

Violence and surveillance in mental health wards

Suki Desai considers the negative impact on vulnerable people.

It is estimated that there are now over four million closed circuit television (CCTV) cameras in Britain watching our every move. The increased use of CCTV monitoring and surveillance within public areas has received much research attention, and there is now a critical body of surveillance literature on the implications of such watching within urban and street settings.

Despite the announcement of the new coalition government to limit the use of CCTV and better regulation of CCTV in public spaces, CCTV cameras have become an established tool as a crime prevention and security measure. They are now widely adopted by both public authorities, such as local authorities and police, as well as private citizens in the prevention of crime. This is despite the fact that the Home Office's own research suggests that CCTV cameras are an 'ineffective tool if the aim is to reduce overall crime rates and make people feel safer' (Gill and Spriggs, 2005).

Public concern and research has tended to focus largely on the use of CCTV surveillance within urban spaces and little attention has been paid to the use of this new surveillance technology and its effects inside organisations. CCTV cameras are now to be found inside schools, children's nurseries and playgroups, care homes, probation hostels and mental health hospitals. CCTV cameras have crept into these organisations with surprisingly little challenge. In these spaces the cameras are not deployed to watch 'strangers', although this may be one of its imperatives; they are primarily

deployed to watch people or children who are known and need to be watched for their own protection and safety. The altruistic perception of the cameras carrying out an important function renders them benign instruments; after all who would not want their child to be safe whilst at nursery or in school?

CCTV intrusion?

CCTV cameras have featured as a surveillance tool inside mental health hospital wards since 2002. Their initial use appears to be sanctioned by the Department of Health as part of their zero tolerance campaign in order to reduce the number of violent attacks on staff working within NHS learning disability and mental health hospitals. It is difficult to state exactly how many hospitals actually use CCTV surveillance in ward environments as there is no one body that maintains such information. A preliminary survey undertaken in July 2008 (cited in Desai, 2009) suggests that there were about 34 NHS Mental Health Trusts using CCTV in patient accessed areas during this time. This amounts to 157 wards in 85 hospitals. The cameras were located in patient bedrooms, seclusion rooms, patient accessed toilets, patient lounge areas, patient dining rooms, education rooms, activity rooms and viewing rooms. The

types of mental health hospitals using CCTV included hospitals that provide secure environments, acute inpatient units, specialist eating disorder units, units that care for children and young adolescents with mental health problems, and learning disability and psychiatric intensive care units. This information does not include all NHS trusts and also does not include private/independent hospitals; hence the actual use of CCTV within ward environments is likely to be higher.

Suspicious behaviour

The intended purpose of the cameras is to provide a safe environment for staff, patients and any visitors, and whilst this purpose may appear straightforward, in their actual use they present a number of complications. The use of CCTV cameras within hospital wards is not based on reciprocity and patients do not have a choice as to whether they are monitored or not. Dissent and avoidance of cameras as a way of resisting surveillance can be interpreted as signs of illness within mental health settings. Indeed it has the added disadvantage for making

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a patients' behaviour look more suspicious, especially if the watching is out of context and undertaken by staff who do not know a patient very well, such as security guards. The fact that patients within mental health hospital

wards operate at varying levels of perception and cognition also influences how they react to cameras and for some patients the existence of cameras is likely to incite a violent response, especially if their mental health problems are linked to feelings of paranoia. It is these aspects that make gaining informed consent from patients for the use of cameras problematic.

The issue of violent attacks on staff by patients is a serious one. The National Audit results (Healthcare

Commission and the Royal College of Psychiatry, 2005) suggest that in the period 2004-2005 alone there were approximately 43,000 assaults reported by staff working in learning disability and mental health hospitals. Violence is not precipitated one-way and whilst violence to patients has not been given much prominence within mental health research, the fact that cameras can also capture violence from staff to patients cannot be underestimated. The deaths of Esmin Green and Wang Xiuying both posted on YouTube, whilst not saving these women's lives, allows for some level of justice for the relatives affected by their death. Claims have been made by patients of serious crimes, such as rape, within mental health wards and it is clear that these hospital wards remain unsafe places for both staff and patients. Whether CCTV surveillance is the solution to the violence is questionable.

Impact of cameras

The effectiveness of CCTV monitoring in reducing violence in hospital wards has yet to be evaluated fully. Apart from some localised studies (see for example Warr et al., 2005) there is very little research that assesses the impact of the cameras on patients and nursing practices. CCTV's potential to control and regulate human behaviour has been a central feature of surveillance studies. Orwellian accounts highlight such surveillance practices through the maintenance of hierarchical social control, whilst Foucauldian analysis draws on Bentham's model of the panopticon to identify disciplinary aspect of surveillance in the production of what Foucault (1977) refers to as 'docile bodies'.

However, these explanations do not easily sit within mental health ward settings. For example, the maintenance of social control within wards does not simply apply to patients; frontline staff are also being watched and this has the potential to change their interaction with patients, affecting nursing practices, not necessarily in a positive way.

Similarly, for patients who are acutely unwell the panoptic practices of the cameras will not affect their behaviour. These patients are more likely to be violent, and positive nursing practices are affected. Staff can feel that they do not need specific knowledge and information; for example, what might trigger a patient's violence behaviour, because the cameras provide this safety measure. Here it is not just the investment of relationship between staff and patients that has the potential to be affected, the diligence required for certain nursing practices, such as undertaking comprehensive and regular patient assessments, also has the potential to be influenced negatively. For some patients, whether they have the capacity to understand or not, the cameras may not be perceived as a safety measure but as punitive, and, together with other practices on mental health wards, such as the use of seclusion, this is also likely to have a negative influence on their behaviour.

Recovery in mental health hospitals is based very much on positive interaction and contact between staff and patients. CCTV has the potential for undermining the intimacy and therapeutic relationship between ward staff and patients and in a reduction of face-to-face contact, resulting in what Lyon (2001) refers to as 'disappearing bodies'. The disembodiment of patients, created by observing them through a two-dimensional reality, coupled with the lack of contact and social interaction between patients and staff, has the potential for failing to see patient behaviour within context, resulting in the failure to see the ward environment as a lived in space.

Benefits and limitations

It is difficult to assess the benefits and limitations of CCTV surveillance within ward settings without extensive research that includes the views of patients and staff. An impact study of the cameras cannot be measured in isolation and needs to be assessed together with other surveillance practices

on the ward, such as one-to-one or close observations of patients. It is probable that the implementation of CCTV cameras has not received significant debate within mental health services as they are not perceived to be a 'therapeutic' tool and like patient observations are seen as way of managing patient behaviours within wards. However, the management of insanity is part of a 'therapeutic' process; this is very evident in the history and rise of psychiatry as the sole arbitrator in controlling madness.

Finally, the issue around violence within mental health hospitals has been around ever since the introduction of asylums and hospital care. The debate around minimising violence within hospitals needs to include the voices of both staff and patients. Currently, expedient responses based on new public management have created the potential for further segregation between staff and the patients that they have a caring responsibility towards. ■

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