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Abstract:	Coercive practices, such as physical restraint, are used globally to respond to violent, aggressive and other behaviours displayed by mental health service users1. A number of approaches have been designed to aid staff working within services to minimise the use of restraint and other restrictive practices. One such approach, the 'REsTRAIN Yourself' (RYS) initiative, has been evaluated in the UK. Rapid ethnography was used to explore aspects of organisational culture and staff behaviour exhibited by teams of staff working within 14 acute admission mental health wards in the North West region of the English NHS. Findings comprise four core themes of space and place; legitimation; meaningful activity; and, therapeutic engagement that represents characteristics of daily life on the wards before and after implementation of the RYS intervention. Tensions between staff commitments to therapeutic relations and constraining factors were revealed in demarcations of ward space and limitations on availability of meaningful activities. The physical, relational and discursive means by which ward spaces are segregated prompts attention to the observed materialities of routine care. Legitimation was identified as a crucial discursive practice in the context of staff reliance upon coercion. Trauma informed care represents a potentially alternative legitimacy.

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Abstract

Coercive practices, such as physical restraint, are used globally to respond to violent, aggressive and other behaviours displayed by mental health service users[1]. A number of approaches have been designed to aid staff working within services to minimise the use of restraint and other restrictive practices. One such approach, the 'REsTRAIN Yourself' (RYS) initiative, has been evaluated in the UK. Rapid ethnography was used to explore aspects of organisational culture and staff behaviour exhibited by teams of staff working within 14 acute admission mental health wards in the North West region of the English NHS. Findings comprise four core themes of space and place; legitimation; meaningful activity; and, therapeutic engagement that represents characteristics of daily life on the wards before and after implementation of the RYS intervention. Tensions between staff commitments to therapeutic relations and constraining factors were revealed in demarcations of ward space and limitations on availability of meaningful activities. The physical, relational and discursive means by which ward spaces are segregated prompts attention to the observed materialities of routine care. Legitimation was identified as a crucial discursive practice in the context of staff reliance upon coercion. Trauma informed care represents a potentially alternative legitimacy.

Introduction

There is international interest in minimising restrictive practices within mental healthcare (Duxbury 2015). This paper reports on a rapid ethnography situated within a larger evaluation of the ReSTRAIN Yourself (RYS) initiative within mental health inpatient wards (AUTHORS 2019a). The ethnographic account provides a contextual overview of the range of environments in included mental health wards; focused attention to specific cultural aspects that could theoretically have been influenced by the RYS approach; and general description of changes occurring on the wards over the time of the study. We explore the legitimacy of restrictive practices in psychiatric services through a sociological lens.

Sociologists have long held an interest in the study of mental illness as a form of social deviance and its relationship to wider society (Rogers and Pilgrim 2014). Classically, Goffman (1961) studied the micro-relational interactions of psychiatric institutions, highlighting how various practices resulted in forms of moral degradation and a mortification of self for detained inmates. Then and now, restrictive practices are deployed within psychiatric services enmeshed with broader systems of governance and control (Foucault 2003, Rose 1996). Notions of epistemic injustice and violence (Fricker 2007) have been taken up in critique of mental health services, whereby psychiatric knowledge stands accused of implicit violence and legitimation of explicitly violent acts such as physical restraint or forced medication (Liegghio 2013, Russo and Beresford 2015). Hence, for Holmes and colleagues (2013: 9) the focus should be on the extent to which violence is 'bred in the practices' of organisations. Furthermore, recent austerity policies have diluted resources, particularly ward staffing levels (Baker et al. 2016), exacerbating restrictive ward cultures (Docherty and Thornicroft 2015).

Increasingly, inpatient mental health services have become characterised by compulsion

and coercion (Szmukler 2015). This has been criticised by progressive organisations, staff

and service users (Rose et al. 2015, 2017), prompting initiatives to minimise restrictive

practices (Duxbury 2015, Moran et al. 2009, Muir-Cochrane and Gerace 2016, Paterson and

Duxbury 2007, Watson et al 2014). Systematic programmes of change including the US Six

Core Strategies (6CS) (LeBel et al. 2014), from which RYS is adapted for the UK context,

and Safewards (Bowers 2014) have been evaluated internationally (Ashcraft and Anthony

2008, Barton et al 2009, Borckardt et al 2011, Bowers et al. 2015, Lewis et al. 2009,

Putkonen et al 2013). These initiatives share a prevention-oriented focus on improving

relational care, de-escalating aggression and violence and debriefing teams following use of

restraint. RYS specifically emphasises trauma-informed care, acknowledging the harm that

restraint can cause. The ethnography aimed to explore ward cultures in relation to

experiences of the use of restraint and the impact of the RYS intervention.

Methodology

This study took place on 14 acute mental health wards within 7 NHS Trusts across the North

West of England. Half of the wards, one in each Trust, received the RYS intervention. The

impact of this was evaluated using a range of measures within a non-randomised trial. Data

collection took place between July 2014-February 2016. A qualitative dimension of the study,

comprising rapid ethnography observations and semi-structured interviews with purposive

samples of staff and service users, undertaken by researchers attending each ward at two

intervals, before and after the intervention phase within each Trust.

Rapid ethnography is an intensive, shortened form of ethnographic data collection designed

for researching a slice of organisational life and workplace cultures (Baines and Cunningham

2011, Handwerker, 2001). It has been utilised in health care research where time,

budgetary, or other pragmatic considerations militate against more extensive anthropological study (Bentley et al. 1988, Johnson and Vindrola-Padros 2017). The approach aims to maximise depth of observation and analysis, even though the period of data collection is relatively short compared with classic ethnographies. Despite various criticisms, robustly conducted rapid ethnographies can usefully inform policy and practice (Vindrola-Padros and Vindrola-Padros 2018).

Two researchers undertook the majority of the ethnography: research assistants from a psychology background (initials) and with lived experience of being detained on mental health wards (initials). Senior researchers (initials) were involved for at least one day of each observation period, and provided regular support and supervision for the research assistants. Having a mixture of service user and professional inputs represented in our team allowed for a richly reflexive relationship to the data (Hammersley & Atkinson 2007). Prior to the study all members of the research team were committed to the possibilities for restraint reduction and were to a varying degree, critical of coercive practices.

The researchers were present on the wards at each data collection interval for approximately a week, mirroring full staff-shifts and observing key practices such as staff team handover, medication rounds, and lunchtime activity. Ethnographic field notes, structured using Spradley's (1980) framework, were written away from the ward at break-times and end of shift each day. In total, across all the wards and both time intervals, 162 interviews were undertaken; 130 with staff, 32 with service users. The staff sample included different levels of work experience, gender and ages, grades and professional roles. The majority of the staff comprised registered mental health nurses and health care assistants (HCAs), all of whom were involved in restraint practices. Service user participants included a mix of age, gender and diagnosis. Interviews aimed for a conversational, open style, exploring aspects

of the participants' experiences of the ward environment and restraint practices. They also sought to reveal attitudes towards coercive care, its context and personal impact. In the interviews undertaken after the intervention, experiences of RYS and attempts to change practice were explored. Interviews varied in length from approximately 20 to 90 minutes, were audio-recorded and transcribed in full. Transcripts and emergent analysis were not shared with participants for pragmatic reasons of limited resources.

Field notes relating to 1260 hours of person-observation and interview data were analysed thematically (Braun and Clark 2005). Analysis was undertaken by the four researchers involved in the ethnographic data collection. Initially, two researchers (initials) independently coded the data via iterative reading and re-reading. A coding framework was defined and refined. Codes were then merged and synthesised into key themes that represented the entire data set. Identified themes were agreed with the other two team members involved in data collection (initials), and finally with the whole team. Findings are presented and illustrated with field note excerpts and quotes from interviews. Additional analysis of interview data is reported elsewhere (AUTHORS 2019b). Analysis was supported using MAXQDA software (version 11).

As with any ethnography, transferability of findings is limited due to the interpretive emphasis on people and relations within a particular context. The relative brevity of data collection under rapid ethnography has been criticised in some quarters, including the potential to constrain reflexivity, but commentators within the health field believe this need not compromise quality (Vindrola-Padros and Vindrola-Padros 2018). Our study addresses these concerns, with the volume of interview data counterbalancing relative brevity of observations.

The study was funded by the Health Foundation and received ethical approval via the Health Research Authority (ref. 14/YH/0164).

Results

The accounts described here represent characteristics of life across the wards, before and after implementation of the RYS intervention. On the intervention wards a number of positive changes were observable. However, the extent of these varied across the different wards and certain negative characteristics of culture and practice persisted beyond the intervention. The findings are presented in four core themes: space and place; legitimation; meaningful activity; and, therapeutic engagement; each with pre and post implementation observations.

Space and Place

All of the wards differed in design. Tellingly, all were initially informally demarcated into service user and staff space, often comprising quite different worlds. Staff spent most time in office areas with service users congregating in areas proximal to the office. Smaller quiet rooms or TV rooms were under-utilised. Typically, offices had large windows allowing observation of nearby areas, but also constituting a physical barrier between service users and staff. On a few of the wards, a large day room was adjacent or near to the office. Interaction between staff and service users was often constrained by locked office doors, and occupation of space by staff that operated to exclude service users. HCAs were more likely to be visible within main ward spaces but, even when senior and other staff were out of the office, they regularly kept to their own 'world' with minimal relational contact; present but not available:

The pattern on this ward appears to be that 'regular' staff (especially nurses) are in the office/clinic/reviews (behind closed doors), and agency staff are the only visible members on the ward. Their visibility is purely for instrumental tasks such as facilitating smoking, doing observations, and they rarely engage with service users, unless the service user initiates. Observation: Site 7_intervention_T1

Whilst in living room with service users for a minimum of 1.5 hours we saw a staff member fleetingly twice conducting observations, again not interacting with service users. Observation: Site 6_intervention_T2

Staff use of space was bound up with simultaneous super-valuation of, and irritation with, record-keeping. This and other work pressures were often related in tandem with bemoaning perceived inadequate staffing levels and associated management support. Positive managerial support for their work, and specifically involvement in change practices, was appreciated but not uncommonly ward staff felt that managers were spatially and relationally distant from practice, or even that they were an active impediment to change. Nursing staff claimed that they were under great pressure to complete care planning and other records associated with (they believed) oppressive risk aversion. They often declared that insufficient data entries on the computerised record would be viewed as a disciplinary offence, justifying lengthy periods spent in the office. Alternately, a different sort of defensive practice involved staff protecting themselves from threat or possibilities for emotionally laborious work by taking refuge in their offices (often justified by the need to complete the paperwork they professed to dislike):

> *Staff although friendly (mostly) appear to hide in their [offices]. I feel this environment*
>
> *is too comfortable, that staff are somewhat reluctant to leave this area, particularly as*
>
> *the atmosphere on the ward is tense.* Observation: Site 6_intervention_T1

The office door was pivotal in the demarcation of ward space, offering a largely impermeable shield from service users. This portal was defended consistently and vigorously, adding to an observed 'us and them' dynamic. At times we observed what we considered to be disrespectful denial of entry or refusal of requests. In the context of a study evaluating approaches to minimise aggression, this appeared provocative and self-defeating:

> *I witnessed several times, service users being ignored by staff. This is done in a few*
>
> *ways. Service users knock on the office door and get no reply. If a staff then comes*
>
> *out of the office, they make no eye contact with the person and ignore what they're*
>
> *saying. This is rude and horrible to watch. It clearly is a source of great irritation*
>
> *amongst service users and is talked about amongst themselves.* Observation: Site
>
> 6_intervention_T1

A subsequent, recurring behavioural refrain on more than one ward involved increasingly frustrated individuals resorting to shouting outside or kicking the office door.

After implementation of the intervention, there was little observed change in the overall demarcation of space on most of the wards observed. The two 'worlds' were still clearly evident. In some cases, change may have been difficult due to factors outside of staff control:

In terms of the occupation of space on the ward, nurses remain behind closed doors either in reviews, in the clinic or behind a computer. They have little to no interaction with service users. However, today I have been made aware that the ward has been placed on a risk register due to the low level of qualified staff (only 3 full-time qualified nurses on the rota). Observation: Site 6_intervention_T2

There were, however, some minor, though perhaps culturally profound changes in some wards, rendering the boundaries between staff and service user space slightly more permeable:

Most staff are still in the office but the door is now open. Observation: Site 4_intervention_T2

Leaving the door open is a powerful symbol of invitation, indicative of an awareness of the importance of design and utilisation of space.

Legitimation: justifying restraint

It was rare to hear unprompted staff talk about restraint. When it did happen, it was usually observed in office spaces in periods immediately following a restraint episode. *Justification* was the primary focus of this talk, informed by particular views or judgements on individuals or specific groups of service users. Before implementation, some staff claimed more legitimacy in restraining service users who came from certain populations, such as individuals diagnosed with personality disorder who self-harmed. Furthermore, such

individuals were frequently typified as manipulative' or 'attention-seeking' (within handovers

for instance), especially following restraint incidents. They were not seen as 'deserving', and

their behaviour was seen as selfish and disruptive to the smooth running of the ward.

Restraint was therefore believed to be the only reasonable option for control and restoration

of order:

> *Conversation with staff engaged in art activity on the ward. A service user who*
>
> *refused to take part was spoken about after she walked away. Staff said this was*
>
> *typical of her because she was a 'self-centred PD patient' who also abused drugs*
>
> *and alcohol and was the sort of person who would inevitably become aggressive if*
>
> *she didn't get what she wanted. And then the use of physical restraint would be*
>
> *equally inevitable.* Observation: Site 4_intervention_T1

Other justifications involved protecting staff and other service users from distress at the

visible signs of self-harm. On one unit, a young woman was restrained and marched down

the corridor to her bedroom:

> *X explained to me that it is documented in Y's care plan that she is not allowed in the*
>
> *dining room at meal times, and that if she is in the communal areas she is to cover*
>
> *her arms. This is due to her severe self-harm wounds that expose muscle tissue, and*
>
> *that Y regularly opens these old wounds. She commented that some service users*
>
> *(and staff) get very distressed at the sight of her wounds. X explained that Y was on*
>
> *1-1 observations with a new HCA* [Health Care Assistant] *to the ward, who wasn't*
>
> *aware Y wasn't allowed to eat in the dining room at meal times, nor enter communal*
>
> *areas without covering her arms. Staff then intervened when Y was in the dining*

room during the meal time, which she reflected led to the incident of restraint.

Observation: Site 2_Intervention_T1

This is not to say that all staff viewed all restraint as legitimate at all times. Instead, certain staff had misgivings about the use of restraint, and did not view the experience of restraining another person positively. Some acknowledged the weakness of legitimation appeals that justified restraint usage as a last resort:

… and we always used to use restraint as a last resort but I think we always used to think we did, rather than actually do it. Interview: Site 1_Intervention_Staff 3_T2

Rationalising restraint as a legitimate, last resort intervention both vindicated staff actions, and consoled those who would rather not administer coercive practices. Addressing these concerns was a central part of the RYS intervention. Such justifications were reinforced by some service users, stating that restraint may have been the correct response on occasion to maintain safety and a sense of security:

Conversation with service user following completion of questionnaire exploring views on experiences of different forms of coercion. This person intensely disliked being subject to physical restraint but spoke of circumstances when they felt it was warranted. This would be either when they had personally been aggressive or out of control, or when applied to other service users they were fearful of or who were seen as disruptive for everyone. Observation: Site 3_intervention_T1

In this sense, service users' views on legitimacy of restraint reflected hindsight awareness about personal behaviour, as well as surfacing concerns about collective social relations. It could equally result from uncritical adoption of staff beliefs about legitimacy. Individuals certainly did not appreciate being subject to coercion or restraint at the time it occurred, particularly if this was deemed oppressive, or undertaken in public view.

The RYS intervention included education about the sort of complex needs represented by a diagnosis of personality disorder. Interestingly, many staff engaged positively in this, keen to develop new knowledge and skills within an external learning environment. Indeed, staff were observed to behave and communicate differently away from ward settings, being much more likely to offer positive, empathic reflections upon service users under their care. This included compassionate insights into the possible traumatic antecedents of self-harm or aggression and violence, and reflective intimations that management of aggression could have been done differently on occasion. Post-implementation, there were some shifts in attitude about self-harm and restraint across the wards, reflected in both talk and action. Post implementation, staff communication appeared to be less derogatory, and a 'hands off' approach was observed more often:

> *Staff have tried to de-escalate (to no effect), and tried to spend time de-escalating in the courtyard (again to no-effect). Some conversation in the office occurred around potentially administering intra-muscular medication, and the doctor has written this up. However, this wasn't acted on. The person was allowed to vent, and be quite severely hostile to staff without being reprimanded or challenged. The Ward Manager has reflected learning 'when not to do anything' has been a positive aspect of the project.* Observation: Site 1_intervention_T2

Staff also began to implement more formal aspects of the RYS approach including ward

community meetings designed to attend to service users' concerns, and imaginative

approaches to address and record aspects of ward atmosphere and safety. In conversation,

many staff appreciated the trauma-informed aspects of the project and better understanding

of reasons why people may harm themselves:

> *I think there's less anxiety around patients being admitted that self-harm. I think it's*
>
> *given people a different way of thinking about it.* Interview: Site 4_Intervention_Staff
>
> 1_T2

For some, this had led to 'epiphanies' about their own practice. Concomitantly, staff grew in

confidence to challenge decisions made about care and attempt to prevent further

psychological and physical harm, although potential for positive risk-taking was not always

accepted within teams and on occasion was countermanded by psychiatrists.

Meaningful Activity

One of the ways in which relatively settled and unsettled wards could be distinguished was

the availability of organised and meaningful activities. Better quality activities were observed

if Occupational Therapy (OT), psychology, or Activities Co-ordinators were attached to the

ward teams. Staff associated with the provision of meaningful activities were notable for their

motivation. They experienced job fulfilment and exuded enthusiasm in ways mainstream

staff did not:

The activities coordinator spoke with us for quite a while about the various activities and complexities of involving as many service users as possible in activities. Her energy is contagious, and she is clearly passionate about the welfare of service users. Observation: Site 4_intervention_T1

Activities included both 'therapies', such as Cognitive Behavioural Therapy (CBT) and opportunities for creativity or practical occupation, such as gardening. Facilitating staff made explicit connections between activities and a calming effect on ward atmosphere:

X also commented that he likes activities that are multisensory, as he feels these are more therapeutic. He reflected that something as simple as mask-making can be particularly therapeutic … the mod-rock and clay is very messy and tactile [the activity] distracts service users for a few moments from their complex issues. Observation: Site 2_intervention_T1

Some units provided specialist activities with invited guests such as professional musicians:

The two musicians invited questions from service users, called everyone by name, and made an effort to engage with every person who attended the activity. For the first time in many days, the focus of conversation was not on emotions, feelings, mental health status, medication etc. but about a topic completely interesting to everyone in the room. Observation: Site 3_intervention_T2

In contrast, there were substantial gaps on many of the wards:

This is the 7th ward I have visited with this project, and this is the first time I have met a full-time Clinical Psychologist on the ward, who runs therapy related sessions x3 a week. This is the first time I have observed and seen available CBT principles. Only one or 2 other wards in other Trust's, mention mindfulness briefly as a way to manage psychological distress. Observation: Site 4_intervention_T1

Ward resources for activities were fairly limited. Intersecting with concerns regarding use of space, a lack of things to do led to people isolating themselves in bedrooms with iPads or mobile phones. Activity rooms were often locked, restricting access to activities at service users' own behest. Moreover, activity rooms were often poorly stocked. We were regularly told that service users produced artwork for the walls, but such work was rarely displayed. Accessible space outside the wards was usually an unkempt area, often used for smoking. One unit had no outside space whatsoever. On another, the staff were fearful of occupying the garden space because the trees were identified as ligature points – confirming tendencies for risk aversion.

Some advertised schedules of activities were subject to substantial cancellations or postponements because of staffing or other resource pressures. Not all service users appreciated what was on offer, felt patronised, or covered up their abilities in order to avoid engaging in activities they considered meaningless. Boredom was reported frequently.

Despite being highly relevant to the RYS intervention, the quality and extent of meaningful activities on the implementation wards did not always improve. If anything, on some of the wards, activity levels reduced due to key staff absences. We observed very few attempts

made by staff who were not activity specialists to facilitate the activity timetables.

Conversely, where activities were better supported, there were attempts to play to staff

interests and talents:

> *X's [staff member] been assigned to do the gardening, and the garden's great. […] Y*
>
> *[staff member] he's really into artwork, he's got an Art Degree so he's been doing [art*
>
> *classes].* Interview: Site 4_Intervention_Staff 8_T2

On the two wards with high observed levels of positive activity pre and post intervention, this

seemed almost entirely due to particular staff, rather than a team commitment. This

suggests that responsibility for meaningful activity vested in specific individuals or

departments may paradoxically lead to reductions in activities if nursing staff do not see this

as their professional concern.

Therapeutic Engagement

Even before the implementation of the RYS intervention there was evidence of particular

aspects of ward culture reinforcing therapeutic relations between staff and service users.

The quality of therapeutic relations was most obvious when staff spent more time engaged in

face to face contact with service users. This theme of therapeutic engagement therefore

interacts with our observations of use of ward space and opportunities for meaningful

activity.

Staff who spent most time with service users tended to be the least qualified team members,

such as HCAs and, in one Trust, apprentices. Conversations started usually with banter,

discussing TV or non-clinical matters, and service users valued this 'ordinary' talk. Positive

social and therapeutic relations were seen to be undermined by resource issues affecting

staffing levels, including difficulties associated with deployment of temporary staff. Service

users on most wards pre-intervention regularly bemoaned lack of time with staff, or that

interactions were clinical and impersonal. Many felt staff did not know them personally, or did

not attempt to get to know them, leading to frustrations, and an 'us and them' mentality:

> *X commented that there was a severe lack of contact time between staff and service*
>
> *users. He felt that before asking clinical questions (e.g. do you think the television is*
>
> *talking to you as a first line of questioning) staff should get to know the person.*
>
> Observation: Site 2_intervention_T1

The traumatic impact of restraint had individual and collective impacts upon therapeutic

relations and ward atmosphere. There were numerous examples of people being distressed

by being restrained or subject to coercion, with staff also upset by these incidents. Feelings

of powerlessness or not being listened to often preceded expressions of aggression and

violence and were then compounded by the experience of being restrained and forcibly

medicated. Traumatic impact also extended to witnesses:

> *X reported that she had seen the individual 'dragged, kicking and screaming' to the*
>
> *clinic and that it was very traumatic to her. She stated that every time she hears the*
>
> *alarm now, she gets a 'funny feeling' in her chest.* Observation: Site
>
> 3_intervention_T1

The application of staff-initiated rules, such as frequency of access to smoking space or egress from ward, often precipitated conflict and aggressive responses. On many wards the flexibility or rigidity with which rules were applied could depend upon which staff were on duty or who was in charge. Service user frustrations were compounded if the notional arbiter of the rule was typically not present to enforce or explain it.

Post intervention, problems with understaffing and with the weight of administrative work persisted on most wards. Congruent with core relational aspects of RYS, there was, however, evidence of improvement in therapeutic engagement. On some wards staff were spending substantially more time with service users. However, it was still mostly HCA's and Activity Co-ordinators who provided most direct contact:

HCAs on this ward are an obvious invaluable asset to the ward, and have fantastic rapport with service users. They can always be seen in service user areas, and are very diligent on their 1-to-1 observations, in terms of not restricting the movement of service users to suit themselves (which I have observed on other wards), and despite being on 1-to-1 observations for a prolonged period of time (an entire shift), they appear alert. HCAs can be seen actioning requests, nipping in the bud people knocking on the office door for things such as: chargers, money, access to their bedroom. This is something that is definitely different [from before implementation]. Observation: Site 3_intervention_T2

Discussion

This study took place in a context of constraining structural and resource factors, including managerial reorganisations and service relocations for some. However, in all the study

wards, both before and after the RYS implementation, culture and practices shared a

number of characteristics. We focus here on the staff legitimation practices, first locating

these within consideration of the spaces of psychiatric care within which the study took place

and the mundane materialities of these ward settings, the objects and built environment, and

the ordinary, everyday interactions therein.

Psychiatric inpatient spaces

The findings indicate constraints on time staff spend in direct encounters with service users,

limiting supportive or therapeutic relationships, confirming previous research into mental

health wards (Gilburt et al 2008, Quirk and Lelliott 2001). The noted temporal rhythms and

spatial demarcations of ward life connect with key dimensions of Spradley's (1980)

framework and previous commentary on space and place in relation to mental health in

society and psychiatric services (Parr 2011, Wolch and Philo 2000), and inpatient services

particularly (Curtis et al. 2007, Spandler 2009).

Within a general delineation of health landscapes, Curtis (2004) distinguishes between

therapeutic 'landscapes' (Gesler and Kearns 2002) and landscapes of power. The former

are informed by understandings of sense of place or identity, and emotional response to

settings, while the latter are concerned with socio-political control within socially defined

spaces. Both analyses of space are relevant to our observations of the ward spaces in our

study, with a demarcation of staff and service user space on all of the wards. This indicates

tensions between therapeutic and coercive potentialities.

The typical staff space was ward offices that service users seldom entered and other areas

mainly occupied by service users that staff inhabited infrequently. These two-worlds recall

Goffman's (1961) classic observations of institutional care, where distinctions between staff

and patient identity were realised through symbolic and ritual interactions and maintained

within the spatial and cultural demarcations of asylum life. The offices in our study were sites

of intensive commentary on behaviour and relations between care team and service users,

collated within computerised care records. Commentators have ascertained a 'fictional'

dimension to such narration activities, given that they involve writing about people or making

assessments without them, and recording aspects of ward life without spending substantial

time present to witness actual behaviour (Coffey et al. 2017). In this sense, whole systems of

bureaucracy act to limit actual engagement, with attention to the perceived importance of

'paperwork' justifying time spent away from service users.

Staff reported oppressive institutional expectations of servicing the record keeping process

(see also Brooks et al. 2018), believing (with some justification) that not to make sufficient

data entries would attract managerial disapproval. It was seldom felt that lack of real

interpersonal engagement would be similarly subject to supervisory discipline. Weber's

(1905/1958) iron cage of bureaucracy offers an interesting means for making sense of the

observation that bureaucratised care was a seductive diversion from more relational

alternatives. For Weber such developments reflect a more general increasing rationalisation

of social life under western capitalism. In the contemporary ward systems, this tendency

towards rationalisation is framed by governance systems of risk management within a wider

frame of risk society (Beck 1992, Lupton 1993); wherein the desire or necessity to be spared

from risk has become a defining feature of modernity, and the mental health system is

prominent within this.

In this context, there is also a prevailing intolerance of uncertainty despite the actual

existence of maximal uncertainty (Bauman 2000). Drawing upon Bauman's work, critical

healthcare commentators have noted the extent to which the organisation and resourcing of modern services has resulted in a destabilised workforce, with colleagues and services users never sure of who they will be working with from one day to the next (Randall & McKeown 2014). Bureaucratic systems offer a phantasy of certainty, and failings are catastrophized rather than viewed as a fact of life. This state of affairs stokes staff anxieties, predicating and justifying a perceived and actual blame culture, further perpetuating staff's commitment to servicing the bureaucracy and legitimising such efforts with the concomitant retreat into particular spaces.

Everyday materialities

Early theorising of a sociology of space notes that various notable sociologists, such as Goffman, have worked with a saliency of space, spatial arrangements, and the interactions therein, ordered by hospital architecture, for making sense of human behaviour and resource mobilisation (Prior 1988). The physical, relational and discursive means by which ward spaces are segregated prompts attention to the observed materialities of routine care. Recent writing on the materialities of care has considered a number of different healthcare settings, highlighting the importance of the seemingly mundane, such as objects and taken for granted elements of the built environment, for making sense of the practices, relationships, spatiality and cultures of care (Buse et al. 2018, Maller 2015, Nettleton et al. 2018). Brownlie and Spandler (2018: 267) have extended this concern with the mundane materialities of care to the informal mental health context, and their conclusions regarding the value of shared space appear to also be relevant to professionalised spaces, with 'the possibility for small acts of care to emerge in and through sharing the most ordinary of spaces and things'. Seen from this perspective, initiatives such as RYS have been conceived in reaction to aspects of discipline, control and bodily regulation that have been quite literally built in to the psychiatric hospital space of the ward settings studied here (Prior

1988). In this sense, RYS represents a counter-discourse to the prevailing discursive

practices that legitimate use of physical restraint.

Thus, our observations of the changes in practice resulting in the seemingly small,

inconsequential act of leaving of the office door open, and how this allowed for less

demarcated ward space and freer contact between staff and service users, represents just

such a scenario where a simple material change can have a profound impact. More broadly

speaking, the observed commonplace demarcation of ward space is enabled by building

design features, offices, day areas and corridors that, whilst representing modern

incarnations, resonate with older spatial configurations harking back to asylum times.

Similarly, the social relations of inpatient ward care also continue to have characteristics of

the rituals of mortification of self that Goffman observed in those latter-day institutions.

Exculpatory legitimation

Ours and other studies show that staff in mental health services collectively and individually

engage in legitimation narratives regarding restrictive practices, in particular, and psychiatry

more generally (Gadsby 2018, Perkins et al. 2012). Burstow (2016) offers a scathing critique

of the wider influence of legitimation narratives within the mental health system as part of a

broader re-emergence of anti-psychiatry scholarship and critical mad studies (Le Francois et

al. 2013). These justifications for how things are done are often linked to 'otherness'

archetypes; though the 'othered' are not a homogenous group (Parr 2000). In this way, self-

other distinctions and the stories staff tell bolster a sense of having acted correctly, and

minimise dissonance between personal ideals, professional practice and associated

negative emotions; such as revulsion at the violent or oppressive aspects of restraint.

Similarly, these narratives operate to induct and socialise staff into prevailing cultures of

coercion and control (Chapman 2014, McKeown et al. 2019).

Generally speaking, violence is viewed as legitimate if principles of fairness and procedural justice prevail, and this sustains cooperation with, and deference to, the exercise of power (Tyler 2006). In the mental health context, when belief in the just administration of power diminishes, trust is highly likely to break down between individuals or communities and services and the practitioners within them. This, in and of itself, may explain crises of legitimacy in a context of service-sanctioned restrictive practices, and, perhaps, escalations of violence in ward settings. Debriefing after violent incidents is a key aspect of RYS, aimed at learning from events. However, debriefing risks defaulting to the telling and retelling of legitimation narratives, becoming more exculpatory than explanatory (Chapman 2014).

Recognition of trauma: an alternate legitimation narrative?

Recognising and responding effectively to trauma is central to RYS and congruent with a contemporary movement towards trauma informed care (Sweeney et al. 2018). Arguably, a turn to more compassionate, relational care should have profound implications for staff and service users alike. This was powerfully noted in Johnston's (2014: 170) auto-ethnographic account of an epiphany in realising the violent trauma of restraint:

> *It was only when I witnessed the tears and felt emotion pouring down the man's cheek that I realized the performative act and fear behind all of our gestures, commands, and established authority.*

A triumph of empathy over otherness indicates an enduring attachment amongst the nursing teams (inclusive of registered nurses and health care assistants) for relational approaches to

care over the instrumental value of coercion. Improved understandings of self-harming

behaviour, for example, open up possibilities to ascribe newly legitimating social meanings

to such acts, involving coping with or soothing trauma, rather than invoking revulsion or

demonization (Adler and Adler 2011).

The pull to coercion, however, is powerful and subject to social forces arguably beyond the

influence of individual nurses and teams. Different use of ward space ought to have been

within the remit of RYS to influence, but this appears to have been relatively impervious to

change. The staff had to gain faith in the instrumental value of alternative approaches

towards volatile and disturbed individuals. In effect, they had to believe that acting differently

would actually work in managing or calming the situation. Quite often, they also had to be

persuaded that doing different things as a team would be managerially supported and,

indeed, legitimated.

Conclusions

RYS had mixed success in impact upon observed culture and practices at ward level. This is

unsurprising given some of the powerful and historically contingent social forces that frame

psychiatric services. Our findings support the view that a pervasive psychiatric knowledge

system underpins the controlling and coercive nature of everyday practices within services

(Foucault 2003) that can be both implicitly and explicitly violent (Liegghio 2013). Social

acceptance of the obviously oxymoronic notion of 'coercive care' reflects the fact that legal

systems and public opinion approve and legitimate force in psychiatric settings in certain

circumstances. Procedural justice concerns regarding proportionality and fairness drive

some of this legitimation. However, other factors also play into the legitimated use of

violence against service users. Not least of these may be a wider societal concern with risk

and danger, exacerbated by austerity driven cuts to staffing and other resources that might

have enabled alternate, more permissive, less restrictive environments (AUTHORS 2019c).

These factors clash with policy and professional rhetoric favouring therapeutic alliance, co-

production and democratised relations of care, along with programmes of change

management seeking to reduce restrictive practices, such as RYS.

The pressures upon staff teams were substantial, and there is evidence of an inter-

relationship between diminished resources and deployment of coercive practices (Quirk and

Lelliott 2001). Empathic engagement made a difference, particularly in spaces where

particular groups of people are 'othered', but various factors transpired to privilege

bureaucratic, non person-centred use of staff time. That staff working within such constraints

are able to make some positive change is commendable.

Ideally, reducing use of physical restraint and other coercive practices requires epistemic

and resource shifts, potentially requiring a rejection of the legitimacy of use of force against

psychiatrised individuals. This needs less emphasis upon perceived dangerousness, and a

move towards recognition of vulnerabilities and trauma as triggers for mental distress, as

well as a shared recognition of humanity rather than otherness. Implicit anxieties about the

assumed unpredictability and lack of control of those with mental health problems can help

to explain slow progress towards lessening coercive practices. Influential factors are at once

mundane, structural, discursive and inter-personal, and thus pose a substantial challenge to

progressive change.

1. The terminology of service user has largely supplanted 'patient' in contemporary

    mental health policy. This is to some extent a reaction to perceived notions of

    paternalism and biomedical power (Cutcliffe and Happell 2009) within a wider crisis

of legitimacy, urging a democratisation of care (Prior 2003). An additional concern for

critics of psychiatry is the association of such paternalism with medical hegemony

and notions of epistemic injustice and violence (Fricker 2007, Liegghio 2013).

Contributors

All authors made substantial contributions to: (1) the conception and design of the study; (2)

the collection, analysis and interpretation of data; (3) drafting the article and (4) revising the

article. All authors have given final approval of the version submitted for publication.

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