



**The Social Impact of Closed Circuit Television (CCTV) Inside  
Mental Health Wards**

being a thesis submitted in fulfilment of the  
requirements for the degree of

Doctor of

Philosophy

in the University of Hull

by

Suki Desai, MA Social Work, University of Leicester, 1988

October 2019



## Acknowledgements

I would like to thank both my supervisor's Dr Mike McCahill and Dr Julia Holdsworth for their time, valued comments and enthusiasm. Mike has been with me for the full five years and has remained both motivating and challenging.

I would like to thank staff, managers and patients who allowed me to intrude into their lives inside the three PICU sites and gave up their time to speak with me. Without this support I would not have been able to produce this thesis.

Finally, I would like to thank my partner, Stuart, who has put up with less of my time and doing so without complaining.

## Abstract

CCTV (Closed Circuit Television) camera use has been a feature of the mental health ward since the 1990s. However, how CCTV surveillance is simultaneously controlling and caring inside the mental health ward has been missing in sociological research. In addition, the use of cameras is also impacted by the nature of patients being cared for inside the ward, that is, those subjects who have a limited cognitive capacity because of the nature of their mental health condition, to understand the panoptic effects of the cameras.

Ethnographic research, inside three psychiatric intensive care units (PICUs), was undertaken in order to examine the actual use of cameras.

Research findings are centred on the perception of violence and mental disorder, the ability of the cameras to undermine the 'face' and ethics of care, and subjective experiences of patients. Data analysis is influenced by Foucault's triangulation of sovereign power, disciplinary power and governmentality and how CCTV shapes patient and staff behaviour, how it coheres with other techniques adopted inside the ward and Foucault's analysis of pastoral power. The findings suggest that CCTV cameras can be used to the benefit of patients inside the ward, for example, in undertaking less intrusive observations when patients are placed in seclusion.

However, their uses can also result in a range of unintended outcomes for patients, for example, through their capacity to criminalise mental health difficulties and potentially minimise the life chances of those people who are already marginalised in society because of their mental health status.

# Contents

Acknowledgements .....	i
Abstract .....	ii
Contents .....	iii
Chapter 1 Introduction.....	1
1.2 <i>CCTV cameras inside mental health wards</i> .....	6
1.3 <i>Research on the use of CCTV inside mental health wards</i> .....	9
1.4 <i>Research aims and objectives</i> .....	14
1.5 <i>Overview of theoretical framework</i> .....	15
1.6 <i>Social Construction of CCTV (SCOT) Approach</i> .....	20
1.7 <i>Overview of methodology</i> .....	23
1.8 <i>Overview of Thesis</i> .....	24
Chapter 2 Surveillance and the Mental Hospital .....	28
2.1    Introduction.....	28
2.2    Surveillance and the Confinement of Madness .....	30
2.2.1 <i>Stultifera Navis: Madness and visibility</i> .....	30
2.2.2    Confinement of madness.....	32
2.3    Surveillance and Madness: Rise of the Mental Hospital.....	34
2.3.1    Sovereign power, disciplinary power and the examination .....	36
2.3.2    The Panopticon .....	39
2.3.3    Pastoral Power .....	45

2.4	Surveillance and Madness: Post-institutional Care.....	50
2.4.1	Politicisation of psychiatry .....	50
2.4.2	NHS reforms and post-institutional care .....	54
2.4.3	Post-Institutional care and self-surveillance.....	58
2.5	Surveillance and Madness in the Post-Panopticon Era.....	62
2.5.1	Surveillant Assemblage .....	64
2.5.2	Resisting Surveillance.....	71
2.6	Conclusion .....	74
Chapter 3 Methodology .....		77
3.1	Introduction.....	77
3.2	Ethnography as a Methodology .....	78
3.2.1	Focused ethnography.....	80
3.2.2	The field.....	83
3.2.3	The research role .....	86
3.2.4	Ethnographic interviewing.....	90
3.2.5	Documentary data sources .....	94
3.2.6	Mental Capacity Act 2005 (MCA) and seeking consent.....	95
3.2.7	Data analysis .....	101
3.3	Conclusion .....	102
Chapter 4 Politics of CCTV Implementation.....		103
4.1	Introduction.....	103

4.2	The Three Sites and Location of CCTV .....	104
4.2.1	Site 1 .....	104
4.2.2	Site 2 .....	105
4.2.3	Site 3 .....	107
4.3	Implementing CCTV .....	109
4.3.1	Reason for cameras in the ward .....	109
4.3.2	CCTV and surveillance expansion .....	112
4.3.3	Responsibility for CCTV in the ward .....	115
4.4	Stakeholder Involvement: Involving Patients and Staff in the Decision to Implement CCTV .....	116
4.4.1	Garnering patient and staff views .....	116
4.4.2	Dissenting voices .....	119
4.4.3	CCTV, Privacy and Ethics of Surveillance .....	120
4.4.4	The ward as a public space and privacy .....	122
4.4.5	CCTV in female ward areas: gendered surveillance .....	129
4.4.6	CCTV in communal areas .....	132
4.5	Conclusion .....	140
	Chapter 5 CCTV in Practice .....	142
5.1	Introduction .....	142
5.2	NAPICU Sanctioned Uses of CCTV .....	143
5.2.1	Opening up difficult to observe areas .....	147

5.2.2	Investigating potential offences and allegations .....	149
5.2.3	Learning from difficult situations.....	155
5.2.4	Using the cameras for night-time observation .....	158
5.2.5	Using the cameras for seclusion monitoring .....	164
5.3	Other Uses of CCTV .....	171
5.3.1	Using the cameras to stay connected.....	171
5.3.2	The cameras as an extra member of staff .....	175
5.3.3	Using CCTV to do peer surveillance .....	181
5.3.4	Using CCTV to negatively categorise patients .....	182
5.3.5	Using CCTV to negatively categorise patient’s visitors .....	185
5.4	Conclusion .....	187
Chapter 6 Subjective Experiences of CCTV .....		189
6.1	Introduction.....	189
6.2	Awareness of CCTV surveillance.....	190
6.2.1	Finding out about the cameras .....	190
6.2.2	Reason for the cameras .....	195
6.2.3	Information about the cameras .....	198
6.3	Experiences of CCTV surveillance.....	203
6.3.1	Camera acceptance.....	203
6.3.2	Shaping behaviour.....	209
6.3.3	Hidden cameras .....	212



6.4	Resisting camera surveillance .....	215
6.4.1	Distorting moves .....	215
6.4.2	Performing for the cameras .....	218
6.4.3	Blocking cameras.....	222
6.4.4	Breaking moves .....	223
6.4.5	Avoidance moves .....	224
6.5	Conclusion .....	225
Chapter 7 Back to Theory.....		227
7.1	Introduction.....	227
7.2	The Politics of Surveillance and Mental Health.....	228
7.2.1	Perceptions of violence and mental illness.....	228
7.2.2	Function creep and the criminalisation of mental illness.....	233
7.3	Sovereign-Discipline-Governmentality.....	239
7.3.1	Care and Control .....	251
7.4	Subjective Experience.....	255
7.5	Conclusion .....	260
Reference list / Bibliography.....		262
Appendix 1 .....		I
Appendix 2 .....		V
Appendix 3 .....		X

## Chapter 1 Introduction

This thesis examines Foucault's analysis of the Panopticon through the triangulation of sovereign power, disciplinary power and pastoral power. The central argument of the research is that existing literature has underplayed the impact of CCTV surveillance on patients, who are already exposed to a range of surveillance practices inside mental health wards. This also includes, how CCTV surveillance shapes patient behaviour and how patients respond to being under surveillance. The thesis also recognises that patients inside mental health wards experience fluctuating cognitive capacity, and as a result, their ability to understand the nature of surveillance will also be influenced by how they respond to it.

The rise in the use of CCTV cameras inside mental health wards has steadily increased since the early 1990s, and how the cameras have evolved in the ward to enhance or limit the care of patients, has received little research attention. The research that is available has tended to highlight the use of cameras for a specific purpose, for example, in monitoring patients inside their bedroom (Warr et al, 2005). The central argument of this thesis is that existing literature has failed to recognise the social impact of cameras in the context of the mental health ward. Especially, in how the cameras shape patient and staff experiences inside the ward, and how they combine with, or stand apart from, a range of practices in the ward that are also about the monitoring and surveillance of patients.

Surveillance literature has largely been dominated by Foucault's (1979) interpretation of Bentham's Panopticon, where the main emphasis has been on the analysis of disciplinary power and sovereign power in the governing of populations. This literature

has tended to emphasise the controlling aspect of surveillance, and in the process, has undermined how control can also be caring. This is especially relevant where caring for certain populations requires controlling them, not necessarily always through self-surveillance mechanisms, but by physically intervening to control their behaviour through the manifestation of sovereign power. The thesis therefore examines Lyon's (2001: 3) theorisation of the 'Janus-faced' nature of CCTV surveillance, and its ability to care and control people's behaviour, often simultaneously. It addresses this gap by focusing on the persistence of sovereign power in the context of the mental health ward, recognising the importance of pastoral power, and by acknowledging that CCTV cameras are part of an assemblage of technical and professional practices that operate inside the ward. It sheds empirical light on these abstract narratives by reviewing the literature on surveillance and mental health and undertaking ethnographic research inside three psychiatric intensive care units (PICUs).

## 1.1 Background to the research

In the mid-1980s I decided to pursue a career in social work. My motivation for the job was influenced by my desire to help others. However, this help was not to readily rely on the legal powers linked to my role, but to influence a person's behaviour and those of others, in order to avoid using legislative power. This research is influenced by this experience, in which I have an appreciation for the fact that not all surveillance is negative nor is it experienced negatively, by those people who are its recipients. In carrying out the task of social work I relied on "face-to-face" surveillance, it felt "down-to-earth", it was a two-way process in which people that I worked with also had a say in what they wanted, even though sometimes it still resulted in an outcome that they might not have chosen (Lyon, 2007: 15).

It was while I was working as a regional director (Mental Health Act Commission) that I became aware of CCTV cameras inside mental health wards. Cameras to me suggested that those people being watched are not to be trusted, because the implication is that they are getting up to no good. The lack of interaction and one-directional watching of people also felt uncomfortable. As Ball (2009) has theorised, cameras have the ability to expose the body in a way that is very different from face-to-face encounters. The patient might look at a CCTV camera, but any eye contact with it is impossible meaning that any look or observation is, as Koskela (2000: 298) claims, “calculated to exclude”. As a regional director I was required to have a view on their presence in the ward, which was difficult at the time as there was, and still is, very little research to draw upon. Most informal debates among mental health practitioners and ex-patients tended to focus on privacy concerns, and while these are important, they could not be the only issues. Anecdotally, some staff and patients told me that they liked the cameras, and others that they really disliked them. It was also difficult to work out the reason as to why the cameras were on the ward and generally several managers and staff felt that it was normal to have them, because CCTV cameras are to be found everywhere. This made it difficult to not only have a view on the use of cameras, but also how to challenge their use in the context of the ward.

My intention for this research is not to suggest that face-to-face surveillance is better, or that CCTV is bad, they are both ways of doing surveillance. However, whilst much has been written about doing direct or face-to-face work with people (for example, Trevithick, 2000; McAndrew et al, 2014; Thompson, 2016), very little has been said about how CCTV surveillance changes the nature of the ward. I wanted to know, for example, how CCTV affected the relationship between patients and staff, how it

impinges on, or can create more privacy for patients in the ward. I wanted to know if, and how, CCTV surveillance was different when the watchers could not be seen, as in face-to-face surveillance. My investigation for this study, therefore, stems from the need to understand this, and how the growing use of CCTV inside mental health wards impacts on patients and staff experience inside it.

There have been some fundamental changes in mental health care since the early 1990s, for example, the closure of large mental hospitals or asylums has resulted in more care of people outside the hospital. Large asylums have been replaced by mental health wards or units that co-exist alongside general hospitals, in order to reduce the stigma of those people needing hospital care. Modern mental hospitals have also become characterised by high rates of violence, abuse, theft and substance use (Whittington, 1994; Bowers et al, 2011). These threats to the ward environment have resulted in the physical shutting down of some wards. It is, for example, difficult to walk into a mental health ward because most wards are locked, and even before it is possible to speak with a patient any visitor has to be vetted, risk assessed and managed when inside the ward in order to ensure that they do not pose a threat to the patient. These practices have changed the ward environment where patient safety, protection, and tackling crime have become the desired goal.

Simon (2007: 5) warns against how “technologies, discourses and, metaphors of crime and criminal justice” have become a feature of a range of institutions, including it seems the mental health ward. Indeed, to some extent, it can be argued that safety and protection from violence and crime have become synonymous with well-being, where a patient’s well-being is all about the creation of a safe and protected ward environment, rather than enhancing specific skills and professional practices that

constitute mental health nursing within it. Haggerty (2004: 215) has argued that the “motivation to ‘do something’ about crime”, has resulted in politicians and policy developers coming into contact with a range of expertise around crime, and that this in turn has resulted in the displacement of experts (such as, mental health nurses, social workers and psychologists) who have attempted to intervene at an individual and social level. This desire to create a safe and protected environment has resulted in the increase of security, not just outside on the periphery of the mental hospital but also inside the mental health ward.

The introduction of CCTV cameras inside the ward has happened without major challenge from staff or patient groups. While other areas using CCTV, such as, commercial retail sector, housing estates, workplaces, schools, and police cells have received attention from social scientific literature (for example, Davies, 1996; Norris et al, 1998; Marx, 1989; McCahill and Norris, 1999; McCahill, 2002; Newburn and Hayman, 2002; Warnick, 2007; Weiss, 2007), this has not been the case inside mental health wards. There have been a few evaluative studies examining the effects of CCTV on patients and staff inside the ward. However, these studies have tended towards evaluating the effectiveness of CCTV as a tool in its own right (see for example, Vartiainen and Hakola, 1994; Holmes, 2001; Page et al, 2004; Warr et al, 2005; Chambers and Gillard, 2005; Page, 2007). This has included aspects such as whether CCTV works for its intended purpose, for example, reducing disruption of night-time nursing observations, or opening up areas of the ward that have not been visible. There is some mention of how staff and patients perceive cameras and what their purpose is, but very little about the camera’s relationship with patients and staff, who are constantly monitored by them. Or, how the cameras combine with, or stand apart

from other ward practices, such as nurse observations, and what the consequences both intended and unintended are of using such technology.

Watching of patients inside mental hospitals is not a new activity. Cohen (1981 cited in Holyoake, 2013: 847) noted how patients were observed in solitary confinement for 24 hours inside Broadmoor hospital in the Victorian era without medication, so that “their ‘true’ psychiatric condition could surface and be observed”. However, how the cameras operate as an observation tool and how they have made their way inside the hospital is not clear. Their initial use was sanctioned for maintenance of safety within the hospital perimeter and in areas accessed by the public inside hospitals, including reception areas and waiting rooms. They have since, found their way inside lived spaces of the ward including lounge areas, recreation areas, dining rooms, therapy rooms, and patient bedrooms (Desai, 2009).

Drawing on three case studies this research will examine the social construction of CCTV inside mental health wards. Whilst CCTV use in publicly accessed areas has resulted in mass publicity and the coining of the term ‘Big Brother’, CCTV use inside mental health wards has not received the same attention. And while some patients and staff welcome its intrusiveness in order to live and work in a ward environment that feels safe, how this affects their therapeutic or social relationships is not fully known.

## 1.2 CCTV cameras inside mental health wards

During the time that I was employed as a regional director I was aware of the growing increase in the use of CCTV inside wards. However, it was difficult to determine exactly how many mental hospitals used CCTV cameras, as there is no one body that keeps

this information. In order to open a debate on this I undertook an audit and wrote to 100 NHS (National Health Service) Mental Health Trusts in England and Wales (this covered all Mental Health Trusts at the time) in 2008. 29 Trusts did not respond to the Freedom of Information Act (2000) request. 37 Trusts stated that they did not use CCTV in patient accessed areas. 34 Trusts admitted to using CCTV inside wards. This approximated to 157 wards located in 85 hospitals who were using CCTV cameras in patient accessed areas (Desai, 2009).

For the purpose of this research I wrote to 57 Mental Health Trusts (this covered all NHS Mental Health Trusts at the time) in England, under the Freedom of Information Act (FOIA) in 2014, and asked them the following questions:

- 1) Do you have CCTV cameras located inside any of x NHS Trust Hospital wards?
- 2) If the answer is Yes. Can you tell me:
  - a) The name of each Hospital, and the name of the Wards within each Hospital, where CCTV cameras are located on the ward?
  - b) The name of each Hospital, and the name of the Wards within each Hospital, where CCTV cameras are located inside patient bedrooms?
  - c) The name of each Hospital, and the name of Wards within each Hospital, where CCTV cameras are located inside seclusion rooms?

All 57 NHS Trusts responded to the FOIA request. 21 Trusts stated that they did not use CCTV inside wards. 36 Trusts admitted to using CCTV, approximating to 388 wards located in 128 hospitals. These figures give an approximation and do not reveal the full scale of CCTV use, as they do not cover private or independent hospitals. The FOIA only extends to the public sector and independent hospitals are not obliged to be



transparent about this information. Hence, the total number of hospitals and wards using CCTV is likely to be higher. CCTV cameras are largely located in communal areas of the ward, seclusion rooms<sup>1</sup>, s.136 suites<sup>2</sup>, corridors inside the ward, and access and exit points. 3 NHS Mental Health Trusts admitted to using CCTV cameras inside patient bedrooms.

In the 6 years between 2008 and 2014 there has been an approximate 147 percent increase in the number of wards using CCTV. This roughly equates to 25 percent rise each year of mental health wards choosing to implement CCTV inside them. The average number of communal area cameras (excluding bedroom cameras) used inside the three mental health wards, which were part of this study equated to 10 cameras. This figure, when multiplied by 388 wards using CCTV cameras, suggests that there are approximately over 3,880 cameras deployed in communal areas in mental health wards in England. What these figures show is that CCTV cameras have the potential to increasingly open up more surveillance of patients and staff inside mental health wards.

---

<sup>1</sup> Seclusion is a specially designed room, with usually en-suite facilities, in which a patient is isolated or secluded from other patients and staff in the ward.

<sup>2</sup> S.136 is detention of a person by the police in a public place, who is thought to be suffering from a mental disorder. The person would be taken to a recognised place of safety. This is usually a designated s.136 suite, similar in design to a seclusion room in a mental hospital, or a designated police custody suite in a police station.

**Table 1.1 showing the rise in the number of NHS Mental Health Trusts using CCTV inside wards**

	2008	2014
<b>Total Number of NHS Mental Health Trusts Contacted</b>	100	57
<b>Nil response to FOIA request</b>	29	0
<b>Response to FOIA request</b>	71	57
<b>No. of Trusts with CCTV inside wards</b>	34	36
<b>Approximate number of hospitals with CCTV inside wards</b>	85	128
<b>Approximate number of wards with CCTV</b>	157	388

### 1.3 Research on the use of CCTV inside mental health wards

Tully et al (2016: 317) believe that CCTV cameras have featured as a surveillance tool inside high security mental hospitals since 2002. They suggest that Broadmoor, a high secure hospital, has been using CCTV in communal areas of high dependency wards for over a decade and that CCTV technology has proved useful in hospital practices such as, “monitoring of visits, protection of staff during searches, and easier monitoring of ward and patient areas where sightlines are suboptimal”. In addition to these uses, Tully et al also suggest that body-worn video cameras have been used in high security hospitals when trained staff have to intervene with aggressive patients, for example, when removing weapons from highly disturbed patients. The trialling in 2014 of body-worn cameras inside Broadmoor was criticised by patients because they claimed that the absence of sound recording had led to a lack of context when reviewing recorded

material. The uses of camera technology, in addition to other electronic devices, has clearly been on the rise and continues to do so in the monitoring and management of patients inside hospitals (Nijman et al, 2011; Hardy et al, 2017). Despite their introduction inside wards to manage and contain patients, there remains very little research to draw on. There have been a few evaluative studies that have identified a range of benefits and concerns around the use of such technology in observing patients. Dix (2001) sums up a number of these debates which relate to intrusiveness, right to privacy and dignity, data protection, implications for nursing practices, potential for negative effects on patients' mental state, especially where they are experiencing paranoia or delusions, and generally questioning whether it is in the patients best interest. Vartiainen and Hakola (1994) describe the effects of CCTV monitoring in two state secure care hospitals in Finland where CCTV cameras are located in two wards, corridors, and seclusion room. The patients cared for in the two wards were predominantly diagnosed as experiencing schizophrenia, therefore their propensity for paranoia and delusions were perceived to be higher, than patients with other mental health conditions. Vartiainen and Hakola claimed that CCTV did not result in the increase of paranoid states amongst these patients, as during their research monitoring periods no cameras were damaged, and that violent acts against other patients and staff had decreased following their implementation. They could not say why and how the cameras had such a calming effect on patients, and whilst it remains inconclusive, Vartiainen and Hakola's research does suggest that even those patients deemed to have a severe mental health condition, could be affected by panoptic influences of CCTV monitoring.

Warr et al (2005) provide the most comprehensive research in relation to the use of cameras inside patient bedrooms to date. They examined the use of CCTV as an aide in undertaking night-time observations of patients inside a low security mental health ward. In their research, they examined the use of infra-red cameras together with audio equipment, placed inside each patient bedroom, in order to minimise disruption of staff doing night-time observations. Patients within the unit had a choice between traditional observations, which required a nurse to either shine a light through a window panel located on the patient bedroom door. And when this was not adequate, for the nurse to physically enter the patients' bedroom and perhaps also turn on the light, in order to carry out an observation. Or, the patient could consent to the use of cameras and audio equipment inside the bedroom for the same purpose. They conducted 10 interviews with nursing staff and 6 with patients, where the patient sample also included those patients who chose to be observed by CCTV, and those who did not. Staff response to using CCTV monitoring for night-time observations varied with some staff choosing to use it and others not. Warr et al (2005) claim that the practice of nurse observations is to ensure patient safety and it is for this reason that nurse observations are considered to be intrusive. Patients when distressed are prone to engaging in behaviours that may result in harm to them or other people, and it is for this reason that Warr et al (2005) claim that patients within mental health ward environments have less autonomy. Patients, for example, cannot opt out nor not consent to night-time observations and therefore aspects such as privacy, dignity and choice about whether they opt for CCTV monitoring or not, have to be examined in this wider context.

Warr et al (2005) believed that staff reticence in using CCTV and audio equipment for night-time observations were linked to a range of reasons. Some staff, for example, questioned the reliability of CCTV observations, while others claimed that they lacked confidence in using the equipment, resulting in these staff admitting that they were not sure as to what they had observed. Some patients felt that the use of cameras meant that they had less personal contact with staff and that the cameras were intrusive, which led to less privacy. For their part, staff believed that the lack of footsteps approaching the bedroom door, and the associated noises of opening and closing of doors meant that patients did not always have time to prepare for observation, leading staff to observe behaviour that they might not previously have seen. Unlike Vartiainen and Hakola's (1994) research, in Warr et al's (2005) study staff also observed that cameras inside patient bedrooms exacerbated some patient's paranoia and made their mental health condition worse. They also reported that some patients were unhappy about the location of cameras in their bedroom and tried to cover them up, especially when they had not consented to their use, resulting in what Marx (2003) refers to as 'blocking moves'. Some patients described the benefits of using CCTV for night-time observations as being much quieter and thus aiding a better night's sleep. They also believed that the cameras provided safety and security for their personal belongings, even though the cameras were not used for this purpose. In addition, Warr et al (2005) also noted that the cameras made patients less aggressive towards staff, because they were not constantly disturbing them when they were trying to sleep during the night.

As well as their intended use, Warr et al (2005: 25) also found that some staff were using the cameras outside consented times to observe patients. For example, a few

staff used the cameras to see if a patients' behaviour in their bedroom differed to their presentation in the communal areas of the ward. While this use of CCTV was not sanctioned, staff claimed "we've been able to get a snapshot picture of people's presentation which is very different to their presentation on the ward on occasions". Other unintended consequences of CCTV monitoring included changes in behaviour suggesting that the cameras did have the ability to shape behaviour. This was not only linked to changes in patient behaviour, it also impacted on staff behaviour. For example, in an internal review of CCTV cameras inside communal areas of a psychiatric intensive care unit (PICU), Chambers and Gillard (2005) noted changes in nursing practices. According to them, some nurses were reluctant to use therapeutic touch with patients in case their actions were deemed to be inappropriate by managers when they reviewed any CCTV footage. This misrepresentation of touch when caring for people is also evident in other areas of care that feature CCTV. For example, in their research on migrant workers in Hong Kong, Johnson et al (2019) also highlight how covert surveillance of migrant workers in their employer's homes impacted on how they interacted with their children. Innocent behaviours, such as, playing with their employer's children, was often misconstrued by the employer as potentially abusive behaviour. These narratives suggest that the cameras do impact on the behaviour of staff in how they do their job. However, while some staff were reticent about using touch, there were other staff who claimed that they felt more confident about using physical intervention with patients such as restraining them, as they believed that any video footage would show that they had intervened appropriately (Chambers and Gillards, 2005). These examples suggest that CCTV has the potential to reduce therapeutic contact between staff and patients, and also perhaps results in the rise of techniques based on sovereign power, such as, the use of more body restraint

in managing the behaviour of patients. In addition, while these studies suggest that CCTV changes patient and staff behaviour inside the ward they are not conclusive in how staff and patients respond to them in any consistent way, how they might use them for their own advantage, or lead to other uses that are yet not fully known.

#### 1.4 Research aims and objectives

Sociological research has yet to recognise the social impact of CCTV cameras inside mental health wards. As tools of surveillance the cameras are not perceived within this research as extrinsic technological instruments that stand apart from other forms of surveillance of patients in the ward. They are perceived as part of an assemblage of practices and techniques used inside the ward in order to monitor patients. Therefore, this research recognises the cameras ability to influence patient behaviour, including other surveillance practices adopted inside the ward.

Research aims will be achieved by examining:

- The political and social circumstances that has led to the introduction of CCTV inside mental health wards.
- The micro-drivers at institutional or organisational level that has led to the introduction of CCTV inside each case study Mental Health Trust.
- The use of CCTV cameras inside the ward and their technological capabilities, such as whether they record through 'live feeds', 'dead feeds'; aspects related to data storage, etc.
- How (if at all) CCTV shapes patient and staff behaviour inside the ward.

- How (if at all) CCTV coheres with other monitoring and observation practices inside the ward.
- Any ethical guidance and the actual use of CCTV inside the ward.

The research draws upon documentary evidence, interviews, and focused ethnographic observation to examine the social impact of CCTV in three mental health wards in three separate NHS Mental Health Trusts. This will be achieved by:

- Reviewing literature on surveillance and mental health to establish the political and social circumstances that has led to the introduction of CCTV inside mental health wards.
- Examining documentary evidence, such as, policy documents and feasibility analyses which establish the need for CCTV monitoring and guidance on its use within the Mental Health Trust and ward context.
- Undertaking focused ethnographic observations to establish how CCTV shapes patient and staff behaviours inside the ward, as well as examining whether it coheres with other practices inside the ward and its actual use in practice.
- Undertaking one-to-one semi-structured interviews with patients, clinical staff, and managers to investigate perceptions and attitudes towards CCTV.

## 1.5 Overview of theoretical framework

In providing an account of the meaning of surveillance, Lyon (2007: 14) states that the word surveillance comes from the French word “*surveiller*”, meaning to “watch over”.



He defines surveillance as the “focused, systematic and routine attention to personal details for the purposes of influence, management, protection or direction”. This he claims includes everything from face-to-face encounters, to surveillance using a range of information technologies. Lyon (2007: 14) also suggests that the ambiguity of surveillance is manifest in its promotion of care and safety of those being watched, as well as in the controlling of people whose behaviour may be under suspicion.

Furthermore, he also believes that surveillance practices are not always focused, and dependent on the purpose of surveillance they can also be general. Haggerty and Ericson (2007: 4) suggest that surveillance “is a feature of modernity”, and that it is “integral to the development of disciplinary power, modern subjectivities, and technologies of governance”. Whilst technological developments and computerised data systems have increased our awareness of surveillance, Haggerty and Ericson (2007:4) suggest that surveillance in itself does not necessarily lead to effective management of the state, and that it coheres to other agendas including, “rational governance, risk management, scientific progress, and military conquest”. They also claim that surveillance is reliant on machines often for discrete observations. Lyon (2001) raises concerns about what he sees as a tendency in surveillance studies to emphasize disembodied technologies of watching, over identities and people. Lyon is not alone in worrying about limited boundaries placed on the field. Ball and Haggerty (2005) also recognise, the techno centric, dystopic and growing narrative of surveillance that they worry leads researchers away from nuanced, complicated and ultimately richer and more varied understanding of what it means to watch and be watched.

Surveillance of populations is not confined to watching strangers in the streets.

Surveillance technologies including CCTV, are also becoming a feature in organisations where people are known to those who are watching them for example schools, workplaces, children's nurseries, general hospital wards, probation hostels, and residential care homes. Whilst CCTV monitoring of school children, patients inside mental hospitals, probation hostels, and residential care homes has been on the rise since 1990s there has been little investigation as to how these technologies have impacted on those people being watched. The sanctioning of covert filming by the Care Quality Commission (2014), the regulatory body for health and social care in England and Wales, suggests that CCTV cameras are not the only surveillance tools to be found in care settings. As previously stated, the growing use of body-worn cameras inside mental health wards to engage with disruptive patients is another example of how differing forms of surveillance are on the increase. These tools of surveillance it can be argued, could come into direct conflict or undermine what Moore (2011: 257) has described, as the more "pastoral and productive" forms of surveillance that are already adopted inside mental health wards.

Specific theoretical perspectives related to CCTV have centred on what the media has labelled as the 'Big Brother' society. The concept of Big Brother is based on George Orwell's (1949) '*Ninety Eighty-Four*' novel where the all-seeing leader, known only as Big Brother (a character who may not even exist), watches and scrutinises the private and public lives of the population of Oceania, through ubiquitous television or 'telescreens'. Academics and researchers have also been drawn to Foucault's interpretation of Jeremy Bentham's architectural design of a prison, named by Bentham as the Panopticon. Within the Panopticon uncertainty is created among

prisoners who are unaware as to whether they are being watched or not, which serves “to induce in the inmate a state of conscious and permanent visibility that assures the automatic functioning of power” (Foucault, 1979:201). Foucault suggested that it did not matter whether the inmate was being watched or not, as what really mattered was whether the inmate believed they were being watched and as a result, conformed their behaviour as if they were being watched. While Foucault’s analysis of Bentham’s Panopticon has been used to critique nurse observation practices inside the ward, this critique has not extended to the use of CCTV cameras in the ward, and as a result the potential for CCTV cameras to influence nurse observations has also been largely ignored within professional academic literature (Holmes, 2001; Stevenson and Cutcliffe, 2006).

Since Foucault’s (1979) analysis of the Panopticon, surveillance literature has expanded to include other theoretical approaches. This includes Mathieson’s (1997) analysis of the synopticon, which is influenced by the ‘viewer society’, where large numbers of people watch the few, resulting in an inversion of the Panopticon where the few watch the many. It also includes Moore’s (2011) analysis of therapeutic surveillance, which not only questions the control aspect of surveillance theories, but also Mathieson’s analysis of the synopticon, concluding that therapeutic surveillance is not about the many watching the few but the many watching the one. These examples, including panoptic aspects of surveillance, Foucault’s analysis of pastoral surveillance and Mann et al’s (2003) analysis of sousveillance are analysed in the context of what Haggerty and Ericson (2000) have described as the surveillant assemblage. Haggerty and Ericson suggest that in the post-Panopticon era surveillance is less about hierarchical power. They draw on Deleuze and Guattari’s notion of the

rhizome plant, which they state does not have a central body that acts as a control centre as in hierarchal surveillance, instead the rhizome grows by extending its interconnected root systems which shoot off into various directions, where some break off and others create further off-shoots. The aforementioned sanctioning of covert filming inside adult care homes is an example of rhizomatic surveillance, where watching is not only the privilege of staff watching residents, residents (and their families) can also watch staff. CCTV has the potential within the ward environment to benefit patients as much as staff, and in this regard, it could be argued that the hierarchical power held by staff is minimised. Although the technology may have initially been installed inside the ward to watch patients, it can also be used by management to watch staff. Similarly, staff can also use the technology to their own benefit as proof that they acted appropriately in the context of an incident inside the ward and in this sense, like patients, prove their innocence in a given situation. Managers, staff and patients as a result, have an interdependent relationship with CCTV.

Ball and Haggerty (2005: 133) state that “multi-dimensional notions of surveillance are thin on the ground”. While panoptic and post-panoptic debates have tended to focus on Foucauldian analysis of discipline or disciplinary power, little has been written on the uses of sovereign power and pastoral power, in relation to surveillance and the regulation of behaviour. In *‘Discipline and Punish’*, Foucault (1979) himself claims that modern society is a disciplinary society, and that power is exercised through disciplinary means in a range of institutions, including hospitals. However, the mental hospital has a historical connection that has strong links to sovereign power through the use of repressive practices, such as, the use of full body restraint of patients and

the use of forcible medication. While it is not yet known how the cameras change power relationships inside the ward, the use of repressive techniques inside the ward to manage patient behaviours cannot be ignored, because of the arrival of the cameras. Similarly, Foucault's analysis of pastoral power maintains strong links to the role of the care provided by the psychiatrist inside the ward (Foucault, 2009). Pastoral power regulates patient behaviour through its focus on caring for them. How the cameras combine with (or not) with the caring aspects of surveillance inside the ward is also not yet known. In order to explore this, the theoretical framework has been opened to examine the contribution of sovereign power and pastoral power in regulating patient behaviour inside the ward.

## 1.6 Social Construction of CCTV (SCOT) Approach

Layton (1977 cited in Bijker et al, 2012: 15) claims that CCTV technology is often treated as a 'black box'. By this he is referring to the ways in which all technologies are often measured on their economic success, or technological innovations. These accounts, according to Pinch and Bijker (2012: 19), miss the point that technology needs to be "understood as a social construct". In defining the Social Construction of Technology (SCOT or the SCOT approach), Bijker et al (2012) take a social constructivist approach and suggest that technology does not only determine human action, but that human action can also shape technology and how it is used. In adopting the SCOT approach in an English city and its relationship with CCTV, McCahill (2002) describes the importance of exploring the technical, social, economic and political aspects of surveillance networks in the analysis of CCTV. He challenges the assumption that the introduction of visual surveillance systems is there to detect or prevent crime. In addition, Graham and Marvin (1996: xiv), also caution against literature based on

“profound pessimism”, and “utopian optimism”. For example, that CCTV will result in reduction or even eradication of crime. SCOT has arisen out of this critique of technological determinism related to technologies. Rather than assuming that CCTV technology is somehow separate from society, MacKenzie and Wajcman (1985: 14) suggest that “the compelling nature of much technological change is best explained by seeing technology not as outside of society, as technological determinism would have it, but as an inextricable part of society”.

According to Latour (2005), CCTV technology inside wards does not simply impact on patients and staff as an external force. It has to be viewed in the context of its emergent social interests (whether these are economic or professional), and its potential to shape social interactions. Cresswell et al (2010: 2) suggest that social reality is both complex and fluid: “The composition of networks tends to become particularly apparent when things in a system go wrong; conversely, these inter-connections tend to be hidden when things are working smoothly”. The SCOT approach therefore enables the examination of CCTV as a surveillance tool alongside a range of other surveillance practices inside the ward and not as a stand-alone tool, as has been the case in previous studies examining CCTV inside mental health wards.

Klein and Kleinman (2002) draw out four key aspects of the SCOT approach in relation to designing new technology, which are also pertinent to how CCTV cameras are accepted inside the ward. Firstly, they claim technologies are often designed with a range of possible outcomes and that the final design of any technology is very much dependent upon the process that takes place in determining it. Secondly, they cite Pinch and Bijker (2012: 30) to claim that “all members of a certain social group share the same meanings, attached to a specific artefact”. In the context of the mental

health ward this could mean that managers, staff and patients all agree that CCTV cameras act as a security tool to manage safety. The third component of the SCOT framework, “closure and stabilisation”, they argue, is achieved through accepting that no further design change is needed, and where the technology does not meet its aim, by redefining the problem. Redefining the problem could mean that rather than stating that the cameras will eliminate crime, their function could be redefined to state that they allow for a better chance of solving crime. However, it is their fourth key aspect, the wider “sociocultural and political milieu”, in which the technological development takes place that is of interest for this thesis, especially in relation to its evolved design and extended uses (Klein and Kleinman, 2002: 30). Monahan (2011: 496) also suggests that when analysing surveillance technologies, it is useful not to perceive them “as exogenous tools that are mobilised by actors to deal with perceived problems or needs”. He believes that surveillance studies should view technologies in the context of cultural practice, which understands technologies “as agential (as “actants” within a social system) and constitutive of knowledge, experience, and relationships.”

Poyser (2004) claims that CCTV cameras began to gain their impetus from the late 1990s. She suggests that the expansion of CCTV technology was as a result of three key factors. These include, New Labour policy embracing CCTV as part of its punitive stance against crime, the availability of government funding to local authorities as part of crime reduction schemes, and CCTV images of James Bulger (a two year old boy) being led away by two boys in a shopping mall who later went on to kill him, strengthening the belief that CCTV works. Whether the cameras solve crime or not becomes immaterial. It is the ability of the cameras to cohere with other agendas, such as risk

reduction or risk management which makes them appealing (Haggerty and Ericson, 2007). While it is possible to trace the expansion of CCTV cameras in the context of their use in open street surveillance in this way, it remains unclear as to how the cameras filtered from managing security outside the hospital to inside the ward. There has been no specific funding initiative for the use of cameras inside the ward, and neither has there been any one significant event that has resulted in the politicisation of mental health care in relation to hospital care. However, the politicisation of the violent nature of the mental patient has received much publicity both in relation to hospital care and community care (for example, Healthcare Commission, 2005; 2007; Ritchie et al, 1994). It is likely that these factors may have influenced the use of cameras inside the ward. One of the aims of this thesis therefore is to identify the drivers for the implementation of CCTV inside the three wards.

## 1.7 Overview of methodology

Qualitative approaches in methodology are anchored in a range of disciplines and worldviews (Avis, 2005). Data collection and analysis are also dependent on the choice of approach the researcher adopts. Holloway and Tordes (2005) suggest that adopting a distinctive approach not only provides better clarity in relation to the phenomenon that is to be explored, but also in enabling better data collection and analysis of findings. This research uses phenomenology as a methodological approach.

In examining their lived experience, the research aim is to gain a deeper understanding of CCTV as a phenomenon through patient, staff and manager experiences and representing this information from the participant perspective. Epistemologically, phenomenological approaches are located in the paradigm of subjectivity and place an



emphasis on personal perspective and interpretation (Stanford Encyclopaedia of Philosophy, 2013). Cresswell (1998) suggests that the open and subjective nature of phenomenology allows the researcher to start with a framework that provides an explanation for the phenomena in the real world.

Heidegger (1988 cited in Gill, 2014: 120) claims that the “self and world belong together in the single entity”; a concept that he refers to as “Dasein”. In order to understand the concept of Dasein, Heidegger highlights the role of interpretation in phenomenology where he claims, “interpretation is not a choice but an integral aspect of the research” (Gill, 2014: 120). Dasein therefore is about “people’s everyday existence... and being part of the situation where things are encountered” (Rapport, 2005: 127). Hence, the adoption of ethnography as a research methodology was critical in enabling the researcher to become involved in the ward environment where patients and staff encounter CCTV monitoring. Van Manen (1990) claims that this allows the researcher to experience the phenomena (as opposed to conceptualising it), as well as maintaining a strong orientation to it, thus potentially enabling a sense of trust between the researcher and participant.

## 1.8 Overview of Thesis

The core analysis underpinning this thesis can be summarised as follows:

1. That the implementation of CCTV cameras inside mental health wards is based on a perception of the violent nature of the mental health patient, and increasingly on the exposure of violence to patients by staff.
2. The introduction of CCTV cameras inside the ward is driven by a lack of clear focus and operational procedures in relation to their use.

3. That this lack of focus has impacted on ethical implications in relation to camera use, and the expansion and opening up of more surveillance inside the ward. This not only includes extended surveillance of patients, but also their visitors, and includes an increase in peer surveillance, leading to increased suspicion of staff, patient and visitor behaviour.
4. That surveillance practice inside the mental health ward is not solely influenced by Foucault's sovereign-disciplinary-governmentality triangle. Foucault's analysis of pastoral power, especially its investment in the role of the psychiatrist, also influences how panoptic power is maintained inside the ward in the shaping of patient's behaviour (Foucault, 2009).
5. That the cameras effect on patients, as surveillance subjects, impact on them in ways that can have negative consequences on their mental health condition and on their ability to demonstrate autonomy and self-governance inside the ward.

These aspects are developed more fully in the following chapters:

## Chapter 2: Surveillance and the Mental Hospital

This chapter expands on Foucault's theoretical concepts of sovereign power, disciplinary power, panoptic power and pastoral power. In doing so, the chapter also provides a detailed background as to how those people commonly (and often legally) described as lunatics, the mad, or insane, and medically categorised as the mentally ill, or people with mental health conditions, have come to be confined and ultimately become the subjects of surveillance.

### Chapter 3: Methodology

The methodology chapter examines the relevancy of adopting ethnography as a methodological approach for the research. The chapter outlines the rationale for using focused ethnography as a method, and some of the challenges of using this methodology in the context of the mental health ward. Especially, in involving those patients who do not have the capacity to consent to participate in the research.

### Chapter 4: Politics of Implementation

This is the first of three chapters which presents empirical data from the research. The chapter describes the location of CCTV cameras inside each research site. In addition, it also examines some of the reasons for CCTV camera implementation from manager perspective, including the decision for camera placement, use of cameras in bedrooms and aspects related to maintenance of patient privacy and dignity.

### Chapter 5: CCTV in Practice

Empirical data within this chapter identifies the different ways in which staff used CCTV cameras in their day-to-day practices inside the ward. The chapter draws on the National Association of Psychiatric Intensive Care Units and Low Secure Wards (NAPICU, 2014) guidance in order to examine those uses of CCTV that have been approved by NAPICU, identified in the chapter as the sanctioned uses of CCTV cameras. The chapter also includes other uses of CCTV that have not been approved by NAPICU or managers, which involve a range of uses, some that are beneficial to patient care, and others that result in the loss of face-to-face contact.

## Chapter 6: Subjective Experiences of CCTV

In exposing the surveillance subject that is produced as a result of CCTV surveillance, the data presentation in this chapter is divided into three broad sections. They include patient's awareness of cameras, their experience of CCTV cameras and their attempts to resist camera surveillance.

## Chapter 7: Back to Theory

The final chapter provides an overview of the themes that have arisen in this research. It examines the care-control continuum inside the mental health ward and the implications of this and the criminalisation of mental health. It also revisits Foucault's sovereign-disciplinary-governmentality triangle and Foucault's analysis of panoptic power. In doing so, the chapter aims to stimulate a discussion about the use of CCTV inside mental health wards.

## Chapter 2 Surveillance and the Mental Hospital

### 2.1 Introduction

This chapter is divided into three main parts. The first part examines factors that led to the confinement of madness, the second explores surveillance of the mad in the context of their confinement, and the final part investigates surveillance of madness in the context of post-institutional care as a result of the closure of large mental hospitals or asylums.

It is assumed that psychiatry is based on an objective, incontrovertible scientific discovery that defines the truth about what is deemed as madness today. Foucault (1971) claims that this scientific understanding of madness is in fact based on questionable social and ethical commitments. In his analysis of madness in *'Madness and Civilisation'*, Foucault (1971) uses what he has termed as an archaeological method, or system of thought and knowledge described by him as epistemes or discursive formations to uncover knowledge about madness. He claimed that he did this in order to "find out how the medical gaze was institutionalised, how it was effectively inscribed in social space, how the new form of the hospital was at once the effect and support of a new type of gaze" (Foucault cited in Gordon, 1980: 146). Foucault described this gaze as the Panopticon, which he expands in his book *'Discipline and Punish'* (Foucault, 1979).

There are several interpretations of how the mad came to be confined. Unlike some academic authors, for example, Porter (2002) and Scull (1993), who provide a chronological account of the confinement of madness Foucault does not do this. In *'Madness and Civilisation'*, a major aspect of his work was based on the notion that

normality could only be achieved by suppression and exclusion of the abnormal within modern society (Foucault, 1971). For Foucault it is not madness that drives how society perceives it, but the society in which madness exists. Therefore, what constitutes madness changes, where this change is dependent upon how each society has treated it. Foucault suggests that each historical period has treated madness differently and that the only stable entity is the split between madness and unreason. Foucault's analysis of the confinement of madness is used within this thesis to develop an understanding of how the mental hospital came to be the site of surveillance of the mad in the form of asylums, and in the rise of medical surveillance.

Asylums themselves have also come under criticism, and the closure of large asylums as a result of community care policies, has also changed how the modern mental hospital manages the care of those people with mental health conditions. The rise of post-institutional community care practices is also examined in the chapter with a view to how they have impacted on modern mental hospitals. These hospitals have continued to largely rely on practices that have been established inside asylums. The more recent addition of modern technologies, such as CCTV, also have the potential to enable modern mental hospitals to distance themselves from the more repressive and coercive practices that were often carried out inside asylums. These new technologies have at their core not only self-surveillance practices but also the normalisation of surveillance where it is not the omnipresent Big Brother watching us, but Big Brother watching over us. This theoretical understanding of the modern mental hospital encapsulates CCTV surveillance not as a separate tool inside the ward, but as part of an assemblage of practices and technologies that are involved in the surveillance of the mad.

## 2.2 Surveillance and the Confinement of Madness

### 2.2.1 Stultifera Navis: Madness and visibility

The notion of lunacy as madness in Europe derives from medieval times when madness or insanity was linked to changes in the moon's cycle. It has been a central theme of interest since this time. In his investigation into the study of reason and power in modern society, Foucault (1971) also begins his analysis of the confinement of the mad in this period, which he claims began with the demise of leprosy. The eradication of leprosy, according to Foucault, made way for confinement of the mad through the availability of special sanatoria that were initially designed to house lepers. Prior to their confinement, Foucault suggests, very little is known about how the mad lived in Western Europe. In *'Madness and Civilisation'*, Foucault (1971) begins the first chapter with the Stultifera Navis or the Ship of Fools. While the ship of fools was based on Plato's allegory of ship of fools, a boat filled with feebleminded people who are unable to see the light or truth, Foucault claimed that there were also real ships into which the mad were extradited: "the Narrenschiff is the only one that had a real existence – for they did exist, these boats that conveyed their insane cargo from town to town" (Foucault, 1971: 8). Foucault (1971) believed that this physical extradition of madness was linked to weakness and self-perception, which resulted in the periodic purging of the mad together with other undesirables, such as beggars and vagabonds, in ceremonies that involved their removal from inside of city walls. For Foucault, this expulsion of the mad involved complex symbolism whereby the mad had to be both excluded and confined on boats that drove them away from the city (Foucault, 1971).

Madness, as a state of mind, was not accepted but neither were the mad habitually confined and subjected to high levels of surveillance during this era. However, this did not mean that there was no confinement. Foucault, for example, mentions how the mad, “were admitted to hospitals and cared for as such; at the Hôtel-Dieu in Paris, their cots were set up in the dormitories” (Foucault, 1971: 9). Bracci et al (2010) show how the Hôtel-Dieu linked to Christianity and the Catholic Church had about 1,000 such hospitals in Paris by the end of the seventeenth century. Yet, despite the purging of the mad from city limits and their internment in institutions, madness was not singled out as a problem. The meaning of the ship of fools was for Foucault, the rite of passage and the notion that the mad had access to hidden truth. These beliefs about madness, according to Scull (2011), have been allegorically epitomised in literature, art, theatre and poetry. Shakespeare, for example, draws on madness as a central theme in several of his plays. In *King Lear*, Lear represents a perfect allegory of madness in which the older medieval society is represented in the character of Lear who falls into error (madness) and is threatened by the new social order (disciplinary society). Cordelia, the King’s daughter embodies within the allegorical scheme individuality, ethics (in her love for her father), and population (community). Concurrently, while the Fool purports to provide insight and truth into Lear’s folly by revealing to the audience the true nature of his daughters, he remains a servant and hence subject to punishment. In the end, the Fool (also a madman) does not abandon his King and joins him in his death, and in doing so, remains as the King’s loyal subject with neither having a role in the new social order. Scull (2011) claimed that these allegorical narratives and perceptions of madness aroused either fear, pity, or disgust and commonly all three emotions at the same time.



Foucault (1971) believed that it was the Classical period from the mid-seventeenth century onwards that silenced madness. It was during this period that he surmised when the old sanatoriums (which became known as Hôpital Général or Houses of Confinement), previously used to house people with leprosy were revived. Foucault suggested that the confinement of the mad inside sanatoriums also revived the “old rites of excommunication”, but this time it was not excommunication from society but also from the “world of production and commerce” (Foucault, 1971: 57). Hôpital Général were not hospitals in the sense that we know them today, they were primarily administrative buildings used to house those people who were unemployed, prisoners, poor people, and those who were deemed insane. The Hôpital Général did not seek to solely confine the mad but the very fact that the mad were also likely to constitute the poor, unemployed and possibly involved in crime, meant they became target for confinement. For Foucault both the Hôtel-Dieu and the Hôpital Général were associated with “the visibility of bodies, individuals and things, under a system of centralised observation”, and the mooring of the ship of fools (Barou and Perrot, 1980: 146).

### 2.2.2 Confinement of madness

It is the confinement of madness which Foucault believes has led to the surveillance of those people deemed to be mad. According to him, it was in the classical period from mid-seventeenth to the end of the eighteenth century when the great confinement of those people deemed to be mad began (Foucault, 1971). Foucault attributed the confinement of madness to idleness. His view suggests that poverty, for example, was not as a result of unemployment, but as a result of “the weakening of discipline and the relaxation of morals” (Foucault, 1971: 59). In this respect, the Hôpital Général had

an ethical status, and it is this “moral charge” Foucault suggests, which has allowed its directors judicial powers and means of repression: “They have power of authority, of direction, of administration, of commerce, of police, of jurisdiction, of correction and punishment” (Foucault, 1971: 59).

Scull (1993) provides a slightly different version for the confinement of madness, especially in the context of the rise of workhouses in Britain. For example, Scull (like Foucault) also did not believe that eighteenth century workhouses or poor houses were specifically designed to include those people who suffered from madness. However, he claimed that while mad people would have found their way inside workhouses, their ability to function within them in the context of carrying out work, would have been limited. It is for this reason that Scull suggests that they would have been unwelcome inside them. He cites a document from St Lukes Hospital (from 1750) to illustrate this point: “The law has made no particular provision for lunatics and it must be allowed that the common parish workhouse (the inhabitants of which are mostly aged and infirm people) are very unfit places for the reception of such ungovernable and mischievous person, who necessarily require separate apartments” (Scull, 1993: 39). Porter (1987) pays less attention to the rise of the Hôpital Général and workhouses, instead he supports Scull’s and Foucault’s claim that madhouses or hospitals for the mad (such as Hôtel-Dieu) did exist prior to the eighteenth century. However, he argues that it was the creation of wealth through industrialisation which resulted in the growth of this service sector in England. Porter claims that Britain was fast becoming a consumer society and that hospitals, specifically designed for looking after those people deemed to be mad were part of this boom. Furthermore, he also argued that such hospitals were supply-led and that a demand for them was created as

a result of the growth of wealth. According to Porter, once a supply was created, “demand soon rose to capacity” (Porter, 1987: 165).

### 2.3 Surveillance and Madness: Rise of the Mental Hospital

For Scull (1993) and Porter (1987) the rise of psychiatry in the context of madhouses was the most obvious development. Madhouses, or lunatic asylums were not only lucrative because bed and board were not free, a charge could also be made for medical treatment. With an increase in medical practices and profession, Porter (1987) claimed that it was inevitable that ‘mad-doctoring’ would eventually lay claim to madness. Many of the practices inside madhouses to contain madness, such as whipping people, keeping them in freezing cold cells and the notion that mad people did not feel pain, cold or humiliation were, according to Scull (1993), based on the notion that madness made people akin to animals, therefore they became desensitised to any feelings. Scull claimed that the eighteenth-century Enlightenment discourse (concerned with questioning taken-for-granted beliefs) and the rise in ‘mad-doctoring’ led to the change in the view of madness. Treatment inside madhouses or asylums were no longer linked to animalistic characteristics and increasingly became more akin to child-like behaviours (Scull, 1993).

The pioneering work of Tuke at the York Retreat (a private mental hospital) in England, and the work of Pinel in Bicêtre, namely ‘moral treatment’ was deemed as leading the way to not only providing humane interventions, but also a backdrop to the emergence of madness as a ‘mental illness’. The word psychiatry was introduced in 1808 by Professor Johann Christian Reil at the University of Halle in Germany.

Marneros (2008: 1) suggests that the “creation of the word ‘psychiatry’ was not in any

way serendipitous or even accidental, but was the result of a considered discussion following many theoretical and practical arguments”, and that Reil’s reason for “establishing a new medical discipline to be named ‘psychiatry’ were, first, the principle of the continuity of psyche and soma, and second, the principle of the inseparability of psychiatry and medicine”. Reil’s account of medical psychiatry, and Tuke and Pinel’s moral treatment are identified as significant developments in the discourse of mental health. Moral treatment, eventually leading to psychoanalytic and behavioural approaches adopted inside mental health wards as a way of managing patients, and medical psychiatry leading to the growth in pharmaceutical interventions and diagnostic categorisation of mental health conditions (or diseases) in the formulation of the Diagnostic Statistical Manual (DSM) and International Classificatory Diagnostic manual (ICD) (Kutchins and Kirk, 1997).

Foucault (1971) believed that the emergence of the mental hospital from the Hôpital Général or Hôtel-Dieu was not as a result of careful design and organisation. He claimed that the emergence of the mental hospital was based on the design of the maritime and military hospitals, whose prime function was not necessarily to seek a cure for madness, but to bring the patient back to their senses so that they could continue to be a productive citizen in society. Foucault (1979) suggested that the influence of the maritime hospital was concerned with quarantine, resulting in patients inside it not being able to discharge themselves from it in the same way as patients can do so in a general hospital. The military influence, according to Foucault, was in the use of continuous surveillance inside these institutions to ensure that patients were not faking their illness. It was this exposure of the body, which Foucault suggests, led to the discovery of the body as an “object and target of power” (Foucault, 1979: 136).

For Foucault it was the techniques used by the military in manipulating bodies that resulted in the rise of hierarchical, continuous and functional surveillance. He also believed that it was through the application of this surveillance that “disciplinary power became an ‘integrated’ system” (Foucault, 1979: 176). The mental hospital, together with other institutions such as schools, factories, prisons became the spatial apparatus in which disciplinary processes operated. In the case of the mental hospital, the segregation of those people deemed to be mad from the rest of society also led to the rise of psychiatry and medicine.

### 2.3.1 Sovereign power, disciplinary power and the examination

In the same way that Lyon (2001: 3) has theorised about the ‘Janus-faced’ nature of surveillance, Foucault’s theorisation of power is similarly contradictory. Foucault (cited in Gordon, 1980) suggests that power can be both oppressive and liberating, and that sometimes these aspects of power can be experienced simultaneously. For Foucault (1979), sovereign power is based on hierarchical power that is asserted through the Crown or other agents. Foucault (1979) claimed that when sovereign power operates, the person on whom it is acted upon, not only knows who is acting upon them but also why. There were a number of practices inside asylums that were characteristic of repressive interventions such as the use of seclusion, forcible medication (in asylums this also meant the use of ECT or electroconvulsive therapy, where the patient has small electrical currents passed through their brain in order to induce a brief seizure), physical restraint of patients, and the carrying out of lobotomies (where part of the brain is removed in order to eradicate certain behaviours). These practices share similar characteristics in that they are about physical interventions on the patient body in which the patient has no influence in what is done to them.

Foucault (1979) also believed sovereign power was not the only way in which power could be exercised. According to him the eighteenth and nineteenth centuries saw the rise of a new economy of power, which he refers to as disciplinary power. Unlike sovereign power which involved physical force on the patient body, under disciplinary power the patient is controlled through observation or constant surveillance (Foucault, 1979). This hierarchical surveillance, according to Foucault (1979: 220), involves “continuous registration, perpetual assessment and classification”. Foucault believed that disciplinary power could be exhibited through spatial and temporal dimensions. The dividing of space, for example, is to “establish presences and absences, to know where and how to locate individuals, to set up useful communication, to interrupt others, to be able at each moment supervise the conduct of each individual, to assess it, to judge it, to calculate its qualities or merits” (Foucault, 1979: 143). The asylum, or the mental hospital is therefore seen as the perfect apparatus in the constant surveillance of patients.

Similarly, disciplinary power also breaks down time “into adjusted threads”, by arranging ward practices inside asylums in certain ways. In this respect, the spatial apparatus of the asylum was, according to Foucault, more than just about segregating those people deemed to be mad from the rest of society. Foucault believed that it was through the process of organising a range of normalising practices inside the asylum, which were about reforming the patient’s behaviour according to societal norms that led to controlled, or ‘docile bodies’ (Foucault, 1979: 138). It is through these spatial and temporal dimensions that the asylum was able to bring the mental patient under control. For Foucault it is this internalisation of discipline which distinguishes the Panopticon from sovereign power. However, behavioural techniques in the context of

the asylum were not only limited to routine living conditions and surveillance of patients. The aforementioned repressive practices, reliant on the use of force on the body, or the threat of force, were also present. These practices are reminiscent of sovereign power and Orwell's (1989) '*Nineteen Eighty Four*' fictional novel, where Big Brother is the fear of both physical and psychological punishment which induces conformity.

Central to disciplinary power Foucault believed was the examination. The examination is the combination of panoptic observation and the normalising judgement. Patients inside the asylum have to be classified (with a mental disorder or having a mental disorder that has yet to be categorised), sorted and differentiated (through their gender, age, ethnicity and capacity). Foucault believed that the examination was important because it showed whether the patient had "reached the level required", through the process of being involved in treatment, while "differentiating the abilities of each individual". This form of power Foucault suggests is a "form of power (*that*) cannot be exercised without knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it" (Foucault, 1979: 158) (*italics in bracket added*). This hierarchical power (in the form of pastoral power), is according to Foucault, imbued in the body of the psychiatrist and is "salvation oriented (as opposed to political power). It is oblativ (as opposed to the principle of sovereignty); it is individualizing (as opposed to legal power); it is coextensive and continuous with life; it is linked with a production of truth" (Foucault cited in Dreyfus and Rabinow, 1983:214). Foucault's analysis of sovereign power, disciplinary power, pastoral power and panoptic power have not been fully examined in the context of the modern

mental hospital. Foucault himself does not make these links and instead made the claim that in order to understand these differing forms of power it is necessary to study the micro-physics of power rather than to understand the mental hospital as an institution (Foucault, 2008).

### 2.3.2 The Panopticon

Harding explains to McMurphy *'Mr McMurphy...my friend...I'm not a chicken, I'm a rabbit. Cheswick here is a rabbit. Billy Bibbit is a rabbit. All of us in here are rabbits of varying ages and degrees, hippity-hopping through our Walt Disney World...'*

(Quote taken from Kesey's (1973: 55) fictional novel *'One Flew Over the Cuckoo's Nest'*)

A primary function of the mental hospital or asylum is to cure madness or to bring it under control and in this regard, Foucault claims that the hospital is a "curing machine", because it is a panoptic machine. For him the panoptic aspect of the asylum is not only created by breaking off contact with the outside world but also with the patient's family. Inside the asylum, the patient must also always be visible. "The madman must not only be someone who is watched; the fact of knowing that one is always being watched, better still the fact of knowing that one can always be watched, that one is always under the potential power of a permanent gaze, has therapeutic value itself" (Foucault, 2008: 102) . Foucault believed that it is the point at which the patient realises that they are looked at as mad that they will no longer display their madness. This does not mean that the patient Harding (in Kesey's novel) no longer believes that he really is a 'rabbit'. Cure in the context of the hospital, is not only a



matter of challenging the patient's perception that they believe they are a 'rabbit'. It is also about not openly vocalising one's belief that they are a 'rabbit' (whether they as the patient believe that they are a 'rabbit' or not) or performing the behaviour of a 'rabbit'. In order to be satisfied that the patient understands this, they "must be in a position of someone who can always be seen" (Foucault, 2008: 102). Therefore, the hospital as a curing machine is not only satisfied with scrutinising a patients' thoughts and feelings, their behaviour must also come under scrutiny.

According to Foucault, the distillation of disciplinary techniques is to be found in Bentham's design of the Panopticon or Inspection-House. Božovič (1995) describes through Bentham's letters how Bentham intended to build a prison, based on his brother's original plans for an Inspection-House or Elaboratory in London. Bentham believed that his Inspection-House was not only applicable to prison (or correction houses), its design could also be applied to "workhouses, or manufactories, or mad-houses, or hospitals, or schools" (Božovič, 1995: 34). Bentham describes the design of the Inspection-House as circular, with cells surrounding its circumference, where each prisoner is unable to communicate with another. At the centre of this circumference, is the inspector's lodge from which the supervisor maintains a watchful gaze over the inmates. The essence of Bentham's Inspection-House is that the supervisor can see the prisoner, without the prisoner being able to see the supervisor. This creates an uncertainty amongst prisoners about who is watching them, when they are watching them and what is watched, making supervision a more intense experience. It is the not knowing whether someone is watching or not, which creates a constant and absolute visibility of bodies. Foucault believed that this generates a particular psychological

assumption in the mind of those being watched, where they are deceived into believing that they are under constant surveillance (Foucault, 1977).

According to Foucault (1977) Bentham's Panopticon ideal was to be found in the design of the ideal prison, hospital, school and army barrack. However, like the prison, the ideal panoptic hospital never materialised. Foucault's analysis of Bentham's Panopticon is based on, and is an analysis of, the functioning of power. Foucault (1977: 205) himself wrote "the panopticon must not be understood as a dream building: it is the diagram of a mechanism of power reduced to its ideal form". Panopticism therefore, according to Foucault, is a power machine that is not limited to institutions such as prisons, it is generalizable across other domains where automatisation and disindividualisation of power are key to surveillance techniques (Peltonen, 2004).

Goffman's (1961) description of life inside asylums, which to date remains one of the few studies on practices inside mental hospitals, demonstrates some of the ways in which panoptic power operated inside such hospitals. For example, through the examination of admission procedures, Goffman describes how the patient is subjected to a whole range of processes in which they understand their subordinate position inside the asylum. These included a series of rituals and practices that were about "abasements, degradations, humiliations, and profanations of self", which he refers to as a process of "self-mortification" (Goffman, 1961: 24). Goffman believed that the role of the mental hospital was to create a barrier between the patient and the wider world. He describes how admission procedures involved the taking of a person's life history, physical body searches of patients, the listing of a person's personal possessions, and so on. These procedures, according to Goffman, ignored the patient's previous status in life prior to becoming a patient. Patients were instead

disindividualised through the seizure of their possessions and by being made to wear standard hospital issued items and clothing. Staff controlled the ward environment, where patients through a range of routinized practices, further became disindividualised inside the asylum. For example, in their treatment as “whole blocks of people”, smaller staff teams could effectively manage large numbers of patients. Therefore, staff did not see patients as individuals who required guidance and inspection but rather as people who need to be surveilled: “a seeing to it that everyone does what he (*sic*) has been clearly told is required of him (*sic*), under conditions where one person’s infraction is likely to stand out in relief against the visible, constantly examined compliance of the others” (Goffman 1961: 18).

Goffman (1961) claimed that aspects such as social mobility and communication among patients and among patients and staff was restricted inside asylums, where staff controlled how patients lived and functioned inside them. The role of staff was to maintain a watchful eye over large groups of patients, where this involvement did not require any emotional engagement with them. While the watchful eye required staff to engage in face-to-face surveillance, the panoptic nature of this gaze is established in the fact that it is not an empathetic gaze:

*In my dark I hear her rubber heels hit the tile and the stuff in her wicker bag clash with the jar of her walking as she passes me in the hall. She walks stiff. When I open my eyes she’s down the hall about to turn into the glass Nurses’ Station where she’ll spend the day sitting at her desk and looking out her window and making notes on what goes on out in front of her in the day room during the next eight hours.*

McMurphy describing Nurse Ratched's typical day inside the ward in Kesey's novel (Kesey, 1973: 10).

It is this detached gaze which enabled staff inside asylums to manage large groups of patients. In addition, patients did not know how staff gathered information about them and how this information was used: "A discreditable act that the patient performs during one part of the day's routine in one part of the hospital community is likely to be reported back to those who supervise other areas of his (*sic*) life" (Goffman, 1961: 147). Therefore, patients inside asylums not only became objects of knowledge but they were also powerless in how this knowledge about them was accumulated and how it was used, resulting in asymmetrical surveillance where patients had to accept their subordinate position. This distancing Goffman claimed, also resulted in antagonistic stereotyping between patients and staff where he states: "Two different social and cultural worlds develop, jogging alongside each other with points of official contact but little mutual penetration" (Goffman, 1961: 20).

Within panoptic surveillance individuals freely succumb to changing their behaviour according to the disciplinary norms, this is because being 'normal' means that they are no longer perceived as 'abnormal', and more importantly they can no longer be marginalised as such. It is irrelevant therefore whether Harding, Cheswick or Billy Bibbit in Kesey's novel believe that they are a rabbit or not. What is relevant is that they understand that they should not demonstrate the behaviour of a rabbit and that once they are seen to be able to do this, and that they can prove to others around them that they can do this, they are seen as having 'insight' into their mental illness. Gaining insight means that they know that their behaviour is abnormal or that their thought process is disordered. It is this insight which suggests that they are 'cured', or

their behaviour corrected enough so as not to need the hospital any longer. It is through this that Foucault (1977: 203) claimed the patient becomes "the principle of his (*sic*) own subjection". This is because the patient has been able to internalise the rules of the wider society who do not want to see people behaving like rabbits, and because they can regulate their own behaviour, even when their behaviour is not causing any harm to other people or themselves, they are able to demonstrate to others they can exercise power over themselves. Haggerty and Ericson (2000: 607) suggest that this "disciplinary aspect of panoptic observation involves a productive soul training which encourages inmates to reflect upon the minutia of their own behaviour in subtle and ongoing efforts to transform their selves". This psyche or soul training results in the internalisation of 'normal' behaviours and ultimately in self-discipline where there is no need for walls (Bogard, 2006).

While the panoptic aspect of visibility and disciplinary power is recognisable in nurse observation practices, it is not the only way in which asylums controlled patient behaviours. The behavioural model adopted inside asylums also relied on punishment or the threat of punishment, through practices involving the seclusion of patients, forcible medication, physical restraint and lobotomies. Some of these practices continue to feature inside modern mental hospitals and are reminiscent of sovereign power as discussed earlier. Surveillance literature around CCTV has tended to focus on the panoptic aspect of the cameras and currently there is very little understanding as to how the cameras combine with other practices inside the ward that are about sovereign power and disciplinary power. Although Goffman's (1961) examination of asylums provides some insights into how patient care was delivered he did not fully explain how nurse practices and other practices (linked to sovereign power or pastoral

power) influenced the normalisation of behaviour inside the asylum. This is possibly because unlike other hospitals the asylum was different, in that most people did not leave them. The lack of ethnographic research examining practices inside modern mental hospitals and their influence in changing the behaviour of patients has also been lacking. While the primary focus of this research is on how the cameras are used inside wards, cameras do not operate on their own, they combine with other practices inside the ward to influence (or not) the surveillance of patients. In this regard this research also examines a range of techniques (such as nurse observations) adopted inside wards that are also about monitoring and managing patient behaviour.

### 2.3.3 Pastoral Power

According to Foucault, the circumstances that led to the confinement of those people deemed to be mad and the rise of the mental hospital or asylum, allowed for the rise of psychiatry and psychiatrists within it. While the initial intention of the Hôpital Général was not to single out the mad, the fact that they did, meant that it also gave rise to the mental patient. This clearly was not the intended function of confinement but nevertheless according to Foucault, psychiatry and psychiatrists within asylums were allowed to both occupy an “empty space”, and “transform the negative into a positive” (Foucault cited in Gordon, 1980: 196). Foucault saw the asylum as a battleground in which the functioning of the psychiatrist also needed to be understood in the context of the struggle between disciplinary power and the patient. Foucault therefore perceived ‘cure’, as something which went beyond the submission of the patient to the mental hospital, the patient also needed to submit to the power of the psychiatrist. Foucault (2008) describes how the figure of the psychiatrist functions as part of the dispositif in the context of the mental hospital. Here, Foucault uses the

term *dispositif* to also demonstrate how the model of the functioning of the psychiatrist in the hospital is dispersed or transferred to wider society. Although the mental hospital might function along the lines of sovereign power and disciplinary power in the regulation of patient behaviour, this ability to influence the patient was limited to their confinement inside the hospital. Foucault claimed that the power of the psychiatrist transcended beyond the hospital.

The patient once discharged from the ward, whether they remained with the same psychiatrist or not, was no longer under the influence of sovereign or disciplinary power. Therefore, how successful the patient is when they are in society is, according to Foucault, dependent on the patient's psychiatrist and her ability to enlist the help of others. These others include, for example, the patients' family, the community mental health nurse, the social worker, and so on. Therefore, it is not just the psychiatrist maintaining a watchful eye on the patient but also their family, community and welfare networks. As a result, Foucault believed that power is not something that is possessed, it is constituted through the family, networks, and other forms of support. It is also defined by struggles, tactics, war, strategies, micro-physics where the hospital also plays its part in the disciplining of the patient (Foucault, 2008). The patient must know that the displaying of abnormal behaviours is unacceptable outside the hospital as it is inside it, and that there are a whole range of people maintaining a watchful eye on them to ensure that they understand this. Foucault therefore, also claimed that a delinquent population is created by disciplinary *dispositifs* (Foucault, 2008).

In demonstrating the power instilled within the psychiatrist, Foucault (2008), describes how the psychiatrist uses pastoral power in order to enlist the support of the patient as well as others in the disciplining of the patient's behaviour. Drawing on the works of

Fodéré and Esquirol (early French psychiatrists), Foucault describes a very masculine and authoritative image of the psychiatrist whom he claims, “must function at first sight”. Although the psychiatrist is “essentially a body”, Foucault suggests that it is the physical presence of the psychiatrist that creates a dissymmetry in the asymmetrical surveillance operating inside the ward. The psychiatrist’s power is therefore essentially polarised in his or her body. Foucault identifies three distinguishing features of pastoral power. First, he links pastoral power to the role that a shepherd carries out in the maintenance and safety of his or her flock of sheep. Here Foucault claims that pastoral power is not “exercised over a territory” but over a flock, and as such, it is “exercised on a multiplicity”. The multiplicity of the shepherd’s role is identified through a range of practices, for instance, as someone who is charged with guiding, protecting and finding suitable pastureland for his or her sheep. This makes pastoral power different in that it is not fixed on the acquisition of territory (that is the ward), and instead has as its focal point the acquisition or the well-being of the flock (the patients) (Foucault, 2009: 125).

Secondly, Foucault claims that pastoral power is ‘fundamentally a beneficent power’. Here Foucault links the beneficence aspect of pastoral power to the salvation of the flock. He suggests that salvation of the flock is achieved through the shepherd leading the flock to green pastures and ensuring that the flock is well-fed. He places an emphasis on the leadership qualities of the shepherd’s role in achieving this task as well as the ability of the shepherd to keep the flock safe, claiming that “pastoral power is a power of care”. The care that the shepherd affords to the flock is not limited to the flock as a whole entity. Foucault suggests that it also extends to individual sheep, “it sees to it that the sheep do not suffer, it goes in search of those that have strayed off



course, and it treats those that are injured”. Moreover, the shepherd does this out of duty and not as a display of her or his strength or superiority. It is this duty which Foucault believes results in equity, fairness and justice inside the ward: “He (*sic*) will keep watch over the flock and avoid the misfortune that may threaten the least of its members. He (*sic*) will see to it that things are best for each of the animals of his (*sic*) flock” (Foucault, 2009: 126-127).

Inside the ward whilst patients might be perceived by nurses as a homogenous group that have to be managed in the context of meal-times, therapy-times, and waking-up and bedtimes, the psychiatrist, who extricates herself from these more mundane activities, is never completely divorced from this process. Although the psychiatrist may not actually be involved in feeding each patient (like the shepherd), she still makes it her responsibility to know which patient is not eating, is agitated, or distressed. This form of watching over her flock is undertaken as part of her duty, and how well she does this task is reliant upon her leadership abilities to influence the staff who care for the flock: “The shepherd (pasteur) serves the flock and must be an intermediary between the flock and pasture, food, and salvation, which implies that pastoral power is always a good in itself” (Foucault, 2009: 128). How well she performs this activity is determined by how others perceive her as a good doctor (someone who works for best outcomes for their patient), or a poor doctor (someone who just wants status or financial benefits). In this regard, the psychiatrist addresses the third aspect of pastoral power, which Foucault refers to as “individualising” power.

The psychiatrists individualising power is demonstrated in how they communicate with staff and patients, as well as what they believed were decisions that they needed to take a lead on, and what could be left to staff discretion. In my own practice as a social

worker I have observed on many an occasion inside wards, where despite their own feelings about how a psychiatrist might be managing their mental health condition, when it came to perceived injustices happening inside the ward (especially between patients and nursing staff), patients often believed that a satisfactory resolution which would favour them, would happen once their consultant psychiatrist became aware of their predicament. The consultant psychiatrist is not involved in the day-to-day decisions about whether a patient should be placed in seclusion, restrained, or forcibly medicated. These decisions are made by the nursing staff who will report to the psychiatrist when a patient has been placed in seclusion, had to be restrained, or forcibly medicated. Unlike nurses who are often driven into taking actions that are sometimes about enforcing practices based on sovereign power, the psychiatrist maintains a distance from this and while she recognises that these interventions may be necessary for the safety of the flock, she is more interested in securing the subordination of each patient through her pastoral role.

The psychiatrist's presence as the guiding shepherd in the context of the hospital has been relatively unexplored. Goffman's (1961) analysis of asylums, for example, places a heavy emphasis on the relationship between inmates (patients) and staff. His analysis also draws on psychological as well as a range of sociological explanations in order to examine how the hospital affects the patient's psyche, in the context of living inside a closed institution. Foucault warns against this claiming that "as soon as we talk about institutions we are talking about both individuals and the group, we take the individual, the group, and the rules which govern them as given". Foucault suggests what is important is, "not institutional regularities, but much more practical dispositions of power, the characteristic networks, currents, relays, points of support,

and differences of a form of power which...are constitutive of...both the individual and the group” (Foucault, 2009:131). For Foucault the concept of ‘discipline’ is not solely linked to an institution (that is, the mental hospital or the institutional practices inside wards), nor is it linked to a specific apparatus (that is, CCTV). It is the culmination of a range of techniques, technologies, procedures, and their application which is critical to how those people with mental conditions whom he refers to as the “residue of all residues”, can be disciplined (Foucault, 2008: 540). Therefore, the individualising nature of the psychiatrists’ power in the context of monitoring patients cannot be ignored, and drawing on Moore’s (2011) analysis of therapeutic surveillance, this relationship between the psychiatrist and the patient is based primarily on a personal relationship in which the patient recognises their subordinate position.

## 2.4 Surveillance and Madness: Post-institutional Care

### 2.4.1 Politicisation of psychiatry

Rose (1995) believes that asylums made way for medicine and medical practices to flourish both inside the asylum and outside it, thus enabling psychiatry as a branch of medicine to distinguish health from mental illness. He also claims that the field of medicine resulted in the deployment of a range of experts who have made, “disease their business and made a business out of sickness and health”. These experts, according to Rose, include lawyers specialising in mental health legislation, nurses, social workers, psychologists, and a range of other clinical, health and social care workers (Rose, 1995: 51). By the late 1960s and 1970s large asylums were falling out of favour with the public who were appalled by the treatment of patients inside them. The number of patients being admitted into them was also falling. Psychiatrists themselves were beginning to question the validity of their interventions and

psychiatry began to become exposed for its political influences rather than its scientific progress.

The link between psychiatry and the politics of the time has a long-standing deep connection especially in relation to which subjects are considered normal and abnormal over time. For example, I have previously argued the relationship between race and psychiatry is so inextricably linked that according to conventional psychiatric wisdom mental disorder is perceived to be “a precondition of black people’s psyche”. The link between slavery and madness is an example of this where slaves attempting to escape or run away from their slave masters, were considered to suffer from the mental disorder ‘drapetomania’. This disease was only prevalent in black slaves for whom it was thought at the time, that slavery was a natural condition (Desai, 2003: 95). Not only has psychiatry had a chequered history in relation to what it categorises as madness, it has also been criticised for not finding a medical cure for most major mental disorders. For example, Bleuler coined the term ‘schizophrenia’ in 1911, yet over one hundred years later psychiatrists are no nearer to definitively stating what causes schizophrenia, or how to cure it successfully. However, despite this the psychiatrist’s power remains dominant both inside the hospital and outside it.

Foucault believed that the examination (linked with the production of the truth) governs “a whole domain of knowledge” and “a whole type of power”. He attributes this to psychiatry’s investment in politics and how knowledge becomes “transformed into political investment”, even when challenges to the profession comes from within it (Foucault, 1979: 185). For instance, during the 1960s and early 1970s, some psychiatrists came to question the role of medical psychiatric practices in seeking a cure for madness. Laing (1961) for example, claimed that schizophrenia was a sane

response to an insane world. Laing was a psychiatrist whose writing influenced other critical psychiatrists (also known as antipsychiatrist or antipsychiatric lobby) such as Szasz who claimed that mental illness is, “not something that a person has but is something that he (*sic*) does or is”, and therefore should not and cannot be defined in a medical context (Szasz, 1974: 267). Critical psychiatrists claimed that mental health problems were linked to problems with living, rather than with illness. In this regard their ideas created an epistemological break with medical psychiatry. However, it was not just the departure from a medical perspective that was different. It was also how people perceived as having a mental health condition should be treated. Rather than distancing themselves from patients, critical psychiatrists proposed the development of therapeutic communities in which psychiatrists and their patients could (symbolically), live side by side and where: “There were no ‘patients’, no ‘doctors’, no white coats, there was no ‘mental illness’, no ‘schizophrenia’ and therefore no ‘schizophrenics’ – just people living together”. This aim according to Laing, was to minimise the hierarchical power held by psychiatrists (Laing, 1977:108). Critical psychiatrists believed that a radical approach to mental health was needed that would break negative labelling of patients as mentally ill, and diffuse hierarchies between doctors and patients.

Critical psychiatrists also challenged the idea that those people identified as insane should be living in isolation from the rest of society, warehoused in large asylums often situated outside of city and town limits. Rather than curing madness, Szasz (1974) and Laing (1977) argued that surveillance and confinement of madness only led to its institutionalisation, and the process described as disculturation by Goffman (1961). Critical psychiatrists and the antipsychiatric lobby challenged the notion whether

madness should be singled out for surveillance, because unlike conventional psychiatrists they did not believe that mental illness was a disease. However, despite this challenge, post-institutional care has continued to rely on the mental hospital as the examining apparatus, and on the role of the consultant psychiatrist as having the knowledge to cure the patient. Foucault (1979: 185) believed that this was because the hospital was able to transform “the economy of visibility into the exercise of power”.

The challenge to medical interventions by critical psychiatrists also led to questioning the accuracy of diagnoses of mental health conditions. Rosenhan’s (1973) study of eight volunteers, none of whom having a formalised mental health diagnosis (therefore deemed ‘normal’), and entering a mental hospital on a voluntary basis feigning symptoms of schizophrenia, has been cited widely in the context of what is deemed to be abnormal behaviour. Once inside the hospital the volunteers reverted to their usual (normal) behaviour and despite this it took staff up to 52 days (with an average of 19 days), to discover that they were pseudopatients. This notion of inaccurate diagnosis was also identified by other psychiatrists such as Rack (1982), Cox (1986), and Fernando (2002). They challenged medical psychiatric diagnostic processes on the basis that white British psychiatrists trained in conventional Western medicine, fail to correctly recognise the medical significance of black patient’s symptoms because they lack an adequate knowledge of a black person’s culture and how it influences mental health problems. Mercer (1993) argued that without this ‘cultural’ knowledge psychiatrists are likely to misinterpret black people’s emotions as signs of schizophrenia. Fernando (2002), Rack (1982), and Cox (1986) were known as the early proponents of transcultural psychiatry. They were concerned with what is normal, social, and cultural from evidence of an individual mental health condition. By

challenging the cultural-reductionist approach practised by medical psychiatrists, proponents of transcultural psychiatry, such as Rack (1982), argued that blame was placed on the black patient whose culture and cultural behaviour was falsely symptomised. Moreover, Carney and Bacelle (1984), also suggested that this approach in itself was also capable of producing its own new pathological states, such as ‘ganja psychoses’, a diagnostic category commonly applied to Rastafarians in the early 1980s.

These concerns raised by critical psychiatrists and transcultural psychiatrists highlighted the deficits of medical interventions, and the ability of the mental hospital to cure madness. Foucault’s (1971) assertion that the only stability is the split between madness and unreason in all societies, is manifested in the inability of critical psychiatry, and transcultural psychiatry’s efforts to close the gap between reason and unreason. However, the politicisation of medical psychiatry in this way did have some influence, even though it maintained its dominant position. It was these challenges, especially from critical psychiatry, which also contributed to closure of asylums.

#### 2.4.2 NHS reforms and post-institutional care

According to Cuff et al, Reason, which in the eighteenth century was celebrated as provenance of liberation from religion, tradition, and superstition had become “domesticated” under capitalism (1990: 119). In addition, psychiatry and science had failed to produce freedom and enlightenment and had instead become instrumental in the creation of mechanised and routinized science which was characterised by conformity, control and politics. Failure in finding an enduring cure for madness meant that asylums or long-stay hospitals became “custodial institutions”, where more emphasis was being placed on security, rather than care, and where large walls and locked gates kept the mad inside them, and the public outside (Crossley, 2006: 57).

Busfield (1986) suggests that asylums were growing out of favour for several reasons and that the decrease in asylum populations from the 1950s onwards was the reason why they were closed down. She suggests that it was the rise in other services outside the mental hospital which were likely to be more palatable to people than entry into an asylum. Also, whilst not necessarily curing madness the rise in the development of pharmaceutical drugs which were able to suppress the symptoms of mental disorders, meant that it became possible to contain people's behaviour outside the hospital through drug treatment.

Rogers and Pilgrim (2003) link the demise of populations inside asylums and long-stay hospitals to the effects of institutionalisation and the economic cost of hospital care. The 1959 Mental Health Act and the 1962 Hospital Plan both aimed to reconfigure mental health services out of large asylums or long-stay hospitals and establish them in general hospital care. However, poor funding for mental health services, together with the lack of community-based services such as day centres and rehabilitation services, meant that it was not until the 1990 NHS and Community Care Act that proper commitment was made to facilitate community care for people with mental health conditions and learning disability (Lester and Glasby, 2006). The 1990 NHS and Community Care Act and the introduction of the Care Programme Approach (1991), whereby people with a known mental health condition in the community could be monitored by community-based multidisciplinary teams, had as its main focus the requirement by health, social care, housing and police to engage in coordinated care for people with severe mental health conditions in the community. This requirement opened up the surveillance of the mad beyond the mental hospital and the influence of the psychiatrist. It involved other professions (for example, the police) in the



monitoring of madness, resulting in the creeping of surveillance of the mad beyond mental health professionals. The legislation also established a new 'internal market' system in health and social care with a strong commitment to community care, as opposed to institutionalised care, and an emphasis on joint health and social care planning for mental health services (Wilson et al, 2008). The creation of internal markets also resulted in the rise of a consumer society inside health and social care, resulting in mental health services being commissioned from the private sector as opposed to being provided by the state, as was the case within the welfare model.

The creation of a mass consumer market in mental health corresponded with the closure of long-stay hospitals or asylums and this process also created what Rogers and Pilgrim (2003) describe as, a post-institutional context of care. Closure of asylums also meant that madness once again became visible in society, leading to concerns in communities about how the care and treatment of those diagnosed with a mental health condition would be managed, especially any risks posed by them to the public. Parton (1996) argues that this focus on risk was driven by global market forces, where for the neo-liberal consumer economic and social life had become the priority and any threat to this way of life was perceived by them as destabilising. The threat of the mental patient in the community as a potentially irrational and dangerous person, was set against them as people who are marginalised and vulnerable. Either way, there was public concern about the lack of surveillance for such people. By the late 1980s most large asylums had closed or their patient population drastically reduced. The rise of people with mental disorders living in communities raised concerns among the public about the welfare and safety of these patients and the public. Wilkinson (1998) highlights the role played by the press and media in the amplification of panic and

social reactions to people with mental health conditions during the early 1990s. His analysis of contents of three newspaper articles taken on one day (22 May 1994) reflected abstractions that had at their core black people and people with mental health conditions, whom he claimed occupied a position as outsiders. Symonds and Kelly (1998: 196) state that although “the construction of the ‘mad’ as a danger on the streets may be part of a populist tabloid myth-making”, people also recognised reality in this perceived danger. During the early 1990s murders committed by people with mental health conditions had received more media attention than, for example, the murder of women by men through domestic violence which statistically were much higher. The deaths of Jonathan Zito (Ritchie et al, 1994), Georgina Robinson (Blom-Cooper et al, 1995), and Frederick Graver (Heginbotham et al, 1994) among others, typified the dangers that people with mental health conditions posed to others as well as themselves, for example, Ben Silcock who was mauled by a lion at London Zoo when he purposely jumped into a lion’s den (Jones, 1993).

Media representations of people with mental health conditions as dangerous, unpredictable and irrational ran alongside medical discourses of them as high risk with violent behaviour, especially by those people diagnosed with severe mental health conditions such as psychosis and schizophrenia. Monahan and Steadman (1994) in a large-scale study conducted in the United States concluded that the risk of a murder (or homicide) being committed by a person (regardless of whether they are male or female) with a diagnosis of schizophrenia, was ten times greater than it was for the general population. Their study was supported by a number of other studies, including Lidz et al (1993), Modestin and Amman (1995), and Coid (1996: 965) who concluded that “the true potential for dangerous behaviour may have been seriously under-

estimated...(and) that the overall risk of violence is still higher than that of the general population” (italics in quote added). Davis (1997: 113), suggests that the perceived failure of community care resulted in the identification of risk concerns posed by people with mental health conditions. He also believed that the subsequent approach linked to risk assessment and risk management supported by government policies such as the Care Programme Approach (Department of Health 1990), had resulted in community care being reduced to the identification of a “deficient and potentially dangerous minority of individuals who need to be identified, registered and managed by medication and surveillance”.

#### 2.4.3 Post-Institutional care and self-surveillance

The closure of asylums and community care policies also influenced the way in which mental disorder was surveilled within contemporary society. The increase in surveillance of people with such disorders within the community via the establishment of community-based services, has also impacted on self-surveillance. Self-surveillance is not based on a deficit model, where a medical professional (psychiatrist or general practitioner) suggests that there is something wrong with a person’s mind. It is based on how the public seeks fulfilment through aspects related to mental health, mental well-being, happiness and positive emotional health. It is also influenced by a better understanding of how certain aspects, like stress, can induce mental health problems. Boyne (2000: 299) suggests that contemporary British society is not only about the few watching the many, it is also “marked by the phenomenon of very large numbers watching the activities of the very few”. He draws on Mathiesen’s concept of the “viewer society”, and Mathiesen’s coining of the term synopticon to describe this phenomenon. According to Boyne (2000: 299), repeated exposure to media society

connect to our own “self-identification and self-understanding” of a range of concerns, including mental health conditions. For example, through exposure to television documentaries about mental health conditions and mental health depictions in television soap opera characters, by the reporting of mental health issues and mental health campaigns in the news, press, and magazines. These all impact on how we develop our own understanding of what it means to be normal. This exposure also influences how, as a society, we understand madness and how we engage in our own self-surveillance practices, by determining what is perceived as normal behaviour and what might be perceived as abnormal behaviour.

This notion of the viewer society also impacts on the behaviour of patients living in communities. Their self-understanding of their condition is simultaneously influenced by wanting to know how others might see them, for instance through depiction in soap operas, therefore allowing them to control their own behaviour so that they are perceived as normal. The actions, behaviours, and bodies of people with mental health conditions are therefore not only surveilled through formal policy interventions, via the numerous mental health services and others designed to keep a watchful eye on them, but also informally by patients themselves as targets of their own surveillance. Government based campaigns and policies, such as ‘Time to Change’, informed by mental health charities and supported by the Department of Health and Social Care (2018) recognise this and enable patients to participate in their own surveillance by encouraging them to monitor their own progress and to seek help when they experience signs of relapse. These government and charity-led campaigns has resulted in the rise of a vast range of self-help and therapeutic models and interventions, for example, WRAP (Wellness Recovery Action Planning). These models have in common a

self-help element, life-long learning and openness about one's mental health status.

Recovery is not linked to cure and is based on individualised meaning that is not necessarily about being symptomless, but about learning to control the negative symptoms of their mental health condition (Ryan et al, 2012). Glover sums up the ethos behind recovery: "Our responsibility is not to assess, manage, monitor, teach and rehabilitate, but to create environments where a person can recognise their own mastery, and continue to learn and thrive beyond the limitations invited by the experience of mental illness or distress" (2012: 15).

Self-surveillance recovery models for the person who has already been labelled as mentally ill run alongside measures to ensure that there is always a safety-net should that person lose the capacity to engage in their own surveillance, or wilfully chooses not to engage in it. The setting up of supervision registers is an example of how information on those people, "who are liable to be, at risk of committing serious violence or suicide, or of serious neglect" is maintained to manage such people (NHS Executive, 1994: 1). Therefore, self-surveillance models do not operate in isolation. These models operate alongside community-based resources which maintain a watchful eye on the person who is diagnosed as having a mental disorder, where failure to successfully manage their mental health condition can include hospital admission when necessary. These recovery models have at their core the recognition that 'mental illness' is an embodiment of the person's being or psyche, thus creating what Heir (2003: 409) describes as "the fusion of synoptic forces and panoptic desires". Coppock and Dunn (2010: 48) observe that these measures are not only coercive, but they are also "at odds with the philosophies of empowerment and integration", and do not enable the reduction of stigma experienced by people with

mental health conditions living in communities. It can be argued that this is because health campaigns, such as, supporting World Mental Health day, have at their core the active surveillance of populations. These campaigns, therefore, do not reduce stigma of mental illness, they promote it and it is the very fact that people fear not wanting to be identified as abnormal, which continues to promote their engagement in self-surveillance. Foucault also investigated practices whereby people either by their own means or through the help of others, “acted on their own bodies, souls, thoughts, conduct and way of being in order to transform themselves and attain a certain state of perfection or happiness, to become a sage, immortal and so on”. This Foucault defined as technologies of the self (Martin, 1988: 4).

Post-institutional care is also reliant on the detection of symptoms and signs of madness, through early detection of madness. It is in the vested interest of medicine and psychiatry to support these political agendas which do not essentially undermine their expertise. Mental health research, based on evidence-based medicine, promoted since the early 1990s supports the claim that early medical intervention leads to better outcomes of recovery from mental illness. This has also influenced a rise in the number of professional and lay groups tasked with identifying people with potential mental health difficulties. These groups have also extended well beyond Rose’s (1989: 2) “new professional groups”, of social workers and psychologists. These groups now include workplace employers, university and college staff, and teachers whose role also involves the seeking out and bringing to the attention of mental health professionals, those people that they believe are showing signs of abnormal behaviour. For example, in their more recent announcement to increase mental health funding, the government has prioritised the training of school teachers in recognising the early

signs of mental health problems in pupils, so that psychiatric intervention can happen early on (Gov.UK: Press Release, 27 June 2017). This agenda for surveilling young people for signs of mental illness cohere with other agendas, such as the identification of future potential political terrorists. These developments in mental health also share several similarities to crime. Simon (2007: 5) for example, makes a distinction between “governing through crime”, from “governing crime” where he claims that it is not only criminal justice organisations that are dedicated to dealing with the threat of crime in society, other institutions such as “families, schools and businesses, are also mobilised to act when crime threatens”. This strategy, also adopted in mental health care, has not only widened its influence in engaging a range of people in the surveillance of madness, it has also successfully cohered with other agendas. The widening of mental health surveillance in this way also produces greater inequalities, because for young people, it has the potential for early medicalisation of their behaviour resulting in possibly life-long surveillance, through their early labelling as mentally ill.

## 2.5 Surveillance and Madness in the Post-Panopticon Era

Unlike the asylum where a large number of patients were clustered together in the one space, post-institutional or modern mental hospitals are defined by their smaller size and segregation of patients according to their age, gender, disability, and by the level of risk they pose. These include, for example, acute mental health wards for those patients deemed to be high risk either because they are a new patient to the service, or they are known to the service and experiencing acute symptoms that cannot be treated in the community. Patients who are deemed to be high risk because they have a mental health condition and have either committed a crime, or have such challenging behaviour that cannot be managed inside an acute ward, can be admitted

to secure care divided into low secure, medium secure, and high secure hospital care. Dependent upon their risk levels, patients can go up the tariff from low security care to medium and high security care and vice versa. Or, they can be detained in any secure hospital via the court system. The average length of stay is much longer for those patients detained in secure care, for example, in medium and high security hospitals a patient can spend over five years in hospital care (Davoren et al, 2015). In addition, the likelihood of them leaving high and medium security hospital care and going straight into the community are low, so they may spend additional years inside low security or medium security hospitals before they are seen as fit to be discharged into the community or a community based facility.

Adult mental health care is also split into wards that cater for patients who are deemed to require short-term secure environment, known as psychiatric intensive care units (PICUs) and rehabilitation wards for people who require long-standing support before they can be reintegrated into the community. Children and young people's mental health and mental health needs of other groups of people, such as learning-disabled people, deaf people, older people and pregnant women is also segregated into different parts of the ward or hospital care. This feature of the modern mental hospital is different to the asylum where patients were confined together, often in the same space regardless of their age, gender, disability and the level of risk they posed either to others or themselves.

The specialised nature of these mental hospitals, units, and wards are not just concerned with providing individualised care for different groups of people, they are also keen to promote the use of new technologies thus acknowledging a difference between the old asylums and the modern mental hospital. These technologies have



been particularly forthcoming in the establishment of new security systems both outside and inside the mental health ward. For example, CCTV is not the only technology that is available to staff; a whole range of other technologies such as person-to-person radio communication, door alarm motion detectors, pin-point infrared ultrasonic and radio personal alarm systems, electronic health records and information systems are all aimed at providing a secure and safe environment for patients (Dix, 2002). Old asylums were defined by their physical distance away from communities, large walls, and enclosed environment. Modern mental hospitals are usually part of a general hospital or located in the grounds of general hospitals, and while security still remains a priority, its features are different in that they use technologies as means of conveying an openness and integration within communities, even though it is not easy for patients to walk out of them or the public to walk into them. Seeking out new ways of controlling the ward environment through technologies is a central defining feature of the modern mental hospital. However, how these technologies on their own, or through combining with existing practices in the ward result in new ways of doing surveillance is yet unknown.

### 2.5.1 Surveillant Assemblage

Bauman argues that the Panopticon is no longer relevant to our present condition and that it is obsolete. He makes his claim on the basis that the panoptic dream of the monolithic 'clockwork' society has failed to materialise and instead what has emerged are consumer societies (Bauman, 1999 cited in Boyne, 2000: 286). In addition, Romein and Schuilenburg (2008: 344) also suggest that rather than 'Big Brother' surveillance what has emerged is "Little Sisters, numerous dispersed surveillant assemblages that are playing an important role in the control of our behaviour". According to Bauman,

modern surveillance methods are concerned with dividing, categorising, and excluding. He refers to Mathieson's synopticon (discussed earlier) in which we as a society are united in the act of watching as opposed to being watched, and Poster's 'superpanopticon' where we are not forced into being watched but are seduced into it (Bauman cited in Boyne, 2000). Similarly, in his 'Postscript on the Societies of Control', Deleuze (1992) claims that Foucault's disciplinary society is increasingly being replaced by societies of control.

Deleuze (1992) argues that societies of control operate with technological machines and whereas the Panopticon relies on the uncertainty of whether one is being watched or not, in societies of control people know that they are being watched and are encouraged not to worry about this. It is in this regard, Deleuze claims, that surveillance becomes normalised. While asylums were defined by their closed environment and regimented living, the modern mental hospital with its emphasis on a range of safety technologies including CCTV cameras, gives the impression of openness. This openness to surveillance has also influenced nursing practices inside wards. Nursing literature for example has begun to question whether disengaged face-to-face watching of patients is the most appropriate way of monitoring them. As the notion of the individual as a mental health service user has evolved in the context of community care, this has also influenced the care of patients inside mental health wards. For example, some nursing literature suggests that rather than standing apart from patients, nurses should seek to engage with patients in order to actively support their recovery. Buchanan-Barker and Parker (2005: 543), have reflected on how nurses could be encouraged to view patients as "consumers" and "service users" to promote the notion of participation and engagement in their care, resulting in a shift from

panoptic practices of surveillance (disengaged nurse observations) to synoptic practices of surveillance (through self-surveillance). Barker (1997), for example, identifies three types of self-monitoring that patients could be encouraged to participate in when in hospital. These include, frequency count, where the intention is to help the patient seek clarification regarding the nature of their problem, for example, between feeling angry and losing their temper and other behavioural patterns, which include how much time the patient engages in an activity and making decisions. Barker concludes by stating that self-monitoring is not easy because the patient is required to watch herself all day (1997: 117-119).

Holmes (2001: 9) has argued that despite measures to engage patients in self-monitoring practices, the panoptic practices of surveillance through the use of nurse observation practice still continues to remain a central feature of the mental health ward, because it is “an ideal vehicle for behaviour modification and for the correction and transformation of individuals”. In reality the modern mental hospital operates a range of interventions, which have at their core sovereign power (use of forcible medication, seclusion, and full body restraint), panoptic power (detached nurse observations), pastoral surveillance (through the body of the psychiatrist) and synoptic surveillance (through self-monitoring). While Foucault (1977) might perceive these practices as separate strategic and tactical means by which to control patients, Deleuze and Guattari suggest that these practices, even though they may seem divergent, form a “fragmentary whole”. This fragmentary whole however, does not constitute a whole picture as in pieces of a jigsaw puzzle but is more akin to a dry-stone wall where everything is held together along divergent lines forming its own assemblage (Deleuze and Guattari cited in Nail, 2017: 23). Each new addition, for

example CCTV, produces a new assemblage and therefore the emphasis of this thesis is not simply about the effectiveness of CCTV cameras as a security measure or deterrence to violence and abuse. It is also about how CCTV cameras cohere, interact, or stand apart from those practices inside the ward which are linked to disciplinary power, sovereign power, pastoral power and synoptic power in order to yield a whole with properties of its own. As a result Deleuze and Guattari also believe that assemblages are political and as Nail (2017: 28) expands, it is “not just the so-called “application” of the assemblage that is practical or political, but the very construction of the assemblage – the way it is arranged or laid”.

Haggerty and Ericson (2000) have drawn on Deleuze and Guattari’s writing to develop the notion of a ‘surveillant assemblage’. They claim that Deleuze and Guattari’s (1980) notion of assemblages is based on horizontal surveillance and that surveillant assemblages operate “by abstracting human bodies from their territorial settings and separating them into discrete flows”. They believe that assemblages are created by multiple heterogeneous objects that work together to form a functional entity, and that if one was to investigate what was beneath a particular assemblage or heterogeneous object, one would find “discrete flows of essentially limitless range of other phenomena such as people, signs, chemicals, knowledge and institutions” (Haggerty and Ericson, 2000: 606-608). For example, Lippert (2009) focuses on CCTV signage in open-street areas and concludes that the presence of CCTV signage goes beyond the mundane representation of centralised governmental technology. In other words, he claims that the function of CCTV signage is to amplify the deterrent effects of the cameras, where through the combination of the cameras and signage there emerges an element of a surveillance assemblage. By identifying CCTV signage as a

tool of assembly, Lippert argues that CCTV signage becomes part of an assemblage through legislation, which is brought into being by a complex web of legal governance. For Haggerty and Ericson (2000), it is not a particular technology (such as CCTV) that interests them but rather the convergence of practices and technologies that result in an overall surveillant assemblage.

In order to demonstrate that contemporary surveillance is neither hierarchical nor asymmetrical, Haggerty and Ericson (2000) draw on Deleuze and Guattari's description of the rhizome plant. They claim that it is the ability of the rhizome plant to reproduce through the process of interconnected root systems, which results in horizontal surveillance. They also believe that the rhizome plant's capacity to "grow like weeds", with interconnected roots that shoot off into different locations means that even when it is broken or "shattered at a given spot", it still has the capacity to "start up again on one of its old lines, or on new lines". In addition, Deleuze and Guattari also believed that "the rhizome operates by variation, expansion, conquest, capture, offshoots" (Deleuze and Guattari, 1987 cited in Haggerty and Ericson, 2000: 614). Haggerty and Ericson interpret this aspect of surveillance as not just having regenerative qualities and suggest that it is also expansive. They conclude that contemporary surveillance is not heralded by the introduction, or the development of a single technology, such as CCTV. Ericson also claims that surveillant assemblages operate in order to "address uncertainty in our society" (2007 cited in Romein and Schuilenburg, 2008: 342).

Haggerty and Ericson's (2000) explanation of rhizomatic surveillance suggests that the difference between surveillance and the surveillant assemblage is that within the surveillant assemblage, surveillance is expanded to those people who were not

previously the focus of attention. It is in this way that the surveillant assemblage has a levelling effect on the targets of surveillance, as new populations are identified for exposure. Inside the ward CCTV cameras are not just exposing the bodies and activities of patients, staff are also captured on camera. Within the panoptic prison Foucault (1977: 204) also envisaged that it was not sufficient for the director (or supervisor) to watch prisoners, they would also be under observation where an inspector, “arriving unexpectedly at the centre of the Panopticon will be able to judge at a glance, without anything being concealed from him (*sic*), how the entire establishment is functioning”. In this sense CCTV plays a dual role in disciplining the behaviour of staff and ensuring their compliance inside the ward. It is the potential of CCTV to expose the behaviour of staff in this way, which changes the asymmetrical nature of surveillance inside the ward.

Mann et al (2003: 332) coined the term *sousveillance* or inverse surveillance in order to “challenge and problematize” surveillance, through the use of surveillance technologies in observing those people in authority. They suggest that the use of surveillance technologies in this way offers people who are not in a position of authority, the opportunity to resist surveillance from such authorities. Inside the ward, CCTV has the potential to provide evidence for a range of injustices that can also be experienced by patients. For example, it can show that a patient behaved appropriately in a given situation which prior to the availability of visual footage would have relied on verbal accounts offered by staff and patients, where often patients felt that their account was less believed by those in authority. CCTV footage can also be used by the patient or their family as a means of citing the same account but with images that back-up what a patient might have experienced. In a previous article I

have drawn on two examples which demonstrate these benefits of CCTV. These are the cases of Esmine Green in the United States and Wang Xiuying in China, where CCTV grabs placed on the world wide web by the patients' families showing the neglect and the abuse of these patients, by those people responsible for looking after them, have resulted in condemnation of those hospitals responsible for their care (Desai, 2010). Without the cameras recording events it would have been harder for the families of these patients, who died as a result of neglect and abuse, to hold the hospital responsible. In this regard, Mann et al (2003) argue that surveillance technologies also have the capacity to neutralise surveillance, through counter-surveilling the information that is collected. The ability to view Wang Xiuying tied to her bed and being beaten around the head with a mop (used for cleaning floors) by care staff, provides a powerful image and clear visual evidence of the abuse that she experienced. The cameras therefore do not only make staff compliant; they can also provide evidence of abusive behaviour by them.

It is not yet known exactly how CCTV surveillance is used inside mental health wards or for what reason, however their use in public settings is justified on the basis that they create secure and safe spaces. The use of cameras inside the hospital could be driven by the same reason. Negative images of the mental hospital, as places where awful things happen to people, is likely to be less amplified by the knowledge that it uses CCTV to monitor everyone. If patients (and staff) believe that CCTV technology could deter people from harming them they are more likely to feel safer inside hospitals and therefore are more likely to use the service without fear, and in the process become more open to receiving medical support. This would suggest that CCTV has a positive impact inside the ward and patients might also be willing to give up privacy for the

feeling of safety, especially where they are also reassured that staff are also under scrutiny.

### 2.5.2 Resisting Surveillance

In his critique of panoptic power, Yar (2003) has claimed that vision has become “synonymous with domination” in that it either represses or oppresses people. In doing so Yar suggests that this one-sided representation of power, renders subjects of the panoptic gaze as passive beings who are “confined to internalising the behavioural repertoires laid out by the disciplining authority”. Yar also claims that if subjects of surveillance are not consciously aware of their visibility, then the relationship between “visibility and discipline collapses” (Yar, 2003: 260-261). In addition, Deleuze (1992) has also identified the limitations of panoptic power by claiming that modern society is becoming replaced by societies of control where people know that they are being watched and do not worry about this. These claims question the influence of panoptic power of CCTV cameras inside wards in two significant ways. First of all, Yar (2003: 262) has raised a doubt about people’s continuous “awareness of CCTV cameras”, and secondly, Deleuze (1992) has suggested that even if they aware of the cameras do people actually care that they are being watched? This research has raised a third concern, which is whether the panoptic aspects of the cameras are even relevant in the context of the mental health ward, where the limited cognitive capacity of patients because of their mental health condition and fluctuating cognitive capacity, means that they may not only lack an understanding of the panoptic aspect of the cameras, but even if they are aware of the cameras, they may not necessarily be in a position to conform their behaviour. Coupled with this, the ward environment is about looking out



or watching patients, where patients know that they are being observed for their own well-being, and as a result may not necessarily be worried by this.

Away from CCTV cameras, Boyne (2000: 295) claims that there are many examples of the failure of the panoptical paradigm within the asylum. He cites Goffman and states that within the asylum there are many examples of resistance and “strategies of subversion”. For example, Goffman (1961) describes how space was used inside the ward by patients as means of undermining or disrupting the totalising effect of the asylum: First, “there was space that was off-limits or out of bounds... everything outside a locked ward was out of bounds”, second, “there was *surveillance space*, the area a patient needed no special excuse for being in”, and third, “was space ruled by less than usual staff authority”. Goffman termed these final spaces as “free places” that staff did not usually know about or if they did, they stayed away from them (Goffman, 1961: 203-204). The visibility of surveillance spaces inside the ward can also be used by patients to undermine surveillance. For example, a patient could potentially use surveilled spaces to visibly demonstrate to staff that they no longer harbour disordered thinking, and thus undermine medical surveillance in the process of facilitating their discharge. These examples, according to Yar (2003: 264), suggest that patients are not “passive object(s) of a normalising gaze (on the way to becoming “docile”)” (italic in bracket added). They are in fact “creative and active” subjects in the management of their own visibility. Whether this is the case or not is difficult to substantiate because, other than Goffman’s (1961) research very little is known about how patients resist any form of surveillance in the context of the mental health ward.

Responses to surveillance were initially observed by Scott (1985) who charted the everyday forms of resistance in a Malaysian village. Scott claimed that ethnographic

field studies tended to emphasise “organised, large-scale, protest movements”, and thereby ignored the everyday protests. These protests he believed were not only significant, they were also “the most effective over time” (Scott, 1985: xvi). For him these everyday struggles had been “confined to the backstage of village life”, and as such largely ignored (Scott, 1985: xvii). Johansson and Vinthagen (2014) claim that Scott’s (1985) analysis of everyday forms of resistance was problematic because he attempted to connect everyday forms of resistance to aspects of domination, placing his analysis in the context of a structuralist Marxist framework. They draw on Foucault’s work to make the claim that power and resistance involve complex interplay between sovereign power, disciplinary power and biopower. In this respect their analysis is based on individualised actions “as well as collective actions that are not organised, formal or necessarily public or intentionally political” (Johansson and Vinthagen, 2014: 5).

Marx (2009) has also argued that new forms of surveillance have emerged as a result of Deleuzian societies of control, where power is both absent and dispersive. He has identified eleven forms of surveillance neutralisation (some of these will be discussed in more detail in chapter 6), which include: discovery moves, avoidance moves, piggybacking moves, switching moves, distorting moves, blocking moves, masking moves, breaking moves, refusal moves, cooperative moves, and counter-surveillance moves. While these forms of surveillance neutralisation were linked to computerised work environments, some of these counter-surveillance moves have also been used by patients inside mental hospitals. For example, detained patients inside mental hospitals have used piggybacking moves by pretending to be a visitor or a staff member and following legitimate staff members or visitors out of the ward, and very

occasionally, successfully out of the hospital. Or, cooperative moves, which require cooperation with other patients, such as, one patient starting a fire in the ward to create a diversion, so that other patients can attempt to abscond from it.

Mental health literature has tended to ignore or undermine patient's attempts to escape from the ward, or to disrupt surveillance in other ways as forms of resistance, primarily because these attempts have been perceived as characteristics of a patient's mental disorder. Or, as a threat to security or safety inside the ward, where attempts such as escaping from the ward, is perceived as a serious security breach. These intentional and tactical responses to surveillance are not perceived in mental health literature as disruptions to surveillance or as a challenge to "institutional power asymmetries", as Monahan (2006: 516) suggests. In addition, Ganesh (2016: 168) also reminds us that responses to surveillance can also be "casual, unexpected, ironic, playful, and feeble". While it is not yet fully known how patients resist CCTV surveillance inside the ward, Marx (2003: 372) claims that human beings 'are wonderfully inventive at finding ways to beat control systems and to avoid observation'.

## 2.6 Conclusion

Through an examination of the rise of the mental hospital and the rise of psychiatry this chapter has situated the modern mental hospital in the context of post-institutional mental health care. It is suggested that the modern mental hospital has aimed to distance itself from asylums in two significant ways. Firstly, through specialised care in which patients are not only categorised by characteristics such as

age, but also by the level of risk they pose. Secondly, through its use of new technologies, including CCTV.

This chapter has also expanded on the theoretical approaches adopted in the research. Surveillance literature has tended to promote Foucault's analysis of the Panopticon in relation to shaping people's behaviour. However, in identifying a gap in surveillance literature in which it is yet unknown how the cameras shape patient behaviour inside the ward, the chapter has also highlighted that some of the existing practices inside mental hospitals continue to be reminiscent of sovereign power, especially the use of seclusion, body restraint and forced medication. In addition, it is also suggested that surveillance literature has underplayed the role of pastoral power. Although Foucault links pastoral power to the body of the psychiatrist, how this form of power works for the benefit of patients in the context of the mental hospital has also not been fully examined. Cameras have featured inside mental health wards for over decade, yet it is not clear how they coalesce or stand apart from other practices inside the ward which are also about monitoring patients, such as, nurse observation practice, seclusion and full body restraint of patients.

Finally, the chapter has also raised concern about the mental patient and their capacity to fully appreciate the panoptic aspects of the cameras in shaping behaviour, especially when they are acutely unwell. Surveillance literature has assumed that subjects of surveillance are fully cognisant of the panoptic aspects of the cameras. However, patients inside mental health wards do not always have the capacity to understand the panoptic nature of the cameras and this might affect how they respond to cameras, if at all. These and other factors, such as, how patients negotiate privacy, how they demonstrate autonomy, what constitutes ethical watching, how the

capacity of the cameras are limited through operationalisation, and how the cameras create equity inside the ward, are some additional questions that CCTV technology also raises.

## Chapter 3 Methodology

### 3.1 Introduction

The methodology used in the fieldwork for this research is focused ethnography. The methods involved included focused observations inside mental health wards. They also included interviews with patients, staff and managers as well as documentary evidence, in order to produce what Agar (1996 cited in Woolcott, 2005) calls a 'holistic perspective'. I was drawn to ethnography because I liked the fact that the research was anchored inside the ward, in other words, patients were not talking about how they felt about CCTV cameras after they had left the ward but while they were inside it and living with them. This places a very different emphasis on the research which aims to examine the lived experiences of patients and staff inside mental health wards. My aim was to capture this lived experience of CCTV within the closed environment of the mental health ward, through what Van Manen (1990) describes as experiential descriptions of the phenomenon.

The chapter is divided into two main sections. The first section examines the use of focused ethnography as a methodology in the context of the mental health ward. The second section examines some of the benefits and challenges of using this methodology when conducting research inside these wards.

In total three psychiatric intensive care units (PICUs) in three separate NHS Mental Health Trusts were involved in the research. The research period was from May 2017 to February 2018. A total of 198 hours of observations were undertaken across three wards, amounting to 8 – 10 weeks inside each ward for 2 hours each day. The observation period covered some weekends and night-time observations with the bulk

of observation period happening during the weekdays between 8.00 and 23.00 hours. For observations of patients placed in seclusion staff consent was taken at the time of the observation and patient consent was taken retrospectively (see Information Sheet for Patients and Staff in Seclusion/Extra Care Area Appendix 1). Application was also made to include those people who do not have the capacity to consent to the research through NHS research ethics process.

In total 14 patients, 27 staff and 10 managers were interviewed. Patient interviews, P1 to P14, included 10 males and 4 females; staff interviews, S1 to S27, included 18 females and 9 males; manager interviews, M1 to M10, included 4 females and 6 males. Staff interviews included a range of mental health nurses and health care workers, who were either employed permanently by the NHS Trust, or were agency or bank staff who were called upon on a temporary basis. Agency and bank staff were either employed by an independent agency or were part of the NHS Trust bank staff system. Manager interviews included those managers that were directly responsible for the ward such as ward managers, as well as, those managers responsible for hospital security, and senior managers responsible for the overall management of the psychiatric intensive care units (PICUs).

### 3.2 Ethnography as a Methodology

According to Atkinson and Hammersley (1998: 110) the benefits of adopting ethnography as a methodology is that it:

- Allows the researcher to explore the nature of a particular social phenomena (for example CCTV inside a mental health ward) without testing out a particular hypothesis;
- Allows the researcher to work with unstructured data;

- Allows the investigation of a small number of studies in depth;
- Allows for an analysis of data which involves interpretation of a phenomena.

Higginbottom et al (2013: 1) draw on Spradley (1979), and, Roper and Shapira (2000) to emphasise that ethnography involves the describing of culture that includes a “process of learning *about* people by *learning* from them”. Furthermore, they claim that ethnography has the potential to link micro and macro concerns, that is everyday interactions within the context in which they occur making it a valuable tool for researching healthcare concerns. These concerns they claim not only include those dimensions of a culture that are known but also the “covert or tacit dimensions”, which may not be voiced by members of a particular culture but nevertheless are still shared by them (Higginbottom et al, 2013: 1). The ideal way in which to learn about others, is according to Van Maanen (1988), through living with and living like those they are studying. However, what this actually means in practice can be difficult to quantify. For example, Hammersley and Atkinson (1995) highlight the tension in articulating the crux of what is ethnography. They claim that ethnography’s convoluted history has resulted in a lack of a standardised definition. Willis and Trondman (2002) in addition highlight how poststructuralist critiques have shone a light on colonial ethnographic writings, which they claim were predominantly about making culture, as opposed to reflecting it. In addition to this, ethnography has also had to contend with its tenuous (or even non-existent) scientific basis, and aspects related to generalisability, validity and reliability in the context of research. It is not surprising therefore that other methodologies, providing a more ‘scientific’ approach to research, have taken precedence in the recent past in relation to methodologies adopted by health researchers. In the context of this research, the use of ethnography as a



methodology is perceived as blending of science and art, where coding is used to manage emerging data.

### 3.2.1 Focused ethnography

Knoblauch (cited in Kühn, 2013) highlights the developing nature of ethnography as a research methodology and its use in a range of disciplines. He uses the term 'focused ethnography' to differentiate between one of the newer forms of ethnographic practice from the more traditional anthropological forms. The use of focused ethnography, as described by Knoblauch (2005), is a relatively well recognized methodology within health research. On a pragmatic level when applying for NHS ethics approval and seeking access to research sites through NHS research and development departments it has been beneficial to use terminology that is familiar to the field. However, focused ethnography was also considered relevant for this research. As Kühn (2013) explains, within focused ethnography field stays are shorter because specific aspects of the field are studied with a purpose as opposed to the whole field. The aim of this research was to identify and understand the phenomena of CCTV and how it impacts on patients and staff inside the mental health ward. The construction of knowledge-repertoires is therefore based around how the cameras shape patient and staff behaviour, and how they cohere (or not) with other practices inside the ward as well as the ethical concerns that they raise.

According to Wall (2015), focused ethnography is based on the premise that cultures and subcultures are everywhere and that focused ethnography not only addresses a distinct problem within a specific context but is also conducted with a sub-cultural group. In addition, Wall (2015: 8) also suggests that within focused ethnographic research participants may not necessarily know one another, and as a result the

researcher focuses on their “common behaviours and shared experiences”, while working from the assumption that they share a cultural perspective. All three wards were psychiatric intensive care units (PICUs), which meant that they shared some similar features. For example, the average length of stay in PICU wards is much shorter (about 4 weeks) than other wards, such as, acute wards (where a patient can be detained for up to a year and longer). Once patients were not deemed to require intensive care, they were occasionally discharged from the ward, or more likely transferred to other wards, therefore the turnover of patients inside each ward was much higher. In this respect their ability to get to know one another was also limited. Patients in all three PICUs were detained under mental health legislation, which meant there were restrictions on their movements and ability to access some parts of the ward, including their ability to leave the ward. Patients in all three wards were subject to nurse observation practices, and while each individual ward had certain practices around mealtimes, visiting times and items patients could bring into the ward, all patients were restricted to what they could do. Staff in all three wards were also typified by a core team of staff, and a whole range of agency and bank staff, who undertook shifts when there were not enough staff in the ward. This practice was quite common and therefore not all staff knew one another on every shift.

My entry into fieldwork was marked by the fact that I entered it with a specific intent, which was to examine how CCTV impacted on patients and staff inside the ward, and by the fact that I had prior knowledge of the field in relation to professional values and work experience. I was, for example, not only familiar with mental health wards as a previous social work practitioner but also during my career had entered the ward as a mental health act commissioner (a role where I was required to interview patients

detained under mental health legislation), a Mental Health Act Commission regional director (where I was required to intervene with patients detained under mental health legislation and line manage commissioners who also met with patients), and a member of Mental Health Review Tribunal (where I was involved in judicial process in the determination of continued detention of a patient). This familiarity with the ward environment and the intention of entering the field with a specific goal, placed me apart from traditional ethnographic researchers. As Wall (2015: 15) states, most ethnographers not only do not enter the field with a specific research question, but also “begin the project with no prior conceptions”. My knowledge, relating to the ward environment was also the driving factor in relation to what I wanted to know. For instance, I wanted to know whether patients and staff knew about CCTV, when they first found out about the cameras, why they believed the cameras were inside the ward, what information they had been given about the cameras, how they experienced the cameras and how they reacted to being watched by the cameras.

Whereas some researchers using ethnography might draw upon guidelines for ethical research from the British Sociological Association exclusively, as a registered professional practitioner I was also required to adhere to the guidelines set by the Health and Care Professions Council (HCPC). These guidelines place a different onus on the researcher who is also a practitioner. HCPC (2017) state very clearly that practitioners “need to protect, safeguard, promote and prioritise the wellbeing of children, young people and vulnerable adults”, whatever the circumstance. The Care Act (2014) defines adult safeguarding as the need to protect an adult’s life to live in safety and free from abuse and neglect, and the need to work with organisations in preventing abuse. Therefore, I did not have the same freedom as Norris (1993)

describes in his research of maintaining anonymity when he witnessed police violence. I recognised that any violence, or potential for violence, either observed or being told about would have to be reported to the line manager in each ward. For some researchers this might mean that they could not carry out the research (Spano, 2006). While it may be the case that professional requirements might impinge on the nature of research that could be undertaken in the context of the mental health ward, in this research this was not the case. Although I did raise a safeguarding concern with a senior nurse and ward manager in one research site, this did not negatively affect my relationship with the staff or the patient.

### 3.2.2 The field

As previously stated, this research was not limited to the one ward, it involved research at three separate NHS Trust PICU sites in different regions of England. While the social impact of CCTV in the context of open-street, workplaces, and schools has tended to focus on Foucault's analysis of the Panopticon and post-panoptic theoretical perspectives, these analyses have not been applied to CCTV use inside mental health wards. Mental health wards are very different, in that they are closed environments in which it is not possible for patients to get away from them at the end of the day. It is for these reasons that Huberman and Miles (1998) claim multiple cases are important because they provide comparisons.

The benefit of the three sites being PICUs meant that the sites had several similarities, hence contextualisation and the process of recurring activities meant that there was homogeneity in the categorisation of meaning (Spradley, 1980). For example, as intensive care units all three PICUs only admitted patients who were detained under mental health legislation, this meant that patients could not leave the ward without

the permission of their consultant psychiatrist. Patient's movement inside all three PICUs was also restricted. For example, men could not enter female ward spaces, and similarly females were not allowed to enter male ward areas. In addition, not all rooms inside the wards were accessible to patients and they could not enter certain rooms without staff presence. These restrictions impacted on how patients used spaces inside the wards. All three PICUs had similar ground rules and practices that were known to the staff, especially regarding how patients should interact with one another. For example, staff on all three sites ensured that male and female patients were discouraged from establishing intimate relationships with one another. This also extended to physical contact between a patient and their visitor. All three PICUs had set mealtimes, and while patients were not obliged to eat at the prescribed times, it did mean that if they did not eat at these times, they would have to forgo a hot meal.

All three PICUs also carried out similar nurse care practices. For example, they all carried out general nurse observations although the intervals at which these happened differed. On one site all patients were seen or observed every half hour, while on the other two sites this was hourly. While nurse observation practices were carried out in similar ways, where staff essentially looked at each patient and recorded either manually on a sheet of paper, or on an electronic pad that they had seen the patient, there were other practices which also differed. For example, only one PICU had a seclusion facility and this meant that how each ward managed potentially difficult and aggressive patients differed. The ward in which there was no dedicated suite of rooms that functioned either as a seclusion room or extra care area (which could be used to isolate patients) was the ward that had the greatest number of cameras inside it. It was also the ward which added more cameras part way through the placement, where

in some communal areas of the ward the cameras had more than doubled. Camera placement in all three sites is described in more detail in chapter 4. These factors did impact on data collection in that patients were more aware of the cameras in wards that had visibly more cameras in them.

There was also a point of difference in the overall leadership of the wards. For example, Foucault's analysis of pastoral care places a heavy emphasis on the role of the consultant psychiatrist in providing a leadership role in the process of managing her flock, where part of her duty is influencing staff (Foucault, 2008). While such a role was held by consultant psychiatrists in two of the wards this was not the case in the third, where leadership was by a nurse consultant. Leadership at times was demonstrated by consultant psychiatrists in two of the wards, through their occasional presence and availability in the wards. Sometimes, this presence went beyond the weekly multidisciplinary meetings, often led by them, as part of monitoring each patient's progress. In one ward the consultant psychiatrist also, on occasion attended the weekly meetings between patients and staff at which patients have an opportunity to raise any concerns about their care in the ward. This notion of pastoral care was less obvious in the ward that had a nurse consultant as the lead. While patients in this ward did have their own consultant psychiatrist, these psychiatrists were detached from the ward and while they did meet with their patient and were involved in weekly discussion about their progress in multidisciplinary meetings, these meetings were chaired by the nurse consultant and it is the nurse consultant who provided leadership in how the care of the patient was managed in the ward. The decision to arrange the ward in this way was driven by the desire to maintain continuity with the patient's own consultant psychiatrist so that when the patient returned to the ward that they were

referred from, or returned back into the community, they could continue to be cared for by their own psychiatrist who has known them longer, rather than being transferred to the unit psychiatrist, and then being transferred back when they were no longer in the PICU. This also impacted on how patients perceived the cameras and some patients saw the cameras as an additional way to make direct contact with their consultant psychiatrist who were the least visible in all three wards (described in more detail in chapter 6).

### 3.2.3 The research role

Atkinson and Hammersley (1998: 111) believe that '*all* social research is a form of participant observation because we cannot study the world without being part of it'. They make a distinction between participant and non-participant observation, suggesting that a researcher is a participant when they are "playing an established participant role", such as, working in the ward as nursing staff or perhaps entering the hospital as a pseudo-patient (as in Rosenhan's study, 1973). In this study I was not playing any professional established role in the ward. In my previous encounters inside the ward I was either entering it as a social worker, as a mental health act commissioner, or a tribunal member. I was comfortable in these roles and knew what they entailed. While I was determined to ensure that I would not get involved in taking on the role of a social worker, I was also unsure what I was supposed to do as a student. Bargiela-Chiappini (2007) uses the term liminality to describe how the researcher can become poised between two worlds, in this instance the PICU and the rest of society. The closed nature of the PICU, limited access to patients in relation to the amount of time allowed inside the PICU, often resulted in what Bargiela-Chiappini

(2007: 128) describes as temporary “terms of engagement” that had to be “negotiated and renegotiated” on each entry into the PICU.

Whilst choosing to distance myself from my former designation as a social worker, the fact that I had felt the need to report a possible safeguarding concern to a senior member of staff and line manager, meant that it was not always easy to define the line between a practitioner and researcher. Even though I was not able to ignore this particular issue, there were other times despite my desperate need to say something, especially when I observed staff talking to patients in a very condescending manner, I stayed out of the matter preferring to take on the role of a total observer. Hammersley and Atkinson (1995) suggest that researchers often adopt a range of roles, including being a complete observer; observer as participant; participant as observer and complete participant in the course of their fieldwork. In those situations where I perceived there were clearly aspects of disrespect of patients, I felt very frustrated, sometimes angry and I keenly felt the humiliation and indignity experienced by the patient. I often questioned some of these observations in my field notes as I attempted to make a distinction between trying to understand the significance of power relationships in the context of the ward, and what I believed was a complete undermining of a patient as a person.

In adopting a reflexive role, I was also aware of other people’s perception of me and how this might also impact on the data (Bolton, 2010). According to Sharkey and Larsen (2005: 175) cultural knowledge not only relates to “a set of belief systems”, it is also “embodied in the researcher”. Implicitly I was professionally aware of some of the frustrations involved in working with people with severe mental health conditions and during ward office observations staff occasionally used what is known as “gallows



humour” or “black humour”, to deal with frustrating patients or situations that were beyond their control (Christopher, 2015). Gallows humour or ‘black’ humour according to Christopher (2015: 611), is humour that derives from “from stressful, traumatic or life-threatening situations”. I was acutely aware that sometimes my reaction to jokes at the expense of patients was monitored by staff. By recognising such humour as a means by which staff dealt with the stresses of the job enabled me to empathise with their dilemma. For example, when a staff member specifically said to me “I bet you’re thinking we’re awful”, my response to her was to let her know that I understood their frustration and dilemma (Field note: 021). This response changed the nature of the communication with some staff. Finlay’s (2003) identification of reflexivity as intersubjective reflection highlights how researchers focus on unconscious processes to structure relationships between them and participants. My empathy for their situation was based on my own experiences of feeling frustrated and helpless, when working as a social worker with people who have a mental health condition. This empathy also enabled me to recognise the difficulties experienced by staff inside the ward as an ethnographer doing research, where no one shift was the same.

Spradley (1980: 55) highlights the need for practitioner researchers, who are familiar with their research setting, to become more “explicitly aware” of their environment. Although it was the case that I was familiar with the ward environment and being around patients with severe mental health disorders and working with staff and managers, I was entering the ward environment as researcher with a specific interest in the use of CCTV cameras. Sharkey and Larsen (2005: 175) suggest that the “researcher has to be able to be open up to the newness in surroundings”. I adopted several strategies in order to anchor myself inside the ward. I would for example sit

with a patient while they smoked a cigarette in the garden/courtyard area and listened to their account of how they ended up on the ward, including listening to other concerns troubling them. A number of patients liked the fact that I was not a staff member, and my openness as a researcher and familiarity with being around people who have a mental health condition, allowed them to interact with me in a way that was different to how they sometimes interacted with staff. For example, patients were surprised that I was interested in talking to them and that I took time to sit with them. They enjoyed talking about things other than the reason as to why they were in the ward. They were interested in my research and wanted to know why I had chosen to examine the cameras. Some patients wanted and needed to tell me why they had ended up inside the ward. I empathised with their dilemma of not being able to do what they wanted and when they wanted, including simple tasks like taking a bath, because in order to do so they have to be watched by staff.

Getting to know the routines inside the ward enabled me to establish the best times in the day and night to speak with certain patients or staff. The time period of two hours of observation period in each ward was arrived at following discussion with the manager at the lead site. The decision of two hours was driven by the need to ensure my safety inside the ward. My presence in the ward meant that staff had to also monitor my safety in the ward as an additional visitor. By initially varying observations at different times of the day and night I was able to ascertain when patients accessed communal areas of the ward and find ways to engage with them. In all three wards from late afternoon onwards there were certain times that patients were most visible in the ward. During these times they were less likely to have visitors, be out on leave,

or engaged in some therapeutic activity and therefore more amenable to talking and socialising.

Huberman and Miles (1998: 204) suggest the researcher should “sample an intricately nested range of activities, processes, events, locations and times”, and that this sample needs to be theory driven as well as involving “waves of data collection”. I therefore not only varied the times that I spent inside each ward but also where I did observations. For example, I wanted to know whether staff used CCTV monitors as part of their nurse monitoring observations in the ward or whether they paid no attention to the monitors, what the significance of having the CCTV monitors in the ward office was for them, and how the monitors enabled (or not) in managing the ward environment. This meant that I did some observations in the ward office. Similarly, I shadowed staff when they were undertaking nurse observations, including night-time observations, using infra-red cameras and audio equipment in patient bedrooms. I also observed staff undertaking observations in seclusion, where they also used CCTV monitors. The uses of the cameras as a surveillance tool in monitoring patients was therefore not limited to communal areas only and went wider to include seclusion and patient bedrooms.

#### 3.2.4 Ethnographic interviewing

Whilst much has been written about conducting interviews with women, men, older people, people who are disabled, children, ethnic minority groups, and other groups (see for example, Cotterill, 1992; Arendell, 1997; Eder and Fingerson, 2003), very little is written about conducting interviews with people with a mental health condition. Morrison and Stomski (2015) attempt to give some practical advice and suggest that when interviewing participants with acute mental health symptoms, it is important to

establish a strong rapport and show empathy. In addition, there is even less advice on ethnographic interviewing with patients inside mental health wards. Sharkey and Larsen (2005) suggest that ethnographic interviewing is a combination of informal interviewing which can happen as part of spontaneous everyday encounters with participants, and formal in-depth interviews. They further suggest that the “more formal the interview situation, the more likely that the perspective will be removed from actions in natural settings” (Sharkey and Larsen, 2005: 176). This research adopted both informal interviews that happened as part of being in the ward and talking about the research, and formal interviews which were also conducted inside the ward. While it was possible to give staff and managers a choice to be interviewed off the ward, this was not the case for patients who could not leave the ward as they were detained under mental health legislation. Interviews with patients therefore had to be conducted in the ward. I interviewed patients and some staff in the visitor room, activity room, the lounge area, dining room, anywhere where we would not be disturbed, except for the patient bedroom, including sometimes rooms that had a camera inside it. I was very aware that some patients might be constrained by the lack of a neutral setting in which they could be interviewed or be willing to freely speak about the cameras within the hearing of staff. In these circumstances I was also concerned that patients might respond to my questions according to what they believed staff may want to hear. I aimed to ensure that when I was talking to patients about the cameras there were few staff around, and when this was not possible I distracted the patient by engaging in activities with them such as playing card games or pool while talking to them about the cameras so that they were less worried about saying the right thing. These informal interviews happened in adjoining rooms from the main communal area where staff could look in but were not actually in the room.

In these circumstances it was helpful that the observation periods were for two hours and no longer, as it allowed me to retain a number of conversations in my head which I immediately wrote down when I left the ward.

Establishing my role as an observer and researcher in the ward enabled me to get to know patients. I was able to develop a rapport with them by taking an interest in those things which were important and mattered to them while I was doing observations. Despite this there were still patients who did not always respond to my request to interview them, even after I had explained the research to them and given them an information sheet (see Appendix 2). I felt that these patients did want to participate in a formal interview but were often reticent to do so. I believed that there were several reasons for this. Firstly, I felt that some patients were afraid to say the wrong thing. For example, I gained a lot of information about the location of the cameras, where the ward had potential hidden cameras, and how she believed the staff used the cameras to observe patients, from a female patient (L) who refused to be interviewed because she was genuinely worried about staff disapproval. I sometimes sat outside in the garden/courtyard area because this area often did not have staff in them. L would often find me when I was sat outside and would speak to me about the cameras, including her experiences inside the ward. I had noted that when any staff came into the garden/courtyard area she would change the subject. She had also told me that she had spoken to her partner about doing a more formal interview and he had advised her not to participate in this aspect of the research. This hesitancy by L links to the second point, which is that patients inside mental health wards are not used to making decisions for themselves. In describing the process of self-mortification in asylums Goffman (1961) also talks about how patients are made to give up their will.

These aspects of the patient's lived experience in the ward, especially in the context of their relational experiences with staff also affected the interview process. Thirdly, it was also the case that some patients because of the reaction to their medication, or as a result of their mental health condition, were not able to participate in conversation for longer lengths of time. Their medication or illness made concentration difficult and therefore speaking with them in blocks was the most appropriate way of gaining their views about the cameras. According to Chow and Priebe (2013: 8), mental health wards are designed to contain patients who have an inability to regulate or control their emotions, and who are deemed as being unable to "structure their time and the organisation of their self-care". This meant that I had to be very thorough in the organisation of my field notes. First of all I had to make extensive notes, which I kept in a separate journal noting down each patient that I had a discussion with and what they said, what I needed to focus on the next time that I had an opportunity to speak with them and secondly, I had to hope that the patient was still on the ward and had not been discharged or transferred elsewhere.

Several patients also felt better able to participate if they could see the interview schedule (Appendix 3). One patient interview happened over a two-day period because not only did he want to see the interview schedule, but he also wanted to write down his response to each question before verbally giving me his response which was audio-taped. Working in this way with patients allowed them to gain control over this process. Over time I learnt how to engage patients by listening to their concerns and identifying different ways in which they preferred to communicate. I recognised how some patients were more able to participate in discussions about the cameras when staff were either not around, or where the patient believed that the staff

member was 'okay' and they did not mind them overhearing their views. Barnes and Mercer (1997) place an emphasis on reciprocity in the relationship between the researcher and the researched in an attempt to recognise those being researched as 'expert-knowers'. Despite the challenges in communication most patients were able to understand the nature of the research and even after they had been interviewed some continued to approach me to give me other information that they believed would be useful for the research. An example of this was when additional cameras were installed inside the ward at site 2, where two patients well-known to me, were eagerly awaiting my arrival onto the ward so that they could show me the location of the new cameras.

*Field note 132: I arrive on the ward to find new CCTV cameras are being installed. Patients x and y (both male) greet me and (patient) y shows me the location of the new cameras.*

### 3.2.5 Documentary data sources

Documentary evidence was also sought alongside observations and interviews. Atkinson and Coffey (1997: 55) claim that documents are "social facts" that are produced, shared and used in socially organised ways. The aim of seeking documentary evidence was to track change and highlight the story behind the introduction of the cameras into the ward (Bowen, 2009). However, inside large NHS Trust organisations it became difficult to identify the people who had access to documents such as minutes of meetings. This was because staff that were involved in the original decision-making process had either left the organisation, or those that were there did not know where to locate documents or were unsure that any documented discussions took place regarding CCTV use and implementation. For

example, on one site there had been a consultation meeting with staff and patients regarding the introduction of cameras inside the ward. Managers referred to this meeting in their interview, but it was not possible to access any minutes of this meeting which had been archived somewhere in the Trust.

The lack of documentary evidence in the form of minutes of meetings available on each site meant that much of the information about how the cameras made their way into the ward relied on managers' memory or knowledge. The only time that documentary evidence regarding the implementation of CCTV was given significant attention was when one site made the decision to use infra-red cameras and audio-equipment in patient bedrooms. This is described in more detail in chapter 4.

In the context of this research the documents that were most useful were those that provided some guidance on the uses of CCTV inside mental health wards (NAPICU, 2014; NAPICU and NHS Clinical Commissioners, 2016). Chapter 5 draws on these documents in order to examine how the cameras were used inside the ward.

### 3.2.6 Mental Capacity Act 2005 (MCA) and seeking consent

Bauman (1993 cited in Seale et al, 2004: 219) warns that a "foolproof – universal and unshakeably founded – ethical code will never be found". Hammersley (1999: 18) has argued that "ethicism" is one of the four main tendencies operating in contemporary qualitative research in which there is a tendency "to see research almost entirely in ethical terms, as if its aim were to achieve ethical goals or to exemplify ethical ideals", and where "ethical considerations are treated by some as constituting the very rationale of research". Social researchers (Holland, 2007; Oeye et al, 2007; Dingwall, 2008; Diniz, 2015), have suggested that the over-regulation of ethics in the shape of



institutional review systems and narrow ethical guidelines informed by medical research traditions, have created an epistemological bias that has limited the type of social research that is undertaken in a range of settings, including health and social care. Haggerty (2004) describes this as 'ethics creep', where he claims that biomedical ethical principles have been insidiously transposed to social science research. Punch (1998: 157) claims that this has narrowed debates surrounding ethics to, "get out and do it perspective" at the one end of the spectrum, and formalised approaches adopted by ethics committees where transparency is superseded at the behest of relevant methodologies.

Any research undertaken inside a mental health ward also has to consider ethical approval under Mental Capacity Act (MCA 2005). Faulkner (2004) claims that at the heart of beneficence and non-maleficence is the desire 'to do good' and 'to do no harm'. Rightly or wrongly people with mental health conditions are viewed as 'vulnerable' in our society. This labelling of such people is based on their probability to be exploited by researchers as a result of their limited capacity (or incapacity) to understand the nature of research that is being undertaken, and hence participate willingly as research participants. Gleason's (1990; 1993) studies of people with profound learning disabilities in ethnographic observations highlights the challenges to the observer of interpreting behaviour and subjective meanings. Davis et al (2000) concur with this and suggest researchers using observations should maintain a stance that holds on to the concept that people, whatever their impairment are competent social actors. An ethical stance that is also promoted by the MCA 2005. Whilst MCA 2005 is sometimes viewed as a hindrance to undertaking research with people who lack capacity because it requires an additional application process under NHS research

ethics approval, the fundamental principle laid down in this legislation is about involving them.

In order to include patients in all aspects of the research a careful consideration as to how to manage consent process were considered prior to the research commencing and as part of making an application for NHS research ethics approval. It was not possible to determine whether all the wards would be PICUs as apart from the lead site, which was a PICU, the other two sites had not been established. In seeking consent from any participant, the MCA 2005 requires the researcher or another person such as a member of staff to assess the patient's capacity. Where it is believed that the patient lacks capacity the researcher has two choices. They can either consult a 'personal consultee', who can be a family member, carer, or an attorney (acting under a Legal Power of Attorney) who is not paid to look after the person. Or, in the absence of such a person, the MCA 2005 advises that the researcher should contact a 'nominated consultee', who is not connected to the research and knows the person in a professional capacity, such as a mental health advocate. In order to know whether a patient lacks capacity or not the researcher or clinical staff (such as the nurse in charge) needs to undertake a capacity assessment with each patient. This assessment requires the patient to:

- Understand relevant information about the decision to be made (*in this instance the research*);
- Retain the information in their mind;
- Weigh up or use the information as part of the decision-making process;
- Communicate their decision (by talking or other means).

(Mental Capacity Act 2005) (Italics added)

Undertaking observations inside the ward proved to be the most challenging aspect of consent. Seeking consent from each patient for two hours of observations each day would be both time consuming and very difficult. I had prepared a Ward Observation Information Sheet (Appendix 4) for all patients, staff and visitors to the ward who wanted to know more about the research. Section 30 of MCA 2005 states that research is considered to be intrusive if those people who had capacity to consent to it believed that it was intrusive and would be legally required to consent to it. Also, any intrusive research is deemed unlawful unless that research is approved by an appropriate body. In the case of this research it was the NHS research ethics committee. In making an application to undertake intrusive research (ward observations) inside mental health wards, the first aspect that was considered during supervisory meetings (with research supervisors) was whether it was possible to leave out those people who did not have capacity to consent to ward observations from the research. Leaving out those patients in the ward, who lacked capacity because of their mental health condition or had fluctuating capacity, would have undermined a critical aspect of the research, which was to examine how CCTV cameras shape patient behaviour inside the ward. The final decision was to carefully present to the NHS research ethics committee different scenarios and the actions that the researcher would take if it was felt that any patient, through either verbal communication or through their behaviour indicated that they did not want the researcher present in the ward while doing research observations.

These scenarios were carefully considered and identified in the IRAS (Integrated Research Application System) application and HRA (Health Research Authority) Research Protocol. They included aspects such as checking whether a patient had an

advance directive (as identified in Mental Health Act 1983/2007), which states explicitly whether a particular patient wishes to participate in research or not. They also included rehearsing different strategies that could be adopted, including moving into another part of the ward and continuing with observations there, or stopping observations altogether and recommencing them at another time or on another day, when a patient has a negative response to the researcher. Consideration of these potential scenarios that the researcher might encounter enabled in the presentation of a carefully thought-out protocol to the NHS research ethic committee, which was well received by them. The benefits of the MCA 2005 was that it engages the researcher in how they might “deal with conflict, disagreement and ambivalence”, prior to starting the research (Edwards and Mauthner, 2012: 19). In the end I did not have to deploy any of the strategies that I had rehearsed with my supervisory team. However, going through this process enabled me in feeling more confident and sensitive towards the needs of those patients who lacked capacity, and I was alert to the possibility that not all patients would want me in the ward environment whether they lacked capacity or not.

A similar ethical dilemma was also considered in relation to observing patients in seclusion or extra care areas. It is difficult to gain a patient’s consent while they are in seclusion for two reasons. Firstly, patients are placed in seclusion because they are usually deemed to be aggressive and violent and hence not safe to approach. Secondly, patients placed in seclusion may not have the capacity to consent because they are acutely unwell, or under the influence of illicit substance or alcohol. Through discussion with my research supervisors it was decided that although it was intrusive, it was safer to observe a patient during their seclusion, and then seek retrospective

consent, when the patient was out of seclusion and had the capacity to consent. The aim being that once the patient had gained capacity and was no longer in seclusion, they could control whether the data that I had collected could be used or not. The NHS research ethics committee questioned why I had not considered seeking consent from a consultee under MCA 2005. They presented an interesting alternative based on the fear of losing potentially valuable data. They were concerned that it was possible that a patient may not gain capacity before the end of the research period, and had this been the case, the data would have to be destroyed. The NHS research ethics committee also believed that a patient may also not want a reminder of their time in seclusion or extra care area, and therefore seeking the views of a consultee might also have been more appropriate. The MCA 2005 only allows the researcher to gain the views of a consultee, consultees under the Act do not provide consent on behalf of a participant, and despite the potential for loss of data it was argued within the NHS research ethics committee that it was better for a patient to have control of any data related to them. Both my own views and that of the Committee were valid considerations. In this respect the discussion with the NHS research ethics committee proved very useful, and despite their views about involving a consultee, this was not placed as a condition of the favourable opinion that was given for the research. During the research all patients observed in seclusion or extra care areas gave their retrospective consent. Seeking retrospective consent also enabled me to have the opportunity to speak to patients about their experience of seclusion and being watched by CCTV cameras, these additional views enriched the data. Patients who were willing to speak with me about their experience in seclusion were not distressed by this, and I believed that they welcomed the opportunity to speak about their experience.

### 3.2.7 Data analysis

Sharkey and Larsen (2005: 179) state that the central endeavour of ethnography “is the intention to depict the lives and world views of other people and cultures”, and in representing their personal insights, the researcher has to draw on analytical aids to ensure that analysis is “ongoing and progressive, interwoven with and shaped by data generation”. It is this process they claim which sometimes leads researchers to abandon their initial research aims in order to form new questions to investigate. While it was not necessary in this research to abandon the initial research aims the process of informal conversations with patients and staff did identify a number of issues that necessitated tweaking of the formal interview questions. For example, during informal conversations with L (a female patient) and another male patient, I learnt about their worry about hidden cameras constantly watching them in the ward, including inside their bedroom, where there were no cameras. Staff also confirmed that patients complained about hidden cameras often and needed reassurance. This dimension of hidden cameras spying on patients when they are in their bedroom or using the bathroom, was an important dimension to the research. While I had considered the impact of real cameras shaping patient’s behaviour in the ward, I had not considered how the potential to be seen at all time, could also arouse suspicion about covert watching. This insight enabled me to explore how hidden cameras also impacted on how patients experienced the ward (see chapter 6). In this sense, these informal conversations with patients were important in relation to how emerging information and categories were analysed as part of data management (Spradley, 1980).

Coding as a means of analysing emerging data was used in this research. Sharkey and Larsen (2005) suggest that this is a common method of analysis and data management. I initially constructed broad themes for analysis. These included, the reasons behind how the cameras found their way inside each ward, how staff used the cameras in their everyday practice and how patients and staff experienced and reacted to the cameras. As I became more familiar with theoretical concepts, I was able to identify different processes at work. For example, how Foucault's (1992: 13) 'practices of the self' enabled patients to manage their everyday experiences inside the ward including identifying ways to resist surveillance (discussed in more detail in chapter 6). These strategies for example provide new understanding of patients as being more than 'docile bodies' (Foucault, 1979: 138).

### 3.3 Conclusion

A core strength of using ethnography as a methodology in this research was its centrality of participant observation and the rooting of the research in "first hand exploration of research setting" (Atkinson et al, 2001: 5). The limited access inside each ward meant that it was not possible to reconstruct the knowledge-repertoire of the whole spectrum of tactics used inside the ward to manage patient behaviour. A focused ethnography method was adopted in order to explore how CCTV has become part of the range of techniques and tactics used inside the ward to manage patient behaviour. Examining this in the context of the lived experiences of the ward has meant that it has been possible not just to trace how the cameras function inside the ward but also (as the next three chapters show) how they have located themselves inside the ward with little challenge from patients and staff.

## Chapter 4 Politics of CCTV Implementation

### 4.1 Introduction

This chapter describes the three PICU wards involved in this research and the location of CCTV cameras within each site. It also includes some of the decision-making processes by which all NHS Trust engaged in the implementation of CCTV, including how they managed ethical concerns around maintaining privacy and dignity of patients.

Devolution within the NHS from national to local bodies has resulted in variation in the reasons for deployment of CCTV. This has meant that each NHS Trust has individually decided whether they want to use CCTV, which mental health wards require CCTV surveillance, whether the cameras provide recording facilities, live feeds or both, where the cameras should be located for example in bedrooms, who should be consulted in the decision-making process for example, staff, patients and patient groups, how the cameras are reviewed, operated and so on.

According to a range of managers interviewed as part of this research, there is no specific national policy or any political event that has resulted in the push for CCTV inside mental health wards. Any guidance or policy documents that refer to its implementation tend to be in the context of ward design, especially in the use of CCTV inside seclusion rooms. Other areas include the use of CCTV within the hospital as well as the ward, such as, monitoring in corridors, day rooms, interviews rooms, therapy rooms, visitor rooms, education rooms and reception areas. The primary function of CCTV coverage described in these documents is to eliminate areas of the ward that are hard to observe, commonly referred to as blind-spots, and in the case of seclusion to



maximise the monitoring of the patient in seclusion. CCTV use is also seen as helpful in providing an up-to-date image of a patient who has absconded from the ward (NAPICU, 2017; NAPICU, 2014; DH, 2013).

However, guidance and advisory documents concerning the use of CCTV are not always consistent. For example, the Department of Health guidance (2013) suggests that CCTV should not be used inside patient bedrooms. Yet, NAPICU guidance (NAPICU, 2014: 29) encourages the use of CCTV and other electronic devices, such as breathing monitors inside patient bedrooms: “There are products available that allow alternative methods of regular night time observation with the aim of minimising disturbance and maximising privacy (e.g. infra-red, breathing monitors). Such products reduce the disturbance caused by regular interval (usually a minimum of hourly) night time observation”. NAPICU (2014) guidance also expands the uses of CCTV to include evidence gathering when an untoward incident, a potential offence, or an allegation has occurred in the ward. It also claims that CCTV is a useful learning tool to review the management of difficult situations. Chapter 5 elaborates on NAPICUs (2014) guidance on CCTV in more detail.

## 4.2 The Three Sites and Location of CCTV

### 4.2.1 Site 1

Site 1 is a relatively new, purpose-built PICU. It is the first ward within the Trust to use CCTV camera technology inside it. CCTV cameras are located in air-locked spaces, visitor room, seclusion room, a de-escalation room (similar in design to a seclusion room), garden areas and exits. There are two CCTV monitors in the ward office. There is no dedicated staff whose job it is to watch the monitors. However, staff are able to

change the screens on the monitors, for example, to enlarge it, reduce it, or switch it off. There are two further monitors, one in the seclusion lobby (adjoining the seclusion room) that allow staff to watch patients in seclusion using CCTV, and one in the de-escalation lobby (adjoining the de-escalation room) that allows staff to watch patients in the de-escalation room using CCTV. The cameras in the seclusion room and the de-escalation room also provide a live feed to the ward office monitors. All cameras do not record and provide live feeds only.

Of the three case study sites, site 1 is the only Trust that made the decision to use live feeds only. Managers emphasised the tension in taking the decision not to record CCTV footage. Their concerns for not recording CCTV footage were primarily linked to implications concerning the 1998 Data Protection Act and the added requirements that the legislation entails in relation to storage, safety and security of recorded materials. However, it was not solely limited to this and managers also described other aspects such as the potential for CCTV to erode patient privacy. Yet despite this concern their primary reason for having the cameras in the ward was to *“have more eyes about the place”* (M1), so that staff would always know whereabouts of patients inside it. Privacy in this respect was limited to not using CCTV in what managers described as ‘private’ spaces inside the ward, these spaces included patient bedrooms, bathrooms and toilets.

#### 4.2.2 Site 2

Site 2 opened about 12 years ago. It is a refurbished ward and is located in an older building that has a number of difficult to observe areas or blind-spots. At the commencement of fieldwork observations, CCTV cameras were located in air-locked space, activity room, female sitting area located at the end of the female ward, inside

the original entrance to the building located at the end of the male ward area, which is used as a de-escalation area, garden area and television lounge area. There were two CCTV monitors located in the ward office. There was no dedicated staff to watch the monitors. There was a further CCTV monitor located in the ward managers office. Staff could not change the screen settings from the ward office. Only the ward manager had access to this facility. The cameras provided a live feed and recording facility.

Of the three sites, site 2 has had cameras inside the ward for the longest time, including having more cameras in what are communal parts of the ward, such as, the television lounge area and activity room. It was difficult to decipher what the original reasons were for installing CCTV, other than at that time the clinical team felt that it was needed. Similarly, site 2 originally had a seclusion room inside it, however this facility no longer exists in the ward. This site had no other area, which included a suite of rooms where they could isolate a patient, from other patients and staff. During the majority of fieldwork observation period inside this ward CCTV cameras were operating mainly on live feed only. The cameras did have the ability to record but this facility was only working sporadically. Towards the end of the fieldwork observation period existing cameras were replaced from analogue to digital, and additional cameras were added. The decision to replace and add new cameras was taken prior to the commencement of the research. Managers at site 2 identified the rationale for the additional cameras as:

- Providing evidence for any incident that happens in the ward, especially where there is a serious assault and the case has to be taken to court.
- As a learning tool for any incident that occurs as way of reviewing practices and enabling a debrief process.
- To cover difficult to supervise areas inside the ward and the garden area.

The consequence of additional cameras in the ward meant that cameras covering the lounge and dining area as an example, increased from one camera to three cameras. The cameras were also introduced in all communal spaces and patient corridors in the ward which previously were not covered.

#### 4.2.3 Site 3

Site 3 opened about 9 years ago. It is a purpose-built PICU. CCTV cameras are located in air-locked space, entrance covering female ward, entrance to visitor's room from the ward, entrance inside the main ward, female communal area, visitor's room, garden areas and Extra Care Area (a room designed same as a seclusion room), used for de-escalation of patients. While separate sleeping areas for women were apparent in all three sites, site 3 was the only site that also used additional cameras in the female-only communal/ward area. These areas were only accessible via a specially programmed key fob, which were allocated to female patients and staff. Hence, male patients would not be able to access this area as their key fob would not have allowed them access. The placement of cameras in female area of the ward created a specific gender dimension to camera placement, discussed in more detail later in this and other chapters.

The ward also uses infra-red cameras and audio equipment located individually in each patient bedroom for less disruptive night-time observations. According to managers, these cameras are only used for those patients who have consented to be monitored in this way. Bedroom cameras provide live feeds only and are only operational when staff are undertaking patient observations in this way. There are two CCTV monitors in the ward office which are visible to patients. There is no dedicated staff to watch CCTV

monitors. Staff can change screen settings from the ward office. The cameras in the Extra Care Area and communal areas provide a live feed and recording facility.

Site 3 made the decision to include an infra-red CCTV camera and audio equipment inside each patient bedroom when the PICU was relocated to the new purpose-built site. Managers at site 3 identified the reasons for the cameras in communal areas as:

- Providing additional observations in the garden area, where it can be difficult to supervise patients.
- Providing additional cover to certain areas in the ward, such as, entrance to female ward for the safety of female patients.
- Providing additional evidence in the event of a serious incident on the ward either for the purposes of investigating the incident for the Trust, or as evidence in any court hearing.
- For training and review of practice.

Site 3 also had several cameras outside the PICU entrance. These cameras were used to:

- Monitor people coming to the unit.
- Provide an up-to-date picture of patients who have absconded from the unit to the police as a missing person.
- Monitor leave for patients at the front of the building.

### 4.3 Implementing CCTV

It was the case that while all three sites were PICUs and drew upon the same guidance documentation (for example, NAPICU, 2014; 2017), camera locations differed. For example, site 3 chose to have cameras in patient bedrooms, while the other two PICUs did not. Site 1 used live feeds only, while the other two PICUs had recording facility. Inside site 2 the cameras also observed patients in the television lounge area and activity room, while the other two PICUs chose not to do this even though the television lounge area did not have sub-optimal site lines from the ward office in both these PICUs. In order to adopt a SCOT approach, it is important to contextualise how the cameras arrived into each unit. Bijker (1995: 10) believes that it is necessary to do this and to “figure out a way to take the common evolution of technology and society as our unit of analysis”. According to him, it is only by doing this that is possible not to treat camera implementation as sociologically unproblematic. The SCOT approach allows the analysis of various uses of the cameras inside the ward where over time, Bijker (1995) suggests, a reciprocal process establishes between the ward and the cameras in which each constructs the other. Therefore, examining some of the factors for the implementation of CCTV inside each PICU was reliant upon what it was that managers wanted to achieve. Camera use was not only about increasing the surveillance of patients, they were also considered as a useful tool in helping patients. For example, in the use of bedroom cameras as an aide to facilitating better night-time sleep.

#### 4.3.1 Reason for cameras in the ward

Most managers believed that the decision to include the cameras inside the ward was a local one, and that this decision was influenced by a number of factors. For example,

below a manager describes how a frontline manager influenced the decision-making progress.

*M3: "We had a Director of Nursing... I must be going back 15 years at least...he started the conversations about CCTV..."*

Several managers saw the introduction and expansion of CCTV as a natural progression. Some managers saw the use of CCTV inside the ward as part of the growth of technical and electronic devices that have evolved in the context of the mental health ward. Other managers saw it as a natural progression from its uses in other sectors, such as prisons, and high secure mental hospitals. What these managers had in common is that they did not see the primary function of the cameras as a means to replace existing observation practices inside the ward, especially nurse observations of patients. The relevancy of the cameras for managers at site 2 and 3 was to bring to their attention things that went wrong inside the ward, where they claimed that the central concern was not to attribute blame but to learn from the incident, and instil changes to create a risk-free environment for everyone using the ward. Ashby (2017) has highlighted the shifting focus of CCTV as a tool in preventing crime and its growing use in investigating it.

Some managers also described how various incidents inside mental health wards also led to hasty responses from the hospital Trust.

*M6: "...and that we needed to put in extra cameras cos there was blind-spots that came about because we had erm an incident where a member of staff broke their leg in a... restraint situation but the CCTV didn't pick it up."*

A number of these managers did not necessarily believe that implementing cameras, or having more cameras in the ward, would actually resolve problems. They perceived these responses as 'knee-jerk' responses, based on quick-fix solutions. These incidents do not have to occur inside their own hospital or NHS Trust, and for these managers the cameras were seen as an easy solution.

*M7: "I think in my role one of the single criticisms that I have of most of the jobs we do is that we don't actually know what we want...Whereas if we spent a little bit more time about right what is it, whether I'm building a new hospital, whether I'm refurbishing a ward or whether I'm installing a new CCTV system what is the desired outcome..."*

This form of response is not unusual within the NHS. For example, South West London and St George's Mental Health Trust placed CCTV cameras monitored by security guards inside its intensive care ward, after it was fined £28,000 for pleading guilty to the murder of a healthcare assistant by a patient (Laurance, 2005). The Trust, following an internal review, eventually abandoned the use of security staff in monitoring the cameras (Chambers and Gillard, 2005). As McCahill (2012: 247) states this form of synoptic representation, in this instance the negligence of care from a known and dangerous patient, generates support for "further panoptic measures". Taylor (2011) claims, for the public to accept and support surveillance those involved in it have to be held accountable. Therefore, when making the decision to implement CCTV, managers also spoke about being prepared for any changes in the future, and "future-proofing" the ward against this sort of perceived danger, which may or may not happen, or become a future policy requirement.



CCTVs potential to provide evidence when a possible offence has been committed, provide evidence when investigating allegations, opening up difficult to observe areas, enabling managers to review difficult situations and providing an up-to-date picture of a patient who has absconded from the ward (NAPICU, 2014), made it a desirable tool in the management of the ward environment. This meant that most managers were aware that while there was no current national government policy enforcing the use of CCTV inside wards, this could not be ruled out in the future. Hence, in site 1 the cameras were installed because local capital funding was available at the time. While the cameras were not fully deployed in all areas of the ward, and those cameras that were already in place were live feeds only, the system was in place should there be a requirement to deploy the technology fully in the future. These debates, based on managing future risks inside the ward, ignore the intrusiveness of the cameras and how they threaten a range of ethical and practice issues inside the ward.

*M2: "...there's a mixture of opinion but there's a good chance if we want it in the future, we don't exactly know how we'll use it but let's just build it in because why would you not do it and have to go back and put it in. It's so disruptive isn't it, so let's just you know go with a fairly minimum thing put it in and then deal with it after and the worst case scenario if you don't want to use it, then don't use it."*

#### 4.3.2 CCTV and surveillance expansion

Several managers also believed that once the decision to implement CCTV was made, and it was already in place, there was no going back. These managers believed that their only option was to expand their use by adding more cameras and by finding more

uses for them (as was the case in site 2). The next chapter draws on Ellul's (1964) work to describe how these uses of CCTV have become rationalised inside the ward.

M5: *"We should look at using the system for all sorts of different purposes and that, that's my feeling on it. It is not just, shouldn't just be used for any one sole purpose. It's there, you've got a system...that you can do all sorts of elements with..."*

These views, by some managers, supported function creep in the use of the cameras (discussed in more detail in chapter 5). In all three sites CCTV was managed at a local ward level. However, in one site some ward staff also had access to other cameras around the hospital.

M8: *"...we can access the rest of the hospitals cameras from a computer here via the software...and the reason for this is that out-of-hours because we tend to have one extra member of staff on nights here, so the wards come to us. For example, if the police need an image of somebody who's absconded from the hospital in the night, we can access that and provide that via remote location on a lap-top here."*

M10: *"...what I'm trying to do is we're taking all the information, we're taking all the CCTV and upgrading them...it means that I can literally, on my lap-top now, here, or at home, should there be an incident, or should there be someone gone missing, where we now have digital cameras linked up to the Trust network, I can dial in from home. If the police want a picture of, you know, Joe Bloggs at two in the morning, someone can give me a call. I can dial into that*

*system. If I know that he left at 1.15 in the morning or thereabouts. I can search and take a snapshot picture within minutes. I can email that to the police, so yeah, I can dial into about five locations currently.”*

The expansion of surveillance therefore also included a number of managers, who were not directly working inside the ward, also wanting more remote access to the ward.

*M6: “So in an ideal world... I’d like to have, be able to tap in and have access to all the CCTV around the Trust...have it all linked to one computer back at head office that’d be ideal.”*

The rhizomatic qualities of surveillance not only opens up more flows and spaces of control, but as Romein and Schuilenburg (2008) suggest, the availability of remote access results in the dispersal of the disciplinary gaze and the perfect flow of control, based on speed and mobility. For these managers, the need to access any issues inside the ward quickly, was not always driven out of a desire to maintain their sovereign power by keeping the patient securely locked up inside the ward. They saw their role as recognising that the patient inside the ward is vulnerable as a target of abuse, because of their reduced cognitive capacity and ability to look after themselves. For those managers, who had responsibility for staff safety, it was the perception of the violent patient who was motivated to deliberately harm staff, which was a driver in wanting more remote access.

### 4.3.3 Responsibility for CCTV in the ward

While the majority of managers perceived a need for CCTV inside the ward, they were not always aware who was responsible for the cameras. Within one Trust, three separate managers named different people within the organisation. Managers also believed that the cameras were the responsibility of other managers and not necessarily them. Across all three Trusts managers identified a range of managers, whom they believed were responsible for the cameras. These included the ward manager, security officer, Chief Executive of the Trust, in-patient directorate, and estates as having primary responsibility. This meant that staff and patients were also unsure about who they should approach if they had concerns about the cameras. Indeed, a number of staff and patients felt that they could not do anything about it.

*S13: "I shouldn't think you could do much because it's part of the fabric of the job. So, I'd have thought you couldn't object to it. I don't know. That's what I think."*

*S14: "I don't think there's anything that I could do, is there? I don't know."*

*S23: "I don't think I would go to a manager and say I don't like the cameras watching me."*

*P3: "Not a lot really. We are on camera here because we are on high security."*

*P2: "In my view I don't want CCTV, but management do."*

*P11: "I don't brood about it. Way I see it that's it, and you know, that's the way it is."*

Despite the fact that most staff and patients did not know that they could complain about the cameras, or know how they might make a complaint, most managers generally worked on the assumption that staff and patients were satisfied with the cameras because they had not received any complaints.

M2: *“I guess the fact we haven’t had any, we’ve had no complaints relating to it at all...So I guess that suggests its, well there’s nothing immediately alarming about it...or we would have heard about it...”*

M5: *“Erm none of the staff have ever come out and opposed, it’s been raised at various meetings.”*

Trusts demonstrated compliancy with the Information Commissioners Office (2014) Code of Practice for CCTV and personal information in relation to documentation. However, apart from the use of infra-red CCTV and audio equipment used for night-time observation of patients, all documentation referred to the use of CCTV in external areas of the hospital, with little guidance on its use inside the ward. While the legality on the varying uses of CCTV remains unchallenged it is likely, as Warnick (2007) suggests, the cameras will quickly become standard practice inside the ward.

#### **4.4 Stakeholder Involvement: Involving Patients and Staff in the Decision to Implement CCTV**

##### **4.4.1 Garnering patient and staff views**

Whereas asylums regarded patients as docile bodies that were voiceless, modern mental hospitals encourage patients to voice their opinion and become active participants in how care is delivered. Jørgensen and Rendtorff (2017) describe how patient participation has become the key goal in mental health care, where some

hospitals also encourage staff to refer to patients as 'clients' or 'service users'. These terms were used by staff in the research sites as way of acknowledging patients as active recipients of care, albeit that these patients were in the hospital on an involuntary basis and could not leave because they were detained under mental health legislation. In an organisational context, patients are also described as 'stakeholders' who are encouraged to actively participate in the development and functioning of the mental hospital. The hospital actively seeks out patient views as a means of improving their plans and delivery of healthcare. In the three case study sites managers described how patient views on installing or expanding CCTV in communal areas were garnered.

*M1: "...when we designed the ward...we involved service users and staff...We did involve service users as part of...asking the question about should we be using CCTV."*

*M3: "I don't remember whether we surveyed staff but I certainly remember we had a meeting here with service users input, estates input and some of the clinical staff, and we debated all the fors and against, and we did, we did a kind of erm, well we captured all the reasons why."*

*M5: "As far as patients are concerned the interaction has been very much, we're looking to do this work and we try and consult at different times with patients around what it is we're looking at. So whether that's furniture, or whether that's changes to the environment, or plans for future activity, plans for future change, we always try and capture that from the individuals (patients) that are there (on the ward) at the time."*

M9: *“so in the different meetings we had, we had a planning committee...for most of it, a range of disciplines that work here, a service user representative...and then we had the estates people...and what they call the M and E people, mechanical and electrical...”*

Whilst patients were invited to participate in the decision to implement CCTV, it was less clear how their views influenced any decision-making around camera use.

Therefore, there were several managers who were not always able to fully articulate what issues they raised. Or, how they as managers handled these views and any concerns.

M2: *“I think getting a service user view that’s balanced is a challenge as well. Like we had polar in the room, you know, somebody that’s totally adamant, don’t you dare put it in, it’s awful. And somebody else, oh yeah put it everywhere and keep me safe and you think they’re both equally valid.”*

M3: *“I can’t remember it (CCTV) being on the wish-list. I don’t remember seeing it on there. It was certainly one of those early discussions about future-proof, and there were lots of people saying that we don’t want it in this kind of environment, and a small group saying we do.”*

Elmer (2012: 24) claims that “the transparency of the (panoptic) building” in Bentham’s design of the panoptic prison would have liberated prisoners from “overtly coercive forms of punishment”. Some managers believed that the cameras had the capacity to liberate patients because in those situations where there was violence, the cameras perceived ability to exonerate the patient (as well as staff) made them an

acceptable tool. Foucault (1979: 218) believed that “one of the primary objects of discipline is to fix”, and while there was no firm evidence of the capacity of the cameras to liberate patients in this way, managers worked on the assumption that this was the case.

#### 4.4.2 Dissenting voices

In all three research sites, the decision-making process by managers to implement CCTV started from the premise that the cameras were generally a good thing. The assumption was also made that staff and patients experienced the ward, and CCTV positively. Staff comments below suggest that this was not always the case, even where they did not in principle mind the cameras:

*S12: “...you feel like it’s too much, too many cameras...”*

*S16: “...if I remember rightly, I wasn’t wholly comfortable with it...”*

*S25: “...staff also feel pressured by it to know that, you know, our every move is being scrutinised.”*

In the context of the ward, patients as stakeholders are arguably left in a vicarious position where their limited capacity (as a result of their mental condition) also impacts on how they, as a marginalised group, participate in organisational decision-making processes in the ward. This participation therefore is both a political and ethical one. It is political because Trusts have to show inclusivity as part of a democratic decision-making process. It is ethical because the level of involvement in the process is governed by the Trust whose primary goal is the prediction of future risks inside the ward, which may not necessarily meet the patient objective. The



availability of technology carries with it a level of unpredictability, in that some of the consequences of using it are predictable and others that are not. These consequences often evolve through an anthropogenic process and therefore decision-making processes were also limited by what is unknown. So, while patient and staff views were sought as part of the decision-making process, ultimately the final driver for CCTV implementation always remained the production of a risk-free and litigation-free ward environment, even though a number of managers realised that this was unattainable.

#### 4.4.3 CCTV, Privacy and Ethics of Surveillance

The erosion of privacy for patients inside mental health wards has been an ongoing concern in mental health literature (Bowles et al 2002; Cox et al, 2010). In addition, ethical debates around the use of CCTV has also raised concerns around the erosion of privacy (Rajpoot and Jensen, 2015). While privacy for patients inside mental health wards is of concern, this section also draws on Macnish's (2014) 'just war tradition', in order to examine other factors that are also important in the ethics of implementing CCTV. Macnish suggests that while the analogy between the ethics of war and ethics of surveillance is not perfect, the intention to examine the principles of ethics of war is to gain a better understanding for assessing the ethics of surveillance. For example, he suggests that "surveillance is often undertaken with the aim of *establishing* guilt" (Macnish, 2014: 144). Although the cameras might feature inside the ward because of perceptions of violence by patients to staff, the fact that staff can also constitute a risk to patients, as potential abusers allows managers to use CCTV as means of tackling both patient and staff violence.

The politicisation of violence by patients inside mental hospitals has been a key factor in how security measures have been implemented inside wards. In chapter 2 I have

suggested that the perception of the violent nature of the mental health patient has been highlighted as a result of post-institutional care of patients, following the closure of large mental hospitals or asylums. While there has been a growing concern about the violent nature of the mental health patient since the early 1990s, more recently violence by patients has been politicised by audits undertaken by the Healthcare Commission and the Royal College of Psychiatrists (both influential organisations) between 2003-2005 and 2006-2007. Their statistical analysis has shown that inside mental health wards there was a greater risk of physical assault to nurses, clinicians and other patients, by patients with a mental disorder (Healthcare Commission, 2005; 2007). Similarly, there is currently more exposure of violence that is done to patients by staff. The televising of two documentaries, Whorlton Hall (BBC 1, 2019) and Winterbourne View (BBC, 2011), both private mental hospitals, in which patient abuse was revealed by undercover exposure in the documentary television programme 'Panorama', are two examples of this. These exposures of abuse and violence create new uncertainties inside the ward, and because it is difficult to establish which staff, and which patients, are a threat or a risk to other patients and staff, Macnish's (2014) 'just war tradition', suggests that surveillance inside the ward is based on suspicion.

Macnish (2014) also raises the question of proportionality in relation to surveillance, an issue which in relation to privacy, has been established in human rights legislation and often cited in the context of the mental health ward. Article 8 of the Human Rights Act 1998 claims that people have a right to a private and family life. The Act goes on to say that any limitations to this must be covered by law, that it should be necessary and proportionate, and it should be for one or more of the following aims:

- Public safety or the country's economic wellbeing;

- Prevention of disorder or crime;
- Protecting health or morals;
- Protecting other people's rights and freedoms;
- National security.

What is proportionate in law has yet to be fully established because there has been no legal challenge around privacy and the use of CCTV cameras inside mental health wards. In the context of this research, the implementation of CCTV has included discussion around whether it should be located in bedrooms accessed by patients, which were considered by some managers as private spaces but not others.

#### 4.4.4 The ward as a public space and privacy

A central argument against CCTV is that it poses a threat to privacy. One of the early accounts of privacy is provided by Warren and Brandeis (1890) who claim that privacy is the right to be let alone (cited in Gottleib, 1996). It has also been argued that privacy is not an absolute right, in other words, an individual's right to privacy cannot be taken away from them regardless of any circumstance or reason. Privacy in the ward is regarded as a qualified right which means that a person's rights are limited because they have to be balanced with the interests of other patients, staff and organisational requirements. For example, a patient who seeks to harm herself inside the ward cannot have an absolute right to privacy. Therefore, Stolovy et al (2015: 276) claim that ward spaces are not private spaces, they are public spaces and that public spaces in the ward also include patient bedrooms, where patients need to be monitored because they have the opportunity to harm themselves. Their point of view would also suggest that patient accessed toilets and bathrooms inside the ward are also public spaces, and therefore should be open to camera surveillance.

However, while some managers believed that bedroom spaces should be open to camera surveillance, all managers believed that patients had a right to privacy when accessing toilet and bathroom spaces, even though these spaces also have the potential for abuse and patients harming themselves. Marx (2001) argues that discussions around the concept of privacy are often ambiguous. He suggests that the meaning of what is public or private space is in the interpretation and meaning of how aspects such as CCTV, are interpreted and framed. Gilligan (1982) argues that traditional ethical theories in relation to privacy are based on legal frameworks, which suggest that they are universal and impartial views, and that any intrusion of privacy inside the ward is justifiable on the basis that it can potentially deter violence, criminal behaviour, harm to oneself and is done for the common good. Therefore, it can be interpreted that all spaces inside the ward could potentially be open to surveillance. For example, when a patient is suicidal and deemed high risk of self-harming behaviour, a staff member will observe them while they are using a toilet, showering or bathing as part of constant observation of the patient in the ward (Cox et al, 2010).

Several managers tended to link privacy inside the ward with maintaining patient dignity. Their interpretation of privacy primarily focused on pragmatic concerns, including ensuring that the cameras were not capturing patients in potentially undignified situations.

*M2: "We haven't put it (CCTV) in the en-suite seclusion room...we had a bit of a discussion about that, so we've kept with having viewing panels and not cameras...I think when we've had discussions about that...If it's a woman and it's a male member of staff...it just feels to me, you know, if you're having a shower in there, and the thought of a camera in there. It feels a step too far.*

*Although probably somebody would be able to open the window and still look at you. It's difficult isn't it? But it feels like a different level of concern really".*

Lyon (1994) argues that rather than reducing privacy debates in relation to CCTV to the technical or legal, it makes more sense to see it as a social relation. The unease expressed by M2 (above) about staff watching a patient taking a shower or using the toilet when in seclusion using a camera is, according to Lyon, based on the notion that when staff undertake in-person observation or face-to-face observation, they have to confront their own feelings about watching patients in this way. These feelings are also impacted by the knowledge that the patient can also see them. In this way watching of a patient is different to using CCTV cameras where the patient has no idea who is looking at them. The continuous exposure of the patient body in seclusion and the potential for CCTV to create a distance between staff and patients also concerned other managers, as more patient backstage behaviours become widely accessible (Goffman, 1969).

*M3: "...if there's a female patient in there (seclusion room) and there's male staff in the office looking in (looking at the seclusion room on the CCTV monitor in the ward office) that's a big problem, I think. I don't think that's okay and I've said to them (staff), on many occasions, women strip off, men strip off as well, people (patients) masturbate in there, they do all sorts of things when they are not well, and have to be viewed without them realising that they're being viewed. It's not something that's right really".*

### CCTV in bedrooms

Site 3 chose to implement infra-red CCTV and audio-equipment inside patient bedrooms in order to undertake night-time nursing observations of patients. This decision was primarily influenced by the availability of technology as a problem-solver and an enabler.

*M9: "The use of CCTV as a piece of equipment, by which I mean the ability to see where otherwise couldn't be seen...with an audit trail. I don't mean in the images, but I mean in the fact that a look was made, the basis of that was very straight-forward, erm additional option to meet a commonly reported problem in a mental health setting. So, put simply, a technological solution to a problem presented itself, mostly for patients, and that was for a period of less disturbance during night-time sleeping hours."*

While some managers extolled the benefits of CCTV for the purpose of undertaking nurse observation practices that are less disruptive at night-time, other managers believed that bedrooms were private spaces and should not be open to CCTV surveillance.

*M5: "...camera settings has been taken into consideration because of elements with regard to where the cameras are looking...obviously we want to avoid, avoid the privacy and dignity of bedrooms and various other places."*

What is deemed as a private and public space in the context of the ward is difficult to decipher. In addition, how CCTV surveillance would disrupt what is deemed as private behaviour in the context of the bedroom was also not clearly defined by managers or staff, even though a number of them felt that CCTV inside patient bedrooms was not a

good idea. Inside all three wards there were some patients who chose to stay inside their bedroom because they wanted to be alone. These and other patients also spent time in communal areas of the ward sometimes choosing to sit away from other patients in order to have privacy and time alone. It could therefore be argued that the challenge of privacy inside the ward is the act of balancing the right of the patient to be left alone versus the duty of the hospital to protect that patient, including harm to themselves. Lyon (1994) claims that the intensification of surveillance increases the wider appeal of privacy and the desire to be let alone. The lack of privacy inside the ward was therefore an issue for some patients (discussed in more detail in chapters 5 and 6).

Considering the ethical position in relation to privacy and the use of CCTV inside bedrooms is complex. Patients do not have a choice about whether they are observed inside their bedroom or not. Even though they may or may not be a suicide risk, all patients are observed in the same time period intervals (that is every hour or thirty minutes) as they are during the day, according to ward policy. Individual patients may be subject to higher levels of observation, dependent on their risk level and propensity to harm themselves or others. In applying the principle of proportionality, it could be argued that when patients are in their bedroom their risk, unless that patient is suicidal, is reduced (Macnish, 2014). This is because the likelihood of them being harmed by others, or them harming others is reduced. However, risk management does not happen in this way. All patients are considered the same and the only way risk levels are changed is if the patient poses a higher risk. Beck (1992) characterises modern society as a 'risk society', which Giddens (1998) claims is not only preoccupied with the future but also with safety and it is this which generates the notion of risk. It

is argued here that this has changed the emphasis in mental health care from the assessment and management of a patient's needs, to believing that all patients are a risk to themselves or others and therefore require constant surveillance. Managers therefore were conflicted between promoting sleep for patients, linked to wellness and health, and at the same time maintaining the patient under surveillance. M9 describes the pressures that managers are under in maintaining safety of patients, even though sometimes this is at the detriment of patient welfare, and therefore a disproportionate response in the context of bedroom observations.

*M9: "Separate debate but nevertheless, in developed democracies, I suppose in which people have their expectations of care and consideration. People just don't, they won't sit very well with the idea in psychiatric intensive care unit. For example, somebody (patient) went to bed at 9, they died at 11 at night but we wouldn't know about it until we open the door at 9 in the morning. People just won't accept that as due care and attention for a facility of this type, so interval observation has become, err it's become a procedure to deal with that problem."*

Several managers at site 3 perceived CCTV inside bedrooms as a way of seeking a solution for this problem. They saw CCTV as a benefit in enabling them to resolve, or at least provide patients with an option, to use the cameras as a way of undertaking discrete monitoring so they can have the benefit of uninterrupted sleep. It is possibly because CCTV camera inside patient bedroom would directly affect patients that when undertaking the decision to implement CCTV inside bedrooms, site 3 made the most effort in proactively seeking patient and staff views about the system. A mock-up of



the technology was set up between two offices so that patients and staff could see how the system would work.

*M9: "The way we tested the...function and the technology for the night-time observation system we had one set up here, looking into the office next door. So...we had hordes of people come through here...at one point err I think probably 40 or 50 people, groups of service users (patients) come in to see it...but that was all part of it really, how it worked, the system, the all-in system...each person had to fill out a semi-structured thing (form) about what they thought about the system and so on."*

*M8: "We were talked to by M9 and I think Dr. X was as well...it was a mock system that had been set up from M9's office to Dr. X's office...the plan was to show the clinicians and canvass the views really on whether the system should be, should it record erm people (patients) that have been there, should it immediately upload to the observation profiles on the clinical system? You know, should it be a recording camera system in the patient's room but I think we moved, that was moved away from on the basis of ethics really because having a recorded CCTV...wasn't the purpose of the system, the purpose of the system was purely to help patients have a good night's sleep and I think that premise was stuck to."*

Once CCTV inside bedrooms was implemented patient input was limited to whether they wanted nurse observation to happen using CCTV or not. Therefore, when reviewing bedroom cameras patient and staff views as to what benefits are gained using the technology, and what is lost as a result of it, became irrelevant. Institutional

audits undertaken by the hospital such as privacy impact assessments, tended to uphold the rights of the public who want to prioritise safety concerns over privacy. Below M10 talks about increasing the capacity of CCTV camera to better view the communal area of the ward, where the desire to capture violent and aggressive incidents inside the ward takes precedence over privacy concerns.

*M10: "Privacy impact assessment I would really apply to external cameras, obviously we don't want to be prying or catching, you know accidentally somebody's lounge windows err we don't want that sort of thing...the internal side of it I'd be suggesting that we're going to replace camera, camera 1 that may look at the communal areas, how many incidents of violence and aggression have taken place in that area, do we need it?"*

#### 4.4.5 CCTV in female ward areas: gendered surveillance

Sites 1 and 3 had locked access to female-only ward areas. In site 3 female patients had their own key fobs that allowed them access inside this ward area. Both these sites also had a specific designated lounge area for those women who preferred to stay away from male patients. It was possible on all three sites to physically see the ward entrance to the female ward area from the ward office. Although during the majority of the fieldwork observation in site 1 this area was not always visible because staff choose to close the blind between the ward office and the communal area, which meant that this part of the ward was not visible. Site 3 not only had visible access to the female ward area it also had two cameras monitoring this area. One camera was located at the entrance to the female ward area and other was located inside the female communal area, which had seating and a television set. This camera could not

only view the communal area, but also two of the three female-only bedrooms located in this area.

The exposure of violence inside mental health wards since the early 1990s has also highlighted the specific abuse experienced by women patients in such wards. Perhaps one of the most influential documents around that time was the Department of Health's (September 2002) document '*Women's Mental Health: Into the Mainstream*'. This document called for a more gendered approach to mental health care which recognises a range of socio-economic, physiological and psychological factors associated with women's mental health. For example, that "women's mental health is affected by experiences of child sexual abuse, domestic violence, sexual violence and rape" (DH, September 2012: 12). Inside some wards women's fundamental right to be kept safe has been interpreted by managers as the need to protect them by increasing surveillance of them. Koskela (2012) believes that women as targets of surveillance are gendered in at least three senses, including how the need to protect them is perceived. Below, M9 describes how the decision to place cameras inside the female lounge area and at the entrance of the female ward area was influenced:

*M9: "So mixed gender PICUs present particular problems. The female service user lobby is quite strong in this, and I'm sure you've come across it, people (female patients) often feel frightened, sexually harassed, or abused or in times when they're making not the best judgements potentially vulnerable. Because we've got a mixed gender thing, we've got other electronic protections like the female fob will only open the female area, and the male fob will only open the male area. And there is a separation by a staff basis, you will have seen and there's one interchangeable bed on the other side of the staff base. So, the*

*approach to the female area is covered by CCTV, so if someone was to take somebody into the female area or somebody was attempting to get into it, we would be able to evidence back who that was. Erm so that's why we put it there."*

Inside the mental health ward this places women, as victims of usually male violence, under more surveillance. Koskela (2012) draws on feminist literature to highlight the exposure of women's bodies, which she claims is viewed differently to male bodies. As part of their ethical consideration in relation to deciding whether to place cameras in the female lounge area or not, below M8 describes how women's bodies are exposed the moment they enter the communal area:

*M8: "Yeah I mean...there were huge ethical consideration around, again particularly the female area because not only, again there's another balance isn't there, protecting females but then absolutely acknowledging that if a female does come out of her room naked they're actually on camera. So there's another sort of example of erm and how are they going to feel, if they're better and they realise that that's the case...yeah I am aware that was all considered relatively, erm well not relatively, strongly and obviously a balance reached really in terms of what we implemented."*

Inside the ward women not only have to accept more surveillance, they also have to recognise that this surveillance is not necessarily going to stop them from being attacked by male patients or staff. This is because, as M9 (above) has described, CCTV use in those PICUs that have recording facility often happens retrospectively. Hence, it is only when an allegation is made, or a concern has been raised that staff can look

back at CCTV footage in order to determine whether it is true or false. Women patients also have to accept that their bodies will be exposed to more surveillance at a time when they are not always in a position to control their behaviour. In this respect, the onus on women “to pay attention to their being-looked-at-ness, as if they are on constant display”, is not negated because of their mental health condition (Koskela, 2012: 52).

#### 4.4.6 CCTV in communal areas

Similar to bedroom cameras the decision to use CCTV in communal areas of the ward was also driven by the availability of the technology. However, the placement of cameras in communal areas of the ward was not influenced by the number of violent incidents that happened in those areas of the ward. For example, during fieldwork observations inside all three wards, the areas where patients tended to become most agitated was around the ward office entrance and corridor spaces near the ward office. Regardless of the number of staff available in communal areas of the ward patients tended to want attention from staff in the office, possibly because some patients recognised that the qualified nursing staff, who were more able to meet their demands, tended to stay inside the ward office. Patients also came to the ward office to gain access to their cigarettes, money, or to find out when they could go on leave, when they could see their psychiatrist, and so on. It is usually around the ward office entrance that patients might be denied access to items, or be told that they cannot go on leave, or see their psychiatrist at that moment, and it was often these encounters that led to aggression in those areas of the ward. In relation to aggressive behaviour it was these areas of the ward that were the ‘hot-spots’ for disruptive and sometimes violent behaviour. However, camera placements were generally justified by managers

on the basis that they covered areas that were difficult to supervise (or blind-spots). Managers also emphasised that in blind-spot areas (where the cameras had capacity for recording) CCTV footage was generally used retrospectively:

*M6: "but from my point of view for CCTV, it's where I'd use it for prosecution. So a lot of, although they're mental health patients, a lot of them do have capacity and they know what they're doing when they're assaulting our staff...we've had a recent arson attack on one of the wards erm and we've got that on CCTV, where it shows a patient going and doing it and coming back and sitting and watching."*

This retrospective use of CCTV recording created an anomaly in how managers justified the placement of cameras. For example, it was not clear whether the role of the cameras was to minimise violence (through CCTV cameras acting as a deterrent), or to take retrospective action against patients (through the cameras acting as an evidence gathering tool). The preferred option by some managers to implement them in some blind-spots of the ward, and not the hot-spots, also appeared inconsistent with what they saw as the primary function of the cameras. This lack of thought about camera placement led some staff to demand more cameras in the ward, especially around the ward office area.

*S22: "we've got the female lounge is covered. The male corridor is not! The air lock is covered by three different cameras. The office is not! We've got about nine cameras in various places outside that we don't need to look at erm the dining room is not! We have cameras in all the rooms in the ECA (Extra Care Area) we don't have cameras in these rooms off err side rooms. Very odd!"*

The expansion of CCTV cameras in site 2 was instigated following an incident in the communal area of the ward, where there was no CCTV coverage, because it was not technically a blind-spot. However, it was a hot-spot where patients were likely to get more aggressive because there was more interaction with other patients or staff with whom they might fall out with. On this site, the rationale for additional cameras throughout the hot-spot areas of the ward was driven by an incident in the ward where a staff member was injured and blamed the NHS Trust for their injury. Hence, in all three sites (even though in site 1 the cameras did not record), there were several staff and some managers who wanted more cameras. Marx (1998) raises the question as to who benefits from this expansion. CCTV's potential to provide evidence, has extended its appeal for location in other areas of the ward especially those areas, where there is more likelihood of violence or aggression. Buchanan-Barker and Parker (2005) claim that this results in changing the basis for how risk is prioritised. They claim that the focus changes from protecting the patient, to protecting the organisation, and that this results in the demise of nursing practice which then places less emphasis on the taking of appropriate risks with patients. The notion of taking appropriate risks with patients becomes absent in risk management discourse, where they claim that even "talking to the patient" becomes too risky (Buchanan-Barker and Parker, 2005: 544). This issue about blind-spots is also discussed in more detail in the next chapter (chapter 4).

In all three sites there was huge emphasis placed on doing observations. Staff were either tied up in undertaking constant observation of a patient (where usually two staff members constantly watch and follow a patient during the day and throughout the night) or undertaking routine observations. These are both very time-consuming

activities. For example, on site 1 staff undertaking seclusion observation were changed every hour. This meant that they could not easily participate in any dialogue with the patient in seclusion and even when they did, it was time limited. In addition, most staff undertaking seclusion observations preferred to watch the patient using CCTV and often remained out of sight of the patient. These staff also closed the blind between the seclusion room and seclusion lobby further ensuring that the patient was not able to see them, thus amplifying the intensity of CCTV surveillance. Buchanan-Barker and Parker (2005: 545) claim that the emphasis on observing patients, as opposed to engaging and exploring with them at a human level the underlying aspect of their distress, has at its roots the most conservative form of psychiatry. This form of psychiatry they claim is based on the premise that medical intervention is about containment of mental illness where distressed patients are placed “on observation”, until the “medication begins to kick in”. While nursing literature places an emphasis on the desire for more engagement with patients in mental health settings (McAndrew et al, 2014; Polacek et al, 2015; Molin et al, 2017), the ward environment is increasingly moving towards practices that minimise contact with patients. This results in the undermining of the value of human contact as CCTV potentially begins to take over as the preferred way for observing patients.

Incidents of violent and aggressive behaviour from patients towards staff and sometimes other patients was also a feature in all three sites. These incidents not only impact negatively on patients but also staff and managers, through loss of time off work and any violence resulting in serious injury, or compensation claims, and so on. For example, in site 1 some staff believed that previous aggressive behaviour during a former admission had led to one particular patient being placed in seclusion for a lot



longer time period than was necessary. However, there were also other staff who were genuinely very frightened of this patient who had seriously attacked one of their colleagues. Macnish (2014) cites Walzer (2006) who believes that in our everyday life we have a right not to be attacked. Inside the ward the question also arises whether staff have the right not to be attacked. The ward environment is different in that it has patients inside it who are angry, frustrated, have little control over their behaviour, feel they have nothing to lose, and who therefore are more prone to becoming aggressive and possibly violent. This focus on violence inside modern mental hospitals has steadily gained momentum. The Department of Health introduced a Health Service Circular in 1999 in which they announced a campaign to stop violence against those staff working in the NHS. This policy was referred to as campaign for zero tolerance. The policy was not necessarily aimed at stopping violence inside mental hospitals, but neither were these hospitals excluded from it. While the notion of zero tolerance to violence continues to be promoted in general hospitals, this is not as easy to enforce in mental hospitals.

*M5: "Zero tolerance policy within mental health is very difficult to manage for all sorts of different reasons. One's mental state doesn't necessarily allow people (patients) to understand the elements of the policy...and equally there are times where other systems don't necessarily support the implication of zero tolerance. So the idea that the police would respond to an incident within and A@E (Accident and Emergency) structure, for instance, in a zero tolerance way is probably very different to dealing with somebody in a mental health unit, who's detained under the Mental Health Act, who's not deemed to have mental capacity. There are all sorts of issues around zero tolerance policies."*

Managers believed that as a result of their mental health condition and the fact that they were detained in hospital meant that there was higher propensity for patients to become aggressive. In supporting staff and patients from aggressive patients, managers found themselves in positions where they were taking on several different, and at times conflicting roles. For example, they were placed in positions where they were an investigator when incidents happened inside the ward, as someone who provided staff and possibly the patient with support at a distressing time, sometimes as the person involved in any disciplinary action or learning process, and at other times the person involved in instigating criminal proceedings. This placed front-line managers in a difficult position when upholding the fundamental values of mental health nursing, while resisting organisational response for more CCTV. In these situations, it is not difficult to see how prevailing discourses around risk management override the welfare benefits of mental health nursing.

*M9: "...depending on when the next serious incident is, and what the characteristics of it are...you know, there is a SI (serious incident) of some sort, erm people can't see exactly what happened. We had somebody that stumbled fell backwards and banged their head and had err erm bleed, and at that point that they'd fallen backwards they were being escorted into their room (bedroom). This was about, I don't know, two years ago. Something like that, err and anyway there was plenty of witness evidence and I think he was okay in the end, and he himself said what had happened but the corridor wasn't covered. And initially, I mean the cynics and those...you know, how do you know he wasn't pushed, tripped up, jumped upon, set upon, whatever. No CCTV, we ought to have it."*

Finally, a more accepted ethical discussion among managers when implementing CCTV was the link between CCTV and the potential for patients to respond negatively towards it, because of the nature of their mental health condition.

*M2: "I think that some people worried that it would make you feel more paranoid...so if people are already frightened that they're being watched why would you put in a camera...that obviously would make people more distressed...that was the biggest one really about making people feel err spied upon and it would fuel paranoia."*

The negative link between some mental health conditions and technologies is quite common. As Cruickshank explains:

*"I believed everything and everyone were put in my path as some sort of psychological test. I believed I had mini cameras implanted in my eyes and that there was a control room somewhere with people analysing the data they saw through my eyes. I believed the crows around me were designed to follow me unobtrusively".*

(Cruickshank cited in Freeman and Freeman, 2008: 12)

While managers showed concern about CCTV heightening the potential for paranoid tendencies in some patients, on the whole they favoured the benefits of CCTV in enabling them to do their job. Staff also believed that because of their mental health condition some patients were likely to experience paranoia, whether there was CCTV in the ward or not, and in this regard, it was a moot point. In addition, managers also believed that while some patients might be disturbed by the presence of CCTV, for other patients it was also a way of bringing equity inside the ward environment.

M10: *"...it's a two-way street, it gives protection to staff, protection to service users (patients), erm that way everybody is, you know, they know it's there and it's looking after them all; it's not just looking after staff. It's not at all discriminatory."*

Equity in relation to CCTV surveillance was justified on the basis that everyone who entered the ward were subject to the gaze of the cameras. The association between social class or socioeconomic status and mental disorders has been a longstanding debate in mental health (Cockerham, 2000; Harper, 2011; Elliot, 2016). The idea that patients also have access to social justice from CCTV is limited. This limitation is demonstrated in the capacity of the patient to understand the context in which they are being observed, as well as having access to legal aid, and as patient P4 explains:

P4: *"Misbehaviour by staff is not at the forefront. It is only patients who misbehave."*

Inside all three sites, apart from their use inside bedrooms, patients were not told that there were CCTV cameras present in the ward. Some managers believed that there should be CCTV signage inside the ward to warn patients, while other managers were surprised that the ward and the unit did not have signs. Some managers believed this should be remedied because it was contrary to data protection legislation, while other managers believed that so long as patients were aware that there were cameras in the ward, this was sufficient.

M4: *"...if there is CCTV, it's more about explaining what it looks like to a new patient. So, these (cameras) are here. They're only in here they're not in your*

*bedroom or if they are in your bedroom this is what it's used for, this is how it's monitored or not monitored, you know so we don't sit and watch you. But it is explained, we believe, whether this happens on a day-to-day basis, I don't know."*

Inside the ward the lack of documentation available to patients about the cameras, including how the cameras are used in relation to maintaining their safety, their rights in relation to not wanting to be monitored in this way, or to complain about their use, and how to access CCTV footage, places them in an inequitable position. It is this lack of information and the taken-for-granted attitude adopted by some managers that the cameras are there for the patient good, which has resulted in the lack of information and choices for patients inside the ward. While staff can walk away from the cameras at the end of their shift, patients have to remain in the ward until they are discharged. This also impacts on how patients experience the cameras and the ward, discussed in more detail in chapter 6.

## 4.5 Conclusion

This chapter has outlined some of the issues that managers considered when deciding to implement CCTV cameras inside the three sites. The localised nature of decision-making within a devolved NHS has resulted in each site prioritising different uses for the cameras. For example, site 3 choosing to implement cameras and audio equipment inside patient bedrooms, and site 1 choosing not to use recording facilities. In all three sites managers believed that cameras were necessary because of the nature of patients that were cared for inside PICUs, that is, patients with acute mental health symptoms and often challenging behaviour. The perception therefore was that

patients inside PICUs were more likely to be violent (a discussion which is expanded in chapter 7). Once the cameras were inside the ward, this underlying belief was a driver for a range of other uses for the cameras. For example, the cameras also aroused suspicion around staff behaviour, where site 2 chose to expand its use of cameras as a result of an incident inside the ward, which although was not captured on CCTV, it could be in the future because of the expansion of the coverage.

Most managers perceived the cameras as a stand-alone technology. By prioritising camera use in blind-spots and not hot-spots for example, managers believed that staff should manage patient behaviours in-person in hot-spot areas. However, there were a few discrepancies associated with this. First, although managers claimed that the cameras were in the ward to cover blind-spots, not all blind-spots were actually covered. For example, in site 3 the dining room area was clearly a blind-spot which was not covered by a camera. Second, when an incident did occur in a hot-spot area, which was not covered by cameras, managers made the decision (as cited earlier in site 2) to expand the use of cameras to cover hot-spot areas. In all three sites, apart from their use inside bedrooms, there was no advice on how staff should use cameras. As the next chapter shows staff therefore used cameras in ways that suited them and their ability to do their job.

## Chapter 5 CCTV in Practice

### 5.1 Introduction

This chapter aims to examine how mental health nurses and care workers used CCTV cameras as part of their day-to-day practices inside the ward. As already suggested surveillance literature has tended to focus on the use of cameras in a range of settings, where the primary focus has often been the criminalisation of those under surveillance (Taylor, 2013). According to Weberman (1995: 193), these accounts have tended to undermine the role of the cameras in their ability to also subtly exercise “authority and influence”. The data analysis in this chapter therefore also examines how staff used the cameras in order to influence the task of maintaining a benevolent or watchful gaze inside the ward in shaping patient behaviour. Lyon’s (2001: 3) theorisation about the ‘Janus-faced’ nature of CCTV is explored through the ability of the cameras to extend care to patients, while at the same time also controlling patients by creating a distance between staff and patients.

In order to understand how CCTV as a technological tool is used inside the ward it is not sufficient to just examine what it does but also examine how human beings give meaning to its function. McCahill and Norris (2003: 46) have referred to this as the “human mediation of technology”. Verbeek (2016: 190) claims that technologies are not “merely functional and instrumental objects”, rather they are “mediators of human experiences and practices”. He goes on to suggest that in order to gain a full understanding of a technological tool (such as CCTV), it is important to examine how human beings give meaning to these mediations. In order to do this, he suggests that it is important to examine technology both empirically and conceptually.

This chapter is separated into two parts. In the absence of any guidance or standard operational procedural documents explaining how and when the cameras should be used, I have drawn on NAPICUs (2014) guidance as a basis for the sanctioned uses of CCTV inside the ward. However, CCTV use was not limited to this, and the chapter also identifies other uses of CCTV inside the ward. NAPICUs (2014) guidance is endorsed by NAPICU as a professional body and according to their website, NAPICU are a registered charity established in 1996 whose primary interest is the development and improvement of psychiatric intensive care units (PICUs) and low secure services ([www.napicu.org.uk](http://www.napicu.org.uk), accessed 3 May 2019). One of their aims is to provide best practice guidance in association with a range of national bodies. The document, *“National Minimum Standards for Psychiatric Intensive Care in General Adult Services”*, referred to within this chapter has been endorsed by a number of professional bodies, including the Royal College of Psychiatrists and the Royal College of Nurses, in developing standards of care inside PICUs (NAPICU, 2014).

It is how staff interact with the cameras in order to undertake a range of tasks (sanctioned by NAPICU or otherwise) which forms the basis for the overall analysis. In this respect my aim in this chapter is not to suggest that CCTV is good or bad. However, because CCTV surveillance is not neutral it is potentially an ethical risk (Coleman and McCahill, 2011).

## 5.2 NAPICU Sanctioned Uses of CCTV

Apart from standard operation procedures linked to use of CCTV inside patient bedrooms, there was no documentation providing staff with guidance on how to use CCTV cameras inside the ward, including the use of CCTV inside seclusion room. This



chapter has therefore drawn on NAPICU's (2014) guidance which provides some recommendations on the use of CCTV in PICUs. This guidance is not embedded in any one piece of legislation but is informed by various legislation such as the Data Protection Act 1998. The document cites the following recommendations on the use of CCTV:

7.2.74. Units should consider the potential value of CCTV as an area of innovation within a PICU in certain circumstances and areas in which it could be carefully deployed.

7.2.75. CCTV has proved useful by providing the following:

- Additional options for observation in difficult to supervise areas (e.g. gardens, smoking areas);
- A means of evidence, recording untoward incidents, potential offences or investigating allegations;
- An additional means by which staff can review the management of difficult situations;
- Up-to-date pictures of patients who may have absconded and are considered at risk.

7.2.76. The CCTV recording system should be easily accessible by designated staff with the appropriate training.

7.2.77. Any use of CCTV should be compliant with all data protection and other CCTV related legislation.

(NAPICU, 2014: 30)

The same document also recommends the use of infra-red CCTV camera technology and audio equipment inside patient bedrooms:

7.2.70. There are products available that allow alternative methods of regular night time observation with the aim of minimising disturbance and maximising privacy (e.g. infra-red, breathing monitors). The value of such products should be considered in diminishing the disturbance caused by regular interval (usually a minimum of hourly) night time observation.

(NAPICU, 2014: 29)

A further document, NAPICU and NHS Clinical Commissioners (2016: 13) Guidance for Commissioners of Psychiatric Intensive Care Units (PICU) also suggests that CCTV should be considered as an observation tool in order to supervise leave:

3.31. To facilitate safe access to outside areas for patients including those on Section 17 leave, a number of safeguards are needed:

- Consideration of appropriate staff supervision, engagement and other observation (including use of CCTV) given the mix and number of patients outside or on leave at any one time.

There are two interesting points to consider about this guidance. First, by suggesting that PICUs should consider CCTV as “an area of innovation”, NAPICU (2014: 7.2.74) guidance has built into it the notion of function creep in that it invites NHS Trusts to seek out other uses for the technology. Secondly, as innovative uses of CCTV become established practice, they become part of future guidance endorsing its uses. For example, the use of cameras in hospital grounds to monitor leave is now approved in the document NHS Clinical Commissioners (2016) guidance, where CCTV use is presented as a desirable tool in the monitoring of leave outside hospital grounds.

Bijker (1995) claims that the expansion of CCTV and changes in its function happen because its uses are interpretive, and therefore not confined by imagination or creativity. Bijker argues that information systems (CCTV) together with their information content can be used in multiple ways. The term function creep was coined by Winner (1977) to describe how technology intended for one purpose is used for a different one. Marx (1988) coined the term surveillance creep while undertaking research for his book *‘Undercover: Police Surveillance in America’*. Similar to Winner’s function creep, Marx used the term surveillance creep, to denote the use of technology ascribed for one purpose being used for another. However, Marx specifically makes a distinction between the uses of surveillance technologies as a means of expanding surveillance through surveillance creep, whereas Winner’s (1977) notion of function creep is not necessarily tied to this.

Haggerty (2012: 236) describes the dynamics of surveillance creep in the context of the police force where aspects such as snitching are described as “low-tech” surveillance and use of CCTV cameras as “high-tech” surveillance. He provides an example of how local authorities have used high-tech surveillance technology, including CCTV, which

was initially authorised to counter terrorism, in order to regulate low level crimes such as, “people putting their garbage out on the wrong day, not cleaning up after their dog, urinating in public...”, and thereby increasing surveillance practices (Haggerty, 2012: 241). Dahl and Sætnan (2009: 88) claim that function creep happens because surveillance techniques are open to interpretation and thus open to new areas of use, and that once CCTV is in place it seems wasteful not to use it to its “fullest acceptable limit”. It is this they claim, which leads to a shift in the “moral terrain” once a new function has been introduced. What remains unknown is how (if at all) CCTV cameras as a surveillance tool change the moral terrain inside the ward, and whether these changes affect the dynamics between staff and patients.

#### 5.2.1 Opening up difficult to observe areas

According to the Collins English Dictionary (1979): “A blind-spot is an area in your range of vision that you cannot see properly but which you really should be able to see. For example, when you are driving a car, the area just behind your shoulders is often a blind-spot”. The phrase blind-spot was used figuratively by managers and staff as a short-hand way to describe difficult to supervise areas inside the ward. These areas included corridors or spaces, where it was not possible to maintain a visual eye on the patient at all times because of structural constraint. In his research inside asylums Goffman (1961: 204) described some spaces inside the ward which he believed were “ruled by less than usual staff authority”, and it is these areas that would have been classed as blind-spots because they were not easy to supervise. For example, in one research site it was not possible to see the whole garden area from the ward as the garden area extended around a corner. This led to patients conducting activities in that area that they may not have in supervised areas.

Field note 018: *“Patient (white, male) enters garden area. He walks past me, goes to the side/back of garden and urinates against a wall. Walks past me again – doesn’t say anything...Speak to staff x about this – why no CCTV there – she says it is a blind-spot and management know about this but don’t do anything”.*

While NAPICU (2014) guidance sanctions the use of CCTV to open up difficult to supervise areas, what is classed as a difficult to supervise area or a blind-spot, was a point of contention between managers and staff (as discussed in the previous chapter). For example, some managers believed that CCTV cameras should not be used in those areas of the ward where staff should be physically present or supervised areas, and in areas where staff have clear sight lines:

M5: *“Cos as I said it’s not used predominantly for observation. It shouldn’t be used for observation.”*

However, in their desire to maintain a constant vigilant eye on patients what constituted a blind-spot differed for staff, who believed that any area which could not be seen at all times constituted a blind-spot. In these instances, staff were not necessarily concerned about how the cameras might affect patients. They were more concerned about maintaining visual contact of each patient so that they had an overview of where each patient was located in the context of the ward.

S7: *“I think they are a benefit because you can’t have eyes in the back of your head, and the ward is so big. You need to have these cameras to be able to give you visual access to the different areas.”*

In one site the dining room area was not covered by CCTV, which staff claimed was a blind-spot. However, managers believed that this area should be supervised by staff when patients are using it. It was often this disagreement between staff and managers which prompted some staff to change the status of blind-spots to hot-spots. These staff for example, believed that there were some patients who were aware that there were cameras in the ward and had worked out where the cameras were located. These patients, according to staff, deliberately targeted those areas where there were no cameras to become angry or aggressive, resulting in the displacement of aggressive and violent behaviour away from sight lines and CCTV cameras.

*S22: "we have so many blind spots that just as many assaults happen off camera! So, it's not always massively err massively helpful in that respect."*

*S9: "I do believe some of the patient's know that there's areas, that there are blind spots they probably don't know all the blind spots, but they've tried moving to different areas and getting angry."*

*S15: "We tend to escort patients to their bedrooms umm but as soon as we're in those areas, we're out of sight of the cameras and things, and they tend to be where quite a lot of incidents can happen."*

### 5.2.2 Investigating potential offences and allegations

While all staff were required to provide verbal accounts and/or written accounts of what happened during an incident where there was violence, some staff tended to believe that CCTV evidence was more reliable than written and verbal accounts. This

was based on their belief that written and verbal accounts were more open to interpretation, whereas camera footage would show what actually happened.

*S16: "I would say I wouldn't feel safe, as daft as it sounds, I wouldn't feel safe if, because personally uh if there was an incident and my err ability came into question. Err I would feel more confident in saying well you can check back and see that I did things right. So, you can see dah, dah, dah. If there was any question of my practice shall we say erm, so yeah for that reason I'd like to think that they've done more good than they have bad."*

When things went wrong inside the ward, for example when a patient became violent or aggressive, it was managers and not the psychiatrist who dealt with these incidents. This sometimes created an anomaly for staff whose natural alliance when caring for patients is with the psychiatrist. Within the pastoral relationship staff take their lead in how to effectively manage the care of each patient from the psychiatrist and not necessarily managers, especially those managers who are not frontline staff. This anomaly is represented in the relationship between staff and managers. Whereas the psychiatrist might be more interested in knowing why the patient became aggressive, managers were more interested in how they as staff allowed the patient to become aggressive, and how they managed the situation. Hence, staff were often concerned about how managers would perceive their behaviour when an incident happened inside the ward. In addition, as people who were responsible for their employment status, in that managers could terminate their employment, they sometimes saw managers as a potential threat. Therefore, even though the cameras placed them under more surveillance, staff saw them as an ally in exonerating them, so much so

that any capture of a situation resulted in staff perceiving this as a “True view” (Cameron, 2004: 136) of the circumstances.

It is when staff come under suspicion in this way that there is a gradual shift in the moral terrain (Dahl and Sætnan, 2009). According to Hope (2009) this suspicion facilitates target hardening, where security measures become prioritised and any problems inside the ward that are linked to patient care are dealt with via system integration (or reliance on CCTV evidence), as opposed to social integration (or talking things out). As a result, the focus shifts from any relationship building between staff and patients to reliance on CCTV, “to deter deviancy or facilitate punishment” (Hope, 2009: 902). Hope cites Garland (2001) to make the point that the implication of this is a shift in values where “crime and deviancy become perceived as mundane, inevitable everyday occurrences”, where the organisation begins to categorise patients and staff in the context of the risk they pose (Hope, 2009: 903). As staff felt more under suspicion it also affected how they perceived patients. It was the patient’s negative behaviour which became the target for surveillance over behaviour that promoted their wellbeing.

*S24: “The one in the garden, a patient...again its allegations. He threw himself onto the hedge...for some reason he decided that he would just, he launched himself...he made an allegation that a member of staff, he pushed me and on the cameras, the staff member is on the other side of the garden and he just threw himself.”*

*S22: “I have had erm CCTV used as part of an investigation...the CCTV was reviewed by the x Board of me searching the patient coming in cos they wanted*



*to review whether I'd searched him erm in line with protocol, which I had...so yeah it was reviewed erm to sort of erm critique my practice, which luckily I did it right and so I've been on that end of it as well where they are using it to try and see whether I've, I've acted wrongly."*

The availability of CCTV footage as evidence, also impacted on how staff were expected to respond to violent situations. For example, during fieldwork observations inside one site, police were contacted on three occasions in order to remove a male patient from the ward because he had assaulted other patients and staff. This patient was taken to the local police station and returned to the ward often on the same day, or the following day. On one occasion his assaultive behaviour was captured on CCTV and staff were annoyed when police decided not to prosecute the patient and instead returned him back to the ward. Managers in this situation were not so concerned about whether the police prosecuted the patient or not. They were more concerned about reporting the incident to the correct authority. However, using CCTV as an additional form of evidence gathering prompted staff to view any act of violence and aggression with less tolerance. Leading some staff to believe that all acts of violence by patients are done knowingly, rather than because they might be frustrated in their environment, or because they were upset with a particular staff member, or because the aggression was associated with their mental health condition.

*S22: "We've had a number of incidents where we've had patients, who have capacity with regards to violent behaviour erm committing assaults against staff members. We've then submitted the CCTV along with statements to the police and still gets dropped for lack of evidence."*

The reporting of violent attacks to the police also meant that violence became a prominent issue inside the ward. Below a staff member describes how the hospital deals with incidents of violence by encouraging the reporting of it to the police, thereby increasing the potential for a patient to end up with a criminal record during a time when they are unwell.

*S14: "It (CCTV) does help in that respect, and again I suppose it benefits the patients because if they're being hurt then, and they want to press charges with the police, which we do encourage that on here, if they're, if they're assaulted by another patient."*

Gilbert et al (2008: 4) describe a range of ways in which patients experience frustration inside mental health wards. In their research patients attributed coercive activities inside the ward as points of their frustration. These included being detained under mental health legislation, where they did not see detention as a legal process but instead as a coercive event. Coercion also included the tension between having to behave in a certain way, referred to by patients as "playing the game", and the use of non-physical force for example being coerced into taking medication. It is these subtle and not so subtle coercive practices inside the ward that patients found frustrating. However, these patient experiences become negated as the actual act of violence becomes dominant in the ward. This impacts on patients in two significant ways. First of all, the patient becomes defined predominantly by her actions and not the circumstances in which she finds herself. Here the moral terrain shifts where maintaining a 'watchful eye', becomes gradually replaced by the policing of patients. Secondly, it raises an ethical concern whereby people, who find themselves as involuntary patients inside a mental health ward, can potentially come out of such

wards with a criminal record, resulting in the criminalisation of patients (discussed in more detail in chapter 7). According to Innes (2003: 1), these situations where patients are reported as criminals is indicative of a ward environment that is “straining for control”.

This also produces conflicting policies resulting in additional stresses for staff who are placed in a position in which any action that they take is perceived as unsatisfactory by the organisation. It also creates a burden on staff who are placed in a situation where their role as caregivers becomes undermined by their role as potential informants of crime. This gradual change also influences how they undertake their pastoral role as there is added requirement on them to become more responsible for security inside the ward. Ball et al (2015: 51) believe that this is a result of de-politicisation of security, which they claim results in security measures becoming “diffused into everyday life”, and where “organisations, as intermediaries and generators of this securitised information flow, become important sites of potential re-politicisation in terms of what they are being required to do”. As security measures begin to influence practices inside the ward some staff begin to have less empathy with certain patient behaviours, where they believe that any aggressive behaviour should be reported. For these staff CCTV evidence took on a greater significance. For managers, as the quote below shows, it also has an added impact in that it leads to anticipatory conformity of staff.

*S18: “I haven’t seen it properly, the process go through, but I’ve seen the CDs where it says like evidence for, and you know it’s marked CCTV cameras...I haven’t done the process but I’ve seen the CD in a case that is evidence for a case that’s happening or going through”.*

### 5.2.3 Learning from difficult situations

A further NAPICU (2014) endorsed use of CCTV is that it aids in the understanding of an event or incident inside the ward. This is so that staff can learn from any incidents and reduce or eliminate any potential triggers or threats from the ward. NHS England require Mental Health Trusts to record untoward incidents and serious untoward incidents inside wards as part of a wider drive to reduce risk factors, which undermine safety. They define a serious untoward incident as:

“events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation’s ability to deliver ongoing healthcare.”

(NHS England, 2010: 12)

Staff provided several examples that they identified as serious untoward incidents inside the ward.

*S9: “Basically a patient, a male patient, actually attempted to strangle another patient, and luckily thank goodness, it was in front of the camera and we were able to, we were able to time line it and show exactly what actually occurred prior to that event happening, and what happened after the event.”*

*S16: “I’ve seen it plain as day, like one (patient) was out the erm the activity room. For example, err this inner door was kicked, then the wrought-back outer*

*door was kicked, a chair was quickly brought out the back and then despite it being, I should imagine incredibly difficult, this person (patient) had still managed to shimmy up over the top and was gone. And you could see it, plain as the day, and it didn't seem to matter a jot that there was a camera watching them all the time."*

If it was available staff tended to use CCTV to construct an account when there was any incident in the ward that involved them.

*S8: "When it came down to the paperwork, we had to pause it, look who was where, on what arm, at what time, and during the restraint...cos so many members of (staff) no one could possibly remember that!"*

*S15: "So the movements (of the patient) were monitored previous the incident and then the build-up just before it erm, to try and find out where he got the cord from, if he had to go looking for it that kind of thing."*

Staff also used CCTV footage to learn from incidents, including sometimes how they could and should have responded differently, and to attempt to put right any other factors in the ward which were missed. In the examples below, without CCTV footage staff would not have the same opportunity to learn best practice, in the carrying out of restraint. Or, find out how a patient managed to abscond from the ward, so that it could not easily happen again. In the final example, staff would not have known that a patient had attempted to strangle another patient, because in that situation it was another patient who had intervened to stop the attack. In this same example while S11 mentions the use of clothing made up as a rope, CCTV footage also showed that the

patient had used a cable wire which should not have been in the ward prompting an investigation as to how the patient had managed to find it. Therefore, for some staff the desire to learn from an incident was linked to providing better care for all patients in the ward.

*S8: "We sort of like had a de-brief afterwards um you know, you look at where everybody was. You sort of reflect on what happened and things, which I always find is good closure because it can be distressing, not just for the patients but for staff as well. It really can be!"*

*S11: "We had a patient absconded the one night...and we couldn't think where they got out from, so we of course we're gonna, we're gonna, you know...myself and the nurse-in-charge went in there (ward managers office) to rewind it, to have a look to see where they got out..."*

*S11: "...like two years ago we had a young male actually trying to strangle a female (patient) with erm, with erm piece of clothing, which was made up like a rope really...that he literally put round her neck...he was strangling her...and there was this other patient...did step in and stopped it..."*

Furthermore, in one site a staff member whose role it was to review minor incidents, used CCTV footage as a learning tool when assessing risk triggers related to each individual patient that was involved in any altercation or restraint inside the ward. This was so that other staff could learn how to better interact with that patient, thus avoiding the need for more repressive intervention, such as, seclusion, time out in an extra care area, full body restraint or additional medication. While managers might

have perceived this as reduction of risk in the context of the ward, for staff understanding the stressors for each patient's reactions to events was more akin to how they saw their pastoral role in terms of nursing patients. Staff welcomed this intervention as this understanding about each patient meant that they also did not have to take an aggressive stance with them while they are involved in day-to-day interactions with them.

*S22: "So I will go back through and have a look at incidents where restraints have happened, and have a look and see like, has everything been done as it should have been, and sort of do a little bit of reflection and use it for debriefing and things like that...so I'll go back and look over incidents, and go like aw okay so that looked a little bit hairy, maybe next time we can try and maybe go into a different area, or we can try and step, sort of help, you go back a little bit further and you can look for any early warning signs and things like that".*

#### 5.2.4 Using the cameras for night-time observation

As discussed in chapter 4 one research site also made the decision to use infra-red CCTV camera and audio-equipment inside patient bedrooms, in order to undertake night-time nursing observation of patients. These bedroom cameras were often referred to as 'in-op' system by staff. The cameras did not record and could only be accessed by staff who used a fob key to operationalise them during their routine observation of each patient during the night. Each time the camera is operational a red light switches on inside the patients' bedroom. This alerts the patient that the camera is operational. The camera is located behind a small viewing box placed inside the bedroom wall. The camera is configured to primarily cover the patient's bed. Staff cannot move the angle of the camera for example to see other areas of the bedroom,

such as the en-suite bathroom, or zoom in and out. It was also possible to hear the patient breathing when the audio equipment was switched on separately. The CCTV monitor and audio-equipment are located next to each patient bedroom door inside a box mounted on the wall. Each time staff turn on the camera to look at a patient, this is not automatically noted anywhere. Staff were therefore required to manually document that they had undertaken an observation of each patient.

Unless specified, all patients were routinely observed throughout the night at hourly intervals. Some staff believed that checking patients inside their bedroom using CCTV was a safer way of undertaking these routine night-time observations, mainly because there were patients that became angry and annoyed when they turned on the light and entered their room every hour. As a result, the cameras had a double advantage in that they allowed patients to gain a good night's sleep and keep staff safe while they were doing their job of monitoring patients. The beneficial aspects of bedroom cameras were not only extended to patients but also staff.

*S21: "some people can get agitated by it (night-time observations). If you've got, if they're on like high observations, like every 15 minutes, it's kind of, obviously be quite annoying if someone like keeps knocking your door, coming into your room every 15 minutes."*

*S22: "it is a source of conflict and it certainly was on the acute wards erm when back then they didn't even have observation windows so you would have to open a patient's door, turn the light on and turn it off, and that was really disruptive."*



Despite the perceived benefits to themselves and patients of doing night-time observations in this way, there were still a number of staff who doubted what they were watching on the screen (similar to Warr et al's, 2005, research cited in chapter 1). These staff sometimes took an over cautionary approach to their observations, using both the in-op system, and manually checking by switching the light on and/or opening the bedroom door, or the louvered observation panel located on the bedroom door. Some staff did this because they feared that their professionalism would come into question if a patient died during the night when they were involved in monitoring them. This fear negated the benefits of the cameras.

*S21: "I mean if you're unsure you can always check the camera, and if you feel like uncertain, you can always knock the door and say like, you okay like, have a look in, or even do the window (observation panel) instead."*

*S23: "I will look through the thing (observation panel) and I will put the lights on because obviously it's our work, isn't it? And if I'm not sure, yeah...Last year I found a girl who committed suicide on my ward...I think experiencing that, finding someone and going through the process writing statements, investigations, and coroner's court, it made me, I think, even more vigilant making sure I see someone properly, yeah."*

*S26: "If there's...someone's say suicidal for instance and you couldn't really see them with their blankets and everything I wouldn't just use that (in-op system). I'd use that and I'd go in if I felt that I had to, if I couldn't see enough on the camera before I go in."*

Koskela (2000: 250) suggests that staff who are watching behind the cameras also find them equally disorientating and alienating. This is because she believes that the “alienated who look from behind the camera see the space under surveillance through the monitor (simplified to two dimensions) and they look at people as if they were objects”. For some staff this two-dimensional watching did not sit easily with their brief of maintaining a watchful eye on the patient throughout the night. For these staff this did not constitute a caring pastoral gaze and was instead a look that was reduced to their bodily movements. This caused them some unease and they did not feel they could trust what they were watching, especially where a patient breathed inaudibly, and where there was little movement from them while they were sleeping. In these situations, staff did not always feel that the cameras were an enabling tool in monitoring patients.

However, by entering the patient’s bedroom they were also diminishing what the managers saw as the positive benefits of the system, which was for patients to get a good night’s sleep without disturbance. In addition, whether a patient had agreed to be observed in this way or not, staff also undertook night-time observations in ways that they believed was most appropriate. For example, patient consent was required in order to use the in-op system. Where consent was given the phrase ‘in-op’ would be written on a white-board mounted outside each patient bedroom door. This would indicate to any staff undertaking night-time observations that the patient had consented to being observed via infra-red CCTV. Where this was not the case the words ‘trad’, short for traditional observations would be noted on the white board. Staff members that I observed generally used their own judgement as to how they did night-time nursing observations.

Field note 223: *“Went around the ward with staff x doing traditional and in-op observations. There are 7 patients on the ward but only 1 patient has agreed to in-op. Staff x tells me that he sometimes uses in-op system even if patient has asked for traditional obs. He says he does this when he knows the patient is asleep. He does this because he does not want to disturb the patient by switching on their bedroom light. I watch staff x use in-op system to carry out obs on 3 patients in addition to the one that has agreed to in-op. One of the patients is awake and sitting on a chair watching tv... Staff x tells me that he knows that this patient is okay about staff using in-op because he has spoken to him.”*

The need to maintain the watchful gaze in the least disruptive way also meant that staff undermined patient’s wishes. Here the desire to do what they perceived as the right action, which was to allow patients to get a good night’s sleep, meant that staff undermined patient’s right to be observed in their bedroom in the way that they consented. This annoyed some patients who were aware that staff did this.

P11: *“They can be switched on or off...and they tend to switch them on or off (laughs) regardless of what you say...Intrusive really...This environment...you have the cameras, you also have the windows with people (staff) looking through, at times it’s like being in prison. You’re being inspected all the time. It’s not very good.”*

P12: *“now I’ve noticed you can see a red light that comes on when they’re using it and they rarely use it cos they can see you through the shutter anyway. They turn the light on at night... they’ll open the shutter and if the lights turned off*

*they turn the light on and off again just to see you, which is like, you've got your camera, use the camera. Like don't turn the light on when I'm sleeping!"*

For some patients not knowing exactly how staff were observing them while they were inside their bedroom created stress. For these patients, the anticipatory conformity of the cameras was apparent in their belief that they were being watched constantly by bedroom cameras, even during the day.

*P12: "when I first came here it was a week or so until someone actually told me that they don't look at the CCTV in my room...and so what for the first two weeks I was under the impression that I was being watched and they can just look at, check in through look in through, I thought they were watching in the office err so you know they could have explained that!"*

Finally, while managers provided a rationale for CCTV placement in female ward areas (see chapter 4), there was less debate around the gendered nature of CCTV use in bedrooms. It was the case in all three wards that both male and female staff took night-time observations of all patients regardless of their gender. Here S27, a male member of staff describes how uneasy he feels when observing female patients through the in-op system:

*S27: "No one (patients) likes them (in-op cameras). I don't think so, they don't. Yeah, even myself I wouldn't like it...it's particularly when we are doing the monitoring for the women. It becomes very...most of them will be their legs are out, open erm the blankets fall off their body...when you check you just see her the way she is and that is not dignity really."*

This form of watching also has the potential to invoke feelings of loss of power associated with abuse that are often common in relation to women's mental health. Karban (2011: 119) states that women's mental health is "more likely to be affected by the experience of violence and abuse, with a recognised association between domestic violence, depression, post-traumatic stress and self-harm". Women patients in these situations, where they have no idea as to who is looking at them, have to rely on the trust of the staff not to turn the watchful gaze to an abusive sexualised one. Koskela (2012: 52) suggests that CCTV surveillance also has the capacity to turn the female body "into a sexualised object *without a mutual commitment* to such sexualisation". The fact that the in-op cameras do not record makes this additionally difficult to prove as there is no mechanism by which an independent person can tell how long a member of staff spent looking at a particular patient and why. CCTV cameras in the communal female ward area did cover all female bedroom doors, however it was not possible to see staff using CCTV equipment for bedroom cameras in all female bedrooms. Even though it was possible to see a staff member doing nurse monitoring using the in-op system and taking longer time to look at the patient, they could easily justify their lingering gaze as necessary because it was not always easy to see the patient clearly.

#### 5.2.5 Using the cameras for seclusion monitoring

There were a number of staff who chose to use the camera in the seclusion room to monitor the patient in seclusion, rather than doing face-to-face observations. Staff gave several reasons for this. Sometimes this was because there was not much happening, where the patient was either asleep and it was clear that they were sleeping, or because the patient was just sitting and doing little else. However, there were some staff who believed that seclusion monitoring was more emotive than doing

routine monitoring or observations in the ward. These staff focused on the intensity of looking at the patient in seclusion and the discomfort of sitting in front of a window, looking into the seclusion room. Below S6 and S1 describe how uncomfortable they feel when they are sitting in front of the window and watching a patient inside the seclusion room. Unlike ward monitoring of patients, where looking at the patient might mean a cursory glance every hour or half hour, they believed that looking at the patient in seclusion was disrespectful because of the frequency of the look. In seclusion, ward staff were required to monitor the patient every five minutes. These staff frequently used the phrase *'it's rude to stare'*, when talking about doing seclusion monitoring. The cameras also provided a relief from this frequent watching of patients, whom they believed also appreciated it, as according to them, patients *'don't like to be stared at'*. CCTV in this context took away the awkwardness out of having to do seclusion monitoring.

*S6: "I guess people see CCTV as intrusive, I guess we, I sometimes, find it less intrusive in the (de-escalation) room and seclusion room because rather than having to stare at them directly through a window, and they know you're watching and they might feel uncomfortable, you can just kinda keep an eye on them on the screen. Sometimes I do feel like it's, don't know if they feel like it, but I definitely feel like it's less intrusive for me like having to stare at them through the window, whereas I can just keep an eye on them on CCTV".*

*S1: "And then in the seclusion...it's quite good cos sometimes your presence umm makes it worse actually for the patient. So you could use, sometimes it's like, there's a blind you can draw it and still watch them but you're not kind of*

*staring through a window at them all the time which I think, you know, some of them it helps."*

The watching of a patient was intensified in seclusion, where the patient is not only constantly looked at by a camera but also a staff member. Staff desire to not be rude, manage their awkwardness, and genuinely attempting to give patients in seclusion some privacy, meant that they tended to rely on the CCTV monitor to observe the patient. Some staff also preferred to close the blind in the window between the seclusion room and lobby, or slightly sit away from the window so that the patient could not see them. This distancing from the patient in order to manage the awkwardness of face-to-face watching also, at times, resulted in rude behaviour towards patients in seclusion by staff. For instance, it was ward policy that a member of staff would watch the patient in seclusion for an hour after which another colleague took over. Staff did not always introduce themselves to the patient when they arrived or say goodbye when they left, and in this respect, they did not see their own behaviour as rude.

The distancing of staff from the patient in seclusion because of the awkwardness of not wanting to directly look at them, is according to Levinas (2006), linked to the exposure of weakness and vulnerability of face-to-face looking. He refers to the 'face' as a term for the other person and believes that it is the opposition of the face which results in the feeling of shame. Therefore, staff's awkwardness of looking at the patient in seclusion is linked to their own discomfort about looking at the patient. Clegg (2012) suggests that awkwardness is an emotion that people experience when they feel threatened that they might not be accepted by others. However, managing their own feelings of awkwardness was not the only reason why some staff preferred

watching patients in seclusion using CCTV monitors. On few occasions when doing fieldwork observations of patients in seclusion, a number of black staff also chose to close the blinds on the seclusion observation window, and to use the CCTV monitor exclusively to watch the patient in seclusion. These staff, who sometimes had previous knowledge of certain patients, claimed that the patient had previously been disrespectful to them by being racially abusive towards them, when in seclusion. For these staff staying out of sight of the patient enabled them to carry out their job of doing observation without having to deal with the emotional aspect of hearing racial abuse. This use of cameras provided relief from patient abuse as it enabled them to remain anonymous, where black staff recognised that the watchful gaze also involved accepting that such abuse was part of doing the job. Gallagher (2014: 1) draws on Levinas to make that claim the “face is characterised by proximity and distance”, and that the closeness of the face “demands a response that could range from a passionate kiss to a punch, or some less extreme or more polite behaviour of moving away or asking for space”. As Van Rompay et al (2009: 62) add, “the presence of others can be seen as a social force, affecting feelings, cognitions, and, to some degree, behaviours”. In these circumstances the closing down of face-to-face encounter while undertaking the job required of them, which is to monitor the patient in seclusion, some black staff used the mediation of CCTV to purposefully create a distance between them and the patient, in order to manage their own emotions, and to protect themselves from racial abuse by the patient.

While some authors have examined the emotive effects of surveillance on those being surveilled (see for example, Koskela, 2012; 2000), little has been said about the emotive effects on those doing surveillance, especially face-to-face or in-person



surveillance. Ellis et al (2013), for example, describe how surveillance has been theorised to evoke feelings of suspicion, while Koskela (2000) describes how those under surveillance can experience a range of emotions such as anger, guilt and fearfulness. The detachment of staff from the patient in seclusion was also expressed in how a number of them felt about doing seclusion observation. Most staff found it a boring and tedious activity because often there was very little happening. Smith (2007: 292) suggests that CCTV operators are “intensely exposed to the *emotional control*” of camera images that they are watching and as a result can become bored, frustrated and can feel guilt, sadness, and anxiety.

Field note 009: *“observation of patient is via CCTV monitor – staff says so long as he can hear the patient he does not feel it is necessary to see him...staff spends most time reading his paper, occasionally checking CCTV monitor before recording that he has seen patient. Patient can be heard talking to himself.”*

Boredom also led some staff to go beyond the role of the watchful nurse to explore meaning behind patient behaviour, through the process of attempting to understand the nature of their madness when they believed that the patient was not aware that they were seen. In this respect some staff saw their role as assisting the psychiatrist in aiming to clinically understand why a patient was behaving the way they were, where the seclusion room literally (as S2 describes below) becomes “*an observatory*”, in which she is a “*fly on the wall*”.

S2: *“It lets us know what they’re like cos everybody has their own, I like to think of it as a mask they put on when they come to the communal area so sort of hide who they are. They might hide how actually ill they are, they might hide*

*how they're feeling. Erm whereas if you've got someone where they can't see you so they think they're on their own, you can help them figure out who that person is, you can say like you do this and you don't like to do that whereas in the communal area you don't like to do this and you don't like that. It's quite interesting really. It's like a little observatory".*

*S2: "It's sort of like being a fly on the wall really, watching the monitors, especially in seclusion. Cos if you're not in their eyesight they can't see you, so they think they're on their own. So, you can kind of see someone's behaviour when they think no one's watching them."*

Levinas (2006) claims that a true relationship can only be ethical when it is demonstrated in the face-to-face encounter. For some staff distancing themselves from patients in seclusion by choosing to watch them using CCTV monitor did not always sit comfortably with the role of the watchful nurse, and for these staff CCTV was not a helpful tool in doing seclusion observations. They felt that relying on CCTV monitoring meant that staff lost an opportunity to engage with patients at a time when they were acutely unwell and perhaps needed more attention. These staff also believed that even when patients are at their worst, for example, wiping their faeces around the seclusion room walls, referred to by staff as 'dirty protest', they were still wanting human contact. There were patients who agreed with this and stated that they felt ignored by staff so that when they asked for things like a book, drink, towel, clean clothes they believed their requests were not taken seriously. Few patients described seclusion as akin to prison and referred it to as "*segregation zone*", "*the blocks*", or "*prison cell*" (P1). These patients believed that staff preferred to view them via the cameras because they were frightened of them.

Inside the ward staff generally tended to perceive patients as a collective body. This sometimes included how they perceived patients when they were in seclusion. Inside seclusion patients have nowhere to hide and everything to do with their behaviour and body is exposed. When they come out of the shower for example and are naked, this exposure is not just viewed by staff directly responsible for observing them in the seclusion lobby area, staff in the ward office and anyone else who is present in the office, can also see the patient on the CCTV monitor. When a patient is in seclusion these behaviours are no longer backroom activities (Goffman, 1990), they are visible for all to see. The ability to watch patients unobtrusively in this way piqued staff curiosity about patient's behaviour. This constant visibility of the patient body in seclusion also resulted in the de-sensitisation of some staff's attitude towards patients:

Field note 029: *"One of the staff (female) looking at the screen (CCTV monitor in the ward office) says "she's taking her clothes off". This prompts another member of staff (female) to look at the CCTV monitor...The other staff tells me... "she settles down in between reviews but when we go in there to do a review, she attacks us. It means she's unpredictable. I don't mind what she says, you know, she calls me a bitch and it's like sticks and stones may break my bones and that. No, it's more she lunges forward to attack us". At this point a male colleague enters the ward office and the staff talking to me says "yeah (she laughs) she's (meaning the patient) really got a thing you know for x (names the male staff). Last time we did a nursing review she said she wanted us to all get out of the (seclusion) room so that she can fuck x". Male staff nurse turns red and looks embarrassed while the other two staff laugh."*

During this discussion the female patient was topless and neither of the female staff thought it appropriate to turn the screen off or reduce its size so that it was difficult to see. Their conversation also prompted the male member of staff who had walked into the room to look at the screen. Rosenhan (1973: 256) describes how he and the pseudo-patients in his study were depersonalised in similar ways: “At times, depersonalisation reached such proportions that pseudopatients had the sense they were invisible, or at least unworthy of account. Upon being admitted, I and other pseudopatients took the initial physical examinations in a semipublic room, where staff members went about their own business as if we were not there”. The humour expressed in this account was also not the same as ‘gallows humour’ or ‘black humour’ described in chapter 3, which was more about the frustrations of working with patients. This humour and the comments above of seclusion as an observatory (S2) is related to what Foucault (1979: 304) refers to as a “normalising judgment”. For Foucault, the “appetite for medicine” results in the appeal of psychiatric experts who then, according to him pass “therapeutic” sentences and periods of rehabilitation through imprisonment or incarceration. As a nurse-judge, the normalising gaze in this humour is reflected in the disinhibited behaviour and actions of the patient in seclusion who must be undermined in order to justify the incarceration. These encounters also undermine the fundamental characteristics of the watchful gaze, which is not about judging but protecting.

### 5.3 Other Uses of CCTV

#### 5.3.1 Using the cameras to stay connected

The availability of the cameras constantly streaming images of patients and staff into the ward office CCTV monitors, meant that staff even when they were in the ward

office involved in administration activities, were always aware of their primary function as the vigilant, watchful observer. Staff kept an eye on CCTV monitors as a matter of habit in the event of being ready for any potential disturbances arising inside the ward, which needed their attention. Here cameras were not used to distance themselves from patients but in order to stay connected with them, and the ward environment. While there may have been an element of the desire to also perpetuate social order inside the ward by being ever-ready for potential disturbances, the cameras were not the only device in the ward which could alert staff of potential conflict inside it. All staff, for example, were required to wear a personal alarm when in the ward, whether they were in the ward office or in communal areas of the ward. These were likely to be far more effective in alerting other staff about any dangers in the ward than the occasional, random watching of CCTV monitors in the ward office. Therefore, whilst staff justified watching the monitors as a means to identify trouble, they looked at the monitors mostly because they wanted to stay connected to the ward environment.

*S14: "If I'm on the computers and I'm opposite them I regularly look up at them to see what's happening, especially if I'm in charge and I'm in the office a lot, then I can see where staff are, I can see where the patients are um and I've got a rough idea about what's happening on the ward."*

Occasionally these non-specific glances did capture an event happening in the ward. Here, an occasional gaze quickly turns into a situation that requires action, as the looks between two patients draws attention to the monitor.

Field note 102: *One staff glances up to the monitor and says, "is that man sitting on the lap of another man?" They both come closer to the monitor. They decide it might be two men behaving inappropriately and go out into the communal area to investigate further. I watch on the screen. One staff stands back while the other speaks with the patients. Both staff return back, and I ask if everything is okay. One staff tells me "It's okay. It's two women comforting each other."*

### Using the cameras to manage anxiety about nurse observations

There were several reasons why staff sometimes believed that it was better not to be directly engaged with patients, but to watch them from a distance or to do discrete watching. Here S10 describes how he used the CCTV monitor in the ward office, to watch a patient who he clearly believed was attempting to out-smart him by finding areas in the ward to hide from him, when he was doing nurse observations. A situation that may previously have raised an anxiety because the patient was out of sight became a playful encounter because he knew where she was:

S10: *"she thought I weren't watching but you try and sort of be, sort of pretty relaxed about it type of thing and she thought I was a bit too relaxed. I knew where she went, and I could see it. She ran down the bottom of the corridor and hid by the back door...but I know there's a camera there so I thought I'm just gonna leave you there cos she thinks that, so I just stood in the office I could see where she was and I could see her on the camera, I could see what she was doing and she thought, she said oh you lost me then. I said I was watching you on the camera I knew where you was all the time."*

Staff's anxiety was also related to ensuring that they were not crowding the patient. Below S11, S21 and S20 describe scenarios in which they recognise that they need to maintain a watchful gaze and equally allow patients a level of privacy. Here cameras inside visitor room, bedroom and outside the ward periphery area are used by staff as a means of creating distance whilst still maintaining a watchful stance.

*S11: "...like with x (patient) and her husband cos they go into the x room, instead of standing outside and making them feel...annoyed...it's a private meeting you know...but even though we're stood outside the door, it's still annoying...So instead of doing that we stand in the office and watch (CCTV monitor)."*

*S21: "Same in their bedroom, cameras can be helpful so it doesn't seem like you're intruding their personal space, you're just looking on the screen instead of having to go in like every 15 minutes and check em, cos obviously when they're asleep, you don't want someone opening your door looking in. At least with the cameras it's done discretely."*

*S20: "...say we had a patient erm who was absconding risk and we were trying to graduate their leave and we took a bit of a risk and we said why don't you go and have some time out at the front of the building for 15 minutes erm initially. What we have done in the past is unobtrusively observe them via the CCTV (CCTV monitor in the ward office) so it kind of gives us and them a bit of space, rather than you know be watching them."*

This discrete watching was beneficial on two accounts. It allowed staff to manage their anxiety because they could still keep an eye on the patient. It also allowed patients to get on with activities in the ward. These include, meeting with their visitor privately, sleeping without being disturbed and demonstrating that they are ready to leave the ward by showing that they can control their urge to run away. Several staff believed the cameras were a benefit because they allowed more freedom for patients in the ward. This freedom is expressed in discrete watching which allows the patient to move around the ward without staff having to follow them, and to be inside their bedroom without being disturbed.

*S23: "You can still observe someone without physically being there which is amazing, cos I think this unit...which is locked, there is no independency whatsoever. You have to ask for every single thing, you know things that you need, then having someone follow you all the time, it's not very nice, isn't it? It's just taking all of your privacy and all of your dignity."*

*S24: "So if you come in you don't have to wake them up. Turn it on, see what they are doing and listen to them breathing rather than disturb them because sleep is very important in mental health and if you keep disturbing them it sort of defeats the objective...So it's got its benefits."*

### 5.3.2 The cameras as an extra member of staff

The cameras, according to staff, had several potential benefits. For example, they allowed staff to occasionally intervene faster in a given situation because the incident had been seen on the CCTV monitor, the cameras enabled staff to view the ward area, which meant that during times when they were short-staffed, they provided a



reassurance, they also enabled staff to maintain contact with the ward environment while they were in the office catching up with administrative tasks. These multipurpose uses of the cameras meant that some staff perceived the cameras as akin to having an extra staff member inside the ward.

*S3: "...it's (CCTV) like having an extra member of staff sometimes cos you can predict it (violent situation) before it happens, you can observe and then intervene quicker."*

*S8: "I think you can have like I said eyes in many places, and you know it's almost like a second workforce you know. You know there's that old saying erm a thousand men holding the sky never got tired, share the workload and then that way, cos if you're looking all the time at something you do get fatigue and you can't always be checking and it's almost like a second workforce. The camera never lies."*

*S12: "...it's our job to stay around the patient so that can be done, maybe need err five staff but maybe when you have a camera, we can release one or two, that's an option."*

The cameras ability to allow staff to see around the ward also meant that it enabled them to use them as a short-cut to locate patients, which previously they may have had to venture out into the ward and physically seek out. They saw this as similar to asking a colleague when they last saw the patient, but better because they could actually see the patient in location. For these staff, it was also a short-hand way of

doing nurse observations as they could see the patient in the ward and did not feel the need to make face-to-face contact with them.

*S10: "Or, if I can't find whoever's on level 2 (observation) because they're right down at the other end of the building. I'll try and see if I can find them on the camera."*

*S8: "So say if somebody is on 5 minute observation checks, so every 5 minutes we need to check them and err say you've got two or three (patients) at the same time and you're in the office and you can see perhaps a couple of people in the day area, you can see one person on the camera, then you've seen them all you know they're safe."*

Bauman (2000: 11) claims that while in Bentham's Panopticon there was limited movement, there was still a level of "mutual engagement" between the inspector in the watchtower and the inmates. However, in the post-panoptical world access to CCTV cameras according to Lyon, have the ability to allow staff inside the ward to "slip away, escaping to unreachable realms", where mutual engagement is over and where mobility is favoured (Lyon in Bauman and Lyon, 2013: 4). It is this function of CCTV as an efficient second workforce, in the rapid response to potential problems arising in the ward, the flexibility to locate patients easily and the opportunity to give staff breaks inside the ward, that elevated its position from being a piece of equipment or technology to the position of 'staff'. Ellul (1964: vi) describes how these behaviours or ways of using technology become rationalised. He uses the phrase 'technique' to describe how behaviour that is "spontaneous and unreflective" is converted into behaviour that is "deliberate and rationalized". Matlack (2014: 50) provides an

example of testing in education when explaining Ellul's concept of technique. He suggests that "once the technique of standardized testing is in place, the primary concern for everyone involved becomes improving the *means* of learning so as to meet the standards, while the *ends* of learning — the ultimate purpose of educating our young — move out of sight". The technique of nurse monitoring has been established in the ward and has not changed significantly since its use inside asylums. While mental health nurse professionals and nurse academics have critiqued this practice and even questioned its relevancy, how this practice ultimately results in the patient's recovery, which is the ultimate reason for the patient being in hospital moves out of sight. It is the perfunctory aspects of the cameras which allows staff to view the patient which becomes the priority over other nurse practice ideals such as talking with patients, taking an interest in what is troubling them, finding out how they are feeling, and so on. It is through technique Ellul argues, that the patient is subtly placed under increasing supervision, as overall nursing care inside the ward becomes constructed around viewing the patient, as opposed to watching out for them in the pastoral sense. Technique, according to Ellul (1964, xxv) is not limited to CCTV, it is also the "the *totality of methods rationally arrived at and having absolute efficiency...in every field of human activity*". In this respect Ellul believes there is no restraint on the rules of technique because the hospital as an institution is also, "orientated towards "performance" and technique is regarded as the prime instrument of performance" (Ellul, 1964: vi).

Ellul's (1964) theoretical analysis of technique provides an understanding of how technology, such as CCTV, can essentially become a by-product of efficiency, resulting in his claim that is the political doctrine of what is useful which dominates over what is

good. Furthermore, Ellul also claimed that it is rational technology, combined with scientific expertise and objectivity that has provided the prerequisite for new technologies to not only become a tool inside the ward, but also expand its uses so that staff believe that the ward could not function the same without it. The establishment and acceptance of CCTV as a necessary tool within the context of the ward has to happen alongside the goals of the staff at an operational level, as well as at an organisational level. Ellul claims that it is when people learn to ignore the mechanisms of technique that technology becomes most efficient. He referred to this process as social plasticity (Ellul, 1964). Social plasticity was demonstrated by the fact that some staff perceived the cameras as indispensable.

*S6: "The cameras are so part of the ward and they're there cos they're needed."*

*S20: "...if we didn't have it, it's hard to imagine what it would be like if it had to be taken away."*

Warnick (2007: 326) when examining the ethics of CCTV use inside schools, believed that one of the reasons why the use of cameras inside schools caused little contention within communities was because they were perceived as, "a natural extension of a watchful and observant school official". However, for some staff unlike human colleagues, whose account of what happened in a given situation might be sketchy, open to interpretation, and potentially judgemental, the cameras were seen as more reliable in their account of what happened in a given situation. In this way the cameras were also perceived as a better ally, especially where a staff's behaviour was under question or suspicion. In these situations, staff also perceived the cameras as an extended member of staff, whose reliability transcended "the vagaries of memory",

and could also potentially provide an accurate account of an incident (Warnick, 2007: 326). As S17 (below) states *“the camera doesn’t lie”*.

S10: *“But the thing is though your anxieties go up! And if they had just gone and turned around and said alright let’s just rewind the camera, oh x (mentions own name) yes you did catch her in the throat accidentally, but I didn’t anyway, but it takes out all that.”*

S13: *“So it’s not going to be just, if you’re having to, for instance a patient attacking you, it’s not only you, your, you know, your opinion and the patient, you’ve got that as proof then that they did attack you.”*

S17: *“But you don’t always remember either. So, there is that element where actually the camera, but the camera doesn’t lie.”*

Some staff also recognised that the cameras had the capacity to expose their own practices to others which could result in gossip. However unlike with human colleagues, where the likelihood is that gossip will probably dissipate quickly, with CCTV recordings there was the potential for the matter to remain longer in people’s memories. Those staff, who had access to recordings, were able to view the footage over and over again and present their own version of an event each time. Thus, events at times were both blown out of proportion, and also remained in the memories of staff much longer. Also, while staff made a judgement about whether they should report another colleague’s misdemeanours, the cameras were not limited by such conventions.

*S12: "...any small thing what's happened...staff will go and check on the camera...then the rumour will start to spread aww this happened...everyone can access a camera, so they will go and check, they will tell other people what exactly happened, who did what, so that's a little uncomfortable sometimes."*

### 5.3.3 Using CCTV to do peer surveillance

The disciplinary aspect of the cameras was also evident in how staff monitored one another's behaviour in the ward. The watchful gaze therefore was not limited to patients. Staff also used the cameras in order to maintain an eye on one another in order to ensure that they were doing the job correctly. Surveillance therefore was not always limited to patients and their visitors but also other staff. Below S4 describes how staff in the ward office regularly maintain a check on visitors and patients using CCTV monitors in the office to watch patients with their visitor in the visitor room, even though there is a member of staff located outside the visitor room physically monitoring the visit. S11 is angry with a manager because they had breached the rules of the ward by allowing a stranger into the air-lock space without checking his credentials. S8 and S24 are questioning the efficacy of agency and bank staff whom they believe are less committed to the job and are likely to take longer breaks, sleep on the job, and so on. The core staff team were often suspicious of some managers who were not regular visitors to the ward and of bank and agency staff, whom they believed were not as committed to watching out for patients as they were.

*S4: "We observe from the staff room (ward office CCTV monitor) so when the patient's actually is on the visit, even though we have staff that physically see (monitoring the visit) we also have staff in the office who actually can see what's going on because being in the room means that we could like, our*

*diversion can switch so the person who is actually physically there might miss something out even though they are there, so it's like we double check instead of making assumptions or that."*

*S11: "The manager allowed that person...onto the ward, never thought nothing of it. So, I go out to the airlock then and there's this chap stood there, Indian chap stood there I recognised him, and I said can I help you? And he said I'm looking for doctor...whoever it is, looking for the Consultant next door. I asked him who'd let him in...I said can you, can you stop here (in the airlock space) because he had no ID, no nothing. I'm fuming a bit now because who's let him on? We don't know him...found out that this person was, is a patient who'd just got out of prison for beating his wife up..."*

*S8: "We do have a lot of agency workers yeah because we cannot predict the amount of staff that we need from a week to week basis, so that's expected. Erm sometimes you get people that take longer breaks than they should, or they might fall asleep at work, or they might not know the protocols or procedures around...performing restraint..."*

*S24: "...sometimes on night-shifts...staff can't take forty-winks knowing that, that thing (CCTV) is watching me...so if anything, it encourages people to be on the floor."*

#### **5.3.4 Using CCTV to negatively categorise patients**

While some patients might be perceived as a problem patient, because of their aggressive behaviour linked to the frustration of being in the ward, or their constant

desire to escape from the ward, Lyon (2001) argues that it is through surveillance practices that they are categorised as a risk or danger. This categorisation according to Lyon, occurs through the process of social sorting where he claims that the categorisation of people is “simple necessities of social life”, which seeks to minimise risk through attempting to work out in advance, “who is likely to break the law, buy the product, or seek the service” (Lyon, 2001: 271).

The availability to view CCTV recording when a patient has absconded, or attempted to abscond from the ward, provided an opportunity for staff to talk about patients in ways that they might not have if the footage had not been available. The ability of patients to escape from a secure ward environment meant that these patients were not only viewed as being problematic. Staff also attributed them with having superhuman strength, which made them dangerous.

*S7: “It’s mainly an absconsion thing, cos from both the gardens people (patients) can get in and out. We’ve had a patient climb up onto the roof from the garden...cos we used to have table and chairs set in there, they’re all weighted down but somehow it (patient) became like Hulk and managed to pick the chair up and managed to put it on top of the table and managed to climb up onto the roof.”*

*S9: “actually someone (patient) was a very, was a Houdini, and actually climbed through the windows up in the ceiling...”*

The over-surveillance of some patients as people who needed to be closely watched because they were a threat to the ward environment, was not confined to their



behaviour in their current admission. The categorisation of a patient as threat to the ward, and their identification as a high risk patient in a previous admission, also impacted on how they were treated by staff in their current admission. For example, a male patient was left in seclusion for 20 days because the clinical team were afraid to let him out due to his violent behaviour in his previous admission to the ward. During his previous admission he had badly damaged the seclusion room, and while he was inside the ward, he physically assaulted a member of staff. These two incidences took precedence over all decision-making processes linked to his current admission. The fear of being left in seclusion meant that the patient was often angry, verbally abusive, threatening violence towards staff, and kicking doors and panels inside the seclusion room. Staff accounts about what had happened in his previous admission to the ward resulted in more scrutiny of the patient and his behaviour, where most staff had labelled him as dangerous, violent and someone to be feared. This included most staff who did not know the patient. The continuous availability of CCTV footage of this patient in seclusion to staff in the ward office exacerbated the situation, because the constant visual image of the patient on the CCTV monitor in the ward office tended to prompt negative discussions about him.

*Field note 026: "Patient x still in seclusion (13th day). When I walk into the ward office there are several staff clustered around CCTV monitor watching patient x. Conversation lasts for about 25 mins. Staff talking about how patient x has been racially abusive to black staff when they have been involved in seclusion monitoring. During this time staff look at the CCTV monitor. Staff are talking about management decision to have 3 staff in seclusion area and leaving the seclusion room door open. Staff are concerned about their safety and the mood*

*is low. This is supposed to happen later today, but managers are in a discussion about whether this should happen or not. Some staff adamant that if they are asked to monitor patient x they will refuse. Staff also talking about contacting their union reps."*

Marx (1998: 180) poses the question whether surveillance technology is "likely to create precedents that will lead to its application in an undesirable way". Whilst it is not definitive, there was a suggestion that the availability of CCTV footage streaming continuously inside the ward office did prompt negative discussions about particular patients, simply because they were more visible. This visibility, went beyond simply watching or keeping an eye on them, it also led to them being categorised as high risk and dangerous, where the focus is on their behaviour and not on the reasons behind the behaviour (discussed further in chapter 7). Here S22 demonstrates how patients become reduced to their behaviour and actions inside the ward.

*S22: "So you can have a look, say okay so this person's (patient) a puncher or this person kicks when you take him in this position or this person is particularly targeting these people or, and just kind of have a look for general patterns and things like that."*

### 5.3.5 Using CCTV to negatively categorise patient's visitors

Jenkins (2012: 160) claims that the "categorisation of a person or group from "outside" by others, is integral to the process of identification, and to knowing "who's who" and "what's what" in the human world". He suggests that this identification is more than "just" knowing, and that knowing is not a neutral exercise. In this regard Jenkins believes that institutional patterns of behaviour are defined by "the way things are

done” and “how things are done” (2012: 157). It is this form of habitualisation or the routinisation of behaviour which results in narrowed ways of doing things. Bourdieu (1984) suggests that this habitualisation is able to disguise itself because staff perceive their world as a common sense activity. The field note below shows how staff believed that a patient’s visitor should have been treated.

Field note 004: *“Staff (in the ward office) expand the CCTV monitor to watch a visit. 2 staff discuss several security concerns (these are security breaches that the member of staff observing the visit has failed to follow) (i) the staff member monitoring the visit should have asked the visitor to leave her bag outside the room (ii) patient is drinking pop and staff are not sure if this was given to him by his visitor – concerned that it could be alcohol (iii) concerned that patient and visitor are kissing, according to staff patients are not allowed to kiss as they could be passing drugs.”*

This negative categorisation of the patient’s visitor was not based on any previous information about the visitor being a risk to the patient. It was based on the assumption that all visitors are a threat to the patient’s well-being. When asked how the staff doing nurse observations outside the visitor room would know the rules about kissing, drinking from a can of pop that was already open, or leaving personal belongings outside the visitor room, staff assumed that all staff should know and be able to use their judgement about how patient visitors can undermine a patient’s recovery. Therefore, the suspicion placed on the patient’s visitor was not always based on any real fact or information that the visitor would harm the patient. Maintaining a cautious or critical eye on the visitor was part of an extended surveillance placed on the patient. Below S21 describes how just moving chairs around the visitor room can

arouse suspicion and how they use the cameras to confirm (or not) their suspicions about patient's visitors.

*S21: "...there was a visitor visiting a patient in the visiting room and they started like turning the chairs around and they were trying to face away from the cameras, so obviously we have to see like what they were doing in there to make sure like nothing was being passed or anything."*

In this way categorical suspicion was placed on all visitors, whether they were an actual threat to the patient or not.

#### 5.4 Conclusion

The research data in this chapter suggests that CCTV cameras inside the ward have subtly changed practices inside it. These changes were not always perceived as negative. For example, the cameras were perceived as a useful learning tool when a serious untoward had occurred inside the ward. The cameras also enabled staff to learn more about each patient and triggers for their aggression and violence, allowing them to respond to patients in more appropriate ways. While it might not have been an intention of staff to punish patients, the influence of the cameras in managing certain patient behaviours, for instance, by reporting incidents of patient violence to the police and using CCTV as evidence of this violence, has other implications for patients (discussed in more detail in chapter 7).

Although the cameras were a useful tool in enabling staff to stay connected to the ward environment, this continuous level of surveillance also impacted on staff's relationship with patients. The cameras, for example, did reduce staff anxiety by

making patients in the ward more visible, allowing staff to constantly be aware of patient whereabouts and their location inside the ward. However, as Ellul's (1964) analysis of technique has shown this has also resulted in the change of focus in nursing practices, where the efficient running of the ward is prioritised over care and therapeutic attention that is paid towards patient recovery.

The cameras also influenced how those patients, who had been aggressive or violent, were perceived by staff. The constant streaming of visual images of a patient in seclusion to CCTV monitors in the ward office, did not prompt positive discussions about them. These negative views were not limited to patients, patient's visitors were also viewed with suspicion, where staff believed that visitor motivation was to undermine the care and progress that they had made with the patient. Some of these themes, for example, the ability of the camera to expose women patient bodies inside the ward will be visited again in the next chapter and chapter 7.

## Chapter 6 Subjective Experiences of CCTV

### 6.1 Introduction

The aim of this chapter is to identify the kind of subject that is produced inside the ward as a result of the use of CCTV surveillance alongside other monitoring practices. It is what Foucault (1992: 13) describes as “practices of the self” that this chapter aims to identify, that is how patients and staff as people under surveillance negotiate and manage everyday experiences inside the ward. Ball (2009: 640) has claimed that surveillance literature has relied on the notion that “surveillance has consequences for the individual”. She has critiqued surveillance literature for not subscribing to a “theory of the subject”, especially in relation to how surveillance is experienced by people. She has drawn on the concept of “exposure” and the impact of surveillance on the exposed body in an attempt to address this gap. Ball claims that the surveillance subject is impacted by surveillance in two significant ways. First, by exposure of the surveilled body as a “source of truth”, and second, by the “nature and character” of exposure of the surveilled body, which she suggests has consequences at an individual level (Ball, 2009: 640).

Subjective experience of CCTV for patients and staff in the ward is both shaped by the ward experience and in turn also shapes the ward experience. Koskela (2000: 244) believes that looking at surveillance in this way changes the nature of “power-relationships” because the lived space is looked at not from “those who control” the space, but those who are looked at. She refers to this as “emotional space” and describes this as a space that is “below the threshold at which visibility begins”. According to Taylor (2014), Foucault believed that subjectivity is not a state that is occupied but is instead an activity that is performed. She draws on Foucault’s 1980

work to analyse the difference between power and freedom. Foucault (1980 cited in Taylor, 2014) believed that engaging in the power of freedom is what keeps power relations dynamic, even when the relationship is not equal. This is because the patient is not in a state of domination in which there are no responses possible. So, for example, even at a very basic level a patient can refuse to take their medication, thus disrupting the actions of staff. Taylor's (2014) analysis suggests that although the relationship between the patient and the nurse/psychiatrist is not equal, the patient can still attempt to change their actions.

Drawing on empirical data this chapter aims to examine how those people who are looked at experience surveillance. Although the chapter shines a light on the experience of CCTV surveillance on patients, staff are also exposed to surveillance. Therefore, the chapter also draws on some staff views. As already stated in chapter 2, how patients resist or engage in the power of freedom remains largely unknown. This chapter therefore also draws on research data to examine how patients resist surveillance inside the ward. The chapter is split into three broad areas. The first part explores patients and staff's awareness of CCTV cameras inside the ward. The second part examines how patients experience CCTV surveillance, and the final part identifies some of the ways that patients attempt to resist surveillance.

## 6.2 Awareness of CCTV surveillance

### 6.2.1 Finding out about the cameras

The Information Commissioner's Office Code of Practice for Surveillance Cameras (2014: 37) states that the hospital "must let people know when they are in an area where a surveillance system is in operation". In all three PICU sites there was no CCTV

signage in the ward or inside the unit to warn patients, staff and any visitors to the ward that there were CCTV cameras being used in communal spaces of the ward. Some patients and staff found out about the cameras through my research or being told about it by another staff member or patient, or asking about the cameras, or spotting the cameras in the ward and noticing the CCTV monitors in the ward office.

P2: *"When you told me. I didn't know. They didn't tell me anything!"*

P3: *"Only from a patient on my first day."*

P4: *"I think I found out last year when I was on x ward. I think they have it in the garden."*

P6: *"...I just noticed the monitor in the office and erm I noticed the, the special cameras are protected erm I wasn't shown. I saw them in the first few days of being here."*

P7: *"No information at all about CCTV on the ward. Nothing."*

P8: *"I'm not gonna lie I wasn't in a great state when I came in but you know I noticed the cameras."*

P11: *"No I saw them on the screen. I saw them on the screen in there (meaning CCTV monitors in the ward office). I saw them on the computers. I saw them on the screen on their computers."*



P12: *"I don't remember being told about it (patient is talking about bedroom camera) but I saw it when I came in. I just, you know it's a big, big black box so I could see it. Yeah no one's had any conversation with me about CCTV."*

P14: *"None. I had to find out myself by being cheeky and asking little questions here and there."*

Although most patients had noticed the cameras, they were not always told about them by staff, and neither were they given an explanation (written or verbal) as to why they were in the ward. In addition, as S22 describes below most staff did not see the need to let patients know about the cameras. As already stated in chapter 4, in all three sites CCTV monitors were visible to patients where they could see the monitors inside the ward office. This aspect of the cameras stands apart from the more common interpretation of them in most surveillance literature. For example, surveillance literature has tended to emphasise the visibility of those under surveillance and the unverifiability of those doing surveillance in disciplining behaviour (Foucault, 1979). Inside the ward patients not only know that they are looked at, but they also know who is looking at them. As S22 claims in the quote below, while they might not be telling patients about the use of CCTV cameras in the ward, they are not attempting to hide them. This raises the question as to how this alters the panoptic principle of the cameras in the context of the mental health ward, discussed in more detail in the next chapter.

S22: *"I don't think we would directly tell them as part of their kind of erm when they come onto the ward and we show them around and things like that but we're quite happy to point them out if a patients like oh what's this, oh that's a*

*CCTV camera. And obviously our viewing station (CCTV monitors) is visible to them as well...we're not trying to hide it."*

In all three sites there were also patients whose mental health condition was linked to other factors such as learning disability or autism, whose behaviour remained unchanged by the presence of the cameras. These patients did not have the capacity to understand that the ward had cameras and what the cameras were used for. During fieldwork observations in all three sites these patients did not appear to be negatively affected by the cameras. In one ward for example, a female patient continued to undress in all areas of the ward whether there were staff around or not, and whether the areas were covered by cameras or not. A few male patients often chose to sleep both at night and during the day in communal areas of the ward where they could be seen by staff and be seen on a camera. This was particularly noticeable in one site where despite a camera being placed directly opposite a sofa (where patients sat to watch television), this sofa was used by some male patients as a preferred place to sleep at night, rather than sleeping in their own bedroom. Not all patients, including those with limited cognitive capacity, were therefore negatively affected by the cameras. For these patients, the cameras were neither a deterrent nor an influence in how they behaved in the ward.

Patients who did have capacity generally found the cameras intrusive and were critical of them. These patients often likened the use of cameras in the ward to popular television programmes, such as 'Big Brother' and 'Gogglebox' (in which the television audience views reactions of members of the public in their home, while they are watching popular television programmes). Below P2 questions the location of the

CCTV camera directly opposite a sofa, and directly next to the television set that they sat on to watch television.

*P2: "It's a strange place to put it... That's the place where people watch tv.*

*What else would you be doing? It's like being on Gogglebox. Why should I be on Gogglebox?"*

It was generally the case that those staff who worked on the ward in a temporary capacity, such as bank or agency staff, did not always tend to know about camera use. Most of these staff tended to find out about the cameras in the ward by noticing CCTV monitors in the ward office. These staff generally expected the ward to have camera surveillance because it was a PICU. However, their expectations about seeing cameras inside the ward were also influenced by camera use outside the hospital, in society. For many staff the cameras were part of a normal backdrop to everyday life that had minimal impact on them, resulting in them adopting a perspective which Ellis et al (2013) claim takes a pro-surveillance view of the cameras. Webster and Murakami Wood (2009) suggest that it is not the proliferation of technologies that results in the normalisation of surveillance. It is when the emotional, symbolic and cultural domains of society become colonised that normalization of surveillance occurs. In other words, when people are no longer shocked or disturbed by the presence of the cameras and believe them to be a normal part of society.

*S8: "I saw the cameras so, and I think it was an assumption as well that I made, doing a bit of background reading into psychiatric intensive care units and what have you, so I was sort of, anticipated that."*

S2: *“So I don’t think that there’s anyone that’s bothered by it really, cos they just know it’s part of the ward.”*

S5: *“I was not surprised that this sort of thing (CCTV) is in place because it’s a standard in every hospital I’ve ever worked. So, for me it was pretty normal.”*

S13: *“It was just part of the ward.”*

### 6.2.2 Reason for the cameras

In light of having no information about the cameras both patients and staff surmised as to the reasons for the cameras being in the ward. Very few patients had any direct experience of the cameras. For instance, they had not been involved in any circumstance where an incident had been caught on camera in which they, another patient, or staff had been implicated. Hence they, like staff, also tended to rely on wider political discourses to explain their presence in the ward. These included the idea that CCTV stops certain behaviours (patients committing suicide, stealing); that the cameras would provide clear evidence that would exonerate them when something went wrong in the ward (even though in one site the cameras did not record and in another site the system was broken and unable to record); that because the hospital is a public building it would be a target for terrorism; and that patients in mental hospitals are more likely to hurt each other (even though patients are more likely to attack staff than other patients – see for example, Noble and Rodgers, 1989).

P3: *“I mean if there was an event and something happened like CCTV recording could be used as evidence.”*

P4: *"I think from 1999 or about then anyway to 2001, three people killed themselves on x ward. I think they might have cameras to make sure that no one does that in here."*

P5: *"Well you know that you're covered if something happens. You know that you're in control."*

P7: *"Erm I automatically assumed that there was CCTV installed because it's a public building open to terrorism."*

One patient believed that the cameras might be used for research purposes. The idea that the body might be surveilled for research purposes inside the ward is not inconceivable. Henderson (1994: 935) draws on Foucault's power/knowledge coupling to suggest that 'micro' practices of nursing are reliant upon knowledge that is not only developed at a ward level but also individual level and that "the way the body is perceived and examined at this 'micro' level is instrumental to how knowledge is constituted".

P12: *"Erm maybe they collect for research perhaps I don't know. I mean...I'm sure there is research that goes on here into mental health err you know statistics and what not and maybe the CCTV maybe plays a role in that. Err I wouldn't I don't understand how that would work... any way that they can collect data they will use I'm sure. I think so yeah."*

In the previous chapter (chapter 5), S2 describes how the ability to scrutinise a patient's behaviour when in seclusion allows her to enhance her understanding of a patient's mental health condition: *"It lets us know what they're like cos everybody has*

*their own, I like to think of it as a mask they put on when they come to the communal area so sort of hide who they are*". Foucault (cited in Gordon, 1980) claimed that power appears in an array of micro-situations, and it is only by understanding internal controls which provide the patient with technologies of the self that it becomes possible for them to construct themselves, in accordance with the ruling power/knowledge configuration. In this regard the 'micro' practices operating within the hospital at the ward level, as well as the individual patient level, are central to the development of knowledge. It is through examining the body of the patient at this 'micro' level in seclusion that S2 is able to create meaning, which then becomes instrumental to how knowledge about that patient is constructed. This unimpeded gaze by S2, according to Sewell and Barker (2007: 358), suggests that this form of surveillance will reveal the "essential truth" about the patient. Similar to Cohen's (1981) description (see chapter 1) of how patients were left in solitary confinement for 24 hours in Broadmoor, so that their 'true' psychiatric condition could surface. Furthermore, Sewell and Barker (2007) claim what was central to Foucault's ideas around power/knowledge is that this surveillance of the patient does not stop at revealing the truth, it also "*creates truth*", where S2 becomes involved in finding out which of the patient's behaviour are real and which are a mask. The ability of the cameras to provide access to what previously was unseen behaviour, can be perceived as research in which staff engage in the categorisation of mental illness symptoms from other behaviours, including patients faking their symptoms or attempting to hide them.

Those few patients who did have some experience of cameras believed that the cameras were on the ward to show their innocence when they have been attacked by

other patients. For these and most other patients feeling safe on the ward was a big factor in their recovery. Below P14 describes an altercation with another patient in which he also implicates staff for not doing their job properly, in how they undertake the task of watching over him.

P14: *“the second time err somebody (another patient) who kept on borrowing coke cola off me and wanting pound coins and then it got to the point at the end of the day when I’d just had enough of that, lending him stuff. So I said, look here mate that’s enough of that let’s get on in here enoughs, enough. He said don’t shout at me. I said I’m not shouting at you, I’m not, and started to walk away. As I’m walking away, he came for me and lamped me in the back of the head. All on camera! Four members of staff around, so they all got to know but if it wasn’t on camera, it’d be my word against his, and the witnesses (staff who were present) word but witnesses aren’t always reliable as you think because not everyone is watching...what they should be watching.”*

### 6.2.3 Information about the cameras

A number of patients who had capacity to understand that the ward used cameras were angry and upset that they had not been given any information about them. They were unsure why the cameras were in the ward and how information about them was being used. While all three sites had warning signs about CCTV use outside the units, for example in car parks linked to the units, none had any signs inside the ward to warn patients or their visitors that CCTV was in use. This was not only contrary to data protection legislation and code of practice, which states that: “There must be as much transparency in the use of a surveillance camera system as possible, including a published contact point for access to information and complaints” (Information

Commissioner's Office, 2014: 43). It also led to patients feeling that they were not valued and were not to be trusted. The lack of information about the purpose of the cameras also led to the feeling that the cameras were there to spy on them. These beliefs also increased anxiety for some patients, resulting in behaviours that were normal responses, but could be conceived as abnormal in the context of the mental health ward. Therefore, there were some patients who viewed the cameras as a threat.

*P2: "I was angry, why are we under surveillance? I was checking my bedroom, toilet, which would compromise my sanity."*

*P10: "And, I'm a bit worried. I've got my injection tomorrow and I don't need it cos I'm not psychotic. I do worry about the cameras because I think they're recording our interview now...I sometimes think are they recording our speech, what we're talking about? I don't know. Do they do that?"*

*P11: "No I think it's a breakdown of trust...because I think you need to have a good relationship between nurses, doctors and the patients and if you're monitoring people you don't, you suspect they're up to no good. You got to have some level, more level of trust and obviously there has to be monitoring going on but it's more, you need the human connection and it (CCTV) dehumanises people. It dehumanises people and I think it's just, it's no good."*

These views by patients raise several interconnected concerns. By not knowing where cameras are located all three patients have identified how this has impacted on their mental health in an adverse way. The main purpose of the hospital is to provide a safe



space or asylum away from mainstream society. This aspect of being somewhere safe was undermined as some patients believed that there were more cameras in the ward than there actually were, and that the cameras had the ability to do more than they actually did, such as record conversation. It is these aspects that have led to what P11 describes as a breakdown in trust, because as P11 states the presence of the cameras start from the premise that they, as patients, are not trustworthy and “*up to no good*”.

In site 3 where there were cameras inside patient bedrooms, most patients stated that they were told about these cameras, and that their consent was also sought as to whether they wanted to be monitored at night via the cameras or not. However, a number of patients stated that they did not like having a camera in their bedroom which they believed was a private space and some staff confirmed this view. Privacy in the context of the bedroom was perceived by patients as having the space inside the ward to be themselves, and not to be judged by staff as having another motive for their behaviour, as explained by P12 below. Although a number of ethical concerns related to implementing CCTV inside patient bedrooms have already been raised in chapter 5, especially issues related to the exposure of patient’s bodies. The relevance of privacy in this chapter is about the stress that the cameras induce for patients inside their bedroom, especially in their inability to be themselves even in those areas of the ward which are perceived as private.

*S27: “Most of them (patients) will insist on being moved to another ward where the cameras are not there you know, yeah...most of them will not want the cameras in their room to be honest.”*

P12: *“Yeah it’s not nice err if I’m thinking sometimes, I like to pace. It’s something I’ve done my whole life and I felt like I couldn’t do that in my room because they might look at it and think oh you know, what’s wrong with him. You know its stuff like that, you can’t, like I can’t feel like myself.”*

For P12, either the lack of understanding as to how bedroom cameras were operated, or that he did not believe that staff were not watching him all the time when he was in his bedroom, resulted in a source of stress. The anticipatory conformity created by the fact that he was unsure as to whether he was being watched or not, meant that he had to make a choice between whether he continued to pace and have staff believe that there was something wrong with him, or stop pacing in his room and possibly become overwhelmed by his emotions. In this regard he found himself in a difficult position as the consequence of not pacing could equally result in him looking troubled. Thus, further perpetuating that there was something wrong with him.

Anticipatory conformity of the panoptic aspect of the cameras impact on the patient in a number of ways, including whether a patient has been given information about how the cameras operate or not. Staying with P12’s experience, even though he knows that the cameras are only operated briefly in order to view him, and that a red light lights up inside the room so that he is aware that an observation has been made, it was the fact that staff might still catch him in the act of pacing, which was enough to suggest to him that staff might perceive his behaviour as odd. In addition, although patients can refuse consent to be observed by bedroom cameras and opt for traditional nurse observations, as discussed in chapter 5 staff tended to use them in ways that suited them or believed were desirable for patients. The panoptic aspect of the cameras inside patient bedrooms therefore resulted in exaggerating or complicating an existing

problem for some patients, because they could not feel that they could behave in ways that enabled them to manage their emotions. This had a direct impact on their mental health condition, which was further exacerbated by their inability to be themselves in the private space of their bedroom.

P12 was not the only patient who believed he could not do anything about the cameras in the ward. Most patients were also unsure and unaware of what they could do if they did not like being watched by CCTV. It was probably for this reason that they were not aware that they could complain about them.

*P4: "Fuck all."*

*P11: "Bugger all! Nothing. Absolutely nothing. No appeal process. No process of stopping it. They just do what they want."*

*P12: "Err nothing...Well I haven't been told anything about CCTV and what my rights are or err what my options are with regard to CCTV. I'm not, I've got no idea whether they're recording or not and what happens to the information that they have."*

Similarly, a number staff also believed that they could not complain or voice their concern about the cameras. These staff believed that they would have no option other than to seek a job elsewhere if they did not like being watched by the cameras, resulting in the loss of potentially good staff from the ward.

*S2: "I think if you don't like being watched then I don't think that this is the place of work for you."*

S8: *"probably look for another job."*

S15: *"Nothing! There isn't anything I...I don't think there is anything I could do other than leave."*

S19: *"Work somewhere else I suppose"*

S22: *"Work on a different PICU I guess."*

S24: *"Probably find another job."*

### 6.3 Experiences of CCTV surveillance

#### 6.3.1 Camera acceptance

Similar to some managers, most staff tended to believe that because patients did not actively complain about the cameras, they were accepting of them and were not bothered by them.

S17: *"not in the time I've been here ever hear a patient complain about it or verbalise that they weren't happy about it."*

S20: *"I don't think I've ever come across anyone who's gone around going switch them off...and that has been that erm distressed by it."*

However, when patients have raised it as an issue staff have not necessarily understood why any patient might want to object about their use or be concerned about them. P12 (below) is talking about staff response to camera use in his bedroom, which he believed staff could view from the CCTV monitor in the office. P14 has been

told by staff to not become too concerned about communal area cameras because their function is limited.

*P12: "I've had one conversation about the cameras, and I've had to err you know raise it and all she said was that they don't look, they don't look through the cameras from the office."*

*P14: "they said we don't even watch the cameras, they're just recording. It's more of a situation if there's an incident and we can go back. So that kind of relieves the pressure a bit. It's not like there's one guy sitting in the office there looking at the multiscreen going huh there goes x (uses his own name) you know, it's not that way so but I still don't know now who's watching the cameras."*

Despite the visibility and verifiability of CCTV monitoring, P14 believed that there might still be someone else watching the cameras. In this regard P14 was not alone, for a number of patient's camera acceptance was also based on who they believed was watching CCTV footage. Some of these patients believed that CCTV footage was used as evidence or means by which their clinical team, especially their psychiatrist, could determine their wellness and eventual release from the ward. Therefore, patients also believed that performing behaviour that showed they were able to control how they could behave would contribute to their discharge from the ward.

*P2: "It's a two-way conversation between me and management and the management and me. Basically, it's my way of saying I am ready to move away."*

P5: *“Erm well the patients need constant monitoring because that’s, that’s why they’ve been brought here. Erm to sort of study their behaviour, understand what treatments need to be given.”*

P8: *“Erm I imagine it goes higher and higher up the hierarchy erm and then is analysed and people’s behaviours is analysed you know letting them get release and stuff like that. Like err Dr x (names consultant psychiatrist) who is coming here. I’m sure he’s reviewed all the CCTV and stuff to see how people are behaving...To think that I know my doctors can err be seeing me. Hello (P8 laughs, looks and waves at the camera in the room) I’m being good. Please let me out!”*

The difference between psychiatric treatments that adopt a moral treatment approach and medical approach (discussed in chapter 2) is that contact between patients and their psychiatrist is much more sporadic in the latter, which is dependent on the treatment of disease as opposed to behaviour. Within a medical approach, symptoms are more relevant than encounters with patients, and therefore psychiatrists contact with patients tends to be less personal (Lewis, 2009). Inside all three PICUs patients had the opportunity to meet with their consultant psychiatrist at least once a week. However, this meeting was not always a private, one-to-one meeting. It often happened during clinical ward reviews where there were ward staff and also other practitioners present, or with the patient’s relative or carer. Therefore, some patients believed that the psychiatrist viewed camera footage in order to decipher their recovery and their eventual discharge from the ward. Also, because patients understood that they were in the ward to be observed, diagnosed and recover, the cameras provided a means of demonstrating behaviour to their clinical team, but

especially their consultant psychiatrist, who also had the power to discharge them from the ward, that they were well enough to be discharged.

Some patients also accepted the cameras because they realised that the cameras made staff accountable.

*P2: "On a macro level management are also being watched. They could be held accountable."*

*P4: "I think if they have CCTV with sound it is a good thing. I think it would be very useful to stop members of staff misbehaving if there is litigation."*

Staff were not alone in expecting PICUs to have cameras inside them. There were also some patients who were not surprised to see the cameras inside the ward. These patients accepted that the cameras were there to look out for them and other people.

*P5: "Erm well when you're on the ward like this there's not really a great deal of power. Erm you've just gotta sort of discuss with staff your issues and fears and see what they can do to erm to resolve it."*

*P6: "I don't own the ward you know (laughs). There's nothing I can do about it."*

*P8: "I'd be very surprised if it didn't a place like this that would be very dangerous. (I: So, you expect there to be cameras here?). Oh god yeah! Definitely!"*

Some patients also believed in the deterrence aspects of the cameras (Welsh and Farrington, 2007). Deterrence for these patients often related to petty crimes, such as,

theft of their personal belongings. It also related to more serious crimes such as attacks on them.

*P10: "I think it's a really good thing. Keeps all the patients safe and it makes sure people aren't being naughty or stealing things or doing anything that should be inappropriate."*

*P3: "One of the patients was really staring at me. People (staff) say keep 10 feet away from him. If there's a camera it might be a deterrent. I don't know, it's not particularly nice for people to be under surveillance."*

There were staff and patients inside all three PICUs who were keen to show that the cameras did not bother them in any way because they had 'nothing to hide' (Solove, 2007). They believed that camera acceptance was linked to wrong doing inside the ward, and as they had done nothing that was wrong, they were not too disturbed by them. Linked to this, some staff also believed that anyone objecting to being monitored by CCTV, was doing so on the basis that they wanted to get up to no good. Therefore, any opposition to surveillance was perceived as arousing suspicion.

*P4: "I am quite pleased. I am a bit unusual like that because I have nothing to hide."*

*P5: "I don't really think oh there's someone watching me. I just think oh there's a camera there. I know that someone can see me."*

*S6: "Well I just feel that if you don't like CCTV then you're probably one of them people that's doing something wrong like, it don't bother me, I'm not doing*



*anything, I'm not doing anything wrong so I don't mind being recorded or on CCTV."*

*S12: "If you're not doing anything wrong, no need to worry about it. If you're doing something wrong, you need to worry about it but if you're doing nothing wrong don't worry about it."*

*S14: "I'm not doing anything wrong. I'm doing my job and I'm doing it to the best of my ability so if I was doing something underhand I would, but I'm not."*

*S26: "I would never be unhappy with it anyway. I'm not doing anything I shouldn't be doing so it doesn't, it doesn't bother me at all."*

Several staff accepted cameras because they expected it as part of their working environment in a PICU. These staff did not believe that it was unusual to have cameras in the ward. They saw them as S18 states, coming *"with the territory"*. This is because they expected PICUs to be caring for patients who were likely to be highly agitated, suffering from acute symptoms and possibly also under the influence of alcohol or other illicit drugs. These patients were perceived as likely to be more aggressive and violent because they had either already been violent inside other wards, or they had threatened violence, or they had been violent during a previous admission. Patients were often referred to a PICU when it was not possible to nurse them in other ward environments such as an acute ward, because their behaviour meant that they needed more intensive support. The normalisation and expectation of the cameras was therefore linked to working in a tough ward environment.

S2: *So, I don't think that there's anyone that's bothered by it really, cos they just know it's part of the ward."*

S4: *"If you move everywhere has got CCTV so you could end up with no job."*

S18: *"But yeah if you, if you choose to work in this environment, you choose to be watched all day...It's just one of those things that comes with the territory of working in a place in, in intensive care."*

### 6.3.2 Shaping behaviour

Ellis et al's (2013) research where they found that participants in their study initially held very fixed views about surveillance, which when probed further became more fluid, ambivalent and ambiguous had similarities to how staff viewed CCTV cameras inside the ward. Some of those same staff who also believed that the cameras were a normal (security) feature of the ward, which they expected to see inside a PICU, who were not bothered by the cameras because they had nothing to hide, and who often tended to forget about them once they were in the ward (seen but unnoticed). These same staff, when probed further, admitted that at times the exposure of camera surveillance did make them feel uncomfortable. Their discomfort was linked to what other staff might think about their behaviour (peer surveillance), how managers might perceive their actions (performance surveillance) and how those staff, who have an understanding about psychology (because it is a mental health ward) might perceive their actions (behavioural surveillance).

S8: *"You get very self-conscious about adjusting clothes and you know that kind of thing. And you know that, that did worry me a little bit as what will people think of my behaviour, would my behaviour be monitored as well?"*

S9: *"Thinking back on it I would, I would sort of be very cautious of what I was doing when I was in the area of the CCTV camera."*

S12: *"Sometimes I feel a bit uncomfortable some time but that's all."*

S15: *"I don't know what x does. He might look at it all the time. (S15 is talking about the CCTV monitor in the managers office)."*

S20: *"I'm a registered nurse, so I'm constantly mindful of how I portray myself but I'm also aware that I'm in an environment where there's a camera watching me as well."*

S25: *"So I think erm yeah it puts extra pressure on you cos like you have to be absolutely sure."*

Although during fieldwork I had not observed any negative behaviour towards the cameras from those patients who lacked the capacity to understand the panoptic aspects of the cameras. For example, as discussed earlier, I had often observed patients choosing to sleep on a sofa where a camera could see them. Several staff disagreed with this view stating that most patients even those with limited capacity, still had an awareness of the cameras. For these patients' staff did not believe that the cameras functioned to conform their behaviour. Instead, they believed that the cameras exacerbated negative symptoms of their mental health condition. The link

between electronic equipment, such as television sets, mobile phones, and other electrical items resulting in paranoia symptoms for some mental health conditions is not unusual as Camus (2010) describes in relation to her own mental health condition: "Sleepless and paranoid, I would wander the house at 3am seeking spy equipment. In the daytime, flickering TVs and 'wrong number' callers to my mobile, things others would hardly register, seemed to signal imminent danger". Staff were convinced that for some patients the cameras did have a negative impact on their mental health condition because of the links with paranoia and electrical equipment.

*S2: "We have a couple of people who are very paranoid and if there's a camera we are recording them, and we'll be watching them and like making fun of them and stuff like that."*

*S15: "It causes patients quite a lot of paranoia erm...because they're being watched so when you've got paranoid patient the fact that they are being watched only fuels their paranoia."*

*S16: "where you have acutely unwell erm often psychotic very often paranoid individuals and they're at a point that it's acute crisis really erm it's often reference to me, who's watching me, is it the government?"*

*S19: "Just patients may be getting paranoid about them sometimes, but you know especially in the communal areas they haven't got a choice whether they're on CCTV or not."*

*S21: "Some patients can be paranoid that you're constantly watching them through the camera, or feel like you could have the screen up in the office"*

*watching so that could be an issue for some patients if they feel that, you know, you're, they're constantly being watched in their bedroom."*

*S24: "Some people (patients) prefer them but some people because of the red light here, cos most of our patients, a high degree of them are paranoid schizophrenic so the idea of someone watching them on camera does not sit well with them." (S24 talking about bedroom cameras)*

### 6.3.3 Hidden cameras

Most staff, including permanent staff, could not accurately confirm how many cameras were on the ward and where they were located. These staff tended to overestimate the actual numbers of cameras in the ward believing that they were being monitored by more cameras than there actually were. Similarly, patients also assumed that there were more cameras on the ward than the actual number. Alongside this a number of patients also believed that other devices in the ward such as smoke alarm indicators, fire sprinkler outlets, heating control devices, and so on, that had hidden cameras located inside them. It was not surprising that patients believed that there were hidden cameras in the ward, as Koskela (2000) suggests not all cameras are placed to be seen. Surveillance in shaping people's behaviour is based on knowing that they are looked at, or being surveilled (Lyon, 2002; Marx, 2009). The intensive nature of surveillance in the ward demonstrated through a range of techniques, such as nurse observations, ward information leaflets telling patients they are in the ward to be observed, the openness of the ward office which enabled staff to see out into communal areas, CCTV cameras and CCTV monitors all constituted part of an assemblage of techniques inside the ward to monitor patients. This intensity of

surveillance led a number of patients, and some staff, to believe or question that there may be hidden cameras in the ward.

P2: *"I had to enquire if that dome shape in my room (P2 is referring to a dome-shape mirror) was CCTV and they told me it wasn't. I asked about the long-shaped box in the bathroom. I thought it was a microphone. They told me it wasn't."*

P3: *"Someone said to me, a patient, the cameras are so small you can't see them. I think it was some babble from a paranoid patient. Maybe there are tiny cameras, I don't know, but I can't imagine."*

P8: *"I don't think there's any in patient rooms are there? (I: No). So, I mean I did see a little, a little black box like that (P8 points to what looks like an old smoke alarm system which has been covered up on the ceiling of the activity room) with a small hole in it and when I first arrived I did cover it up with toothpaste, just in case...Just cos you know, you want a degree of privacy."*

P11: *"Well, there's the obvious ones and there's also hidden cameras."*

These patient concerns about hidden cameras, especially in what they considered as private spaces of the ward such as bedrooms, were also confirmed by staff. A number of patients, even those who believed that the cameras were a good thing, found the idea of hidden cameras a threat. Warnick (2007) suggests while there is some symmetry in power with face-to-face surveillance, with hidden cameras there is no recourse to the balance of power. Unlike the real CCTV cameras, where patients can see images of what is being viewed on the CCTV monitor in the ward office, most

patients who believed that the ward had hidden cameras inside it, also believed that the monitors too were hidden. It was the thought of hidden cameras in the ward which tended to increase anxiety in some patients. In addition, more damage to the ward environment was caused as a result of patients wrecking fire alarms, fire sprinkler outlets and so on, because they believed these devices housed hidden cameras, rather than actually damaging CCTV cameras.

*S6: "you do talk to them sometimes and they say erm like they're recording me in my bedroom and like, no there ain't no cameras in your bedroom."*

*S10: "like Big Brother type thing but you try and tell em no we don't put cameras in your bedroom, you know what I mean, that's your area you can go and do what you want in that area. I don't particularly want to see it on a monitor in the office."*

*S11: "sometimes it's not even a camera, it's erm you know, it's erm the fire alarms, thinking that, the amount of times the fire alarms in their bedrooms have been, have you heard that? (I: No). They've been broken off because they think it's a camera."*

*S15: "again they don't always necessarily believe that those cameras are the only cameras so there's a lot of erm they then start trying to take apart things in their bedroom so the fire alarms, they smear the mirrors, all those kind of things because they don't believe that they are not."*

## 6.4 Resisting camera surveillance

Most managers and staff believed that using available mechanisms already operational inside the ward such as weekly patient and staff community meetings where patients can raise issues about anything that concerns them about what is happening in the ward and the Trusts complaints process, were the most appropriate ways of raising concerns about CCTV. During fieldwork observations patients were not always aware that they could do anything about the cameras. Most felt that their best course of action was to ignore them. However, despite this, staff identified various ways in which patients attempted to minimise, or reduce the effects of CCTV monitoring inside the ward. Some of these actions taken by patients did frustrate the ability to undertake CCTV monitoring.

Marx (2003) identifies eleven different behavioural techniques that people use to subvert surveillance and maintain their privacy. Inside the ward it was also the case that patients used different ways to create privacy including some of those described by Marx, such as blocking moves, breaking moves, and distorting moves. These reactions to the cameras were neither strategic nor coherent tactics but as Johansson and Vinthagen (2016: 418) suggest, they were "*heterogeneous and contingent*".

### 6.4.1 Distorting moves

Marx (2003) describes distorting moves as actions by which people manipulate surveillance processes in such ways that the data becomes disrupted. Those patients that understood the nature of CCTV surveillance, were more able to manipulate how the cameras were used in order to monitor them. For example, P14 who said that he does not mind the cameras, spoke about how the cameras changed his behaviour.



P14: *"The disadvantages were privacy and the fact that you don't act the same as what you would do when you're on camera."*

P14 recognised how CCTV surveillance happened and could weigh-up how to use such surveillance to his advantage. He believed that he was able to make the cameras work for him because he knew how to manipulate and distort surveillance by discovering whether the cameras were fake or real.

P14: *"so situations like is that camera really a camera or is it a dummy camera? If it's a dummy camera I'd just act like my normal self, if it's a real camera then I have to put on a, on a front and pretend to be somebody I'm not."*

Similarly, P8 was also someone who did not mind the cameras in the ward. P8 often played up to the cameras for example by gesticulating in a friendly way at the cameras showing a victory V-sign (which she referred to as her "rock-on" sign) or waving at the camera. P8 did this throughout our interview and I had also observed her doing the same in the ward. She treated the cameras, especially those in the communal area and garden as if they were real 'people' watching her as opposed to some faceless technology that was just recording her:

P8: *"I give them my rock-on sign. (I: I notice you doing that now). Yeah, I like I don't know, I just like, they're watching me like I'm still here. I'm still remembering who I am but I'm not going to turn it around and be offensive erm but I am still me."*

While P14 distorted the information that staff might have about him through the process of demonstrating conformity and showing that he could behave himself. P8s

distortion of surveillance was linked to her desire to be recognised as an individual. P8 did not see herself as communicating with the cameras but with those staff that she believed were watching her through the camera. P8 distorted surveillance by treating the camera as if it were a person and not a piece of equipment. This was different to her performing for the cameras (described in more detail in the next section). P8 interacted with the cameras in ways that showed that she would not be ignored by staff and she did this in a playful way (Ganesh, 2016).

To some extent P1 (below) in our interview also for example described how he maintained his personhood and individuality in the context of surviving seclusion. Again, he did not respond to his surveillance in a negative way and attempted to maintain his dignity and autonomy by being cooperative but also trying to remember that he was also a person. The field note is an interview with P1 (not audio-taped) in which I also gave him a written account of our interview at his request. The quotes are from this written account.

*Field note 011: You told me when you were "in the blocks" (seclusion) you decided to "embrace your power". You said, "they put music on, so I started dancing", and that this made you feel better. You told me you enjoyed "dancing around". You said you had your "boxers on" and that you were "dancing like a stripper... to give them (meaning staff) a show". You thought the best way to embrace your power was to "enjoy yourself", while you were in seclusion.*

These distorting moves were different from simply performing for the cameras. These patients recognised that CCTV technology had the capacity to expose their body to surveillance. The need to know whether the cameras are fake or not, and the desire to

interact in certain ways with the cameras (for example playfully) was driven by their need to let those doing CCTV surveillance know that they were not negatively influenced by such monitoring.

#### 6.4.2 Performing for the cameras

Some patients accepted the cameras because they enjoyed the possibility of being watched by other people and performing in front of them. Patients who enjoyed performing in front of the cameras did not necessarily do this in order to distort surveillance. They just enjoyed the fact that they were being looked at, or the possibility for being looked at by more than the staff in the ward. Mathiesen (1997: 223) argues that panopticism and synopticism have developed in fusion with each other. This fusion, according to him is evident in Orwell's (1949) '*Nineteen Eighty-Four*' novel where panopticism and synopticism completely merge "through a screen in your living room you saw Big Brother, just as Big Brother saw you". Mathiesen (1997: 226) claims that within synoptic space celebrities are seen as important figures who through their visibility, "actively filter and shape information". Inside mental health wards where patients become depersonalised and have little say in who they are, celebrity status can for some patients take on greater importance. In addition, Koskela (2012: 54) also makes the claim that surveillance is not always perceived as "restricting and repressive", and that people also "*play with* various forms of surveillance equipment". Her analysis of surveillance in this way suggests that patients are also "weary of being passive targets" of surveillance. She further suggests that most "performances that people engage in are not necessarily their own creation, but often mimic assorted 'commercial idols' presented in reality TV shows such as Big Brother, where imitating

surveillance is a key part of the appeal of such shows” (Koskela, 2012: 54). Patients below identify several different reasons as why they are keen to be seen by others.

Field note 130: *“I ask her if she has noticed that the ward has cameras. She tells me she has noticed one by the tv. I ask her what she thinks about it. She tells me she that likes it. She asks me if I’m recording for my research. I tell her no. She says it’s a shame, she wants to be on tv and that this is what she’s wanted all her life.”*

P3: *“Yeah one of my favourite tv shows is Celebrity Big Brother at the end of the day erm, I always...wanted to go on Big Brother.”*

P8: *“and other things as well people (other patients) act up for the cameras. They act like they’re bloomin Madonna or something...”*

P14: *“I do a lot of dancing when I’m outside and I’m on camera from multiple angles...and I thought to myself do you know what I’m doing some really good (moves) and I wouldn’t mind some camera footage...I was quite impressed with my own moves I wouldn’t mind some of the footage and then play it back to music and make an art piece out of it because it’s, it’s been recorded isn’t it...But they won’t give me the footage. I did ask politely as well.”*

While some staff were aware that patients liked to perform for the cameras there were other staff who tended to link patient’s camera performances to their mental disorder (usually personality disorders) and as a form of attention-seeking behaviour.

S8: *"I mean knowing that they're on camera they might behave in a different way, I mean particularly service users (patients) with personality disorders. They will display certain behaviours to gain attention and they know that you're watching them on camera, and I've seen that a few times, yeah."*

A few staff also described how some patients engaged in intimate performance activities such as masturbating in front of the cameras in order to stop staff from using bedroom cameras. Patients knew when the cameras were operational as a red light came on inside their bedroom when the camera was operated. Or, in seclusion where there was no respite from being watched. These intimate performances had some similarity to Koskela's (2012: 55) analysis of a "move from voyeurism to exhibition". Koskela believes that the rise of "camming", where "camgirls" and "camguys" perform live on-line self-presentations, where they turn their real-life images into "reality porn", do so in order to gain some control of what and how these images are presented. Below staff describe the different ways in which patients, both male and female change the nature of surveillance by engaging in sexualised activity as means of controlling how they are seen.

S27: *"but the girls are so bad, men are better yeah, men do it also, lie on their bed make sure the camera is looking at them... They put the light on. So, women in x (names another ward which uses CCTV in bedrooms) will do that almost every day so you're forced to shut up the screen."*

S3: *"or they can get naked and stuff."*

S8: *"Or take their clothes off and go Look at Me!"*

While these actions may be a form of resistance to surveillance Koskela (2012: 55) also states that “we should not lose sight of the fact that most instances of surveillance remain oppressive or simply sustains unequal power”. In the context of maintaining their dignity and safeguarding patients these aspects were of some concern, as CCTV monitors for bedroom cameras in site 3 were located outside each patient bedroom door, and not in the ward office as described above by S27 (which was the set up in a different ward). Here, the isolation of the location of the CCTV monitor next to each patient bedroom, meant that there were no other staff around who might maintain an eye on those staff looking at bedroom cameras in order to police their behaviour (doing peer surveillance). Similarly, when a patient is being supervised in seclusion there was usually only one member of staff (sitting in the seclusion lobby) who had responsibility for monitoring the patient in seclusion. This meant that staff sitting in the seclusion lobby did not have other colleagues to monitor their behaviour. The cameras therefore posed a potential safeguarding concern in the context of their use in bedrooms and seclusion. In addition, when patients are in seclusion, they might believe that they are performing for the staff doing seclusion monitoring. However, CCTV footage can also be viewed in the ward office. Therefore, the audience was much wider than the staff doing seclusion monitoring. This was sometimes a source of amusement for staff in the ward office who told me that patients often danced when in seclusion. Some staff were very sensitive to this.

*S5: “They are observed by one person but when you are on the camera it is more than that. You might think you are only observed by that particular person who is allocated to supervise you in seclusion. It could be that those pictures are seen by many people that you don’t trust especially.”*

### 6.4.3 Blocking cameras

Marx (2003: 379) describes blocking and masking moves as explicit forms of intervention that are undertaken by surveillant subjects in order to physically block “access to communication or to render it...unusable”. Staff gave several examples of how patients attempted to block camera view. These attempts were not only on cameras located in the communal and garden areas of the ward, they also included the camera in seclusion and the camera located inside patient bedroom.

*S2: “they’ve tried to cover up the camera in the seclusion room. Like we’ve had to go to clean up ketchup and sandwiches and stuff like that off em cos they will try and cover that up and they’ll try and cover up the observation or the observation window so you can’t see them.”*

*S1: “The most common thing is food, smearing food on em.”*

*S11: “One by the tv, that one gets covered up.”*

*S15: “Or people put toothpaste a lot on them...or paper, cover them or things like that.”*

*S27: “they normally cover them, so if they don’t like it in their room some of them climb up there and cover them...They know they are lenses they cover them.”*

Patients also described how they put toothpaste, shaving foam, hand cream and other items on mirrors and smoke alarms in their bedroom because they believed that these

were hidden cameras in their rooms. Hence, blocking moves were not only deployed on real cameras but also on those cameras that patients believed were hidden.

#### 6.4.4 Breaking moves

Alongside attempting to block camera view some patients also attempted to break or damage cameras. Marx (2003: 381) describes breaking moves as the “crudest form of neutralisation”. In the first two quotes S1 and S7 describe how patients placed in seclusion have damaged the camera. However, rather than questioning whether it was the correct decision to use a CCTV camera in seclusion, S7 describes how the camera was changed for a different model which was harder to destroy. The rhizomatic nature of surveillance and its ability to regenerate when one system fails and another is deployed to take over, was demonstrated in how the technology is also never questioned.

*S1: “I mean there was the one lad that did manage to erm actually pull one.*

*Yeah, they’re high up but he managed to pull. He managed to get like a, we’ve got like a big block on the side and he climbed on that.”*

*S7: “It’s mainly been like in seclusion when people (patients) have been poorly and like they’ve just been delusional and wanting to basically attack anything and don’t like the fact that there’s a camera in there and can see them.”*

*S7: “and we had to have them taken down and different camera put in with a plate over it so it was like flat and you can’t grab it, whereas before you could grab it.”*

Also, most breaking moves were not feeble attempts at damaging the cameras.



S10: *"The one outside, one of em actually took it off, put his cigarette on the lens to burn the lens so you couldn't see much."*

S11: *"down the female pod as well that one's been hanging off...I think they just smashed it!"*

In order to block staff looking at them in their bedroom, staff also reported the different ways in which patients attempted to damage bedroom cameras on site 3.

S24: *"Yeah, yeah, yeah so you can't see. Like scratching and he smeared stuff so you can't see through...but he was scratching, the view was fuzzy you can't really see."*

S27: *"they will be fighting the camera trying to kick them out and you know once they have removed them, they can do silly things."*

#### 6.4.5 Avoidance moves

Marx (2003) states that avoidance moves are passive and involve withdrawal from surveillance. Both staff and some patients identified those areas inside the ward and unit that they could go to when they wanted to get away from the cameras.

S2: *"Cos there are places where you are not being observed on a camera, like the staff room or the actual communal area."*

P8: *"Go in my room. Go in the bathroom...there were previously blind spots, but I think they've covered them a lot more now cos I've been watching them put*

*up, well I've been talking to them, electrician."* (P8 is talking about the addition of new cameras inside one of the research site wards).

P9: *"Go to my bedroom. I assume there's no cameras there, is there?"*

P12: *"I know a spot where I think there aren't any so I can sit there if I want to, not be, you know looked at by a camera."*

## 6.5 Conclusion

The aim of this chapter was to identify a range of experiences and reactions that patients and staff held about the cameras. These views similar to Ellis et al's (2013: 721) research were not fixed views, they were instead at times "contradictory, ambivalent, fluid and ambiguous". Although most staff, and some patients, believed that the cameras were part of society and that when they were in the ward they tended to forget about them, this chapter suggests that the cameras formed a large part of patient's experience inside the ward. Similar to their views in chapter 5, staff tended to believe the cameras were necessary because the wards were psychiatric intensive care units and as a result patients would not only have acute mental health symptoms but that the patients that they work with are more likely to be violent.

In shaping patient and staff behaviour inside the ward it was not just the cameras that staff and patients could see which were of significance. Both staff and patients over-estimated the number of cameras in the ward, and some patients also believed that there were hidden cameras that were also involved in watching them. Patients saw the cameras, both real and hidden, as a way to communicate with their consultant psychiatrist who mainly remained absent from the ward. The empirical data in this

chapter also suggests that patients are not passive recipients of surveillance. Patients also deployed a range of tactics and strategies to minimise CCTV surveillance. As Purdy (2015: 9) states this view suggests that patients also have power in the context of the ward, and that “resistance is in and of itself a form of power”.

## Chapter 7 Back to Theory

### 7.1 Introduction

In this concluding chapter my aim is to provide an overview of some of the key themes that have arisen in this research. In this chapter I propose to return back to a range of theoretical frameworks adopted within this research, including Lyon's (2001: 3) theorisation of the 'Janus-faced' nature of surveillance. In doing so, my intention is not to suggest that CCTV use inside mental health wards is a good thing or a bad thing. The empirical data presented in this research is intended to stimulate a discussion about the use of CCTV inside mental health wards. A discussion that also has to be considered alongside other monitoring and observation practices used inside the ward.

This thesis has provided a range of research data from manager, staff and patient perspectives examining the care-control continuum inside the ward. This concluding chapter provides an analysis of how this data is shaped by the wider political context and the criminalisation of mental health. It also argues for a need to avoid a sharp break between Foucault's (1977) analysis of disciplinary power and Deleuze's (1992) societies of control. In order to do this, I have drawn on Foucault's later work to explore how the sovereign-disciplinary-governance triangle manifests itself in the context of the mental health ward (Foucault, 2009). The remainder of the chapter outlines how CCTV has impacted on the experiences and behaviour of patients and staff inside it, raising issues that are relevant for ethical mental health care.

## 7.2 The Politics of Surveillance and Mental Health

### 7.2.1 Perceptions of violence and mental illness

Although managers could not identify any specific drivers for the implementation of cameras inside PICUs, it is suggested in this research that there are several factors that has led to the use of cameras inside mental health wards. I have suggested that perceptions of violence by staff towards patients and violence to staff by patients has been an enduring feature of the mental hospital. The politicisation of certain research, for example, the research undertaken by the Healthcare Commission and the Royal College of Psychiatrists (2005; 2007) highlighting violence experienced by staff in mental health wards. As well as the exposure of violence towards patients from staff in documentaries, including *Winterbourne View* (2011) and *Whorlton Hall* (2019), suggests that there is a culture of violence inside mental health wards. NAPICU (2014) endorsement of CCTV cameras in the ward to provide evidence for potential offences and investigating allegations, also promotes the notion that mental health wards are unsafe places whether you are a patient or a member of staff. Although managers did not believe that there was a single policy driver for the introduction of cameras in the ward, the fact that the cameras had a multipurpose function, in that they opened up the ward environment, allowed them as managers to review difficult situations in the ward, examine how difficult situations were managed, gather evidence and so on, meant that some managers believed that the cameras had more than a deterrence impact inside the ward.

The ability of the cameras to provide evidence for an offence increasingly places patients and staff under suspicion, where this research suggests that the ethics of care is increasingly becoming compromised over the maintenance of control of patient and

staff behaviours. In addition, while mental health research (see for example, Brown et al, 2015; Antonysamy, 2013) continues to highlight violence inside mental health wards, little has been said about the reasons for such violence. Few researchers have questioned the impact on patients of living inside ward environments that are alien to them, and from which they cannot easily leave. Where any attempt has been made to understand why mental hospitals have more violence inside them, it is often aspects such as, increase in substance abuse as a contributory factor (Stuart, 2003), or non-compliance with medication and active symptomology (Whittington, 1994; Bowers, et al; 1998) which are offered as some of the more common explanations. Solutions and intervention in managing violence has tended to focus on developing better techniques in controlling patients (Lantta et al, 2016), including developing better and more accurate risk assessment and risk management tools (Varshney et al, 2016). These explanations and interventions are often from clinical or management perspectives, and not necessarily a sociological perspective.

The demise of asylums and large mental hospitals as a result of community care policies, has been prominent in highlighting the relationship between violence and mental hospitals, where violence has become established as a key feature of modern hospital care. Modern mental hospitals have adopted a range of new technologies as a way of tackling violence inside them in order to maintain staff and patient safety. Inside asylums it was violence towards patients that was perceived as one of the key factors for the demise of the asylum. Within this thesis I have suggested that it was community care which changed the perception of violence. Especially, in the reporting and high media profile of some incidents involving violent acts and murder committed by people with mental health disorders. It is this exposure of people with mental

health problems as being more violent that has also influenced the profile of violence inside mental hospitals. This exposure has also resulted in new ways to control patient's propensity for violent behaviours in the ward, including the use of CCTV technology and body-worn cameras. There has always been literature highlighting the violence done to patients by staff. However, it is new technologies, especially the use of covert filming adopted by the media in the exposure of violence done to patients by staff, which has been influential in highlighting the violence that is done to patients inside mental hospitals. In this way the ward environment, has to some extent, become a battleground in which both patients and staff are increasingly becoming exposed for their violent and abusive behaviour, resulting in more security measures being introduced inside it.

There are very few studies that examine violence from a patient perspective. Hide (2018: 733) for example, exposes how the sexual abuse of women by male patients and staff inside mental hospitals is linked to attitudes that they hold "towards female sexuality, mental illness and age". Similarly, Gilbert et al (2008) for example, identified how aspects such as medical treatment, loss of freedom, and the ward environment defined patient experiences during the time that they were hospitalised. Some of these experiences centred on the breakdown of cultural competency (for example, racist or sexist attitudes of staff), communication, safety, trust, and the use of coercion based on staff attitude towards some patients. These studies suggest that the culture of violence in the ward is associated with power. Inside the ward patients and staff have differential positions in which patients are ascribed an inferior status. The behavioural techniques adopted in their recovery require staff to intervene with patients, where patients have to recognise their subordinate role. Face-to-face

encounters are therefore not always experienced socially or equally. In all three PICUs there were patients who told me that they felt under pressure to be present in communal areas of the ward and to interact with staff. They did this, even when they did not like doing it, or wanted to do it, because they believed that showing staff that they could be in the company of them and other people, would demonstrate that they were ready for discharge from the ward. In these circumstances patients found face-to-face interactions stressful.

However, it was also the case that the proximity of patients and staff in communal areas of the ward meant that the lives of patients and staff doing monitoring in those areas became linked. Staff were not always sure the reasons why patients chose to be in communal areas. Levinas (cited in Hand, 1997) believes that the face becomes ethically compelling because it has the ability to present a range of responses, including anger, loathing, joy, pleasure and so on. Some staff worried that patients came into communal areas to specifically “kick off”. During ethnographic fieldwork observations staff would often warn me about certain patients and the need to maintain a distance around them. In these circumstances patients are also unsure as to what is expected of them, and it is through this that Levinas (cited in Hand, 1997) claims that the patient becomes the ‘other’. This is because staff are never quite sure what the patient is thinking, why they are in the communal area, whether they want to talk or be left alone, or cause trouble. Most staff when doing observation in communal areas tended to ignore patients and monitor the ward area discreetly by not always giving eye contact to patients and choosing to adopt a professional distant stance. Occasionally there were some staff who made an effort to interact with patients, whether this was to play football in the courtyard, or playing cards and other games



indoors. These activities were not pre-planned, they were spontaneous responses. When these staff were on ward observations more patients used communal areas in order to participate in conversation or be involved in activities. It was often the case that when these staff were not around, patients also wanted to know when they were on duty again. As one of these staff told me, she did not think of patients as patients, but as people, and that despite being involved in altercations with them where she has been punched, scratched, had her hair pulled, she felt a sense of responsibility towards them. This staff also believed that some patients should be made accountable for their behaviour. For example, she sometimes reminded a female patient about how she had deeply scratched, bitten and spat at her when she was first admitted to the ward. She would show the patient a scratch on her arm which was still healing. The patient responded by apologising to her and letting her know that she was now embarrassed by her behaviour and that she was sorry. This exposure of the patient's behaviour when she was ill was not done to embarrass or upset the patient, it was done to genuinely help the patient recognise how she behaves when she is unwell.

Although he is talking about special observations, Chu (2014: 1) has also argued that just observing someone, either by directly being present in the room with them (or watching them from a CCTV monitor), is as "illogical response to acute (*mental*) illness" as the "idea that a nurse would merely observe someone under their care as they experienced a haemorrhage or a stroke" (italics in quote added). Psychiatry and medicine, with its desire to catalogue knowledge, has according to Levinas (cited in Hand, 1997), resulted in the elimination of otherness, where patients have become objectified through their behaviour and separated from staff by their status. It was those staff who were able to by-pass the staff status and were able to see patients as

people, who were able to engage them most effectively. These staff showed a sense of responsibility to patients, even when patients were at their worst. It is in this sense that these staff were more ethical, because they were open about how the patient's behaviour also impacted on them. It is this proximity that was lost when some staff chose to use CCTV cameras to do monitoring or remain detached from the patient while doing nurse monitoring in communal areas of the ward.

In their desire to address what is perceived as a culture of violence inside the PICU, managers believed that the cameras would provide additional evidence when something did go wrong. Their pragmatic approach to using the cameras to understand what happened did not only solely rely on using CCTV footage. They also emphasised the value of verbal accounts. However, research data has shown (see chapter 5) that a number of staff believed that CCTV evidence was more superior to verbal accounts. The marking up of CCTV video footage as evidence for the police, demonstrates the profound anticipatory conformity of the cameras in influencing staff behaviour. Although these and other staff claimed that they were not bothered by the cameras, and that once they were in the ward they tended to forget about them, there were a range of comments and behaviours which suggested that staff did not entirely forget about them. For some staff the ability to see and not be seen in observing patient, visitors and staff behaviours did not always result in positive talk about them. The cameras, for example, were used as a way to raise suspicion and negatively categorise patients and their visitors.

### 7.2.2 Function creep and the criminalisation of mental illness

The SCOT approach has asserted it is not the technological tool (CCTV) in itself that is problematic but how people use technology to carry out various functions inside the

ward (McCahill and Norris, 2003). Although some managers paid a lot of attention to the implementation of CCTV inside private areas of the ward especially the use of cameras in patient bedrooms, this level of consideration was not always given to camera placement in communal areas of the ward. Few senior managers were also unsure about why the cameras were inside the ward. While some cited the opening up of blind-spots and the usefulness of additional evidence when things went wrong inside the ward, these reasons did not always coincide with actual camera placement. For example, it was the case inside all three PICUs that there were blind-spots that were not covered by cameras or staff. It was also the case that those areas where most incidents of aggression and violent behaviour was likely (or hot-spots), for instance around the ward office, there were no cameras (although latterly one PICU did add more cameras that also covered this area). NAPICU are the only body that has provided some guidance on the use of CCTV inside PICUs (NAPICU, 2014). However, this guidance in itself is not comprehensive. Apart from operating procedures around the use of bedroom cameras there were no standard operation procedures on the use of CCTV in other parts of the ward, including seclusion room. Rather than advising on consolidating the existing uses of CCTV, NAPICU (2014: 7.2.74) guidance encourages the adoption of function creep, by suggesting that PICUs should consider CCTV as “an area of innovation”, suggesting that any use of the cameras is acceptable.

Wajcman (2000) believes that research and audits that only function on singular technological uses of cameras results in a poor analysis of CCTV technology, mainly because it involves a teleological and unidimensional view of the technology. In addition, Wajcman also suggests that such a view undermines the politicisation of technology. In explaining the SCOT approach, Pinch and Bijker (1987) have also

highlighted how technology (CCTV cameras) has the capacity to produce a range of outcomes dependent on the social circumstance. For example, assaults captured on camera were passed to the police, together with verbal accounts from staff and patients. Both patients and staff accepted that this was good use of the cameras, because it would show their innocence in a situation, where they might come under suspicion of causing harm or starting violence. This also prompted some patients to identify the limitation of the cameras to only their visual function. These patients believed that there should also be audio-equipment linked to the cameras so that anyone examining the footage could gain a full understanding of the circumstances leading up to the violence. Ellul (1969: 50) suggests that when people find themselves in difficult and hostile situations, they unconsciously and spontaneously attribute, “sacred values to that which threatens him (*sic*) and to that which protects him (*sic*)”. In this way, both staff and patients elevated the abilities of the cameras as a tool, which they believed would objectively show that their behaviour was without reproach. It was also the reason why some staff believed that cameras were vital to the ward environment. These staff wanted more cameras in the ward to change the status of ‘hot-spots’ inside the ward to ‘blind-spots’ because they claimed that just as many incidents of violent and aggressive behaviours took place in hot-spot areas (see chapter 5).

Haggerty and Ericson (2007) suggest that the expansion of surveillance is dependent on its ability to cohere with other agendas. The idea that the cameras could create risk free ward environments was also appealing to managers who were unsure how to respond to violent situations inside them. Most managers did not believe that the cameras would deter patient violence, because according to them, those patients who

did become violent often did so when they did not have full capacity to control their behaviour, or necessarily understand what they were doing. Therefore, most managers did not believe that Department of Health policies, such as 'zero tolerance' to violence, could be successfully implemented inside mental health wards (DH, 1999). However, despite this, site 2 made the decision to increase the number of cameras in the ward following an incident in which a member of staff was injured and blamed the Trust for his injury. The expansion of surveillance was therefore not always limited to the creation of risk free environments. For these managers, the expansion was also linked to the need to reduce litigation disputes which not only resulted in loss of money through compensation but also loss of labour, as staff who were injured required time off work to recover.

A number of managers believed that the cameras potential for providing additional evidence in resolving disputes and in reducing compensation claims made them invaluable. This was their belief even when the cameras were not successful in resolving disputes, because the incident was not captured on camera, or what was captured was of insufficient quality or did not show the whole incident. The justification for their continued use, and addition of more cameras, was based on their potential to resolve these matters. It was therefore the cameras potential to bring about order inside the ward that had appeal for managers. This is because it saves managers "continually having to make exhausting decisions", where the cameras function to give them "stable coordinates", so that they can be orientated inside the ward, without always having to be physically present (Ellul, 1969: 51). Ellul (1969: 51) also suggests that not everything in the world is "identical and indifferent", and therefore the cameras also enabled managers to discriminate between different

accounts of what actually took place inside the ward. It is in this way that the expansion of surveillance in the ward became less hierarchical and more horizontal. In arriving at a decision about what was the most responsible outcome, managers generally tended to adopt a pastoral role in seeking solutions, for example using the cameras to learn from incidents. As a result, their action was to promote a more stable environment through the process of learning from incidents. This done well has the potential to integrate the group, including those individuals who have perhaps not acted according to what is expected of them.

Whatever intentions managers had for the cameras and however they were used in reality, the presence of the cameras and their expansion, raised expectations about how order could be created inside the ward especially by staff. Ellul (1969: 66) warns that society's "fundamental experience today is with the technical milieu", where society "now becomes the ground and the place of the forces which man (*sic*) discerns or feels as sacred, but is society turned technician, because technique has become the life milieu of man (*sic*)". The availability of CCTV recordings to provide evidence, when a violent incident happened inside the ward, resulted in the expectation by some staff that this would lead to serious consequences for those patients carrying out violent acts. In one PICU the assaultive behaviour of a patient led to staff and managers reporting the patient to the police on three separate occasions. This patient (see chapter 5) had been taken away from the ward and detained in a police station as a result of his assaultive behaviour, towards staff and another patient. On one occasion part of the assault was captured on camera. Several staff believed that this evidence, together with their verbal accounts should have resulted in a police prosecution of the patient. This is because in addition to their verbal accounts, there was also visual

evidence of the part capture of the patient assaulting staff. In this situation staff were less motivated to comply with ethics of care, based on human compassion and morality, where they have a responsibility for the 'Other' (Levinas, 1991). As Ellul (1964) has claimed technologies also carry a set of values that can potentially be dehumanising and destructive. In this example the reporting to the police of the patient's assaultive behaviour has serious consequences for the patient in ways that he might not have imagined when he was detained in the ward. That is, if the police had prosecuted him, he would be leaving the mental health ward with a criminal record. This use of the cameras also has the potential to further marginalise those people who are already discriminated against, because of their mental health status, by criminalising their behaviour when they are unwell.

The introduction of other visual technologies such as body-worn cameras, the sanctioning of covert filming by Care Quality Commission (regulatory body for health and social care) also impacts on mental health practice in similar ways. The rise of these technologies has the potential to make mental health wards a battlefield, in which staff and patients increasingly rely on the visual capacity of these technologies to justify their intervention or exonerate themselves. While these technologies might aid in the exposure of those staff who wish to harm patients, the same technology can also be used against patients whose behaviour, as a result of their mental health condition, becomes criminalised or has the potential for becoming criminalised, leading to what Hope (2009) has described as target hardening.

### 7.3 Sovereign-Discipline-Governmentality

Surveillance literature has tended to prioritise the invisibility of power in the shaping of people's behaviour. Foucault's panopticism was reliant on the visibility of those being watched and the invisibility of those doing the watching, where according to Foucault Bentham's Panopticon, "laid down the principle that power should be visible and unverifiable. Visible: the inmate will constantly have before his (*sic*) eyes the tall outline of the central tower from which he (*sic*) is spied. Unverifiable: the inmate must never know whether he (*sic*) is being looked at any one moment" (Foucault, 1979: 201). However, inside all three PICUs not only were patients visible, but so were the staff who were watching them. Foucault (1977: 201-202) describes Bentham's central tower as having "venetian blinds on the windows of the central observation hall, but, on the inside, partitions that intersected the hall at right angles and, in order to pass from one quarter to another, not doors but zig-zag openings; for the slightest noise, a gleam of light, a brightness in a half-opened door would betray the presence of the guardian...in the peripheric ring, one is totally seen, without ever seeing; in the central tower, one sees everything without ever being seen". In its perceived architectural design Foucault's 'central tower' in all three PICUs constituted the ward office. However, unlike his explanation of the central tower, where inmates struggle to decipher who is watching them, inside all three PICUs the ward office shared similar architectural features in relation to their openness. Glass windows surrounding the ward office and glass panels inside ward office doors exposed staff inside them. Patients could look into the ward office and know who was in there, and staff could look out of the office easily surveilling large parts of the ward and patients inside them. Communal area camera use was adopted similarly in all three PICUs and although each ward chose to justify the placement of cameras differently, dependent on what



managers perceived to be blind-spots, the decision to place CCTV monitors in the ward office was the same in all three PICUs. CCTV monitors were therefore also visible to patients, where a number of patients claimed that they had seen the monitors and believed that staff looked at the monitors in order to watch them. The visibility of CCTV monitors was such that patients and temporary (bank and agency) staff working in the ward were aware that the ward had cameras inside it, not because they had noticed the cameras in the ward or had been told about them, but because they had seen the monitors inside the ward office.

CCTV monitors were not only visible inside the ward office. Monitors inside seclusion and in bedroom camera use were also exposed. In their use in seclusion, for example, CCTV monitors were not discreetly hidden inside the seclusion lobby. The monitors were attached to a wall directly opposite the window panel which separated the seclusion room from the seclusion lobby. This meant that patients could see the CCTV monitor and their own image on it. Therefore, although they were not told about the camera in seclusion, they could see the monitor and knew that the ward used CCTV to monitor them. Some patients in seclusion were also aware that even when staff closed the blind restricting their direct vision into the seclusion room, they were still being monitored by staff via the CCTV monitor in the seclusion lobby. Patients in seclusion did not know and were not told that the camera did not record visual information or record sound. The camera located inside the patient bedroom was also visible.

Patients knew that a dark box placed over the top of the door inside their bedroom housed a camera inside it. Most patients also knew that the CCTV monitor was located next to their bedroom door, and that staff used a personalised electronic fob key to operate the camera and audio-equipment. Most patients also knew when the camera

inside their bedroom was operational, or when staff were monitoring them, because a red light lit up inside the dark box in their room. Although there was no signage in the ward to let patients and staff know that there were cameras in the ward, most patients were aware that the ward did use cameras, even though these patients, and some staff in one PICU site, believed that the cameras recorded when they did not. When patients did raise any concerns about the cameras with staff, these patients were told by staff that the cameras were there as a safety feature and not to worry about them. Rather than identifying with the disciplinary function of the cameras, most staff saw the cameras as an extension, or part of a continuous network of cameras that were in society, even when the cameras did make some staff feel uncomfortable inside the ward. Similarly, most patients were also not surprised that the ward had cameras. The practice inside all three PICUs to give patients an admission information sheet in which they are told that they are in the ward to be observed (although not by cameras), meant that most patients assumed that the cameras were there to watch them and not necessarily staff. Therefore, while patients and staff were not explicitly informed about the cameras, most patients and most staff were aware that the ward used cameras.

The primary form of monitoring patients in the ward was by either hourly (inside two PICUs) or half hourly (inside one PICU) nurse observation of patients. Although some staff did take a short-cut by looking at the CCTV monitor to place the patient in the ward, and then sign them off as having been seen, most staff tended to undertake face-to-face observations of patients. Inside all three PICUs patients knew that they were looked-at by staff via the cameras and via routine nurse observations. Holmes (2001) has claimed that the panoptic nature of nurse observations is reliant on the

patient not knowing when the nurse will next come to view them. According to him, it is this uncertainty as to when they might be looked at again which results in the panoptic gaze. In all three PICUs although nurse observation was carried out each hour or half hour, these observations were staggered. This meant that patients were not seen by staff on the hour or half hour, they might be seen slightly sooner or later. It is this which creates the not knowing when they will be observed again which Holmes (2001) suggests creates an uncertainty and in the shaping of patient behaviour. However, the cameras were not used in the same way. It was not about not knowing when they might be looked at next which created the “power of the permanent gaze”, it was the knowing that they were actually seen at all times which had therapeutic value (Foucault, 2008: 102). This therapeutic value was not necessarily about self-regulating their behaviour. A few patients, for example, believed that the cameras and nurse observations were about pastoral care and that the cameras were in the ward to keep them safe, usually from other patients who might want to harm them. A few patients admitted that even at those times when they were acutely unwell, especially when they were first admitted to the ward, they were aware that the ward used cameras because they had noticed the CCTV monitors in the ward office. Therefore, for some patients even when their cognitive capacity was temporarily impaired as a result of their mental health condition, these patients recognised CCTV monitors. The location of the CCTV monitors, the openness of the ward office and the ability to see staff inside it were all designed to expose the gaze, and although patients did not always know which staff were looking at them and when, they knew that they were seen. Therefore, most patients, even those with reduced cognitive capacity to understand the panoptic effects of the cameras knew that they were watched by staff.

Visibility of CCTV monitors inside the ward office also led several patients to believe that the ward had hidden cameras. Even those patients who were deemed well enough to leave the ward (and thus having the cognitive capacity to understand the panoptic effect of the cameras) remained unsure about the possibility of hidden cameras. In all three PICUs there was no dedicated staff who was involved in watching CCTV monitors. This also led some patients to believe that the real cameras and hidden cameras were watched by other people, whom these patients believed were either their psychiatrist or managers. Patients were not alone in assuming that the ward had hidden cameras, some staff also believed that this was likely. Foucault's (1979) metaphor of the Panopticon was probably more relevant in the shaping of a patient's behaviour through their belief in hidden camera use, although perhaps the behaviour they encouraged was not always what was intended. Most patients, in the wards that did not have CCTV cameras inside patient bedrooms, believed that there were hidden cameras in their bedroom. Patients deployed a range of tactics, including some which also undermined ward safety. For example, by pulling apart, hitting, or attempting to smear food, or other liquids, such as, shaving foam, and in the process damaging fire alarms and other safety features. Similarly, in the ward that did have a camera inside their bedroom, some patients, even when they were aware that a red light came on when the camera was operational, still continued to believe that staff could see them at all times while they were in their bedroom. In this ward patients tended to primarily damage the screen protecting the lens outside the box which housed the camera, by scratching it, so that it obscured staff's view into the room or to cover up the camera in some way. Most staff tended to link patient's fear of hidden cameras to their symptomology and mental disorder, believing that patients were displaying paranoid

behaviour. These staff did not see the actions taken by patients as resistance to surveillance (see chapter 6).

Inside all three PICUs the transparency of the tower (the ward office) and the visibility of the supervisor/guardian (staff) operated as a reminder to patients that they were always under surveillance. The visibility of the cameras and CCTV monitors acted as part of an assemblage, in which patients were always aware of the permanent gaze that was on them while they were inside the ward. CCTV observation happened alongside other observation practices that were also about regulating the patient's behaviour through the exposure of the gaze, for example, through nurse observation practices and the physical presence of staff in communal areas of the ward and inside the ward office. The cameras therefore functioned to stabilise the activity of observations (or maintaining a watchful eye on patients) inside the ward, and in order for this to be effective, surveillance subjects (especially patients) have to know that their behaviour is actually seen at all the times by staff. This interesting social phenomenological process in the context of the mental health ward was not based on leaving the patient (as the surveillance subject) guessing whether they were being watched or not in shaping their behaviour. It was about exposing the gaze so that patients knew that they were seen, and where staff openly engaged in looking at them. This placed a heavy burden on patients because they were aware that staff were continuously looking at them, and therefore judging them through their behaviour. It was in this way that the cameras became a tool, alongside other practices, in normalising patient behaviour.

Foucault (2009: 107-108) has also asserted that in the government of populations other forms of power (sovereign power, disciplinary power) have not been replaced:

“So we should not see things as the replacement of sovereignty by a society of discipline, and then of a society of discipline by a society, say, of government. In fact, we have a triangle: sovereignty, discipline, and governmental management, which has population as its main target and apparatus of security as its essential mechanism”. Similarly, I have also suggested that the rise of the post-institutional mental hospital, following the closure of asylums, has not resulted in the adoption of completely new practices inside mental health wards. Modern mental hospitals continue to adopt a range of practices and techniques that have at their core sovereign power, disciplinary power and pastoral power. Although the cameras have been largely linked to Foucault’s analysis of disciplinary power, the empirical data in this research has also shown that cameras have the potential to promote pastoral power by reducing the controlling aspect of sovereign power, for example, in facilitating patients to be discharged from the ward. At one PICU the cameras immediately outside the site were used by staff to monitor how patients would manage being outside the unit, so that they could decipher their readiness for leave from the ward. Staff used the cameras to watch the patient from a distance. The patient’s ability to show staff that they could sit outside the unit, walk around the grounds where there was CCTV coverage and return back to the ward, enabled them to assess their suitability for leave from the ward. This use of the cameras was about enabling the patient to achieve their goal, which is to show staff that they can lead a normal life again away from the ward. Here the cameras were used by patients to show staff that they could control their behaviour and not be governed by their emotions or voices in their head, which might be urging them to seize the opportunity to get away. Therefore, the maintenance of safety in the ward is not a linear process, it has multiple strands some that emphasise safety through security, and others that promote safety through care. DeLanda (2016) claims

that the assemblage actively works to link these parts together. According to Deleuze and Guattari (1980), there are some connections that are more mutually compatible, which they refer to as relations of interiority (or intrinsic connections) and others that come together through extrinsic (exteriority) relations.

Deleuze (1992) also claims that in societies of control individuals have become 'dividuals' through the process of coding. Through their ability to disengage information about each individual patient the cameras also have the capacity to undermine the 'face' of the patient both ethically and socially (Levinas, 2006). The more patients become defined by their behaviour the less they are constructed by their identities, such as, their ethnicity, gender, sexuality, disability and age. The shift, since the early 1990s towards evidence-based psychiatry also promotes the ideals around symptoms of mental disorders, as opposed to the individual who is experiencing it. As Drake et al (2005: 1) state: "The term evidence-based medicine was introduced in 1990 to refer to a systematic approach to helping doctors apply scientific evidence to decision-making regarding treatment with individual patients". This focus on symptoms of illness as opposed to the 'face' of the patient takes away any uncertainty about the psychiatrist's ability to 'cure'. In addition, it continues to maintain her panoptic power inside the ward. As Levinas states: "In front of the face, I always demand more of myself; the more I respond to it, the more the demands grow" (Levinas in Hand, 1997: 294). Both critical psychiatrists and transcultural psychiatrists in recognising patients as people with identities undermined their own disciplinary position. In doing so both these movements lost their momentum as recognising the patient as a 'person', that is, beyond them as symptoms, requires making judgements

where these narratives of the patient body are used to not only critique psychiatry, but also undermine the position of the psychiatrist.

According to Foucault (1979) the operation of power requires the exposure of bodies in three significant ways. This includes bodies as targets of surveillance, expert knowledge and corrective measures. Central to disciplinary power Foucault believed was the examination. The examination is the combination of panoptic observation and the normalising judgement. Patients inside the asylum have to be classified (with a mental disorder or having a mental disorder that has yet to be categorised), sorted and differentiated (often through age and the risk that they pose). Inside the ward the examination of the patient body as a target for surveillance has importance, because it shows whether the patient has “reached the level required” for recovery, through the process of being involved in treatment. In order for this to happen, the examination of each patient body also requires “differentiating the abilities of each individual” (Foucault, 1979: 158). This form of power Foucault suggests, is a form of power which cannot be exercised without knowing the inside of people's minds and “without exploring their souls”. It also “implies a knowledge of the conscience and an ability to direct it”. This hierarchical power is vested in the body of the psychiatrist (through pastoral power). It is, according to Foucault, “salvation oriented (as opposed to political power). It is oblation (as opposed to the principle of sovereignty); it is individualizing (as opposed to legal power); it is coextensive and continuous with life; it is linked with a production of truth” (Foucault cited in Dreyfus and Rabinow, 1983:214).

Inside the ward the presence of the consultant psychiatrist was demonstrated in her invisibility and in her ability to control the patient’s destiny, for example, in her ability



to discharge the patient from the ward. When patients did meet with their psychiatrist this was often during weekly multidisciplinary meetings, where the patient would not necessarily be alone with the psychiatrist but would be seen alongside a range of clinical practitioners responsible for her care. In all three PICUs the psychiatrist was not involved in the day-to-day problems linked to patient care, she was more interested in factors such as the circumstances which led to the patient being in the ward, aiming to understand why a patient is disruptive, why they might not be sleeping well, and the circumstances surrounding a patient's sadness, and so on. Information about the patient was provided by nursing staff, junior doctors or registrars and the patient's family. The psychiatrist had very little contact with the patient, who may or may not have differing views.

It was the consultant psychiatrists positioning in the ward, through power invested in the visibility of her body, and her invisibility through her power to control the patient's destiny, which resulted in panoptic disciplinary surveillance. This is very similar to Moore's (2011) analysis of courtroom judges, where the site of power is clearly visible in the body of the judge as an authority. While the consultant psychiatrist decided what treatment regime was best for each patient, it was the ward staff who delivered it. Therefore, it was not surprising that the lack of private contact with their consultant led some patients to believe that staff, especially nursing staff, did not always provide their consultant with accurate information about their conduct in the ward. Therefore, for these patients the cameras became a significant point of contact with their consultant psychiatrist. They believed that CCTV footage showing their ability to control their behaviour in the ward was being looked at by their consultant or was likely to be seen by their consultant (although they were not always sure). Patients

based this belief on the basis that they could see inside the ward office that there was no dedicated staff looking at CCTV monitors. The belief that camera footage must be seen by someone (because they did not know why the cameras recorded) resulted in them surmising that camera footage would be seen by their consultant, similar to their consultant looking at them through a two-way mirror. For these patients the supervisor/guardian in the panoptic tower was not the staff but their consultant psychiatrist. Despite the fact that they remained unsure whether their consultant viewed CCTV footage or not, they aimed to conduct their behaviour as if they did, so that they could directly prove to them that they were ready for discharge. These patients not only understood the hierarchical nature of the psychiatrists' power and her ability to discharge them from the ward, they also saw the cameras as direct link to their consultant, by-passing ward staff whom some did not always trust. It was in their ability to maintain the hierarchical position of the consultant psychiatrist that the cameras were most effective in shaping patient behaviour.

In carrying out the task of clinical observations some staff also used the cameras to watch patients in those parts of the ward that had cameras in them, so that they could learn more about each individual patient. This use of cameras was based on bettering their understanding of each patient and the stimulation and risk triggers of these patients, so that they could engage with them more productively. This use of CCTV was not motivated by the desire to belittle, mock or expose the behaviour of the patient, it was a genuine attempt to enable the patient to understand their behaviour so that they could change it. This need to understand how their behaviour changes when they are unwell was also something that interested some patients. For example, during fieldwork observations there was a patient who told me that he would like to see CCTV

footage of himself when he is unwell in order to gain a better understanding of how his behaviour changes. He claimed that although his wife and others around him described how his behaviour changes, he wanted to see this for himself in order to understand why he continuously ends up in hospital under detention. Rose (1989: 11) claims that it is through “self-inspection, self-problematization, self-monitoring and confession”, that we learn to “evaluate ourselves according to the criteria provided for us by others”, and in this regard the use of the cameras in enabling patients in the process of ‘normalising’ their behaviour, were seen as a useful tool. In societies of control, Deleuze (1992:5) argues individuals are no longer going from one closed site to another such as from the mental hospital to the family, because “one is never finished with anything”. This development suggests that the psychiatrist is no longer required to enlist the support of other people in the disciplining of the patients behaviour as the patient becomes more proficient at governing herself not only through self-monitoring practices, but also by becoming efficient at developing her own expertise and understanding about medical interventions. Thus, promoting the rise of synoptic surveillance practices through the process of self-examination, which for some patients begins inside the ward.

Foucault (cited in Gordon, 1980) believed that power in order to be effective, has to be productive and that repressive power is limited by its prohibitive force. CCTV cameras were also used in the production of knowledge about each patient. For instance, in all three wards it was common practise to review incidents in the ward where repressive force was used (for example, full body restraint), so that staff could learn how to handle future altercations with patients better. Where this was available CCTV footage was used to enable this learning. Some staff also used the cameras to better

understand a patient for whom they were a keyworker. In all three PICUs each patient was allocated a keyworker (staff member), who changed each shift. Patients could approach their keyworker if they need additional emotional support. The role of the keyworker is to produce a report of the patient for whom they are a keyworker at the end of their shift. While this practise is essentially about documented surveillance practice, it was based on the principle of individualised care of each patient which recognises that all patients have differing emotional needs. In this respect, keyworkers were keen to understand the emotions and behaviour of their particular patient during each shift, and at staff handover meetings. These practices were designed around ensuring the individuality of each patient, where Foucault (2009) claims that pastoral care also extends to each individual sheep. Governing and shaping the behaviour of patients in the ward was not dependent on uses of techniques that were reliant on sovereign power, disciplinary or pastoral power, they included all of these in varying degrees. In this way the modern mental hospital in adopting new surveillance technologies did not reject all techniques that asylums had to offer.

### 7.3.1 Care and Control

Moore (2011: 256) has claimed that surveillance literature has tended to focus too heavily on the control aspect of surveillance and in the process the surveillant assemblage has undermined how “care and control are blended and at times synonymous”, within such assemblages. Assemblages, according to DeLanda (2016), operate on the basis that various practices and techniques, such as CCTV camera use and nurse practices of observation, while they may share similar traits, for example they are both about keeping patients safe in the ward, how they do this differs. The cameras disciplinary influence has the ability to move beyond the hospital. For

example, when a patient absconds from the ward, managers (even out-of-hours, when they are at home) can pass on information about them to community police officers. Visual images available through CCTV grabs, such as how they looked, what they were wearing, which direction they were headed can quickly be passed on to community police officers who, because of this information, can find the patient quickly and return them back to the safety of the ward. It is in this way that discipline, in the context of enclosed institutional settings and assemblages work together. The networked assemblage (displayed through images to the managers laptop at home) allows the capture and return of the patient to the enclosed and disciplinary setting of the ward. This aspect of finding the patient quickly is not done in order to punish the patient but to protect them. It is based on the recognition that their mental health condition (and possibly reduced cognitive capacity) has made the patient vulnerable, and therefore unable to manage outside the hospital. Therefore, this capture and return of the patient to the ward is done with the aim of their care and welfare.

According to Hernandez and Roberts (2008: 353) ethical mental health care practice requires the nurse practitioner to be sensitive and have “empathy for the patient as an individual”. This they claim is based on the ethical principle of beneficence (doing good), non-maleficence (not doing harm) and justice (treating people fairly). The use of CCTV in the context of these ethical implications inside the ward were varied. For example, the cameras were used in the maintaining the well-being of patients (where staff used them to maintain a watchful eye inside the ward), they were also used to provide individual care (through their use in attempting to understand how staff could have responded differently), and in their ability to give patients space (by using the camera in seclusion to do less intrusive monitoring). In maintaining the safety and well-

being of patients staff relied on a range of techniques and practices that were about the simultaneous use of care and control, where sometimes although it appeared that they were being over-controlling (using repressive force) their goal was about keeping a patient safe. Full body restraint of a patient by staff, where a patient is pinned to the floor in order to restrict their movement, can and is often experienced by the patient as degrading and punishing. Equally, when staff physically restrained a patient in one fieldwork site by pinning him to the floor and holding him in this position, until he was forcibly sedated, this action was not done out of the desire to punish the patient but to ensure that he did not harm others and possibly himself.

The shepherd, according to Foucault, demonstrates a range of characteristics in the process of making the sheep compliant and do her bidding (Foucault, 2009). This was also evident inside the ward where, for example, seclusion was sometimes used in order to break a patient's wilfulness through the process of allowing them to play out their behaviour (usually believed to be related to their illness and/or the use of substances such as alcohol or drugs ) before they are integrated into the ward community. While there were problems with how seclusion was sometimes used (see chapter 5), this appeared to be the primary use of seclusion, where the act of physically removing the patient from his or her peers is part of a range of behavioural tactics deployed in the ward to sequester the patients' compliance. These seemingly aggressive and tough responses are seen as necessary in bringing the patient back to their sense, and as such are different to prison where the process of incarceration is about reflecting on one's actions. Within prisons Foucault's panoptic analysis in shaping behaviour is significantly different because the prisoner (it is assumed) has the cognitive capacity to understand the nature of their incarceration, and the ability to

reflect on their actions. Inside the PICU this is not always the case, the closed nature of the ward is more about protecting the patient who does not always have the cognitive capacity (because of their mental health condition) to reflect on why they have been confined. Confinement to the PICU, and seclusion in this sense is done in order to help and protect patients and not to punish them. These behavioural techniques therefore form part of an assemblage of a range of interventions in the ward that are not always about reflecting on one's actions and behaviours but are about normalising behaviour.

There were some examples during fieldwork observations where staff doing seclusion observations attempted to engage patients by trying to speak with them, or by putting music on so that the patient can be distracted from their thoughts or entertained when bored. Staff, in discussion with the psychiatrist, also negotiated on patient's behalf to allow them to have access to personal belongings, such as books, magazines, soft toy, etc. to help them pass the time while in seclusion. Similarly, some staff also used cameras in order to minimise the intensity of watching patients in seclusion. For example, by opting to use the cameras to monitor patients so that they did not feel "stared at". Although staff described their uncomfortableness and awkwardness in sitting in front of a window panel watching a patient inside the seclusion room as a factor in opting to use the camera, it is also the case that this act of looking at the patient in seclusion, is also closely linked to the long-standing voyeuristic fascination of looking at the mad. In his book 'The Man of Feeling', Mackenzie (1886: 47) describes how one of the "Sights of London" in the late nineteenth century, was the desire by the wealthy to visit Bedlam mental hospital, where for a shilling patrons could wander about the hospital and look at the mad. The staring or looking at the mad patient therefore also has historical links in which the modern day use of seclusion has

embedded within it this notion of voyeurism. The feeling of awkwardness is therefore not only linked to directly looking at the face of patient. It is also embedded in the social and historical context of the treatment of the mental patient, where the voyeuristic gaze has not necessarily been driven by the ethical motive of care. It is potentially this context that arouses feelings of awkwardness. Some staff in this circumstance saw the cameras as enabling in maintaining a patient's dignity. This is because by remaining anonymous and watching the patient using the CCTV monitor meant that the patient did not have to look at strangers peering at them when they were at their most vulnerable. As the staff doing seclusion monitoring changed every hour and the likelihood that the staff doing the monitoring would be agency and bank staff, this exposed the patient to a lot of individuals who could look at her when secluded. Therefore, in choosing to use CCTV cameras in seclusion staff sometimes did this so that the patient did not have to look at them. While this resulted in the distancing of staff from the patient through the loss of the face, this distantiating was done for the benefit of the patient.

#### 7.4 Subjective Experience

Ellul (1964) believes that technology has become a dominant and sacred force in our lives and that these technologies are creating new virtues and moralities. These new virtues, Ellul (1969) suggests, are undermining virtues that are related to the family, fellowship, humour and play. Ellul (1964) did not view technology such as CCTV, as an individual isolated machine. He saw it as an ensemble of "means" or technological tools and practices that are characterised by rationality, artificiality and efficiency. Therefore, technologies in the ward not only included CCTV, radio personal alarm systems or electronic health records, they were also characterised by various practices



based on human technologies. These included activities such as doing nurse observations, giving patients their medication at set times, encouraging patients to eat at set times, enabling patients to engage in normalising activities (through occupational therapy support, and so on). According to Ellul (1969), it is because technologies are precise and exacting in their function that they also demand the same from people. Therefore, behaviour becomes not about intention but about conduct. Aspects, such as being detained (or as some patients believed being imprisoned) inside the ward, losing the liberty to move around the ward freely, not having access to everyday items such as mobile phones all contribute to why a patient might feel frustrated, angry and potentially violent.

Staff did not always appreciate the loss of liberty experienced by patients, because they saw their function as integrating the patient in the ward. During fieldwork observations in one research site a newly admitted patient, who believed that the ward was a prison, often became aggressive because he wanted to know why he had been placed in prison when he had done nothing wrong. Staff continued to respond to his question by reiterating that he was not in prison and that he was in hospital. Ellul (1969) believed that ethical values embedded in technologies are designed to promote normality, where it is not acting well that is perceived as the benchmark of achievement but acting normally. Therefore, inside the ward it was not about recognising and acknowledging that patient behaviour would be affected by confinement, it was about judging the ability of the patient to accept their confinement. Patients were well aware of being judged in this way and most patients felt the stress of conforming their behaviour according to the new norms that were

required of them. In this way these patients believed all their behaviour had the potential to be judged negatively.

Postman (1993: 12) suggests that as a society we have become so accustomed to technology that we are “hardly aware of its significance”. During ethnographic observations inside all three PICUs when staff were questioned as to why they were doing nurse observations every half hour or hour, most staff were unsure. Responses to this question ranged from “good question”; “I don’t know”; “we have to make sure that patients are safe”, where safety of the patient was often cited as the main reason. When questioned further as to how looking at every patient every half hour or hourly would maintain their safety, staff were often perplexed. In their report on sexual safety inside mental health wards, the Care Quality Commission (2018: 10) found that most alleged incidents of sexual abuse inside mental health wards took place “in communal areas (416 incidents), with a smaller proportion of incidents taking place in patients’ rooms or other private areas such as toilets and bathrooms (194 incidents), in outside areas of the ward such as gardens and courtyards (70 incidents), or in areas where staff may be present (23 incidents)”. Most of these areas, apart from bedrooms and toilets, are monitored continuously by staff and sometimes CCTV cameras. It is therefore perplexing how, despite all the technologies adopted inside the ward such behaviour was still prevalent.

Abuse of women inside mental health wards is not only limited to sexual and physical abuse. Nicki (2001) also describes how the use of language and the problematization of women’s behaviour can lead to discriminatory responses to women. Inside two PICUs there were women patients who kept removing her clothing. One of these women also engaged in sexualised behaviour with other patients and was sometimes

also inappropriate with male staff. This patient was placed in seclusion as her sexual advances towards other patients were perceived as a threat to male patients, whom because of their mental health status, were also deemed to be vulnerable. Although seclusion is not the ideal solution it did, to some extent, protect the female patient because it physically removed her from those patients and staff who could also take advantage of her. While staff believed that this was appropriate action to take in order to protect her, they did not seem to understand how the continuous view of her often seen naked on the CCTV monitor in the ward office was also inappropriate. Not only this, it also led to staff being critical about her behaviour and citing incidents to me about how she attempted to be promiscuous with male staff or vulnerable male patients. The more her naked body was exposed the less she became a person where, as Koskela (2000) suggests, she was only seen for her body parts. This changed the nature of staff's relationship with her and how she was judged by them. In this way the camera inside seclusion was more than a "black box", submissively passing information from one space to another (Layton, 1977 cited in Bijker et al, 2012: 15). It was also responsible for a set of values, which Ellul (1964) claims left ignored or unrecognised, impose themselves on staff and the relationships that they form with patients.

Similarly, inside research site 3, the female-only ward area was covered by more cameras than the male-only ward area, which was not covered by any cameras. These women could be watched while they were sleeping through infra-red cameras, they could be seen on CCTV monitors as they left their bedroom area and entered the women-only lounge area. The only place that they could not be seen by cameras was in the communal area where they spent most time of their time (which the aforementioned Care Quality Commission, 2018, data suggests is where most incidents

of sexual abuse is likely to occur). Managers justified the use of additional cameras in the female-accessed ward areas (which could only be accessed by a personalised key fob given to each female patient), in order to protect women from male patients. According to Bordo (1993), women therefore not only have to be disciplined in relation to their madness, their bodies also have to be regulated according to societal expectations that are dominated by male expectations. In this ward, the over-surveillance of women using CCTV technology was justified on the basis that the cameras in this part of the ward protected women from male patients.

Finally, the exposure of women's bodies, especially when they are displaying disinhibited behaviour was not always perceived by staff as a safeguarding issue under the Care Act (2014) (raised in chapter 2). This left women patients, who did engage in disinhibited behaviours vulnerable in two ways. First, while women patients might believe that engaging in sexualised behaviours is a way of controlling how they are seen (similar to Koskela's "camgirls", discussed in chapter 6). When staff are doing night-time observations using bedroom cameras they are working alone (similar to day time observations). Therefore, they are looking at women patients engaging in a wide range of sexualised behaviour with no other staff policing their behaviour. At night-time the number of staff on shift is significantly reduced, which means that the ward is often empty. When a staff member operates the bedroom CCTV monitor there is no record of how long they spent looking at the patient in their bedroom, and because bedroom cameras are live feeds only, there is no recording of what they were observing. As the monitoring is undertaken by a lone staff member there is no other staff around to question why they spent longer looking at a particular patient. This makes the patient vulnerable because it leaves them open to the voyeuristic gaze.

Second, Soomar and Ali (2018) identify a range of disinhibited sexualised behaviours, which they claim patients with certain mental disorders, including dementia, schizophrenia and anxiety disorders are apt to engage in. They propose a behavioural model of intervention, which is about diverting this behaviour. However, in both PICUs that had women patients inside them who engaged in disinhibited sexualised behaviour, the responses did not appear to reflect this. In one PICU a woman patient was placed in seclusion, and in the other the woman patient was allowed to wander around the ward, often without supervision, where I observed her topless in front of a male patient and completely naked in front of a workman. Although some women might use sexualised behaviours in order to as S27 (in chapter 6) suggests shut down surveillance, these women's experiences are different because their behaviour is part of the symptomology of their mental disorder. It is this aspect which makes them vulnerable and open to abuse and therefore a safeguarding concern.

## 7.5 Conclusion

In this final conclusion I would like to raise three linked points in relation to CCTV camera use inside mental health wards. First, this research has drawn attention to how the perception of increased violence inside mental health wards has the potential to criminalise a patient's behaviour. This is done to them at a time when they are not always in a position to control their emotions. Second, while CCTV cameras have a range of perceived benefits, this research has also shown that they do have the potential to undermine the 'face', and ethics of care. This leads to the third point, where it is suggested that the lack of an overarching ethical approach to camera implementation has meant that the cameras have undermined the underlying principles and values of professional mental health care practice, where the ethics of

surveillance, based on establishing guilt and raising suspicion, has at times been prioritised over the ethics of care, which emphasises relationships and compassion.

## Reference list / Bibliography

- Antonyamy, A. (2013) How we can reduce violence and aggression in psychiatric inpatient units. *British Medical Journal Quality Improvement Reports 1-3*. Available online: <http://www.bmjopenquality.bmy.com> [accessed 15/8/2019].
- Arendell, T. (1997) Reflections on the researcher-researcher relationship: A woman interviewing men. *Qualitative Sociology*, 20 341-368.
- Ashby, M.P.J. (2017) The value of CCTV surveillance cameras as an investigative tool: An empirical analysis. *European Journal on Criminal Policy and Research*, 23(3) 441-459.
- Atkinson, P. and Coffey, A. (1997) Analysing documentary realities. In Silverman, D. (ed) *Qualitative Research: Theory, Method and Practice*. London: Sage, 56-76
- Atkinson, P. and Hammersley, M. (1998) Ethnography and Participant Observation. In Denzin, N.K. and Lincoln Y.S. (eds) *Strategies of Qualitative Inquiry*, London: Sage, 110-136.
- Atkinson, P., Coffey, A., Delamont, S., Lofland, J. and Lofland, L. (eds) *Handbook of Ethnography*, London: Sage.
- Avis, M. (2005) Is there an epistemology for qualitative research? In Holloway, I. (ed) *Qualitative Research in Health Care*, Berkshire: Open University Press, 3-16.
- Ball, K. (2009) Exposure: Exploring the subject of surveillance. *Information, Communication and Society*, 12(2) 639-657.
- Ball, K., Canhoto, A., Daniel, E., Dibb, S., Meadows, M. and Spiller, K. (2015) *The Private Security State? Surveillance, Consumer Data and the War on Terror*. Frederiksberg: Copenhagen Business School Press.

- Ball, K. and Haggerty, K. (2005) Editorial: Doing surveillance studies. *Surveillance and Society*, 3(2) 129-138.
- Bargiela-Chiappini, F. (2007) Liminal ethnography: Understanding segregated organisations. *Qualitative Research in Organizations and Management*, 2(2) 126-143.
- Barker, P. (1997) *Assessment in Psychiatric Mental Health Nursing*. Cheltenham: Stanley Thornes Publishers.
- Barnes, C. and Mercer, G. (eds) (1997) *Doing Disability Research*. Leeds: The Disability Press.
- Barou, J-P. and Perrot, M. (1980) The eye of power. In Gordon, C. (ed) *Michel Foucault Power/Knowledge: Selected Interviews and Other Writings 1972-1977 by Michel Foucault*. New York: Harvester Wheatsheaf, 146-165.
- Bauman, Z. (2000) *Liquid Modernity*. Cambridge: Polity Press.
- Bauman, Z. and Lyon, D. (2013) *Liquid Surveillance*. Cambridge: Polity Press.
- Beck, U. (1992) *Risk Society: Towards a New Modernity*. London: Sage.
- Bijker, W.E. (1995) *Of Bicycles, Bakelites and Bulbs: Towards a Theory of Sociotechnical Change*. Cambridge: MIT Press.
- Bijker, W.E., Hughes, T.P. and Pinch, T. (eds) (2012) *The Social Construction of Technological Systems*, 2<sup>nd</sup> edition. Cambridge MA: MIT Press.
- Blom-Cooper, L., Hally, H. and Murphy, E. (1995) *The Falling Shadow: One Patient's Mental Health Care 1978-1993*. London: Duckworth.
- Bogard, W. (2006) Surveillance assemblages and lines of flight. In Lyon, D. (ed), *Theorising Surveillance: The Panopticon and Beyond*. Portland: Willan Publishing, 97-123.



- Bolton, G. (2010) *Reflective Practice: Writing and Professional Development*, 3<sup>rd</sup> edition. London: Sage.
- Bordo, S. (1993) *Unbearable Weight: Feminism, Western Culture and the Body*. Berkeley: University of California.
- Bourdieu, P. (1984) *Distinction: A Social Critique of the Judgement of Taste*. London: Routledge.
- Bowen, G.A. (2009) Document analysis as qualitative research method. *Qualitative Research Journal*, 9(2) 27-40.
- Bowers, L., Stewart, D., Papadopoulos, C., Dack, C. Ross, J., Khanom, H. and Jerrfrey, D. (2011) *Inpatient Violence and Aggression: A Literature Review: Report from the Conflict and Containment Reduction Research Programme*. Kings College London: Institute of Psychiatry, London.
- Bowles, N., Dodds, P., Hackney, C., Sunderland, C. and Thomas, P. (2002) Formal observations and engagement: A discussion paper. *Journal of Psychiatric and Mental Health Nursing*, 6 255-260.
- Boyne, R. (2000) Post-panopticism. *Economy and Society*, 29(2) 285-307.
- Božovič, M. (1995) *The Panoptic Writings: Jeremy Bentham*. London: Verso.
- Bracci, E., Maran, L., and Vagnoni, E. (2010) Saint Anna's Hospital in Ferrara, Italy: Accounting and Organizational Change during the Devolution. *Accounting History*, 15(4) 463–504.
- Buchanan-Barker, P. and Parker, P. (2005) Observation: the original sin of mental health nursing? *Journal of Psychiatric and Mental Health Nursing*, 12 541-549.

British Broadcasting Company (BBC) *Panorama Undercover Care: The Abuse Exposed*.

Shown on BBC 1 on 31 May 2011.

British Broadcasting Company (BBC) *Panorama Undercover Hospital Abuse Scandal*.

Shown on BBC1 on 22 May 2019.

Brown, J., Facuzi, W., McCarthy, C., Stevenson, C., Kwesi, S., Joyce, M., Dusoye, J.,

Mohamudbuscus, Y. and Shah, A. (2005) Safer wards: reducing violence in older people's mental health wards. *British Medical Journal Quality Improvement Reports* 1-4. Available online: <http://www.bmjopenquality.bmj.com> [Accessed 15/8/2019].

Busfield, J. (1986) *Managing Madness*. London: Unwin Hyman.

Cameron, H. (2004) CCTV and (In)dividuation. *Surveillance and Society*, 2(2/3) 136-144.

Campbell, D. (2017) Rise in violent attacks by patients on NHS mental health staff.

*The Guardian*. Internet edition. 7 October. Available online:

<https://www.theguardian.com/society/2017/oct/07/rise-in-violent-attacks-by-patients-on-nhs-mental-health-staff> [Accessed 8/8/2019].

Camus, E. (2010) Living with psychosis: I'm mad, but not bad. *Independent*. 13 July.

Available online: <https://www.independent.co.uk/life-style/health-and-families/features/living-with-psychosis-im-mad-but-not-bad-2025012.html> [Accessed 5/5/2019].

Care Quality Commission (CQC) (2014) *Monitoring the Mental Health Act in 2013/14*.

London: Care Quality Commission HMSO.

Care Quality Commission (CQC) (2018) *Sexual Safety in Mental Health Wards*.

London: Care Quality Commission HMSO.

- Carney, M.W. and Bacelle, L. (1984) Psychosis after cannabis abuse. *British Medical Journal* 288 1047-1052.
- Chambers, M. and Gillard, S. (2005) *Review of CCTV on John Meyer Ward, 19 July 2005 Agenda Item 9, South West London and St George's NHS Mental Health Trust.* South West London and St George's NHS Mental Health Trust Board Meeting 28 July 2005.
- Christopher, S. (2015) An introduction to black humour as a coping mechanism for student paramedics. *Journal of Paramedic Practice*, 7(12) 610-615.
- Chow, W.S. and Priebe, S. (2013) Understanding psychiatric institutionalisation: a conceptual review. *BMC Psychiatry* 13(169) 1-14 Open Access Article Available online: <https://bmcp psychiatry.biomedcentral.com/track/pdf/10.1186/1471-244X-13-169?site=bmcp psychiatry.biomedcentral.com> [accessed 26/10/2017].
- Chu, S. (2014) *What do we know about Special Observations in the Care of Psychiatric Patients? Review of the Literature and Development in Practice.* Mersey Care NHS Foundation Trust: Ashworth Research Centre, Ashworth Hospital.
- Clegg, J. (2012) Stranger situations: Examining a self-regulatory model of socially awkward encounters. *Group Processes and Intergroup Relations*, 15(6) 693-712.
- Cockerham, W.C. (2000) *Sociology of Mental Disorder*, 5<sup>th</sup> edition. New Jersey: Prentice Hall.
- Coid, J. (1996) Dangerous patients with mental illness: Increased risks warrants new policies, adequate resources, and appropriate legislation. *British Medical Journal*, 312 965-969.
- Coleman, R. and McCahill, M. (2011) *Surveillance and Crime.* London: Sage.

Collins English Dictionary (1979) *Collins English Dictionary of the English Language*.

London: Collins.

Coppock, V. and Dunn, B. (2010) *Understanding Social Work Practice in Mental Health*. London: Sage.

Cotterill, P. (1992) Interviewing women: Issues of friendship, vulnerability and power. *Women's Studies International Forum*, 15 5-6.

Cox, A., Hayter, M. and Ruane, J. (2010) Alternative approaches to 'enhanced observations' in acute inpatient mental health care: A review of the literature. *Journal of Psychiatric and Mental Health Nursing*, 17 162-171.

Cox, J.L. (1986) *Transcultural Psychiatry*. London: Croom Helm.

Cresswell, J.W. (1998) *Qualitative Inquiry and Research Design: Choosing Among Five Traditions*. London: Sage.

Creswell, K.M., Worth, A. and Sheikh, A. (2010) Actor-Network Theory and its role in understanding the implementation of information technology developments in healthcare. *BMC Medical Informatics and Decision Making* 10(67) 1-11. Available online: <http://www.biomedcentral.com/1472-6947/10/67> [accessed 12/12/2015].

Crossley, N. (2006) *Contesting Psychiatry: Social Movements in Mental Health*. London: Routledge.

Cuff, E.C., Sharrock, W.W. and Francis, D.W. (1990) *Perspectives in Sociology*. London: Unwin Hyman.

Dahl, J.Y. and Saetnan, A.R. (2009) "It all happened so slowly" – On controlling function creep in forensic DNA databases. *International Journal of Law, Crime and Justice* 37 83-103.

- Davies, S. (1996) *Big Brother: Britain's Web of Surveillance and the New Technological Order*. London: Pan Books.
- Davis, A. (1997) Risk, Work and Mental Health. In Kemshall, H. and Pritchard, J. (eds) *Good Practice in Risk Assessment and Risk Management 1*. London: Jessica Kingsley, 109-120.
- Davis, J., Watson, N. and Cunningham-Burley, S. (2000) Learning the lives of disabled children. In Christensen, P. and James, A. (eds) *Research with Children: Perspectives and Practices*. London: Routledge, 220-239.
- Davoren, M., Byrne, O., O'Connell, P., O'Neill, H., O'Reilly, K. and Kennedy, G.H. (2015) Factors affecting length of stay in forensic hospital setting: need for therapeutic security and course of admission. *BMC Psychiatry* 15. Available online: <https://www.ncbi.nlm.nih.gov> [accessed 5/4/2019].
- De Landa, M. (2016) *Assemblage Theory*. Edinburgh: Edinburgh University Press.
- Deleuze, G. (1992) Postscript on the societies of control. *October* 59 3-7.
- Deluze, G. and [Guattari, F.](#) (1980) *A Thousand Plateaus: Translated by Brian Massumi*. New York: University of Minnesota Press.
- Department of Health (DH) (1990) *Care Programme Approach. Health Circular (90)23/Local Authority Social Services Letter (90)11*. London: Department of Health.
- Department of Health (DH) (1999) *Campaign to Stop Violence against Staff Working in the NHS: NHS Zero Tolerance HSC 1999/226*. London: Department of Health.
- Department of Health (DH) (2002) *Women's Mental Health: Into the Mainstream Strategic Development for Mental Health Care for Women*. London: Department of Health.

Department of Health (DH) (2013) Health Building Note 03-01: Adult acute mental health units. Available online: <http://www.nationalarchives.gov.uk/doc/open-government-licence/> [accessed 10/2/2019].

Department of Health and Social Care (2018) *Time to Change*. Mind and Rethink Mental Illness. Available online: <http://www.time-to-change.org.uk> [accessed 10/10/2018].

Desai, S. (2003) From pathology to postmodernism: a debate on 'race' and mental health. *Journal of Social Work Practice*, 17(1) 95-102.

Desai, S. (2009) The new stars of CCTV: What is the purpose of monitoring patients in communal areas of psychiatric hospital wards, bedrooms and seclusion rooms? *Diversity in Health and Care*, 6(1) 45-53.

Desai, S. (2010) Violence and surveillance: Some unintended consequences of CCTV monitoring within mental health hospital wards. *Surveillance and Society*, 8(1) 85-92.

Dingwall, R. (2008) The ethical case against regulation in humanities and social science research, 21st Century society. *Journal of the Academy of Social Sciences*, 3(1) 1-12.

Diniz, D. (2015) Zefinha the name of abandonment. *Ciência and Saúde Coletiva* 20:9 2667-2674.

Dix, R. (2002) Observation and Technology: Logical progression or ethical nightmare. *National Association of Psychiatric Intensive Care Units Bulletin*, 2(4) 21-29.

Drake, R.E., Merrens, M.R. and Lynde, D.W. (eds) (2005) *Evidence-Based Mental Health Practice: A Textbook*. New York: WWW Norton and Company.

Dreyfus, H.L. and Rabinow, P. (1983) *Michel Foucault: Beyond Structuralism and Hermeneutics*. 2<sup>nd</sup> edition. With an Afterword by an Interview with Michel Foucault. Chicago: The University of Chicago Press.

Eder, D. and Fingerson, L. (2003) Interviewing children and adolescents. In Holstein, J.A. and Gubrium, J.F. (eds) *Inside Interviewing: New Lenses, New Concerns*. California: Sage, 33-53.

Edwards, E. and Mauthner, M. (2012) Ethics and feminist research: theory and practice. In Miller, T., Birch, M., Mauthner, M. and Jessop, J. (eds) *Ethics in Qualitative Research*. London: Sage, 14-29.

Elliot, I. (2016) *Poverty and Mental Health: A Review to Inform the Joseph Rowntree Foundation's Anti-Poverty Strategy*. London: Mental Health Foundation.

Ellis, D., Tucker, I. and Harper, D. (2013) The affective atmospheres of surveillance. *Theory and Psychology* 23(6) 716-731.

Ellul, J. (1964) *The Technological Society*. New York: Vintage Books.

Ellul, J. (1969) *To Will and To Do*. Philadelphia: Pilgrim Press.

Elmer, G. (2012) Panopticon – discipline – control. In Ball, K., Haggerty K.D. and Lyon, D. (eds) *Routledge Handbook of Surveillance Studies*. London: Routledge, 21-29.

Faulkner, A. (2004) *The Ethics of Survivor Research*. Bristol: Joseph Rowntree Foundation, The Policy Press.

Fernando, S. (2002) *Mental Health, Race and Culture*. 2<sup>nd</sup> edition. Basingstoke: Macmillan Press.

- Finlay, L. (2003) The reflexive journey: Mapping multiple routes. In Finlay, L. and Gough, B. (eds) *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences*. Oxford: Blackwell, 3-21.
- Foucault, M. (1971) *Madness and Civilization: A history of insanity in the Age of Reason*. New York: Pantheon.
- Foucault, M. (1979) *Discipline and Punish: The Birth of the Prison*. New York: Vintage.
- Foucault, M. (1992) *The Use of Pleasure: The History of Sexuality 2*. London: Penguin Books.
- Foucault, M. (2008) *Psychiatric Power: Lectures at the Collège de France 1973-1974*, edited by Jacques Lagrange and translated by Graham Burchell. Basingstoke: Palgrave.
- Foucault, M. (2009) *Security, Territory, Population: Lectures at the Collège de France 1977-1978*, edited by Michel Senellart and translated by Graham Burchell. Basingstoke: Palgrave.
- Freeman, D. and Freeman, J. (2008) *Paranoia: The Twenty-First Century Fear*. Oxford: Oxford University Press.
- Gallagher, S. (2014) In your face: Transcendence in embodied interaction. *Frontiers of Human Neuroscience* 8 1-6. Available online: <http://www.frontiersin.org> [accessed 20/5/2019].
- Ganesh, S. (2016) Managing surveillance: Surveillant individualism in an era of relentless visibility. *International Journal of Communication*, 10 164–177.
- Gilbert, H., Rose, D. and Slade, M. (2008) The importance of relationships in mental health care: A qualitative study of service users' experiences of psychiatric hospital



admission in the UK. *BMC Health Service Research* 8(92) 1-12. Available online:

<http://www.biomedcentral.com/1472-6963/8/92> [accessed 8/5/2019].

Giddens, A. (1998) *The Third Way: The Renewal of Social Democracy*. Cambridge: Polity Press.

Gill, M.J. (2014) The possibilities of phenomenology for organisational research. *Organisational Research Methods*, 17(2) 118-137.

Gilligan, C. (1982) *In a Different Voice: Psychological Theory and Women's Development*. Cambridge: Harvard University Press.

Gleason, J.J. (1990) Meaning of play: Interpreting patterns in behaviour of persons with severe development disabilities. *Anthropology and Education Quarterly*, 21 59-77.

Gleason, J.J. (1993) The creation of meaning: What persons with severe or profound multiple developmental disabilities do in context. *Australia and New Zealand Journal of Developmental Disabilities*, 18(3) 157-167.

Glover, H. (2012) Recovery, lifelong learning, empowerment and social inclusion: Is a new paradigm emerging? In Ryan, P., Ramon, S. and Greacen, T. (eds) *Empowerment, Lifelong Learning and Recovery in Mental Health*. Basingstoke: Palgrave Macmillan, 15-35.

Graham, S. and Marvin, S. (1996) *Telecommunications and the City: Electronic Spaces, Urban Places*. London: Routledge.

Goffman, E. (1961) *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*. New York: Anchor Books.

Goffman, E. (1990) *The Presentation of the Self in Everyday Life*. Harmondsworth: Penguin Books.

Gordon, C. (ed) (1980) *Michel Foucault Power/Knowledge: Selected Interviews and Other Writings 1972-1977 by Michel Foucault*. London: Harvester Wheatsheaf.

Gotleib, C.C. (1996) Privacy: A concept where time has come and gone. In Lyon, D. and Zureik, E. (eds) *Computers, Surveillance and Privacy*. Minneapolis: University of Minnesota Press, 156-174.

Gov.UK: Press Release 27 June 2017 *PM: mental health training for teachers will "make a real difference to children's lives"*. Available online: <https://www.gov.uk/government/news> [accessed 23/1/2018].

Haggerty, K.D. (2004) Displaced expertise: Three constraints on the policy relevance of criminological thought. *Theoretical Criminology*, 8(2) 211–231.

Haggerty, K.D. (2004) Ethics Creep: Governing social science research in the name of ethics. *Qualitative Sociology*, 27(4) 391-420.

Haggerty, K.D. (2012) Surveillance, crime and the police. In Ball, K., Haggerty, K. and Lyon, D. (eds) *Routledge Handbook of Surveillance Studies*. London: Routledge, 235-243.

Haggerty, K.D. and Ericson, R.V. (2000) The surveillant assemblage. *British Journal of Sociology*, 51(4) 605-622.

Haggerty, K.D. and Ericson, R.V. (eds) (2007) *The New Politics Surveillance and Visibility*. Toronto, Buffalo, London: University of Toronto Press.

Halliday, J. (2014) Jimmy Savile: timeline of his sexual abuse and its uncovering. *The Guardian*, Internet edition. 26 June. Available online:

<http://www.guardian.com/media/2014/jun/26/jimmy-savile-sexual-abuse-timeline>  
[Accessed 13/7/2017].

Hammersley, M. (1999) Some reflections on the current state of qualitative research. *Research Intelligence*, 70 16–18.

Hammersley, M. and Atkinson, P. (1995) *Ethnography: Principles in Practice*. 2<sup>nd</sup> edition. London: Routledge.

Hand, S. (1997) *Difficult Freedom: Essay on Judaism Emmanuel Levinas*. Translated by Hand, S. Maryland USA: John Hopkins University Press.

Hardy, S., Bennett, L., Rosen, P., Carroll, S., White, P. and Palmer-Hill, S. (2017) The feasibility of using body worn cameras in an inpatient mental health setting. *Mental Health in Family and Medicine*, 13 393-400.

Harper, D.J. (2011) Social inequality and the diagnosis of paranoia. *Health Sociology Review*, 20(4) 423-436.

Health and Care Professions Council (HCPC) (2017) *Standards of proficiency: Social Workers in England*. London: Park House. Available online: <http://www.hcpc-uk.org> [accessed 15/4/2019].

Healthcare Commission and the Royal College of Psychiatrists (2005) *The National Audit of Violence (2003-2005)*. London: Royal College of Psychiatrists.

Healthcare Commission and the Royal College of Psychiatrists (2007) *The National Audit of Violence 2006-7: Final Report – Working Age Adult Services*. London: Royal College of Psychiatrists.

- Heginbotham, C., Carr, J., Hale, R., Walsh, T. and Waren, L. (1994) *Report of the Independent Panel of Inquiry Examining the Case of Michael Buchanan*. London: North West London Mental Health Trust.
- Heir, S.P. (2003) Probing the surveillant assemblage. *Surveillance and Society*, 1(3) 399-411.
- Henderson, A. (1994) Power and knowledge in nursing practice: The contribution of Foucault. *Journal of Advanced Nursing*, 20 935-939.
- Hernandez, J.M. and Roberts, L.W. (2008) Ethics and culture in mental health care. *Ethics and Behaviour*, 18(4) 353-372.
- Hide, L. (2018) In plain sight: Open doors, mixed-sex wards and sexual abuse in English psychiatric hospitals, 1950s – early 1990s. *Social History of Medicine*, 31(4) 732-753.
- Higginbottom, G.M.A., Pillay, J.J. and Boadu, N.Y. (2013) Guidance on performing focused ethnographies with an emphasis on healthcare. *The Qualitative Report*, 18(17) 1-6.
- Holland, K. (2007) The epistemological bias of ethics review: constraining mental health research. *Qualitative Inquiry*, 13(6) 895-913.
- Holloway, I. and Tordes, L. (2005) The status of method: flexibility, consistency and coherence. In Holloway, I. (ed) *Qualitative Research in Healthcare*. Berkshire: Open University Press, 90-103.
- Holmes, (2001) From iron gaze to nursing care: Mental health nursing in the era of the panopticism. *Journal of Psychiatric and Mental Health Nursing*, 8(1) 7-15.

Holyoake, D-D (2013) I spy with my little eye something beginning with O: looking at what the myth of 'doing observations' means in mental health nursing culture.

*Journal of Psychiatric and Mental Health Nursing*, 20 840-850.

Hope, A. (2009) CCTV, school surveillance and social control. *British Educational Research Journal*, 35(6) 891-907.

Huberman, M.A. and Miles, M.B. (1998) Data management and analysis. In Denzin, N.K. and Lincoln, Y.S. (eds) *Collecting and Interpreting Qualitative Materials*. London: Sage Publications, 179-210.

Innes, M. (2003) *Understanding Social Control: Deviance, Crime and Social Order*. Maidenhead: Open University Press.

Information Commissioner's Office (2014) *In the Picture: A Data Protection Code of Practice for Surveillance Cameras and Personal Information*. London: Information Commissioner's Office Version 1.2 20170609.

Jenkins, R. (2012) Identity, surveillance and modernity. In Ball, K., Haggerty, K.D. and Lyon, D. (eds) *Routledge Handbook of Surveillance*. London: Routledge, 159-166.

Johansson, A. and Vinthagen, S. (2014) Dimensions of Everyday Resistance: An Analytical Framework. *Critical Sociology*, 42(3) 417-435.

Johnson, M., Lee, M., McCahill, M and Mesina, M.R. (2019) Beyond the 'All Seeing Eye': Filipino Migrant Domestic Workers' Contestation of Care and Control in Hong Kong. *Ethnos: Journal of Anthropology*. Available online:

<https://doi.org/10.1080/00141844.2018.1545794> [accessed 4/4/2019].

Jørgensen, K. and Rendtorff, J.D. (2017) Patient participation in mental health care – perspectives of healthcare professionals: An integrated review. *Scandinavian Journal of Caring Sciences*, 31(2) 490-501.

Jones, J. (1993) Why aren't people such as Ben Silcock in hospital? *The Independent*. 10 January. Available online: <https://www.independent.co.uk/life-style/care-in-the-community-ben-silcocks-mauling-by-a-lion-at-london-zoo-has-highlighted-the-plight-of-the-1477674.html>

[Accessed 10/6/2014].

Karban, K. (2011) *Social Work and Mental Health*. Cambridge: Polity Press.

Kesey, K. (1973) *One Flew Over the Cuckoo's Nest*. London: Pan Books.

Klein, H.K. and Kleinman, D.L. (2002) The social construction of technology: Structural considerations. *Science, Technology and Human Values*, 27(1) 28-52.

Knoblauch, H. (2005) Focused ethnography. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*. 6(3) Art. 44. Available online: <http://nbn-resolving.de/urn:nbn:de:0114-fqs0503440> [accessed 11/4/2016].

Koskela, H. (2000) 'The gaze without eyes': video-surveillance and the changing nature of urban space. *Progress in Human Geography*, 24(2) 243–265.

Koskela, H. (2012) "You shouldn't wear that body": The problematic of surveillance and gender. In Ball, K., Haggerty, K.D. and Lyon, D. (eds) *Routledge Handbook of Surveillance Studies*. London: Routledge, 49-56.

Kühn, J-M. (2013) Focused ethnography as research method: A case study of techno music producers in home recording studios. *Dancecult: Journal of Electronic Dance Music Culture*. 5(3). Available online:

<https://dj.dancecult.net/index.php/dancecult/article/view/356/361> [accessed 11/4/2016].

Kutchins, H. and Kirk, S.A. (1997) *Making Us Crazy: DSM – The Psychiatric Bible and the Creation of Mental Disorders*. London: Constable.

Laing, R.D. (1961) *The Divided Self: An Existential Study in Sanity and Madness*. London: Penguin.

Laing, R.D. (1977) *Conversations with Adam and Natasha*. New York: Pantheon.

Lantta, T., Antilla, M., Kontio, R., Adams, C.E. and Välimäki, M. (2016) Violent events, ward climate and ideas for violence prevention among nurses in psychiatric wards: A focus group study. *International Journal of Mental Health Systems*, 10(27) 10-27.

Latour, B. (2005) *Reassembling the Social: An Introduction to Actor-Network-Theory*. Oxford: Oxford University Press.

Laurance, J. (2005) Health Trust is fined after a mentally ill patient kills a nurse. *The Independent*. 6 May. Available online: <https://www.independent.co.uk/life-style/health-and-families/health-news/health-trust-is-fined-after-mentally-ill-patient-kills-nurse-495266.html> [17/9/2018].

Lester, H. and Glasby, J. (2006) *Mental Health Policy and Practice*. Basingstoke: Palgrave Macmillan.

Levinas, E. (1991) *Totality and Infinity*. The Netherlands: Kluwer Academic Publishers.

Levinas, E. (2006) *Humanism of the Other*. Translated by Nidra Poller and Introduction by Richard A. Cohen. Urbana and Chicago: University of Illinois Press.

- Lewis, B. (2009) *Moving Beyond Prozac, DSM and the New Psychiatry: The Birth of Postpsychiatry*. USA: Michigan Press.
- Lidz, C.W., Mulvey, E.P. and Gardner, W. (1993) The accuracy of predictions of violence to others. *Journal of the American Medical Association*, 269(8) 1007-1011.
- Lippert, R. (2009) Signs of the surveillant assemblage: Privacy, regulation, urban CCTV, and governmentality. *Social and Legal Studies*, 18(4) 505-522.
- Lyon, D. (1994) *The Electronic Eye: The Rise of Surveillance Society*. Minnesota: University of Minnesota Press.
- Lyon, D. (2001) *Surveillance and Society: Monitoring Everyday Life*. Buckingham: Open University Press.
- Lyon, D. (2003) Surveillance as social sorting: computer codes and mobile bodies. In Lyon, D. (ed) *Surveillance as Social Sorting: Privacy, Risk and Digital Discrimination*. London: Routledge, 13-30.
- Lyon, D. (2007) *Surveillance Studies: An Overview*. Cambridge: Polity Press.
- MacKenzie, D. and Wajcman, J. (eds) (1985) *The Social Shaping of Technology*. Milton Keynes: Open University Press.
- Macnish, K. (2014) Just surveillance: Towards a normative theory of surveillance. *Surveillance and Society*, 12(1) 142-153.
- Mann S., Nolan J. and Wellman B. (2003) Sousveillance: Inventing and Using Wearable Computing Devices. *Surveillance and Society*, 1 331-355.
- Mathieson, T. (1997) The viewer society: Michel Foucault's 'Panopticon' revisited. *Theoretical Criminology*, 1(2) 215-233.
- Matlack, S. (2014) Confronting the technological society. *The New Atlantis*, 43 45-64.



- Marneros, A. (2008) 'Psychiatry's 200th birthday' Editorial. *The British Journal of Psychiatry*, 193 1–3.
- Martin, R. (1988) Truth, Power, Self: An interview with Michel Foucault. In Martin, L.H., Gutman, H. and Hutton, P.H. (eds) (1988) *Technologies of the Self: A Seminar with Michel Foucault*. USA: The University of Massachusetts Press, 9-15.
- Marx, G.T. (1988) *Undercover: Police Surveillance in America*. Berkley: University of California.
- Marx, G.T. (1998) Ethics for the new surveillance. *Information Society*, 14 171-185.
- Marx, G.T. (2001) Murky conceptual waters: The public and the private. *Ethics and Information Technology*, 3 157-169.
- Marx, G.T. (2003) A tack in the shoe: Neutralising and resisting new surveillance. *Journal of Social Issues*, 59(2) 369-390.
- Marx, G.T. (2009) A tack in the shoe and taking off the shoe: Neutralisation and counter-neutralisation. *Surveillance and Society*, 6(3) 294-306.
- McAndrew, S., Chambers, M., Nolan, F., Thomas, B. and Watts, P. (2014) Measuring the evidence: Reviewing the literature of the measurement of therapeutic engagement in acute mental health inpatient wards. *International Journal of Mental Health Nursing*, 23(3) 212-220.
- McCahill, M. and Norris, C. (1999) Watching the workers: crime CCTV and the workplace. In Davis, P. Francis, P. and Jupp, V. (eds) *Invisible Crimes: Their Victims and their Regulation*. London: Macmillan, 208-231.
- McCahill, M. (2002) *The Surveillance Web: The Rise of the Visual Surveillance in an English City*. Cullompton: Willan Publishing.

- McCahill, M. (2012) Crime, surveillance and media. In Ball, K., Haggerty, K.D. and Lyon, D. (eds) *Routledge Handbook of Surveillance Studies*. London: Routledge, 244-250.
- McCahill, M. and Norris, C. (2003) Victims of surveillance. In Davis, P., Jupp, V. and Francis, P. (eds) *Victimisation: Theory, Research and Policy*. Basingstoke: Palgrave Macmillan, 121-147.
- Mercer, K. (1993) Racism and transcultural psychiatry. In Clarke, P., Harrison, M., Patel, K., Shah, M., Varley, M. and Zack-Williams, T. (eds) *Improving Mental Health Practice*. Leeds: Northern Curriculum Development Project, 18-53.
- Modestin, J. and Ammann, R. (1995) Mental disorders and criminal behaviour. *British Journal of Psychiatry*, 166 667-675.
- Molin, J., Lindgren, B-M., and Graneheim, U.H. (2017) Does 'Time Together' increase quality of interaction and decrease stress? A study protocol of a multisite nursing intervention in psychiatric inpatient care, using a mixed method approach. *British Medical Journal Open* 2017; 7: e015677. doi: 10.1136/bmjopen-2016-015677.  
Available online: <http://www.bmjopen.bmj.com> [accessed 31/8/2018].
- Monahan, T. (2006) Counter-surveillance as political intervention? *Social Semiotics*, 16(4) 515-534.
- Monahan, T. (2011) Surveillance as cultural practice. *The Sociological Quarterly*, 52(4) 495-508.
- Monahan, J. and Steadman, H.J. (eds) (1994) *Violence and Mental Disorder: Developments in Risk Assessment*. Chicago: Chicago University Press.

Moore, D. (2011) The benevolent watch: Therapeutic surveillance in drug treatment court. *Theoretical Criminology*, 15(3) 255-268.

Morrison, P. and Stomski, N.J. (2015) Embracing participation in mental health research: Conducting authentic interviews. *Qualitative Research Journal*, 15(1) 47-60.

Nail, T. (2017) What is an assemblage? *SubStance* 46:1 21-37. John Hopkins University Press. Project MUSE Database Available online: <http://www.muse.jhu.edu> [accessed 16/8/2019].

National Association of Psychiatric Intensive and Low Secure Care Units (NAPICU) (2014) *National Minimum Standards for Psychiatric Intensive Care in General Adult Services*. East Kilbride: NAPICU International Press.

National Association of Psychiatric Intensive and Low Secure Care Units (NAPICU) (2017) *Design Guidance for Psychiatric Intensive Care Units*. East Kilbride: NAPICU International Press.

National Association of Psychiatric and Intensive and Low Secure Care Units (NAPICU) and NHS Clinical Commissioners (2016) *Guidance for Commissioners of Psychiatric Intensive Care Units (PICU)*. East Kilbride: NAPICU International Press.

Newburn, T. and Hayman, S. (2002) *Policing, Surveillance and Social Control*. Cullompton: Willan.

NHS Executive (1994) *The Operation of the NHS Internal Market: Local Freedoms, National Responsibilities*. Leeds: Department of Health.

Nicki, A. (2001) The abused mind: Feminist theory, psychiatric disability and trauma. *Hypatia*, 16(4) 80-104.

- Nijman, H., Bowers, L., Haglund, K., Muir-Cochrane, E., Simpson, A. and Van Der Merwe, M. (2011) Door locking and exit security measures on acute psychiatric admission wards. *Journal of Psychiatric Mental Health Nursing*, 18 614-621.
- Noble, P. and Rodgers, S. (1989) Violence by psychiatric in-patients. *British Journal of Psychiatry*, 155(3) 384-390.
- Norris, C. (1993) Some ethical considerations on field-work with the police. In Hobbs, D. and May, T. (eds) *Interpreting the Field: Accounts of Ethnography*. Oxford: Clarendon Press, 122-144.
- Norris, C., Moran, J. and Armstrong, G. (1998) *Surveillance, Closed Circuit Television and Social Control*. Aldershot: Ashgate.
- Oeye, C., Bjelland, A.K. and Skorpen, A. (2007) Doing participant observation in a psychiatric hospital – research ethics resumed. *Social Science and Medicine*, 65 2296-2306.
- Orwell, G. (1949) *Nineteen Eighty-Four*. London: Secker and Warburg.
- Page, M. (2007) Engaging the disengaged: collecting the views of patients in low secure unit on methods of observation. *Journal of Psychiatric Intensive Care*, 3(1) 13-19.
- Page, M., Meiklejohn, C. and Warr, J. (2004) CCTV and night-time observation. *Mental Health Practice*, 17(10) 12-15.
- Parton, N. (ed) (1996) *Social Theory, Social Change and Social Work: The State of Welfare*. London: Routledge.
- Peltonen, M. (2004) From discourse to “dispositif”: Michel Foucault’s two histories. *Historical Reflections/Réflexions Historiques*, 1(2) 205-219.

Pinch, T. and Bijker, W.E. (2012) The social construction of facts and artifacts: Or how the sociology of science and the sociology of technology might benefit each other. In Bijker, W.E., Hughes, T.P. and Pinch, T. (eds) *The Social Construction of Technological Systems*. 2<sup>nd</sup> edition. Cambridge MA: MIT Press, 11-44.

Polacek, M.J., Allen, D.E., Damin-Moss, R.S., Swartz, A.J., Sharp, D., Shattell, M., Souther, J. and Delany, K.R. (2015) Engagement as an element of safe inpatient psychiatric environments. *Journal of American Psychiatric Nurses Association*, 21(3) 181-190.

Porter, R. (1987) *A Social History of Madness*. London: Weidfeld and Nicholson.

Porter, R. (2002) *Madness: A Brief History*. Oxford: Oxford University Press.

Postman, N. (1993) *Technopoly: The Surrender of Culture to Technology*. New York: Vintage Books.

Poyser, S. (2002) Does the effectiveness of CCTV as a crime prevention strategy outweigh the threat to civil liberties? *The Police Journal*, 77(2) 120-134.

Punch, M. (1998) Politics and ethics in qualitative research. In Denzin, N.K. and Lincoln, Y.S. (eds) *The Landscape of Qualitative Research: Theories and Issues*. London: Sage, 156-184.

Purdy, S. (2015) Surveillance, knowledge and inequality: Understanding power through Foucault and beyond. *The Hilltop Review*, 8(1) 1-13.

Rack, P. (1982) *Race, Culture and Mental Disorder*. London: Tavistock.

Rajpoot, M.Q. and Jenson, C.D. (2015) Video surveillance, privacy issues and legal compliance. In Kumar, V. and Svensson, J. (eds) *Promoting Social Change and*

*Democracy through Information Technology*. USA: Information Science Reference, IGI Global, 69-91.

Rapport, F. (2005) Hermeneutic phenomenology: the science of interpretation of texts. In Holloway, I. (ed) *Qualitative Research in Health Care*. Berkshire: Open University Press, 125-146.

Ritchie, J.H., Dick, D. and Lingham, R. (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. Norwich: HMSO.

Romein, E. and Schuilenburg, M. (2008) Are you on the fast track? The rise of surveillant assemblages in post-industrial age. *Architectural Theory Review*, 13(3) 337-348.

Rose, N. (1995) Medicine, history and the present. In Jones, C. and Porter, R. (Eds) *Reassessing Foucault: Power, Medicine and the Body*. London: Routledge.

Rose, N. (1989) *Governing the Soul: The Shaping of the Private Self*. London: Free Association Books.

Rosenhan, D.L. (1973) On being sane in insane places. *Science*, 179 250-58.

Rogers, A. and Pilgrim, D. (2003) *Mental Health Policy in Britain*. Hampshire: Palgrave.

Roper, J. M. and Shapira, J. (2000) *Ethnography in Nursing Research*. London: Sage Publications.

Ryan, P., Ramon, S. and Greacen, T. (2012) *Empowerment, Lifelong Learning and Recovery in Mental Health*. Basingstoke: Palgrave Macmillan.

Scott, J.C. (1985) *Weapons of the Weak: Everyday Form of Peasant Resistance*. New Haven: Yale University Press.

- Scull, A. (1993) *The Most Solitary of Afflictions*. New Haven: Yale University Press.
- Scull, A. (2011) *Madness: A Very Short Introduction*. Oxford: Oxford University Press.
- Seale, C., Gobo, G., Guberium, J.F. and Silverman, D. (2004) *Qualitative Research Practice*. London: Sage.
- Sewell, G. and Barker, J.R. (2007) Neither good, nor bad, but dangerous: Surveillance as an ethical paradox. In Heir, S. and Greenburg, J. (eds) *The Surveillance Studies Reader*. Maidenhead: McGraw-Hill Education, Open University Press, 354-367.
- Sharkey, S. and Larson, J.A. (2005) Ethnographic exploration: participation and meaning in everyday life. In Holloway, I. (ed) *Qualitative Research in Health Care*. Berkshire: Open University Press, 168-190.
- Simon, J. (2007) *Governing Through Crime: How the War on Crime Transformed American Democracy and Created a Culture of Fear*. Oxford: Oxford University Press.
- Smith, G.J.D. (2007) Exploring Relations between Watchers and Watched in Control(led) Systems: Strategies and Tactics. *Surveillance and Society*, 4(4) 280-313.
- Solove, D.J. (2007) I've got nothing to hide and other misunderstandings of privacy. *San Diego Law Review*, 44 745-772.
- Soomer, S.M. and Ali, U.U. (2018) Understanding and managing sexual disinhibition in mentally ill clients. *Psychology and Psychiatry: Open Access*, 1(1). Available online: <http://www.omiconline.org/ope-access/understanding-and-managing-sexual-disinhibition-in-mentally-ill-clients-105356.html> [accessed 25/9/2019].
- Spano, R. (2006) Observer behaviour as a potential source of reactivity: Describing and quantifying observer effects in a large-scale observational study of police. *Sociological Methods and Research*, 34(4) 521-553.

- Spradley, J.P. (1979) *The Ethnographic Interview*. Wadsworth USA: Cengage Learning.
- Spradley, J.P. (1980) *Participant Observation*. New York: Holt, Rinehart and Winston.
- Stanford Encyclopaedia of Philosophy (2013) *Phenomenology*. Available online: <http://www.plato.stanford.edu/phenomenology> [accessed 9/11/2016].
- Stevenson, C. and Cutcliffe, J. (2006) Problematizing special observation in psychiatry: Foucault, archaeology, genealogy, discourse and power/knowledge. *Journal of Psychiatric Mental Health Nursing*, 13(6) 713-721.
- Stolovy, T., Melamed, Y. and Afek, A. (2015) Video surveillance in mental health facilities: Is it ethical? *The Israel Medical Association Journal*, 17(5) 274-276.
- Stuart, H. (2003) Violence and mental illness: An overview. *World Psychiatry*, 2(2) 121-124.
- Symonds, A. and Kelly, A. (eds) (1998) *The Social Construction of Community Care*. Basingstoke: Macmillan Press Ltd.
- Szasz, T. (1974) *The Myth of Mental Illness*. New York: Harper Row.
- Taylor, D. (ed) (2014) *Michel Foucault: Key Concepts*. London: Routledge.
- Taylor, E. (2013) *Surveillance Schools: Security, Discipline and Control in Contemporary Education*. Basingstoke: Palgrave Macmillan.
- Taylor, N. (2011) A conceptual legal framework for privacy, accountability and transparency in visual surveillance systems. *Surveillance and Society*, 8(4) 455-470.
- Thompson, N. (2016) *The Professional Social Worker: Meeting the Challenge*. 2<sup>nd</sup> edition. London: Palgrave Macmillan.



Trevithick, P. (2000) *Social Work Skills: A Practice Handbook*. Buckingham: Open University Press.

Tully, J., Fahy, T. and Larkin, F. (2016) New technologies in the management of risk and violence in forensic settings. In Warburton, K.D. and Stahl, S.M. (eds) *Violence and Psychiatry*. Cambridge: Cambridge University Press, 287-294

Van Maanen, J. (1988) *Tales of the Field: On Writing Ethnography*. 2<sup>nd</sup> edition. Chicago: The University of Chicago Press.

Van Manen, M. (1990) *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy*. Ontario: Althouse.

Van Rompay, T.J.L., Vonk, D.J. and Fransen, M.L. (2009) The eye of the camera: Effects of security cameras on prosocial behaviour. *Environment and Behaviour*, 41 60-74.

Varshney, M., Mahapatra, A., Krishnan, V., Gupta, R. and Sinha Deb, K. (2016) Violence and mental illness: What is the true story? *Journal of Epidemiology Community Health*, 70(3) 223-225.

Vartiainen, H. and Hakola, P. (1994) The effects of TV monitoring on a ward atmosphere in a security hospital. *International Journal of Law and Psychiatry*, 17(4) 443-449.

Verbeek, P.P. (2016) Toward a theory of technological mediation: A program for post phenomenological research. In Friis, J.K.B.O. and Crease, R.C. (eds) *Technoscience and Postphenomenology: The Manhattan Papers*. London: Lexington Books, 189-204

Vinthagen, S. and Johansson, A. (2013) "Everyday Resistance": Exploration of a concept and its theories. *Resistance Studies Magazine*, 1 1-46. Available online: <http://www.pdfsemanticscholar.org> [accessed 12/2/2019].

Wajcman, J. (2000) Reflections on gender and technology studies: In what state is the art? *Social Studies of Science*, 30(3) 447-464.

Wall, S. (2015) Focused ethnography: A methodological adaptation for social research in emerging contexts. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research*. 16:1. Available online: <http://www.qualitative-research.net/index.php/fqs/article/view/2182/3728> [accessed 15/4/ 2015].

Warnick, B.R. (2007) Surveillance cameras in schools: An ethical analysis. *Harvard Educational Review*, 77 317-393.

Warr, J., Page, M. and Crossen-White, H. (2005) *The Appropriate Use of Closed Circuit Television (CCTV) in a Secure Unit*. Study undertaken by Montpellier Unit and Bournemouth University, England.

Weberman, D. (1995) Foucault reconception of power. *Philosophical Forum*, 26(3) 189 – 217.

Webster, W. R. and Murakami Wood, D. (2009) Living in surveillance societies: The normalization of surveillance in Europe and the threat of Britain's bad example. *Journal of Contemporary European Research*, 5 259–273.

Weiss, J. (2007) 'Eyes on Me Regardless': Youth response to high school surveillance. *Educational Foundations*, Winter-Spring 47-69.

Welsh, B.C. and Farrington, D.P. (2007) *Closed-Circuit Television Surveillance and Crime Prevention*. Stockholm: Swedish National Council for Crime Prevention.

- Whittington, R. (1994) Violence in psychiatric hospitals. In Wykes, T. (ed) *Violence and Health Care Professionals*. Boston: Springer, 23-43.
- Wilkinson, J. (1998) Danger on the streets: mental illness, community care and ingratitude. In Symonds, A. and Kelly, A. (eds) *The Social Construction of Community Care*. Basingstoke: Macmillan, 208-219.
- Willis, P. and Trondman, M. (2002) Manifesto for ethnography. *Critical Studies Critical Methodologies*, 2(3) 394-402.
- Wilson, K., Ruch, G., Lymbery, M. and Cooper, A. (2008) *Social Work: An Introduction to Contemporary Practice*. Harlow: Pearson Longman.
- Winner, L. (1977) *Autonomous Technology: Technics-Out-Of-Control as a Theme for Political Thought*. Cambridge: MIT Press.
- Wolcott, H. F. (1999) *Ethnography: A way of seeing*. Walnut Creek, CA: AltaMira Press.
- Yar, M. (2003) Panoptic power and the pathologisation of vision: Critical reflections on the Foucauldian thesis. *Surveillance and Society*, 1(3) 254-271.

Below this line is a hidden Section Break (Next Page). DO NOT DELETE THIS!

You can see hidden elements by using the Show/Hide option (  ) on the home ribbon.

# Appendix 1

Appendix 8 Version 3 27/10/2016 IRAS ID: 210115



Information Sheet for Patients and Staff in Seclusion/Extra Care Area

Research Title: The Impact of Closed Circuit Television (CCTV) Inside Mental Health

## Wards

What is the purpose of this information sheet?

My aim is to give you information about the research and answer any questions that you might have in deciding whether you would like to be involved in it. I have anticipated some questions that I hope will help you. If it does not answer all your questions you can approach me and ask me for more details when I am on the ward, email me or contact me by phone – my details are at the end of this Information Sheet.

Who am I and what is my research about?

My name is Suki Desai. I am a PhD student at the University of Hull. The aim of my research is to examine the social impact of CCTV inside mental health wards. As part of this research I am undertaking observations in seclusion and extra care areas where there are CCTV cameras.

How can you help me?

I undertook ..... minutes of observation when you were in seclusion or the in extra care area. It was not possible, during this time, to approach you directly to find out if it was okay for me to undertake observations. However, now that you are no longer

in seclusion or extra care area, I am asking you if it is possible for me to use the information that I have collected as data for my research.

How can the research benefit you?

There are no direct benefits to you if you agree. However, at the moment there is very little research information about CCTV use inside mental health hospitals. The observation will help in filling this gap and in improving the care of people with mental health conditions in the future.

Do you have to take part in the research?

No. You do not have to take part in this research if you don't want to. Not taking part will not affect any care and treatment that you receive in this hospital, or, if you are a member of staff, your employment status.

You will have a minimum of 24 hours to decide if you want to be involved in the research after you have received this information sheet. I will approach you after 24 hours, and if you need more time to decide this is okay. When you are ready I will go through this information sheet again with you and answer any questions that you might have. When you are satisfied that all your questions have been answered, I will go through a form with you and you can say that you do not give your consent, and, you want to withdraw from the research. I will ask you to sign this form.

Will everything be kept confidential?

I will not be recording your name or any personal details about you.

Breaking confidentiality

The only time that I will have to break confidentiality is if I observe any behaviour that I believe might result in harm to you or other people. If I believe that this is the

case I will report what I have observed to a senior member of staff on the ward in the first instance.

What do you need to do if you do want to take part in the research?

If you would like me to include you in the research you will have a minimum of 24 hours to decide if you want to participate. I will speak with you after 24 hours to ask you if you want to be involved in the research. If you need more time, this is also okay. I will arrange to meet with you again when you are ready.

When you are ready, I will go through this Information Sheet again with you and answer any questions that you might have about the research. When you are satisfied that all your questions have been answered, and you would still like to take part in the research, I will go through a form with you saying that you consent to the research and ask you to sign it.

While you might be agreeable to taking part in the research, if any of the other people who were with you, in the seclusion or extra care area, say that they do not want to be involved in the research, then all participants will be withdrawn from the research. Unless, you were in the seclusion or extra care area on your own.

**Personal information**

I will destroy any personal information that I have about you three months after the research has ended.

What if you are not happy about the research?

Ethical approval for this research has been given by the University of Hull and NHS Ethics Committee (ref no. 16/YH/0373). A Research Ethics Committee is a group of

independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

If you are not happy about any aspect of the research or if you want to say something good about the research you can contact either one of my supervisors at the University of Hull. Their contact details are:

Dr Mike McCahill: [M.McCahill@hull.ac.uk](mailto:M.McCahill@hull.ac.uk)

Tel: 01482 465715

Dr Julia Holdsworth: email: [j.holdsworth@hull.ac.uk](mailto:j.holdsworth@hull.ac.uk)

Tel: 01482 466086

If you want to make a complaint about any aspect of the research you can contact:

Monica Magadi

Professor of Social Research

Email: [m.magadi@hull.ac.uk](mailto:m.magadi@hull.ac.uk)

Tel: 01482 462032

What happens at the end of the research?

I will write a short report that I will pass to the Trust and the Ward. If you are interested in knowing what that report says you can contact the ward and ask for a copy of my report or you can email me [S.Desai@2014.hull.ac.uk](mailto:S.Desai@2014.hull.ac.uk) and I will email you a copy. Or call me on 0772 488 8173

Thank you.



## Appendix 2

Appendix 10 Version 3 27/10/2016 IRAS ID: 210115



### Interview Information Sheet for Patients

Research Title: The Impact of Closed Circuit Television (CCTV) Inside Mental Health

#### Wards

What is the purpose of this information sheet?

My aim is to give you information about the research and answer any questions that you might have in deciding whether you would like to be involved in it. I have anticipated some questions that I hope will help you. If it does not answer all your questions you can approach me and ask me for more details when I am on the ward, email me or contact me by phone – my details are at the end of this Information Sheet.

Who am I and what is my research about?

My name is Suki Desai. I am a PhD student at the University of Hull. The aim of my research is to examine the social impact of CCTV inside mental health wards. As part of this I am very interested in knowing what you think about CCTV use.

How can you help me?

I want to know what you know about CCTV cameras and what you think of them.

This interview will last up to one hour.

I would like to record the interview with you on an audio-tape so that I can concentrate on what you are saying. However, if you really do not want me to do

this, I can take notes. You can also ask me to turn the tape-recorder off, during the interview, if you change your mind.

How can the research benefit you?

There are no direct benefits to you if you agree to be interviewed by me. However, at the moment there is very little research information about CCTV use inside mental health hospitals. Your views will help in filling this gap. Your views will also help me make any recommendations to the Trust. So whilst the research will not directly change your circumstances, I am hoping that sharing your views, will help by giving you a voice and improving the care of people with mental health conditions in the future.

Will the research harm you?

No. The research will not harm you. I hope that you will enjoy speaking with me. However, you might find some questions upsetting. If this is the case I will, with your permission, ask a member of staff to support you. If you did not wish to speak with a member of staff I will give you information about advocacy groups, or, patient groups that are linked to the hospital, who you can contact in your own time.

Do you have to take part in the research?

No. You do not have to take part in this research if you don't want to. Not taking part will not affect any care and treatment that you receive in this hospital.

What do you need to do if you do want to take part in the research?

If you would like to be interviewed by me you will have at least 24 hours to decide from reading this Information Sheet and making up your mind. If you want more information before you decide, you might want to approach me when I am on the

ward, or email, or telephone me (see contact details below). Or, you might want to talk it through with a family member or friend, this is also okay. If you want more than 24 hours to decide, this is also okay, however, you do have to be a patient inside the ward to be involved in the research.

**Will everything you say be kept confidential?**

I will not use your name in any documents linked to my research. I will also not use your name when I am discussing what you tell me with my supervisors at the University of Hull. However, I would like to sometimes directly quote something that you have said to me in documents that are read by the public. This is because directly quoting what you say makes the research more interesting. The problem with this is that some people, who know you well, might recognise the quote as something that you might say. The only way that they would know for sure is if you tell them. I will not tell them and in this respect I will keep your identity confidential.

**Breaking confidentiality**

The only time that I will have to break confidentiality is if you tell me something that I believe might result in harm to you or other people. If I believe that this is the case I will, if it is possible, speak with you about it in the first instance, and then, we can either speak to a senior staff member about what you have told me together, or, I will report what you have told me separately.

**Personal information**

I will destroy any personal information that I have about you three months after the research has ended.

**What if you change your mind?**

If during the interview you decide that you do not want to continue with the research, this is okay, you can change your mind. Just let me know and I will stop the interview. Unless you tell me otherwise, I will use the information that you have given me up to the point that you decided to end the interview. If you do not want me to do this you can let me know and I will withdraw you from the research.

If there are any questions that you feel uncomfortable answering, this is also okay. If you let me know I will move to the next question. If you are feeling tired, or, unable to carry on part way through the interview, and you would like to take a break, or, resume the interview on another day, this too is okay.

I may also withdraw you from the research if I believe that you no longer have the capacity to understand what the research is about.

You can also change your mind up to one week after the interview if you no longer want to be involved in the research.

What if you are not happy about the research?

Ethical approval for this research has been given by the University of Hull and NHS Ethics Committee (16/YH/0373). A Research Ethics Committee is a group of independent people who review research to protect the dignity, rights, safety and wellbeing of participants and researchers.

If you are not happy about any aspect of the research or if you want to say something good about the research you can contact either one of my supervisors at the University of Hull. Their contact details are:

Dr Mike McCahill: [M.McCahill@hull.ac.uk](mailto:M.McCahill@hull.ac.uk)

Tel: 01482 465715

Dr Julia Holdsworth: email: [j.holdsworth@hull.ac.uk](mailto:j.holdsworth@hull.ac.uk)

Tel: 01482 466086

If you want to make a complaint about any aspect of the research you can contact:

Monica Magadi

Professor of Social Research

Email: [m.magadi@hull.ac.uk](mailto:m.magadi@hull.ac.uk)

Tel: 01482 462032

What happens at the end of the research?

I will write a short report that I will pass to the Trust and the Ward. If you are interested in knowing what that report says you can contact the ward and ask for a copy of my report or you can email me (see details below) and I will email you a copy.

What do you need to do next?

If after reading this Information Sheet you would like to take part in this research you can either approach me on the ward. Or:

Email: [S.Desai@2014.hull.ac.uk](mailto:S.Desai@2014.hull.ac.uk)

Mobile telephone: 0772 488 8173

I will go through this Information Sheet again with you before we start the interview to answer any questions that you might have or explain anything that you don't understand. If after that you are still okay to go ahead I will go through a Consent Form with you and ask you to sign this form. Thank you.

## Appendix 3

Appendix 2 Version 1 29/07/2016

### Interview Schedule for Patients

Remind participant that the interview is about an hour long and that they can stop at any time.

Ask for permission to switch on audio-recorder and remind them that they can ask this to be switched off at any time.

#### *A. Awareness*

1. If you can remember, can you tell me how long have you been a patient on x ward?
2. What do you like about being on x ward? Can you give me some examples of what it is that you like about x ward?
3. Are there any CCTV cameras on x ward? Do you know how many? How do you know?
4. Who do you think is being watched by CCTV?

#### *B. Knowledge*

5. When did you find out that x ward uses CCTV to watch patients? Who told you? Was it staff or another patient or someone else? If it was someone else, who was this person?
6. Why do you think x ward has CCTV cameras?

7. What information have you been given about CCTV cameras on x ward? How were you given this information? Can you remember anything about what the information said?

**C. Subjective experience of CCTV**

8. Do you think that having CCTV cameras is a good thing? Can you explain why? Have you got some examples that you can tell me which shows that it is a good thing?

9. Can you remember how you felt when you first found out that x ward has CCTV?

10. How do you feel about being watched by CCTV? Is there anything that you don't like about CCTV in x ward? Can you give me some examples of the things that you don't like?

11. If you don't like being watched by CCTV, what can you do about it? Could you give me some examples of the things that you could do?

**Finally:**

***Gender:***

**Female**

**Male**

***How would you describe your race/ethnicity?***

**Note response:**

***Can you tell me your age or roughly what age group you are in?***

**Note response:**

***What is your current or last job that you did?***

**Note response:**

**Finish**

**I have finished asking you all my questions. I just want to check out that you are okay? Thank you for sparing your time to talk to me. The information that you have given me is really useful. Thanks again.**





