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# ‘Becoming restrained’: Conceptualising restrictive practices in the care of people living with dementia in acute hospital settings

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## Abstract

The use of restrictive practices within health and social care has attracted policy and practice attention, predominantly focusing on children and young people with mental health conditions, learning disabilities and autism. However, despite growing appreciation of the need to improve care quality for people living with dementia (PLWD), the potentially routine use of restrictive practices in their care has received little attention. PLWD are at significant risk of experiencing restrictive practices during unscheduled acute hospital admissions. In everyday routine hospital care of PLWD, concerns about subtle and less visible forms of restrictive practices and their impacts remain. This article draws on Deleuze’s concepts of ‘assemblage’ and ‘event’ to conceptualise restrictive practices as institutional, interconnection social and political attitudes and organisational cultural practices. We argue that this approach illuminates the diverse ways restrictive practices are used, legitimatised and perpetuated in the care of PLWD. We examine restrictive practices in acute care contexts, understanding their use requires

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examining the wider socio-political, organisational cultures and professional practice contexts in which clinical practices occurs. Whereas 'events' and 'assemblages' have predominantly been used to examine embodied entanglements in diverse health contexts, examining restrictive practices as a structural assemblage extends the application of this theoretical framework.

#### KEYWORDS

assemblages, becomings, dementia, events, restrictive practices, stigma

## INTRODUCTION

By diagnostic category, people living with dementia (PLWD) are the single largest patient group admitted to acute National Health Service (NHS) hospital settings (authors). Official figures suggest that as many as 1 in 4 NHS beds are occupied by PLWD (Alzheimer's Society, 2016; DoH, 2014), reflecting international prevalence estimates within the acute setting of 12.9%–63.0% (Mukadam & Sampson, 2011). Retrospective reviews of patient notes suggest that this is a significant underestimation (Crowther et al., 2017). Recent ethnographies within the hospital setting suggest that the proportion of patients living with dementia within acute wards can be as high as half of all admissions (authors).

Analysing this level of admissions is important because acute hospital settings are recognised as 'challenging' (Sampson et al., 2014, p. 194) and 'dangerous' (Mathews et al., 2014, p. 465) places for PLWD. Routine practices within these wards are designed for patients without cognitive impairment (Featherstone & Northcott, 2020), despite the prevalence of PLWD within them. This leaves PLWD at a significant risk of adverse events, including incontinence (Hofmann & Hahn, 2014), reduced mobility (Moyle et al., 2011), increased agitation (White et al., 2017), delirium (Pan et al., 2018), prolonged admission (Tan et al., 2014) and distress (De Bellis et al., 2013). These in-turn result in further dependency, institutionalisation and death during or following an acute admission (George et al., 2013).

These adverse events often emanate from the acute admission itself, in particular, the requirement that patients follow the rules of the ward (Featherstone & Northcott, 2020). PLWD often behave in ways perceived, by staff, as challenging (Wolverson et al., 2021), in turn disrupting the business of the ward. In response staff will reinforce and 'tighten' control of PLWD (Featherstone & Northcott, 2020). This transcends Goffman's (1967) total institution, to the observable (Hope et al., 2022), prioritising routine, control, and risk management over the will of the person (Wolverson et al., 2021). Against this backdrop, this article examines how control via the use of restrictive practices emerges within these settings.

## CARE AND THE USE OF RESTRAINT

Restrictive practice constitutes a wide range of practices across hospital settings, encompassing actions from overt restraint to more subtle means of control (Clark et al., 2018). Within acute wards, restrictive practice typically falls into three categories and excludes the traditional concept of 'physical' restraint: (1) 'chemical' restraint, whereby medication such as anti-psychotics are prescribed for patients perceived as 'disruptive', a routine occurrence for PLWD (Banerjee, 2009). (2) 'technological' restraint, where safety measures (such as chair sensors), positional aids (Minnick et al., 2007) and PIN-accessible doors restrict movement. (3) 'covert' restraint, involving the routine and unrecorded use of ward furniture, devices and methods of containment (Weiner et al., 2003). This latter category has been discussed as 'necessary evils' (Griffiths, 2013), or 'the elephant in the room' (Zerubavel, 2006) of care. This includes raised bedrails, positioning of ward furniture, institutional clothing and the repeated use of verbal commands (Saarnio & Isola, 2009) to contain PLWD.

The use of restrictive practice is often rationalised by safety concerns for both the patient and for others around the ward. However, inquiries (Care Quality Commission, 2014; House of Lords, 2007) have found that restrictive practices have become entrenched in the care of older people and PLWD due to cultures of care that prioritise work and organisational targets over the needs of patients. Within these contexts it is possible for the use of restrictive practices to become routine and unchallenged without much reflection as to their impact on patients. In addition, there is little evidence of restrictive practices improving safety, but rather increase distress (De Bellis et al., 2013), deterioration and institutionalisation (Tan et al., 2014) of PLWD admitted to acute medical settings. We focus on acute medical settings because it is an area of care of older people and PLWD that has, to date, received little scrutiny, yet the routine use of restrictive practice is an established part of everyday clinical care when admitted to these settings.

PLWD are the group most likely to experience restrictive practice as a feature of their everyday care (Minnick et al., 2007). These practices are not uniquely an NHS phenomenon, with research studies suggesting that these practices are widespread in hospital settings globally (Huizing et al., 2007), significantly so in the USA (DeSantis et al., 1997), Japan (Nakanishi et al., 2018), Australia (O'Connor et al., 2004) and Germany, where restraint of older patients is considered part of 'standard care' (Krüger et al., 2013).

While this suggests widespread use of restrictive practices, any quantification likely underestimates their prevalence (Evans et al., 2002) because restrictive practices remain poorly recorded or undocumented (Kirkevold & Engedal, 2004). Australian studies report observing restrictive practices in hospital settings considered mostly covert and non-reportable (O'Connor et al., 2004), methods also frequently observed in the care of PLWD in England and Wales (Featherstone et al., 2022). Recorded levels of restrictive interventions, are reduced by re-categorising interventions as 'safety measures' and 'positional aids' (Minnick et al., 2007). Such approaches mean senior staff may be out of touch with the extent of the use of restrictive practices (Moyle et al., 2011). Our contribution to this subject is twofold; first, conceptually situating the use of restraints as an assemblage as it illustrates the complexities associated with the use of restrictive practices. Secondly our article shows a light on a neglected practice, and yet has significant consequences for the health and wellbeing outcomes of PLWD in acute hospital settings. The following section outlines the theoretical framework underpinning our argument in this paper.

## THEORISING RESTRICTIVE PRACTICE AS AN EVENT ASSEMBLAGE

To better understand how restraint becomes feasible, justifiable, and routinised in the care of PLWD, we draw on the Deleuzian (Deleuze & Guattari, 1994) concepts of ‘assemblage’ and ‘events’. Deleuze and Guattari originally conceive of an assemblage as *agencement*—which refers to ‘a construction, an arrangement, or a layout’ ... of heterogeneous elements (Nail, 2017, p. 22). These heterogeneous elements consist of both the material and immaterial—‘one of content, the other of expression’ (Deleuze & Guattari, 1987, pp. 88–89). These dual elements coalesce and produce ‘events’ which have a performative effect—enacting what Deleuze & Guattari call ‘incorporeal transformations’ (Hristov, 2018, p. 193). For Deleuze and Guattari ‘events’ and ‘becoming’ point to the relational and processual nature of being, in which individual actions result from particular associations of networks that ‘spatially and temporarily link one actor with another’ (Duff, 2014). Assemblages are connected through the events they produce, and by their reception of other events in turn produced by other assemblages. Deleuzian ethics centres on being ‘worthy of the event’; this means receiving events in such a way that affirms the multiplicity of the event and its possibilities and potentiality for becoming (Deleuze, 1990; Williams, 2008).

Health-care professionals’ use of restrictive practices should be seen as an entanglement of multiple bodies and processes across policy, social and institutional spheres (Armstrong, 1997). For Deleuze, events denote how bodies are transformed in the specific relations they are entangled in. Deleuze posits, ‘becoming’ and ‘events’ are ontologically prior to being (Dennis, 2017) and thus perceive individual experiences as a continuous flux rather than fixed (Duff, 2014). Via this theoretical lens, the use of restrictive practices in the care of PLWD as an event requires considering the ‘*commingling of bodies within and outside [the ward], and the incorporeal transformation rendered in such bodies by the event (restrictive practice)*’ (Duff, 2014, p. 46). Therefore, understanding ‘becoming’ and ‘event’ requires drawing on an approach ‘*underpinned by a relational and processual ontology, with the human always caught in the ebbs and flows of becoming*’ (Dennis, 2017, p. 340).

Deleuze’s concepts have been widely used to shed light on embodied experiences in diverse contexts in health care (Buse & Twigg, 2014; Dimond et al., 2022; Helosvuori, 2020; Latimer & Lopez Gomez, 2019; Mwale, 2020). This extends the concept of assemblages, which has frequently been implemented to analyse institutional processes and practices (Beltrame, 2019; Dimond et al., 2022; Gibbon, 2017; McDougall et al., 2016; Rabeharisoa, 2006). This article adds to these sociological interests in mundane, every day and routine care practices and the intersections between cultures, institutions and policies.

Assemblage theory allows the consideration of both the material and discursive aspects of events. The concept can be utilised to consider the biological, pragmatic and physical sides of hospital care on one hand and the discursive aspects on the other. This may also allow for an examination of both the embodied experiences of patients and carers in the physical institution of the hospital, while simultaneously considering the policy and discursive influences (Cluley et al., 2020). As such, the use of restrictive practice should not be seen as a single isolated practice but instead located in a rhizome of organisational, policy, professional processes, practices, interests and cultures.

The model of the assemblage and event can aid an articulation of how the event of ‘restraint’ connects and interacts with other events, such as ageing, cognitive impairment, and stigma. By locating assemblages within wider socio-political contexts, we examine how heterogeneous activities and interests within and between the policy, organisational and social spheres bring

about the use of restrictive practice and their incorporeal implications in the care of PLWD in acute hospital ward settings. We therefore reject the use of restraint in care as an inherently individual action by rational and capable individuals. Instead, restrictive practice should be considered to stem from the contingencies within wider socio-political yet specific intersections of networks of events and processes that spatially and temporarily link with each other in acute hospital ward settings.

Rather than simply use assemblage as a metaphor, Buchanan (2017) posits assemblage theory as a method of analysis that seeks to find out what the components of this phenomena are, and how these elements enact 'incorporeal transformations under different conditions (Buchanan, 2017, p. 473; Deleuze & Guattari, 1987, pp. 88–89)'.

In what follows, we draw on wider existing health and social care and sociological literature to outline how events in the social, organisational and policy spheres lead PLWD to become subject to restrictive practices within acute hospital settings.

## **WIDER SOCIETAL ATTITUDES OF STIGMA: AFFECT AND USE OF RESTRICTIVE PRACTICE IN THE CARE OF PLWD**

To make sense of restrictive practice as an assemblage, we first focus on stigma to illustrate how social attitudes and affect coalesce around ageing and dementia, which in turn legitimises restrictive practice in care. For Deleuze and Guattari (1994) the social is a set of relations that is continuously constituted and a space where 'associations and affect between bodies, objects, ideas, beliefs, desires and events' (Duff, 2014, p. 104; see also) are produced, reproduced, legitimised, sustained and disputed (Dewsbury, 2011). Social contexts provide the social, material and affective resources for everyday interactions including discourse and delineated moral boundaries. These resources delineate the diverse processes, encounters and means for nurturing and sustaining relations in societies (Deleuze & Guattari, 1987; Duff, 2014). It is in these contexts that affect and effect of discourse comes to bear; as such there is a need to pay particular attention to the impact of social, and material on social relations and various entangled actions within these contexts (Duff, 2014) on perceptions of ageing and dementia. For Deleuze and Guattari (1987, p. 220) the social should be taken as an infrastructure that contours and directs a multiplicity of interactions in everyday life. An assemblage is a method of regarding these interactions where discursive and material elements interact to form these contexts which produce, and are impacted by, events.

One such event relevant to restraint assemblages is ageing. There has been established sociological concern about ageing, particularly the stigma associated with old age and its social and political implications. Stigma experienced during old age as an event can be said to emerge from a pervasive societal obsession with youthfulness and physical beauty in western contemporary society, which results in entrenched aversion to ageing (Low & Purwaningrum, 2020), and resultant biomedical technologies aimed at remedying the impacts of ageing (Andrews & Duff, 2019; Duff, 2014; Moreira, 2016).

Ageist attitudes are a creation of society (Angus & Reeve, 2006). For Butler (1969) ageism is the result of an entanglement of the 'uneasiness' and 'distaste' towards those perceived to be growing old. Here we draw attention to 'uneasiness' and 'distaste' as affective states (Duff, 2014) where resentment and revulsion towards old age are delineated, produced and reproduced, informing care of the perceived 'old'. Pointing to its affective nature, Turner (1989) refers to these views as politics of resentment, at the core of which is the negative affect towards ageing



and older people (Andrews & Duff, 2019). This is because ageing becomes socially synonymous with perceived depreciating social value (Clarke & Griffin, 2008), failing bodies and disabilities (Widrick & Raskin, 2010) of those seen to be 'getting old'.

The entanglement of stigma, as an affective state, attached to ageing as bodies in physical and cognitive decline, indicating failure to hold one's own and contributing to society's entrenched stigma towards those living with dementia (Andrews & Duff, 2019). As Fuchs (2020) observes, dementia and other cognitive impairing conditions associated with old age are socially disconcerting and often perceived with a sense of foreboding, as they challenge what is considered the fundamental core of being human: rationality, cognitive and reflective abilities. In making an individual lose these abilities, dementia predisposes the individual to stigma, as further symptoms of dementia such as incontinence and perceived 'confused' mental state adds to stigmatised societal views of dementia as a state of poor-quality life and with no capability for pleasure. These affective responses further fuel perceptions of lack of value to society and can also lead to perceptions of insignificance in which people considered to be of less value can easily become disposable (Fiske et al., 2002; Kontos et al., 2020; Mautner, 2007; Widrick & Raskin, 2010).

However, in suggesting that wider social attitudes common in society themselves emanate from a multiplicity of networks of sociocultural and socio-political beliefs, we are not proposing these ideas are fixed. On the contrary, these beliefs are fluid and in a constant state of flux (Duff, 2014). However, the tendency to distinguish old age from younger populations has a devaluing effect on older people in society (Turner, 1989), which in turn results in affective responses of stigmatised attitudes of fear of ageing or being seen as getting old (Clarke & Griffin, 2008) with material consequences for older people. Therefore, we take the definition stigma beyond Goffman's view of stigma as merely a mark or an identity ascribed to an individual with psychological impacts, to consider the entanglements of material violence, power and dehumanisation of older people as undeserving citizens (Tyler, 2013; Tyler & Slater, 2018) by locating stigma of ageing and dementia at the connexion of socioeconomic, public interest and policy processes. The discourse of ageing as a societal burden and thus a process to be slowed and avoided (Benbow & Jolley, 2012; Milne, 2010) portrayed in media and political debate leads to the legitimisation of ageism and the use of restrictive practices on vulnerable populations. This is illustrated in what Tyler (2013) calls 'heightened stigmatisation' which refers to how inequalities are mediated, imagined and made in public, and the forms of public understandings' of inequality, about who deserves welfare support and protection (Duff, 2014; Tyler, 2013; Tyler & Slater, 2018); in this case, through the stigmatisation of ageing and dementia. Common public discourse of ageing and later life is imbued with images of ageing associated with failing bodies (Corrigan, 2004; Kontos et al., 2020; Otepieniu, 2015) pejoratively posited as morally failing to keep up with the appropriate material consumption to maintain their youth and thus threat to national economic resources; this perception is paradoxical to public health calls for better health and wellbeing to avoid ill health and facilitates living longer to the oldest age possible (Latimer, 2018; Mwale, 2024).

Stigma associated with ageing is complex, with many people ageing with multiple layers of stigma that have contoured their lives forming the background (Fisher, 2020; Scambler, 2006) to old age and experiences of living with dementia. These include stigmatised characteristics linked to race and racism, sexism, sexuality, victims of violence and refugees (Aosved & Long, 2006; Clarke & Griffin, 2008), all forming part of their lives leading to old age and all entangled in shaping the care they receive including the use of restrictive practice. These are further compounded by the socioeconomic circumstances that influence whether they require

state support or not. Mwale et al. (forthcoming) work points to ways in which working-class, male and Black patients with dementia are likely to face restrictive practices, including the use of security guards during a hospital admission; this is often characterised in lightly veiled yet engrained racist stereotypical views of Black male patients with dementia as ‘difficult’, ‘angry’ and or ‘violent’ to justify their restraint. This is despite their perceived behaviours being no different to their White male and female patient counterparts on the same wards.

This illustrates Scambler’s (2006) observation that social structures of power, class relations, gender and ethnicity stigma exist beneath the surface of the life-world, simultaneously active to contour everyday life and practices. Equally aligns with Fisher’s (2020) concept of ‘imbricated stigma’ in which the layered connexion of stigma operates in the life-world to contour everyday life. Such stigma operates singly or in tandem with other stigmatised characteristics to bring about material inequality in and experiences of care, with each stigma adding to or bringing its own implications for the patients in these ward settings. Therefore, the everyday socioeconomic and political stigmatised discourse that frames ageing and dementia as a burden on national resources and its connexions with other stigmatised characteristics works to produce and entrench public consent (Tyler, 2013) to the routine and often unquestionable use of restrictive practice in the care of older in acute medical settings. Stigmatising old age results in material dispossession, uncertainty and restrictions for older people during hospital admissions impacting their care. As Duff (2014, p. 44) observes ‘affect is more than a feeling or an emotion; it is also a potential for action, a dispositional orientation to the world’. Equally stigma is not merely a feeling or identity label but rather imbued with power relations with material and physical consequences for the stigmatised as they coalesce into an assemblage of care part of which facilitates the use of restrictive practices (DeLanda, 2006).

Stigma is therefore an affect produced by a particular reception of the event of ageing. Instead of affirming the event of ageing through the possibilities it engenders, and affirmation of the immanence of life (Deleuze, 1997), life is regarded through a static chronology of decline as one ages. Consequently, it reduces the individual in this process to the neurological impairment the event of dementia brings. Negative attitudes on their own are of no object, but it is the intensities they transmit or not in connection with other bodies (Deleuze & Guattari 1994) that are of interest. Nor are stigma and the use of restrictive practice in care separate binary co-productions, rather they are inseparable entanglements embedded in organisational cultures and socio-political contexts. In the following section, we outline the entanglement of dementia, and stigma and organisational practice.

## RESTRICTIVE PRACTICE IN MATERIAL AND ORGANISATIONAL CULTURAL CONTEXTS

For Deleuze and Guattari (1994), analysis of organisational contexts as assemblages requires elements (concrete assemblages) and agents (personae) to facilitate relations between bodies, power, technology and professional expertise to bring institutional care into being. Therefore, the entanglement of contexts of care (elements) and health-care professionals (agents) become central to understanding how restrictive practice come into being. While public health experts aim to change public attitudes towards dementia and old age to combat stigma, research studies have shown how these attitudes equally permeate institutional and professional spaces (Acktoy-Stolarz, 2008; Bianchini, 2000; Ray et al., 1985) to contour approaches to care (Corrigan, 2004), with material consequences for PLWD. Illustrating the materiality of stigma,



Benbow and Jolley (2012) argue that stigma and its associated affect in care settings have implications across levels of services including how and where people seek support, how services are designed and delivered and how policy priorities are defined. In this context the material conditions in which care is provided are perceived to influence the decisions, approaches adopted and the quality of care received by older patients (Wells et al., 2004) and including the use of restrictive interventions.

The manifestation and use of restrictive practice is a complex process, and in a constant state of flux shaped, mediated and materialising in practice for many reasons. In most cases, they are justified as a creative (Deleuze, 1992) means to manage perceived challenging behaviour (Wolverson et al., 2021) and the need to protect the patient's and others' health and safety (De Bellis et al., 2013) on the ward. PLWD are perceived to present a risk of harm to themselves and others, therefore the use of restrictive practices become a routine clinical practice response. These practices have become established and acceptable among staff that most find it difficult to challenge or question their use (Natan et al., 2010). It is when restrictive practice becomes routine and used without reflection as to their impact on the embodied experience and outcome of care of PLWD that they become of sociological significance.

Pressures on the NHS are described as being on the brink of breaking down completely (Dunn et al., 2022). Waiting times for appointments are at historic levels, exacerbated by shortages in social care places, delaying discharge into care settings (NHS Confederation, 2022). These issues are intensified by longstanding understaffing on hospital wards, worsened by the COVID-19 pandemic (NHS Confederation, 2022). During the COVID-19 lockdowns and the subsequent years, increasing numbers of PLWD forcibly detained in hospital wards longer than was needed due to fears they may catch and or spread COVID-19 in care homes. During this time, family visits to hospitals were banned (Comas-Herrera et al., 2020). This left many people isolated and turning the ward itself into a restrictive space. Additionally, there is a perception that 'at risk' patients, particularly PLWD, admitted into these settings 'block' (Digby et al., 2017) the systems fundamental to maintaining essential patient flow through over-stretched institutions. Organisationally, restrictive practices allow understaffed and underfunded wards to maintain schedules, routines and patient flow. This legitimises the use of restrictive interventions, particularly in the delivery of care for PLWD (Featherstone et al., 2022), providing a sticking plaster which prioritises the function of the institution over the wellbeing of the patient.

Research studies identified material conditions in hospitals have an influence on their willingness to use restrictive practice (Karlsson et al., 2001; Werner, 2002; Werner & Mendelsson, 2001) with nursing becoming highly reliant on the use of restraints in the care of older PLWD. Internationally, research studies have shown nursing staff recounted using restraint and force and approved of its use in everyday care of older people and PLWD (Hynninen et al., 2015; Yan et al., 2009). The most common restraints reported include the use of limb restraints, geriatric chairs, to minimise perceived 'wandering' (Featherstone and Northcott, 2020) and the use of antipsychotics or chemical restraints (Hynninen et al., 2015) to sedate perceived disruptive patients. In this context, the material conditions of the ward seem to creatively determine the use of restrictive practices. Research studies in Israel (Werner & Mendelsson, 2001), Sweden (Karlsson et al., 2001) and elsewhere (Courtney et al., 2000; Nakahira et al., 2009) show view of older people as difficult patients highly correlated with use of restrictive interventions in care, including tray tables, tub chairs and beanbags used within acute wards (O'Connor et al., 2004). Cultural, organisational, and racial factors have been found to impact the use of restrictive practice and the types of restraint used (Miller et al., 2006). This

illustrates that the entanglement of dementia with material structures and wider health-care professionals characterisation of ethnic minority PLWD are prone to 'aggression' and 'challenging behaviour' (Wolverson et al., 2021) entrench the need for restrictive interventions in care contexts to manage these perceived behaviours.

Additionally, resource constraints and the need to attend to safety concerns and the prioritisation of risk reduction, resulted in increased use of restrictive practice. We recently reported elsewhere on the timetables of care and time constraints within wards as a factor shaping the care of PLWD (Featherstone and Northcott, 2020). In this context, PLWD exhibiting not only distress but any movement from the bedside was perceived to seemingly disrupt the workflow of the wards (Featherstone and Northcott, 2020). As such, to contain PLWD in place, health-care staff routinely use raised bedrails to prevent someone from leaving the bed and place furniture to contain the person at the bedside to prevent them from perceived risks of harm (Hughes, 2008). In many ways, PLWD experiencing delirium and perceived challenging exhibiting symptoms including 'aggression' are a challenge to the perceived ideals of what constitutes a patient and how a ward should function (Featherstone & Northcott, 2020). Ideals and ideas of a compliant and sedentary patient on the ward are disrupted by patients for whom the hospital ward itself may be impacting their care experience. Therefore, restrictive practices in such cases become part of the routine and culture of working on the ward, including using furniture to block patients or verbal commands to sit down and stop wandering around the ward as a means to maintain order to the ward (Featherstone & Northcott, 2020).

In a Hong Kong study, Chien and Lee (2007) found that health-care professionals believed the use of restraints was necessary for older patients in order to facilitate the work of the ward even if they were resisted by the patients and their families, and even if restraint meant loss of dignity. In this context, the material conditions of the ward commingle with staff's understandings of work to allow for the use of restraint. Arguably, in a Deleuzean sense, restrictive practices emanate from the entanglement of inarticulable coalescence of affects (Duff, 2014), surrounding health-care professionals' desire for order, risk reduction and material conditions within the contexts of care delivery.

Further to concerns about order and disruption, restrictive practice as an assemblage emerges in a wider material context of competing priorities. PLWD are perceived to interfere with ward or care context priorities (Chien & Lee, 2007; Hughes, 2008). In a Deleuzean sense the concrete elements that structure how care 'should' be delivered, entangle with the embodied needs and experiences of living with dementia. While for health-care staff, care delivery is attending to the perceived priorities of the ward, which may involve taking and recording patient vital signs, giving medication and moving patients on to perceived specialities, liaising with multidisciplinary teams; for patients, care is about attempting to make sense of the environment they find themselves in, including the entrenched fear of being in hospital (Featherstone et al., 2022). Arguably, in these contexts, PLWD in need of closer support and care become viewed as an impediment to the work of caring and therefore become subject to restrictive practices. It is important to note that care often occurs in a context of intensified affect brought to bear by the pressure of performance management, staffing levels and increasing patient demands, in which key performance indicators shape and delineate ward priorities and practices (De Bellis et al., 2013), these in turn influence staff decisions and practices in the use of restraints. The factors described above do not follow in the order presented and described; therefore, we need to highlight here that these events are in continuous flux shaping and reshaping approaches to care.

## THE POLITICAL ECONOMY OF RESTRICTIVE PRACTICE

Arguably the politics and effect of resentment do not exist in isolation in the social sphere, rather they are alive in the policy sphere as well. Here, the affective discourse of the ageing population and the perceived potential burden posed to national budgets and health-care systems have, in recent years, flooded both public and policy debates (Nichols et al., 2019; Wittenberg et al., 2019). In a context which values participating in work, economic productivity and contribution to society, income and job status have led to entrenched negative views of older people. Policies such as mandatory retirement have unintentionally forced older people out of work and located them as surplus to requirement and making many financially vulnerable, while at the same time positioning them as a drain on state resources. Arguably the affective (Deleuze & Guattari 1994) politics of resentment (Turner, 1989) devalues older people and are thus unlikely to be considered a priority for protection. This is in keeping with Tyler's (2013; Tyler & Slater, 2018) view about ways in which power relations in stigma imagine, mediate, make and reinforce public understandings' of inequality and delineating deserving and underserving citizens for welfare support and protections.

Research identifies a relationship between policy and legislative priorities on supporting older people with reduced use of restraints (Abraham et al., 2020; Bower et al., 2003). In countries, such as Scotland and Denmark, where legislation limits and prohibits the use of restrictive practice—as a form of discipline or compliance, staff convenience or to prevent perceived 'wandering' have often resulted in decreased use of restrictive practices (Dimant, 2003). However, this is highly debatable as Wales has similar policy priorities and yet still experiences high levels of use of restrictive intervention. Nonetheless, in a Deleuzian sense, the use, experience, and ethical-policy intensities in the use of restrictive interventions should be seen as an assemblage of spaces, bodies and affect.

In England and Wales, policy and legislative attention on restrictive practice interventions have only emerged in the past decade (CQC, 2018; DoH, 2014). The care of the PLWD in acute medical settings has for a while attracted public and health policy attention. Among the concerns within this sphere are questions of dignity and improving quality of care (Banerjee, 2009; Edwards et al., 2021). While there has been an increase in policy focus to improve the experience and care of PLWD, the problem remains. The failure of successive governments' attempts to address care for PLWD in health and social care can be seen to result from the framing of care as an individual's responsibility in a liberal market sense. In this context, the individual either as PLWD or a health-care professional are seen as rational and capable of rational thoughts. Health-care professionals are positioned as rational and well-meaning actors, while patients are positioned as capable of rational thought and able to protect and pursue their interests if provided with adequate information and choices (Lemke, 2001), removed from the complex socio-political milieu shaping the delivery and experiences of care. Seen this way, challenges in care, including the use of restraint become distant and invisible from the policy sphere as they become analysed as actions of rational and capable actors. However, for PLWD this is compounded by the fact that the health-care system often simultaneously locates them as being 'biologically flawed', 'a risk to self and others' and prone to 'aggressive behaviour' (Wolverson, et al., 2021). These perceptions infused with affective politics of resentment (Turner, 1989) underpin policies, creating and recreating the means through which the othering and devaluing of PLWD occurs and acts as the rationale for legitimating the use of restrictive practices, with material and embodied consequences for their welfare.

Rather than locating the use of restrictive practice as emanating from actions of rational health-care professionals, we suggest analysing restrictive practices as an entanglement of sociocultural attitudes, the value of older people, the event of dementia and ageing, the materiality of stigma and the socio-political and economic milieu in which care is delineated, delivered and appraised. Doing so lays bare the myriad social, structural, political and economic forces (Duff, 2014) that may be brought to bear on PLWD in acute medical settings. This situation arises from an established failure in the analysis of restrictive practices, in Duff's (2014, p. 126) words, to link 'context' with 'practice', the 'macro' with 'micro' and 'structure' with 'behaviour', such that one may meaningfully connect the web of social, experiential, economic, cultural, material and affective forces' that entangle in the use of restrictive practices. The NHS has in the recent past been embroiled in political debates about the best way to provide health care. In this context, the focus has been on maximising care and pledges to improve care and little attention on the actual practices of care and their impact on PLWD. The Care Quality Commission (CQC) highlighted the need for policy action on the use of restrictive practices by emphasising that health-care professionals across the care system should take appropriate actions to ensure care approaches for managing the perceived challenging behaviour of PLWD include the least restrictive strategies. However, as McSherry and Maker (2020, p. 40) observe there is a 'lack of clear legal and practical guidance on avoiding and using alternatives to restraints in policy and legislation'. This illuminates how care, professional practice and experiences of restrictive practice by PLWD are intertwined with modalities of care and institutional cultures, engendered by wider socio-political contexts.

Research reports and government-commissioned policy reviews have all pointed to reduced staff numbers and the increasing burden of care as a factor in shaping the use of restrictive practices. However, legislative attempts have not sought to address low staff numbers as an issue, beyond providing training for those already in service. This is despite research studies showing that staffing levels have an impact on the use of restrictive practices. Houghton et al. (2016, p. 111) found 'restraint was sometimes inappropriately used because staff were too busy and did not have time to care for the person with dementia.... Being under pressure due to limited time and resources .... The use of restraint was also justified in terms of staff and patient safety'.

The policy sphere, like the social, is not fixed, but a space in continuous flux where affect, socioeconomic and socio-political forces entwine to shape the materiality of care for PLWD. A focus on the policy context prompts us to consider how health care is configured, specifically in acute medical settings, concerning the entanglement of the sociocultural, organisational, socioeconomic and socio-political factors to facilitate and legitimate the use of restrictive practices with adverse implications for those providing and receiving care. While the UK legislation has sought to regulate the use of restrictive practices to promote choice and human rights, such legislation and related guidance '...do not generally provide detailed guidance on what is required to realise these rights. Nor do they create enforceable rights or redress mechanisms for breaches' (McSherry & Maker, 2020, p. 39). Equally, health care provision in the NHS has been modelled on the compliant patient, one pliable to medical interventions and yet rational and able to negotiate their way through the health system. However, if patients sit outside this framework and enter the health system in search of care, policy discourse has often pointed to the need to encourage and train staff to adopt less restrictive approaches.

There is a paucity of research studies examining the impact of policy and legislative initiatives on the use of restrictive practices in the care of PLWD. While global research studies have pointed to the psychological and physical impacts of restrictive practice (Featherstone

et al., 2022), in the UK, while valued for ethical reasons, policy frameworks have not considered the direct impacts of restrictive practices and the benefits of adopting alternative approaches. The Social Care Institute for Excellence (2015, p. 26) identified the need for organisational, policy and political will in bringing about change in the use of restrictive practices. Historically, policy responses to restrictive practice have often taken an over-generalisation, where a solution for one becomes unquestionably a solution for all, to the detriment of the care of many. There is a need to examine how the implementation of legislation and policies to reduce restrictive practices impact care experiences and outcomes, but also staff welfare and retention (SCIE, 2015).

## CONCLUSION

Set against the backdrop of increasing concern over pressures in the health and social care services and the need to provide adequate and appropriate clinical care for PLWD (Britton & Zimmermann, 2022), this article contributes to the use of the concepts of assemblage and events (Deleuze & Guattari 1994; Duff, 2014), and how these may be used to further understand restrictive interventions in acute medical care of PLWD.

We have shown how cultures and rationales for restrictive practices are produced within particular social contexts and entangle with a range of affective relations of power and material inequalities. Understandings of restrictive practices cannot be decoupled from wider socio-political contexts in which the events of ageing, dementia and care are also produced, reproduced and reconfigured in particular ways, enacting affect within assemblages.

The use of restrictive practice in the care of PLWD has particular implications for both patients and staff involved in their care. Restrictive interventions are more than merely restraining an individual but have affective and embodied impacts on both patients and staff. We argue that their use is processual and mediated via socially situated processes of stigma which also permeate institutional and policy spheres to shape practices. To better understand the use of the restrictive practice in everyday clinical practice requires situating their use as a process located at the intersections 'of social processes, political conditions, economic forces and collective norms' (Duff, 2014, p. 126) relating to the 'events' of ageing and dementia. The use of restrictive practices in the care of PLWD in acute medical settings goes beyond biomedical objectivity and rational decision-making in everyday clinical practices. We must also consider it as an assemblage situated in the entanglement of the events of ageing and dementia, and their related social and organisational affects, and the material spaces in which care is provided.

Here we underscore the significance of the concept of 'assemblage' which is described as 'agencement—which refers to a construction, an arrangement, or a layout ... of heterogeneous elements' (Nail, 2017, p. 22). We draw on this concept to recognise the relevance of the entanglement of the events in social, institutional practice and policy in making the use of restrictive interventions in clinical practice meaningful. In using this concept, we have also illustrated the social situatedness of stigma. Restrictive interventions as an assemblage emanate from the wider societal reception of the events of dementia and ageing with material implications. The commingling of affect and material conditions in social relations contours the entanglement of attitudes, bodies and space to produce, sustain and recreate resentment towards the event of dementia and ageing. These particular attitudes become the basis for both the production and reproduction of stigma.



The use of restrictive interventions in clinical practice on PLWD should be seen as a peak of events across the policy, institutional and social spheres. The coming together of events (ageing and dementia) and affective attitudes within these spheres necessitates PLWD becoming subject to restrictive practice within the specific relations in which they are involved (Duff, 2014; Marks, 1998). In this conceptualisation of restrictive practice, we have sought to illustrate the complex and multifaceted nature of clinical practice, acutely aware of the real experiences that PLWD encounter in everyday clinical practice.

The assumptive logic of rationality and objectivity that has worked as the foundation of clinical practice presumes health-care professionals as entirely rational actors and clinical practice as an objective process. However, examining restrictive practice as an assemblage (Deleuze & Guattari, 1994) with dementia and ageing as events in the life course generates a critical approach to clinical practice by drawing attention to the paradigms of process and relationality, and epistemologies that trouble the rational and objective approaches to clinical practice and the material contexts of care delivery. This reveals a complex set of relations that are in constant flux, as this perspective disrupts the dominant epistemic modes of seeing and being in clinical practice, to highlight the materiality, intercorporeality, interaffectivity and relationality (Deleuze & Guattari, 1994; Fuchs, 2017) of restrictive interventions.

In this article, we have explored how an analysis of the entanglements of social and institutional practices and processes and policy make visible the events of ageing and dementia and the use of restraints in clinical practice. We sought to bring the use of restrictive practice into contemporary Science and Technology Studies debate and consideration bearing in mind the growing ageing population and increasing cases of dementia (Booth & Duncan, 2022). These events occur in a landscape laden with tensions between the calls for improved care of PLWD and the ever-increasing cost of care this presents for health-care systems. In this context, it becomes even more prudent to recognise and explore the entanglement of the events of ageing and dementia in the social, institutional and policy context in this complex terrain. Drawing, on the analysis of the social, policy and institutional contexts in the use of restrictive interventions, and how the practice is brought to bear, reveals the role of subjective and social affective desires, how views and beliefs about ageing and dementia coalesce in social interactions to bring about stigma. These affects and attitudes generated through this phase permeate into clinical practice, legitimised by the power of the bodies involved. Further research is needed to capture the impacts of restrictive interventions by focusing on the experiences of both PLWD and staff administering them in care settings. Doing so is vital to inform appropriate approaches to the care of PLWD.

## AUTHOR CONTRIBUTIONS

**Shadreck Mwale:** Conceptualization (lead); formal analysis (lead); funding acquisition (supporting); investigation (lead); methodology (supporting); project administration (supporting); writing – original draft (lead); writing – review & editing (lead). **Andy Northcott:** Conceptualization (supporting); formal analysis (equal); funding acquisition (equal); investigation (equal); project administration (lead); writing – original draft (supporting). **Imogen Lambert:** Conceptualization (supporting); formal analysis (equal); investigation (equal); methodology (supporting); writing – original draft (supporting); writing – review & editing (supporting). **Katie Featherstone:** Conceptualization (supporting); formal analysis (supporting); funding acquisition (lead); methodology (supporting); project administration (supporting); supervision (lead); writing – original draft (supporting); writing – review & editing (equal).



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## DATA AVAILABILITY STATEMENT

This paper is based on a qualitative synthesis of existing literature, therefore there is no data to be made available.

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