Ethical aspects of technologies of surveillance in mental health inpatient settings – Enabling or undermining the therapeutic nurse/patient relationship?

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A global escalation of disabling anxiety, depression and serious and enduring mental ill-health negatively impacts people of all ages.[1] Mental health nurses have an increasingly important role in the prevention of, and responsiveness to, mental distress. They rightly take pride in their contribution to the development and sustainability of therapeutic relationships. Recognising that the therapeutic use of self is a key contributor to the alleviation of mental distress, mental health nurses enable care-recipients to trust, feel respected and have support to flourish. However, the use of self may not always be considered therapeutic and mistrust is now common. Recent cases of poor nursing practices, such as English nurses sedating patients to 'keep them quiet' while in hospital[2], suggest that interventions are needed to protect vulnerable people. Mental health nurses and recipients of their service can now utilise technological means to record and evidence their interactions. Some such technologies are described as 'surveillance technologies'.

The Editorial explores ethical aspects of utilising surveillance technologies in mental health care contexts: Might such technologies enable or diminish the effectiveness of the therapeutic relationship? How might their adoption impact trust, trustworthiness, respect and respectfulness in mental health nursing practice?

In simple terms, technologies encompass digital devices, software and/or systems to gather information and modify behaviour. However, technologies are also socio-political mechanisms to mitigate unconventional societal acts. Writing in 1995, Foucault[3] defined surveillance as disciplinary power loosely tied to cultural, historical, and political forces. Surveillance is internalised to shape the self and correct behaviours. It is argued that building designs, such as the Panopticon[3] and associated practices, aim to reduce risk to self, others and society at large. In-patient unit nursing offices, for example, are often situated to maximise visibility of all corridors, while its see-through window enable such surveillance. Hence, this is internalised by staff and patients to indicate conformity to the hospital apparatus.

Internal video surveillance is increasingly used in mental health hospitals and has three key functions: alerting staff to changes in patient behaviour that may raise concern and require intervention; protecting staff from violent and aggressive incidents; and as a tool for organisational investigation and learning. Digital innovation companies such as Oxevision, now market products directly at NHS mental health care organisations. Features of OxeObs technology include warning systems that alert staff to patient movements, monitoring of pulse and breathing, 24-hour video capture and storage following adverse incidents and activity logs, which reportedly support care planning. Body worn cameras may also be issued to staff, who can operate these, when necessary, to record potential incidents of violence.

Surveillance has potential to meet the needs of, and enhance the relationship between, individuals and institutions. On the one hand, surveillance technologies could stimulate reflection and learning from role modelling when good practice is demonstrated. Surveillance technologies may also promote self-correcting behaviours of patients and staff and thus, improve therapeutic interaction and reveal possibilities to live in a fulfilling manner.[4] Organisations may utilise surveillance technologies to support and reward ethical care practices. However, a delicate balance is to be struck between individual nurses' autonomy and organisational interventions which may be defensive and risk averse, minimising creativity and meaningful engagement with people experiencing mental distress. The perspectives of patients/care recipients must be central to decision-making regarding surveillance technologies in mental health care contexts. Patients who are monitored by digital technology may prefer this to high frequency or continuous monitoring by staff, and it may reduce the associated sleep disturbance. In a context of understaffing in health and social care, warning systems which alert staff to concerning behaviour may protect patients from further harm. Furthermore, it may serve as a deterrent to unethical practices and protect patients. Recordings have, for example, have been used as evidence in cases where staff have engaged in abusive care or fallen below expected professional standards.[5]

Alarm regarding surveillance technologies have been brought to public attention. Groups such as 'Stop Oxevision' and the National Survivor User Network (NSUN) have campaigned to halt the roll-out of video surveillance within psychiatric inpatient settings. Concerns are raised that video surveillance allows organisations to compensate for their resource problems, such as low staffing,

with digital solutions, removing the need for relational approaches to improve patient safety.[6] There is some evidence that video surveillance may help patients and staff feel safer. However, evidence of a reduction of violent and aggressive incidents is lacking.[7] Regarding risk of self-harm and suicide, a recent high-profile case, indicates issues with illusory safety and alarm fatigue.[8] These issues highlight a lack of evidence to support the belief that surveillance technologies actually improve patient safety.

Returning to the questions posed at the beginning of this Editorial in terms of ethical aspects of utilising surveillance technologies in mental health care contexts: Might such technologies enable or diminish the effectiveness of the therapeutic relationship? How might their adoption impact trust, trustworthiness, respect and respectfulness in mental health nursing practice?

Important considerations in any ethical analysis is whether video surveillance may be operated, monitored and used by a mental health care organisation without the consent of patients and, perhaps also, of staff. This can undermine trust and may compound epistemic injustice and the power imbalances that already exist in psychiatry. Mental health nurses do – and must - prioritise values that support the development and sustainability of therapeutic relationships with people experiencing mental distress. Safeguarding ethical mental health care practices necessitate activities which include advocacy, allyship and activism. Activities which require the demonstration of nurses' trustworthiness, respectfulness and a commitment to social justice and inclusion.

It is our view that surveillance technologies may make some small contribution to supporting these activities. However, the most important contribution will come from creative pre-registration ethics education, from continued professional education and – most significantly – from confident, courageous and articulate mental health nurses. Mental health nurses who involve patients, and engage in values-based decision-making, regarding the risks and benefits of adopting surveillance technologies. Whilst some such technologies, in some situations, may enhance therapeutic relationships, some others may devalue meaningful therapeutic relationships. Mental health nurses, therefore, need to have, and demonstrate, critical evidence- and value- based discernment to thwart quick fixes and ensure their voices are heard at executive boards in mental health care organisations.

References

1. GBD 2019 Mental Disorders Collaborators. Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry* 2022; 9: 2: 137-215.
2. The Guardian. Blackpool nurse found guilty of sedating patients to 'keep them quiet'. https://www.theguardian.com/uk-news/2023/oct/05/blackpool-nurse-found-guilty-of-sedating-patients-to-keep-them-quiet (2023, accessed 6 February 2024).
3. Foucault M. *Discipline and punish the birth of prison*. (A. Sheridan, Trans.). London: Vintage Books, 1995.
4. Vallor S. 'Surveillance and the Examined Life: Cultivating the Technomoral Self in a Panoptic World' In: *Technology and the Virtues: A Philosophical Guide to a Future Worth Wanting*. New York: Oxford Academic, 2016, pp.108-207.
5. Independent. *Staff at private hospital caught on CCTV kicking and slapping vulnerable patients*. https://www.independent.co.uk/news/health/hospital-cctv-video-private-essex-cqc-abuse-mental-health-b536261.html (2020, accessed 6 February 2024).
6. NSUN. Surveillance in mental health settings – NSUN response to JCHR inquiry. https://www.nsun.org.uk/news/surveillance-in-mental-health-settings-jchr/ (2021, accessed 6 February 2024).
7. Wilson K, Foye U, Thomas E, et al. Exploring the use of body-worn cameras in acute mental health wards: A qualitative interview study with mental health patients and staff. *International Journal of Nursing Studies* 2023; 140: 104456. https://doi.org/10.1016/j.ijnurstu.2023.104456.
8. BBC. Essex mental health unit neglect led to teen's death – inquest. https://www.bbc.co.uk/news/uk-england-essex-67595301 (2021, accessed 6 February 2024).