**Coercive practices in mental health services: stories of recalcitrance, resistance and legitimation**

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**Introduction**

This chapter is written by people with quite different experiences of violence in relation to the practice and organisation of psychiatric services. It is our intention to draw upon our own collective experiences, including some relevant research studies to explore the notion of legitimacy with regard to violence and psychiatry. The social relations of care and associated power distribution demand more nuanced understandings than are often applied in practice, and critical reflection on the ways in which legitimacy is established, or appealed to, is similarly required.

Our intention is not to condone violence, rather we argue that complexities associated with coercive psychiatric practices are often unacknowledged in the justification for implicit and explicit violence. Furthermore, the idea that violence enacted by people subject to psychiatric care and treatment may have its own legitimacy is a neglected aspect of scrutiny, and may be conceived of as a form of resistance, or recalcitrance, towards psychiatric power (McKeown et al 2016). We highlight research and commentary beyond psychiatry which reinforce notions of legitimacy grounded in fairness and social justice, and refer to some illustrative accounts drawn from research of our own.

**Locating ourselves**

Before developing our thoughts it is opportune that we clarify our positioning and personal journeys and how these situate us in terms of this subject matter. Mick is a sociologically inclined academic located in a university with an extensive background working in mental health nursing, including at the so-called hard end of psychiatry in secure care units. Despite a critical disposition towards psychiatry and a personal aversion to the use of coercive measures, never having used physical restraint or forcibly administered medication, he has undoubtedly shared complicity in psychiatric services as we know them. Amy is a research

assistant, with a background in psychology, currently working on a large scale study, with Mick, Fiona and others, aimed at developing and evaluating practices in inpatient units designed to minimise or obviate the use of physical restraint. Fiona is a researcher and a survivor of mental health services with substantial experience of coercion, including time spent in secure facilities. Will has had numerous compelled admissions to acute psychiatric wards and is studying for a PhD focused upon contradictions in mental health policy. Both Will and Fiona have been subject to significant psychiatric violence, have also been violently recalcitrant, and are retrospectively troubled by both.

The policy and practice context is, arguably, replete with contradictions and we are aware that our contribution is also open to critique. Not least of these concerns relate to tensions between reformist as opposed to transformative objectives. To a greater or lesser degree we are all involved in activist inspired debates for revolutionising mental health thinking and practice, such as those propounded in the insurgent mad studies field (Le Francois et al. 2014, Reville & Church 2012, Russo & Beresford 2014). Yet, we recognise that this movement is largely external to the concentrated psychiatric power that continues to dominate services. Large numbers of individuals remain legally compelled into coercive psychiatric services. Hence, we are committed to pragmatic efforts to minimise the violence that patients are, right now, subject to. Furthermore, we contend there is value in attempting to persuade the psychiatric workforce to consider the violence of their own actions together with alternative ways of understanding and responding to violence, or its threat.

**Violence begets violence: an unfortunately commonplace experience**

We set the scene for our focus on legitimacy with a first person recollection from Will deriving from his most recent compulsory hospital admission:

> *I was on a PICU* [Psychiatric Intensive Care Unit] *ward and got put on depot medication by the psychiatrist. I argued against this during the consultation and refused to have it. The following day a nurse asked me at breakfast when I wanted to have the depot. I continued to say I did not want it then, about two days later, 6 or maybe 7 men came into my room, led by a male nurse I quite liked, charged with administering the depot. I backed into the corner of my room. I told them that I disagreed with the legislation that empowered them. I also told them that I understood the consequences of resistance to myself both criminal and psychiatric. I removed my watch and threw it on the bed. I told them that I would drop the first*

*person that came near me with a needle and probably get a punch in on someone else. There was a momentary stand off and then the attempt was called off. I didn't sleep at all that night, partly because I thought they would try again and partly because I had so much adrenaline sloshing about my system. That night I explained to the lead nurse the reasons for my refusal and self-defence.*

*Over a week and a half passed. I was asked every day to have the depot and politely declined. I learnt from my medical notes that their next step had been to request the assistance of the police, who had refused to get involved. I was informed that my transfer to the acute ward had been postponed by my 'recalcitrance'. During that month on the ward I was physically assaulted twice by another patient. On both occasions I did not fight back, but reported both incidents. Both assaults were violent, injurious, unprovoked, witnessed and accurately documented by staff, including the absence of retaliation. My point is, I had sufficient insight know when violence is permissible or warranted, and to exercise restraint.*

*I was eventually administered the injection by guile. I was tricked out of my room by a nurse on the pretence of providing me with a nicotine replacement cartridge for my inhaler. On leaving my room there was a team in wait. My hands were grabbed from behind and I was marched along in a well-executed sting. I was sensible not to resist, like being thrown out of a club by an overzealous bouncer. I also had the composure to request that they march me into the medical room as their intention had been to administer the depot in the communal corridor. They then took me into the seclusion suite because I guess they assumed there may be some reaction. I remained calm and polite for a minute and requested to return to my room, which was allowed. I sulked for about three days, quit nicotine capsules, didn't eat, and read a book. I was able to think about the level of pre-meditation and the involvement of all the staff on the ward in co-operating and conspiring to do something most disagreeable to me.*

*I got out about a month later at a managers hearing and avoided a CTO, refusing to engage with secondary services since because it has made me more recalcitrant and fucking angry.*

Will's account evokes various responses for us. On one level, it is most apparent that the staff and patients' interpretations on the course of such events can differ tremendously, and are not necessarily contemplated by all parties whilst circumstances unfold. Both staff and patients will, from different perspectives, claim legitimacy for their actions, and in the staff's case may feel that the application of coercive measures are in a person's best interests, even as they forcibly resist. For us, however, the most profound impact of this narrative is the moment where purposeful deception by the staff is a precursor to physical restraint, and how this act is built upon a presentation of *kindness*. For us, this represents a microcosmic metaphor, for all that is wrong with that ultimate oxymoron – coercive care.

The actual and potential impact for patients appear obvious, leading to a breach of trust and diminution, if not complete negation, of any sense of therapeutic alliance. In addition, as Will describes, these staff tactics inculcate grievance at perceived unfairness and become the seed for legitimating a recalcitrant or violently pre-emptive response. The corruption of kindness speaks volumes of wider crises of legitimacy facing the so-called caring professions and begs deeper questions of morality and ethics, beyond instrumental considerations of effectiveness. If the consequence of efficiently applied coercion is fundamentally undermined therapeutic relations and provocation of recalcitrance on the part of patients, then even efficiency is called into question.

**Coercive mental health services**

Unlike other health care contexts, mental health services are unique in legally mandating compulsion and coercion. The most obvious coercive measure utilised in the UK is physical restraint, and less extensively, seclusion; though in North America and other parts of the world mechanical restraints are also used. All forms of restraining and coercion predate psychiatry as a medical discipline and, indeed, modernity (Paterson & Duxbury 2007). Restraint is most commonly used in response to violence on the part of patients but is a legitimated staff response to such diverse circumstances as absconding, refusing medication, self-harm, property damage, and verbal aggression; it is also reported in relation to staff refusing requests from patients (Bowers et al. 2012, Gudjonsson et al. 2004, Ryan & Bowers 2006, Southcott & Howard 2007).

Physical restraint can have significant impacts for patients, including physical and psychological injury (on occasion associated with re-traumatisation), or death. From an

organisational perspective it can be distressing for other patient witnesses and staff, precipitate further aggression or violence, add to service costs, and damage therapeutic relations (Ashcraft & Anthony 2008, Fisher 2003, Foster et al. 2007, Moran et al. 2009, Sequeira & Halstead 2004). Moreover, the more coercive aspects of services and most restrictive environments are typically disproportionately visited upon ethnic minorities, especially young black men in the UK and aboriginal populations in North America and the antipodes (Gone 2007, Stowell Smith & McKeown 2001, Zubrick 2010). Hence, these groups are more likely to be subject to compulsion, be detained in secure services, receive physical treatments as opposed to talking therapies, and be secluded. A pernicious mix of racialized stereotyping and staff fears has been implicated in serious failings of care, including deaths whilst subject to restraint in psychiatric and other contexts (Aiken et al 2011, Anthony 2016, Keating & Robertson 2004, Prins 1993, Razack 2015, Sivanandan 1991).There is some mixed evidence of disproportional use of physical restraint, but recording processes are often insufficiently systematic or thoroughly completed (Stewart et al 2009).

Violence between patients and care staff can proceed in avoidably escalating, vicious cycles of conflict or avoidance (Duxbury 2015, Whittingham & Wykes 1994). Holmes et al. (2012) dispute the commonplace assumption that violence in health care settings is always perpetrated by patients, highlighting the violence implicit in the system and enacted by staff upon patients, distributed horizontally amongst staff or initiated by employers. Similarly, Choiniere and colleagues (2014) emphasise the influence of clinical settings where bio-technologies are privileged to the detriment of relational care. Indeed, the systemic nature of violence within mental health care services has been conceptualised as inextricably bound up with the power of psychiatric knowledge to order and constrain human relations; in this sense, the violence is a form of epistemic injustice (Carel & Kidd 2014, Fricker 2007, Liegghio 2013, Russo & Beresford 2014). Russo and Wallcraft (2011) make the case for survivor research into coercion to resist professional and institutional framings of the topic and variables. For Holmes and colleagues (2012: 9) the analysis of violence in health care settings needs turning on its head: *to look to health care and its organization for how violence is bred in its practices.*

The England and Wales Mental Health Act (MHA) was reformed most recently in 2007 and despite ambitions that new Community Treatment Orders (CTOs) would reduce compelled hospital admissions the opposite has occurred. Levels of compulsion and coercion in

hospital and community have risen annually since the Act came onto the statute book (Care Quality Commission 2015). The quality of inpatient care has also been questioned, with concerns regarding over-occupancy, low staffing levels, over-use of agency staff, and limited alternatives to medication. For critics such as Bauman (2000), much of the problems stem from unfettered neo-liberalism, condemning public sector services to benighted conditions of liquid uncertainty; a state of affairs implicated in notable systems failures and scandals (Randall & McKeown 2013). To compound this, the Care Quality Commission (CQC) has warned that many positive aspirations of national mental health policy are relatively meaningless in the face of services characterised so much by compulsion, coercion, containment and control (CQC 2012, 2015). Arguably, these policies aspire to promote participation in decision making, other involvement practices and, essentially, forms of cooperation between staff and patients, ambitions that are thwarted by the tendency to control. We contend that tensions between coercion and cooperation expose more fundamental questions of legitimacy, and it is to these that we now turn.

**Legitimacy: rightful violence**

Numerous studies of wider society seem to show that people perceive violence on the part of the state, as exercised by the police for example, to be legitimate if procedural justice and fairness principles are adhered to, and this underpins cooperation with authorities and deference to their power (see Jackson et al. 2013, Tyler 2006a, 2006b). In this sense, societies expect that the police and the legal system hold a monopoly on the use of physical force, usually obviating the need for citizens to behave violently (Weber 1968; 1919). For Young (202: 277), Hannah Arendt provides a critical perspective that 'official violence is always questionable, and thus requires justification'. Where belief in the just exercise of power becomes diminished, trust breaks down between individuals or communities and the authorities. In such circumstances, citizens can understand a range of violent acts, such as those committed in the pursuance of protest or even riot, as fundamentally legitimate.

Edward Thompson (1971) makes similar observations through an historical lens about the implicit morality of riotous behaviour in reaction to social injustice. Jackson et al. (2013) hypothesised that public assumptions about the nature and quality of democracy may also be influential in their disposition towards violence on the part of themselves or fellow citizens. From this general perspective, the legitimacy or otherwise of violence perpetrated by patients detained on mental health wards is open to understanding with regard to perceived unfairness at the hands of the psychiatric system, and this may extend to whether the public

at large condones violence perpetrated by the system or in response to it. Furthermore, democratisation of the social relations of care may prove to be important in the minimisation of violence in either direction.

**Legitimating psychiatric violence**

Appreciation for progressive measures aimed at reducing or ameliorating coercive practices positively highlights such notions as recovery journeys, the value of different types of communication, the importance of different settings and places, and quality of relationships. This results for many service users in the establishment of apparently cooperative relations with care staff, who also then experience reward and fulfilment in their work. We do not wish to be overly critical at this juncture, as such scenarios seem preferable to the more austere, autocratic and institutionalising regimes that exist in contrast or combination. We do, however, suggest that there are a number of philosophical and practical problems with an uncritical affinity for these policy notions and practices. Psychiatry's adoption of seemingly progressive measures, some inspired by psychiatric survivor movements, indicates a wider colonisation project, offering a legitimating smokescreen for more unpalatable coercive practices. Positive experiences of advocacy, recovery and cooperation may mask the imperviousness and immutability of prevailing power dynamics: individuals may better enjoy the experience of care interventions or hospitalisation, compelled or otherwise, but still have their core demands, wishes and needs denied (McKeown et al. 2013).

The extent to which patients are inclined to cooperate with mental health care is compounded by the entrenched dominance of bio-medicine. One interesting aspect of legitimation is recourse to research evidence within a scientific paradigm. Psychiatry, on its own terms, faces a significant epistemological legitimacy crisis as the evidence underpinning medicalisation of mental distress appears frayed at the edges or, indeed, coming apart at the seams (Bentall 2004, Whitaker 2010). Specifically violent treatments such as Electro Convulsive Therapy (ECT) are difficult to scientifically justify (Breggin 2007, Weitz 2008). Similarly, the ways in which elderly patients are also subject to restraint, seclusion, ECT and over-medicating is more often than not contrary to established evidence and provokes unease and outrage (Andrews 2006, Banerjee 2009, Coon et al. 2014, Foebel et al. 2016, Muir-Cochrane et al. 2015). Thus, evidence critiques supplement moral and ethical objections in framing campaigns of resistance (Burstow 2016). That said, psychiatric orthodoxy is a long way from being transformed or de-legitimated, despite increasing

appeals of alternative, more benign, democratic, relational options which minimise or eschew medication, such as Soteria (Mosher 1999), Open Dialogue (Seikkula et al. 2011), or the growing panoply of survivor-led or inspired alternatives (see Russo & Sweeney 2016).

Practitioner staff embroiled in a risk management paradigm promote cooperation but doubt the sincerity of cooperating patients, whilst patients equally doubt the sincerity of staff claims to care (McKeown et al. 2016). Paradoxically, advocacy, cooperation, involvement and recovery practices may actually constitute means for the *pacification of dissent* rather than living up to rhetorical transformational or even emancipatory claims (McKeown et al. 2013). As such, the apparently progressive becomes subsumed into more longstanding systems of governance and tyranny.

Numerous studies of psychiatric staff attitudes towards coercion and physical restraint in particular show that there is at the very least ambivalence over its use, and indeed a degree of consensus that there are counter-therapeutic consequences (Bonner et al. 2002)). Closer reading of this body of work reveals that nurses and other staff when questioned about their views on violent interventions initiated by staff, such as physical or mechanical restraint or forced medication, offer a range of justifications. In one recent review, Riahi and colleagues (2016) describe various appeals for legitimacy that include: necessity, maintaining safety for all, maintaining control over challenging situations, and the well-worn contention that such interventions are only used as *last resort*. Interestingly, this review also reveals circumstances where staff are conscious of the adverse psychological impact of physical interventions, for both patients and themselves, and critical of gung-ho colleagues who are indiscriminate in their use of violence. All of this applies in the context of legitimated coercive practices, but there is also a lengthy history of illegitimate and abusive use of coercion (Department of Health 2012, Hopton 1997) so much so that nursing in the UK is currently facing its own crisis of legitimacy (McKeown & White 2015), characterised by an alleged lack of compassion (Flynn & Mercer 2012, Spandler & Stickley 2011, Stenhouse et al. 2016).

The fact that health care staff and service users might see matters of violence differently is demonstrated in Rose and colleagues' (2013) research on UK wards. In this study, nurses felt impotent to carry out care in the face of administrative burden and patients in turn viewed the nurses is uncaring and inaccessible.  These nurses saw coercion as a legitimate response to violence, caused by internal patient factors, whereas patients felt 'driven to

extreme behaviour' and viewed coercive measures as 'unnecessary and heavy handed' (Rose et al. 2013: 1). In our own study, ethnographic observations and interviews revealed a mixed picture, with legitimacy of nurse or patient initiated violence understood differently depending upon context and circumstances (Duxbury et al. 2015). Some service users might object to coercive measures applied to themselves, but see them as reasonably warranted for others or, indeed, on occasion resign themselves to proportional application of coercion (see also Dickens et al. 2013, Duxbury & Whittington 2005).

Debating notions of legitimacy concerning violence in mental health settings, on the part of patients or staff and services, is not new; though much of the available literature focuses upon understandings gleaned from the field of ethics rather than necessarily sociological theory (see Paterson & Duxbury 2007). A focus on ethics can result in a degree of pragmatism, upholding last resort rationalisations, ultimately validating physical restraint as a necessary evil (Perkins et al. 2012).

Chris Chapman (2014) in a searing, honest and insightful reflection on working in a children's unit that routinely used physical restraint and seclusion observes that staff become enmeshed in their own narrative accounts of such events. These operate to legitimate, explain and exculpate actions that clearly are distressing for the children and provoke discomfort in staff sensibilities. Chapman draws insights from Arendt's thinking on violence, power and legitimacy, as do Roberts and Ion (2015) in attempting to make sense of the abuse of patients in a series of recent UK scandals. The essential feature of these staff narratives is to cast the person subject to coercion as the perpetrator of violent acts, such that violent staff responses, albeit controlled and formalised restraint techniques, are justified, and their own violence is reinterpreted in more palatable terms of necessity, protection and safety. Chapman (2014: 25) draws attention to the processes by which potential staff moral, ethical or political objections are systematically dampened and contained by means, such as collective debriefings, which serve to consolidate legitimation narratives and, effectively, also individualise and psychologise patients *and* any staff who experience revulsion or upset:

> *When we restrained children, we 'debriefed' newer staff afterwards, knowing it was difficult to witness or participate in a restraint, and approaching it as something to*

*address through something like a "talking cure" with a predetermined destination: to accept perpetrating violence as necessary.*

**Commented [MM1]:** Scare quotes in the original

However, Prilleltensky and Nelson (2002) propose a *psychopolitical* framing that concentrates on unequal power dynamics and social causation, and argue for interventions to address these matters rather than simply respond to their effects.

What other options are open to resistive psychiatric patients who might assert their will, reject diagnosis or treatment, and fight with care staff? In the wider context of civil disobedience, McWilliams (1970) discusses non-violent tactics as holding potential, but only if the oppressor is ultimately bound by sufficient moral conviction to be (eventually) moved by such protest. He wryly acknowledges that such tactics would not have prevailed in the context of Nazi oppression, where the final solution was locally legitimated, and the victims were effectively de-humanised. We might consider that the formal legitimation of psychiatric violence would also substantially discount the value of non-violent patient protests, faced for example with the circumstances of forced medication. As an aside, the UK psychologist and survivor activist Rufus May offers training courses in non-violent communication for negotiating challenges in services (http://www.rufusmay.com/index.php/news-and-views/136-how-i-ve-found-nonviolent-communication-helpful).

**The inevitability of coercion and restraint**

We now turn to present some illustrative snapshots of data from some of our research studies that support our arguments concerning legitimacy. These include the *ResTrain Yourself* project (RTY), designed to evaluate an initiative aimed at reducing the use of physical restraint (Duxbury et al. 2015) and a study of views on the recovery concept in a high secure hospital (HSR) (McKeown et al. 2016). These excerpts are of necessity selective, but similar accounts have emerged in many of our studies and are apparent in the wider literature. The RTY study involved a substantial amount of ethnographic observation and interviews on 14 acute inpatient wards across the North West of England.

**RTY Observation 1: The prior planning of a restraint to administer IM, before the patient has even protested the treatment or before any violent incident has occurred.**

*Staff discussed the fact handover will have to be brief due to a planned restraint at 2pm, to administer a depot. Staff anxiety was clear from tone and body language. In the past few weeks there have been various incidents involving administering medication to this woman patient, some leading to seclusion. Handover was interrupted by an older male nurse, who stated that "2 big men have come over from X ward for the depot, and they want to leave, so can we do it now?" There was some awkwardness in the room as the staff seemed conscious of the presence of the research team, and the stark contradiction of the trauma-informed practice posters displayed above their heads. The NIC [nurse in charge] said they would have to wait until handover was finished, at which point the other nurse said he would draw up the injection. The incident concluded with the patient taking their medication without the need of a restraint team.*

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This decision to form a team with intention to administer medication against a person's will exposes the inadequacies of typical rationalisations of coercion, not least as last resort. Such claims are surely not sustainable in a context where physical restraint is pre-planned. Whether it was the implicit threat or proximity of a team (including large men) that influenced compliance at this time is open to conjecture. Clearly, in this case prior violent incidents were understood as patient behaviour, without thinking about interaction with staff violence in terms of use of restraint and seclusion, and pragmatic concerns over staff safety over-rode any inclination to do without restraint tactics. The case for legitimacy is also supplemented by belief that taking medication is ultimately beneficial:

*There has been a lot of planned restraints with the patients that have been non-compliant with medication. And they're informed and, obviously, in their treatment plan, we've got the power to give them this medication for their best interests.* [Nurse, RYT interview];

**Violence as legitimate response?**

Even when not looking for them, time and again we have elicited accounts of experiences illustrating how service responses precipitated violence, contemplation of violence, or other acts of resistance, which might in turn fuel further application of coercion. In the following excerpt a patient describes such a cycle:

*I can't remember what, I wasn't happy with something, so I ran for the push bar to get out. It was not like me. I ran for it and I was like, argh, get out. And then I think two members of staff got me in there, I think someone sat on me. And they said it was either take Lorazepam or have this injection in the bum. So I opted for the Lorazepam … Yes, probably, I laugh at things that I should be crying about. But I don't find it funny being in here at all, so that's probably why I was trying to get out in the beginning* [patient, RYT interview]

UK public health policy has promoted prohibition of smoking in NHS units and their grounds. For detained persons this *best interest* initiative is yet another reminder that whilst a mental health patient, basic autonomous decisions regarding your lifestyle are controlled; adding to the plethora of mortifications to which you are subject. Predictable violence and aggression is often reported as a consequence of patient's resistance to these policies:

*We're saying to somebody, you're coming into hospital against your will, bringing you into this distressing environment, and saying you can't smoke. Even I think, oh my god, I'd go mad. And you know when you say you can't have one, you want one more, don't you? … the doors were kicked in every single day trying to get out for fags. Like the staff, we were attacked and all sorts for fags.* [nurse, RYT interview]

Medication, and specifically compliance with medication, are pivotal issues relating to perceived cooperation, or its flip-side, non-cooperation, typically referred to by services as non-compliance. As such, matters of compliance are at the centre of much violence and aggression. Medication and coercion often go hand in hand, the administration of medication can be replete with violence, is a trigger for patient violence, and is a front-line response to violence – in repeated cycles of anti-therapeutic practice and resistance, or submission, to it:

*... first and foremost, I think they have to be in control of you. It's part of the psychiatric system, to be brought down a peg or two, shatter their confidence and then build it back up just enough for them to be able to leave hospital … Because while a person is under the chemical cosh, or that type of medication, they do become aggressive … I think if you harm somebody on the ward, you would be [put] on the harder medication…* [patient, RYT interview]

In our framing of the notion of recalcitrance, people effectively position themselves in opposition to the psychiatric episteme when they link choices and behaviour to rejection of labelling, diagnosis and medication:

> *That was one of the things I questioned and because I've been labelled with 'this' and because I was challenging something I didn't agree with, I was rebelling against how the system viewed me.* [patient, HSR interview]

*Mortification of the self* can be seen to persist within modern psychiatric units given that most of them continue to exhibit characteristics of total institutions (Goffman 1961). The interplay between staff and patient violence, the rhetorical valuation of cooperation amidst the reality of coercion, are indicative of the symbolic and actual interactions between individuals subject to institutionalising mortification and their various coping strategies. Goffman (1961: 143) pinpointed the means by which cooperation becomes singularly defined in terms of compliance with the institutional perspective:

> *The difficulties caused by a patient are closely tied to his version of what has been happening to him, and if cooperation is to be secured, it helps if this version is discredited. The patient must 'insightfully' come to take, or affect to take, the hospital's view of himself.*

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Faced with psychiatry as *the only show in town*, persons who resist diagnostic labelling and medication, especially more coercive forms, can be compelled to take on the identity of *recalcitrant*. Individuals who defy the system and practitioners within it have previously been referred to as *difficult patients* or exhibiting *challenging behaviour* as they confront layers of psychiatric control and struggle to assert their own agency (see Repper & Breeze 1998). Will's opening story demonstrates that the descriptor *recalcitrance* can be both a pejorative applied by staff, or can be positively claimed by patients themselves. The term has been deployed similarly in the context of movement activism and resistance to the vicissitudes of neo-liberalism (Clarke 2007, Law & Mooney 2006). For some individuals subject to psychiatric coercion, the struggle erupts in violence and quite literally fighting against institutional regimes and the staff who service them. We have attempted to theorise

recalcitrance in terms of resisting the psychiatric episteme and, in these terms, as a legitimate and rational response to illegitimate coercion[1].

**Alliances for change: possibilities and perils**

If the problem of violence within psychiatric services is one of interaction between an oppressive system, staff working within it, and detained patients, then arguably solutions have to involve all interested parties. Revolutionary solutions demand total transformations. More pragmatic approaches seek to reform the most egregious aspects of the system. Peter Sedgwick (1982/2015) in his arguments for a left-leaning *psychopolitics* made the case for cross-sectional coalitions between survivor and labour movements. At least one possibility is to frame efforts to reduce workplace violence as an employment relations matter (McKeown & Foley 2015), holding out potential for politicised alliances between the health care workforce and survivor activists (McKeown et al 2014). Of course, to some extent practitioner workers' unions have always been visible on this territory. Unfortunately, however, their contribution has been, more often than not, implicitly conservative. Hence, in the UK, employers in conjunction with unions have designed *Zero Tolerance* campaigns which appear to locate the entire responsibility for hospital violence with patients and the public, neglecting to consider wider contributory factors and care staffs' own role in precipitating or perpetrating violence.

One set of possibilities is that survivor movements and unions seek mutual interest in challenging both psychiatry *and* the neo-liberal forces that weaken worker interests and stigmatise and impoverish disabled and mad citizens (McKeown 2016)[2]. Models of community mobilisation offer a helpful starting point, and survivor activists are already formulating their demands (see Psychiatric Disabilities Anti-violence Coalition 2015). For trade unions to make credible efforts towards forging alliances on this and other territory, issues of asymmetrical power need to be faced up to (McKeown et al 2014).

[1] It is not our intention here to essentialise the notion of recalcitrance or in any way support a meaning that overly internalises the opposition of the person or, indeed, infers pathology. We do however make links to matters of personal agency, as likely to connect with wider forms of collective resistance and considerations of power.

[2] In this regard it is possible for members of the psy-workforce and other external commentators to adopt the identity of recalcitrant, adopting movement aims and activist strategies commensurate with resistance to the dominance of bio-medicine and its entanglement with neo-liberalism.

Without holding to any great optimism for a revolution in psychiatry, we prefer to posit an *inside-out* strategy – reforming from inside whilst simultaneously working towards a transformative ideal, and opening up the system to be receptive to alternative organisational forms articulated externally. The obvious counter argument to such tactics is this may do little to dismantle psychiatric hegemony. Yet, not to directly engage beyond critique and protest appears to cede all ground *within* services to the current orthodoxy. Alternative models of care emphasise the appeal of deliberative, democratised dialogue and relationships that also might inspire or sustain political activism and alliances on the same territory. There is so much room for improvement in rendering psychiatric services as we know them more humane, respectful of rights, less coercive and as free of violence as we can make them. This much is in our scope right now, without anything like a revolution, however desirable that might be.

The implicit violence and injustices which flow from epistemic and hegemonic power are something else. These require much more substantial remediation or transformation, and the forms of equality and democratisation that are necessary may need to be realised as much in wider society as the micro-territory of psychiatric services. That said, to paraphrase Sedgwick, if the social relations of psychiatry can be thus transformed we have a blueprint for a desirable transformation of society as a whole. For Arendt (1970: 56), absolute power is deferred to, not requiring violence to exert control; places replete with violence indicate 'where power is in jeopardy'. For psychiatry this may be the case, reflecting profound crises of legitimacy. The struggle is ongoing, and perhaps the recalcitrants will win.

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**Glossary terms**

Coercion: persuading someone to do something by using force. In this context, and range of coercive practices are in use within psychiatric services, including physical restraint, seclusion etc.

Compulsion: in this context, using the law to bring someone into hospital against their will.

CTO – Community Treatment Order, enabling forced treatment in community settings; the legal instrument provides for compelled hospital admission if community treatment is resisted.

Democracy – there are different forms of democracy, which are more or less participatory. In mental health settings this often refers to efforts to equalise power relations and open up opportunities to exert autonomy and voice within decision-making processes. Arguably, deliberative forms are better suited to progressive change in services.

Depot medication: medication given by injection which is slowly released into the body over a number of weeks.

ECT: Electroconvulsive therapy

Employment relations – the social relations and dynamics between workers and employers, often, but not exclusively the province of trade unions.

Intra-muscular (IM) medication: An injection of medication directly into a large muscle. Includes depot medication, but can also be medication (usually sedatives) administered via injection without consent.

Legitimacy: the right and authority to assume a powerful position; usually this assumes a settled consensus, yet is always open to question and resistance.

Managers Hearing – a form of formal appeal against detention, made to hospital managers, allowed under the prevailing English mental health legislation

Mortification of self: the process by which an individual's original identity is lost or attacked, through being subjected to the restrictions of an institution.

NIC – Nurse in Charge

Obs – short for observations; various degrees of intrusive watching of patients by mental health staff, ostensibly to ensure safety.

Physical restraint: Physically holding someone to prevent movement; mental health staff are trained in specific methods for physical restraint, similar to those deployed by police and prison officers.

Psychiatric Intensive Care Unit (PICU): A secure environment aiming to provide short-term alternative to standard acute inpatient environments, violence and aggression can form rationale for PICU disposal.

Recalcitrance: a disposition or acts of resistance in the context of psychiatric or other oppressions. Within psychiatric services recalcitrance can be both a pejorative, applied by staff to challenging patients, or a more noble ideal, framing dissent and reaction to coercive practices – often in the face of few alternatives.

Section – Clause of the Mental Health Act. Has entered popular argot to refer to the use of the Act – for instance, a person is 'on a section' or has been 'sectioned' when subject to particular provisions of the Act.

Secure unit: A secure (low, medium or high) environment providing assessment and treatment for individuals experiencing severe and enduring mental health conditions, who may pose a risk to others.