Introduction

Since 2005, CCTV cameras have featured as a tool for managing safety within mental health hospital wards in England and Wales, and surveillance studies and literature have yet to fully recognise the impact of new surveillance technologies in monitoring psychiatric patients within hospital wards in this way. In a survey of 100 National Health Service (NHS) Mental Health Trusts (within England and Wales), 34 NHS Trusts admitted to using CCTV cameras to monitor patients. This amounts to approximately 157 wards located in 85 hospitals (information taken from preliminary work undertaken by University of Hull in 2008). These figures do not include all NHS trusts or private/independent mental health hospitals, therefore this is a conservative estimate and the actual use is likely to be higher. The growing trend in the use of CCTV within mental health wards is not limited to the UK; Holmes (2001) for example, also identifies its use within Canadian psychiatric hospitals.

The intended purpose of CCTV surveillance is justified on the basis that they make hospital environments safe and secure for patients, staff and visitors. The aim of this review is to open up a debate and consider the potential for some unintended consequences of CCTV monitoring on patients with mental health problems and clinical staff. The primary focus is on the relationship between nursing staff and patients within mental health hospital wards. However, CCTV monitoring also has the capacity for influencing clinical mental health practices at a wider level.

Violence within British Psychiatric Hospitals

The concern that violence within British psychiatric hospitals is increasing has been a central feature of mental health research for some time (Noble and Rodger, 1989; Gray and Thomas, 1998; Gould, 2000; O’Dowd, 2001). However, it was not until the Department of Health’s zero tolerance campaign in 1999 (HSC 1999/226) that CCTV cameras began to emerge as a tool for managing security within mental health hospital wards. The zero tolerance campaign was supported by frontline hospital staff at the receiving end of violence from patients. Violence against staff is a serious matter within all NHS hospitals. A national audit of violence undertaken by the Healthcare Commission and the Royal College of Psychiatrists (2005) suggests that in the period 2004-5 there had been approximately 43,000 assaults against NHS staff in learning disability and mental health hospitals. These assaults not only have implications for the long-term health and emotional needs of those staff that are assaulted, they also create...
a financial strain in an area of healthcare that receives little attention.

CCTV cameras were identified as a tool, amongst other practices, in maintaining staff safety. CCTV surveillance was not just limited to hospital car parks, reception/waiting areas and access points onto wards; it also monitored staff, patients and visitors within wards. Inside wards, CCTV cameras have been located in patient accessed areas, such as lounge and dining areas, activity rooms, viewing rooms, education rooms, therapy rooms as well as patient bedrooms, toilets and seclusion rooms.

The higher incidence of violence within mental health hospitals has also run parallel with the closure of large asylums following the implementation of care in the community since the early 1980s. Financial resources have been redirected towards community services, leaving mental health hospitals with a number of challenges that have included aspects such as ‘bed blocking’, where patients who are well enough to be discharged are held on wards because of the lack of community resources to support them, creating frustration for such patients who no longer need hospital care (Sharkey, 2000). In addition to this, inadequately designed hospital buildings that have not been updated (Curtis et al, 2007), and bed over-occupancy – where inpatients who are not well enough to be discharged are sent on leave to their home or elsewhere, whilst their bed is being used for other, more acutely unwell patients – are also poorly addressed (Desai and Kinton, 2007).

The primary focus of the zero tolerance campaign has been on protecting staff, and Wood and Pistrang (2004) argue that little attention has been paid to the violence experienced by patients, who also feel unsafe on psychiatric wards and have experienced assaults and threats from other patients as well as staff. The abuse of patients captured on CCTV has been documented on the world-wide web in two recently well-publicised cases. Firstly, there is the CCTV footage of Esmin Elizabeth Green, a 49 year old social worker, who following her admission to Kings County Hospital in Brooklyn, United States, collapsed on the floor and died. The medical report, logged after her death, stated that she had been ‘sitting quietly in (the) waiting room’ until it was noticed that she had passed away. The CCTV footage shows her collapsing onto the floor within the waiting area; a security guard approaching her, looking at her and then walking away, whilst she is lying on the floor in pain and visibly distressed. An hour later, medical personnel arrive at the scene to assist her, by which time it was too late and she had died following a heart attack (Hartocollis, 2008).

The second CCTV footage shows the extreme violence experienced by Wang Xiuying, a patient who, following a mental health breakdown, was admitted to a psychiatric hospital in China, where she also died. Screen grabst of CCTV footage placed on the internet by the victim’s son show nursing staff kicking Wang Xiuying whilst she is on the floor and lying on her bed, and hitting her in the face and poking her with a floor cleaning mop. (Break Website, 2009).

Whether we look at violence from the point of view of staff or patient, it appears that mental health hospitals are increasingly becoming unsafe and sometimes dangerous places for both staff and patients. The government’s response to this rise in violence is increased surveillance. It is suggested here that watching patients through the lens of a camera also brings with it some unintended consequences and that the justification of using new surveillance technologies, such as CCTV, needs to be balanced alongside these outcomes.

Some unintended consequences of CCTV surveillance

The original mandate for CCTV surveillance identified within the government’s zero tolerance campaign (HSC 1999/226) is for the management of violent situations within psychiatric wards and hospitals. Haggerty and Ericson’s ‘function creep’ (2006), where new applications for CCTV are justified that did not feature in the original mandate suggest the ease with which technology intended for one purpose can easily be drawn into use for another.
Despite the legal control of CCTV, as identified within the Data Protection Act 1998 and the Information Commissioner’s Office Code of Practice, CCTV can easily find other uses within the everyday practices of the ward environment. The Information Commissioner’s Office Code of Practice states that users of CCTV will need to establish the purpose for which CCTV is used and to prove that there is a legitimate reason for processing the images. There is little research available on the experiences of patients and frontline staff monitored by such technology. However, two evaluative studies highlight the significance of function creep. In Chambers and Gillard’s (2005) internal review of CCTV monitoring, staff were concerned that CCTV could be used by line managers to observe their practice despite reassurances that this was not the case, suggesting that staff were aware of the presence of the cameras, and their potential for being used beyond their intended purpose. In Warr et al’s (2005) independent evaluation of CCTV monitoring in a medium secure hospital unit, where CCTV cameras were located in patients’ bedrooms as well as communal areas, nursing staff admitted that they had used CCTV cameras to monitor whether a patient’s behaviour in their own bedroom was different to their behaviour on the ward. This use of CCTV was not originally sanctioned, as per the Information Commissioner’s Office Code of Practice, but it highlights the ease with which, despite legislation, to justify its use in every day practices of the ward environment. CCTV brings with it the potential to manage patients (and possibly staff) as opposed to managing violent situations (which is its intended purpose) and where the line is drawn becomes increasingly difficult to define in the context of the everyday practices of the ward environment.

CCTV cameras also have the advantage of covering a much wider area of surveillance (Marx, 2002) and on poorly designed hospital wards, where it is difficult to have continuous staff presence, CCTV cameras can be the perfect disciplinary apparatus, in that a single gaze can provide information on what patients are doing on the ward, as well as providing an opportunity to observe clinical staff and see what they are doing. The management of violence and the distrust created in the patients’ inability to discipline their behaviour is also extended to staff. The potential for CCTV to be used in this way manipulates the hierarchical social control at ward level, as both patients and nurses become subject to the panoptic practices of surveillance. The surveillance of nursing staff does suggest an added advantage for patients in safeguarding them from violent staff. However, this form of watching also has the potential for manipulating the relationship between patients and nursing staff more widely. Nursing staff, as well as some patients, are aware of the hierarchical power invested in the ward manager, who acts as the ‘supervisor’ keeping a watchful guard over the ‘inmates’ as depicted in Bentham’s ‘panoptican’ (Foucault, 1979). Both patients and staff learn ‘self-discipline’ through not knowing when they are being watched and it is this uncertainty that allows the ward manager to maintain control. The use of CCTV monitoring has therefore the potential to influence and change nursing practices with patients, and these may not necessarily be to the advantage of patients. For example, Chambers and Gillard (2005) found that not only were nurses concerned about management observing their practices but that knowing that they were being observed changed their interaction with patients. Some nurses stated that they were less likely to use ‘touch’ as therapeutic contact with patients, in case this was perceived to be inappropriate by ward managers, but of greater concern is that they also stated that they were more likely to use bodily restraint with difficult to manage patients, as the CCTV footage, they believed, would show that they were using restraint techniques correctly. This suggests that patients are more likely to be nursed using coercive practices and, whilst there is no substantial evidence that CCTV does distort nursing practices, Chambers and Gillard’s review suggests that it does have the potential to do so.

The use of CCTV surveillance with some patients, who are very acutely unwell and subject to a wide range of cognitive distortions, raises the question of the panoptic effects of CCTV in managing violent situations. For some of these patients, the presence of cameras in the ward environment is more likely to incite a violent response because the cameras heighten levels of paranoia that are associated with their delusions and mental health problem (Page et al, 2004). Mental health research suggests that people who experience severe mental health problems, such as schizophrenia or psychotic illness, are more likely to have symptoms that can result in violent behaviour, and more importantly, that this violence is unpredictable (Swanson et al, 1996; Taylor, 1997; Taylor and Gunn, 1999). The unpredictable nature of violent reactions to their surrounding suggests that it is not always possible to respond to nursing staff that
are being attacked in real time, as how and what precipitates such responses cannot always be easily determined, unless clinical staff know patients very well and understand the ‘triggers’ that result in violent responses, and even this is not always accurate. The added value of CCTV surveillance in these instances is limited, as it would not contribute in the management of those patients, whose cognitive distortions make them resistant to the panoptic influences of surveillance. In the context of the ward environment it is these very patients that the original mandate for sanctioning of CCTV cameras within wards was focused on.

CCTV surveillance also brings with it the potential for less face-to-face contact with patients, as routine surveillance practices gradually become replaced by cameras. Warr et al’s (2005) justification of nighttime observation practices, for example, highlights the benefits of the installation of CCTV cameras and audio equipment in patients’ bedrooms, which, they state, allows staff to undertake routine observations safely as it is no longer necessary for staff to enter patient bedrooms in order to undertake observations. The reduction of contact with patients also has the potential for altering the ward environment, as it becomes more reflective of how people with mental health problems are perceived in wider society; that is, as people to be avoided and controlled. In this respect, new surveillance practices also challenge what is perceived as patient care within ward environments. Patients with mental health problems should be perceived as different from other patients with general health care problems, in that the nature of their illness can leave them vulnerable and at a disadvantage. When a person with a mental health problem becomes ill and needs hospitalisation, it is often the case that their capacity for decision making and living independently has broken down. However, this understanding of the patient as a ‘vulnerable’ individual is challenged within a ward environment where staff not only has to care for patients, but also discipline madness.

**Paradox of dangerous patient and vulnerable staff**

Clinical practice in mental health care does recognise the difficulty in maintaining a balance between the controlling and caring aspects of intervention with patients (Hamilton and Manias, 2007). What is not yet recognised is that new surveillance practices bring with them the potential for a shift of balance towards the controlling aspect of clinical care. This alters the perception of patients, who are seen to need more custodial intervention and less therapy. In addition, increasing surveillance of patients also influences the relationship between patients and clinical staff, where it is nursing staff that are perceived to be ‘vulnerable’ in this relationship. Such discourses falsely assume that all patients with mental health problems are violent and that staff have to be protected from them. Winstanley and Whittington (2002) suggest that health research and literature has overly focused on violence to healthcare staff, particularly nurses, within psychiatric hospitals. They suggest that staff who work in general hospital settings are more likely to be at risk of violence than staff working within psychiatric wards. Their reasoning for such claim is that staff within general hospital settings, and especially accident and emergency wards, have less knowledge and personal information about their patient in relation to background histories. In addition, aspects such as substance misuse, often cited as a common factor in the provocation of unpredictable violence, are difficult to detect in the context of (mainly) emergency wards where it is not always possible to gauge if a patient has a history of substance misuse. Those mental health patients with severe and enduring mental health problems are more likely to be known to mental health services and are potentially more likely to be violent because of their mental health condition. These patients constitute about 1% of people with mental health problems which is why they are very likely to be known to mental health services (Golightley, 2004).

The paradox of the ‘dangerous’ patient and ‘vulnerable’ staff create competing discourses, where ‘risk’ and ‘dangerousness’ linked to wider society and media interpretations of people with mental health problems are also reflected within the microcosm of the ward environment. ‘Moral panic’ created by the media and society following the death, or assault by a person with a mental health problem within community settings are also absorbed into the care of patients within psychiatric hospital wards. These discourses are synonymous with mental illness becoming inextricably linked to dangerousness. Hinsby
and Baker (2004) explore the difficulty in managing the ‘caring’ and ‘controlling’ aspects in day-to-day mental health nursing practices within the context of medium secure hospital environments. They suggest that where a patient was perceived to be ‘in control’ of their behaviour then violence by them was seen as ‘premeditated, selective, purposeful, and manipulative’ by the nursing staff (ibid: 344). This emerging view of patients, they argue, is influenced by policy initiatives that require active participation of patients within care plans and decisions regarding treatment and so on. These policy initiatives recognise the patient as having the capacity to make decisions (see Mental Capacity Act 2005). This, Hinsby and Baker argue, is the reverse of how patients were viewed historically, as not being able to make decisions about their future, nor having control over their behaviour. The fact that patients are now seen as having the capacity to make decisions and choices about their care influences the way in which nursing staff interpret their behaviour. This growing trend which suggests that patients purposely react violently within mental health hospital wards is also apparent in the increased number of NHS staff, including staff in mental health settings, taking legal action against patients who attack them. They are supported by government sanctioned bodies, such as NHS Security Management Services (for England established in 2003) whose main purpose is to protect NHS staff from violence by patients by taking appropriate legal action to protect them. Such interventions suggest that on a day-to-day basis, staff make decisions regarding ‘rationality’ and the ability of patients with mental health problems to make decisions, including the decision to be violent. This trend is worrying in that it suggests that violence on mental health wards is no longer perceived as being perpetrated by acutely unwell patients, whose mental health problems limit them from controlling such behaviours, but by patients who have the capacity to understand what they are doing and deliberately choose to be violent towards staff.

The fact that clinical staff perceive patients to engage in deliberate violence also curtails patient’s choices about whether they consent or not consent to CCTV surveillance. In public spaces people have the option to avoid CCTV surveillance cameras, but on confined psychiatric wards this is not always possible. Whilst some hospitals seek patient consent for use of CCTV surveillance within patient bedrooms, if the clinical team deem that such surveillance is necessary, then patient dissent may be overridden. Special institutions, such as psychiatric hospitals, are deemed to require rigid rules and structures. CCTV monitoring may be seen by some patients as undermining their privacy, but service providers maintain that this is essential for maintaining order within wards. It appears then that patients have the capacity to decide whether they are violent or not, but not the capacity to decide whether they choose to be monitored by CCTV. For mental health patients this creates a dilemma as to how they react to the cameras. Accepting the cameras can determine that they have insight into their mental health problem. It also, however, results in the notion that to have a mental health problem is to accept that one has the potential for violence and can be perceived as a dangerous individual to society. For a large proportion of people who experience mental health problems and need hospitalisation this is not the actual case.

This shift towards the custodial aspects of mental health care is also apparent in relation to which type of psychiatric hospitals has chosen to adopt the use of CCTV cameras. A number of CCTV cameras are located within medium secure and high secure mental health hospitals or wards. Both Chambers and Gillard’s (2005) and Warr et al’s (2005) evaluations, for example, are set within medium secure mental health units. Those staff caring for mental health patients within medium secure hospitals (where the average length of hospitalisation may be up to four years on a locked ward) and high secure hospitals (where the average length of hospitalisation is approximately seven years on a locked ward) should have ample information and knowledge about the patients in their care so the previous argument for the use of CCTV is, thus, undermined. Routine monitoring practices, such as regular assessments, including risk assessment and management procedures, as well as constant and special nursing observation practices, should allow clinical staff to identify ‘triggers’ related to a patient’s mental health problem, and ensure that steps are taken to minimise risks. There may be some justification for having CCTV monitoring on acute mental health wards, where the average length of stay for patients could be between a few weeks and up to a year, as there is perhaps less information about some patients on these wards. In medium secure and high secure hospital environments there is enough personal information about patients to suggest that these hospitals may be using CCTV monitoring alongside other disciplinary practices, such as
placing patients in seclusion or isolation, not just to calm down and manage violent or aggressive behaviours, but to also punish patients. Whilst interventions, such as seclusion practices, should not be used as punishment (see Revised 1983 Mental Health Act Code of Practice, Department of Health, 2008), it is clear that many patients perceive such practices as punitive (Wood and Pistrang, 2004). Page also suggests the potential for CCTV to be perceived punitively by patients:

... just a bit intrusive really, it’s like being in a prison or something like that you know. I think every patient has a right to have time on their own and stuff. If the cameras are watching you, you really don’t feel you can relax or anything.

(Page, 2007: 16)

**Medical gaze**

The Janus-faced nature of surveillance is not confined solely to the controlling gaze of the camera; it is also evident within the medical gaze. Koskela (2000:249) alerts us to the fact that the ‘camera itself has no eyes’ and its gaze is therefore determined by whoever is undertaking the watching. Whilst CCTV cameras are currently deployed to manage violent situations, there is no reason why they could not be used to gain a better clinical understanding of mental health problems. Seeking a ‘cure’ for madness within asylums has been a feature of psychiatry since the transformation of asylums from madhouses to curative hospitals. Scull’s (1979) account of the birth of asylums encapsulates the struggles that psychiatrists have faced in securing the notion that insanity was a disease of the mind that could be cured. However, some 200 years later, since the first asylum opened in Britain, psychiatrists are no closer to arriving at a definitive cure for even the most serious mental health problems, such as schizophrenia. The medical approach within psychiatry has been to seek pharmacological solutions and other invasive medical interventions, such as electro convulsive therapy (ECT) and lobotomy, solutions based on a limited understanding of how the mind works, and are representative of some of psychiatry’s most basic flaws which have been explored by a number of anti-psychiatry protagonists (such as Scheff, 1984; Szasz, 1972; Fanon, 1970; and Laing, 1965). For example, the continued use of ECT as a treatment today still does not have a clear mandate for how it impacts on the brain. Its initial use was sanctioned by German and Austro-Hungarian doctors during the First World War, who believed that shell-shocked soldiers ‘were malingerers who produced symptoms in order to receive pension payments... or to avoid combat’ (Kutchins and Kirk, 1997:103). This might suggest a close link between mental health problems and political morality which also compromises the medical evidence purported by psychiatrists.

New surveillance technology, such as CCTV, brings with it the capacity for more ‘scientific’ observation of human behaviour. The clinical gaze of the camera brings with it objectivity and allows the psychiatrist to observe patients first-hand and unobtrusively. This apparent need to eradicate subjectivity in mental health diagnosis and treatment has been reflected since the 1990s in the impetus for and the prominence of evidence-based mental health, where the pressure on psychiatrists has been to seek ‘the best available scientific evidence’ to explain madness (Davidoff et al, 1995:1085). Foucault (1972), Dubbeld (2003) and Koskela (2000) caution against this form of medical gaze and its entrapments; Dubbeld, for example, warns of the disembodiment of those who are ‘watched’ in this way, whilst Koskela warns of the two-dimensional reality of CCTV and its inability to see space as ‘lived, experienced space’ (2000:250). The potential for using CCTV surveillance to increase the efficacy for clinical diagnosis and treatment has not yet been fully explored. However, like the introduction of CCTV into psychiatric wards, the Department of Health (in England and Wales) has also encouraged the development of telepsychiatry and e-mental health (online websites and support groups) whose purpose is to offer people better access to mental health care, particularly in rural and underserved areas (Norman, 2006). Whilst new technologies might suggest more expediency and more objective observation of patients, its impact on the relationship between patients and their professional carers has received little recognition.
Conclusion

The efficacy for CCTV cameras to control and manage violence within psychiatric wards remains inconclusive as there is a dearth of research within this area. CCTV cameras have been implemented in psychiatric wards within communal areas, as well as private areas, such as patient bedrooms and patient-accessed toilets, with very little discussion of the impact that they might have on those who are under the gaze of the camera. This review suggests that CCTV has the potential for influencing mental health practice within the closed environment of the ward in a number of ways, but that the voices and opinions of those people – frontline staff and patients – must be acknowledged and form part of the debate on how such cameras influence the ward environment and mental health practices.

References


