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Article

Surveillance, Security and Violence in a Mental Health Ward: An ethnographic case-study of an Australian purpose-built unit

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Abstract

This paper discusses the potential relationship between surveillance techniques, the enactment of security measures, and patient violence in mental health wards. The paper draws upon data from an ethnographic study conducted in a purpose-built mental health unit containing two wards (one locked and one open) in South Australia, and argues that acts of violence observed in the unit were typically preceded by an incident within the unit that was related to the implementation of security measures aimed at controlling non-compliant behaviours. The paper argues that if a relationship between security measures and violence does exist in mental health wards, then close attention must be paid to the ways in which forms of surveillance may arguably exacerbate, rather than prevent, the need for security measures.

Introduction

Over the past two decades in countries such as Australia there has been a marked shift in mental health care away from institution or asylum-style care to a more community-based approach (Novotná, Urbanoski and Rush 2011). This has typically meant that mental health units are located within hospital settings, rather than as stand-alone institutions. The aims of such a shift, it is argued, have been threefold. The first has been to reduce the stigma attached to mental health by including it under the broad banner of medicine. The second has been to improve the likelihood of successful reintegration of patients back into everyday life. And the third has been to reconceptualise mental health care as a service provided to consumers, rather than as the punitive management of individuals traditionally unvalued as citizens. Of these three aims, only the second has truly been met, with patients being admitted for shorter periods of time in many mental health settings (Quirk and Leillott 2001; Middelboe et al. 2001). With regard to the other two aims, research continues to find considerable stigma attached to mental health concerns, although there is some suggestion that patient-centred designs are perceived as reducing the stigma attached to patients within them (e.g., Brickell and McLean 2011; Novotná, Urbanoski and Rush 2011). Additionally, recent research on mental health practice indicates that many 'reformed' mental health units still centre a practice ethos focused on surveillance, containment, and risk management (Morrall and Hazelton 2000).

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The present paper is concerned with the last of the aims outlined above in regards to the reformation of mental health care in Australia. Specifically, and drawing upon a pilot ethnographic study conducted within one mental health unit in South Australia, the paper conjectures about the possible relationship between surveillance techniques and their outcomes. Our argument is that in contemporary mental health care surveillance is used primarily as a form of risk management, rather than also as a way of facilitating healing relationships between staff and patients. In other words, and as our data indicate, surveillance is often used to identify potential risks (to staff, to the facility, and perhaps only then to patients), and to then manage those risks through forms of control labelled as 'security'. In a sense, then, what we argue in this paper is that when surveillance is used primarily to justify forms of control over patients, this may evoke precisely the behaviours that staff and institutions seek to minimize (i.e., violent behaviours amongst patients). Before presenting our findings in this regard, we first provide a brief overview of previous literature on the topic and a summary of our research project.

Previous Literature

A considerable body of previous research has focused on issues of control as they pertain to patients in mental health care wards (e.g., Duxbury 2002; Quirk, Lelliott and Seale 2004). Arguably this is because issues of control are germane to mental health care, given entering any facility (either voluntarily or upon orders) entails a degree of relinquishment of control (Andes and Shattell 2006; Quirk, Lelliott and Seale 2004). However whilst control is an inherent feature of mental health wards (and particularly those that are locked), it is important to note that it is not always the case that patients within such facilities experience this relinquishment of control in a negative way. For example, Shattell (2002) argues that patients in locked wards experience the enactment of control over them as imparting a sense of freedom from the stresses of living in the outside world.

Whilst it is clearly the case that issues of control are a necessary feature of contemporary mental health care, the literature in this area has also identified a need to examine how particular mental health contexts may produce certain behaviours as much as manage them. Research concerning violence in relation to mental health wards in particular has increasingly argued for a situational approach that considers the interaction of internal and external causes for any violent behaviour exhibited by patients (Duxbury 2002; Nijman et al. 1999). Such models consider both the more established connection between mental health conditions and violent behaviour, alongside examining the role of the physical environment (and particularly aspects of the environment that result from security features) in producing violent behaviour. Whilst Duxbury (2002) argues that considering such environmental factors can be a fraught research process (given the multiple variables that need to be considered), it is also acknowledged that factors such as limited privacy, overcrowding, and changing staff members do indeed play a role in violent behaviours require ongoing research (see Quirk, Leillott and Seale 2004).

These issues related to the impact of the mental health care environment upon patient behaviour are particularly vexed in contemporary settings with the introduction of new modes of surveillance. In particular, Holmes (2001) argues that the use of surveillance features such as CCTV in mental health settings is problematic, stating that such devices are another measure for 'disciplining' patients, rather than building therapeutic relationships through the direct contact of nurses and patients (relationships which are arguably one of the most important features of time spent within mental health units—see Hall 2004; Cleary and Edwards 1999). Contrarily, previous research does suggest that properly implemented surveillance features can be successful in this area and that some patients within mental health wards prefer a visible level of surveillance (with the reported perception that surveillance reduces levels of risk, including risk of self-harm—see Quirk, Lelliott and Seale 2004).

Unsurprisingly, then, given the vexed nature of surveillance (and the subsequent enactment of security measures aimed at controlling patients) in the context of mental health care, the literature in this area

indicates that further research on the relationship between surveillance, security measures, and patient behaviour is 'urgently required', with little agreement across mental health units as to what constitutes best-practice when it comes to issues relating to surveillance and security (Bowers et al. 2002: 427). It is these issues that are addressed in the remainder of this paper.

Before turning to the findings, it is important to note that the word 'security' is used in this article to refer to security for both staff *and* patients. That is, a form of security or control is perceived as required to ensure that staff are kept safe from assaults from potentially violent patients, and also to ensure that patients are kept safe from such patients, or from themselves. Security also refers to the protection of property – both that belonging to the unit in question and the personal belongings of other patients (Bowers et al. 2002). As such, security, and the forms of control related to it, are seen as performing a diverse range of functions within the space of the mental health unit. Further, another distinction that needs to be drawn here is the difference between acts of aggression and acts of violence. For the purposes of this paper, acts of violence refer to acts in which physical violence is present, whilst aggression refers to instances in which patients shouted, expressed intentions to do harm to someone, or otherwise acted in a threatening way (but didn't include acts of physical violence).

Method

The present study was conducted in the mental health unit of a large public hospital in South Australia. The buildings in which the mental health unit was located were completed in stages between 2009 and 2010, and comprised both a secure or 'locked' ward, and an open ward. The locked ward had a total of 6 beds that were all single rooms, and three bathrooms with one disabled bathroom. The open ward contained 20 beds, and 10 bathrooms with one disabled bathroom and one assisted bathroom. Both of these wards were typically full throughout the study.

Ethics and Participants

Ethics approval was granted from both the University of South Australia's Human Research Ethics Committee and from the Ethics Committee of the hospital involved in the study. Patients, staff and visitors at the hospital were informed of the study through information sheets placed around the unit. Staff speaking to the researchers were assured that anything they said would remain strictly confidential, and the information sheet similarly stated that no identifying information would be used in any publications that arose from the study. We informed all users of the two wards of the times that the ethnography would take place (typically one day a week for a three hour time slot). This information was provided through the use of information sheets posted on the walls of the wards and within corridors. The movements of patients, staff and visitors were observed throughout the ethnographic observations.

Procedure

The first author carried out ethnographic observations on ten occasions for three hours each. These observations were conducted during both the morning and afternoon over a ten-week time period, and the time was split evenly between both the secure and the open ward. In the open ward, the first author spent time both within and outside the duty station, however in the secure ward the majority of time was spent observing from within the duty station for security reasons. In addition to these 30 hours, the second author also conducted four hours of ethnographic observations entirely from within the wards, including the secure ward. Both the first and second authors remained neutral during these times, rarely asking questions of staff unless wishing to gain clarification in relation to a particular procedure or space. Where patients or staff asked questions about the data collection, both of the authors who undertook observations replied that they were observing the use of space and the architecture within the unit.

We chose ethnographic observations as the methodology for this study for two reasons. First, previous literature has emphasized the utility ethnography as a tool for understanding how particular spaces are

used (Johansson, Skärsäter and Danielson 2006; Savage 2000; Sinding 2010). In terms of the research questions to be addressed by the ethnography, undertaking observations allowed the researchers to develop a flexible approach to understanding the environment (both in terms of the physical environment created by the architecture and design including surveillance and security features of the wards, as well as the resulting atmosphere within them), and to gain insight into the relationships between the environment and the behaviour of the people within it. The ethnography was thus useful for the project in light of its tenet that human and environment contexts are locally specific (LeCompte and Schensul 2010).

In terms of the second reason why ethnography was chosen, in returning to the points made above about the ethics of the research, the reason why individual consent was not sought from participants was that the hospital ethics committee expressed concern about the capacity of patients to give informed consent to undertaken an interview. The ethics committee did feel, however, that given hospitalization for mental health concerns *a priori* requires a degree of observation, that the observation of patients would pose no particular risk or burden to patients. As such, ethnography met the requirement of the ethics committee to undertake research that was minimally intrusive and did not require patients to consent to personal information being disclosed (a point that has been made in previous research—see Oeye, Bjelland and Skorpen 2007).

Analytic Approach

Once the observations were finalized, we analyzed the field notes using thematic analysis, following the approach laid out by Braun and Clarke (2006). In their paper, Braun and Clarke provide rigorous guidelines for conducting thematic analysis in qualitative research within the broad study of psychology and these guidelines were followed in each stage of the analysis of the field note data. This analysis focused on issues concerning interaction between staff and patients, and security concerns were one mediating factor that impacted upon both those interactions and the use of the space by patients in both the open and locked wards. Security was also a theme that recurred repeatedly throughout the data in terms of the number of incidents that occurred throughout the observational period that revolved around security issues.

Analysis

The two mental health wards in question used a variety of security measures to ensure the safety of both staff and patients. Modes of surveillance differed somewhat between the locked and open wards (as in the following sections); however there were also general security measures shared across the two wards. These included a system of closed-circuit television (CCTV) or surveillance cameras with screens located in each duty station to ensure that patients in all areas of each ward (except bedrooms) could be monitored continuously. These cameras were not included in bedrooms or bathrooms for ethical reasons, and so regular head-counts were also conducted within both wards to ensure that all patients were accounted for. Bedroom doors could not be locked, and while bathroom doors could be locked, separate inward-opening doors were included in bathrooms so that if a patient had been in a bathroom for a long period and was not responding, staff could easily enter the room.

Security personnel, who serviced the hospital as a whole and who were located in the main building of the hospital, were also available to be called as ward staff saw fit. Security staff were called through a number of ‘codes’ depending on the risk level and urgency of the presenting situation. Security staff were easily distinguishable from medical or other staff by their distinct uniform and badging.

The final general security measure was the use of patient seclusion, with a number of seclusion rooms available just outside the wards. This security method, however, was not used during the observations conducted for this study.

In the following analysis we examine issues of security observed in both the locked and open wards, in addition to outlining some of the issues relating to security that were specifically raised by staff to the researchers throughout the study.

Open Ward

Patients in the open ward had free access to most personal items and could move freely into and out of the ward. The open ward contained a drinks fridge and other food items, as well as readily available craft and other entertainment items (including a piano). There was thus typically more 'movement' within this ward and this is something noted by the two authors engaged in the ethnographic observations. Importantly for this paper, there were few acts of aggression or violence within the open ward, and hence the enactment of security measures such as the presence of security personnel was rare—indeed, security staff were only called on one occasion during the observational period. As such, there were relatively few field notes which related to reactive security measures (i.e., those made in response to violence or aggression) taken within the open ward observations.

However, one point of particular interest in regard to security within the open ward noted by the authors was the use of CCTV cameras. As the open ward is a bigger space than the locked ward, there are some public areas where patients can spend time that are not directly visible from the duty station, but which are located near cameras on the ceiling. Interestingly, patients did not appear any more likely to spend time away from these cameras than near them—that is, patients did not appear to actively avoid sitting or spending time where they knew cameras were located. This is outlined in the following extract:

> *I watch where people are in terms of cameras and nurses station, but don't immediately notice that they are away from these areas—if anything I notice that they are close, except that no-one sits right near the station. On other days I have noticed some people sitting here although it seems to be more a 'waiting area' after patients have approached the station and then wait for the doctor to come and see them. As I walk around I don't notice that people sit in areas less likely to be observed, however, such as in the second TV area behind the fridge and tea and coffee area.*

This extract indicates that whilst patients were unlikely to sit immediately in front of the duty station, they did not avoid spending times in areas where they knew they could be directly monitored. Of course, patients were free to spend time in their rooms, which were out of sight of the cameras. Interestingly, however, the observations conducted within this ward indicated that the majority of patients actually spent time outside their rooms in communal spaces rather than in their private bedrooms. In fact, in the open ward the most popular areas tended to be those in which organized activities (such as craft activities) were conducted.

As such, the presence of surveillance features such as CCTV did not appear to negatively impact upon the patients' use of spaces within the open ward, and patients appeared to prefer the more 'passive' form of observation from cameras than the more direct observation of sitting directly around the duty station. On the other hand, patients did not attempt to avoid contact with staff, who regularly sat with patients in the open ward and engaged in activities such as craft, music or general conversation.

Locked Ward

The locked ward contained patients who were considered to pose a higher risk to themselves or others, or who were required to be detained for legal reasons. The locked ward therefore was considered a more 'secure' ward and thus involved higher levels of surveillance and security protocols than in the open ward (including the requirement for staff entering the locked ward to carry a personal duress alarm, and alarm buttons located in the duty stations to use as required, along with frequent use of security personnel). The ethnographic notes concerning this ward note surveillance issues such as the ways in which all doors to

outside areas were kept locked, and the lack of objects within the ward unless patients directly requested items from nursing staff (including entertainment items such as magazines or craft activities, as well as food and drink options, which were limited to a plastic jug and cups outside meal times).

In terms of clear examples of security concerns in the locked ward, one of the main reasons security personnel were summoned was in response to patients who refused medication. At times these patients were aggressive or agitated, and at other times they would remain in their rooms and refuse to eat or drink. In these instances it was generally accepted within the unit that staff required extra assistance to deal with these patients, and that extra assistance took the form of security personnel. The extract below illustrates an example in which security were called by staff to assist with a patient refusing their medication:

> *Security staff arrive in response to requests from nursing staff. Two security staff and four other staff and a doctor and nurse all come and put gloves on and go through to the bedroom of the patient who is refusing medication (and who hasn't come out of their room). This is quite a presence, and while they go through ward two patients go and sit on the couches, whilst two others go and sit at a table and chairs near where they have been standing and just watch quietly. As they walk back from the bedroom, however, one of the patients who is sitting on the couch taunts them, making aggressive motions with his arms, and the doctor makes a 'shush' motion to him with her finger on her lips. These events all push out morning tea, and so at 10:45 (about 45 minutes late) this is finally organized for patients after a patient asks about it.*

This extract outlines an incident in which security staff were called to assist nursing staff with administering medication. This was not an uncommon occurrence during the observation time period, and echoes previous research which has similarly found that security personnel are a frequent presence in mental health wards to address concerns that are depicted as security related, but which might otherwise be understood as issues of control (O'Brien and Cole 2004). In this extract it can be seen that the presence of the security staff appeared to be somewhat troubling for the patients who all ceased what they had been doing to sit still and watch as the group of people—including doctors, nurses and security staff—walked through the ward to the bedroom of the patient in question. The presence of all these staff members also elicited an aggressive response from one of the patients who had been a troublesome member of the ward; however he did not attempt to approach the security personnel, and stopped acting aggressively upon being reprimanded by a staff member.

This extract also demonstrates the control over patients' lives held by staff members in terms of the day-to-day functioning of the ward, including the availability of food and drinks; the provision of which was postponed as a result of this incident. In the open ward, patients had access to a fridge and other facilities to prepare hot drinks and food; however in the locked ward these features were not available. As such, apart from water, patients in this ward relied upon staff for access to food and drink, and when security concerns such as the one above became evident, the routine, and therefore day-to-day functioning of the other patients, was also affected.

Interestingly, such attempts by staff to administer medicine using security personnel were not always successful, as was the case in the incident described in the extract below:

> *A doctor and nurse return to the duty station as a patient was threatening them—he is refusing nicotine patches and is very upset about not being able to smoke. The Station is busy with four nurses, one doctor and six security personnel. They chat about medications, then four of the security personnel and a male nurse go to give the patient the medications but he refuses still and they return unsuccessfully. When security personnel arrived other patients stopped talking and one lay down on the ground.*

In this instance the staff involved were unsuccessful at administering medication and the man remained in his room after staff left. A security member stayed within the duty station for a short period of time after this event before leaving, and during the observation period staff did not attempt to approach the man again, except for conducting periodical head counts. This incident is interesting as it outlines an instance in which a patient resisted the efforts of security personnel, however the presence of these security staff appeared to provide a level of support for medical staff who otherwise indicated an unwillingness to deal with the patient in question on their own.

It is also interesting to note that the incident in this extract occurred subsequent to a ban on smoking within the hospital premises. As patients in the locked ward were typically unable to leave the unit for any period of time, this meant that patients admitted to this ward were unable to access cigarettes, and instead, other alternatives (such as nicotine patches) were offered. This ban was anticipated with some trepidation by staff working inside the ward, who expressed concerns to the first author about the effect that the ban would have on the patients they worked with. This was particularly the case as smoking was a common habit amongst patients in the locked ward, with walking around the courtyard and smoking being among the primary ways in which many patients spent their time. This extract illustrates the fact that this further control over patients' lives also could be read as leading to security and violence issues.

Much like the first extract, the second extract above highlights the apparently disturbing effect of the use of security in this instance on other patients located in the locked ward. Here, patients stopped talking amongst themselves and one even lay down on the ground. This is particularly interesting given the fact that these same patients had seemed unbothered by previous aggressive behaviour of the man (although this behaviour was not being directed at them but at members of staff). It would appear that the presence of security staff changed the way in which the other patients responded to this second instance of aggressive behaviour by the patient. Also interesting is the fact that the resistance of the patient in question to medication can also be seen as a resistance to the exercise of control over his life evident in the security practices within the unit.

In the locked ward tensions also arose over security issues related to the items of property patients were or were not allowed to have, and the corresponding loss of liberty experienced by patients. The policy in this particular ward was that when a patient considered at-risk of self-harming was present, any items that could facilitate self-harm were removed from the ward; a practice that echoes findings of research in mental health units within the United Kingdom (Bowers et al. 2002). Items such as knives, forks and scissors were never allowed in the ward without close monitoring by staff, however when particular patients were present other items such as belts, shoe-laces, and draw-strings were also all removed from the ward, meaning that some items of clothing weren't able to be worn by *any* of the patients. An example of this appears in the following observation:

> *A patient comes out with a pile of clothes. She wants her belt but is told that is not allowed. She gets upset as wants to be able to wear pants which need a belt and she feels all her other clothes are 'daggy'. She wanders off crying.*

In this extract the policy in place in the locked ward surrounding particular items of clothing clearly upsets the patient in question, to the point that she walks away from the duty station in tears. This was not an uncommon occurrence, particularly in relation to female patients in the locked ward. The next extract illustrates a similar example:

> *A patient slams her bedroom door, then comes back and asks for her shoelaces which she isn't allowed to have. She is upset as she can't wear a particular pair of shoes. She slams her door again but then comes back to station and apologises to staff, saying she 'closed her door too loud and did a bad thing'.*

Here, the patient is upset by the consequence of a particular policy and 'acts out' accordingly. She later approaches staff again about her behaviour, and apologizes for it. From their actions and statements in these incidents it is clear that the women referred to in both of these extracts are upset by the policies in place concerning items that are allowed in this ward. Importantly, we wish to point out that we recognize the necessity for policies which minimize the risk of self-harm or attempted suicide in locked mental health wards, however some regulations were in place in this particular ward which appeared to have less to do with minimizing risk, yet were still just as upsetting for patients as were those explicitly aimed at minimizing risk. For example, patients had little control over their possessions in the locked ward, with many items kept in a separate storeroom that they needed to request to access from staff members. Similarly (perhaps as in any hospital setting), patients were sometimes reliant upon help from staff to do their washing for them. Such issues around clothes resulting in a couple of incidents during the observational period, such as that outlined in the next extract:

> *A patient gets up impatiently and walks to door then wanders off down the corridor then comes back asking for her clothes that had previously been taken to be washed. Staff say her washing has already been done and returned. The patient comes back after checking in her room saying it is not there. She is quite agitated and upset. Staff say it has been done and it is on her bed. The patient insists it is not and then walks off crossly, seeming agitated, and muttering some abuse under her breath. She comes back a minute later saying sorry—she was confused—however the staff member ignores her.*

In this extract it is clear that the lack of control over her own belongings elicits what could be called aggressive behaviour from the patient. This sense of a lack of control appears to be compounded by the staff member who dealt with the patient in an abrupt fashion throughout the exchange. This lack of control resulting in aggressive or violent behaviour can also be seen in the next extract:

> *There is a man in the locked ward who is very angry. He wants a cigarette as he says he hasn't had one for a long time and he is having trouble without them. Staff say he was brought in last night from emergency and he left his packet there and they are trying to get someone over there to get them but no one is available at the moment. The man is standing at the nurses' station window and is banging it with his fist and being quite intimidating. Staff are trying to explain the situation to him through the window.*

In this situation staff are exposed to violent behaviour as a result of the fact that the man in question did not have any cigarettes with him when he arrived in the ward. Staff were trying to get some cigarettes to the man in this extract, however due to staff shortages this was taking some time and resulted in violent behaviour from the man in the form of verbal abuse and banging the window with his fist. Again, whilst we acknowledge the need for the containment of some people suffering from mental illness, it is also clear that a loss of control serves to pre-empt some acts of violent behaviour. This incident also occurred prior to the enforcement of the ban on smoking inside the hospital, and illustrates the legitimacy of staff concerns around the effect of this ban raised above. Also interesting was the way such violent or aggressive acts occurring at the start of the day often resulted in staff later describing patients as being highly stressed. Indeed, it was common knowledge in this particular ward that patients would have 'good' or 'bad' days and this resulted in 'good' or 'bad' days for the entire ward—thus reinforcing the concept of the impact of the environment on instances of aggression or violence from patients. Here, this impact can be read both in terms of the effect of the physical environment (and the security and surveillance features contained within it), as well as the resulting atmosphere within the ward.

As can be seen through the extracts above, the enactment of control over patients through a variety of forms of security (particularly the use of security guards and the restriction of available items) often precipitated acts of violence or aggression from patients within the locked ward. In turn, these acts of

aggression or violence frequently resulted in further control over patients by staff, including ignoring patients' subsequent attempts at interaction or in further delaying routines. Security features in the locked ward, then, frequently included physical attempts at controlling patients, or the withdrawing of face to face interaction with nursing staff.

Staff Concerns

In this section we turn to some of the concerns expressed by nursing staff on the wards. Interestingly, previous literature has identified that nursing staff feel that certain aspects of security measures can be unethical, such as locking ward doors (see for example Haglund, von Knorring and von Essen 2006). However, at the same time, the literature suggests that violent incidents towards nursing staff are not uncommon, and are an ongoing concern for those working in this area (Duxbury 2002; Owen et al. 1998). The latter issue was one which was expressed to the researchers more commonly in this study, with staff typically advocating for the use of security cameras more rather than less, as seen in the following extract:

> *Some staff express concerns about there being no cameras in the bedrooms, saying that this is where patients do the most self-harming. One particular nurse says that he thinks there should be cameras in bedrooms, describing some of the lengths patients go to attempt to commit suicide.*

In this extract from the field notes a staff member discusses his perceived need for increased security and surveillance in the locked ward in order to prevent patients from harming themselves. In this instance, the motivation for security features was to prevent self-harming, and indeed there is some evidence that increasing surveillance—as well as making sure patient/nurse interactions are optimized—are features which are important in preventing suicides from occurring in mental health wards (Meehan et al. 2006).

Staff also mentioned other aspects of the design of the locked ward which posed dangers to patients at risk of self-harm, as seen in the following extract:

> *A staff member takes me for a walk and shows me the doors at the end of the corridor past the storage room and tells me they open outwards which he says is a design flaw since patients with enough weight have managed to break through them. He also shows me how it is reinforced with metal which has studs on it. He reports that once someone went up and scratched their head on the metal studs and sometimes they have to have a guard standing there.*

As such, it is clear that security features and design were a key issue for some staff—and indeed this is understandable where staff have witnessed forms of violence and self-harm that result from failures in the physical design of the ward.

Whilst these two extracts indicate staff concerns related to the likelihood of patients self-harming, our observations also included instances in which staff appeared to be apprehensive of some of the patients. Such apprehension could be illustrated by the fact that staff often used the duty station as a form of security. Whilst the use of duty stations in violent situations may be entirely understandable, in our observations this mode of usage extended beyond violent incidents and into the everyday functioning of the wards. For example, in the open ward where the duty station windows could be kept open, staff routinely kept the windows closed, and when a staff member was not present in the duty station it was a requirement that the windows not be left open for security reasons.

As our research was observational we were not able to speak with staff intentionally about their views on security measures; however it was clear from the observations that were conducted (and the comments made indirectly to us) that staff considered security measures to be paramount. Certainly this indicates an

important area for future research—namely the interaction between security features and the views of nursing staff on security issues. This is particularly the case given the results of previous research which has suggested that nurses working in acute mental health wards are frequently torn between what they see as the ethical treatment of the patients and the implementation of security features that promote harm minimization for staff (see for example Bowers et al. 2002).

Discussion

In this paper we have illustrated some of the issues surrounding violence, aggression and security that occurred in one purpose-built mental health unit. We would note that issues surrounding security concerns occurred on almost every one of the days that observations were conducted, with security personnel called frequently in the locked ward. Our observational research thus confirms the findings of previous research (Bowers et al. 2002; Duxbury 2002, Owen et al. 1998; Nijman et al. 1999; Desai 2010) in finding that violent or aggressive incidents are common occurrences mental health units.

Our research also reinforces the findings of previous research in relation to the causes of some of these violent incidents. In particular, it was noted that issues which precipitated the need for the presence of security personnel in the locked ward included an unwillingness to take medications, and a negative interaction between staff and the patient in question. Whilst, as an observational study, our research cannot definitively argue that either of these examples was not firstly the result of the patient's mental illness or condition, our findings do illustrate that it is likely at least partly the result of the characteristics of the locked ward itself that leads to the exhibition of violent behaviours. Additionally, our research suggests that acts of aggression such as verbal abuse or shouting were often similarly the outcome of features of the mental health ward in question. For example, acts of aggression were often precipitated by the control exerted over patients in relation to issues such as the restriction on the belongings they were allowed to have in the locked ward.

In relation to staff security, it is important to note that much of the literature indicates that many staff working in mental health units have been the victims of assault by patients (Duxbury 2002). Whilst the study reported here did not set out to explicitly discuss security concerns with staff, casual conversations held with staff during the observations indicated that security issues were at the forefront of staff concerns, and this was reflected in both the conversations held with various staff members as well as the behaviours of staff during the observation period, as outlined in the analysis section.

Given that security features are an important aspect of the design and practice of any mental health ward—and particularly locked wards housing more dysfunctional patients—it is important to give due consideration to how security features can be implemented in ways which are not likely to provoke outbursts of aggression or violence. Contrary to previous research which has raised concerns about the ethics of surveillance, our research would suggest that the presence of CCTV cameras within the wards did not appear to upset patients or motivate them to spend time in spaces that were less directly in the view of such cameras. As such, we would argue that focusing on forms of surveillance which patients are passive about (such as CCTV monitoring) is likely to ensure that both staff and patients are kept safe—and indeed feel safe—and that this has the potential to result in aggressive or violent incidents engendered by forms of direct control. However, the effectiveness of CCTV specifically is an area which future research could focus on given the possible impact of surveillance on patients who are psychotic (Desai 2010).

Overall, then, our findings do not necessarily argue for a lessening of security in mental health wards *per se*. Rather, the findings do point to the need for future research to be completed in this area to further examine the cause and effect relationships of patient violence and the security measures in place in mental health wards. Such research is particularly required as there are indications that a properly implemented

community care model can provide effective results in the treatment of those with mental illnesses using methods that do not rely on forcible forms of control (Stephens 2007). Indeed, if the controlling features of mental health wards contribute to violent behaviours or outbursts of aggression, as our research would suggest, this has significant connotations for the role of mental health wards in terms of the care of patients, their ability to cope with the ward environment, and their rehabilitation.

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