

Video Surveillance in Mental Health Facilities: Is it Ethical?

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ABSTRACT: Video surveillance is a tool for managing safety and security within public spaces. In mental health facilities, the major benefit of video surveillance is that it enables 24 hour monitoring of patients, which has the potential to reduce violent and aggressive behavior. The major disadvantage is that such observation is by nature intrusive. It diminishes privacy, a factor of huge importance for psychiatric inpatients. Thus, an ongoing debate has developed following the increasing use of cameras in this setting. This article presents the experience of a medium-large academic state hospital that uses video surveillance, and explores the various ethical and administrative aspects of video surveillance in mental health facilities.

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Utilizing photographic techniques for various policing and security tasks has become ubiquitous and is practiced worldwide [1]. Video surveillance was developed in Britain, still the largest user of camera surveillance in Europe, with London having the highest prevalence of cameras – inside institutions, in open public spaces and on countless street corners [1]. In Israel, video surveillance is widely used in public and private spaces [2]. Closed circuit television (CCTV) is part of the widespread security system in Israel, which also involves security checks at entrances to public spaces.

Video surveillance is also used for security management in hospitals. The common assumption is that surveillance has a natural effect on human obedience [2]. The purpose of the cameras is to prevent theft, smoking and various other violations of the law inside the hospital. Videotaping also enables the review of routine material in order to identify any unusual events, after they occur.

VIDEO SURVEILLANCE IN MENTAL HEALTH FACILITIES

The role of the camera as a tool for managing security within mental health hospitals began in the late 20th century. It was an integral part of the British Health Department's campaign

of “Zero tolerance” that was instituted in response to the rising violence towards psychiatric staff [3].

At the Lev Hasharon Mental Health Center in Netanya, Israel, video surveillance has been used for about a decade. Cameras were initially installed in seclusion and restraint rooms and monitored without recording. This surveillance still serves solely as ad hoc supervision by clinical staff. Following a board management decision in 2007, cameras were systematically installed for both security and clinical supervision. These cameras monitor public spaces throughout the hospital (including parking lots) as well as ward environments, such as corridors, TV rooms and entrances to dining rooms. The system now also includes a recording capability. The monitoring of the hospital's surroundings is viewed by the security staff. Monitoring of wards is viewed only by clinical staff, principally a nurse who is also the ombudsman. The public is informed of the presence of cameras by prominently displayed signs.

In this article we present our experience with video surveillance and explore various aspects of CCTV in psychiatric hospitals.

COST VERSUS BENEFIT OF VIDEO SURVEILLANCE

The major benefit of video surveillance is that it enables 24 hour monitoring of patients on the wards and hospital grounds, which may reduce violent and aggressive behavior [4,5]. Psychiatric hospitals have the potential to be unsafe environments for both staff and patients. Aggressive behavior by patients is not uncommon in mental health settings [6]. Individuals with schizophrenia are four times more likely to behave aggressively than people not suffering from mental illness, especially during a psychotic episode [7]. Long periods of hospitalization are also related to a higher risk of aggressive behavior [8]. Aggressive behavior leads to physical and psychological harm of both the psychiatric staff and the patients and adversely affects the quality of care [6]. Thus, CCTV is identified as a tool for maintaining staff safety [3]. Qualitative interviews with psychiatric staff revealed that CCTV increased their feeling of security, perceiving it as helpful in avoiding or reducing situations of violence towards them [5].

CCTV can also encourage better practice by deterring staff from mistreating patients [9]. Patients can feel threatened by mistreatment by the staff or aggressive behavior by other

patients. CCTV enhances the feeling of security among patients as well as their families. Recently, the Israeli media reported on abuse and neglect in two private hospitals, revealed in one of these facilities by a camera installed by concerned family members [10-12]. Similar cases are occasionally reported in other countries; for example, cameras exposed abuse and neglect of a patient in Winterbourne View Residential Hospital near Bristol, UK [9].

From a health care management perspective, viewing the recorded images is the first step taken when investigating and evaluating any incident in a psychiatric ward [13]. The photographed scene helps to clarify the situation and mitigates any conflict between two versions of the same event.

Despite these benefits, the major shortcoming of video surveillance is that observation is necessarily intrusive. Since CCTV diminishes privacy, an element of huge importance for psychiatric inpatients particularly, an ongoing debate accompanies the increasing use of cameras.

The issue of consent for video surveillance in psychiatric hospitals is complex. First, psychiatric patients are in a vulnerable state; they are frequently overwhelmed by the health care system and are unable to express their wants and needs [14]. Some patients may have an impaired or fluctuating capacity to provide consent [4]. Second, video surveillance exemplifies the inevitable tension between patient autonomy and the system's paternalism [15]. This paternalism implies that the architectural design of mental health facilities focuses on security for all patients, namely, locked doors, bolted windows, and video surveillance [16]. It is also important to consider that the ward is a public space and many public spaces are similarly monitored without explicit consent of the public.

Another issue is the effect of cameras on patients. For patients who experience paranoid symptoms, cameras have the potential to increase aggressive and violent behavior [5]. On the other hand, patients may also be oblivious to cameras in the ward [17]. The disadvantages of video surveillance are reinforced by the fact that it is unknown whether the presence of cameras actually reduces violence. The benefit is derived mostly *after* the event has occurred [3,4].

From the perspective of Israeli law, the right to privacy is central to the law of human dignity and liberty. Since cameras may violate that right, people must be informed by signs declaring the presence of cameras in public spaces. Installation of cameras in public areas should begin with a close examination of its intention versus the extent of violation of the public's privacy. In other words, the benefit should be greater than the harm incurred. Surveillance cameras should not record sound unless it accords with the law of eavesdropping (1979). The recording system should be designed for privacy; hence the data should be automatically deleted following a defined period. An individual's right to review the information should not harm the privacy of other people who were also photographed [2].

At the Lev Hasharon Mental Health Center, cameras in public areas record without sound and are not viewed by staff unless there is a specific need, such as an irregular event or a patient's complaint. The data are automatically deleted after a month. We present some case examples to illustrate our use of video surveillance in our facility.

CASE EXAMPLES

- The following case exemplifies the beneficial use of video monitoring in the case of a false accusation towards a staff member:

A woman in her forties was hospitalized in the long-term closed ward. Her husband turned to the local police station and accused a staff member of violent behavior towards his wife. The ombudsman submitted the relevant videotape to the police investigator. The videotaped scene showed the woman attacking another patient who was lying on the floor. The woman took a chair and aimed to throw it at the patient. The accused staff member grabbed the woman and restrained her by holding her from the back. In light of this tape, the complaint was canceled.

- Another case indicates the usefulness of cameras in maintaining professional practice and surveillance on staff:

A camera installed in the public area of a long-term closed ward photographed a staff member leading patients into the dining room and shoving the last patient in. The staff was convened and watched the film of the event, with professional intervention aimed to insure that this behavior will not happen again. In this case, the staff member, who was a new employee, was summarily dismissed.

- Another case specifies the efficacy of video surveillance in improving the staff's work:

The filmed scene showed a patient punching a staff member. The nurse tried to defend himself with his arms. Another staff member tried to assist, but virtually hung on the nurse's arms and made it harder for him to defend himself. Following this event, the staff was instructed by the security officer on effective ways of self-defense.

ADDITIONAL CONSIDERATIONS

Lev Hasharon's internal ethics committee discussed the subject and agreed that video surveillance is necessary. The Israeli National Mental Health Council convened in January 2014 and reached the same consensus. In addition, the internal committee addressed the issue of installing cameras inside patients' private rooms. This question arose because cameras placed in public spaces cannot protect helpless patients for whom most of their treatment is carried out in their own rooms. This kind of patient characterizes the cases of neglect and abuse reported

by the media [10-12]. However, placing cameras in patients' rooms may be considered by some to be a severe violation of privacy. On the other hand, these rooms, by virtue of the fact that they are hospital property, are communal and to some extent therefore not private space.

We believe that this thorny issue should be considered from the therapeutic perspective. The concept of surveillance is generally a negatively loaded term associated with the use of "panoptic control," that is, restriction and control through the use of cameras. However, in the context of treatment of the helpless, surveillance is an integral part of the professional observation of patients. Nursing care is also intended to provide surveillance and maintain security [18,19]. Since only professionals (psychiatrist and/or nursing staff) are allowed to view the filmed data, it becomes an essential part of the treatment and not merely a security check.

CONCLUSIONS AND RECOMMENDATIONS

The primary reason for video surveillance in psychiatric hospitals is the same as for any public area – to ensure the safety of the space and its occupants [20]. Our experience, based on ongoing reports from staff and the ombudsman, indicates that video surveillance serves that very purpose. Staff and patients perceive the surveillance positively, and there have been no complaints regarding the use of cameras since their installation. Moreover, the surveillance did not evoke paranoid symptoms; quite the contrary, patients perceive the surveillance as a safeguard and have asked to view material that involves them. This, however, is problematic since it infringes on the privacy of other patients. In all cases, the material is viewed only by professionals

In the current era with cameras becoming increasingly more common, it seems reasonable and necessary to monitor psychiatric hospitals. Nonetheless, in view of the patients' vulnerability and impaired or fluctuating capacity to provide consent we recommend raising patients' awareness to the existence of cameras in their surroundings and explaining the rationale of video surveillance. This may provide the balance between paternalism and respecting patient autonomy.

Another consideration we raise concerns helpless patients. We believe that in cases where most of the care is conducted in the patient's private room, video monitoring in the room may be necessary.

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“The greatest analgesic, soporific, stimulant, tranquilizer, narcotic, and to some extent even antibiotic – in short, the closest thing to a genuine panacea – known to medical science is work”

Thomas Szasz (1920-2012), American psychiatrist and academic, well known as a social critic of the moral and scientific foundations of psychiatry, of what he saw as social control aims of medicine in modern society, and scientism