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Therapeutic Institutions of Violence: conceptualising the biographical narratives of mental health service users/survivors accessing long term 'treatment' in England

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Purpose: This article aims to conceptualise the residential and psychiatric hospital as a space where criminality and social harms can emerge. Due to recent media scandals over the past 10 years concerning privately owned hospitals, this study examines the lived experiences of service users/survivors, family members and practitioners to examine historic and contemporary encounters of distress and violence in hospital settings.

Methodology: The study consists of 16 biographical accounts exploring issues of dehumanising and harmful practices, such as practices of restraint and rituals of coercive violence. A Biographical Methodology has been employed to analyse the life stories of service users/survivors (n = 9), family members (n = 3), and professional health care employees (n = 4). Service users/survivors in this study have experienced over 40 years of short-term and long-term periods of hospitalisation.

Findings: The study discovered that institutional forms of violence had changed after the de-institutionalisation of care. Practitioners recalled comprehensive experiences of violence within historic mental hospitals, although violence that may be considered criminal appeared to disappear from hospitals after the Mental Health Act (1983). These reports of criminal

violence and coercive abuse appeared to be replaced with dehumanising and harmful procedures, such as practices of restraint.

Originality: The data findings offer a unique interpretation, both historical and contemporary, of dehumanising psychiatric rituals experienced by service users/survivors, which are relevant to criminology and MAD Studies. The article concludes by challenging oppressive psychiatric 'harms' to promote social justice for service users/survivors currently being 'treated' within the contemporary psychiatric system.

- The article intends to conceptualise residential and psychiatric hospitals as a space where criminality and social harms can emerge.
- The three aims of the study examined risk factors concerning criminality and social harms, oppressive and harmful practices within hospitals, and evidence that violence occurs within these institutionalised settings.
- The study discovered that institutional forms of violence had changed after the de-institutionalisation of care.
- These reports of violence include dehumanising attitudes, practices of restraint, and coercive abuse.
- The data findings offer a unique interpretation, both historical and contemporary, of dehumanising psychiatric rituals experienced by service users/survivors, which are relevant to criminology.

Introduction

Since 2011, the British media have reported numerous incidents concerning institutional violence within residential care homes and privately commissioned hospitals (Bubb 2014). Examples of violence that have been exposed in these institutions are Winterbourne View Hospital Bristol, Ash Count Hospital London, Purbeck Care Home Dorset, Muckamore Abbey Hospital Belfast and Whorlton Hall Hospital County Durham. In each case practices of systemic physical violence and psychological abuse were exposed and arrests and prosecutions of employees were made (Bubb 2014; Murphy 2019). The first example of abuse was broadcast by the BBC's *Panorama* programme from within the psychiatric hospital of Winterbourne View (Flynn and Citarella 2013). Staff at this hospital were secretly filmed, and this revealed the systemic use of violence, dehumanising psychological abuse of patients, and the overuse of restraint. Patients were enticed by staff to react violently so restraints could be justified within these hospital spaces (Flynn and Citarella 2013). Although there have been a significant number of scandals concerning these mental health hospitals, criminology as a discipline appears to have paid little attention to these abuses.

This wave of recent hospital scandals is not a new occurrence as the BBC in the 1960s, 1970s and 1980s exposed similar incidence of abuse concerning the then NHS mental hospitals (Jessel and Boulding 2010). These hospitals were later decommissioned in the 1980s partly because of some of these exposures (Martin 1985; Cummins 2010). Thus this article proposes to examine the practices of institutional violence by presenting the biographical accounts of patients, practitioners, and family members who have visited lived and worked in a range of psychiatric institutions over the past 40 years. The data findings will illustrate that although there has been a move to deinstitutionalise mental health services, for participants in this study their life histories seem to have been dominated by a range of psychiatric institutions,

from historic mental hospitals to contemporary short-stay psychiatric hospitals to residential care homes. Within the data analysis, the key issue is not regarding criminal violence occurring within these hospitals, but dehumanising and harmful practices concerning the use of restraint, particularly in contemporary residential care homes. Thus this article will present evidence of dehumanising attitudes and practices by staff within these institutions of care, which could reveal a space for systemic forms of violence to occur within these hospital environments (Martin 1985; Cummins 2010; Flynn and Citarella 2013).

Criminology and Disability/MAD Studies

It should be noted that the author has employed Disability Theory, deriving significant influence from MAD Studies scholarship, to analyse the data presented in this study (Dowse et al. 2008; Macdonald 2012; 2015; Voronka 2013). The use of Disability Theory within criminology was first employed by Leanne Dowse, Eileen Baldry, and Philip Snoyman in their 2008 article entitled 'Disabling Criminology'. Since the publication of this article, disability scholars (see Sherry 2010; Roulstone et al. 2013) and criminologists (see Macdonald 2012; 2015) have applied Disability Theory within their work on victimisation and criminality. To conceptualise how Disability Theory can be applied within a criminological context we need to examine the origins of Disability Studies and the emergence of MAD Studies. Disability Studies in the UK emerged from a grassroots political movement which led to the formulation of a social constructionist approach of disability (Shakespeare 2013). Disability Studies developed a critique of the bio-medical model that dominates professional practice and pathologises social problems that affect disabled people's lives (Barnes 2019). Early Disability Studies scholars suggest that the problems people experience are not due to their biological

limitations but due to environmental factors that prevent disabled people from interacting or participating in general social life (Oliver 2009; Barnes 2019).

From this perspective, Disability Studies offers an alternative constructionist approach to conceptualise disability and impairment. Thus, the problems that disabled people experience are not just due to functional limitations, i.e. an impairment effect, but due to constructed environmental barriers that prevent people with biological, sensory, neurological, cognitive, or mental health conditions, from fully participating in social life. At the core of Disability Studies is the importance of service user voices which construct knowledge concerning the experiences of disability (Oliver 2009). Listening to service user experiences is of significant importance as these stories can often illustrate oppressive, harmful (and sometimes criminal) effects of professional practice. One of the most noteworthy scholars who have applied Disability Theory to the experiences of mental health is Peter Beresford. For Beresford (2004), Disability Studies has provided a successful framework for challenging the harmful effects of the bio-medical dominance within professional practice and in academia.

Beresford (2004) suggests that Disability Theory offers a structural analysis that recognises and challenges discriminatory practices, social stigmatisation, unemployment, forced hospitalisation and institutional harms. Yet he also concedes that Disability Studies does not entirely represent the voices of mental health service users/survivors, as this approach was developed out of concerns over 'disability' rather than 'mental distress'. Within his research on mental health, many service users/survivors reject the term 'disability'. To represent service user/survivor voices Beresford suggested the formulation of a specific theoretical framework within Disability Studies to conceptualise experiences of mental distress

(Beresford 2004). Due to Beresford's research numerous scholars, such as Richard Ingram, Brenda LeFrançois, and more recently Jasna Russo, have helped to formulate the concept of MAD Studies as a sub-discipline of Disability Studies. From LeFrançois et al.'s (2013) perspective, MAD Studies utilises knowledge from Disability Studies, the anti-psychiatry movement, and Mad Pride activism to critically evaluate the construction of 'mental illness' and to reclaim 'madness' from a service user's standpoint.

From a MAD Studies perspective, the psychiatric system is not scientifically neutral but ideologically driven and needs to be critically examined and held accountable for their oppressive practices (Macdonald, et al. 2018). MAD Studies is a unique examination of psychiatry and psychiatric services; for example, there are critiques of the pathological construction of mental 'illness', the use of medication as a system of social control, the legal acceptance of forced institutionalised care, and the continual use of hospital restraints and Electroconvulsive Therapy. As Filson (2016: 46) illustrates, the psychiatric system often misinterprets service users' stories of 'what happened to us' as 'what is wrong with us'. As Filson explains, the psychiatric system has ownership over the construction of knowledge that defines professional practices under the discourse of 'medical treatment'. Thus, by applying a Disability/MAD Studies approach within criminology, this study aims to analyse the lived experiences of service users/survivors and their allies to conceptualise oppressive and harmful practices by presenting examples of routine institutional violence within mental health services.

Hospitalisation, Restraint and Violence

To examine criminal, dehumanising and harmful practices within hospitals and care homes the author has drawn on the emergence of theoretical ideas from within critical criminology and MAD Studies (see Dowse et al. 2008). This is to offer criminology an alternative critical perspective to mental health other than that of the dominant forensic psychological, i.e. bio-medical, approaches which define mental 'illness' within criminal justice practices. This conceptualisation of psychiatric treatments as harmful rather than therapeutic is a common theme that has emerged from critical approaches to psychiatric practices from disciplines such as critical psychiatry, the anti-psychiatry movement, and MAD Studies (Szasz 2007; LeFrançois et al. 2013; Middleton and Moncrieff 2019). From a bio-medical perspective, there are countless psychiatric studies which define mental 'illness' as a bio-social reality that can be successfully treated with pharmaceutical interventions (Semple and Smyth 2019), hospitalisation (Johnstone 1999; Steinert et al. 2000; Walsh 2002) and electroconvulsive therapy (Fitzgerald et al. 2015; Moeller et al. 2017; Nuninga et al. 2018). Yet critiques have emerged for MAD Studies scholarship that has questioned the effectiveness of psychiatry's biological reductionist methods of treatments (LeFrançois et al. 2013; Weitz 2013; Russo and Sweeney 2016). As Menzies et al. (2013) suggest, hospital-based psychiatric treatments are often ineffective and are described by many service users/survivors as harmful, escalating rather than reducing experiences of mental distress. The extensive use of restraint, forced hospitalisation and forced medication has been conceptualised as equating to human/civil rights violations by MAD Studies scholars (Menzies et al. 2013; Weitz 2013; Russo and Sweeney 2016). From a MAD Studies approach, coercion and biomedical violence are such controversial topics in the psychiatric care system because forced hospitalisation and the use of restraint are sanctioned by the State under the Mental Health Act (1983/2007). Thus, medical and nursing staff presume that biomedical violence is part of their daily working

routines. Although psychiatry and its allied disciplines would suggest that compulsory measures such as hospitalisation, seclusion and restraint are generally considered to be used as a last resort to avert acute danger to patients or practitioners, MAD Studies scholars such as Lee (2013) imply that these practices have an important role in objectifying experiences of symbolic violence. In a study by Lepping et al. (2016) comparing the use of restraint in four European countries (Netherlands, Germany, Ireland and the UK), they discovered a relatively consistent use of officially recorded restraints where up to 9.4% of patients were exposed to this practice. Yet cultures of restraint were different depending on each country. For example, the Netherlands and Germany predominantly used the practice of seclusion as a form of restraint and were less likely to use restraint to force the use of medication due to their mental health policies (Lepping et al. 2016). Yet within the UK and Ireland practitioners were more likely to use physical restraint to force the use of medications and to restrict the movement of service users/survivors to prevent violence (Lepping et al. 2016). Research conducted on the use of hospital restraints discovered that the more staff engaged in this practice the more normalised it became, like a routine intervention (Dahan et al. 2018).

The normalisation of restraint has been a significant issue concerning recent media scandals in private commissioned psychiatric residential hospitals (Flynn and Citarella 2013). As Flynn and Citarella (2013) illustrate, the first media scandal occurred when an NHS nurse contacted the BBC to report systemic violence and serious abuse at Winterbourne View Hospital. Winterbourne View was a privately run hospital that aspired to treat patients with autism and learning difficulties with behavioural problems (Flynn and Citarella 2013; Bubb 2014). A senior nurse had reported witnessing bullying, violence and abuse taking place within the hospital and had reported this to senior management in Castlebeck Care and to the Quality Care

Commission (Bubb 2014). However, his concerns were not taken seriously and Winterbourne View was subsequently assessed and rated as outstanding by the Quality Care Commission (Bubb 2014). This led to the nurse contacting the BBC who placed a covert journalist employed as a care assistant in the hospital. The TV programme broadcast significant scenes of violence and abuse that occurred within the hospital. In the aftermath of the BBC investigation, 11 staff members acquired criminal convictions and six of these received a custodial sentence relating to neglect and abuse (Bubb 2014). The UK government conducted a Serious Case Review and concluded that:

‘(1) too many people had been placed in inpatient services for assessment and treatment and has stayed there for too long ... (2) there was evidence of poor quality of care, care planning and over-reliance on restraint techniques’ (Department of Health 2014: 3)

After the Serious Case Review was published by the Department of Health, the Care Quality Commission closed several hospitals that fell short of the standards expected of hospitals and residential care homes (Bubb 2014; Murphy 2019). However, since this Serious Case Review, several other instances have appeared through similar investigations by the media, such as abuse occurring at Ash Count Hospital in London, Purbeck Care Home in Dorset, and Muckamore Abbey Hospital in Belfast. Yet despite claims by the Care Quality Commission to have improved their inspection procedures so that another Winterbourne View could not happen again, the BBC conducted an almost identical investigation into Whorlton Hall Hospital in 2019 (Lacobucci 2019; Murphy 2019). The undercover reporter filmed almost identical forms of physical and psychological abuse occurring on the hospital wards (Murphy 2019). Similar to Winterbourne View Hospital there was an overuse of restraints to instigate

violence between patients and staff. These employees are now also currently under investigation and could face custodial sentences because of the systematic abuse which took place within this hospital (Lacobucci 2019; Murphy 2019).

Yet, these scandals are not new, as in the 1960s, 1970s and 1980s the BBC also conducted several investigations into abuse within historical mental hospitals which revealed similar forms of physical and psychological violence (Jessel and Boulding 2010). These documentaries revealed systematic physical abuse, the overuse of restraint, and widespread psychological violence occurring within these institutions. These investigations intersected with the anti-psychiatry movement which was calling for the end of institutional care for patients with mental health or learning disabilities (Wall 2017). Following the implementation of the Mental Health Act (1983), the NHS moved from a model of NHS funded institutional care to that of a local authority funded community care system. Although in the UK the 1990s have been celebrated as a period of deinstitutionalisation, many scholars from within the anti-psychiatry movement and MAD Studies have questioned the success of this policy initiative (Slovenko 2003; Szasz 2005; LeFrançois et al. 2013; Wall 2017; Macdonald et al. 2018). Scholars such as Szasz (2005) and Macdonald et al. (2018) have suggested that many service users/survivors with significant mental health conditions have been moved from the large state-owned NHS hospitals to smaller privately commissioned hospitals. Thus, at the turn-of-the-century, a number of academics have argued that we are now progressing through a period of trans-institutionalisation, where privately run psychiatric hospitals and residential care homes are replacing the old hospitals as a new form of institutional care for people with learning disabilities and mental health conditions (Slovenko 2003; Szasz 2005; Macdonald et al. 2018).

From a criminological perspective, there has been little focus on the harmful and criminal behaviours occurring within these institutional spaces. In fact, until recently there has only been a small number of studies examining associations between disability, mental health and victimisation (Roulstone et al. 2011; Thomas 2011; Chakraborti and Garland 2015; Macdonald et al. 2017). Yet as disability is now recognised as a protected characteristic within the Criminal Justice Act 2003, concerns around disability hate crime have begun to appear within the literature (Chakraborti and Garland 2015). Unfortunately, as Roulstone et al. (2011) suggest, although disability is now a protected characteristic within criminal justice policy, very few prosecutions have applied hate crime legislation, even in extreme cases of murder. Furthermore, these studies in the field of hate crime have presented some anecdotal evidence that when acts of violence take place by care staff, these acts of violence are not dealt with through the criminal justice system but as a human resource issue (Sherry 2010; Roulstone et al. 2011; Macdonald 2015). Although more research is needed, if these disability hate crime scholars are correct then care employees are often dismissed from their employment rather than prosecuted for committing a criminal offence (Sherry 2010; Roulstone et al. 2011; 2013).

This study will present the narratives of psychiatric service users/survivors to challenge the notion that these hospitals are safe spaces free of violence and abuse. As it was senior nurses who were the whistle-blowers in the Winterbourne View and Whorlton Hall hospitals, for this reason, service user voices will appear alongside voices of practitioners and family members throughout the findings section. The stories presented in this article will be both historical and contemporary as patients, family members, and practitioners present narratives from throughout their life histories. The study presents narratives concerning experiences of

criminal violence and narratives of dehumanising and harmful practices concerning psychiatric treatments.

Methodology

Design: The article aimed to explore risk factors concerning criminality and social harms, oppressive and harmful practices within hospitals, and evidence that violence occurs within these institutionalised settings. The study sought to collect the biographical narratives of individuals who had experienced severe mental distress in a pre- and post- (de)institutional care setting (pre- and post-Mental Health Act 1983). By comparing staff and service user/survivor experiences of long-term care, the study's intention is to comprehend the lived experiences of people diagnosed as having a long-term mental health condition in the contemporary care system. This qualitative study analysed the biographical narratives of people with mental health conditions by using Wengraf's (2001) and Bertaux's (2003) biographical interviewing technique. Semi-structured interviews lasting between thirty minutes and two hours were undertaken. Each participant was interviewed in accordance with the biographical interpretative method of interviewing (Wengraf 2001). Participants were asked the same single question to induce narrative: *'Can you please tell me your life story, with all the events and experiences which you feel relevant, concerning your life?'* (Wengraf 2001: 119). Once participants had discussed their life stories, probing questions were asked so participants could expand on key aspects of their life stories concerning experiences of long-term care (Wengraf 2001; Bertaux's 2003).

However, probing questions were limited to avoid interview bias. Thus, this approach asks only a small number of focused questions relating to participants' life experiences. By limiting

questions, this encourages a biographical narrative that gives more control to the participant and restricts the interviewee from being drawn into a structured hierarchy (Wengraf 2001). The importance of this kind of interview is that participants were allowed to start their life story at any historic point they chose, enabling them to speak freely about their position in relation to the research issue raised. It also allowed participants to translate their own events, themes and meanings within their own biographies to produce their own narratives.

Sample: In total sixteen participants were interviewed, consisting of nine service users/survivors, three family members and four psychiatric practitioners. The study employed a snowball sample where information was sent out to local health and social care services in the North East to facilitate recruitment. Hence, a number of social work/social care/nursing practitioners helped the research team promote the study to recruit service user/family volunteers. Service users/survivors were recruited who had experienced hospitalisation because of a diagnosed mental health condition. They had all experienced long-term hospitalisation between 1975 and 2014, which was defined in this study as a minimum period of six months in the hospital. All service users/survivors were still receiving support due to their long-term mental health conditions. The age of service users/survivors ranged from 55 to 71 years. All service users/survivors were from a white ethnic background, and more male service users/survivors (n = 6) were interviewed compared to females (n = 3). Although black and minority ethnic (BAME) communities are overrepresented in psychiatric services in the UK, and people from these communities are more likely to be diagnosed with a significant mental health problem (Bradley 2009), this was not reaffirmed by this study. It should be noted that the North East of England has the lowest BAME population in England, at 6% compared to the national average of 19% (ONS 2011). When conducting the research the

team observed that there was a visible lack of BAME service users/survivors accessing psychiatric residential and community care services, and this may account for why no BAME service users/survivors volunteered to take part in this study. However, the majority of service users/survivors were from traditional working-class backgrounds (n = 8), with one participant defining himself as middle-class.

The psychiatric practitioners had all been employed within a mental hospital before or during the implementation of the Mental Health Act (1983). They had actively worked in health or social care services during the 1990s, and had witnessed the transition from hospital-based care to community care services. With reference to the practitioner group, two female participants were from a white ethnic background and two male practitioners were from black/Asian ethnic minority communities. The majority of practitioners described growing up in a traditional working-class setting (n = 3), with one participant indicating that they were from a middle-class family. Finally, all family members who were included in the study had actively visited and/or been part of supporting a close family member throughout their time as a service user. The age of family members ranged from 50 to 72 years. Two of the female family members were from a white ethnic background and one male family member was from a black ethnic minority community. All family members interviewed could be defined as growing up within a traditional working-class community. Interviews in the study took place in 2014–2016, in the North East of England.

Analysis: A phenomenological approach was used to interpret the biographical narratives of participants in this study (Kafai 2013), presenting participants' interpretations of their life events to situate the analysis from a service user/survivor perspective in line with MAD

Studies. By employing Daniel Bertaux's (2003) methodology to service users'/survivors' biographical narratives, the findings explored personal experiences of social change (Bertaux 2003; Kafai 2013). *N-Vivo* was used to help organise the data to apply a thematic analysis to the research. To protect the identities of participants, pseudonyms are used to represent the narratives of participants throughout the findings section of this article. Full ethical approval was gained by the research team from the host university as well as through the relevant health and social care organisations before the research commenced.

Finally, within the data findings, psychiatric services will be defined by a single historical point identified by the Mental Health Act 1983. This Mental Health Act is a significant milestone in UK health policy as it ended long-term institutional hospital care. Within the UK this Act of parliament led to the deinstitutionalisation of psychiatric services and the introduction of community care services. Therefore, the findings will indicate and compare the time frames of pre-Mental Health Act as historical, i.e. institutional, and post-Mental Health Act as contemporary, i.e. community-based care.

Limitations: It should be recognised that no definitive conclusions can be drawn from this article as there were several limitations to the study. This study was exploratory in nature and aimed to target a relatively hidden and hard-to-reach community so a small snowball sample was employed that significantly affects the representativeness of the findings. Due to the study's small sample size, the research does not claim to be representative of any group outside of the sample. Experiences of violence were also self-reported, and no objective measurement was used to categorise these experiences. Thus, participants' knowledge was accepted as a valid representation of their constructed realities. Although these limitations

exist, and the study cannot and does not attempt to estimate the extent of violence in residential and psychiatric hospitals, the data presents some interesting theoretical findings that need further exploration.

Findings: Employment Motivations and Dehumanising Attitudes

In the data findings, a dominant theme emerged relating to risk factors associated with dehumanising attitudes. Reports of dehumanising attitudes occurred in the narratives of practitioners, service users/survivors and family members within the historical mental hospitals (pre-1983), and in contemporary residential care units and psychiatric hospitals (post-1983). From a practitioner perspective, a fundamental issue that led to increased risk factors concerning dehumanising attitudes was the motivations and working ethos of staff employed within these care environments. Both within the pre-1983 and post-1983 care systems it was narrated that employees had often left low-paid and insecure manual occupations before relocating into the care industry. A number of practitioner participants suggested that they had known that the motivation of many of their colleagues working in the care industry was not because this was a vocation but due to it being secure work in a region with high levels of unemployment. As Christopher illustrates:

I think a lot of the [people] who worked in the hospital had come from industries which they didn't particularly like. So they weren't necessarily in the hospital because they had a passion for caring for people, but it was a job that was secure and they were in control and they didn't have to do very much. ... [Because of this] there were some people who were absolutely vicious and cruel.

(Christopher: mental health nurse)

Within Christopher's narrative, he is describing the attitudes of mental health nurses who he worked alongside in the 1970s and 1980s in historical mental hospitals (pre-1983). However, similar narratives emerge from practitioners working in contemporary residential care units and psychiatric hospitals (post-1983). This is illustrated by Joanne, a senior care manager, who reports similar motivations that she associates with negative working attitudes. Within her narrative, she often described these employees as 'uneducated' and 'underqualified'. As she states:

I've seen people with crappy attitudes I think is the word I would use, more uneducated attitudes. You know what I mean? ... Where they would think that they could speak to somebody the way they did because, so if I did see anything like that, I would pull them and I would say, 'You can't talk to somebody like this'.

(Joanne: care manager)

Joanne reports that, because of low wages, finding the right staff who are suitable for care work is a particular problem in the contemporary system. Joanne, similar to Christopher, suggests that for some of her employees the choice to work in the care industry was not made for moral reasons but due to limited employment opportunities. From her perspective, the disregard for service users'/survivors' emotional well-being predominantly occurs because the majority of residential care units have now been privatised and are run for profit. From her perspective, these organisations are looking for cheap staff and offer limited training. The implications of having inappropriately motivated and undertrained staff have had significant

consequences, both in the historical and contemporary care systems, with regard to the emergence of coercive violence.

Narratives of Restraint

Within the data analysis, although glimpses of dehumanising attitudes emerged from within practitioner narratives, the most normalised oppressive and harmful practices within hospitals in the pre- and post-1983 care eras refers to the excessive use of restraint. The use of restraint was portrayed by participants as being the most commonly administered example of dehumanising and harmful practices employed within hospital settings. Within the narratives of practitioners, the use of restraint was often justified as a response to violent incidents with service users/survivors. As Johnny, a mental health nurse reported:

I've seen people physically restrained because if somebody is going to be violent or aggressive or something like that and, you know, there were techniques, and I was trained in that technique. I've been involved in that, but physically abused or giving, I don't know, a clip or something, I've never seen that.

(Johnny: mental health nurse)

Although Johnny acknowledged the practicality of restraint in his own professional practice, he did not conceptualise this as a form of violence. In fact, from his perspective using physical restraint in his professional practice is acceptable (under the Mental Health Act 1983), but he clearly separated this practice from the use of physical harmful or abusive/criminal behaviours. Similar to Joanne, Johnny suggested that he had never witnessed any form of physical abuse other than restraint. From his perspective, the use of restraint is an

unavoidable procedure due to the nature of his work, and this practice is employed primarily to protect service users/survivors and staff from injury.

In Joanne's narrative, she recounted that it was not until later in her career, after the year 1999, where she was introduced to the practice of restraint (post-1983). This was due to a change in her employment, as previously she had worked in small residential units where restraint was never used. Within her narrative, when discovering that restraint was commonly used within her new care setting she described that this had an emotional impact on her as a new member of staff:

Yeah. I never realised when I applied for the job that there was going to be restraint involved. So when they started talking about restraint, I was going, 'Are you allowed to do this?' You know what I mean? My first day was a twelve-hour shift and again I couldn't really do anything because I hadn't had the training. ... It was my first day when I seen a lady restrained and that's why I said I would never go back. I thought it was horrific. It was a lady and she tried to attack a member of staff and she had to be taken to the floor and she was restrained in a T-supine position which means she was laid on her back in a T position with four members of staff that restrained [her]. And for a person who's never seen restraint before, didn't really understand why it was there, to see this lady on the floor was like, it was horrific. I'd gone home and I'd talked to my partner and I said, 'I don't want to go back'. I said, 'I don't know if I can do that', but I did.

(Joanne: care manager)

Within Joanne's narrative, at first, she considered resigning from her new position after witnessing a restraint, but her attitude to restraint changed and the process of normalisation occurred within her narrative. Joanne did not report observing service user/survivor violence until starting to work in this institution. Within her narrative, there seems to be an interesting change between her experiences of working in smaller residential care units where restraint was not used to larger psychiatric hospitals where restraint appeared to be normal practice. Within her narrative, she individualised the characteristics of service users/survivors in that particular institution as 'risky' and 'violent' to justify the use of restraint:

Very challenging behaviour, yeah, it was the place where I was at for people who would be considered a danger in the community. ... They had their own rooms, personalised rooms, had big-screen TVs. So it was a mixture between a hospital and a home setting.

(Joanne: care manager)

For Joanne, these service users/survivors were conceptualised as inherently violent and their behaviour needed controlling. From her perspective, the use of restraint bestowed security and protection to staff and other service users/survivors within this hospital setting. From a service user/survivor perspective, a number of participants reported being restrained both in the pre- and post-1983 hospitals. Harry was somewhat representative of service users'/survivors' views of why restraint occurs in certain hospitals. From his perspective, the use of restraint usually occurred to control behaviour within busy (post-1983) psychiatric hospitals. He described these hospital environments as 'chaotic':

[These hospitals are] pretty chaotic and I was glad to get out. I didn't see it as a help and I don't think I got the support. I was glad to get away.'

(Harry: service user/survivor)

Another service user, Jack, also described violence occurring in these often chaotic psychiatric hospital environments, where he described witnessing the use of restraint on other patients due to violence. As Jack reported:

Some of the patients could be angry and nasty and the odd one would be violent. I'd seen people held down and took off the ward to the, it's called the Picard Ward now, but it was for people who get violent and stuff like that.

(Jack: service user/survivor)

Within Jack's narrative, he described how violence was often accompanied by the use of restraint. He also described that patients who are restrained are often transferred to another ward for a period of time. However, one of the female participants, Donna, experienced a slightly different practice of restraint from other service users/survivors as she described that restraint took place alongside solitary confinement. Within her narrative, she explained how she found this experience particularly upsetting, and from her perspective, it offered no therapeutic rewards.

Yes [restraint was used] and they locked me in [a room]. I don't know if that was in [name of North East hospital] or [name of South East hospital]. ... I had to be

locked up because I was being naughty ... I had to scream for somebody to come but I don't know if they heard us.

(Donna: service user/survivor)

She described the administration of restraint as a system of punishment in order to control her disruptive behaviour on the wards. Within her narrative, we can observe that Donna was not only restrained but also confined and isolated for a period after a restraint occurred. She reported that these experiences were particularly traumatic. From Donna's narrative, this gives us an example of how restraint and isolation were used in conjunction with each other as a system of disciplinary control for this service user/survivor.

Coercive Violence and Power

When observing if criminality occurs within institutionalised care settings, practitioners, service users and family members described examples of coercive and sometimes criminal violence. It is through the testimonies of practitioners where we can see the clearest examples of how coercive violence operates and may have affected incidents described by service users and family members within this study. The most detailed example of coercive violence is illustrated by Christopher. He suggested that on numerous occasions throughout his career he had been 'set up' by members of staff who manipulated patients for entertainment purposes or to relieve boredom in a ward.

Deliberately they [senior nurses] left us in charge while they went on their lunch, but it was meant to be for half-an-hour. They were away for about two hours. So by the time they came back, we knew we'd been set up because what happened

in that first half-an-hour was that one of the patients who they were very close to, decided to have a go about who was in charge. 'I'm in charge, you're not in charge!'

(Christopher: mental health nurse)

Throughout Christopher's narrative, he separated nurses who were committed to the care of patients from those who he often described as 'cruel'. He explained that abusive sub-cultures often emerged on certain wards because of particular uncaring attitudes, and suggested that particular members of staff were 'absolutely vicious and cruel' which resulted in the 'setting up' of scenarios for patients engineered to entertain staff and relieve boredom.

There was people there who brought their own baggage in. So I mean very early on in my time there as a student nurse, two people tried to show me how to hit people with wet towels to, you know, you could leave no bruising. ... And there was a guy in there who was a qualified nurse who decided to put some aftershave onto this old man's testicles. He was a big guy. So he was known to be aggressive. ... So what happened was that they set this guy up, put this stuff on his balls. He then came running up the ward, you know, I had to calm him down and immediately I realised what had happened. So I took him for a bath. I took him for a bath and I bathed him and he was really kind with me after that.

(Christopher: mental health nurse)

Within his narrative 'being set up' by other nursing staff became a prominent feature of abuse and 'entertainment' within the pre-1983 mental hospitals. Christopher described examples

of abuse where service users/survivors and staff were taunted, manipulated, or even assaulted in these hospitals. He illustrated that these assaults were rarely administered by the nursing staff but occurred from the manipulation of patients, where scenarios were created with the intention of coercing patients into carrying out the assaults on other patients or members of staff. From a service user/survivor perspective there was some evidence of this form of coercive violence emerging from their narratives. It should be noted that examples of violence by other patients were discussed by the majority of service users/survivors in pre- and post-1983 hospitals, and although service users/survivors described some nursing and care staff as 'cruel', no participant reported being physically assaulted by a staff member. However, Christopher's account of how coercive violence operates on the wards may help frame some of the incidents described by service users/survivors in this study. An example of what may have been coercive violence was discussed by a female service user/survivor describing an incident concerning other patients (pre-1983). Donna reported voluntarily putting her head through a window because of the encouragement of other patients. As Donna states:

These two patients dared me to put my head through the window and I did it. And I've [still] got all the scars on the side of my head.

(Donna: service user/survivor)

Donna could not verbalise why she carried out this act of self-harm and reported that she just wanted to comply with the wishes of these patients. When describing this act Donna pointed to the scarring on her head which was still visible many years later. When asked how the nursing staff responded to this particular act Donna could not recall any repercussions for the

patients who encouraged this act of self-harm. One of Donna's family members, Gloria, also described this incident within her narrative, yet the coercive aspect was not illustrated as a central concern; the key emphasis of Gloria's narrative was on the act of her sister voluntarily smashing her head through a glass window. From Gloria's perspective, this act seemed to illustrate how mentally 'unwell' Donna was during this time and at no point was the quality of care questioned by Gloria. This seems to illustrate the power dynamics and attitudes of trust between nursing staff/carers, service users/survivors, and family members. As Gloria states:

I don't know what made her do this, but she said somebody told her to do it so she did it. Then she put her head through the window at [North East mental hospital] and that's why they kept her in longer.

(Gloria: family member)

Gloria reports that a consequence of this act was an extension of Donna's hospitalisation. Although there is no evidence that this particular incident was instigated by nursing or care staff, the impact of this incident did not seem to lead to any form of investigation into nursing malpractice but resulted in further forced hospitalisation for the service user/survivor.

A contemporary example (post-1983) of coercive violence was illustrated by Jack when sectioned in a psychiatric hospital. Within this example, the coercive aspect of his experience was not instigated by another patient but by a member of the care team. This experience intensified his suicidal feelings. As Jack reports:

I mean I had no bother with most of the staff. ... But this one staff member come down, he was pretty abusive. ... I was very poorly and he made us a bit suicidal to be honest. ... I'd put in a complaint funnily enough. I just said he'd shouted at us to one of the other staff members. Another staff member came down and said I was a liar that I'd just made it up.

(Jack: service user/survivor)

Within Jack's narrative, no physical abuse took place by staff but he does describe these interactions which he considers abusive and harmful. What differs between Jack's and Donna's narratives is that Jack made a complaint to another care practitioner. Unfortunately, although he made a complaint about this particular staff member, he describes being dismissed as dishonest. As Jack discusses, this had a significant impact on his mental health which intensified his suicidal feelings. Similar to Donna, no investigation took place and from his perspective, his voice was disregarded by the hospital. Jack reports that a consequence of these staff attitudes and his frustration of being hospitalised resulted in an increase in self-harm. *'I used to bang my head off the walls and punch the walls. That was out of anger mostly.'* Similar to Donna's experiences, his responses to these oppressive practices always led to a restriction of his privileges or an extension of forced hospitalisation. From his perspective, hospital and care employees were never questioned and the acts of violence or self-harm were always conceptualised as symptoms of his 'illness'.

From a practitioner's perspective, Joanne acknowledged that abusive cultures could emerge within the contemporary psychiatric hospitals or residential care units similar to those of the historical mental hospitals. As she suggested:

I mean I would never say that there wasn't any abuse where I worked, but I could say there was always potential. I could see how easy the card could be flipped because of the power that you have with the restraints, with these people being sectioned, with the locked doors. You know what I mean? I could understand how that happened down in Winterbourne View. ... I think in them environments there are cultures built up because you were working fourteen-hour shifts.

(Joanne: care manager)

From Joanne's perspective, although she had not witnessed any forms of physical or coercive violence when working in professional practice, she accepted how coercive sub-cultures could develop within a care setting. Although she acknowledged that she had witnessed poor attitudes by staff, she also recognised how these attitudes could develop into forms of institutional violence. Within her narrative, she referred to the criminal case of Winterbourne View and conceded the potential for violence occurring within these contemporary institutions by acknowledging how difficult physical or coercive violence would be to detect.

Discussion

Although the hospital is conceptualised as an environment of care, this article has presented some evidence that this institution can also be a space where violence and abuse can manifest itself. Although criminology has very rarely explored the hospital as an institution of harm, the author suggests that due to recent scandals the psychiatric hospital could in some cases create a space where criminal and abusive activities can flourish. By examining the experiences of participants, the data findings reveal small windows of dehumanising harmful

practices and coercive violence that were present both within pre- and post-1983 psychiatric hospitals. This was particularly exposed in the practitioners' narratives concerning how coercive violence arose within pre- and post-1983 hospitals. Interestingly, a number of these practitioners suggested that underqualified, underpaid, and disillusioned staff, and the size of an institution, led to the risk of coercive violence within the hospital and residential environments.

The data findings also portrayed corresponding narratives that emerged from family members concerning these oppressive practices. Similar to practitioners, family members were also extremely critical of the use of restraint within hospitals. Yet it should be noted that even when serious incidents occurred, such as relatives enduring injury, these participants very rarely questioned the treatment or techniques used by psychiatric professionals. The findings seem to reveal that family members in this study did not confront the power dynamics which operated within these hospital environments, even though they sometimes conceptualised these treatments as oppressive. From a service user/survivor perspective, most participants described negative experiences that they conceptualised as harmful. Service users/survivors reported significant feelings of distress relating to forced hospitalisation, restraint by staff, and violence dispensed by other patients. Thus, although this study did not reveal many incidents of criminal violence, this article opens up the debate about whether mental health hospitals may be conceptualised as potential sites of coercion and harm, as well as care, noteworthy of contemporary criminological investigation.

Implications for Practice

This article illustrates several significant issues that have implications for professional practice. Firstly, although this study found little evidence of criminal violence perpetrated by staff towards service users, the data did reveal some evidence of dehumanising and harmful practices concerning restraint. Key concerns that emerged from the data analysis were harmful attitudes by certain members of staff and coercive forms of violence within these institutions. Senior practitioners also raised concerns relating to appropriate levels of training and the professional commitment of some employees. The author would argue that privatisation has led to the deprofessionalisation of care staff within these institutions. Thus, to reduce the chances of violence and social harms within these institutions staff should require entry qualifications and professional training to work within these highly stressful and complex environments. Furthermore, to attract employees of this calibre institutions must reward staff with acceptable pay scales rather than minimum wage salaries, and this may reduce risk factors associated with the prevalence of violence that emerged in this study.

Secondly, the data revealed that staff in larger institutions were more likely to use restraint in their day-to-day practices. Over recent years we have seen the growth of larger institutions housing a greater number of service users for an increased length of time (Burki 2018). Thus, if mental health services continue commissioning the use of larger residential care homes and psychiatric hospitals, then history may repeat itself and these contemporary 21st-century institutions could run the risk of becoming replicas of the historical 19th- and 20th-century mental hospitals/asylums, which are described by some historians as 'warehouses for the mad' (Shorter 1996).

Finally, this article has applied Disability Theory within a criminological context. By doing this the data analysis has been guided by service user/survivor voices to interpret and comprehend experiences of violence and harm. Within the data analysis, similarities and distinctions were drawn between service users/survivors, family members and practitioners; however, these different narratives revealed glimpses of criminality, violence, and social harms within these institutional environments. Therefore, this article advocates for future criminological research to move away from the biomedical interpretation of disability and mental health to a critical perspective which is emerging from contemporary scholarship within Disability Studies and criminology (Dowse et al. 2008; Sherry 2010; Macdonald 2012; 2015; Voronka 2013).

Conclusion

This article has presented data examining violence and harm within mental health services which is relevant to criminology. The study indicates that contemporary residential care homes and psychiatric hospitals are not free from violence and social harms. As this study illustrates, there were a number of examples where violence was prevalent within these institutions. Thus, the article argues that these institutions are legitimate sites for criminological investigations into confinement, criminality and its associated social harms. The study has been theoretically inspired by Disability Studies, and in particular by scholarship from the sub-discipline of MAD Studies. From a MAD Studies perspective, it is vital to employ a constructionist framework to critically evaluate aspects of bio-medical oppressive practices drawn from the lived experiences of service users/survivors and their allies (Faulkner 2017). As LeFrançois (2013) proposes, by applying a MAD Studies perspective, practitioners can allow a safe space to bring together service users/survivors to facilitate anti-oppressive ideas

concerning treatments. Hence, the simple task of listening to service users'/survivors' voices, and their allies, may give rise to social justice and empowerment for these individuals who have been made vulnerable to institutional harms and violence within these hospital and residential settings.

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