Written evidence from The National Survivor User Network (HCS0047)

ABOUT NSUN

The National Survivor User Network (NSUN) is a network of people who have and do experience mental distress who want to change things for the better. NSUN connects people and influences policy, practice and perceptions by amplifying the experiences and aspirations of our members.

As a user-led organisation who pioneered what is often considered the gold standard tool of co-production, the 4Pi involvement standards (https://www.nsun.org.uk/projects/4pi-involvement-standards/), all our work is carried out from design to delivery by people with lived experience. We are also a sector voice for user-led and community-led groups: https://www.nsun.org.uk/news/what-do-user-led-groups-need/.

This submission was prepared by Mary Sadid, Policy Officer.

EXECUTIVE SUMMARY

1. NSUN takes a rights-based approach to mental ill health and distress, we work on policy areas including the Mental Health Act and securitisation of health.
2. Human rights issues in mental health settings are an ongoing source of concern for NSUN and our members.
3. We welcome the inquiry whilst noting that human rights issues in care settings and beyond are systemic and institutional. This means that rights violations can be insidious, presented as innovation and/or an effective means of care.
4. In this submission we are primarily focusing on two areas of concern:
    a. Surveillance as restrictive practice
    b. Criminalisation of distress

What human rights issues need to be addressed in care settings in England, beyond the immediate concerns arising from the Covid-19 pandemic?

Surveillance as restrictive practice

1. Surveillance in mental health settings can take a number of forms including body-worn cameras, CCTV in individual rooms and in wards and common areas.
2. When considered, and put in place with the input and consent of the individual under surveillance, it can constitute a 'least restrictive' option.
3. However, we are increasingly hearing of blanket 24-hour surveillance in mental health settings including in patient rooms.
4. This can constitute disproportionately restrictive practice, which does not consider the rights and needs of individuals in mental health care settings.
5. Staffing levels are a critical issue when discussing the use of surveillance. We are concerned that surveillance may be used in lieu of adequate and safe staffing levels.

6. Examples of tools which can be used to implement blanket surveillance include oxehealth's oxevision system, described as a 'contact-free vision-based patient management system' which is currently being piloted in some trusts.
7. Whilst surveillance can play a role in good care, including potentially less intrusive monitoring for those under continuous observation, expansion cannot be justified by positive experiences of some or indeed by the economic benefit to trusts of using blanket surveillance instead of treating each person as an individual (a key principle in Mental Health Act reform) and addressing staffing inadequacies.
8. Surveillance must continue to be framed as a *restrictive practice* and only employed when it is the least restrictive option from the perspective of patients (and carers or family members if appropriate) and staff.
9. In addition to fixed surveillance in the form of CCTV, body worn cameras are also present in some trusts.
10. We have particular concerns about the use of body worn cameras which may be hugely distressing for some (including for those who experience paranoia around being watched).
11. Body worn cameras may be turned on and off in such a way that it decontextualises what is being captured, and focuses on patients' reactions (including any perceived threat) instead of the wider context.
12. Given that footage from body worn cameras may be used in prosecution in the aftermath of an incident, there are significant ethical concerns regarding their use by care staff.

Criminalisation of distress: securitisation and racial disparities

13. Criminalisation of distress is linked to the use of surveillance and is a wider trend in mental health care.
14. Criminalisation of distress has recently been spotlighted by the StopSIM campaign, a service user and survivor-led campaign to stop the rollout of the Serenity Integrated Monitoring model, a programme which uses police intervention and threat of legal action (such as Community Behaviour orders which carry a maximum penalty of 5 years) for individuals who frequently come into contact with emergency services because of their mental ill health or distress.
15. In a recent session on the Human Rights Act and surveillance run by the Restraint Reduction Network, the use of body worn cameras by mental health care staff was highlighted as a means to collect evidence for prosecution in cases where staff may feel threatened by patients.
16. We are particularly concerned about criminalisation of distress given the existing data that paints a stark, troubling picture of racial disparities in detention and mental health outcomes.
17. Individuals from racialised backgrounds disproportionately enter mental health settings via the criminal justice system. Black people are 40% more likely to enter treatment through a police or criminal justice route. Black people are also more likely to be on medium or high secure wards and more likely to be subject to restraint.

18. We must contextualise and situate the use of surveillance within punitive attitudes towards distress and the structural and institutional racism that exists within and beyond services.

Conclusions

19. Psychiatry has been described as having an 'exclusion culture': this is fundamentally linked to the human rights issues in care settings we have highlighted in our submission.
20. Punitive and coercive approaches to mental health care are not new phenomena. It is therefore unsurprising that technologisation of care does not sidestep existing inequalities and human rights issues. We must be cautious about how we define innovation, and whether this is from the perspective of service providers and staff alone or if it meaningfully considers the wellbeing and perspectives of service users.
21. Excluding service user voices or undertaking tokenistic engagement practices facilitates the emergence and rollout of practices under the banner of innovation, such as the SIM model and blanket surveillance systems, that risk violating the rights of service users.
22. Whilst proposed changes to the Mental Health Act emphasise principles of choice and autonomy; least restriction; therapeutic benefit and the person as an individual, 'we also observe that these are not the same as a set of rights for the individual subject to the Mental Health Act'.

FURTHER LINKS

- StopSIM: https://stopsim.co.uk/
- Restraint Reduction Network: https://restraintreductionnetwork.org/
- https://www.researchgate.net/publication/354585416_Magical_thinking_and_moral_injury_exclusion_culture_in_psychiatry
- https://recoveryinthebin.org/2020/03/05/neorecovery-neoliberalism-and-enforced-positive-risk-taking/
- https://www.nsun.org.uk/news/response-to-the-mha-white-paper/

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