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Title: What do Patients find Restrictive about Forensic Mental Health Services? A Qualitative Study

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Abstract

Forensic care settings are often isolated spaces with high levels of security. Where these settings are overly restrictive, this can affect recovery, autonomy and the therapeutic milieu. It is not clear what phenomena patients themselves identify as restrictive and how, subjectively, they experience these.

Semi-structured interviews were conducted with 18 patients in secure hospitals in England. Respondents included male and female patients with mental illness or personality disorders on both civil and criminal detentions.

The results suggest a model of restrictiveness consisting of five themes: 1) the antecedent conditions to restrictive phenomena; 2) restrictive phenomena themselves; 3) how these are enacted, 4) how these phenomena were subjectively experienced by patients; and 5) the consequences of these phenomena as expressed by patients.

Restrictiveness understood in this way is broader than 'least restrictive practices' typically understood as restraint, seclusion and forced medication. Respondents' comments encourage us to rethink the unintended effects of placing individuals within secure hospitals.

Keywords

forensic, mental health, mentally disorders offenders, restrictiveness, qualitative

WHAT DO PATIENTS FIND RESTRICTIVE ABOUT FORENSIC MENTAL HEALTH SERVICES? A QUALITATIVE STUDY

Introduction

This paper explores patients' experiences of the restrictiveness of forensic mental health services. Forensic hospitals aim to facilitate the treatment, safety and risk management of mentally disordered offenders and individuals assessed to be at a risk of harm, necessitating the levels of security forensic settings entail (Sugarman & Dickens, 2015). The National Health Service of England and Wales (NHS) commissions 7718 male and female beds across low, medium and high levels of security. Patients are diagnosed with a range of mental disorders; primarily mental illness and personality disorders (NHS England, 2015). The present study is based in England; but we propose that many issues have relevance internationally given the shared characteristics of secure forensic settings.

Secure forensic settings can be described as 'Total', directing many aspects of patients' lives (Goffman, 1961); and approximate general psychiatric, penal and geriatric sites (Jones & Fowles, 1984). However, forensic mental health services straddle both criminal and healthcare systems, oftentimes splitting operational prerogatives between duties of care and custody (Holmes & Murray, 2011). This tension can engender punitive and restrictive attitudes. Forensic care settings are often large, enclosed spaces with secure perimeter fencing and high levels of security. Visits are regulated, patients may not be afforded leave and can have restriction orders placed upon them. Access to personal belongings is restricted, as is sexual intimacy and contact with the outside world. These restrictions can last for decades (Hare Duke et al., 2018).

In recent years, forensic mental health settings have embraced the Recovery Paradigm with concomitant notions of autonomy, empowerment and agency (Mann, Matias, & Allen, 2014; Simpson & Penney, 2018). These values reflect broader paradigm shifts in the provision of

mental health care that have their roots in various social, political and economic reforms of the 1950s and 60s (Pouncey & Lukens, 2013). There were movements to try and provide care as close to the individual's home setting as possible and in the 'least restrictive manner' (Atkinson & Garner, 2002; MHA Code of Practice, 2015). This aimed to help individuals reintegrate or stay integrated within their social and economic circles and reduce a stigmatizing 'otherness'. These reforms built on research that found large asylums were at times harmful, and advances in psychopharmacological medication that made psychotic symptoms more self-manageable (Caldas-Almeida, Mateus, & Gina, 2016).

A review of qualitative research collating patients' experiences of secure care found that increasing attention is being paid to this area of practice (Coffey, 2006). Studies highlighted several key themes in patients' responses including: therapeutic relationships, punitive controls, negative professional responses to behaviours, restrictions on liberty, a lack of information, community integration and reoffending.

The coercive, punitive aspects of secure care and restrictions upon liberty deserves further attention. Studies suggest that higher levels of security are associated with lower quality of ward atmosphere (Dickens, Suesse, Snyman, & Picchioni, 2014; Long et al., 2011). Coercive measures can lead patients to feel dehumanized, confused, dissatisfied with care, and powerless (Kontio et al., 2012; Soininen, Kontio, Joffe, & Putkonen, 2016). Lengthy stays may lead to institutionalization characterised by lost independence, responsibility and identity; and identifying as one of the sick (Chow & Priebe, 2013). Restrictive features of forensic mental health services are often predicated on risk concerns but can jeopardize recovery, negate autonomy and agency, and deny patients meaningful citizenship in both the hospital and wider community (Mann et al., 2014; Markham, 2018).

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

extended 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 lacking. Indeed, “[t]he notion of ‘least restrictive practices’ however, is not clearly defined” (Ada Hui, 2017: p.1).

We have argued elsewhere that the restrictiveness of secure care is a concept *‘amorphous, tied together by a notion of subjective experience that is at times contradictory’* (Tomlin, Bartlett, & Völlm, 2018: 40). We proposed that restrictiveness comprises a range of phenomena operating on individual, institutional and systemic levels including: restricted relationships with others, prohibitions of sexual intercourse, legal sections, indefinite lengths of stay, banned personal belongings, limited access to meaningful activities and the built environment. The extent to which these phenomena are restrictive for patients is a product of whether their care was considered therapeutic or custodial, and how risky patients were perceived to be by staff.

Research Questions

Thus, there is a gap in our understanding of how patients in all levels of security experience a key part of life in forensic care and if and why this differs between individuals. This study sought to further our understanding of how patients experience forensic care by qualitatively exploring their experiences through a rich analysis of the data and developing the Model of Restrictiveness.

The study asked:

1. What elements of secure forensic psychiatric care do patients experience as restrictive?
2. How, subjectively, do they experience these phenomena?
3. What self-reported consequences do these phenomena have for patients?

Methods

This study was part of a larger project to conceptualise and develop a questionnaire to measure patients' experiences of restrictiveness. This project had a Mixed Methods Methodology (Creswell & Clark, 2007; Teddlie & Tashakkori, 2009). The phase reported in this paper used a qualitative interviewing method.

Design

The ontological and epistemological assumptions were constructivist and interpretivist. Constructivism assumes that data are socially constructed by situationally-located and biographically-endowed actors (Benton & Craib, 2010). Thus, knowledge claims derived from qualitative research are constructed by the interviewer and interviewee (Silverman, 2015). Interpretivism presumes that individuals' understandings of reality are constructed and subjective (Blaikie, 2007, 2010). The interviews in this project consequently involved interpretation in understanding interviewee's meanings and narratives.

Two mini-focus groups (n=2 and n=3) and 13 individual interviews were conducted. These were semi-structured (Kvale, 2008). Focus groups were initially chosen but these were replaced by individual interviews. This change was made given difficulties in aligning patient schedules and attrition rates. All data were analysed together. Interview questions were informed by a literature review reported elsewhere (Tomlin et al., 2018). Semi-structured interviews helped facilitate a directed exploration of patient experience but allowed for subjective narratives to emerge (Silverman, 2015). Interviews were audio-recorded and transcribed verbatim.

Data Analysis

Thematic Analysis was used to analyse the data. 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). Thematic Network Analysis (TNA) is a specific type of Thematic Analysis (Attride-Stirling, 2001). TNA provided a method to depict Basic, Organizing and Global Themes that emerged from the data.

TNA is an inductive process that proceeded as follows: 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). NVivo software v.14 was used. Coding was undertaken by the first author. To ensure the strength of the interpretation all members of the research team reviewed and discussed the findings. This constituted a measure of reliability checking in qualitative research called ‘objectivity as intersubjective knowledge’ (Kvale, 2008).

Sampling and Recruitment

Sampling proceeded as non-probabilistic, accessible and purposive (Creswell & Clark, 2007; Lynn, 2016). This was because patients could not be randomly chosen as they needed to have capacity to consent and be willing to participate. A purposive sampling design was followed to mitigate these limitations. Individuals with a range of diagnoses, levels of security, genders and ethnicities were approached. Thus, low, medium and high secure hospitals were

involved, and different wards that provide care for specific diagnoses and genders were approached. Table 1 summarizes the inclusion and exclusion criteria.

The project was presented at ward community meetings to both patients and staff. Interested patients could approach the researcher directly or by indicating their interest to staff. Patients were given information sheets and the project was explained to them. Patients were given at least 24 hours to reconsider participation before a meeting was set.

Table 1 – Inclusion and Exclusion Criteria

Participants

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 Mental Health Act 1983 section was a Hospital Order with Restrictions s.37/41 (n=10), followed by a Prison Transfer with Restrictions s.47/49 (n=4) and a Civil Section s.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). All interviews were audio recorded and transcribed verbatim.

Ethics

Ethical approval for this project was granted by the Leicestershire South Research Ethics Committee. Administrative approval was granted by the Health Research Authority of the NHS. The study reference code was: 17/EM/0159.

Results

Five Global themes and twenty-one Organizing themes were identified inductively in the data. These were supported by Basic themes as direct references to the interview data. Basic themes included for instance: ‘safety’, ‘risk’, ‘culture’, ‘skills’ and ‘punitive’; and were grouped into Organizing themes. Global and Organizing themes are depicted in Figure 1 as a Model of Restrictiveness as described by respondents. Basic themes are presented as references to direct excerpts from the interviews in the results below and marked with the participants’ number (e.g. P3 is participant three). Many Basic themes were situated across several Organizing themes forming a network of related themes. A complete list of all codes is available upon request by contacting the corresponding author.

Respondents articulated narratives in which restrictiveness was deeply subjective. Reasons were given for why they felt care was at times restrictive. Arguments were proffered by respondents justifying or delegitimizing restrictions. The analysis revealed five Global themes that help explain this view. 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 subjectively experienced by patients; and 5) the consequences of these phenomena as expressed by patients. These five Global themes are presented as a Model of Restrictiveness and are discussed in turn.

Figure 1 – Model of Restrictiveness

Antecedent Conditions to Restrictive Phenomena

This theme consisted of three sub-themes; risk, resources, and the purpose of the forensic psychiatric system. It highlights the reasons why restrictive phenomena exist in the first place, representing the first level of the Model of Restrictiveness.

The management of risky behaviours to avoid harm such as aggression, bullying or self-harm was frequently given as a justification for the perceived 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 concern. Concerns over risk led to certain items and activities being prohibited and limiting patients' scope for agency; participating in activities, reading a book about karate and accessing certain spaces, for instance. Risk management was felt to stretch beyond that necessary to provide a safe therapeutic milieu. It was described as if omniscient, woven into the fabric of the hospital.

P 12 – 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.

Respondents felt that certain aspects of life 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. The consequence of staff shortages included not being able to get a hot drink made (P10), having fresh air trips cancelled (P10), asking staff to do things for them (P11), visiting occupational activities (P12, P18, P7, P9), having a limited number of communal rooms open at one time (P15), cancelled visits (P18), being confined to rooms for easier observation (P4) and accessing personal belongings in locked cabinets (P9).

The degree to which life in a secure setting was experienced by patients as restrictive was to some extent contingent on whether they felt care or custody, and their accompanying ideological commitments, prevailed. These perspectives were felt to be influenced by staff attitudes, levels of security and media representations of secure care. A clear illustration of this lies in a civilly sectioned patient's feelings about being taken out of hospital grounds in handcuffs.

P5 – I'm a section 3 so there's no way I'm gonna wear handcuffs to go to the dentist.

The punitive aspects expressed by patients were also discussed by some in frustration 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 a mentally disordered offender (P14), bedrooms described as cells (P17) and the number of locked doors (P18).

Restrictive Phenomena

Restrictive elements of care were described as discrete phenomena. These included 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 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. Themes concerned the day-to-day, relational, symbolic and temporal; they depict the second level of the Model of Restrictiveness.

Daily Life.

Phenomena of daily life refer to the built environment, the number and types of possessions and consumable goods permitted on-ward and the range of activities available to patients. In different ways these restricted patients' autonomy of movement and their ability to develop social and occupational skills.

The built environment was described by one patient 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).

The number and types of personal belongings and consumable goods limited included alcohol (P9), a dictaphone (P10), pets (P7, P15), opposite gender clothing and wizard's robes (P15), Islamic dress (P16), shoelaces (P8), modern games consoles (P3) and internet access (P1, P2, P12, P15, P17, P5, P9).

Activities such as OT, education, leave and exercise were discussed as being inaccessible or lacking meaningfulness. Respondents felt they were deprived of opportunities to increase occupational or social skills. 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).

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.

Relationships with staff were described as an 'Us v Them' dynamic. Staff were gatekeepers, playing a role in accessing certain belongings and progressing through one's pathway. Some staff attitudes were described as custodial or abusive. Where this was the case, patients felt staff would be less likely to enable their progression through care or facilitate day-to-day activities and tasks.

Other patients were felt to restrict respondents in where they could go, monopolizing resources, instigating incidents leading to blanket bans and jeopardising progression out of care. Respondents felt mixed wards put them in danger, experiencing other patients as bullies and having to alter their daily routine around them. A cumulative effect of these interactions was an atmosphere described as 'intense' and 'unpredictable' (P11), 'tense' (P12), 'terrible' (P14) and 'non-therapeutic' (P17).

Association with family and friends outside secure hospitals was often experienced as limited, leaving many feeling estranged. Lengthy accreditation processes to admit visitors or the hospital's geographic distance from their hometown were cited as some reasons for this.

Sexual interaction with others was banned. One participant felt unable to develop a meaningful intimate relationship whilst inside 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 time's getting short for that sort of thing.

Symbolic.

Restrictive phenomena also operated in a symbolic fashion. These phenomena were described as sometimes having a material element but resonated at a more abstract level. Participants described feeling like an object to be managed; with a reshaped identity as an excluded 'other'; and voiceless, denied agency in both hospital and wider social citizenship.

Several patients felt they were not unwell and thus well placed to move on in their pathway with one describing his frustration at being told "you're unwell" you know, 'there's something wrong with you', 'you need help' kinda thing', you know' (P1). This led to dissatisfaction with treatment, feeling stuck in care (P15).

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

P10 – 'You need to give us this, this, this and this explain[ation]' but then if you can't give them that explanation 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.

For some, the notion of being managed felt compounded and reinforced by clinical notes. They felt staff only wrote examples of adverse behaviour or symptoms of their mental health which left them painted in a negative light.

The aforementioned left some patients aiming to play the system, eschewing the hope of meaningful recovery. Feeling objectified or denied patient-centred care was expressed by respondents as voicelessness. This disempowerment was evidenced in the degree to which patients felt they could act with agency in life inside and outside the hospital.

This was in part because they felt a significant restriction on information flows. This refers to the extent to which patients were given comprehensible information about their care and rules on the ward that they understood and in turn could speak out about, appeal their stay, participate in care plans, alter day-to-day life on the ward or express themselves more broadly (P5, P14, P15).

Some patients felt stigmatized, existing as an ‘other’ group in society (P1, P2, P4, P14, P18). P2 felt the wider public saw him and other patients as ‘mad axe men’. This was largely born of their status as a mentally disordered offender but furthered by their inability to engage meaningfully inside hospital or in wider social interactions. P17 expressed feeling that they are ‘...not in the real world, because things aren’t like that in the real world’. 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.

Temporal.

Patients described a feeling that time moved more slowly in the hospital than it did outside. Respondents struggled with indefinite lengths of stay, particularly if this 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). Such lengths of stay meant some felt ‘stuck’ and ‘bed-locked’ (P10) or saw this as a form of punishment (P18).

Respondents would refer to ‘hospital-time’. This was felt on a day-to-day basis with simple requests for goods or help from staff (P12, P9), gaining leave (P6), being added to OT sessions (P10) or more significantly in relation to communications with the Ministry of Justice (P4, P7, P8). This left patients disempowered, denied information or agency in both menial and significant aspects of their life. This restrictiveness is not immediate. Rather it follows the forensic patient beyond the confines of their care.

Mechanisms of Enactment

Restrictive phenomena were both intended and unintended. Unintended restrictions are those experiences of restrictiveness recounted by patients that cannot be attributed to the hospital or wider forensic psychiatric system. Conversely, intended restrictions described the exercise of power and control that shaped the enactment of phenomena considered restrictive. The third level of the Model of Restrictiveness highlighted that power and control were described as both soft, distal and bureaucratic; and visible, routine and coercive.

Soft, Distal and Bureaucratic.

Respondents experienced 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 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.

Respondents asserted that decisions were taken out of their spheres of influence. The hospital and Ministry of Justice operated in a hidden space or black box described as overly bureaucratic.

P7 – 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 say [one says] it's waiting for bureaucracy to pull their finger out and the bureaucracy is too much.

Power was described as a punishment and reward system. This system rewarded institutionally desirable behaviour but restricted privileges and the progression of those in discordance with these aims. Gaining leave was given as an example of this (P9). Observation also fell within this form of soft power. Observation was described as constant and persistent (P1, P15, P12, P9). This ever-present gaze left patients feeling untrusted.

Visible, Routine and Coercive.

Mechanisms of power were also described in more obvious and tangible ways. Security was described as one of the most significant. This included room searches, limitations on visitors, the walls, restricted phone calls and locked cupboards and doors.

Respondents felt that there were too many rules and regulations and that these were too strict (P3) or stupid (P5). Patients also expressed a dislike for the highly routinized environment. This was felt to limit autonomy of movement and choice when structuring one's day, diminutive of normality and spontaneity (P2) and individuality (P14). Blanket bans were highlighted by patients as especially restrictive, perceived as unfair given they were enacted due to the past actions of others or were unnecessary (P1, P10, P12, P18, P4, P12). Participant four described these as '*...patronizing, it feels kind of like untrusting*'.

Coercive measures, typically defined, were not discussed at length in the interviews. This is because patients' experiences of coercive measures are well documented (Bergk, Flammer, & Steinert, 2010; Brunt & Rask, 2005; Daffern, 2013; Haw, Stubbs, Bickle, & Stewart, 2011; Hui, Middleton, & Vollm, 2012; Repo-Tiihonen, Vuorio, Koivisto, Paavola, & Hakola, 2004; Soininen et al., 2016; Vincze, Fredriksson, & Wiklund Gustin, 2015). However, respondents described seclusion as punishing (p4), rare (P9), boring (P5) or distressing to witness (P17). Forced medication was described as a violation of one's will and a scheme to control patients (P14, P15). Others chose to take medication only to avoid being forced to do so (P5).

Experiences of Restrictive Phenomena

The data shed light on how, subjectively, patients experienced restrictiveness. These experiences fall into the fourth level of the Model of Restrictiveness. Restrictive phenomena were sometimes described symbolically as infringements of autonomy, self and personhood. Prior, vicarious, normative and logical knowledge were drawn upon when patients described their expectations and experiences of the restrictiveness of their care. Experiences of

restrictiveness were largely described in a fashion consistent with Sexton's (2015) analysis of Penal Consciousness. This proposes that the *severity* and *saliency* of an analogous experience (punishment in prisons) is shaped by the degree to which one experiences a restrictive phenomenon as symbolic in its consequence and the gap between one's expectation and experience of a restrictive phenomenon.

Severity.

The severity of restrictiveness lay in to what extent respondents experienced a restrictive phenomenon as something violating their autonomy, sense of self or personhood. For instance, P17 discussed not being able to have perfume or a smartphone in her room. When relaying her experience of this she considered it in symbolic terms. The ban represented a loss of normalcy, pointing her out as different and spoiling her identity.

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.

Participant fourteen highlighted that 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. Participant five stated that the restrictions we had been discussing affected his sense of self and identity, leaving him feeling like '*...just a number or something*' (P5). Discriminating between restrictive phenomena that have little symbolic consequence and those experienced as affecting one's autonomy, sense of self or humanity added to the severity of those restrictive phenomena.

Saliency.

The saliency of a restrictive phenomenon for an individual was the expression of an expectation-reality gap. The greater the distance between patients' expectations of the severity of the restrictiveness of their setting and their experience of this, the higher the level of saliency.

Respondents' prior and vicarious knowledge of the restrictiveness of secure care was based upon their expectations of a secure hospital, their experiences of previous secure hospitals or prison-life, and anecdotes heard from others.

One individual thought his care 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). Patients compared stories they had heard and reflected on these differences. Participant one stated *'I've heard that you know out of all the high secures, this one's most strict'*. 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.

Normative knowledge refers to what extent patients felt restrictive phenomena ought to be like and whether these seemed fair. Several respondents felt their placement in secure care was unfair, considering their detention inappropriate given they felt wrongfully convicted (P13, P14, P15). Some expressed that it was unfair when the actions of other patients had a rippling effect with consequences for them (P1, P2, P12, P18). Conversely, respondents felt some restrictions were fair or justified. Participant seven stated that it was fair he was not allowed leave yet as *'I do need to be punished for what I did'*.

Logical knowledge refers to respondents' efforts to make sense of restrictive phenomena. 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. Participant twelve felt it contradictory that he was able to use a lawn mower off-ward but no nail-clippers on-ward. Participant four highlighted this illogicality:

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.*

Where restrictive phenomena did make sense to respondents, the expectation-reality gap was smaller and the salience of these lesser.

Consequences of Restrictiveness

The final level of the Model of Restrictiveness concerned the consequences of restrictive phenomena that respondents identified. They noted how these made them feel and how they altered their behaviour deliberately or unintentionally over time.

Participants described feeling bored (P2, P3, P14, P17, P18, P5, P7, P8); and 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). Other emotional consequences included: 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); degradation, patronization, insignificance and humiliation (P10, P4); and sadness at not having leave, not being able to visit family and having restricted access to the internet (P8, P14, P15). These had the net effect of diminishing individuals' sense of dignity. 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.

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 short-term adjustments were discussed.

Many years of intensive therapy sessions in the controlled secure environment left P4 feeling ‘therapized’. He felt unable to have normal interactions and conversations with others. 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 ‘*just cope with it*’. Participant seventeen felt the controls of the secure setting have 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.

Discussion

The present study sought to better understand patients’ experiences of the restrictiveness of forensic mental health services. 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 patients’ experiences as depicted in the Model of Restrictiveness (Figure 1). The model provides a framework through which to understand the restrictiveness described by patients in forensic mental health services.

Restrictive phenomena do not exist in a vacuum. They are influenced by the antecedents of risk management, resources and the purpose of forensic care. Risk has been cited as a primary concern across forensic settings (Markham, 2018), its 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). Where the purpose of forensic care is perceived as more carceral, respondents feel punished, experience limited freedom of movement, suffer long-term stigma and receive mixed messages about their recovery (Adshead, 2000; Brunt & Rask, 2005; Holmes & Murray, 2011; Horberg, Sjogren, & Dahlberg, 2012; Ruane & Hayter, 2008; Vincze et al., 2015).

Other studies reporting on patients' experiences of their care found patients perceived limitations on personal belongings and the built environment as custodial, restricting autonomy, leaving some feeling punished and preferring prison (Enser & MacInnes, 1999; Haw et al., 2011; Holmes, 2005; O'Connell, Farnworth, & Hanson, 2010; Parrott, 2005; To, Vanheule, De Smet, & Vandevælde, 2015). Risk concerns are often cited by services as a justification for less engaging activities and restricted access to personal belongings (Mann et al., 2014; Markham, 2017).

Relationships with staff, other patients and individuals outside the hospital were described as restricted or restricting. Staff have elsewhere been described as key-holders, lacking in empathy, disempowering, forceful, abusive and of a higher-status (Davies, Heyman, Godin, Shaw, & Reynolds, 2006; Haw et al., 2011; Holmes, 2005; Larkin, Clifton, & de Visser, 2009; McKeown et al., 2014; O' Sullivan, Boulter, & Black, 2013; Whitehead & Mason, 2006). Such dynamics result in poor therapeutic relationships and ward atmosphere; and patients feel disempowered when having to ask staff for everything (Ireland, Halpin, & Sullivan, 2014).

Respondents attributed some restrictions to the behaviour of others. Reduced movement around hospitals was due to perceived manipulation by individuals with different diagnoses (O'Connell et al., 2010); cumulated stress and noise (To et al., 2015); or raised likelihood of aggression and risky incidents (Becker, Love, & Hunter, 1997; Urheim, Rypdal, Palmstierna, & Mykletun, 2011). Patients in other studies have expressed not being allowed meaningful time with significant others (Quinn & Happell, 2015), finding it easier to receive visits from children in prison than in a medium secure hospital (Parrott, 2005) and being denied any sexual contact (Dein et al., 2016; Mercer & Perkins, 2014; Quinn & Happell, 2015; Ruane & Hayter, 2008).

Respondents described symbolic restrictions. They discussed being treated as an object to be managed, restricted participation in flows of information and ultimately 'othered' by society.

Studies have reported some patients aim to ‘play the system’ to avoid being stuck in settings they don’t think they belong in (Goffman, 1961; McKeown et al., 2014; Vincze et al., 2015). Patients describe not being listened to or taken seriously (Davies et al., 2006; McKeown et al., 2014), having behaviours pathologized by staff (Larkin et al., 2009) and resorting to engaging in risky incidents to gain attention or control (Ireland et al., 2014). The pathologization and curtailed participation in care described by respondents might add to patients’ sense of exclusion and otherness, furthering the stigma experienced by mentally disordered offenders (Mezey, Youngman, Kretzschmar, & White, 2016).

Restrictive phenomena were enacted in ways both soft, distal and bureaucratic; and visible, routine and coercive. The former was described as unnegotiable security, inaccessible decision-making processes, incentive schemes to encourage certain behaviours, and constant observation. These restrict autonomy and choice in subtle and hidden ways that shape patients’ ability to self-determine (Foucault, 1977; Holmes & Murray, 2011).

Overt restrictive phenomena were also described. These included physical and procedural security, regulations, and coercive measures that restrict more visibly. Security conceived of as a hegemonic power is sometimes prioritized over ideals central to a therapeutic milieu (Brunt & Rask, 2005; Cashin, Newman, Eason, Thorpe, & O’Discoll, 2010; Holmes, 2005; Mann, Matias, & Allen, 2014; McKeown et al., 2014). Rigid ward rules have been found to lead to power struggles (Urheim et al., 2011) and as obstructive to patients’ control, leaving them feeling stressed and infantilized (To et al., 2015).

Experiences of restrictiveness were deeply subjective. This can be explained by Sexton’s (2015) Model of Penal Consciousness. Respondents in this study described feeling that their autonomy, self and personhood were negatively affected during their care. Where the experienced severity of a restrictive phenomenon exceeded that anticipated by a patient this had greater salience. Respondents’ expectations of the restrictiveness of their care comprised

four knowledge types: prior, vicarious, normative and logical. Respondents' previous experiences of secure 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 often to a greater salience and sense of restriction.

Respondents discussed several consequences of restrictive phenomena. They noted how these made them feel and how they altered their behaviour deliberately or unintentionally over time. Experiences of boredom and a sense of resignation are represented in other studies and is a result of a dearth of meaningful activities, length of stay and rigid and routinized nature of forensic care (Horberg et al., 2012; O'Connell et al., 2010; Parrott, 2010; Phillips, Burnard, & Morrison, 1996). Respondents described adapting deliberately and unintentionally to aspects of care they experience as restrictive. Extreme adaptations to a perceived lack of control reported in other secure settings include engaging in critical incidents such as absconding and hostage-taking (Ireland et al., 2014).

The above demonstrates that the experiences of restrictiveness described in this study reflect the reality of life in secure care for patients in other secure hospitals and lends empirical support to the themes presented within the Model of Restrictiveness.

Limitations

This study has some limitations. Interviews were conducted within one NHS Trust and therefore cannot be assumed to generalize to other regions. Although undertaken in low, medium and high secure hospitals, the spread of participants was not reflective of national distribution of patients across these levels of security. Indeed, the results might reflect the experiences of patients in high secure settings more than other levels. Only two female patients were involved in the study, and black and minority ethnic individuals were underrepresented.

Patients with learning difficulties were not included in this study. This was largely due to logistical limitations in recruitment and the sites available to the study team; but decreases the transferability of the findings for individuals outside this group. For this reason, further research with a larger, more heterogenous sample is needed to explore the themes in this study further.

Implications for Practice

The results indicate implications for practice. 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 patients to demonstrate responsibility and thus exercise autonomy and choice.

The Model of Restrictiveness, informed by Sexton (2015), helps us understand why restrictions are not equally severe or salient for each patient. Praxis should include meaningful conversations with patients to explore whether restrictions are experienced as diminutive of their autonomy, sense of self or humanity. Thus, alternative approaches that have less consequence on 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 patients if they are logical and accessible. This will promote a sense of legitimacy and fairness. Relatedly, improving relationships with security teams will diminish perceptions of security as a distant hegemonic power and give opportunities to discuss restrictive security measures.

Conclusion

The Model of Restrictiveness described in this study helps us to understand what and how phenomena in forensic mental health services are experienced as restrictive and what consequence these may have. Restrictiveness understood in this way is broader than ‘least restrictive practices’ typically understood as restraint, seclusion and forced medication. The interviews provide a rich account of respondents’ experiences of life in secure care and encourage us to reflect critically on these conditions. These findings should inform decision-making processes when striking the correct balancing between a safe and secure setting that manages risk and one that offers a positive and sensibly-permissive therapeutic milieu.

Future research should attempt to better understand the consequences of experiences of restrictiveness. This study is part of a larger project to measure experiences of restrictiveness and explore associations with outcomes of interest including quality of life, ward atmosphere, frequency of aggressive incidents, recovery and recidivism. To that end a valid and reliable measure of subjective experiences of restrictiveness is needed.

Declaration of Interests

There are no interests to declare.

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