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Women's experiences of special observations on locked wards

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ABSTRACT

This article discusses 'special observation', a practice used in inpatient units and in mental health and learning disability services. I present some perspectives on this practice from women detained on locked wards, and staff members. Despite the many valid criticisms, I show that constant observations can be used as a way to harness engagement and to improve relationships between staff and residents.

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KEYWORDS
Observations; inpatient services; self-harm; therapeutic relationship

Points of interest

- Special observation is used in services when a resident is at risk of harm. It means that staff need to watch a resident all the time.
- I talked to women with learning disabilities and/or autism who lived in a secure unit.
- They told me they did not like being watched all the time, and they wanted their privacy in the bathroom above all.
- Some women told me that special observation is better when the staff talk to them and do activities with them. It is better when staff do not stare at them in the bathroom.
- I show that it is important to keep people safe. Special observation can be used in positive ways to do this.

Introduction

> Enhanced observation is a therapeutic intervention with the aim of reducing the factors which contribute to increased risk and promoting recovery.
>
> (Mental Health Act Code of Practice 1983, 26)

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> They don't come to your house do they and sit and watch you?
>
> I've no privacy and that's difficult.
>
> It's frustrating for me, you wouldn't like it.
>
> I've had to lock myself up somewhere before now,
>
> because everywhere I go there's staff.
>
> ('Catherine' in Harker-Longton and Fish 2002, 145)

In this article, I aim to draw attention to a practice used in mental health and learning disability inpatient units: 'special' (or constant) observation. This practice involves staff observing residents throughout the day, either constantly or intermittently, and is used with people who are at risk of serious self-harm or absconding. This is a current (and ongoing) issue, evidenced by the deaths of young women with autism or learning disabilities in inpatient or residential services, deaths that were found at inquest to be related to reduced observations. A jury concluded on 7th October 2021 that 23-year-old Sarah Price's death at St Cadoc's hospital in Wales was contributed to by neglect. Her observations were reduced on the morning of her death without fully taking into account her risk of self-harm (Inquest 2021). Sarah had a learning disability, Cerebral Palsy and mental health conditions. Also in 2021 the inquests of Sophie Bennett and Brooke Martin, both autistic young women aged 19, mentioned reduced or insufficient observations in the inquest decision. This article argues that the use of observation is controversial but necessary, and can be done in ways that sustain the therapeutic relationship.

Experiences of being observed

I was the researcher in an ethnographic study that took place in an NHS mental health forensic unit in England (Fish 2017). I spent 120 hours observing daily life on 3 locked wards for women with learning disabilities and/or autism, and then I interviewed 16 residents and 10 staff from those wards. The women talked about the many restrictive behavioural interventions they had been subjected to, including physical restraint and being placed in seclusion (Fish and Hatton 2017; Fish 2018). Some of my participants told me that they had been put 'on a level', which meant they had to be watched at all times by staff. 'Level 3' or 'level 4' were the most extreme levels, indicating they were kept within eyesight or within arm's reach of staff at all times, respectively.

All of the women residents I interviewed pointed out that they did not like special observations. They felt that their right to privacy was being violated. For example, they were unable to go to the toilet when being watched:

> 'Jessica': I really didn't like people watching me on the toilet, watching me get dressed. I just didn't like it, I said, 'Get away from the door, I don't want you

> watching me!' It put me off. I couldn't sleep because they were there. It puts me off sleeping, if someone's there watching you. On the toilet, I didn't like it. I said 'Get out of the room, I don't want you standing there!' It put me off.

Alexis Quinn is an autistic woman who authored a book, *Unbroken*, about her experience of inpatient services. She mentions special observation practices, stating that 'When I was being observed I felt like a science experiment' (Quinn 2018, 58). She describes the observations as 'invasive', and 'embarrassing':

> Now I not only had the sensory overload of the physical environment, but I also had two people invading my space, watching me at all times. The observers rarely want to interact with you…So, you don't want to shower or go to the toilet because it's embarrassing. Then you can get constipated.

Criticisms of the use of observation

The use of special observations has been criticised widely in the literature relating to psychiatric services. Horsfall and Cleary (2000) describe how the use of observation is often ineffective, and is linked to the traditional medical hierarchy of power relations. In other words, it becomes another act that is 'done to' people.

Keeping a patient under constant observation can be detrimental to the therapeutic relationship and can cause distress due to the lack of privacy (Chu 2016; Powell 2001). It may show a lack of trust, placing the onus of control and responsibility on the staff member (Lindgren, Molin, and Graneheim 2021). Further, Mccorkel (2003, 65) theorised that this embodied surveillance 'solidified' the power of staff, enabling them to undermine peer relationships and to gather evidence of women's deviancy. This is acknowledged by other writers:

> The technologies of observation cannot be an addendum to the therapeutic because their use creates the identity of the observed and the observer, destroying the possibility of prior or subsequent interactions premised on any humanistic commonalities. (Sullivan and Mullen 2012, 294–5)

There was some evidence of this relational distancing in my research. As well as causing discomfort to the observed, the observer can become resentful about having to observe for long periods, further damaging the therapeutic relationship, as my participant Jackie described here:

> 'Jackie' (staff member): I can completely see why the staff get resentful sitting outside somebody's room, doing that for ages and watching them on the toilet, and women getting really cross about losing their privacy and their dignity.

The way forward

Although the power disparity is implicit in such an arrangement, this can be reduced by staff using flexibility and discretion and engaging with the resident

in a positive way. If the staff are actively engaged with the resident, then the person cannot fail to be observed: '*Engagement* is concerned with inspiring hope through the interpersonal relationship. It is concerned with exploring and attempting to understand the nature of the person's problems' (Cutcliffe and Barker 2002). Some research shows that constant observation makes no difference to outcomes of self-harm but *flexible* observation can be beneficial (Stewart, Bowers, and Warburton 2009; Bowers et al. 2008; Sullivan et al. 2013). My argument however, is that constant observations can be effective where there is real engagement and dignity is recognised.

The Mental Health Act Code of Practice 1983 gives the following guidance about the use of observation:

> It should focus on engaging the person therapeutically and enabling them to address their difficulties constructively (e.g. through sitting, chatting, encouraging/supporting people to participate in activities, to relax, to talk about any concerns etc).

Monica points out here that engaging with the women at times like these can ensure that no further harm is done:

> 'Monica' (staff member): It should be used to engage with the woman, not to sit with your feet up reading the paper and ignoring them. Because generally they're on a high level of observation because they feel pretty crap, and then if you sit and you're mad that you're doing it, they're going to pick up on that and feel even worse. Use the time to engage and talk to them, because if they're going to talk and trust you, they're likely to feel better quicker.

Monica's views were supported by other residents and staff in my study. When asked how the system should be changed, there was agreement between both groups that staff should use the time for by being truly 'with' the woman, allowing her to talk or providing emotional support, for example:

> Me: So if you are on a level, what can staff do to make it better for you?
>
> 'Marion': Just to sit down together and listen to my problems.

Insua-Summerhays et al. (2018) interviewed psychiatric inpatient residents and staff. They describe the use of observation from the perspective of residents as being '*physically together but emotionally apart*' - yet able to contribute to positive therapeutic relationships when staff and residents feel '*in it together*'. This is something that Dodds and Bowles (2001) refer to as giving '*the gift of time*'.

There was debate about this in my research; some staff mentioned that positive experiences of special observation may cause women to deliberately instigate it as a way of accessing engagement with staff. My argument is that if the organisational culture accepts that engagement with staff is a legitimate requirement, then this point is moot.

The women I spoke to had ideas about how being 'on a level' could be made less intrusive, and these were about staff bending the rules slightly, for example by being within sight but avoiding looking directly at the woman when she is in the bathroom:

> 'Reenie': Um, well some staff, when I go to the toilet they will stand outside the door and just put their leg at the door, and talk to me, which I don't mind. It's when they're standing at the toilet door with the door wide open [I don't like].

Reenie pointed out that some staff can interpret the policy flexibly, and are able to be more discreet than others (see also Bowles et al. 2002; Quinn 2018; Mason, Mason-Whitehead, and Thomas 2009). This flexibility can be equated with 'trust', and works to mediate the already unequal hierarchical power relations (Mason, Mason-Whitehead, and Thomas 2009; Yates 2005).

Conclusion

My argument shows that special observation is extremely relevant to all relationships on the locked ward. It can be an opportunity for improving or damaging the therapeutic relationship. Self-harm happens when observation is not being employed, and sometimes when it is. I suggest that 'effectual engagement', as described in policy, and importantly, implemented in practice, is a more appropriate and progressive model than observation, and would save money in the longer-term (Dodds and Bowles 2001). This would require a shift in culture of services, including adopting a collaborative leadership style and reducing hierarchy (Pryor and Buzio 2010). Where the traditional response to self-harm has been prevention through special observation, and confiscation of belongings, I argue that engagement in the form of meaningful therapeutic relationships can reduce incidence of self-harm, and enable progression through services (Fish and Morgan 2021; Fish and Morgan 2019).

Disclosure statement

No potential conflict of interest was reported by the authors.

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