

# Mind legal newsletter

Issue 12, October 2012



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## Welcome

Welcome to issue 12 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 from Mark Neary describing his experience of the Deprivation of Liberty Safeguards and the access to justice problems that they pose
- An article from Lucy Series on the UN Convention on the Rights of Persons with Disabilities and its implications for mental capacity law in England and Wales
- A human rights and mental health law update
- Case notes on recent decisions relevant to the mental health sector, including from the Court of Protection, the Employment Tribunal 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 34.

**Mind Legal Unit**

## Articles

### 358 Days by Mark Neary

Mark Neary is a counsellor and advocate and the father of Steven Neary, whose situation was the subject of *London Borough of Hillingdon v Neary* [2011] 13 EWHC 1377 (COP). For more of Mark's writing and campaigning see his [blog](#) and his [book](#) about his experiences with Hillingdon Council.

2010 was the worst year of my life. For 358 days my son, Steven Neary, was held by the London Borough of Hillingdon in a positive behaviour unit against his and my wishes. During that time, he was held under four Deprivation of Liberty (DoL) authorisations. In December 2010, in the High Court terminated the latest authorisation and allowed Steven to return home. In June 2011, in a blaze of publicity, the Court of Protection held that all four DoLs had been unlawful and for a whole year Hillingdon had breached Steven's rights under Article 5 and Article 8 of the European Convention on Human Rights. This is my account of wrestling with the Mental Capacity Act 2005 (MCA) in an attempt to get Steven home.

I should say that ultimately, the Deprivation of Liberty Safeguards saved Steven. For all its faults (and there are many), without the DoLs being in place, I have no idea how we would ever have got to court. It is stated many times in the Court's judgement that Hillingdon had an agenda that they chose not to reveal to me or Steven for much of 2010. On the contrary, Hillingdon led Steven and me to believe that we were in a transition home programme whilst concealing their real agenda, which was to move Steven to a hospital in Wales, under section. The Court held: "if that had happened, Steven would have faced a life in public care that he did not want and does not need". As a DoL was in place, we were able to bring the matter to court, expose the extent of Hillingdon's duplicity and give Steven the sort of life that he had been denied for 358 days.

None of the DoL authorisations made any reference to the fact that being in the unit was the actual deprivation of Steven's liberty. That was one of the biggest battles throughout the year. I had to learn about the MCA very quickly and it seemed pretty obvious to me what the deprivation was, but it was impossible to challenge it until it was recorded. If that was the biggest stumbling block, there were several more that made it very hard for us to gain access to justice. It took seven months to be referred for an Independent Mental Capacity Advocate (IMCA). Once we had an IMCA on board, the result was transformative. It is surely a flaw in the system that the person or their representative is completely reliant on the supervisory body that authorised the DoL to refer you to the IMCA service. To put it bluntly, as in our case, if the authority doesn't want you to have an IMCA, there is no way of getting one.

In the court judgement, there are repeated references to the safeguarding manager responsible for the DoLs, who stated that it was my responsibility to bring the matter to court. Thankfully, the judge gave him short shrift on that one. But it is another example of the barriers put in the representative's way if the authority doesn't want their actions scrutinised. Even when I learned that I could bring the matter to court, I foolishly trusted Hillingdon who told me they would be submitting an immediate application to court - they didn't. Now, wiser, I always advise people to apply to the court themselves: it is too risky to leave it up to the supervisory body.

The other big problem I faced when challenging the DoLs process was the best interests assessments. Everything I had read, told me that a best interests assessor (BIA) must be neutral and, the clue is in the title, in the person's best interests. In our case, I spoke to the first two BIAs on the telephone and met the third one face to face but I couldn't get any of them to acknowledge the real deprivation, still less address whether Hillingdon's actions were the "least restrictive option" for Steven's care. This was bewildering to me: how could such fundamental and crucial factors be overlooked? Call me cynical but my experience has led me to become very suspicious of the independence of best interests assessors, particularly when the BIA might go against their paymaster. In fairness, I was recently invited to speak at a BIA conference and encountered a completely different stance to what I experienced with Hillingdon. But it is an issue: what is the person or their representative to do if their position isn't recorded or they feel that the assessment is fundamentally flawed.

As I said earlier, the DoLs saved Steven's life. Both he and myself as his representative, were automatically entitled to legal aid to challenge the DoL, just by virtue of a DoL being in place. That afforded us the excellent representation that we received. Joe Public cannot fight a DoL on their own; the power imbalance is too great and the legislation can be impenetrable. I would regularly go to review meetings with Hillingdon on my own and find there would be eight local authority officials present. It was very intimidating. Independent advocacy and the courts are the best hope for the vulnerable when faced with the might of the supervisory body.

Recently, the Care Quality Commission published its [latest report on DoLs](#). I had a nagging concern all the way through reading it. What about all those people being held in care homes or hospitals without a DoL – where is their redress? How can another Steven Neary challenge his detainment if a DoL is not in place? The huge variation in the number of DoLs authorised across the country suggest there must be thousands of people in this position and without the safeguards applied, they could be trapped forever.

Tonight is my respite night and I'd always planned to write this article tonight. Coincidentally, today I was contacted by two people through the Facebook group I set up; both have sons being held in care homes/assessment centres without their consent. One has been there three months; the other, three years. Neither is under a DoL. My battle is over but these two sad stories show that regardless of the MCA and the DoLs legislation, the struggle of people with disabilities to uphold their human rights, especially their right to a family life and their right to liberty, remains a huge problem for many people.

I'll end on a personal note. Two years on, I still have to deal on a daily basis with the trauma Steven experienced as a result of the DoL's legislation being turned upside down by Hillingdon. It is painful to watch. Two years on, I still have to deal with my own feelings of anger and sadness and the guilt that I wasn't able to protect Steven from the nightmare. Living with his and my feelings, I wouldn't wish that on my worst enemy. And that is why there is still so much to do in making sure the MCA and DoLS truly protect the vulnerable people that the Act was designed for.

## Legal capacity and the UN Convention on the Rights of Persons with Disabilities by Lucy Series

Lucy Series is a doctoral candidate in law at the University of Exeter. She blogs about mental capacity and community care law at [The Small Places](#).

The [UN Convention on the Rights of Persons with Disabilities](#) (CRPD) has been hailed as a ‘revolutionary’ treaty, symbolising a ‘paradigm shift’ in approach to disability rights. The CRPD was drafted in response to a ‘call to arms’ by disability rights NGOs and activists for a legally binding international convention on the rights of all people with disabilities to full participation and equality in society. Disabled people, disability rights NGOs and activists were heavily involved in the negotiations and drafting of the treaty. It is based on a social model of disability whereby ‘long-term physical, mental, intellectual or sensory impairments’ in interaction with various social or other barriers, hinder the ‘full and effective participation in society on an equal basis with others’ (Article 1). The UK ratified the CRPD in 2009, as well as an Optional Protocol which recognizes the competence of the Committee on the Rights of Persons with Disabilities (“the CRPD Committee”) to receive and consider complaints from individuals.

Article 12 CRPD – the right to equal recognition before the law – was one of the most contentious articles during the drafting of the CRPD, and is said to lie at the core of the Convention. In its final form, Article 12 CRPD requires states to provide tailored and proportionate support which respects a person’s will and preferences for the exercise of legal capacity. Supports must have appropriate safeguards against abuse, undue influence and conflicts of interest. On some interpretations Article 12 CRPD prohibits any legal framework which permits ‘substituted decision-making’ by third parties on disability related grounds. However, others have argued that the drafting was deliberately framed to be ambiguous on this controversial question. Several states explicitly (for example, Canada and Australia) or implicitly (for example, the UK) interpret the CRPD as permitting substituted decision making. However, the CRPD Committee’s first reports suggest that they interpret Article 12 as prohibiting substituted decision making mechanisms (CRPD Committee (2011) Consideration of reports submitted by States parties under article 35 of the Convention. Concluding observations of the Committee on the Rights of Persons with Disabilities: Tunisia (Fifth Session: 11-15 April 2011)). This interpretation would present serious difficulties for several areas of law in England and Wales, not least the Mental Capacity Act 2005 (MCA) which permits decisions to be made by third parties in the ‘best interests’ of people assessed to lack ‘mental capacity’. Article 12 could also bring the CRPD into conflict with the European Convention on Human Rights (ECHR) and its case law.

For proponents of a shift towards supported decision making, substituted decision-making mechanisms – even those which employ a ‘functional’ model of capacity like the MCA – are outdated and paternalistic. It is said that substituted decision-making mechanisms treat people as objects rather than human beings and expose them greater risks of harm and abuse. Some argue that a finding of ‘incapacity’ is a self-fulfilling prophecy that deprives people of the opportunities to learn from their mistakes. ‘Incapacity’ is also said to be closely linked to institutionalisation, resulting in the segregation and isolation of disabled people.

The alternative to substituted decision making mechanisms, it is argued, is to use a model of supported decision making. Such models stress the interdependent nature of autonomy, and the degree to which all people – not just disabled people – need support

from others when making decisions. Supported decision making models emphasise the importance of establishing natural support networks and enabling people to *choose* their supporters. Proponents of supported decision-making acknowledge that issues around undue influence would need addressing but emphasise that this issue is relevant to everybody regardless of disability. It is also acknowledged that for people whose will and preferences are difficult to discern, supported decision making may resemble substituted decision making in some respects. However, it is suggested that full legal capacity – the right to have one’s choices respected on an equal basis with others – flows ‘from a recognition of personhood — something that does not depend on cognitive ability’ ([Centre for Disability Law and Policy](#), 2011).

Those familiar with the MCA and the MHA will recognise how radical these proposals are and will no doubt have many questions and concerns about whether supported decision making does offer a viable alternative to ‘guardianship’ type regimes. Given the ‘revolutionary’ nature of Article 12 CRPD it is both surprising and disappointing that so few professionals, activists and policymakers have begun to acknowledge the challenges it poses and to grapple with them. Indeed, many domestic disability rights organisations continue to advocate for approaches which accept substituted decisions in a person’s ‘best interests’ on mental capacity related grounds. Yet grapple we must. As a signatory, the UK has a legal obligation to implement the CRPD, and may risk adverse findings from the CRPD Committee if it receives complaints related to Article 12. The CRPD is also increasingly influencing European Court of Human Rights jurisprudence on legal capacity (see, for example, [Stanev v Bulgaria](#) [2012] ECHR 46 and [DD v Lithuania](#) [2012] ECHR 254), it binds EU law within its areas of competence and is considered ‘persuasive authority’ in domestic law (see [Burnip v Birmingham City Council & Anor](#) [2012] EWCA Civ 629). There is still considerable uncertainty around how Article 12 should be interpreted and implemented and it remains to be seen whether we as a society are ready to embrace the opportunities and tolerate the risks introduced by this new approach. But one thing is clear: emerging from a treaty so heavily influenced by the voices and experiences of disabled people, we have a moral obligation to engage with Article 12.

## Case reports

GP v Derby City Council (2012) EWHC 1451 (Admin) - High Court, 27 April 2012

Reported by Joanna Sulek, Mind Legal Unit

This case concerns the rights of the nearest relative to be consulted under s.11(4) of the Mental Health Act 1983 (MHA 1983) in connection with a section 3 MHA admission and the granting by the court of a writ of habeas corpus to the patient against a local authority following the patient's unlawful detention in hospital.

In [Legal Newsletter 8](#) we discussed the case of [TTM v London Borough of Hackney](#) (2011) EWCA Civ 4, where the failure of an approved mental health professional (AMHP) to consult a nearest relative about a section 3 MHA application, based on the unreasonable belief that the nearest relative had withdrawn his objection, rendered the detention unlawful.

In GP v Derby City Council (2012) (a habeas corpus action brought by GP) consultation with the nearest relative before a section 3 detention would not have involved unreasonable delay, so in the absence of any other justification, the failure to consult resulted in unlawful detention. Several unsuccessful attempts had been made to telephone the nearest relative but it turned out that the nearest relative's phone number on the GP's (the defendant's) records was an old mobile phone number.

Judge Pelling QC explained that there were circumstances described in section 11(4)(b) where a relevant professional is entitled to dispense with consultation of the nearest relative, where either:

- (a) consultation is not reasonably practicable; or
- (b) it would involve unreasonable delay.

The defendant local authority was seeking to rely upon the second of these grounds.

The Judge asserted, however, that the decision of the relevant professional (the Approved Mental Health Professional) was one which was hard to justify, given that section 11(4) constitutes 'a vital protection to the liberty of the subject in circumstances where the effect of a section 3 admission is to deprive the person concerned of liberty, in circumstances where to obtain a discharge from such an admission may take many months and involve a number of different and difficult procedural steps.' Section 11 was designed to ensure that the MHA was compliant with the European Convention on Human Rights, specifically Article 5 (the right to liberty).

Moreover, there was no evidence that the claimant had been deteriorating acutely during the period of assessment such that there had been no alternative to admit him immediately to a PICTU Unit, or evidence of significant risk to nursing staff.

It was the decision of the Court therefore that it would not have taken a disproportionate amount of time to drive to the home of the nearest relative for the purpose of consulting her prior to the section 3 application, so the failure to consult the nearest relative rendered



the section 3 admission unlawful. The *habeas corpus* application was granted and the claimant was entitled to be discharged.

Note: We are indebted to [Mental Health Law Online](#) for information about this case. Newsletter subscribers may find it of interest to compare this case with those of [TTM v London Borough of Hackney](#) (mentioned above) and [CX v A Local Authority and A NHS Foundation Trust](#) [2011] EWHC 1918 (Admin), reported in [Legal Newsletter 10](#).

## The X Primary Care Trust v XB and YB (2012) EWHC 1390 (Fam) High Court, 1 May 2012

Reported by Joanna Sulek, Mind Legal Unit

This case concerns the validity of advance decisions. The Mental Capacity Act 2005 (MCA 2005) section 24(1) gives adults with the mental capacity to do so, the power to create advance decisions refusing medical treatment, which will be legally binding after they lose mental capacity to make the treatment decision for themselves. The Act does not provide a statutory form for their creation, nor do all advance decisions have to be in writing or witnessed. However, these and other safeguards are required if the advance decision contains a refusal of life-sustaining medical treatment (section 25(5)). There is no recommended form for refusing life sustaining treatment, but the [MCA Code of Practice](#) does provide some helpful guidance on what an advance decision should include (at paras 9.10 – 9.28).

Section 25(4) MCA 2005 gives the High Court the power to make a declaration as to whether an advance decision is valid. In this case, the Trust had applied for such a declaration regarding an advance decision made by XB, in which he had requested that his artificial ventilation should be removed in certain specified circumstances.

XB had Motor Neurone Disease and had had a tracheotomy (a tube leading directly to his windpipe) and an invasive ventilation machine fitted some years prior to bringing the legal action. He was being cared for at home by his wife YB, care workers and through his GP. He was being fed via a PEG (percutaneous endoscopic gastrostomy) tube, a tube that passes directly through the skin of the abdomen. XB was able to communicate, although he could not speak. As his disease progressed, he was able, for example, to move his eyes to the right as a sign that he agreed with the question being asked.

In the years immediately preceding this legal action XB had indicated on several occasions that he wished to have life-sustaining treatment withdrawn, but had not expressed his instructions consistently enough and with the necessary formalities for his instructions to be considered to amount to a legally binding advance decision.

On 2 November 2011 he made such an advance decision. It was based on a pro forma downloaded from the Internet, and stated that he wished to have the life sustaining treatment withdrawn should he reach the position where he was unable to communicate his needs or decide about his own care and management. The date of 2 May 2012 was entered in the document as the date for review of the advance decision.

In 2012 one of XB's carers raised concerns about the way in which XB had made the advance decision, and in particular, that she had not seen XB move his eyes as a clear sign that he consented to the advance decision. This prompted the Primary Care Trust to bring an application for a declaration of the advance decision's validity, and also the fact that the advance decision appeared to be time limited, therefore it was necessary to bring proceedings with some degree of urgency, as by this time it was 23 April 2012.

Theis J gave the judgment, which is available [here](#).

On the question of whether XB had capacity currently to decide on withdrawing the life-sustaining treatment, the experts were agreed that XB now lacked the capacity to communicate. This meant that XB had reached the position he had specified in his advance decision, which triggered the activation of the advance decision. It also meant that XB would no longer be able to make a new advance decision, should it turn out that this advance decision proved to be invalid.

As to the question of whether the advance decision had actually been made by XB in November 2011 and whether it was a valid and applicable advance decision, XB's GP gave evidence in court, in addition to a written statement, about how the advance decision had been made. The evidence was that each section of the advance decision had been read out to XB, at which XB had signified his consent by moving his eyes. Although the carer had raised concerns about the making of the advance decision, the evidence showed that she had not been present on 2 November 2011. In addition, XB's wife YB and mental capacity co-ordinator (AW) supported the GP's evidence.

Consequently Theis J declared that XB had had capacity to make the advance decision and that it had been made validly. Also, although there was no set form for creating an advance decision, and individual circumstances would vary widely, the guidance as to what should be included contained in the [MCA Code of Practice](#) (paras 9.10 to 9.23) should be heeded.

The proceedings determining the validity of the advance decision had to be expedited as a matter of urgency in case the time limit stipulated on the advance decision rendered the decision invalid before it could be followed, and the consequences of this would have been grave, as XB no longer had capacity to make a fresh advance decision. Accordingly it might be desirable for organisations that include a suggested *pro forma* for advance decisions on their website, to re-consider the advantages and disadvantages of including a 'Valid until' section on the form.

Note: No discussion appears to have been taken place here about XB's human rights under The European Convention on Human Rights (ECHR). This is in contrast to the case of *A Local Authority v E and others* [2012] EWHC 2639 (COP), where a careful balancing act was carried out between E's rights to autonomy and her right to life under Article 2. It was said that E was a 32-year-old intelligent woman suffering from severe anorexia nervosa and borderline personality disorder, seeking to refuse all food and life-sustaining treatment. She clearly had the ability to communicate her decision and had, in fact, made more than one advance decision, but it was held by the Court that her mental capacity had been overpowered by her overwhelming need 'to prevent calories entering her system'. The Court decided that it was in E's best interests under the MCA 2005 for her to be force-fed and, that were this to happen, any interference with her Article 8 rights (right to respect for private and family life) and Article 3 rights (right to be protected from torture and inhuman or degrading treatment) were proportionate and necessary to protect her right to life under Article 2. Although the treatment would be extremely burdensome to E, there was a prospect that the treatment would succeed and save E's life. The Judge in E's case seems to have taken the view that, although proceeding with the treatment may not seem to be in E's best interests now, E may view the uniqueness of her life, its value and the desirability of continuing it, differently in the future.

The balancing exercise carried out in the case of *An NHS Trust v D* [2012] 885 (COP), appears to have been a very different one. D had developed a terminal illness which required treatment of an invasive nature. D had drafted a letter stating that he authorised his sister-in-law to act on his behalf in the event of his becoming unable to make decisions for himself in the future. He also sought to refuse any medical treatment of an invasive nature, including a gastric tube, if the procedure was only to extend a reduced quality of life. As the letter had not been witnessed, it did not comply with s.25 (5) and (6) MCA 2005. The treatment was expected to prolong D's life by 2 years, but without it, he was expected to live only 10 to 14 days. He was not refusing palliative care. The Trust argued that treatment was futile and would be of no benefit to D, he was unaware of himself and his surroundings, and it was not what D would want. Also, D's family and friends, his medical team and the experts considered that withdrawal of treatment would be in D's

best interests and there was an assurance that the rest of his life following withdrawal of treatment, would be managed appropriately. Notwithstanding the apparently fatal flaw in the execution of D's advance decision in the absence of formalities set out in the MCA, the Court accepted these arguments and granted the application as being in D's best interests. Unlike D, E was not judged to be impossible to save by medical intervention, and it is also pertinent that her mental capacity was judged to be overpowered and her judgment clouded by beliefs and attitudes apparently springing from her mental health problems and disorders. Also in D's case, family, friends and medical experts had declared themselves in favour of withdrawing and withholding treatment, and under MCA 2005 (s.4) such opinions are taken into account in determining the best interests of the person who lacks capacity.

## Munjaz v United Kingdom - European Court of Human Rights, (Application number 2913/06), judgment of 17 July 2012

Reported by Martha Spurrier, Mind Legal Unit

This case concerned the lawfulness of the seclusion policy at Ashworth Hospital, which departed from the Mental Health Act 1983 [Code of Practice](#) in that it reduced the number and frequency of medical reviews. The applicant, Mr Munjaz, claimed that his periods of seclusion for 9, 14 and 18 days violated his right to liberty under Article 5 of the European Convention on Human Rights (ECHR), his right to a private and family life under Article 8 ECHR and his right not to be treated in a way that was inhuman or degrading under Article 3 ECHR, in conjunction with his right not to be discriminated against under Article 14 ECHR. The House of Lords had held by a majority that there had been no violation of Mr Munjaz's human rights and that the Code could be departed from where there were cogent reasons for doing so (which the court found that there were in this case).

The European Court of Human Rights considered Mr Munjaz's human rights arguments, with the assistance of an intervention from Mind. Each argument will be dealt with in turn.

### Article 3

Mr Munjaz argued that the operation of a seclusion policy that reduced the safeguards provided for by the Code of Practice carried with it a real risk that the secluded person would suffer ill-treatment contrary to Article 3 ECHR, not least because of the particular vulnerability of detained psychiatric patients. However, the Court found that there was no evidence to support the proposition that the frequency of medical reviews provided for in Ashworth's policy risked any breach of Article 3 ECHR and dismissed this part of Mr Munjaz's complaint.

### Article 5

Mr Munjaz argued that his seclusion amounted to a further deprivation of liberty (he was already detained under the Mental Health Act 1983) that was not prescribed by law, with no right to review or appeal to an independent body. The Court held that there may be situations in which a further deprivation of liberty, or a deprivation of a person's residual liberty, might engage Article 5 ECHR, a principle that was hitherto unclear in the Court's case law. This is significant because it departs from the domestic position where English law does not recognise the concept of a 'prison within a prison' (*R v Deputy Governor of Parkhurst Prison, ex parte Hague and Weldon*

[1992] 1 AC 58) and has clear implications for lawyers and advocates seeking to challenge restrictive regimes that are imposed on detained patients. The European Court's approach echoes that of Lord Steyn in the House of Lords, who stated in dissent that the majority's decision on this point was "a set-back for a modern and just mental health law" (paragraph 48).

However, in this case the Court held that there was no deprivation of Mr Munjaz's residual liberty for the following reasons:

1. Mr Munjaz was a long-term patient in a high security hospital: even when he was not in seclusion, he was already subjected to greater restrictions on his liberty than would normally be the case for a mental health patient

2. Seclusion, though coercive, was not imposed as a punishment but to contain severely disturbed behaviour likely to harm others
3. While its duration, notably of 9, 14 and 18 days, would point towards a further deprivation of liberty, duration alone was not determinative and the length of seclusion was foremost a matter of clinical judgment
4. The manner of implementing the seclusion policy carried the greatest weight: the hospital's approach was to allow secluded patients the most liberal regime that was compatible with their presentation, and seclusion was being flexibly applied.

#### Article 8

Mr Munjaz argued that the practice of seclusion was very likely to interfere with a person's physical or psychological integrity, right to personal development and right to establish and develop relationships with other people and the outside world. In contrast to the House of Lords, the European Court held that seclusion does interfere with a person's rights under Article 8 ECHR but that in Mr Munjaz's case the seclusion policy was adequately accessible and sufficiently foreseeable to be in accordance with the law and the discretion enjoyed by the hospital was exercised with sufficient clarity to protect him against arbitrary interference with his Article 8 ECHR rights.

#### Article 14

Whether permitting different hospitals to apply different seclusion policies amounted to discrimination had not been argued before the domestic courts and so the European Court declined to consider it.

A copy of the European Court's judgment is available [here](#).

The Mind legal unit will be looking at the issue of seclusion in more detail in a forthcoming article for *Legal Action* magazine, which will be published in May 2013.

## MS v United Kingdom - European Court of Human Rights, (Application Number 24527/08), judgment of 3 May 2012

Reported by Martha Spurrier, Mind Legal Unit

This case concerned the detention of a mentally ill man in a police cell as a place of safety under section 135 of the Mental Health Act 1983 for over 72 hours. During his time in the cell MS descended into an acute mental health crisis. This included him banging his head against the cell wall, beating his chest, stripping naked, drinking from the toilet bowl, ranting incoherently and smearing himself in food and faeces.

Various medical professionals examined MS during his time in the cell. It was unanimously agreed between the doctors and the police that MS urgently needed to be transferred to a psychiatric ward to receive treatment. However, no bed was available in the local area and, despite the police's best endeavours, MS remained in the cell for over 72 hours, beyond the statutory maximum.

In the domestic courts MS alleged that the situation he had had to endure had breached his rights under Articles 3 and 8 of the European Convention on Human Rights (ECHR). MS's domestic claim was unsuccessful and so he took his case to the European Court of Human Rights, where he argued that the failure to transfer him to a psychiatric hospital had led to a situation which was inhuman and degrading, contrary to Article 3 ECHR.

The European Court reiterated that people with mental health problems are particularly vulnerable when they are detained by the State, finding that:

“[MS] was in a state of great vulnerability throughout the entire time at the police station, as manifested by the abject condition to which he quickly descended inside his cell. He was in dire need of appropriate psychiatric treatment, as each of the medical professionals who examined him indicated. The Court considers that this situation, which persisted until he was at last transferred to [hospital] early on the fourth day, diminished excessively his fundamental human dignity [...] Throughout the relevant time, the applicant was entirely under the authority and control of the State. The authorities were therefore under an obligation to safeguard his dignity, and are responsible under the Convention for the treatment he experienced.”

The Court thus held that MS had had his rights under Article 3 ECHR violated.

This is an important judgment in the mental health field as it is the first of its kind to recognise that an administrative delay in providing urgent medical care to people with mental health problems can result in a situation that breaches Article 3 ECHR.

The European Court's judgment is available [here](#).

For a more detailed analysis of the case and the wider human rights issues surrounding the use of police cells as places of safety under the Mental Health Act 1983, have a look at this [blog](#) by Mind legal unit lawyer, Martha Spurrier and see the details of the forthcoming [seminar](#) on this topic at Doughty Street Chambers (see Training and Events on page 30).

## X v Finland - European Court of Human Rights (Application number 34806/04), judgment of 3 July 2012

Reported by Angela Truell, Mind Legal Unit

An in-house doctor decided X had a delusional disorder and met the criteria for involuntary confinement. In February 2005, the Board for Forensic Psychiatry of the National Authority for Medico-legal Affairs (the Medico legal authority) ordered, on the basis of hospital doctor's proposal, her involuntary treatment in that mental hospital. The Board considered that, if untreated, X's condition would considerably worsen. As of March 2005 the hospital started injecting X with Zyprexa and then Risperdal Consta, as she consistently refused to take those two medications orally. X was finally released from hospital in January 2006 and her treatment was officially terminated in June 2006. In 2005, X unsuccessfully challenged her placement in psychiatric care in the Finnish courts. Following two subsequent decisions to continue her treatment, taken in July 2005 and January 2006 by the hospital's head doctor she appealed before the administrative courts, to no avail. X also repeatedly challenged, before different authorities including the Medico-legal authority, the ombudsman and the police, the fact that she was forcefully given medication in the psychiatric hospital. However, those institutions found that they were either incompetent to interfere with the administering of medication, or that no offence had been committed.

The European Court of Human Rights found that safeguards against arbitrariness had been inadequate in the continuation of X's involuntary treatment. There had been no independent psychiatric opinion, as the two doctors who had decided on it had been from the same hospital where she had been detained. In Finnish law, X could not start proceedings for review of the need to continue her treatment; periodic review could only take place every six months at the initiative of the relevant domestic authorities. Finally, the situation had been aggravated by the fact that, in Finland, a care order issued for the involuntary hospitalisation of a psychiatric patient also contained an automatic authorisation to treat the patient compulsorily. The Court concluded that there had been a violation of Article 5 § 1(e) as a result of the continuation of X's involuntary confinement in a mental hospital.

The European Court of Human Rights held that a medical intervention in defiance of the subject's will gives rise to an interference with Article 8 ECHR. The question was whether it was justified under Article 8 (2). The Court noted that a care order for the involuntary hospitalisation of a psychiatric patient contained an automatic authorisation to treat the patient against her will. Looking at the system as a whole, the Court considered that there were inadequate safeguards against arbitrariness and found a breach of Article 8, stating:

“The decision to confine the applicant to involuntary treatment included an automatic authorisation to proceed to forced administration of medication when the applicant refused the treatment. The decision –making was solely in the hands of the treating doctors who could take even quite radical measures regardless of the applicant's will.”

While the system in Finland differs from that in England and Wales, this is nonetheless an important advance in the jurisprudence in this area. In its judgment the European Court makes a clear distinction between the decision to detain and the decision to treat. The



absence of this distinction in the domestic courts may now be something that representatives could challenge.

The judgment is available [here](#).

## Discrimination case report

Reported by Pauline Dall, Mind Legal Unit

### Stott v Thomas Cook Tour Operators Ltd / Hook v British Airways plc [2012] EWCA Civ 55

This case relates to claims of discrimination as a result of limitations being placed on disabled air passengers. The Court of Appeal has decided that this type of claim should be covered by the Montreal Convention on International Carriage by Air rather than by European or UK legislation. The difficulty that flows from this is that the Convention doesn't allow recovery of damages for injury to feelings which could be recoverable under the Equality Act. The claimants are asking for permission to appeal this decision to the Supreme Court. The case relates to providing assistance to disabled passengers with mobility problems but it will be interesting to see whether the Court is willing to bring this type of service provision within UK law.

The judgment is available [here](#).

### Hutchings v Aspire Defence Services Ltd [2012] EqLR 903

Generally, proving that direct discrimination has taken place, which involves showing a clear link between someone's disability and the poor treatment that they are complaining about, is regarded as fairly difficult to do. Often the facts of the case may make it easier to show that there was unfavourable treatment of a disabled person for a reason arising from that disability. However, the employer (or service provider) then has an opportunity to try to justify any unfavourable treatment.

In this case, Mr Hutchings employer had taken disciplinary action against him for aggressive behaviour at work and his behaviour towards his managers and colleagues. He was given a written warning. He had been unwell around that time and became unwell again later and was absent from work. After he returned a similar situation arose again leading to disciplinary action by the employer, which resulted in Mr Hutchings being dismissed. The Tribunal was prepared to look principally at how he had been treated when compared with the way that a non-disabled employee in similar circumstances would have been treated. The Tribunal decided that another employee would not have been dismissed. Therefore Mr Hutchings had received less favourable treatment 'because of' his disability. The employer had no opportunity to try to justify its stance, so the Tribunal found that it had unlawfully discriminated against Mr Hutchings.

### X v West Sussex CAB

We have reported the progress of the case of X v West Sussex CAB in previous issues of this Newsletter. The case – which is focussed on whether volunteers who receive no remuneration should be protected by anti-discrimination legislation – is due to be argued before the Supreme Court on 31 October 2012. We will report on the outcome on our website as soon as it is available.

## Mental health and human rights update

In February 2012, the Independent Advisory Panel on Deaths in Custody published its [End of Term report](#), noting 3628 deaths of psychiatric patients detained in inpatient mental health settings in 10 years (ending 31.12.10).

In March 2012 the Equality and Human Rights Commission published its [Human Rights Review](#) which assesses how well Britain is meeting its human rights obligations. Of particular relevance to mental health, it identifies that:

- Individuals in detention remain vulnerable to suicide and self-harm
- People with mental health conditions and addictions do not always receive appropriate support in the prison system, leaving them at risk of suicide and self-harm
- Investigations into deaths of people under state protection are not always independent, prompt or public
- Unsafe use of restraint is a problem across all forms of detention
- Inspections of health and social care services should be improved
- People detained in immigration removal centres have inadequate access to mental health services.

The report also highlights the lack of an independent person or agency with responsibility for investigating deaths of patients in mental health settings, something that Mind and other organisations want to see changed.

In March 2012 the Council of Europe Commissioner for Human Rights, Thomas Hammarberg, published an issue paper, [The Right of People with Disabilities to Live Independently and Be Included in the Community](#). The report makes a series of recommendations to member states, including:

- Define a statutory and enforceable individual entitlement to a level of support which is necessary to ensure one's dignity and ability to be included in the community
- Review the nature and purpose of services offered to persons with disabilities with a view to enabling them to lead the life they prefer, by maximising their choice and control of support services and by avoiding bundling such services in a way which compromises that choice
- Allocate the necessary budgetary and other resources towards community-based supports rather than institutional placements and services, in accordance with the principle of progressive realisation.

In April 2012, the UN Office of the High Commissioner for Human Rights Brussels office published [Getting a Life: Living Independently and Being Included in the Community](#), a legal analysis of the current use and future potential of the EU structural funds to contribute to the achievement of Article 19 of the UN Convention on the Rights of Persons with Disabilities. The report considers the obligation on the EU not to allow structural

funds to be used to build or maintain institutions for disabled people and calls for the EU to use structural funds to develop appropriate models of community living.

In May 2012, Open Society Foundation contributed to the debate about EU structural funds and the right to independent living under the UN Convention on the Rights of Persons with Disabilities in its report [The European Union and the Right to Community Living](#), which argues that using structural funds to build or renovate institutions for disabled people is a violation of EU law. The report includes a legal opinion on the issue from Richard Gordon QC.

In June 2012, the EU Agency for Fundamental Rights published two reports relating to people with mental health problems. [Involuntary Placement and Involuntary Treatment of Persons with Mental Health Problems](#) provides an analysis of international and national legal standards for the detention of people with mental health problems, finding that experiences of involuntary placement or treatment are overwhelmingly negative and urging informed discussion about the use of compulsion in the light of the UN Convention on the Rights of Persons with Disabilities. [Choice and Control: the Right to Independent Living](#) examines the experiences of people in nine EU Member States and concludes that more needs to be done to ensure independent living in the community.

In June 2012, the Department of Health published its [interim report](#) on services for people with autism and learning disabilities arising from the events in Winterbourne View. It outlines key objectives to reform the system, translated into 14 local actions, including NICE producing Quality Standards on learning disabilities and autism Quality guidelines. The full report will be published after the criminal proceedings against former Winterbourne View staff are completed.

In September 2012 the NHS Information Centre published [Mental Capacity Act 2005, Deprivation of Liberty Safeguards assessments - England, 2011-12, Third report on annual data](#). Some of the key facts included:

- There has been a year-on-year increase in the number of applications completed for Deprivation of Liberty Safeguards (DoLS) since the safeguards were first introduced in 2009/10.
- The number of people subject to a standard authorisation at the end of the quarter had increased each quarter since the safeguards were introduced.
- Dementia accounted for 53 per cent of all DoLS applications.
- There are wide variations in population-based application rates by region. The East Midlands has the highest rate of applications at 51 per 100,000, whilst London had the lowest rate at just 17 per 100,000.

Martha Spurrier  
Mind Legal Unit

## Legal aid update

From 1 April 2013 a number of areas of law will no longer be covered by legal aid. For people with mental health problems, loss of key areas like employment, welfare benefits (except for higher appeals) consumer and most clinical negligence law will have a serious negative effect. Coupled with this there will be changes to the way some areas of legal aid advice can be accessed with the introduction of 'the telephone gateway'.

### Telephone gateway

From 1 April 2013 people will be required to apply for legal aid using 'a telephone gateway' in three areas of law:

- Discrimination (claims relating to a contravention of the Equality Act 2010 or previous discrimination legislation)
- Debt (legal aid will only cover debt advice if it is mortgage possession of your home, orders for sale of the home, involuntary bankruptcy including dealing with a statutory demand where the person's estate includes their home)
- Special Educational Needs

Anyone applying for legal aid advice in these areas has to use the gateway unless they are:

- A person in detention in hospital or prison
- A child (under 18 years old)
- A person who has in the last 12 months been assessed as needing face to face advice and wants help with a linked problem
- A person with an emergency such as an urgent need to be represented in court.

There will be no exception for a person whose disabilities or health condition place barriers in the way of accessing the line.

### How is the telephone gateway going to work in practice?

There is already a Community Legal Advice helpline (CLA) and this will be the first point of contact. There will be two stages to the process:

1. A caller has to contact the central operator by phone or by email. That operator has to complete a financial assessment to confirm financial eligibility for legal aid and decide whether the caller has a problem that actually is within one of the three categories.
2. When the caller has satisfied these checks then s/he is then transferred to a specialist telephone adviser. That specialist can decide that the caller may access

advice by phone only or if they decide the caller will not be able to access advice by phone then they will refer the caller for face to face advice.

For the first stage there will be an initial call routing system with limited options. The line will also offer use of BSL via webcam if people email the gateway. Text Relay will be offered and a call back service by email. The initial calls will be recorded and there will be a complaints procedure allowing for review. The second stage specialist telephone advice provider service is out to tender. The Ministry of Justice say they will monitor for equality and diversity with a full report after three years.

### Comment

Discrimination is a particularly complex and difficult area of law and it can require detailed investigation to determine whether a person has an arguable claim. It is hard to understand how this can be dealt with by telephone alone. Mind is aware that while telephone or email access is preferred by some, some people with mental health problems are likely to experience very real difficulties in accessing advice using a telephone gateway. Callers may require face to face contact for a variety of reasons including cognitive or communication problems or issues of trust and understanding relating to their health condition. Using another person to access the advice for you can compromise confidentiality, risk inaccuracy and undermine independence.

Angela Truell  
Mind Legal Unit

## News

### Care and Support Bill 2012

In July 2012 the government published a Care and Support Bill as well as a White Paper - *Caring for our future: reforming care and support* July 2012 and a [Consultation on new safeguarding powers](#). Consultation on the Care and Support Bill was open until 19 October and will now go through the parliamentary process in 2013. It is to be implemented in 2015.

Mind is providing a detailed response to the Bill together with Rethink Mental Illness, the Centre for Mental Health and Royal College of Psychiatrists. Mind is also a member of the Care & Support Alliance, a consortium of over 50 organisations that represent and support disabled people who are also submitting a joint response. The following is a brief summary of some of the key elements in the Care and Support Bill.

1. A new local authority duty to promote the well-being of the adults using their services, whenever they exercise their functions doing so the LA must have regard to a number of issues including the assumption that the adult is best placed to judge their well-being (Cl.1)
2. Other general LA duties include
  - maintaining an information and advice service to help adults plan and meet care and support needs (Cl.2)
  - promoting diversity and equality in care services (Cl.3)
  - cooperating with key statutory agencies to promote well-being, improve quality and protect adults at risk (Cl.4)
3. An assessment and care and support planning framework. The terms care and support are not defined but examples of what may be provided to meet needs are given including accommodation and homecare and counselling (Cl.8).
4. National Eligibility Criteria are to be set by the government in regulations with a minimum threshold for care and support.
5. Portability of care packages – when a person moves from one LA area to another the sending authority has to provide a copy of a care and support plan and other information on request and the receiving authority has to assess and provide care but if not it has to continue to provide the existing care package.
6. Safeguarding – there is a new LA duty to investigate where there is reasonable cause to suspect that anyone with care and support needs is at risk of abuse or neglect and a duty to establish Safeguarding Adult Boards (Cl 34 &35).

This Bill does serve an important purpose in consolidating provisions although it is not clear how it will mesh with the provisions of the Mental Capacity Act 2005.

There are a number of areas where Mind considers that there is a need for provisions or changes to assist people with mental health problems. These include:

1. **Provision of advocacy.** The bill does not make adequate provision for advocacy which can be essential for people to be able to access assessment processes and support planning as well as providing support in safeguarding processes and in the complaints procedures.
2. **Eligibility and prevention.** Eligibility for care and support will depend on the provisions made in the National Eligibility criteria in regulations yet to be devised or published. It is important that these take account of the fluctuating nature of some health conditions and the need for care to prevent deterioration in health condition. If only critical needs are to be met, important preventative services will not be provided.
3. **Hospital discharge and aftercare.** Transition from hospital to community can be difficult and there is currently no adequate provision in the Bill to ensure that people who need support on leaving hospital can have their care needs considered and met. Unlike under section 117 of the Mental Health Act 1983, which provides for aftercare services without defining what those services are, the Bill defines aftercare services as services:
  - to meet a need arising from the mental disorder of the person concerned; and
  - to reduce the likelihood of the person requiring admission to a hospital again for treatment for the disorder (CI 48).

In practice it is difficult to make distinctions between which services do

and do not arise from a mental disorder and which do not. Mind is concerned that there will be disputes over what counts as section 117 after-care, leading to delay and distress.

## Eligibility for IMHA support in Wales

Currently in England, only certain people in receipt of treatment for mental health problems, normally when detained under specified detention sections of the Mental Health Act 1983, are eligible for support from an Independent Mental Health Advocate (IMHA). Informal patients generally do not have access to an IMHA. This significant gap in IMHA provision is remedied in Wales by Part 4 of the Wales Measure 2010, which introduces provision for all mental health patients in Wales, both detained and informal, to have an IMHA. This change came into force in April 2012 following the implementation of the Mental Health (Independent Mental Health Advocates) (Wales) Regulations 2011 No 2501 (W273).

## SOAD opinions for consenting patients on supervised CTOs

Part 4A of the Mental Health Act 1983 (MHA 1983) sets out the rules on treating supervised community treatment patients. A person on a community treatment order (CTO) who has the capacity to consent to treatment may not be treated unless s/he provides consent. Until now medication (beyond one month) and ECT could only be administered if approved as appropriate by a Second Opinion Appointed Doctor (SOAD). The Health and Social Care Act 2012 amends the requirements for SOAD certificates for treatment of patients on CTOs. From 1 June 2012 SOAD approval is no longer necessary if the community patient has capacity and is consenting to the treatment. Sections 64C



and 64E of the MHA 1983 are amended so that if the patient consents to the treatment, the approved clinician alone will satisfy the certificate requirement by issuing his or her own Part 4A certificate, stating that the patient has capacity and consents to the treatment.

The new form to be completed by the approved clinician is set out in the Mental Health (Hospital, Guardianship and Treatment) (England) (Amendment) Regulations 2012 SI No 1118, and the Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) (Amendment) Regulations 2012 SI No 1265.

Patients under 18 consenting to ECT, however, still require SOAD approval. Unless it is an emergency, ECT cannot be given to patients under 18 on the responsible (approved) clinician's approval alone.

A community patient who consents but then loses capacity, is treated as having withdrawn consent. A Part 4A certificate from a SOAD is then required. If the approved clinician considers that stopping the treatment would cause serious suffering to the patient, treatment is allowed to continue while a SOAD certificate is obtained. However, treatment cannot continue in the case of a patient with capacity who has withdrawn consent, who can only be treated against his or her will if recalled to hospital under s.17E MHA 1983.

If a community patient is recalled to hospital, or the CTO is revoked and the patient is in hospital, and a Part 4A certificate from the approved clinician is in place, as long as the patient continues to consent and has the capacity to do so, a new certificate is not required. If the patient, however, before or during recall withdraws consent or loses capacity to consent, s.62A (6A) MHA 1983 allows an approved clinician to continue giving medication if stopping the treatment would cause serious suffering to the patient.

## Safeguarding vulnerable groups: changes to vetting and barring

The Protection of Freedoms Act 2012 came into force on 10 September 2012 and has made the following changes to the Vetting and Barring System, previously introduced by the Safeguarding Vulnerable Groups Act 2006 (though not brought fully into force) and regulated by the ISA (Independent Safeguarding Authority):

The ISA can only bar a person from working in regulated activity if it believes the person is, has been or might in the future, engaged in regulated activity. The only exception is where a person is convicted or cautioned of a relevant offence (automatic barring). Work with vulnerable groups is a "regulated activity" only if undertaken regularly, and falls under these headings:

- Teaching, training, instruction, care of, supervision and providing advice/guidance to children
- Driving a vehicle only for children
- Working in places such as schools, children's hospitals, children's homes, children's centres, but not work done by volunteers under supervision – this no longer calls for compulsory registration of the volunteers with ISA
- Physical assistance with washing and bathing, using the toilet or dressing, regardless of how regularly undertaken
- Healthcare provided by or supervised by a professional, regardless of how regularly undertaken

- Registered child minding, foster carers

“Regulated activity” performed in connection with adults does not have to be repeated a certain number of times in order to be considered “regulated activity”. They are:

- Provision of healthcare to an adult by or under the direction or supervision of a healthcare professional
- Provision of relevant personal care
- Provision by a social care worker of relevant social work to a client or potential client
- Provision of assistance with general household matters to an adult who needs it by reason of age, illness or disability
- Relevant assistance in the conduct of an adult’s affairs (this can include a Lasting Power of Attorney or Enduring Power of Attorney, actions concerning Court of Protection Orders, appointment of an IMCA (Independent Mental Capacity Advocate) or IMHA
- Conveying of adults who need to be conveyed by reason of age, illness or disability (this does not include family, friends or taxi drivers)

“Controlled activity”, which was meant to catch activities of people having some minimal contact with vulnerable groups, has been abolished. The provisions for registration and monitoring have been repealed and will not now be introduced. Local authorities and other bodies such as Keepers of Registers and Supervisory Authorities, have a power to refer to the ISA rather than a duty. The ISA also has duties and powers to share information with professional bodies, such as the GMC and Care Quality Commission.

Further changes have been made in connection with CRB checks from 10 September 2012. The Police can no longer disclose additional information on enhanced CRB certificates, without applying a new, more rigorous test in order to disclose. It can be included if they ‘reasonably believe [it] to be relevant’ (instead of ‘might be relevant’) and consider that it ought to be disclosed. An applicant for the CRB checks who believes that information has been wrongly disclosed can now request the Independent Monitor to amend the information, and/or for a new certificate to be issued.

It is planned that the CRB (Criminal Records Bureau) and the ISA will be merged into one organisation in December 2012, although the precise details have not yet been announced. Further changes are set to come into force during 2013 and 2014.

## Mental Health (Discrimination) Bill

On 14 September 2012 the [Mental Health \(Discrimination\) Bill](#) passed its second reading and will now move to the committee stage. The Bill will repeal and amend three pieces of outdated legislation that discriminate against people with mental health problems:

- Repeal section 141 of the Mental Health Act 1983 under which an MP automatically loses their seat if they are sectioned under the 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”.

## Department of Health Suicide Prevention Strategy

On 10 September 2012 the Department of Health launched a new cross-government strategy [Preventing Suicide in England](#). The strategy aims to reduce the suicide rate in England and support people who have been bereaved or affected by suicide. It identifies six key areas for action:

- A better understanding of why people take their own life and how it can be prevented – supported by new suicide prevention research funding.
- Working with the media, and with the internet industry to help parents ensure their children are not accessing harmful suicide-related websites
- Reducing opportunities for suicide by making sure prisons and mental health facilities keep people safer
- Providing better support for high-risk groups
- Improving services for groups like children and young people or ensuring the mental health needs of those with long-term conditions are being met
- Providing better information and support to those bereaved or affected by suicide.

## Replacement of Equality and Human Rights Commission helplines

At the end of September 2012 the Equality and Human Rights Commission helplines will close. They will be replaced with the Equality Advisory and Support Service (EASS), which will begin operation on 1 October 2012. The new service is directed towards people who think they may have experienced discrimination and will not be available to employers, service providers or educators. The service will only be open to individuals who have been referred on by local organisations, advisory groups, faith based organisations and other groups working within the community: it is not available to the public at large.

The EASS will advise individuals on human rights and discrimination. This will include helping people work out if they are eligible for legal aid and signposting them on to legal service providers. The EASS will not provide legal advice or advise individuals on the merits of their case. The focus of the EASS will be on supporting individuals to resolve their issues informally or through mediation and conciliation.

More information about the new service, including how referrals to the EASS should be made, can be found [here](#).

In addition to the EASS the Equality and Human Right Commission is launching a Lawyers Referrals Helpline. This service will enable legal advisers and representatives to get advice about referring legal cases to the Commission. Solicitors, barristers and advisers can call the Commission’s legal team directly to discuss whether the issues in a case

might fall within the Commission's strategic priorities and, if so, how to request the Commission's involvement.

The telephone number for the Lawyers' Referrals Helpline in England is 0161 829 8407. The service is available initially on a three month trial each Tuesday, Wednesday and Thursday between 10am and 1pm. More details can be found [here](#).

## Now available from Mind publications

### New outline guide to the Mental Health Act 1983

The Mind Legal Unit has published an updated edition of its outline guide to the Mental Health Act 1983. The guide is available to download or purchase in hard copy [here](#) or you can order a copy by calling the Mind publications team on 0844 448 4448.

### Disability discrimination under the Equality Act 2010 series

The Mind Legal Unit has published two new briefings on disability discrimination under the Equality Act 2010: [Disability discrimination in education](#) and [Disability discrimination in employment](#). The final briefing in this series, *Disability discrimination in the provision of services*, will be published shortly.

### Mental Capacity Act 2005 overview and key provisions

The Mind Legal Unit has published a [guide to the Mental Capacity Act 2005](#), providing an outline of the key structures and safeguards under the Act. More detailed briefings on making financial and welfare decisions under the Mental Capacity Act 2005 will follow shortly.

Briefings on other legal topics affecting people with mental health problems can be found on Mind's [website](#).

## Training and events

### Mental Disability Advocacy Centre and Doughty Street Chambers UNCRPD seminar series

The Mental Disability Advocacy Centre and Doughty Street Chambers are collaborating on a series of seminars considering the UN Convention on the Rights of Persons with Disabilities and how it might be used effectively by lawyers and campaigners for disability rights. The next seminar is on 10 December in London, details will be available [here](#) nearer the time.

### Seminar on *MS v United Kingdom* and the use of police cells as places of safety

On 29 October Doughty Street Chambers will be holding a seminar on the case of *MS v United Kingdom* (see case note on page 15), where the European Court of Human Rights unanimously found that the detention of a mentally ill man in a police cell for over three days violated his right not to be held in inhuman and degrading conditions. The speakers, including Martha Spurrier from Mind's Legal Unit, will discuss the process of pursuing the claim in the European Court of Human Rights, the Court's judgment, how the judgment has contributed to the European case law on this issue its impact in terms of bringing human rights claims in the mental health context in the future.

Details of the event can be found [here](#).

### Mental Health Lawyers Association annual conference

The 13<sup>th</sup> Annual Conference of the Mental Health Lawyers Association will take place in London on 2 November 2012. It will include a session by Judge Hinchliffe on Mental Health Review Tribunal practice, a session by Judge Jacobs on recent case law and a talk by Robert Robinson on Mental Health Panel Accreditation. Details are available [here](#).

### Legal Action Group training courses

- Community care law update, 2 November 2012
- Inquest law and practice, 9 November 2012
- Defending mentally disordered persons, 10 January 2013

Details of all courses are available [here](#).

## 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 Mind legal newsletter 12. We look forward to your comments and suggestions on anything you think would be of interest to our readers.

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