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Title: Experiences of Restrictiveness in Forensic Psychiatric Care: Systematic Review and Concept Analysis

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Abstract

Mentally disordered offenders may be sent to secure psychiatric hospitals. These settings can resemble carceral spaces, employing high levels of security restricting resident autonomy, expression and social interaction. However, research exploring the restrictiveness of forensic settings is sparse. A systematic review was therefore undertaken to conceptualize this restrictiveness. Eight databases were searched for papers that address restrictive elements of secure forensic care in a non-cursory way. Fifty sources (empirical articles and policy documents) were included and subject to thematic analysis to identify 1) antecedent conditions to, 2) characteristic attributes, 3) consequences and 4) 'deviant' cases of the developing concept.

The restrictiveness of forensic care was experienced across three levels: individual, institutional and systemic. Restrictiveness was subjective and included such disparate elements as limited leave and grounds access, ownership of personal belongings and staff attitudes. The manner and extent to which these are experienced as restrictive was influenced by two antecedent conditions; whether the purpose of forensic care was to be more caring or custodial and the extent to which residents were perceived to be risky. We argue that there must be a reflexivity from stakeholders between the level of restrictiveness needed to safely provide care in a therapeutic milieu and enable the maximum amount of resident autonomy.

1. Introduction

Forensic psychiatry is a specialism within the practice of psychiatry. As a discipline, it aims to both treat individuals suffering from a mental disorder who have committed a criminal offence and protect the public from further harm. It therefore fits within both healthcare and criminal justice systems (Sugarman & Dickens, 2015). Individuals residing in forensic settings (herein after referred to as residents) need a safe environment to recover free from stigmatization and victimization and the public has a right to be free from harm (Urheim, 2011). Residents' lives may be fully encapsulated within a forensic hospital. Forensic settings detain individuals found not guilty by reason of insanity; are considered too unwell at the time of conviction to receive a penal sentence or stand trial; are detained for assessment; or have been designated too risky for general psychiatric settings.

The environment within which this care is provided is therapeutically driven, yet risk-averse and highly secure. Forensic settings have been described as both unethical apparatuses of state control wherein behavioural modification programmes deny residents any true autonomy (Holmes & Murray, 2011) and as "a crucial element in the delivery of therapeutic outcomes for patients, their safety and the safety of the wider community" (DoH, 2010a). These competing prerogatives pose significant challenges to staff when delivering care and can result in a finely-balanced weighting of operational objectives.

1.1. Deprivation of Liberty and Forensic care

In attempting to provide treatment and manage risk, forensic psychiatry operates within prevention and protection models of liberty deprivation (Slobogin & Fondacaro, 2000). A 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 that

may occur 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).

Crucial in achieving these aims is the provision of forensic services in a humane, ethical and treatment-oriented manner that encourages residents' personal recovery (Pouncey & Lukens, 2013; Simpson & Penney, 2011) adopting offence- and personality-centred individual or group approaches (Borchard et al., 2012). Good therapeutic relationships between staff and residents and positive ward atmosphere (Schalast et al., 2008; Tonkin, 2016), satisfaction with care (Bressington et al., 2011), improved quality of life (Vorstenbosch et al., 2014) and engagement in meaningful activity (Craik et al., 2010; Linstead & Brooks, 2015) amongst other considerations are integral to residents' recovery pathways and in reducing reoffending (Bouman, 2009; Ward & Brown, 2004).

Deprivation of liberty for these ends is codified in international human rights law. Art. 5(1)(e) of the European Convention on Human Rights (ECHR) stipulates that states can deprive an individual of their liberty when of 'unsound mind'. Case law of the European Court of Human Rights (ECtHR) asserts that individuals can be detained in psychiatric healthcare settings for as long as treatment is offered, even if this treatment amounts simply to the presence of a 'therapeutic milieu' (Hutchison Reid v the United Kingdom (2003), 37 EHRR 9; MD v Nottinghamshire Healthcare NHS Trust (2010) UKUT 59 (AAC)). According to the ECtHR, where a therapeutic milieu exists in the forensic care setting these individuals may be kept for indefinite periods of time. This represents a significant deprivation of liberty. It is crucial that forensic settings are therapeutic and do not restrict residents beyond that necessary to manage actual risk and provide care.

1.2. 'Least Restrictive' Philosophy

It is increasingly considered best practices to provide psychiatric care in the 'least restrictive' setting or manner (Atkinson & Garner, 2002). Rationale for the 'least restrictive' alternative is grounded in a desire to promote resident autonomy and choice in their care pathways and respecting individual's rights of liberty and to humane treatment (Markham, 2017). This sentiment is embodied in national law, jurisprudence and clinical best practice across Western democratic nations. 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' and 'least restrictive' was commonly considered as a general philosophy of 'paramount importance' (Salize et al., 2002). The Dutch *Argus* national database stores data on every intervention that limits or restricts a resident's freedom of movement (OECD, 2014). In the U.K., the National Health Service (NHS) has initiated a payment-incentive scheme to reduce restrictive practices in adult low and medium secure forensic settings, in line with national guidelines (Mental Health Act 1983, Code of Practice 2015). The programme 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, 2017). The U.S. Supreme Court in *Olmstead* held that states are required to transfer residents from institutional settings to community care when considered clinically appropriate, can be reasonably accommodated, is not opposed by the resident concerned and having consideration for state resources and other residents' needs (Olmstead V. L. C. (98-536) 527 U.S. 581 (1999)).

Despite the attention given to providing care in the least restrictive setting or manner, no effort has been made to conceptualize this phenomenon so that a common definition generated from empirical reality inside secure settings may be adopted. What elements of forensic care are restrictive? Is there a hierarchy of restrictive practices? Do all residents experiences the restrictiveness of their care in the same way? How does restrictiveness differ from coercion? The NHS considers restrictive practices to include physical and medical restraint, observation, segregation, negative ward culture, poor service user involvement across care and blanket restrictions that are not "*proportionate, measured and justified responses to individuals' identified risks* NHS, 2017). The U.S. Supreme Court ruling in Olmstead would suggest restrictiveness arises from an individual's placement within institutional care but does not elaborate on degrees of restrictiveness within care settings.

Academic literature in the field of (forensic) mental health discusses at length coercive measures such as restraint, seclusion and forced medication (Hui et al., 2013); the ethical issues of hospitalizing residents in psychiatric institutions (Adshead, 2000; Jones & Fowles, 1984; Völlm et al., 2016); resident satisfaction with forensic care (Bressington et al., 2011; MacInnes et al., 2010); human rights in psychiatric care (Penny & Exworthy, 2015) and institutionalization (Chow & Priebe, 2013) but no research has yet addressed the explicit question of how residents experience the restrictiveness of forensic care. 'Repression' in Dutch Youth Offender Institutes (YOIs) has however been explored (de Valk et al., 2016; de Valk et al., 2017). The authors define repression in YOIs as interactions between youth, staff and the institution that intentionally harms or unlawfully or arbitrarily deprives youth of their autonomy or liberty. This systematic review builds on the work of de Valk et al. (2016) by focusing on literature pertaining to adult forensic settings.

1.3. Aims and Rationale

Asking how forensic residents experience the restrictiveness of their care is important as it will add empirical weight to discussions around the ethical conditions of forensic care; permit us to operationalize the concept and measure associations with resident recovery, outcome measures, and develop more sophisticated individualized care pathways. This is a sensitive task as much of what is restrictive in forensic care is subject to security measures maintaining the safety of staff and residents – however, there is a moral imperative to ensure that burdensome and prohibitively restrictive elements of care do not adversely affect resident recovery and autonomy and are not rooted in institutional stagnation, cultural paternalism or retributive attitudes.

Here we present a systematic review of both empirical and policy literature with the aim of conceptualizing the restrictiveness of forensic care as described by residents, staff and academic commentators. With a better understanding of this phenomenon we can explore the effects that restrictiveness can have on residents directly and forensic psychiatry's aims of treatment and risk reduction more broadly.

2. Material and Methods

This systematic review is a qualitative concept analysis (Booth et al., 2012) that aims to synthesize the defining attributes of a concept of 'restrictiveness' across forensic psychiatric care settings of all security levels. 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 we wish to understand (Walker & Avant, 2011: 157). Adapting the approach advocated by Walker & Avant (2011) this

systematic review identified 1) antecedent conditions to, 2) characteristic attributes, 3) consequences and 4) 'deviant' cases of the concept of restrictiveness in forensic care.

The terms 'forensic', 'psychiatry', 'mental disorder', 'restrict', 'autonomy', and 'freedom'; and respective synonyms/antonyms were put into PsychINFO, Medline, EMBASE, Westlaw, PubMed, the Cochrane Library, Google Scholar and Google Search. 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 of any clinical diagnoses. 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 as any externally-derived negation of resident autonomy against their will. Papers were excluded if they were opinion or commentary pieces; set in prisons, general or out-patient care settings; or not in the English language. A full list of search terms and inclusion/exclusion criteria can be found in Table 1.

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 & Clark, 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. Themes were generated by JT and discussed with all three authors to strengthen the analytic validity of the results (Kvale, 2008). Fereday & Muir-Cochrane (2008) emphasise the importance of coding data deductively within the thematic

framework the researcher is developing. For instance, certain personal belongings such as photographs from family could be coded within the 'individual – tangible' or 'individual – resident to outside world' subthemes. Thinking deductively helped code personal belongings into the former theme when such items are simply described as prohibited or coded into the latter when prohibited access is discussed as being illustrative of lost connections to outside world. Combining inductive and deductive approaches therefore provided a richer and more rigorous thematic framework to inform the concept analysis.

3. Results

3.1. Articles Included in the Systematic Review

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 fifty sources were included in the systematic review. This process is illustrated in figure 1. Articles originated from the U.K. (62%), Canada (10%), Sweden (6%), the United States (4%), Australia and New Zealand (4%) and five other European nations (10%). A full list of sources included in this systematic review can be found in Table 2. Three of the documents from the U.K. were Department of Health guidelines on providing forensic care and security in forensic mental health.

3.2. Superordinate and Subordinate Themes

Ten subordinate themes developed throughout the analysis with four superordinate themes. This is illustrated in Figure 2. Over 600 codes were generated in NVivo, the ten most widely appearing are listed in Table 3 and a complete list of all codes is available upon request by contacting JT. Themes consist of clusters of elements of care and the forensic setting that

residents, staff or commentators identified that were considered by the authors to be negations of resident autonomy or against their will. These themes fall into the three superordinate themes, or levels; individual, institutional and systemic. A fourth superordinate theme identified as the antecedent conditions of the forensic setting comprises the purpose, or *telos*, of the forensic care system and the extent to which residents are considered risky by those working in forensic care. Consequences of these restrictive elements of care are outlined as are some deviant-cases – those elements of care identified as restrictive by some but not by others. The four superordinate themes are now described in turn. Examples that capture the essence of each theme as constructed during the coding process are given.

3.2.1. Individual

3.2.1.1. Relational

The literature identified four types of relationships that affect the restrictiveness of the setting; resident to resident, staff to resident, staff to staff and resident to outside world. Resident to resident interaction that was characterized by mistrust, fear, superficiality or dislike limited movement around the care setting, engagement in certain activities and the development of social skills. Residents may prefer to be segregated from each other depending on their grouping or diagnosis or for fear of aggressive incidents. A resident 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..." (O'Connell et al., 2010). Parrot (2010) discovered an informal market of trade between residents developing debts towards each other. One resident said of being in such debt "[s]ometimes they disturb you at night, banging on the door, it's hard to avoid. But it just causes a lot of arguments when things get exchanged". Most forensic settings prohibit sexual contact between residents predicated on the perceived risks of harm,

pregnancy, exploitation and detrimental therapeutic impacts despite there being “no evidence that the prohibition of sexual contact on psychiatric wards will improve the safety of inpatients” (Dein et al., 2016).

The interaction between residents and staff was the most salient theme addressed in the literature. This dynamic was oftentimes framed in ‘Us v Them’ or ‘oppositional’ language (Horberg et al., 2012; Larkin et al., 2009; Brunt & Rask, 2005; Dickens et al., 2005). Staff were described variously as key-holders, lacking in empathy, insensitive, disempowering, forceful, abusive, prone to over-reaction or of a higher-status (Davies et al., 2006; Haw et al., 2011; Holmes, 2005; Larkin et al., 2009; McKeown et al., 2014; O' Sullivan et al., 2013; Whitehead & Mason, 2006). Ireland et al. (2014) and To et al. (2015) report residents asserting that they had to beg staff to get anything on the ward or having to demand attention.

Staff attitudes were identified as restrictive for residents. These were described as authoritarian, conservative and enforcing conformity (Dein et al., 2016; Holmes, 2005). It was largely the attitudes of staff that prevented sexual expression between residents (Ruane & Hayter, 2008). Residents frequently expressed frustration at a lack of communication and information provided by staff. This was felt most acutely during coercive measures wherein residents felt they lacked information as to why they were being secluded, restrained or injected intra-muscular medication (Haw et al., 2011; Repo-Tiihonen et al., 2004). Residents described the importance of being listened to, “staff 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). Horberg et al. (2012) interviewed residents who avoided expressing to staff how they felt for fear of punishment or loss of privileges. Interaction amongst staff plays a crucial role in constructing ward atmosphere, institutional policies – both written and spoken – and

affecting the provision of care. A nurse reported "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). Such interaction can serve to reinforce attitudes and practices.

Residents' interactions with the outside world manifested in several ways; some direct, including receiving visitors or taking periods of leave; others less so, using radio and other media or aid memoires such as clothing or photographs of loved ones. These manifestations are all to various degrees restricted in forensic care. Restrictions on visitors include who, when, and at what time family or friends may visit and what food they may bring with them (Urheim et al., 2011; s.12 (5)(a) High Secure Directions, 2013). Residents found restrictions on contact with loved ones 'frustrating' and 'terrible' (Quinn & Happell, 2015). In one instance a mother could see her children immediately when in a prison setting but had to wait weeks for permission after transfer to a secure psychiatric setting (Parrott, 2015).

3.2.1.2. Tangible

The literature identified various consumable goods that residents may be restricted access to including: tea and coffee, smoking, foodstuffs and illicit drugs. Oakley et al. (2013) found in a study of medium secure units in the UK that two-thirds of participating centres restricted access to caffeine. Possessions such as toys, photos, clothing or pornography may serve practical use, contain memories or provide excitement in the face of boredom (Parrot, 2010). Such objects may be personal and private or for sharing and to facilitate social interaction. The degree to which personal belongings are restricted varies across institutions and levels of security but is often the result of risk-averse security policy (Brown et al, 2001; Parrott,

2010). These restrictions may preclude ownership of any personal belongings (Holmes & Murray, 2011).

3.2.2. Institutional

3.2.2.1. Built Environment

Some forensic care hospitals were characterized by their oppressive physicality and prison-like appearance. These settings were described as total and panoptical with “perimeter security, windows that barely open, panic alarms and double-locked entrance and exit doors are featured alongside garden landscaping” (Parrot, 2005). ‘Prison’ was a 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). Some residents felt incarcerated, reporting “[b]eing dragged away and put in a room on my own and locked in” (Haw et al., 2011). The restrictiveness of these settings can stretch beyond the bricks and mortar of the buildings to include the range and meaningfulness across the activities available to residents, the hospital or ward culture and its resources, the mode of therapeutic care provided and the range of security measures employed.

3.2.2.2. Activities

The literature lists a disparate range of activities that may be prohibited or restricted such as cooking, fishing, occupational therapies, sports, sewing, accessing the internet or leave. In some cases no activities will be offered at all. “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). Access to activities is often based on risk assessment. For instance, in high secure settings in England and Wales individuals are not permitted access to hospital grounds unless recommended by their clinical team and approved by the site’s grounds

access committee, headed by the security team, or medical director (s. 36 (1) High Secure Detections, 2013). Not being able to go 'bushwalking', a resident 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). Access to many activities is often limited by staff shortages or security constraints, and when accessible, lack meaningfulness. This meaningfulness was crucial for residents who may consequently lack motivation to participate in hospital activities. A resident in the study by Craik et al. (2010) stated, "[p]ottery for grown men… finger painting, we've all done them when we were 5 years old at school".

3.2.2.3. Culture & Atmosphere

The culture of the forensic hospital plays a crucial role in enforcing or mitigate restrictive measures. Culture and atmosphere here refers to descriptions of the way wards felt to residents, staff or commentators. Secure settings were criticized in the literature for being conservative, oppressive, paternalistic, security-prioritizing, institutionalizing and introverted. Such climates could be volatile, "…it is almost like the thread that could burst at any time and it would be big trouble here. Everyone goes around and hates everyone" remarked a Swedish maximum security resident (Horberg et al., 2012). Even where a sense of domesticity and homeliness is achieved on a ward, residents may reject this not wanting to accept a sense of permanence. One resident added photos to her wall but later removed them stating, "It's not my home. My heart wasn't in it. I just want to leave here" (Parrot, 2005). Urheim et al. (2011) assert that culture is significant in defining attitudes towards discipline, punishment, coercion, the levels of autonomy given to residents and structured activity, rules and behaviour more generally. Such an environment may lead nursing staff to adjust to the demands of the culture of the unit instead of their residents' individual needs subjecting the

resident to the will of others, rather than empowering him/her to ‘ascribe meaning to his/her own life’ with the help of staff (Vincze et al., 2005).

3.2.2.4. Therapeutic

Certain aspects of therapy and medication employed in forensic settings were experienced as restrictive or difficult by residents. Medication, particularly anti-psychotics, can restrict resident engagement in activities and lead to weight gain (Mat et al., 2014; Oakley et al., 2013; Parrott, 2005). Medication might be used as a ‘plan B’ when staff are not able or willing to keep residents engaged in activity, “[the unit] sometimes feels like a nice new building to house people they don’t know what to do with. So we’ll pump them full of medication and sit them in the smoking room” (Davies et al., 2006).

Coercive measures such as seclusion, restraint and forced medication are often justified on therapeutic grounds (Daffern, 2013; Haw et al., 2011; Vincze et al., 2015). These interventions may be considered some of the most restrictive elements of psychiatric care as they can inhibit or preclude physical movement and cognitive activity. One resident said of restraint that “[staff] twist your wrists hard and dig their nails to put your face on the ground. They hold you down hard. You are screaming. They say calm down. It is harsh on us” (Haw et al., 2011).

Certain residents and commentators saw an over application of the medical model to be restrictive. Having a diagnosis of a particular disorder and being present in a secure unit served to classify residents, labelling them as deviant from social norms (O' Sullivan et al., 2013). This pathologization of behaviour was present elsewhere in the literature. “It's like/say when I hit Doctor White. The first week after I hit Doctor White, ‘Doctor Brown,’ I said, ‘Do

you know why I hit Doctor White?' He said, 'Because you was angry.' I said, 'Spot on.' The next week he said, 'I think you was suffering persecutory delusions.' The next week he says, 'It was a psychosis.' But that's it you see, the first week it was anger, which it was. It was just anger" (Larkin et al., 2009).

3.2.2.5. Security

Security measures (relational, physical or procedural) can constitute one of the most restrictive elements of secure care (Brunt & Rask, 2005). An over application of physical and procedural security measures can take priority over freedom of movement, therapeutic goals, positive risk-taking and individualized care (McKeown et al., 2014; DoH, 2011). A nurse in the study by McKeown et al. (2014) said, "[o]n my ward it is safety and security first, involvement and anything else come second to this". Security was sometimes used as a smokescreen through which to mask staff attitudes to certain behaviours; "[b]y claiming the importance of patient safety informants [staff] are able to accomplish their personal values whilst also linking this to their duty of care" (Ruane & Hayter, 2008). Settings that overemphasize safety can justify blanket policies engendering a no-risk culture. This affects the range of activities, accessible spaces and social interactions open to residents. This is echoed in Craik et al. (2010) who highlighted encumbrances upon occupational therapy sessions imposed by security, such as the prohibition of certain tools.

Residents are observed constantly in secure care (Parrot, 2005; Vincze et al., 2015). Observation plays a key role in managing resident and staff safety, and identifying potential risk and protective factors. However, Holmes & Murray (2011) write that constant observation leads residents to internalize their own behaviour and comport themselves accordingly. This embeds within the resident a way of thinking and behaving that serves to

further their classification as mentally ill restricting their autonomy in self-discovery and personal growth.

3.2.2.6. Practicalities

Certain constraints affect the running of forensic settings including the available financial resources, bed-occupancy rates and the extent to which hospitals engage in academic research. Poor budgets may limit staff numbers and training, access to occupational therapies and activities whilst soaking up staff resources during critical incidents (Craik et al., 2010; Ireland et al., 2014; Prebble et al., 2011; Urheim et al., 2011). A limited number of beds on-site may cause some residents to feel overcrowded and frightened (Mezey et al., 2010). The availability of suitable beds at external sites presenting a more suitable level of security for residents can mean they are restricted from progressing along their care pathway into less restrictive settings (Phillips et al., 1996; Whitehead et al., 2006).

3.2.3. Systemic

The literature discusses the regulatory and temporal qualities of the forensic care system. Fulfilling bureaucratic expectations around the management of residents was sometimes prioritized over optimizing individualized care plans; a formal rationality took precedence. Residents talk of 'navigating' this, cooperating and just doing what needs to be done (McKeown et al., 2014; Horberg et al., 2012). One individual remarked, "[y]ou go to the right groups… for 2 years… You've got to do all that before they let you go" (Craik et al., 2010). A nurse 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.'

3.2.3.1. Regulatory

A resident's legal status, such as being detained on a hospital or restriction order under the UK Mental Health Act 1983, can curtail their autonomy beyond merely being present in a secure unit to the available choices he/she has for exercise (Oakley et al., 2013). This regulation was seen by some residents as coercive, classifying them as objects to be managed, denied fundamental rights (Larkin et al., 2009; Daffern et al., 2010). A resident in the study by Quinn et al. (2015) stated, "[j]ust because we draw a pension and we're under the Mental Health Act doesn't mean that we don't have needs and wants for a relationship and sex". Given that forensic residents are often subject to legal or political controls, public opinion and media discourses surrounding forensic care may affect individuals' future prospects, restricting the likelihood of release or leave for high-profile residents (Whitehead & Mason, 2006).

Certain aspects of forensic care are enshrined in national law; however, many potentially restrictive elements of care are provided for in institutional policy. Restrictive policies highlighted in the literature include the banning or limiting of residents trading goods within a medium-secure unit (Parrott, 2010), smoking (Dickens et al., 2005), sexual expression between residents and with visitors (Mercer & Perkins, 2014), access to media such as computers, video games consoles and telephones (s.23 High Secure Directions, 2013), clothing (Brown et al., 2001; Holmes, 2005), the type, number and volume of resident belongings (s.21 High Secure Directions, 2013), resident access to their rooms and keys (To et al., 2015), seclusion (Repo-Tiihonen et al., 2004), and permission to open a fridge earlier than scheduled in the course of a healthy living programme (Prebble et al., 2011).
Certain restrictions may be necessary given the context of certain individuals' care plans but current literature and policy is unequivocal in discouraging blanket bans or policies. To et al.

(2015) found that ward rules were enforced to provide structure to the residents' day, security and for organizational practicalities but were "obstructive to the participant's feeling of control". They further write that residents experienced these restrictions as "stressful, childlike, too strict, too rigid, and not adjusted to the individual needs of each person" (To et al., 2015).

3.2.3.2. Temporal

Time featured as an element of the systemic constraints of secure care, discussed particularly in relation to residents' length of stay. Residents saw the indeterminacy of their length of stay as unbearable (Wilkie et al., 2014). As highlighted by one resident, "[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). Desiring to see their stay as temporary, Parrott (2005) observed that residents chose to express themselves in a fluid medium such as clothing and talk rather than investing effort and resources in furniture or decorating their rooms as this promoted a sense of permanence they wished to reject.

3.2.4. Antecedent Conditions

Underpinning each of the restrictive elements of care and daily life in forensic psychiatry listed above are the ways in which they are practiced or enforced. 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.

3.2.4.1. 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 penality. 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." 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". The fundamental nature of nursing practice changes as nurses are responsible for security and control alongside care (Vincze et al., 2015; Ruane et al., 2008).

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". 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).

3.2.4.2. Perceived or Actual Risk of Residents

The notion of risk management is ever-present in secure care, inhibiting the provision of services and activities and increasing security measures. Risk is considered the possibility of an individual engaging in abusive, harmful or antisocial behaviours to others or themselves. Forensic populations are perceived as being a particularly risky group to society (Wilkie et al., 2014). A nurse in a study by Dein et al. (2016) reported that "…[e]verything in this unit [MSU] is risk based…".

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). Few aspects of forensic psychiatric life avoid risk assessment. Holmes (2005) observed on ward rounds that resident rooms would be searched for "suspicious-looking 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).

Commentators point out an inauthenticity or falseness 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". 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.

3.3. Consequences

The elements of care described above were identified as having various adverse effects upon residents. Space precludes full discussion of these here but several examples will be given to highlight the consequences restrictiveness may engender. Residents subjected to overly restrictive settings can experience difficulties in (re)developing and expressing a sense of 'self' (O'Sullivan et al., 2013; Parrot, 2010; Horberg et al., 2012), building relationships with staff and others (Vincze et al., 2015) and engaging in meaningful activity that develops occupational, social and creative skillsets which are crucial for recovery (Craik et al., 2010; Repo-Tiihonen et al., 2004). These outcomes can lead to individuals becoming

institutionalized, bored, hopeless, lonely, or lethargic. 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 or achieve a sense of control and space (Ireland et al., 2014; Wilkie et al., 2014). Residents may see their situation as fixed and determined, leaving them feeling resigned, lacking control and existing in a state of 'not-living' (Horberg et al., 2012).

3.4. Deviant Cases

For each of the restrictive elements of care identified in the literature, instances wherein an individual appreciated these elements were also found. For instance, certain residents appreciated being on mixed wards with a heterogenous group. A female resident preferred being on a mixed-gender ward as in her words it "[s]tops the bitching" (MacInnes et al., 2010). 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 individual described his previous ward as a 'nice environment, the staff were engaged and they had time to listen to me' (Ferrito et al., 2012). Some residents reported an appreciation for techniques of seclusion, stating "[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).

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). Features of the secure setting that are physically restrictive for some were beneficial for others. 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). Confusing and opaque for some, the legal framework governing forensic care was used as a tool by one resident to prevent perceived mistreatment from staff to himself or other residents. "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).

4. Discussion

Forensic psychiatric care settings are tasked with the treatment of, at times severely, unwell individuals. It may therefore be difficult to reconcile in full defences of autonomy on the ward. Contemporary approaches to mental health care prioritize maximising autonomy through decision-making and accepting responsibility flowing from resident empowerment (Leamy et al., 2011; Simpson & Penney, 2011). Given that forensic care settings are ostensibly hospitals and not prisons and being cognisant of the potentially detrimental effects psychiatry can have when practiced in large and enclosed Total Institutions (Goffman, 1962) it is important we think critically about the restrictiveness of these settings.

This systematic review aimed to conceptualize the restrictiveness of forensic psychiatric care by identifying 1) antecedent conditions to, 2) characteristic attributes, 3) consequences 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. 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 systematic review mirror to a large degree 'repression' in YOIs (de Valk et al., 2016). 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, with these resulting in intentionally inflicted harm or unlawful or arbitrary deprivations of liberty and autonomy. This is an important parallel as qualitative work by de Valk et al. (2017) found repression was described by youth as consisting of an abuse of staff power, reduced personal autonomy, arbitrary and contradictory rules, feeling dehumanized and ultimately resigned to accepting repression as 'just the way it is'.

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". Markham (2017) 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 and therefore 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 systematic review outlines potentially restrictive elements of care and the manner in which they are experienced, practiced or

enforced 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.

4.1. Limitations

There are several limitations to this paper. A conceptual mapping of a construct that has not previously been conceptualized or operationalized poses many challenges. First, the concept developed is subjective. This will remain so until ‘restrictiveness’ has been subject to empirical testing or criticism by other commentators. It is through dialogue, analysis and reconceptualization that concepts develop validity and reliability (Adcock & Collier, 2001). However, all efforts at developing a concept must undergo this process and the simple fact that a concept is ‘young’ does not preclude analytic and potential empirical weight.

Second, the range of sources included in this systematic review were limited. The fifty sources were drawn from disparate disciplines including psychology, law, nursing and governmental documentation and only in the English language. It is contended, however, that within the scope and aims of this systematic review, a sufficient number of papers were included to reach ‘data-saturation’ (Silverman, 2014).

Third, it must be acknowledged that this systematic 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. These views can be subjected to confirmation or refutation in subsequent qualitative research. This article should therefore be seen as a springboard from which empirical research focusing on resident experience can proceed.

Finally, the sources included in this systematic review do not directly address 'restrictiveness'. The sources consider and explore elements of forensic psychiatric care that the authors have considered potentially restrictive in line with the guiding definition of any negation of resident autonomy against that resident's will.

5. Conclusion

The conceptualization of restrictiveness generated in this systematic review is amorphous, tied together by a notion of subjective experience that is at times contradictory. What may be restrictive for one resident may be inconsequential for another and we cannot hope to define restrictiveness comprehensively. It may seem that we have not departed very far from our initial conceptualization of any negation of resident autonomy against that resident's will. However, this paper has attempted to scope out how wide a concept of restrictiveness can be. It has highlighted the antecedent factors that direct the restrictiveness of care – the telos of the forensic system and the perceived and actual risk associated with forensic residents – and identified many aspects of care across individual, institutional and systemic levels that may be considered restrictive. The systematic review highlighted the negative physical, social and psychological outcomes of such restrictive measures ranging from loss of hope and social roles to metabolic syndrome.

This systematic review serves to spark debate and to critically reflect on practices, procedures and policies in forensic care settings. Such efforts help us to better understand the potential consequences of this restrictiveness. Forensic psychiatry's dual aims of treatment and reducing recidivism are therefore 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. Future research needs to be undertaken to better understand how residents

experience the restrictiveness of their care. This needs to generate empirical data from which a more refined conceptualization of restrictiveness may be brought to life. Residents will inevitably discuss characteristics of the forensic system not included in this systematic review and can elaborate on how and why they find these elements restrictive. Subsequent to this, associations between restrictiveness and other outcomes of interest such as quality of life, satisfaction with care, recovery, recidivism and frequency of aggressive incidents can be explored. These findings can help colour service provision and nuance discussions on least restrictive practices.

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