

Research paper

The new stars of CCTV: what is the purpose of monitoring patients in communal areas of psychiatric hospital wards, bedrooms and seclusion rooms?

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What is known on this subject

- A number of NHS mental health trusts have started to use CCTV cameras in psychiatric wards, and this is a growing trend.
- CCTV monitoring constitutes one of a number of precautions adopted within the NHS for managing the growing violence experienced by healthcare staff while caring for patients.
- Open-street use of CCTV surveillance in urban areas suggests that CCTV cameras have the capacity to distort the reality of what is being observed.

What this paper adds

- The rationale and need for further research in this area are discussed.
- A debate is opened on the potential for CCTV surveillance to undermine psychiatric patients' human rights.
- The potential for change in frontline practice in mental healthcare for hospital patients is considered.

ABSTRACT

The recent gradual introduction of closed-circuit television (CCTV) cameras on psychiatric wards to monitor patients in communal areas, bedrooms and seclusion rooms has taken place without much prior debate. This paper is an attempt to open such a debate by raising a number of concerns. The author suggests that CCTV monitoring is not a wholly benign activity, and that it influences the way in which patients in psychiatric wards are perceived by those responsible for their care, as well as raising ethical concerns about the use of such monitoring. This paper critically reflects on the lack of research on the use of CCTV in psychiatric wards. The author draws on the literature about the use of surveillance

cameras in other settings (such as public streets) as well as on psychiatric wards, and also considers other critical surveillance literature, when questioning the efficacy of CCTV monitoring in effectively managing violent incidents on psychiatric wards and in maintaining a 'safe' environment for patients and staff. The paper concludes that CCTV monitoring is fraught with difficulties and challenges, and that 'watching' patients and staff through the lens of a camera can distort the reality of what is actually happening within a ward environment.

Keywords: disappearing bodies, function creep, panoptic practices, safety, surveillance

Introduction

The introduction of closed-circuit television (CCTV) cameras into psychiatric wards has taken place on an ad hoc basis, with some NHS trusts and independent private hospitals choosing to use it, and others not doing so. There has been very little debate about or research into the efficacy of these cameras in monitoring and assisting the management of aggressive behaviour by psychiatric patients. This paper is an attempt to open such a debate. It begins with a review of what is currently known about the use of CCTV monitoring in psychiatric settings, and then goes on to address some of the key issues that arise. These include professional ethics and the potential for CCTV monitoring to be used and abused while care is being provided for some of the most vulnerable members of society. Discussion of these issues draws on critical research into the use of open-street CCTV monitoring to highlight the potential for changes in mental health-care following its adoption in psychiatric wards. The paper concludes that although CCTV monitoring may have the potential to provide a safer and less intrusive means of monitoring patients, it can also have a potentially negative impact on patient privacy, dignity and rights, as well as on professional practice.

Background

It is difficult to establish the full extent of the use of CCTV monitoring in psychiatric wards in England and Wales, as there is no single body that collects and monitors this information. A recent survey of 100 NHS mental health trusts revealed that 34 of them used CCTV monitoring in patient areas. These included 157 wards located in 85 hospitals. Six of these hospitals had installed CCTV cameras in some or all patient bedrooms, and nine hospitals confirmed that CCTV was used in seclusion rooms. The remaining 37 NHS trusts confirmed that they did not use CCTV monitoring, except in the external hospital grounds and reception areas (information taken from a preliminary audit undertaken by the University of Hull in 2008). These findings suggest that CCTV monitoring is not just limited to hospital wards that provide a secure care environment, but is also being used in acute inpatient units, specialist eating disorder units, units that care for children and adolescents with mental health and learning disabilities, and psychiatric intensive-care units (PICUs). Within these wards/units, CCTV cameras are located in lounge areas, dining rooms, education rooms, activity rooms and viewing rooms, as well as in patient bedrooms and seclusion rooms.

This development seems to have taken place without any clear policy decisions being made in advance. At present there is no specific, coherent government policy or strategy for the use of CCTV monitoring on psychiatric wards, other than general guidance provided by the Information Commissioner's Office (2008) and the Mental Health Act Commission (2005). The Commission states that 'CCTV is not a general substitute for the use of skilled staff as a method of observing patient behaviour. Nor is it the answer to all security concerns' (Mental Health Act Commission, 2005, p. 6). Similarly, the Information Commissioner's Office (2008) requires that organisations should look at alternative ways of improving security before resorting to CCTV monitoring as a solution. These two sources state that any use of CCTV cameras should result in minimum interference with privacy and the rights of patients and that, in all circumstances, an impact assessment should be undertaken to determine whether the use of CCTV cameras is justified. CCTV monitoring is presented by the Department of Health (1999) as a benign tool for maximising 'safety' on psychiatric wards, but there have been no national or comprehensive investigations or evaluations of the ways in which it is used, and consequently there is a lack of evidence that it is effective in psychiatric settings.

It is likely that the amount of information and evidence that is available for evaluating the efficacy of CCTV monitoring in psychiatric settings is limited, because these cameras have only been introduced recently. Although the Information Commissioner's Office requires an impact assessment to be carried out in all NHS mental health trusts that use CCTV cameras in psychiatric wards, there appear to be only two evaluative reviews available to the public. A review by Warr *et al.* (2005) of the Montpellier Medium-Secure Unit in Gloucestershire reports the use of infra-red CCTV cameras, together with an audio facility to undertake night-time observations of patients in their bedrooms. An internal review by Chambers and Gillard (2005) evaluated the use of CCTV monitoring on John Meyer Ward, a psychiatric intensive-care unit (PICU). CCTV cameras were installed on this ward as an additional safety measure, following the murder of a mental health nurse by a patient in this ward.

The benefits of CCTV monitoring

Both of the above evaluations highlight a number of issues with regard to the application of this technology. Positive findings showed that both organisations installed CCTV cameras in order to make the process of observing patients in communal ward areas safer and less intrusive. In the Montpellier Unit, for example, the inclusion of infra-red CCTV cameras, together

with audio facilities, in patients' bedrooms allowed night-time observations to take place without disturbing the patients (Warr *et al*, 2005). CCTV monitoring also helps to reduce the number of unwelcome intrusions into patients' bedrooms by other patients in the ward (Dix, 2002).

The use of CCTV cameras not only enabled better detection of risk factors in managing patients on a ward, but also provided video footage for training purposes. For example, Chambers and Gillard (2005) found that maintaining recorded images of incidents allowed an opportunity for after-the-event evaluation that could be used for training purposes, especially in recognising the antecedents to violent episodes and in preventing suicide. Staff believed that the recorded images provided a more accurate and therefore objective account of incidents.

Some patients in both the Montpellier Unit and John Meyer Ward expressed positive views about the presence of CCTV cameras on the ward, stating that this made them feel safer (Warr *et al*, 2005; Chambers and Gillard, 2005). However, it is prudent to note that in both of these studies the patients' views were limited, which indicates another neglected area of research into the use of CCTV technology.

Problems with the use of CCTV monitoring

Four broad groups of problems have been associated with the use of CCTV cameras.

Ethics and consent

Article 8 (1) of the European Convention on Human Rights contains the 'right to respect for private, family life, home and correspondence.' This Convention has informed the Mental Health Act Revised Code of Practice, which places an obligation on 'public authorities to respect a person's right to a private life. This includes people detained under the Act. Privacy and safety are therefore important constituents of the therapeutic environment. Hospital staff should make conscious efforts to respect the privacy of patients while maintaining safety' (Department of Health, 2008, Paragraph 16.2). However, this right to privacy is a qualified right that can be overridden so long as there is justification for doing so – that is, where there is a threat to public safety, or where the protection of other people's rights or freedom may be compromised (Hewitt, 1998).

Any interference with Article 8 (1) has to be justified under Article 8 (2). In psychiatric wards this includes

the safety of staff and other patients. The critical issues here are as follows:

- patients' capacity to give consent for observation
- the extent to which constant observation by CCTV cameras is necessary to prevent or manage violent or untoward incidents in communal ward areas, seclusion rooms and patients' bedrooms.

Patients in psychiatric settings, especially those in intensive-care settings, may have an impaired or fluctuating capacity to provide consent. The Mental Capacity Act 2005 Code of Practice (Department for Constitutional Affairs, 2007, p. 5) states that the expression 'a person who lacks capacity' means 'a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken.' Thus, although patients may lack the capacity to make some decisions for themselves, this does not negate their ability to make other decisions related to everyday issues, such as what to wear or what to eat. Good practice in line with the Mental Capacity Act suggests that patient consent should be sought when CCTV monitoring is used.

It is unclear how and when consent should be sought. If the ward environment is classed as a public space, then it is questionable whether patient consent is required at all. The Mental Capacity Act 2005 promotes the principle that all adults have the capacity to make their own decisions, unless it is proved otherwise. However, this becomes problematic when CCTV monitoring is used in communal areas. The decision that a person should be monitored by CCTV cameras, especially in communal areas, affects patients as a group. Not all patients who use communal areas would necessarily consent to this form of surveillance. This raises concerns about the rights of those patients who do not want to be monitored by CCTV cameras, over those who have consented to this. Heath (2007) raises the issue of consent in the context of probation hostels that use CCTV cameras in communal areas and along corridors to monitor residents. He noted the lack of warning given to new offenders prior to admission to hostels regarding the extent of CCTV surveillance. Patients who are detained under mental health legislation have their rights curtailed even further. For these patients, who are held in psychiatric hospitals without their consent, access to space outside the ward environment is restricted. This suggests that detained patients who object to being monitored by CCTV cameras inadvertently have their right to privacy curtailed, as the number of places they can access is limited if they want to avoid the cameras. Within psychiatric wards, this avoidance behaviour can also be misconstrued as evidence of illness. Staff in the study by Warr *et al* (2005) sought consent to use infra-red CCTV monitoring for night-time observations. However, there has been no research into whether

patients who are placed in seclusion have the choice of being monitored by CCTV cameras or not. Even with patient consent, Warr *et al* (2005) also noted that, at times, staff witnessed patient behaviours which raised ethical concerns for them and to which they did not know how to respond. Although it might be prudent for those NHS mental health trusts that use CCTV monitoring to have practice-relevant ethical guidelines, the study by Warr *et al* (2005) suggests that the reality of situations is such that not all privacy and ethical issues can be covered by these guidelines, and that additional training for staff who use this form of surveillance may also be necessary.

The use of CCTV cameras also raises concerns about potential abuse in relation to monitoring, how and by whom the operation of CCTV cameras in psychiatric wards should be regulated, and whether internal audits and reviews are an appropriate means of evaluating the effectiveness of this technology. Despite the placing of restrictions on the use of CCTV monitoring – for example, by seeking patient consent – it is very easy to engage in discriminatory practices in order to gather evidence that confirms an individual patient's behaviour. For example, Warr *et al* (2005) noted the targeting of certain patients' bedrooms where staff took the opportunity to assess the patient's behaviour when the patient was alone, in order to gauge whether this was reflective of their behaviour in the ward. This use of CCTV monitoring was in breach of the agreement initially reached with patients regarding its use. Such breaches can easily be justified by arguing, on clinical grounds, that the information is necessary to avert a potentially violent incident. Neyland (2006, p. 3) refers to the 'binary opposition' that is created by CCTV monitoring. There may be rules or procedures with regard to what is observed, for which patients may have given their consent. However, the distinction between which activities are watched and which are not can become blurred in some situations, and this is often linked to some form of suspicion about a particular patient. It is clear that the Data Protection Act 1998 and the CCTV Code of Practice 2008 are insufficient to address these issues, and that the use of CCTV monitoring within psychiatric ward environments may require much tighter regulation and independent monitoring.

Why use CCTV monitoring at all?

The introduction of CCTV monitoring on psychiatric wards has been justified on the grounds that it might reduce the amount of violence and aggressive behaviour in the same way as open-street CCTV monitoring. Open-street CCTV monitoring is justified on the grounds that it allows safer spaces to be created which

then become more accessible to others (Koskela, 2000). The fact that psychiatric wards have become unsafe environments for patients and staff who are working in them is not in dispute. The National Audit of Violence (Healthcare Commission and the Royal College of Psychiatrists, 2005) reported that during 2004–2005 a total of 43 031 assaults against NHS staff were reported. The same report also found that 36% of inpatients on psychiatric wards had been personally attacked, threatened or made to feel unsafe. This suggests that there has been a serious increase in the number of violent attacks upon staff and patients. The response of some NHS mental health trusts – to introduce CCTV cameras to tackle such violence – is likely to be a pragmatic one. Patients and staff are more likely to access communal areas on wards if they feel safe while using this space.

Achieving a balance between safety and privacy for patients is difficult. Clinical practice requires decision making on a daily basis, and patients' mental health and well-being do not remain static. Individuals' dignity and rights have to be managed in ways that ensure the dignity and safety of everyone involved.

Mental health professionals have the right to be protected from those patients whose behaviour is severely disturbed and/or who have become aggressive and violent. In this context, CCTV surveillance can be used to protect patients from abuse by other patients and staff (Department of Health, 2000). Local codes of practice have been established to tackle abuse of vulnerable adults in residential and institutional settings. Stored CCTV footage has the advantage of providing visible evidence where incidents of abuse have occurred. However, this evidence should be used with caution, and should not be presented as a full account of an incident. Whether constant surveillance by CCTV cameras is perceived by patients as a disproportionate response to the increase in violence on psychiatric wards, and therefore a human rights issue, has yet to be challenged legally. In the mean time, those NHS mental health trusts that use CCTV monitoring establish their own guidelines for its operation.

The prevention of violence

In neither of the evaluative reviews was there any conclusive evidence that having CCTV cameras in place guaranteed a safe environment or prevented violent incidents from occurring (Chambers and Gillard, 2005; Warr *et al*, 2005). Nevertheless, CCTV monitoring was perceived to offer greater security in that staff came to place greater emphasis on the recorded images, regarding these as more accurate than their own professional judgements. Viewing the recorded images became the first response when investigating and evaluating any incidents on the ward (Chambers

and Gillard, 2005). Chambers and Gillard (2005) also found that, even when security guards were monitoring the cameras continuously, this did not lead to an improved real-time response in preventing violent incidents, and that on some occasions, by the time help and support had been instigated, the violent incident had already occurred. Thus the reality of using CCTV cameras as a deterrent does not necessarily lead to a violence-free environment, as the 'camera itself has no eyes', and someone still needs to make professional judgements (Koskela, 2000, p. 249). The presence of CCTV cameras will not stop violent incidents from occurring. Indeed, for some patients, who experience paranoid symptoms, the cameras have the potential to increase aggressive and violent behaviour (Warr *et al*, 2005).

The potential for changes in practice

Both Warr *et al* (2005) and Chambers and Gillard (2005) noted the potential for 'function creep' (Haggerty and Ericson, 2006, p. 8). This relates to the use of CCTV equipment for other purposes. In the review by Chambers and Gillard (2005), for example, nurses were concerned about being watched by managers as they went about their daily activities. Although this was not in fact the case, nurses were concerned that the cameras had the potential to monitor their own activities as well as those of patients. Chambers and Gillard (2005) also noted changes in nursing practices that arose as a result of the introduction of CCTV cameras. For instance, some staff expressed reluctance to engage in therapeutic touch, in case their actions were later misconstrued as inappropriate in any viewing of CCTV footage. Some Black African Caribbean staff felt that their body language might be misconstrued as being inappropriately aggressive. However, staff also claimed that they felt more confident about using physical interventions, such as bodily restraint, because they believed that CCTV footage would provide evidence of their proper conduct. In other words, the introduction of CCTV cameras caused staff to become more self-conscious about their actions and to behave differently towards patients. These factors could alter therapeutic relationships.

Research about the impact of CCTV monitoring in other areas, such as urban/public or open-street areas (see, for example, Norris *et al*, 1998; Ditton, 2000; McCahill, 2002), confirms that such changes do occur. There seems to be an association between monitoring and changes in human behaviour and expectations among both the observed and the observers (Foucault, 1977; Yar, 2003). Lyon (2001, p. 142) argues that although CCTV monitoring might be presented as a potential solution to the problem of increased violence on psychiatric wards, it also has the capacity for

greater surveillance of patients and staff generally. The result is 'disappearing bodies' (Lyon 2001, p. 15), a situation in which over-reliance on CCTV monitoring creates a potential for less face-to-face interaction between staff and patients, when this should be the primary function of mental health practice (Cutcliffe and Barker, 2002). Dubbeld (2003) warns that observing patients only through CCTV monitors could result in dehumanising them to the extent that they are perceived only as a series of body movements. CCTV surveillance makes space a container in which the watcher operates in a two-dimensional reality, and where those people who are being watched become objects (Koskela 2000). As a result, the people who are being observed are reduced to 'doll-like bodies lacking personal qualities, and surveillance is reduced to the observation of bodily movements. The technical equipment that separates the two sides of surveillance makes it difficult for the space to be recognised as a lived, experienced space' (Koskela, 2000, p. 250). This in turn results in further separation of psychiatric patients from those who are tasked with their care, and when hospital space becomes a container, it can no longer be perceived as a therapeutic environment. Although violence against healthcare staff has to be taken seriously, it is also the case that alienation of staff from patients is divisive and creates the potential for more conflict, rather than less. Vulnerable patients are then scrutinised ever more closely, when what they really need is more human engagement (Stevenson and Cutcliffe, 2006).

One solution might be to use security staff to monitor the cameras. However, evidence from studies of the use of open-street CCTV cameras suggests that this can result in discriminatory practices. Norris and Armstrong (1999) found that there was disproportionate targeting of young black men for observation by some security guards. Similarly, McCahill (2002, p. 8) coined the term 'rogues gallery' to describe those individuals who were singled out for intensive observation in open-street surveillance. Within psychiatric settings, the use of security staff to monitor the cameras raises additional problems, such as inappropriate alerts, where the lack of clinical understanding of the patient group results in either inaction or overreaction to certain situations by security staff (Chambers and Gillard, 2005). Security staff can also abuse their position by targeting those patients whose behaviour, because of their mental health problems, has become inappropriate and disinhibited, thereby compromising patient dignity.

Whether the monitoring is undertaken by professionals or security staff, it is argued that watching patients through the lens of a camera alienates professionals from patients. Psychiatric discourse is based on the interaction between psychiatrists and their patients. In order to obtain an aetiological explanation

for mental ill health, the challenge for the psychiatrist is to distinguish between 'normal', 'social' and 'cultural' behaviour and narrative, and evidence of individual mental illness. Psychiatry is therefore not an exact science. It depends on interactions and the analysis of both behaviour and conversation. Inherent in this analysis is a power imbalance, in that the professional can determine whether or not someone is ill depending on their current knowledge of the nature of mental illness (Foucault, 1972). Psychiatry is thus an evolving and changing discipline that depends on people talking to each other and being together. The impersonal nature of CCTV monitoring therefore has the potential to undermine the basis on which psychiatry functions.

Surveillance, criminality and punishment

CCTV monitoring of patients in psychiatric wards is one of a number of electronic aids that are currently being used to ensure safety. These include person-to-person radio communication, door-alarm motion detectors and other means of perimeter monitoring, the use of pinpoint infra-red, ultrasonic and radio personal alarm systems, electronic health records and information systems (Dix, 2002). In addition to these, there are also a number of nursing and other professional practices linked with the assessment of patients' mental health, such as risk assessment and risk management. This routine gathering of information about individual patients currently allows staff to regulate, control and manage patient behaviour. Thus surveillance itself, whether direct or indirect, is not a new phenomenon (see, for example, Fletcher, 1999; Barker and Cutcliffe, 2000; Bowers *et al*, 2000). It includes a variety of practices, such as special observations, monitoring patients' involvement in therapeutic activities, and monitoring patient participation in care planning and ward activities. Patients who are acutely unwell are observed for trigger points, and action is then taken to minimise arousal. The principal objective of such observations has been to prevent self-harm, violence towards others or absconding (Bowers *et al*, 2000). The addition of CCTV monitoring could be seen as an extension of the routine surveillance practices that are currently utilised on psychiatric wards.

However, Marx (2002) argues that CCTV monitoring is different in that it has the capacity to monitor more widely, as well as specifically. The uncertainty that is created by not knowing whether one is being watched or not results in the 'self-monitoring' of behaviour (Marx, 2002, p. 10). This argument for the potential of CCTV monitoring to control and regulate human behaviour has been a central feature of surveillance studies (Koskela, 2000; Morgan and Pritchard, 2005). Orwellian accounts highlight CCTV

surveillance as maintaining hierarchical social control (Haggerty and Ericson, 2000), while Foucauldian analysis draws on Bentham's model of the panopticon to identify the disciplinary aspect of surveillance in the production of 'docile bodies' (Norris *et al*, 1998, p. 7). It is this latter analysis that has some relevance to psychiatry. For Foucault (1977), the panoptic prison, which was designed by Jeremy Bentham in the late eighteenth century, encapsulates in its architecture an uncertainty among prisoners as to whether or not they are being watched, resulting in an 'automatic functioning of discipline and control' (Heir, 2004, p. 543). This function of discipline is not limited to regulatory power that is created through constant supervision – as, for example, in patient-accessed communal areas where discipline is maintained through self-regulation and the fear of being caught. Disciplinary power also brings with it the capacity for punishment (Lagrange, 2006). This is exemplified by the installation of CCTV cameras in seclusion rooms, where the safety of staff is not a key factor, as most patients who are placed in seclusion are held in locked units away from everyone else. Although the Mental Health Act Revised Code of Practice (Paragraph 15.45: Department of Health, 2008) states that seclusion should only be used as a last resort and not to punish a patient, those patients who are subjected to seclusion practices still experience it as punishment:

Seclusion is the most awful experience: the hopelessness and despair that one feels locked in a cell with no knowledge when one can get out, the powerlessness that one feels, the sense of being punished, is overwhelming. Even after relatively short periods – hours let alone the days or weeks that it can go on for – one finds it having a traumatising effect on the mind.

Gul Davis, s.3 patient, cited in Mental Health Act Commission (2006, p. 306)

The panoptic principle that is used in seclusion involves a punitive and continuous reflection on behaviour – recovery cannot take place until the patient concedes his or her power. This supports Goffman's (1961) assertion that the total institution is where the intransigent patient's rebellion must be contained. Both aspects of disciplinary power have at their core the subjectification of the individual. In this regard, CCTV cameras represent a 'tactical functioning of power' (Foucault, cited in Lagrange, 2006, p. 6) alongside other routine surveillance practices previously mentioned. This functioning of power is said to be successful when patients who are subject to the gaze of the camera do not perceive it as manipulative or negative. For example, Warr *et al* found that some patients welcomed such an intrusion:

I feel that having CCTV in the courtyard prevents violence. I have noticed from wards there has been a lot of violence where there have not been cameras. I feel this

ward is very much relaxed, because the cameras are there no one is actually going to strike at you without being observed by the staff.

(Warr *et al*, 2005, p. 31)

This ‘psychological’ perception of safety is an important aspect for those patients who willingly concede to the gaze of the camera. It also brings with it the potential for more favourable treatment by staff on the ward, denoting a concession of power, and modelling the ideal type of patient within a total institution (Goffman, 1961).

Conclusion

The primary reason for sanctioning the use of CCTV monitoring in psychiatric wards is not dissimilar to that for using open-street CCTV cameras, namely to make space more safe (Koskela, 2000). What impact CCTV monitoring will have in reducing violence in hospital psychiatric wards is as yet unknown, as there has been very little research on this topic. The efficacy of CCTV monitoring and its impact on crime reduction in urban areas have already been questioned by the Home Office’s own research, which concluded that ‘CCTV is an ineffective tool if the aim is to reduce overall crime rates and make people feel safer’ (Gill and Spriggs, 2005, p. 61). The impact of such technology on psychiatric wards is also open to question.

In this paper it is suggested that CCTV monitoring serves a dual purpose. First, it provides a feeling of safety for some patients in communal ward areas. This purpose is based on the naive assumption that all patients on a ward will be restrained by awareness that they are under surveillance. However, the very real possibility that the presence of CCTV cameras could incite paranoia, and possibly lead to violence, has not been considered. Secondly, the panoptic practices of seclusion have some resonance with controlling and disciplining behaviours which are intensified by the introduction of CCTV cameras in seclusion rooms. Although guidance from the Department of Health (2008) states that seclusion should not be used to punish patients, it is apparent that patients who are placed in seclusion do experience this as punishment. Majid Yar (2003, p. 256) suggests that in open-street CCTV surveillance, ‘corrective techniques of “normalisation” are simply not present in the surveillance and management of free populations.’ However, this is not the case in the context of psychiatric settings, especially when CCTV cameras are used in seclusion rooms, where it is argued that this *does* concern the normalisation of behaviour. The intensification of

punishment conferred by the cameras allows control to be enforced through the complete absence of verbal communication and human contact with the patient, where periodic monitoring, undertaken by a nurse physically looking into a seclusion room, is replaced by the camera and the patient has no knowledge of how and when they are being observed.

CCTV monitoring also raises a number of ethical concerns, especially with regard to abuse and the unethical use of such monitoring. It is naively assumed that staff will use this technology responsibly. However, the limited evidence that is available suggests that this is not always the case (Warr *et al*, 2005). In addition, the camera impinges on the space that patients can occupy within a ward environment and how this might be perceived. For example, the psychological effect of safety that it confers for some patients is counteracted by its negative effects on other patients who do not want to be under the constant gaze of the camera. For those patients who resist the gaze of the camera, not only does this mean that the space that they can occupy is limited, but also they are open to more scrutiny and surveillance, as their behaviour is perceived as suspicious, and perhaps as further evidence of their illness.

It is also suggested that CCTV footage could be used as evidence when instigating adult protection procedures or evaluating violent incidents. However, it is debatable whether it does provide reliable evidence. Most CCTV monitoring does not include an audio element, and therefore if used as evidence will be completely reliant upon visual images. The nature of CCTV footage and the story that it might convey about a particular incident was highlighted by African Caribbean staff at Springfield University Hospital, who were concerned that their body language might be misconstrued on video footage (Chambers and Gillard, 2005).

Overall, there is no evidence to suggest that CCTV monitoring is associated with a reduction in violence on psychiatric wards. It is suggested that the presence of these cameras minimises the space that is available to patients, especially those who want to avoid the gaze of the camera. The minimal information that is currently available also suggests that CCTV monitoring affects nursing practices, as well as patient privacy, dignity and rights. Further research is needed not only to assess how CCTV monitoring affects frontline healthcare staff, especially nursing practices, but also to examine what impact it has on patients. Current information suggests that the use of CCTV monitoring on psychiatric wards is fraught with difficulties, and the answer to the key question, concerning the purpose that is served by CCTV monitoring, remains inconclusive.

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CONFLICTS OF INTEREST

None.

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