

MHPRU research evidence summary for policy:

Surveillance technology in inpatient mental health services

Who we are: The National Institute for Health and Care Research (NIHR) [Policy Research Unit in Mental Health \(MHPRU\)](#) is an academic team based at University College London and King's College London. The MHPRU conducts rapid research in response to policymaker need (e.g. in the Department of Health and Social Care or NHS England).

Executive summary

Surveillance technologies, like CCTV and body-worn cameras, are increasingly used in inpatient mental health services in the UK. Their aims are to improve safety, care quality, and reduce costs. However, their use is contentious, and ethical concerns have been raised.

The MHPRU systematically reviewed and synthesised current evidence on these technologies. The review was co-produced with lived experience researchers, who contributed to every aspect of the project. It included 32 studies conducted in over nine countries.

Identified surveillance technologies included CCTV, body-worn cameras, GPS trackers, smartwatches, and Vision-Based Patient Monitoring and Management (VBPM). Research on VBPM focused exclusively on Oxevision, a device developed by a UK-based company, which uses an infrared-sensitive camera to remotely monitor patients' vital signs and movements in their bedrooms or seclusion rooms. Most studies, including all on body-worn cameras and VBPM, were conducted in the UK.

The review concluded that **current evidence does not support the use of surveillance technologies in inpatient mental health services**, including VBPM and body-worn cameras.

The findings of this review informed NHS England's (2025) [‘Principles for using digital technologies in mental health inpatient treatment and care’](#).

Key research findings:

- **Potential harms and ethical concerns:** Stakeholder interviews raised serious ethical concerns about body-worn cameras, VBPM, and CCTV use violating patients' human rights, privacy, and dignity, increasing distress and paranoia, worsening power imbalances between patients and staff, and negatively impacting therapeutic relationships. There were also concerns about a lack of informed consent, data protection issues, and data misuse.
- **Limited quantitative evidence of effectiveness:** There was insufficient quantitative evidence to determine whether or not surveillance technologies in inpatient settings are achieving their aims of improving safety, care quality, or reducing costs.
- **Potential benefits:** Some patients and staff thought there were potential benefits to using CCTV, body-worn cameras, VBPM, and wearable sensors, such as improved patient safety and less intrusive monitoring, e.g., by enabling remote rather than in-person observation of patients by staff.
- **Conflicts of interest:** Over a quarter of the studies reported conflicts of interest, including receiving funding from technology companies, or having direct ties to them. This raises concerns about potential bias in the evidence.

- **The full range of potential benefits and harms remain unknown:** Few studies explored important outcomes such as care quality, self-harm, mental health, therapeutic relationships, and service use.
- **Limited research on children and young people:** Few studies focused on children and young people, therefore the unique ethical considerations of using surveillance technologies with this patient group are not well understood.
- **Methodological issues:** Half of the studies were rated low quality, potentially undermining the validity of their findings. Common limitations included a lack of control groups in most studies, and limited reporting on recruitment and data collection methods.
- **Lack of lived experience involvement:** Most studies did not involve people with lived experience in the implementation or evaluation of surveillance technologies.

Implications for implementation

- Further **independent, co-produced research is needed** evaluating surveillance technologies' full range of potential benefits and harms – they should **only** be deployed if the evidence supports their use.
- If surveillance technologies are to be used, or where they are already in use, **trauma-informed best practice policies, procedures, and guidelines are required**, prioritising patient perspectives. These should address ethical concerns, including informed consent, confidentiality, data protection, and protect patients' privacy, dignity, and human rights. The feasibility of adhering to these guidelines must be critically evaluated.
- **Training and monitoring:** Comprehensive, ongoing training for staff, ideally co-produced with patients, would be required, as well as regular monitoring and auditing to ensure compliance with best practice standards. Insights from this review should also be integrated into pre-registration education for health professionals.
- **Lived experience involvement:** All stakeholders, particularly patients – who are most directly affected by surveillance technologies and their potential harms – need to be involved in all future implementation, evaluation and decision-making regarding surveillance technology use in inpatient mental health settings.

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Competing interests: Three authors (AS, UF, ET) have previously undertaken and published research on body-worn cameras. All other authors declare no competing interests. No financial support was received from any surveillance technology companies.

Lived experience involvement: All stages of this review were co-produced with five lived experience researchers. Two experts by experience wrote the paper's lived experience commentary.