2005; Repo-Tiihonen et al., 2004). It is also in part because few respondents had been recently secluded or restrained and these experiences were less salient for them. Seclusion and restraint, undeniably restrictive in their capacity to reduce autonomy of movement, were however discussed in brief. In the following

excerpt, a respondent describes an experience of seclusion he felt as punishing:

> *P4 – This is punishment, this is payback. So, they decked me, stripped me, ri-, decked me, stripped me you know, inhumanely, left me naked, d'you know what I mean? You know left me naked for a long time, nothing in there … there was a time when I was in there when I, one point I had 9 piss bottles and 6 shit hats full of shit all lined up on the back wall cos they didn't wanna take em out, wouldn't take em out, would not let me empty em in the toilet, they treat me like a cunt for a long time because its punishment, that's punishment in my opinion, d'you, there was a time yea when my teeth were going loose cos all they was feeding me was chips.*

Other respondents thought of seclusion as rare (P9), boring (P5), or distressing to witness (P17).

Forced medication, a third frequently discussed coercive measure, was addressed in more detail. Medication was described earlier as demonstrative of respondents' perceptions of being treated as a diagnosis to be managed and medicated. However, important to note is the coercive nature of forced medication and how respondents experienced this.

Several patients expressed a dislike for their medications but accepted these as part of their recovery. Others disagreed with the necessity to take medication and found its forced administration archaic, negating autonomy of choice and consent, and disagreed with it on normative grounds.

> *P3 – I don't think medication should be mandatory, I don't think you should be forced in this day and age to take medication if you don't agree to it. I'm being forced to take medication with my consent and have been for about a year now. Erm, I think that's wrong, I think that should be abolished.*

Respondent fourteen felt being forced to take medication violated his will and lacked his consent, making him upset. One individual wished not to be medicated as he felt his medication was part of a U.S. government scheme to control his mind restricting his freedom (P15). Another chose to take medication only to avoid being forced to do so (P5). He described how he felt during forced intra-muscular injections.

> *Int – mm, what does it feel like when you're being forced to take depot?*
>
> *P5 – Horrible, they twisted my arms and everything*
>
> *Int – mm, and you think the medicine does help or doesn't help?*
>
> *P5 – Doesn't do anything no, cos there's nothing wrong with me so.*

5.4.4 Experiences of Restrictive Phenomena

The data also shed light on how, psychologically, residents experience restrictiveness. Experiences of restrictiveness were deeply subjective with certain phenomena being described as restrictive for some and not for others. In attempting to better understand this, this aspect of the Model of Restrictiveness builds upon the Sexton's (2015) model of penal consciousness outlined in chapter two.

Experiences of restrictiveness were largely described in a fashion consistent with Sexton's (2015) analysis. Restrictive phenomena were sometimes described symbolically, as infringements of autonomy, self, or personhood. The salience of these restrictions was an expression of an expectation-reality gap. Prior, vicarious, and normative knowledge all shaped residents' expectations of the restrictiveness of the setting and how this aligned with their reality.

The data add a fourth knowledge-type to Sexton's (2015) model: logical knowledge. This refers to respondents' descriptions of many restrictions being arbitrary (P12, P7, P17), inconsistent (P12), hypocritical (P15), or nonsensical (P4). Experiences of restrictive phenomena are presented within Sexton's (2015) slightly adapted model now.

5.4.4.1 Severity

The severity of a restrictive phenomenon was described by respondents in relation to how deeply it affected them subjectively. The significance of this effect lay in whether and to what extent respondents experienced restrictive phenomena to have symbolic consequence. This involved the internalization of a restrictive phenomenon as something violating one's autonomy, one's sense of self and identity, or one's humanity or personhood. The more symbolic the interpretation the more severe the experience.

For instance, participant seventeen discussed not being able to have perfume or a smartphone in her room. This proscription of personal belongings is the restrictive phenomenon and her description of this might have stopped there. However, when relaying her experience of this she considers it in symbolic terms also. The ban represents a loss of normalcy, pointing her out as different and spoiling her identity. Restrictiveness is therefore felt more severely.

> *Int – How does it make you feel, knowing that you can't have, for instance, the perfume or a smart phone with a camera in your room with you?*
>
> *P17 – Well it makes you feel different, you know, you're sort of singled out different from the norm you know, from people on the outside, yes, yes.*

Respondents would often describe experiences in this way – as both restrictive phenomenon and symbolic. Participant two identified not being able to cook for himself as a restriction which he then felt was diminutive of his 'self-worth' as an individual. Participant fourteen highlighted that for him, having strict dinner times in a particular room made him feel like '*…just another brick in the wall*' emphasising how he felt '*herded*' like cattle. In this latter example what may be considered by some as a restrictive phenomenon of little consequence – set meal times are a familiar experience for many, featuring in school, family, and social life – is interpreted as dehumanizing, with participant fourteen comparing himself to an animal.

Participant five was asked whether he felt the restrictions we had been discussing affected his sense of self and identity. He responded that it also affected his status as a human being:

> *Int – So, many of these things that we've been talking about, erm, do you think they affect your sense of self and your identity?*
>
> *P5 – They do, yea*
>
> *Int – mm, in what ways?*
>
> *P5 – You just don't feel like you're a person here or something like that, you're just, I'm just sorta treated horrible*
>
> *Int – What do you feel like?*
>
> *P5 – Just a number or something.*

In describing himself as being treated as '*…just a number or something'*, participant five has internalized restrictions experienced in the setting in a highly symbolic manner. Arguably there can be little more restrictive an experience than the removal of one's personhood. This example of a

restrictive phenomenon experienced with symbolic weight was similar to an example described by participant ten when relating a trip to the (somatic) hospital in handcuffs. The excerpt shows that he experienced handcuffing and his treatment in hospital as symbolically dehumanizing and mitigating his identity and sense of self.

> *P10 – We are completely dehumanized you know and as I walked out, I came out and there was a prisoner from wherever prison, erm, he was in the same clinic and he was just sat in a public area with handcuffs on, two prison officers with him and I come out, 'oh, the fucks that?' Surrounded by fucking staff, cuffed to fuck? yea? Fucking dragged out of the room*
>
> *Int – mm how did that feel?*
>
> *P10 – Humiliating*
>
> *Int – Humiliating, yea*
>
> *P10 – Yea it's degrading*
>
> *Int – Yes. And you say you feel dehumanized?*
>
> *P10 – Absolutely*
>
> *Int – If you don't feel like a, if you don't feel like a person, what do you feel like?*
>
> *P10 – Whatever they fucking want me to be. … Insignificant would probably be the most logical word to use.*

It is important to note that not all restrictive phenomena were interpreted with such symbolic weight. In the excerpt below, respondent eighteen describes restrictive rules on the ward. She feels they make managing the ward easier for staff but stops short of describing this in more symbolic terms, instead highlighting this experience as a pragmatic feature of secure life.

Int – mm you talk about erm, individual needs, the, the patient's needs, do you feel treated as an individual here? With your own unique history, background, er sense of humour, interests?

P18 – Less likely. You're more treated as a general, the rules are the same for all the patients. They don't erm, they, they try and put individual care to some extent but still it is more generalized

Int – mm why do you think they do that?

P18 – I guess it's easier for them to manage.

The above examples demonstrate that restrictive phenomena can be felt more or less severely by different residents given the extent to which they interpret these as having symbolic consequence. The level of symbolic abstraction residents bestowed upon phenomena they experience as restrictive is a complex psychological phenomenon. Why one resident endows certain experiences with symbolic *severity* another would not can be understood better when considering how *salient* that restrictive experience is for that individual.

5.4.4.2 Salience

The salience of a restrictive phenomenon for an individual is the expression of an expectation-reality gap. Sexton (2015) refers to this as the punishment gap. More appropriate here would be the 'restrictiveness gap'. Where the experienced severity of a restrictive phenomenon exceeds that anticipated by a resident this has a positive salience. Where a restrictive phenomenon is less severe than one anticipated this has a negative salience – although is still experienced as restrictive. The greater the distance between residents' expectations of the severity of the restrictiveness of their setting and their experience of this, the higher the level of saliency. Respondents' expectations of the restrictiveness of their care comprised

four knowledge types: prior, vicarious, normative, and logical. These are discussed in turn.

5.4.4.2.1 Prior Knowledge

Respondents' prior knowledge of the restrictiveness of secure care was based upon their expectations of a secure hospital prior to arriving, and their experiences of previous secure hospitals and prison-life.

Respondents recalled that some aspects of secure care were more restrictive than they thought they would be prior to their arrival. One individual thought it would be less secure than it was and that he would be able to smoke (P5), and another was surprised he couldn't shave as he pleased:

> *P12 – There's lots of things that are restrictive, that I, that I didn't think would be in place when I came here, like the, the simple thing of erm having a shave, for example in, in obviously in prison I could shave whenever I wanted with razors in my room.*

Participants frequently compared the restrictiveness they currently felt with experiences from other hospitals. Comparisons were made in reference to other secure settings being less restrictive as they allowed access to gardens (P2), permitted leave (P15, P5), offered a greater range of individualised activities (P17), or facilitated smoking (P5).

Comparisons were also made to prison wherein respondents expressed feeling less restricted as sexual contact occurred there but not in the hospital (P15), smoking was (at one point) permitted (P5, P3), prisons enabled visits with minor relatives (P2, P1), and gave a sense of greater freedom overall (P12). Given the ostensibly non-punitive intentions of

secure hospitals these comparisons had a strong normative element; respondents interpreted these differences as unfair punishment.

Prior knowledge also meant restrictive phenomena had negative salience for respondents. Respondent eight was quite content with his current conditions of care explaining that they were *'[…] very good … because I came from another hospital, I came from the, the high secure hospital'*. Participant sixteen felt less restricted than he did on another ward as he was given a larger number of privileges more readily:

> *P16 – [All] I am saying is I've been on [another ward name] downstairs and it took me a good year or two, to get all the privileges and that's not as much as what I've got up here, so they're doing a good job up here.*

The above examples indicate that respondents' previous experiences of secure and prison settings shaped how they experienced the severity of restrictive phenomena. Where other settings were less restrictive this was lamented, and current conditions were felt as more salient and restrictive. The reverse was also true in that transitions from conditions of greater restriction led two respondents to feel restrictive phenomena with a lower level of salience.

5.4.4.2.2 Vicarious Knowledge

This form of knowledge is similar to prior experience in its content and consequence. Residents would compare stories they had heard and reflect on these differences. Where it was felt other settings were less restrictive as proffered by others, this made the experienced restrictions more salient for participants as they perceived an unfair mismatch between what conditions they could expect and what they lived with.

Participant one, residing in a high secure hospital, had been told by a friend that in his medium secure setting patients were permitted thirty minutes internet access a week. This was discussed in the context of a total ban on internet access, something he wished would change. He also expressed feeling his current hospital was the strictest:

> *P1 – I've heard that you know out of all the high secures, this ones most strict.*
>
> *Int – uh huh*
>
> *P1 – Out of all the high secures, that's what I've heard.*

Respondent nine felt that although his low secure setting was not overly restrictive for him he had heard of another mental health hospital in Turkey that provided water a '*[…] fountain in the middle of the room and er back lighting and music playing so that's how I imagine kind of a really nice atmosphere*'. Despite this he felt his conditions of care were not restrictive given what he'd heard of a high secure hospital:

> *P9 – I think probably the worst you could possibly be at is [high secure hospital] which has got quite violent criminal people er with, obviously with men-, well, mental ill problems as well. That would be a challenging environment to be in, I think it'd be much more restrictive.*

Similar to prior knowledge, vicarious knowledge shapes residents' expectations of secure care. Where examples were heard of restrictions more severe than theirs, residents experienced their situation as less salient as in the latter example of participant nine. Alternatively, where anecdote suggested other settings were less restrictive, this led respondents to emphasise the greater level of restrictiveness they felt subject to, increasing the salience of this.

5.4.4.2.3 Normative Knowledge

Normative knowledge refers to what residents felt restrictive phenomena ought to be like for them and whether experienced restrictions seemed fair or justified. This included involuntary detention itself, the application of unfair rules and practices, but also highlighted a range of restrictive phenomena respondents found fair or justified.

Several respondents felt their placement in secure care was unfair. Three participants considered their detention wrong given they felt wrongfully convicted (P13, P14, P15). This made any experienced restrictiveness more salient as they felt they ought not to be in this setting to begin with. Participant three's experience of his length of stay was more salient as his stay in secure care will exceed his initial prison sentence. For him this was unfair and unwarranted:

> *P3 – I don't think my index offence was serious enough to warrant somewhere like this, erm, I don't think, erm, I think I'm gonna be kept here a number of years and I don't think that I should be kept here for as long as I'm going to be, I think I should be kept in here for as long as a prison sentence would have been.*

He further felt that given this he should be afforded '*[…] every advantage*' in his hospital care.

Others expressed feeling blanket bans should not be used in secure care. They felt it unfair when the actions of another had a butterfly effect with consequence for them (P1, P2, P12, P18). Participant twelve expressed this:

> *P12 – I mean with, with the hospital environment as far as restrict-, restrictions are concerned if, if you got these things put in place and you don't abuse it, then you should be able to keep these things but*

when when something goes wrong and somebody abuses the situation then 9 times out of 10 it will become a blanket ban…

Int – mm

P12 - …where everybody loses, and I think that's a bit unfair.

This sense of normative incorrectness was also present for residents discussing being observed by staff (P1) and having a lava lamp in a bedroom (P13) as it was felt these restrictions belied a lack of trust. They felt this to be unjustified, that they ought to be trusted and had proven they were trustworthy.

Conversely, respondents also demonstrated a reflexivity as to when some restrictions were fair or justified. These rationalizations were made on grounds of the danger patients thought they or others posed, maintaining the safety of the environment, and a sense of justice following their criminal behaviour. Participant two accepted many of the restrictions in his care:

P2 – Yea, yea you know I can't complain considering what I've done

Int – Yea?

P2 – Where do I expect to be you know, I could be on the worst wing of the worst prison of the country you know and that would be a worse place than here, so I can't really expect too much.

Another expressed that it was fair he was not allowed leave yet:

Int – So for you not having leave is a, is a form of punishment?

P7 – Yea, yea, yea, I, I, I take that, cos like I say I do need to be punished for what I did

Int – So you think it's fair?

P7 – Yea, yea, yea.

The above shows that residents' normative assessments of some restrictions and whether these were thought to be fair impacted upon their

experiences of restrictive phenomena. The consequence of these normative judgements sat within how respondents constructed their expectations of restrictiveness. Normative knowledge therefore played an important role in the salience the restrictive phenomena had for individuals.

5.4.4.2.4 Logical Knowledge

Logical knowledge refers to respondents' efforts to make sense of restrictive phenomena that seemed illogical to them. This illogicality increased the salience of restrictive experiences for individuals because they were not able to cognitively master the rationale for the restrictive phenomenon, or experienced this illogicality as normatively wrong. This distorted the expectation-reality gap as respondents were less able to compose their expectations. This knowledge-type was not present in Sexton's (2015) model of penal consciousness but is added here as it was a significant and recurring theme in participants' talk.

Respondents found some restrictive phenomena nonsensical. Participant four highlighted in his mind the illogicality of a rule precluding certain sharp belongings:

> *P4 – If they just say you can only have three sharp things in your room even though, some, them three sharp things might be sharper than other things you can't have in your room, it does not make friggin' sense at all.*

The origins of these restrictive phenomena were often contradictory. Respondent twelve expressed that staff found them nonsensical also. He illustrated this by describing how he is allowed to use machinery unsupervised off-ward but not a razor on-ward.

P12 - I came back from work, I'd been down horticulture cutting all the grass, even, even the back bit, I come to the ward and I said [to a staff member] you 'know that's so frustrating', he went 'why?', so I said 'I can use a whopping great petrol lawnmower, massive great blades spinning around unsupervised, yet I can't come to the ward and have a shave' haha. And the staff looked at me and said, 'I know', like even they say, 'we know'.

Some restrictive phenomena were described as hypocritically applied. Participant fifteen felt it unfair that he was expected to follow rules when staff themselves did not.

P15 – [staff] they are lazy. They get paid for nothing at all, some of them just sit there eating and farting and, and smoking on duty and just doing things they shouldn't do. They just dictate to us but they don't abide by their own rules.

Participant twelve highlighted this inconsistency:

P12 – You just don't know where you stand when it comes to security. Like I say there are so many things that we used to have that we can't have anymore, there are, some things they say we won't have which we end up having back, you know it's just, there's absolutely no consistency whatsoever as far as security is concerned. Absolutely none whatsoever.

However, some restrictive phenomena did make sense. Where this was the case, the expectation-reality gap was smaller and the salience of these lesser. Residents could more comfortably compose their expectations around what they felt logical restrictions. Participant four felt the tight regulations around receiving visits were necessary to prevent drugs getting on-site as often happens in prison (P4). He also expressed that although he struggled with involuntary detention and found many aspects restrictive,

they were necessary *'[…] cos you don't, you don't want us lot running around the streets, do you?'* (P4).

Restrictive phenomena that seemed inconsistently or hypocritically applied or that were nonsensical were illogical to patients. This illogicality made it difficult for respondents to configure their expectations, leading often to a greater sense of restriction.

5.4.5 Consequences of Restrictiveness

Respondents discussed the consequences of restrictive phenomena. They noted how these made them feel, how they altered their behaviour deliberately or unintentionally over time and how these affected their recovery.

5.4.5.1 Emotional Consequences

Participants described feeling bored (P2, P3, P14, P17, P18, P5, P7, P8). This was in part due to the lack of meaningful activities but also a consequence of the slowness of life in secure care. Respondent eight described waiting for unescorted leave to be granted by the MoJ:

> *P8 – My situation waiting for unescorted leave, five months my unescorted, no, the MoJ answers, no, not coming. After that maybe, maybe this is a push from MoJ, five month I feeling that. But last, last couple of months, few months, it is very difficult to me, very, very difficult, everyday I waiting for MoJ and er other activity it is not very interesting for me. It is, it was very good, very, very good but little bit now like bored, like bored you know, I feel bored.*

Frustration with these restrictive phenomena was a commonly cited emotional consequence. Respondents felt frustrated in relation to the perceived hypocrisy of restrictions (P12), waiting for help from staff (P11),

being placed too far away from home and family (P15), and a lack of available beds to progress in their pathway (P4). Participant twelve stated the lack of trust he felt following a restriction on using a toilet by himself as frustrating:

> *Int – How does it make you feel though, what kind of response does it elicit within you?*
>
> *P12 – It's like erm*
>
> *Int – Is it acceptance, frustration, annoyance?*
>
> *P12 – It's more frustration for the simple fact that, that the one area where I'm trusted to do everything is gone, I'm not trusted to go to the toilet now on me own.*

Other emotional consequences for respondents were as follows: confusion when waiting to hear from the MoJ (P8); annoyance at having a range of restrictions placed upon them (P5); hurtfulness having to ask permission for things indicating a lack of trust from staff (P12); distress witnessing others being restrained (P17); and sadness at not having leave (P14), being able to visit family (P15), and having restricted access to the internet (P8).

The restrictiveness of the setting also elicited in respondents feelings of punishment, degradation, patronization, insignificance, and humiliation (P10, P4). These had the net effect of diminishing individuals' sense of dignity. For participant four, he felt having to ask permission to use batteries degrading and patronizing:

> *P4 – Yes of course it feels punitive and things feel punitive on a day to day basis*
>
> *Int – They do?*
>
> *P4 – Yes of course they do. It's like er, and not just punitive but patronizing and not just patronizing but sometimes really degrading.*

When experienced in this way, as punishing and a degradation of dignity, respondents regarded restrictive phenomena with a high level of severity and symbolic consequence.

5.4.5.2 Behavioural Consequences

Respondents described a range of behavioural consequences following experiences of restrictive phenomena. Both long-term unintended changes that might be conceived of as indicators of institutionalization, and small behavioural adjustments such as altering sleep positions to avoid observations were discussed.

Participant ten described a difficult relationship with his Responsible Clinician (RC). At one time he sought to make a complaint about the actions of his RC. Earlier in our interview, he expressed dissatisfaction with how notes were being made. However, he set about using the hospital's information governance systems to support his complaint. This adjustment to controls demonstrated a reimagining of phenomena he previously found restrictive.

> *P10 – So I write back to doctor [name] and I go 'here is evidence to you', sending him copies of both those letters 'here is evidence to you that it is in fact the doctor that's is lying to you and not me'.*

Deeper and more long-term adjustments were made by respondents. When asked how he felt about the built environment of his high secure setting, one participant responded:

> *P10 – Personally, I don't even think about it. I've been in the system so long, I've been locked up for so long now, it's irrelevant.*

Many years of intensive therapy sessions in the controlled secure environment left participant four feeling 'therapized'. He recalled feeling

unable to have normal interactions and conversations with others when he progressed from a high to medium secure setting.

> *P4 – You cannot be expected to be so complexly and intensely and intricately kind of like vocal for years and years and years and years and years, absolutely focused and, and single minded on therapy for years and years and years and years, and that not have an effect on you on your day to day life … But it … probably took me about two years to stop being so analytical in conversations, I just couldn't talk about shit. D'you know what I mean? I just couldn't have a conversation about shit.*

Respondents expressed becoming institutionalized by their length of stay in secure settings. This led to feelings of resignation. Participant eighteen wanted to bring newspapers into her care setting but this was not allowed. She decided not to get upset by this but rather simply accept it:

> *P18 – I've been in the system for some time now so I just feel this is one of the policies and you just cope with it, don't mind too much.*

Some practices that were restricted were not contemplated as ever being possible. For instance, when asked to consider the possibility of having mixed-gender wards, respondent fourteen felt it would be impossible.

> *P14 – I miss female company*
>
> *Int – You miss female company?*
>
> *P14 – Yea*
>
> *Int – Yes. I think it's a really important thing and it's good that you mention that. Er do you think that we should have maybe mixed gender settings?*
>
> *P14 – It would be impossible at top security level.*

Significantly, respondents felt the institutionalizing effects of secure care would follow them into the community. Interviewees described becoming

deskilled, with poor perceived job prospects and social skills as a result of their oftentimes lengthy stay. This sentiment is captured in the following excerpt. Participant seventeen felt the controls of the secure setting left her unable to look after herself, stripping away a degree of autonomy necessary for independent living.

> *P17 – I've been in and out of so many different places in my case in the last two or three years that erm, it's become excessively difficult for me to actually function in my home, erm, I feel like a stranger in my own home, erm, and er you know just getting through a day is difficult, er on my own.*

5.4.5.3 Consequences upon Health

This organizing theme explores how respondents described the ways restrictive phenomena affected their health. Individuals discussed the consequences of taking unwanted medication, and the quality of food on physical and dental hygiene.

Respondents listed several adverse effects following medication. They described medication as ineffective (P1, P2). Others highlighted a shortness of breath (P7), and disrupted sleep patterns and bowel movements (P9). Respondent fifteen felt medication was used to destroy his mind:

> *P15 – And they're using that tree drug to kill the mind up in a certain way to use as a weapon, a secret weapon to take out individuals, you see, I'm a Madonna.*

This was also significant where medication was forced. For participant fourteen, being forced to take medication diminished his relationship with staff.

> *Int – Do you think you have a good relationship with staff on the ward?*

P14 – I did have, but, I stayed on the haloperidol for about a year and a half which took me until the summer of last year, 2016, and then I came off it and erm I was feeling well, with no medication and erm it should have stayed that way but they forcefully gave me injections after that time and I'm still on them.

Consequences to physical health were discussed also. One respondent felt the quality of the food given to him in seclusion made his teeth loose (P4). Another that he was being denied necessary dental care as he refused to be escorted off-site in handcuffs given he was a civilly-detained patient and he would '*…just have to suffer in pain while I'm waiting*' (P5). This same patient also chose to avoid dinners as he felt the food offered to patients made them gain weight.

Participant seven felt 'tick-box'-style occupational therapies weren't good for rehabilitation, and participant seventeen that her healthcare setting made her more depressed.

Little was discussed in relation to the health consequences of the restrictiveness of their care and this deserves further attention. However, this organizing theme indicates that respondents have attributed some negative mental and physical health consequences to a selection of restrictive phenomena.

5.4.6 Deviant Cases

Respondents did not experience all aspects of care as restrictive. Many phenomena described as restrictive were appreciated by other patients. Indeed, P16 asserted:

P16 – […] in your room you can do what you want. You can have different stereos and electrical equipment, clothes, Gameboy,

megadrive, two mp3 players, four mp3 players, personal CD player, caps, trainers, boots, toilet ro-, basically, whatever you want you can have it.

Reflecting on security measures, some felt these were fair (P2) and necessary for maintaining safety and preventing drug-use (P1, P2, P4). Interviewees did feel able to develop new skills (P4), engage in meaningful activities (P9, P12, P16), and grow positively (P1).

Although some respondents felt disconnected from the machinations of the hospital, several also felt involved and included. Participants two and four felt that their multi-disciplinary teams and social workers kept them up to date on developments in their care pathway. Participant four recalled being asked to sit on a panel hiring new members of staff. Interviewee nine described a patient work group that was established to help design a garden on-site:

P9 – They actually, they actually go out of their way to include, for example there's, er in the design of the [garden] before it, this is about a year or two back, before it was a waste ground, nothings been developed on it at all. They allowed patients in as a kind of a work group to brainstorm and come up with ideas about what they could put in the garden area, er, so in that way they have invited patients in to decide on policy.

Not all respondents expressed a custodial sentiment to their care. Participant 12 preferred his current unit to prison wherein he felt '*lost'* and ignored. Respondent four expressed that notwithstanding external staff, members of his own multi-disciplinary team did treat him humanely:

P4 – I think the team that you're given, your staff nurse, and your erm, associate nurse, I think on the whole do treat you humanely, do individualise you as a, as a person, they do want you to succeed.

A civilly detained patient was asked if he felt in any way punished, residing in a secure hospital.

> *Int – Some patients in secure hospitals erm, aren't here on a criminal section or a prison transfer but they feel as if they're being punished somehow because it's a secure hospital. Do you feel like that?*
>
> *P11 – Not at all no. No I'm not punished at all, you know what I mean?*

Several participants felt equipped to move through their pathway and ultimately into the community. P4 expressed feeling supported to move to a medium secure unit. Interviewee 11 wanted to decrease the amount of medication he was on, but stated he didn't mind it currently. Respondents 11 and 18 stated they maintained close links to family outside the hospital and were able to call them frequently.

Respondents voiced further instances wherein they did not feel restricted. P12 communicated that he was able to express himself on the ward, and P16 that he could practice his religion as he pleased. P5 asserted he could decorate his room, and P18 that staff were not strict on enforcing limitations to her personal belongings. Finally, P8 communicated that for him:

> *P8 – In my opinion this hospital is best, in my opinion is best. I don't know [other participant in focus group] if you agree or not. Is best, everything is fine.*

5.5 Discussion

The interviews conducted in this phase generated data to provide answers to the research questions:

1. What elements of secure forensic psychiatric care residents experienced as restrictive

2. How, psychologically, they experienced these phenomena
3. What consequences of restrictive phenomena residents identified

The Model of Restrictiveness provided a framework to help understand residents' experiences of restrictiveness. This identified 1) why elements of care might be restrictive; 2) what phenomena are frequently discussed as restrictive; 3) how these phenomena are enacted in an intended or unintended manner; 4) subjective experience of the severity and salience of these; and 5) the consequences restrictiveness might have for individuals. The following sections discuss the significance of these themes and situate them within the wider literature.

5.5.1 Antecedent Conditions

Respondents described risk management procedures, the purpose of the forensic system, and available institutional resources as reasons for the existence of restrictive phenomena. Risk management shapes much of secure care. This has been acknowledged in other studies exploring risk and forensic care and was discussed in chapter two. Risk management has been found to overshadow therapeutic care (Mann et al., 2014), and split the roles of nursing staff between the caring and custodial (Holmes, 2005; Vincze et al., 2015). It can prevent possession of certain goods, engagement in activities, and can exist as a culture used to justify restrictions felt as unacceptable by residents (Cashin et al., 2010; Craik et al., 2010).

Residents described a sense of carcerality and punitiveness. This blurred the boundaries between care and custody. This was captured by one interviewee describing his cognitive dissonance at being sent back to prison

after a period in secure care. This tension between care and custody is well documented in forensic literature (Adshead, 2000; Brunt & Rask, 2005; Holmes & Murray, 2011; Horberg et al., 2012; Ruane & Hayter, 2008; Vincze et al., 2015).

The custodial aspects of forensic care may be born of wider political and societal views; and the normative values held by institutions and staff, shaped by media and public perceptions. Punitive attitudes to MDOs are reflected in broader commentaries on social control and the management of deviant individuals, captured by Garland's (2001) 'Criminologies of the Other'. Strategies to manage social deviants in this vein are characterised by expressive punishments, the condemnation and exclusion of wrongdoers, and a depiction of deviants as incorrigible others (Feeley & Simon, 1992; Goshe, 2017; Loader & Sparks, 2004; Matthews, 2005).

Risk-averse, custodial, and under-resourced settings are less likely to promote positive therapeutic risk-taking, facilitate meaningful therapeutic activity, and encourage wider social engagement. They are more likely to calcify residents' perceptions of themselves as deviant others. These antecedents not only generate or shape the restrictive phenomena experienced by residents, but they provide material for legitimizing or delegitimizing them. The degree to which phenomena are experienced as restrictive is reliant on residents' rationalizations of them; their logical and normative underpinnings. Residents identified systemic features of forensic care that shape the existence of restrictive phenomena, demonstrating a reflexivity in understanding their current living conditions.

5.5.2 Restrictive Phenomena

Interviewees described myriad restrictive phenomena. Accounts centred on daily life on the ward, relationships with others, symbolic restrictions affecting their identity, and the operation of time.

Respondents voiced restrictions on the number and type of belongings they were allowed; the availability and meaningfulness of daily activities; and the limited physical space. Underpinning these is a sense of reduced agency. Interviewees were not able to visit certain spaces as they chose or participate in activities when they chose. This was captured by one respondent's description of the lack of spontaneity and the loss of normalcy this carried. This lack of choice is well acknowledged in the literature, described as a 'false autonomy' or 'optimal' choice-making (Clarke et al., 2016; Holmes & Murray, 2011; Sustere & Tarpey, 2019). Exercising choice is an important part of the recovery paradigm and key aspect of self-expression (Mann et al., 2014). Small liberties such as decorating ones' bedroom have been associated with positive mental health outcomes (Seppänen et al., 2018).

Relationships were restrictive and restricted. Interviewees described staff and other residents limited where they would go on the ward. Some staff and patients were described as bullies or manipulative. Interactions with other residents in this vein is reminiscent of Gresham Sykes' oft' quoted, '*[…] the worst thing about prison is living with other prisoners'* (quoted in Jewkes & Johnston, 2006: 171). Chaotic or closed ward atmospheres are characterised by tensions, aggressivity, bullying, and poor therapeutic alliances (van der Helm, Stams, & van der Laan, 2011). Studies

demonstrate that poor ward atmosphere is associated with recidivism, further aggression, coercive interventions, low quality of life, and poor mental health outcomes (Auty & Liebling, 2019; Puzzo, Aldridge-Waddon, Bush, & Farr, 2018). Such atmospheres restrict patient engagement, encouraging time spent in bedrooms.

A series of symbolic restrictions were reported by residents. They communicated feeling objectified, denied citizenship, and othered. Residents felt treated as a diagnosis, their behaviour pathologized. Thus, interviewees described a loss of identity and self, indicative of Goffman's (1961) 'mortification of self' discussed in chapter two. Part of this self-expression was contingent on information flows. Patients communicated feeling confused or bombarded by information and left without meaningful avenues of complaint or opportunities to be heard. A lack of communication has been identified in the literature, particularly in relation to coercive measures (Repo-Tiihonen et al., 2004; Soininen et al., 2016).

Without sufficient information, patients' ability to comprehend developments in their care or understand hospital machinations was reduced. This curtailed a kind of active citizenship in these and wider social domains. This denial of social citizenship is made most plain in MDOs disenfranchisement from public elections (Rees & Reed, 2016).

As noted previously a double-stigma is experienced by forensic patients. The literature describes public fear, intolerance, and prejudice to these individuals as widespread (Mezey et al., 2016). The 'othered' status bestowed on patients lingers beyond the immediate hospital setting and restricts recovery, future accommodation, employment opportunities, and

social inclusion (Corrigan & Watson, 2006). Passing through the forensic system thus marks out individuals as significantly different, restricting their intercourse with society more broadly; they become an out-group (Bauman, 2000).

Patients' narratives gave significant attention to time. Length of stay was discussed in all but one interview. Length of stay was described as most restrictive in relation to its indefinite nature. No end-date made some feel trapped. This was most salient where respondents' length of stay exceeded their prison tariff. These frustrations are expressed elsewhere in the literature (To et al., 2015; Völlm et al., 2016; Wilkie et al., 2014). Patient accounts of length of stay depict a normative sense of unfairness and resignation. Time was perhaps salient in interviews as it provided a single meta-level metric for all the restrictive or difficult elements of care expressed in months or years.

5.5.3 Mechanisms of Enactment

Respondents communicated how restrictive phenomena were enacted. The modalities of power enacting these were described in ways that were covert and overt. Bureaucratic processes, the machinations of the hospital or Ministry of Justice, treatment decisions, and certain security measures were described as intractable and incomprehensible. These experiences point to a lack of information around these procedures and few opportunities to exercise agency to engage in them.

Patients expressed just playing the system. This is reminiscent of Foucault's (1977) concept of 'governmentality', and recent studies on discipline within Late Modern penal regimes discussed in chapter two (Crewe, 2007; Scott,

2010). When applying these concepts to the data presented in this chapter, patients are disciplined into the aims of secure hospitals instead of exercising self-determination. Their autonomy is limited or as described by Holmes and Murray (2011) 'false'. Covert, distal, and bureaucratic power was experienced as unnegotiable and unnavigable, tinged with an agentic fruitlessness.

Some restrictive phenomena were described as being enacted in ways that were more immediate and coercive. Residents described the physical and procedural aspects of security as detrimental to autonomy of movement and privacy. Other studies relate this notion that security is a hegemonic power that subsumes therapeutic ideals (Cashin et al., 2010; Mann et al., 2014). The application of routine rules consistently applied was described by some as diminutive of individuality. Respondents used metaphor to compare themselves to cattle or bricks in a wall. Blanket bans were highlighted as unfair, and coercive measures as dehumanizing.

Common throughout these accounts is the sense that respondents felt their autonomy, self and identify, and at times sense of humanity were restricted by what was in their eyes the over-application and routinization of strict or unfair rules. Studies report that the enforcement of rigid ward rules can lead to power struggles between staff and patients (Urheim et al., 2011). Power manifest in these ways is both *per se* restrictive and colours the enactment of restrictive phenomena outlined in section 5.4.2.

5.5.4 Experiences of Restrictive Phenomena

Patients' accounts of restrictiveness were subjective. Although there were clear themes, no phenomenon was universally described as restrictive. The

manner in which these aspects of care were described varied. Some restrictions were described as frustrating; others as dehumanizing or degrading. Residents vocalised some restrictions to be unfair; yet others as justified given their index offence.

Such subjectivity is noted in literature on other Total Institutions. Indeed, discussing experiences of healthcare receipt in prison settings, Awofeso and Guggisberg (2011) note:

> *'[e]ach individual's personality extracts a subjective psychological environment from the objective surroundings, and it is that subjective environment that shapes personality sensitivity to environmental factors and behaviour [...] Different people who are exposed to the same environment interpret, experience, and often also react to it very differently' (Awofeso & Guggisberg, 2011: p. 151; quoted in Jordan, 2012).*

The Model of Penal Consciousness (Sexton, 2015) was drawn upon as a framework for understanding these subjectivities. Respondents described feeling that their autonomy, self, and personhood were negatively affected during their care. Interviewees internalized certain restrictions and gave them symbolic consequence; P17 felt bans on personal belongings in her room didn't just stop her using these (autonomy), but that they stopped her belonging to wider society, that it '*singled [her] out different from the norm'*, thus tainting her identity.

Respondents' previous experiences of secure care and prison settings shaped how they experienced the salience of restrictive phenomena. Where other settings were less restrictive this was lamented, and current

conditions were felt as more salient and restrictive. Restrictive phenomena that seemed unfairly, inconsistently, illogically, or hypocritically applied made it difficult for respondents to configure their expectations, leading to greater salience and sense of restriction. A recent study by Sustere and Tarpey (2019) reported that patients and staff held different definitions of what Least Restrictive Practices meant. This resulted in patients feeling that they lacked information and created confusion on the units.

Thus, differences in residents' experiences of restrictiveness can be better understood if we consider to what extent individuals ascribe symbolic consequence to them and to what extent the realities of secure care conflict with their expectations.

5.5.5 Consequences of Restrictive Phenomena

The consequences of restrictive interventions were woven throughout respondents' narratives. Respondents reported a range of emotions they connected with restrictions. These included: sadness, frustration, boredom, and degradation, amongst others. These emotions are identified in other qualitative studies of forensic patients (Coffey, 2006; Hui, 2017; O'Connell et al., 2010; Soininen et al., 2016). These emotional reactions were tied to consequences on health. Patients reported that forced medication made their mental health worse, and that the iatrogenic effects of anti-psychotics and the restricted environment were conducive to poor somatic outcomes. These outcomes are well documented elsewhere (Mat et al., 2014; Oakley et al., 2013; Sustere & Tarpey, 2019).

Respondents reacted to restrictive phenomena and the aforementioned consequences in different ways. Reactions ranged from passive acceptance,

making small alterations to lifestyles to suit the setting, to more intentional acts of rebellion. Crewe (2007) suggests that inmates in prisons can acquiesce and internalise institutional norms. This is indicative of interviewees' accounts describing institutionalization; feeling resigned and becoming deskilled over time. Goffman (1961) discussed the 'secondary-adjustments' psychiatric in-patients make. In the present study one resident recalled altering his sleeping position to lessen the intrusiveness of observations.

Rubin (2016) proposes that prison inmates exercise agency by using 'friction' and 'resistance' as subtle acts of defiance to the penal regime. Indeed, a participant in this study voiced that notes written about him were untrue and unfair; yet later used information governance procedures to compel a complaint against his doctor, thus reimagining a restrictive phenomenon as one that worked for him. Consequently, some residents internalized restrictions on the ward and others sought out small acts of defiance. These indicate a sense of resignation or inability to exercise sufficient autonomy.

5.5.6 Deviant Cases

Interviewees described instances where they did not feel restricted. They also identified phenomena others found restrictive, but voiced that these perceptions were not shared. These supported the proposition that restrictive experiences are subjective. These subjectivities were informed by the expectations of residents and the degree to which they bestowed symbolic import to these. For instance, some participants did not ascribe

restrictive measures, such as the proscription of leave, significance; instead, they saw this as fair or legitimate given their index offence.

Others recalled a range of meaningful activities, sufficient information flows, involvement in care, and positive support from staff. These instances point to moments of good practice and demonstrated these are achievable within secure settings. If all aspects of care were experienced as restrictive there would be a problem of definition, and a questionnaire developed to measure this would not be valid.

5.5.7 Connecting the Thematic Network Analysis themes to the Literature Review Findings

There were significant overlaps between the themes described in the analysis of participants' interviews and the concept analysis categories (Walker and Avant, 2011) and thematic analysis themes (Braun and Clarke, 2006) described in the literature review. Specifically, the concept analysis categories 'antecedents', 'consequences' and 'deviant cases' are also present in this analysis. The thematic analysis themes 'relational', 'personal belongings', 'pathologization and labelling', 'built environment', 'activities' and 'communication and expression'.

The reasons for this overlap are fourfold. First, this overlap indicates that participants' accounts are to some extent shared by other patients as described elsewhere. This lends the present analysis validity and generalizability as some of the derived themes are supported by the literature. Second, the literature review was updated in January 2019 following the present analysis. The concept analysis categories did not change but the literature review thematic analysis themes 'communication

and expression' and 'pathologization and labelling' and 'personal choice' were added with the introduction of new literature and in light of the present interview analysis.

Third, interview questions were derived from the findings of the literature review and thus were likely to have shaped the scope and foci of participants' responses. Finally, the overlap in themes might reflect the unintended use of a deductive heuristic as the literature review categories and thematic analysis themes shaped the present analysis. Future qualitative research would profit from a second coder for this reason.

There were differences in the analyses. First, the theme 'institutional resources' was considered an antecedent condition in the interview analysis as opposed to a characteristic attribute in the literature review. This reflects my developing thinking and patients' accounts offering institutional resources as a reason for restrictive phenomena they identify. Second, the 'temporal' theme was expanded upon. In the literature review this was discussed in relation to length of stay. In the interview analysis patients further described the slowness of time in secure settings and discussed the implications of care on long term outcomes such as reintegration.

Third, several new themes emerged including the description of restrictions in a symbolic manner, 'citizenship', 'otherness', the 'mechanisms of enactment' and 'experiences of restrictive phenomena'. The experience of restrictiveness in symbolic terms, as a product of expectations and normative accounts, and enacted through various overt, distal or routine and coercive mechanisms is a novel contribution of this chapter. Finally, the present analysis describes patients' accounts of care they directly described

as restrictive; the literature review interpreted this subjectively. The interview data offer more valid accounts of restrictiveness.

5.6 Summary

A revised definition of restrictiveness can be derived from the above findings and discussion. This takes into account the symbolic weight residents attach to phenomena as they internalize them. The definition replaces 'will' with a more descriptive measure of the extent to which individuals' feel restricted.

This definition maintains that restrictions can be intended or unintended, proposing that phenomena may be maintained or augmented by forensic care, as well as deriving directly from it. This definition subsequently includes, for instance, the long-term restrictions resulting from social stigma towards individuals with mental disorder and those who have committed crimes which is further maintained or augmented by a stay in a secure hospital. Phenomena deriving directly from the forensic system would include the hospital's built environment, forced medication, and so forth.

Final Definition. *The extent to which phenomena created, maintained or augmented directly or indirectly by forensic psychiatric care are subjectively experienced by a resident as infringing negatively upon their autonomy, self or personhood.*

The above definition conceptualizes restrictiveness from patient experience. The Model of Restrictiveness unpacks this definition, systematizing this concept in line with the study's protocol for developing a questionnaire (Adcock & Collier, 2001).

5.7 Conclusion

The present phase sought to better understand residents' experiences of the restrictiveness of forensic psychiatric hospitals. Of particular interest were what phenomena respondents found restrictive, how they experienced the restrictiveness of these subjectively, and what consequences were identified following these experiences. These themes were interrelated, illustrating the complex and interacting nature of residents' experiences as depicted in the Model of Restrictiveness. The model provides a framework through which to understand the restrictiveness described by residents in secure care. The interview data and thematic analysis findings informed the generation of a pool of items used in the FRQ. This is discussed in the following chapter.

Chapter 6
Developing the FRQ

6.1 Summary

The present chapter describes the development of the pilot FRQ. This includes the generation of items to reflect the data described in the preceding chapter and the literature review described in chapter three. A total of 80 items were generated. Fifteen of these were removed or altered based on discussions with supervisors and 65 items were submitted to a panel of five experts for an assessment of face validity. Following this, 58 items were included in the FRQ. In the following sections the choice of Likert scales, how response bias was addressed, and the wording of items is described and justified in light of the target population and study aims.

6.1.1 Aims

This phase of the project aimed to:

1. Generate a large pool of items that captured residents' experiences of restrictiveness in a meaningful way.
2. To send these items to a panel of experts for an assessment of face validity.
3. To amend, remove, or add items in light of these steps.

6.2 Methods

This phase of the study falls within the 'operationalization' step for developing questionnaires identified by Adcock & Collier (2001) and Luyt (2012). This involved '*[d]eveloping, on the basis of a systematized concept, one or more indicators for scoring/classifying cases'* (Adcock, 2001: 531). In this, "*[t]he items of the pool should be chosen so as to sample all possible contents which might comprise the putative trait according to all known*

alternative theories of the trait" (Loevinger 1957: 659 quoted in Streiner & Norman, 2008: 26). This is similar to data saturation in qualitative studies (Ness & Fusch, 2015). Thus, a range of items were generated to ensure as much of the range of concepts elicited by patients' experience of restrictiveness was captured.

The development of the item pool took place as follows. Eighty items were developed directly from themes within the Model of Restrictiveness, with reference to literature data (see Appendix I for a full list). Steiner & Norman's (2008) criteria for constructing items were applied to these to ensure they were appropriate for the target audience. Items were constructed in a way that ensured a subjective assessment of restrictive phenomena, rather than asking for their absence or presence (objective). A Likert response scale was chosen to capture participants' responses. Following these steps, a reduced pool of items was sent to a panel of experts for an assessment of face validity. Finally, items were amended in light of this and the pilot FRQ was compiled. This is presented in Appendix J.

6.3 Developing Items for the Pilot FRQ

6.3.1 Cognitive Ability

The cognitive processes involved when answering questionnaires is complex. It involves understanding each question; recalling relevant behaviours, attitudes or beliefs; inferring and estimating the frequency and typicality of events; mapping answers onto alternate responses (translating one's experience onto a scale); and editing an answer (Streiner & Norman, 2008).

Such tasks can be more difficult for people living with mental illness. A study of cognitive impairment found schizophrenic patients scored 1.5 to 2 standard deviations below matched controls on a series of cognitive tasks (Keefe & Fenton, 2007). Although high intelligence is a trait of some psychopathic individuals (Howard & Duggan, 2015), some severely mentally unwell patients will struggle with the FRQ as a cognitive task. This might be exacerbated by mental illness and other complex mental health needs of forensic patients, including: substance abuse, intelligence, or brain dysfunction affecting cognition.

As many forensic patients have multiple diagnoses and comorbidities and fluctuate between states of mental health, the pilot FRQ was targeted at all patients with a diagnosis of Mental Illness or Personality Disorder. Items on the FRQ were thus aimed at those individuals that have lower levels of cognitive ability. A single questionnaire permits meaningful comparison of FRQ scores across these diagnoses.

6.3.2 Criteria for Constructing Items

To make comprehension as easy as possible for respondents, criteria identified by Streiner & Norman (2008) for constructing questionnaire items were adopted. Items were constructed to be as close to respondents' talk as possible; aimed at 12 year-old readers (Flesch reading score 70-80), single-barrelled; without unnecessary jargon; positively-phrased to avoid double-negatives in response; reverse-coded to mitigate fatigue bias; short; and have fidelity to the latent construct of restrictiveness (Streiner & Norman, 2008). Each item was mapped onto an aspect of the Model of

Restrictiveness. Items were therefore developed in accordance with these criteria.

Examples of the item-writing process are given below:

'Staff stop me doing what I want' (this item was reflective of the attributes of the Model of Restrictiveness: 'Restrictive Phenomena > Relational > Staff' and 'Experience of Restrictive Phenomena > Severity > Autonomy').

This item is short; has a Flesch reading score of 100 (average 10-year-old (Flesch, 1979)); uses simple language; does not contain a negative such as 'not' or 'doesn't'; refers to only one object (staff); and contains no jargon.

'I feel included in my care plan (CPA and Ward Rounds)' (this item was reflective of the attribute of the Model of Restrictiveness: 'Restrictive Phenomena > Symbolic > Objectification and Pathologization).

This item has the same characteristics as the item above. However, it does contain jargon. This jargon is context-specific however and it was felt patients would understand 'CPA' and 'Ward Rounds'. These are integral parts of their care pathways and used daily, thus reflecting respondents' own 'talk'. It had a Flesch reading score of 95.6 (average 10-year-old).

The total Flesch reading score for this item pool was 82.7. This corresponds to an average reading score of an 11-year old (Flesch, 1979).

6.3.3 Response Biases

Responses to questionnaires can be biased (Streiner & Norman, 2008). Of most relevance in this study are social desirability, response fatigue, and yay- or nay-saying. These biases were addressed in the following ways when generating the items.

Patients might be inclined to provide positive responses on the pilot FRQ to please members of their care team. This was mitigated by telling respondents that it is important to be honest and that for this study the results will be kept anonymous by using study IDs. Where possible, members of the local research teams were involved in collecting the data instead of care staff. Respondents were reminded that the FRQ asks how they feel, and that there were no 'right' answers that we were looking for.

Respondents may become tired completing the FRQ and exert less effort on considering their responses. Each item was simplified as much as possible and a speech and language therapist was consulted. A simple 5-point Likert scale was chosen, and a 'not sure' option gave participants an option to check if they were struggling and could move on to another item.

Patients might respond with 'strongly agree' or 'strongly disagree' for all or most of the items. This could be due to fatigue or apathy. Therefore, some items were worded to capture more restrictiveness and others less restrictiveness. Relevant items were reverse coded in the subsequent psychometric analysis. For example, an individual scoring highly on the FRQ would be expected to respond, 'strongly agree' and then 'strongly disagree' to the following items: 'My Doctor has too much control over me' and 'I can express myself enough here', instead of giving the same response for both.

FRQ responses were reviewed to investigate if nay- or yay-saying occurred across the whole instrument. Items demonstrating high ceiling effects were removed from the final FRQ in the psychometric testing phase.

6.3.4 Ensuring Subjectivity was captured

The FRQ is a measure of subjective experience. Therefore, no items were generated that gave an objective assessment of restrictiveness. This reflected a key finding in chapter five: that restrictiveness is a subjective experience. No phenomeon was universally described as restrictive; and other phenomena that might objectively be described as restrictive, such as proscriptions on leave, were not given much salience by participants where they felt this was fair given their index offence.

Measuring subjective experience is further justified in light of some patients' psychotic beliefs. Participant 15 felt his anti-psychotic medication was a control tactic of the U.S. government (see §5.4.3.2.2). Indeed, this belief may lack empirical support but nonetheless had weight, significance, and lived-consequence for participant 15 as a restrictive phenomenon. It was therefore important to capture the subjective experiences of patients.

This was also acknowledged by Bergk and colleagues (2010) in a study to develop the Coercion Experience Scale (CES). The authors proposed that experiences of restraint and seclusion cannot be captured by discrete objective measures: '*Safety, psychopathological symptoms, and duration of an intervention as main outcome variables cannot meet the demand to indicate subjective suffering and impact relevant to posttraumatic stress syndromes'* (p. 2).

Accordingly, in the present study the frequency of restraint incidents was not asked. Instead, the item 'I get restrained too much' was. This allowed respondents to give a subjective response and express to what extent he/she agreed with this regardless of how much they were restrained

objectively. A patient may feel one instance of restraint as restrictive as another patient considers ten instances to be. This is crucial as the latent construct measured is subjective restrictiveness.

To ensure subjectivity, each item included a 'qualifier' so that respondents inflected a subject assessment of its content. For instance, 'I have to wait too long to hear about changes in my care' asks respondents to give an assessment of 'too long', not simply whether they have to wait a long time. This is illustrated later in Table 6-3, which highlights the subjective assessment element of each item in italics.

6.3.5 Likert Scales

A 5-point Likert scale was chosen for the FRQ. The scale was bipolar and asked respondents to what extent they agree or disagree with each item. This was beneficial for several reasons. Likert scales are easy to understand (Streiner & Norman, 2008). Bipolarity allowed respondents to express feeling restricted or unrestricted by being asked whether they disagree or agree. This was important to capture given patients did not express feeling restricted in relation to all aspects of secure care as demonstrated in §5.4.6 'Deviant Cases' of the preceding chapter.

The scale also included a 'not sure' option. This gave patients space if they were unable to gather their thoughts on an item. It also represents a mid-point between agreeing and disagreeing. A sixth option of 'Not Applicable' or 'N/A' was included. This allowed participants to indicate if some items were not relevant to them. This was pertinent for responses to the item 'I am put in seclusion too much', if a respondent had never been put in seclusion.

Adjectival and numeric anchors were provided. This was because including only 'Strongly agree' or giving the number '2' might be too abstract for some respondents. Visual Analogue Scales were not adopted as they have been found to be difficult for some populations (Streiner & Norman, 2008). Numeric anchors are all positive to avoid negative associations when disagreeing with an item. The number 1 represents 'Strongly Disagree' and 5 represents 'Strongly Agree' to reflect a greater amount of agreement, rather than a greater amount of disagreement.

The Likert scale was ordinal. This necessitated the use of non-parametric statistical analyses on individual items (Cooper, 2018). However, total scores can be calculated for parametric analyses. The items in the pilot FRQ were not weighted. This is because this would impose an objective measure of severity; and there is little empirical evidence that weighting items adds validity to a questionnaire (Streiner & Norman, 2008). Finally, Likert scales permit associations with other measures and outcomes to be explored quantitatively.

6.3.6 Linking the Model of Restrictiveness and FRQ Items

The initial item pool reflected the Model of Restrictiveness presented in chapter five. Each theme within the model was reviewed and an item definitive of that theme developed. For instance:

The theme 'Restrictive Phenomena > Symbolic > Otherness' was captured by the following item 'I feel a stigma being here'.

The theme 'Restrictive Phenomena > Relational > Other Residents' was captured by 'Other patients stop me from going where I want on the ward'.

The theme 'Experience of Restrictive Phenomena > Salience > Logical' was captured by 'The restrictions on the ward make sense'.

In this way, a wide range of possible interpretations of the latent concept of restrictiveness were accounted for (Raykov & Marcoulides, 2011). A table that demonstrates the link between each item and the Model of restrictiveness can be found in Appendix K.

6.3.7 Initial Item Reduction

Following discussions with supervisors, these 80 items were reduced to 65. Items were removed where they were felt not to reflect restrictiveness directly. For instance, one item was identified as a possible consequence of secure care that may or may not be attributable to restrictiveness and was thus not sufficiently linked to restrictiveness. This item was: 'I feel physically healthy' (this item was reflective of the attribute of the model of restrictiveness: 'Consequences > Consequences upon Health'). The remaining 65 items were subject to an assessment of face validity by a panel of experts.

6.4 Expert Assessment of Face Validity

Face validity is defined as the extent to which judges consider items appear to capture the latent construct they are intended to (DeVellis, 2016; Hardesty & Bearden, 2004; Streiner & Norman, 2008). It therefore is a necessary but not sufficient condition of construct validity and is helpful in developing new questionnaires (Hardesty & Bearden, 2004). This was conducted with a panel of five experts in the field of forensic psychiatry. Their feedback was considered in revising items. However, data collected in

this phase were used to compliment the empirical data collected directly with participants. Assessing face validity opened the FRQ to external scrutiny, provoking critical reflection on the items included in the FRQ.

Expert respondents were asked for their feedback on 1) to what extent they felt items reflected restrictiveness, and 2) were likely interpretable by the target population. The aim of this phase was to remove any items that were felt to measure something other than restrictiveness or amend items that were identified as being too difficult or ambiguous.

6.4.1 Recruitment and Survey

The survey consisted of four parts. The first gave a description of restrictiveness as operationalized following the interviews described in chapter five. The second and third listed the revised pool of 65 items and requested participants indicate to what extent: a) each item reflected restrictiveness so defined, and b) each item would likely be interpretable by the target population. Respondents could indicate 'Not at all', 'Somewhat', 'Totally' or 'Not Sure' on each of these. A qualitative box provided space for specific feedback on items. The fourth section of the survey asked for respondents' qualitative feedback on the FRQ as a whole.

Items were considered for exclusion or amendment based on a 'sumscore' heuristic (Hardesty & Bearden, 2004). This involved assigning a value to each response. The following values were assigned: 'Not at all' = 0, 'Somewhat' = 1 or 'Totally' = 2. In this study, items in the second and third

sections of the survey could score a maximum of 8 and 10 respectively[10]. This is presented in Table 6-1. The heuristic was derived to help decide which items to exclude or amend.

A 'sumscore' heuristic was chosen over a 'complete' or 'non-representative' heuristics as a review of consumer-related scales found that these were less predictive of items included in developing questionnaires (Hardesty & Bearden, 2004).

Seven experts were approached to participate in this phase. They were identified through published academic work or through the research team's network. Individuals in different roles were approached so that multiple perspectives could be included. Respondents were approached over email and informed of the overall study and what they were being asked to do in this particular phase. Participants signed consent forms and responded to the survey online. The Bristol Online Surveys tool was used. No patients were involved in this phase as there was a qualitative space on the pilot FRQ for their feedback in the subsequent 'Quant' phase of this study.

Table 6-1. Heuristic for Retaining, Amending or Removing FRQ Items

	Score Range	**Action**
Reflective of Concept Restrictiveness		
	< 4	Remove or re-word with reference to qualitative data, feedback and literature.
	5-7	Keep or re-word with reference to qualitative data, feedback and literature if necessary.

[10] The maximum score for items in the first section of the survey was 8 as one expert did not complete this section.

	> 8-10	Keep as is.
	One or more 'Not Sure'	Look to qualitative comments for reasons why 'Not Sure' and keep, remove, re-word with reference to comments and literature.
Interpretable by target population		
	< 2	Remove or re-word with reference to qualitative data, feedback and literature.
	3-5	Keep or re-word with reference to qualitative data, feedback and literature if necessary.
	> 6-8	Keep as is.
	One or more 'Not Sure'	Look to qualitative comments for reasons why 'Not Sure' and keep, remove, re-word with reference to comments and literature.

6.4.2 Participants

Five of the seven individuals approached agreed to participate. Anonymized basic information about participants' roles, current employer, and years of experience are listed in Table 6-2. Participants had expertise in clinical forensic psychiatry; academic research on repression in Dutch YOIs, and ward atmosphere in secure hospitals; national mental health policy development; and speech and language therapy in secure settings.

Table 6-2. Profiles of Expert Participants

Identifier	Role	Location	Experience
P1	Lecturer in Criminology	University, U.K.	16 months
P2	Consultant Forensic Psychiatrist	Low Secure Hospital, U.K.	8 Years
P3	Consultant and Researcher/PhD Student	University, NL	Consultant: 5 months PhD researcher: 4 years

P4	National Mental Health Act Policy Advisor	Care Quality Commission, U.K.	25 years
P5	Clinical Lead Speech and Language Therapist	High Secure Hospital, U.K.	Current Role: 2 years Qualified Speech & Language Therapist: 5 years

6.5 Results

6.5.1 Qualitative Feedback

One item was added to the item pool and nine were removed. The majority of items were reworded slightly to become more interpretable or to ensure they were subjectively framed. Qualitative feedback suggested changes to item phrasing and questioned to what extent some items indeed reflected restrictiveness. For instance:

Participant four highlighted that individuals' sense-making of restrictive phenomena will make a difference in how they are experienced:

> *'There are perhaps two different categories of subjective experiences of restrictiveness: the ones that a patient resents but understands […] and those that are felt to be institutional rules of no personal applicability. I suspect this has some relevance to whether people 'mind' restrictions'.*

This comment reflects the content of the attribute 'Experience of Restrictive Phenomena > Salience' in chapter five. Thus, the items: 'The restrictions on the ward make sense' and 'The rules on the ward are fair' were kept.

Other feedback pertained to the direction of items and whether they could be read in different ways. For instance, Participant one noted that:

> *'[a] number of items (e.g. 33) are quite vague and agreement or disagreement with them might not be anything to do with*

restrictiveness. For example, a respondent might want to be in prison rather than hospital for loads of reasons that are not related to restrictiveness'.

In light of this, item 'I would rather be in any prison than here' was removed and the sentiment behind the item captured in the item 'It feels more like a prison than a hospital here'.

Participant three was unsure of the subjective nature of the measure:

'I am doubting about the 'subjective' part. Some restrictive elements may not be experienced by residents as such. For example, because the residents have gotten used to the amount of restrictions or because of their psychiatric problems. The restrictions may be harmful or illegal though'.

This reflects the notion that some objective restrictions may not be experienced as such and conversely that some phenomena may be experienced as restrictive that are less likely to be considered as objectively restrictive.

The FRQ aims to measure subjective experiences as questionnaires concerning phenomena considered to be objectively restrictive capture as rich a different picture of patient experience. Further, instruments developed to explore coercive measures and involuntary detention (legal coercion) already exist. These include the Coercion Experience Scale (CES) and the MacArthur Perceived Coercion scale (AES) (Bergk et al., 2010; Gardner et al., 1993). These measures could be used alongside the FRQ to triangulate data on coercive and restrictive experiences.

Specific words were changed to make items more interpretable following the advice of the speech and language therapist. The following words: 'sufficiently', 'humanely', 'human rights', and 'individuality' were replaced

by ‘enough’, ‘like a human being’, ‘rights’, and ‘individual’ respectively. Other flagged words were retained, including: ‘stigma’, ‘blanket bans’ and ‘tribunal hearings’. These were kept as they were considered likely to be understood by participants as relevant mental health terms.

6.5.2 Quantitative Feedback

A list of each of the 65 items, their sumscores, and what action was taken to exclude, amend, or retain is presented in Table 6-3. *Italicized* text represents the subjective function of each item. Sumscores for both how much the item reflects restrictiveness and would be interpretable by the target audience are listed as per the heuristic in Table 6-2. The action taken column describes how and in what way items were amended, kept, and removed.

Table 6-3. Results of Expert Panel Feedback

No.	Item	Reflect Score	Interpret Score	Action Taken
1.	I have *enough* contact with friends outside the hospital	7	8	Action taken: Amended to make it not family specific; 'people' was chosen instead. Combined with item 2. Changed to: 'The hospital helps me contact people outside the hospital *if I want to'*
2.	I have *enough* contact with family outside the hospital	7	8	Action taken: Removed to be included in item 1.
3.	I am treated humanely here	5	5 2 NAA	Action taken: Removed the word 'humanely' based on comments. Changed to: 'I am treated like a human being here'.
4.	The hospital listens to my concerns *sufficiently*	5	7	Action taken: Changed to: 'The hospital listens to my concerns *enough'*. Uses simpler language.
5.	I can express my feelings here *enough*	7	9	No action taken.
6.	I have *enough* privacy in my room	8	8	No action taken.
7.	I am allowed to bring *what I want* into my room	7	10	No action taken.
8.	I can practice my hobbies *enough*	7	8	Action taken: Reworded to: 'The hospital helps me practice hobbies I like' to ensure the item captures what the hospital does/does not do; rather than measure a patient's physical or mental ability to practice hobbies.
9.	I can follow current events outside the hospital I find *interesting*	7	9	No action taken.

10.	I feel *sufficiently* included in my care plan (CPA and Ward Rounds)	6	7	Action taken: Removed 'sufficiently' and added 'enough'. 'I feel included in my care plan enough (CPA and Ward Rounds)'
11.	I am given *enough* information about my care	7	9	No action taken.
12.	Hospital management is *too* controlling	8	7 1 NAA	No action taken.
13.	I can practice my religion or beliefs *enough*	8	10	No action taken.
14.	The law stops me progressing through my pathway *the way I should*	4 1 NS 1 missing	6 1 NS	Action taken: Kept 'the law' – for patient to interpret, could be human rights, tribunals, or MHA. This item aims to capture systemic constraints. Removed 'the way I should' to shorten the item.
15.	I feel supported *enough* to move on in my care pathway	5	8 1 NAA	Action taken: Removed 'in my care pathway' to shorten the item.
16.	I can express my gender in the *way I want*	7	7 1 NAA	Action taken: consulted with expert in transgender studies regarding the word 'gender'. He suggested this word would be interpretable to individuals who identify as non-binary. Changed to 'I am allowed to express my gender', and 'able' may indicate an internal process of discovering, acceptance and ability to demonstrate one's sexuality, distinct to the setting.
17.	Staff respect my individuality here *enough*	7	7 1 NAA	Action taken: Changed to: 'Staff treat me as an individual'.

18.	Other patients stop me from going *where I want* on the ward	8	9	Action taken: Removed 'from'
19.	I *feel* a negative stigma being here	2 1 NS 1 NAA	5 1NAA	'Negative' was removed to simplify the item, and it is was redundant in this sentence.
20.	Staff stop me doing *what I want*	8	9	No action taken.
21.	Other patients stop me participating in some activities	6 1 NS	8	Action taken: Simplified language and added subjective element: 'Other patients stop me doing some activities *I want to'.*
22.	I *think I should* be in this hospital right now	3 1 NAA	9	Action taken: Removed in light of expert feedback as unrelated to 'restrictiveness'. Also, captured elsewhere in item 35.
23.	I *think I need* help with my mental health	2 2 NAA	9	Action taken: Removed in light of expert feedback as unrelated to 'restrictiveness'.
24.	I am given *sufficient responsibility* on the ward	5 1 missing	7	Action taken: Replaced 'sufficient' with 'enough'.
25.	I am trusted by staff *enough*	7	9	No action taken.
26.	My Doctor uses *too much* control over me	8	9	No action taken.
27.	I want to socialize with members of the opposite sex *more*	6	8	No action taken.
28.	I can choose what *I want to do* each day	7	10	No action taken.
29.	Tribunal hearings *help* me move to a more *appropriate* place	2 1 NAA 1 NS	8 1 NS	No action taken as this draws directly on qualitative results.

30.	I am in this hospital for *too long*	6	8	Action taken: Removed because meaning captured in the item 'The hospital is the right place for me right now' (item 35).
31.	There is *too much* security here	8	10	No action taken.
32.	It is *fair* I am here right now	3 1 NAA	9	No action taken.
33.	I would *rather* be in any prison than here	4 2 NAA	10	Action taken: Removed. Already included an item on prison and it is not clear why one would rather be in prison. It might be that a patient wants to be with a particular friend in prison, but this does not tell us much of the forensic setting.
34.	I can participate in *meaningful* activities	8	6 1 NAA	Action taken: Changed order to make seem more subjective by adding 'I find meaningful' to the end.
35.	The hospital is the *right* place for me right now	5	9	Action taken: Replaced right with 'best' to avoid repetition.
36.	I am *satisfied* with my sex life right now	5	7 1 NAA	Action taken: Added 'right now' to distinguish from past trauma
37.	I *feel* punished here	6	10	No action taken.
38.	I am treated *worse* than other patients on the ward	6	10	No action taken.
39.	It *feels* more like a prison than a hospital here	7	8	No action taken.
40.	The hospital is helping me *enough*	5 1 NAA	8	No action taken.
41.	I can have a loving relationship with a significant other *if I want*	6	7	No action taken.

42.	I can access the internet *enough*	7	9	No action taken.
43.	I can listen to music *enough*	7	9	Action taken: Changed to include other similar leisure activities: 'I can listen to music/read/play video games enough'.
44.	I have to wait *too long* to hear about changes in my care	5 1 NAA	9	No action taken.
45.	Physical restraint is *helpful* for me	5 1 NAA	8 1 NAA	Action taken: Changed to restrained 'by staff' to make clearer and less ambiguous. Removed 'helpful' as something may be both restrictive and helpful. 'I get restrained by staff too much'.
46.	I can learn new skills *if I want* to	8	9	No action taken.
47.	I find seclusion *helpful*	1 3 NAA	8 1NAA	Action taken: Removed 'helpful' as something may be both restrictive and helpful. Changed to: 'I get put in seclusion too much'.
48.	There are *too many* blanket rules here	8	5 1 NAA 1 NS	Action taken: added 'bans' to make this clearer.
49.	I can go outside for fresh air *enough*	8	9	No action taken.
50.	I have the *right* amount of leave for *me*	8	8	Action taken: Simplified to 'I have *enough* leave'/
51.	My human rights are respected *properly* here	7	6 1NAA	Action taken: deleted 'human' to simplify sentence and broaden meaning.
52.	Having locked doors is a *bad* thing	5 1 NAA	10	No action taken.
53.	I have to ask for permission for things *too much*	8	9	No action taken.
54.	I am *happy* to be here	4	10	Action taken: Removed because 35 captures this.

55.	I get segregated from others *too much*	6	8	Action taken: Removed because 47 captures this.
56.	I am forced to do things *I don't want* to do	8	9	No action taken.
57.	I am *OK* with being called a patient	1 3 NAA	9	No action taken as this draws on qualitative results and stigma themes and reflects pathologization theme.
58.	The atmosphere on the ward stops me doing *what I want*	5	8 1 NAA	Action taken: Removed because it is captured by items 18 and 20.
59.	I am *forced* to take medication I *don't want* to	8	9	No action taken.
60.	I *should* be in the community now	3 1 NAA	8	No action taken.
61.	There are *enough* staff to run the ward *properly*	3 2 NAA	9	Action taken: Removed because this is an antecedent and is not restrictive *per se*.
62.	I have to wait *too long* for things on the ward	6	10	No action taken.
63.	The rules on the ward are *fair*	7	10	No action taken.
64.	The restrictions on the ward *make sense*	8	8	No action taken.
65.	I can have food and drink *I want*	-	-	Action taken: This item was added following expert feedback.

Note. NAA, 'Not at all'. NS, 'Not Sure'. Missing, indicates a missing response.

6.5.3 Ancillary Questions

Two further items were included in the pilot FRQ. These asked 'How restricted do you feel in general' and 'Has anything difficult/hard/hurtful happened to you in the last week?' The inclusion of this final item is based on research suggesting that individuals' recall of painful events (restrictive phenomena) are the product of a peak-end bias. This proposes that individuals are more likely to recall the peak amount of pain and final moments of pain rather than create an average across the total duration of the experience (Redelmeier & Kahneman, 1996). It was hypothesised that as respondents were asked to recall restrictive experiences across the previous seven-day period, a particularly adverse, restrictive, or hurtful event might increase the likelihood of a higher restrictiveness score across multiple items. The results of this are presented in chapters seven and eight.

6.6 The Pilot FRQ

The pilot FRQ consisted of 56 items and two ancillary questions. Two qualitative spaces were included to allow respondents to write what difficult/hard/hurtful event occurred in the previous week (if applicable), and to write any comments they had on the pilot FRQ itself. This feedback was used to revise the FRQ as described in chapter seven. All items were self-report; this facilitates anonymous research designs but does not preclude use as a clinical measure.

Respondents were asked to consider their experiences over the preceding seven days when completing the FRQ. A week was chosen so that the FRQ is temporally-specific and can be used to examine change over time, thus

measuring a state rather than a trait; but still investigate experiences of restrictiveness that incorporates aspects of secure care occurring over a typical week.

The FRQ items were dynamic and not static (Cooper, 2018). This has clinical consequence as dynamic items can reflect change over time. This is meaningful as FRQ scores can be investigated before, during, and after clinical intervention or other meaningful life change. Respondents' FRQ scores can be examined over time and throughout their care pathway.

The pilot FRQ asked respondents for demographic, clinical, and legal data. These included: age, gender, ethnicity, length of stay at current institution, index offence, diagnosis, and Mental Health Act (1983) section. These permitted the investigation of group-level differences; the hypotheses and results of which are described in chapters seven and eight.

The font, serif, and spacing were chosen to make reading the items easy as possible. The total Flesch reading score for the pilot FRQ was 83.2; slightly easier than the initial item pool. This corresponds to an average reading score of an 11-year old (Flesch, 1979).

The pilot FRQ is presented in Appendix J.

6.7 Conclusion

This chapter presented the 'qual/quant' phase of the study's 'qual->Qual->qual/quant->Quant' MMR (Teddlie & Tashakkori, 2009). It illustrated the operationalization of a series of indicators based on the systematized concept of restrictiveness described in chapter five in line with the project's framework for developing a questionnaire (Adcock & Collier, 2001).

The pilot FRQ consisted of 58 items. This was designed to be readable by population that may struggle with cognitive tasks. Steps were taken to mitigate response biases. The expert panel gave an indication of face validity as items were amended, removed, or added in light of their feedback. The following chapter describes the process of testing the pilot FRQ with the target population of forensic patients.

Chapter 7
Psychometric Properties of the FRQ

7.1 Summary

This chapter presents the psychometric properties of the pilot FRQ. In total 230 patients were recruited from low, medium and high secure hospitals in 16 NHS Trusts across England. The dimensionality of the FRQ was tested using Principle Axis Factor Analysis (PAF) and parallel analysis. Internal consistency was explored with Cronbach's α. Ward climate (EssenCES) and quality of life (FQL-SV) questionnaires were completed by participants as an indicator of convergent validity. EFA and Cronbach's α guided the removal of items that did not scale adequately.

The analysis indicated good psychometric properties. Exploratory Factor Analysis revealed a unidimensional structure, suggesting a single latent trait. Convergent validity was confirmed as restrictiveness is significantly negatively correlated with quality of life (Spearman's ρ=-0.70) and ward climate (Spearman's ρ=-0.61). Internal consistency was demonstrated to be strong (a=0.92). Forty-one items were removed. The data indicate that the final 15-item FRQ is a valid and internally reliable measure. The FRQ offers a novel and helpful method for clinicians and researchers to measure and explore forensic patients' experiences of restrictiveness within English secure hospitals.

7.2 Introduction

This chapter presents the 'Quant' phase of the project's mixed-methods 'qual->Qual->qual/quant->Quant' study design (Teddlie & Tashakkori, 2009). The qualitative data and analysis discussed in chapter five provided the empirical grounding for the pilot FRQ; the construction of which was described in chapter six. In accordance with suggested protocols for

developing questionnaires (Adcock & Collier, 2001; Luyt, 2012), the task of piloting or 'scoring cases' to explore the reliability and validity of the FRQ is discussed in this chapter.

First, the aims of this phase are listed. Second, the methods used to achieve these aims are described and situated within the study's broader methodology. Third, the process of participant recruitment and the sample's demographic details are described. Fourth, the results of the psychometric analysis are described. Specifically, the investigation into the reliability and validity of the pilot FRQ; and the extent to which the occurrence of recent adverse events, and different demographic, clinical, and legal profiles were associated with FRQ scores. Finally, the revised 15-item FRQ is presented. A discussion of the results is presented in chapter eight.

7.2.1 Aims

The aims of this phase of the study were:

1. To assess the psychometric properties of the pilot FRQ, including:
    a. Its reliability
    b. Its construct validity
2. To remove items that did not strengthen construct validity and reliability, so that a psychometrically strong and shorter FRQ remained.
3. To explore whether individuals who have expressed experiencing a recent adverse event have significantly different FRQ scores than those not expressing this.
4. To explore to what extent respondents' demographic, clinical, and legal profiles were associated with FRQ scores.

7.3 Methods

As outlined in chapter four, the methods used in this phase of the study explored to what extent the pilot FRQ represented a psychometrically valid measure of subjective experiences of restrictiveness. This involved piloting the FRQ with the target population of forensic patients. This represents the final level of Adcock & Collier's (2001) framework for scale development before amending the questionnaire and administering with a second sample in future studies.

7.3.1 Recruitment and Data Collection

The process for recruiting was described in chapter four (§4.4.1). In total N=230 patients participated in the study. Of this number, nine individuals dropped out after consenting and their data were excluded from the analysis presented in this chapter. Therefore, N=221 participants remained.

The amount of time taken by each participant to complete the three questionnaires varied significantly. Data were not recorded for all participants; however, of the 24 participants for whom data are available, mean length of participation was 44 minutes (Min=16, Max=120). Several patients approached simply wanted to talk informally and not complete the questionnaires. Eleven participants participated in both the qualitative and quantitative phases of this study. One participant required the presence of a translator, a second requested a member of staff be present to help him understand the questionnaires, a third was only able to meet with me where two members of staff were present. Data collection took place between May 2018 and April 2019.

7.3.2 Dataset

7.3.2.1 Missing Data

Data were missing on each of the questionnaires. Missing data represented 0.28% of responses to items on the FRQ; 0.42% on the EssenCES; and 1.7% on the FQL-SV. This represented 0.6% of all questionnaire data. Patterns of missingness were assessed with Little's test of missing completely at random (MCAR). This indicated that missing data were missing at random: $\chi^2(2686)=2771.7$, p=0.122. MCAR scores for each questionnaire are illustrated in Table 7-1.

Table 7-1 MCAR Scores for FRQ, EssenCES and FQL-SV

Questionnaire	MCAR Score
FRQ	$\chi 2$ (639)=535.0, p=.999
EssenCES	$\chi 2$ (106)=113.8, p=0.284
FQL-SV	$\chi 2$ (177)=176.5, p=0.497

N=221

Missing data represented 1.6% of the demographic data points. Individuals for whom demographic data were missing were excluded from relevant group-level analyses.

The imputation of mean scores or the removal of data pairwise or case-wise are unsatisfactory imputation techniques (Cooper, 2018; Dancey & Reidy, 2014). This is because they can lead to a smaller sample size reducing the power of the analysis, or to systematic biases. Little's test of Missing Completely at Random (MCAR) revealed that data were Missing at Random (MAR) and were missing in a non-monotone fashion. Non-monotone data missing at random (MAR) are suitable for sophisticated imputation methods

that impute values based on respondents' scores on other variables (Tabachnick & Fidell, 2013).

Thus, values were imputed using the Multiple Imputation function in SPSS version 24. SPSS's Automatic Imputation Method was chosen; imputed data were constrained to whole values; and the fifth of five imputed datasets was selected for use in the study. The psychometric analysis was computed without imputed data, using a case-wise deletion pattern and results were not meaningfully different. The results of the imputed data are described as they present a more robust methodology (Cooper, 2018; Tabachnick & Fidell, 2013).

7.3.2.2 Coding the Data

Data for the FRQ and EssenCES consisted of 5-point Likert scales. The FRQ also offered a 'Not Applicable' option which was coded as '0' to suggest this item was not relevant and therefore had no significance for that participant, thereby not affecting total scale scores. The FQL-SV has a visual analogue scale from 0-100. This was recoded into 10 data points (1-10). This recoding was necessary as in several participating sites, printing issues meant the VAS line was 96mm long. Patients that marked 96 on these scales are consequently comparable to those that marked 100 on the complete scales.

High scores on the FRQ indicate a greater amount of restrictiveness. High scores on the EssenCES and FQL-SV indicate more positive perceptions of ward atmosphere and quality of life respectively. Where necessary, items were reverse-coded to ensure a higher score indicated a higher amount of the measured latent concept (Cooper, 2018).

For the comparison of FRQ scores between different demographic, clinical and legal profiles, some variables were recoded so that where a subgroup had <10 participants, this group was merged with another group with <10 participants so that the comparison between groups would be sufficiently powered. The new group was identified as a 'mixed' group and this is made clear in the results. Groups were only combined where it was theoretically meaningful to do so. Where it was not meaningful to combine a smaller group (n=<10) with another then this was removed from the analysis.

7.3.2.3 Normality of Data

The normality of data was investigated statistically with the Shapiro-Wilk statistic and visually with histograms (Ghasemi & Zahediasl, 2012; Hinton et al., 2014; Tabachnick & Fidell, 2013). Where the assumption of univariate normality was violated, non-parametric adjustments or alternatives were used (as described in chapter four, §4.7.2). See Appendix L for histograms of the distributions of each FRQ item.

7.4 Hypotheses

1. It was hypothesized that the FRQ items would measure a latent construct of restrictiveness. No explicit hypotheses were made as to the dimensionality of the FRQ given the inductive and iterative nature of EFA on a new questionnaire; however, it was anticipated that items may group together in a manner resembling the themes of 'Restrictive Phenomena' and 'Experiences of Restrictive Phenomena' in the Model of Restrictiveness as most items on the FRQ were derived from these themes.

2. It was hypothesized that the items on the FRQ would be internally consistent.
3. It was hypothesised that the FRQ would correlate significantly with the FQL-SV and EssenCES (including its three sub-domains) in a negative direction. It was further hypothesised that the FQL-SV and EssenCES would be positively associated.
4. It was hypothesized that individuals who express having experienced an adverse event in the previous week would have higher FRQ scores.
5. The following hypotheses were put forward for each demographic, clinical and legal variables:
    a. There would be a negative correlation between age and FRQ scores.
    b. There would be a negative correlation between length of stay and FRQ scores.
    c. BAME participants would have higher mean FRQ scores than White patients.
    d. FRQ mean scores would differ across security levels, with mean scores increasing with level of security.
    e. Respondents detained under the MHA (1983) with restriction orders will have higher mean FRQ scores than patients not under restriction orders.
    f. There will be no difference in mean FRQ scores across diagnostic groups.

g. Individuals with no index offence or a sexual index offence will have higher mean FRQ scores than those with a (non-sexual) index offence.

7.5 Results

7.5.1 Participants

In total, 230 patients participated. The data for nine patients were excluded for reasons outlined above. Participants were predominantly male (96%) and white (71%). Black and Caribbean participants comprised 14% of the sample. Mean participant age was 39 (S.D.=10.7; Min=19 Max=74). Median length of stay in current hospital was 19 months (Min=1 Max=277).

The majority of participants were given a primary diagnosis of a mental illness (61%). Individuals with a personality disorder as primary diagnosis constituted 16% of the sample. Respondents with a mixed diagnosis of MI and PD comprised (9%); and those with MI and/or PD and an 'other' diagnosis comprised 10%. The 'other' category (4%) included: organic brain disorders, mood disorders, and ASD.

A simple majority of participants were on a Hospital Order with Restrictions (40%); one-fifth were on Civil sections for treatment (20%); and 17% were Prison Transfers with Restrictions. The majority of index offences were offences against the person (38%), followed by 'other' index offences (17%), sexual offences (10%), and offences against property (6%). A number of respondents had 'mixed' offences e.g. combination of offence-types (17%). These data are described in more detail in Table 7-2.

Table 7-2. Demographic, Clinical and Legal Profiles of Participants

Variable	Frequency	%
Security Level		
Low	89	41
Medium	81	37
High	49	22
Total	219	100
Sex		
Male	209	96
Female	9	4
Total	218	100
Ethnicity		
White	153	71
Black / Caribbean	31	14
Asian	16	8
Mixed	11	5
Other	4	2
Total	215	100
Diagnosis		
Personality disorder	34	16
Mental illness	132	61
Mixed PD/MI	19	9
Mixed MI + Other	15	7
Mixed PD + Other	5	2
Mixed PD + MI + Other	2	1
Other	9	4
Undiagnosed	1	1
Total	217	100
MHA Section		
s. 3	43	20
s. 37	30	14
s. 37/41	87	40
s. 41(5)	8	3
s. 45(A)	6	3
s. 47	0	0
s. 47/49	37	17
s. 36	1	1
s. 48/49	5	2
s. 38	1	1
Total	216	100
Index Offence		
Offences against the person	83	38
Offences against property	14	6
Sexual offences	22	10
Other	36	17
Mixed	36	17
No offence	24	11
Did not disclose	1	1
Awaiting trial	2	1
Total	217	100

	N	*Mean (S.D.)*	*Min, Max*
Age (years)	219	39 (10.7)	19, 74
	N	*Median (Q1, Q3)*	*Min, Max*
LoS (months)	217	19 (9, 54)	1, 277

7.5.2 Initial Item Removal

Nine items were removed before Exploratory factor Analysis was conducted. Two items were removed for correlating significantly with at least one other item where Spearman's ρ=>.0.7 and with three other items where Spearman's ρ=>0.6. In these instances the two items were similar in wording and were considered redundant. Two items were removed for demonstrating ceiling effects; four items demonstrated CITC scores <.3 and were removed; and one item was removed as it was felt it did not capture 'restrictiveness' with reference back to qualitative data. For instance, item 2 'I am treated like a human being here' and item 4 'I can express my feelings here enough', correlated significantly at Spearman's ρ=0.73. Item 4 was removed from further analyses as redundant.

7.5.3 Exploratory Factor Analysis

7.5.3.1 Factor Extraction

The remaining 47 items (N=221) were suitable for factor analysis. The participant to item ratio was 4.7:1. The Kaiser-Meyer-Olkin measure of sampling adequacy indicated variance across the FRQ items was most likely influenced by underlying factors (KMO= 0.919). Bartlett's Test of Sphericity was significant (χ^2(1035)=4621.6, p<.001), suggesting that the overall

item correlation matrix was meaningfully different from an identity matrix. Data were therefore suitable for Factor Analysis.

Principle Axis Factoring revealed four factors with Eigenvalues greater than 1.0 (

Table 7-3). These four factors accounted for 79.1% of the variance across items. The first factor accounted for significantly more variance than the second (see

Table 7-3). A Scree plot of these was inspected. This suggested there was one clear factor positioned above the bend in Eigenvalues (Figure 7-1). However, factors two and three deserved further inspection as they were located slightly higher than the remaining factors on the Scree plot.

Parallel Analysis was then conducted to explore whether the four factors would occur by chance. The Monte Carlo simulation technique with 10,000 iterations was computed. Parallel Analysis suggested that the four observed factors were not likely to occur at random. This was consistent with the PAF results. Therefore, four factors were retained for extraction to iteratively explore the possible factorial structures.

7.5.3.2 Rotation

Four factors were rotated using the promax, oblique method (Cooper, 2018).

Table 7-3. Initial Observed and PA Eigenvalues with Variance Explained (N=221)

	Principle Axis Factoring		**Parallel Analysis**
Factor	Eigenvalue	Variance	Eigenvalue
1	**13.87**	0.60	1.23
2	**1.97**	0.09	1.11
3	**1.38**	0.06	1.03
4	**1.06**	0.05	0.95
5	0.83	0.04	0.89
6	0.79	0.03	0.83
7	0.69	0.03	0.77
8	0.61	0.03	0.72
9	0.59	0.03	0.67
10	0.52	0.03	0.63

Note: Bold denotes observed Eigenvalue greater than PA Eigenvalues.

Note: Bold denotes observed Eigenvalue greater than PA Eigenvalues

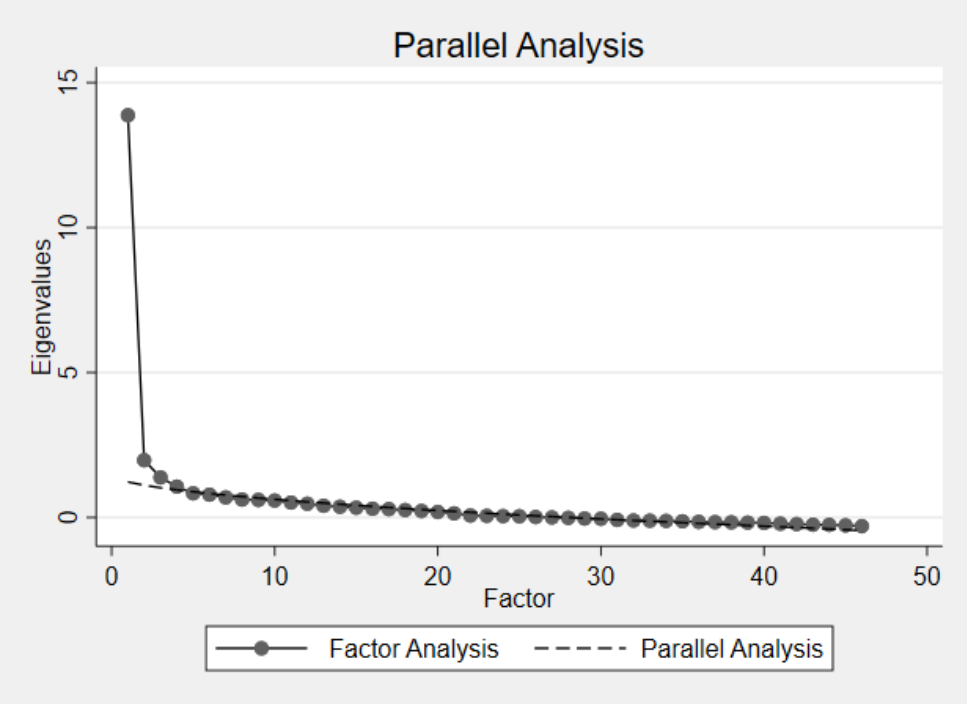


Figure 7-1 Scree plot of Parallel Analysis and PAF Factors

Items with low factor loading scores (<0.3) were removed from further analyses and rotation was repeated following the removal of low loading items (Dancey & Reidy, 2014; Fabrigar et al., 1999).

The fourth factor in this solution contained no items that did not cross load onto one other factor. There were no observable theoretical underpinnings in this factor when considering these three items. Had these items not cross-loaded onto other factors, three items is insufficient to form a meaningful factor. Five or more items are recommended (Fabrigar et al., 1999). This rotated solution, item loadings, and uniqueness values can be seen in Appendix M.

Therefore, a three-factor solution was extracted and rotated. The three-factor solution comprised a first factor with positively-worded items, and a second factor with negatively worded items. This was the only distinguishing feature of these factors; no underlying qualitative theme could be discerned. The third factor identified items that could loosely be grouped together around a qualitative theme 'contact with the outside world'. It included items: 24, 31, 32 (this cross-loaded with factor two), 37, 44, and 45.

Accordingly, a two-factor solution was run to see if this third factor would remain. However, the third factor disappeared when a two-factor solution was extracted and rotated. One of the six items that loaded onto the third factor did not load onto the two-factor solution. The remaining five items loaded onto factor two. The two-factor solution largely reflected the positive/negative wording of the FRQ items: all of the 21 items that loaded onto factor one was positively-worded; factor two had 16 negatively-worded items, four positively-worded items, and one positively worded item that also loaded onto factor one.

The two factor EFA solution was hypothesized the reflect differences in the wording of the items (as positive and negative); not the content. However, it is plausible that the two factors reflected restrictiveness and/or a third latent construct. This third construct might more represent the absence or restrictiveness or rather 'autonomy'. This 'autonomy' factor might have been captured by the positively worded items and restrictiveness by the negatively worded items. The analysis of the items in both factors concluded that differences were not substantive; however, an unidentified construct cannot be ruled out with certainty.

Given the absence of meaningful theoretical interpretation of a multifactorial solution, it was concluded that the FRQ has a unidimensional structure. This is supported by the steep slope depicted in the parallel analysis scree plot presented in Figure 7-1. Although four factors had observed Eigenvalues greater than 1.0 that were not likely to occur by chance, these fell below a clear bend in the scree plot. Those factors with Eigenvalues greater than 1.0 might have been observed due to the large number of items included in the analysis (47 items), or the positive/negative wording of the items generating spurious factors.

7.5.3.3 Item Retention

The data suggested the FRQ had a unidimensional structure. Items were removed from the FRQ where they did not significantly reflect this dimension. As one of the aims of this study was to generate a parsimonious measure of restrictiveness that would not lead to response fatigue, items with lower loadings were removed.

Items were included if they loaded highly onto the unidimensional factor. This level was set to >0.6. Twenty-seven items were removed for loading onto this single factor under 0.6. Fifteen items remained that reflected different elements of the Model of Restrictiveness described in chapter five. The uniqueness scores, which describe the amount of variance on each item not explained by the unidimensional structure, were mostly within the typical range for social science data (30-60%) (Costello & Osborne, 2005). Four items (22, 23, 28 and 49) were slightly higher than this. This indicated that over 60% of the variance in these items was not accounted for by the single latent factor.

The items, factor loadings and uniqueness scores for the unidimensional FRQ scale are presented in Table 7-4. The process of arriving at this factorial solution was examined with my supervisor and the same solution was concluded. Accordingly, the hypothesis that items might group around themes of the Model of Restrictiveness was not upheld.

Table 7-4. Items, Factor Loadings and Uniqueness Scores for the Unidimensional FRQ

Item	**Statistic**	
	Factor Loading	*Uniqueness*
2. I am treated like a human being here	0.682	0.535
7. The hospital helps me practice hobbies I like	0.641	0.590
9. I feel included in my care plan enough (CPA and Ward Rounds)	0.707	0.501
10. I am given enough information about my care	0.676	0.543
16. Staff respect me as an individual	0.680	0.538
21. I am given enough responsibility on the ward	0.662	0.563
22. I am trusted by staff enough	0.609	0.629
23. My Doctor uses too much control over me	0.612	0.626
25. I can choose what I want to do each day	0.636	0.595

28. It is fair I am here right now	0.606	0.632
29. I can participate in activities I find meaningful	0.644	0.586
46. My rights are respected properly here	0.724	0.476
49. I am forced to do things I don't want to do	0.620	0.616
54. The rules on the ward are fair	0.714	0.491
55. The restrictions on the ward make sense	0.660	0.660

7.5.4 Reliability

7.5.4.1 Internal Consistency

The resulting FRQ scale was highly internally consistent. Cronbach's α=0.92. CITC scores ranged from α=0.54 to 0.75. This suggested the FRQ is internally reliable and supported the hypothesis for this test. Table 7-5 presents these data in full.

Table 7-5 Internal Consistency of 15-Item FRQ (N=221)

Item	**Statistic**		
	Item-test correlation	*Item-rest correlation*	*Alpha*
FRQ2	0.742	0.695	0.91
FRQ4	0.684	0.630	0.92
FRQ7	0.789	0.748	0.91
FRQ10	0.728	0.678	0.91
FRQ16	0.750	0.706	0.91
FRQ21	0.716	0.664	0.91
FRQ22	0.660	0.602	0.92
FRQ23	0.600	0.523	0.92
FRQ25	0.671	0.610	0.92
FRQ29	0.632	0.562	0.92
FRQ46	0.674	0.625	0.92
FRQ48	0.745	0.695	0.91
FRQ49	0.612	0.540	0.92
FRQ54	0.719	0.668	0.91
FRQ55	0.663	0.606	0.92
Total			0.92

7.5.5 Participant Total Scores

Before investigating the convergent validity of the FRQ, participant total scores were calculated for the FRQ, EssenCES, and FQL-SV. These are presented in Table 7-6. The FRQ and FQL-SV were not normally distributed. The Shapiro-Wilk statistic indicated p=<.001 for both. The EssenCES was normally distributed (p=0.28). The distributions of the total scores for the FRQ, EssenCES and FQL-SV are demonstrated in the histograms below (Figures 7-2, 7-3 and 7-4).

Table 7-6 Total scores for the FRQ, EssenCES and FQL-SV

Questionnaire	**Descriptive Statistics**		
	N	*Mean (S.D.)*	*Min, Max*
FRQ	221	36.1 (14.7)	14, 75
EssenCES	221	35.0 (10.5)	5, 57
FQL-SV	219	124.7 (34.3)	38, 183

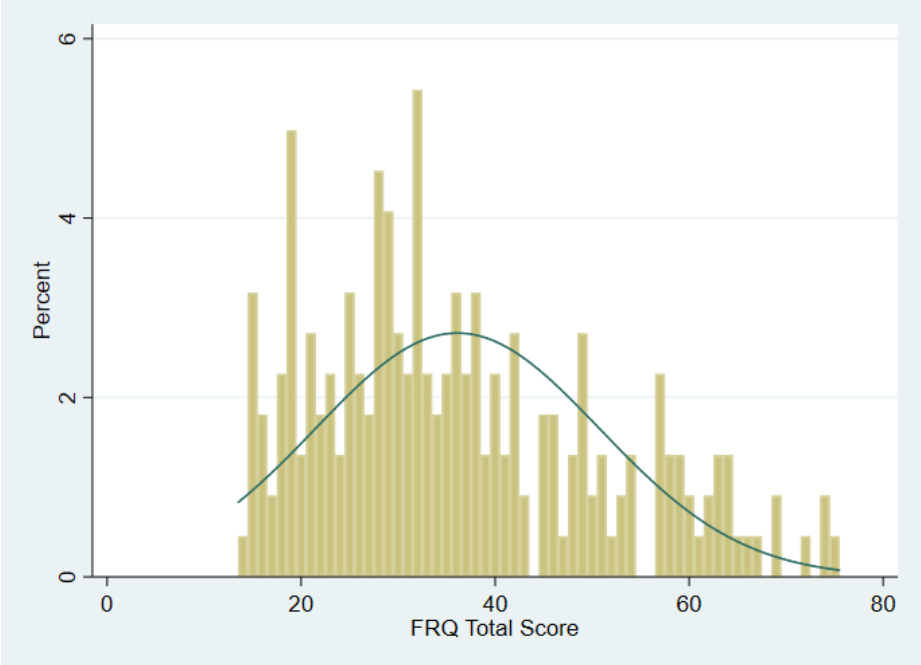


Figure 7-2 Histogram of FRQ total scores

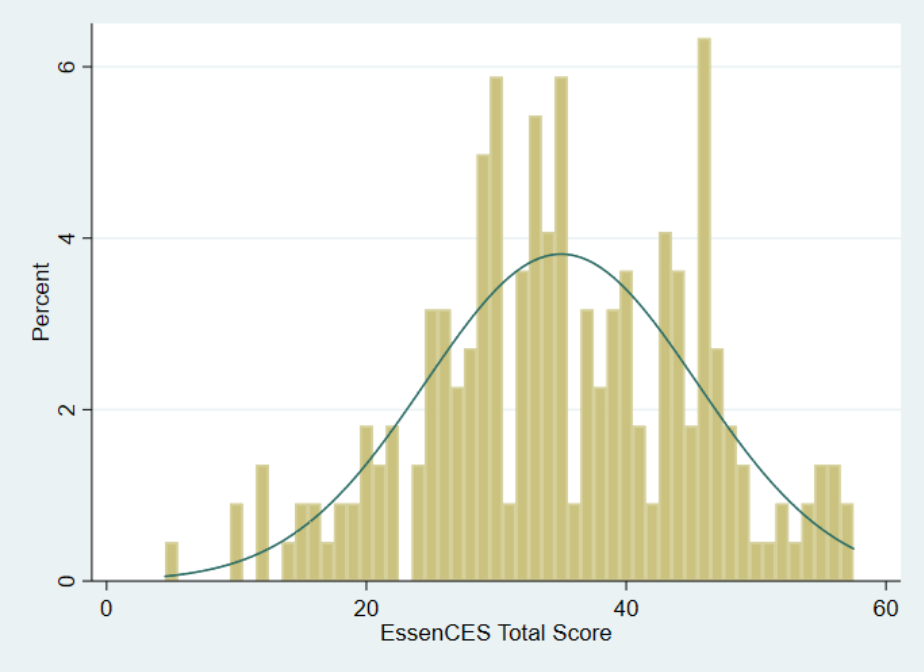


Figure 7-3 Histogram of EssenCES total scores

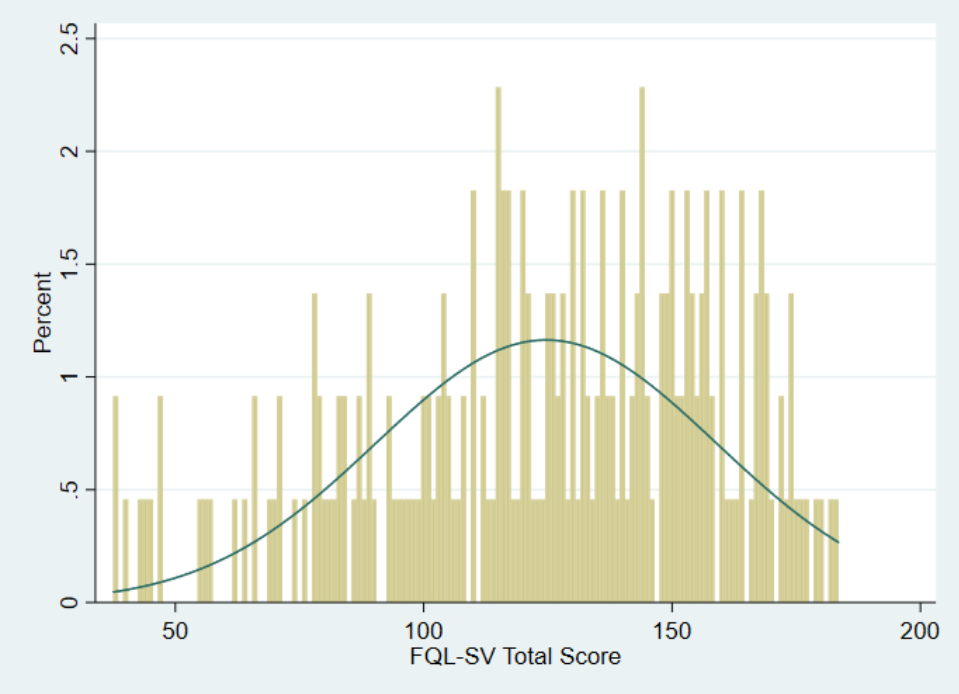


Figure 7-4 Histogram of FQL-SV total scores

7.5.6 Convergent Validity

Convergent validity was explored by using the EssenCES measure of ward climate and the FQL-SV quality of life questionnaire. Spearman's RHO was used as the FRQ and FQL-SV total scores were non-parametric (Dancey & Reidy, 2014). The FRQ showed significant negative associations with both ward climate and quality of life. The FRQ also correlated negatively with the three sub domains of the EssenCES: Patient Cohesion (PC), Experienced Safety (ES), and Therapeutic Hold (TH).

The directions and significance of the associations were as hypothesised. The FRQ correlated negatively with the EssenCES total score (Spearman's ρ=-0.62, p<.001, n=219). There was a negative correlation between the FRQ and the FQL-SV (Spearman's ρ=-0.70, p<.001, n=219). The EssenCES and FQL-SV correlated significantly in a positive direction (Spearman's ρ=0.58, p<.001, n=219). These correlations are presented in Table 7-7. Scatter plots of the relationships between the questionnaire total scores are depicted below.

Table 7-7 Correlations between FRQ, EssenCES (and Domains) and FQL-SV

	FRQ	**EssenCES**	**FQL-SV**
EssenCES	-0.62*		
FQL-SV	-0.70*	0.58*	
Patient Cohesion	-0.36*	0.78*	0.45*
Experienced Safety	-0.40*	0.62*	0.27*
Therapeutic Hold	-0.64*	0.74*	0.58*

** p<0.001; n=219*
The sub-domains of EssenCES are italicized.

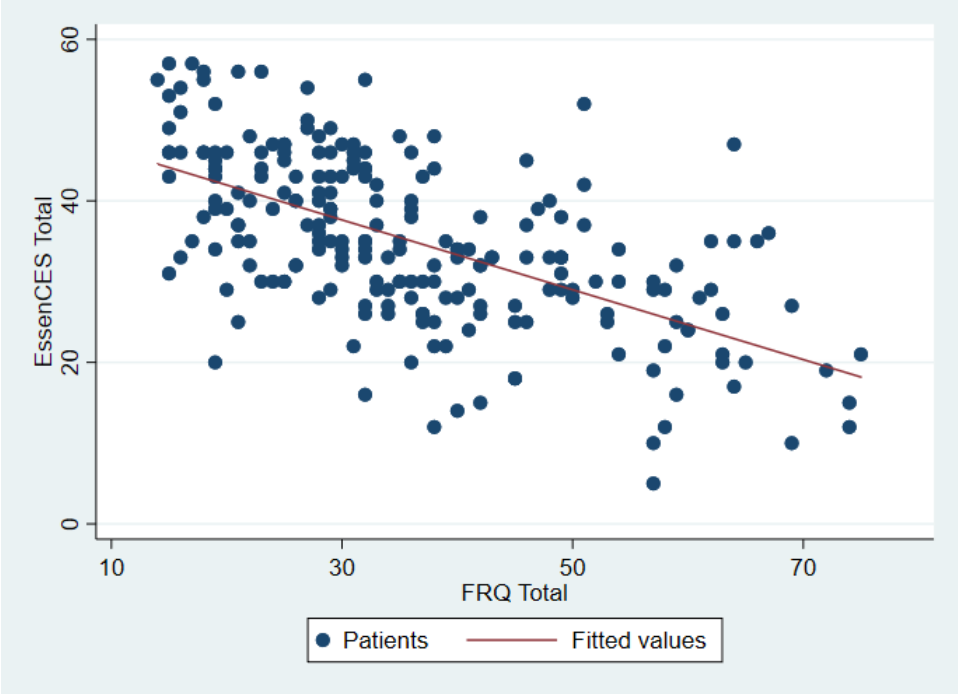


Figure 7-5. Scatter plot of correlation between the FRQ and EssenCES

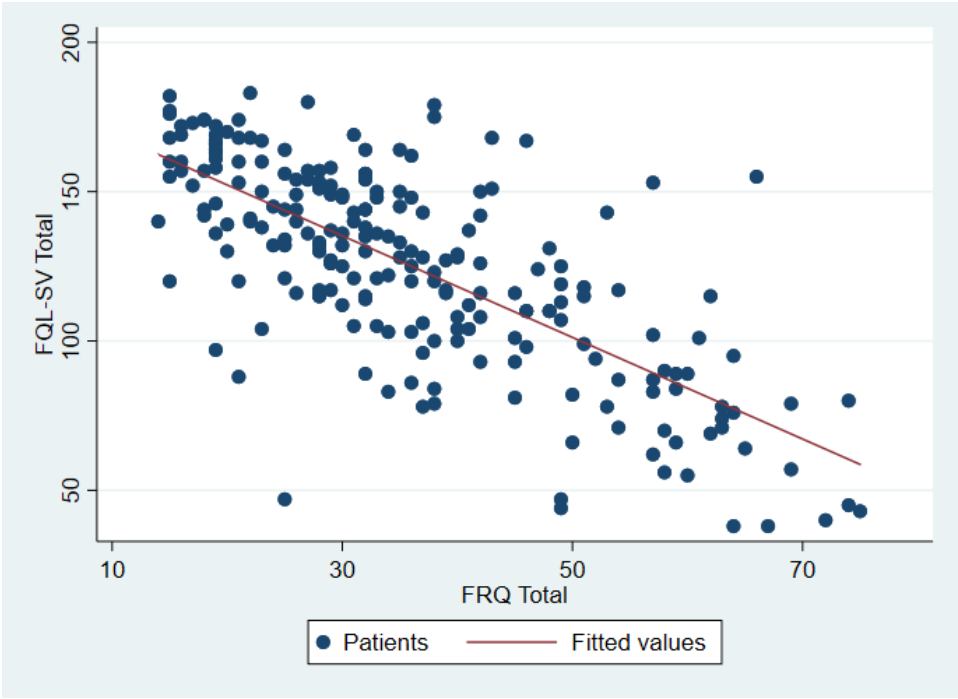


Figure 7-6. Scatter plot of correlation between the FRQ and FQL-SV

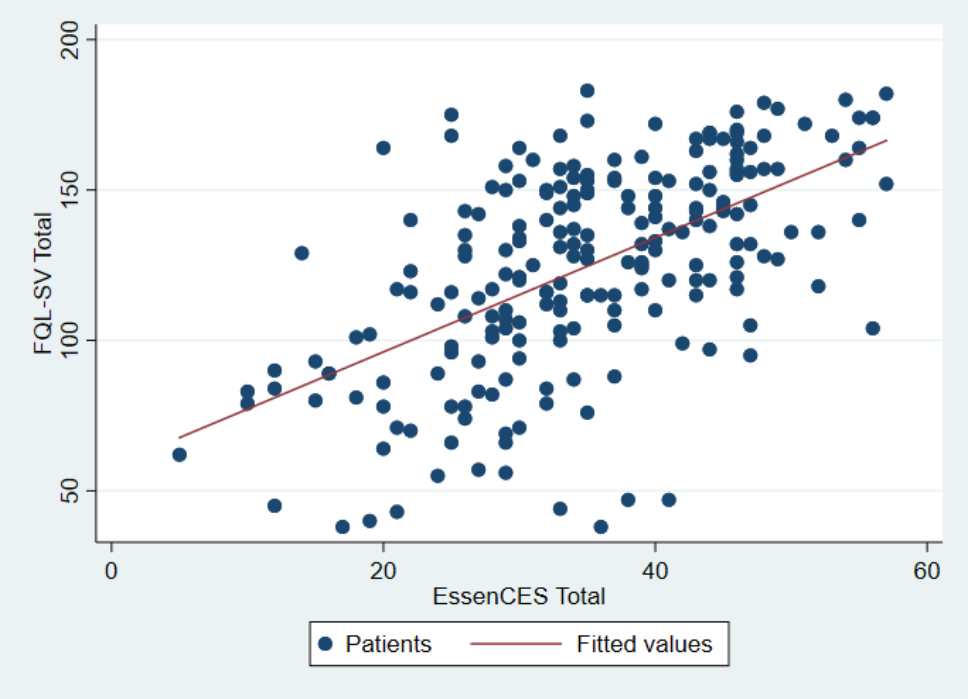


Figure 7-7. Scatter plot of correlation between the EssenCES and FQL-SV

The associations between the FRQ, FQL-SV and EssenCES were in the hypothesized directions. According to criteria identified by Dancey and Reidy (2014) the relationship between the FRQ and EssenCES was moderate to strong (Spearman's ρ=-0.62); the relationship between the FRQ and the FQL-SV was strong (Spearman's ρ=-0.70). As restrictiveness scores increased, quality of life and ward atmosphere scores decreased.

The EssenCES domain Therapeutic Hold correlated more strongly with the FRQ than the domains Patient Cohesion and Experienced Safety. This suggests that relationships with staff are a significant factor in experiences of restrictiveness and supports the prominence of the theme 'Staff' in the qualitative analysis presented in chapter five.

The significance of these results suggest that these relationships are empirically meaningful. The data indicate that the FRQ measures a

construct that exists within a nomological network of other previously validated constructs.

7.5.7 Recent Occurrence of Adverse Events

An independent samples t-test was conducted to explore whether total FRQ scores were significantly different between individuals stipulating that they had experienced something hard, difficult or hurtful within the week prior to completing the FRQ and those not stipulating this. Levine's Test for Equality of Variances indicated that variance between groups was not equal (F=8.10, p=0.005). Therefore, equal variances was not assumed and the Welch-Satterthwaite adjustment was employed (Ruxton, 2006).

There was a significant difference between those not identifying such an adverse event (M=33.3, S.D.=13.0, n=161) and those that did (M=44.0, S.D.=16.3, n=59) (t(87) =-4.58, p<.001). The mean difference was -10.89. The effect size was large, Cohen's d=0.73 (Cohen, 1988).

Independent samples t-tests were conducted to explore whether there were meaningful differences for the FQL-SV and EssenCES total scores also. There were significant differences between groups for these measures. The results of these independent samples t-tests are presented in

Table 7-8.

The t-tests suggest that patients that have experienced an event they consider to be adverse (hard, difficult, or hurtful) within the last week are significantly more likely to rate their level of restrictiveness higher.

Table 7-8 Independent t-tests for FRQ, EssenCES and FQL-SV total scores between individuals experiencing adverse event and those not

Measure	Group					95% CI Mean Difference		
	No Event			*Event (n=59)*				
	M	S.D.	n	M	S.D.		t	df
FRQ†	33.3	13.0	161	44.0	16.3	-15.3, -6.1	-4.45*	78
EssenCES	36.5	9.7	161	30.9	11.6	2.5, 9.0	3.34*	218
FQL-SV	130.6	31.6	160	108.49	36.2	11.2, 33.8	4.41*	217

**p<.001; †Welch-Satterthwaite approximation employed due to unequal group variances in the FRQ t-test.*
Note: 95% CI are Bootstrapped.

They are also likely to rate their quality of life and the ward atmosphere as worse. However, the presence of an adverse event had a larger effect on total FRQ results. This indicates that such events could have significance for how patients experience the restrictiveness of their setting within one week of an adverse event occurring. These findings support the hypothesis made for this test.

7.5.8 Demographic, Clinical, and Legal Data and FRQ Scores

Demographic, clinical, and legal data were collected on participants to explore whether there were significant relationships between patients' profiles and FRQ scores. Data were collected on security level, age, gender, ethnicity, length of stay in current institution, MHA Act section, index offence (if relevant), and diagnosis.

7.5.8.1 Gender

The number of women participating in the study (n=9) was too low to conduct a meaningful analysis of difference between mean FRQ scores.

7.5.8.2 Age

The Shapiro-Wilk statistic demonstrated that the distribution of participant age was non-parametric (p<.001). Therefore, Spearman's RHO was used. This indicated that there was no significant relationship between age and FRQ score (Spearman's ρ=-0.03, p=0.62, n=219). The hypothesis for this variable was not upheld.

7.5.8.3 Length of Stay at Current Institution

The Shapiro-Wilk statistic illustrated that respondents' length of stay at current institution was not normally distributed (p<.001). Spearman's RHO suggested there was no significant relationship between age and FRQ score (Spearman's ρ=0.02, p=0.77, n=217). The hypothesis for this variable was not upheld.

7.5.8.4 Ethnicity

As described in §7.3.2.2 groups that had fewer than 10 observations were recoded or removed from the analysis of variance. Accordingly, a one-way, between groups ANOVA investigated the differences between three ethnic groups: White, Black and Caribbean, and 'other' populations. Levene's test indicated homoscedasticity (F=2.45, p=0.09). The one-way analysis of variance suggested that there were no significant differences between the three ethnic groups (F(2, 212)=1.84, p=0.162, n=215).

Table 7-9 FRQ Scores by Ethnicity

Group	Descriptive Statistics		
	n	*Mean (S.D.)*	*Bootstrap 95% CI*
White	153	34.9 (13.9)	32.7, 37.3
Black & Caribbean	31	40.1 (14.8)	35.1, 45.7
Asian & Mixed & Other	31	37.3 (17.3)	30.6, 43.8
All	215	36.0 (14.6)	33.9, 38.2

It was hypothesised that BAME respondents would score higher than their White peers; thus, a follow-up analysis was conducted to explore mean differences between these groups. An independent samples t-test indicated that there was no significant difference between White (M=34.9, S.D.=13.9) and BAME (all non-White participants) (M=38.7, S.D.=16.0) populations, although this was close to significance (t(213)=-1.75, p=0.08, N=215)). The mean difference was -3.8 (Bootstrapped 95% C.I [-8.5, 1.07]). The hypothesis for this variable was not upheld with statistical significance.

7.5.8.5 Level of Security

A one-way, between groups ANOVA investigated the difference between FRQ mean scores for respondents in low, medium, and high levels of security. The assumption of equal variances between groups was not violated, indicating homoscedasticity (Levene's Test F=0.87, p=0.42). A one-way, between groups ANOVA revealed that there were no significant differences on FRQ scores between low, medium, and high levels of security (F(2, 216)=2.58, p=0.08, n=219). The hypothesis for this variable was not upheld with statistical significance.

Table 7-10 FRQ Scores by Security

Group	Descriptive Statistics		
	n	*Mean (S.D.)*	*Bootstrap 95% CI*
Low	89	34.3 (14.2)	31.4, 37.3
Medium	81	35.7 (14.1)	32.5, 38.9
High	49	40.2 (16.2)	35.7, 45.2
All	219	36.1 (14.7)	34.2, 38.2

7.5.8.6 Mental Health Act (1983) Section

A one-way, between groups ANOVA investigated the difference between: residents on civil sections (§3), hospital orders (§37), hospital orders with restrictions (§37/41), prison transfers with restrictions (§47/49), and 'other' (a combination of other groups).

The assumption of equal variances between groups was not violated (Levene's test F=0.47, p=0.76). The ANOVA suggested there were no significant differences between Mental Health Act (1983) sections (F(4, 211)=0.64, p=0.64, n=216).

Table 7-11 FRQ Scores by MHA Section

Group	Descriptive Statistics		
	n	*Mean (S.D.)*	*Bootstrap 95% CI*
§3	43	37.0 (13.2)	32.9, 41.0
§37	30	37.5 (14.5)	32.4, 42.7
§37/41	87	34.5 (14.7)	31.7, 37.5
§47/49	37	36.8 (16.6)	31.3, 42.1
Other	19	39.7 (15.3)	33.3, 47.8
All	216	36.3 (14.8)	34.4, 38.0

It was hypothesised that there would be a difference in mean scores between patients without restriction orders under the MHA (1983)[11] and those with restriction orders under the MHA (1983)[12]. An independent samples t-test was run with non-restricted (M=37.7, S.D.=14.0, n=92) and restricted patients (M=35.2, S.D.=15.3, n=124). Equal variances were assumed as the data were homoscedastic (Levene's Test F=0.97, p=0.33). The t-test revealed no significant difference (t(214)=0.23, p=0.22, n=216).

7.5.8.7 Diagnosis

A one-way, between groups ANOVA investigated the difference between FRQ mean scores for respondents with a primary diagnosis of personality disorder, mental illness, or MI or PD with a dual diagnosis.

The assumption of equal variances between groups was violated, indicating heteroscedasticity (Levene's test F=4.80, p=0.009). However, the ANOVA suggested there were significant differences between diagnoses (F(2, 204)=8.5, p<.001, n=207). This reflected an effect size (partial eta^2) of .08. A *post hoc* analysis using the Games-Howell multiple comparisons test demonstrated there was no significant difference between personality disordered group and the dual diagnosis group (p=0.981, bootstrapped 95% C.I [-7.1, 7.9]).

[11] Individuals on §§3, 37 MHA (1983) and individuals in the 'other' grouping.
[12] Individuals on §§37/41, 47/49 MHA (1983)

Table 7-12 FRQ Scores by Diagnosis

Group	Descriptive Statistics			
	n	*Mean (S.D.)*	*Bootstrap 95% CI*	
Personality disorder	34	41.7 (15.1)	36.9, 46.7	
Mental illness	132	32.9 (13.0)	30.7, 35.2	
Dual diagnosis	41	41.0 (16.9)	35.6, 46.4	
All	207	36.0 (14.7)	33.9, 38.1	

The Games-Howell multiple comparisons test demonstrated that there was a significant difference between the mental illness group and the personality disordered group (p=0.009, bootstrapped 95% C.I [-14.7, -3.5]). The Games-Howell test also demonstrated that there was a significant difference between the mental illness group and the dual diagnosis group (p=0.017, bootstrapped 95% C.I [-14.2, -1.9]). However, given the assumption of equal variances was violated, these must be interpreted with caution.

It was hypothesized that the violation of the assumption of homogeneity of variance was due to the inclusion of the dual diagnosis group. This was because a heterogeneous range of secondary diagnoses were included in the group. Thus, an independent samples t-test was conducted to explore the differences between mental illness and personality disorder groups.

Levene's Test indicated there was homogeneity of variance between the two groups (F=1.40, p=0.24). The t-test supported the analysis of variance findings, suggesting that there was a significant difference between the mental illness group and the personality disorder group (t(164)=3.41, p=0.001). The mean difference was 8.9 (Bootstrapped 95% C.I [3.6, 14.4]). The effect size was moderate, Cohen's d=0.63.

7.5.8.8 Index Offence

A one-way, between groups ANOVA investigated the difference between FRQ mean scores for respondents convicted of offences against the person, against property, sexual offences, 'other' offence, mixed/a combination of offences, and no offence.

The assumption of homogeneity of variance was not violated (Levene's test F=1.79, p=0.12). The ANOVA suggested that there were no significant differences between index offence groupings (F(5, 209)=0.44, p=0.82, n=215).

Table 7-13 FRQ Scores by Index Offence

Group	**Descriptive Statistics**		
	n	*Mean (S.D.)*	*Bootstrap 95% CI*
Against the person	83	35.5 (16.5)	32.1, 39.3
Against property	14	40.0 (16.5)	27.9, 46.5
Sexual offences	22	37.0 (12.5)	32.0, 42.4
Other	36	37.3 (14.4)	32.4, 42.4
Mixed	36	33.5 (13.3)	29.0, 38.0
No offence	24	38.5 (12.5)	33.7, 43.5
All	200	37.3 (14.9)	35.2, 39.7

Probing the data further, an independent samples t-test reported there was no significant difference between patients convicted of any crime (M=35.7, S.D.=15.0, n=191) and patients not convicted of any crime (excluding people awaiting a verdict) (M=38.5, S.D.=12.5, n=24) (t(213)=-0.85, p=0.39).

7.5.8.9 Summary

The above indicate that there are few meaningful associations between the demographic, clinical, and legal profiles of participants and experiences of restrictiveness as measured on the FRQ. This offers preliminary support for the hypothesis that experiences of restrictiveness are subjective and thus not different between groups. However, the data did suggest that FRQ scores differ by diagnosis, most notably with the mental illness group scoring significantly lower than the personality disorder or dual diagnosis groups. The results also indicated that there was a trend towards a meaningful difference between White and BAME populations but that significance was not obtained. These findings are discussed further in chapter eight.

7.5.9 Qualitative feedback

Space was given in the FRQ for respondents to provide qualitative feedback. Not every participant responded and the data were too few to conduct a meaningful thematic analysis. However, a summary of this is presented here.

Several participants felt the questionnaire was too long (P013), '*confusing'* (P58), unclear (P39), grammatically difficult (P169), or cognitively difficult (P12). Some felt that having reverse-worded items was difficult (P3, P122). One participant with dyslexia felt the FRQ was easy when someone read them the questions (P123).

Two highlighted that the word '*stop'* might be read as physically stopping or psychologically inhibiting (P28, P40). Others suggested the FRQ was useless: '*All these surveys are a waste of time and money'* (P80). One

respondent felt there were too many questions about sex and this made them uncomfortable (P147).

Other patients wrote that they found completing the FRQ a helpful exercise: "Th[e] questions in [the] questionnaire are very good" (P7); 'It asks important questions and felt relevant' (P153); and '[i]t seems applicable on the whole' (P145). Others that it was 'easy' (P17), 'balanced' (P49), 'helpful' (P111), 'good' (P25, P76), or not too long (P212, P213). Some hoped it might make a tangible difference in their care (P46, P64). For instance, 'I hope this questionnaire bring[s] about positive changes' (P19).

P157 reported that it was a very interesting questionnaire and they were happy to complete it for other people (the researchers). Participant (P129) wrote, *'[…] it was good to know people care'*. Respondents appreciated the chance to express themselves through the FRQ*, 'I think it is a good thing to get patients' views about the system here and to question things'* (P45).

Others recognised the temporality of restrictiveness, supporting the assertion that restrictiveness is a state rather than a trait. For one individual *'[m]y answers would be different if I was asked to complete the questionnaire a year or so back into my stay at [hospital]'* (P6). Another stated *'[…] my answers would've been different at the beginning of my hospital stay due to my mood'* (P148).

Six respondents suggested alterations. These included adding urine tests, searches and rubdowns (P69); changing '*not sure'* to '*indifferent'* (P118); using dichotomous responses (P61, P122); adding pictures (P122); and conducting more surveys like the FRQ in secure settings (P112). P181

suggested it would be helpful to have had more questions on restraint; and P185 that there should be more on visitors and their access.

The brief summary of this feedback demonstrates that respondents felt the FRQ had value. Many felt it was adequate in its composition and helpful. Several patients suggested the FRQ was too long and others that it was too difficult. Others suggested some changes that have been incorporated into the design of the revised FRQ.

In light of the qualitative comments, items were removed from the FRQ to make it more parsimonious. Items demonstrating high collinearity and content redundancy were removed, this process was described throughout this chapter. The complexity of the Likert scales was reduced by removing the 'N/A' option, reducing cognitive demand necessitated when processing more options (Streiner & Norman, 2008).

7.6 The Final FRQ

The final FRQ has 15 self-report items. These items were identified as reflecting a unidimensional construct of restrictiveness. These items are measured on a 5-point Likert scale (1-5). The pilot FRQ had a 'Not Applicable' ('N/A') option. Across the 15 items included in the final FRQ 'N/A' was selected on 0.74% of all responses. This suggests the 'N/A' option had little added value for respondents. Therefore, the 'N/A' option was removed to simplify the FRQ in light of respondents' feedback and add clarity to data interpretation.

A section at the start of the FRQ asks for patients' demographic, clinical and legal data. This is to be completed by patients or by researchers and clinicians where appropriate. The section includes: age, sex, length of stay

in current institution, ethnicity, diagnosis, Mental Health Act section, and index offence (if applicable). This will permit confirmation or refutation of the group-level findings presented in this study.

The FRQ has a total score of 75. The results of this pilot study are not generalizable enough to warrant the creation of different scoring grades. Further research and clinical use is required. However, understanding where individuals score in relation to others can be informative for patients, clinicians, and academics. The spread of FRQ scores divided into quartiles was as follows: Q1=27, Q2=34, Q3=47, with Min=13, Max=75. Accordingly, it might be helpful to consider the following grades as a preliminary guide:

Table 7-14 Interpreting FRQ Scores: a Preliminary Range

Score Range	Grade
15-27	Low
28-34	Low to Moderate
35-47	Moderate to High
48-75	High

7.7 Conclusion

The 58-item FRQ was piloted in sample of 230 patients from 16 NHS Trusts. These patients resided in low, medium and high secure forensic settings across England. Patients with a range of demographic, clinical, and legal backgrounds participated. The findings of the psychometric investigations suggested that a unidimensional structure is the most adequate for explaining a meaningful proportion of variance in FRQ scores. The short,

15-item final FRQ was internally consistent. The final FRQ correlated with measures of ward climate and quality of life in the hypothesised direction, thus placing the FRQ within a nomothetic network and providing empirical evidence supporting claims of construct validity.

The FRQ was revised in light of participants' qualitative feedback suggesting the pilot-FRQ was helpful if somewhat long. Respondents that had experienced adverse events in the week prior to completing the FRQ were significantly more likely to have higher FRQ total scores than those that did not. The findings also indicated that patients with a diagnosis of mental illness felt less restricted than their peers, and that there was a trend towards BAME individuals feeling more restricted than White patients. These points are discussed further in the following chapter.

The FRQ offers a novel, simple, and valid measure of restrictiveness in English forensic settings. The final FRQ can be found in Appendix N.

Chapter 8
Discussion

8.1 Summary

NHS England commissions approximately 7,700 forensic beds (NHS England, 2015), a figure that has been steadily rising in previous decades (Chow & Priebe, 2016). A significant number of individuals are therefore placed within settings that have been described in this thesis as 'Total', subject to proscriptive daily regimes. Secure hospitals aim to provide a safe, therapeutic milieu in light of restrictive risk-averse policies and practices. Contemporary efforts to provide mental health care in the least restrictive environment possible are ubiquitous in policy and best practice guidelines (Care Quality Commission, 2018; DoH, 2015; JCPMH, 2013; NHS England, 2018a, 2018b; NICE, 2011; The Mental Health Taskforce, 2016; Wessely, 2018).

Involvement in care plans, empowering patients, and increasing individual autonomy are key tenets of a recent independent review into U.K. mental health law, government and NHS policy, the Recovery paradigm, Self-Determination Theory, and the Good Lives Model of offender rehabilitation. Understanding patient experiences of the restrictiveness of secure settings in light of the 'least restrictive' movement, and theories of rehabilitation and good mental health is crucial. The aim of this project was the conceptualization, operationalization and measurement of forensic patients' experiences of restrictiveness.

This project adopted a mixed-methods research design (chapter four). Qualitative interviews were conducted to inductively collect patients' accounts of restrictiveness (chapter five). The data suggested that restrictions experienced by residents were myriad and subjective. This

reflected the broad array of themes discerned in the literature review in chapter three. The thematic analysis led to the generation of a Model of Restrictiveness which helps us understand 1) the antecedent conditions to restrictive phenomena; 2) restrictive phenomena themselves; 3) the enactment of these, either intended or unintended; 4) how these phenomena were psychologically experienced by residents; and 5) the consequences of these phenomena as expressed by residents. Restrictiveness was thus defined as:

> *The extent to which phenomena created, maintained or augmented directly or indirectly by forensic psychiatric care are subjectively experienced by a resident as infringing negatively upon their autonomy, self or personhood.*

The results of this model were operationalized into a pool of items (chapter six). Sixty-five items were sent to a panel of experts for an assessment of face validity. Items were re-worded, added or removed based on qualitative and quantitative feedback. The remaining items formed the Forensic Restrictiveness Questionnaire (FRQ). The FRQ was piloted with 230 patients in high, medium and low secure settings (chapter seven). Psychometric testing suggested a unidimensional structure provided a valid and internally reliable instrument in English settings.

This final chapter addresses several outstanding issues. First, the results of the psychometric testing presented in chapter seven are discussed and situated within current literature. This chapter revisits the theoretical model underpinning this project's approach to understanding restrictiveness as a subjective phenomenon – Penal Consciousness (Sexton, 2015) – in light of

the quantitative analysis in chapter seven. Attention is then paid to the relationship between restrictiveness and both quality of life and ward atmosphere. Subsequent to this, the distribution of patients' FRQ scores are discussed in relation to the presence of a recent adverse event; and participants' demographic, clinical and legal profiles.

In light of the preceding discussions, 15 key knowledge claims derived from this study are enumerated. The type of evidence offered in support of these claims and where this evidence can be found in the thesis is detailed. The limitations of this study are described. Finally, the project's novel contributions, impact, and future research and clinical applications are outlined.

8.2 The Psychometric Properties of the FRQ

This discussion is largely framed by the notion of construct validity detailed in chapter seven. Reliability, measured in this study as internal consistency, is discussed subsequent to this. Construct validity as described by Streiner and Norman (2008) is a process of hypothesis testing to make assertions as to the strength of the inferences that can be drawn from a psychological instrument. Construct validity consists of several measures of validation, including content, criterion and convergent validity (Furr, 2011; Streiner & Norman, 2008). Content validity was explored in part in chapter six. Criterion validity was not tested in this study as no comparable 'gold standard' measure of restrictiveness exists in the literature (Tomlin et al., 2018).

Construct validity was investigated by use of Principle-Axis Factor Analysis to discern the latent dimensionality of the FRQ. Construct validity was

further examined by investigating the relationships between participants' FRQ scores and demographic, clinical and legal profiles; and recent occurrence of an adverse event. Convergent validity was assessed by placing the FRQ in a nomological network with measures of quality of life and ward atmosphere. These are discussed in turn.

8.3 Factor Analysis and Restrictiveness as Subjective Experience

Construct validity assumes validity-testing is inferential (Streiner & Norman, 2008). Therefore, individuals scoring higher on the FRQ should experience a higher real-world level of restrictiveness than others scoring lower on the FRQ. EFA suggested a unidimensional latent structure explained most of the variance in respondents' FRQ scores. This indicated that observed scores measured a single construct of restrictiveness and not several latent constructs. Given that a large number of items designed to capture the empirical experience of restrictiveness as discussed by patients in chapter five were included in the EFA process, the analysis suggests the retained FRQ items captured 'restrictiveness' so-conceptualized.

This assertion is further supported by the inclusion of expert feedback as an indicator of content validity (face validity) detailed in chapter six. A unidimensional scale allows for the calculation of a single FRQ score. It is reasonable given the data to infer that individuals that score higher on the FRQ experience a greater amount of real-world restrictiveness. This section discusses how the results of the Exploratory Factor Analysis support the qualitative analysis in chapter five, that restrictiveness is a subjective phenomenon.

Many of the 15 retained items on the FRQ are abstract in content. The questions that were predicted most strongly by the latent variable of restrictiveness as indicated by the EFA procedure concern: being respected as an individual, the perceived fairness of ward rules, being given responsibility, meaningfulness in activities, and legal rights. Few items address specific concerns of restrictive measures. This reflects the subjective nature of the restrictive experience.

Items concerning more concrete restrictions including leave, access to food and drink, internet access, and following current events were not explained as strongly by the latent unidimensional structure. This can be understood with reference to the literature review (chapter three) and interview data (chapter five). Restrictive phenomena were disparate and subjective; therefore, items particularly specific in meaning were unlikely to covary strongly in Factor Analysis.

Relatedly, the literature suggests that individual pathology is related to satisfaction with care in mental health settings. Dolan and Millington (2002) found that forensic patients with high levels of psychopathic personality traits were more likely to launch complaints procedures. Specifically, a lack of insight and the projection of blame onto others were traits associated with lower perceived satisfaction levels. The authors suggest that individual pathology is more important in predicting levels of satisfaction than the quality of care provided.

The findings of Dolan and Millington (2002) would support the qualitative analysis in chapter five. A resident's interpretation of a restrictive phenomenon as severe and salient is a contingent and subjective process.

The application of the Model of Penal Consciousness (Sexton, 2015) to this study helps explain why items with a narrow focus in the 56-item pilot FRQ did not load strongly onto the unidimensional structure suggested by the EFA analysis: more abstract items gave more scope for subjective application to specific phenomena.

The subjective nature of restrictiveness is further supported by the sections titled 'Deviant Cases' in chapters three and five. These sections described resident accounts wherein aspects of care were not experienced as restrictive or reducing autonomy. Instead, residents expressed relationships with staff as helpful and caring, not restrictive and difficult (Haw et al., 2011; Phillips et al., 1996); feeling able to express oneself and be heard, instead of ignored and misunderstood (Ferrito et al., 2012); or appreciating seclusion as a form of alone time, not a coercive measure (Haw et al., 2011).

The retained 15 items measure a latent restrictiveness that manifested subjectively in each respondent. An FRQ that would include all the restrictive phenomena identified in patients' empirical accounts would be too long and cognitively overbearing (Cooper, 2018), and include many items that are not relevant for all respondents. The FRQ thus positions individuals along a continuum of restrictiveness, captured by 15 abstract items, the specific manifestations of which deserve further qualitative or clinical interviewing.

This interviewing should be part of patients' care plans. Specific elements of life in secure care should be identified and addressed by patients in tandem with their care team. The FRQ can provide a springboard for care

staff to discuss specific elements of care patients wish to describe based on their answers to each of the FRQ items. This proactive and inclusive approach to care planning is integral to the Recovery paradigm (Mann et al., 2014; Simpson & Penney, 2018), the Good Lives Model of offender rehabilitation (Ward & Brown, 2004), and the ethos of patient-centred care, independence, and shared decision-making (JCPMH, 2013; NHS England, 2018a; NICE, 2011; The Mental Health Taskforce, 2016; Wessely, 2018).

The FRQ therefore provides a measure of subjective experience. To further investigate the empirical validity of restrictiveness so conceived and measured, the following section discusses the associations between the FRQ and measures of QoL and ward climate.

8.4 Restrictiveness and its Relationship to Other Concepts

The convergent validity of the FRQ was tested by exploring its relationships with measures of quality of life and ward atmosphere. These situated the FRQ in a nomological network that permitted hypothesis-testing, which is a necessary element in construct validation (Streiner & Norman, 2008). The FRQ correlated negatively with the FQL-SV and EssenCES measures as hypothesized. This section discusses the nature of these relationships.

8.4.1 Quality of life and Restrictiveness

There was a significant negative correlation (Spearman's ρ-.70) between the FRQ and FQL-SV scores. As this is evidence of association rather than causation, we cannot say low restrictiveness scores caused high quality of life scores, or vice versa. These data indicate that 51.8% (R^2=0.518) of the

variance in the two scores is shared. The analysis implies that aspects of forensic psychiatric care have consequence on both perceptions of quality of life and restrictiveness simultaneously; and other aspects of forensic care affect these experiences idiosyncratically.

The analysis suggests that quality of life and restrictiveness overlap conceptually. This overlap is due to the theoretical considerations described in the following section, and the amount of shared variance discerned in the squared correlation coefficient (R^2=0.518).

This overlap is unsurprising when considering the literature on quality of life. QoL consists of objective and subjective elements. The latter comprises individuals' 1) ratings of external aspects of their life such as satisfaction with finances and social relationships; and 2) internal aims such as self-esteem, life-fulfilment, and autonomy (Bouman et al., 2009).

Nieuwenhuizen et al. (2002) note that quality of life in forensic psychiatric hospitals must be conceptualised differently from general settings. Conceptions of QoL specific to forensic settings need to accommodate special legal, temporal and autonomy-related domains and be mindful of punitive public attitudes (Nieuwenhuizen, Schene, & Koeter, 2002; Swinton, Oliver, & Carlisle, 1999; Vorstenbosch et al., 2014). Vorstenbosch et al. (2011) highlight that autonomy is an important aspect of quality of life, which is significantly curtailed in restrictive secure settings. Punitive attitudes and risk management in commitment to public protection mean forensic QoL measures have included items that pertain to topics relevant for restrictiveness.

The FQL-SV derives its items from the domains of the larger parent FQL instrument (Schel et al., 2017; Vorstenbosch et al., 2014). These domains included: Activities, Autonomy, Self-actualisation, Residence, Nutrition, Leave, Hygiene, Health, Sexuality, Social Relations, Other Residents, Daily Staff, Affection, Finances and Religion. The first four of these overlap with the 15-item FRQ. The latter eleven represent domains not included in the 15-item FRQ. Some of these eleven were salient within the qualitative interviews with patients (chapter five) and were included in the 56-item pilot FRQ, yet did not emerge as especially salient (i.e. factor loadings <0.6) in the EFA process detailed in chapter seven. These themes include sexual intimacy, interactions with other residents and staff, and being able to express one's religion. This supports the proposition that restrictiveness shares some conceptual overlap with QoL but retains its own idiosyncrasies.

Given the association between restrictiveness and QoL, it is important to explore the literature on QoL and both reducing reoffending and improving patient outcomes; two key aims of forensic psychiatry.

The relationship between QoL and recidivism has received recent academic and clinical interest. Recent models of offender rehabilitation seek to move away from programmes derived from the Risk-Need-Responsivity model to frameworks that embrace protective factors (de Vries Robbé, 2014) and elements of the Good Life (Ward & Brown, 2004). Indeed, the Good Lives Model of Offender Rehabilitation:

> '*…takes seriously offenders' personal preferences, values and goals and draws upon this understanding to motivate them to lead better lives; and (b) it equips offenders with the capabilities and resources to*

obtain primary goods in socially acceptable ways' (Barnao, Ward, & Robertson, 2016: 3).

QoL and satisfaction with care have been linked to improved patient outcomes. Research in a forensic out-patient context has demonstrated that higher levels of satisfaction with one's quality of life and health are associated with lower recidivism rates (Bouman et al., 2009). Preliminary data exploring subjective well-being suggested that the specific domains of satisfaction with health and life fulfilment had a mediating effect on short-term self-reported deviant behaviour when controlling for risk-levels, and a buffering effect on long-term official reoffending behaviour (Bouman et al., 2009). Bressington et al. (2011) found that forensic in-patients' satisfaction with care was highly correlated with perceptions of ward atmosphere and therapeutic alliance with key workers – two key variables in patient outcomes.

Given the relationships between restrictiveness and QoL, taking seriously patients' accounts of restrictiveness might therefore be significant in improving satisfaction with one's quality of life and care. In doing so, patients are encouraged to articulate personal preferences as they are an active agent in describing their care and possible changes to this. This could have positive consequences upon reoffending.

The strength of the association and level of shared variance between the FQL-SV and FRQ demonstrates that restrictiveness and quality of life are highly related concepts. Further quasi-experimental studies need to be conducted that collect data with the FRQ and FQL-SV over time to explore

to what extent there is a causal relationship. Such a design would be longitudinal and involve repeated measures.

Alternative QoL instruments could also be used to further explore the relationship; although few forensic-specific QoL measures exist (Nieuwenhuizen et al., 2002). The FQL full-version, which provides a richer operationalization of QoL might be used. It is further recommended that aspects of quality of life and restrictiveness are considered within care plans and discussed with patients as it is likely that positive change in either QoL or restrictiveness will have dialectical effect on the other.

8.4.2 Ward Atmosphere and Restrictiveness

There was a significant negative correlation between the FRQ and the EssenCES (Spearman's ρ=-.61). This indicates that a respondent with a high restrictiveness score is likely to have a low ward climate score. It further suggests that 37.2% (R^2=0.372) of the variance explaining respondents' scores on both measures is shared. As with quality of life, the analysis indicates that experiences of restrictiveness and ward atmosphere are related and likely to be influenced by similar aspects of forensic care. However, given the qualitative differences between restrictiveness and ward atmosphere and that 62.8% of the variance explaining respondents' scores on both measures is not shared, these two instruments also measure concepts that are distinct.

Ward atmosphere and restrictiveness are similar in several regards. The former is a broad and multidimensional concept (Tonkin, 2016). Operationalizations include various features of secure care: experienced safety, therapeutic alliances, interactions between and amongst staff and

patients, opportunities for growth and learning, and the presence of meaningful activities (Schalast et al., 2008; Tonkin, 2016; van der Helm et al., 2011). As early as 1953 the World Health Organization identified relationships, patient individuality, activities, and giving residents trust and responsibility as crucial to a positive hospital atmosphere (World Health Organization, 1953).

Tonkin's (2016) discussion of bad ward atmosphere describes several features similar to characteristics of restrictiveness; for instance: the use of coercive measures such as seclusion, and verbal or physical aggression. Characteristics of 'closed climates' in youth prisons and secure hospitals as identified by Van der Helm et al. (2011) resemble characteristics of restrictiveness identified in the present study. The authors write that:

> *'A closed prison climate is also reflected by a grim and uninviting atmosphere (e.g., lack of safety and boredom) and high repression, including incremental rules, little privacy, and (frequent) humiliation of inmates' (p.161).*

Repression is operationalized by the authors as including: being told what to do, being bored, trusting staff, and asking for permission for things. The measure of prison climate developed by these authors correlated with a measure of institutional repression used in a subsequent study of young offender institutions, suggesting further links between ward/prison atmosphere and repressive or restrictive environments (De Valk et al., 2018; de Valk et al., 2017).

The EssenCES measure of ward climate focuses on the three domains: experienced safety, patient cohesion, and therapeutic hold. The moderate

to strong correlation (Spearman's ρ=-.61) with the FRQ is to some degree explainable by the presence of items concerning relationships with staff and expressing oneself that are present in both instruments. The correlation is further understood when acknowledging a degree of abstraction present in both measures and their items. EssenCES asks respondents about 'support' between patients (items 5, 11, 14); whilst the FRQ asks about the ability to 'express' oneself (item 2). 'Support' and 'express' are both open to subjective interpretation. It could be that a respondent felt both unable to express himself and unsupported, and consequently scored similarly on these items despite their apparent difference at face value.

Given the association between restrictiveness and ward atmosphere, it is important to explore the literature on ward atmosphere and both reducing reoffending and improving patient outcomes; two key aims of forensic psychiatry.

Ward atmosphere has been labelled as '*[…] the most important single factor in the efficacy of the treatment given in a mental health hospital'* (World Health Organization, 1953: 17). Closed ward atmospheres characterised by stress, fear and aggression have been associated with negative emotions, hostility, anti-social behaviour, low social engagement; and with increased verbal and physical aggression in forensic settings (Dickens, Suesse, Snyman, & Picchioni, 2014; Tonkin, 2016; van der Helm et al., 2011).

Using the EssenCES, Long et al. (2011) found that in a U.K. sample of 65 forensic female patients ward atmosphere was associated positively with motivation for treatment, engagement in treatment, and therapeutic

alliance; and negatively with level of security, risk behaviours, and seclusions.

A recent study utilizing the EssenCES on high dependency and assertive rehabilitation wards in a U.K. high secure hospital explored the relationship between ward climate and sense of community (SOC), and disruptive behaviours (Puzzo et al., 2018). These behaviours included physical and non-physical aggression, and seclusion. The authors reported that both ward climate and SOC independently predicted overall incidents, but that only SOC independently predicted non-physical incidents. The authors further found ward climate did not predict overall incidents when controlling for SOC. Neither predicted seclusion rates. These findings suggest there is a relationship between environment and disruptive incidents, but that it is complex.

Social climate has been shown to predict reoffending. A recent study explored the predictive ability of prison social climate on proven reoffending within 12 months of release. Prison social climate was rated by 24,508 inmates in England and Wales on the Measuring Quality of Prison Life questionnaire (MQPL) between 2009-2013 (Auty & Liebling, 2019).

A multilevel regression model controlling for security level, inmate age, inmate ethnicity and percentage of prisoners completing an offending behaviour program found that prisoner adaptation, drugs, bullying, exploitation, safety, staff supervision and control, and individual autonomy most strongly predicted reoffending.

Given the evidence suggesting that ward atmosphere plays a role in patient outcomes, rehabilitation, and reoffending it is important to explore further

its relationship with restrictiveness. The present study provides evidence for an associational relationship. Further studies need to be conducted to investigate whether there is a causal relationship. Such studies would be routine and longitudinal.

Alternatively, other context-specific measures of ward atmosphere operationalized in a different way such as the forensic-specific Prison Group Climate Index-Revised (van der Helm et al., 2011), might be used be to further explore this relationship; mindful of its limited use thus far in adult forensic psychiatric settings (de Vries, Brazil, van der Helm, Verkes, & Bulten, 2018).

8.4.3 Reliability of the FRQ

The FRQ was demonstrated to be reliable within this sample. The analysis of internal consistency, explored through Cronbach's Alpha, indicated that the 15 items in the FRQ were highly correlated (α= .92) (Cooper, 2019). Further tests of reliability need to be considered. It was beyond the scope of this project to examine the test retest reliability of the FRQ. Future research should administer the FRQ at two time points with a 2-4 week interval and explore the correlation of these scores (Furr, 2011; Streiner & Norman, 2008). Thus, all that can be concluded concerning the reliability of the FRQ, is that it was internally consistent in the sample recruited in this study.

8.5 Recent Adverse Events and Restrictiveness

It was hypothesised that respondents that expressed experiencing an adverse event in the previous week would score higher on the FRQ. This

was supported by the empirical data (chapter seven). Participants in this study were significantly more likely to score higher on the FRQ if they described experiencing an adverse event in the described time period. The effect size for this difference was large (Cohen's *d*=.73) (Cohen, 1988). The strength of this effect could be attributed to the content of some of the identified adverse events being in themselves restrictive; however, this was not the case for all identified events.

In total, 53 adverse events were described by participants. These included: being slapped on the bottom (P24), being denied a hospital transfer from current ward (P10) or leave (P172), being bullied by staff (P16, P14), the death of a mother (P105), being denied medication (P109, P132), assault by another resident (P207), a change in care team (P39), anniversary of a death in family (P41), and seclusion and subsequent self-harm (P25). These vary in their content and severity but share in common that respondents felt they were 'hard, difficult or hurtful'.

This finding can be understood in light of the proposition that individuals' recall of discomforting events are subject to a peak-end bias (Redelmeier & Kahneman, 1996). The peak-end bias describes the phenomenon wherein individuals do not generate a mean average score when asked to describe past experiences of painful events; rather they focus on the most intense and the most proximate pain levels when describing their experience.

The analysis in this study suggests that patients' recall of restrictive experiences over the preceding week are affected by experiencing an event they internalised as hard, difficult or hurtful. This adverse event was associated with an increased FRQ score. In light of the peak-end bias, it is

possible that these individuals considered this adverse event as they responded to items on the FRQ and scored higher because of this recollection.

There are clinical implications for this finding. Care team staff should inquire into and be sensitive to hearing about patient experiences of such adverse events. Regardless of the content of the adverse event, patients' experience and assessment of them are likely to have consequence on wider aspects of care that stretched beyond the circumstances of the immediate adverse event. This is further supported by the data in this study that demonstrate the experience of an adverse event also decreased respondents' perceptions of their QoL and ward atmosphere (chapter seven). The implications of poor QoL and ward atmosphere have been described above.

The long-term consequences of restrictiveness need to be explored in future longitudinal studies. The FRQ can be treated as a predictor variable in a logistic regression model to explore whether feeling restricted may cause patients to engage in adverse events. There is literature to suggest feeling unheard or disempowered are antecedents to absconding and hostage-taking incidents (Ireland et al., 2014; Wilkie et al., 2014).

8.6 Restrictiveness across Demographic, Clinical, and Legal Profiles

The profiles of participants in this study were described in chapter seven. Hypotheses were made for each of the demographic, clinical and legal variables and their relationship to FRQ scores. The number of female participants recruited in the study was too small to explore meaningful

differences. This is a limitation of this study. The relationships between each profile variable and FRQ scores are discussed in turn.

8.6.1 Length of Stay at Current Institution

Participants' length of stay in current institution did not correlate significantly with FRQ scores. In English forensic settings 23.5% of high secure patients, and 16.9% of medium secure are 'long-stayers'; (Hare Duke, Furtado, Guo, & Völlm, 2018). It was hypothesised that length of stay in current institution would have a negative relationship with restrictiveness. This hypothesis drew on literature identifying the institutionalizing effects of long-term stays in institutions (Chow & Priebe, 2013; Goffman, 1961; Jones & Fowles, 1984).

This literature describes patients becoming familiar with organizational routines, docile, apathetic, and stripped of their previous 'self' by assuming a new institutional 'self'. Further, Bronsteen et al. 2008 propose that individuals grow used to their situation over time. Their 'Hedonistic Adaptation' thesis proposes that the immediate pain experienced by imprisonment diminishes over time *as* '[…] *people tend to shift their attention away from the novel consequences of the event and back toward the mundane features of daily life'* (Bronsteen et al., 2008: 1517, quoted in: De Vos & Gilbert, 2017). In light of this, restrictiveness might have carried less significance for participants over time.

Two reasons are put forward to explain the null finding. First, length of stay was described as a restrictive experience by some patients (chapter five). Some respondents felt the length of stay to be unfair in light of their index offence or that they had been in care too long. In these cases, the

correlation between FRQ scores and current length of stay might have had a positive relationship.

Second, length of stay in current institution offers an incomplete picture of the psychiatric and institutional 'careers' of participants (Goffman, 1961; Swinton et al., 1999). An individual that has spent much of their life in various institutions will likely have a different experience of the current institution than another individual for whom the present stay is their first. A study by (Harty et al., 2004) of 1244 high security patients found 21% had more than five previous psychiatric admissions. Further research should collect data on total time spent in institutions throughout the life-course, controlling for institution-type where possible.

8.6.2 Age

Participants' age did not correlate significantly with FRQ scores. It was hypothesised that these variables would be associated in a negative direction. The reasons for this hypothesis were similar to those described in the section above. The hypothesis was premised upon the assertion that given forensic patients' institutional histories, institutionalization may be associated with age.

Age and length of stay are linked in the literature. A qualitative exploration of older-aged patients reported that barriers to recovery faced by older patients such as social isolation and lack of age-appropriate activities are likely to reduce optimism for the future and treatment engagement thereby increasing time spent in secure care (Di Lorito, Dening, & Völlm, 2018). Hare Duke et al. (2018) compared characteristics of long-stay and non-long-stay forensic patients in English medium and high secure hospitals and

found that mean ages for long-stayers were 9.28 and 9.19 years older than for non-long-stayers in high and medium secure settings respectively.

This null finding could be explained in part by recourse to the qualitative data in this study. For example, participant 14 stated that as an older patient he wanted to '*[…] find myself a wife and start a family. I'm 55 and times getting short for that sort of thing*'. This statement indicates that personal goals that patients wish to achieve at certain points in their life are important factors when considering age. The relationship between age and experiences of restrictiveness needs further in-depth qualitative research. This would help us better understand how age relates to institutionalization, achievement of personal goals, optimism for future care, and experiences of restrictiveness.

8.6.3 Ethnicity

There were no significant differences on FRQ scores when comparing white, black and Caribbean, and 'other' groups. A follow-up t-test showed that there was a trend towards BAME individuals scoring higher on the FRQ than their white peers. Further, although not significant in the ANOVA, Black and Caribbean respondents' mean FRQ scores were 5.2 points higher than White respondents. This partial finding deserves further exploration and might be better understood with recourse to the negative treatment of BAME individuals in the mental health and criminal justice systems more widely (Wessely, 2018).

BAME individuals are over-represented in mental health settings (Galappathie, 2015); are subject to higher rates of involuntary detention and restraint (The Mental Health Taskforce, 2016; Wessely, 2018); and

spend twice as much time in low secure care than non-BAME patients (The Mental Health Taskforce, 2016). BAME individuals are also over-represented throughout the criminal justice system (Lammy, 2017). These differential interactions with criminal justice agents lead to poorer relations with, perceptions of, and trust in the criminal justice system (Braithwaite, 1982). The heightened use of coercive measures, longer periods of stay, and weaker levels of trust and legitimacy held towards the criminal justice and mental health systems resonate with patients' descriptions of restrictiveness and might explain the non-significant higher FRQ scores of BAME respondents.

8.6.4 Level of Security

There was no significant difference between levels of security and FRQ scores. It was hypothesised that increased security levels would be associated with increased FRQ scores. This was premised on the assumption that levels of security reflect the level of risk posed by patients (JCPMH, 2013; Kennedy, 2002). These stratifications are intended to have concomitant levels of restriction, security, and risk management practices and policies (High Secure Directions, 2013; DoH, 2011; NHS England, 2018a, 2018b). However, the results were close to significance and might be considered a trend ($p=0.08$). FRQ scores did increase as levels of security increased.

Respondents in high security scored highest on the FRQ. The general trend in support of the hypothesis might be indicative of the following observations: high secure settings are objectively the most restrictive environments in which leave is proscribed except for rare exceptions (High

Secure Directions, 2013), and interaction with one's community is therefore severely curtailed. Contrastingly, medium secure settings do permit leave, are often located within communities, have lower average lengths of stay (Hare Duke, Furtado, Guo, & Völlm, 2018), and a move to medium secure care can represent positive progression in one's treatment pathway towards discharge.

Respondents in low secure settings had the lowest FRQ scores. However, given the lower levels of restrictions imposed in these settings, it interesting these scores (M=35.7) were not significantly different from medium secure settings (M=36.6). This may be attributable to the likelihood of patients being transferred directly from the community to low secure care and the proximity to life outside secure care.

This point is supported by the work of De Vos and Gilbert (2017). The authors explored individuals sentenced to closed or open prison stays, or electronic monitoring in the community. Although respondents described conditions of lesser liberty deprivation more reintegrative and less harmful in the long-term; confrontation with freedom on a routine basis and the expectation of self-management were discussed as more painful than isolation in a closed prison in the short-term. This may explain why low secure settings were not experienced as significantly less restrictive than medium secure settings.

8.6.5 Mental Health Act (1983) Section

There were no meaningful differences on FRQ scores between categories of Mental Health Act (1984) sections. It was hypothesised that individuals detained on a prison transfer (§47/49) or hospital order (§37/41) with

restrictions would have higher FRQ scores. This was because patients subject to restriction orders are *de facto* and *de jure* subject to greater restrictive measures as Ministry of Justice approval is needed before medical teams can transfer, grant leave, and discharge patients. Further, qualitative research has reported whilst some forensic out-patients appreciated having the support that comes with being on a restriction order, other felt these to have negative labelling and social control functions (Dixon, 2015).

Contrary to the hypothesis, respondents subject to hospital orders with restrictions had the lowest mean FRQ scores – although this difference was non-significant. This might be because those individuals are assessed to represent an especially high risk to public safety in light of their criminal behaviour; the severity of these behaviours may be internalised by these participants as to some extent justifying conditions of security and restriction. This was the case for P2 and P7 in the qualitative interviews (chapter five). These respondents felt their current situation was warranted given their criminal actions. This normative account of residents' placement in secure care is similar to the notion of legitimacy considered in penal literature. Inmates are more likely to accept prison authorities and regimes where it is felt the penal regime is legitimate and fair (Crewe, 2007; Rubin, 2016).

The absence of significant differences across groups might be rooted in patients' (lack of) understanding of the MHA (1983). As found in the literature review and interview data residents were not always aware of the systemic framework mandating their care or otherwise saw it as distant and unnavigable. When describing the legal aspects of the forensic system in

this latter way, residents would describe it as a holistic law rather than system of discrete laws. Thus patients might be less likely to feel differentially restricted by their MHA (1983) sections if they are not familiar with them.

8.6.6 Diagnosis

There was a significant difference across diagnoses. This significance pertained to differences across mental illness, personality disorder, and mental illness or personality disorder with a dual diagnosis. A *post hoc* analysis indicated mentally ill patients scored significantly lower than their peers.

Relevant differences between mentally ill and personality disordered patients might help explain these findings. An older study found that forensic patients with a personality disorder in an English high secure hospital reported lower global QoL scores than residents with mental illness (Swinton et al., 1999). The authors suggest that this may be related to the greater degree of expectation personality disordered patients have of their care, particularly their responsible clinician. If these expectations are not met then dissatisfaction might be greater. Further, a study by (Dolan & Millington, 2002) found that patients with personality traits associated with psychopathy such as grandiosity and not accepting responsibility, are more likely to make use of NHS complaints procedures than individuals with lower amounts of psychopathic traits.

Given the findings of the above two studies, it might be possible that these groups of patients scored differently on the FRQ for similar reasons. The FRQ was highly correlated with a measure of QoL, some personality

disordered residents might have used the FRQ as an opportunity to express dissatisfaction with the restrictions on their ward in a manner consistent with the findings of Dolan and Millington (2002).

8.6.7 Index Offence

There were no significant differences on FRQ scores between categories of index offence. It was hypothesised that individuals convicted of having committed a sexual offence would score higher on the FRQ. This hypothesis built on the propositions that sexual offenders are subject to greater amounts of social stigma for their actions (Simon, 1998), and they are one of the most isolated offender-groups in criminal justice settings (Mbuba, 2012). It was felt plausible that the effects of this labelling and social isolation would lead sexual offenders to feel more restricted.

It was also hypothesised that respondents without an index offence would score higher on the FRQ. The absence of significant difference might be explained by the lack of information included in one's index offence. Many forensic patients have extensive criminal backgrounds; the reductive snapshot offered by the most recent offence for which the individual was placed within secure care offers no insight into respondents' criminogenic history. The index offence does not provide sufficient information about how each respondent has dealt with their offending history – sexual or otherwise – and the complex, subjective experience of this (Ferrito, Vetere, Adshead, & Moore, 2012).

In summary, the results of this section demonstrate that FRQ scores do not differ markedly across the demographic, clinical and legal profiles of participants involved in this study. This may point to the idiosyncratic nature

of restrictiveness as captured by the FRQ. The only variable that did demonstrate differences at the level of significance was an individual trait: diagnosis. Variables measuring objective characteristics such as security level, length of stay, or MHA section; or that describe an action an individual has performed (and is thus distinct from the individual themselves) did not achieve significance.

This supports the analysis of the qualitative data in chapter five which proposed that restrictiveness is a subjective phenomenon contingent upon internal thought processes constructing the severity and salience of a restrictive measure.

8.6.8 Summary

This chapter has placed the results of the psychometric tests conducted on the FRQ within broader scientific literature. The associations between the FRQ and measures of ward atmosphere and quality of life were described, with particular attention paid to links with patient recovery and reoffending. The recent occurrence of an adverse event had a large effect on FRQ scores; this was discussed in light of a peak-end bias recollection of painful experiences. The discussion suggests that restrictiveness as measured in this sample might not lend itself to group-level analysis; a proposition that supports the claim that restrictiveness is a subjective experience. The following section summarizes the key knowledge claims derived from the study's analyses and discussion.

8.7 Key Knowledge Claims

This section makes explicit the key knowledge claims of this study. These have been derived from the research aims, background, and qualitative and quantitative data collected and analysed throughout this project. Each claim is listed alongside supporting evidence and the location of these within the thesis.

Table 8-1 Key Knowledge Claims of the Project

Knowledge Claim	Evidence	Location
1. Forensic settings are proscriptive, (almost) total settings	Literature review	Chapter 3
	Patient accounts of forensic care	Chapter 5
2. Forensic patients do experience secure hospitals as restrictive	Qualitative Interviews	Chapter 5
3. Patients' experiences and narratives of restrictiveness are subjective	Qualitative data describing restrictiveness	Chapter 5
	Qualitative data describing 'deviant accounts' of restrictiveness	Chapter 7
	Absence of significant differences across most demographic variables studies and FRQ scores	Chapter 8
4. The Model of Restrictiveness helps us understand restrictiveness in forensic psychiatry holistically	Qualitative data describing why restrictions are in place, what aspects of care are felt as restrictive, whether these are intended or unintended, how experiences are subjective, and some of the consequences of this	Chapter 5
5. The empirical data collected in patients' accounts of restrictiveness are evidenced elsewhere (albeit not conceptualized as 'restrictiveness' per se)	Literature review	Chapter 3
6. Restrictiveness can be defined as: 'The extent to which phenomena created, maintained or augmented directly or indirectly by forensic psychiatric care are subjectively experienced by a resident as infringing negatively upon their autonomy, self or personhood.'	Synthesis of literature review data	Chapter 3
	Qualitative data used to conceptualize restrictiveness	Chapter 5
7. The adapted Model of Penal Consciousness (Sexton, 2015) offers a theoretical lens through which to understand experiences of restrictiveness	This Model was supported by patients' empirical accounts of restrictiveness. To it was added the 'logical' knowledge-type	Chapter 5 Chapter 7
	The high factor loadings (>0.6) of items taken from the 'Experiences of Restrictive Phenomena' qualitative theme	

8. It is possible to indirectly measure restrictiveness by psychometric instrument	Restrictiveness was conceptualized and operationalized in accordance with questionnaire development methodologies. Validated with patients	Chapter 4 Chapter 5 Chapter 6
9. The FRQ is a valid and reliable measure of subjective accounts of restrictiveness in the sample recruited	Qualitative and quantitative data collected for the assessment of face validity Quantitative analyses conducted on the FRQ data include: Cronbach's alpha, principle axis factor analysis, correlations with convergent constructs	Chapter 6 Chapter 7
10. Restrictiveness was only significantly associated to the demographic, clinical and legal variable: diagnosis	ANOVA, independent samples t-test, and Spearman's RHO	Chapter 7 Chapter 8
11. The recent occurrence of a self-defined adverse event is likely to lead patients to feel more restricted in general	Independent samples t-test, Cohen's D effect size	Chapter 7 Chapter 8
12. Restrictiveness is a conceptually distinct empirically-measured construct that overlaps with other empirically-measured constructs	The FRQ correlated significantly with the EssenCES and FQL-SV (Spearman's RHO)	Chapter 7 Chapter 8
13. Restrictiveness has a negative relationship with quality of life and ward atmosphere	The FRQ correlated significantly with the EssenCES and FQL-SV in a negative direction (Spearman's RHO)	Chapter 7
14. Restrictiveness should be a crucial consideration for forensic services	'Least restrictive practice' featured in best practice policy and guidance (e.g. NICE, MHA Code of Practice, NHS commissioning) There is a clinically significant relationship between restrictiveness and ward atmosphere and QoL Maximizing autonomy is key in several theoretical approaches to offender rehabilitation (e.g. GLM, Recovery paradigm, SDT) Overly restrictive environments may infringe human rights (e.g. art. 5 ECHR)	Chapter 1 Chapter 6
15. The FRQ offers a simple, novel, valid, and internally reliable measure for clinical and research use	The methodology, qualitative and quantitative data and analyses put forward throughout this study	Chapters 1-8

8.8 Limitations of the Present Study

There were several limitations to this study. Limitations pertaining to the qualitative phase include the inherent difficulties of conducting social scientific research as an independent, biographically-endowed actor. It is necessary to highlight that all phases were conducted by myself in consultation with my supervisors. This means that the collection, analysis and interpretation of the qualitative data might have looked different if the study was primarily conducted by another researcher.

To address these concerns, researcher reflexivity was used to question the emerging data collection and analyses processes; interview question guides, resulting transcripts and analyses discussed with supervisors, presented at conferences, or peer-reviewed by journals; and patients were asked for their feedback on the face validity of the initial pool of items, which shaped aspects of the revised FRQ. Field notes were taken and an analysis diary was kept. Researcher reflexivity was addressed in more detail in chapter four.

It was a further limitation that mini-focus groups were initially conducted prior to individual interviews. Although there are strengths to conducting focus groups at the commencement of an exploratory study design (Barbour, 2008; Kvale, 2008), this does have epistemological consequences on the data (Benton & Craib, 2010). Focus groups were more likely to derive opinions than interviews, which are more likely to derive experiences. Future studies should ensure fidelity to one method, or alter data analysis to recognise the differentially socially-constructed nature of

focus group and individual interview settings (Onwuegbuzie & Dickinson, 2009).

The sampling method chosen was non-probabilistic, accessible and purposive (Lynn, 2016; Silverman, 2015). For both qualitative and quantitative phases participants were recruited from low, medium, and high secure settings; male and female participants were sought; and sites were approached to ensure a mixture of diagnoses.

However, as participation was voluntary and consensual, only individuals who had an interest were involved. This may have attracted participants that felt especially restricted and wanted an opportunity to express this. Certain wards were difficult to gain access to which reduced potential patient participation. Ethical approvals did not permit the participation of patients confined in seclusion – a situation of extreme restriction – or those that lacked capacity. These factors may have skewed the sample; missing patients who were difficult to access, were less concerned by the restrictiveness of the setting, lacked interest in research projects, or were secluded; thus leading to systematic bias (King, Keohane, & Verba, 1994). Further, Principle Axis Factor Analysis assumes a random sample in ideal conditions (Cooper, 2018).

The quantitative sample size was adequate given the study population and is comparable to other studies developing scales in forensic settings (Bergk et al., 2010; MacInnes et al., 2010). Debate exists in the literature as to the ideal sample size for Exploratory Factor Analysis, with useable participant-to-item ratios being described as ranging from 2:1 to 10:1

(Cooper, 2018; Costello & Osborne, 2005; Furr, 2011; Hinkin, 1998). In this study this ratio was 4.7:1 following the initial item removal. Although these ratios depend largely on the nature of the data and the relationships between items, more reliable statistical results would have emerged had a larger sample size been achieved. Future research should aim for a larger sample size and embrace a probabilistic sampling technique if possible.

It was not possible to compare demographic, legal or clinical data between participants and non-participants. This was because it was not in accordance with ethical approvals to collect data on individuals that did not consent to participate. As a proxy comparison, previous studies in forensic populations were sought to check if the range of demographic profiles broadly matched these. This suggested a reasonable level of generalizability in the results. These studies are described in chapter one, in which the forensic population is described. This process was difficult however; as national, regional, or institutional data are not published. Indeed, as Rutherford and Duggan noted in 2008, *'… the facts and figures relating to these services are patchy and not widely published'* (p.4). Future research should collect data on individuals that do not complete the FRQ to see if there are meaningful differences between these groups.

There were some limitations in relation to the convergent validity described in this study. It is plausible that ward atmosphere might have correlated with the FRQ more strongly than quality of life did. This might indicate that the FRQ shared considerable conceptual overlap with the FQL-SV or that the FRQ measured a sense of restriction describing aspects of care beyond the immediate ward setting.

The FRQ correlations with these measures were high for distinct concepts. Further research needs to further explore in what ways restrictiveness as captured by the FRQ differs from these concepts or is mutually influenced by a variable not measured in this study. Future studies should also include convergent measures of related concepts not investigated here, including indicators of: mood, anger, severity of illness, insight into illness or of a more directly related concept such as perceived coercion.

There are several limitations to the possible uses of the FRQ. At a group level, the FRQ might not be able to distinguish between objective conditions of restrictiveness. This is not entirely problematic as the FRQ is a subjective measure; however, low restrictiveness scores as captured on the FRQ should not be used to ignore objectively restrictive conditions where these are harmful, detrimental to recovery or unnecessary. High FRQ results pertaining to a ward or hospital should be interpreted cognizant of the type of service provided and the group of services users; the FRQ should not be used as a tool to persecute well-run, efficacious, human rights -observing services working in difficult settings. Group level analyses (such as mean ward or hospital scores) will not capture patients scoring at extreme ends of the FRQ; each individual's scores need to be inspected.

At an individual level, the FRQ offers a measure of experience of restrictiveness but does not identify specific elements of care. The FRQ might be used by patients to complain about their care (thus scoring highly) or to attempt to please staff (by scoring low) and thus not give an accurate representation. Accordingly, the FRQ should be used to complement

qualitative clinical interview work. The test retest reliability of the FRQ needs to be investigated before it can be asserted to be a reliable measure of individual change in restrictiveness as a state as it is argued to be in this thesis.

Finally, internal consistency was the only test employed to measure the reliability of the FRQ. This is a useful statistic and best practice for scale development (Cooper, 2018). However, as stated previously, this should be supported by further evidence of reliability. Future research should issue the FRQ at two time-points and assess its test retest reliability. This would strengthen the reliability claims of the FRQ.

8.8.1 Specific Contributions of the Author

The work presented in this thesis was conducted by myself, with the academic guidance of my supervisors, access support by NHS staff and data collection support from the NIHR CRN. The CRN assisted in collecting the questionnaire data presented in chapter seven. 170 participants were recruited by the CRN. Questionnaire and participant data were then forwarded to myself for analysis.

This offered a positive learning experience and control over the project; however, this carries some limitations. Having assistance in collecting and coding the literature review materials, conducting the interviews and analysis the interview data would have added to the reliability and validity of the findings. For instance, no inter-rater reliability was calculated for the

literature review or interview coding. Future projects should involve multiple researchers.

8.9 Distinguishing Restrictiveness and the FRQ

Restrictiveness as conceptualized, operationalized and measured by the FRQ in this project has conceptual and empirical similarities with other concepts. These include repression in youth facilities (De Valk, Kuiper, Van Der Helm, Maas, & Stams, 2018), perceived institutional restraint in forensic settings (Franke, Büsselmann, Streb, & Dudeck, 2019), perceived coercion across psychiatric settings (Horvath, Steinert, & Jaeger, 2018; Høyer et al., 2002) and the use of coercive measures in forensic settings typically understood (Hui, Middleton, & Vollm, 2016).

It is important to distinguish restrictiveness and the FRQ from these constructs and the instruments developed to measure them. Repression in young offender institutes as measured by the Institutional Repression Questionnaire has not been empirically tested in adult settings and conceptually focuses on repressive elements of care enacted by an authority figure (De Valk et al., 2018; de Valk, Kuiper, van der Helm, Maas, & Stams, 2016). Perceived institutional restraint as measured by the aMQPL encompassed the constructs fairness, respect and transparency of procedures and decisions. Measures of perceived coercion measure perceptions of the admission process (MacArthur Perceived Coercion Scale; Gardner, Hoge, & Bennett, 1993) or restraint and seclusion (Coercion Experience Scale: Bergk, Flammer, & Steinert, 2010).

The FRQ was piloted in adult settings and does not require that an authority figure act in a way that represses patients, nor does it focus solely on coercive measures such as involuntary admission, restraint, seclusion or forced medication. Indeed, restrictiveness captures unintended restrictions or phenomena resulting from the actions of wider society or other patients as well as staff and institutions. The FRQ was derived directly from patient experience and is intended to measure patient experience over the past week and not in relation to a particular event.

8.10 Novel Contributions of the Present Study

This project makes four novel contributions to research and clinical care conducted in secure hospitals. First, this study gave voice to patients' experiences of the restrictiveness of their care. This adds an important contribution to current understandings of living within conditions of liberty deprivation in secure settings. It builds on recent qualitative studies exploring least restrictive practices in England (Hui, 2017; Sustere & Tarpey, 2019); and quantitative studies exploring the role ward atmosphere and quality of life play in offender rehabilitation (De Valk et al., 2018; de Vries et al., 2018).

The data presented in this project enrich and deepen descriptions of secure environments. Patients' accounts ask us to critically consider features of forensic care we might not have previously. These deserve recognition when commissioners, clinicians, courts, and policy-makers place individuals within secure care, prolong lengths of stay, and develop best practice care plans. This contribution can be placed within the contemporary penal

literature exploring the unintended pains of imprisonment (Crewe, 2011; Crewe et al., 2014; De Vos & Gilbert, 2017; Rubin, 2016; Sexton, 2015), and other literature describing life in secure hospitals (see chapter three).

Second, the data generated through interviews with patients conceptualized a single, useable definition of restrictiveness. Namely:

> *The extent to which phenomena created, maintained or augmented directly or indirectly by forensic psychiatric care are subjectively experienced by a resident as infringing negatively upon their autonomy, self or personhood.*

'Least restrictive practices' have been conceptualized differently in best practice guidelines or policy documents. The definition developed for this project embodies patient experiences of the phenomenon empirically. It is broad enough to permit description of subjective accounts described by participants but sufficiently narrow to give conceptual clarity (Adcock & Collier, 2001; Luyt, 2012).

Third, the Model of Restrictiveness presented in chapter five provides a framework for understanding why phenomena are experienced differentially by patients. The model is a helpful when considering why restrictive aspects of care are in place, what aspects of care were described as restrictive by patients, how these are enacted by the institution (as intended or unintended), how individuals psychologically process these (building on the Model of Penal Consciousness), and what some of the identified consequences of restrictive experiences can be. This model should be explored in settings outside England.

Fourth, the FRQ offers a short, easy to comprehend measure of subjective experiences of restrictiveness. The 15-item FRQ is of value to researchers, clinicians, and patients. The FRQ can be integrated into a set of routine outcome measures employed in forensic settings and completed by patients themselves. This tool can provide an opportunity for patients to express themselves on an aspect of care of which they are not frequently questioned and do so in a structured manner. Staff can review the results of the FRQ with patients to discuss what specific adaptations can or cannot be made to their care pathways, and why.

8.11 Implications for Practice

The results of this study indicate implications for practice. Italy has started the process of closing down its large forensic 'asylums' (Carabellese & Felthous, 2016; Fioritti, 2018). Beyond such large systemic change, smaller alterations and additions to practice can be identified. Some are well recognised, including: adequate resourcing and staffing to facilitate activities that promote autonomy and skill-development; avoiding blanket restrictions by tailoring care to each individual; promoting positive risk-taking; and trusting residents to demonstrate responsibility and thus exercise autonomy and choice.

The Model of Restrictiveness helps us understand why restrictions are not experienced as equally severe or salient for each resident. Praxis should include meaningful conversations with residents to explore whether restrictions are experienced as diminutive of their autonomy, sense of self, or humanity. Thus alternative approaches that carry less perceived

consequence on residents' perceptions of humanity and identity should be sought.

The data suggest that information flows are crucial. Respondents felt they were not given enough or any information regarding aspects of their care, and were in turn precluded from expressing themselves. Barriers to information flows deny agency in one's care pathway, hospital activities, and wider social citizenship. Restrictions will have less salience for residents if they are logical and accessible. Consequently, residents should be given on-going information about their care pathways, developments, changes within the hospital, and be kept up to date when no changes occur. This will increase knowledge of the environment, and promote a sense of legitimacy and fairness.

Legitimacy and fairness need to be embedded within the whole forensic system. From the moment individuals first interact with mental health or law enforcement teams, individuals need to be appropriately represented and included. This inclusion should be meaningful and supported by guardians where necessary. A key finding from the present study would suggest informing individuals of what is going on and why these events are occurring will help mitigate the expectation-reality gap experienced upon arrival in secure care.

Studies exploring victims' perceptions of the legitimacy of criminal justice processes have found that the outcomes of investigations or successful prosecutions were less important to individuals than being meaningfully and continually involved in the process (Shapland, 1984). Accordingly,

individuals place high value on knowledge of, and inclusion in, criminal justice processes. Information packets such as those developed by the NGO 'MIND' ought to be used; and localized, easy to understand information packages should be made for each secure hospital. Initiatives highlighted in the present study to include patients on hiring panels or form brain-storming groups to input into the development of a garden are good examples of this (see chapter five).

Relatedly, improving relationships and flattening hierarchies with security teams should be sought. This will diminish perceptions of security as a distant hegemonic power and give opportunities to discuss restrictive security measures. Anecdotal evidence informs me that one unit, not involved in this study, has removed security uniforms so as to soften this organizational division.

Units should engage in efforts to reduce coercive measures. These include the NHS CEQUINN MH3, and the Mental Health Safety Improvement Programme to Reduce Restrictive Practices, discussed in chapter one. Both have information available online. Best practices to identify possible harm and mitigate this using relational security are well summarized in Ewington (2016). Reducing restrictive practices should help develop a less coercive culture in some sites, making discussions of restrictiveness more feasible or commonplace.

8.12 Impact of the Study and Future Projects

This study hopes to make future impact on both academic scholarship and clinical praxis. In relation to academic impact, the FRQ is being validated in

a Canadian sample. This project aims to culturally translate, pilot, and validate the FRQ in a sample of forensic in-patients in Toronto, Ontario. The project will assess the convergent validity of the FRQ by using two measures of QoL (FQL-SV and WHOQOL-Bref), ward atmosphere (EssenCES), and recovery (RAS). This project will add to the scientific validity of the results found in the present study and offer insights into how restrictiveness is associated with recovery.

The FRQ offers exciting and meaningful future research opportunities. Several of these have be identified in the body of this thesis. These proposals suggest elucidation of the present findings. For instance, the associational relationship between both the EssenCES and FQL-SV, and the FRQ could be further explored. Such studies could explore causality between these constructs by employing repeated measures and conducting an analysis of variance over time controlling for possible confounding variables such as ward-type, level of security, medications, treatment and recovery outcomes, diagnosis, patient profiles and adverse events.

The FRQ also offers opportunities for international comparison. Following the presentation of the preliminary results of this study at international conferences, short-term scientific missions, in a peer-review journal, and online; researchers from the following countries have expressed an interest in translating and validating the FRQ: Canada, Germany, Belgium, the Netherlands, Egypt and Poland. If the FRQ retains the same 15 items, then this makes total score comparison possible and meaningful. Intranational and international comparisons of sites and wards can be undertaken. Such

a project falls within other efforts to compare international best practices on forensic psychiatric care[13].

The FRQ has received interest from a human rights body. During a short-term scientific mission to Poland, the country's Deputy Ombudsman and a representative of the National Preventive Mechanism (NPM) expressed interest in the FRQ. The interest concerned making a version of the FRQ that was applicable to other closed institutions that the NPM visits to recommend changes in light of the provisions of the UN Convention on the Prevention of Torture and Inhuman and Degrading Treatment. These institutions of liberty deprivation include immigration detention centres, psychiatric institutions (forensic and general), and prisons. This discussion was salient in light of a 2017 CPT visit to Poland which was broadly positive about the Regional Centre for Forensic Psychiatry, Gostynin (Council of Europe, 2018b). However, recent concerns over the use of preventive detention at this site have arisen.

In relation to clinical praxis, patients and staff expressed finding the FRQ a helpful experience. Patients' positive feedback was described in chapter seven. A researcher based at a participating site in England felt the FRQ study was an important factor in deciding they would re-enter clinical work:

> *"I am very thankful to have been involved in your study; in the time that I spent recruiting patients to the survey I reconsidered my career path and applied for a Deputy Ward Manager role at [site name*

[13] Such European efforts include the 'Ghent Group', the 'COST ACTION on Long-Term Forensic Psychiatric Care'

anonymised]. I missed the patient group and your study highlighted this to me."

"I especially found that it was refreshing to encourage patients to express how they feel about their care with no direct implications for them; I think a few of the patients found the survey somewhat therapeutic, in that they felt their opinions might be useful and get heard in some way eventually."

It is hoped that the above projects will have academic, clinical, and human rights impact.

8.13 Conclusion

The primary objective of this study was to generate a questionnaire to measure subjective experiences of restrictiveness in secure forensic psychiatric care.

The qualitative phase of this study found that that experiences of restrictiveness are deeply subjective phenomena. The conditions of liberty deprivation described by patients as restrictive are broader than least restrictive practices and coercive measures typically understood. This study has explored intended and unintended restrictions, why these are in place, how they are enacted and then felt by patients.

Residents' accounts further our understanding of the encompassing nature of forensic psychiatric settings. These narratives ask us to critically consider the spaces within which we place individuals and practice mental health care. These data are salient for contemporary discussions on recovery-

focused and patient-centred care, especially when considered within the frameworks of the Good Lives Model and the recovery paradigm (Simpson & Penney, 2018; Ward & Brown, 2004).

The quantitative phase of this study indicated that the final 15-item FRQ is a valid and internally reliable unidimensional measure. The FRQ captures the subjectivity inherent within patients' descriptions of restrictiveness and offers a tool for both academic and clinical use. The strong correlations between restrictiveness and quality of life and ward atmosphere suggest these constructs are linked. The FRQ is an important tool for provoking dialogue between staff and patients and directing changes in care plans.

A key implication from this study is that interventions and policy concerning quality of care and living conditions in secure hospitals must consider and address experiences of restrictiveness. The FRQ offers a novel and simple measure of an important phenomenon in forensic settings.

References

Acock, A. C. (2008). *A gentle introduction to Stata*. Stata press.

Adcock, R., & Collier, D. (2001). A Shared Standard for Qualitative and Quantitative Research. In *American Political Science Review* (Vol. 95, pp. 529–546). Cambridge Univ Press. https://doi.org/10.1017/S0003055401003100

Adshead, G. (2000). Care or custody? Ethical dilemmas in forensic psychiatry. *Journal of Medical Ethics*, *26*(5), 302–304.

Adshead, G., & Davies, T. (2016). Wise restraints: Ethical issues in the coercion of forensic patients. *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges*, 69–86. https://doi.org/10.1007/978-3-319-26748-7_5

Affleck, W., Glass, K., & Macdonald, M. E. (2013). The Limitations of Language. *American Journal of Men's Health*, *7*(2), 155–162. https://doi.org/10.1177/1557988312464038

Albrecht, H. J. (2016). Legal aspects of the use of coercive measures in psychiatry. *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges*, 31–48. https://doi.org/10.1007/978-3-319-26748-7_3

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal*, *16*(4), 11. https://doi.org/10.1037/h0095655

Appelbaum, P. S. (1999). Law & Psychiatry: Least restrictive alternative revisited: Olmstead's uncertain mandate for community-based care. *Law & Psychiatry*, *50*(10), 1271-1272,1280. https://doi.org/https://doi.org/10.1176/ps.50.10.1271

Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, *1*(3), 385–405.

Auty, K. M., & Liebling, A. (2019). Exploring the Relationship between Prison Social Climate and Reoffending* Exploring the Relationship between Prison Social Climate and Reoffending Ã. https://doi.org/10.1080/07418825.2018.1538421

Awofeso, N., & Guggisberg, M. (2011). *Prisons, prisoners and health care : history and contemporary issues*. LAP Lambert Academic Publishing. Retrieved from https://espace.curtin.edu.au/handle/20.500.11937/11084

Barbour, R. (2008). *Doing Focus Groups*. SAGE Publications. Retrieved from https://books.google.co.uk/books?id=TzZTCEAK6N4C

Barnao, M., Ward, T., & Robertson, P. (2016). The Good Lives Model: A New Paradigm for Forensic Mental Health. *Psychiatry, Psychology and Law*, *23*(2), 288–301. https://doi.org/10.1080/13218719.2015.1054923

Bateson, G. (1972). *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution and Epistemology*. New York: Ballantine. https://doi.org/cblibrary

Bauman, Z. (2000). Social Uses of Law and Order. In D. Garland & R. Sparks (Eds.), *Criminology and Social Theory* (p. 224). Oxford University Press.

Beck, U. (1992). Risk society: Towards a new modernity.

Becker, M., Love, C. C., & Hunter, M. E. (1997). Intractability is relative: Behaviour therapy in the elimination of violence in psychotic forensic patients. *Legal and Criminological Psychology*, *2*(Part 1), 89–101. https://doi.org/http://dx.doi.org/10.1111/j.2044-8333.1997.tb00335.x

Benton, T., & Craib, I. (2010). *Philosophy of social science: The philosophical foundations of social thought*. Palgrave Macmillan.

Bergk, J., Flammer, E., & Steinert, T. (2010). "Coercion Experience Scale" (CES) - validation of a questionnaire on coercive measures. *BMC Psychiatry*, *10*(1), 5. https://doi.org/10.1186/1471-244x-10-5

Blaikie, N. (2007). *Approaches to social enquiry*. Polity. Retrieved from https://books.google.co.uk/books?hl=en&lr=&id=a8LAIqk0-nIC&oi=fnd&pg=PR4&dq=blaikie&ots=TCJh-syREt&sig=G_S6RaSSkwlxd-bLyPnQSU635xo#v=onepage&q=blaikie&f=false

Blaikie, N. (2010). *Designing social research : the logic of anticipation*. Polity Press. Retrieved from https://books.google.co.uk/books?hl=en&lr=&id=AcQ7mBUIkGEC&oi=fnd&pg=PR7&dq=blaikie+designing+to+social+enquiry+2010&ots=otLkk-CQ_Z&sig=JoH7eMFiVn8NVShTsKD7jNVI7tw#v=onepage&q&f=false

Booth, A., Sutton, A., & Papaioannou, D. (2012). *Systematic approaches to a successful literature review* (1st ed.). Retrieved from https://books.google.co.uk/books?hl=en&lr=&id=JD1DCgAAQBAJ&oi=fnd&pg=PP1&ots=IYkIIQhRaF&sig=fR6XB7AYCMweuG8Z-P9tIvqMIKg

Bouman, Y. H. A. (2009). *Quality of life and criminal recidivism in forensic outpatients with personality disorders A Good Lives approach*. Retrieved from http://digitalarchive.maastrichtuniversity.nl/fedora/get/guid:a2e42f76-252a-4e95-b341-b9737d0eba89/ASSET1

Bouman, Y. H. A., Schene, A. H., & de Ruiter, C. (2009). Subjective Well-Being and Recidivism in Forensic Psychiatric Outpatients. *International Journal of Forensic Mental Health*, *8*(4), 225–234. https://doi.org/10.1080/14999011003635647

Bowser, A., Link, W., Dickson, M., Collier, L., & Donovan-Hall, M. K. (2018). A Qualitative Study Exploring the Causes of Boredom for Men with a Psychosis in a Forensic Setting. *Occupational Therapy in Mental Health*, *34*(1), 32–48. https://doi.org/10.1080/0164212X.2017.1331151

Braithwaite, J. (1982). *Paradoxes of class bias in criminal justice*. *Rethinking criminology*. Retrieved from http://johnbraithwaite.com/wp-content/uploads/2016/05/1982_Paradoxes-of-Class-Bias-in-Cri.pdf

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Bressington, D., Stewart, B., Beer, D., & MacInnes, D. (2011). Levels of service user satisfaction in secure settings – A survey of the association between

perceived social climate, perceived therapeutic relationship and satisfaction with forensic services. *International Journal of Nursing Studies*, *48*(11), 1349–1356. https://doi.org/10.1016/J.IJNURSTU.2011.05.011

Brink, J., & Goossens, I. (2016). Coercion in forensic healthcare: A North American perspective. *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges.*, 185–208. https://doi.org/http://dx.doi.org/10.1007/978-3-319-26748-7_10

Brown, A. P., Fishbein, D. J., & Fisher, W. H. (2001). "Titicut follow-up": Successful transfer of assaultive patient from a high security facility to a less restrictive setting. *Administration and Policy in Mental Health*, *29*(1), 67–79. https://doi.org/http://dx.doi.org/10.1023/A:1013121032479

Brunt, D., & Rask, M. (2005). Patient and staff perceptions of the ward atmosphere in a Swedish maximum-security forensic psychiatric hospital. *Journal of Forensic Psychiatry & Psychology*, *16*(2), 263–276. https://doi.org/http://dx.doi.org/10.1080/1478994042000270238

Bryman, A. (2003). *Quantity and quality in social research*. Routledge.

Buchanan, A. (2013). Violence Risk Assessment in Clinical Settings: Being Sure about Being Sure. *Behavioral Sciences & the Law*, *31*(1), 74–80. https://doi.org/10.1002/bsl.2045

Caldas-Almeida, J., Mateus, P., & Gina, T. (2016). *Towards community-based and socially inclusive mental health care. Joint Action on Mental Health and Well-being. Situation analysis and recommendations for action.* Retrieved from https://ec.europa.eu/health/sites/health/files/mental_health/docs/2017_towardsmhcare_en.pdf

Capone, G., Braham, L., Schroder, T., & Moghaddam, N. (2017). Perceptions of therapeutic principles in a therapeutic community. *Therapeutic Communities*, *38*(2), 60–78. https://doi.org/10.1108/TC-02-2017-0009

Carabellese, F., & Felthous, A. R. (2016). Closing Italian Forensic Psychiatry Hospitals in Favor of Treating Insanity Acquittees in the Community. *Behavioral Sciences & the Law*, *34*(2–3), 444–459. https://doi.org/https://dx.doi.org/10.1002/bsl.2234

Care Quality Commission. (2018). The state of care in mental health services 2014 to 2017 | Care Quality Commission. https://doi.org/CQC-380-072017

Cashin, A., Newman, C., Eason, M., Thorpe, A., & O'Discoll, C. (2010). An ethnographic study of forensic nursing culture in an Australian prison hospital. *Journal of Psychiatric and Mental Health Nursing*, *17*(1), 39–45. https://doi.org/10.1111/j.1365-2850.2009.01476.x

Centre for Mental Health. (2013). *Briefing Note: Secure Care Services*. Retrieved from www.centreformentalhealth.org.uk

Chalmers, A. F. (2013). *What is this thing called science?* Hackett Publishing.

Chambliss, W. J. (1973). *The Saints and the Roughnecks*. Retrieved from http://people.morrisville.edu/~reymers/readings/soci101/saints_and_the_ro

ughnecks-chambliss.pdf

Chow, W. S., & Priebe, S. (2013). Understanding psychiatric institutionalization: a conceptual review. *BMC Psychiatry*, *13*(1), 169. https://doi.org/10.1186/1471-244x-13-169

Chow, W. S., & Priebe, S. (2016). How has the extent of institutional mental healthcare changed in Western Europe? Analysis of data since 1990. *BMJ Open*, *6*, 10188. https://doi.org/10.1136/bmjopen-2015

Clarke, C., Lumbard, D., Sambrook, S., & Kerr, K. (2016). What does recovery mean to a forensic mental health patient? A systematic review and narrative synthesis of the qualitative literature. *Journal of Forensic Psychiatry and Psychology*, *27*(1), 38–54. https://doi.org/http://dx.doi.org/10.1080/14789949.2015.1102311

Coffey, M. J. (2006). Researching service user views in forensic mental health: A literature review. *Journal of Forensic Psychiatry and Psychology*, *17*(1), 73–107. https://doi.org/http://dx.doi.org/10.1080/14789940500431544

Cohen, J. (1988). *Statistical power analysis for the behavioral sciences*. L. Erlbaum Associates. Retrieved from https://books.google.co.uk/books?id=2v9zDAsLvA0C&pg=PP1&redir_esc=y#v=onepage&q&f=false

Coid, J., Kahtan, N., Cook, A., Gault, S., & Jarman, B. (2001). Predicting admission rates to secure forensic psychiatry services. *Psychological Medicine*, *31*(3), 531–539. https://doi.org/10.1017/S003329170100366X

Coombs, C. H. (1964). A theory of data.

Cooper, C. (2018). *Psychological testing: theory and practice*. Retrieved from https://books.google.co.uk/books?hl=en&lr=&id=XmNwDwAAQBAJ&oi=fnd&pg=PT19&dq=Psychological+testing:+Theory+and+Practice+Colin+Cooper&ots=1ITieM01an&sig=6kBUKqSgG3ktIdIGm8Wzkkyh8zM#v=onepage&q=Psychological testing%3A Theory and Practice Colin Cooper&f=fal

Cope, K. A., & Encandela, J. A. (1998). Organizational features affecting the use of coercion in the administration of psychiatric care. *Adm Policy Ment Health*, *25*(3), 309–319.

Corrigan, P. W., & Watson, A. C. (2006). The Paradox of Self-Stigma and Mental Illness. *Clinical Psychology: Science and Practice*, *9*(1), 35–53. https://doi.org/10.1093/clipsy.9.1.35

Costello, A. B., & Osborne, J. W. (2005). Best practices in exploratory factor analysis: four recommendations for getting the most from your analysis. *Practical Assessment, Research & Evaluation*, *10*. Retrieved from http://www.statsoft.com/textbook/

Council of Europe. (1998). *European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) CPT/Inf(98)12-part*. Retrieved from https://rm.coe.int/16806cd43e

Council of Europe. (2004). *Reccomendation No. REC(2004)10 of the Committee of*

Ministers to member States concerning the protection of the human rights and dignity of persons with mental disorder and its Explanatory Memorandum.

Council of Europe. (2018a). *Report to the Government of the United Kingdom on the visit to Northern Ireland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 29 August to 6 September 2017. CPT/Inf (2018) 4*. Retrieved from https://rm.coe.int/16806cd43e

Council of Europe. (2018b). *Report to the Polish Government on the visit to Poland carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 11 to 22 May 2017. CPT/Inf (2018) 39*.

CQC. (2017). *Brief guide: the use of 'blanket restrictions' in mental health wards*. Retrieved from https://www.cqc.org.uk/sites/default/files/20170109_briefguide-blanket-restrictions.pdf

Craik, C., Bryant, W., Ryan, A., Barclay, S., Brooke, N., Mason, A., & Russell, P. (2010). A qualitative study of service user experiences of occupation in forensic mental health. *Aust Occup Ther J*, *57*(5), 339–344. https://doi.org/10.1111/j.1440-1630.2010.00857.x

Creswell, J. W., & Clark, V. L. P. (2007). *Designing and conducting mixed methods research*. Thousand Oaks, CA, US: Sage Publications.

Crewe, B. (2007). Power, Adaptation and Resistance in a Late-Modern Men's Prison. *The British Journal of Criminology*, *47*(2), 256–275. https://doi.org/10.1093/bjc/azl044

Crewe, B. (2011). Depth, weight, tightness: Revisiting the pains of imprisonment. *Punishment & Society*, *13*(5), 509–529.

Crewe, B., Liebling, A., & Hulley, S. (2014). Heavy–light, absent–present: Rethinking the 'weight'of imprisonment. *The British Journal of Sociology*, *65*(3), 387–410.

Daffern, M. (2013). The impact of interpersonal style on aggression, therapeutic alliance and treatment non-completion in patients admitted to hospital for psychiatric treatment. *Australian and New Zealand Journal of Psychiatry*, *47*, 18. https://doi.org/http://dx.doi.org/10.1177/0004867412486854

Dancey, C. P., & Reidy, J. (2014). Statistics Without Maths for Psychology: Using Spss for Windows. *Prentice Hall (UK)*, 619. Retrieved from http://catalogue.pearsoned.co.uk/educator/product/Statistics-Without-Maths-for-Psychology/9780273774990.page

Davies, J. P., Heyman, B., Godin, P. M., Shaw, M. P., & Reynolds, L. (2006). The problems of offenders with mental disorders: a plurality of perspectives within a single mental health care organisation. *Soc Sci Med*, *63*(4), 1097–1108. https://doi.org/10.1016/j.socscimed.2006.03.002

De Valk, S., Kuiper, · C, Van Der Helm, · G H P, Maas, · A J J A, & Stams, · G J J M. (2018). Measuring Repression in Residential Youth Care: Conceptualization,

Development and Validation of the Institutional Repression Questionnaire. *Adolescent Research Review*, *0*, 3. https://doi.org/10.1007/s40894-018-0091-6

de Valk, S., Kuiper, C., van der Helm, G. H. P., Maas, A. J. J. A., & Stams, G. J. J. M. (2016). Repression in Residential Youth Care: A Scoping Review. *Adolescent Research Review*, *1*(3), 195–216. https://doi.org/10.1007/s40894-016-0029-9

de Valk, S., Kuiper, C., Van der Helm, G. H. P., Maas, A. J. J. A., & Stams, G. J. J. M. (2017). Repression in residential youth care: A qualitative study examining the experiences of adolescents in open, secure and forensic institutions. *Journal of Adolescent Research*, 1–26. https://doi.org/10.1177/0743558417719188

De Vos, H., & Gilbert, E. (2017). Freedom, so close but yet so far: The impact of the ongoing confrontation with freedom on the perceived severity of punishment. *European Journal of Probation*, *9*(2), 132–148. https://doi.org/10.1177/2066220317710393

de Vries, M. G., Brazil, I. A., van der Helm, P., Verkes, R. J., & Bulten, B. H. (2018). Ward Climate in a High-Secure Forensic Psychiatric Setting: Comparing Two Instruments. *International Journal of Forensic Mental Health*, *17*(3), 247–255. https://doi.org/10.1080/14999013.2018.1478915

de Vries Robbé, M. (2014). *Validation of the Structured Assessment of Protective Factors for Violence Risk in Forensic Psychiatry*. Retrieved from http://repository.ubn.ru.nl/bitstream/handle/2066/126440/126440.pdf

Deci, E. L., & Ryan, R. M. (2008). Self-determination theory: A macrotheory of human motivation, development, and health. *Canadian Psychology/Psychologie Canadienne*, *49*(3), 182–185. https://doi.org/10.1037/a0012801

Dein, K. E., Williams, P. S., Volkonskaia, I., Kanyeredzi, A., Reavey, P., & Leavey, G. (2016). Examining professionals' perspectives on sexuality for service users of a forensic psychiatry unit. *International Journal of Law and Psychiatry*, *44*, 15–23. https://doi.org/10.1016/j.ijlp.2015.08.027

Denzin, N., & Lincoln, Y. (2013). Introduction: Disciplining the Practice of Qualitative Research. In *Strategies of Qualitative Inquiry*. Retrieved from https://books.google.co.uk/books?hl=en&lr=&id=hD7W095U66cC&oi=fnd&pg=PR7&dq=Denzin+%26+Lincoln+().+The+discipline+and+practice+of+qualitative+research,+in+Strategies+of+qualitative+inquiry&ots=7X-eq7DlT_&sig=dT3XTROQ74tbIQ9DEGwE9HbOJyQ

Department of Health. (2010a). *High secure building design guide: Overarching principles for Ashworth, Broadmoor, Rampton Hospitals*. Retrieved from www.dh.gov.uk/en/Healthcare/Mentalhealth/Policy/mentalhealthsecureservice

Department of Health. (2010b). *See, Think, Act. Your guide to relational security*.

Department of Health. (2011). Environmental Design Guide Adult Medium Secure Services. Retrieved from

www.dh.gov.uk/en/Healthcare/Mentalhealth/Secureservices.index.htm

DeVellis, R. (2016). *Scale development: Theory and applications*. Retrieved from https://books.google.co.uk/books?hl=en&lr=&id=48ACCwAAQBAJ&oi=fnd&pg=PT14&dq=devellis+scale+development&ots=K-WMxeLbKs&sig=IVtoje9hJF8G3HwJ7xqRtlOPaaE

Di Lorito, C., Dening, T., & Völlm, B. (2018). Ageing in forensic psychiatric secure settings: the voice of older patients. *The Journal of Forensic Psychiatry & Psychology*, *29*(6), 934–960. https://doi.org/10.1080/14789949.2018.1513545

Dickens, G, Stubbs, J., Popham, R., & Haw, C. (2005). Smoking in a forensic psychiatric service: a survey of inpatients' views. *Journal of Psychiatric and Mental Health Nursing*, *12*(6), 672–678. https://doi.org/10.1111/j.1365-2850.2005.00892.x

Dickens, Geoffrey, Suesse, M., Snyman, P., & Picchioni, M. (2014). Associations between ward climate and patient characteristics in a secure forensic mental health service. *Journal of Forensic Psychiatry and Psychology*, *25*(2), 195–211. https://doi.org/10.1080/14789949.2014.903505

Dixon, J. (2015). Treatment, deterrence or labelling: mentally disordered offenders' perspectives on social control. *Sociol Health Illn*, *37*(8), 1299–1313. https://doi.org/10.1111/1467-9566.12313

DoH. (2015). *Mental Health Act 1983: Code of Practice*. Retrieved from www.tsoshop.co.uk

Dolan, M., & Millington, J. (2002). The influence of personality traits such as psychopathy on detained patients using the NHS complaints procedure in forensic settings. *Personality and Individual Differences*, *33*(6), 955–965. https://doi.org/10.1016/S0191-8869(01)00204-5

Drennan, G., Wooldridge, J., Aiyegbusi, A., Alred, D., Ayres, J., Barker, R., … Shepherd, G. (2014). Making Recovery a Reality in Forensic Settings, 1–28. Retrieved from https://www.nhsconfed.org/-/media/Confederation/Files/Publications/Documents/making-recovery-reality-forensic-settings.pdf

Elcock, S., & Lewis, J. (2016). Mechanical restraint: Legal, ethical and clinical issues. *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges.*, 315–331. https://doi.org/http://dx.doi.org/10.1007/978-3-319-26748-7_17

Enser, J., & MacInnes, D. (1999). The relationship between building design and escapes from secure units. *The Journal of the Royal Society for the Promotion of Health*, *119*(3), 170–174. https://doi.org/10.1177/146642409911900307

Ewington, J. (2016). Best practices for reducing the use of coercive measures. *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges.*, 285–314. https://doi.org/http://dx.doi.org/10.1007/978-3-319-26748-7_16

Fabrigar, L. R., Wegener, D. T., MacCallum, R. C., & Strahan, E. J. (1999).

Evaluating the use of exploratory factor analysis in psychological research. *Psychological Methods*, *4*(3), 272–299. https://doi.org/10.1037/1082-989X.4.3.272

Fazel, S., Gulati, G., Linsell, L., Geddes, J. R., & Grann, M. (2009). Schizophrenia and violence: systematic review and meta-analysis. *PLoS Med*, *6*(8), e1000120.

Feeley, M., & Simon, J. (1992). The new penology: Notes on the emerging strategy of corrections and its implications. *Criminology*. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1745-9125.1992.tb01112.x/full

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92.

Ferrito, M., Vetere, A., Adshead, G., & Moore, E. (2012). Life after homicide: Accounts of recovery and redemption of offender patients in a high security hospital - a qualitative study. *Journal of Forensic Psychiatry and Psychology*, *23*(3), 327–344. https://doi.org/http://dx.doi.org/10.1080/14789949.2012.668211

Fioritti, A. (2018). Is freedom (still) therapy? the 40th anniversary of the Italian mental health care reform. *Epidemiology and Psychiatric Sciences*, *27*(4), 319–323. https://doi.org/10.1017/S2045796017000671

Flesch, R. (1979). *How to write plain English: a book for lawyers and consumers*. (Harper Collins, Ed.). U.S.

Foucault, M. (1977). Discipline and punish: The birth of the prison.(Trans A. Sheridan). Retrieved from http://psycnet.apa.org/record/1980-70596-000

Furr, R. (2011). *Scale Construction and Psychometrics for Social and Personality Psychology*. *SAGE*. SAGE. https://doi.org/10.4135/9781446287866

Galappathie, N. (2015). Mental disorder and offending. In Geoffrey L Dickens, P. Sugarman, & M. Picchioni (Eds.), *Handbook of Secure Care* (pp. 15–26). London, United Kingdom: RC Pysch Publications.

Games, P. A., & Howell, J. F. (1976). Pairwise Multiple Comparison Procedures with Unequal N's and/or Variances: A Monte Carlo Study. *Journal of Educational Statistics*, *1*(2), 113–125. https://doi.org/10.3102/10769986001002113

Gardner, W., Hoge, S., & Bennett, N. (1993). Two scales for measuring patients' performance perceptions of coercion during hospital admission. *Behavioral Sciences and the Law*, *20*. https://doi.org/10.1002/bsl.2370110308

Garland, D. (2001). *The Culture of Control Crime and Social Order in Contemporary Society*. London: Oxford University Press. Retrieved from http://www.antoniocasella.eu/nume/Garland_control_2001.pdf

Ghasemi, A., & Zahediasl, S. (2012). Normality tests for statistical analysis: a guide for non-statisticians. *International Journal of Endocrinology and Metabolism*, *10*(2), 486–489. https://doi.org/10.5812/ijem.3505

Goffman, E. (1961). Asylums : essays on the social situation of mental patients and other inmates, 386.

Goshe, S. (2017). The lurking punitive threat: The philosophy of necessity and challenges for reform. *Theoretical Criminology*, 136248061771945. https://doi.org/10.1177/1362480617719450

Greene, J. (2006). Toward a methodology of mixed methods social inquiry. *Research in the Schools*, *13*(1). Retrieved from http://msera.org/docs/rits-v13n1-complete.pdf#page=100

Hammersley, M., & Atkinson, P. (1995). *Ethnography: Principles in practice* (2nd ed.).

Hannah-Moffat, K. (2005). Criminogenic needs and the transformative risk subject: Hybridizations of risk/need in penality. *Punishment & Society*, *7*(1), 29–51. https://doi.org/10.1177/1462474505048132

Hardesty, D., & Bearden, W. (2004). The use of expert judges in scale development: Implications for improving face validity of measures of unobservable constructs. *Journal of Business Research*, *57*(2), 98–107. https://doi.org/10.1016/S0148-2963(01)00295-8.

Hare Duke, L., Furtado, V., Guo, B., & Völlm, B. A. (2018). Long-stay in forensic-psychiatric care in the UK. *Social Psychiatry and Psychiatric Epidemiology*, *53*(3), 313–321. https://doi.org/10.1007/s00127-017-1473-y

Hare Duke, L., Furtado, V., Guo, B., Völlm, B. A., L., H. D., V., F., … Vollm, B. A. (2018). Long-stay in forensic-psychiatric care in the UK. *Social Psychiatry and Psychiatric Epidemiology*, *53*(3), 313–321. https://doi.org/http://dx.doi.org/10.1007/s00127-017-1473-y

Harty, M. A., Shaw, J., Thomas, S. D., Dolan, M., Davies, L., Thornicroft, G., … Jones, P. (2004). The security, clinical and social needs of patients in high security psychiatric hospitals in England. *Journal of Forensic Psychiatry and Psychology*, *15*(2), 208–221. https://doi.org/10.1080/14789940410001703967

Haw, C., & Stubbs, J. (2011). What are we doing about weight management in forensic psychiatry? A survey of forensic psychiatrists. *The British Journal of Forensic Practice*, *13*(3), 183–190. https://doi.org/http://dx.doi.org/10.1108/14636641111157823

Haw, C., Stubbs, J., Bickle, A., & Stewart, I. (2011). Coercive treatments in forensic psychiatry: A study of patients' experiences and preferences. *Journal of Forensic Psychiatry & Psychology*, *22*(4), 564–585. https://doi.org/http://dx.doi.org/10.1080/14789949.2011.602097

Hill, C. D., Rogers, R., & Bickford, M. E. (1996). *Maxi-mum Security Forensic Psychiatric Hospital*. *Journal of Forensic Sciences, JFSCA* (Vol. 41). Retrieved from https://compass.astm.org/download/JFS13897J.15341.pdf

Hilton, A., & Armstrong, R. (2006). Statnote 6: Post-hoc ANOVA tests. *Microbiologist*. Retrieved from https://research.aston.ac.uk/portal/en/researchoutput/statnote-6-posthoc-

anovatests(920c73af-ecb7-4213-b59f-725b6f6e4ab3).html

Hinkin, T. R. (1998). A brief tutorial on the development of measures for use in survey questionnaires. *Organizational Research Methods*, *1*(1), 104–121.

Hinton, P., Brownlow, C., & McMurray, L. (2014). *SPSS Explained* (2nd ed.). Routledge. Retrieved from https://content.taylorfrancis.com/books/download?dac=C2010-0-31792-X&isbn=9781315797298&format=googlePreviewPdf

Hirschi, T. (1969). *Causes of delinquency.* University of California Press. Retrieved from https://books.google.co.uk/books/about/Causes_of_Delinquency.html?id=53MNtMqy0fIC

Holmes, D. (2005). Governing the captives: forensic psychiatric nursing in corrections. *Perspect Psychiatr Care*, *41*(1), 3–13. Retrieved from http://onlinelibrary.wiley.com/store/10.1111/j.0031-5990.2005.00007.x/asset/j.0031-5990.2005.00007.x.pdf?v=1&t=iobm3bu7&s=dcbd859b2ea04f08e489bdfc7882ad52daab9252

Holmes, D., & Murray, S. J. (2011). Civilizing the "Barbarian": a critical analysis of behaviour modification programmes in forensic psychiatry settings. *J Nurs Manag*, *19*(3), 293–301. https://doi.org/10.1111/j.1365-2834.2011.01207.x

Horberg, U., Sjogren, R., & Dahlberg, K. (2012). To be strategically struggling against resignation: the lived experience of being cared for in forensic psychiatric care. *Issues Ment Health Nurs*, *33*(11), 743–751. https://doi.org/10.3109/01612840.2012.704623

Horvath, J., Steinert, T., & Jaeger, S. (2018). Antipsychotic treatment of psychotic disorders in forensic psychiatry: Patients' perception of coercion and its predictors. *International Journal of Law and Psychiatry*, *57*, 113–121. https://doi.org/http://dx.doi.org/10.1016/j.ijlp.2018.02.004

Howard, R., & Duggan, C. (2015). Personality Disorders: Their Relation to Offending. In D. A. Crighton & G. J. Towl (Eds.), *Forensic Psychology* (pp. 281–290). London, United Kingdom: Wiley-Blackwell.

Høyer, G., Kjellin, L., Engberg, M., Kaltiala-Heino, R., Nilstun, T., Sigurjónsdóttir, M., & Syse, A. (2002). Paternalism and autonomy: A presentation of a Nordic study on the use of coercion in the mental health care system. *International Journal of Law and Psychiatry*, *25*(2), 93–108. https://doi.org/10.1016/S0160-2527(01)00108-X

Hughes, J. A., & Sharrock, W. W. (1997). The philosophy of social research.

Hui, A. (2017). *Least restrictive practices: an evaluation of patient experiences*. University of Nottingham. Retrieved from http://eprints.nottingham.ac.uk/48816/

Hui, A., Middleton, H., & Vollm, B. (2013). Coercive measures in forensic settings: Findings from the literature. *The International Journal of Forensic Mental Health*, *12*(1), 53–67.

https://doi.org/http://dx.doi.org/10.1080/14999013.2012.740649

Ireland, C. A., Halpin, L., & Sullivan, C. (2014). Critical incidents in a forensic psychiatric population: An exploratory study of motivational factors. *Journal of Forensic Psychiatry & Psychology*, *25*(6), 714–732. https://doi.org/http://dx.doi.org/10.1080/14789949.2014.955809

Jacobson, N., & Greenley, D. (2001). What Is Recovery? A Conceptual Model and Explication. *Psychiatric Services*, *52*(4), 482–485. https://doi.org/10.1176/appi.ps.52.4.482

JCPMH. (2013). *Guidance for commissioners of forensic mental health services: Joint Commissioning Panel on Mental Health*. Retrieved from www.jcpmh.info

Jeglic, E. L., Vanderhoff, H. A., & Donovick, P. J. (2005). The Function of Self-Harm Behavior in a Forensic Population. *International Journal of Offender Therapy and Comparative Criminology*, *49*(2), 131–142. https://doi.org/10.1177/0306624X04271130

Jewkes, Y., & Johnston, H. (2006). *Prison readings : a critical introduction to prisons and imprisonment*. Willan.

Johnson, R., Onwuegbuzie, A., & Turner, L. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research*, *1*(2), 112–133.

Jones, K., & Fowles, A. J. (1984). *Ideas on Institutions: Analysing the Literature on Long-term Care and Custody*. Routledge & Kegan Paul. Retrieved from https://books.google.co.uk/books?id=Pq49AAAAIAAJ

Jordan, M. (2012). *Prison mental health: context is crucial: a sociological exploration of male prisoners' mental health and the provision of mental healthcare in a prison setting.* University of Nottingham.

Jung, S., & Lee, S. (2011). Exploratory factor analysis for small samples. *Behavior Research Methods*, *43*(3), 701–709. https://doi.org/10.3758/s13428-011-0077-9

Kallert, T. W., GlÖCkner, M., Onchev, G., Raboch, J., Karastergiou, A., Solomon, Z., … Kjellin, L. (2005). The EUNOMIA project on coercion in psychiatry: study design and preliminary data. *World Psychiatry*, *4*(3), 168–172. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1414770/

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health*, *78*(3), 458–467. https://doi.org/10.1093/jurban/78.3.458

Keefe, R. S. E., & Fenton, W. S. (2007). How should DSM-V criteria for schizophrenia include cognitive impairment? In *Schizophrenia Bulletin* (Vol. 33, pp. 912–920). https://doi.org/10.1093/schbul/sbm046

Kennedy, H. G. (2002). Therapeutic uses of security: Mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment*, *8*(6), 433–443. https://doi.org/10.1192/apt.8.6.433

King, G., Keohane, R. O. (Robert O., & Verba, S. (1994). *Designing social inquiry: scientific inference in qualitative research*. Retrieved from

https://press.princeton.edu/titles/5458.html

Kjellin, L., Høyer, G., Engberg, M., Kaltiala-Heino, R., & Sigurjónsdóttir, M. (2006). Differences in perceived coercion at admission to psychiatric hospitals in the Nordic countries. *Social Psychiatry and Psychiatric Epidemiology*, *41*(3), 241–247. https://doi.org/10.1007/s00127-005-0024-0

Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: the case for reflexivity. *Journal of Advanced Nursing*, *28*(4), 882–890. https://doi.org/10.1046/j.1365-2648.1998.00725.x

Kvale, S. (2008). *Doing interviews*. Sage.

Lammy, D. (2017). *The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/643001/lammy-review-final-report.pdf

Larkin, M, Clifton, E., & de Visser, R. (2009). Making sense of "consent" in a constrained environment. *Int J Law Psychiatry*, *32*(3), 176–183. https://doi.org/10.1016/j.ijlp.2009.02.003

Larkin, Michael, Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*. https://doi.org/10.1191/1478088706qp062oa

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *The British Journal of Psychiatry*, *199*(6), 445–452.

Lewis, S., Crawford, A., & Traynor, P. (2016). Nipping Crime in the Bud? The Use of Antisocial Behaviour Interventions with Young People in England and Wales. *British Journal of Criminology*, azw072. https://doi.org/10.1093/bjc/azw072

Litosseliti, L. (2003). *Using focus groups in research*. A&C Black.

Livingston, J. D., Crocker, A. G., Nicholls, T. L., & Seto, M. C. (2016). Forensic mental health tribunals: A qualitative study of participants' experiences and views. *Psychology, Public Policy, and Law*, *22*(2), 173–184. https://doi.org/http://dx.doi.org/10.1037/law0000084

Loader, I., & Sparks, R. (2004). For an historical sociology of crime policy in England and Wales since 1968. *Critical Review of International Social and Political Philosophy*, *7*(2), 5–32. https://doi.org/10.1080/1369823042000266495

Loevinger, J. (1957). Objective Tests as Instruments of Psychological Theory. *Psychological Reports*, *3*(3), 635–694. https://doi.org/10.2466/pr0.1957.3.3.635

Long, C. G., Anagnostakis, K., Fox, E., Silaule, P., Somers, J., West, R., & Webster, A. (2011). Social climate along the pathway of care in women's secure mental health service: Variation with level of security, patient motivation, therapeutic alliance and level of disturbance. *Criminal Behaviour and Mental Health*, *21*(3),

202–214. https://doi.org/10.1002/cbm.791

Long, C., & Shine, J. (2015). Specialist psychological treatment programmes in secure mental healthcare. In G. L. Dickens, P. Sugarman, & M. Picchioni (Eds.), *Handbook of secure care*. London, United Kingdom: RC Pysch Publications.

Luyt, R. (2012). A framework for mixing methods in quantitative measurement development, validation, and revision: A case study. *Journal of Mixed Methods Research*, *6*(4), 294–316.

Lynn, P. (2016). Principles of Sampling. In T. Greenfield & S. Greener (Eds.), *Research methods for postgraduates*. Retrieved from https://ebookcentral.proquest.com/lib/nottingham/reader.action?docID=4644084&ppg=268

MacCall, C. A. (2017). Drug testing in forensic mental health settings. *Addiction*, *112*(4), 729–730. https://doi.org/http://dx.doi.org/10.1111/add.13727

MacCallum, R. C., Widaman, K. F., Zhang, S. B., & Hong, S. H. (1999). Sample Size in Factor Analysis. *Psychological Methods*, *4*(1), 84–99. https://doi.org/10.1037/1082-989x.4.1.84

MacInnes, D., Beer, D., Keeble, P., Rees, D., & Reid, L. (2010). The development of a tool to measure service user satisfaction with in-patient forensic services: The Forensic Satisfaction Scale. *Journal of Mental Health (Abingdon, England)*, *19*(3), 272–281. https://doi.org/10.3109/09638231003728133

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The Lancet*, *358*(9280), 483–488.

Mann, B., Matias, E., & Allen, J. (2014). Recovery in forensic services: Facing the challenge. *Advances in Psychiatric Treatment*, *20*(2), 125–131. https://doi.org/10.1192/apt.bp.113.011403

Markham, S. (2018). Red-teaming the panopticon* (mobilising adaptive change in secure and forensic settings). *Journal of Forensic Psychiatry and Psychology*, *29*(1), 16–36. https://doi.org/http://dx.doi.org/10.1080/14789949.2017.1335761

Mason, J. (2002). Qualitative researching.

Mat, A., Hoare, T., McCarran, P., Kennedy, H. G., & O'Shea, D. (2014). The prevalence of obesity and metabolic syndrome among inpatients at a forensic psychiatric hospital in the Republic of Ireland. *Irish Journal of Medical Science*, *1)*, S461. https://doi.org/http://dx.doi.org/10.1007/s11845-014-1186-0

Mathias, K., & Hirdes, J. P. (2015). Gender differences in the rate of restriction to room among Ontario forensic patients. *Healthc Manage Forum*, *28*(4), 157–162. https://doi.org/10.1177/0840470415581232

Matthews, R. (2005). The myth of punitiveness. *Theoretical Criminology*, *9*(2), 175–201. https://doi.org/10.1177/1362480605051639

Mbuba, J. M. (2012). Lethal Rejection. *The Prison Journal*, *92*(2), 231–252.

https://doi.org/10.1177/0032885512439009

McKeown, M., Jones, F., Wright, K., Spandler, H., Wright, J., Fletcher, H., … Turton, W. (2014). It's the talk: a study of involvement initiatives in secure mental health settings. *Health Expect*. https://doi.org/10.1111/hex.12232

Mercer, D., & Perkins, L. (2014). Theorising sexual media and sexual violence in a forensic setting: men's talk about pornography and offending. *Int J Law Psychiatry*, *37*(2), 174–182. https://doi.org/10.1016/j.ijlp.2013.11.003

Messick, S. (1995). Validity of psychological assessment: Validation of inferences from persons' responses and performances as scientific inquiry into score meaning. *American Psychologist*, *50*(9), 741–749. https://doi.org/10.1037/0003-066X.50.9.741

Mezey, G., Kavuma, M., Turton, P., Demetriou, A., & Wright, C. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *Journal of Forensic Psychiatry & Psychology*, *21*(5), 683–696. https://doi.org/http://dx.doi.org/10.1080/14789949.2010.489953

Mezey, G., Youngman, H., Kretzschmar, I., & White, S. (2016). Stigma and discrimination in mentally disordered offender patients – a comparison with a non-forensic population. *Journal of Forensic Psychiatry and Psychology*, *27*(4), 517–529. https://doi.org/10.1080/14789949.2016.1172658

Milsom, S. A., Freestone, M., Duller, R., Bouman, M., & Taylor, C. (2014). Factor structure of the Essen Climate Evaluation Schema measure of social climate in a UK medium-security setting. *Criminal Behaviour and Mental Health*, *24*(2), 86–99. https://doi.org/10.1002/cbm.1878

Mohan, D., Jamieson, E., & Taylor, P. J. (2001). The use of trial leave for restricted special hospital patients. *Crim Behav Ment Health*, *11*(1), 55–62. Retrieved from http://onlinelibrary.wiley.com/store/10.1002/cbm.369/asset/369_ftp.pdf?v=1&t=iobm8ico&s=3b7c715a5cd92445bc875051e30a0e7f16f45df5

Murphy, P., Potter, L., Tully, J., Hearn, D., Fahy, T., & McCrone, P. (2017). A cost comparison study of using global positioning system technology (electronic monitoring) in a medium secure forensic psychiatric service. *Journal of Forensic Psychiatry and Psychology*, *28*(1), 57–69. https://doi.org/10.1080/14789949.2016.1261172

Ness, P., & Fusch, L. (2015). Are We There Yet? Data Saturation in Qualitative Research. *The Qualitative Report*, *20*(9), 1409–1416. Retrieved from http://www.nova.edu/ssss/QR/QR20/9/fusch1.pdf

Newton-Howes, G., & Banks, D. (2014). The subjective experience of community treatment orders: patients' views and clinical correlations. *The International Journal of Social Psychiatry*, *60*(5), 474–481. https://doi.org/http://dx.doi.org/10.1177/0020764013498870

Ng, J. Y. Y., Duda, J. L., Ryan, R. M., Thøgersen-Ntoumani, C., Deci, E. L., Williams, G. C., & Ntoumanis, N. (2012). Self-Determination Theory Applied to Health Contexts. *Perspectives on Psychological Science*, *7*(4), 325–340. https://doi.org/10.1177/1745691612447309

NHS England. (2015). *C02/S/a 2014/15 NHS STANDARD CONTRACT FOR HIGH SECURE MENTAL HEALTH SERVICES (ADULTS*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2013/06/c02-high-sec-mh.pdf

NHS England. (2017). *MH3 Reducing Restrictive Practices within Adult Low and Medium Secure Services*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/11/mh3-reduc-restrictive-practices.pdf

NHS England. (2018a). *Service specification: low secure mental health services (Adult)*. Retrieved from https://www.england.nhs.uk/publication/service-specification-low-secure-mental-health-services-adult/

NHS England. (2018b). *Service specification: medium secure mental health services (Adult)*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2018/03/adult-medium-secure-service-specification-v3.pdf

NICE. (2011). *Service user experience in adult mental health services: Quality standard*. Retrieved from https://www.nice.org.uk/guidance/qs14

NICE. (2015). Violence and aggression: short-term management in mental health, health and community settings | Guidance and guidelines | NICE. *NICE Guidedance*, *NG10*.

Nieuwenhuizen, C. Van, Schene, A. H., & Koeter, M. W. J. (2002). Quality of life in forensic psychiatry: an unreclaimed territory? *International Review of Psychiatry*, *14*(3), 198–202. https://doi.org/10.1080/09540260220144993

O' Sullivan, M., Boulter, S., & Black, G. (2013). Lived experiences of recalled mentally disordered offenders with dual diagnosis: A qualitative phenomenological study. *Journal of Forensic Psychiatry & Psychology*, *24*(3), 403–420. https://doi.org/http://dx.doi.org/10.1080/14789949.2013.795238

O'Connell, M., Farnworth, L., & Hanson, E. C. (2010). Time use in forensic psychiatry: A naturalistic inquiry into two forensic patients in Australia. *The International Journal of Forensic Mental Health*, *9*(2), 101–109. https://doi.org/http://dx.doi.org/10.1080/14999013.2010.499558

Oakley, C., Mason, F., Delmage, E., & Exworthy, T. (2013). A right to be fat? A survey of weight management in medium secure units. *Journal of Forensic Psychiatry & Psychology*, *24*(2), 205–214. https://doi.org/http://dx.doi.org/10.1080/14789949.2013.771279

Office for National Statistics. (2012). Ethnicity and National Identity in England and Wales. *Office for National Statistics*, (December), 1–15. Retrieved from https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/ethnicityandnationalidentityinenglandandwales/2012-12-11

Onwuegbuzie, A. (2012). Introduction: Putting the MIXED back into quantitative and qualitative research in educational research and beyond: Moving toward the radical middle. *International Journal of Multiple Research Approaches*, *6*(3), 192–219.

Onwuegbuzie, A., & Dickinson, W. (2009). A qualitative framework for collecting and analyzing data in focus group research. *Journal of Qualitative …*. Retrieved

from http://journals.sagepub.com/doi/abs/10.1177/160940690900800301

Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in Qualitative Research. *Journal of Nursing Scholarship*, *33*(1), 93–96. https://doi.org/10.1111/j.1547-5069.2001.00093.x

Pagden, A. (2013). *The Enlightenment: and why it still matters*. Oxford University Press.

Parrott, F. (2005). "It's Not Forever": The Material Culture of Hope. *Journal of Material Culture*, *10*(3), 245–262. https://doi.org/http://dx.doi.org/10.1177/1359183505057151

Parrott, F. (2010). "Real relationships": sociable interaction, material culture and imprisonment in a secure psychiatric unit. *Cult Med Psychiatry*, *34*(4), 555–570. https://doi.org/10.1007/s11013-010-9188-5

Parrott, F., Macinnes, D., & Parrott, J. (2015). Mental illness and parenthood: being a parent in secure psychiatric care. *Crim Behav Ment Health*, *25*(4), 258–272. https://doi.org/10.1002/cbm.1948

Pervin, L. A. (1984). *Personality: Theory and Research*. Wiley. Retrieved from https://books.google.co.uk/books/about/Personality.html?id=ESERAQAAIAAJ&redir_esc=y

Pouncey, C. L., & Lukens, J. M. (2013). Madness versus badness: The ethical tension between the recovery movement and forensic psychiatry. In *Applied ethics in mental health care: An interdisciplinary reader* (pp. 237–253). Cambridge, MA: MIT Press; US. https://doi.org/http://dx.doi.org/10.7551/mitpress/9780262019682.003.0017

Prebble, K., Kidd, J., O'Brien, A., Carlyle, D., McKenna, B., Crowe, M., … Gooder, C. (2011). Implementing and maintaining nurse-led healthy living programs in forensic inpatient settings: an illustrative case study. *J Am Psychiatr Nurses Assoc*, *17*(2), 127–138. https://doi.org/10.1177/1078390311399094

Puzzo, I., Aldridge-Waddon, L., Bush, E., & Farr, C. (2018). The Relationship Between Ward Social Climate, Ward Sense of Community, and Incidents of Disruptive Behavior: A Study of a High Secure Psychiatric Sample. *International Journal of Forensic Mental Health*. https://doi.org/10.1080/14999013.2018.1532972

Quinn, C, & Happell, B. (2015). Consumer sexual relationships in a forensic mental health hospital: perceptions of nurses and consumers. *Int J Ment Health Nurs*, *24*(2), 121–129. https://doi.org/10.1111/inm.12112

Quinn, Chris, & Happell, B. (2016). Supporting the Sexual Intimacy Needs of Patients in a Longer Stay Inpatient Forensic Setting. *Perspectives in Psychiatric Care*, *52*(4), 239–247. https://doi.org/10.1111/ppc.12123

Ranjit, B. (2016). Can the use of the Mental Health Act be the "Least Restrictive" approach for psychiatric in-patients? *International Journal of Mental Health and Capacity Law*, *22*, 51–56. Retrieved from http://www.northumbriajournals.co.uk/index.php/IJMHMCL/article/view/551/

Raykov, T., & Marcoulides, G. A. (2011). *Introduction to psychometric theory*. Routledge.

Reavey, P., Brown, S. D., Kanyeredzi, A., McGrath, L., & Tucker, I. (2019). Agents and spectres: Life-space on a medium secure forensic psychiatric unit. *Social Science and Medicine*, *220*(June 2018), 273–282. https://doi.org/http://dx.doi.org/10.1016/j.socscimed.2018.11.012

Redelmeier, D. A., & Kahneman, D. (1996). Patients' memories of painful medical treatments: real-time and retrospective evaluations of two minimally invasive procedures. *Pain*, *66*(1), 3–8. https://doi.org/10.1016/0304-3959(96)02994-6

Reed, J. (1997). The need for longer term psychiatric care in medium or low security. *Criminal Behaviour and Mental Health*, *7*(3), 201–212. https://doi.org/10.1002/cbm.173

Rees, G., & Reed, J. (2016). Patients or prisoners ? Time to reconsider the voting rights of mentally disordered offenders. *BJPsych*, 169–172. https://doi.org/10.1192/pb.bp.115.050781

Repo-Tiihonen, E., Vuorio, O., Koivisto, H., Paavola, P., & Hakola, P. (2004). Opinions About Treatment Modalities Among Patients Involuntarily Committed to a Forensic Psychiatric Hospital in Finland. *Journal of Offender Rehabilitation*, *38*(3), 81–95. https://doi.org/http://dx.doi.org/10.1300/J076v38n03_06

Ritzer, G., & Stepnisky, J. (2017). *Modern sociological theory*. SAGE Publications.

Rose, N. (1998). Governing risky individuals: The role of psychiatry in new regimes of control. *Psychiatry, Psychology and Law*, *5*(2), 177–195. https://doi.org/10.1080/13218719809524933

Ruane, J., & Hayter, M. (2008). Nurses' attitudes towards sexual relationships between patients in high security psychiatric hospitals in England: an exploratory qualitative study. *Int J Nurs Stud*, *45*(12), 1731–1741. https://doi.org/10.1016/j.ijnurstu.2008.06.003

Rubin, A. T. (2016). Resistance as Agency? Incorporating the Structural Determinants of Prisoner Behaviour. *British Journal of Criminology*, *57*(3), azw003. https://doi.org/10.1093/bjc/azw003

Rutherford, A. (2006). Dangerous people: beginnings of a New Labour proposal. Retrieved from https://eprints.soton.ac.uk/27906/

Rutherford, M., & Duggan, S. (2008). Forensic mental health services: facts and figures on current provision. *The British Journal of Forensic Practice*, *10*(4), 4–10. https://doi.org/10.1108/14636646200800020

Ruxton, G. D. (2006). The unequal variance t-test is an underused alternative to Student's t-test and the Mann–Whitney U test. *Behavioral Ecology*, *17*(4), 688–690. https://doi.org/10.1093/beheco/ark016

Ryan, K. E., Gandha, T., Culbertson, M. J., & Carlson, C. (2014). Focus Group

Evidence: Implications for Design and Analysis. *American Journal of Evaluation*, *35*(3), 328–345. https://doi.org/10.1177/1098214013508300

Salize, H., Dreßing, H., & Peitz, M. (2002). *Compulsory admission and involuntary treatment of mentally ill patients-legislation and practice in EU-member states*. *Central Institute of Mental Health Research Project Final Report*. Retrieved from http://www.mentalhealthalliance.org.uk/pre2007/documents/salize.pdf

Schalast, N., Redies, M., Collins, M., Stacey, J., & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health*, *18*(1), 49–58. https://doi.org/10.1002/cbm.677

Schel, S. H. H., Bouman, Y. H. A., Vorstenbosch, E. C. W., & Bulten, B. H. (2017). Development of the forensic inpatient quality of life questionnaire: short version (FQL-SV). *Quality of Life Research*, *26*(5), 1153–1161. https://doi.org/10.1007/s11136-016-1461-9

Schutz, A. (1953). *Common-Sense and Scientific Interpretation of Human Action*. *Source: Philosophy and Phenomenological Research* (Vol. 14).

Schutz, A. (1962). Concept and Theory Formation in the Social Sciences. In *The Problem of Social Reality: Collected Papers I* (pp. 48–66). Springer, Dordrecht. https://doi.org/10.1007/978-94-010-2851-6_2

Scott, S. (2010). Revisiting the total institution: Performative regulation in the reinventive institution. *Sociology*, *44*(2), 213–231. https://doi.org/10.1177/0038038509357198

Seppänen, A., Törmänen, I., Shaw, C., & Kennedy, H. (2018). Modern forensic psychiatric hospital design: Clinical, legal and structural aspects. *International Journal of Mental Health Systems*, *12*(1), 58. https://doi.org/10.1186/s13033-018-0238-7

Sexton, L. (2015). Penal subjectivities: Developing a theoretical framework for penal consciousness. *Punishment & Society*, *17*(1), 114–136. https://doi.org/10.1177/1462474514548790

Shapland, J. (1984). Victims, the criminal justice system and compensation. *British Journal of Criminology*, *24*(2), 131–149. https://doi.org/10.1093/oxfordjournals.bjc.a047436

Shearing, C., & Stenning, P. (1997). From the Panopticon to Disney World: The Development of Discipline. In *Perspectives in Criminal Law: Essays in Honour of John LL.J. Edwards* (pp. 300–304). Retrieved from http://www.popcenter.org/problems/crimes_against_tourists/PDFs/Shearing_Stenning_1997.pdf

Shingala, M. C., & Rajyaguru, A. (2015). Comparison of Post Hoc Tests for Unequal Variance. *International Journal of New Technologies in Science and Engineering*, *2*(5), 2349–2780. Retrieved from http://www.ijntse.com/upload/1447070311130.pdf

Silva, M. (1995). Ethical guidelines in the conduct, dissemination, and

implementation of nursing research.

Silverman, D. (2015). *Interpreting qualitative data*. Sage.

Simon, J. (1998). Managing the monstrous: Sex offenders and the new penology. *Psychology, Public Policy, and Law*, *4*(1–2), 452–467. https://doi.org/10.1037/1076-8971.4.1-2.452

Simpson, A. I. F., & Penney, S. R. (2011). The recovery paradigm in forensic mental health services. *Criminal Behaviour and Mental Health*, *21*(5), 299–306. https://doi.org/10.1002/cbm.823

Simpson, A. I. F., & Penney, S. R. (2018). Recovery and forensic care: Recent advances and future directions. *Criminal Behaviour and Mental Health*. https://doi.org/10.1002/cbm.2090

Slobogin, C., & Fondacaro, M. (2000). Rethinking deprivations of liberty: possible contributions from therapeutic and ecological jurisprudence. *Behav Sci Law*, *18*(4), 499–516.

Soininen, P., Kontio, R., Joffe, G., & Putkonen, H. (2016). Patient experience of coercive measures. *The Use of Coercive Measures in Forensic Psychiatric Care: Legal, Ethical and Practical Challenges.*, 255–270. https://doi.org/http://dx.doi.org/10.1007/978-3-319-26748-7_14

Steinau, S., Brackmann, N., Sternemann, U., Biller-Andorno, N., & Habermeyer, E. (2018). Conflicting Priorities Between Risk Management and Treatment of Schizophrenia in Swiss Forensic Services—A Case Report. *Frontiers in Psychiatry*, *9*(December), 1–5. https://doi.org/10.3389/fpsyt.2018.00680

Streiner, D. L., & Norman, G. R. (2008). *Health Measurement Scales*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199231881.001.0001

Sugarman, P., & Dickens, G. (2015). The evolution of secure and forensic mental health care. *Handbook of Secure Care*. Retrieved from https://www.researchgate.net/profile/Geoffrey_Dickens/publication/280600949_The_evolution_of_secure_and_forensic_mental_healthcare/links/55bd43a608ae092e96638668.pdf

Sustere, E., & Tarpey, E. (2019, January 20). Least restrictive practice: its role in patient independence and recovery. *Journal of Forensic Psychiatry and Psychology*, pp. 1–16. https://doi.org/10.1080/14789949.2019.1566489

Swinton, M., Oliver, J., & Carlisle, J. (1999). Measuring Quality of Life in Secure Care: Comparison of Mentally Ill and Personality Disordered Patients. *International Journal of Social Psychiatry*, *45*(4), 284–291. https://doi.org/10.1177/002076409904500407

Szmukler, G. (2015, October). Compulsion and "coercion" in mental health care. *World Psychiatry*, *14*(3), 259–261. https://doi.org/10.1002/wps.20264

Tabachnick, B. G., & Fidell, L. S. (2013). *Using Multivariate Statistics*. *Harper Collins* (6th ed.). New Jersey: Pearson. https://doi.org/10.1037/022267

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences*. Sage Publications Inc.

The Mental Health Taskforce. (2016). *The Five Year Forward View for Mental Health*. Retrieved from https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf

The Prison Reform Trust. (2018). *Prison: The Facts. Bromley Briefings Summer 2018*. https://doi.org/10.1016/j.envint.2016.01.019

Thomson, L. D. G., Bogue, J. P., Humphreys, M. S., & Johnstone, E. C. (2001). A survey of female patients in high security psychiatric care in Scotland. *Criminal Behaviour and Mental Health*, *11*(2), 86–93. https://doi.org/10.1002/cbm.373

Tingleff, E. B., Hounsgaard, L., Bradley, S. K., & Gildberg, F. A. (2018). Forensic psychiatric patients' perceptions of situations associated with mechanical restraint: A qualitative interview study. *International Journal of Mental Health Nursing*. https://doi.org/10.1111/inm.12549

Tiwana, R., McDonald, S., & Vollm, B. (2016). Policies on sexual expression in forensic psychiatric settings in different European countries. *Int J Ment Health Syst*, *10*, 5. https://doi.org/10.1186/s13033-016-0037-y

To, W. T., Vanheule, S., De Smet, S., & Vandevelde, S. (2015). The Treatment Perspectives of Mentally Ill Offenders in Medium- and High-Secure Forensic Settings in Flanders. *Int J Offender Ther Comp Criminol*, *59*(14), 1605–1622. https://doi.org/10.1177/0306624x14566355

Tomlin, J., Bartlett, P., & Völlm, B. (2018). Experiences of restrictiveness in forensic psychiatric care: Systematic review and concept analysis. *International Journal of Law and Psychiatry*, *57*, 31–41. https://doi.org/http://dx.doi.org/10.1016/j.ijlp.2017.12.006

Tonkin, M. (2016). A Review of Questionnaire Measures for Assessing the Social Climate in Prisons and Forensic Psychiatric Hospitals. *International Journal of Offender Therapy and Comparative Criminology*, *60*(12), 1376–1405. https://doi.org/10.1177/0306624X15578834

Urheim, R., Rypdal, K., Palmstierna, T., & Mykletun, A. (2011). Patient autonomy versus risk management: A case study of change in a high security forensic psychiatric ward. *The International Journal of Forensic Mental Health*, *10*(1), 41–51. https://doi.org/http://dx.doi.org/10.1080/14999013.2010.550983

van der Helm, P., Stams, G. J., & van der Laan, P. (2011). Measuring group climate in prison. *The Prison Journal*, *91*(2), 158–176. https://doi.org/http://dx.doi.org/10.1177/0032885511403595

Vincze, M., Fredriksson, L., & Wiklund Gustin, L. (2015). To do good might hurt bad: exploring nurses' understanding and approach to suffering in forensic psychiatric settings. *Int J Ment Health Nurs*, *24*(2), 149–157. https://doi.org/10.1111/inm.12116

Völlm, B., Bartlett, P., & McDonald, R. (2016). Ethical issues of long-term forensic psychiatric care. *Ethics, Medicine and Public Health*, *2*(1), 36–44.

https://doi.org/10.1016/j.jemep.2016.01.005

Vorstenbosch, E. C., Bouman, Y. H., Braun, P. C., & Bulten, E. B. (2014). Psychometric properties of the forensic inpatient quality of life questionnaire: quality of life assessment for long-term forensic psychiatric care. *Health Psychol Behav Med*, *2*(1), 335–348. https://doi.org/10.1080/21642850.2014.894890

Wacquant, L. (2010). Crafting the Neoliberal State: Workfare, Prisonfare, and Social Insecurity1. *Sociological Forum*, *25*(2), 197–220. https://doi.org/10.1111/j.1573-7861.2010.01173.x

Walker, L., & Avant, K. (2011). *Strategies for theory construction in nursing* (5th ed.). Retrieved from https://www.pearsonhighered.com/assets/preface/0/1/3/4/0134754077.pdf

Warburton, K. D. (2016). A new standard of care for forensic mental health treatment: Prioritizing forensic intervention. *Violence in Psychiatry.*, 252–257. Retrieved from http://ovidsp.ovid.com/ovidweb.cgi?T=JS&PAGE=reference&D=psyc13a&NEWS=N&AN=2016-09977-024

Ward, T., & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime & Law*, *10*(3), 243–257. https://doi.org/10.1080/10683160410001662744

Wessely, S. (2018). *Modernising the Mental Health Act: Increasing choice, reducing compulsion. Final report of the Independent Review of the Mental Health Act 1983*. Retrieved from www.gov.uk/dhsc

Whitehead, E., & Mason, T. (2006). Assessment of risk and special observations in mental health practice: a comparison of forensic and non-forensic settings. *Int J Ment Health Nurs*, *15*(4), 235–241. https://doi.org/10.1111/j.1447-0349.2006.00429.x

Wilkie, T., Penney, S. R., Fernane, S., & Simpson, A. I. F. (2014). Characteristics and motivations of absconders from forensic mental health services: a case-control study. *BMC Psychiatry*, *14*(1), 1–13. https://doi.org/10.1186/1471-244x-14-91

World Health Organization. (1953). *Expert Committee on Mental Health : third report [of a meeting held in Geneva, 24-29 November 1952].*

Appendices

Appendix A. Systematic Review Search Terms

Pubmed:

((restrict* or coerc* or coers* or restrain* or repress* or freedom* or libert* or autonom* or involuntar* or constrain* or constrict* or self determin*) and (mental health or mental illness or mental disorder* or mentally ill or mentally unwell or mentally disordered or psychiatry or psychology or psychiatrist* or psychologist* or psychiatric) and (forensic or secur* or offen* or crim*))

Medline:

((restrict* or coerc* or coers* or restrain* or repress* or freedom* or libert* or autonom* or involuntar* or constrain* or constrict* or self-determin* or self determin*) and (mental health or mental illness or mental disorder* or mentally ill or mentally unwell or mentally disordered or psychiatry or psychology or psychiatrist* or psychologist* or psychiatric) and forensic).mp. [mp=title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms]

Cochrane Review:

"#1 - ((restrict* or coerc* or coers* or restrain* or repress* or freedom* or libert* or autonom* or involuntar* or constrain* or constrict* or self-determin* or self determin*) and (mental health or mental illness or mental disorder* or mentally ill or mentally unwell or mentally disordered

or psychiatry or psychology or psychiatrist* or psychologist* or psychiatric) and (forensic))”’

Embase:

((restrict* or coerc* or coers* or restrain* or repress* or freedom* or libert* or autonom* or involuntar* or constrain* or constrict* or self-determin* or self determin*) and (mental health or mental illness or mental disorder* or mentally ill or mentally unwell or mentally disordered or psychiatry or psychology or psychiatrist* or psychologist* or psychiatric) and forensic).mp. [mp=title, abstract, heading word, drug trade name, original title, device manufacturer, drug manufacturer, device trade name, keyword, floating subheading word, candidate term word]

PsychINFO:

((restrict* or coerc* or coers* or restrain* or repress* or freedom* or libert* or autonom* or involuntar* or constrain* or constrict* or self-determin* or self determin*) and (mental health or mental illness or mental disorder* or mentally ill or mentally unwell or mentally disordered or psychiatry or psychology or psychiatrist* or psychologist* or psychiatric) and forensic).mp. [mp=title, abstract, heading word, table of contents, key concepts, original title, tests & measures]

West Law:

Free Text = = = restrict* OR freedom OR coerc* OR autonom* & = mental* OR psych* & = forensic

Content type = Journals

Google scholar:

First 150 hits

restrict AND mental AND forensic

restrict AND psych AND forensic

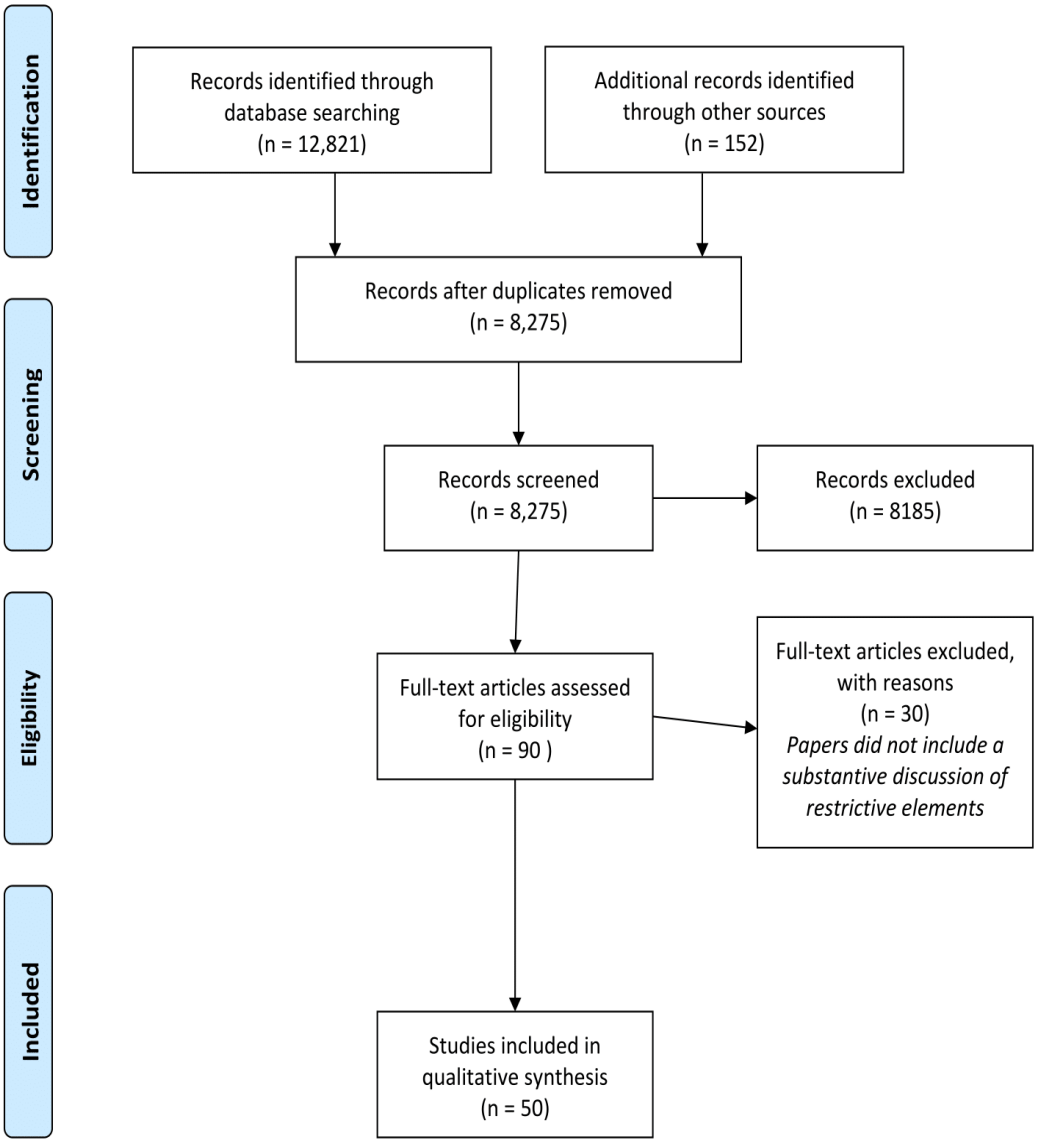
Google search:

First 150 hits

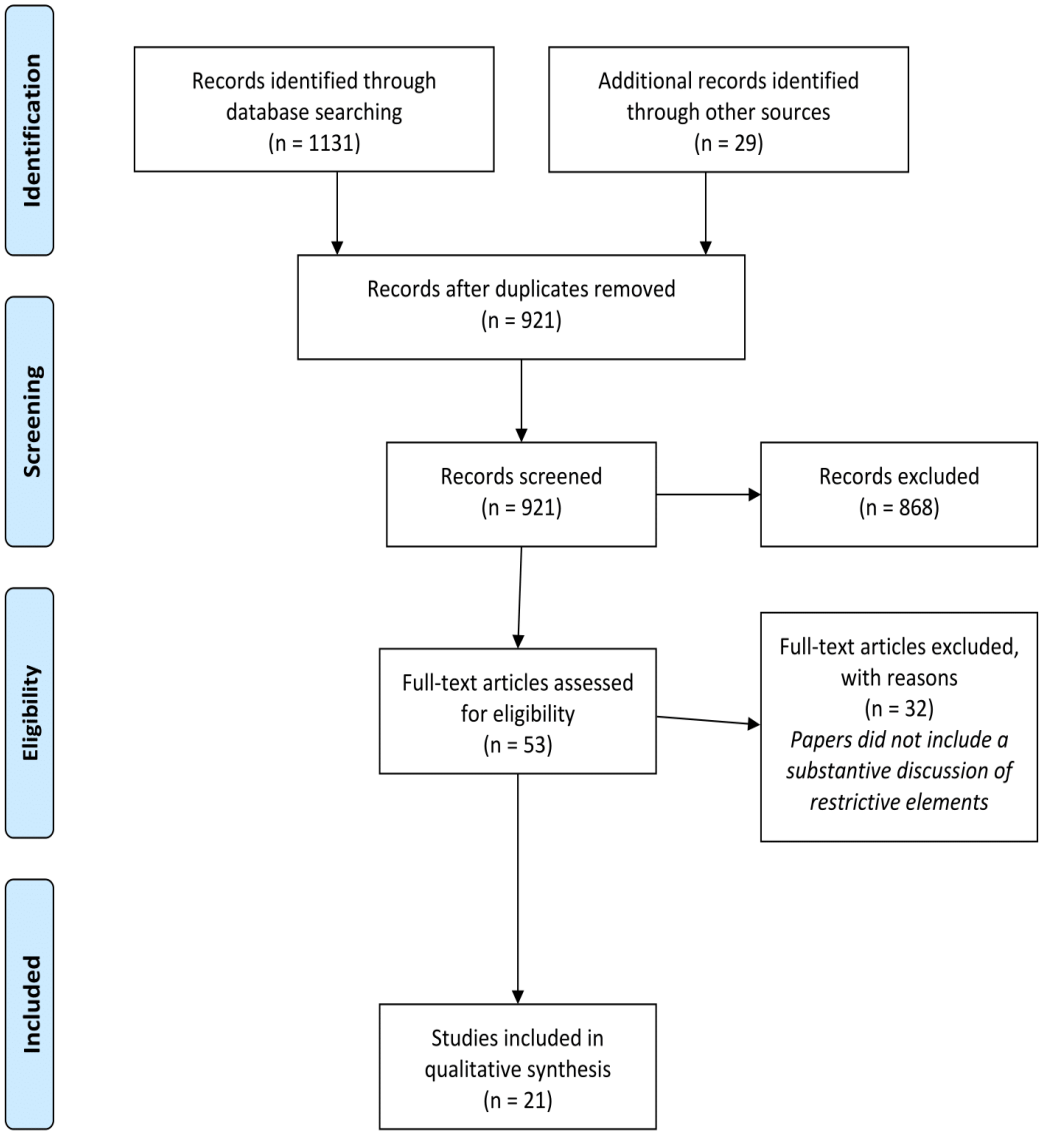
restrict AND mental AND forensic

restrict AND psych AND forensic

Appendix B. PRISMA flow diagram literature first search



Appendix C. PRISMA flow diagram literature second search



Appendix D. Ten Most Frequent Codes Identified in Systematic Literature Review

	Node	No. of Sources	%
1	Patient & Staff Interaction	30	60
2	Environment	22	44
3	Control	19	38
4	Restrictions	19	38
5	Time	18	36
6	Locked Doors	18	36
7	Staff	17	34
8	Systemic	17	34
9	Security	16	32
10	Activities	16	32

Appendix E. Interview Question Guide

Opener

1. Can you please tell me what it's like to be here?

Restrictiveness Introduction (Definition)

2. Is there anything that frustrates you about your care?
3. Do you find being here restrictive? If so, how?
4. What is the most restrictive thing about your care? When do you feel most restricted?
5. Are there any freedoms you have here that you appreciate? Can you think of any examples?

Relational (Individual)

6. What are your interactions with other patients like? Staff? Are you happy with these?
    a. Or do they make life difficult sometimes?
7. How would you describe staff attitudes towards you?
8. How would you describe the atmosphere on the ward?
9. How connected do you feel to the world outside the hospital? (People, the media, news)

Personal and Self (Individual)

10. Are you able to express yourself in a way you are happy with? Who listens to you mostly?
11. Can you remember what you thought secure care would be like before you came in? Were you surprised?
12. Do you feel prevented from developing social/occupational skills whilst in care? Why/not?
13. Do you feel there is a stigma being here? Does this restrict you in any way? (labelling)
14. Do you feel you are being treated humanely?

The Setting and Care (Institutional)

15. Are there any activities you would like to engage in further and currently can't? What might that be for example?
16. Do you feel you have a sense of control over your everyday life? Can you give examples?
    a. What about your long-term life? Do you have control over long-term plans?
17. Does the restrictiveness of care vary a lot across different hospitals and wards?
18. What do you think about the level of security?
19. Can you spend money in a way you are happy with?

Systemic (Systemic)

20. Do you think the law is 'on your side' or against you? (Legal representation / right to appeal)
21. Do you feel you should be here?
22. Do you feel you are here for care or for punishment? Is it both?
23. Do you think the amount of time you spend here is too short, too long or just right?
24. Do you think care has become more or less restrictive for you across throughout your time in secure care?
25. Are the ward rules too strict, helpful or in-between?
26. Are you allowed leave?
27. Do you think staff are to blame for these restrictions? Or resources? Politics?

Restrictiveness Revisited ()

28. Has your understanding of 'restrictiveness' changed because of this focus group? If so, how?
29. Do you think it is good or necessary to have many of these restrictions?
30. What do you think are some of the consequences for you following the restrictiveness you have described?

Appendix F. Research Ethics Committee Letter of Approval

NHS
Health Research Authority

East Midlands - Leicester South Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

21 June 2017

Professor Birgit Vollm
Professor in Forensic Psychiatry, Head of Section Forensic Mental Health
University of Nottingham, and, Nottinghamshire healthcare NHS Trust
Institute of Mental Health, University of Nottingham Innovation Park, Jubilee Campus
Nottingham
NG7 2TU

Dear Professor Vollm,

Study title:	**Measuring Experiences of Restrictiveness in Secure Forensic Psychiatric Care: Developing a Scale**
REC reference:	**17/EM/0159**
IRAS project ID:	**220000**

Thank you for your letter of 08 June 2017, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Copies of advertisement materials for research participants [INFORMATION POSTER restrictiveness in secure care]	v.1.1	08 June 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [EVIDENCE OF INSURANCE restrictiveness in secure care v.1 04-04-2017]	v.1	04 April 2017
Interview schedules or topic guides for participants [TOPIC GUIDE FOCUS GROUPS restrictiveness in secure care]	v.1.1	08 June 2017
IRAS Application Form [IRAS_Form_13062017]		13 June 2017
Letter from funder [TOMLIN, Jack - Award Letter ESRC]	v.1	30 March 2017
Letter from sponsor [SPONSOR LETTER restrictiveness in secure care v.1 04-04-2017]	v.1	04 April 2017
Other [Clarification email from JT]		10 April 2017
Participant consent form [CONSENT FORM FOCUS GROUP restrictiveness in secure care]	v.1.1	08 June 2017
Participant consent form [CONSENT FORM QUESTIONNAIRES restrictiveness in secure care]	v.1.1	08 June 2017
Participant information sheet (PIS) [INFORMATION SHEET FOCUS GROUPS restrictiveness in secure care]	v.1.1	08 June 2017
Participant information sheet (PIS) [INFORMATION SHEET QUESTIONNAIRES restrictiveness in secure care]	v.1.1	08 June 2017
Research protocol or project proposal [PROTOCOL restrictiveness in secure care]	v.1.1	08 June 2017
Response to Request for Further Information		08 June 2017
Summary CV for Chief Investigator (CI) [C.V Birgit Vollm]	v.1	30 March 2017
Summary CV for student [C.V Jack Tomlin]	v.1	30 March 2017
Summary CV for supervisor (student research) [C.V Peter Bartlett]	v.1	30 March 2017
Summary CV for supervisor (student research) [C.V Birgit Vollm]	v.1	30 March 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [SUMMARY PROTOCOL restrictiveness in secure care v.1 30.03.2017]	V.1	30 March 2017
Validated questionnaire [EssenCES English]	v.1	30 March 2017
Validated questionnaire [FQL English]	v.1	30 March 2017
Validated questionnaire [FQL-SV ENGLISH restrictiveness in secure care]	v.1.1	

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research

Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

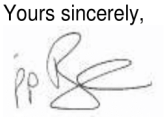
HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/EM/0159	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely,



Mr John Aldridge
Chair

Email:NRESCommittee.EastMidlands-LeicesterSouth@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Ms Angela Shone*
Mrs Shirley Mitchell, Nottinghamshire Healthcare NHS Trust

Appendix G. Health Research Authority Letter of Approval

NHS
Health Research Authority

Professor Birgit Vollm
Professor in Forensic Psychiatry, Head of Section Forensic Mental Health
University of Nottingham, and, Nottinghamshire healthcare NHS Trust
Institute of Mental Health, University of Nottingham
Innovation Park, Jubilee Campus
Nottingham
NG7 2TU
birgit.vollm@nottingham.ac.uk

Email: hra.approval@nhs.net

22 June 2017

Dear Professor Vollm,

Letter of HRA Approval

Study title:	**Measuring Experiences of Restrictiveness in Secure Forensic Psychiatric Care: Developing a Scale**
IRAS project ID:	**220000**
REC reference:	**17/EM/0159**
Sponsor	**Nottingham University**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators",* issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

IRAS project ID	220000

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **220000**. Please quote this on all correspondence.

Yours sincerely

Gemma Oakes
Assessor

Email: hra.approval@nhs.net

Copy to: *Mr Jack Tomlin, Nottingham University [Student]*
jack.tomlin@nottingham.ac.uk
Ms Angela Shone, Nottingham University [Sponsor Contact]
angela.shone@nottingham.ac.uk
Mrs Shirley Mitchell, Nottinghamshire Healthcare NHS Trust [Lead NHS R&D Contact]
shirley.mitchell@nottshc.nhs.uk

Appendix H. University of Nottingham Sponsor Letter

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Research, Enterprise and Graduate Services
University of Nottingham
King's Meadow Campus
Lenton Lane Nottingham
NG7 2NR

Professor Birgit Völlm
Professor in Forensic Psychiatry
Division of Psychiatry and Applied Psychology
School of Medicine
University of Nottingham
Jubilee Campus
Nottingham
NG7 2TU

Our reference: RGS 17021
IRAS Project ID: 220000

0115 8467906
sponsor@nottingham.ac.uk

Health Research Authority
Research Ethics Committee

31 March 2017

Dear Sir or Madam,

Sponsorship Statement

Re: Measuring Experiences of Restrictiveness in Secure Forensic Psychiatric Care: Developing a Scale

I can confirm that this research proposal has been discussed with the Chief Investigator and agreement to sponsor the research is in place.

An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*

Any necessary indemnity or insurance arrangements will be in place before this research starts. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**

* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Yours faithfully

Angela Shone
Head of Research Governance
University of Nottingham

world-changing research
from The University of Nottingham

Appendix I. Initial eighty items for the pilot FRQ

1. I feel connected to family outside the hospital
2. I am treated humanely here
3. The hospital listens to my concerns
4. I can express my feelings here
5. I have enough privacy in my room
6. I am happy with what I can bring into my room
7. Other patients affect my care in a bad way
8. I can practice my hobbies enough
9. I am treated with respect by other patients
10. I am aware of current events happening outside the hospital
11. The hospital gives me enough to do in the daytime
12. I do not feel included in my care plan (CPA and Ward Rounds)
13. Staff communicate with me enough
14. I feel connected to hospital management
15. I can practice my religion or other beliefs here
16. The law is on my side
17. I feel supported to move on in my care pathway
18. I can express my gender here
19. The level of security is just right for me
20. Other patients help me get better
21. I am treated as an individual here
22. Other patients stop me from going where I want on the ward
23. I have enough privacy on the ward
24. I have enough personal belongings in my room
25. I feel a stigma being here
26. I am confident I will belong in the community at some point
27. Staff affect my care in a bad way
28. Other patients stop me from participating in some activities
29. I understand why I am here right now
30. I agree with my diagnosis
31. I am given responsibility on the ward
32. I am trusted by staff
33. I get along well with my care team (MDT)
34. I do not like my Doctor
35. Medication helps me get better
36. I feel connected to friends outside the hospital
37. I miss members of the opposite sex
38. I can choose what I do each day
39. Tribunal hearings are in my best interests
40. I am here for too long
41. Security levels are too high here
42. I feel safe here
43. It is not fair I am here right now
44. I would rather be in a prison than here
45. I can participate in meaningful activities
46. I agree with my diagnosis
47. The hospital is the right place for me right now
48. I feel punished here

49. I am treated worse than other patients on the ward
50. The hospital feels more like a prison
51. I am treated with respect by staff
52. The hospital is helping me
53. I am optimistic about my future
54. I am bored here
55. Staff help me get better
56. I can access the internet enough
57. I can listen to music enough
58. I am learning new skills here
59. I can express my sexuality enough
60. There are too many blanket rules here
61. I can go outside for fresh air enough
62. I have the right amount of leave
63. The hospital stops risky things happening
64. I feel physically healthy
65. My diagnosis defines who I am
66. I can practice my hobbies enough
67. My human rights are respected here
68. Having locked doors is a good thing
69. I have to ask for permission for everything here
70. The ward feels homely
71. Other patients worry or concern me
72. I am happy to be here
73. I am forced to do things I don't want to do
74. I am OK with being called a patient
75. The atmosphere on the ward is good
76. I am treated like an adult here
77. I am forced to take medication I don't want to do
78. I should be in the community now
79. There are enough staff to run the ward properly
80. The rules on the ward are fair

Appendix J. Pilot 58-item FRQ

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

NHS
Nottinghamshire Healthcare
NHS Foundation Trust

The Forensic Restrictiveness Questionnaire (FRQ)

Instructions for use:

This questionnaire asks how you experience the restrictiveness of your care. We want to know how you feel about each of the statements included below.

Please read the following statements and mark 'Strongly Disagree', 'Disagree', 'Not Sure, 'Agree' or 'Strongly Agree'.

If something is not relevant to you, mark 'N/A' (Not Applicable).

Please think about how you have felt over the last week when completing this.

If you have any questions, please ask a member of staff.

Information about you:

(To be filled by yourself or member of staff)

Date: _____

PSN: _____

Age: _____

Ethnicity: _____

Gender: _____

Diagnosis: _____

Mental Health Act Section(s): _____

How long have you been in this Secure Hospital: _____

How long have you been other Secure Hospitals: _____

Index Offence(s) (if applicable): _____

_____

(2018) J. Tomlin, B. Völlm, P. Bartlett & V. Egan, University of Nottingham IRAS: 220000

Question	Strongly Disagree 1	Disagree a Little 2	Not Sure 3	Agree a Little 4	Strongly Agree 5	Not Applicable N/A
1. The hospital helps me if I want to contact people outside	1	2	3	4	5	N/A
2. I am treated like a human being here	1	2	3	4	5	N/A
3. The hospital listens to my concerns enough	1	2	3	4	5	N/A
4. I can express my feelings here enough	1	2	3	4	5	N/A
5. I have enough privacy in my room	1	2	3	4	5	N/A
6. I am allowed to bring what I want into my room	1	2	3	4	5	N/A
7. The hospital helps me practice hobbies I like	1	2	3	4	5	N/A
8. I can follow current events outside the hospital I find interesting	1	2	3	4	5	N/A
9. I feel included in my care plan enough (CPA and Ward Rounds)	1	2	3	4	5	N/A
10. I am given enough information about my care	1	2	3	4	5	N/A
11. Hospital management is too controlling	1	2	3	4	5	N/A
12. I can practice my religion or beliefs enough	1	2	3	4	5	N/A
13. The law stops me progressing through my pathway	1	2	3	4	5	N/A
14. I feel supported enough to move on	1	2	3	4	5	N/A
15. I am allowed to express my gender	1	2	3	4	5	N/A
16. Staff respect me as an individual	1	2	3	4	5	N/A
17. Other patients stop me from going where I want on the ward	1	2	3	4	5	N/A
18. I feel a stigma being here	1	2	3	4	5	N/A
19. Staff stop me doing what I want	1	2	3	4	5	N/A

(2018) J. Tomlin, B. Völlm, P. Bartlett & V. Egan, University of Nottingham IRAS: 220000

The Forensic Restrictiveness Questionnaire (FRQ) v.1.5

Question	Not at all Restricted 1	A Little Restricted 2	Quite Restricted 3	Very Restricted 4	Could Not be More Restricted 5	Not Applicable N/A
57. How restricted do you feel in general?	1	2	3	4	5	N/A

58. Has anything very difficult/hard/hurtful happened to you in the last week?	**Yes**	**No**

Please write what this was (if applicable):

_____

_____

Please write any comments/questions you might have about the questionnaire:

_____

_____

_____

_____

Please tell a member of staff if you were unable to complete any of the questions.

Thank you for taking the time to complete this questionnaire.

(2018) J. Tomlin, B. Völlm, P. Bartlett & V. Egan, University of Nottingham IRAS: 220000

Appendix K. How the 58 FRQ items map onto the Model of Restrictiveness

	Item	Link to qualitative data
1.	The hospital helps me if I want to contact people outside	Restrictive Phenomena > Relational > Other Meaningful Relationships: Family, Friends and Sexual Intimacy
2.	I am treated like a human being here	Restrictive Phenomena > Symbolic > Objectification and Pathologization Experience of Restrictive Phenomena > Severity > Personhood
3.	The hospital listens to my concerns enough	Restrictive Phenomena > Symbolic > Citizenship Mechanisms of Enactment > Intended > Soft, Distal and Bureaucratic
4.	I can express my feelings here enough	Restrictive Phenomena > Symbolic > Citizenship Mechanisms of Enactment > Intended > Soft, Distal and Bureaucratic Experience of Restrictive Phenomena > Severity > Self
5.	I have enough privacy in my room	Mechanisms of Enactment > Intended > Soft, Distal and Bureaucratic
6.	I am allowed to bring what I want into my room	Restrictive Phenomena > Daily Life > Personal Belongings and Consumable Goods
7.	The hospital helps me practice hobbies I like	Antecedent Conditions to Restrictive Phenomena > Resources Restrictive Phenomena > Daily Life > Activities
8.	I can follow current events outside the hospital I find interesting	Restrictive Phenomena > Symbolic > Citizenship
9.	I feel included in my care plan enough (CPA and Ward Rounds)	Restrictive Phenomena > Symbolic > Objectification and Pathologization Restrictive Phenomena > Symbolic > Citizenship
10.	I am given enough information about my care	Restrictive Phenomena > Symbolic > Objectification and Pathologization Restrictive Phenomena > Symbolic > Citizenship Mechanisms of Enactment > Intended > Soft, Distal and Bureaucratic
11.	Hospital management is too controlling	Restrictive Phenomena > Symbolic > Objectification and Pathologization Experience of Restrictive Phenomena > Autonomy Mechanisms of Enactment > Intended

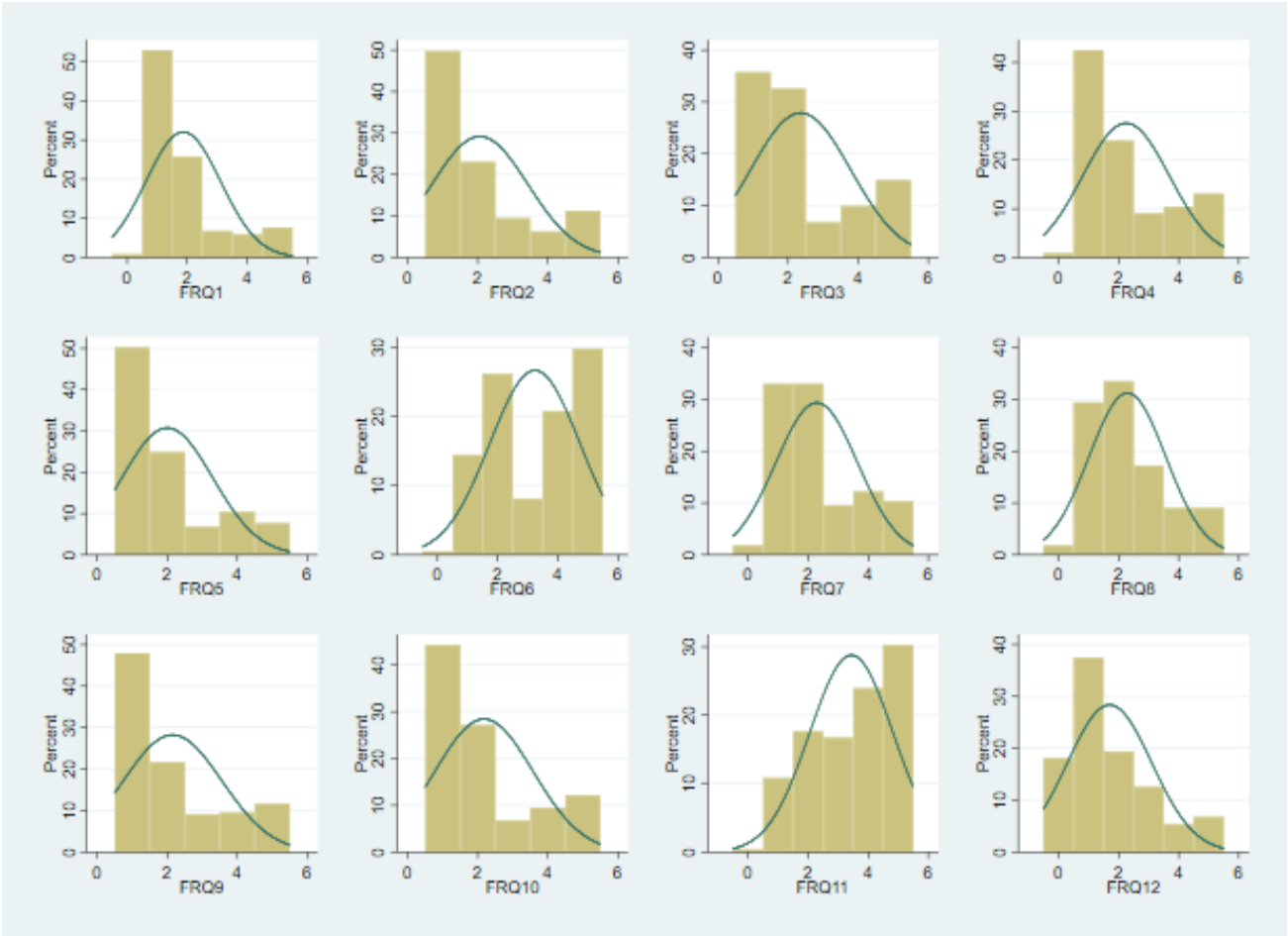
12.	I can practice my religion or beliefs enough	Experience of Restrictive Phenomena > Severity > Self Restrictive Phenomena > Daily Life > Activities
13.	The law stops me progressing through my pathway	Antecedent Conditions to Restrictive Phenomena > The Purpose of Forensic Psychiatric Care Mechanisms of Enactment > Intended > Visible, Routine & Coercive
14.	I feel supported enough to move on	Restrictive Phenomena > Temporal > Prospects: Looking to Integration
15.	I am allowed to express my gender	Experience of Restrictive Phenomena > Severity > Self
16.	Staff respect me as an individual	Experience of Restrictive Phenomena > Severity > Self
17.	Other patients stop me from going where I want on the ward	Restrictive Phenomena > Relational > Other Residents Experience of Restrictive Phenomena > Severity > Autonomy
18.	I feel a stigma being here	Experience of Restrictive Phenomena > Severity > Self Restrictive Phenomena > Temporal > Prospects: Looking to Integration
19.	Staff stop me doing what I want	Restrictive Phenomena > Relational > Staff Experience of Restrictive Phenomena > Severity > Autonomy
20.	Other patients stop me doing some activities I want to	Restrictive Phenomena > Relational > Other Residents Experience of Restrictive Phenomena > Severity > Autonomy
21.	I am given enough responsibility on the ward	Experience of Restrictive Phenomena > Severity > Autonomy Restrictive Phenomena > Symbolic > Objectification and Pathologization
22.	I am trusted by staff enough	Experience of Restrictive Phenomena > Severity > Autonomy
23.	My Doctor uses too much control over me	Restrictive Phenomena > Symbolic > Objectification and Pathologization Experience of Restrictive Phenomena > Autonomy
24.	I want to socialize with members of the opposite sex more	Experience of Restrictive Phenomena > Severity > Autonomy, Self Restrictive Phenomena > Relational
25.	I can choose what I want to do each day	Experience of Restrictive Phenomena > Severity > Autonomy
26.	Tribunal hearings help me move to a more appropriate place	Restrictive Phenomena > Temporal > Prospects: Looking to Integration Mechanisms of Enactment > Intended > Visible, Routine & Coercive

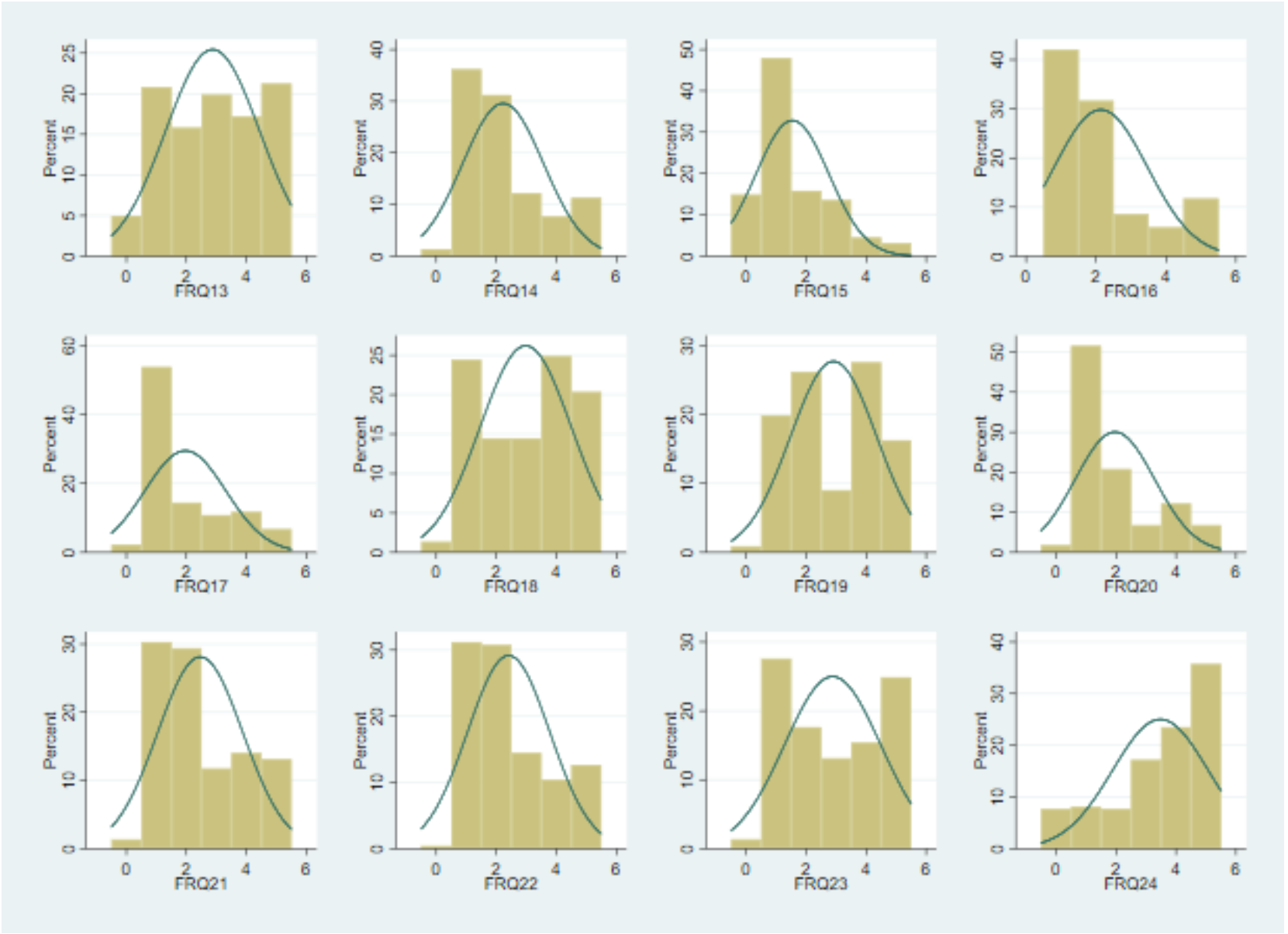
27.	There is too much security here	Antecedent Conditions to Restrictive Phenomena > Risk Mechanisms of Enactment > Intended > Visible, Routine & Coercive
28.	It is fair I am here right now	Experience of Restrictive Phenomena > Salience > Normative Knowledge
29.	I can participate in activities I find meaningful	Experience of Restrictive Phenomena > Severity > Autonomy Restrictive Phenomena > Daily Life > Activities Antecedent Conditions to Restrictive Phenomena > Resources
30.	The hospital is the best place for me right now	Experience of Restrictive Phenomena > Salience > Normative Knowledge Antecedent Conditions to Restrictive Phenomena > Purpose of Forensic Psychiatric Care Restrictive Phenomena > Temporal > Length of Stay
31.	I am satisfied with my sex life here	Experience of Restrictive Phenomena > Severity > Personhood Restrictive Phenomena > Relational
32.	I feel punished here	Antecedent Conditions to Restrictive Phenomena > Purpose of Forensic Psychiatric Care Experience of Restrictive Phenomena > Salience > Normative Knowledge
33.	I am treated worse than other patients on the ward	Experience of Restrictive Phenomena > Salience > Normative Knowledge Experience of Restrictive Phenomena > Salience > Vicarious Knowledge
34.	It feels more like a prison than a hospital here	Experience of Restrictive Phenomena > Salience > Normative Knowledge Antecedent Conditions to Restrictive Phenomena > Purpose of Forensic Psychiatric Care
35.	The hospital is helping me enough	Experience of Restrictive Phenomena > Salience > Normative Knowledge
36.	I can have a loving relationship with a significant other if I want	Experience of Restrictive Phenomena > Severity > Personhood Restrictive Phenomena > Relational
37.	I can access the internet enough	Experience of Restrictive Phenomena > Severity > Autonomy Restrictive Phenomena > Daily Life > Activities

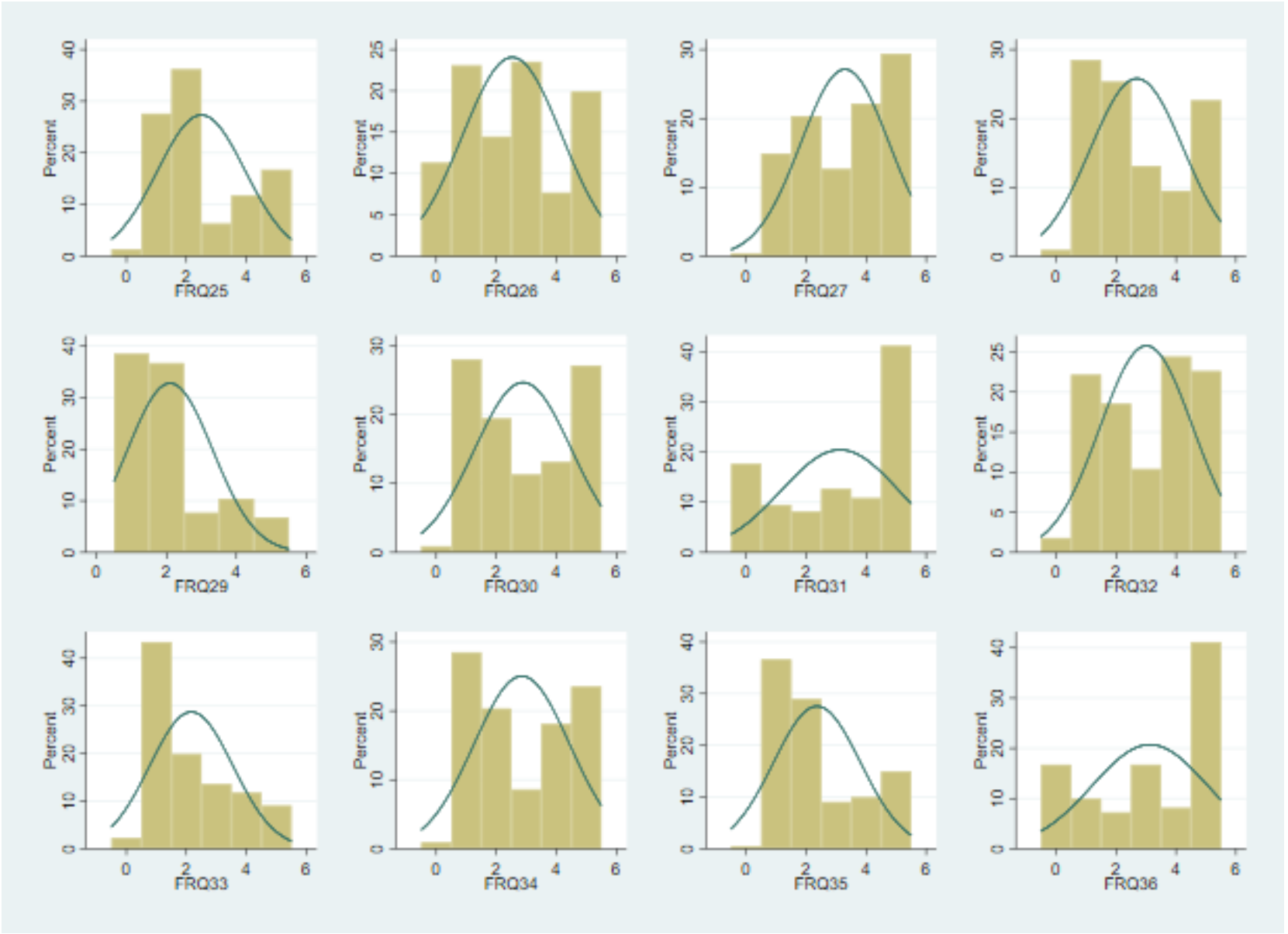
38.	I can listen to music/read/play video games enough	Restrictive Phenomena > Daily Life > Activities
39.	I have to wait too long to hear about changes in my care	Restrictive Phenomena > Temporal > Slowness of Time Restrictive Phenomena > Symbolic > Citizenship
40.	I get restrained by staff too much	Experience of Restrictive Phenomena > Severity > Autonomy + Personhood Mechanisms of Enactment > Intended > Visible, Routine & Coercive
41.	I can learn new skills if I want to	Restrictive Phenomena > Daily Life > Activities Consequences > Behavioural
42.	I get put in seclusion too much	Experience of Restrictive Phenomena > Severity > Autonomy + Personhood Mechanisms of Enactment > Intended > Visible, Routine & Coercive
43.	There are too many blanket rules (bans) here	Mechanisms of Enactment > Intended > Visible, Routine & Coercive Experience of Restrictive Phenomena > Severity > Autonomy
44.	I can go outside for fresh air enough	Restrictive Phenomena > Daily Life > Activities Experience of Restrictive Phenomena > Severity > Autonomy + Personhood
45.	I have enough leave	Experience of Restrictive Phenomena > Severity > Autonomy Restrictive Phenomena > Daily Life > Activities
46.	My rights are respected properly here	Experience of Restrictive Phenomena > Severity > Personhood Mechanisms of Enactment > Intended > Visible, Routine & Coercive
47.	Having locked doors is a bad thing	Restrictive Phenomena > Daily Life > Built Environment Antecedent Conditions to Restrictive Phenomena > Purpose of Forensic Psychiatric Care
48.	I have to ask for permission for things too much	Experience of Restrictive Phenomena > Severity > Autonomy
49.	I am forced to do things I don't want to do	Experience of Restrictive Phenomena > Severity > Autonomy
50.	I am OK with being called a patient	Experience of Restrictive Phenomena > Severity > Self Restrictive Phenomena > Symbolic > Objectification and Pathologization
51.	I am forced to take medication I don't want to	Restrictive Phenomena > Symbolic > Objectification and Pathologization

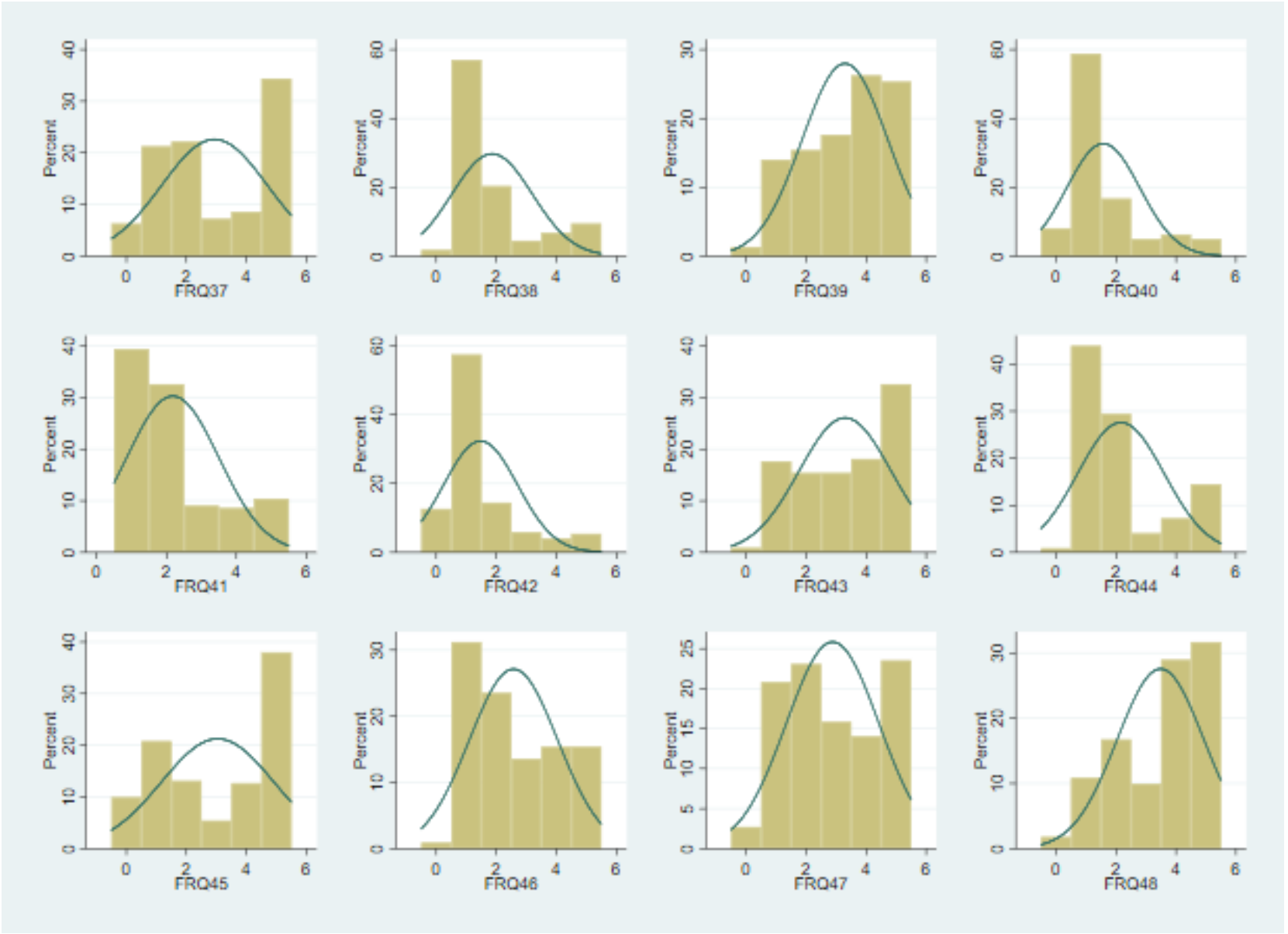
		Experience of Restrictive Phenomena > Severity > Autonomy Mechanisms of Enactment > Intended > Visible, Routine & Coercive
52.	I should be in the community now	Restrictive Phenomena > Temporal > Prospects: Looking to Integration Restrictive Phenomena > Daily Life
53.	I have to wait too long for things on the ward	Restrictive Phenomena > Temporal > Slowness of Time
54.	The rules on the ward are fair	Experience of Restrictive Phenomena > Salience > Normative Knowledge
55.	The restrictions on the ward make sense	Experience of Restrictive Phenomena > Salience > Logical Knowledge
56.	I can have food and drink I want	Restrictive Phenomena > Daily Life > Personal Belongings and Consumable Goods Experience of Restrictive Phenomena > Severity > Autonomy

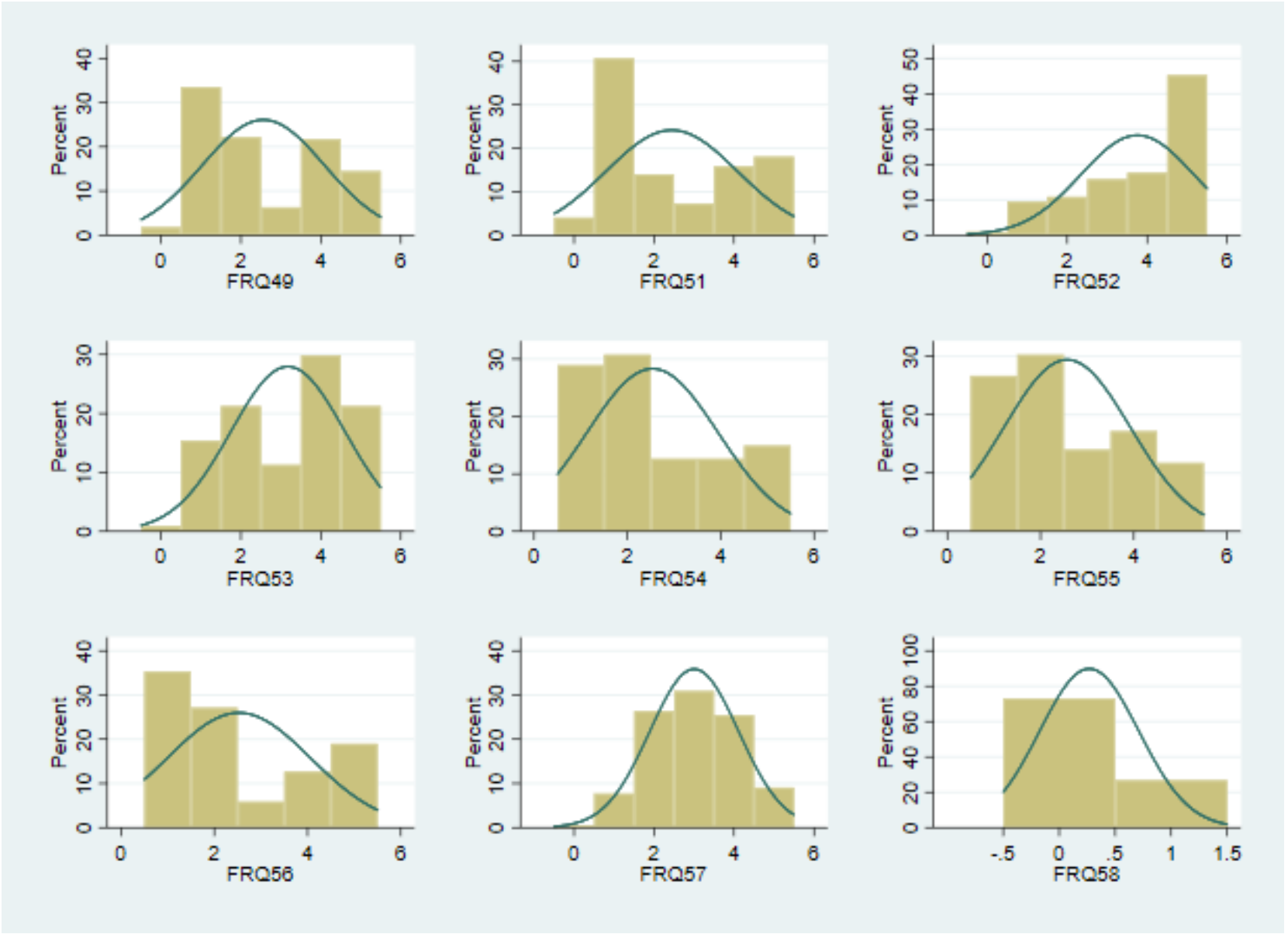
Appendix L. Histograms of FRQ item distribution




Percent
FRQ13
FRQ14
FRQ15
FRQ16
FRQ17
FRQ18
FRQ19
FRQ20
FRQ21
FRQ22
FRQ23
FRQ24


Percent
FRQ25
FRQ26
FRQ27
FRQ28
FRQ29
FRQ30
FRQ31
FRQ32
FRQ33
FRQ34
FRQ35
FRQ36


Percent
FRQ37
FRQ38
FRQ39
FRQ40
FRQ41
FRQ42
FRQ43
FRQ44
FRQ45
FRQ46
FRQ47
FRQ48


Percent
FRQ49
FRQ51
FRQ52
FRQ53
FRQ54
FRQ55
FRQ56
FRQ57
FRQ58

Appendix M. Rotated Four-Factor Solution with Principle Axis Factoring, Promax Rotation

Rotated factor loadings (pattern matrix) and unique variances

Variable	Factor1	Factor2	Factor3	Factor4	Uniqueness
FRQ1	0.4111				0.6097
FRQ2	0.7285				0.4432
FRQ5	0.3144				0.6533
FRQ6					0.6622
FRQ7	0.5730				0.5177
FRQ8					0.7192
FRQ9	0.9312				0.3111
FRQ10	0.7089				0.4520
FRQ11		0.5970			0.6215
FRQ12					0.8177
FRQ13		0.3287			0.8636
FRQ14	0.7430				0.5965
FRQ16	0.8072				0.4093
FRQ18		0.3683			0.6164
FRQ19		0.4688		0.3097	0.5679
FRQ20		0.3217		0.4354	0.6812
FRQ21	0.7695				0.4528
FRQ22	0.7211				0.5056
FRQ23		0.6502			0.5386
FRQ24			0.6400		0.6795
FRQ25	0.5084				0.5589
FRQ26					0.8983
FRQ27		0.5705			0.6832
FRQ28	0.3248				0.5735
FRQ29	0.5513				0.5342
FRQ30		0.4027			0.6210
FRQ31			0.6202		0.6004
FRQ32		0.3478	0.3154		0.6553
FRQ33		0.3479		0.4179	0.5364
FRQ34		0.4494			0.6244
FRQ37			0.6377		0.5960
FRQ38	0.3849				0.6224
FRQ39		0.6105			0.5861
FRQ41	0.4110				0.6428
FRQ43		0.6927			0.5641
FRQ44			0.3876		0.7000
FRQ45			0.6774		0.5396
FRQ46	0.4996				0.4651
FRQ47		0.3228			0.8659
FRQ48		0.6888			0.5059
FRQ49		0.5315			0.5590
FRQ51		0.6018			0.7285
FRQ53		0.5910			0.6240
FRQ54	0.3721	0.3868			0.4863
FRQ55		0.5186			0.5285
FRQ56	0.4050				0.6885

(blanks represent abs(loading)<.3)

The Final FRQ

The Forensic Restrictiveness Questionnaire (FRQ)

Instructions for use:

This questionnaire asks how you experience the restrictiveness of your care. We want to know how you feel about each of the statements included below.

Please read the following statements and mark 'Strongly Disagree', 'Disagree', 'Not Sure, 'Agree' or 'Strongly Agree'.

Please think about how you have felt over the last week when completing this.

If you have any questions, please ask a member of staff.

Information about you:

(To be filled by yourself or member of staff)

Date: _____

PSN: _____

Age: _____

Ethnicity: _____

Gender: _____

Diagnosis: _____

Mental Health Act Section(s): _____

How long have you been in this Secure Hospital: _____

How long have you been other Secure Hospitals: _____

Index Offence(s) (if applicable): _____

_____

(2019) J. Tomlin, B. Völlm, P. Bartlett & V. Egan, University of Nottingham

Question	Strongly Disagree 1	Disagree a Little 2	Not Sure 3	Agree a Little 4	Strongly Agree 5	Not Applicable N/A
1. I am treated like a human being here						
2. The hospital helps me practice hobbies I like						
3. I feel included in my care plan enough (CPA and Ward Rounds)						
4. I am given enough information about my care						
5. Staff respect me as an individual						
6. I am given enough responsibility on the ward						
7. I am trusted by staff enough						
8. My Doctor uses too much control over me						
9. I can choose what I want to do each day						
10. It is fair I am here right now						
11. I can participate in activities I find meaningful						
12. My rights are respected properly here						
13. I am forced to do things I don't want to do						
14. The rules on the ward are fair						
15. The restrictions on the ward make sense						

(2019) J. Tomlin, B. Völlm, P. Bartlett & V. Egan, University of Nottingham