

Coming together:

mental health, equality and human rights

The Disability Rights Commission

The Disability Rights Commission (DRC) is an independent body, set up by an Act of Parliament, which has the goal of creating a society where disabled people including those with long term health conditions can participate fully as equal citizens.

We work with the voluntary sector, the business community, government and public sector agencies to achieve practical solutions which benefit disabled people and society as a whole.

There are around 10 million people with rights under the Disability Discrimination Act (DDA) in Great Britain. The legal definition of disability covers people with physical, sensory, communication and intellectual impairments, and people with mental health and other long term health conditions such as diabetes, epilepsy, cancer, multiple sclerosis, HIV and schizophrenia.

Under the Disability Discrimination Act 1995, disabled people have the legal right to fair treatment in employment, in education and as customers of services. Most duties of the Act are now in force. A new Disability Discrimination Act received royal assent in 2005. This created a duty on public bodies to actively promote disability equality from December 2006 as well as closing some of the loopholes in the previous Act.

The DRC has offices in England, Scotland and Wales and can support both those with rights and those with responsibilities under disability legislation. For further details of how we can help you please contact our Helpline – contact details can be found on the back cover.

In October 2007, a new Commission for Equality and Human Rights will begin its work. This body will have responsibility for the activity currently undertaken by the DRC. Their website is at www.cehr.org.uk

Contents

Executive summary	2
Coming together: mental health, equality and human rights	5
Introduction	6
Building on success	13
Nine priorities for a new agenda	14
Conclusion	23

Executive summary

The DRC's Mental Health Advisory Group (MHAG) believes the new Commission for Equality and Human Rights (CEHR) could significantly reduce social exclusion.¹

Discrimination and inequality systematically destroy people's mental health. People with long term mental health conditions face some of the most severe exclusion in Britain, including an 80 per cent² unemployment rate and a high likelihood of dying young, from preventable illnesses.³

The CEHR has the potential to break these vicious cycles that damage life chances and restrict social and economic contribution.

There are big successes to build on: improvements in education and employment opportunities; more people choosing to talk openly about their experience of mental health conditions; rights to be free of discrimination under the Disability Discrimination Act (DDA); and good practice on mental health now included in guidance on disability access.

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- 1 In October 2007, the Commission for Racial Equality, Disability Rights Commission and Equal Opportunities Commission will cease to exist. Their work, along with work on age, religion and belief, sexual orientation and human rights, will be covered by the CEHR.
 - 2 The source is Labour Force Survey (Spring 2005) Office of National Statistics, p. 5.
 - 3 See evidence from Disability Rights Commission (2006) Formal Investigation Report: Equal Treatment: Closing the Gap.

The CEHR and government need to build on this by:

- **Promoting equality**

Ensuring that institutional discrimination is rooted out. Mental health conditions and use of mental health services should not be bars to employment, jury service, voting, or being an MP, magistrate or company director. The Disability Equality Duty should be used to close gaps of inequality between people with mental health conditions and other citizens, with regular tracking of progress.

- **Promoting human rights**

People should be able to decide where they live and what treatment they receive (with a few rare exceptions). The purpose of health and social services should be to support people's participation in family, community, social, educational and economic life.

- **Promoting good relations**

Prejudiced and disparaging statements by politicians and the media that equate mental health conditions with violence should be challenged. Agencies, from mental health services to the Crown Prosecution Service and courts, should provide access to justice and believe people with mental health conditions who report crimes.

- **Being exemplary**

The new equality commission's own employment, service delivery and communications should be exemplary with regard to mental health and should involve people with mental health conditions across all strands of work.

This paper sets out MHAG's priorities for the CEHR in the following areas as set out in the DRC's overall Disability Agenda:

- 1. Promoting a culture of equality and human rights**
- 2. Bringing an end to child poverty**
- 3. Increasing life chances through learning and skills**
- 4. Ending poverty and widening employment opportunity**
- 5. Increasing democratic participation and active citizenship**
- 6. Developing a social care system fit for the future**
- 7. Tackling health inequalities**
- 8. Meeting the future housing challenge**
- 9. Building stronger, safer communities**

Coming together: mental health, equality and human rights

“People with mental health conditions, who used to be written off completely, are now contributing throughout British society. One test of the success of the new Commission for Equality and Human Rights (CEHR) will be how well it further transforms their opportunities”

[Sir Bert Massie, Chairman, DRC](#)

“Racism and discrimination on all other grounds affect mental health; and then discrimination on mental health grounds and poverty often follow, in a vicious cycle. That’s why we welcome the new CEHR. It could break the cycle by addressing mental health and equality across all its programmes of work”

[Abina Parshad Griffin, Chair, DRC Mental Health Advisory Group](#)

Introduction

The CEHR, Office for Disability Issues (in England and Wales), the proposed Scottish Human Rights Commission, and other equalities organisations, need explicitly to address the experience of people with mental health conditions⁴ if they are to deliver their core agendas effectively.

Why?

Because:

- 1. Disability access is not just about revamping the front entrance. Making adjustments for full inclusion of people with mental health conditions is part of good disability practice.**
- 2. Exclusion of people with mental health conditions from social and economic life is extreme. This is a huge waste to individuals, the whole community and the British economy:**
 - Eighty per cent of the non-disabled British working-age population is in paid employment, yet 80 per cent of Britons with long term mental health conditions are NOT in paid employment;⁵ and around 95 per cent of people

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- 4 We respect different views on what language to use to describe ourselves and our experience. We have used the overarching term 'people with mental health conditions' in preference to 'users and survivors of mental health services' – since some people with mental health conditions do not use mental health services or do not wish to be defined by their use of them. We have used 'condition' rather than 'problem' because 'condition' is neutral, making no evaluation of whether or not the experience is a 'problem'.
 - 5 Labour Force Survey (Spring 2005) Office of National Statistics.

with a diagnosis of schizophrenia are not in paid employment, a higher figure than other countries in Europe.⁶

- Evidence shows that with fair treatment by employers, and the right support, most people with long term mental health conditions can successfully undertake paid work or contribute in other ways – for instance, by engaging in user-involvement to improve services or by taking public appointments. This applies to people with all diagnoses – including schizophrenia and personality disorder.⁷
 - Some people who are not in paid work participate actively in their communities but many are left isolated doing nothing or only ‘pass-time’ activities.
 - People with mental health conditions are highly likely to live in poverty, which impacts on them, their families, their future in older age – and on child poverty.
- 3. People with mental health conditions experience many other forms of exclusion and breaches of human rights:**
- For instance: people with mental health conditions are more likely to get major illnesses like heart disease, diabetes and some cancers than other people; are more likely to become ill at a younger age; and are more likely to die young. Yet we do not receive equal treatment for physical health conditions from health services, nor support with grief when loved ones die.⁸

6 Thornicroft, G. (2006) *Shunned: Discrimination against people with mental illness*, Oxford: Oxford University Press.

7 Bond, G., Becker, D.R., Drake et al (2001) ‘Implementing supported employment as an evidence-based practice’, *Psychiatric Services*, 52 (3), pp. 313-322.

8 Disability Rights Commission (2006) *Equal Treatment: Closing the Gap. A formal investigation into physical health inequalities experienced by people with learning disabilities and/or mental health problems.*

- We are particularly likely to be homeless or experience acute housing problems.⁹
- We are denied basic human rights: to dignity; to fair access to justice (we are viewed as ‘unreliable witnesses’, which means our testimony is not taken seriously by health and social services, police, courts and tribunals); to make decisions on our own treatment, even when we are mentally competent to do so; or to raise families – we are too readily perceived as unfit parents.
- We face bullying, hate crime, harassment, ‘nimby’ campaigns and exploitation, to the point of feeling unsafe, mocked and humiliated.
- We face inflammatory media coverage (for example, ‘Knife maniac freed to kill. Mental patient ran amok in the park’.¹⁰ This is incitement of hatred.
- We use mental health services which themselves often discriminate or leave people vulnerable to abuse. To cite just two examples, lack of safety on psychiatric wards (the National Patient Safety Agency identified 19 reported rapes in two years as well as other sexual assaults)¹¹ and separate older people’s services mean people often receive a worse mental health service after age 65.¹²

9 Stephens, J. (2002) *The Mental Health Needs of Homeless Young People*, London: Mental Health Foundation.

10 Daily Mail, February 26 2005.

11 Scobie, S., Minghella, E., Dale, C. et al (2006) *With Safety in Mind: mental health services and patient safety*, London: National Patient Safety Agency: www.npsa.nhs.uk

12 Healthcare Commission (2006) *Survey of users of mental health services 2006*: www.healthcarecommission.org.uk

4. Limited life chances have many causes, which compound one another, including long-standing poverty and discrimination on grounds such as race, gender, class, age, sexual orientation and mental health status:

- Vicious cycles occur, whereby social exclusion and/or discrimination impact on people's mental health; then, once in the system, a person's life chances are further reduced. For instance, amongst children excluded from school there are disproportionate numbers of boys, often black and often identified as having special educational needs. A common life course is for these young people to be without basic skills and qualifications at age 16, often ending up in the criminal justice system. These experiences impact on mental health and a diagnosis of mental illness further reduces the chance of ever 'getting back in' to mainstream opportunities.¹³
- Race and mental health status interact. In England, black people (including people of Caribbean, African and black/white mixed heritage) are at least three times more likely than average to be admitted to psychiatric hospital; and eight times more likely to be in high security psychiatric hospitals. (This increases to 25 times in North West England.)¹⁴ In Scotland in 2001, one-third of ethnic minorities compulsorily detained were of African origin, despite comprising only 10 per cent of the total ethnic minority population. Once diagnosed, black people face discrimination on grounds of **both** race and mental

13 Rutter, M. (1976) *Cycles of Disadvantage: A review of research*, London: Heinemann; Wilkin, A., Archer, T., Ridley, K. et al (2005) *Admissions and Exclusions of Pupils with Special Educational Needs*, Research Report No. 608, Nottingham: Department for Education and Skills.

14 Healthcare Commission (2005) *Count me in: results of national census of inpatients in mental health hospitals and facilities in England and Wales*.

health status, in wider society and within mental health services.¹⁵

- Sexual orientation and mental health status interact. People from lesbian, gay, bisexual and transgender communities are more likely than others to experience mental health conditions, partly because of discrimination; yet face further discrimination within mental health services.¹⁶
- Physical/sensory impairment and mental health status interact. The Department for Work and Pensions¹⁷ found that three-quarters of people meeting the DDA definition of disability had more than one type of impairment, often a sensory or mobility impairment AND a mental health

15 Keating, F., Robertson, D., McCulloch, A. and Francis, E. (2002) *Breaking the Circles of Fear*, London: Sainsbury Centre for Mental Health; Williams, J. and Keating, F. (2005) *Social Inequalities and Mental Health* in A. Bell and P. Lindley (editors) *Beyond the Water Towers: The unfinished revolution in mental health services*, London: Sainsbury Centre for Mental Health.

16 King, M. and McKeown, E. (2003) *Mental health and social well-being of gay men, lesbians and bisexuals in England and Wales: A summary of findings*, London: MIND; King, M., McKeown, E., Warner, J., Ramsay, A., Johnson, K., Cort, C., Wright, L., Blizard, R. and Davidson, O. (2003) *Mental health and quality of life of gay men and lesbians in England and Wales: A controlled, cross-sectional study*, *British Journal of Psychiatry*, 183: p.p. 552-558; Golding, J. (1997) *Without Prejudice: MIND lesbian, gay and bisexual mental health awareness*, London: MIND; McFarlane, L. (1988) *Diagnosis: Homophobic. The experiences of lesbians, gay men and bisexuals in mental health services*, London: Project for Advocacy, Counselling and Advice (PACE); HMSO (1984) *Police and Criminal Evidence Act 1984*.

17 Department for Work and Pensions (2002) *Disabled for Life*.

condition.¹⁸ People with physical impairments are ill-served in mental health services and vice versa, so people experiencing both often fall through the cracks.¹⁹

5. There is, however, some very positive progress to build on:

- The employment rate amongst people with mental health conditions has risen steadily from 14.6 per cent in 1998 to 20.2 per cent in 2005 – faster than the rise for disabled people overall, though from a lower base.
- The DDA has resulted in some important cases that show it is no longer legally or socially acceptable to refuse someone a job because the employer believes, without evidence, that it may be ‘too stressful’ for someone with a mental health condition; nor to fire someone ‘behaving strangely’ without first discovering whether ‘reasonable adjustments’ like time off, gradual return to work, extra support, or time out for medical appointments would enable the person to stay.
- More people are deciding to declare their mental health status – from Dame Kelly Holmes, Alistair Campbell and Stephen Fry to employees in ordinary businesses. This has the power to change cultures.
- As people with mental health conditions have become more involved in mainstream society, many organisations – some user-led – have brought improvements in community services that enable people to determine the care they receive and to live the lives they choose.

18 Ibid.

19 Morris, J. (2004) ‘One town for my body, another for my mind’: Services for people with physical impairments and mental health support needs, York: Joseph Rowntree Foundation.

- The DRC's Mental Health Advisory Group (MHAG) has broken through the myth that 'disability access' is only about physical access and has advised on wide-ranging good practice. CD-ROMs and leaflets have been produced, including a guide for trade unions; a formal investigation into whether 'fitness standards' to become a teacher, nurse or social worker discriminate has been undertaken; a hard-hitting film, 'The Appointment', showing the absurdity of having to conceal health conditions at work has been produced; and mental health good practice has been illustrated in statutory Codes of Practice on the Disability Equality Duty and on Transport.
- The DRC has undertaken a major formal investigation into physical health inequalities experienced by people with mental health conditions, which has involved hundreds of people with personal experience of mental health conditions and has fed into government policy and practice in England and Wales.
- The DRC, with advice from MHAG, has developed a principled position on mental health law: that compulsory treatment for people who have the capacity to make their own decisions is wrong, and should be illegal. MHAG members contributed to the review and introduction of the Mental Health (Care and Treatment) (Scotland) Act 2003.²⁰
- MHAG advised the DRC on legislative changes, which resulted in the Government making the DDA fairer to people with mental health conditions in 2005.

²⁰ The Stationery Office (2003) The Mental Health (Care and Treatment) (Scotland) Act 2003: www.opsi.gov.uk

Building on success

The CEHR should use its equality, human rights and good relations powers to tackle Britain's most entrenched social exclusion. It has most chance of succeeding if it factors mental health considerations into work across the equalities strands; because mental ill health is a core component of the process of severe exclusion.

The CEHR could promote the Disability Equality Duty as the tool to close gaps of inequality, by requiring public organisations to involve people with long term mental health conditions to create action plans, undertake disability equality impact assessments of new developments and monitor progress for people from different impairment groups, including mental health conditions. This will enable us to judge over time whether gaps are closing. We seek to build bridges with other disabled people and people facing exclusion on all the different grounds and our experience means we can contribute to the solutions – to reversing vicious cycles of exclusion.

Nine priorities for a new agenda

We have based the priorities in this section on the DRC's overall Disability Agenda, published in February 2007. While the Agenda takes account of the issues facing different groups of disabled people, this paper draws together issues of particular relevance to people with mental health conditions.

When we refer to government, unless otherwise stated, we mean central and local government and devolved national governments in Scotland and Wales, as necessary to the context. We wish to see best use made of the legislative, executive and administrative mechanisms available to effect change across Britain.

Priority 1: Promoting a culture of equality and human rights

The CEHR should continue the practice of involving people with mental health conditions in advisory groups. All parts of the CEHR should make links with mental health agendas.

The CEHR should report on the impact of its activities on different groups of disabled people, including people with mental health conditions, under its own Disability Equality Scheme. The DDA is less easy to use for people with mental health conditions.²¹ The CEHR should advise government on the legislative reform needed to rectify this.

21 Crowther, R. et al (2004) Cochrane review quoted in Social Exclusion Unit, 2004, 'Mental Health and Social Exclusion'; Rinaldi, M. and Perkins, R. (2005) 'Vocational Services Annual Report April 2004–March 2005, London: South West London and St George's Mental Health Trust; Roberts, S. et al (2004) 'Disability in the workplace: employers' and service providers' responses to the DDA in 2003 and 2004', DWP Research Report 202, Leeds: Corporate Document Services.

The CEHR should adopt a principled position on mental health law, rooted in human rights principles, and advise government on non-discriminatory approaches to reform.

The CEHR should ensure it has exemplary organisational policies on mental health: across its own employment, service delivery, communication and involvement practice. It should convey and model the position that people affected by mental health conditions have a right to full participation in society.

Priority 2: Bringing an end to child poverty

Given the 80 per cent unemployment rate amongst people with long term mental health conditions and the frequent impossibility of building up assets or pensions, it is necessary to consider poverty through the whole life course.

One-third of children living in poverty have at least one disabled parent, most often someone with a mental health condition.²² The group of 'disabled' parents least likely to be in work is those with mental health conditions. Employment support programmes and health and social service care plans should explicitly include support for parents with mental health conditions, and parents of children with mental health conditions, so that those who choose to can combine work or other community participation with parental responsibilities. The Mental Health (Scotland) Act 2003 includes a child welfare principle requiring commitment to minimise disruption to the parent/child relationship, which has the potential to help whole families.

Similarly, many people with mental health conditions provide informal care for others with such conditions, or older or disabled relatives and friends. Services should explicitly offer support in these roles.

Health, social and educational services should improve

22 Lyon, N., Barnes, M. and Sweiry, D. (2006) Families with Children in Britain: Findings from the 2004 Families and Children Study, Department for Work and Pensions.

transition planning, both from childhood into adulthood, to ensure that young people can retain education, employment and other citizenship opportunities; and from middle to older age, when services need to help people retain independence, choice and control. Different and lower benefit levels paid after 65 should be changed to ensure equality on age grounds and to reduce pensioner poverty.

Priority 3: Increasing life chances through learning and skills

In schools, the CEHR should promote adjustments to the curriculum, teaching methods, pastoral support, and social and health care to enable inclusion of children with mental health conditions, autism or emotional and behavioural difficulties. Evidence-based teacher support is available and should be spread.²³ This includes those children in the care system who could be offered places at Britain's most successful schools.

The implicit or explicit view that children with mental health conditions should be excluded in the interests of other children should be challenged. Access to the social and educational environment should be accorded as high a priority as access to the physical environment.

The CEHR could consider an investigation into school exclusions, on grounds of disability, race and gender. Lessons from this could help transform the common life pattern from school exclusion to lifelong disadvantage.²⁴

23 Scott, S., Spender, Q., Doolan, M., Jacobs, B. and Aspland, H. (2001) 'Multicentre controlled trial of parenting groups for childhood antisocial behaviour in clinical practice' *British Medical Journal*, 323; Scott, S. (2002) Classification of psychiatric disorders in childhood and adolescence: Building castles in the sand? *Advances in Psychiatric Treatment*, 8, pp. 205-213.

24 Rutter, M. and Smith, D. (1995) *Psychosocial Disorders in Young People: Time Trends and their Causes*. London: Wiley.

The CEHR should take action to ensure colleges and universities do not debar people with mental health conditions from courses of study; and that they respect people's aspirations and support them to gain skills and achieve their potential.

Priority 4: Ending poverty and widening employment opportunity

The CEHR, government and all public services should raise expectations of the potential for people with mental health conditions to contribute; and make it easier for employers to implement good practice, through support on flexible working, recruitment, retention and promotion.

The CEHR should vigorously tackle discrimination through legal cases and formal investigations under the DDA, especially given evidence that only 37 per cent of employers say they would employ someone with a mental health condition;²⁵ and 31 per cent think employees should reveal any mental health condition because they may be a health and safety risk (a common stereotype not backed by evidence).²⁶

Government should use welfare reform and changes in health and social care to:

- remove benefit disincentives to working for those people who can work a few hours a week and those with fluctuating conditions
- base employment and health/social care support on best evidence on enabling people with mental health

25 Bunt, K. et al (2001) 'Recruiting benefit claimants: A survey of employers in ONE pilot areas', Department of Work and Pensions Research Report 139, Leeds: Corporate Document Services.

26 Disability Rights Commission (2006) Poll by GfK NOP for the Disability Rights Commission of small and medium businesses: www.drc-gb.org

conditions to work, in particular using 'place and train' approaches to securing real jobs and salaries

- end the exploitation in sheltered workplaces of economically-based work at below minimum wage (sometimes 50p an hour)
- ensure decent benefit levels; and reform assessments and medical examinations to remove the discriminatory approach to people with mental health conditions.

Priority 5: Increasing democratic participation and active citizenship

The CEHR and government should end the discriminatory exclusions of people with mental health conditions from leadership positions (jury service, being a member of the Westminster Parliament, the Scottish Parliament or the Welsh Assembly, a magistrate, tribunal member or company/charity director).²⁷

They should reform the risk-averse policies that prevent people contributing to families and communities.

Unaccountable assessments of risk can currently lead to

27 In 2006, the government was committed to removing the bar on jury service for people receiving psychiatric treatment but had not yet done so. Under company law, directors of companies, including charities, are required to leave their position if they are detained under mental health law. Similar requirements affect MPs. This unnecessarily leads to long term exclusion. A fairer approach would be to welcome the person back once well and make reasonable adjustments as needed. In 2007 there were positive developments in relation to magistrate recruitment, influenced by MHAG; and the DRC, with partners, worked in Parliament with the aim of removing barriers to MPs retaining their office in the case of mental ill health.

refusal of housing or to children being received into care for the want of support to the parents, without effective appeal.

Government should promote leadership initiatives that support people's aspirations and development. They should design relevant policies (on community cohesion, health and social care) explicitly to support service users in contributing to their families, friends and communities. This requires making 'reasonable adjustments' not only for employees but for people taking up volunteering, public appointments and other community roles.

Priority 6: Developing a social care system fit for the future

Government should legislate for rights to independent living, including:

- choice and control over one's own support
- outcomes of health and social services focused on people's aspirations for participation in family and community life – specified in care plans
- direct payments
- independent, trained user-controlled advocacy, equitably available to people of all ages and ethnic backgrounds, focused on day-to-day living
- the right to choose not to live in residential or other institutional care.

Policy on mental capacity and mental health law should consistently promote non-discrimination, choice and control²⁸ and contradictory policy should be reconsidered. Disability equality impact assessments can be a useful tool for this.

28 See the principles on the face of the Mental Health (Scotland) Act 2003 and in mental capacity legislation in both Scotland and England/Wales.

Government should reform mental health law so that no-one is obliged to live or stay in a particular place if they have the capacity to decide for themselves and do not want to be there.

The CEHR should formally support the DRC's position that when someone has capacity to make their own decisions about treatment they have the right to do so.

Care planning in health and social services should be used to improve choice about long term living situations, with advocacy available where needed. Advance directives or statements made by people with mental health conditions should be supported, so people can determine where they want to be and who should be contacted for immediate decisions in the case of future crises.

Government should support national networks of groups offering individual and collective advocacy.

Accessible and non-discriminatory transport, goods and services are essential for independent living. The CEHR should enforce and promote the Disability Discrimination Act to stop overt discrimination – for instance, exclusion from pubs or transport vehicles – and promote equality in these sectors.

Priority 7: Tackling health inequalities

Government should take action on the 2006 recommendations of the DRC's formal investigation into health inequalities, including putting the great physical health inequalities experienced by people with mental health conditions at the heart of national health inequalities and primary care access programmes and reporting regularly under the Disability Equality Duty. Government should use the GP contract, commissioning frameworks, evidence-based training for health professionals and partnerships with organisations of people with mental health conditions as levers to raise expectations; and drive improvement through performance management and inspection.

Commissioners and providers of services should improve

straightforward physical health service access for people with mental health conditions and ensure regular health checks and medication monitoring. People should be given improved information and choice of treatment, including information on physical adverse effects like weight gain and diabetes. People at particular risk of unsafe prescribing include those who are compulsorily detained, who are often prescribed high doses and multiple medications, and older people.

Priority 8: Meeting the future housing challenge

The CEHR should ensure the concept of accessible housing is extended from the physical to the social environment: for instance, some people with mental health conditions may, because of their condition, be unable to cope with common entry arrangements or need privacy or somewhere they can be up at night without disturbing neighbours.

The CEHR should expect local authorities to assess patterns of homelessness (both rooflessness and hidden homelessness) amongst people with long term mental health conditions, take action to reduce it (including enabling people to leave abusive domestic situations) and monitor improvement over time.

Priority 9: Building stronger, safer communities

The CEHR and Government should be leaders in tackling prejudice and preventing hate crime, by:

- publicly challenging statements by politicians and journalists that equate mental ill health with violence (as when perpetrators of horrific crimes are described as 'psychotic', which fosters hatred and fear, creates unsafe communities and unfairly makes people with psychosis afraid of being open)
- promoting examples of people with long term mental health conditions as contributors, as in the Scottish See Me campaign²⁹

²⁹www.seemescotland.org.uk

- promoting mental health policies covering all aspects of school life. This would equip teachers with skills to tackle bullying and promote respect for all; empower young people; and integrate equality and human rights across the curriculum where relevant. This work could be cross-strand, building on initiatives like Stonewall's Education for All campaign and the DRC's pack for use in citizenship classes.

Governments should create legislation across Britain to recognise hate crimes and monitor its impact.

All agencies in touch with people subject to harassment and bullying (social and health services, police, the Crown Prosecution Service, Procurators Fiscal, courts and tribunals) should commit to equal access to justice. This means outreach to clarify that reports of crime against people with mental health conditions will be treated with equal weight as all others; believing the evidence of people with mental health conditions; supporting them to give evidence; and taking action when they report crimes or seek to take a civil action. Reports of domestic violence or elder abuse should be vigorously pursued.

If people with mental health conditions are accused of a crime or aggression, natural justice should be exercised: ending the current denial of basic rights like housing or employment because of an unsubstantiated claim – on medical notes – of violence or aggression. People should be genuinely innocent until proven guilty. Health and social services should also remove biased policies that signal greater priority to assaults on staff than on service users.

The CEHR should consider formal investigations to expose discriminatory practices.

Conclusion

Raising expectations of the contribution of people with mental health conditions would profoundly affect individuals, families and Britain as a whole. This can only be achieved through improving tangible rights and opportunities.

Members of the DRC's MHAG have an ongoing commitment to full citizenship for people with mental health conditions. We are not visiting the experience of exclusion; we live here.

Ongoing advice to the CEHR on mental health will be vital to its success.

We welcome feedback on this document. Please email us at: coming.together@drc-gb.org

June 2007

You can contact the DRC Helpline by voice, text, fax, post or by email via the website. You can speak to an operator at any time between 08:00 and 20:00, Monday to Friday.

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INVESTOR IN PEOPLE

