The framing of Swedish forensic mental health services

Practical implications of ethical valuation, legally defined goals, and patients' needs

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To Anna, Bill, and Madelene.

For your patience and support.

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ABSTRACT

Forensic mental health services (FMHS) face challenges due to a limited evidence base for common interventions and an unclear framing of their fundamental task in relation to the patients they serve. This creates difficulties for organizing care and developing services in a consistent and meaningful way. The overarching aim of this thesis is to contribute to a clearer framing of FMHS by examining how ethically relevant values are enacted and experienced in practice (studies I and II), by operationalizing the goals established in forensic mental health law (study III), and by exploring how patient needs relate to service organization (study IV).

Study I is based on interviews with thirteen individuals under FMHS care. It shows that experiences of distress and disempowerment can be consistent with what is understood as beneficent professional conduct. This suggests that outcomes of professional actions depend not only on intent but arguably also on context. **Study II** explores value practices as described in interviews with patients and professionals participating in administrative court hearings. The study shows that abstract values may offer insufficient guidance in practice and that values beyond risk reduction and mental health are prioritized. **Study III** uses qualitative comparative analysis of Camberwell Assessment of Need – Forensic version assessments to identify rehabilitative need profiles associated with outpatient status. The analysis indicates that no single need domain is decisive; rather, satisfied and unsatisfied needs combine in diverse ways, pointing to a flexible operationalization of legal goals and an expanded view of relevant needs. **Study IV** uses latent class analysis to identify subgroups within the FMHS patient population based on rehabilitation needs. The analysis supports the identification of three meaningful subtypes of patients, each implying different tasks for FMHS and different possible endpoints for care.

Taken together, the findings suggest that the task of FMHS involves a broader and more complex set of objectives than is commonly assumed. Some of these may extend beyond what FMHS can provide alone, and the goals of care may vary between different groups of patients. FMHS must therefore accommodate complexity without becoming arbitrary and delineate its responsibilities in relation to adjacent services.

Keywords: Forensic psychiatry, Multi-method research, Psychiatric rehabilitation, Pragmatism, Medical Ethics

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SAMMANFATTNING PÅ SVENSKA

Den rättspsykiatriska vården i Sverige står inför utmaningar i att organisera och utveckla vården. Delvis kan det sägas bero på att det saknas forskning om interventioner och patienters behov, men det kan också bero på att rättspsykiatrins ramverk är otydligt. Den här avhandlingen handlar om att förtydliga dessa ramar genom att undersöka hur vårdens etik tar sig uttryck i och formas av praktiken (studie I och II), genom att reda i de mål som ställs upp av lagarna som styr tvångsvården (studie III) samt genom att fastställa hur vården kan organiseras utifrån olika patientgruppers behov (studie IV).

De första två studierna bygger på intervjuer med patienter, läkare och jurister om förvaltningsrätten, där beslut om tvångsvård fattas. I den första behandlas patienters beskrivningar och det framkommer att när professionella försöker vara omhändertagande och välvilliga kan det paradoxalt nog upplevas påfrestande och nedtryckande för patienter. Möjligen handlar detta om förväntningar på olika sammanhang, men oavsett tycks professionellas handlande kunna upplevas på ett annat sätt än avsett. I studie II utforskas hur det som görs i förvaltningsrätten speglar värdering av olika slag, i relation till patienter. Juristers, läkares och patienters ageranden pekar på att de håller för värdefulla oväntade saker, såsom att patienter accepterar vårdens världsbild eller framstår som normala. Det verkar som att en modell där enbart samhällsskydd och mental hälsa är det som värderas inte räcker för att beskriva etiken inom rättspsykiatrin. Detta återspeglas också i studie III där vårdteamens bedömningar av vad patienter har för rehabiliteringsbehov ställs i relation till om de är redo för öppenvård. Det framkommer att ingen enskild form av behov är avgörande, utan att det är en balanserad sammanvägning som ligger till grund för att en patient bedöms redo för öppenvård. Även behov som inte har att göra med samhällsskydd och hälsa verkar ha betydelse. Slutligen visar studie IV, som också bygger på bedömningar av rehabiliteringsbehov, att det finns undergrupper av patienter som kräver olika saker av vården och som kanske också kräver olika måttstockar för när vården kan avslutas.

Tillsammans pekar dessa studier på att rättspsykiatrins uppdrag i praktiken är bredare än samhällsskydd och hälsa, att vissa mål inte kan nås av rättspsykiatrin själv och att slutpunkten för vården kan se olika ut för olika grupper av patienter. För att undvika godtycke bör ramarna för rättspsykiatrin tydliggöra *hur* värden och mål utöver kärnan av samhällsskydd och hälsa ska spela in och då ta hänsyn till att det kan se olika ut för olika grupper.

LIST OF PAPERS

This thesis is based on the following studies, referred to in the text by their Roman numerals.

I. Pedersen, S. H., Nilsson, T., & Eriksson, L. Potential pitfalls of applying a therapeutic logic in mental health law proceedings. International Journal of Forensic Mental Health 2020; 19: 354-364

II. Pedersen, S. H., Radovic, S., Nilsson, T., & Eriksson, L. Dual-roles and beyond: Values, ethics, and practices in forensic mental health decision-making. Medicine, Health Care and Philosophy 2025; 28: 199-211.

III. Pedersen, S. H., Lindström, F., Nyman, J., Crocker, A. G., Eriksson, L., & Nilsson, T. The practical goals of inpatient forensic mental health services in Sweden – a qualitative comparative analysis of met and unmet rehabilitative needs in the transition to outpatient care. International Journal of Law and Psychiatry 2025; 103: 102138.

IV. Pedersen, S. H., Sjödin, A.-K., Eriksson, L., Crocker, A. G., Norrbin, L., & Nilsson, T. A national, cross-sectional study of rehabilitative needs among forensic mental health patients – Identifying latent classes to guide service organization. Submitted manuscript.

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ABBREVIATIONS

AIC	Akaike Information Criterion
BIC	Bayesian Information Criterion
CANFOR	Camberwell Assessment of Need – Forensic version revised
CRPD	Convention on the Rights of Persons with Disabilities
FMHS	Forensic Mental Health Services
FMCA	Forensic Mental Care Act
GLM	Good Lives Model
ICD-10	The International Statistical Classification of Diseases and Related Health Problems 10th Revision
ICF	The International Classification of Functioning, Disability and Health
LCA	Latent Class Analysis
QCA	Qualitative Comparative Analysis
RNR	The Risk-Need-Responsivity model
SCS	Swedish Code of Statutes
SDR	Special Discharge Review
SMD	Severe Mental Disorder
SNFPR	Swedish National Forensic Psychiatric Register, RättspsyK
VLMR	Voung-Lo-Mendell-Rubin adjusted likelihood test ratio

DEFINITIONS IN SHORT

Forensic Mental Health Services	A clinical practice that involves the provision of mental health care to individuals with severe mental disorder and an offending history or a high risk of offending (cf. Perlin, 2016).
Jurisdiction	A country or state where a specific set of laws apply (Cambridge Business English Dictionary, 2025)
Rehabilitative need	Something an individual requires to have an acceptable function in relation to social independence and quality of life (Slade & Thornicroft, 2020).
Person-oriented research	Research methodologies which assume that each individual contains an inseparable network of characteristics that must be studied together to not lose important information. Contrasts with variable-oriented methodology which treats specific characteristics as the object of study (Bergman & Trost, 2006).
Severe Mental Disorder	A mental disorder that causes a marked functional disability. This definition is closer to what has been labelled *serious mental illness* in the international literature (e.g., National Institute of Mental Health, 2025). Severe mental disorder is also used to denote the Swedish medicolegal term *allvarlig psykisk störning* which is defined as being a mental disorder of a degree or type that is equivalent to a psychotic disorder (Prop. 1990/91:58). As severe mental disorders are also serious mental

	disorders, the former has been chosen in this thesis to accord with the Swedish forensic mental health literature.
Valuation practices	Acts and conduct which express valuation of something or construe something as valuable. A pragmatist understanding of value which puts the doing of value at the centre (Dewey, 1939).

1 INTRODUCTION

In a series of investigative reports published between 2008 and 2013 (e.g., Råstam, 2012), what was for a long time Sweden's most notorious serial murder case was gradually dismantled and ultimately exposed as a fraud. The alleged perpetrator, Sture Bergwall, was acquitted of all murder convictions and the case came to be seen as a striking miscarriage of justice. A separate process in the administrative court system (legally independent from the criminal justice process) eventually saw Bergwall leave the forensic mental health service (FMHS) in which he had been kept and treated under compulsory forensic inpatient care for decades. These revelations caused quite a stir. Set up to examine the actions of the judiciary and the FMHS in relation to the case, the Bergwall Commission (SOU 2015:52) called for evidence-basing the care in FMHS, which led to significant research efforts and dedicated grants and pushed change in a setting which had been somewhat peripheral and isolated until that point. New methods and a nationwide research infrastructure aimed at making FMHS more effective are in development because of these efforts. Yet, the object of all this development remains opaque. What is being developed and what does it mean for it to be more effective? This thesis will discuss FMHS from a naïve starting point that treats the nature and purpose of FMHS as unsettled.

1.1 FORENSIC MENTAL HEALTH SERVICES IN SWEDEN

The terms *forensic psychiatry* or *forensic psychiatric care* are sometimes used interchangeably with *forensic mental health services* to refer to the care institutions that are the focus of this thesis (see e.g., Kennedy, 2022). However, forensic psychiatry also denotes a broader set of clinical practices and academic subfields. In one sense, a forensic psychiatrist is someone who treats people with severe mental disorders (SMD) [1] and offending histories in secure hospitals. In another sense, the same title refers to someone who provides psychiatric expertise in the service of the courts. These roles differ significantly in their relationship to the patient, in the legal and ethical boundaries that apply, and in the forms of expertise they demand. Forensic psychiatry can also be understood both as a medical subspecialty and as a label

[1] See definition on page xiv.

for the multi-professional clinical practice of caring for individuals with SMD who have been "admitted to psychiatric institutions following involvement in the criminal justice system" (Perlin, 2016, p. 9). It is this latter, multi-professional practice and its organization that constitute the focus of this thesis, which is why I use the term *forensic mental health services* or FMHS.

FMHS in Sweden are organized under regional administrations, as other healthcare services. There are 25 FMHS settings across the country, comprising between less than 15 and more than 300 patients. The largest inpatient service has 155 beds, while other services have a greater share of patients in outpatient care (Swedish National Forensic Psychiatric Register, RättspsyK, SNFPR, 2024). Among the 25 clinics, five hospitals have a specific responsibility to accept patients on referral from other clinics, most often if care has been unsuccessful or due to adverse events. These have what is called a regional uptake responsibility.

The median length of stay is circa 7.5 years, but longer for individuals with psychosis, violent index offences, substance use problems, and special discharge review (SDR, Sivak et al., 2023). FMHS are predominantly inpatient services in Sweden, with 57-61% of patients registered as under forensic care in 2024 being committed to hospitals or units with security classification (SNFPR, 2024). According to the Swedish National Board of Health and Welfare (2025), the number of patients in FMHS inpatient or outpatient care has increased by over 50% in the last decade. There is some uncertainty about these numbers, though. While all forensic care in Sweden starts in a clinic with a security classification, an individual can transition to the general psychiatric services while still being under Forensic Mental Care Act (FMCA, SCS 1991:1129) coercive care. The best available data follows healthcare provision, not the laws under which an individual is treated. As a result, there is no robust data on how many patients are given involuntary care under the FMCA in the general psychiatric services. Additionally, a small number of patients come to be treated in FMHS without being sanctioned in court. There is no available summary statistics describing this group, but individuals can be transferred to FMHS from general psychiatric care due to difficulties managing behavioural problems (Mellgren & Hagelbäck Hansson, 2018). Individuals can also be transferred from prisons or jails if they have a need for psychiatric inpatient care, usually for a limited time.

FMHS in Sweden offer a broad range of rehabilitative interventions and supports, although availability varies considerably across sites. In a report from

the Swedish Association of Local Authorities and Regions, a plethora of occupational, educational, somatic/physical, psychiatric, and psychological interventions were listed (Mellgren & Hagelbäck Hansson, 2018). The prevalence of specific interventions in different sites ranged from 5-100%, with few interventions being consistently available across the country.

1.2 STATE OF THE FIELD

1.2.1 LACK OF EVIDENCE AND AVAILABILITY OF DATA

Following the Bergwall Commission's report (SOU 2015:52), a number of government reports were commissioned by the Swedish state. The Swedish Research Council (Vetenskapsrådet, 2017) identified several knowledge gaps in relation to the academic field of forensic psychiatry, among them research on assessments, pharmacological treatment, the use of coercion, but also on the ethics of FMHS and on rehabilitation. The Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU) commissioned three reports on the evidence base for FMHS (Howner et al., 2018; Howner et al., 2020; SBU, 2018). They too concluded that there are significant knowledge gaps in FMHS research, finding insufficient support for all studied domains. However, important and promising developments have been presented in recent years, such as development and testing of virtual-reality assisted assessment and treatment programmes, risk management procedures, treatment for overweight and obesity, and cognitive remediation, to name a few (Berlin et al., 2025; González Moraga, 2025; O'Reilly et al., 2019; Sass et al., 2024).

Apart from increased research activity, the infrastructure for FMHS research has been described as an important area to develop. The FMHS population is comparatively small and difficult to recruit for research, which highlights the need for pooled data and research cooperations across sites, improved research infrastructure, and more (Kennedy et al., 2019; McLaughlin et al., 2023; Pedersen et al., 2021). But there are significant challenges in the availability of good quality, comparable data within and across jurisdictions. Tomlin et al. (2021) find that the quality of epidemiological information for FMHS in Europe is unsatisfactory, concluding that comparability of basic epidemiological data is key for equitable care for persons with mental disorders who have committed crimes. Salize et al. (2023) draw similar conclusions

regarding access to data to compare forensic services between EU states. However, the available data indicate vast discrepancies between EU states. Fundamentally similar ideas that persons with SMD who have offended ought to be given care and not punishment yield rates of forensic beds between 0.9 and 23.3 per 100 000 population. In terms of court determinations that divert offenders to FMHS, the differences between EU states are equally stark. In Ireland, 0.1 per 100 000 population are given a not criminally responsible on account of mental disorder equivalent sentence while in Denmark the same rate is 11.4 according to Salize and colleagues (2023). Average lengths of stay in FMHS differ between one and ten years in Slovenia and the Netherlands, respectively (Tomlin et al., 2021).

1.2.2 CONSISTENCY OF FMHS AS A CONCEPT

Some of the discrepancies found between different jurisdictions may be attributable to poor availability, reliability, and validity of data. Likewise, much of the paucity of evidence for FMHS interventions identified by Howner et al. (2018) may be attributable to insufficient research efforts regarding FMHS. But these results may also stem from an inconsistent and incoherent operationalization and conceptualization of FMHS. Barnao, Ward and colleagues (Barnao & Ward, 2015; Robertson et al., 2020) have argued along these lines. Investigating the foundations for FMHS in published literature and in qualitative interviews with clinicians, they conclude that several, potentially conflicting frameworks for FMHS can be found. Drawing on published studies of interventions, they identify three broad categories of FMHS interventions: FMHS as therapy targeting mental disorders; FMHS as risk-reduction targeting criminogenic needs; and FMHS as rehabilitation-oriented, targeting the development of patients' strengths.

Forsberg and Douglas (2020) identify a similar conceptual confusion when it comes to criminal rehabilitation more broadly. They map the philosophical literature on the subject and offer a taxonomy that partly echoes the work of Barnao and Ward (2015). Five conceptions of criminal rehabilitation that are theoretically compatible with FMHS are identified: anti-recidivism; harm-reduction; ameliorating a mental deficit; moral improvement[2]; and restoration.

[2]Moral improvement could be considered incompatible with FMHS, as moral responsibility is generally not the reason for such a disposition. However, Forsberg and Douglas (2020) seem to open for the possibility that interventions to improve the capacity for moral judgement can be categorized as moral improvement, which seems applicable to FMHS.

Drawing on the opinions of clinical experts in a DELPHI-design, Tapp et al. (2016) concluded that a plethora of components were considered essential for FMHS. The participating experts agreed to the importance of 27 components, although they were unable to reach consensus on how important they were. Components identified as important included interventions to provide patients with information and help them understand their needs and care process; interventions and procedures to ensure safety in care units; meaningful activities and opportunities to leave the ward; pharmacological and psychological interventions; and more. These results indicate that FMHS are not a uniform and straightforwardly defined concept.

1.2.3 EXISTING FRAMEWORKS

Some theoretical works have attempted to tie together research on various facets of FMHS and offered descriptions of the phenomenon. Blackburn (2004) presents an analysis of FMHS in the light of the "what works" paradigm (cf. McGuire, 2013). He concludes that the evidence tentatively implies that FMHS need to accommodate individualized treatment planning, multi-factorial treatment programmes, and continuity in care trajectories. Bonta and Lee (2025) propose that the Risk-Need-Responsivity model (RNR) ought to be applied for the treatment of persons with SMD and justice involvement. This model prescribes that interventions are provided such that those with the most significant risk of reoffending receive the most attention, that interventions target needs which are empirically linked to reoffending risk, and that interventions be tailored to the individual to increase the likelihood that they will be effective. The Good Lives Model (GLM, Barnao et al., 2016) offers an alternative approach that emphasises the pursuits of what the proponents call *primary human goods*. These include characteristics of the individual and their life which are intrinsically good, but also conducive to a life without crime. Examples include knowledge, inner peace, friendship, excelling in work or play, and more. Based on a GLM framework, FMHS may be organized around developing skills and conditions which enable an individual to secure these primary goods.

There are arguments for the superiority of both RNR and the GLM respectively. RNR is tied to a more substantive body of literature and is generally considered the gold standard model for offender rehabilitation (Ogloff & Davies, 2004). GLM encompasses the principles of the RNR but goes beyond to incorporate positive and aspirational goals, which has been taken to mean that support for RNR principles is also support for GLM (Willis

& Ward, 2013). Yet an alternative understanding of the disagreement between proponents of RNR and GLM is that they are best measured with different sticks. Ogloff and Davies (2004) propose such an explanation, highlighting that the models have different goals and therefore ought not to be compared on the same outcomes. However, independent reviews seem to indicate that RNR is also suffering from insufficient evidence such that neither model appears to have robust support (Fazel et al., 2024).

The frameworks discussed above are normative in that they describe what FMHS *ought to be*. Any development towards an optimally functional institution presupposes a clear vision of the intended goal, but available models have yet to produce the effectiveness that has been envisioned (Kennedy et al., 2019). More work using robust designs and innovative interventions may resolve this problem. However, the development of novel treatments may benefit more from a clearer understanding of how FMHS currently function and what goals they actually pursue in practice. Models that fail to account for how FMHS currently operate risk overlooking key premises of a clinical practice that is unlikely to be a straightforward and unidirectional process (cf. Björklund, 2024; Tapp et al., 2016). Livingston (2018) illustrates how practitioners in FMHS value multiple objectives beyond preventing recidivism and promoting health. From this standpoint, there is reason to revisit the basic premises of FMHS, based on how the services are practiced and understood on the ground.

1.3 INDUCTIVE RESEARCH IN FMHS

The previous section lays out considerable gaps in the evidence-base for FMHS interventions, but also in the conceptual foundations for what FMHS are. These gaps indicate the need for more research in FMHS, to develop clinical interventions but also to elaborate on the framework within which these interventions are deployed. The sections below will cover some epistemological reasons for emphasizing non-experimental designs in the current state of the field. They will also cover methodological strategies related to discovering novel perspectives on phenomena such as FMHS.

1.3.1 EPISTEMIC CHALLENGES

Psychology, psychiatry, and several other disciplines were drawn into the reproducibility crisis that gained momentum in the early 2000's (Bell, 2017; Ioannidis, 2005; Sherry et al., 2020). Observed shortcomings of scientific

rigour prompted proposals to strengthen the robustness of research, particularly experimental designs. For example, the Center for Open Science advocates practices such as preregistration, open data, and open resources (Grant et al., 2025).

Taking a different approach to that of open science proponents, Debrouwere and Rosseel (2022) offer the suggestion that the reproducibility crisis in psychology is not remediable by fine-tuning practices. Instead, they argue that fundamental assumptions in the field are flawed. They describe an insufficient connection between data and the hypotheses that the data is supposed to prove or falsify, such that a statistically rejected null hypothesis generally gives very little support for the alternative hypothesis. Further, they claim that accepted hypotheses rarely give robust evidence for the theories that they have been posited to support and specific theories are poorly connected to other theories in networks of knowledge that help inform future predictions.

Many of the issues identified by Debrouwere and Rosseel (2022) are not unique to psychology but resonate across several disciplines concerned with the human minds or social systems. Psychiatry faced considerable challenges in replicating findings too, much like psychology (Sherry et al., 2020). Unsatisfactory connections between data, hypotheses, and theory are also present in psychiatry where the lack of evidence for proposed aetiological models remains a problem. Relevant to FMHS, research on schizophrenia has yet to establish robust evidence for causal theories, for example (Insel, 2010).

Similar criticisms can be levied against criminal rehabilitation; Fazel et al. (2024), in their review of RNR as applied to offenders with and without mental disorders, suggest that its widespread influence partly derives from conjectural links between theoretical frameworks that are not empirically integrated. By extension, the claim by Willis and Ward (2013) that empirical support for RNR translates into support for GLM could be subject to this kind of critique.

In sum, these examples point to a broader challenge of translation from observations to general theories. The point made by Debrouwere and Rossel (2022) applies particularly well to experimental research seeking causal models, but the more general argument that inductive research has an important role in laying the foundation for a field seems highly relevant to understanding the framing of FMHS.

1.3.2 MULTIPLE METHODS AND PERSPECTIVES

Healthcare settings are increasingly complex, with a plethora of goals, interventions, and providers all interacting within one system and with individual patients (Braithwaite et al., 2021). FMHS check all the boxes for a complex healthcare system, having different and potentially conflicting goals, multiple stakeholders, multiprofessional care teams, and numerous available interventions. Such settings are difficult to evaluate or explore in their component parts, using a single method (Plsek & Greenhalgh, 2001). Certain aspects of a complex system such as a FMHS are difficult to operationalize in a way that allows quantitative analysis, while other aspects are difficult to cover broadly enough using qualitative methods (Craig et al., 2008). Combining the detailed and flexible analyses of rich, narrative data with the generalizability of studying larger samples offers the potential for responding adequately to some questions unfit for either qualitative or quantitative designs in themselves.

Medical research and FMHS research more specifically are increasingly taking in the perspectives of patients in developing healthcare systems and interventions (Tapp et al., 2013). This development parallels the rise of person-centred care models that prioritize the knowledge and values held by patients (El-Alti, 2022). Incorporating the perspectives of multiple stakeholders has been employed to evaluate interventions, to identify knowledge gaps, and to revise care objectives (Staniszewska et al., 2025). It helps better map a service as it is in practice, rather than how it is imagined by a few stakeholders (Braithwaite et al., 2021).

Morgan (2013) suggests that the use of multiple methods of inquiry and the use of multiple perspectives on the object of study are design choices that can be made to improve the applicability and the impact of research in a specific setting. Viewing the phenomenon of FMHS through different lenses and from different vantage points can also help make the inquiry more direct in its impact on clinical practice (Plsek & Greenhalgh, 2001).

1.3.3 CONTEXT-SENSITIVE RESEARCH

FMHS share some important features across different jurisdictions, but in many ways the practice is shaped by national law and the operations of adjacent services such as general psychiatry and social services (Crocker et al., 2017). Any complex healthcare setting is bound to local practices and conditions (Plsek & Greenhalgh, 2001), but the local dependence is likely

amplified in FMHS due to these preconditions. Research that is sensitive to the context in which it is conducted also has the benefit of being more directly applicable in the clinical practice (Morgan, 2013). In this way, context-sensitive and complexity-informed research designs can overcome some of the challenges inherent in conducting research and implementing findings in a setting like FMHS (Plsek & Greenhalgh, 2001).

1.4 BASIC FEATURES THAT SHAPE FMHS

The practical operations of an institution such as FMHS will depend on a number of defining features that set the stage for what the task is. Aspects such as staff competence and qualifications, organizational structure, or physical facilities will limit what can be done but also promote certain interventions or goals. Fully understanding a complex healthcare system requires that the defining features are made clear and workable. For this thesis, a non-comprehensive set of defining features of FMHS are explored, which were deemed operationalizable, accessible, and highly relevant: The legal framework, the patient population's rehabilitative needs, and ethical guidance.

1.4.1 LEGAL FRAMEWORK

Criminal and administrative law set the boundaries for FMHS in important ways. As noted above, FMHS are systems defined by the task of working with individuals who have mental disorders and who have committed criminal offences in Sweden as in many other jurisdictions (Crocker et al., 2017; Perlin (2016). Thus, the start of any FMHS trajectory begins with a determination based on criminal law. At the other end, administrative law sets out the criteria for leaving FMHS by defining when compulsory care can end (Kindström Dahlin, 2014)[3]. Bennet (2025) argues that FMHS are caught between two separate and at times conflicting legal frameworks which influence the practice: criminal law brings a punitive framing; administrative law governing compulsory healthcare brings both public safety and solidarity with or care of the individual.

[3] Like any other health care, FMHS are also governed by legislation regulating responsibilities of health care professionals and the relationship between patients and care givers (Health and Medical Services Act, SCS 2017:30; Patient Act, SCS 2014:821), and more. These laws are important side constraints on FMHS but will not be covered in depth here.

1.4.1.1 CRIMINAL LAW

The penal code's (SCS 1962:700) 30th and 31st chapters outline the criteria for who may be sanctioned to care under the FMCA and therefore who becomes a patient within FMHS. The decision to sanction an individual to care under the FMCA is made by criminal courts. This decision depends on general requirements of criminal law and parallels punitive sanctions in Sweden. Notably, forensic psychiatric care is not the result of a non-accountability determination, as it is in many other countries (Crocker et al., 2017). Offenders who suffer from an SMD are considered criminally responsible under Swedish law and an individual can only be sentenced to forensic psychiatric care if they are deemed to have had criminal intent, which can be the case even under the influence of an SMD (Bennet, 2020). The mental disorder of a person who has offended has direct impact on the choice of sanction instead of affecting the consideration of guilt (Bennet et al., 2022). Deciding whether an individual will be sentenced to forensic psychiatric care as opposed to some other sanction requires the consideration of two specific criteria. The first is that the crime in question must be severe enough to warrant incarceration (SCS 1962:700), which typically excludes minor crimes such as disturbing public order or shoplifting. The second is that the individual must have suffered from an SMD at the time of the crime as well as at the time of assessment. The determination that an individual has an SMD is made by a multi-professional team at the Swedish National Board of Forensic Medicine, which acts as an expert body serving the court (Bennet et al., 2022). What constitutes an SMD in the view of the multi-professional teams is not static and time-trends show an increasing share of individuals being sanctioned to forensic psychiatric care having primary neurodevelopmental disorders, for example (SNFPR, 2021).

The risk for criminal recidivism is a separate, third criterium, which is used to determine not whether someone is sentenced to forensic psychiatric care, but whether such a sanction will include an SDR. An SDR is recommended by the Swedish Board of Forensic Medicine and affixed by the court when an individual is deemed to run a significant risk of serious recidivism. Although it was intended to be the exception, over 80% of current FMHS patients have an SDR (Bennet, 2025).

1.4.1.2 ADMINISTRATIVE LAW

When an individual is sentenced to care under the FMCA, they are committed to FMHS inpatient care to be rehabilitated. For the 80% who have an SDR, any transition to more freedom and less restrictions is determined by administrative courts (Radovic et al., 2020; Prop 1990/91:58). This means that the outflux of

patients from FMHS is largely determined by administrative law through the FMCA (SCS 1991:1129). If an individual cared for under the FMCA is to leave the hospital without the company of FMHS staff, either once or be granted the opportunity to leave repeatedly, it must be approved in court. This includes being allowed to move freely on hospital grounds, being granted furlough to leave hospital grounds by yourself, transitioning to compulsory outpatient care, and discharge from forensic care altogether (Radovic et al., 2020).

Any transition to less confinement and more liberty depends on the satisfaction of the FMCA criteria. These criteria echo those in the Penal Code, except that FMCA criteria are forward-looking. These criteria indicate that mental illness, risk of violence or recidivism, and the individual's "personal circumstances" (SCS 1991:1129, 3§a and b) must be satisfactory for a patient to transition to less restrictions[4]. These criteria are defined in the legislative history of the FMCA (Prop. 1990/91:58). They are intentionally vague to allow the judiciary to interpret them for a variety of situations and establish precedent (Kindström Dahlin et al., 2017). Few cases have been tried in the Supreme Administrative Court, and there is little precedent to narrow down the ways in which the FMCA can be interpreted.

The Penal Code (SCS 1962:700) and the assessments of the Swedish National Board of Forensic Medicine define the characteristics that make an individual appropriately a patient of FMHS at the outset. The FMCA defines when an individual is no longer appropriately a patient of FMHS and sets the mark for what FMHS need to achieve for each patient before compulsory care can end. Given that FMHS as a form of compulsory ought to end as soon as voluntary care is realistic (Kennedy, 2022), these criteria become targets for the clinical service that is demarcated by its task to provide compulsory forensic care.

This legal framework presents FMHS with a set of loosely defined objectives that must be met for a patient population derived from an imprecisely delineated concept. While both criminal and administrative law are essential in establishing the outer boundaries of FMHS, they offer limited guidance for what clinical care should attain. Thus, the legal framework is at once foundational and underdetermined: it is indispensable in shaping the scope and operation of FMHS yet lacks the precision necessary to provide clear direction

[4] For the minority of patients without an SDR, the criteria are largely the same, but the question is inverted such that criteria specify whether coercive elements of care may continue, not whether it may end. There is also no explicit reference to recidivism risk.

for the everyday practices it governs. To define the task of and purpose of FMHS, the boundaries and objectives provided by the courts must be operationalized in a clinically workable way.

1.4.2 CARE AND REHABILITATIVE NEEDS AMONG PATIENTS

The task of FMHS is further shaped by the needs of the individuals who are diverted to the services, such that interventions, support, and goals must be adequate and effective for the resulting population. However, entry into FMHS is not determined by the service itself, but by the courts. FMHS are thus not able to select patients based on a predefined clinical task or mandate. Instead, the population diverted to FMHS and the needs with which they present serve to define what FMHS ought to do. Consequently, to understand the purpose of FMHS we must also understand what the patients who reside there need help with. The following section will concern itself with known characteristics of FMHS patients and some knowledge gaps that remain to be filled in order to guide the practice.

1.4.2.1 CLINICAL AND DEMOGRAPHIC CHARACTERISTICS

Patients in Swedish FMHS are described annually in the SNFPR (2024) which presents data on demographic information, clinical diagnostics, index crimes, somatic concerns, and more. Over the last decade and a half, many characteristics of the population have remained stable. Degl'Innocenti et al. (2021) compared data from the register for 2010 and 2018. For both time points, there were five men for each woman, the average age was approximately 40 years, and the majority of patients had a psychotic disorder. As noted above, there is a difference in primary diagnoses between 2010 and 2018. In 2018, fewer patients had personality disorders and more patients had substance use disorders or autism-spectrum disorders as primary diagnoses (Degl'Innocenti et al., 2021).

In the latest report from the SNFPR, data for 2024 is presented. For this year, the majority of both women and men (55% and 68% respectively) still have a primary clinical diagnosis of schizophrenia, schizoaffective disorder, delusional disorder or other disorder marked by psychotic symptoms. Neurodevelopmental disorders (the register combines the chapters F80-89 and F90-98 in the report) were the second most common primary diagnoses for men and for women. By 2024, men are almost six times more common than women. Although less than 5% of patients had a primary substance use

disorder, as many as 58% of women and 72% of men had a documented history of substance abuse. The register also describes many patients having somatic concerns, with as many as one third having diabetes and a quarter having cardiovascular disease (SNFPR, 2024). Poor physical ability has also been described among FMHS patients (Bergman et al., 2020).

Many of the characteristics of the Swedish population are echoed in other countries. For example, in France, Canada, Japan, Switzerland, and Germany the most common FMHS patient is a male with a schizophrenia spectrum disorder or similar, approximately 40 years of age, who has committed a non-sexual, violent offence (Crocker et al., 2015; De Lassus Saint-Genies et al., 2024; Koike et al., 2024; Stürner et al., 2024; Weber et al., 2023). However, the FMHS population is highly heterogenous and not all FMHS patients have the same or even similar needs. Comorbidity is common with a disproportionate share of FMHS patients also having a substance use disorder, intellectual dysfunction, and personality disorders (Blackburn, 2004; Crocker et al., 2015; Edberg et al., 2020).

1.4.2.2 CRIMINOLOGICAL CHARACTERISTICS

The most common index offence among FMHS patients in Sweden is assault and just below half of the patients had committed a non-sexual violent offence. Among men, the second most common offence category in 2024 was crimes against peace and freedom, accounting for 18% of index offences. This category includes offences such as stalking, systematic harassment, or threats. Lethal violence accounted for less than 15% among men, half of which was attempted but not completed. Among women, attempted lethal violence was as common as among men, but less often led to death. The second most common category of offence among women was public safety offences, such as arson, accounting for 23%. As many as half of the male patients and a little less than a third of the women committed their index offence under the influence of alcohol or drugs (SNFPR, 2024).

Swedish FMHS requires a crime severe enough to warrant imprisonment, which is not the case in Canada, for example. Thus, it is unsurprising to find a higher share of severe index crimes among Swedish FMHS patients than in Canada. In a large-scale Canadian project, a third of patients had committed a non-sexual violent offence, 7% being attempted or completed lethal violence. Threats were the index offence for 27% of patients and property offences for 17%. Less than a quarter of patients had committed their offence while having substance use problems (Crocker et al., 2015). As with clinical and

demographical characteristics, there is considerable heterogeneity among FMHS patients regarding criminological information among Swedish patients and patients in other countries.

1.4.2.3 TYPOLOGIES BASED ON PATIENT CHARACTERISTICS

The needs and characteristics of FMHS patients vary considerably, but there have been attempts to structure the variability in systematic ways. Most well-known is probably Hodgins' typology based on type of offence and age at first offence, which concerns people who have committed offences and who have schizophrenia (Hodgins et al., 2013; see also Crocker et al., 2018; Lau et al., 2019; Penney et al., 2018; Penney et al., 2021). This typology separates individuals with an early onset of offending and who often offend repeatedly (*early starters*) from individuals who offend for the first time later in life (*late starters*), often with a single and serious offence. A later iteration extended the typology with a third group of individuals who have their first offence late in life, but then continue to offend (*late starters, persistent offending*, Hodgins et al., 2013).

Hodgins' typology focuses on the trajectory to offending and forensic care for individuals with schizophrenia. Fewer studies have concerned themselves with indicators related to care needs in the identification of subgroups of FMHS patients. Kirchebner et al. (2021) indicated that early starters may benefit more from FMHS care and Green, Lindqvist Bagge, Laporte et al. (2023) identified patterns of substance use that map onto diagnoses and offending behaviour. Noland et al. (2023) indicate that there are subgroups among those discharged from FMHS in terms of rehabilitative needs when they identify four groups who differ in terms of support, need, and community reintegration. Relatedly, Thomas et al. (2004) found a number of clusters of patients in their study of the high-secure hospital population in England and Wales. The most robust cluster was characterized by complex needs and there were clusters characterized by substance use, social needs, health concerns, and more. However, less than half of patients could be clustered in this study.

Based on the studies discussed above, there seems to be a potential for subtyping FMHS patients in a coherent manner. Yet few studies have included direct measures of what patients manage in life or what they need in terms of support.

1.4.2.4 IMPLICATIONS FOR FMHS FRAMING

A consistent pattern across many jurisdictions is that FMHS patients often present with a schizophrenia spectrum disorder or other psychotic disorders, are male, and have committed a non-sexual violent offence. Patients have considerable needs in a broad range of rehabilitation domains, including education and occupation, physical health, risk reduction, and more (Glorney et al., 2010). The broad spectrum of relevant rehabilitative needs to meet presents FMHS with a considerable challenge. In addition, needs may combine in different ways to yield even more presentations among the patient population.

Organizing care only according to specific characteristics such as diagnoses, index crimes, or specific rehabilitative needs is likely to overlook interactions between different needs. For example, being lonely may elicit different responses if a person has a history of substance use problems and anti-social associations, as compared to if the person has just lost contact with an otherwise prosocial network because they feel ashamed for having committed a crime. For the first individual, progression may hinge on distancing oneself from previous connections, even at the cost of feeling lonely for some time. For the second individual, progression may instead take the form of overcoming personal hindrances to reconnect with the old network. Managing the interactions between different characteristics of an individual and their context is key to an effective rehabilitation (Alexander et al., 2016). But designing individualized care pathways for every possible combination of needs would yield unmanageable complexity in the system and demand unrealistic resources. Conversely, a uniform care pathway designed on the basis of statistical averages is likely to suit very few patients. A more viable approach would be to identify a limited number of recurring need profiles or constellations. These could serve as the basis for flexible, yet structured, care pathways capable of addressing the most common patterns in a clinically meaningful and administratively feasible way. In this sense, adapting FMHS to meet complex and interacting patient needs requires the identification of a few core constellations of care needs, of types of patients, that can help guide how the practice is designed.

1.4.3 ETHICAL GUIDANCE FOR FMHS

Ethical discourse related to FMHS covers areas such as patient rights, professional duties, and fundamental principles. Broadly applicable frameworks such as the big four principles of bioethics (Beauchamp &

Childress, 2001) or the Convention on the Rights of Persons with Disabilities (CRPD, United Nations, 2006) inform discussions about FMHS but need specification for that context. For example, article 14 of the CRPD specifies a right to liberty that can be annulled by national law (United Nations, 2006) such as Swedish forensic mental health law, as described in the previous section. In the following section, three themes of ethics as they pertain to FMHS will be discussed: professional duties; ethical values; and institutional objectives, and relevant gaps will be identified.

1.4.3.1 PROFESSIONAL DUTIES

The predominant ethical discourse on FMHS broadly stems from the duality found in the tasks assigned to the institution and is centred on professional ethics. The ethics of forensic psychiatry often trace back to Alan Stone (2008) and Paul Appelbaum (1990) debating the ethical foundations for using psychiatric expertise in service of the courts. Stone argued that using medical expertise to serve another master than the patient or to pursue non-health related objectives is deeply problematic. Appelbaum on his part took the position that the expert witness has a professional role entirely different from that of a conventional doctor and is not bound by the same ethical code. Both seemed to take the position that the dual-role dilemma – the problems inherent in combining two roles serving different masters (Robertson & Walter, 2008) – is unresolvable and that a side had to be chosen.

While their debate resonates with challenges in FMHS, this was not the subject of their arguments. How to manage ethics in the clinical setting of FMHS differs from how to manage ethics as an expert witness and management of the dual-role dilemma – which emerges in many settings – may look quite different. Robertson and Walter (2008) review the literature on the dual-role dilemma in psychiatric ethics and find similar but not identical tensions being described in military, general, and paediatric psychiatry, among others. They place the source of the dilemma in the existence of a third party outside the therapeutic relationship with a stake in the outcome, but also in the power granted the psychiatric profession. Most of the literature revolves around the role of medical doctors, but other professions are also affected by conflicting obligations (Ross et al., 2008).

In line with influential medical ethics paradigms, the ethics of FMHS have largely been discussed in terms of principles. Principles formulated as ethical guidance have been criticized for being difficult to translate into practical guidance and for being poor complements to global ethical theories (Clouser

& Gert, 1990). Yet the predominant ethical guidance for medical practice are the four principles proposed by Beauchamp & Childress (2001) - beneficence, non-maleficence, autonomy, and justice. The weighting and perhaps the interpretation of these principles can be different for FMHS, such that justice and welfare for patients and third parties alike are prioritized higher than autonomy, for example (Adshead & Sarkar, 2005).

1.4.3.2 ETHICAL VALUES

The FMHS professional is bound by duties and principles connected to their professional roles. These duties gain their importance from being connected to something deemed valuable, which can be brought about by the professionals performing their duties within a certain system. As values underpin duties and principles, the discussion about which duties and which principles apply is intimately tied to ideas about what is valuable.

In FMHS, the focus on patients' mental health and the avoidance of harm to the community reflect a prioritization of the values of health and safety among patients and the public. But other values will also feature in any healthcare institution and in coercive settings. The values underpinning the big four principles listed by Beauchamp and Childress (2001) – beneficence, non-maleficence, autonomy, and justice – are relevant to coercive mental health care too. Adshead and Sarkar (2005) discuss a broad conception of patient welfare that goes beyond medical needs, which implies other values than health being relevant to determining the wellbeing of the patient. But even beyond the big four and variants of them there may be values specifically relevant to guiding FMHS. Discussions on the role of mental healthcare institutions historically have implied that they have served implicit purposes and reflected implicit values such as protecting the community from deviance (Fakhoury & Priebe, 2007; see also Chappell & Jeppsson, 2023; Gildberg et al., 2012). While aspects of health and safety appear central to the practice, it seems plausible that other values may play important, specific roles in relation to FMHS, values that do not figure in the mainstream ethics discourse on FMHS.

1.4.3.3 INSTITUTIONAL OBJECTIVES

Ward and colleagues bring attention to the role of values in guiding interventions and coordinating services (Barnao & Ward, 2015; Ward & Durrant, 2021; Ward & McDonald, 2022). Conversely, objectives and interventions described in other work reflect values and ethical considerations. When Blackburn (2004) brings attention to treatment targets beyond patients'

mental health and post-discharge recidivism, he also highlights ethical duties to strengthen an individual and their capacity to function in society and even to isolate problematic individuals. Drawing on the expertise of FMHS patients, Livingston (2018) adds still more relevant objectives of FMHS, which are connected to values other than mental health and public safety. Interviewees in this study describe the value of having a normal life, independence, compliance, and more. The typology presented by Forsberg and Douglas (2020) additionally identify values that could be relevant to FMHS.

Hartvigsson et al. (2024) discuss the ambiguity of FMHS goals and seek to operationalize them in a way that could bring order to the sort of heterogeneity described above. They conclude that at the core, FMHS goals can be divided into a medical goal, a public safety goal, constituent parts of these goals, instrumental objectives to these goals, and side-constraints. The model they present leaves the definition of each respective core goal open to enable applicability in various jurisdictions and side-constraints are exemplified but no conclusive list is provided. In part, this openness is a consequence of the ambition for broad application of their model, but it is also a sign of the many ways in which FMHS goals can overlap and conflict.

The practical objectives risk being even less clear-cut, though. As noted by Hartvigsson et al. (2024), side constraints that are unrelated to the desired goals set limits to what FMHS can do. But the context also places demands on what *ought to be done*. For example, when someone is confined in a hospital, goals such as patient safety or a healthy diet are introduced. There are also studies indicating that punitive values influence decision-making in FMHS (Green, Lindqvist Bagge, Olausson et al., 2023), consistent with Bennet's prediction that the logic of FMHS will bear traces of criminal law's punitive aspects (2025). Thus, the list of goals and values included in existing conceptual models does not extend to all imaginable. Arguably, understanding how and which values are enacted and prioritized in practice is an important foundation for the development of FMHS ethics and should be used to inform the discourse.

In sum, the legal framework is essential but insufficiently concrete to give guidance. Additionally, the complexity of FMHS patients' needs extends beyond them having multiple and severe psychiatric problems in that such problems may combine in various and as yet uncharted ways within different patients. The ethical guidance for FMHS risks missing considerations that are too salient or pressing be ignored in the care setting. Given these

complications, bringing order to how FMHS ought to be framed in a way that is applicable in its given setting requires a mapping of these central tenets as practiced.

2 AIM

The overarching aim of this thesis is to contribute to a better formulation of the framing, purpose, and goals of FMHS, with a particular focus on the Swedish context. To understand the framing of FMHS, the thesis will investigate three central features with implications for the practical task and purpose of FMHS: ethics and values as guidance for clinical practice; clinical operationalizations of the goals set out in law; and the service tasks inherent in what the patients need. Each of these features is explored in a separate constituent part of the overarching aim and is presented in the chronological order in which the studies were conducted.

The first constituent aim is to use empirical data to refine and enhance the *ethical guidance* for FMHS, making it more attuned to clinical practice. Study I contributes to the first constituent aim by incorporating how valuation practices are received by those affected. The study aims to resolve an apparent paradox in the literature on administrative court hearings – that they are described both as guided by a benevolent and therapeutic culture and as distressing and disempowering (Thom & Nakarada-Kordic, 2014) – and thereby develop the ethical guidance pertaining to FMHS patients.

Also related to the first constituent aim concerning *ethical guidance,* Study II aims to identify whether there are ethical considerations relevant to FMHS that are not sufficiently covered by the mental health and public safety values that are commonly considered to be the core of FMHS ethics. The study seeks to identify implicit ethical values by using empirical data and find valuation practices in descriptions of administrative court hearings, as told by those who have a role as parties in the hearing.

The second constituent aim is to clarify the *practical goals* of inpatient FMHS that result from the legal criteria for discharge and transition to outpatient care set out in the FMCA. Based on the assumption that the criteria must be operationalized as goals to be reached, study III seeks to empirically identify under what circumstances FMHS patients are considered fit for outpatient care, based on configurations of rehabilitative need satisfaction. It will map rehabilitative needs onto the three areas of concern identified by the FMCA – mental illness, violence risk, and personal circumstances – and identify configurations which are consistent with a patient being deemed ready for outpatient care.

The third constituent aim is to identify core tasks for FMHS as indicated by *the needs of the patients*. Drawing on the idea that the needs of the patients is one defining feature of a service's purpose and that a practicable organization needs to both retain complex individual configurations and make the variability of possible configurations manageable, study IV seeks to identify types of FMHS patients based on configurations of self- and staff-rated rehabilitative needs. In addition, the study also seeks to identify clinically relevant implications of the statistically derived needs-based typology by relating it to clinicians' experiences of FMHS patients.

3 PATIENTS AND METHODS

3.1 THEORETICAL FRAMEWORK

Research conducted within FMHS inevitably inherits many of the complexities of the clinical practice. Interventions take place in socially and organisationally intricate environments; the aims of both practice and research are often multifaceted and potentially conflicting. Moreover, there is a limited foundation for robust assumptions regarding key phenomena, such as causal relationships between mental illness, criminal behaviour, and functional capacity. Much like what Debrouwere and Rosseel (2022) describe for psychology, the connection between empirical observation and theoretical conclusion is tenuous. The theoretical framework of this thesis reflects a way of managing these problems and making research in FMHS as useful as possible. The designs and analyses of the four included studies share three important, basic assumptions with a pragmatist tradition: 1) that the value of research can be found in how it serves to develop practices as much as in how it identifies objective facts about the world; 2) that pluralism in terms of methods and perspectives is important for a useful understanding of the study object; and 3) that a practicable ethic requires an understanding of how ethics is done.

The first point above traces back to the original pragmatist ideas of accepting fallibility and the primacy of practice (Peirce, 1868). These ideas are reflected in the thesis as a support for research that is easily applicable in the area to which it relates, even if it is at the expense of broad generalizability. The studies within this thesis are designed with a focus on national matters, making the distance between data and the object of generalizability shorter. This does not mean that generalization to other jurisdictions is unwarranted, but such generalizations must be tempered by the differences between settings, known or unknown (Reiss, 2015).

The second point supports the use of multi- or mixed-methods research as a means of enriching the foundations for conclusions (Morgan, 2013; Onwuegbuzie & Leech, 2005). The idea that the confidence we can have in conclusions is strengthened by multiple, harmonizing strands of evidence (Reiss, 2015) is also reflected in how the studies have sought to broaden the perspectives which are brought to bear on the respective questions. In study I and study II, the perspectives of patients are brought to bear on a matter that

has often been considered a professional ethical matter. In one, patients' understandings and experiences of administrative court proceedings are used to give a different perspective on benevolent intentions in the courtroom. In the other, we sampled all the actors who normally would have a stake in the decisions made in administrative courts and brought their different understandings with equal weight to the analysis. In study III, the knowledge of clinical staff is used in an analysis built around legal criteria. In study IV, we used needs-assessments by both clinical staff and patients (weighted equally) to identify subgroups of patients. As an overarching strategy, all categories of informant are treated symmetrically such that no group's understanding has priority over any other group.

The third and final point traces back to Dewey's (1939) understanding of ethical goals as inseparable from the practice of making something a goal and of pursuing a goal. Building on this idea, Dussauge et al. (2015) describe a programme for studying ethical values that emphasizes the act of valuation. In their perspective, focusing on the practical brings the discourse closer to where it is supposed to be applied and, it is hoped, makes it more useful in the relevant setting. This point about ethical values and practice is relevant to study I in how apparent intended valuation relates to how it is experienced in practice. In study II, the perspective is more explicit and focus is precisely on valuation practices. In study III, the goals of FMHS are explored by analysing how they are realized in the real world.

3.2 PARTICIPANTS

Three sets of participants were included in this thesis. The first two relate to the qualitative studies and will be described together in the section below. In the next sections, participants and recruitment procedures for studies III and IV are described.

3.2.1 STUDIES I AND II – QUALITATIVE DATA COLLECTION

Qualitative interviews about administrative court proceedings were conducted for studies I and II with individuals who at the time were patients in FMHS. For study II, qualitative interviews were also conducted with professionals with specific roles in administrative court hearings. The professionals who were interviewed were psychiatrists acting as representatives of the hospital and public counsels representing patients in these hearings. They were selected

on the basis that they represent the interests of the patient in administrative court hearing, such that they act as parties on either side of the trial. A total of 13 patients, 5 psychiatrists, and 6 public counsels were interviewed. All informants were recruited because of their expected knowledge and expertise. Thus, the recruitment of patients and professionals alike was a form of purposive expert sampling.

Recruitment procedures differed between patients and professionals due to access to informants among other considerations. All patients were recruited from the same hospital or the corresponding outpatient service. Inclusion criteria were specified as having experience of at least one administrative court hearing under the FMCA and being able to participate in an interview in Swedish. Exclusion criteria specified that informants must not suffer from acute and severe psychiatric symptoms which would have hindered their ability to participate and that there would not be safety concerns for anyone involved. For those being treated in inpatient units, information was provided in fora which gathered all patients in a unit. All who expressed interest in participation were given individual verbal and written information, and written consent was collected. For outpatients, recruitment followed the same procedure with the exception that FMHS clinicians helped contact patients to set up individual information meetings. Interviews with patients were conducted at a location convenient for the interviewee. For some, this was in a room at their unit of care and for others it was in their home outside the hospital.

Psychiatrists and public counsels were recruited using a combination of a broad offer to participants active in a court district, random sampling of court verdicts, and snowballing. Interviews were conducted by experienced researchers from the fields of philosophy, legal studies, and theory of science.

Demographic, clinical, and criminological data were not collected for these studies. The reason for this was that diversity of perspectives was ensured by iterative analysis and interviewing, not by sampling different identities (see further under section 3.4.1). The sample did however include men and women from inpatient and outpatient care. Some talked about being from a different country and culture and some discussed their crime being particularly severe while others noted that they had spent a long time behind locked doors despite only having committed minor offences, indicating a diverse sample.

3.2.2 STUDIES III AND IV – QUANTITATIVE DATA COLLECTION

The sample included in studies III and IV were recruited from six FMHS hospitals in Sweden. Basic information about the hospitals is given in Figure 1 below. The included hospitals represented approximately 30% of FMHS capacity in Sweden according to the latest SNFPR report at the time that data collection was concluded (SNFPR, 2023).

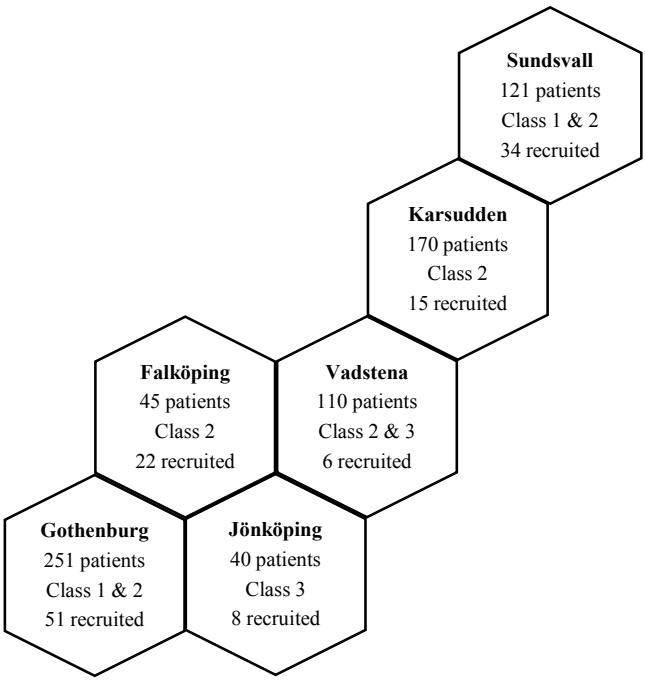


Figure 1: Included FMHS hospitals with approximate numbers of patients under care, security class, and numbers of participating patients. Information about numbers of patients is based on data from the most current report from the SNFPR (2023) at the time that data collection was closed, complemented with information from liaisons at each clinic at the time of recruitment.

Participation criteria were designed to be inclusive with the aim to avoid unwarranted exclusions or limiting representativeness. Anyone who was treated under the FMCA at the time of recruitment, able to provide informed consent (assessed by their treating psychiatrist and by the informing researcher

upon recruitment), could participate in a Swedish language interview, and with whom the safety of all involved could be maintained were offered information and the opportunity to enlist[5]. Enrolled in the hospitals at the time of recruitment were 737 patients. Just under half of these were reached by the research team to offer information because 390 were either treated in wards that did not participate, were living in the community too far from the hospital, could not be informed within the project time frame, or similar. Of the total population enrolled in the participating hospitals, 19 % were informed and included. Of those informed in person by the researchers, approximately 50 % chose to participate. The total sample size amounted to 136 individuals.

For study III, missing data on relevant variables resulted in twelve recruited individuals being excluded from the analyses. For study IV, seven individuals were excluded. Thus, the sample sizes differ somewhat between studies with study III having 124 participating individuals and study IV having 129. Demographical, clinical, and criminological participant information for the full sample is given in Table 1. The sample resembles the population registered in the SNFPR (see Alexiou et al., 2023; Degl'Innocenti et al., 2021; Sivak et al., 2023) although participants in our sample were more often inpatients.

Table 1: Descriptive information about participants in studies III and IV. Comparison with Swedish National Forensic Psychiatric Register (SNFPR).

	Sample Studies III & IV (n=136)	SNFPR
Male gender (%)	89%	82.2%[1]
Age (years/SD)	39.8 (12.1)	39.1 (12.5)[2]
Length of stay (years/SD)	6.2 (6.6)	7.5 (N/A)[1]
Primary psychotic disorder – F20 (%)	70.4%	63.4%[2]
Primary mood disorder – F30 (%)	6.7%	5.9%[2]
Primary neurodevelopmental disorder – F80-98 (%)	14.8%	16.3%[2]
Inpatient (%)	83.6%	61.2%[2]
SDR (%)	89.0%	85%[2]
Index crime assault (%)	39.3%	33.9%[3]
Index crime lethal violence (%)	16.3%%	12.9%[3]
Index crime threats (%)	14.1%	11%[3]
History of substance use	67.7%	64.7%[2]

[1]Data from SNFPR as reported by Sivak et al. (2023)
[2]Data from SNFPR as reported by Degl'Innocenti et al. (2021)
[3]Data from SNFPR as reported by Alexiou et al. (2023)

[5] The rationale behind our overall recruitment strategy is given in Pedersen et al. (2021).

3.3 MATERIALS

3.3.1 DESCRIPTIVE PARTICIPANT INFORMATION

Studies I and II did not collect descriptive information about participants. Descriptive information was collected from clinical files for studies III and IV, none were self-reported. A protocol was devised and used to structure the data available in clinical files. Current diagnoses were collected from the most recent version of a number of sources such as care plan, responsible psychiatrist's latest assessment of the patient, or a specific field for diagnoses in the background data of the patient file. The reason for including several sources was that no single field could be identified where the most up to date and comprehensive diagnostic information was available. Diagnoses were coded by the corresponding chapter in the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10, World Health Organization, 2019). Level of institutional control defined as furlough, hospital grounds privileges, outpatient, etc. was collected from specific fields in the files. Gender was collected from each participant's personal identity number which contains a digit representing *legal* gender. Thus, gender in this thesis is not defined by self-identification nor by biological indicators. Age and length of stay were calculated as the difference between the date of the patient interview, and the date of birth and the date that the criminal sanction became legally binding.

3.3.2 QUALITATIVE INTERVIEW DATA

Interviews with patients were begun with different versions of the question "could you tell me about the last court hearing you attended?" The initial question was used to spark a description of events that the individual had experienced, which could be the starting point for continued exploration. A semi-structured interview guide was used to ensure certain topics were covered, but the interviews were for the most part allowed to progress according to what interviewees found worth sharing. The subject areas covered in the interview guide included the roles of the actors in court and relationships between them, the agential and epistemic status of the patient, the purpose of the trials, relevant facts and expertise, and more. Initial pilot interviews were conducted and used to develop the procedure. Analyses were conducted in

parallel with the data collection so that preliminary themes could be explored further in subsequent interviews.

Interviews with psychiatrists and public counsels were conducted by members of the research project Expertise, Evidence and Ethics in Decisions on Involuntary Care (e.g., Radovic et al., 2020). The interview process was iterative and relevant prompts for interviews were developed throughout the data collection period. Members of the interdisciplinary project group brought specific focus on their respective area of expertise, such that philosophy, theory of science, and legal studies were used to inform the data collection.

All interviews were audio-recorded, transcribed verbatim, pseudonymized, and imported into the research software NVivo (Lumivero, n.d.). Some of the patient interviews were transcribed by the doctoral student, particularly those that had poor sound quality or were otherwise difficult to transcribe. The remaining interviews were transcribed by professional transcription services with experience of working with sensitive research material. All transcriptions were double-checked against the recordings and mistakes were corrected by members of the Expertise, Evidence and Ethics in Decisions on Involuntary Care project or by the doctoral student.

Interviews lasted between 15 minutes and 2,5 hours. Some patient participants were interviewed repeatedly to ensure that themes which had been touched upon were concluded or because a participant had chosen to cut the first session short. At the most, one participant was interviewed on three separate occasions.

3.3.3 CLINICAL DOCUMENTS

Three documents created as part of participants' care were collected for this project, if they were available. The documents were the most recent version of each participant's care plan, violence risk assessment, and the biannual application sent by the responsible psychiatrist to the administrative court. Each will be briefly described below.

3.3.3.1 CARE PLAN

Swedish law mandates the establishment of an individual care plan as soon as possible after a decision to commit an individual to compulsory care, including forensic psychiatric care (Compulsory Psychiatric Care Act, SCS 1991:1128). The FMHS care plan is a document that serves both to coordinate interventions and assessments related to a broad spectrum of needs and to provide material for court decisions on compulsory care. An FMHS care plan must include an

individual's medical, psychological, and social needs, as well as risk-related needs. The care plan must also include information about what the individual will need from social services, primary care providers, and general psychiatric services (National Board of Health and Welfare, 2022). As far as possible, the care plan should be created in collaboration with the patient and with their close ones. Thus, the care plan is a document that incorporates relevant rehabilitative needs, treatment progress, as well as required coordination with external parties.

3.3.3.2 VIOLENCE RISK ASSESSMENT

Violence risk assessments were collected from clinical files in the project. The research protocol did not specify the instrument upon which the risk assessment would be made to accommodate local practices. This also allowed for the collection of risk assessments using a combination of instruments. The most common instrument was the Historical Clinical Risk management-20 third version (HCR-20 V3, Douglas et al., 2013) followed by the Structured Assessment of Protective Factors (SAPROF, de Vogel et al., 2009). No other instruments were identified, but for some participants there were only summary clinical risk determinations on file which were not included for analysis.

Structured clinical judgement assessments such as the HCR-20 and the SAPROF contained information on a range of violence-related indicators, making them rich sources of information on criminological data. They were not controlled for fidelity to manuals or best practice and were used as free text documents.

3.3.3.3 COURT APPLICATION FOR COMPULSORY CARE

Compulsory care under the FMCA is limited to six-month increments (SCS 1991:1129). At least twice yearly the continuation of care is tried in court. An application or report is submitted to the administrative court by the chief psychiatrist responsible for the medical care in a clinic, or by their proxy (usually the patient's treating psychiatrist). The application specifies the level of institutional control that the psychiatrist considers appropriate for the patient and a motivation for these determinations.

There is considerable leeway in how these applications are constructed depending on what the court district demands and the culture at the specific clinic. Generally, the application specifies the index offence and sentence as well as reference to the last administrative court determination. Further, the

application usually contains information about the patient's psychiatric and criminal histories and an overview of the current care period. An application would typically also describe the latest developments for the patient and provide a summary assessment including whether legal criteria are deemed to be met and what form of care or discharge is being applied for. Consequently, the application is a succinct but unstandardized summary of much relevant information about the patient.

3.3.4 CAMBERWELL ASSESSMENT OF NEED – FORENSIC VERSION REVISED

The Camberwell Assessment of Need – Forensic version revised (CANFOR, Thomas & Slade, 2021) is part of the Camberwell Assessment of Need (CAN, Slade & Thornicroft, 2020) suite which includes six variants tailored to clinical subgroups. The original CAN was developed to enable systematic and manageable assessment of an individual's potential to benefit from healthcare interventions among those with an SMD (Phelan et al., 1995). CAN comprises 22 domains of need, all of which are repeated in other variants within the CAN suite (see Appendix 1). Each domain is rated as either No need, Met need, or Unmet need. The domains Accommodation, Dependents, and Transport can also be rated as Not applicable. For example, if an individual does not have children or other dependents to care for, that domain can be neither met nor unmet.

The CANFOR was developed to incorporate needs considered particularly relevant to individuals with a risk for or history of offending among those with an SMD (Thomas & Slade, 2021). To this end, three domains were added to the original CAN – Treatment, Sexual offences, and Arson. Treatment captures problems with concordance between how caregiver and patient understand the treatment plan and interventions. Sexual offences and Arson capture problems related to specific forms of offending which are not included in the Safety to others domain of the original CAN, and both are rated only if the individual has a history of such offending or if they are considered at risk of future offending. Appendix 1 provides the 25 CANFOR domains, the response options for each, and a brief comment on each domain.

CANFOR has been evaluated for reliability and validity. Thomas et al. (2008) found evidence for content validity, consensual validity, face validity, inter-rater reliability, and test-retest reliability. They also found some evidence for construct validity, although only tentative. It has been translated to six

languages with clinical and psychometric evaluations in three of them (Thomas & Slade, 2021). The Swedish CANFOR was translated for the overarching research project that this thesis is connected to and has shown overall excellent reliability (Nilsson et al., 2025). Previous evaluations of the original CAN indicate good validity and reliability of the Swedish version (Ericson et al., 1997; Hansson et al., 1995). CANFOR has been identified as the most well-supported instrument overall for outcome measurement for FMHS patients, particularly based on content validity indicators (Ryland et al., 2021).

3.4 ANALYTIC METHODS

3.4.1 QUALITATIVE ANALYSES

A similar analytic process was sought for the two qualitative data sets, although different premises for the analyses made some aspects impossible for study II. The analytic procedure was inspired by Charmaz (2006) and Hallberg (2006), who enlist practices and procedures of grounded theory without being bound by the full programme spelled out by Strauss & Corbin (1990). The practices and procedures of grounded theory are useful outside of the ontological frameworks of major proponents, similar to how thematic analysis as described by Braun and Clarke (2006) can work with a range of ontological and epistemological assumptions (Ralph et al., 2015). The procedure inspired by both grounded theory and thematic analysis is described below in terms of data collection, coding, thematization, and summary analysis. All qualitative analyses were conducted using the research software NVivo, versions 11 and 12 (Lumivero, n.d.).

3.4.1.1 DATA COLLECTION

For the patient sample used in both studies, initial reading and coding of the first interviews were conducted parallel to further interviewing. This meant that preliminary analyses could be used to inform later interviews to pursue avenues that had not been considered previously. However, the initial recruitment strategy was broad and was deemed to have exhausted the available participants in the hospital and those available in the outpatient clinic. In relation to study II, data was collected independent of the specific research question of this study. Thus, no specific interview questions were put to informants to explore valuation or ethical conflict. Instead, the analysis was conducted on transcripts of data and this procedure did not allow the same iterative movement between data collection and analyses connected to the specific aims of the study that was employed for study I.

The limited possibility to add participants on the basis of preliminary analyses made considerations of saturation challenging (Saunders et al., 2018). The later patient interviews could be tailored to develop subject that had been raised in previous interviews, and the addition of the final three interviews did not substantially change the analysis as it stood. This indicated that further sampling of the available population would not have affected the conclusions. In study II, the specific research question had not been the explicit focus of the interviews. However, the data collections for both samples were designed to iteratively explore practices and the purposes of practices in such a way that the research questions of study II were covered extensively.

3.4.1.2 CODING, ANNOTATIONS, AND THEMATIZATION

For patient interviews, all recordings were listened to repeatedly and read in full more than once before coding began. Audio-recordings were not accessed for interviews with professional actors in study II, but transcripts were read and reread as an initial analytic step. Constant comparisons were used to ensure close connection between raw data and themes (Hallberg, 2006). Meaningful segments of text were given codes, which meant that coded segments could be a few words but also a full paragraph. Codes were then grouped in preliminary themes, which were checked against the raw data and other themes, and revised.

For study I, two authors separately coded a subset of the interviews and compared their codes before one author formulated a broad initial analysis to provide an overview of the material and its important facets. One specific theme relating to distressing and disempowering processes in administrative court hearings was selected for continued analytic work and discussion.

For study II, a broad initial analysis was conducted with the professional actors' interviews but not for the patient interviews which had already undergone this process for study I. The second step consisted of identifying excerpts which related to valuation as practiced, which were the focus of the remaining analytic work. Instances where interviewees discussed important considerations related to the benefit of the patient or others or when interviewees described seeking to reach specific aims are examples of valuation in this sense. Hence, the focus was not on explicit but abstract statements about ethical priorities, but rather on descriptions of when certain values were actively pursued in some way.

The qualitative analyses used annotations to summarize cases so that general impressions of full interviews could be compared to codes and themes which were derived from the case and to the overall summary analyses. Annotations were also written as descriptors of themes which helped trace the connections between different codes and with the overarching theme. Coding, annotations, and preliminary thematization was done by one author in preparation for coordinated analyses.

3.4.1.3 COMPILING THE ANALYSIS

For study I, the final analysis was compiled primarily by one author, but with ongoing discussions with a coauthor. The two authors worked jointly on developing preliminary themes and the summary analysis. These were then discussed among all authors.

For study II, one author compiled the preliminary analysis of value practices and valuation. After initial thematization, a number of analytic workshops were held with all authors where codes, themes, and thematic structure were discussed and honed. Two of the authors then formulated the final analysis, which was reviewed and approved by the remaining coauthors.

3.4.2 DESCRIPTIVE ANALYSES

Clinical, demographic, and criminological data were analysed using measures of central tendency and tests of frequency distributions. Continuous variables are analysed using means and standard deviations. Count variables are described using frequencies and percentages of the total sample. In study III, the three outcome groups that were included in the main analyses were compared on a number of clinical and demographic variables to test whether they were significantly different at index. Chi-square tests were used for the categorical variables gender, SDR, primary diagnosis, history of alcohol abuse, and history of other substance abuse. Kruskal-Wallis tests were used for the continuous variables age, length of stay in care, and number of secondary diagnoses. Kruskal-Wallis was used because the assumption of normal distribution was not met.

3.4.3 QUALITATIVE COMPARATIVE ANALYSIS

Qualitative Comparative Analysis (QCA) is a method seeking to combine the generalizability and stringent comparisons of quantitative methods with the individual-level detail of qualitative methods. It is a person-oriented method (see definition on page xiv) using individual cases as the object of study, not

sample-level variables (Ragin, 1987; 2014). QCA is based on Boolean algebra, which is similar to formal logic calculations. Boolean algebra is used on the truth-value of a condition, such that a condition can have the value of true (1) or false (0) and relations such as *and, or,* and *not* can be expressed.

An advantage of QCA is the possibility to analyse complex relations and causality such as equifinality, conjunctural causality, and asymmetric association. Equifinality means that multiple paths can produce the same outcome (Mello, 2021). Conjunctural causality reflects that combinations of factors may be necessary to produce an outcome – each individual factor cannot lead to the outcome, however much of the factor there is. Asymmetry in QCA is the idea that a condition does not have to relate symmetrically to the outcome and to the absence of the outcome. Instead, the relations can be unique and ought to be analysed separately (Duşa & Cernat, 2019).

3.4.3.1 CALIBRATION OF CONDITIONS AND OUTCOMES

The CANFOR-domains considered irrelevant to the legal criteria, based on the legislative history and precedent cases[6], were excluded from further analyses. Physical health, Information on condition and treatment, Sexual expression, Dependents, Basic education, Digital communication, Transport, and Treatment were not used in the analyses. The remaining 17 domains were clustered to form 8 conditions covering: accommodation; activities of daily life (ADL); occupation; financial situation; social situation; substance use; mental illness symptoms, and violence risk.

As recommended for categorical data, we used dichotomous conditions, called *crisp calibration* (Duşa, 2019). In line with the ambition to study ongoing problems, ratings of No need or Met need were coded as managed situations. Unmet needs were coded as unmanaged situations. For composite conditions, any rating of Unmet need was sufficient to render the condition unmanaged in

[6] The FMCA specifies three areas of concern for transitions between levels of institutional control such as granting furlough or outpatient care – mental disorder, risk of serious recidivism, and other personal circumstances. The CANFOR domains connected to mental illness and violence risk were clustered accordingly. Personal circumstances are not clearly defined in law or in related documentation. However, Prop. 1990/91:58 exemplifies personal circumstances as relating to housing, the management of daily life, occupation, and substance use. In Regeringsrätten verdict 2001-11-02, case 4517-2001 social relations are added as a form of personal circumstances by the public counsel, although this is not confirmed by the court as legally relevant. These sources serve as a foundation for the selection used in this study.

our analyses. One rating of Unknown was deemed acceptable in a composite condition. Any missing rating would mean the case was excluded if the information was not available from other sources (e.g., if Sexual offences did not have a rating, but it was clear from available documents that the participant did not have a history of sexual offending, then a rating of Not applicable would be imputed). A total of twelve cases were excluded due to missing data or ratings of Unknown.

Testing for skewness in relation to the outcome indicated that three conditions were above the threshold of 80% suggested by Mello (2021). Recalibration yielded the new conditions *No risk for violence* and *No risk for substance use* for which a stricter definition of a managed situation was employed, such that only No need was considered managed. For the condition *Manages activities of daily living*, no appropriate alternative calibration was identified and the condition was not changed.

The outcome and non-outcome for the study were outpatient care and inpatient care, respectively. They were calibrated as crisp categories using clinical documents. Participants who were in outpatient care both practically and legally and those for whom the responsible psychiatrist had applied for outpatient care in the latest application to the administrative court were categorized as belonging to the outcome. Participants who had been in FMHS for more than 10 months, whose responsible psychiatrist had applied for continued inpatient care, and who were not described in clinical documents or the research protocol as being in the process of transition to outpatient care were categorized as belonging to the non-outcome. This calibration meant that the outcome and non-outcome were clearly separated as being considered ready for or not ready for outpatient care by the responsible psychiatrist. Half of the participants could not be clearly separated into either category, as they were in the process of discharge or had not been in care for long enough to have had the question properly raised. This group was not included in the necessity and sufficiency analyses. Of the remaining, 26 were classified as belonging to the outcome and 40 were classified as belonging to the non-outcome, totalling 66 participants, which is above the threshold suggested for csQCA with eight conditions (Mello, 2021).

3.4.3.2 NECESSITY AND SUFFICIENCY

The software fsQCA was used for the analyses of necessity and sufficiency in the relations between the conditions and the outcomes (Ragin & Davey, 2022). Necessity concerns whether a condition is always present whenever the

outcome or non-outcome is present, respectively. A threshold for consistency of .9 was used, where 1 represents perfect consistency (Mello, 2021). This threshold allows for a small number of exceptions to the necessity of a condition. Coverage is a complementary measure of empirical relevance, where a score of .5 or higher indicates an empirically relevant necessity score (Mello, 2021).

Sufficiency analysis is an empirical investigation of Millsian causation and what Mackie called INUS-conditions: Insufficient but Necessary parts of an Unnecessary but Sufficient solution (Mackie, 1965). The analysis identifies configurations of conditions which, when they are all present in a case, then the outcome is also present. The first step is the construction of a truth table with all logically possible combinations, amounting to 256 rows for each of the outcome (outpatient) and non-outcome (clear inpatient) analyses in our study.

Following convention, a consistency threshold of .75 was used (Mello, 2021). Thus, configurations were considered to be associated with outpatient care or clear inpatient care respectively if more than 75% of cases presenting with that configuration also displayed the corresponding outcome. The intermediate minimization was used and coverage for the full solution term as well as for each of the configurations were presented. Coverage in the sufficiency analysis is a measure of how much of the outcome is explained by each configuration (Duşa, 2019). No cut-off was used for coverage, but higher scores represent greater empirical relevance (Schneider & Wagemann, 2012).

3.4.4 LATENT CLASS ANALYSIS

Latent Class Analysis (LCA) is a statistical method used to infer unobserved subgroups in a population, based on a number of observed indicators in a study sample. It belongs to a family of techniques called finite mixture models and is a person-oriented method operating with categorical data (Nylund-Gibson & Choi, 2018). Sample sizes of 300 have been proposed based on model accuracy (Sinha et al., 2021). However, the method has been shown to be applicable with smaller samples given model parsimony and good class-separation (Weller et al., 2020).

A bias-adjusted, three-step approach has been recommended for the construction of typologies and covariate analyses using LCA (Vermunt, 2010). According to this approach, subgroups are constructed using indicator variables in the first step. In the second step, each participant is given a

probability based membership to each class. Class-membership probabilities are used in the third step where regression analysis of covariates is conducted.

In this thesis, LCA was used in study IV to identify latent subgroups of FMHS patients based on rehabilitative needs, and to explore the relationships between subgroup membership and a range of clinical, criminological, and demographic information. Maximum likelihood-based bias correction was used (Vermunt, 2010). The study design was preregistered on AsPredicted.org with identification number 100 176 (https://aspredicted.org/vzcy-72dt.pdf). The final study design differs from the preregistered version in four important ways. One author stepped back and was replaced by another; the minimum accepted sample size was not met within a reasonable time frame; patient- and staff-ratings were not analysed separately; and security class was not included as a covariate.

3.4.4.1 DATA PREPARATION

Combined self- and staff-ratings on the CANFOR were used to model latent classes. For each domain, any rating of Met or Unmet need by either the individual themself or by the care team was coded as *Need present*, indicating that the domain was one in which the participant had difficulties managing on their own. If both the self-rating and the staff-rating were either No need or Not applicable, the domain was coded as *Need not present*. Ratings of Unknown were treated the same as missing data. If a participant had two or more ratings of Unknown or missing data points within either the patient interview or the staff interview, the participant was excluded from further analyses.

To reduce the number of parameters in the LCA and to improve model parsimony, the CANFOR-domains were clustered into nine composite indicators: Home life needs; Needs related to own body; Needs related to education, occupation, and finances; Mental health needs; Needs related to cooperation with care; Needs related to risk of crime or violence; Substance use needs; Needs related to interpersonal relations; and Needs related to public infrastructure. The composite indicators were constructed to match the International Classification of Functioning, Disability and Health (ICF, World Health Organization, 2001).

Covariates were mostly collected from patient files with the descriptive information protocol used for the project. Age, legal gender, length of stay in FMHS, furlough or leave, and ICD-10 diagnoses were collected using the

protocol. Index crimes were identified from the clinical documents, mostly from risk assessments and court applications. For international comparisons, we used the Canadian Centre for Justice Statistics Policing Services Program (2008) UCR2 to categorize the offences.

3.4.4.2 CLASSIFICATION AND COVARIATE ANALYSIS

In the first step, models for 1-5 classes were calculated. Model fit was assessed using the Bayesian Information Criteria (BIC), Akaike Information Criteria (AIC & AIC3), Bootstrap L^2, the Vuong-Lo-Mendell-Rubin adjusted likelihood test ratio (VLMR), and interpretability of the resultant classes. Entropy was investigated as an indication of class separation in each model. We used the bootstrap estimation of L^2 due to the relatively small sample size and because CANFOR domains were not expected to follow a chi-square distribution (Vermunt & Magidson, 2005). The second step involved assigning all participants class membership. For use in the subsequent third step, all participants were given a probabilistic membership for each class. This prevents bias from unprecise modal assignment. In the third step, the covariates described in the section above were added as predictors of class membership and tested using Wald tests. Statistical analyses were conducted using the software LatentGold 6.0 (Statistical Innovations, 2021).

3.4.4.3 MODEL VALIDATION

A multi-professional group of experienced FMHS clinicians were assembled to validate the classes identified in the LCA. The team consisted of a specialist forensic psychiatrist, a psychologist, a social worker, a treatment assistant, a physiotherapist, a rehabilitation assistant, and a specialist nurse. The clinicians represented different areas and stages of forensic psychiatry and FMHS including pre-trial assessment, activity centre rehabilitation, inpatient wards, care development, and outpatient care. In two sessions with different participants, the clinicians were presented with information about the classes and significant predictors of class membership. They were asked to reflect on the classes using their clinical experience of working with FMHS patients. Notes were taken from the discussions, and the notes from the first session were used to inform the second. The reflections of the clinicians were incorporated into the conceptualization of the LCA-derived classes.

3.5 ETHICS

The collection of sensitive data from FMHS patients requires consideration of their vulnerabilities, both in terms of their restricted liberties and in terms of

the prevalence of mental impairments. There is concerning paucity of research relating to FMHS and the current status of a clinical practice which has little support for interventions and extends over many years of coercive care is just as ethically problematic. Thus, low-risk research seems imperative and very much ethically motivated within FMHS (Munthe et al., 2010; Pedersen et al., 2021).

Oral and written information about the studies were given to all eligible participants, unless they explicitly rejected it. After receiving information, each participant was given the choice to participate or not with clear instructions that it was voluntary. Inclusion was broad to offer information and the opportunity to contribute to individuals who seldom are given such opportunities. The choice to seek a wide distribution of information and a broad inclusion was inspired by reasoning by Nilsson & Broström (2020) regarding the rights of persons with disabilities to participate in research.

Patients who participated in the quantitative studies were given a small renumeration (200 SEK approximately £15) to reward participation without exerting undue influence.

Conducting research in a compulsory setting where observation and control are paramount comes with caveats. As much of data collection was conducted in the inpatient settings and some hospitals required that staff were present during interviews, confidentiality could not be fully satisfactory. Additionally, it seemed that some participants expected things that could not be delivered, such as broad and quick impact of the findings. Thus, the ethics of the research practice did not fully square with the reasoning above but there is still cause to pursue research within FMHS that is mindful of and seeks to remedy these problems.

3.5.1 ETHICAL APPROVALS

Ethical approval was provided for qualitative interviews with patients by the regional ethical review board of Gothenburg (D.nr. 247-15). Written informed consent was collected prior to interviews. The interviews with professional actors about their area of expertise did not pertain to sensitive data as defined by Article 9 of the EU's General Data Protection Regulation (Regulation (EU) 2016/679 of the European Parliament and of the Council). Therefore, they do not fall under the Swedish Act concerning the ethical review of research involving humans (SCS 2003:460) requiring ethical approval. Verbal informed consent was collected prior to interviews. For studies III and IV all participants

were provided with oral and written information about the project, and they provided written consent before being included. The Swedish Ethical Review Authority approved the original research protocol (D.nr. 2019-03557). The addition of measures and participating clinics brought further reviews (D.nrs. 2020-03574 and 2021-00999).

4 RESULTS

Four studies are presented below, grouped according to the three aims of the thesis: ethical guidance, practical goals, and rehabilitative needs of the patients.

4.1 ETHICAL GUIDANCE

Two studies are presented that investigate ethical valuation. Together, the two studies look for novel and unexpected relationships between ethics in FMHS as conventionally understood and how it can play out in practice.

4.1.1 STUDY I: THERAPEUTIC LOGICS IN COURT SETTINGS

Study I focuses on themes which are connected to patients' experience of administrative court proceedings being distressing and disempowering. It does not determine *whether* court proceedings generally are distressing, but *how* they may be experienced as such, even when conduct is intended to be considerate. The themes tie together to describe a process that seems to build on paternalistic beneficence but echoes the literature on how stress and powerlessness relate to exacerbated mental illness. Six themes summarize the findings and together describe how beneficence can be distressing.

The first theme describes a hierarchy in the administrative court hearings that is expressed through the patient being the last to speak, other actors discussing matters without involving the patients, and more. The second theme builds on the first and describes how patients' experiences and their contributions in court are treated as without consequence or reason, even unwanted. Patient contributions are only relevant as evidence of the patient's capacities or symptoms, as described in theme three. The patient's presence is generally considered valuable as a source of evidence for the court, according to this theme. The fourth theme further conveys how not only the contributions of the patients are treated as irrelevant, but also that they as individuals do not matter or even that they are considered to be bad persons. The interviews also relay how patients lack support from professionals who have the power to influence matters, as described in theme five. Finally, in the sixth theme it is described how patients experience a need to be loyal and compliant, such that even mild challenges are risky and problematic, especially when directed at the treating psychiatrist's propositions.

Taken together, these themes describe how conduct which is consistent with a therapeutic culture in administrative courts contribute to keeping the patient powerless and causing distress.

4.1.2 STUDY II: DUAL ROLES AND BEYOND

The primary findings of study II suggest that the values in play in relation to FMHS and the administrative courts are manifold and less well-separated than the dominant ethical discourse on FMHS would have them be. Unlike what would be expected under the dual-role dilemma (Robertson & Walter, 2008), our analysis suggests that balancing mental health and public safety, albeit important, is not always at the fore. Under some circumstances, it may not even be possible to differentiate which distal goal is in focus or how reaching such a goal would look. The valuation practices that were described by informants are presented in five themes below.

Acceptance – adjustment of behaviour and alignment of thinking is the first theme and one that is prominent in the material. It relates to patients accepting the worldviews and norms of professionals and the institution. This acceptance goes beyond compliance as it involves internalizing the norms, and it is enacted through what professionals say, do, and what institutional rules dictate. *Telling it like (you think) it is* contrasts with acceptance in that it is an encouragement and enabling of making patients' thoughts, feelings, and wants explicit and of having them taken seriously. *Atonement and assuming responsibility* brings together descriptions of when making good for or repairing the harm done by offending is enacted as valuable. Examples include patients admitting their wrongdoings and apologizing, or repairing relationships in the community. Interestingly, this theme includes no examples of when it may be negative to atone, from professionals or from patients. The fourth value *Normality* is enacted in several ways that partly conflict but have in common the valuation of fitting in or being like others. In one form, this value is about seeming normal or hiding what is abnormal from view. The other forms involve including the patient within the scope of acceptable normality. Contextualizing and explaining aspects of a patient's life which seem abnormal makes these aspects understandable and less deviant. Alternatively, treating a patient like a normal person is a way of expanding normality to cover the patient too. Finally, *Ensuring the future – durability/continuity and pre-emption* involves parts of the interviews where a satisfactory future is the focus of practices. What satisfactory means in this context is elusive as the focus is on maintaining something over time or preventing something negative in the future. The

descriptions include continuing a satisfying state or dealing with minor current problems to avoid future catastrophes.

4.2 PRACTICAL GOALS IN THE LAW

4.2.1 STUDY III: THE PRACTICAL GOALS OF INPATIENT FMHS

Study III included 124 individuals, of which 66 were considered clearly inpatient or outpatient and were analysed using QCA. The remaining 58 individuals were in the process of transition to outpatient care or, to a lesser extent, had not been within inpatient FMHS for more than 10 months. Based on this, they were understood as not clearly inpatients nor outpatients. There were no statistically significant differences between the three outcome groups on gender, care with SDR, primary diagnosis, number of secondary diagnoses, history of alcohol abuse, history of other substance abuse, age, or length of stay, as assessed using chi-square and Kruskal-Wallis test.

4.2.1.1 NECESSITY ANALYSIS

No condition had a consistency over .9 for outpatient status, although Accommodation, Financial situation, and ADL were close (.88, .85, and .85, respectively). Coverage, which is a measure of empirical relevance of a necessary condition, indicated that the high necessity scores for Financial situation and ADL were potentially trivial.

Among cases with inpatient status, no condition was above the threshold of necessity at .9. Again, Accommodation was an important condition with the absence of fitting accommodation reaching a consistency of .85. The presence of managed ADL was also close to the threshold at .88.

4.2.1.2 SUFFICIENCY ANALYSIS

The number of conditions used in the study gave 256 logically possible configurations for each of the outcome and non-outcome analyses. Relative to the inpatient non-outcome, 29 configurations were empirically represented. The solution term for this analysis was exceedingly complex with problematic model ambiguity when minimization was attempted. Due to this complexity and the study's focus on outpatient status, we chose not to pursue this analysis further.

Forty-seven of the logically possible configurations for outpatient status were empirically represented in our sample, 16 of which were consistently (at .75 threshold) associated with outpatient status. The intermediate minimization process was used, which produced seven configurations in the final solution term. The solution term had a coverage of 1.0 and a consistency of .96, indicating that almost all cases represented in the solution term were considered ready for outpatient care and that all cases considered ready for outpatient status were covered by the solution term. The configurations indicated that outpatient status was associated with a combination of conditions under which two of three broad areas covered by the FMCA (mental health, recidivism risk, and personal circumstances) were satisfactory. No configuration had only one or all three areas covered. Additionally, some configurations had *unsatisfactory* conditions as constituent parts. Thus, patients in outpatient care could have considerable problems in one area of concern, if the other areas were in good order, and they all had some problems in at least one area.

4.3 REHABILITATIVE NEEDS AMONG FMHS PATIENTS

4.3.1 STUDY IV: A NEEDS-BASED TYPOLOGY OF FMHS PATIENTS

The final study included 129 participants in the final analyses after seven individuals had been excluded due to missing data or domains being rated as Unknown in CANFOR. The following sections will describe first how the chosen model was derived and how demographic, clinical, and criminological information predicted class membership. A conceptualization of the classes is presented after this, taking into account both the statistical analyses and the clinical validation.

4.3.1.1 CLASSIFICATION BASED ON NEEDS

Models of one to five classes were calculated, of which the three-class solution was chosen based on relevant statistics, model parsimony, and interpretability of the classes. Home life needs; Needs related to education, occupation, and finance; Mental health needs; and Needs related to participation and cooperation with care differed significantly between the classes (see Figure 2).

4.3.1.2 CLASS CONCEPTUALIZATION

Class one, comprising 51% of participants, was labelled *Psychosis and poor cooperation*. This class was characterized by considerable needs in areas relating to education, occupation, and finance; mental illness; relationships; and cooperation with care but less problems in areas relating to the private sphere, relative to the other classes. Covariate analyses (see Table 3 for a summary presentation of covariate analyses) indicated that having a psychotic disorder, being convicted of a violent, non-sexual offence, and having an SDR were indicative of being a member of class 1. They were also more often in outpatient care than the other classes. The clinical team related this class to patients who had ongoing symptoms of psychosis and problems establishing a working relationship between clinicians and patients. Outwardly good functioning but risk for relapse in serious psychotic symptoms implied a need for securing continued pharmacological treatment, a possible reason for the class having a high probability of being in compulsory care even if inpatient care was not needed.

Class two, comprising 36% of participants, was labelled *Need of institutional care.* This class presented with problems across all indicators but particularly relating to the personal sphere of their homes and their own bodies, as well as cooperation with care. Predictors of being part of this group were organic or neuropsychiatric disorders, as well as having a sexual but not a lethal index offence. In terms of institutional control, members of the *Need for institutional care* class were more often inpatients without any chance to leave the hospital without staff, or inpatients with furlough. The clinical team related this class to experiences of patients who struggled with self-directedness and passivity, often as a result of low cognitive function. Offending could be the result of not understanding other people or being unable to control impulses. Members of this group were understood to be unable to manage life outside the hospital on their own, but being able to leave in the company of staff or on furlough with family or to care homes.



Figure 2 - Three-class model with level of need within each condition (adjusted to a scale of 0-1).

Table 2: Statistically significant covariates by latent class.

	1. Psychosis poor cooperation	2. Need institutional care	3. High function lethal violence
PRIMARY DIAGNOSIS***			
Organic disorders	0,01	0,05	0,00
Substance use disorders	0,01	0,00	0,06
Psychotic disorders	0,77	0,61	0,58
Mood disorders	0,05	0,00	0,14
Personality disorders	0,05	0,06	0,00
Intellectual dysfunction	0,03	0,04	0,00
Autism and other disorders of psychological development	0,06	0,21	0,23
ADHD and other disorders with early onset	0,02	0,03	0,00
INSTITUTIONAL CONTROL*			
Inpatient, no privileges	0,19	0,23	0,15
Inpatient w/ grounds privileges	0,12	0,04	0,14
Inpatient w/ furlough	0,44	0,73	0,56
Outpatient	0,25	0,01	0,14
SDR**	0,94	0,82	0,83
INDEX CRIME**			
Lethal violence	0,19	0,06	0,48
Sexual offences	0,06	0,18	0,11
Assaults	0,40	0,35	0,01
Offensive weapons	0,08	0,13	0,22
*p<.05, **p=0.01, ***p<0.01			

The third and smallest class, accounting for 12% of participants, was labelled *High function, lethal violence.* Members of this class were characterized by low levels of need across most domains. Compared to the other classes, they have fewer needs in domains related to major life areas such as education, occupation, and finances, mental health, and cooperation with care. Members of this class more often had a mood disorder or an autism-spectrum disorder, and they were more often sentenced to forensic psychiatric care for lethal violence. The clinical team described experiences of individuals who had intense episodes of mania or psychosis when ill but functioning well for the

most part. Alternatively, they discussed invisible symptoms such as non-bizarre delusions or obsessive fixations as something that could result in unexpected and severe violence among individuals who otherwise managed life well enough.

5 DISCUSSION

5.1 SUMMARY OF RESULTS

5.1.1 AIM I: ETHICAL GUIDANCE

Two qualitative studies were conducted to address the first aim. In the first, the practical consequences of certain paternalistically benevolent ideals were investigated. In the second, valuation as seen in described practices were the focus. Administrative courts were the arena for both studies, under the assumption that ethical dilemmas central to the need for FMHS would be particularly salient in that setting.

In the first study, we find descriptions of practices that imply a *therapeutic logic* setting the priorities (Jacobsson, 2006; Peay, 1986). A therapeutic logic is a system of norms and practices which prioritize goals related to improved health or the provision of care. Hallmarks can be said to include benevolent paternalism to benefit health – prominence of the medical expertise, prioritization of health-related goals, and strategies to bring the patient in line with the medical goals. The results from study I indicate that these practices are consistent with patients experiencing them as highly distressing and disempowering, and that such experiences correspond to risk factors for exacerbated psychiatric symptoms (see Myin-Germeys & van Os, 2007; Siddaway et al., 2015). This indicates that a) therapeutic ambitions can fail to account for paradoxical effects on health by the paternalistic control employed; and b) introducing benevolent and therapeutic ambitions in judicial settings may not produce the same responses as they do in healthcare settings, where paternalistic beneficence is expected (Sandman & Munthe, 2010).

Study II further shows how ethics can be a different matter when applied in a complex setting than when theorized. Two main findings are drawn from this study: that clear cut values corresponding to theoretical ethical discourse are not always what guide practice and that values that go beyond what is commonly understood as the core of FMHS ethics are treated as important in decision-making. Relating to the first finding, the dominance of principles-based guidance in medical ethics (e.g., Beauchamp & Childress, 2001) has been criticized for being insufficiently coherent and unwieldy in practice (Clouser & Gert, 1990; Hedgecoe, 2004; Pols, 2015). Study II provides two reasons for why such guidance can be hard to apply in clinical decisions.

Firstly, the considerable temporal distance between when an intervention in FMHS can be employed and when the desired outcome will happen is significant and makes connections between the two very tenuous. Secondly, translating abstract values into concrete and practicable valuation can be challenging. The value of normality is an example of this, where hiding abnormality on one hand, and being included in what is considered normal enough on the other, are two different ways of operationalising normality.

In relation to the second finding, variants of conforming and complying come across as important to pursue but also being seen and taken serious as a person with moral agency, a relevant perspective, and an acceptable way of being. Useful ethical frameworks need to account for these values, if they are being treated as important by the actors in FMHS, or they risk impacting decisions implicitly. This might be how compliance plays into court decisions, for example, where it is subsumed in and obscured by the concept of insight (Radovic et al., 2020). Thus, practicable ethics that serve to guide action in clinical decision-making may have to be based on aspects which are abstract and generalizable as well as those that are salient and accessible, while also accounting for valuation that is less openly discussed but seemingly unavoidable.

Taken together, these two studies show that the application of abstract and generalized ethical guidance is complicated by the risk of producing effects which are contrary to what is desired, possibly because of the context demanding something else. It is also complicated by other, in the context more salient, values having to be accommodated when abstract and generalized ethical guidance is *too* abstract or generalized.

5.1.2 AIM II: PRACTICAL GOALS IN THE LAW

The second aim, investigated in study III, relates to the goals that FMHS derive from the legislative criteria that govern discharge. Three main areas of concern are indicated by the FMCA (SCS 1991:1129) – mental illness, recidivism risk, and the less strictly defined personal circumstances. The satisfaction of rehabilitative needs across a range of domains deemed relevant to the three areas of concern among individuals under outpatient care and those under inpatient care revealed two main findings: 1) no single area of concern alone can differentiate between inpatient and outpatient status and no single area of concern was necessarily satisfied among outpatients; 2) a systematic pattern of need-satisfaction was identified among those under outpatient care.

The first main finding was that neither of the three areas of concern was uniquely important for a patient to be considered fit for outpatient care, including ongoing risk for violence and serious mental health problems. Closest to be considered necessary was appropriate accommodation, possibly because accommodation is what most obviously must be replaced when an individual leaves inpatient care. Instead, several different combinations of conditions, some of which included *unsatisfied* conditions, were consistent with outpatient status.

The second main finding is that the combinations of conditions which were consistent with outpatient status mapped onto Swedish legal criteria systematically such that if two of the three main areas of consideration were satisfactory, then outpatient status was a possibility. This implies a flexible logic where problems in one area can be compensated by stability in the other two. For example, individuals can be deemed fit for outpatient status having ongoing serious hallucinations or delusions, if other aspects of their lives are well-managed.

Whether individual conditions are important in their own right or instrumentally in relation to some other condition is unclear. Appropriate housing, substance use, social relations, and finances have all been identified as important protective factors (or problems in these areas have been identified as risk factors) for both criminal recidivism or for poor mental health outcomes (Alegría et al., 2018; Bonta et al., 2014; Noland & Strandh, 2021; Whiting et al., 2021). The role of the personal sphere in some configurations indicates that there are conditions without an obvious connection to mental health or recidivism which are still relevant for outpatient status.

Among conditions that play a role in differentiating between outpatient and inpatient status are also needs that lie outside the mandate of FMHS in Sweden. Thus, reaching goals important to the transition to outpatient care is dependent on efforts by other actors in the welfare system. These results imply a need for improved transparency and that FMHS goals need to be clearly separated into those that are 1) relevant for transition to outpatient care; 2) important but unrelated to transition to outpatient care as well as those that are a) amenable to FMHS interventions; or b) require external actors.

5.1.3 AIM III: REHABILITATIVE NEEDS AMONG FMHS PATIENTS

The third aim concerns how the needs of patients determine the task of FMHS and was addressed in study IV. This study used a person-oriented design to identify subgroups of FMHS patients based on rehabilitative needs. Identifying subgroups who represent large shares of patients in FMHS provides a base for service development that is tailored to common combinations of needs in the population. The main findings relating to this aim were that 1) three classes of patients could be identified based on rehabilitative needs; 2) that criminological, clinical, and demographical characteristics differed between the classes in ways that resonate with previous typologies of persons with SMD and offending histories; 3) that the classes were clinically meaningful; and 4) that they implied a need to think about different endpoints for FMHS for different types of patients.

Relating to the first main finding, three classes were identified and conceptualized: 1) Psychosis and poor cooperation; 2) Need for institutional care; and 3) High function, lethal violence. The second main finding was that the classes could be linked to previous typologies. For example, the Psychosis and poor cooperation class could be representatives of those described by Hodgins et al. (2013) as having a late onset of offending but then persisting or those with early onset and persistent offending. They could also be the same group identified by Noland et al. (2023) as persistently reoffending, using substances, and being subject to coercive care after discharge from FMHS or by Green, Lindqvist Bagge, Laporte et al. (2023) as having polysubstance abuse and psychotic disorders. Similarly, the second class resembles Noland's et al. (2023) high-need group or Thomas' et al. (2004) complex needs groups. The final class connects to the group Hodgins et al. (2013) identified as late starters with a single, serious offence or to those identified by Noland et al. (2023) as managing life reasonably well.

The third main finding was that the identified classes resonated with clinical experience and particular clinical challenges were identified. For the first class, establishing a working relationship between patient and care team, and a consistent pharmacological regimen were identified as key tasks for clinicians. They could also require effective substance use treatment to reach the kind of long-term stability required. For members of the second class, daily support and compensation of functional disabilities were identified as primary tasks. Rehabilitation in the sense of acquiring new or reacquiring lost skills so as to

manage independent living was considered beyond the reach of FMHS for this group. Finally, the third class was related to patients who clinicians thought primarily needed monitoring to identify early signs of relapse, exacerbation of symptoms, or tendencies towards acting on persistent symptoms.

Relating to the fourth main finding, the different need-profiles between the classes indicate that FMHS must adapt their targets depending on the needs that patients present with. Reaching such goals as preventing recidivism and relapse in psychiatric symptoms may require different interventions for different individuals. However, the task of FMHS may also differ depending on what are reasonable and proportionate ambitions. In cases where current functioning is high and there is no consistent pattern of violence in the past, most of the risk reduction may be achieved by relatively unintrusive monitoring, while very minor additional reductions in future risk of violence could be attained with considerable rehabilitative interventions. Paradoxically, the same may be true for class 2, where rehabilitative interventions seem unlikely to result in considerably lowered risk of violence or improved mental health. If establishing and coordinating community supports such as appropriate housing and daily support can achieve much of the possible risk reduction, then it seems disproportionate to mandate rehabilitative interventions for this group.

5.2 STRENGTHS AND LIMITATIONS

5.2.1 QUALITATIVE STUDIES

The two qualitative studies have two primary limitations that apply to them both, albeit to different extents. The first of these relates to data collection and limits to data saturation (Saunders et al., 2018). In the first study, recruitment proceeded alongside initial analyses and preliminary themes could be explored in more depth in subsequent interviews. However, the recruitment strategy involved a broad and general initial recruitment and not a stepwise model. Stability in the thematic structure over the last few interviews indicated that additional recruitment would make little difference, but it is possible that more interviews could have been used to explore certain themes further. Study II used previously collected data, which meant that there was no possibility to explore preliminary themes in subsequent interviews, which likely affected saturation. Therefore, interpretations of and generalizations based on these studies ought to account for the lack of certainty regarding saturation.

As noted above, study II entailed reanalysing previously collected data. This impacted the possibility to assess saturation, but it also meant that the specific research questions explored in the study did not guide the data collection. Prompts relating to ethics were used during data collection, but valuation practices were not intentionally queried. It is likely that additional valuation practices could have been found if an iterative data collection with this in focus could have been conducted. However, the analysis was concerned to a considerable extent with implicit valuation in described practices. As such, there is reason to think that explicitly asking about valuation would have shifted focus to theoretical values, contrary to the aims of the study.

The second limitation relates to the analytic process. Eschewing specific structured protocols for the analyses, we prioritized flexibility over stringency. The analyses drew methods selectively from grounded theory and from thematic analysis. The reasoning was that the questions we explored were well met by a constant comparative method with thematic coding. However, the analysis may have been more robust if a strict, manualized analysis would have been employed.

5.2.2 QUANTITATIVE STUDIES

The limitations of the quantitative studies can be divided into three types: Sample size-related; the cross-sectional design; and analytic choices that prioritize complexity. Relating to the first one, the absolute number of participants was lower than expected based on the recruited clinics because the share of eligible patients who participated was disappointingly low. Generally, this affected the confidence in the representativeness of results, which brought some limitations to the conclusions that could be drawn from the analyses. In relation to QCA, confidence in the generalizability and empirical representation of specific configurations were affected, which made the conclusions of study III more tentative. The same is true for study IV, where it is possible that specific subtypes of individuals were missed. To address this limitation, a basic analysis of representativeness was conducted by comparing the sample with the SNFPR (2024). The participants in studies III and IV were generally similar to the population described in the register on available variables.

Relating to the second type of limitation, it is most relevant to study III. A comparison is made in that study between those currently deemed fit for outpatient care and those clearly not deemed fit. A longitudinal design would have enabled discussing causality in a way that was not possible in this study.

Finally, the third type of limitation is a down-side of using the kind of person-oriented methods employed in the thesis. The methods chosen prioritize incorporating complexity over generalizability. Both methods require more interpretation and decision-making than some frequentist methods, introducing more subjectivity in some stages of the analysis. The small sample size also affected the robustness of both quantitative methods, requiring more manual effort. For example, clustering CANFOR items in both studies was done to improve the parsimony of the analyses at a later stage.

In terms of strengths, the studies use several methods particularly well-suited to accommodate complex interactions and incorporating complementary perspectives. Flexible qualitative methods allow for connections to be made which may have been lost if rigidly following rules regarding coding, for example. Person-oriented methods treat each participant as a whole, allowing for a more nuanced analysis of how characteristics interact within an individual. Although aggregation is more complicated, as noted above, disaggregation to applications in individual cases is often more straightforward when clinical research findings are reintroduced in the practice, making them more easily implemented.

6 CONCLUSION

FMHS are services that deal with considerable complexity and potentially conflicting priorities. The four studies presented here indicate a number of defining features of how FMHS ought to be framed to better manage this complexity.

Firstly, interventions, goals, and professional conduct need to be adapted to the context in which they are applied and to the individual patient. Otherwise, practices seeking some value – like the patient's best health related interest – risk becoming paradoxical and counterproductive. Olsson et al. (2014) describe a related problem in their study, where the timing of paternalism or cooperation with the patient can result in unwanted consequences if it is not tailored to their current needs. Beneficent paternalism would appear to be a viable way to pursue better mental health in a healthcare setting if the patient is lacking in autonomy, but not in a legal setting with clients seeking to make reasonable contributions, and ought to be employed accordingly.

Secondly, decision-making in relation to FMHS is not always based on conceptually clear and generalizable values. For ethical guidance to be practically useful it must incorporate values and goals closer at hand, even if they do not correspond to the public safety-mental health-duality that is a hallmark of FMHS ethics (Robertson & Walter, 2008). For example, if FMHS in reality pursue acceptance, it is important to be able to discuss how acceptance can be pursued in a defensible way and what shape it may take. Similarly, the goals given by the Swedish FMCA are not simply and directly mapped onto public safety and mental health only. Rather, the goals of FMHS are many and relate to transitions across a care trajectory conjuncturally and asymmetrically. Thus, transparent and predictable assessment of goal attainment requires a better separation of important goals that are relevant to progress and those that are not. The role of FMHS in Sweden seems to not be limited to mental health treatment and violence risk reduction. Indeed, there seem to be elements of FMHS that serve to separate patients from society, even if that separation is not based on a clear risk for relapse in serious psychiatric symptoms or crime. Why this is, remains unclear, although the role of FMHS in separating some individuals from society has been discussed before in relation to de- and reinstitutionalisation (Kaliski, 2013). Regardless, if such considerations influence decisions about care transitions, they need to be made explicit to avoid arbitrariness.

Finally, the framing of FMHS ought to recognize that patients' trajectories through care will differ considerably and with them the endpoints of care. Three clusters were identified in study IV which imply very different measures of success. These clusters are similar in many ways to those identified by Noland et al. (2023) and who had very different outcomes after discharge from FMHS. For some patients, the goal of care may be to establish minimal but enduring monitoring for recurrence of serious symptoms, while for others the goal of care may be to establish a comprehensive support system for basic and psychiatric needs in the community. Both would mark the end of FMHS, but in very different ways. Seemingly arguing along the same lines, Edberg (2024) makes the case that FMHS ought to be split into different services with different sanctions leading to them, depending on offenders' cognitive disabilities.

Bringing these findings together points toward a framing of Swedish FMHS that would incorporate (at least three) different trajectories with different endpoints for care. It would also allow for objectives unrelated to recidivism risk or mental health to affect decisions about progress and discharge, but establish structured ways to make a flexible weighting of different objectives non-arbitrary and transparent. The framing would further incorporate valuation of matters such as normalizing individuals under care or promoting enduring acceptance. This is not to say that such matters are generally desirable, only that they likely will have an impact on decisions and therefore must be accounted for in ethical guidance. A framing that can encompass all of these matters could result in more effective care in terms of shorter periods care; in improved rule of law and legal certainty for FMHS patients; and in a practice with a more workable ethical guidance.

7 FUTURE PERSPECTIVES

The studies presented here are explorative and a pragmatist pursuit to develop the practice of FMHS. They seek to map broad facets of a complex service without claiming definitiveness. Thus, having found support for expanding the concept of FMHS in Sweden, there are numerous avenues to pursue. Below will be listed those deemed most promising, although there are many more that are relevant.

Firstly, studies in this thesis concerned with ethical guidance are based on interviews where informants describe actions and analyse intentions of a limited set of actors involved in FMHS decision-making in some way. There are a host of other actors involved in FMHS, many who are central to the daily practice. It is plausible that valuation practices differ in important ways depending on the context in which it happens and the actors who perform them. The type of ethical enquiry proposed by Pols (2015) or by Dussauge et al. (2015) benefits from direct observation of how valuation is done in specific contexts. Ethnographic designs and observational studies are promising ways to extend the empirical ethics research in FMHS. Determining how prevalent these forms of valuation are would require quantitative designs such as self- and other rated questionnaire studies, studies involving quantitative observations of behaviour (e.g., Sturidsson et al., 2007), or analyses of clinical files (e.g., Berlin et al., 2025).

Secondly, studies III and IV indicate multiple possible trajectories through care and ways to progress to less restrictions. Exploring these trajectories longitudinally would help clarify the connections suggested by these studies. Using longitudinal latent modelling (Collins & Lanza, 2010) and register data (cf. Noland et al., 2023) are promising avenues for this. Using trajectory-based versions of qualitative comparative analysis (Pagliarin & Gerrits, 2020) is another relevant way to capture the proposed trajectories. Relatedly, analyses of transitions other than that from inpatient care to outpatient care are perhaps tied to other considerations. Discharge from FMHS or the first decisions to allow furlough are examples of transitions that deserve further investigations. Descriptions of such transitions are important in their own right and the goal need not be causal models.

Thirdly, participant recruitment is challenging in Swedish FMHS (Pedersen et al., 2021). Reaching larger sample sizes likely requires strategies other than those employed here. Using data from clinical files in combination with

implementing routine outcome measures in clinical FMHS could make accepting participation easier for FMHS patients. However, care must be taken to avoid such data collection becoming exploitative.

Finally, and related to the question of transitions, the boundaries of FMHS in relation to other services help determine the framing of the services. The end of FMHS in Sweden typically means that one or more non-forensic services take over the responsibility to meet some of the remaining needs of the individual. Social services provide accommodation to individuals who leave inpatient care and general psychiatric services provide mental health care to individuals after FMHS. This means that the measure of when FMHS have fulfilled their purpose for an individual depends on what adjacent services provide and how those boundaries are drawn. The studies in this thesis show that the boundaries of FMHS include matters beyond directly targeting public safety and mental health needs. Specificities of these boundaries, how they are negotiated and how coherent they are across the Swedish system is another key area to explore in future studies.

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APPENDIX

Appendix 1: CANFOR domains, response options, and brief explanations for each domain.

CANFOR Domain	Response options	Explanation
1. Accommodation	N, M, U, N/A, ?	Whether an individual has appropriate accommodation. N is rated if the individual has acquired appropriate housing without professional support. N/A is rated if the individual is within institutional care now and the next 6 months.
2. Food	N, M, U, ?	Whether individual can manage their sustenance.
3. Looking after the home	N, M, U, ?	Whether individual can manage to care for their home environment.
4. Self-care	N, M, U, ?	Whether individual can manage hygiene, teeth, etc..
5. Daytime activities	N, M, U, ?	Manages to stay active in a meaningful way.
6. Physical health	N, M, U, ?	Physically healthy with or without ongoing treatment.
7. Psychotic symptoms	N, M, U, ?	Whether an individual has ongoing psychotic symptoms or have ongoing treatment that ameliorates symptoms.
8. Information on condition and treatment	N, M, U, ?	Whether individual has received and understood information about their condition, treatment, and rights
9. Psychological distress	N, M, U, ?	Whether individual is experiencing psychological distress.
10. Safety to self	N, M, U, ?	Whether individual is at risk of harming themselves.
11. Safety to others	N, M, U, ?	Whether individual is at risk of harming another.
12. Alcohol	N, M, U, ?	Whether individual has ongoing alcohol abuse or is at risk of developing.
13. Drugs	N, M, U, ?	Whether individual has ongoing drug abuse or is at risk of developing.

N=No need, M=Met need, U=Unmet need, N/A=Not applicable, ?=Unknown
*=Addition to original CAN

CANFOR Domain	Response options	Explanation
14. Company	N, M, U, ?	Whether individual has satisfying social relations and can manage them.
15. Intimate relationships	N, M, U, ?	Whether individual has a satisfying intimate relationship and can manage it.
16. Sexual expression	N, M, U, ?	Whether individual has a satisfying sex life.
17. Dependents	N, M, U, N/A, ?	Whether individual has and can manage dependents such as children or sick parents. Relates to both contact with dependents and to dependents' care needs. N/A is rated if there are no dependents.
18. Basic education	N, M, U, ?	Whether individual can manage basic reading, writing, and counting.
19. Digital communication	N, M, U, ?	Whether individual can manage digital communications such as internet and smart phone.
20. Transport	N, M, U, N/A, ?	Whether individual can manage public transportation or otherwise transport needs. N/A is rated if the individual has no experience or if they will not use public transportation over the coming 6-12 months.
21. Money	N, M, U, ?	Whether individual can manage their finances and pay bills.
22. Benefits	N, M, U, ?	Whether individual receives the benefits they are entitled to.
23. Treatment*	N, M, U, ?	Whether individual consents to and follows treatment plan.
24. Sexual offences*	N, M, U, N/A, ?	Whether individual is at risk of committing sexual offences. N/A is rated if there is no history of sexual offence.
25. Arson*	N, M, U, N/A, ?	Whether individual is at risk of committing arson. N/A is rated if there is no history of arson.

N=No need, M=Met need, U=Unmet need, N/A=Not applicable, ?=Unknown
*=Addition to original CAN