

Mind legal newsletter

Issue 13, April 2013

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Welcome

Welcome to issue 13 of the Mind legal newsletter.

In this issue we have included coverage and analysis of recent legal matters that affect the mental health sector.

Highlights in this issue include:

- An article on Mind's recent intervention in the immigration detention case of *HA (Nigeria) v Secretary of State for the Home Department*
- A human rights and mental health law update
- A legal aid update now that the Legal Aid, Sentencing and Punishment of Offenders Act 2012 is in force
- Case notes on recent decisions relevant to the mental health sector, including from the Court of Protection, the High Court and the European Court of Human Rights.

We hope you enjoy reading it and welcome any comments and suggestions you may have. Our contact details are on page 48.

Mind Legal Unit

Articles

Systemic failings of mental health care in immigration detention: Mind's intervention in HA (Nigeria)

Martha Spurrier, Mind Legal Unit

In 2012 Mind was granted permission to intervene in the appeal to the Court of Appeal of the case of [*HA \(Nigeria\) v Secretary of State for the Home Department* \[2012\] EWHC 979 \(Admin\)](#). The case concerned the detention of a Nigerian man who suffered from mental health problems and whose mental health deteriorated drastically while he was in detention. More broadly, the case addressed a [policy change](#) made by the Secretary State in August 2010 which made it more likely that people with mental health problems would be detained in immigration detention centres.

In the High Court hearing Mr Justice Singh held that HA's detention had been unlawful and that his human rights had been breached because he descended into a mental health crisis for which he received no adequate treatment or monitoring. Mr Justice Singh also held that the policy change had been unlawful because it had been introduced without an equality impact assessment. As a result of the hearing, the Secretary of State made a formal undertaking to carry out an equality impact assessment.

The Secretary of State appealed to the Court of Appeal to have Mr Justice Singh's judgment overturned. Mind intervened in the case, with [Medical Justice](#) (represented by [Sue Willman](#) from Deighton Pierce Glynn Solicitors), and with the assistance of [Nick Armstrong](#) from Matrix Chambers. Mind submitted a witness statement setting out its grave concerns about the state of mental healthcare in immigration detention and provided the Court of Appeal with evidence of the systemic abuses of the rights of mentally ill detainees. Weeks before the hearing, the Secretary of State abandoned her appeal. This was a major victory for all those concerned with the human rights and mental health of some of the most vulnerable members of our society. As a result, Mr Justice Singh's judgment stands and the Secretary of State must carry out the equality impact assessment of her detention policy.

However, the systemic failings of mental healthcare in immigration detention persist and it is vital that the campaign for improvement goes wider than litigation. The following is an extract from Mind's witness statement in the HA case which sets out some of our key concerns, which are shared by [Her Majesty's Chief Inspectorate of Prisons](#), the [Equality and Human Rights Commission](#) and the [Joint Committee on Human Rights](#), among others:

The mental health profile of immigration detainees

Immigration detainees form a large and growing group of vulnerable people in the United Kingdom who are particularly susceptible to mental illness. In 2012 the [number of immigration detainees rose](#) by 14 per cent to 3,034, the highest since comparable data began to be collected in 2001.

Findings consistently report high levels of mental health problems among immigration detainees. High proportions of immigration detainees display clinically significant levels of depression, post traumatic stress disorder (PTSD) and anxiety, as well as intense fear, sleep disturbance, profound hopelessness, self-harm and suicidal ideation. In a study monitoring immigration detainees over a nine month period 85 per cent reported chronic depressive symptoms, 65 per cent reported suicidal ideation, 39 per cent experienced paranoid delusions, 21 per cent showed signs of psychosis and 57 per cent required psychotropic medication.

In a study reported in *Forensic and Legal Medicine*, Juliet Cohen found that the estimated percentage of self-harming in Immigration Removal Centres (IRCs) during a 12 month period was 12.79 per cent, compared to between 5 and 10 per cent for the prison community.

These findings are not surprising. They are certainly consistent with what is known about migrants generally, and asylum seekers in particular. Mental health problems are particularly prevalent among asylum seekers, who may have suffered trauma in their country of origin and developed trauma-related mental health problems as a result.

Mental healthcare in immigration detention

There is, unfortunately, a growing body of evidence concerning failures to identify and meet the needs of people with mental health problems in immigration detention. The HM Inspectorate of Prisons (HMIP) inspection reports on IRCs over the last four years offer a snapshot of the ongoing and unresolved failures in this area. They include:

- Failure to properly diagnose mental health problems;
- Failure to provide timely access to mental health care, including delays in transferring detainees to hospital under the Mental Health Act 1983;
- Failure to offer a counselling service;
- Failure to provide medication in accordance with NICE Guidelines and British National Formulary limits;
- Failure to provide an appropriate environment for people with serious mental health problems and the inappropriate use of segregation units to house people suffering from a mental health crisis;
- Failures in the Rule 35 reporting procedure;
- Failure to provide accessible health information in a range of languages;
- Failure to use interpreters in health assessments;
- Failure to provide mental health awareness and mental health first-aid training to custody and healthcare staff; and
- Inadequate staffing levels to meet detainees' mental health needs.

This picture of widespread and systemic failings accord with Mind's experience of mental health care provision in immigration detention centres. In [*A civilised society: Mental health provision for refugees and asylum seekers in England and Wales \(2009\)*](#), Mind reported that mental health care within detention centres was inadequate to deal with the high levels of mental distress experienced by detainees, especially those with severe and long-term problems. It is clear from the HMIP reports that the concerns Mind identified in 2009 have not been addressed and that mental health care in IRCs remains far below the standards of mental health care in the community.

In Mind's view a person's mental health will not be satisfactorily managed in detention if:

- The experience of detention causes or exacerbates mental health problems;
- The person is susceptible to acute or crisis episodes of mental illness which a detention centre does not have the facilities or staff to deal with appropriately;
- The person's mental health could be improved if treated in the community;
- The person's mental health could be improved by a particular treatment, such as counselling, but that treatment is not available in detention, or it is not available without delay; or
- The person's mental health could be improved in hospital but transfer to hospital cannot be facilitated without delay.

If Mind had been consulted on the Secretary of State's new policy of detaining people whose mental health conditions could be 'satisfactorily managed' in detention, it would have suggested some standards and safeguards would need to be attendant on such a policy for it to comply with clinical best practice and human rights and equality principles. These standards and safeguards can be broken down into the following areas:

- a) The principles of mental health care;
- b) The standards of mental health care;
- c) Access to treatments;
- d) Staffing and staff training;
- e) Policies to deal with challenging behaviour;
- f) Safeguards for people in mental health crisis.

In Mind's view these standards and safeguards should form a [binding part of the contracts that private health care contractors hold with IRCs](#).

The principles of mental health care

In order to fulfil the requirement that mental health care in detention is the same as mental health care in the community, satisfactory management must mean more than simply preventing the mental health of a detainee from deteriorating. Modern mental health services have adopted the recovery model as an underpinning philosophy of care. This involves a [shift](#)

[away from traditional clinical preoccupations](#) such as managing risk and avoiding relapse, towards new priorities of supporting the person in working towards improvement, wellbeing and recovery.

The cross-government mental health strategy, [No health without mental health](#) (2011) emphasises the need for prevention and early intervention in mental health care and has as its objectives, *inter alia*.

- 1) More people with mental health problems will recover;
- 2) More people will have a positive experience of care and support;
- 3) Fewer people will suffer avoidable harm; and
- 4) Fewer people will experience stigma and discrimination.

This approach is also reflected in the [NHS Outcomes Framework 2012-2013](#), which sets out the outcomes targets for the NHS Commissioning Board:

- 1) Preventing people from dying prematurely;
- 2) Enhancing quality of life for people with long-term conditions;
- 3) Helping people to recover from episodes of ill health or following injury;
- 4) Ensuring that people have a positive experience of care; and
- 5) Treating and caring for people in a safe environment; and protecting them from avoidable harm.

If mental health care is to be the same in detention as it is in the community, these outcomes and objectives must be applied.

Finally, the [Code of Practice to the Mental Health Act 1983](#) identifies the following guiding principles for mental health care under the Act:

- 1) Purpose principle.
- 2) Least restriction principle.
- 3) Respect principle.
- 4) Participation principle.
- 5) Effectiveness, efficiency and equity principle.

In Mind's view the provision of mental health care in immigration detention should be governed by a similar set of principles.

The standards of mental health care

Mental health care in detention should comply with the Clinical Guidance on [Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services](#) produced by the NHS and the National Institute for Health and Clinical Excellence (NICE). This guidance is extensive, but the following quality standards are particularly relevant for providers of mental health care in detention:

- 1) People using mental health services, and their families or carers, feel they are treated with empathy, dignity and respect;
- 2) People using mental health services are actively involved in shared decision-making and supported in self-management;

- 3) People can access mental health services when they need them;
- 4) People using mental health services understand the assessment process, their diagnosis and treatment options, and receive emotional support for any sensitive issues;
- 5) People using mental health services jointly develop a care plan with mental health and social care professionals, and are given a copy with an agreed date to review it.

It is self-evident that this person-centred approach can only be facilitated in IRCs if independent interpreters are available during mental health assessments and consultations and if all information relating to mental health care is provided in a language and format that detainees can access and understand. In the past, “major concern” has been about the lack of consistent use of professional interpreters in IRCs, as identified by Juliet Cohen in *Forensic and Legal Medicine*. If mental health care in detention is to be adequate, these concerns must be addressed.

IRC's should also comply with the national standards set by the Department of Health's National Service Framework for Mental Health. These standards apply to a range of areas, including:

- 1) Mental health promotion;
- 2) Primary care and access to services;
- 3) Effective services for people with severe mental illness; and
- 4) Preventing suicide.

The Royal College of Psychiatrists' Centre for Quality Improvement has produced a set of three standards for inpatient mental health services entitled [Accreditation for Inpatient Mental Health Services \(AIMS\) Standards for Inpatient Wards – Working Age Adults \(2009\)](#). Under this framework failure to meet the Type 1 standard would result in “a significant threat to patient safety and dignity” while Type 2 standards are those that an accredited ward would be expected to meet and Type 3 are the standards that an excellent ward should be meeting.

Mind considers that there should be an equivalent set of standards that apply to the provision of mental health care in immigration detention. These standards should be independently monitored with enforceable recommendations and penalties for non-implementation.

Finally, IRCs should comply with the Care Quality Commission's [Essential Standards of Quality and Safety](#), which is designed to help providers of health care to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people receiving health care services (including immigration detainees) have a right to expect.

Access to treatments

Mental health care in the community involves a range of treatments that are not limited to medication. The same range and quality of treatments must be available to immigration detainees. It is important to remember that the fact that medication is being prescribed does not mean that treatment is adequate or that a mental health problem is being satisfactorily managed. Furthermore, where medication is prescribed, detainees should be given information about its risks and possible side effects.

Mental health care in detention should therefore include the provision of talking therapies such as counselling, cognitive behavioural therapy, access to therapeutic groups and activities, drop-in sessions, specialist services and alternative therapies, all delivered by competent practitioners and consistent with NICE guidance. This is not the position at present: a [study in 2011](#) found that “few [IRCs] employ counsellors, therapists or have access to community psychology services.” The HMIP reports outlined above support this.

In accordance with the Mental Health Act 1983 Code of Practice and the NICE Clinical Guidance, detainees should be provided with comprehensive information about the available treatment options in a language and format that they understand.

Finally, it is Mind’s view that people with mental health problems in immigration detention should have access to a trained mental health advocate to assist them in understanding their rights and advocating for appropriate, effective and timely treatment. This is one of the recommendations made by NICE.

Staffing and staff training

Mind is of the view that the UKBA’s policy cannot be operated by immigration staff without adequate training. All immigration caseworkers should undergo compulsory mental health awareness and mental health first aid training. UKBA staff and IRC (including initial accommodation) Healthcare Teams should receive training in identifying mental distress. They should have a clear understanding of why someone may not disclose mental health problems at screening or within initial accommodation, and have the skills to recognise indicators of mental ill-health and respond appropriately.

Staff should also receive training on the difference between the Mental Health Act 1983 and the Mental Capacity Act 2005 so that they understand how the two statutory regimes relate to each other and can recognise a situation where a detainee’s capacity needs to be assessed.

Staff ratios should be sufficient to provide adequate care to detainees with mental health problems. The Royal College of Psychiatrists has made recommendations about appropriate staff to patient ratios on psychiatric

wards and in my opinion a similar recommendation should be made for staffing levels in IRCs.

Policies for dealing with challenging behaviour

Mind is also concerned about the ongoing use of disciplinary sanctions (particularly under Rules 40 and 42) to deal with people who present challenging behaviour as a result of their mental health problems. In Mind's view policies must be developed to ensure that challenging behaviour is dealt with in the least restrictive and most therapeutic way possible. This means that staff must be trained in using de-escalation techniques and care plans should be developed with detainees to plan responses to their behaviour if it becomes challenging. The correct approach to control techniques is laid out in the [Code of Practice to the Mental Health Act 1983](#) and IRCs should apply the same principles.

In addition, IRCs must develop appropriate facilities for detainees who present challenging behaviour as a result of their mental health problems. It is not appropriate for mentally ill detainees to be housed in areas designed for punishment or with detainees who are subject to disciplinary sanctions.

If segregation is used, it is Mind's view that the UKBA should implement the HMIP's recommendation that an initial health screen be carried out prior to segregation and that multi-disciplinary reviews of segregation take place as they do in the prison context.

Mind's press release announcing that the Secretary of State had abandoned her appeal can be read [here](#).

Community Treatment Orders and the Octet Study

Angela Truell, Mind Legal Unit

According to the Care Quality Commission's (CQC) report, '[Monitoring the Mental Health Act in 2011/12](#)', 4,220 patients were placed on community treatment orders (CTOs) in 2011/12. This was an increase of 10% in the use of CTOs from the previous year. Between Trusts, the CQC has identified a wide variation in use of CTOs (p.76). Once on a CTO, it can be difficult to achieve discharge. There is a low rate of success on appeal to a tribunal (84% of appeal hearings are unsuccessful).

When CTOs were introduced in 2008 by the Mental Health Act 2007, there was concerted opposition on civil liberties grounds. A key argument for CTOs was that they would reduce rates of re-detention for patients.

Introducing the Mental Health Bill in the House of Lords in 2006, Lord Warner said:

"We know that some patients stop taking their medication or treatment once they leave hospital, and so relapse and end up being readmitted. This detrimental cycle is often referred to as the revolving door. Patients on supervised community treatment will benefit from a structure designed to promote safe community living. This will reduce the risk of relapse and re-detention."

Now a detailed study published on March 26, 2013 by Professor Tom Burns and others in [The Lancet](#) reports that imposition of compulsory supervision does not reduce the rate of readmission for psychotic patients. The authors conclude that they found no support in terms of any reduction in overall hospital admission to justify the significant curtailment of patients' personal liberty.

What are community treatment orders and how do they work?

Patients detained in hospital for treatment under section 3 of the [Mental Health Act 1983](#) or unrestricted criminal patients can be discharged subject to a CTO by their responsible clinician (RC) (ss17A -G Mental Health Act 1983). The RC has to consider that the criteria for a CTO are met. An approved mental health professional (AMHP) must agree and confirm it is appropriate to make the CTO. The relevant criteria are that:

- 1) The patient has a mental disorder of a nature or degree making it appropriate for them to receive medical treatment;
- 2) It is necessary for the patient's health or safety or the protection of other persons that they should receive such treatment;
- 3) Subject to being liable to be recalled, such treatment can be provided without the patient continuing to be detained in a hospital;

- 4) It is necessary that the responsible clinician should be able to exercise the power to recall the patient to hospitals; and
- 5) Appropriate medical treatment is available for the patient (s17A(5)).

A CTO patient has to comply with conditions, which can be suspended or varied by the RC with wide discretion. Conditions imposed by the RC only have to be necessary or appropriate for one or more specified purposes -

- 1) Ensuring receipt of treatment;
- 2) Preventing risk of harm to patient health or safety; or
- 3) Protecting others.

Conditions can be highly restrictive, for example specifying where someone should live, but they must not amount to a deprivation of liberty. The patient has no right to seek a review to a tribunal of the conditions imposed.

A CTO patient can be recalled to hospital for a period of up to 72 hours in certain circumstances, and within that time the CTO can be revoked, reinstating the detention order that was in force before the CTO took effect.

Patients subject to CTO who have capacity are required to consent to treatment in the community as there is no authority to treat under compulsion. The nature of the actual consent that can be given in a situation where a person is subject to recall is debatable. In the recent case of [SH v Cornwall Partnership NHS Trust \(2012\) UKUT 290](#) the Upper Tribunal decided that the issue of consent in a CTO was outside the jurisdiction of the First Tier Tribunal. The exact nature and meaning of consent in the context of a CTO is a key issue at the very heart of the CTO framework.

The Octet Report- summary

The study postulated that patients with a diagnosis of psychosis discharged from hospital on CTOs would have a lower rate of readmission over 12 months than those discharged on the pre-existing Section 17 leave of absence. 333 patients who had been admitted to hospital with a diagnosis of psychosis and were aged 18-65 were randomly assigned to be discharged either on CTO or Section 17 leave. The primary outcome measure was whether or not the patient was admitted to hospital during the 12 month follow-up period. The number of patients readmitted did not differ between the Section 17 group and the CTO group. The authors of the study conclude that in well coordinated mental health services compulsory supervision in the community does not reduce the rate of readmission of psychotic patients.

It is hoped that this study will lead mental health professionals to review their use of Community Treatment Orders with particular reference to the guiding principles of the Code of Practice to the Mental Health Act including the least restrictive principle and the participation principle.

Mind Crisis Care Campaign

Martha Spurrier, Mind Legal Unit

The findings of Mind's year-long independent inquiry into crisis care were published in a report [Listening to Experience](#) in 2011. In 2012, under the Freedom of Information Act, Mind asked mental health trusts in England and health boards (LHBs) in Wales to provide information about their crisis care services. In November 2012, as part of its Crisis care campaign, Mind published a summary of the responses and a briefing for Clinical Commissioning Groups - [Mental Health crisis care: commissioning excellence](#) - to help ensure that they commission the type of crisis care services that people need to make a full recovery. The key issues include:

- **Under-staffing:** 41% of mental health trusts in England with staffing levels below Department of Health guidelines.
- **Access:** Huge variation between trusts in the number of people referred to crisis teams.
- **Support:** On average, crisis teams visit service users every three days. Visits may be more frequent in the early stages and less frequent before discharge. More than half (13 out of 25 trusts) have an average of one visit every two days or more. There is no national guidance on average visits but when crisis teams were first introduced, the Mental Health Policy Implementation Guidance 2001 provided that visits should be "frequent" and in the early phase, several visits a day may be needed. The Royal College of Psychiatrist's Centre for Quality Improvement has started a [Home Treatment Accreditation Scheme](#), stating that crisis teams must have capacity to visit service users twice per day.
- **Treatment options:** Only twelve trusts/LHBs said they had more than one alternative option to hospital or home treatment (such as crisis houses) and five had none.
- **Ethnicity:** Overall, minority ethnic groups had lower rates of access than would be expected from their representation in the local population, especially Indian, Pakistani and Chinese people. Those referred generally had equal or higher rates of access to home and hospital treatment.

Mind considers that a range of options should be available for people in crisis including crisis houses, retreats/respite care, peer/survivor-led services, host families and crisis-focused therapeutic programmes. It is possible to use the [online tool](#) on the Mind website to identify what crisis services any particular mental health trust provides.

These deficiencies were borne out by the findings of another report entitled '[The Abandoned Illness](#)' undertaken by the Schizophrenia Commission, set up by Rethink Mental Illness, also published in November 2012. Its findings include:

- People with severe mental illness such as schizophrenia die 15-20 years earlier than other citizens.
- Only 8 per cent of people with schizophrenia are in employment.
- 87 per cent of service users report experiences of stigma and discrimination.

There are also a number of recommendations including: the need for a radical overhaul of poor acute care units; better prescribing and a right to a second opinion on medication involving, where appropriate, a specialist pharmacist; increasing access to psychological therapies in line with NICE guidelines, and delivering effective physical health care to people with severe mental illness.

In March 2013 Mind released further data from trusts which shows stark inequalities in the way people from Black and minority ethnic (BME) groups are treated when they're in crisis and published another briefing for clinical commissioning groups, on ensuring that crisis care meets the needs of diverse communities. Read more at www.mind.org.uk/crisiscare. You can sign up to support the campaign here too.

The next focus for Mind's campaign will be on the use of restraint in health care settings. If you would like to feed into this please contact Rezina Hakim at r.hakim@mind.org.uk

Care and Support Bill and section 117 of the Mental Health Act 1983

Angela Truell, Mind Legal Unit

Background

[The Care and Support Bill](#) was published in July 2012. The pre-legislative scrutiny committee published [its report](#) on the bill in March 2013. They observe that enactment of the Care and Support Bill will constitute the biggest change in the law governing the operation of care and support in England since the National Assistance Act 1948, placing on a statutory footing the principles and practices of self-directed personalised care. Following the Dilnot Report, Fairer Care Funding and the government's decision to introduce a capped costs system for working age adults for paying for care, the committee observe that there is a significant implementation challenge for all concerned in social care.

Paul Farmer, Chief Executive for Mind gave evidence to the committee to explain Mind's particular concerns. Mind wants to ensure:

1. Adequate provision of advocacy. (Clause 2) The bill does not make adequate provision for advocacy. Advocacy is essential to enable some people to access assessment processes and support planning as well as to provide support in safeguarding processes and in the complaints procedures. The scrutiny committee does recommend that advocacy is available before any social care assessment process begins but does not recommend provision that is more extensive.
2. Social care is available for those who need preventive help. Eligibility for care and support will depend on the National Eligibility criteria in regulations yet to be published. It is important that these take account of the fluctuating nature of certain health conditions and the need for care to prevent deterioration in health conditions. If only critical needs for care and support are met, people who can recover or avoid crisis, if given timely care will be left out.

Clause 1 of the draft Care and Support Bill contains the well-being principle. This requires local authorities to promote an individual's well-being when exercising their functions. The scrutiny committee recommend that in making regulations relating to eligibility for care and support, the Secretary of State should have regard to the duty of local authorities to promote well-being, and that the bill should be amended to make this a specific requirement (clause 13(2)).

The committee have also recommended that the Bill be amended to require local authorities to have regard to the importance of identifying adults at risk of developing care and support needs or increasing such

needs who may benefit from support to prevent deterioration in their well-being. They consider that the Bill needs amending to ensure that, when local authorities provide information and advice, and when they promote diversity and quality of services, these functions take account of the need to provide preventive services (clauses 2 and 3). They recommend that the local authorities' obligation to promote diversity and quality of service should explicitly refer to involvement of service providers, service users and carers.

3. Adequate care and support on discharge from hospital. Mind has argued that the Bill needs to ensure that people with mental health problems who need support on leaving hospital have their care needs considered and met. The [Mind Legal Advice Line](#) hears of people discharged without adequate provision of care and support.

Voluntary patients and people who have been subject to section 2 of the [Mental Health Act 1983](#) can face problems in securing social care assessments or getting the community care they need when they are discharged from hospital. The delayed discharge provisions in Clause 47 and Schedule 2 of the Bill do not apply to mental health patients (Schedule 2, section 7(7)). Additional provisions are arguably needed for joint planning and assessment for patients with after-care needs at the time of discharge from psychiatric hospitals to ensure that they are not discharged without the services that they need.

The committee agreed that integration between health providers and social services at the time of discharge from hospital needs to be included in the bill with particular emphasis on the adequacy of housing when people are discharged (Clause 5(1)). It also recommends that the government consider redrafting Schedule 2 to the Bill. It asks the government to take account of the need for parity of esteem between mental and physical health and to codify best practice in coordination of care before, during and after discharge.

The committee's report also highlights the crucial role that housing can play in effective and successful hospital discharge and emphasises housing as "a key partner of adult care and support"

Mind hopes that the Government will at least adopt the committee recommendations but is arguing that wider advocacy provision is needed.

Aftercare services under section 117 of the Mental Health Act

The committee did not agree that changes were required to the Bill in relation to aftercare services under s117 of the [Mental Health Act 1983](#) (MHA). However, Mind remains very concerned about Clause 48(5) of the Bill and how it will affect care planning under s117 MHA.

Section 117 MHA places a joint duty in England on Clinical Commissioning Groups and local authorities to provide free after-care services for people detained under treatment provisions of the Act and for community patients, those on Community Treatment Orders. Currently, there is no definition of after-care services although chapter 27 of the [Code of Practice to the MHA](#) gives a non-exhaustive list of possible services and guidance about how aftercare should be planned and what aspects of a person's care need to be considered. The purpose of aftercare is to prevent readmission.

The Care and Support Bill defines after-care services for the first time in clause 48(5) as follows:

- “(a) To meet a need arising from the mental disorder of the person concerned; and
- (b) To reduce the likelihood of the person requiring admission to a hospital again for treatment for the disorder.”

To qualify for aftercare services will therefore require a two-part test. Mind considers that the first part of this test - “to meet a need arising from the mental disorder” narrows the range of services that can be deemed to be after-care services. This in turn may lead to disputes or additional social care financial and eligibility assessments that delay discharge or discourage uptake. If a service is not part of the s117 after-care package it will be subject to eligibility and if assessed as eligible then a person will be expected to undergo a financial assessment and pay.

To prevent readmission, a person detained under section 3 MHA may require a care package with a wide range of services including housing support, a community care worker to help budget and manage bills and appointments, medication administered by a CPN and provision of meaningful daytime activities. Mind considers there is a serious risk that essential services such as housing support, employment advice and budgeting can be excluded from the s117 package using this two-part definition as they are not services that, strictly meet a need *arising from the mental disorder* of the person concerned. On a medical model it may be only medication or nursing that meet a need arising from a mental health disorder

Like the Law Commission, the Pre-legislative Scrutiny Committee report takes the view that the proposed definition in Clause 48(5) is merely a restatement of the current law. We consider this is not so. The two-part definition is not one that reflects the range and detail of aftercare considerations currently outlined in chapter 27 of the Code of Practice. Nor is it consistent with broad definition of after-care in the case of [R \(Stennett\) v Manchester City Council \(2002\) UKHL 34](#). At paragraph 9 of this case, Lord Steyn confirms that after-care services would normally include social work, support in helping the ex-patient with problems of employment, accommodation or family relationships, the provision of domiciliary services and the use of day centre and residential facilities. The guidance in the Code of Practice and the broad outline in *Stennett* are consistent with a

social model of disability and a recovery approach to mental health after-care.

The wording for the Care and Support Bill comes from the first instance case of [R \(Mwanza\) v Greenwich LBC \(2010\) EWHC 1452 \(Admin\)](#). There are a number of problems with this case including the fact that the judge appears to misunderstand the relationship between s 21 [National Assistance Act 1948](#). Section 21 may sometimes be used to provide accommodation for people with mental health problems who are in the community. The definition he ascribes to s117, which arguably is *obiter*, comes from a commentary on the MHA and is not fully consistent with the Code of Practice or *Stennett*.

The drafting of both clauses refers to “the mental disorder” and it is unclear what the mental disorder will refer to. People enter hospital with a range of diagnoses and symptoms. If aftercare is to be provided by reference to only one particular disorder this will lead to further controversy.

Mind proposes that Clause 48(5) (a) be removed and if there is to be a statutory definition of after-care services the definition should be services the purpose of which is to reduce the likelihood of the person requiring admission to a hospital again for treatment of mental disorder. Effectively this would be Clause 48(5)(b) without the use of the definite article.

Additionally, any specific concerns about aftercare could be addressed specifically in the update to the Code of Practice to the Mental Health Act promised by the government by 2014 in their timetable for actions contained in the final report released following [Winterbourne View, Transforming Care: A national response to Winterbourne View Hospital](#) (see Recommendation 59).

Case reports

R (Chatting) v (1) Viridian Housing (2) Wandsworth LBC [2012] EWHC 3595 (Admin), 13 December 2012

Reported by Joanna Sulek, Mind Legal Unit

The judgment in this case can be read [here](#).

The facts

Since 1995 the Claimant Miss Chatting ('Miss C') had been housed by the Local Authority under s21 [National Assistance Act 1948](#) in residential care at Mary Court in a self-contained flat. This was owned by the Housing Association Viridian Housing, who provided care services as well as accommodation.

In 1999 the Claimant and one other resident of Mary Court had challenged a decision of the Housing Association to close Mary Court, as it was making a loss. The result of this case was that the Housing Association was not amenable to judicial review, as at that time, s6 of the [Human Rights Act 1998](#) had not yet come into force. However, Miss C was able to stay at Mary Court under a compromise agreement made in 2001, under which the Housing Association were to continue to provide residential accommodation with board and care. However, their obligation would cease if a local authority community care assessment were to find that her needs could no longer be met at Mary Court and/or that she required nursing care.

Miss C was therefore able to remain at Mary Court under a residential care arrangement, even though the rest of the block was converted into sheltered housing. Her flat was covered by the care home registration of a residential unit situated on the floor below, but in the same building. However, in 2011 the Housing Association decided to withdraw from the provision of care services in general and contracts were exchanged for another provider, Goldcare, to take these over. Miss C challenged the transfer of management through a Litigation Friend, asking that the flat should be registered as a single residential care unit.

By this time, anyone who provided for any person accommodation with nursing or personal care in a care home under certain statutory provisions such as the National Assistance Act was to be defined as exercising a function of a public nature under s5(3)(b) Human Rights Act 1998, and was therefore bound to act in accordance with that person's human rights under the [European Convention on Human Rights](#) (ECHR). This meant that the Housing Association should be regarded as acting as a public body in relation to the care and accommodation function (s145 [Health and Social Care Act 2008](#)).

A social work consultant in her report had questioned why LBC Wandsworth had not set up a 'residential unit of one' within Mary Court, which would have been the option that would have best met Miss C's needs. Moreover, in her view such an arrangement would have been "consistent with best principles of Best Interests decision-making, a statutory requirement under the [Mental Capacity Act 2005](#) given Miss Chatting's lack of mental capacity to make decisions about her care, treatment and residence" (para.36 of the judgment). The implication is that the local authority acted unlawfully by failing to consider her best interests in coming to a decision about her care arrangements. The Council replied that this proposal was not financially or practically viable, but that they would continue to meet Miss C's needs either at Mary Court or elsewhere. They also contended in a reply to her solicitors that they could not control Viridian's decisions about its premises, how the flat was managed or how care was provided. This stance was criticised by Counsel for Miss C as it showed that the Council were not prepared to give weight to the evidence given by the independent social worker as to where her best interests lay.

The Claimant sought permission to bring judicial review proceedings in April 2012 seeking a declaration that Viridian had breached her human rights under the ECHR and an order reversing its decision to withdraw from her care; also a declaration that Wandsworth LBC had not carried out their duty to meet her needs and/or had failed to take her best interests into account. Permission was granted for judicial review of these matters. The case against Wandsworth was based on its duties under s21 National Assistance Act 1948 and Department of Health guidance on social care for people who lack capacity issued under Local Authority Social Services Act 1970 (LASSA), regarded as binding on local authorities ('LASSA' guidance). The guidance stresses the importance of following the principles for decision-making set out in the Mental Capacity Act 2005.

The judgment

The Deputy Judge held that the Housing Association had not given any assurances in the compromise agreement as to the management of Mary Court or who would perform this. The transfer to Goldcare of the Claimant's care did not therefore breach the compromise agreement.

Viridian's obligation was to "bring about the result that Miss Chatting continues to receive accommodation with board and care in Mary Court ..." (judgment, para.75) as opposed to any obligation to provide or perform services personally.

In addition the compromise agreement did not entitle Miss C to remain in the flat if a lawful community care assessment carried out by the Local Authority found that she required nursing care of a sort that cannot be provided in a residential care home. Any assurance of providing Miss C with a 'home for life' had been subject to such a proviso.

Her claim under Article 8 ECHR also failed, as the changes in the management of the care home had not interfered with her private life. The Judge could find no obligation under Article 8 for the Housing Association to preserve the same legal identity of the organisation providing her accommodation and care. In fact, the transfer of responsibility to a new organisation had not brought about a break in continuity in the environment or staff.

As for the 'best interests' challenge of the local authority decision not to register Miss C's flat as a single residential unit under s26 National Assistance Act 1948, the judgment indicated that the correct legal test was whether its actions were compatible with the Claimant's welfare, but not whether those decisions were in her best interests (even if she lacked capacity as defined under the Mental Capacity Act 2005). Her best interests had been a material consideration for the authority and not been disregarded, but under public law, the authority was required primarily to have due regard to the Claimant's welfare (and, it is submitted, the requirements of procedural fairness e.g. consulting of those affected by the decision), rather than meet the best interests test set out in s4 Mental Capacity Act 2005:

" ... the fact that Miss Chatting is mentally incapacitated does not import the test of 'what is in her best interests?' as the yardstick by which all care decisions are to be made (para 99) ... They could rationally conclude that the decisions were compatible with her welfare. They did not as a matter of law require Miss Chatting's assent to these decisions; no decision, or participation in a decision was involved on her part" (para.100).

Comment

Presumably, the emphasis here lay in meeting Miss C's 'assessed needs' (judgment para.92), as identified by the local authority in her care assessment, rather than prioritising what Miss C and her family preferred or might have preferred; or otherwise following the steps outlined in s4 Mental Capacity Act 2005 and the MCA Code of Practice for ascertaining what lies in the best interests of the person lacking capacity when taking a decision on behalf of that person – arguably a more demanding procedure for the local authority to have undertaken. Nor would a local authority normally be required to seek a best interests declaration from the Court of Protection. An exception might be where a person lacking capacity were to refuse a care option proposed by a public authority, a scenario raised in the [Thirty Nine Essex Street Court of Protection Newsletter January 2013](#). Compare the case alluded to in this judgment, of [R \(W\) v Croydon BC \[2011\] EWHC 696 \(Admin\)](#), where, in contrast to the case under discussion, a change of accommodation was actually being proposed.

Bureš v the Czech Republic [2012] ECHR 1819, 18 October 2012

Reported by Joanna Sulek, Mind Legal Unit

The judgment in this case can be read [here](#).

This was an application to the European Court of Human Rights from a Czech national alleging ill-treatment in a sobering-up centre in violation of Article 3 of the [European Convention on Human Rights](#) ("the Convention") and that he was detained in a psychiatric hospital contrary to Article 5.

This case is of interest as it attempts to set some parameters around the use of force and particularly, of restraint, when a State seeks to deprive a person of their liberty.

The facts

The applicant B was a cello player with a diagnosis of a psycho-social disability who in the past had been treated in Italian psychiatric hospitals as a voluntary patient. At the time of the alleged ill-treatment he was on psychiatric medication. On 9 February 2007 he accidentally overdosed on it and left his home without noticing that he was wearing only a sweater. A police patrol, assuming he was a drug addict, called an ambulance which took him to a psychiatric hospital. His examination by a doctor showed that he had no injuries at this time. On the same day he was sent to the sobering-up centre in the same hospital. Again he was examined and had no injuries on admission to the centre. On 10 February he was transferred to the Intensive Psychiatric Care Unit where on admission he was recorded to have visible abrasions on his neck and both wrists and ankles.

On 15 February 2007 he was examined by a neurologist, who concluded that as a result of the use of restraining straps on B, he had suffered severe paresis of the left arm and medium to severe paresis of the right arm.

B's evidence was that he had been strapped to a bed with leather straps around his wrists, ankles and knees by two male nurses, which had been left on all night, during which time staff had not checked on him. The straps had caused him to struggle to breathe and restricted circulation in his arms so that the nerves in his arms were damaged. The Government disputed his evidence and in particular claimed that he had been strapped to his bed for 3 shorter periods.

In the course of a police investigation of a criminal complaint by B concerning the restraint, a female nurse stated that B had been strapped to the bed because he had been restless and intoxicated by an unknown substance, which it was impossible to verify as B had refused to take a blood test. It was also possible that B had not been checked at regular intervals owing to the high number of patients in the centre that night. A

doctor who had been on duty stated, however, that he and other staff had made regular checks on B.

In a report commissioned by the police a forensic expert stated that B had suffered bilateral severe paresis of the elbow nerves as a result of compression of the nerves and blood vessels, and that the injury limited B's ability to play the cello. The effect would be long-lasting but was unlikely to be permanent.

The judgment

The judgment refers to Czech Guideline no. 1/2005 of the Journal of the Ministry of Health on the use of measures of restraint on patients in psychiatric facilities in the Czech Republic:

"The use of measures of restraint must be considered as a last resort in cases when it is necessary for the protection of the patient, other patients, the patient's surroundings and staff of psychiatric facilities. They may be used only after all other possibilities have been exhausted. Any decision to restrain the patient must be sufficiently grounded. Restraint cannot be used to facilitate treatment or to deal with a restless patient. ...The benefit of the use of restraining means must outweigh the risks ...

2. Measures of restraint can be used only exceptionally ... In the case of each individual patient it is necessary to use the most gentle and appropriate means of restraint ..."

The Guidelines also stated that a restrained person shall be checked on a regular basis at specified intervals and that measures of restraint shall be used for the shortest time possible. The use of restraint and frequency of checks should be recorded.

The judgment also referred to other relevant international standards, such as the CPT Standards (The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment) concerning the use of restraints in psychiatric establishments (CPT/Inf/E (2002) 1-Rev.2010). *Inter alia* these state that resort to 'instruments of physical restraint' shall only very rarely be justified and should be removed at the earliest opportunity.

The applicant maintained that he had been calm when he had been transferred to the psychiatric hospital and his alleged restlessness could not justify the use of the restraint for 10 hours. The straps applied to his wrists, ankles and knees had been so tight that he could not move and the treatment had had a long-term effect on his health and prevented him from completing his studies and working as a cellist. The treatment had therefore reached the minimum level of severity required for Article 3. The

Government contended that the restraint had been necessary for the protection of B's health and, as he had refused to supply a blood sample, it had not been possible to use a less severe measure.

The Court found that B's injuries were not an unintended result of medical treatment, so that the relevant case law would not concern medical negligence but the use of restraints on persons in detention, which the Court had always considered from the point of view of negative obligations. The restraints were not medical treatment that the detainee could refuse. The restraints and force used on him would only be permitted by Article 3 if they were made strictly necessary by B's own conduct. The Court had previously recognised the "special vulnerability" of mentally ill persons (judgment, para.85) and in assessing whether the treatment is incompatible with Article 3 it must take this vulnerability into account.

Recourse to physical force in respect of persons deprived of their liberty which has not been made strictly necessary by their own conduct "diminishes human dignity and is in principle an infringement of the right set forth in Article 3 of the Convention" (para 86). A measure which is a therapeutic necessity cannot be inhuman or degrading under the principle in [*Herczegfalvy v Austria*](#) but the medical necessity must be convincingly shown. Restraints can be used when shown to be necessary, but their use must not be excessive or for an excessive length of time.

The assessment of whether the ill-treatment reaches the minimum level of severity is relative and depends on the circumstances of the individual in question. Here the Court referred to the fragile build of B, his mental illness and his particularly vulnerable position as a patient at the sobering-up centre in a state of intoxication. The serious consequences of the treatment were shown by the expert report commissioned by the police which described the severe bilateral paresis of B's elbow nerves and the effects of this injury on B. The Court considered that the strapping of B must have caused him great distress and physical suffering, and that in principle Article 3 was applicable to his case.

The Court noted that the Government cited B's restlessness for his initial restraint on the evening of his admission to the sobering-up centre and afterwards his allegedly aggressive behaviour towards staff. It also noted that under the Czech Guidelines restraints cannot be used when the patient is merely restless, and was not satisfied that the purpose of applying restraints to strap B to his bed subsequently was to prevent attacks on staff.

The Court considered that "using restraints is a serious measure which must always be justified by preventing imminent harm to the patient or the surroundings and must be proportionate to such an aim" (para.96). Not only had alternative methods not been attempted, but strapping had been applied as a matter of routine, so even the domestic guidelines had not been complied with. The Court therefore concluded that the Government

had not justified the use of restraints on a detained person and had failed to show that their use was necessary and proportionate in the circumstances.

The Czech police investigation had established that regular checks had not been performed on B and the Court found that this was one of the reasons for the long-lasting effect on B's health. The Czech authorities had failed in their obligation to protect the health of persons deprived of their liberty ([*Keenan v the United Kingdom*](#) and [*Jasinskis v Latvia*](#)).

The Court concluded that B had been subjected to inhuman and degrading treatment contrary to Article 3 of the Convention, holding that there had been a substantive violation of Article 3. The Court also upheld B's complaint of a procedural violation of Article 3 in respect of the police authority's investigation. However, B's complaint that his involuntary admission and detention in the psychiatric hospital violated his right to liberty under Article 5(1) of the Convention was rejected as he had not exhausted all domestic remedies.

ZH v Commissioner of Police for the Metropolis [2012] EWHC 604 (QB), 14 February 2013, Liberty and the Equality and Human Rights Commission intervening

Reported by Martha Spurrier, Mind Legal Unit

The judgment in this case can be read [here](#).

The facts

ZH was a severely autistic and epileptic nineteen year old, who suffered from learning difficulties and could not communicate by speech. He brought a claim for assault and battery, false imprisonment, unlawful disability discrimination under the [Disability Discrimination Act 1995](#) (DDA) (which is no longer in force, having been replaced by the Equality Act 2010) and breaches of Articles 3, 5 and/or 8 of the [European Convention on Human Rights](#) and for declaratory relief.

In September 2008, ZH was on a group trip at a swimming baths, although they were not swimming. He became fixated by the water and could not be encouraged to move away. His teacher went back to his nearby school to fetch help. His carer told pool staff not to touch him, otherwise he would jump in. The manager at the pool decided to call the police, telling them that ZH was aggressive. When the police arrived, the carer explained that ZH was disabled, but they approached him and he jumped into the water. ZH could not swim. The lifeguards entered the water and grabbed ZH. He was then moved into the shallow end of the pool and lifted out, struggling. Leg restraints and handcuffs were applied and ZH was put into a police van. The restraints were later removed. ZH suffered psychological trauma as a result of the experience, and exacerbation of his epileptic seizures.

In the [first instance hearing](#) of the case in the High Court, Sir Robert Nelson found that the police had not only committed the torts of trespass and false imprisonment, but had also breached ZH's rights under Articles 3, 5 and 8 ECHR and also the DDA 1995.

The Metropolitan Police appealed this decision to the Court of Appeal.

The judgment

The Court of Appeal had no hesitation in dismissing the appeal, the sole – very strong – judgment being given by the Master of the Rolls, Lord Dyson, with whom Richards and Black LJ agreed.

As regards the conclusions reached by Sir Robert Nelson upon the [Mental Capacity Act 2005](#) (MCA) issues, the primary basis of the appeal was that the judge had failed to have regard to the “fact that the reasonableness of the officers' conduct and beliefs fell to be assessed by reference to a fast moving situation in which swift decisions had to be taken. In short, he failed

to take account of the need to accord to the police a reasonable degree of operational discretion. She goes so far as to say that the judge's decision makes it impossible to conduct practical policing in emergency situations which involve persons who suffer from incapacity" (para.35). Having made some general observations about the MCA, Lord Dyson MR held that Sir Robert's conclusions that the police officers reasonably believed that ZH lacked capacity before any touching took place, and that they had no reasonable belief that there was in fact an emergency which required them to act before speaking to his carers (paras 46 and 49) were unassailable. Nor did he consider it unrealistic for Sir Robert to have concluded that it was practicable and appropriate for the officers to consult the carers before approaching and touching ZH (para.49):

"[T]he MCA does not impose impossible demands on those who do acts in connection with the care or treatment of others. It requires no more than what is reasonable, practicable and appropriate. What that entails depends on all the circumstances of the case. As the judge recognised, what is reasonable, practicable and appropriate where there is time to reflect and take measured action may be quite different in an emergency or what is reasonably believed to be an emergency."

On the issue of reasonable adjustments, Lord Dyson MR stated as follows (para.67):

"I do not find it necessary to make detailed observations as to the scope of the duty to make reasonable adjustments. What is reasonable will depend on the facts of the particular case. Section 21E(2) states in terms that it is the duty of the authority to take such steps as it is reasonable in all the circumstances of the case to have to make to change the practice, policy or procedure so that (relevantly for the present case) it no longer has detrimental effect. I accept that police officers are not required to make medical diagnoses. They are not doctors. But the important feature of the present case is that, even before they restrained ZH, they knew that he was autistic and epileptic. They knew (or ought to have known) that autistic persons are vulnerable and have limited understanding. Further, I see no basis for holding that the duty to make reasonable adjustments is not a continuing duty. In my view, the judge was entitled to reach the conclusion that he did on this issue. It was a decision on the particular facts of this case. I reject the submission that his decision makes practical policing unduly difficult or impossible."

The Court of Appeal also upheld Sir Robert's conclusion that the treatment experienced by ZH had met the threshold of inhuman and degrading treatment, contrary to Article 3 ECHR (para.76):

"[...] The following features of the present case are important. ZH was a very vulnerable young man. He suffered from autism and was an epileptic. He was only 16 years of age at the time. The episode lasted about 40 minutes. He would not have understood what was going on and why he was being forcibly restrained by a number of officers by the poolside and later in the police van. He was restrained by handcuffs and leg restraints. He was wet and lost control of his bowels. His carer was not permitted to get into the cage to comfort him. He had done nothing wrong and he was extremely distressed and crying. The consequence of the experience was that he suffered (i) post traumatic stress disorder from which he was only recovering by the time of the trial (more than two years after the event); and (ii) a significant exacerbation of his epilepsy for about two years. On the other hand, it is also relevant that the officers did not intend to humiliate or debase him, although this is not a conclusive factor.

77. I acknowledge that a court should not lightly find a violation of article 3. The ECtHR has repeated many times that a minimum degree of severity of treatment is required. Whether that degree of severity is established on the facts of a particular case involves a question of judgment. The judge was better equipped than this court to be able to evaluate the seriousness of the treatment, taking all the circumstances of the case into account. In my view, we should only interfere if we consider that it is plain that the judge made the wrong assessment. It is clear from para 144 of his judgment that he took into account all the essential relevant factors. Although the police officers were acting in what they thought to be the best interests of ZH, on the judge's findings they made serious errors which led them to treat this vulnerable young man in a way which caused him great distress and anguish. In my judgment, the judge was entitled to find that the threshold of article 3 had been crossed on the particular facts of this case."

Lord Dyson MR also rejected a submission (founded upon the decision of the European Court of Human Rights in [*Gillan v UK*](#)) that Strasbourg would usually view a detention of less than 30 minutes as not coming within the scope of Article 5, holding that ZH was deprived of movement throughout the entire period of the restraint. The restraint was intense in nature and lasted for approximately 40 minutes and its effects on ZH were serious.

The police having conceded that their appeal upon the judge's findings in respect of Article 8 stood or fell with their appeals against the findings in respect of Articles 3 and 5, Lord Dyson MR held that the appeal fell in this respect as well.

At paragraph 90, Lord Dyson concluded with an important general observation:

“As I have said, I reject Ms Studd's submission that this decision unreasonably interferes with the operational discretion of the police or that it makes practical policing impossible. I accept that operational discretion is important to the police. This was recognised by the judge. It has been recognised by the ECtHR (see Austin at para 56). And I have kept it well in mind in writing this judgment. But operational discretion is not sacrosanct. It cannot be invoked by the police in order to give them immunity from liability for everything that they do. I doubt whether Ms Studd intended to go so far as to suggest that it can. Each case must be carefully considered on its facts. I do not believe that anything said by the judge or by me in this judgment should make it impossible to carry out policing responsibly. One is bound to have some sympathy for the police in this case. They were intent on securing the best interests of everyone, not least ZH. But as the judge said, they behaved as if they were faced with an emergency when there was no emergency; and PC Colley and PC McKelvie did not in fact believe that there was an emergency. Had they consulted the carers, the likelihood is that ZH would not have jumped into the pool in the first place. The police should also have consulted the carers before lifting ZH from the pool. Had they done that, it is likely that with their help, the need to restrain him would have been avoided. Finally and most seriously of all, nothing could justify the manner in which they restrained ZH.”

For more commentary on this case, see this [article by Owen Bowcott](#) in *The Guardian* and Lucy Series' [blog post](#) on the High Court judgment on the UK Human Rights Blog.

RCW v A Local Authority [2013] EWHC 235 (Fam), 12 February 2013

Reported by Martha Spurrier, Mind Legal Unit

The judgment in this case can be read [here](#).

The facts

This case concerned physical disability but has clear relevance in the context of mental disability. The applicant, RCW, was a prospective adopter who lost her sight following an operation. The child, SB, had been placed with RCW under a placement order in October 2012 by the local authority, LBX. SB was born prematurely, weighing just 1kg. She had been abandoned by her mother at birth. SB spent 3 months in hospital with specialist nursing care before being discharged into foster care. SB was matched with RCW for the purposes of adoption. It was known by LBX that RCW was a single woman with a full-time career. On that basis the placement was made and it was extremely successful, by all accounts.

RCW began experiencing problems with her vision and it was found that she had a brain tumour which was pressing on an optic nerve. She required immediate surgery. By 4th January 2013 SB had been with RCW for 10 weeks, therefore RCW was able to make an application for adoption. However, on 4th January RCW went into hospital. RCW had made detailed plans for SB's care while she was in hospital, enabling the help of a group of her friends who were all familiar to SB. RCW was in hospital for 3 weeks during which SB was taken care of and visited RCW every other day.

After the operation RCW found that she had lost her vision. One of her friends informed LBX of the situation. While RCW was still in hospital there was a planning meeting to take into account the possible need to move SB. On the day of RCW's release from hospital there was a social worker visiting her at home to assess her. At this stage the health professionals could not determine whether this was to be a temporary or permanent situation. RCW and SB continued to be cared for by RCW's friends, with RCW involved in feeding and cuddling SB.

There were two further social worker visits on 25th January and 30th January followed by a meeting on 30th January at which it was decided that SB would be removed from RCW's care. On 4th February RCW's solicitor lodged an adoption application with the court. On the same day LBX wrote to RCW informing her of their intention to remove SB from her care. RCW made an application for urgent injunctive relief under sections 6 and 7 of the [Human Rights Act 1998](#) to prevent the local authority from removing a child from a prospective adopter due to the prospective adopter's loss of sight after an operation.

The judgment

Mr Justice Cobb stated that:

"A decision to remove a child who has been placed with prospective adopters is a momentous one. It has to be a solidly welfare-based decision, and it must be reached fairly."

The judge noted that RCW had not been involved in any of the meetings which were held to plan SB's future. Further:

"[I]t is difficult to identify on what material LBX could truly contend that it had reached a proper welfare-based evaluation; there had been limited direct observation and assessment by that time, no apparent discussions with the friends and supporters, and little knowledge of RCW's condition or, more pertinently, its likely prognosis."

LBX had been aware, before they had placed SB with RCW, that SB would, ultimately, be at nursery or have a nanny involved in her daily care as RCW was employed on a full-time basis. That others would now be caring for SB alongside RCW did not make for a good reason to remove SB from RCW's care.

The judge continued:

"Visual impairment does not of itself disqualify an adult from being a capable loving parent. In my judgment, the ability for RCW to provide good emotional care for SB (probably with support) needs to be properly assessed. It was not fairly assessed on 24 January 2013 when the social worker visited RCW's home.

I stop short of finding that the assumptions which the authority has made about parenting by a carer who is blind are discriminatory, but in ruling RCW out as a prospective carer so summarily, LBX has shown a worrying lack of enquiry into the condition or the potential for good care offered by a visually impaired parent."

Cobb J was critical about the lack of any support from LBX for RCW and SB before they decided to remove SB."

As a result, the application was granted.

Mental health and human rights update

Martha Spurrier, Mind Legal Unit

UN Special Rapporteur on Torture: No More Treatment without Consent

On 5 March 2013 the UN Special Rapporteur on Torture, Professor Juan A. Méndez issued a groundbreaking [report](#) and [statement](#) on torture and ill-treatment in healthcare settings. Professor Méndez presented the report to the UN Human Rights Council and States gave their formal feedback on the report.

The report and the statement are together groundbreaking contributions to global efforts to mainstream standards of the [UN Convention on the Rights of Persons with Disabilities](#) (UNCRPD) across all human rights mechanisms. This is the first time that the UN's expert on *torture* (not disability, or mental health) has established that:

- It is unacceptable for laws to allow doctors to enforce mental health treatment on people when that person is refusing such treatment. This means that laws should be adjusted to give primacy to the consent of the person concerned.
- Any form and duration of restraint and seclusion should be immediately banned, wherever they occur, including in psychiatric hospitals.
- Mental health services should be oriented to voluntary community-based services rather than compulsion-based hospital confinement and treatment.

In his speech to the UN Human Rights Council, Professor Méndez explained that “the severity of the mental illness cannot justify detention nor can it be justified by a motivation to protect the safety of the person or of others.”

Disability Rights Watch evidence gathering for the UN Committee on the Rights of Persons with Disabilities

The [Disability Rights Watch website](#) has been set up to collect evidence about disabled people's human rights. It is designed to ensure that disabled people are fully involved in monitoring the UK's performance in implementing the [UN Convention on the Rights of Persons with Disabilities](#). The information and stories that are gathered through the website will be used to show the UK Government where they need to improve law, policies and practice to ensure disabled people can enjoy full human rights. They will also form the basis of a report to send to the UN Disability Monitoring Committee outlining where the UK is not meeting the standards required.

Equality and Human Rights Commission report on human rights and business

In March 2013 the Equality and Human Rights Commission published a [guide to human rights for businesses](#). In its list of human rights relevant to

businesses it includes the right to physical and mental health and access to medical services.

Independent Advisory Panel on Deaths in Custody bulletin

The latest [bulletin](#) from the Independent Advisory Panel on Deaths in Custody provides an update on the Metropolitan Police inquiry into mental health and policing as well as the Department of Health and Care Quality Commission's positions on investigating deaths in psychiatric care.

Thematic inspection on section 136 police cells as places of safety

HM Inspectorate of Prisons and the Care Quality Commission have undertaken a [joint thematic inspection](#) of the use of police cells as places of safety for people with mental health problems under section 136 Mental Health Act 1983. This follows the finding of the European Court of Human Rights in [MS v United Kingdom](#) that a mentally ill man's Article 3 ECHR rights had been violated by his inappropriate detention in a police cell under section 136.

Legal aid update

Martha Spurrier, Mind Legal Unit

The [Legal Aid, Sentencing and Punishment of Offenders Act 2012](#) came into force on 1 April 2013, along with a number of attendant regulations. The Act drastically reduces the availability of civil legal aid, removes success fees in conditional fee agreements and makes changes to the rules on [financial eligibility](#) for legal aid. The following is a brief summary of the new legal aid regime. More information about all of the changes is available on the [Law Society website](#).

What is out of scope for legal aid?

The following areas of law are out of scope for legal aid:

- Housing, except cases involving homelessness or anti-social behaviour orders
- Immigration, except people who are in immigration detention
- Private family law, except where there is evidence of domestic violence, child abuse or child protection issues.
- Education, except special educational needs.
- Welfare benefits, except appeals on a point of law to the Upper Tribunal, Court of Appeal and Supreme Court, and situations where the First Tier Tribunal reviews its own decision after there has been an error of law
- Debt, except repossession cases and cases where the home is at risk
- Clinical negligence except where neurological injury to unborn child or baby under 8 weeks
- Employment (except Equality Act 2010 cases)

What is in scope for legal aid?

The following areas are in scope for legal aid:

- Community care
- Mental health
- Actions against the police
- Actions against public authorities, i.e. judicial review
- Discrimination contrary to the Equality Act 2010
- Special educational needs
- Homelessness
- Asylum and immigration detention
- Public family law i.e. care proceedings
- Private family law where there are issues of domestic violence and child abuse (see the [2012 Procedure Regulations](#) for more information about the evidential requirements for these cases)

The Mandatory Telephone Gateway

Another big change is the way in which people will be able to access legal services for certain areas of law. From now on the only way that someone will be able to get legal aid and publicly funded legal advice in discrimination, special educational needs and debt is by calling the government's Telephone Gateway. The Gateway will be staffed by non-legally qualified telephone advisers who will decide whether a person's legal problem falls within the scope of legal aid. If it does, they will be referred to a legally qualified adviser over the phone, who will determine whether they should receive legal advice over the phone or face to face.

Only the following people are exempt from using the Telephone Gateway:

- 1) Is in detention (including prison, a detention centre or secure hospital), or
- 2) Is under 18, or
- 3) Has been previously assessed by the gateway as needing face-to-face advice, has received this advice within the last 12 months, and is seeking further help to solve a linked problem from the same provider.

More information on the operation of the Telephone Gateway is set out in the [2012 Procedure Regulations](#).

How will people get funding for the areas that are no longer in scope?

Where an area of law has gone out of scope, the only way for a person with a legal problem in that area to get public funding is via the exceptional funding provisions under [section 10 of the Act](#). These provisions allow for a person to get legal aid if the absence of legal aid would result in a breach of their [human rights](#) or European Union law rights. The individual will also have to be financially eligible for legal aid and be able to demonstrate that their case has sufficient merits for legal assistance.

This means, for example, that where Article 6 of the European Convention on Human Rights (ECHR) (right to fair hearing) would be breached if someone did not have a lawyer, the UK government will have to provide legal aid. The question that the Legal Aid Agency will ask is whether without legal aid it would be practically impossible for someone to bring their case and/or whether the absence of legal aid would result in obvious unfairness in the proceedings.

The circumstances in which someone might be eligible for exceptional funding because of their rights under Article 6 ECHR include:

1. They are too emotionally involved in the proceedings to represent themselves e.g. where there are allegations of abuse
2. The proceedings are too legally, factually or procedurally complex e.g. expert evidence, hundreds of pages of documents
3. The personal characteristics of the litigant make it especially difficult for them to represent themselves e.g. mental health problems, learning disabilities, low level of education, English not first language

4. The financial consequences of losing the case are ruinous for the litigant
5. The issues at stake are of huge importance to the litigant e.g. issues of life, liberty, independence, child protection, safeguarding
6. There is no other way that the litigant could get help with the proceedings e.g. free legal assistance, help from a charity, private funding

There will also be circumstances in which other Articles of the Convention will require the provision of exceptional funding (including Article 2 (the right to life), Article 3 (the right not to be treated in a way that is inhuman or degrading and the right not to be tortured), Article 5 (the right to liberty), Article 8 (the right to a private and family life) and Article 14 (the right not to be discriminated against)). In addition, Article 47 of the Charter of Fundamental Rights of the European Union may require the provision of legal aid in cases where the UK is implementing EU law.

More information on exceptional funding is available in the [Lord Chancellor's guidance on civil cases and inquests](#) and also from the [Public Law Project](#), which is running a project designed to assist people with making exceptional funding applications.

News

The Fifth Year of the Independent Mental Capacity Advocacy Service 2011/2012

In February 2013, the Department of Health published its [fifth annual report on the Independent Mental Capacity Service](#) and reviewed the five years of Independent Mental Capacity Advocate (IMCA) service from April 2007 to October 2012. It makes for interesting reading.

The legal framework for IMCA service

The [Mental Capacity Act 2005](#) (MCA) created the IMCA service imposing a legal duty to provide an IMCA in certain situations to empower and safeguard people who lack capacity to make key decisions, usually when they do not have friends or relatives to represent them

Since April 2007, there has been a duty to instruct IMCAs for people who lack capacity to make decisions about serious medical treatment (s37) and about the arrangement or change of long-term hospital or care home accommodation (s39).

There is a power to instruct an IMCA when there is a review of long-term accommodation if this would be of particular benefit. Likewise, there is power to instruct an IMCA when there has been an allegation of abuse or neglect by another person or that the person who lacks capacity has been abusing or neglecting someone else and it is of benefit (s41 Mental Capacity Act 2005 and [The Independent Mental Capacity Advocates \(Expansion of Role\) Regulations 2006](#) regs 3 and 5).

For deprivation of liberty safeguards (DoLS), there are three situations when an IMCA must be appointed for a person who lacks capacity:

- 1) To support and represent them when they are being assessed as to whether they should be or are deprived of their liberty.
- 2) To cover the gap in the appointments of the relevant person's representatives when they are already subject to an authorisation.
- 3) To support them or their unpaid relevant person's representative in relation to exercising their rights where a deprivation of liberty has been authorised.

The report

Year on year the number of IMCA referrals is increasing and there were 11,899 eligible instructions for the IMCA service in England in the last year. This is an expanding service and so commissioners are recommended to take note of this.

The report provides some interesting data analysis. The Appendix A, detailing IMCA instructions by local authority for 2011-2012, shows wide

disparities in the rate of IMCA instruction which cannot be explained by population variations alone. It indicates that duties to appoint IMCAs are still not well understood.

From the 130,000 safeguarding alerts reported by local authorities in 2011-2012, only 1533 received an IMCA and this number has declined slightly for the first time. The report has provided a list of authorities, starring those that it recommends should review their adult protection referrals. It also recommends that all Safeguarding Co-ordinators review the basis on which they make referrals.

In relation to decisions about accommodation, the report highlights the case of [CC v KK & STCC \(2012\) EWHC2135 \(CoP\)](#). This was an accommodation case where the judge decided that KK did have capacity to choose where she lived, despite expert evidence to the contrary as she understood the salient features of the decision. He emphasised that it was for the authority to prove a person lacks capacity and the decision about accommodation - whether to place a person in a care home or to keep them there - cannot be made without clarifying what a return home with a care package would entail.

As for Deprivation of Liberty Safeguards, there was an increase of 18% in referrals over the last year - nearly 2000 referrals were made. The report welcomes the increased use of s39D IMCAs. Section 39D IMCAs are an important safeguard in ensuring that the person deprived of liberty and their representative understands they have a right to review and to go to the Court of Protection. Early appointment of a 39D IMCA in the [Nearu](#) case might have avoided an unlawful deprivation of liberty sooner. The report includes in the Appendix a set of useful research references including the ADASS and SCIE good practice guide on The IMCA roles within the Deprivation of Liberty Safeguards.

The referral rate for care reviews has increased but it is still low. The report questions why IMCAs are not involved in reviews following an accommodation change. Good practice dictates that there should be a review within 3 months of a person moving to new accommodation and then annually. It recommends that local authorities ensure that all who would benefit from IMCAs in their Reviews should receive one and that the Mental Capacity leads in CCGs monitor compliance with the requirement to make referrals to IMCAs as part of their MCA responsibilities.

Winterbourne View – The Department of Health Final Report

In December 2012 the Department of Health published its Final Report [“Transforming care: A national response to Winterbourne View Hospital”](#) in response to the abuses of people detained in that hospital that remained undetected.

The Department provides a model of care with key principles of high quality services for people with learning disabilities and challenging behaviour. It provides a timetable for key national actions that it considers will deliver a redesign to the care and support for people with learning disabilities or autism and mental health conditions or behaviours viewed as challenging (Annex B). The 63 actions include:

- The Care Quality Commission (CQC) making unannounced inspections to providers of learning disability and mental health services, with people who use the services and their families on the inspection team from June 2012 (1).
- Tougher enforcement action by the CQC including prosecutions and closures if providers consistently fail to have a manager in place and taking enforcement action against providers who do not operate effective processes to ensure they have sufficient trained staff from June 2012 (2).
- [National minimum standards](#) and a code of conduct for healthcare support workers, published in March 2013 by Skills for Health (15).
- Working with independent advocacy organisations to identify key factors needed in commissioning advocacy for people with learning disabilities in hospitals and working to drive up the quality of independent advocacy through strengthening the Action for Advocacy Quality Performance Mark from December 2012 (7, 8).
- Commissioning a review of prescribing antipsychotic and antidepressant medicines for people with challenging behaviour (45).
- Publishing guidance on best practice around positive behaviour support so that physical restraint is only ever used as a last resort by end 2013 (54).
- Updating the Mental Health Act Code of Practice in 2014 taking account of findings from the review (59).

Over 70% of admissions to Winterbourne View were under the Mental Health Act 1983. The role of the CQC has been the subject of scrutiny and operational changes relating to the CQC are included in the timetabled action plan. There remain serious questions about how the individual rights, including access to lawyers, advocates and tribunals, operated in Winterbourne View and what changes may be required to protect and promote access in the future.

Disability Hate Crime

In July 2012 the [Government responded](#) to the Equality and Human Rights Commission's 2011 inquiry report [Hidden From Sight](#) about disability related harassment. It accepted partially or fully the recommendations and committed to further action particularly around working to make the criminal justice system more accessible and responsive to victims and disabled people and to provide effective support to them.

On 22nd October 2012 the Equality and Human Rights Commission published a follow up to the Inquiry. [*Out in the Open: a manifesto for change*](#) makes recommendations in 7 strategic areas that need to be addressed if disability harassment is to be reduced. On December 14th the Law Commission announced a [review of hate crime](#) the report on which is due imminently.

Care Quality Commission Reports

On 22 November 2012, the Care Quality Commission (CQC) published its [State of Care Report](#) for England, documenting the shape and quality of the health and social care services. Key findings include:

- 91 % of NHS hospitals compared with only 86 % of NHS mental health, learning disability and substance misuse services were treating people with dignity and respect.
- Independent mental health and learning disability and substance misuse services were poorer in relation to safeguarding people from abuse (73% as opposed to 86% in the NHS).
- In private health care services, people with learning disabilities spend disproportionate time in assessment and treatment settings with no clear discharge plans and far away from their families.
- In adult social care in the learning disability sector only 63% of care homes met care and welfare standards for people with learning disabilities and 51% on safeguarding.

The CQC also published its [community mental health survey 2012](#) of people receiving care or treatment for a mental health condition. Findings included:

- The majority of participants said that they were treated with respect and dignity and listened to carefully.
- Over a quarter of those prescribed new medication in the last 12 months were not told about possible side effects and a third of those on the Care Programme Approach did not know who their care coordinator was.
- A considerable proportion of participants wanted more support from a member of staff with some aspects of day-to-day living including physical health needs, caring responsibilities, finding work, finding or keeping accommodation and financial advice or benefits.

In January 2013 the CQC published its third annual report on the operation of the Mental Health Act (MHA) [Monitoring the Mental Health Act 2011/2012](#). Key messages from the report are that the number of people who are subject to the MHA is rising (detentions rose by 5% and Community Treatment Orders by 10%) while the services e.g. approved mental health professionals, bed occupancy and access to psychological therapies are under pressure. It recommends that policy makers consider why numbers are rising.

In relation to respect and participation, there was some improvement but 37% care plans showed no evidence of patient views and in 21% records

there was no evidence of patients being informed of the right to an Independent Mental Health Advocate. 45% of patient records showed no evidence of consent to treatment discussions before the first administration of medication to a detained patient. The report records that while in many hospitals restraint practices were safe and appropriate, following Winterbourne View where restraint was used abusively the CQC outlines some points of good practice in relation to training, recording and patient involvement, ensuring that restraint is the last resort. Disturbingly, the CQC record two uses of restraint on wards by police with tasers. The CQC concludes that cultures persist where control and containment are prioritised over treatment and support. Because of this, it calls for:

- Care planning to include clear statements about how a person is to be helped to recover and follow CPA guidance.
- Hospitals to review their policies, procedures and practices to ensure there are no blanket rules that cut across treating patients as individuals
- Clinical staff to be appropriately trained in assessment and recording of mental capacity to consent to treatment.

They recommend that Boards of mental health trusts, community trusts and independent providers of mental health care drive changes needed and promote good practice with robust mechanisms to understand how people experience that service and that the NHS Commissioning Board and other commissioners of health services guarantee a person's dignity, recovery and participation.

Future focus of the CQC 's work will include increased involvement of people who use services in the MHA monitoring work; work with Healthwatch England to develop the CQC's understanding of the experience of those using the health services when subject to the Act and holding providers to account to improve in areas identified in the report.

In March 2013 the CQC published its [Monitoring Deprivation of Liberty Safeguards Report 2011/2012](#). It finds that use of the safeguards is increasing. 11393 application were made in 2011/2012, a 27% increase on last year. The CQC observes that:

- The Mental Capacity Act (MCA) is not well understood or implemented in practice.
- Staff on mental health hospital wards did not understand the difference between the powers of the Mental Health Act and use of the Deprivation of Liberty Safeguards (DoLS).
- Use of restraint was not always recognised or recorded.
- There is wide variation in how supervisory bodies carry out their roles in the DoLS system.
- It is not clear whether people's views and experiences of the Safeguards are being heard in care homes and hospitals.

For future action the CQC intends to:

- Improve inspectors' understanding of the MCA and DoLS.

- Develop ways to gather experiences of people lacking capacity and their friends, families and carers.
- Develop its work with local authorities in their role as supervisory bodies.
- Highlight and promote best practice.

It expects the following outcomes:

- Providers and commissioners of vulnerable adult services to improve understanding of the MCA and DoLs.
- Care providers to implement policies to minimise use of restraint.
- Providers and commissioners to have robust review processes and mechanisms for understanding the experience of people subject to DoLs.

Mental Health Discrimination Act 2013

On 28 February 2013 the [Mental Health Discrimination Act 2013](#) became law. The Act removes three legal barriers that contribute to a stigmatised view of mental health problems.

The three provisions in the Act:

- Repeal section 141 of the Mental Health Act 1983, under which a Member of the House of Commons, Scottish Parliament, Welsh Assembly or Northern Ireland Assembly automatically loses their seat if they are sectioned under the Mental Health Act for more than six months
- Amend the Juries Act 1974 to remove the blanket ban on “mentally disordered persons” undertaking jury service
- Amend the Companies (Model Articles) Regulations 2008 which states that a person might cease to be a director of a public or private company “by reason of their mental health”

Update on the review of the Public Sector Equality Duty

In March 2013 the Government issued a call for evidence to inform the review of the Public Sector Equality Duty (PSED). The Review was announced by the Home Secretary in May 2012 as part of the outcome of the Red Tape Challenge spotlight on equalities. The review sets out to establish whether the duty is operating as intended. The review is expected to be completed by June 2013, rather than the previous announced date of the end of April. Evidence can be submitted until 19 April 2013 (new closing date).

The review is particularly focusing on the following key themes:

- How well understood is the PSED and guidance
- What are the costs and benefits of the PSED
- How organisations are managing legal risk and ensuring compliance with the PSED
- What changes, if any, would ensure better equality outcomes (legislative, administrative and/or enforcement changes, for example).

The Chair of the steering group is particularly interested in looking at equalities paperwork and policies related to PSED (particularly in relation to public sector procurement processes) and the collection, retention and use of diversity data by public bodies, for example, in relation to goods, facilities and services.

If you have evidence about how the PSED works that relate to any or all of the above points, you can submit this to PsedReviewEvidence@geo.gsi.gov.uk by Friday 19 April. More information about the review is available [here](#). You may also want to read the briefings from the [Equality and Diversity Forum](#) and the [Local Government Information Unit](#).

Public Law Project helpline on civil legal aid and exceptional funding project

The [Public Law Project](#) has set up an advice line on civil legal aid to assist advisers with their queries about public funding under the Legal Aid, Sentencing and Punishment of Offenders Act 2012. The line is open from 10am-11am on Mondays, Tuesdays, Wednesdays and Fridays and is free for callers. The telephone number is 0808 165 0170.

The Public Law Project is also running a project designed to assist applicants with making exceptional funding applications under the new legal aid regime. Exceptional funding is available for people whose legal problem is not in scope for legal aid but whose human rights or European Union law rights would be breached if they were not given funding for legal assistance. More information on exceptional funding and on how to refer yourself or your clients to the Public Law Project is available [here](#).

Implementing a ban on age discrimination in the NHS – making effective, appropriate decisions

This Department of Health briefing, published on 28 September 2012 provides an overview of changes to the Equality Act 2010 which fully implement the ban on age discrimination in the provision of NHS services and aims to advise those who plan, commission or provide NHS services. Since 1 October 2012 it has been unlawful for healthcare professionals to apply stereotypical assumptions that in resource allocation decisions, treatment of younger patients should automatically take precedence over that of older patients.

Doctors and other healthcare professionals can, however, continue to exercise their “clinical judgment” when making decisions. Depending on individual circumstances, people can still be treated differently because of their age where this is beneficial or justifiable, for example where age may pose a risk factor. Positive use of age in providing, commissioning and planning services can continue.

Older patients still do not have a legally enforceable right to demand specified treatment, nor is there any legal duty on professionals to deliver on demand specified treatment on grounds of age. However, decisions to withhold treatment can no longer be made on the basis of age alone. Certain statutory exceptions apply to the age discrimination prohibition, such as aged based charging for prescriptions and eligibility for NHS eye tests. However, any age-based regime not set out in legislation needs to be objectively justified. Where the motivation for different treatment on grounds of age is cost, the advice is that it will not be acceptable to use age as a criterion.

This is one of the last parts of the Equality Act 2010 to come into force in England, Wales and Scotland. A ban on age discrimination is also in place in relation to other services, clubs and associations in the exercise of public functions.

Now available from Mind publications

Disability Discrimination: Services and Public Functions

We have recently published a new legal briefing on disability discrimination in relation to provision of services and public functions under the Equality Act 2010.

One person who contacted our advice line took the step of issuing proceedings against a service provider and, funded by the Legal Help and Help at Court Scheme, a local solicitor supported her to bring a claim that reached a confidential settlement. Here she sets out her reflections on the case.

“There seems to be a whole array of activities that one may want to try. These opportunities should be open to all but still even though 1 in 4 people will suffer a mental health problem in their life there still seems to be stigma and misconceptions around mental health issues. This has meant I personally was turned away from taking up an opportunity that would enrich my life. This was very upsetting for me as it seems so unfair that someone is judged by an illness they have rather than seen for the person they are beyond their disability. I was very hurt and upset by the fact I wasn't able to participate in such an opportunity because I knew full well I was able to because I had done before with success. I was angry that someone who had never met me took my right to enjoy a social life a way for no other reason than knowing I suffered with mental health issues. It seemed very judgemental and I felt the need to stand up for myself and others with mental health issues to make sure at least one person learns that everyone is human, including those who live the legacy of mental ill health. I decided to make a complaint to the Mind legal advice line and found that I had grounds to take court action under the Equality Act 2010. This seemed very daunting but in my heart I knew I had been treated unfairly and the actions of others should be at least accounted for. Going to court was very nerve wracking but was worth it. I had a very understanding lawyer who supported me on the day. I got to meet the person who had caused me such upset and they saw me for the person I was. I was very pleased to sit down for coffee and allow the person to get to know me and most importantly be given an apology for the misunderstandings. I hope in future I have helped them understand that people with any disability are not to be feared and that everyone deserves a chance to simply enjoy life. We only get one shot and every one deserves the right to be happy and enjoy what ever activity they

choose to participate in. I like to treat everyone the way I like to be treated with fairness and respect. In taking my case to court I feel like I at least got the person to be able to acknowledge this is the most helpful way for all. It was worth the journey because it gave me the confidence to prove I can stand up for injustices. This should be the right of all.”

Training and events

- The [British Institute of Human Rights](#) will be running 3 open courses on Human Rights and Mental Health in April 2013 as part of an ongoing project supported by the Department of Health.

These 1-day events will be based on a new Guide to Human Rights for Mental Health Advocates (forthcoming, March 2013) and will provide a practical introduction to using human rights to address concerns relating to inadequate care for those with mental illness.

The events are free to attend and are in:

- London – 23rd April 2013
- Bristol – 24th April 2013
- Manchester – 25th April 2013

More details are available [here](#).

- The following [Legal Action Group](#) courses may be relevant for mental health practitioners:
 - Introduction to community care on 25 April 2013
 - Safeguarding vulnerable adults on 24 September 2013
 - Community care law update on 25 September 2013

More details are available [here](#).

- The following [consultations and reviews](#) may be of interest to readers:
 - [Improving the Code of Practice for Victims of Crime](#), closing date for consultation responses 10 May 2013.
 - [Implementing the coroner reforms in Part I of the Coroners and Justice Act 2009](#), closing date for consultation responses 12 April 2013.
 - The [review of the NHS complaints system](#) is now up and running. Anyone wishing to submit evidence to the review should email: ComplaintsReview@dh.gsi.gov.uk
 - The [review of the Public Sector Equality Duty](#) is reaching the end of its evidence-gathering phase. Anyone wishing to submit evidence to the review should email PsedReviewEvidence@geo.gsi.gov.uk by 19 April 2013.

Contact us

The Mind legal newsletter provides you with coverage and analysis of legal matters of importance to the mental health sector.

We hope you have enjoyed reading the Mind legal newsletter 13. We look forward to your comments and suggestions on anything you think would be of interest to our readers.

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