View metadata, citation and similar papers at core.ac.uk
brought to you by CORE
provided by Stirling Online Research Repository (RIOXX)

Journal of Risk and Governance 2008, Volume 1, Issue 2 ISSN 1939-5922
Editor: Matthias Beck, pp. © 2008 Nova Science Publishers, Inc.

VIOLENCE TOWARDS MENTAL HEALTH NURSES IN ENGLAND AND THE NATURE OF THE POLICY RESPONSE: A FRAME ANALYSIS

Brodie Paterson*
Department of Nursing and Midwifery, University of Stirling, Stirling,
FK9 4LA, Scotland, UK

ABSTRACT

Nurses working in services for people with mental health problems are twice as likely to be assaulted as nurses working in general hospital settings (Health Care Commission 2007). The emergence of the issue of violence towards nurses as a social problem has however been accompanied by a contest to date unexamined, between conflicting 'frames' of the problem, which this paper seeks to make transparent. Two distinct 'master' frames are discussed the 'individualising' and the 'co-creationist'. It is concluded that the influence of these frames has influenced the nature of responses to the problem but the recent dominance of the individualising frame is being challenged by the emergence or perhaps re-emergence, of the ideals and values of the therapeutic community.

INTRODUCTION

This paper will firstly, place the method of frame analysis in context as a sub type of discourse analysis whose origins lie in social psychology and with the work of Erving Goffman (1974) before discussing more recent applications of the concept in the social policy literature which inform this study. An individualising frame that locates responsibility for violence primarily within the individual will then be contrasted with a co-creationist frame. Pathology in terms of the origins of violence for the latter is seen as residing in the staff involved, the organisation, the perpetrator and the pattern of their interactions, which are collectively co-created.

Discourse analysis encompasses an influential methodological tradition related to a number of different disciplines ranging from linguistics to ethnomethodology and social psychology (Potter and Wetherell 1994). This study used a subtype of discourse analysis called frame analysis developed by a number of authors since the 1980's including Snow and

* E-mail: b.a.paterson@stir.ac.uk

Benford (1992) in their work analysing social movements, Gamson et al. (1992) examining political communication and more recently, by Triandafyllidou and Fotiou (2006) to examine the processes involved in policy making. The concept of frames in the social sciences has a long history. Erving Goffman (1974) contended that we use 'frames' in order to make sense of our life experience. In his description, frames are internal cognitive structures consisting of systems of classification and rules of interpretation. Such frames allow us (Goffman 1974:21) to "locate, perceive, identify and label" the diverse phenomena we may encounter throughout the course of our lives. Framing theory posits that we make sense of our experience on an ongoing basis by continually relating it to patterns, which are already known. This tendency to refer to stable and recurring patterns in order to recognise new stimuli has been confirmed by a number of psychological studies. Heider (1958) affirms that people perceive reality and form expectations with respect to it by linking temporary attitudes with pre-existing stable patterns of behaviour. Thus, diverse new stimuli are interpreted for meaning by being linked to a known and enduring background, which serves as a point of reference.

However, the concept of framing has also found application in the study of social policy. Here, the process of framing is described as involving the selection of some aspects of a perceived reality that in turn, promotes a particular definition of a putative problem, in such a way as to construct a particular causal interpretation, moral evaluation and consequently specific recommendations regarding the type of solution that needs to be adopted (Entman 1993:52). Snow et al. (1986) propose that we can usefully distinguish between two levels of frame that they describe as 'master frames' and 'domain-specific interpretative frames'. Master frames signify meaning on a broader scope and serve to organise sets of 'domain-specific frames', such as those, which both depict and inform how we should understand violence to mental health nurses.

How the available master frames 'organise' the domain specific frame around any particular issue cannot readily be predicted. Two or more, different master frames can coalesce to produce a novel domain specific frame. Further what sometimes occurs is a competition to frame an issue within a given domain in a particular way congruent with one master frame or set of frames, as opposed to another (Snow et al. 1996). It is this position on frames that will be used to inform a critical exploration of the framing process in relation to the 'problem' of violence to nurses working with people with mental health problems.

In the case of workplace violence in mental health the influence of a series of master frames can be identified. First, is the classic 'discourse of deviancy', a frame of some antiquity. Its assumptions are that deviants real or imaginary, are easily identifiable, the reasons for their deviance reside within the individual and social actions to control or punish them are therefore justifiable. Moreover, because such actions serve to clarify the moral boundaries between 'the good' and 'the bad' that must always be maintained, a failure to punish the deviant would be remiss (Leadbetter et al. 2005).

This frame interacts however with those of mental health and mental illness. The frame of mental illness can in certain circumstances absolve a perpetrator of culpability both morally and legally of what would otherwise constitute a crime. However, the possession of a psychiatric diagnosis has never meant that punishment may not play a role in treatment. Control in extremis in contemporary services by means of coercion is often justified by reference to the need to maintain a safe environment (Paterson and Duxbury 2006). The perception of service users is though that coercion is being used to punish rather than enable treatment (Duxbury 2002). The use of systematic punishment to induce compliance, as a form

of treatment was once orthodox practice (Foucault 2006). The belief that 'fear (*is*) the most effectual principle to reduce the insane to orderly conduct' appalled Tuke (1882:90) however, to assume that such long established practices and discourses no longer exert any influence on practice would be naive. Perhaps instead as Shapiro observes (1988: xi) it is precisely because such discourses are so familiar that they are able ‘operate transparently’ upon those affected who are effectively blinded to such influences on both their thinking and behaviour (Keywood 1995).

When such older frames interact with more current preoccupations of risk one consequence is the development of a particularly narrow understanding of the sources of risk where only the risks attached to individuals and their behaviour become the focus of examination and action. This fundamental attribution error (Heider 1958) can lead to the exclusion of consideration of risks arising from wider factors whether in the immediate and wider social context. The novel discourse that results can be described as an ‘individualising frame’ and is unfortunately that which seems to have informed what has been characterised as the ‘security’ or ‘high tariff’ approach to violence prevention in health and social services in the UK (Leadbetter et al. 2005). This approach is exemplified in the ‘Zero Tolerance’ policy on violence adopted by the National Health Service (s) of the UK in 1998 due in part to campaigning by the Royal College of Nursing. Such approaches promote intolerance of aggression by service users and/or provide for greater punishment or exclusion for perpetrators.

Snow and Benford (1988) observe that in order for frames to be successful they must either resonate with the sentiments of the population concerned. The individualising discourse with its location of the reasons for deviancy within the individual has several advantages in this respect. Research into the explanations for the violent acts of in-patients suggests a tendency amongst nurses to stress aspects of the service users’ personality as causal (Duxbury 2002). However, service user’s explanations for violence tend to differ stressing instead the situational dimensions of violence particularly that it was often a response to controlling behaviour by staff (Hinsby and Baker 2004). The apparent preponderance of individualistic explanations by nursing staff for service users’ violence in studies may mean that the safety / security framing of the problem resonated with the beliefs of many practitioners regarding the origins of violence (Duxbury 2002).

The seeming success of the individualising frame may though also stem from the form of the frame it uses to construct the problem of workplace violence. Gamson (1992) argued that three kinds of issue frames delineate how problems are framed. What he terms ‘Aggregate’ frames effectively define putative issues as ‘social problems’ but the burden of responsibility for action to resolve the issue is placed with individuals. ‘Consensus’ frames, in contrast, whilst also defining an issue as a social problem, represent it as one that can only be solved via collective action but leave unspecified who must act. ‘Collective action’ frames differ in three key respects from aggregate or consensus action. Firstly, they define the problem as one, which is intrinsically ‘unjust’. Secondly, ‘agency’ i.e. responsibility for the problem is placed with an identifiable actor. Thirdly, and perhaps crucially, the frame establishes an adversarial relationship between 'us' in terms of identity as members of the in-group and ‘the other’ i.e. whomsoever the imputation suggests is responsible for the problem (Gamson 1992).

Evidence of the use of the latter frame is exemplified in the title of the Zero Tolerance resource pack sent to every NHS Trust in England in 1999 (Health Service Circular 199/226).

Entitled ‘we don’t have to take this anymore’ the identification of ‘in’ group and an implied ‘other’ is clearly evident and an adversarial if not counter aggressive dimension is suggested. In the individualising frame the problem of violence to the worker is defined as an injustice’ perpetrated upon an ‘innocent’ (or sometimes unskilled) victim and responsibility for the behaviour is placed with the perpetrator. Of more significance in terms of social policy the resulting discourse is productive more specifically deontic, in creating an obligation on those charged with protecting nurses from such a threat to address this injustice.

This evoked what appears to have been a search for solutions to this construction of the problem which was found in Control and Restraint, (‘CandR’) an intensive physical restraint training program developed within the English prison service. The conventional explanation for the extraordinarily rapid adoption of CandR training across mental health services is that it was a consequence of a recommendation of an inquiry into the death of a patient while being restrained in Broadmoor high secure hospital in 1984 (Ritchie 1994). However, given the failure to adopt many of the other recommendations of the inquiry and a lack of concern about such deaths outside the special hospital sector over this period attributing causality for what was a radical change in policy to a single event seems highly questionable. A Michel Foucault (1980:114) reminds us, “there are actually a whole order of levels of different types of events differing in amplitude, chronological breadth and capacity to produce effects”. Foucault (1991:76) suggests that we should therefore approach the question of the role played by events by means of an analysis of the multiple processes which constitute them, a process he terms “eventalization”. The implications of adopting this approach are that what must be understood becomes not only ‘where the seed comes from’, that is, what event appeared to prompt a reaction in terms of social policy but more importantly ‘what makes the soil fertile’, that is, why is a particular sector may be uniquely responsive to a suggested initiative at a particular time (Kingdon 1995:77).

From this perspective the adoption of CandR provided a means of responding to growing concerns over the problem of violence towards nurses that was congruent with the dominant individualising frame of the problem. It resonated strongly with the assumption contained within the individualising frame that violence results from individual pathology whether ascribed to madness demanding control or badness demanding punishment (Crichton 1997). The former is addressed in terms of prevention via ‘treatment’ directed towards goals specified by the service (although the extent and nature of the ‘treatment’ is not specified) whilst dangerous manifestations of the disorder are managed, via restraint if necessary. The latter is addressed via the deterrent affect of restraint conveniently maximised by the use of ‘pain compliance’ an integral dimension of CandR as then practised (Paterson 2005).

WHY WAS THERE NO OPPOSITION?

All frames are 'temporally variable and subject to reassessment and renegotiation' (Snow et al, 1986: 476). The individualising frame of the problem was successful at least for a time, not only because of its resonance with internal attributions of responsibility for violence or that it was articulated by means of a collective action frame, but also because it faced comparatively little coordinated opposition. Given the long history in the UK of the non-restraint movement with its emphasis on moral treatment this is puzzling. The reductionist

explanations for violence offered by the individualising frame should have been countered by the discourses of social psychiatry and the insights provided to psychiatry by social psychology and sociology.

Perhaps at least in the UK, this did not happen because these discourses were marginalised during the nineteen eighties and nineties by the dominance achieved by bio-medical psychiatry. Ironically the ascendance of biological psychiatry as *the* dominant treatment paradigm may have been at least in part a response by psychiatry to critics from sociology and radical psychiatry in seeking to reassert its historical dominance by claiming equal status to its oft times distant cousin medicine. Exposed to criticism from within by Szasz (1994) and Laing (1964) and without by sociological studies such as 'on being sane in insane places' (Rosenhan 1973) psychiatry could have sought to engage with such critics, and initiate a creative dialogue. Instead with a few honorable exceptions, it promptly discarded it's former raison d'être psychoanalysis and any pretensions regarding milieu therapy (Pilgrim and Rogers 2005). The dominance by the discourse of bio psychiatry was so complete that it almost led to the demise of social psychiatry and a decades long estrangement by psychiatry from sociology (Pilgrim and Rogers 2005). Consequently psychiatry or at least many services experienced a form of collective amnesia that served to obscure their memory of previous treatment regimes based on moral treatment and the ideals of the therapeutic community (Bloom 2006).

Unfortunately psychiatry in its retreat from the social dimensions of causation was accompanied on its journey over this period by clinical psychology whose dominant paradigms over the period were of behaviour modification and cognitive behavioural psychotherapy. Such perspectives, or rather common misunderstandings and misapplications of them, located pathology almost wholly within the individual. As a result the emphasis in many settings was primarily on ameliorative interventions focused on trying to find solutions to violence within individuals rather than transformative interventions that sought to uncover and address the causes of violence in the social context (Duxbury and Paterson 2005).

The interaction between the individualising master frame and the frames of biomedical psychiatry and cognitive behavioural psychotherapy resulted in the creation of what Michel Foucault (1986) has described as an episteme. Epistemes exercise an all-pervasive influence saturating and governing thinking rather than being held consciously and their power is exercised insidiously by delimiting how we can think about a given issue (Bevir 1999). As a result of the dominance of this episteme the conceptual frameworks offered by alternative paradigm essential if the social dimensions of causation were to be recognised and addressed became devalued in many settings for almost a generation. Sadly, an early if rarely recognized upon casualty of psychiatry's whole hearted embrace of biomedicine was mental health nursing itself (Hunter 1956). Stripped of any pretence regarding parity of esteem with psychiatry, the previous partnership of equals dissolved at least in relation to violence prevention, by the privileging of biological and thus scientific knowledge over the centrality of the therapeutic relationship, nurses became the handmaidens not just of the psychiatrist but of bio-psychiatry.

The result was unfortunate, self esteem diminished, knowledge base devalued and in some settings such as London latterly near overwhelmed by decreases in the number of acute beds and rising acuity and co-morbidity in those admitted to antiquated and understaffed services, nurses retained however their almost complete power over the day to day lives of those they cared for (Patrick et al 1989). This juxtaposition of a lack of power and status in

one dimension with almost complete control in another produced a situation eloquently captured in a phrase used by Wardhaugh and Wilding (1993) with reference to a similarly problematic dynamic in residential childcare, as one of ‘dangerous ambivalence’. All too readily nurses could unconsciously displace their unmet needs for self-esteem, power and control in their professional lives into their relationships with service users.

Where such displacement took the form of over controlling behaviour by staff it increased the risk of service user non-compliance and the likelihood of counter aggression in turn (Paterson and Duxbury 2007). However when repeatedly exposed to violence nurses coping strategies are characterised by avoidance or counter aggression (Maier 1999). These reflect the emotions of fear and/or anger produced by exposure to violence (Colson et al. 1986). Where the dominant emotional response was of counter aggression, control and restraint may have served to facilitate if not legitimate the expression of such hostility. Consequently control and restraint may have chimed not only with how nurses understood the problem of violence but with how nurses felt about the problem or rather its source as they perceived it, in ‘the service users’.

It is though important to recognise that not all settings, services or practitioners adopted the individualising frame That there were many gaps in the dominance of the frame supports Snow et al’s (1986) observations that while we are susceptible to influence by frames we can simultaneously be capable of reflection and opposition to the frames we encounter. Opposition to the dominance of the individualising frame has grown persistently over the last decade representing the emergence or perhaps more properly re-mergence of an alternative discourse that has been described as a co-creationist perspective by Paterson and Miller (2006).

The new/old frame operates from very different assumptions in adopting a focus that extends beyond the pathology of the individual (Bloom 1997). It assumes that a safe environment cannot be created without the active participation of the patients. Violence is seen as arising from the interactions between individuals operating within complex social systems whose interaction gives rise to violence. In this frame the problem of violence to the worker is defined not as an injustice’ but as a failure to adequately understand and address the root causes of violence. Pathology in terms of the origins of violence is seen as potentially residing in the staff involved, the organisation, the perpetrator and the pattern of their interactions, which are collectively co- created. These are of course, the ideas integral to the concept of the therapeutic community and they remain equally valid some fifty years on. Our developing understanding of the impact of exposure to trauma has however served to add emphasis to the need to adopt such principles. As an approach to violence prevention co creationism’s emphasis is on primary prevention in asking what 'kind of human environments we are creating in our workplaces' (Braverman 1999:4). In order for a environment to be truly ‘safe’ it must be physically, psychologically, socially, and morally safe for everyone in the community. The achievement of that level of safety can though only be reached by means of a shared process over time (Bloom, 1997).

Of interest perhaps, is why this counter discourse and the frame it utilises have seemingly been successful after the long standing dominance of the individualising discourse. A number of developments are of particular note each involving research. Research into deaths amongst patients being restrained has contributed to the reframing of such events as part of a potentially preventable social phenomena rather than isolated individual tragedies (Paterson et al. 2003, Blofeld 2003). This has made the nature of the methods used to control behaviour in

many mental health services and injuries and deaths related to their use subject to a level of scrutiny previously absent (Frueh et al. 2005). The inclusion of service user voices in research studies has led to increasing scrutiny of the reasons why interventions such as restraint and seclusion are used because of findings that suggest service users perceive that such interventions are used not to manage dangerous behaviour but more often as forms of punishment (Duxbury 2002). Research into the antecedents to violence in in-patient mental health settings has also identified conflict linked to needs frustration as a common precipitant. This has led to increasing scrutiny of service cultures and staff attitudes and behaviour as key variables in the prevention of violence (Forquer et al. 1996, Whittington and Wykes 1996, Duxbury and Whittington 2005, Estryn-Behar et al. 2007).

Research has also identified high levels of trauma among users of mental health services and has led to demands for services to routinely screen for and treat the multiple potential consequences of trauma including aggression (Jennings 2004). Finally research has demonstrated that multilevel systemic organisational interventions can reduce the use of restraint and by so doing also reduce violence towards staff even where staff believe they neither can be reduced further (Lebel et al., 2004, Schreiner et al., 2004, Murphy and Bennington-Davis 2005). The reduction of violence towards staff as a consequence of efforts directed to reduce the use restraint is of course not a novel observation with such an effect consistent asserted by some of the much earlier proponents of restraint reduction including Conolly (Page 1904).

It may seem that a co-creationist framing of the problem cannot be refuted. The co-creationist perspective framing of violence is though vulnerable to a number of potential threats. It is not an exclusive strategy but an inclusive one, which challenges the categorical differentiation between the mentally ill and care providers that serves to justify the inequalities of power that embedded within the mental health system (Laurance 2003). Lacking a villain the co-creationist frame rejects simplistic moral judgements but this may not resonate with the master frames of our society or the sensitivities of practitioners because it challenges explanations for service user violence that attribute responsibility to character or personality deficits in the service user. If there is no villain there can be no punishment and punishment fulfils important symbolic functions in our society. The individualising frame is not dead rather it lurks in the policy corner waiting for the opportunity perhaps to be provided by an event or events yet to happen, in order to reassert itself.

CONCLUSION

A ‘battle among discourses and through discourses’ (Foucault (1975:x) has been described in relation to how the problem of violence towards nurses in UK mental health services should be framed and the nature of the response determined. In these battles individuals and alliances have strived to construct the issue of violence in particular ways unconscious it appears, of the potential influence of societal master frames to that debate. An awareness of the cultural resources and master frames drawn upon in this debate may not alter its outcome but can at least illuminate one dimension of the conflict. It is though no small matter, that Zero Tolerance was quietly dropped by the English National Health Service as an inappropriate response to violence in mental health services (Department of Health 2004).

This analysis has focused on an examination of the role played by discourses in the policy process rather than that played by national and local policymakers in their struggle (Bendor 1995). This is not to suggest that such individuals did not exert an influence in the direction that policy took. However, the effect of the episteme suggested was so all encompassing that whilst policy makers may at one level consciously have known why they did what they did at another their decisions were determined by the dominant frame.

REFERENCES

Bauman, Z. 1988. *Freedom.* Milton Keynes, Open University Press.

Bendor J. 1995. A Model of Muddling Through, *The American Political Science Review*, 89(4): 819-40.

Bevir, M. 1999. Foucault, Power and Institutions, *Political Studies* XLVII: 345-359.

Blofeld, J. (chair) 2003. *An Independent Inquiry Set Up Uunder HSG (94)27 into the Seath of David 'Rocky' Bennett.* Cambridge, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority.

Bloom, S. 1997. *Creating Sanctuary: Toward an Evolution of Sane Societies*. New York, Routledge.

Bloom S. 2006. *Organizational Stress as a Barrier to Trauma-Sensitive Change an System Transformation,* www.sanctuaryweb.com accessed 20.09.08.

Braverman, M. 1999. *Preventing Workplace Violence A Guide for Employers and Practitiones.* London, Sage Publications.

Colson, D.B., Allen, J.G. and Coyne, L. 1986. An Anatomy of Counter Transference: Staff Reactions to Difficult Psychiatric Hospital Patients, Hospital and Community Psychiatry, 47: 923.

Crichton, J. 1997. The Response of Nursing Staff to Psychiatric In-patient Misdemeanor, *Journal of Forensic Psychiatry,* 8: 36–61.

Duxbury J. 2002. An Evaluation of Staff and Service User Views of Strategies Employed to Manage In-patient Aggression and Violence on One Mental Health Unit: a Pluralistic Design, *Journal of Psychiatric and Mental Health Nursing,* 9(3): 325-37.

Duxbury, J. and Whittington, R. 2005. Causes and management of service user aggression and violence: staff and service user perspectives, *Journal of Advanced Nursing,* 50(5): 469–478.

Duxbury, J. and Paterson, B. 2005. The use of Physical Restraint in Mental Health Nursing: An Examination of Principles, Practice and Implications for Training, *Journal of Adult Protection,* 7(4): 13-24.

Entman, R.M. 1993. Framing: Towards clarification of a fractured paradigm, *Journal of Communication,* 43(4): 51-58.

Estryn-Behar, M., Duville, N., Menini, M.L., Camerino, D., Le Foll, S., ans le Nezet, O. 2007. Factors Associated with Violence Against Healthcare Workers Results of the European Presst-Next study, *Presse Medicale*, 36(1):21-36.

Forquer, S., Earle, K., Way, B., and Banks, S. 1996. Predictors of the Use of Restraint and Seclusion in Public Psychiatric Hospitals, *Administration and Policy in Mental Health and Mental Health Services Research,* 23(6): 527-532.

Foucault, M. 1980. *Power / Knowledge: Selected Interviews and Other Writings*, New York, Pantheon Books.

Foucault, M. 1991. Questions of method, in Burchell, G., Gordon, C. and Miller, P. (eds) *The Foucault Effect: Studies in Govermentality.* Chicago: University of Chicago Press.

Foucault, M. 1975. Foreword, in Foucault, M. (ed) *I, Pierre Riviere: Having Slaughtered My Mother, My Sister, My Brother: A Case of Parracide in the 19th Century*, vii-xiv. Lincoln, University of Nebraska Press.

Foucault, M. 1986. *The Order of Things: an Archaeology of the Human Sciences.* London, Routledge.

Foucault, M. 2006. Psychiatric Power: Lectures at the Collège de France, 1973-1974. Basingstoke, Palgrave Macmillan.

Frueh, C.B. Knapp R.G., Cusack, K.J., Grubaugh, A.L., Sauvageot, J.A., Cousins, V.C., Eunsil, Y., Robins, C.S., Monnier, J. and Hiers, T.G. 2005. Special Section on Seclusion and Restraint: Service User Reports of Traumatic or Harmful Experiences within the Psychiatric Setting, *Psychiatric Services,* 56: 1123–1133.

Gamson, W., Croteau, D., Hoynes W. and Sasson T. 1992 Media Images and the Social Construction of Reality, *Annual Review of Sociology*,18: 373-93.

Goffman, E. 1974. *Frame Analysis: An essay on the Organization of Experience.* New York, Harper and Row.

Heider, F. 1958. *The Psychology of Interpersonal Relations*. New York, Wiley and Sons.

Health Service Circular 1999/226. 1999. *Campaign To Stop Violence Against Staff Working in The NHS: NHS Zero Tolerance Zone.* London, Department of Health.

Health Care Commission. 2007. *Mental Health and Learning Disability Trusts: Key Findings from the 2006 Survey of Staff.* London, Health Care Commission.

Hinsby, K. and Baker, M. 2004. Service user and Nurse Accounts of Violent Incidents in a Medium Secure Unit, *Journal of Psychiatric and Mental Health Nursing,* 11: 341–347.

Hunter R.A. 1956. The Rise and Fall of Mental Nursing, *Lancet,* 270(6907):98-9.

Jennings, A. 2004. *Models for Developing Trauma Informed Behavioural Health Systems and Trauma Specific Services.* Virginia, National Association State Mental Health Hospital Program Directors.

Keywood, K. 2005. Psychiatric Injustice? The Therapeutic Ppresumption of Behaviour Management in Mental Health Law. *The Journal of Adult Protection,* 7(4): 25-30.

Kingdon, J.W. 1994. *Agendas, Alternatives, and Policy Alternatives*, Boston, Little Brown.

Laing R.D. and Esterton W. 1964. *Sanity, Madness and the Family.* London. Tavistock.

Laurance, J. 2003. *Pure Madness: How Fear Drives The Mental Health System.* London, Routledge.

Leadbetter, D., Paterson, B. and Crighton, J. 2005 Physical Intervention In Human Services: From Moral Panic To Moral Action, Paper Presented At *Examining The Safety Of High Risk Interventions With Children And Young People An International Symposium For Researchers Policy Makers Advocates And System Providers*, New York, Cornell University.

Lebel, J., Stomberg, N., Duckworth K., Kernzer J., Goldstein, R., Weeks, M., Harper, G., LaFlair, L. and Sudders, M. 2004. Child and Adolescent Restraint Reduction: A State Initiative to Promote Strength- Based Care, *Journal of Academic Child and Adolescent* Psychiatry, 43(1): 37-45.

Maier, G.J. 1999. Psychological Issues In Treatment: Transference and Counter transference, in ardiff K. (ed) *Medical Management of the Violent Patient: Clinical Assessment and Therapy,* 277-209. New York, Dekker.

McMillan I. 2005. Unrealistic NHS Policy on Violence Ditched, *Mental Health Practice*, 8(6):8.

Morrall, P. and Hazelton, M. 2000. The Restoration of Asylumdom in Mental Health Care? *Australian and New Zealand Journal of Mental Health Nursing* 9: 89–96.

Murphy, T. and Bennington-Davis, M. 2005. *Restraint and Seclusion: The Model for Eliminating theirUse in Healthcare*, hcPro, Marblehead, Ma.

Page, C.W. 1904. Mechanical Restraint and Seclusion of Insane Persons, *Boston Medical and Surgical Journal,* 590-595.

Paterson, B., Bradley, P., Stark, C., Saddler, D., Leadbetter, D. and Allen, D. 2003. Deaths Associated with Restraint Use in Health and Social Care In the United Kingdom: The Results of A Preliminary Survey, *Journal of Psychiatric and Mental Health Nursing,* 10: 3-15.

Paterson, B. 2005. Thinking the Unthinkable: A Role for Patient Compliance and Mechanical Restraint in the Management of Violence?, *Mental Health Practice,* 8(7):18-2.

Paterson, B. and Miller, G. 2006. *Promoting Safe and Therapeutic Services, National Health Service Security Management Service, Trainers Handbook,* Security Management Services, London.

Paterson, B. and Duxbury, J. 2006. Developing a Perspective on Restraint and the Least Intrusive Intervention, *British Journal of Nursing*, 14(22): 1235-1241.

Paterson, B. and Duxbury, J. 2007. Restraint. A Question of Validity? *Nursing Ethics,* 14 (4): 535-545.

Patrick, M., Higgit A., and Holloway, F. 1989. Changes in an Inner City Psychiatric inservice User Service Following Bed Losses: a Follow up of the East Lambeth 1986 survey, *Health Trends* 21: 121-123.

Pilgrim, D. and Rogers, A. 2005. Social Psychiatry and Sociology, *Journal of Mental Health,*14(4): 317 – 320.

Potter, J. and Wetherell, M. 1994. Analyzing Discourse, in Byrman, A. and Burgess, R. (eds). *Analyzing Qualitative Data,* 47-66. London, Routledge.

Ritchie, S. 1995. *Report to the Secretary of State for Social Services*, London, Special Hospitals Authority.

Rose, D. (1996) *In the Name of the Law: The Collapse of Criminal Justice.* London, Jonathan Cape.

Rosenhan, D. 1973. On Being Sane in Insane Places. *Science*, 179: 250-8.

Schreiner, G.M., Crafton CG, Sevin J.A. 2004. Decreasing the use of Mechanical Restraints and Locked Seclusion. *Administration Policy Mental Health* 31: 449-463.

Shapiro, M.J. 1988. *The Politics of Representation: Writing Practices in Biography, Photography and Policy Analysis.* Wisconsin, University of Wisconsin Press.

Snow, D.A., Rochford B. Jr., Worden S.K. and Benford R.D. 1986 Frame Alignment Processes, Micromobilization and Movement Participation*, American Sociological Review*, 51(4): 464 - 81.

Snow, D.A. and Benford, R.D. 1988 Ideology, Frame Resonance, and Participant Mobilization, in Klandermans, B., Kriesi, H. and Tarrow, S. (eds) *International Social Movement Research*: Volume 1, 197-219. London: JAI Press.

Snow, D.A, and Benford R.D. 1992 Master Frames and Cycles of Protest, in Morris, A.D. and McClurg-Mueller, C. (eds) *Frontiers in Social Movement Theory*. New Haven, Yale University Press.

Szasz, T. 1994. Mental Illness is Still a Myth, *Society:* 31(4), 34-9.

Triandafyllidou, A. and Fotiou, A. 1998. Sustainability and Modernity in the European Union: A Frame Theory Approach to Policy-Making, Sociological Research Online, 2(1) *http://www.socresonline.org.uk/socresonline/3/1/2.html.*

Tuke, D.H. 1882. *Chapters in the history of the insane in the British Isles.* London, Kegan Paul.

Wardhaugh, J., and Wilding, P. 1993. Towards an Explanation of the corruption of Care. *Critical Social Care* 37(13): 4 – 31.

Whittington, R. and Wykes, T. 1996. Aversive Stimulation by Staff and Violence by Psychiatric Service Users, *British Journal of Clinical Psychology,* 35(1): 11-20.

Young, J. 1999. *The Exclusive Society: Social Exclusion Crime and Difference in Late Modernity.* London, Sage.