The Appropriate Use of
Closed Circuit Television (CCTV) Observation
in a Secure Unit

Dr Jerry Warr

Mathew Page

Holly Crossen-White

Acknowledgements

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Executive Summary

Background to the research

Observation is a necessary procedure in maintaining the safety of people with mental health problems in in-patient settings. Traditionally this has involved the physical actions of a nurse or other care worker to maintain surveillance.

Improvements in CCTV technology have meant that such observations are now possible remotely and this was the thinking behind a system being introduced in a purpose-built low secure unit. The installation of cameras in bedrooms was seen as a means of reducing night-time disruption for the patients, but it also raised unforeseen criticisms from an ethical and rights viewpoint.

Purpose of the study

This study sought to address the introduction of the system in an acceptable and safeguarded manner, while undertaking an evaluation of some of the impacts. The chosen approach was action research. The developments comprised:

- Producing protocols for use;
- Staff training in the use of CCTV;
- A review of the literature;
- Explaining to patients and gaining consent for use.

The areas evaluated included:

- A review of the protocols;
- Interviews with patients;
- Interviews with staff;
- An analysis of reported incidents.

The research and development was conducted over an 18-month period and was subject to approval from the Local Research Ethics Committee.

Findings

- Some errors had been made in the early stages of the project;
- Training was essential to ensure appropriate use;
- Protocols are important to ensure compliance;
- The system is not seen as more ethically problematic;
- It did not appear to produce incidents or paranoia;
- Staff saw many therapeutic advantages;
- Patients saw security advantages and less disruption;
- It does not have the potential to reduce staffing numbers;
- There is greater potential for less restricted use.

Conclusion

Overall, the study did not identify problematic areas that are not also associated with traditional observation methods. By offering it as an option to patients it negates any real benefits of its use.

Recommendations

- Safeguards in the shape of protocols and training are vital;
- If it is to be a therapeutic intervention, it should be prescribed on an individual basis;
- Offering options does not give benefits beyond convenience;
- It is observation itself that requires researching.

Introduction

Background

There is no doubt that since the first hospitals were developed for treating the mentally ill the process of maintaining safety has been problematic. Incarcerating people who are actively trying to harm themselves or other people is fraught with obvious difficulties. The practice of what has become known as 'nursing observation' developed for this group. In modern times, nursing observation is used as a therapeutic intervention and is now generally undertaken according to a policy suggesting that a patient is placed on a certain level of observation according to the level of risk they pose. Levels vary from immediate proximity to occasional checking of whereabouts.

Observation

This practice of observation is necessarily intrusive. It involves the removal of privacy and associated dignity, and individuals are expected to tolerate a constant disregard for their autonomy.

In recent years, academic debate has occurred over whether observations are still necessary in a well-resourced facility with well-trained staff. Authors such as Barker and Cutcliffe (1999) advocate an alternative approach that relies on engagement. At its basic level, observation seems to provide safety but little else.

Despite this debate, observation appears to continue to be one of the most common interventions in in-patient mental health care (Porter et al. 1998; Bowers et al. 2000; Meiklejohn et al. 2003). The local policy of in-patient units (Gloucester Mental Health Partnership 2002) requires patients to be attributed a level of observation concordant with risk assessment.

Use of CCTV

It was with this in mind that the project commissioning team for the Montpellier Low Secure Unit requested that infra-red closed circuit television be incorporated into the design of the new unit. Each of the 12 bedrooms was fitted with an infra-red camera hard wired to a monitor in the main office.

The cameras were each fitted with a sensitive audio facility, which easily detects the breathing of most people while they are asleep. The benefit of infra-red light is that there does not need to be any visible light in the room for observation. The monitor is positioned in the office so that only members of staff can see it. The images and sound are not recorded.

Long before the unit was opened, the presence of this system proved to be highly contentious and it became the subject of considerable criticism and occasional ridicule - the new building was nicknamed the 'Big Brother House' in reference to the popular Channel 4 television programme. The logic of the system was apparent to the commissioners and managers; however the only way to answer many of the questions raised was to subject it to rigorous evaluation.

The system was installed with the intention of making the practice of observation less disruptive to its subjects, but it was important to recognise that such a system could be problematic. Prior to opening, discussions with in-patients, as documented by Dix (2001), gave a favourable reception to the notion of using electronic means to make observation less disruptive. More recently, in focus groups conducted by Dimery et al. (2003) on the issue of observation, patients suggested that CCTV should be used more.

It is thought that there are probably a number of CCTV systems installed in wards around the UK that have not been evaluated. Anecdotal evidence suggests that CCTV is already being used for observation, but there has been no academic reporting.

The Study

Context of the study

Montpelier Unit is a brand new, purpose-built, low secure in-patient mental health unit, which received its first patients in February 2003. Low secure units are now a common feature within many NHS Trusts and their aim is to:

> …provide expert, supportive, individualised care for those whose psychiatric condition requires treatment in conditions of security. The service will be provided by a multi-disciplinary team which will have a therapeutic focus on rehabilitation and social inclusion. Every patient's clinical management will depend upon thorough and continuous assessment of risk. (Gloucester Mental Health Partnership 2002, p1)

Perceived benefits of CCTV

Part of the assessment strategy was the inclusion of closed circuit television cameras with infra-red facilities and videoing capabilities in the design of the building. This technology has the potential to enable 24-hour surveillance of patients in all areas of the unit including bedrooms. Such an approach could be viewed as a positive response to Standard 7 of the *National Service Framework for Mental Health* (DoH 1999a), and the *Suicide Prevention Strategy for England* (DoH 2002), in that constant

surveillance of vulnerable patients would be possible. It also complies with the need for 'regular night-time observation' identified in the report *Safe Supportive Observation* (DoH 1999b). The following advantages have been suggested by Dix (2001) for the use of infra-red CCTV surveillance:

- No need for an interior light in the room as would be necessary for observation through a door mounted panel;
- Greatly diminished risk of one patient being able to look in on another as is common with a door mounted louver panel;
- No need for members of staff to enter the room to make observations;
- A clear image of the individual resulting from infra-red illumination.

Potential problems of using CCTV

Such perceived advantages need to be considered in relation to the potentially negative effects of remote surveillance. Newman and Hayman (2002, p179) describe the technology as 'Janus-faced' in trials in police cells, in that 'thought needs to be given to how the tension between the protection (of suspects) and their right to privacy can be reconciled'. Indeed, Dix (2001) identified possible complications in the use of infra-red cameras:

- An infringement of the human rights of the individual being observed with regard to the right to privacy;
- Ethical considerations, in terms of the justification of this means of monitoring;
- The protection of data collected on individuals by this means (Regulations of Investigatory Powers Act 2000);
- Practical implications for using this approach and its ramifications for nursing practice;
- Possible negative effects on the patient's mental state.

Little research has been conducted into the use of this form of surveillance in mental health care.

Need for study

Against this uncertainty, the lead applicant was approached by the unit manager of the Montpelier Unit, with the support of the medical consultant and the consultant nurse, to discuss a possible proposal to both develop the appropriate use of CCTV technology and evaluate the issues involved.

Purpose of the research study

It was felt that the study should examine whether or not the use of CCTV observation has a role in the management and care of patients in a low secure mental health in-patient unit. The technology was already installed in the Montpelier Unit but there was little guidance, locally, nationally or internationally, for its use in a therapeutic setting. It was important,

therefore, that the study involved the staff and patients of the unit in developing protocols for CCTV use and evaluating its effectiveness and acceptability. It was hoped that the findings of the research might help to inform policy and procedure for CCTV observation in other health care settings.

From an initial review of the published literature, the protocols, training and procedures were established and evaluations undertaken from a range of perspectives.

Literature Review

The current literature on observation appears to fall into two groups. A few authors concentrate on the effects of observation on patients but, more commonly, papers seem to review policy and practice.

Effects of Observation

Constant observation

There is an emphasis on the effects of constant observation (Ashaye et al. 1997; Cardell and Pitula 1999; Fletcher 1999; Jones et al. 2000) but little on the effects of intermittent observation such as that practised via CCTV. The issues associated with these two types of observation are markedly separate. Most of the themes reported by respondents reflect the necessity of a nurse being present at all times, such as when using the toilet (Bowles et al. 2002). Some, but not all, findings of research into this practice may be applied to intermittent observation. For instance, Cardell and Pitula (1999) identify both positive and negative effects of observation. Positive effects include the sense of support experienced by individuals being observed, which may also apply to intermittent as well as constant observation. One feature of the proposed CCTV research should therefore be to establish whether recipients of the new form of observation feel less supported than when traditional methods are used. In the same research project, non-therapeutic effects included patients feeling that observers were remote and not empathetic, and that they were not given sufficient information as to the purpose of the process.

A study of patients' experience of constant observation by Ashaye et al. (1997) found that patients felt they had not received enough information about observation. Jones et al. (2000) also identify this problem.

Effects on behaviour

Outside of the healthcare literature, a criminological research project by Short and Ditton (1998) evaluated the effects of CCTV on offenders through interview. They found that respondents were knowledgeable about the CCTV and that they displayed a wide variety of attitudes about its use in crime prevention; some favourable, others not so. Offenders acknowledged two types of change in behaviour: desisting from offending and geographical displacement of offending. There is a case for investigating whether patients subject to CCTV observation describe either of these phenomena in terms of any kind of behaviour or that it contributes to problems.

Distancing staff and patients	Rosenhan (1973) reports on an experiment where 'pseudo patients' (individuals without mental illness) were admitted to various psychiatric hospitals in the USA and then recorded their experiences. Despite its age, the results of this study are enlightening and remain relevant to the way psychiatric institutions are organised. The pseudo patients noted that staff and patients were strictly segregated, each having their own areas. Staff would gather in the office and only emerge for care-giving duties. It would be beneficial to establish whether or not patients feel that the use of CCTV observation adds to a sense of segregation.

Policy and Practice

Disciplinary application	Foucault (1975) conducted a philosophical discourse into the history of the prison. Along the way, he addressed some ideas that remain relevant to modern psychiatry. He discussed the development of several types of institution and how these are mirrored in punitive environments, noting that hospitals began to be organised as instruments of medical action, to allow better observation and ensure the best calibration of treatment. Meanwhile, he assumes that disciplinary environments function as a microscope on conduct, creating fine analytical divisions within the apparatus of observation. In the perfect environment, a single gaze would see everything constantly. This leads on to his description of the panopticon.
The panopticon	The panopticon is an architectural construction reflecting the ideas outlined above. From a central tower, an attendant can look through windows into a ring of cells around the central pillar. It is lit so that inmates can be seen from the tower, but they cannot see in. Foucault concludes that all types of inmate can be adequately observed in this way, the most significant effect being that permanent visibility ensures power. For this to be effective, the inmates must never know whether or not they are being observed.
	The function of the panopticon may be assumed by anyone, regardless of rank or status, and motivation is also irrelevant, be it curiosity, malice or perversity.
Disempowerment	The concept of panopticism may well be relevant to institutional psychiatry and the practice of observation. No doubt most would argue that one of the main functions of observation is to ensure that treatment can be correctly calibrated. However, themes discussed by both Foucault (1975) and Rosenhan (1973) revolve around the notion of power in psychiatry. Within secure care, this may be even more obvious as individual liberty is greatly infringed upon. The practice of nursing

observation, whether intentionally considering Foucault's arguments or not, is likely to disempower a group who are often already disenfranchised by society. Without doubt, the provision of CCTV for observation is one step closer to panopticism than most modern psychiatric wards. The ability to observe everyone with 'a single gaze' is more achievable with CCTV than when corridors have to be walked down and windows looked through. It is perhaps more reflective of wards 30 years ago where patients slept in dormitories and could be easily viewed. Consequently, providing CCTV for observation could be seen as a technological panopticon, with all the associated risks and benefits this brings.

Use of CCTV in care

Little research has been conducted into the use of this form of surveillance in mental health care. In the United States of America, the Florida Medical Directors' Association has recommended that the technology should not be used in nursing homes in Florida as 'it will do nothing but harm the relationship between patient and caregiver and they should not be used in bedrooms', despite a ruling in favour of their use by the Joint Attorney General for Health Care Administration. In the United Kingdom, the Royal College of Psychiatrists emphasised the need for informed consent to be given by the patient who is being recorded, and stressed that surveillance for investigative purposes raises 'particular ethical issues' (Royal College of Psychiatrists 1998).

Questions Arising from the Review

Areas from the literature that were thought to require addressing in the study include:

- How does CCTV observation compare with traditional methods?
- How do patients feel about the use of CCTV observation?
- How do staff feel about using CCTV for observation of patients?
- Does the presence of CCTV make it less likely that patients will harm themselves or anyone else?
- Does the presence of CCTV in bedrooms raise further ethical questions?
- Does the use of CCTV add to a sense of segregation between staff and patients?
- What safeguards need to be considered with the use of CCTV?

The need to evaluate the use of new initiatives is well founded in the principle of practice development. Patients should be involved as much as staff in this process and an action research model allows for this involvement in the design, implementation and evaluation of a proposed change in practice (Greenwood 1984).

The process should facilitate the achievement of:

- Improvement of a *practice* of some kind;

- Improvement of the *understanding* of a practice;

- Improvement of the *situation* in which the practice takes place (Carr & Kemmis 1986, p165).

The process should facilitate the achievement of:

- Improvement of a *practice* of some kind;

The Study

Preparations for the Use of CCTV

Development of protocols for appropriate use

A working group was established to consider the appropriate use of this method of observation. The draft guidelines and procedures devised by the working group (see Appendices 1 & 2) were then reviewed by the whole team. Revisions were made to the draft documents in light of the comments received.

The documentation derived from this process had three purposes. It provided a policy document for the unit, formed the basis for training, and offered clarification on how to explain to patients about the CCTV facility available on the unit and their choice about consenting to its use.

The structure of the draft protocol drew on published evidence and considered the following:
- A clear statement on the purpose of observation;
- An outline procedure commencing on admission;
- Levels of observation;
- Relationship to the care plan;
- Use of CCTV or traditional observation at night;
- Gaining consent for CCTV use and a draft care plan.

Review of the protocol developed

The initial protocol was clear in relation to the mechanics of undertaking observations and securing consent but it did not consider the issues related to best practice. Particular aspects that could have been addressed involve:
- The differences (and potential differences) associated with remote observation compared with traditional methods;
- Potential for misuse of CCTV;
- Potential for unacceptable use of CCTV.

The assumption made within the document was that CCTV was a variation on traditional observation and, as such, could be considered jointly in a single protocol.

The implicit view was that the use of CCTV was desirable on the basis that it would be a less disruptive approach for patients. The guidelines failed to explore this standpoint or evaluate particular therapeutic situations and the use of CCTV. Consequently, the opportunity to improve its therapeutic application for some mental health patients, or indeed to recognise that there may be circumstances when the use of

CCTV could have negative outcomes, was overlooked. The subsequent research reveals that CCTV needs to be considered as a distinct approach and that its operating characteristics and potential should be outlined in separate procedures and protocols.

Methodology

The approach to the study was through an action learning framework to allow for the development of CCTV procedures while using concurrent data collection to provide a comprehensive evaluation.

Research question

There were two aspects to the study and these are reflected in the following research question:

What is acceptable use of CCTV surveillance in a secure mental health in-patient unit and does it benefit patient care?

Study objectives

The objectives for the study can be categorised into two specific areas: improving operational understanding and developing appropriate practice.

Improving operational understanding:

- To trial the use of the technology to establish its benefits and limitations;
- To evaluate the acceptability of CCTV surveillance to patients;
- To evaluate the acceptability of CCTV surveillance to mental health practitioners;
- To consider the effects on skill usage;
- To identify areas for further consideration and research.

Developing appropriate practice:

- To develop protocols for acceptable usage with reference to the perceived benefits and effects on privacy, the law and therapeutic relationships;
- To produce safeguards for ethical use of the technology;
- To identify areas for skill development;
- To develop 'best practice' guidelines where the technology is employed.

Sources of evidence

The process of analysis drew on three data sources, combining documentary evidence and qualitative data. The sources were:

- Reported 'untoward' incidents on the unit over a 12-month period;
- Interviews with staff within the unit (n=10);
- Interviews with patients from the unit (n=6).

Project Timetable

Ethical approval from the Local Research Ethics Committee was sought prior to the commencement of the study. The progress of the research is summarised below:

May 2003:
Initial meeting of the action research team. Identification of issues and problems/strategy planning.

June 2003 – January 2004:
Action research review: implement and evaluate.

February 2004:
Action research review: commence qualitative interviews (patients).

March 2004:
Action research review: commence qualitative interviews (staff).

September 2004:
Action research review: data analysis of staff interviews.
Commence patient interviews.

December 2004:
Action research review: data analysis of patient interviews.

January 2005:
Report writing.
Evaluation of process and outcomes.

March 2005:
Dissemination of results.

Data Collection

The evaluation was structured around documentary material and qualitative interviews with both staff and patients. The nature of the data collection process is outlined in the following section.

Documentary evidence:

Reported 'untoward' incidents
One measure of change following the introduction of CCTV was considered to be found in the nature of 'untoward' incidents occurring during the night (defined as when CCTV was in operation).

Incidents that occurred were documented, giving details of the date and time, the patient, the nature of the incident, who else was involved and a description of the incident. Whether any injuries were sustained was also noted. It may be difficult to determine whether the presence of CCTV had a more beneficial effect in such circumstances than traditional observation methods. Despite this, a review of all incidents occurring at night was undertaken, and each incident was assessed for any differences in the nature of events and whether or not the use of CCTV may have had a contributory role.

Reviewed incidents
In total, 45 incidents were recorded as 'untoward' over a 12-month period, but only eight of these occurred at night (defined as the period when CCTV cameras were in use) and could therefore be included in the analysis. All the reported incidents involved verbal or physical abuse on staff or other patients.

Qualitative evidence:

Interview data
The interviews involved both staff and patients from the unit. The recruitment criteria for participants varied between the two groups of interviewees. For staff, the requirement was that the individual had experience of operating CCTV at night. For patients, the criteria were wider to include any patient on the unit whether using CCTV or not.

Recruitment procedures
Within the unit, potential participants (as defined by the inclusion criteria) were informed of the study verbally and given a prepared information sheet about the study, its purpose and what participation would involve. Those approached were given the opportunity to ask questions and a period of time to reflect on their decision to participate. Those who decided to participate were asked to complete a standard consent form. Prior to the patient interviews, the relevant procedures were undertaken in terms of a formal application to the appropriate Research Ethics Committee.

Format of the interviews
The interviews were conducted at the unit by members of the research team in a private room to ensure confidentiality. With the permission of participants, the interviews were tape-recorded and later transcribed for analysis.

The interviews with both staff and patients were structured around the following areas:

- Views on night-time observations generally;
- Interviewees' experience of the CCTV or, for patients not using CCTV, why they had not consented to the use of CCTV;
- Interviewees' impression of the impact that the introduction of CCTV had on the unit.

Staff sample

Ten interviews were undertaken with a cross-section of staff that included representatives of all nursing grades employed on the unit. All interviewees had experience of using the CCTV cameras for observation at night.

Patient sample

Six patient interviews were undertaken. This equated to two-thirds of the unit's occupancy. The interviewees were all male, with ages ranging from 21 to 45 years. They all had a primary diagnosis of schizophrenia with lengthy histories of previous admissions to hospital and penal institutions. The sample included those being observed by CCTV and those who were not.

It had been anticipated that interviews with the patients would be more problematic but in the event this was not the case. However, the data gathered was more limited in terms of its depth and the extent to which a considered opinion could be offered. Despite this, the data conveyed a clear sense of the patients' views on the use of CCTV within the unit.

Findings

Documentary Evidence: Reported Incidents

Reported 'untoward' incidents

The analysis showed that there were fewer reported incident during the night period but this is likely to be the case as most patients are asleep at this time. However, the nature of the incidents did not differ significantly from incidents reported during the day and there is nothing in the reports to suggest any association with:

- The presence or use of CCTV;
- The choice of the patient to be observed using CCTV or not.

Qualitative Evidence: Interviews with Staff

The data collected through interviews with staff are reported below, structured around the themes identified through content analysis of the transcripts. These themes are:

- Staff attitudes to CCTV;
- Impact on undertaking observations;
- Benefits to patients;
- Benefits to staff;
- Issues that arose from the use of CCTV.

The interviews indicated that staff responded to the introduction of CCTV in different ways. Some appeared to be very enthusiastic about it and so placed great reliance on it for patient observations.

> *I think it is good. I think it is a good way forward.* (I3)

> *The benefit is that you can see more clearly than actually going in and disturbing the patient…you can just keep an eye on them in there.* (I5)

> *You just flick on for a couple of seconds and we know they are breathing.* (I5)

> *From the point of view of the nurses we can do it all from one place.* (I6)

Other members of staff used CCTV but did not do so exclusively, choosing to check patients physically at times.

> *I will still, you know, double check anyway throughout the night shift. I don't tend to just reply wholly on that* [CCTV]. (I2)

A few staff also had reservations about CCTV, feeling that it could not be relied on and so preferred to undertake physical observations.

> *Sometimes you don't really get a very good sort of picture so you have to go and check anyway.* (I2)

> *You can't always be entirely convinced that they are OK. So sometimes it does need to actually go down to their room and check visually anyway.* (I4)

> *It's only machines, it's like on the movies, the picture can get stuck and you think, 'Oh they're still fine…they're still fine'. I think it's good to be aware it's just machines.* (I3)

The interviews therefore offered a good range of opinion on the use of CCTV. An analysis of the resulting interview transcripts provided a number of themes:

- Issues relating to undertaking observations generally;
- The benefits of CCTV;
- Issues that arose because of the use of CCTV;
- Changes in practice;
- Ethical issues;
- Improvements to the current system for the use of CCTV.

Undertaking observations

The interviewees all discussed how the actual process of conducting observations at night on patients was highly disruptive.

> *A traditional routine of observing can be quite intrusive…and it wasn't very helpful for those people who are quite disturbed and wanted a good night's sleep.* (I4)

> *When you've got people coming into your room every 15 minutes or half an hour and shining a torch through your door, it's very intrusive.* (I6)

Several staff pointed out that the disruption caused by undertaking observations at night had the effect of reducing the amount of sleep the patient could have. This was particularly unfortunate, as often patients required more sleep to improve their condition.

> *I think it gives the patient more opportunity to get quality sleep…They* [patients] *would hear you coming round at night and suddenly to get interrupted every hour of their sleep…obviously it does their mental state…not very good.* (I1)

> *We all need sleep whether we are unwell or mentally stable. We all need a certain amount of sleep.* (I5)

Interviewees reported how the disruption caused by observations at night could make patients quite irritable and potentially aggressive towards staff.

> *…safer for the nurses because you're not just getting into altercations with the patients, waking them up. I've seen that quite a lot.* (I3)

> *You know you're going to wake them. Sometimes you do, and they get aggressive.* (I8)

> *I've had a patient come flying at me doing a manual check. It's quite noisy and you disturb them and they complain.* (I7)

Providing this context to their perceptions of how effective CCTV was for observations was useful and provided insight into how the staff would assess the benefits of the new system. Broadly speaking, the benefits they outlined fell into two main areas: those they identified as benefiting the patient and those that aided staff.

Benefits for patients

Many of the interviewees spoke about how the use of CCTV enabled patients to have less disturbed nights because less movement of staff meant the ward was quieter. CCTV meant they could easily observe a patient without entering their room and/or waking them. Some of the staff believed that the CCTV camera in the patient's bedroom was actually less intrusive than a member of staff physically entering the patient's room.

> *The difference is it's a lot quieter. Obviously when you are walking down the corridor with keys that we collect…obviously it's a nightmare…noise travels and it echoes. So it's a lot quieter. You're not disturbing the patient.* (I5)

> *It's very inconvenient for them, you know, keep waking them up every hour…but if you have got a camera…* (I3)

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I think it gives the patient more opportunity to get quality sleep as opposed to going round because they hear us. (I1)

I think it's [CCTV] *probably less intrusive for patients…I suppose it promotes a better night's sleep for the patient.* (I2)

I think having someone coming into my room every hour would be more obtrusive than having a little red ring of lights come on. (I4)

It was highlighted how CCTV could benefit the patients when incidents occur on the ward that might require most staff to be involved for a period of time. Such incidents may not leave staff enough time for physical observations of the other patients, but CCTV means that these observations can be completed quickly and are therefore more likely to be done during an incident. Thus, CCTV ensured that the welfare of other patients was not infringed by any unexpected incident on the ward.

If we've got something else going on…and we need to do a quick check to make sure the other guys are safe…it allows us to get back to what we were dealing with. (I7)

Several staff also felt that CCTV improved the level of patient observation.

The benefit is that you can see more clearly than actually going in and disturbing the patient. (I5)

We can hear if they are breathing and things like that which we can't do from outside the door. (I6)

Benefits to staff

The staff felt that the use of CCTV offered them a range of benefits, particularly regarding improving their personal safety. As discussed, observations at night often made patients irritable and aggressive towards staff and CCTV helped avoid or reduce these situations. Furthermore, staff believed that CCTV could help them assess emerging violent situations with patients because they can observe a patient's behaviour without entering the bedroom and putting themselves at risk. CCTV also offered the potential for one colleague to monitor the safety of another who had entered a bedroom of an aggressive patient.

That's obviously quite a vulnerable situation for a member of staff, knowing full well that that person is quite hostile at that time. (I4)

> *We can use the cameras as a mode to check the safety of the staff.* (I7)

Several of the staff also identified that CCTV in the patient's bedroom gave them the opportunity to assess whether a patient's behaviour in communal areas of the ward was truly reflective of their general behaviour/well-being when alone. This perhaps indicates that some staff may have been using the CCTV equipment outside the hours stated in the protocol.

> *So we've been able to get a sort of snapshot picture of people's presentation which is very different to their presentation on the ward on occasions.* (I4)

It should be noted that using CCTV in this way was in breach of the agreed arrangements explained to patients regarding the use of CCTV.

Issues that arose from the use of CCTV

Since the introduction of CCTV, various issues emerged for staff. During the interviews, staff discussed how the system had been refined by the fitting of new monitors that had enhanced the picture quality and thus the usefulness of the system to staff. Despite the improved quality of the monitors, it was apparent from the interviews that physical observation of patients was still required in some circumstances where the well-being of the patient could not definitely be established, for example if bedcovers were obscuring the patient's face.

> *If there is no movement in the room, all you are seeing basically is a lump in the bed and that's not very satisfactory. You know you can't see if anybody's breathing or not so you have to go and check physically to make sure everything is OK.* (I2)

There was also indication that some staff lacked confidence in using the equipment and so continued to do physical checks.

> *In general not many people seem that confident with the technology…It's much easier to walk around, listen at door…* (I10)

> *I'm not sure what I'm seeing on the screen, I still use traditional methods as well.* (I3)

The interviews also highlighted that, even if staff did know how to operate CCTV and were satisfied with what they saw on the monitor, a few still felt the need to carry out physical checks at some point during their shift.

> *I don't know, sometimes you can get more from personally seeing someone than observing them through the cameras.* (I4)

An area of particular note was the response from patients to CCTV. The take-up among patients seemed to have been lower than anticipated. In addition, CCTV did seem to have produced a negative affect for some patients. According to several members of staff, the presence of the cameras seemed to make some patients more unwell, by increasing their paranoia.

> *I'd feel that could make you feel quite paranoid.* (I6)

> *It's very difficult when you have a certain number of patients on the ward who've got paranoid schizophrenia, for example, who become very paranoid about the fact that you are using cameras and observing them.* (I4)

In addition, staff described how some patients had been unhappy at the presence of the cameras, whether they were in use or not. The existence of the equipment alone made some patients uneasy. Staff reported that some patients who had cameras in their rooms, but who had not consented to their use, had attempted to cover up the cameras.

> *The patients put white paper on* [the camera]*…I don't know but the paper seems to be working…Because they want to be sure if they haven't consented they still don't want that camera looking at them, cause they won't know it's off.* (I3)

> *Some guys who really don't like them* [cameras] *being in there even when they are covered up.* (I10)

It seemed the patient's concerns were partly fuelled by several incidents that occurred over the period since CCTV was installed. Specifically, the system had not been fully turned off at the control unit on one occasion and this meant lights remained illuminated on the cameras leading to patients believing they were being observed continuously when in fact they were not.

> *There was one incident where, like the cameras were left on instead of being switched off at the wall. They've accidentally been on and the screen had been switched off so no-one was looking but to all intents and purposes to the patients the red ring of lights to say it was on had remained on.* (I4)

However, the interview data did suggest that the cameras had been used outside the designated night-time periods and this was confirmed by comments made by one of the interviewees.

> *When I first started people were still using them throughout the day.* (I10)

Furthermore, on occasions the wrong CCTV camera had been switched on during observations. With no apparent safeguard in place to put a block on individual cameras, there is the potential for staff to mistakenly observe patients via CCTV who had not consented to the use of this method. This situation would therefore validate the concerns of some patients about the presence of a camera in their room.

Taken together, the data suggest that the anxiety of patients about the camera may have been fuelled by two factors: apparent daytime use as reported by staff at interview and a lack of patient confidence in the staff about how and when the cameras would be used.

Several staff also suggested that the introduction of cameras meant patients had less privacy. Use of CCTV had, at times, led some staff to see things that perhaps they might not otherwise have seen. Attention was drawn to how the sound of an approaching member of staff, either in terms of footsteps, voice or opening and closing of doors, meant that patients had some opportunity to prepare themselves if they wished by putting on clothing for example. With the introduction of CCTV this opportunity was lost. Several interviewees reported switching on the CCTV and seeing patients in circumstances that they would rather have not seen.

> *You could be in a situation when you flicked the camera on and thought 'Oh I don't want to see that,' whereas if you were observing in the traditional method they'd hear you and maybe cover up.* (I4)

However, another interviewee believed that CCTV was an improvement in this respect as the member of staff could switch off the monitor and the patient would be unaware, thus avoiding any embarrassment.

> *You automatically…quickly turn it off. But at least I think that's another good thing about the cameras at least you maintain your dignity on both sides…So it's uncomfortable…but it's better than walking in.* (I3)

One member of staff interviewed did indicate that being mindful of the routine of patients avoided such incidents. Considering this before switching on the CCTV meant the patient's privacy was less likely to be infringed.

> *…never caught anyone undressing or anything like that. Usually you know if they've been in their room about an hour usually they're sorted and I can check them…check them ten minutes after they've gone to bed and you're likely to catch them undressing.* (I10)

During the course of the interviews, some staff spoke about how the introduction of CCTV had made them feel more remote from the patient. They recounted how doing physical observations on patients enabled them to get a general feel for how things were on the ward in terms of relationships between patients, or the general mood of particular patients.

> *You may be going down specifically to see them or check on them but you notice something else is going on with someone else. That sort of thing can be missed if you're sitting in front of a screen.* (I10)

Some also went further in stating that physical observations provided the patient with an opportunity to engage with a member of staff if they had a worry or concern.

> *From the CCTV point of view they look as if they are asleep…so you take that as sleep as opposed to…if their mental state wasn't very good at the minute they could be stood staring at the wall…We would know at that point that maybe you know they want a chat…we can intervene.* (I1)

> *I think with the CCTV that it's colder. When I say colder we were ensuring that they are alive, that they are breathing, that they were there, that they were safe. We weren't intruding on them but one could say that if they wanted to speak to us they could come out of their room and talk to us but sometimes when people are awake or distressed at night, I think perhaps they wouldn't do that; that they would just lie there and maybe we would miss some of those opportunities.* (I6)

One interviewee stated how the use of CCTV meant that they were not always sure who they had observed. This was not an issue that was discussed by all the interviewees and so may be an area more relevant to individuals rather than a factor involved in the introduction of CCTV.

> *I sort of feel that I haven't seen them even though I've seen them…by the end of the shift. I have seen them and I know they are safe but I feel I haven't seen them; I haven't engaged with the patient, haven't spoken with the patient.* (I6)

A further issue to emerge was how the operation of the CCTV equipment was easier if you used it regularly and were more familiar with it.

> *When I come off nights, for a long period* [when I come back to nights] *I'm like 'OK, which is that room and that one,' but when you do it regularly on night shift it's quite easy.* (I3)

However, the patient interview data suggested that the ward tended to be covered at night by a number of bank staff who may be less familiar with CCTV. From the research evidence it was not clear whether the bank staff were drawn from the same core group and would therefore be familiar with the CCTV equipment. If the same bank staff were not used regularly, there is the potential for errors to be made when using the equipment. This could either be in terms of incorrect use of the equipment or lack of experience in carrying out observations by CCTV. Using the equipment incorrectly could mean either observing the wrong person or missing out a patient and not observing them at all. The potential for errors to be made was confirmed by one interviewee who indicated that there had been some issues relating to the use of bank staff.

> *We have a lot of bank staff on night shifts rather than on day shifts and sometimes they haven't had the proper induction.* (I10)

Qualitative Evidence: Interviews with Patients

The data collected through interviews with patients is reported below, structured around the themes identified through content analysis of the transcripts. These themes are:

- Issues related to patient care;
- Safety on the ward;
- Privacy of patients;
- Information giving about use of CCTV on the ward.

Issues related to patient care

The main issue cited by four of the six interviewees was that the use of CCTV meant less noise and less disruption at night.

> *It helps to save disturbance at night.* (P5)

The next most cited issue was that the patients perceived a change in the relationship with their carers in that the use of CCTV reduced the level of personal contact.

> *What I like in the mornings is for someone to come in and say would you like a cup of tea or something.* (P4)

> *R: Is there anything that you dislike about CCTV?*
> *P3: The lack of communication.*

Several of the patients also stated a belief that CCTV was beneficial in particular circumstances rather than general use. For example, CCTV was considered more appropriate for patients when they were ill.

> *I suppose you've got a camera in the quiet room and that is probably necessary isn't it…I think it's probably necessary, but I mean if you're in a reasonably good state of mind and the nurses don't think you're unwell and stuff, then I don't think you should watch people with cameras really.* (P1)

Another patient found the cameras reassuring when they were taking a lot of medication.

> *I think it is a good idea because obviously I am on a lot of medication at the moment and I certainly don't want to die in my sleep from medication and I don't think the staff would either.* (P6)

One patient who did not wish to have CCTV was concerned that the presence of CCTV and its use with other patients could mean that staff might overlook them by not doing traditional observations.

> *…but when I need help the help doesn't come. And now I'm realising that I do need the cameras.* (P4)

Another patient highlighted how the presence of the cameras made them feel less able to relax.

> *It's like being in prison or something like that you know. I think every patient has the right to have time on their own and stuff. If the cameras are watching you, you really don't feel you can relax or anything.* (P1)

Safety on the ward

Four of the six interviewees expressed views that the presence of CCTV made the ward a safer place and all offered examples of how they believed this to be the case. Three of the patients felt that their personal safety was improved with CCTV.

> *I feel that having CCTV in the courtyard prevents violence. I have noticed from other wards there has been a lot of violence where there have not been cameras. I feel this ward is very much relaxed, it's very much relaxed because the cameras are there no-one is actually going to strike at you without being observed by the staff.* (P6)

Several interviewees thought that CCTV deterred others from breaking certain rules, which generally made things safer. For example, patients were less likely to try and smoke in their bedrooms because they could be observed. Therefore, the risk of a fire starting was reduced.

> *…and it stops people from causing fires, people don't smoke in their rooms much because the camera's on them.* (P3)

> *…and the other thing, fire risk, I suppose.* (P6)

A further aspect of improved safety on the ward related to security of personal property.

> *I know that no-one is going to steal anything out of my room.* (P6)

> *Keeps my items safe.* (P5)

When it was explained to one of the patients that the CCTV was only on for specific periods, not all the time, their view was that the cameras should be used 24 hours a day.

Privacy of patients

One patient spoke of how the cameras were an invasion of their privacy because their camera had come on when they were naked. The patient felt that, in this instance, it was inappropriate for the camera to remain on.

A patient who had chosen not to have CCTV expressed the view that the use of cameras was *'just a bit intrusive'* (P1).

Another patient felt that the cameras infringed their privacy at particular times and that patients should have the right to ask for the camera to be switched off for short periods.

> *I think they* [patients] *should have the right to ask for the cameras to be switched off for privacy and obviously the ward is all lads and young lads and you know certain, as you know what lads do, basically it can be embarrassing in the sense that you know.* (P6)

One patient felt that CCTV was more intrusive than the traditional method of observation:

> *P1: I mean it's OK [traditional method] because they are outside the room, you know, they don't sort of come in and shine torches in your face or anything, you know.*
> *R: So you think it might feel more intrusive because the camera's in the room then?*
> *P1: I think so; I mean your room is your personal space.*

One patient (P6) did seem to become more comfortable with the use of CCTV as they got to know the staff.

> *I used to think, 'Oh God I'm being watched in my room all the time,' but now it's like you said confidential and that's fine by me. I know all the staff, they're great people.* (P6)

However, one patient did state that CCTV was a much better method of observation as they felt less conscious of being monitored.

> *It's a lot better…'cause you don't get so many people coming and looking through your door window.* (P3)

Information-giving about use of CCTV on the ward

The interviews showed that information-giving around the use of CCTV could be improved. The comments of a number of the patients suggested that most believed the cameras were in use all the time rather than being switched on and off periodically throughout the night.

Interview data also indicated that patients thought the cameras recorded what was seen. This is supported by the patients' views that CCTV improved personal safety and the security of property. Implicit in these statements is the view that cameras are in operation all the time, including during the day, otherwise the patients would not be so assured of improved safety. Several of the patients explicitly refer to the cameras recording incidents.

> *P3: …'cause sometimes I'm naked.*
> *R: OK, so you think sometimes…*

> *P3: I can see the camera's on*
> *R: So you are concerned people might be looking at you?*
> *P3: Yeah, recording, I don't know just recording.*

Again the comments below from another interviewee show an implicit belief that CCTV records when in operation. In this example, the interviewee talks of how accounts of incidents could be verified afterwards using footage from the cameras.

> *Also it allows staff to see what's actually happening in that room at the time so if there is an incident and the staff made untruths, basically the staff will be able to look at those cameras to see if the actual facts are correct which goes in my favour very much.*
> (P6)

The assumption that the camera would be on when the theoretical incident occurs also suggests that the patient believes the cameras are generally on.

One further issue identified was that the illumination of the infra-red light on the camera does not necessarily mean that the person in the room is being observed as cameras cannot be switched on individually, only collectively, and the pictures from all the cameras cannot be observed at once. The interview data suggest that patients believed that if the infra-red light was on, they were being observed. This may be an issue that requires clarification with patients, given that the infra-red light may remain on for some time while each of the patients is observed in turn. For the patients, seeing their camera light on would indicate that they were actually being viewed for a much longer time than the brief period of observation.

Discussion

Principles of Observation

Observation of people with mental health problems derives from three basic principles:

- Policy of prevention;
- A duty of care;
- Therapeutic endeavour.

Advances in technology often offer the opportunity to reduce the burden of human effort while making improvements to the previous methods of doing things. Therefore, in many industrial settings, new technology can improve productivity while reducing the number of people required to carry out activities.

However, mental health care as presently constructed does not equate to an industrial model. Instead, its effectiveness is based on the interaction of one human with another and, historically, the profession has been resistant to making use of impersonal methods of observation and care delivery. The incorporation of remote systems of observing could be seen as contrary to the philosophy of an interactive model of care. Indeed, many of the initial concerns (and the impetus for this study) were provoked by the alien nature of an apparent 'big brother' method of surveillance.

In fact, the research findings demonstrated that the technology was viewed as a means to improve patient care in two specific areas:

- To promote the comfort of the patients through reduced disturbance at night;
- To improve monitoring of patient safety.

Issues Arising from the Study

The use of CCTV in patient observations

The system is welcomed by the staff as an addition to previous ways of working but is definitely not viewed as a complete replacement for the traditional methods. Staff identified particular situations where the application of the new technology would both be helpful to them and beneficial to patients. For example, during incidents where a number of staff may be involved and, as a result, the traditional observations may be delayed. The use of CCTV here offers the opportunity for one member of staff to undertake observation of the other patients more quickly because they can be done from a central point and enhances the

likelihood of the task being completed at the specified time, an outcome which is beneficial to the other patients.

Interestingly, both staff and patients shared the view that CCTV could not become a replacement for traditional methods of observation. Both groups expressed the opinion that traditional observation had other benefits beyond the intended purpose of ensuring a patient had not come to any harm. These included:

- Opportunities to informally discuss issues of concern before they become more serious;
- General reassurance of being 'looked after';
- Instilling a feeling that help is near by.

CCTV, by its remote nature, cannot replicate these outcomes and this probably explains why some staff members felt that, when using CCTV, there was a certain lack of reality to what they were doing. Some staff reported needing to go and physically check on some occasions to reassure themselves about what they had observed on CCTV. This could of course also be a reflection of a lack of confidence in either their ability to use the equipment or in CCTV itself.

Operation of CCTV

The introduction of CCTV to the unit also brought with it new training and development needs beyond that of therapeutic skills. Effective use of the equipment could only be achieved when the staff felt confident in operating it. Several interviewees expressed uncertainty on occasions about whether they were viewing the correct patient and these anxieties were heightened when they had not been regularly operating the equipment for a while e.g. on returning to night shift.

Interestingly, some patients told how they lacked confidence in the way staff operated the CCTV, mainly relating to times of use (there were indications that staff had made such errors). However, this would indicate that greater patient confidence in the ability of staff to operate the equipment correctly may have an impact on the take-up of CCTV.

Some patients interviewed were also uncertain about the operation of CCTV in general. This may be another area that could be improved to make the patients more confident about the use of CCTV on the unit.

Identification of CCTV with therapeutic patients

Patients did not acknowledge CCTV as being a therapeutic intervention. Some recognised it as a way of monitoring them when extra care was needed, for example when they were on higher levels of medication. A greater number saw CCTV as a way to enable a more secure environment in terms of rule-breaking, petty theft or assault, much as a member of the general public would view CCTV on their street.

If the patients' view of CCTV is primarily as an enhancement to the security of their environment then it is reasonable to compare their decision-making with that of the general public's views about the use of CCTV as a crime prevention strategy. Some members of the community oppose CCTV either because they do not perceive a threat to themselves or would not wish their movements, no matter how innocent, to be observed using CCTV.

The patients' preoccupation with safety and security is also to be expected given the purpose of their hospitalisation, but their lack of therapeutic association is interesting. Also of interest is the fact that none of the patients saw the use of CCTV as an erosion or further infringement of their liberty. This is probably a reflection of their acceptance of their current situation.

In terms of staff views on the therapeutic use of CCTV, the absence of much comment during interview must be seen in relation to how CCTV was implemented within the unit. At the outset, attention was given to the fact that CCTV was:

- Impersonal;
- More intrusive as a constant feature within a bedroom;
- Did not naturally draw on learned human skills of interaction;
- Open to abuse by staff.

In addition, the protocols and training subsumed its use within the necessity of observation in general. As a result, the opportunity to explore the potential of CCTV observation as a therapeutic intervention was neglected.

However, the interview data did show that staff identified situations where CCTV has the potential to enhance care and management. Also, some staff expressed their frustration about the decision of particular patients not to consent to the use of CCTV as they believed these patients might have been better observed with the use of such technology.

Ethical issues

During the course of the interviews, certain ethical issues emerged. CCTV enabled staff to witness more than they may have done before and this presented an ethical dilemma as to how they should respond. The scale of these incidents varied, ranging from a misdemeanour such as patients smoking in their room (which is not permitted), to a more serious incident such as witnessing an assault that would not otherwise have been seen. To assist staff, guidelines to ensure consistency in dealing with such incidents would be useful. Such guidance should also be made available to patients.

Conclusion

Summary of Findings

Use of CCTV

- The use of CCTV is not a replacement for traditional methods of observation.

- The use of CCTV is an effective, complementary approach to traditional observation methods, and would appear to have specific beneficial applications.

- The study did not find particular difficulties with the use of cameras in rooms as might have been expected.

- The use of CCTV at night did not have a measurable effect on 'untoward' behaviour either in a positive or negative manner. The ability to observe an incident by camera before it became more serious is a possibility but this is not generally confirmed in the subsequent interview data.

Patient perceptions

- CCTV was valued by the patients who chose it as a less intrusive night-time option.

- There was some indication that the greater the confidence of the patients in the ability of staff to efficiently operate the CCTV may have an impact on take-up by patients.

- Many patients associated the use of CCTV with the security of their environment, for example reducing rule breaking, petty theft or enhancing personal safety, rather than an intervention to assess their state of well-being during the night.

- Some of the patients demonstrated that they were unsure of how CCTV was operated. This indicates an area for further work.

Emerging issues

- The issues that emerged were around observation and surveillance per se and are thus beyond the scope of this study.

- Some staff felt less confident about operating the CCTV equipment if they did not use it regularly. Therefore, refresher training may be an appropriate option to offer staff on returning to nightshift.

- Greater association of CCTV with therapeutic purpose and the identification of appropriate applications would enhance the potential outcomes of this method of intervention.

- There is a need to give further consideration to ethical issues, some of which were unforeseen and relate to witnessing activities that would not otherwise have been observed by staff had they not been operating the CCTV.

Overall Conclusion

To conclude, CCTV observation has no major objectionable features compared with conventional observation and only really has significant advantages if it is used as a prescribed intervention to best suit individual observational needs.

Recommendations

Improvements to the current system for the use of CCTV

The interviews highlighted a number of issues where improvements could be made to the operation of the CCTV. These improvements can be grouped into three areas: technical, operational and ethical.

Technical

To reduce the concerns of patients not consenting to the use of CCTV but who still have a camera in their room, it might be advisable to look at ways of making the cameras clearly inoperable. This could include the possibility of temporarily removing the camera or providing a means of covering the camera, such as a wooden casing that could be placed over the area where it is located.

The location of the CCTV monitors may also be another issue to consider in terms of monitors being visible to individuals other than the staff authorised to view them.

Operational

It would appear that occasionally the wrong camera was switched on, leading to staff mistakenly observing the wrong person. This could be overcome by improved labelling of camera switches with the relevant patient name to ensure that those patients who have not consented do not have their privacy infringed, and that those who have consented are observed when they should be and do not get overlooked.

The operation of the camera appears to present some difficulties for staff and several suggested that greater familiarity through regular use improves their ability to operate the CCTV effectively. Therefore, every effort should be made to ensure that particular members of staff with experience of using CCTV are regularly on duty at night.

Ethical

Possibly the largest area for review is in relation to ethical issues. These can be broken down into specific areas:

- Management of the consent process;
- Staff training;
- Guidance on specific incidents relating to the use of CCTV;
- Patient information.

In terms of the *management of the consent process,* the main area is ensuring that everyone who has consented is known to staff and that the appropriate camera in the office is clearly identifiable. Any changes

regarding the consent given by patients needs to be effectively communicated to all staff, possibly through a list of current CCTV patients being displayed in the control room with any changes visibly highlighted.

All staff need to receive *training* on the use of the cameras, the consent process and how subsequent changes might be notified. Staff who have not been on a night shift for a period of time should receive a refresher briefing before re-starting nights.

Training should also include instruction on when and how the cameras are to be used. This should take into account advice that might help avoid observing patients perhaps when they are undressed. For example, CCTV should not be used for 30 minutes after the patient goes to bed to allow them the privacy to settle down for the night.

Given the range of ethical considerations highlighted in the interviews, there would seem to be a need for consideration of these issues and *guidance on specific incidents relating to the use of CCTV.* This would be helpful in supporting both staff and patients. Particular areas of note are observing patients engaged in an activity not permitted on the ward or where CCTV has enabled staff to witness situations they would not otherwise have seen. This would include aggressive/violent situations or any incident where the images seen on CCTV could be used against the patient.

Information needs to be given to the patients to reflect the issues noted above, thus enabling consent to be fully informed.

Methods for taking the research forward

The stated aim of this proposed study was to determine the appropriate use of CCTV surveillance in a mental health in-patient unit. Through the chosen approach, a variety of reports, protocols and guidance materials were generated and are therefore available to other practitioners facing the same dilemmas. The full report has been discussed with the team and has influenced practice development. The team has gained pragmatic understanding of 'research in action' and working together, which should produce future benefits for the unit. Additional areas for research and development have emerged from the process. The action research approach provided a documentary account of the issues, problems, solutions and evaluations explored. This means that others can reconsider the issues in relation to their practice without having to replicate the processes. The issues, process of exploration and findings have been widely disseminated and offered for policy development.

Examples include:

- Professional mental health journals;
- Open websites;
- Prison health care;
- User groups;
- Conference presentations.

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Appendix 1

Draft Guidelines and Procedures for Patient Observation

Introduction

Observation is not simply aimed at preventing harm by controlling patient activity. It provides the healthcare professional with the opportunity to engage in therapeutic exchange. Cardell and Pitula (1999) noted that patients experienced observations as therapeutic if the staff involved actively engaged them in the process.

Barker and Cutcliffe (1999) take the argument further, suggesting that observation should be abandoned completely. They argue that it is used because of organisations' 'fear of litigation' and that it serves a useful function by assuring the absent doctor of the physical safety of the patient.

Procedure for patient observations

- On admission, both a nurse and a doctor will assess patients (UKCC 1992, Severn NHS Trust 1995).
- Admitting staff will identify any risk behaviours relating to self, others and self neglect and associated level of risk. This will involve considering actual and clinical indicators. The levels of risk are defined in the CPA (GMHS 1999) and should be utilised.
- The admitting nurse and doctor will jointly agree an initial level of 'observation' based on identified levels of risk.
- Where staff do not agree upon a level, then all efforts should be made to negotiate an agreement. Ultimately the nurse in charge of the ward is responsible for the Health and Safety of those within the ward environment and therefore the immediate level of patients' supervision.
- The named nurse once appointed will be responsible for ensuring observation levels are regularly reviewed and recorded in the Unified Care Plan. Normally reviews will take place during multi-disciplinary/inter-professional meetings. Should a level of observation prove to be counterproductive and in need of being reduced, then the team should agree such a decision during a handover period. All decisions and rationale should be recorded in accordance with Trust and Unit risk-taking procedures.
- The evidence suggests that a MDT review should take place when one-to-one observations have exceeded 72 hours (Shugar & Rehaluk, 1990) as problems with behavioural escalation, secondary gain for the patient and staff burnout may arise.

- The patient should be kept informed of their care plans and any level of observation prescribed. In rare circumstances the team may make a decision not to do so. The rationale for this decision should be recorded.

- The nurse co-ordinating the shift is responsible for ensuring that adequate resources are available for implementing observations within the ward. Any unresolved staffing issues should be reported to the head of nursing.

- Where 15 minute observations or higher (up to one-to-one) have been prescribed then a supervision record should be maintained. Once completed, the supervision record should be filed in the health record. Any specific instructions should be recorded at the top of the form.

- Ideally the nurse responsible for carrying out observations will know the patient, the staff member will understand the patients. Nursing care plans will include known risk factors and staff will have received training in undertaking observations.

- Staff should not undertake one-to-one observations for longer than two hours and ideally between 30 minutes and an hour. Staff should then have a break from undertaking observations for at least an hour (DOH 1999).

- There will be times when staff other than nursing will assume responsibility for observing the patient e.g. occupational therapist. All staff including nurses, other professionals and medical staff, should have received training prior to undertaking 'observations'.

- During night shifts, patients within the acute directorate, including the Montpellier Unit, will be observed hourly. This is a minimum standard. A number of units within other directorates are of a residential or rehabilitative nature. Patients residing within those units may have observations set at a lower level than this following appropriate assessment of risk.

Levels of observation and their description in the care plan

The Gloucestershire CPA defines risk into three categories: low, medium, and high. For reasons of consistency, the table below contains suggestions as to the range of observations levels that might be required in response to the three levels of risk. It is important for staff to remember that the observation levels listed in the table are only suggestions and do not replace proper individual assessment. The specific observation level will be determined from a detailed assessment of the patient and their immediate situation.

Level of assessed risks	Suggested level of supervision
Low risk (little or no risk)	Knowledge of intended whereabouts, e.g. whilst on leave etc. up to hourly checks at night.
Medium risk (intermediate)	Half hourly checks up to 15 mins at nights or 15 mins when awake/30 mins at night.
High risk (marked degree)	15 mins when awake/30 mins when asleep, up to 15 mins checks when awake and asleep or randomised observations within 15 mins or 1:1 contact e.g. audible/visual or 1:1 contact (within physical reach).

The observation available for description within the care plan ranges from one-to-one contact to no formal observations. When describing observations in the care plan, the nurse should enter as much descriptive detail as necessary to leave no doubt as to the exact observational behaviour that is necessary by nurses who are carrying out the observation. Useful terms for inclusion in the care plan may include:

- One-to-one visual contact within arms reach;
- One-to-one contact within easy distance of physical contact;
- One-to-one visual contact at all times;
- Five minute randomised observations;
- Ten minute randomised observations (this statement can then be repeated at increasing five minute intervals as required by the assessment).

Note: The phase 'no formal observations within a care plan' equates to:

- To know the intended whereabouts of a patient e.g. while out on leave;
- To visually check at the start of each shift, drug round, lunch and supper time;
- Hourly checks throughout the night.

Suggestions for night-time observations

The Montpellier Unit has the facility to use CCTV for night-time observations between 11pm-7am, offering the patient an unobtrusive approach which facilitates sleep. CCTV is not recorded and patients are able to ascertain when cameras are on from the bedroom. CCTV will only be used by healthcare professionals at prescribed observation times for the minimum duration needed to establish need/intervention required.

- On admission patients will be offered the option of being observed via CCTV or through traditional methods of night-time observation.
- CCTV and traditional methods will be explained and demonstrated to the patient.
- Patient consent must be explicit before CCTV is used. If in doubt, traditional methods will be used.
- Patient consent must be documented, signed and kept in the patients' notes.

Appendix 2

Draft Care Plan for Night-Time Observations

Date	No.	Problem	Goal/Objective	Intervention	Evaluation Date	Signed
		Montpellier Unit has the facility to offer a choice of two methods of night-time observations. 1. CCTV can be used for night-time observations between 11pm-7am, offering the patient an unobtrusive approach, which facilitates sleep. CCTV can detect both movement and sound. CCTV is not recorded and patients are able to ascertain when cameras are on from the bedroom. 2. The traditional method of opening the bedroom door and using a torch.	To allow the patient to have a choice of method used for night-time observation.	1. On admission patients will be offered the option of being observed via CCTV or through traditional methods of night-time observation. 2. CCTV and traditional methods will be explained and demonstrated to the patient. 3. CCTV will only be used by healthcare professionals at prescribed observation times for minimum duration needed to establish need/intervention required. 4. Patient consent must be explicit before CCTV is used. If in doubt traditional methods will be used. 5. Patient consent must be documented, signed and kept in the patients' notes.		