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

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 as many as 1 in 4 NHS beds are occupied by a PLWD (DoH 2014; Alzheimer's Society, 2016), reflecting international prevalence estimates within the acute setting of 12.9–63.0% (Mukadam and Sampson, 2011). Retrospective reviews of patient notes suggest this is a significant underestimation (Crowther et al 2017). Recent ethnographies within the hospital setting suggest 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 recognized as 'challenging' (Sampson et al., 2014:194) and 'dangerous' (Mathews et al, 2013:465) places for PLWD. Routine practices within these wards are designed for patients without cognitive impairment (authors), despite the prevalence of PLWD within them. This leaves PLWD at a significant risk of adverse events, including incontinence (Hofmann and 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 and Northcott 2020). PLWD often behave in way perceived, by staff, as challenging (Wolverston et al 2021), in turn disrupting the business of the ward (Gladman et al 2011). In response staff will reinforce and 'tighten' control of PLWD (Featherstone and 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 paper 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 (Bernajee 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. 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 and 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 (House of Lords, 2007; Care Quality Commission, 2014) have found that restrictive practices have become entrenched practice in the care of order 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 suggesting 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) and 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 (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, 2010). 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 paper 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 Deleuzean (Deleuze and 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 heterogenous elements* (Nail, 2017; 22). These heterogeneous elements consist of both the material and immaterial – "one of content, the other of expression" (Deleuze & Guattari 1987: 88-89). These dual elements coalesce and produce 'events' which have a performative effect – enacting what Deleuze & Guattari call "incorporeal transformations" (Hristov, 2018;193). For Deleuze and Guatarri '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 (author). Deleuzean 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).

Healthcare 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 restraint in the care of PLWD, restrictive practice 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;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; 340).

Deleuze's concepts have been widely used to shed light on embodied experiences in diverse contexts in healthcare (Buse & Twigg 2014, Latimer & Lopez Gomez 2019, Helsovouri 2020, Mwale 2020, Dimond et al 2022). This extends the concept of assemblages, which has frequently been implemented to analyse institutional processes and practices (McDougal et al 2014, Rabeharisoa 2006, Buse et al 2018, Beltrame 2019, Dimond et al 20222). This paper adds to these sociological interests in mundane, every day, and routine care practices and their 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 (Cluey, Fyson & Pilnick, 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 seeks to find out what the components of this phenomena are, how in what conditions do these elements enact 'incorporeal transformations (Buchanan, 2017: 473; Deleuze & Guattari, 1987:88-89).

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 Guatarri (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; 104; see also) are produced, reproduced, legitimised, sustained, and disputed (Drewsbury 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 (Duff 2014; Deleuze and Guatarri 1987). 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 Guatarri (1987;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 and Purwaningrum 2020), and resultant biomedical technologies aimed at remedying the impacts of ageing (Duff 2014; Moreira 2016; Andrews & Duff 2019).

Ageist attitudes are a creation of society (Angus and 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 and Duff 2019). This is because ageing becomes socially synonymous with perceived depreciating social value (Clarke and 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 (Kontos et al 2020; Widrick and Raskin, 2010; Mautner, 2007; Fiske et al 2002).

However, in suggesting that wider social attitudes common in society themselves emanate from a multiplicity of networks of socio-cultural 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 and 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;2018) by locating stigma of ageing and dementia at the connexion of socio-economic, public interest and policy processes. The discourse of ageing as a societal burden and thus a process to be slowed and avoided (Benbow and Jolley 2012; Milne 2010) portrayed in media and political debate leads to legitimisation of ageism and the use of restrictive practices on vulnerable populations. 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 (Tyler 2013;2018; Duff 2014), 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, Otepieniu 2015; Kontos et al 2020) pejoratively posited as morally failing to keep up with the appropriate material consumption to maintain their youth and thus threat to national economic resources, paradoxical to public health calls for better health and well-being to avoid ill-health, facilitate living longer to the oldest age possible (Mwale 2024; Latimer 2018).

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) to old age and experiences of living with dementia. These include stigmatised characteristics linked to race and racism, sexism, sexuality, victims of violence,

refugees, (Aosved & Long, 2006; Clarke and Griffin 2008; Harbison, 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 socio-economic circumstances that influence whether they require state support or not. Mwale, Northcott and Featherstone' (forthcoming) work points to ways in which working class, male, black patients with dementia are likely to face restrictive practices including the use of security guards during a hospital admission, often characterised in lightly veiled yet engrained racist stereotypical views of black male patients with dementia, "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 (2015) observation that social structures of power, class relations, gender and ethnicity stigma exist beneath the surface of the lifeworld, 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 socio-economic 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;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 (De Landa 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 the event 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 and 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 healthcare 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 has shown how these attitudes equally permeate institutional and professional spaces (Acktoyd-Stolarz, 2008; Bianchini, 2000; Klein, 2007; Ray, Raciti, & Ford, 1985; Rosowsky, 2005) 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 (Wolverston et al 2021) 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 at 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, saw increasing numbers of PLWD forcibly detained in hospital wards longer than was needed due to fears they may catch and or spread covid 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 2018) 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 identified material conditions in hospitals have an influence on their willingness to use restrictive practice (Werner 2002; Karlsson et al 2001; Werner & Mendelsson 2001) with nursing becoming highly reliant on the use of restraints in the care of older PLWD. Internationally research has shown nursing staff recounted

using restraint and force and approved of its use in everyday care of older people and PLWD (Yan et al, 2009; Hynninen et al, 2015). The most common restrains 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 in Israel (Werner & Mendelsson 2001), Sweden (Karlsson et. al. 2001) and elsewhere (Helmuth et al. 1995; Courtney, Tong, & Walsh, 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, organizational, 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, the entanglement of dementia with material structures and wider healthcare 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 increasing 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, healthcare staff routinely use raised bedrails to prevent someone from leaving the bed and the placement of 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 and 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 and Northcott 2020).
In a Hong Kong study Chien and Lee (2007) found that healthcare 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 healthcare 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 and 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 healthcare 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 multi-disciplinaries 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, 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 healthcare 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 and Guattari 2004) 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;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 (Bower et al 2003; Abraham et al 2020). 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 Deleuzean 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 (DoH 2014; CQC 2017). 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 (Edwards et al 2021; Banerjee 2009). 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 a PLWD or a healthcare professional are seen as rational and capable of rational thoughts. Healthcare 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 choice (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 healthcare 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 locate the use of restrictive practice as emanating from actions of rational healthcare professionals, we suggest analysing restrictive practices as an entanglement of socio-cultural 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;126) words, to link "'context' with 'practice', the 'macro' with the 'micro', '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 healthcare. 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 healthcare professionals across the care system 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 (2021;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 showing that staffing levels have an impact on the use of restrictive practices. As Houghton et al (2016;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 healthcare is configured, specifically in acute medical settings, concerning the entanglement of the sociocultural, organisational, socio-economic, and socio-political factors to facilitate and legitimate the use of restrictive practices with adverse implications for those providing and receiving care. While in 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 and Maker 2021; 39). Equally healthcare 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 examining the impact of policy and legislative initiatives on the use of restrictive practices in the care of PLWD. While global research has 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 (2009; 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, in which 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 2009).

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 and Zimmermann 2022), this paper contributes to the use of the concepts of assemblage and events (Deleuze and Guattari 2004; 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;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 practice. 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 heterogenous elements '(Nail, 2017; 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 healthcare professionals as entirely rational actors and clinical practice as an objective process. However, examining restrictive practice as an assemblage (Deleuze and Guattari 2004) 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 (Fuchs 2017; Deleuze and Guattari 2004) of restrictive interventions.

In this paper, 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 STS debate and consideration bearing in mind the growing ageing population and increasing cases of dementia (Booth and 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 healthcare 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.

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