

NDA advice on CCTV in residential settings

The attached briefing paper sets out the considerations regarding use of CCTV in residential settings, along with findings from research in other jurisdictions. Based on this review, the National Disability Authority advises as follows:

We advise against introducing CCTV

The National Disability Authority advises against the introduction of CCTV as practice in residential disability centres for the purpose of detecting or deterring abusive behaviour. .

The introduction of CCTV technology can not be a substitute for tackling issues around culture, practice, and fundamental respect for the human rights of service users that should underpin disability services. People with disabilities say that what makes them feel safe is being treated with dignity and respect by staff, feeling included, being supported to be independent and to advocate for themselves. Even with CCTV, abuse can take place off-camera or in private zones like bedrooms if there is a negative culture and a lack of respect.

The introduction of CCTV would also raise serious issues around privacy, consent, and security and retention of recorded material. In practical terms, the volume of recorded material would make it very difficult and expensive to review even a sample.

Next steps – convene workshop to explore what technology could add

The National Disability Authority however feels there could be scope to explore the potential of other technologies to support people with disabilities.

The first step would be we would offer to host a workshop to explore what other technology options could add value in the context of safeguarding. This might lead to trials of possible technologies in both residential and day support settings.

A whole systems approach is needed which considers how any new technology would be funded, who delivers, how individuals with disabilities and staff would be trained to use it, and maintenance and follow-up.

The individual is central to the process of selection of the technologies, be they

- Passive technologies – monitoring sleep patterns, room temperature, etc
- Personalised technology – communication devices, panic alarms etc.

A second stage would be to select a combination of settings and trial a number of the technologies – new innovations and existing technologies – in partnership with service users

A third stage could be to work with SFI-funded Innovation Centres on bridging the gaps in technologies that could be trialled as part of the overall solutions. (NDA is already working with such centres on development of new kinds of user-friendly water meters.)

NDA briefing paper

Use of CCTV in residential settings

Introduction

On 9 December 2014, RTÉ's **Prime Time** programme broadcast a report that documented the abuse experienced by people with intellectual disabilities in the Áras Attracta residential service. The abuse was captured using hidden cameras. The management, staff and the residents in the centre were unaware that they were being filmed.

In response to the documentary, Minister Kathleen Lynch suggested that there might be a role for the use of CCTV, among other measures, to safeguard people living in residential centres from abuse.

Subsequently, the Health Service Executive (HSE) issued a Prior Information Notice/Classic Sector/Directive 2004/18/EC seeking expressions of interest for the design and installation of information and communications technology/ surveillance and security system solution.

Purpose of CCTV

CCTV is often used to survey and monitor premises and to record any activity that may be taking place. In the context of residential settings, it is perceived as increasing residents' safety because:

- it can be used to capture and record abuse
- the presence of this technology deters potential abusers and prevents abuse¹

Key points for consideration

There are a number of key issues that need to be considered, in relation to the suggested use of CCTV in residential services for people with disabilities. These include:

- HIQA's National Standards for Residential Services for Children and Adults with Disabilities (2013)
- Legislation on the use of CCTV
- Other consideration regarding Data Protection

¹ Social Care Institute for Excellence (2014) Electronic Surveillance in Health and Social Care Settings: A brief review of literature on the use of video and associated technology. www.scie.org.uk

- The impact of CCTV on residents and staff
- The effectiveness of CCTV in capturing and preventing abuse
- Technological issues regarding CCTV
- Value for Money

HIQA standards

HIQA's **National Standards for Residential Services for Children and Adults with Disabilities (2013)** outline the actions that service providers should implement to provide safe and effective care and support to people living in residential and respite services.

This includes:

- people with disabilities having access to high quality services and supports that maximise their independence and choice
- people with disabilities being supported by staff with whom they can communicate easily, who respect their individuality, dignity and privacy and who are sensitive to their aspirations and needs
- people with disabilities being protected from abuse, and their safety and welfare being promoted

Residential services are people's homes and the Standards say that people's dignity and privacy should be respected in their homes. They also say that if CCTV systems are used, they should not intrude on people's privacy. The service providers should have a policy on the use of CCTV which is informed by relevant legislation.

A summary of the standards which relate to privacy, safety and the recording of information is provided in Appendix A

Legislation on the use of CCTV²

- Recognisable images captured by CCTV are personal data. They are therefore subject to the provision of the Data Protections Acts (1998, 2003)
- Under these Acts, an organisation must be clear regarding the purpose of using CCTV cameras that collect personal data on a regular basis. This purpose must be justifiable, for example, if an organisation was using CCTV to monitor premises

² Data Protection Commissioner – Data Protection and CCTV. <http://www.dataprotection.ie/docs/Data-Protection-CCTV/242.htm>

- Using CCTV to monitor employee behaviour, for health and safety reasons, can be seen as an invasion of people's privacy. Organisations have to present a strong argument to justify the use of CCTV in this context
- The location of cameras is a key consideration. Cameras should not be placed in areas, for example, bedrooms or toilets where people would expect to have privacy

Other data protection issues

The use of CCTV in residential centres raises the following legislative and data protection issues regarding privacy and consent:

- Residential centres combine communal/shared and private spaces. Defining what a public space means in the context of residential settings can be difficult. A shared space, like a living room, is still a place in a person's home and would not necessarily fall within the meaning of "a public space"
- Who owns the data generated e.g. CCTV footage? Who is allowed look at it?
- Have residents and staff given clear written consent to be the subject of surveillance? The issue of consent also impacts on families, carers, visitors and staff
- What are the policies and procedures if some people consent to being monitored on CCTV and other people don't?
- What procedures are in place to deal with footage of people who are not involved in an incident but are captured on tape?
- Do organisations have the resources and the competencies to store and retain data securely and to ensure that access to this data is restricted to authorised personnel?
- Where and within which jurisdiction, will data be transferred, stored etc
- Do organisations have effective procedures in place to destroy footage in a secure manner?

Technology Issues

Organisations implementing CCTV can experience some of the following technological issues:

- Integrating and embedding CCTV technology into an existing system and ensuring the CCTV operates effectively
- CCTV captures huge volumes of data so there are delays in processing information and warning messages when an incident has occurred
- Poor video quality
- Inadequate back up services

- Depending on the technology and the processes used for transferring information, phone coverage and broadband availability could be significant issues

Effectiveness of CCTV

Research shows that there is limited evidence on the effectiveness of CCTV as a means of preventing abuse and of increasing the safety of people living in residential centres.³

Under the Data Protection Acts (1998, 2003), CCTV cameras cannot be placed in areas, for example, bedrooms where people expect to have privacy. CCTV will not capture any abuse that takes place in areas outside the cameras' range.

Impact on residents and staff

In 2014, the Social Care Institute for Excellence produced a literature review on the use of electronic surveillance in health and social care settings. (See Appendix B for the review). The primary findings from this review showed that:

- If residents are aware that CCTV is in place, they may act differently because they are afraid that their behaviour could alarm or concern staff
- Staff may also change their behaviour because they're on CCTV. Good care practice may be lost because people are being guarded
- Treating staff like potential suspects, who need to be monitored, can have a negative impact on staff morale
- Professional judgement is also required when reviewing incidents on CCTV footage. CCTV does not prevent abusive incidents happening even when captured in 'real time', because it does not replace professional judgement about when to intervene and how

Residents' Perspective

There is very little research on residents' perspectives of CCTV and whether it increases their feelings of safety. In 2013, the NDA consulted with people with intellectual and/or physical disabilities on the draft Interim Standards for New Directions, Services and Supports for Adults with Disabilities. While these Interim Standards are for day services, rather than residential services, the views put forward in this consultation are relevant as people with disabilities spoke about what made them feel safe when using services and supports. In the

³ Social Care Institute for Excellence (2014) Electronic Surveillance in Health and Social Care Settings: A brief review of literature on the use of video and associated technology. www.scie.org.uk

consultation, the NDA asked them what would be the best way for their services to make them feel safe.

People with disabilities said that what made them feel safe was:

- being treated with dignity and respect by the staff
- being supported to do things that they liked
- feeling included
- being proud of what they did
- being supported to live independently
- being supported to be a self-advocate

Before any decision to proceed with CCTV services, it would be essential to ascertain the views of disability service residents about CCTV, and also to get their views on what measures would make them feel safe.

(See Appendix C for an extract from the report on the consultation relating to Safe Supports and Services).

Tackle root issues

The introduction of CCTV technology can not be a substitute for tackling issues around culture, practice, and fundamental respect for the human rights of service users that should underpin disability services.

If negative attitudes, culture and practice are not addressed through strong leadership and management of change, abuse is likely to continue off camera.

Value for Money

Whether CCTV does provide value for money is another key issue that needs to be considered.

There is limited evidence that CCTV can prevent abuse in residential services and there are likely to be significant costs involved in implementing and maintaining a CCTV system, for example:

- Equipment costs
- Maintenance and backup costs
- Licensing costs
- Training for staff to use the technology appropriately

- The cost and personnel to review the high volumes of CCTV footage which would be generated if this were introduced

The practical reality is that while CCTV may have a deterrent effect, it is not feasible to have a system to go further than spot checking the millions of hours of footage that could potentially be recorded.

Conclusion

These key points need to be considered in relation to the suggested use of CCTV as a safety measure for people with disabilities living in residential centres

- HIQA standards on the safe and effective care and support of children and adults with disabilities in residential settings (2013) state that people with disabilities should be treated with dignity and respect by staff, and services should promote people's privacy. A key element to ensuring that people with disabilities feel safe and receive safe and effective care is that they can trust the staff in residential centres and that they form positive relationships with them
- There is concern that CCTV may impact adversely on the privacy of people with disabilities in residential services
- The HIQA standards, the legislation on CCTV and on data protection are all pertinent to the privacy concern
- The NDA advises that people who use residential services for people with disabilities should be asked for their views on the use of CCTV in their home, It would also be important to have an effective means of engagement and consultation with residents with regards to what makes them feel safe before any programme for the installation of CCTV proceeds
- There is limited research on the effectiveness of CCTV in preventing abuse and increasing the safety of people with disabilities
- Research also shows that CCTV may have a negative impact on the behaviour of residents and staff
- The cost of implementing and maintaining CCTV equipment and data needs to be carefully considered in the context of its effectiveness and providing value for money
- A key issue that impacts on the safety of people with disabilities in residential services is how they are treated by staff. The culture of a residential centre will influence how staff perceive and treat people with disabilities. If the culture promotes a positive and respectful behaviour towards people with disabilities then this is central towards ensuring their safety in a residential service. The NDA advises that the factors that will transform the culture in residential settings should be examined in the first instance before CCTV is considered

- Greater impact may be achieved by using such funds as may be available for purchase of CCTV instead towards investing in changing and improving the culture of residential centres and ensuring that people with disabilities living in, and or using residential services receive safe and effective care as outlined in the HIQA standards.

References

Care Quality Commission (2015) Thinking about using a hidden camera or other equipment to monitor someone's care. UK

Data Protection Commissioner – Data Protection and CCTV.
<http://www.dataprotection.ie/docs/Data-Protection-CCTV/242.htm>

Department of Health (2012) The Value for Money and Policy Review of Disability Services. Ireland

HIQA (2013) National Standards for Residential Services for Children and Adults with Disabilities. Ireland

Social Care Institute for Excellence (2014) Electronic Surveillance in health and social care settings: a brief review of literature on the use of video and associated technology.
www.scie.org.uk

Appendix A – Relevant HIQA standards

Summary of HIQA Standards for Residential Services relating to privacy, safety and recorded information

Standard 1.2

The privacy and dignity of each person are respected.

Feature 1.2.1:

Each person has an area of personal space that comprises their own person, possessions, thoughts and feelings that no other person enters, uses or intrudes upon without their expressed permission.

Feature 1.3.4:

People have opportunities to be alone, with due regard to their safety. Privacy and dignity are respected at all times, and particularly in relation to:

- receiving visitors
- personal communications
- expressions of intimacy and sexuality
- consultations with social care and other professionals
- examinations by healthcare professionals
- the provision of intimate and personal care and support
- circumstances where confidential and/or sensitive information is being discussed
- entering bedrooms, toilets and bathrooms

Feature 1.2.9:

Staff and managers consult with people living in the residential service in relation to the business of the service where it has implications for their privacy and sense of home.

Standard 1.6

Each person makes decisions and, has access to an advocate and consent is obtained in accordance with legislation and current best practice guidelines.

Feature 1.6.7

Any measures taken by staff that impact on what a person may wish to do provide for appropriate and effective safeguards to prevent abuse, and respect the rights, will and preferences of the person with a disability. Any such measures taken by staff are free of any

conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible, and are subject to regular review.

Standard 2.2

The residential service is homely and accessible and promotes the privacy, dignity and welfare of each person.

Feature 2.2.12

Where closed circuit television (CCTV) systems are used, they do not intrude on privacy and there is a policy on the use of CCTV which is informed by relevant legislation.

Standard 3.1

Each person is protected from abuse and neglect and their safety and welfare is promoted.

Standard 8.2

Information governance arrangements ensure secure recordkeeping and file-management systems are in place to deliver a person-centred safe and effective service.

Record: a record includes any memorandum, book, plan, map, drawing, diagram, pictorial or graphic work or other document, **any photograph, film or** recording (whether of sound or images or both), any form in which data are held, any other form (including machine-readable form) or thing in which information is held or stored manually, mechanically or electronically and anything that is a part or a copy, in any form, of any of the foregoing or is a combination of two or more of the foregoing.

Appendix B - SCIE review on electronic surveillance

Electronic surveillance in health and social care settings: a brief review

Review of literature on the use of video and associated technology

Introduction and methods

The Social Care Institute for Excellence conducted this brief review of the literature on surveillance in health and social care settings, on behalf of the Care Quality Commission. The review focuses on the use and effectiveness of electronic surveillance tools in health and social care settings. It provides a concise summary of a sample of relevant evidence on the topic (nine peer reviewed articles) and signposts routes to further information, rather than offering a definitive or comprehensive statement of the research. The approach involved

- **agreeing key search terms and themes** related to the high-level concepts of interest, namely; electronic surveillance (video recording, video surveillance, devices sensors, monitors, CCTV, covert surveillance), health and social care settings and adult abuse
- **conducting systematic search of relevant databases** and other sources
- **screening records retrieved** against agreed inclusion and exclusion criteria.
- **extracting data, and synthesising key themes** for this brief report.

The searches were conducted in August 2014.

History

There are two main forms of surveillance: overt (that which people are made aware of, for example, Closed Circuit Television, CCTV) and covert (designed to ensure the person subject to the surveillance is not aware it is being used (Home Office, 2014).

The use of technology for surveillance has become increasingly pervasive in public places (Mortenson 2013), and the same is said to be true for its application in health and care settings (Desai, 2009; Woolrych *et al.*, 2013). While there is 'a long history of surveillance of those living in institutional settings' (Mortenson *et al.*, 2013 citing Salzmänn-Erikson and Eriksson, 2012), the availability and range of new technologies now provide more options in this respect. These include, for example: cameras (video surveillance); alarms, monitors and sensors (assistive technologies and telecare); and web-based technologies. It is also likely to be difficult to estimate the extent of usage; in relation to CCTV in psychiatric wards alone, Desai notes that 'there is no single body that collects and monitors this information' (2009, p46)

Surveillance has been a controversial issue for some time. Mortenson *et al.* (2013, pp4-5) typologised the debate about surveillance in terms of:

- **‘technical discourse’**: what the system does and how. Related to this, Niemeijer *et al.* (note 2010) note that technology typically aims to help support independence, or help protect against harm. They highlight a further distinction between technologies ‘that enable residents, and interventions that *control* residents’ (p1139 citing Astell, 2006).
- **‘discourse on rights’**: the ‘acceptability’ of the system and of any trade-offs between benefits (e.g. supporting independent living) and harms (e.g. intrusion into private life)
- **‘managerialist discourse’**: how the system can support effective use of scarce resources (and/or prevent use of more costly resources). Related to this, Woolrych *et al.* highlight that the aim of surveillance technologies is to ‘support health and independence within the context of limited resources’ (2013, p1)

There is recognised need for further research on the effects of its use in health and care settings (Desai, 2009; Woolrych *et al.*, 2013). Its benefits have been identified as its potential to: complement traditional observation techniques; provide ‘continuous, real-time data’ (Mortenson *et al.* 2013 p2, citing Sixsmith, 2013; Woolrych *et al.*, 2013); and, provide better information about (and therefore help manage) ‘high risk behaviour (e.g. falls)’ (Mortenson *et al.*, 2013 p2, citing Moffat, 2008). On the other hand, there have been serious concerns raised about the implications of surveillance for individual privacy, choice and consent (Minuk, 2006). In the United States (US) there has been a relevant, high-profile debate about the use of video surveillance in the rooms of care home residents (termed “granny cams”) as a mechanism for preventing abuse. Bharucha *et al.* (2006) note that advocates of this technology identify it as a necessary response to widespread abuse of vulnerable people. The literature sampled suggests the legal and funding implications of this technology (within the US context) has been particularly prominent in this debate.

Ethics, privacy and consent

- **The ethical implications of surveillance are complex and under-researched.** The issue of ethics was one of the most prominent themes in the literature sampled. Niemeijer *et al.*, 2010 note that ‘is it still not clear what the ethical and practical implications of [surveillance] interventions would be in a formal residential care setting’ (p1130) and that the limited existing research in this area provide ‘a perfunctory summary of the views rather than an in-depth analysis’ (p1138). There is also a noted gap in terms of evidence on views of people using services (Niemeijer *et al.*, 2010).
- **Privacy is inextricably linked to the notion of consent.** In terms of legislation affecting the UK, Article 8 (1) of the Human Rights Act 1998 gives individuals the right to respect for a private and family life. This is a qualified right in that it can be limited if there is a legitimate aim (Liberty, online). There are ethical issues, therefore, stemming from whether or not a person knows about, and gives their permission to be the subject of surveillance. The issue of consent to the use of surveillance in health and care settings relates not only to that of the person using the service, but also to families, carers, visitors and staff. There are questions about ‘moral acceptability’ of technological interventions, that is to say, the extent to which any benefits derived from their use are

justifiable when there is a conflict with personal freedoms and/or a potential impact on the service user-carer relationship (Niemeijer *et al.*, 2010, p1138).

- **There is a range of relevant government policy and some concern that it is not coherent** - In relation to overt surveillance (CCTV) in NHS settings, Desai (2009) highlighted that government has not had a 'specific, coherent...policy or strategy' (p46). She also notes that the Information Commissioner's Office (2008) stipulated it should be used only after 'alternative ways of improving security' have been explored (p46), and that it should result in 'minimum interference with privacy and rights' (p46, also referencing Mental Health Act Commission 2005). In terms of covert surveillance, the Home Office recently (2014) issued a draft Code of Practice which also summarised a range of UK legislation surrounding its use by public authorities.
- **Environments that comprise both communal and private spaces are particularly complex in terms of surveillance and ethics** - This review found evidence of complexities related to consent - and levels of privacy to which one is entitled - in communal spaces (e.g. lounges, corridors) compared to private spaces (e.g. bedrooms and flats). The definition of what constitutes 'public' and 'private' space may be disputed or unclear (Adelman, 2002) even when care is being provided in an individual's home (Mortenson *et al.*, 2013) and this can have an impact on whether consent is deemed to be required (Desai, 2009). There may also be tension between balancing the rights of patients who do not wish to be subject to monitoring (CCTV, in this case) with those who have given consent (Desai, 2009). One could reasonably extend this to professionals, carers and visitors. Minuk (2006, 224) argues strongly that use of video cameras in residents' bedrooms as a preventative measure, i.e. before any evidence of abuse, are "excessively intrusive" on the grounds that they are an invasion of privacy even though workers will be providing care in that space.
- **The issue of professionals' right to privacy is complex** for example, Kohl notes that 'some commentators make a distinction between professional and non-professional staff in assessing their rights to privacy' (2002, p2098, citing Galloro *supra* note 114, at 24). There is also a debate about implied consent, i.e. if staff have been informed about the use of surveillance technologies and carry on working for the employer, this equates to them giving their consent to be subject to surveillance (Bharucha *et al.*, 2006 citing Rothstein, 2000).

Impact of surveillance

Overall

- **Overall, research on impact, including preventative capability, is limited.** For example, Desai (2009) noted little evidence on effectiveness of CCTV on managing aggressive patient behaviour in NHS settings and concluded that its impact in this respect 'is as yet unknown' (p51). Similarly, Niemeijer *et al.*'s 2010 systematic review of surveillance technologies in residential care for people with dementia or intellectual disabilities noted that 'the effects of this technology...have scarcely been studied' (p1138). Woolrych *et al.* highlight the lack of before-and-after comparative analysis (2013) and,

indeed, gold standard measures of effectiveness of an intervention require suitably robust study design (Eccles *et al.*, 2003).

- **Understanding perspective is important.** Niejeimer *et al.*, highlight ‘three perspectives: that of the institution, the resident; and the care relation’ (2010, p1131). They go on to suggest that institutions are likely to be concerned with whether something works, as well as the impact on risk and on staffing. Critical for residents, they note, are the complex relationships between surveillance and personal freedoms, while carers are likely to be concerned with ‘duty of care versus autonomy of the resident’ as well as how technology features within an overall care package (2010, p1131).

Benefits and harms

- **Limited research has indicated there may be potential benefits in terms of patient care.** Desai (2009) highlighted some evaluation evidence that use of infra-red CCTV ‘helps to reduce the number of unwelcome intrusions into patients’ bedrooms by other patients on the ward’ (p47, citing Dix, 2002). She also noted that use of infra-red CCTV allowed less intrusive night-time observations (Desai, 2009, citing Warr *et al.*, 2005). Woolrych *et al.* conclude that ‘video surveillance has the potential to generate observational data on the movements and behaviours of various actors within the care facility’; complementing traditional observation techniques through the provision of ‘continuous, real-time data’ (Mortenson *et al.*, 2013 p2, citing Sixsmith, 2013; also, Bharucha *et al.*, 2006).
- **Surveillance data can support professionals as they review incidents.** Reviewing video footage can help to build a picture of what led to a negative event, such as an accident, occurring (Mortenson *et al.*, 2013). The potential for video footage to provide ‘hard evidence’ that can be used either by families or in a court of law is reported to be one of the potential benefits cited by proponents of this technology (Cottle, 2004) but a number of authors assert that this should be as part of a holistic approach, rather than something used in isolation (see: **Considerations**).
- **Use of surveillance technology offers some potential efficiencies in terms of staffing.** Whereas previously, surveillance could be burdensome in terms of human resources, improved technologies mean that it can now complement traditional staff models, offering potential efficiencies (Mortenson *et al.*, 2013). Mortenson *et al.*, provide the example of how Ambient Assistive Living (AAL) technologies such as fall detectors or other sensor-based products ‘[offer] the possibility for large numbers of individuals to be monitored automatically and continually...by a relatively small number of people’ (2013, p6) although this was within the context of enabling people to live at home independently for longer (rather than in institutions).
- **Awareness of surveillance could have positive and negative impacts on staff behaviour.** Desai (2009) suggests that staff may change their behaviour out of fear that their actions could be perceived in a negative way when viewed on CCTV. She highlights a study in which they are ‘reluctant to engage in therapeutic touch’ (Desai, 2009, p49

citing Chambers and Gilliard, 2005). Providing a range of legal references, Cottle sets out some of the concerns from staff about how their actions may be perceived negatively on video, as well as noting, on the other hand, that proponents of this type of surveillance include some care home administrators who think its use will help 'to raise previously concealed issues' (Cottle, 2004, p126). On the other hand, in the same study, staff felt better able to restrain patients appropriately, on the basis that CCTV 'would provide evidence of their proper conduct' (Desai, 2009, p49 citing Chambers and Gilliard, 2005).

- **There may be the potential for misuse of CCTV by staff.** Desai also noted the potential for abuse of overt surveillance by staff, for example (p48, citing Warr *et al* 2005) 'targeting of certain patients' bedrooms' to judge whether their behaviour when alone was consistent with that observed in communal settings and highlighted how the guidance available at that time (specifically, Data Protection Act 1998 and CCTV Code of Practice 2008) 'are insufficient' for addressing the risk of staff breaching agreements made with service users about how CCTV will be used (p48).
- **Awareness of, or uncertainty about whether surveillance is in use can potentially have a negative impact on people using services.** Evidence from research on telecare indicates that awareness of surveillance can have an impact on the behaviour of people using services, specifically, leading them to act in a way they would not do otherwise, out of fear that their normal behavior would trigger 'alarms, warnings and contact from care-givers' (Mortenson *et al.*'s 2013 p10, citing Percival and Hanson, 2006). They also highlight research which shows that when people are aware surveillance is in use, they 'anticipate having a sense of 'being watched' even without the presence of video-cameras' (Mortenson *et al.*'s, 2013, citing: Percival and Hanson, 2006; Savage 2010; and, Sixsmith and Sixsmith, 2000). From wider literature, Desai notes that 'not knowing whether one is being watched or not results in the 'self-monitoring' of behaviour' (p50, 2009, citing Marx, 2002, p10).

Considerations

- **Implementing surveillance technology can have unintended consequences.** Woolrych *et al.* emphasise the importance of recognising that technology can be 'socially transformative in nature' (2013, p8). It can change the way people behave in unexpected ways. Mortenson *et al.* also urge the reader to recognise that '[u]ltimately, surveillance is about power, or the way individuals and groups within society interact and influence one another.' (2013, p8). They note this can be positive or negative and, within the context relevant here '...attention should be focused on how the new technology will affect power relations in informal and formal caring relationships...' (2013, p15)

It is likely to be important to provide support and guidance to enable staff to engage with surveillance technologies appropriately. Staff may not always be comfortable with using surveillance to monitor patient behaviour, or clear about how to respond when patients behave in a way that caused concern. As a result, additional surveillance-specific staff training may be warranted (Desai, 2009). A number of authors note the importance of having clear legislation, policies and procedures for use of surveillance in

place specific to the care environment, recognising it as both a place where people live and a workplace (Adelman, 2002; Cottle, 2004; Kohl, 2002)

- **Professional judgement is critically important when using video to reflect on incidents.** Desai conclude that CCTV per se does not prevent violent incidents, even when monitoring is undertaken in 'real time' (p49) because it does not replace professional judgement about when to intervene and how (Desai, 2009, citing Koskela 2000) and can distort reality (Desai, 2009) or create 'trial by video' approach to incident review (Woolrych *et al.*, 2013 p7 citing Schnellet *et al.*, 2004). Evaluation of CCTV use in psychiatric wards illustrated that it can affect the culture, becoming the first port-of-call in the event of an incident (Desai, 2009, citing Chambers and Gilliard, 2005). Woolrych *et al.* highlighted impact on safety culture as a potential benefit of video surveillance, but cautioned against over-reliance on this technology given the complexity of the care environment and the 'narrow frame of reference' it provides (2013, p7, citing Nowak and Hubbard, 2009). This was supported by Desai who argues that CCTV evidence of abuse 'should not be presented as a full account of an incident' (2009, p48).
- **Overall, this review found no definitive evidence** about: when and when not to use surveillance; and effectiveness or impacts (positive and negative) of different methods with different populations, under different circumstances. Evidence was limited and patchy. There was also a notable gap in terms of service user and carer views on the topic although there was reference to the value of person-centered care, and a theme indicating it is important that surveillance is not used in isolation, and does not replace human intervention. The study on CCTV in psychiatric units, for example, emphasised it should complement human observation and face-to-face therapeutic activities (Desai, 2009, citing Koskela, 2000; Lyon, 2001; and, Mental Health Act Commission, 2005).

Limitations

This is a brief review aimed at illustrating some of the key issues related to the topic. It therefore includes, necessarily, only a very small sample of the literature. It should be noted that the types of surveillance technologies included in the literature seem very diverse (for example, a CCTV camera on a hospital ward aimed at preventing aggressive behaviour, and sensors in a person's own home, with remote monitoring triggering a response if they have an accident). While the review comprises literature from peer-reviewed academic journals as well as relevant guidance from established, credible organisations, it has not undergone critical appraisal to assess quality. It should also be noted that the literature comes from the US as well as the UK and there are considerable differences, for example, in terms of policy, practice, funding and culture that mean results may not be directly comparable or transferable. There is a noted paucity of studies designed to address questions of intervention effectiveness. Finally, as the legal aspect is prominent in the US "Granny-cam" debate, some of the literature included comes from legal journals rather than from the health or social sciences.

References

- Adelman, E. (2002) Video surveillance in nursing homes, *Alb. L.J. Science & Technology*, 12: 821-838
- Bharucha, A.J., London, A.L., Barnard, D., Wactlar, H., Dew, M.A. and Renolds III, C.F. (2006) Ethical considerations in the conduct of electronic surveillance research, *Journal of Law, Medicine and Ethics*, 611-619
- Cottle, S.N. (2004) "Big Brother" and grandma: an argument for video surveillance in nursing homes, *The Elder Law Journal*, 12: 119-148
- Desai, K. (2009) The new stars of CCTV: what is the purpose of monitoring patients in communal areas of psychiatric wards, bedrooms and seclusion rooms? *Diversity in Health and Care*, 6:45-53
- Eccles, M., Grimshaw, J., Campbell, M. and Ramsay, C. (2003) Research designs for studies evaluating the effectiveness of change and improvement strategies, *Quality and Safety in Health Care*, 12: 47-52 [online] Available at: <http://qualitysafety.bmj.com/content/12/1/47.full> (Accessed: 12.09.14)
- Home Office (2014) *Draft Code of Practice*, London: Home Office
- Kohl, T. (2002) Watching out for grandma: video cameras in nursing homes may help to eliminate abuse, *Fordham Urban Law Journal*, 30 (6): 2083-2106
- Liberty (no date) *Article 8. Right to private and family life*, [online] Available at: <https://www.liberty-human-rights.org.uk/human-rights/what-are-human-rights/human-rights-act/article-8-right-private-and-family-life> (Accessed: 10.09.14)
- Minuk, L. (2006) Why privacy still matters: the case against prophylactic video surveillance in for-profit long-term care homes. 32 *Queens Law Journal*, 224-277
- Mortenson, W.B., Sixsmith, A. and Woolrych, R. (2013) The powers of observation: theoretical perspectives on surveillance technologies and older people, *Ageing & Society* [online] 1-19
- Niemeijer, A.R., Frederiks, B.J.M., Riphagen, I.I., Legemaate, J., Eefsting, J.A., Hertogh, C.M.P.M. (2010) Ethical and practical concerns of surveillance technologies in residential care for people with dementia or intellectual disabilities: an overview of the literature, *International Psychogeriatrics*, 22 (7): 1129-1142
- Woolrych, R., Sixsmith, A., Mortenson, B., Robinovitch, S. and Feldman, F. (2013) The nature and use of surveillance technologies in residential care. *ICOST 2013, LNCS 7910*: 1-9
SEPTEMBER 2014

Appendix C:

What the consultation with people with disabilities said about day services in relation to safe services and supports in a consultation held in May 2013.

In May 2013, Safe Services and Supports were described in the current draft of Interim Standards for New Directions as services that:

- promote the safety of people using their services through the assessment of risk, learning from adverse events and the implementation of policies and procedures designed to protect people with disabilities
- support people with disabilities to make decisions about the services and supports they receive. People with disabilities should feel safe and secure when using these services. They have the right to choose to take appropriate risks
- protect people from abuse and follow policies and procedures in reporting any concerns of abuse to the relevant authorities. Safe services and supports are open, transparent and accountable

This description of Safe Services and Supports formed the basis for the questions participants were asked at the consultations. Participants were asked the following questions:

- **What would be the best way for your services to make you feel safe?**
- **What do you think your services should do if you feel afraid or that something is wrong?**
- **Is there anything else that you think is important?**

Responses from Consultations

Supported to be responsible for their own safety

Participants in both groups said that their services made them feel safe. The majority of participants in both groups said that they understood that for health and safety reasons, their services had to contact them to make sure they got to their appointments and that they were where they should be.

The participants with intellectual disabilities also commented that in their services, activities were organised along a timetable and that there was a routine so that staff knew where people were. They added that this did not prevent them from doing things they wanted to do. Participants said that their services also supported them to be responsible for their own safety inside their services. Many participants had received training in health and safety and how to keep their property safe.

The participants with intellectual disabilities had received training in their services' anti-bullying policy. A number of them said they had never seen anyone being bullied. Some of the group felt that if they saw someone being bullied they would ask the person if they would like someone to tell their key worker about it. The person had to decide what they wanted

to do and their wishes had to be respected. Other members of the group felt that if someone was being badly treated they would tell their key worker about it. All of them agreed that no one should be bullied. They also reported that they would go to their key workers if they felt unsafe or they thought something was wrong. The participants said that they meet with their key workers every week to discuss issues and their Person-Centred Plans. One participant goes to a weekly house meeting and it really works for him.

Choice in activities

The participants with intellectual disabilities said that their services made them feel safe by supporting them to do things that made them happy, for example, going to the weekly friendship clubs, art classes and drama.

Risk taking

One participant said that having a choice to do new and challenging things made her feel safe. She was supported to do woodwork and her key worker said that it “brought out a new side of her”.

A Completely Different World

Participants in both groups said that it was important for them to have some place to go and to be busy. One participant said that going to her services two days a week was: “Like being in a completely different world. You are made feel welcome. You can tell people things, get advice and feel listened to.”

Participants in both groups said that being included, being busy and feeling proud of what they do, contributed to their sense of safety.

Self Advocacy

Being supported to set up a self advocacy group or become a self advocate increased participants’ self confidence and their sense of safety. Participants gave examples of this:

- One participant had been supported to set up her own advocacy group with Headway. She felt more confident in herself and better able to deal with her disability (acquired brain injury) as a result
- One participant commented that it was not what you said but how you said it. She had worked with her key worker on how to say things that would ensure she got a more timely response. This increased her sense of safety
- Another participant said people in his services spoke to a local bus service to get them to stop at an accessible location so that people with disabilities could get on the bus and use the public bus services. He commented that if you don’t ask for something you don’t get it

Safe in the Community

Participants also felt that they were supported to feel safe working or doing activities in the community. Three of the participants with intellectual disabilities worked outside of their services. One participant worked as a drover for the cattle market. Two other participants

made furniture in a factory. One of them was a qualified machinist. He said that he helps other people who can't do other tasks. He works as part of team and sees himself as part of a team. They all said that they could go to their supervisors at work if they felt unsafe or that something was wrong and that it would be sorted.