

CRI98

Guidance for the use of audio-visual recording in child psychiatric practice

COLLEGE REPORT

College Report 198

July 2015

Approved by the Policy and Public Affairs Committee: January 2015

Due for review: 2020

Revision of earlier report CR167 (2011)

© 2015 The Royal College of Psychiatrists

College Reports constitute College policy. They have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

For full details of reports available and how to obtain them, visit the College website at <http://www.rcpsych.ac.uk/publications/collegereports.aspx>

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

Contents

Introduction	4
Purpose of audio-visual recording	5
Making the recording	7
Storage of audio-visual recordings	12
Copyright/ownership of audio-visual recordings	14
Appendix	15
References	18

Introduction

Audio-visual recording is now commonplace within child mental health services. Previously, such recording was made and stored by means of videotape and more recently on DVDs. However, videotape is gradually becoming obsolete and, in future, it can be assumed that this type of data will be captured and stored digitally (e.g. memory sticks, computer hard drives). The relative ease of availability and low cost of sophisticated digital equipment means that the use of audio and image recording is now more available to many people. Although digital images are not intrinsically different from traditional recordings, they are easier to copy, store, manipulate and distribute and are, therefore, potentially at greater risk of inappropriate use.

The implication of digital data storage is that security of the ‘hard copy’ (e.g. tapes, discs) will no longer provide sufficient guarantee of usage and confidentiality of the data obtained. Hence, the following guidelines will address all forms of recording, storage and transmission of audio-visual recording within child mental health practice, regardless of whether or not the recording forms part of the clinical record.

Audio-visual recording of interviews with patients and their families is now commonly used in child psychiatric practice. Involvement in audio-visual recording has a unique meaning for each patient and their family, and can potentially have a profound effect. Recording cannot be made without prior negotiation with the patient and/or a responsible adult, including verbal and written explanation and the gaining of formal consent.

This document outlines the procedures involved in audio-visual recording including ensuring confidentiality and obtaining consent. It provides guidance for all child and adolescent psychiatrists who are involved in the making and subsequent use of audio-visual recordings.

Purpose of audio-visual recording

A recording may sometimes be used for more than one purpose. In child psychiatric practice, audio-visual recordings are usually made for clinical purposes, for which consent is obtained. The recordings may later be suitable for teaching and training. If, at a later stage, an audio-visual recording is to be used for any purpose other than that for which the original consent was obtained, then specific additional consent must be acquired. In the course of assessment or treatment, material may emerge which affects the original purpose for making the recording. For example, child protection issues may become apparent and the recording may be required as legal evidence and may be subpoenaed. On very rare occasions, a clinician may be asked to provide a segment of an audio-visual recording for a television programme. Additional consent must always be sought in each situation.

Examples of the ways in which audio-visual recordings of a child psychiatric session may be used are listed below.

Clinical uses

- Monitoring therapeutic change over time.
- Enabling children and/or family members to observe and learn from their own interactions.
- Giving feedback to the children about their behaviour.
- Providing parents with training in handling children's behaviour.
- Facilitating the clinical involvement of the wider multidisciplinary team.

Teaching

- Illustration of clinical signs.
- Demonstration of interviewing techniques.

Training

- For demonstration purposes in the ongoing training of the clinical team.
- For clinical supervision in the training of psychiatrists and other staff.

Research

- As a defined aspect of a research project or study.

Making the recording

Consent

The process of gaining consent

When the clinician wishes to make an audio-visual recording of a clinical interview, it is desirable to send the family an explanatory letter in advance. The letter should explicitly state that the family can decline the request without any detriment to their treatment. Sending a letter prior to the interview gives the family time to consider how they wish to respond to the request.

At the interview, the reasons for making an audio-visual recording and the means by which confidentiality will be protected should be explained. Wherever practicable, the clinician should explain any possible secondary uses of the recording (which would be in an anonymous or coded form) when seeking consent to make the recording. The key elements of the discussion should be recorded in the patient's medical record.

Each individual should be asked for their verbal agreement, which should be recorded before the beginning of the interview. This includes all people over 16 years of age and all children who are regarded as of an age and understanding to be able give their consent. (Children under 16 years of age have not been deemed capable of refusing consent in case law. However, it would probably be unwise to override the refusal of a competent minor as there is always the risk of a challenge on human rights grounds.) Children or young people under 16 years of age who have the capacity and understanding to give consent for a recording may do so, but the clinician should encourage them to involve their parents in the decision. Where a child or young person is not able to understand the nature, purpose and possible consequences of the recording, consent to make the recording must be obtained from a person with parental responsibility. If children are to be interviewed on their own, the parent or guardian must give their verbal and written consent. This process may be better done through a pre-therapy meeting to discuss only the issues regarding audio-visual recording to try to ensure that consent is truly informed. Every competent individual has the right to refuse permission for audio-visual recording. Where there is a reluctance to agree, an exploration of the reasons for this reluctance may facilitate agreement. However, there should be no pressure to agree.

All the potential uses of the audio-visual recording should be mentioned at this point and informed consent sought separately for each. It should be explained that further consent will be sought if, at a later stage, it is desired to use the recording for other purposes. Explanatory written material, translated if necessary, including a discussion of the right to confidentiality, should be provided. Recordings made as part of the patient's care form part of the medical record, and should be treated in the same way as written material in terms of security and decisions about disclosures.

Consent forms

One technique used is that after gaining verbal consent at the beginning of the interview, the consent forms are signed at the end of the session by all those participating (see Appendix). The advantage of this is that participants will then know what was discussed in the interview and will be in a better position to give informed consent for use of the audio-visual recording. The forms can also be signed at the beginning of the interview. In either event, it is important to remember that consent can be revoked at any time during or after the interview by family members with capacity. In a family disagreement, withdrawal by even one family member with capacity will revoke consent for the procedure. On withdrawal of consent, the recordings must be deleted. The professional seeking consent has the responsibility to ensure that family members have read the consent form and know what they are signing.

Consent forms should be kept in the clinical file and copies retained by the patient/family. The file should also contain copies of any explanatory notes or information leaflets given to the patient/family. When an individual/family has regular recorded sessions, they should be reminded on each occasion that the session is being recorded.

Recording telephone calls

Anyone using a telephone is subject to licence conditions under the Telecommunications Act 1984. Every reasonable effort must be made to inform callers that their call may be recorded, and maintain a record of the means by which callers have been informed. Telephone calls from patients to healthcare organisations may be recorded for legitimate reasons, for example, for medico-legal, staff training or audit purposes, provided clinicians take all reasonable steps to inform callers that their call may be recorded. Given the sensitive nature of calls to medical advice lines or similar services, clinicians should pay particular attention to ensuring that callers are aware that their call might be recorded. Clinicians must not make secret recordings of calls with patients.

Recordings for use in widely accessible public media

In general, the principles discussed earlier also apply to recordings for use in widely accessible public media (e.g. television, radio, internet, print) that are intended for a broad public audience. There are, however, some issues specific to recordings used in this context. Clinicians must get the patient's consent, which should usually be in writing, to make a recording that will be used in widely accessible public media, whether or not the patient will be identifiable.

Before making any arrangements to record patients, their relatives or their visitors in a healthcare setting, the clinician must get agreement from their employing or contracting body, and from the organisation in which the patients are being treated if this is different. Within the National Health Service (NHS), a contract with the filmmaker will normally be required. If in doubt, seek advice from the employing or contracting body; for example, from the department of medical illustration or a Caldicott Guardian.

If a clinician is involved in recording patients for broadcast media, they should satisfy themselves that the patients' consent has been obtained in accordance with this guidance, even if they are not responsible for getting that consent or have no control over the recording process. The Ofcom Broadcasting Code (Ofcom, 2015), which covers all UK broadcasters, requires consent to be obtained in a way that is consistent with this guidance.

In addition, one should check that patients understand that, once they have agreed to the recording being made for broadcast, they may not be able to stop its subsequent use. If patients wish to restrict the use of material, they should be advised to get agreement in writing from the programme maker and the owners of the recording before recording begins.

Children or young people under 16 years of age who have the capacity and understanding to give consent for a recording may do so, but the clinician should encourage them to involve their parents in the decision. If a child or young person lacks capacity to consent to a planned or unplanned recording being made, a person with parental responsibility may consent on their behalf. However, the clinician should stop the recording if the child or young person objects verbally or through their actions, if they show distress in other ways about the recording, or if the person with parental responsibility asks for it to stop.

When a child or young person has developed the maturity to make decisions about recordings for themselves, one should use any

opportunity that arises to offer them the option to withdraw or vary consent previously given by a person with parental responsibility:

- if the child or young person is or might be identifiable in the recording
- if it is reasonably practicable to act in accordance with the child or young person's wishes.

Clinicians must not participate in the making or disclosing of recordings of a child or young person who lacks capacity if they believe the child may be harmed or distressed by making the recording or by its disclosure or use, even if a person with parental responsibility has given consent.

Use of recordings in teaching and training

Recordings made exclusively for the purposes of teaching, examination or training are not regarded as medical records. Any part of the recording that might identify the family (e.g. surnames, addresses) should be erased.

It must be remembered that if a clinician wishes to use for teaching an audio-visual recording that was originally made for clinical purposes, then informed consent must be obtained from the individual/family. It should be explained that the recording will be shown only to clinicians. Audiences at a teaching event must be reminded of the need for confidentiality and all participants must sign a form relating to the safeguarding of confidentiality. They should be invited to declare personal acquaintance, in which case the presenter should either ask the participant to leave or decide not to use the recording.

Use of recordings in research

Research ethics committees require that specific consent forms are drawn up and completed where audio-visual recordings of individuals/families are being undertaken in the course of research.

During the recording

If requested, a recording must be stopped at any time during the recording process and subsequently erased, deleted or destroyed.

After the recording

If consent forms have not already been signed in advance of the audio-visual recording, they need to be signed at the end of the recording. If the individual/family does not give consent for the recording to be kept, the recording must be erased, deleted or destroyed immediately.

Making a recording covertly

The circumstances where a covert recording is likely to be undertaken are rare. It will always follow multiagency consultation and be led or carried out by the police. Covert recording should be undertaken only when there is no other way of obtaining information that is necessary to investigate or prosecute a serious crime, or to protect someone from serious harm.

This might arise in cases where there are grounds to suspect that a child is being harmed by a parent or carer. Before any covert recording is carried out, authorisation must be sought from a relevant body in accordance with the law. If clinicians consider making a covert recording, they must discuss this with colleagues, their employer or contracting body and relevant agencies, except where this would undermine the purpose of the recording, in which case they should seek independent advice. They must follow national or local guidance. In most circumstances, covert recording should be carried out by the police.

Covert recording falls within the scope of the Regulation of Investigatory Powers Act 2000, or the Regulation of Investigatory Powers (Scotland) Act 2000, when it is used by a public body, such as an NHS body or those contracted to or employed by an NHS body. Anyone finding themselves in circumstances where they might be involved in a covert recording must ensure that they comply with the requirements of the relevant Act.

Storage of audio-visual recordings

Storage

Hard copies of audio-visual recordings should be stored in a safe place under lock and key.

Audio-visual recordings made for clinical purposes are a part of the medical record. In the same way that trusts decide how long the medical records should be preserved, a policy decision about how long recordings are kept before erasure/deletion/destruction needs to be made by each trust, covering the various uses of recordings made within the work of that trust. Families should be informed how long the audio-visual recording will be kept at the time of giving consent.

The Department of Health's *Records Management: NHS Code of Practice* (Department of Health, 2006a,b) provides guidance to the NHS on minimum retention periods of patient health records (Department of Health, 2006b, Annex D1). The guidance states that audio-visual recordings relating to patient care should be treated in the same way as any other part of the patient health record. Such records should be retained for a minimum period of 8 years for adults; for children, until their 25th birthday or 26th birthday if they were 17 at the time of treatment, or for 8 years after the patient's death if sooner. For people with a mental illness, records should be retained for at least 20 years (as stated in the Mental Health Act 1983) after the last date of contact between the patient and any healthcare professional, or for 8 years after the patient's death if sooner.

Erasure

Recording over videotapes is not permissible. A professional tape wiper should be used. If this is not available, then the tape can be erased by rewinding it, pressing play and record together without connection to any source and allowing the tape to record to the end. DVD or CD hard copies that cannot be erased must be physically destroyed.

Audio-visual recordings that are or might become of evidential significance may not be erased. Audio-visual recordings made for the purposes of teaching, training and supervision may be erased at the discretion of the clinician.

Copyright/ownership of audio-visual recordings

Audio-visual recordings are owned by the trust, the university of a medical school or the practitioner (if working independently). They need to be treated in the same way as written medical records with regard to confidentiality, removal from the institution and access by patients.

Audio-visual recordings, like medical records, are susceptible to being subpoenaed by the courts. When recordings are subpoenaed, it is suggested that they should be viewed, if possible, on the premises of the institution. When disclosure of such recordings is required by the court, the General Medical Council's (2009) guidance should be followed. In contentious cases, it is advisable to seek advice from the Caldicott Guardian of the trust (Department of Health, 2006a).

Multiple copies of audio-visual recordings should not be made, as this limits control over access to them and their future use. However, for teaching and research purposes, edited segments may be required. (Normally, audio-visual recordings should not be removed from the institution. However, there might be circumstances in which institutions modify the rules concerning the removal of audio-visual recordings by trainees for the purposes of study. Under these circumstances, it is suggested that the trainees are asked to sign the document relating to the safeguarding of the recording.)

For digital recordings, safeguards regarding electronic transmission are as important as the safeguarding of the physical location of the recording. Where recordings are made for clinical purposes, the same conditions apply to them as to health records under the Access to Health Records Act 1990.

Families or individuals may ask to see audio-visual recordings at which they were present. In considering such requests, clinicians must consider the protection of confidentiality for third parties (in the same way as requests for access to medical notes). If clinicians are able to agree to the request, a health professional able to provide support and explanation should be available while the recording is viewed. Families may also request a copy of their audio-visual recordings under the same legislation.

In ensuring the safe storage of audio-visual recordings within organisations, it is desirable to create an audit loop to check for adherence to the relevant guidelines or policies of the organisation.

Appendix

The following are examples of what to include in consent forms and information for families about audio-visual recordings, which can be modified according to the needs of the institution carrying out the recording.

Information for families about the use of audio-visual recordings

Why record?

We like to make audio-visual recordings of family work where possible, as it can be very helpful in our work. Audio-visual recordings allow us to look over the interview in detail so we can think more about the family and about our work with them. We sometimes also use audio-visual recordings for teaching and research. Because we are a training institution, audio-visual recordings are useful to demonstrate the way we work to other professionals. When we do this, people look mainly at what we are doing as therapists, so they can learn from this experience.

We use some audio-visual recordings for research when we try to learn more about a particular problem experienced by families, or a way of working to help us in our future work.

We are aware that making an audio-visual recording can sometimes make family members uncomfortable. However, as we find audio-visual recordings so useful, we have decided to discuss the possibility of audio-visual recording with families when we first meet them. Not all the work at the clinic is recorded.

Consent

Although we find that audio-visual recording helps us in our work, we also want to make clear that everyone who has the capacity to do so has the right to refuse permission for audio-visual recording. We will not record unless we have your permission and your child's. Only in exceptional circumstances should parental permission overrule that of a child. Even if you agree to recordings being made, you have the right to stop at any time and to ask that all the recordings, or a particular one, or one piece of the recording be erased.

We ask you to sign a consent form at the beginning/end of the first interview when you know what has been discussed and whether

you are willing for us to keep the recording, and for which purposes. Any special conditions for its use that you would like specified will be written on the form.

At the end of your work at the clinic, we will again discuss the recordings with you to confirm for which purposes we can use them and when they will be erased or deleted.

Audio-visual recordings are treated as confidential material. All staff undertake to safeguard the recordings (in whatever form) at all times. If you have agreed for the recording to be used for teaching, this will only be to professionals who agree to keep the material confidential. We always ensure before showing audio-visual recordings that there is no one present who knows your family. If there is, we ask that they are not present either for the showing of the recording or for any discussion.

Sample consent form content

1. Consent for audio-visual recording (clinical purposes only)

I/We agree to the audio-visual recording of the consultations and/or therapy sessions in which I/we take part, and understand and agree that these recordings are for the sole use of the team working with my/our family and consultations within the clinic only. The recordings will be erased/deleted 1 year after the last appointment (unless there are special circumstances which would be explained to you by your therapist).

Full name(s)

Signature(s)

Date

Name(s) of therapist(s)

Signature(s)

2. Consent for audio-visual recording (clinical and other purposes)

I/We agree to the audio-visual recording of the consultations and/or therapy sessions in which I/we take part, and understand and agree that these recordings may be shown as follows (delete as applicable):

- to professional colleagues working within the clinic
- for the purpose of teaching and research within the clinic
- to a professional group on occasion(s) outside the clinic.

Full name(s)

Signature(s)

Date

Name(s) of therapist(s)

Signature(s)

References

- Department of Health (2006a) *Records Management: NHS Code of Practice, Part 1*. Department of Health.
- Department of Health (2006b) *Records Management: NHS Code of Practice, Part 2*. Department of Health.
- General Medical Council (2009) *Confidentiality*. GMC.
- Ofcom (2015) *The Ofcom Broadcasting Code*. Ofcom (<http://stakeholders.ofcom.org.uk/broadcasting/guidance/programme-guidance/bguidance>).

Other sources

- General Medical Council (2011) *Making and Using Visual and Audio Recordings of Patients*. GMC.
- Royal College of Psychiatrists (2000) *Guidance on the Use of Audio-Visual Recording in Child Psychiatric Practice* (CR167). Royal College of Psychiatrists.