Damaging dichotomies and confounding contradictions in mental health inpatient nursing:
Lessons learned from Orwell's *1984*

Michael Haslam & Keir Harding

Abstract

Purpose: Our discursive paper considers the use of restrictive practices in mental health inpatient settings and how these are often prioritised over relational approaches, especially where the diagnostic label of personality disorder intersects with risk.

Approach: Key concepts from Orwell's *1984* are studied for their pertinence to mental health inpatient settings, supporting our argument that restrictive practices arise from dichotomous thinking and externalised fears.

Findings: Drawing upon Orwellian themes of power, social control, and digital surveillance from *1984*, we highlight the role of fear in perpetuating restrictive practices under a guise of benevolent care in mental health inpatient settings, especially for those who are diagnosed with a personality disorder. A lack of preparedness to work with complexity in such environments, coupled with a deficit in self-reflexivity and critical thinking, can exacerbate challenges.

Originality/value: We use Orwell's novel to support a critical discourse around those damaging dichotomies and inherent contradictions that contribute to restrictive practice in contemporary mental health settings and to question whose interests' these restrictive practices serve.

Implications: To transcend damaging dichotomies and reduce restrictive practices in inpatient settings, we make the argument for the adequate preparation and education of the mental health nurse and authentic, collaborative, user-involved care.

Keywords

Personality Disorder; risk-aversion; restrictive practice; inpatient; mental health nursing; risk management; fear; anxiety; relational practice

Introduction

Our discursive paper seeks to highlight how restrictive practice is prioritised within mental health inpatient settings, over the relational and interpersonal approaches needed, especially when working with service users with the diagnostic label of personality disorder. In our paper, the links throughout to Orwellian themes of power, coercive social control, and digital surveillance, are purposeful; George Orwell's *1984* (Orwell, 1949) providing a framework against which we intend to explore the use of restrictive practice (as referring to the use of both chemical and physical restraint) for this patient group in mental health inpatient settings.

Published 75 years ago this year, the relevance of this novel's themes have never been more pertinent to contemporary mental health inpatient care in the UK, given the failure by the previous UK government to see through planned reforms of the Mental Health Act, despite its perceived obsolescence (Thomas, 2023). The necessity, however, for such reforms were illustrated not too long ago by the BBC undercover program, '*Panorama'* (Panorama, 2022) and the ensuing independent review (Shanley, 2024); both which exposed indefensible cultures of restrictive practice and abuse in mental health inpatient settings. And in highlighting concerns, they have figuratively pricked our collective professional consciences, all while posing an existential challenge to our very 'being' as mental health clinicians.

While we acknowledge that within mental health nursing some of the strategies used to contain people physically may be necessary to ensure the physical safety of those under the care of inpatient services (Crowe & Carlyle, 2003), and for some may even form an essential element of a healthy therapeutic milieu within such settings (Winship, 1998; 2006), we may also be failing to recognise the inherent harms caused by the routine use of such measures and how they may reinforce for the service user, feelings of powerlessness, and a sense of dehumanisation, and stigma (Gillespie & McEwan, 2019). Our central argument here, is that under particular situational forces (Zimbardo, 2007), risk management strategies can go beyond a benevolent paternalism, possibly even legitimising violence, in an attempt to alleviate the fears and anxieties of society, the organisation and individual mental health nurses.

Furthermore, despite our focus in this paper being upon risk-averse cultures and restrictive practices within inpatient settings, we also acknowledge a parallel argument, critical of those narratives that justify the inaction of services and individual mental health nurses (Fisher, 2023; Beale, 2022; Ware, *et al.* 2022) under the guise of 'positive risk-taking'. We argue, however, that such practices might be considered the reverse side of the same coin, also arising from dichotomous thinking and externalised fears, and so carry the same risk of iatrogenic harm. Such practices can also be, and often are, the antithesis of the relational, collaborative approaches needed to support those experiencing mental distress.

Our objective here, is not necessarily to discourage, or to attribute moral judgment to, colleagues currently employed within mental health inpatient services, but instead, to use Orwell's novel as an analogy to explore the impact of those broader political and institutional forces upon mental health nursing practice. Our hope is that this paper will gently prompt individuals to critically examine their own practice, identifying areas of cognitive dissonance and to ensure that personal practices reflect a therapeutic milieu.

"*Doublethink*": Examining inherent contradictions within mental health inpatient care

In his novel, *1984*, Orwell coined the term: "*Doublethink*"; an idea that a person can hold two contradictory beliefs in their mind simultaneously, while accepting both as true (Orwell, 1949). The obvious contradictions in the novel, "*War is Peace*", "*Freedom is Slavery*" and "*Ignorance is Strength,*" are examples of doublethink used as propaganda by a totalitarian government to undermine the autonomy and individuality of its citizens, thus establishing a culture

of fear to maintain social control. Our application of these contradictory phrases to mental health inpatient settings, is used to frame discussions around those inherent contradictions already existing within mental health nursing practice, and to support a critical discourse around the use of power and restrictive measures under the rhetoric of benevolent care, specifically in environments where staff are fearful, lack the adequate resources to perform their role effectively, and are inadequately prepared to work with service users labelled with a personality disorder diagnosis.

"*War is Peace*": the identification and physical containment of the 'other'

We begin by discussing the first contradiction within *1984*: "*War is Peace*" (Orwell, 1949), representing how people are united through the fear of a common enemy. In the novel, this fear is used both as a device to justify poor conditions, and to maintain social order. This first contradiction, we argue, has a relevance to those practice settings where restrictive measures implemented in response to complexity are founded upon dichotomous thinking and legitimised by fears and anxieties experienced in respect of perceived risk.

The dominant discourse around safety in mental health inpatient settings, at least at face value, appears compatible with ethical mental health nursing practice, implying a benevolent obligation to protect the individual through the mitigation of potential harms. Our argument, however, is that risk management strategies are often counter-productive given that they are misused and often have little to do with the service user and their actual presentation (Felton, *et al*. 2018; Wright, *et al.* 2007). Paternalistic, restrictive practices are borne out of, and legitimised by the fears and anxieties arising from the potential harms posed by those with mental ill-health to wider society, the mental health nurse, and their organisation (Kolar, *et al.* 2023; Slemon, *et al.* 2017).

Beginning first with the fear experienced at a societal level, western representations construct those with mental ill-health as being of a fundamental difference, feeding into a popular public perception and discourse that when acutely unwell, mental health service users represent the potential to pose harm to self and others (Kolar, *et al.* 2023). In a parallel with Emmanuel Goldstein's role in Orwell's *1984* as the primal source of public fear and revulsion, a damaging dichotomy is established here, positioning the mental health service user as the 'other'; as diametrically opposed to the 'self' (Wright, *et al*. 2007; Mckeown, & Stowell-Smith, 2006). As a consequence of this demarcation, the chances of denigration and exclusion of the individual are increased, especially at the intersection between the diagnostic label of personality disorder and risk. This dichotomous thinking is also conveniently aligned with, and so reinforces those toxic neoliberal dichotomies that emphasise 'us and them' and 'deserving vs undeserving' cultures (Collier-Sewell & Melino, 2023).

In relation to those experiencing mental ill-health, this public identification of embodied difference (Shildrick, 2002) or 'otherness' (Wright, *et al.* 2007; Mckeown, & Stowell-Smith, 2006) therefore permit us to view mental health inpatient settings through a similar lens to that with which Goffman (1961) and Foucault (1967) regarded historical psychiatric institutions. Beyond their principal purpose of ensuring the physical safety of all (Veale, *et al.* 2023; Bowers, *et al.* 2005), mental health inpatient settings may function as both a *physical* and a *psychic* barrier (Mckeown, & Stowell-Smith, 2006) fixing the 'other' at a safe distance of both society and the 'self' (Shildrick, 2002).

Such a position allows us to consider the notion that it is society who is the ultimate end-user of psychiatry; mental health inpatient units existing as contemporary 'containers' of, and as defences against, collective anxieties (Bion, 1961). It is within this context, that organisations are served with a mandate to pathologise, and supported via legislative frameworks, to incarcerate service users (Kolar, *et al.* 2023), especially those of whom exhibit risk behaviours that provoke visceral emotional responses (Harding, *et al.* 2020). Not unlike the society depicted in

Orwell's *1984*, institutions are therefore sanctioned to inaugurate paternalistic measures, serving the dual purpose of both maintaining social order, and alleviating public fears and anxiety, through the medicalisation and surveillance of individuals whose behaviours deviate from cultural norms (Foucault, 1967). For the mental health nurse working in inpatient settings, this sets the stage for tensions at a more individual level between the desire to deliver person-centred psychotherapeutic care, and shouldering the accountability for patient and public safety (Kanerva, *et al.* 2016).

This accountability leads us to consider how the focus of service user risk extends beyond the potential for direct physical harms to self and others, to also encompass those indirect occupational, professional, and reputational costs. A fear of criticism, blame, sanctions and even a threat of litigation can perpetuate defensive practises (Beale, 2022; Ware*, et al.* 2022; Ahmed, *et al,* 2021; Slemon, *et al.* 2017; Higgins, *et al.* 2015) fostering cultures of risk-aversion and restriction. This issue is further amplified, however, where risk issues intersect with the diagnostic label of personality disorder; structural stigma and personal affective heuristics having the potential to colour clinician perceptions of risk (Blumenthal, *et al.* 2018).

Consequently, we argue that restrictive risk-management approaches in inpatient settings can be less a method of providing benevolent and optimal care, and more a means of self-preservation for the mental health nurse in the face of potential adverse events (Veale, *et al.* 2023; Ahmed, *et al.* 2021). The danger here is that in risk-centric organisations and teams, risks posed to the service user become secondary; the clinician's primary focus being upon the management of risk to the self and their organisation (Harding, *et al.* 2020). And so clinical decisions are made in respect of anxieties around perceived risk, over those factors perhaps more relevant to service user presentation (Felton, *et al,* 2018; Wright, *et al.* 2007). Such a position is not a new one, if we consider those observations of Menzies Lyth, regarding the management of staff anxieties in hospital settings that ultimately prioritised the needs of the institution over those of its patients (Menzies Lyth, 1988).

Often overlooked, however, are those iatrogenic harms experienced by service users, arising from such practices. Beyond the use of physical force and coercive measures justified under declarations of 'last resort' and 'best interests', more subtle forms of harm such as discrimination and blame resulting from countertransference enactments, and the loss of independence and self-determination are also possible within an organisational culture of risk-aversion and restrictive practice. These reinforce for the service user, a sense of powerlessness, dehumanisation, and stigma (Gillespie & McEwan, 2019). Yet in the face of indifferent mental health nurses, these harms are rarely, if ever, acknowledged (Coffey, *et al.* 2017); the dehumanisation of service users clouding a person's view like a 'cortical cataract' (Zimbardo, 2007, pg.xii).

Moreover, a focus upon strategies to ensure physical safety alone as a way of mitigating those harms to the organisation and individual mental health nurse, may result in a reduction in service users' emotional safety, given that this may remove their own method of dealing with intense emotions (Veale, *et al.* 2023; Harding, *et al.* 2020). Indeed, restrictive, coercive treatments and infringements on autonomy, are said to be contributors, and even provocations, to aggression (Jenkin, *et al.* 2022), and for some, may increase rather than decrease levels of mental distress (Ware, *et al.* 2022). Such measures defy those recovery-orientated approaches which emphasise self-determination by re-enabling those with mental ill-health to take back, rather than relinquish control (Deering, *et al.* 2019; Felton, *et al.* 2018). This is particularly problematic for those service users who are diagnosed with a personality disorder and who have experienced a misuse of power in their lives (Johnstone, *et al.* 2018).

Fundamentally, the public fears and anxieties we have described here in respect of perceived service user risk, parallel those themes of fear, social control, and coercion present in Orwell's *1984*, thus highlighting the

dehumanising effects of societal fear for our service users, especially where risk issues intersect with a diagnosis of personality disorder. Furthermore, the fear of legal repercussions for the mental health nurse echoes the atmosphere of oppressive scrutiny and punishment in *1984*. In both cases, we argue that the fear of external consequences leads to and normalises defensive, restrictive practices in inpatient settings that prioritise the interests of the mental health nurse and their organisation under a guise of benevolent care. And yet these are often to the detriment of the person-centred and relational care approaches needed in these settings.

"*Freedom is Slavery*": the paradox of using surveillance technologies to improve 'care'

The second contradiction in *1984*, "*Freedom is Slavery*" (Orwell, 1949), represents the idea that paternalism will keep people free from danger. Order and social control in the novel are maintained by surveillance under the guise of "*Big Brother*" whom it is claimed, has the best interests of the people in mind. Given its relevance to those paternalistic approaches used within inpatient services to mitigate risk, it is discussed here, specifically in relation to the proliferation of technological surveillance in inpatient settings, thus building upon our previous section around how restrictive measures in inpatient services in respect of perceived risk, arise from dichotomous thinking and externalised fears.

Here, we argue that "*Non-contact Health Monitoring to Support Care*" (Ndebele*, et al.* 2022) is perhaps a phrase that is reminiscent of Orwellian "doublethink", given the obvious opposition of the terms "non-contact" and "care". This oxymoron is used to justify the use of modern surveillance technologies over more traditional monitoring techniques that involve human interaction and clinical judgement (Holmes, 2008) all while alluding to how care is improved as a result. This is facilitated by the ambiguity of the word 'care' as used in this context; it's shift from a verb to a noun grounded in neoliberal ideology. That is, its meaning is less an act of feeling concern or interest, than a service provided. Ironically, however, it's use in this context serves to perpetuate the myth of interaction (Lipsky, 1980), despite a clear reference to maintaining physical distance from the 'other' (Shildrick, 2002).

To be clear, our argument here, is not necessarily a critique of the need for observation in mental health inpatient units. We point out that the ethical debate addressing the paternalistic nature of observation; that is its role in transferring the responsibility for individual safety from service user to mental health nurse, is already documented elsewhere (Warrender, 2018). Indeed, used in response to the immediacy of a mental health crisis, we posit that observation saves lives, and when used to engage with those who are experiencing distress, serves as an effective intervention, providing it is perceived by the mental health nurse as being more than a meaningless task (McKeown, 2024; Gillespie & McEwan, 2019; Simpson *et al.*, 2016). Rather, it is the over-surveillance and digitisation of treatment carried out under a rhetoric of care that is on the dock here. A blanket use of the panopticon to maintain order and control; quite literal 'technologies of power' (Foucault, 1977) are legitimised in the name of 'risk management' (Kolar, *et al.* 2023; Slemon, *et al.* 2017), though carry iatrogenic harms for those experiencing a mental health crisis.

Despite neoliberal assertions that digital surveillance can save the health service money and standardise treatment (Malcolm, *et al.* 2022), this does not necessarily lead to better outcomes as alluded. Not least, the technology is considered controversial (Evans, 2023); its use, effectively maintaining and even intensifying power relations (Foucault, 1977), while also a violation of service users' privacy and dignity under a pretext of providing treatment (Holmes, 2008). Furthermore, digital surveillance, as a pragmatic response to risk behaviours, can reduce the accessibility of the mental health nurse, and so is to the detriment of relational approaches needed especially when working with service users diagnosed with a personality disorder.

Given how crucial the physical presence of the nurse is in supporting empathic responses to underlying distress (Wright, 2021; Olsen 1998) and in ensuring emotional safety (Veale, *et al.* 2023), digital surveillance systems are, therefore, a folly, prioritising efficiency at the expense of interpersonal connection and engagement needed for recovery (Delaney & Johnson, 2014). Such systems have significant implications for the emotional safety of service users, supporting avoidance behaviours that divert the mental health nurse from involving themselves directly with the distressed individual, at a time when their presence is most needed (Haslam, *et al.* 2022; Menzies Lyth, 1988). And in doing so, minimising those opportunities for mental health nurses to spend more time occupying the same relational space as service users at the time of crisis, engaging with them around specific needs (Deering, *et al.* 2023) and working collaboratively on skills and strategies that can support recovery (Ware, *et al.* 2022; Gillespie & McEwan, 2019).

Fundamentally, the Orwellian paradox of "*Freedom is Slavery*" is used here to highlight how an increase in the blanket use of digital surveillance technologies in inpatient settings under a fallacy of care provision, raises moral concerns when caring for those diagnosed with a personality disorder, given that they not only have the potential to intensify forms of biopower, but also limit opportunities for meaningful connection and engagement with individuals who are experiencing emotional distress. Furthermore, our discussions emphasise the irony of removing individual freedoms within inpatient settings, under a pretext of ensuring the *physical safety*, although in the act of doing so, neglects the *emotional safety*, of service users. In essence, we argue that the reduction of 'care' to the monitoring of screens prioritises efficiency over the safety of the individual, thus aligning the mental health nurse closer with Big Brother than with Florence Nightingale.

"*Ignorance is strength*": acceptance of the status quo and insufficient preparation of the nurse

Our final contradiction from Orwell's *1984*, "*Ignorance is strength*" (Orwell, 1949), represents the idea that the absolute acceptance of orthodoxy, even in the face of obvious contradiction, strengthens and maintains the status quo. 'Ignorance' here, might refer to a clinician's lack of comprehension of, or desire to challenge, those reductionist biomedical hegemonies that maintain hierarchical relations and power differentials within the context of mental health inpatient settings, especially where decision-making and power are centralised, and held by the psychiatrist (Kolar, *et al.* 2023). Within these systems it is often the mental health nurse, operating at the forefront of care, who is entrusted with executing psychiatry's 'dirty work' (McKeown, 2023a; Gadsby & McKeown, 2021). Again, in a parallel with members of the party in Orwell's 1984, their role is also one that complicitly enacts institutional power in fulfilment of the societal and organisational agendas discussed in the earlier sections of this paper (Liberati*, et al.* 2023; Lipsky, 1980; Foucault, 1967), through a range of coercive, restrictive and at times, punitive measures.

Furthermore, in a further parallel with Orwell's novel*,* we suggest that the individual fears arising from the potential for individual scrutiny, criticism and sanctions discussed in earlier sections of this paper, skew the focus of the mental health nurse, providing an expedient distraction from the damaging effects of neoliberalism upon the services delivered. Contemporary mental health nursing practice is conducted against a backdrop of service fragmentation, resource limitations, harmful workforce deficits, systemic constraints and redundant metrics (Ahmed*, et al.* 2021) breeding staff burnout and moral injury, neither of which are conducive to compassionate and relational care (Liberati, *et al.* 2023; Beale, 2022). A paucity of resources; doing "more with less", however, is passively accepted by organisations and clinicians in times of economic austerity, despite its potential to reduce the quality of services offered and this feeding back into a service response that relies more heavily upon restrictive, coercive practices (McKeown, *et al.* 2019).

'Ignorance', within this context, also extends to the lack of preparedness to work with complexity in inpatient settings. Against a backdrop of ongoing critical discourse around the direction of mental health nurse education in the UK and beyond (Warrender, *et al.* 2023; McKeown, 2023; Haslam, 2023; Connell*, et al.* 2022) we acknowledge that the move towards generic nursing curricula is contentious and, in keeping with the theme of Orwell's *1984*, is its own confounding contradiction of sorts. Such a move seeks to upskill mental health nurses in irrelevant procedural-based skills under the guise of improving the physical health of our service users, though by doing so, illogically risks the dilution of the specialist skillset needed to deliver safe and effective mental health care. While undoubtedly, mental health nurses have needed upskilling in physical health care skills to meet the complex needs of service users, our critique here lies in *the sort of skills required*, and *the extent to which these are needed* over those mental health-specific skills considered more critical to the role.

Fundamentally, this position neglects the unique needs of those of our service users and the challenges that the mental health nurse faces in practice (Haslam, 2023; Connell, *et al.* 2022). The profession is one borne from conflict; mental health nurses, already walking a tenuous tightrope between paternalistic restrictive practices and collaborative, recovery-orientated care (Felton*, et al,* 2018; Hurley, *et al,* 2022). Arguably, however, the need for a nuanced understanding of complex power dynamics and those advanced relational and interpersonal skills required to navigate said challenges are poorly served in mental health nursing curricula, in favour of more technical, and quantifiable aspects of care (Lamph, *et al.* 2023; Connell, *et al.* 2022). As such, we argue that despite the increasing complexities of those we work with, the profession remains just as ill-equipped (if not, more so) to work with service users diagnosed with a personality disorder than it was 20 years ago (Bateman & Tyrer, 2004; National Institute for Mental Health England [NIMHE], 2003) and the creeping genericization in mental health nursing curricula further compounds this issue, shifting the mental health nurse even further away from being the sort of nurse service users require them to be (Haslam, 2023).

The implications of the inadequate preparation of the mental health nurse to work with complexity include a limited or skewed grasp of risk assessment. Those who locate risk, for instance, within the person rather than considering wider contextual and environmental factors, will likely prioritize the reductionist and procedural aspects of risk assessment, and are naturally more risk-averse (Coffey, *et al.* 2017), thus aligning their practice with that of the biomedical model. Especially in environments where meaningless 'box-ticking', administrative tasks associated with defensive practices are already prioritised above those skills needed for relational working (McKeown, 2024; Simpson *et al.* 2016), such an approach is an example of technocratisation of mental health nursing, serving neoliberal systems, and again prioritising the needs of organisations over the people cared for (Fisher, 2023; McKeown, *et al.* 2017; Menzies Lyth, 1988; Lipsky, 1980). Furthermore, the repercussions of inadequate preparation might also be extended to those mental health nurses who lack the self-reflexivity in the face of complexity (Romeu-Labayen*, et al.* 2022; Troupe, *et al.* 2022; Burke, *et al.* 2019), especially where it is necessary to recognise and to challenge existing personal cognitive heuristics around decision-making within the context of risk.

Critical thinking skills and the confidence to challenge poor practice are also necessary to facilitate the cultural changes needed for the reduction of restrictive practices in inpatient settings (Muir-Cochrane*, et al.* 2018; Bowers, *et al.* 2015). Without such qualities, our educational establishments may inadvertently become breeding grounds for the harmful dichotomous 'us and them' thinking, discussed in previous sections of this paper. This is especially an issue when coupled with an exposure to clinical cultures where experienced clinicians lacking understanding in the face of distress (Ware, *et al*. 2022; Muir-Cochrane*, et al.* 2018) disseminate those harmful "splitting the team" mantras. Where this happens, misplaced beliefs around collusion and service user manipulation compound poor attitudes, and in toxic environments risk the 'othering', dehumanisation (Wright, *et al.* 2007; Zimbardo, 2007) and even the objectification (Felton, *et al.* 2018) of service users. Conversely, increasing clinicians understanding may

reduce conflict and containment events and therefore contribute to a more efficacious treatment milieu as exemplified by Psychological Informed Planned Environments (Kuester, *et al.* 2022; Turley, *et al.* 2013) and Safe Wards (Bowers, *et al.* 2015).

Fundamentally, the Orwellian paradox of "*Ignorance is strength*" is discussed here both in relation to a blind acceptance of those damaging biomedicine-centric hegemonies, and those harmful resource limitations that impact upon the care delivered in mental health inpatient settings. Such complacency, we argue, ultimately positions the mental health nurse as complicit in perpetuating restrictive practice. Furthermore, we suggest that where risk aversion and restrictive practices are often rooted in dichotomous thinking and externalised fears as discussed in previous sections of this paper, the notion of 'ignorance' here might also be extended to include the lack of effective preparation of the mental health nurse to work with complexity. While accepting that many of the challenges raised in this paper will not be resolved by nurse education alone, we still posit that increasing understanding, self-reflexivity, and critical thinking skills, would ensure that the profession would better meet the complex needs of service users, particularly those diagnosed with a personality disorder.

A manifesto for collaborative, user-involved care?

Extending our *1984* analogy further, we ask readers to reflect upon the concept of "*Room 101*" (Orwell, 1949) where individuals' worst fears are realized. Perhaps, we might suppose, we are already living in a version of "*Room 101*" and through our experiences of powerlessness, have already learned to accept (though not necessarily to *love*) the status quo, akin to a neoliberal-induced, profession-wide Stockholm syndrome. Considering, however, an urgent requirement to redress the balance, our final section goes beyond the mere recognition of restrictive practice and dichotomous thinking, and beyond educational approaches, to emphasising user-involved approaches as a further antidote to some of the issues discussed in this paper.

We begin this final section with the ideal "*where there is equality, there can be sanity*" (Orwell, 1949); contrasted starkly against the dystopian society painted in the novel. Speaking to a broader concept of resistance (Tyner, 2004), this sentence represents what *could be*, if individuals were to unionise and reject the oppressive constraints of the status quo, in favour of a healthier and more democratic society. In a direct parallel with mental health nursing practice, McKeown (2024; 2023; *et al.* 2017) challenges us to do the same, proposing the forging of cross-sectional links with those who use services in order to democratise mental health care. Similarly, Collier-Sewell & Melino (2023) invite us to a 'radical re-imagining' (pg.4) of future mental health nursing care, if we are to look beyond the constraints of existing practice and come together in solidarity and cooperation with our service users.

We suggest that perhaps such an aspiration may not actually be that radical, after all. Especially considering those progressive ideologies of democratic user involvement in therapeutic communities between the 1930s and 1990s (Clarke, *et al.* 2024; Winship *et al.* 2009). In order for us to be successful, however, a starting point is in our eschewing of damaging dichotomies, in favour of launching a unified challenge upon those structural causes of inequality that contribute to some of the issues discussed in this paper. Such a discursive shift would go some way to remedying the 'crisis of legitimacy' currently facing mental health nursing (McKeown, *et al.* 2017).

Still, recognizing that achieving this ideal may nevertheless be arduous (emancipatory approaches requiring as much the commitment and motivation of those who wield the power, as they also demand careful and thoughtful negotiation, Einboden, *et al.* 2024), crucial first steps to reducing power differentials in the caring relationship at a more local level include enhancing individual user involvement in the decisional aspects of their own treatment. While in the initial stages of a crisis, it may be necessary for the mental health nurse to hold the responsibility for

the management of risk, the service user's role as a partner in risk assessment and management is essential (Kanerva, *et al.* 2013), supporting individualised and flexible measures that minimise restrictive cultures and harmful practice (NHS England 2024; Ware, *et al.* 2022). Yet where there is a noticeable absence of service user voice in assessments and decision-making around risk, this may be a contributor to risk-aversion and an antecedent to restrictive practice and oppressive inpatient environments (Felton, *et al.* 2018).

Collaborative partnerships in risk management, therefore, do not only support relational and interpersonal approaches (Lamph, *et al.* 2023), but are also for the service user, a part of the process of regaining personal control (Liberati, *et al.* 2023; Deering, *et al.* 2019), thus going some way to resolving those existing tensions between the exertion of organisational control and the promotion of personal agency. Authenticity here, is also crucial; an incongruence between those ideas expressed and action taken appearing disingenuous, and otherwise undermining service user trust.

The justification for not involving service users in their risk assessment and management likely arises out of a misplaced view that a discussion of personal risk can increase distress or hinder the therapeutic alliance (Coffey, *et al.* 2017). Arguably, such a defence is purported by the clinician who may themselves lack the confidence to discuss service user risk with them and find such dialogue difficult (Ahmed*, et al.* 2021), taking us back to our earlier argument pertaining to the adequate preparation of the mental health nurse to work with complexity. Without service user collaboration, however, risk assessments are likely to focus solely upon the potential harms to others, while overlooking service user priorities and strengths (Ball, 2020; Deering, *et al.* 2019), so lacking user 'investment' in subsequent risk management and safety planning (Butler & Haslam, 2024).

Furthermore, where the service user is excluded from risk assessment and management, there are missed opportunities for intersubjectivity; a collaborative 'sense-making' through a reciprocal dialogue around risk behaviours that can support a shared humanity and mutual understanding (Haslam, *et al*. 2024; Deering, *et al.* 2023; Harrison, *et al.* 2018; Crossley, 1996). As such, without service user collaboration, risk assessments may be considered as irrelevant and 'meaningless' (Simpson*, et al.* 2016), serving little purpose beyond the demonstration to colleagues that an administrative task has taken place, or being used to legitimise action that may elicit discomfort in clinicians (Coffey, *et al*. 2017).

Concluding our discussion, while Orwell's *1984* is usually read as a cautionary tale against oppressive systems, the novel also speaks more broadly to ideas of discipline and resistance (Tyner, 2004) that resonate with contemporary mental health care. Our own playful application here of Orwell's novel, provides a lens through which we might better understand those critical issues defining the current landscape of mental health inpatient care, especially for those diagnosed with a personality disorder. Lessons learned, highlight the dehumanising effects of societal fear and enactments of institutional power for our service users, and the promotion of organisational and individual interests above those of the person being cared for. Through the novel, Orwell could be challenging us to scrutinise and reform those systems that support restrictive mental health nursing practices under a guise of benevolence, so that instead they prioritise interpersonal connection and the relational approaches needed. We end our paper by suggesting a reorientation of the mental health nurse priorities to support a contestation of existing damaging dichotomies, and work alongside our service users in an authentic and collaborative way across mental health settings. Viewing service users as active agents in their own treatment is an ethical imperative and would be the first step to supporting a reform of mental health inpatient care so that it is more compassionate and empowering for those who need to use it. Such a move would shift the balance of power and pave the way to more ethical and relational-based mental health nursing practice.

References

Ahmed, N., Barlow, S., Reynolds, L., Drey, N., Begum, F., Tuudah, E., and Simpson, A. (2021). Mental health professionals' perceived barriers and enablers to shared decision making in risk assessment and risk management: a qualitative systematic review. *BMC Psychiatry.* 21 (1) 594, 1-28. https://doi.org/10.1186/s12888-021-03304-0

Ball, M. A. (2020). *Service User Involvement and Co-Production in Personality Disorder Services: An Invitation to Transcend Re-Traumatising Power Politics*. In Ramsden, J., Prince, S. & Blazdell, J. (eds) (2020). *Working Effectively with Personality Disorder: Contemporary and Critical Approaches to Clinical and Organisational Practice*. Pavilion Publishing.

Bateman, A., & Tyrer, P. (2004). Services for personality disorder: Organisation for inclusion. *Advances in Psychiatric Treatment*. 10(6). 425-433. https://doi:10.1192/apt.10.6.425

Beale, C. (2022). Magical thinking and moral injury: Exclusion culture in psychiatry. *BJPsych Bulletin*, 46(1), 16-19. https://doi.org/10.1192/bjb.2021.86

Bion, W. R. (1961). *Experiences in Groups*. London. Tavistock.

Blumenthal, S., Wood, H. & Williams, A. (2018). *Assessing risk: A relational approach*. Routledge. London.

Bowers, L. James, K. Quirk, A. Simpson, A. Stewart, D. Hodsoll, J. (2015). Reducing conflict and containment rates on acute psychiatric wards: the Safewards cluster randomised controlled trial. *International Journal of Nursing Studies*. 52 (9) pp. 1412-1422, https://doi.org/10.1016/j.ijnurstu.2015.05.001

Bowers. L., Simpson, A. Alexander, J. Hackney, D. Nijman, H. Grange, A. & Warren J. (2005). The nature and purpose of acute psychiatric wards: The tompkins acute ward study. *Journal of Mental Health*. 14:6, 625-635, https://doi.org/10.1080/09638230500389105

Burke, L., Kells, M., Flynn, D. *et al.* (2019). Exploring staff perceptions of the utility of clinician connections when working with emotionally dysregulated clients. *Borderline Personality Disorder and Emotion Dysregulation.* 6, 12. https://doi.org/10.1186/s40479-019-0109-0

Butler, J. & Haslam, M. (2024). *Mental health risk assessment: a personalised approach*. In Wright, K.M. & McKeown M. [Eds] *The Essentials of Mental Health Nursing*. London (2nd edition). pp. 499-518. Sage. ISBN 9781529733044. https://us.sagepub.com/en-us/nam/essentials-of-mental-health-nursing/book273689#description

Clarke, J. Manning, N. Winship, G. & Clarke, S. (2024). *Therapeutic Communities, democracy and the new recovery movement*. In Wright, K.M. & McKeown M. [Eds] *The Essentials of Mental Health Nursing*. London (2nd edition). pp. 499-518. Sage. ISBN 9781529733044. https://us.sagepub.com/en-us/nam/essentials-of-mental-health-nursing/book273689#description

Coffey, M., Cohen, R., Faulkner, A., Hannigan, B., Simpson, A. & Barlow, S. (2017). Ordinary risks and accepted fictions: how contrasting and competing priorities work in risk assessment and mental health care planning. *Health Expect.* 20(3):471-483. https://doi.org/10.1111/hex.12474

Connell, C., Jones, E., Haslam, M., Firestone, F. *et al.* (2022). Mental health nursing identity: a critical analysis of the UK's Nursing and Midwifery Council's pre-registration syllabus change and subsequent move towards genericism. *Mental Health Review Journal*. https://doi.org/10.1108/MHRJ-02-2022-0012

Crossley, N. (1996). *Intersubjectivity: The Fabric of Social Becoming*. Sage.

Crowe, M. & Carlyle, D. (2003). Deconstructing risk assessment and management in mental health nursing. *Journal of Advanced Nursing*. 43(1):19-27. https://doi.org/10.1046/j.1365-2648.2003.02669.x

Delaney, K. R. & Johnson, M. E. (2014). Meta synthesis of research on the role of psychiatric inpatient nurses: what is important to staff? *Journal of American Psychiatric Nurses Association*. 20(2):125-37. https://doi.org/10.1177/10783903145275

Deering, K., Wagstaff, C., Williams, Jo, Bermingham, I. & Pawson, C. (2023). Ontological insecurity of inattentiveness: Conceptualizing how risk management practices impact on patient recovery when admitted to an acute

psychiatric hospital. *International Journal of Mental Health Nursing*. 00, 1–11. Available from: https://doi.org/10.1111/inm.13245

Deering, K., Pawson, C., Summers, N., and Williams, J. (2019). Patient perspectives of helpful risk management practices within mental health services. A mixed studies systematic review of primary research. *Journal of Psychiatric and Mental Health Nursing.* 26 (5-6), 185–197. https://doi.org/10.1111/jpm.1252113652850

Einboden, R. Dawson, L. McCloughen, A. & Buus, N. (2024). Power, position and social relations: Is the espoused absence of hierarchy in Open Dialogue naïve? *Health.* https://doi.org/10.1177/13634593241249101

Evans, N. (2003). All you need to know about non-contact monitoring. *Learning Disability Practice.* Vol. 26 Issue 3, p15-16. 2p. https://doi.org/10.7748/ldp.26.3.15.s5

Felton, A., Repper, J. & Avis, M. (2018). The construction of people with mental health problems as risk objects: Findings of a case study inquiry. *Journal of Psychiatric and Mental Health Nursing*. 25 pp558–568. https://doi.org/10.1111/jpm.12501

Fisher, J. (2023). Epistemic injustice: The silenced voices. *International Journal of Mental Health Nursing*. 32, 1186–1189. Available from: https://di.org/10.1111/inm.13163

Foucault, M. (1977). *Discipline and Punish: The Birth of the Prison*. New York: Vintage Books.

Foucault, M. (1967). *Madness and civilization: A history of insanity in the age of reason*. New York: Random House Inc

Collier-Sewell, F. & Melino, K. (2023). Towards a new (or rearticulated) philosophy of mental health nursing: A dialogue-on-dialogue. Nursing Philosophy, https://doi.org/10.1111/nup.12433

Gadsby, J. & McKeown, M. (2021). Mental health nursing and conscientious objection to forced pharmaceutical intervention. *Nursing Philosophy*. 22(4). https://doi.org/10.1111/nup.12369

Gillespie, M. & McEwan S. (2019). From task to intervention: rethinking mental health observation practice in Scotland. *British Journal of Mental Health Nursing*. Vol. 8, No. 1. https://doi.org/10.12968/bjmh.2019.8.1.28

Goffman, E. (1961). *On the characteristics of total institutions. In Asylums: Essays on the social situation of mental patients and other inmates* (pp. 1–124). New York: Anchor Books

Harding, K., Poole, R. & Robinson, C. (2020). The outsourcing of risk: out-of-area placements for individuals diagnosed with personality disorder in the UK. *The Lancet Psychiatry*. Vol. 7 No. 9, pp. 730-731. https://doi.org/10.1016/S2215-0366(20)30148-6

Harrison, H. F., Kinsella, E. A. & DeLuca, S. (2018). Locating the lived body in client-nurse interactions: Embodiment, intersubjectivity and intercorporeality. *Nursing Philosophy*. https://doi.org/10.1111/nup.12241

Haslam, M., Lamph, G., Jones, E., & Wright, K. (2024). Care giving and receiving for people with complex emotional needs within a crisis resolution/home treatment setting: A qualitative evidence synthesis. *Journal of Psychiatric and Mental Health Nursing*. 00, 1–15. https://doi.org/10.1111/jpm.13033

Haslam, M. (2023). The erosion of mental health nursing: the implications of the move towards genericism. *British Journal of Mental Health Nursing*, 12(1), 1-6 Available: https://www.magonlinelibrary.com/doi/full/10.12968/bjmh.2022.0039

Haslam, M., Ellis, S. & Plumridge, M. (2022). 'It's not you; it's us!': the relevance of mental health team psychodynamics to the care of individuals with complex emotional needs. *British Journal of Mental Health Nursing*. https://doi.org/10.12968/bjmh.2021.0033

Higgins, A., Doyle, L., Downes, C., Morrissey, J., Costello, P., Brennan, M. and Nash, M. (2015). "There is more to risk and safety planning than dramatic risks": mental health nurses' risk assessment and safety management practice. *International Journal of Mental Health Nursing*, Vol. 25 No. 2, pp. 159-170. https://doi.org/10.1111/inm.12180

Holmes, D. (2008). From iron gaze to nursing care: mental health nursing in the era of panopticism. *Journal of psychiatric and mental health nursing*. Volume8, Issue1. https://doi.org/10.1111/j.1365-2850.2001.00345.x

Hurley, J., Lakeman, R., Linsley, P., Ramsay, M. & Mckenna-Lawson, S. (2022). Utilizing the mental health nursing workforce: a scoping review of mental health nursing clinical roles and identities. *International Journal of Mental Health Nursing*. 31(4):796–822. https://doi.org/10.1111/inm.12983

Jenkin G, Quigg S, Paap H, Cooney E, Peterson D, & Every-Palmer, S. (2022). Places of safety? Fear and violence in acute mental health facilities: A large qualitative study of staff and service user perspectives. *PLoS ONE*. 17(5). https://doi.org/10.1371/journal.pone.0266935

Johnstone L, Boyle M, With Cromby J *et al.* (2018). *The power threat meaning framework: towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. Leicester: British Psychological Society

Kanerva, A., Lammintakanen, J. & Kivinen, T. (2016). Nursing Staff's Perceptions of Patient Safety in Psychiatric Inpatient Care. *Perspectives in Psychiatric Care*. 52(1):25-31. https://doi.org/10.1111/ppc.12098

Kolar, M., Varcoe, C., Brown, H. & Einboden, R. (2023). Involuntary psychiatric treatment and the erosion of consent: a critical discourse analysis of mental health legislation in British Columbia, Canada. *Health.* 27(6), 1076-1095. https://doi.org/10.1177/13634593221096241

Kuester, L. Freestone, M. Seewald, K. Rathbone, R. & Bhui, K. (2022). *Evaluation of Psychologically Informed Planned Environments (PIPEs): Assessing the first five years*. Ministry of Justice Analytical Series. HM Prison & Probation Service. Retrieved from: https://assets.publishing.service.gov.uk/media/63467b7fd3bf7f6184a293c2/evaluation-of-psychologically-informed-planned-environments-pipes.pdf

Lamph, G., Nowland, R., Boland, P. *et al.* (2023). Relational practice in health, education, criminal justice, and social care: a scoping review. *Systematic Reviews*. 12, 194 (2023). https://doi.org/10.1186/s13643-023-02344-9

Liberati E, Richards N, Ratnayake S, Gibson J, Martin G (2023). Tackling the erosion of compassion in acute mental health services. *BMJ* 382. https://www.bmj.com/content/382/bmj-2022-073055

Lipsky, M. (1980). *Street-Level Bureaucracy: Dilemmas of the individual in public services*. Russell Sage Foundation. New York.

Malcolm, R., Shore,J., Stainthorpe, A., Ndebele, F. & Wright, K. (2022). Economic evaluation of a vision-based patient monitoring and management system in an acute adult and an older adult mental health hospital in England, *Journal of Medical Economics*. 25:1, 1207-1217, https://doi.org/10.1080/13696998.2022.2147753

McKeown, M. (2024). On the bullshitisation of mental health nursing: A reluctant work rant. *Nursing Inquiry.* https://doi.org/10.1111/nin.12595

McKeown, M. (2023). Resisting genericization: Towards the renewal of mental health nursing. *Journal of Advanced Nursing*. https://doi.org/10.1111/jan.15598

McKeown, M, Thomson, G, Scholes, A, Jones, F., Baker, J., Downe, S., Price, O., Greenwood, P., Whittington, R. & Duxbury, J. (2019). "Catching your tail and firefighting": The impact of staffing levels on restraint minimization efforts. *Journal of Psychiatric and Mental Health Nursing*. 26: 131–141. https://doi.org/10.1111/jpm.12532

McKeown, M., Wright, K., & Mercer, D. (2017). Care planning: A neoliberal three card trick. *Journal of Psychiatric and Mental Health Nursing.* Volume 25, Issue 9-10. https://doi.org/10.1111/jpm.12501

Mckeown, M. & Stowell-Smith, M. (2006). *The Comforts of Evil: dangerous personalities in high security hospitals and the horror film*. In: Forensic Psychiatry: Influences of Evil. Humana Press Inc., Totowa, NJ, pp. 109-134. ISBN 978-1-59745-006-5

Menzies Lyth, I. (1988). *Containing anxiety in institutions: selected essays*. London: Free Association Books; 1988

Muir-Cochrane, E., O'Kane, D. & Oster, C. (2018). Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint. *International Journal of Mental Health Nursing*. 27, 1511–1521. https://doi.org/10.1111/inm.12451

Ndebele, F. Wright, K. Gandhi, V. Bayley, D. (2022). Non-contact Health Monitoring to Support Care in a Psychiatric Intensive Care Unit. *Journal of Psychiatric Intensive Care*. Volume 18, Number 2. https://doi.org/10.20299/jpi.2022.008

National Institute for Mental Health England (NIMHE 2003). *Personality Disorder: No longer a diagnosis of exclusion: Policy implementation guidance for the development of services for people with personality disorder*. NIMHE: London.

NHS England (2024). *Culture of care standards for mental health inpatient services*. Retrieved from: https://www.england.nhs.uk/long-read/culture-of-care-standards-for-mental-health-inpatient-services/#:%7E:text=%E2%80%9CDay

Olsen, D.P. (1998). Ethical considerations of video monitoring psychiatric patients in seclusion and restraint. *Archives of Psychiatric Nursing* 12, 90–94.

Orwell, G. (1949). *1984*. Penguin Classics.

Panorama (2022). *Mental health: young lives in crisis*. British Broadcasting Company (BBC). https://www.bbc.co.uk/programmes/m00190bq

Romeu-Labayen M, Tort-Nasarre G, Rigol Cuadra MA, Giralt Palou R, Galbany-Estragués P. (2022). The attitudes of mental health nurses that support a positive therapeutic relationship: The perspective of people diagnosed with BPD. *Journal of Psychiatric & Mental Health Nursing*. (2):317-326. https://doi.org/10.1111/jpm.12766

Shanley, O. (2024). *Independent Review of Greater Manchester Mental Health NHS Foundation Trust*. NHS England. https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2024/01/Final-Report-Independent-Review-of-GMMH-January-2024.pdf

Shildrick, M. (2002). *Embodying the monster: Encounters with the vulnerable self*. Thousand Oaks: Sage.

Simpson, A., Hannigan, B., Coffey, M., Jones, A., Barlow, S., Cohen, R., Vseteckkova, J. & Faulkner, A. (2016). Cross-national comparative mixed-methods case study of recovery focused mental health care planning and co-ordination: collaborative care planning project (COCAAP). *Health Services and Delivery Research*. Vol. 4 No. 5, pp. 1-189. https://doi.org/10.3310/hsdr05260

Slemon, A., Jenkins, E. & Bungay V. (2017). Safety in psychiatric inpatient care: The impact of risk management culture on mental health nursing practice. *Nursing inquiry.* 24. https://doi.org/10.1111/nin.12199

Thomas, H. (2023). Tory MP accuses government of 'failing' patients after Mental Health Act reforms dropped from King's Speech. *The Independent.* Accessed at: https://www.independent.co.uk/news/health/mental-health-bill-act-kings-speech-b2441071.html#

Troup, J. Lever Taylor, B. Sheridan Rains, L. Broeckelmann, E. Russell, J. Jeynes, T. Cooper, C. Steare, T. Dedat, Z. McNicholas, S. Oram, S. Dale, O. & Johnson, S. (2022). Clinician perspectives on what constitutes good practice in community services for people with complex emotional needs: A qualitative thematic meta-synthesis. PLoS One. 17(5) https://doi.org/10.1371%2Fjournal.pone.0267787

Turley, C. Payne, C. & Webster, S. (2013). *Enabling features of Psychologically Informed Planned Environments*. Ministry of Justice Analytical Series. National Offender Management Service. Retrieved from: https://assets.publishing.service.gov.uk/media/5a7ce5aded915d36e95f0525/enabling-pipe-research-report.pdf

Tyner, J. A. (2004). Self and space, resistance and discipline: a Foucauldian reading of George Orwell's 1984. *Social & Cultural Geography*. 5(1). Pp.129-149. https://doi.org/10.1080/1464936032000137966

Veale, D., Robins, E., Thomson, A. B. & Gilbert P. (2023). No safety without emotional safety. *Lancet Psychiatry*. 10(1):65-70. https://doi.org/10.1016/S2215-0366(22)00373-X

Ware, A., Preston, A. and Draycott, S. (2022). “It doesn’t get taken seriously until it gets bad”: experiences of risk management from people diagnosed with a borderline personality disorder. *Mental Health Review Journal.* Vol.27(3). pp333-347. https://doi.org/10.1108/MHRJ-02-2021-0016

Warrender, D., Connell, C., Jones, E., Monteux, S., Colwell, L., Laker, C. *et al.* (2023). Mental health deserves better: Resisting the dilution of specialist pre- registration mental health nurse education in the United Kingdom. *International Journal of Mental Health Nursing*, 00, 1–11. https://doi.org/10.1111/inm.13236

Warrender, D. (2018). Borderline personality disorder and the ethics of risk management: The action/consequence model. *Nursing Ethics.* 25(7):918-927. https://doi.org/10.1177/0969733016679467

Winship, G. Repper, J. Bray, J. & Hinshelwood, R. D. (2009). Collective biography and the legacy of Hildegard Peplau, Annie Altschul & Eileen Skellern; the origins of mental health nursing and its relevance to the current crisis in psychiatry. *Journal of Research in Nursing.* 14, 6, 505-517. https://doi.org/10.1177/1744987109347039

Winship, G. (2006). Further thoughts on the process of restraint. *Journal of Psychiatric and Mental Health Nursing.* 13, 55–60. https://doi.org/10.1111/j.1365-2850.2006.00913

Winship, G. (1998). Intensive care psychiatric nursing. *Journal of Psychiatric & Mental Health Nursing*. 5, 361-365. https://onlinelibrary.wiley.com/doi/10.1046/j.1365-2850.1998.00150.x

Wright, K. M. (2021). Exploring the therapeutic relationship in nursing theory and practice. *Mental Health Practice*. https://doi.org/10.7748/mhp.2021.e1561

Wright, K., Haigh, K. & McKeown, M. (2007). Reclaiming the humanity in personality disorder. *International Journal of Mental Health Nursing*. 6(4):236-46. https://doi.org/10.1111/j.1447-0349.2007.00480.x.

Zimbardo, P. (2008). *The Lucifer effect: How good people turn evil*. Rider. London.