# Response of the Equality and Human Rights Commission to the Consultation

## Consultation details

**Title:** Call for evidence to inform the independent review of the Mental Health Act

**Source of consultation:** Request from the independent review

**Date:** 2 February 2018

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## About the Equality and Human Rights Commission

1. The Equality and Human Rights Commission (EHRC) is a statutory body established under the Equality Act 2006. It operates independently to encourage equality and diversity, eliminate unlawful discrimination, and protect and promote human rights. It contributes to making and keeping Britain a fair society in which everyone, regardless of background, has an equal opportunity to fulfil their potential.
2. The Commission enforces equality legislation on age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. It encourages compliance with the Human Rights Act 1998 and is accredited by the UN as an ‘A status’ National Human Rights Institution. You can find out more about our work on our [website](http://www.equalityhumanrights.com).
3. Ensuring that everyone has access to and the best possible outcomes from mental health services, and have their rights respected within these services, cuts across our equality and human rights remits. There is considerable evidence that services are not adequately respecting the rights of all patients, and that there are deep and significant inequalities between different groups of people. These challenges appear most stark in respect to secure mental health services. At their worst, this can result in lives being lost, treatment environments that are cruel and degrading, unnecessary restrictions on the liberty of individuals and families being broken apart due to the geographic remoteness of some inpatient services. Improving this situation is a priority for the Commission in our strategic and business plans for this year and next.[[1]](#footnote-1)

## Summary

1. The Mental Health Act 1983 (the MHA) is over three decades old and a comprehensive review is now required. We welcome the independent review (the Review) and particularly its focus on three key areas:

* Why there are rising rates of detentions under the Act;
* Why there are disproportionate numbers of Black and ethnic minority groups being detained under the Act;
* Whether the processes of the Act are out of step with a modern mental health care system.

1. The Review provides a significant opportunity to pause and to consider whether the MHA is fit for purpose, or whether a fundamentally new approach is required. Critically, it provides the opportunity to consider whether the significant inequalities and human rights challenges which arise through the operation of the MHA can be addressed through changes in practice or do we require more fundamental legislative reform to guarantee the best possible care and the human rights of all patients?
2. It will be important for the Review to determine whether the scale of changes required demands legislative reform, and what changes may be required through secondary legislation and/or changes to Codes of Practice in England and Wales. It is clear that some changes might be made through improved practice and procedure, without the need for legislative reform. Consideration should also be given to how the MHA interacts with other legislation, particularly the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.[[2]](#footnote-2) The Review should look at how MHA is operating within the wider system of mental health services. In the paragraphs below we set out our concerns that failures at earlier treatment stages are likely to be playing a role in the increasing use of the MHA as well the challenges in returning people to less-restrictive community care settings. Another factor influencing the growth in the numbers of people detained relates to how existing safeguards are being applied. We believe there is scope to further improve these.
3. EHRC is currently building a case for reform in line with equality and human rights principles, drawing on research we have commissioned to inform our contributions to the Review. Through our national and international role, our extensive research and stakeholder networks, and our legal enforcement powers, we occupy a unique position and have considerable experience of how the MHA is working in practice and its impact on equality and human rights. We are keen to work closely with the Review to share our expertise.
4. The Commission welcomes the opportunity to respond to the call for evidence from the Review. Our understanding is that the call for evidence is particularly aimed at finding reports and research which relate to the Review’s terms of reference and which the Review may not otherwise be aware of. It asks that key points are highlighted for ease of reference.

## Why are levels of mental health detentions increasing?

1. The scale of demand for mental health services far outstrips the provision of services.[[3]](#footnote-3) This inevitably leads to many people not receiving the help that they need and to others experiencing long delays before accessing treatment. These factors are likely to play a role in the year-on-year increases in the numbers of people who are being detained under the MHA.
2. In our view levels of funding and therefore access to mental health services are not sufficient and there is a strong case to be made in favour of ring fencing mental health funding to ensure that it is no longer redirected to support other service that are under pressure.[[4]](#footnote-4) The UK Independent Mechanism’s submission to the UNCRPD recommended that the UK and devolved governments provide sufficient funding to provide high quality mental health services to meet demand.[[5]](#footnote-5)
3. As a National Human Rights Institution (NHRI), EHRC monitors and reports on the UK’s compliance with the seven United Nations (UN) human rights treaties it has signed and ratified.[[6]](#footnote-6) A number of these treaties include provisions that cover access to, outcomes from and respect for human rights within mental health services. In this section we are drawing a link between the comments made by international treaty monitoring bodies in respect to inadequate provision of mental health services in general and the rise in use of the MHA.
4. The International Covenant on Economic, Social and Cultural Rights (ICESCR) requires the UK to ensure (protect, respect and fulfil) the right of everyone, without discrimination, to the highest attainable standard of physical and mental health (***Article 12*). In its 2016 concluding observations on the state of mental health services in the UK, the UN Committee on Economic Social and Cultural Rights (UNCESCR) noted with concern that mental health services are not receiving proportionate levels of funding (with physical health) and that this means that ‘parity of esteem’ between physical and mental health is not being realised.** UNCESCR also expressed concern about shortcomings in the implementation of mental health legislation and the lack of adequate mental health care provided to people in detention.[[7]](#footnote-7)
5. During 2018 we will be publishing a series of reports providing further evidence and analysis of the factors contributing to poor mental health. This will include our statutory review *Is Britain Fairer*? 2018 measuring the experience of people across Great Britain against a series of key equality and human rights indicators.[[8]](#footnote-8) Mental health is one of the three core indicators for health and is likely to be a theme running through much of the evidence.
6. We will also be publishing the findings from our inquiry into the provision of housing for disabled people in March 2018.[[9]](#footnote-9) Emerging findings from this are that an absence in the provision of specialist mental health supported housing leads to delays in people being released from secure, inpatient care or released without adequate support.[[10]](#footnote-10) These lead to a greater likelihood of people not being able to reintegrate into the community and being more likely to relapse.
7. Since the closure of the central government Supporting People fund, there has been a gap in provision supporting people to sustain a tenancy and prevent a mental health crisis occurring in the first place. While not exclusively a mental health issue, and while capturing a broader range of vulnerabilities, efforts to fill this gap in relatively low cost support, would potentially save resources and relieve pressure on acute services, as well as having much better outcomes for the individual. A recent report by Mind identified that support and advice is particularly important for people with more acute mental health conditions when changing between tenures, such as from supported housing to private rental accommodation.[[11]](#footnote-11)
8. The lack of safeguards for people in hospital and other care settings who are deemed incapable of consent, but are compliant with their admission and/or treatment is likely to also play a role in the year-on-year increases in the numbers of people detained in secure care (and their length of detention). This is a point that we examine in further detail in the paragraphs below.[[12]](#footnote-12)

## The disproportionate use of the MHA:

## The experience of people with different protected characteristics

1. To fully understand how effectively mental health services are working, it is important to consider the experience of people with different protected characteristics as required under the Equality Act 2010, in line with the requirements of the Public Sector Equality Duty (PSED).[[13]](#footnote-13) [[14]](#footnote-14) However, there is a need for better system wide data on the experience of people with different protected characteristics under the MHA and to understand the reasons for variations. The absence of this data and analysis limits the ability of service commissioners and providers to tackle key inequalities and to improve outcomes for all patients at different treatment stages.
2. In our 2017 submission to the UN Committee on the Elimination of Racial Discrimination (UN CERD) we noted that data collection on ethnicity and mental health does not enable effective planning to tackle the poor outcomes and experiences of ethnic minorities.[[15]](#footnote-15) The UN CERD has previously stressed the importance of the UK state party addressing the overrepresentation of persons of African Caribbean descent treated in psychiatric institutions and the disproportionate use of restraint, seclusion and medication.[[16]](#footnote-16) Recent data indicates that Black groups were over four times more likely to be detained under the MHA than White groups, and are almost nine times more likely to be subject to a community treatment order.[[17]](#footnote-17)
3. The CERD Committee also expressed concern at the experience of people from Gypsy and Traveller communities within the mental health system.[[18]](#footnote-18) This is a community for whom there is very little data within the health system. This is a gap that we believe needs to be tackled.[[19]](#footnote-19)
4. The UN Committee on the Rights of Persons with Disabilities has also expressed its concern over ‘the high number of black people with disabilities who are compulsorily detained and treated against their will’, and urges the UK ‘to initiate new policies in both mental capacity and mental health laws’ to address this problem, in close consultation with disabled people’s organisations, including organisations representing black and minority ethnic groups.[[20]](#footnote-20)
5. We welcome confirmation that the MHA Review will be commissioning new research into the experience of ethnic minorities within the mental health system and also that it is seeking to actively involve people with lived experience. Where possible, we urge the Review to disaggregate its analysis and to consider ‘intersectionality’, such as whether the experiences of a young Black male are different from those of a young Black female. We hope that this research will include a review of how Community Treatment Orders are being used and the impact of their use.
6. In a 2015 submission to the UN Committee on the Rights of the Child, the Commission states that failures to invest in adequate mental health provision for children and young people is leading to system wide problems, and that the state ‘*may not be complying its obligation to “address mental ill-health among children and adults and to invest in primary care approaches that facilitate the early detection and treatment of children’s psychosocial, emotional and mental problems”’.[[21]](#footnote-21)*
7. We continue to be extremely concerned by geographic variations in the provision of services, including inpatient care for children, long delays in referrals to services and evidence that some young people are being turned away when they are in clear need of help inevitably leading some to reach crises.[[22]](#footnote-22) There is also evidence that physical restraint was used most frequently in child and adolescent mental health services, acute wards in learning disability services and psychiatric care.[[23]](#footnote-23)
8. We are also concerned about the particular experience of people with autism and learning disabilities who continue to be held in inappropriate institutional environments, including for long periods of time within assessment and treatment units.[[24]](#footnote-24) [[25]](#footnote-25) It will be important for the Review to establish why this is happening and whether it relates to a misuse of s.2 of the MHA which provides for people to be temporarily admitted into treatment for assessment.
9. The UK Independent Mechanism (UKIM) recommended that the UK and devolved governments should ‘ensure that people with learning disabilities and/or autism: Can access community-based services to avoid involuntary placement in psychiatric hospitals, assessment and treatment units, or general acute wards’, which ‘includes ensuring that sufficient community-based provision is in place’.[[26]](#footnote-26) UKIM further recommended that people with learning disabilities and/or autism should ‘Remain in inpatient care (for the purpose of assessment and treatment) for the shortest possible time…Are provided with appropriate services for their needs, and are not placed in the psychiatric estate unless they have a mental health need’ and ‘are protected by effective safeguards, including access to advocacy, peer support and supported decision-making’.[[27]](#footnote-27)

## Processes that are out of step with a modern mental health care system

1. Through our work we have come across a range of different perspectives on the MHA. In the paragraphs below we set out the key perspectives, from the need to repeal the MHA because it is seen as discriminatory against disabled people to the need for changes to the current procedures and processes to accord more autonomy and capacity for people to make decisions about their own care and treatment, including the need for improved levels of supported and advance decision making. These are areas on which we are commissioning further research which we intend to use to inform our future submissions to the Review.

## Is it appropriate to detain people on the basis of their impairment?

1. In its Concluding Observations on the UK in 2017, the UN CRPD Committee recommended that the UK should ‘repeal legislation and practices that authorise non-consensual involuntary, compulsory treatment and detention of persons with disabilities on the basis of actual or perceived impairments.’[[28]](#footnote-28) This particularly refers to the MHA and equivalent legislative provisions in Scotland and Northern Ireland. It also covers the Mental Capacity Act 2005.
2. There are tensions – or at least *apparent* tensions – between Article 5 of the European Convention of Human Rights (ECHR), which permits deprivation of liberty of ‘persons of unsound mind’ in certain circumstances, and Article 14 of the UN CRPD, which states that ‘the existence of a disability shall in no case justify a deprivation of liberty’. [[29]](#footnote-29)
3. Article 5 of the ECHR, and the European Court of Human Rights (ECtHR) jurisprudence, permits (though it does not require) disability-specific deprivation of liberty, and does not regard these as *de facto* human rights violations. In contrast, the UN CRPD Committee has interpreted Article 14 of the UN CRPD on Liberty and Security of the Person, to prohibit all deprivations of liberty where the existence of disability is a factor justifying the detention – i.e. even when disability is only one ground for the deprivation of liberty.[[30]](#footnote-30)
4. One argument put forward on deprivation of liberty is that it can be necessary to protect the detained person’s safety, or to protect members of the public. This aspect of the debate therefore engages questions relating to Article 2 of the ECHR on the right to life and the positive obligation of the state in relation to these rights. Key points raised by scholars and practitioners in relation to this include a large body of evidence to show that for people who are self-harming or at risk of self-harm or suicide, care and support can be provided in non-coercive ways, and often these ways are more effective than more restrictive inpatient care. E.g. trauma-based approaches, trauma-informed care, peer support models.[[31]](#footnote-31)
5. Some scholars argue that a disability-neutral assessment of decision-making capability, i.e. that it is not specifically about mental health but the mental capacity of an individual, can provide the basis for involuntary detention or treatment.[[32]](#footnote-32) Others argue that ‘deprivation of liberty on the basis of a determination of either ‘unsound mind’ or lack of mental capacity is highly subjective and value-laden, and therefore fall foul (… ) of the requirements of both the ECHR and international human rights law that deprivations of liberty must not be arbitrary’.[[33]](#footnote-33)

## Placing greater weight on the capacity of the individual to determine their own treatment

1. In the event that the MHA is not substantially reformed. It will still be important to examine how different measures within the Act are working in practice and whether there are less restrictive measures that could be taken. For example, whether steps might be taken under Part 4 of the MHA to introduce further safeguards (as apply in other sections of the Act) for people who do not consent to their treatment in the first three months of their detention.
2. We are concerned to hear that some patients who may be assessed to lack capacity are not able to challenge their detention either via a tribunal or managers’ hearing.[[34]](#footnote-34) Where ever possible decisions should be made by the patient. In the event this is not possible they should be supported to do this as required under S.130 of the MHA. We have spoken with a number of stakeholders who have expressed concern about the inconsistent use of and varied quality of independent mental health advocates**.** The availability and quality of independent advocates should be considered by the Review.

## Does the MHA restrict supported decision-making?

1. As we set out below, a modern mental health system should place far greater emphasis on the ability of each individual to make decisions about their own care and treatment. This is an overarching principle within the revised Code of Practice. However, it does not appear to be happening uniformly under the MHA, with many patients not being involved in their treatment plans.[[35]](#footnote-35)
2. In its 2017 submission to the UN Committee on the Rights of Persons with Disabilities, UKIM expressed its concern that legislation across the UK continues to provide for substituted decision-making, including through the Mental Health Act 1983 as amended, and the Mental Capacity Act 2005.[[36]](#footnote-36) UKIM recommended in its report that ‘the UK Government should increase the scope of supported decision-making in England and Wales, and put in place safeguards to enable the removal of a supporter if they are not acting in accordance with a disabled person’s will and preferences…’[[37]](#footnote-37) The CRPD Committee expressed its concern over ‘the prevalence of substituted decision-making in legislation and in practice, and the lack of full recognition of the right to individualised supported decision-making that fully respects the autonomy, will and preferences of persons with disabilities’.[[38]](#footnote-38) The Committee recommended the abolition of substituted decision-making and improved practice around supported decision making, including through fostering research and good practice. This is equally relevant to both mental capacity and mental health laws.[[39]](#footnote-39)
3. There is extensive literature on what good supported decision making looks like in practice.[[40]](#footnote-40) More consideration also needs to be given advance decision making to enable patients to determine future treatment preferences when they are well, as applies in physical healthcare settings.[[41]](#footnote-41)

## The location of mental health services

1. The location and environment in which care is provided remain areas of concern. The lack of capacity in some areas results in patients having to receive support ‘out of area’.[[42]](#footnote-42) For many patients the experience of going ‘out of area’ and away from friends and family is likely to add additional trauma to their experience. This is apparent across different protected groups, including inpatients beds for children.[[43]](#footnote-43)

## Safety and conditions within inpatient care

1. The most recent reviews of inpatient mental health services by the Care Quality Commission have found that conditions within some providers are poor.[[44]](#footnote-44) This can include concerns around the safety of patients due in part to some building being old which makes it more difficult to prevent self-harm and suicide. Reasons can include a greater prevalence of potential ligature points and greater difficulty for staff in monitoring the location of patients. Safety is also a concern where there is a high prevalence of restraint and seclusion, which may run contrary to Article 3 of the ECHR on prohibition of torture and inhuman or degrading treatment. We refer to concerns about the disproportionate use of restraint at paragraph 18, above.
2. Some older buildings are also inaccessible to people with reduced mobility,[[45]](#footnote-45) which may breach the requirements of Equality Act 2010, in respect to disability discrimination and a failure to provide reasonable adjustments.

## Unnecessary deprivations of liberty

1. Constraints on space and the availability of beds can lead to patients being held in higher security wards than they need due to a lack of suitable alternatives and to care environments that are not therapeutic.[[46]](#footnote-46) Shortages in staff numbers are also like to exacerbate this situation. It can also lead to the use of blanket bans on mobile phones and the locking of wards, including situations where there is no power to lock some patients in, i.e. where they are voluntarily admitted.[[47]](#footnote-47) All patients whether admitted voluntarily or not should have the same stringent safeguards, regardless of their age. It is also essential that all patients receive the same rights to aftercare. Currently not all patients will be entitled to support under the Care Programme Approach and we have been told by stakeholders that this may influence the decision of some clinicians on which powers to use.

## Patients awaiting trial and/or arriving from prison

1. We are further concerned about the experience of people who are being admitted to secure mental health treatment via the criminal justice system. This applies to the transfer of convicted prisoners who need more intensive mental health treatment, who are often subject to long and unnecessary delays in accessing the treatment that they need. Some unconvicted offenders may also be admitted to hospital via the magistrates’ courts, which may leave them with an untried criminal charge on their record for an indefinite period of time. This has implications for Article 6 and 7 Convention Rights.

## Conclusion

1. The Commission welcomes the Review of the MHA. It provides a significant opportunity to pause and to consider whether the MHA is fit for purpose, or whether a fundamentally new approach is required. Critically, it provides the opportunity to consider whether the significant inequalities and human rights challenges which arise through the operation of the MHA can be addressed through changes in practice or whether we require more fundamental legislative reform to guarantee the best possible care and the human rights of all patients?
2. We have set out evidence and analysis to back up our observations and considerations from research that we and others have published. This includes analysis of how the UK is meeting the requirements of its treaty obligations. It is apparent that the rising numbers of detentions under the MHA cannot be viewed in isolation from other mental health services, which require greater levels of funding and a clearer understanding of how to meet the needs of patients with different protected characteristics.
3. There is a strong case for reform. In 2018/19, the Commission will be undertaking a broad range of work to improve practice in these areas:

* We will be engaging with national and international stakeholders and developing our evidence base of alternative models to the MHA, including the provision of care in less restrictive, community settings.
* Working with regulators, inspectorates and ombudsmen to ensure that human rights are adequately reflected in their regulatory frameworks to ensure that inappropriate use restraint and seclusion are identified and tackled and sharing learning across sectors.
* Commissioning research to better understand the barriers to information on rights and legal redress for breaches of the MHA;
* Developing new thinking to examine the barriers to the uptake and completion of IAPT mental health services and to identify ways to tackle existing barriers.

1. The Commission looks forward to working closely with the MHA review. Please let us know if you would like further information on any of the above. We are organising a meeting for David Isaac, our Chair, to meet with Sir Simon Wessely, Chair of the MHA Review.

1. Our Business Plan can be found [here](https://www.equalityhumanrights.com/en/what-we-do/our-strategic-plan). [↑](#footnote-ref-1)
2. This is a point made in the Law Commission’s response (unpublished) to the MHA Review’s call for evidence (Jan, 2018). [↑](#footnote-ref-2)
3. EHRC shadow report to the Committee for Economic, Social and Cultural Rights April 2016, Para 6.2. Available [here](https://www.equalityhumanrights.com/en/our-human-rights-work/monitoring-and-promoting-un-treaties/international-covenant-economic-social). [↑](#footnote-ref-3)
4. The Kings Fund (2018), Funding and staffing of NHS mental health providers: still waiting for parity. [ONLINE]. Available [here.](https://www.kingsfund.org.uk/publications/funding-staffing-mental-health-providers) [↑](#footnote-ref-4)
5. UK Independent Mechanism (2017), ‘Disability rights in the UK’ Para. 89 Available [here](https://www.equalityhumanrights.com/sites/default/files/crpd-shadow-report-august-2017.pdf). [↑](#footnote-ref-5)
6. Treaty monitoring page is available [here.](https://www.equalityhumanrights.com/en/our-human-rights-work/monitoring-and-promoting-un-treaties) [↑](#footnote-ref-6)
7. Concluding observations on the sixth periodic report of the United Kingdom of Great Britain and Northern Ireland July 2016, Paras 57-58. Available [here](http://docstore.ohchr.org/SelfServices/FilesHandler.ashx?enc=4slQ6QSmlBEDzFEovLCuW3XRinAE8KCBFoqOHNz%2FvuCC%2BTxEKAI18bzE0UtfQhJkxxOSGuoMUxHGypYLjNFkwxnMR6GmqogLJF8BzscMe9zpGfTXBkZ4pEaigi44xqiL) [↑](#footnote-ref-7)
8. For more information on ‘Is Britain Fairer? 2015’ see [here.](https://www.equalityhumanrights.com/en/britain-fairer)  [↑](#footnote-ref-8)
9. Equality and Human Rights Commission (2017), Inquiry into housing for disabled people. [ONLINE]. Available [here](https://www.equalityhumanrights.com/en/housing-and-disabled-people-britain%E2%80%99s-hidden-crisis). [↑](#footnote-ref-9)
10. BBC News (2017), Mental health patients stranded in units for years [ONLINE]. Available [here.](https://www.bbc.co.uk/news/health-40631929)  [↑](#footnote-ref-10)
11. Mind (2017), ‘Brick by brick – A review of mental health and housing’. Available [here](https://www.mind.org.uk/media/17947884/20171115-brick-by-brick-final-low-res-pdf-plus-links.pdf). [↑](#footnote-ref-11)
12. UKIM (2017), ‘Disability rights in the UK: Updated submission to the UN Committee on the Rights of Persons with Disabilities in advance of the public examination of the UK’s implementation of the UN CRPD’, p 50. Available [here](https://www.equalityhumanrights.com/en/publication-download/disability-rights-uk-updated-submission-un-committee-rights-persons): [↑](#footnote-ref-12)
13. Equality Act 2010. Available [here.](https://www.legislation.gov.uk/ukpga/2010/15/contents)  [↑](#footnote-ref-13)
14. S.149, Equality Act 2010. Available [here](https://www.legislation.gov.uk/ukpga/2010/15/section/149). [↑](#footnote-ref-14)
15. EHRC (2017), ‘Race rights in the UK: Submission to the UN Committee on the Elimination of Racial Discrimination’. Available [here](https://www.equalityhumanrights.com/en/publication-download/race-rights-uk-submission-un-committee-elimination-racial-discrimination). [↑](#footnote-ref-15)
16. UN CERD (2016), ‘Concluding observations on the combined twenty-first to twenty-third periodic reports of the United Kingdom of Great Britain and Northern Ireland, paras 30-31. Available [here.](https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fGBR%2fCO%2f21-23&Lang=en)  [↑](#footnote-ref-16)
17. NHS Digital (2017), Mental Health Act Statistics, Annual Figures: 2016-17, Experimental Statistics. [↑](#footnote-ref-17)
18. UN CERD (2016), ‘Concluding observations on the combined twenty-first to twenty-third periodic reports of the United Kingdom of Great Britain and Northern Ireland, paras 30-31. Available [here.](https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CERD%2fC%2fGBR%2fCO%2f21-23&Lang=en) [↑](#footnote-ref-18)
19. EHRC (2017), ‘Race rights in the UK – Submission to the UN Committee on the Elimination of Racial Discrimination in accordance with the Committee’s procedures to follow up on Concluding Observations’, section 4.7, Pages 35-36. Available [here](https://www.equalityhumanrights.com/en/publication-download/race-rights-uk-submission-un-committee-elimination-racial-discrimination). [↑](#footnote-ref-19)
20. CPRD (2017), ‘Concluding Observations on the initial report of the United Kingdom of Great Britain and Northern Ireland’, paras 30-31. Available at [here.](https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD%2fC%2fGBR%2fCO%2f1&Lang=en)  [↑](#footnote-ref-20)
21. EHRC (2015), ‘Children’s Rights in the UK: EHRC Submission to the United Nations Committee on the Rights of the Child on the UK’s implementation of the CRC’, para 114. Available [here](http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/health-committee/child-and-adolescent-mental-health-services/written/73900.html). [↑](#footnote-ref-21)
22. Available here. [↑](#footnote-ref-22)
23. Ibid., [↑](#footnote-ref-23)
24. Ibid., P66 [↑](#footnote-ref-24)
25. UKIM (2017), ‘Disability rights in the UK: Updated submission to the UN Committee on the Rights of Persons with Disabilities in advance of the public examination of the UK’s implementation of the UN CRPD’, p 74. Available at [here](https://www.equalityhumanrights.com/en/publication-download/disability-rights-uk-updated-submission-un-committee-rights-persons).

    Ibid., p.46. The EHRC and Children’s Commissioner for England highlighted these issues to the Minister for State for Health (letter 10 August 2016, unpublished). The response to the letter (21 March 2017, unpublished) acknowledges the concerns about the long-term detention of young people with learning disabilities/autism in mental health settings for prolonged periods of time. The letter refers to the Transforming Care programme, and the recommendations of the Lenehan review. However, it is unclear whether these initiatives will transform the system sufficiently to ensure that children and adults with learning disabilities are not inappropriately detained. [↑](#footnote-ref-25)
26. UKIM (2017), ‘Disability rights in the UK: Updated submission to the UN Committee on the Rights of Persons with Disabilities in advance of the public examination of the UK’s implementation of the UN CRPD’, p 28. Available [here](https://www.equalityhumanrights.com/en/publication-download/disability-rights-uk-updated-submission-un-committee-rights-persons). [↑](#footnote-ref-26)
27. Ibid. [↑](#footnote-ref-27)
28. Committee on the Rights of Persons with Disabilities (2017), ‘Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland’, para 35. Available [here:](https://tbinternet.ohchr.org/_layouts/treatybodyexternal/Download.aspx?symbolno=CRPD/C/GBR/CO/1&Lang=En) [↑](#footnote-ref-28)
29. Available [here](https://www.ohchr.org/EN/HRBodies/CRPD/Pages/ConventionRightsPersonsWithDisabilities.aspx). [↑](#footnote-ref-29)
30. CRPD (2015), Guidelines on article 14 of the Convention on the Rights of Persons with Disabilities: The right to liberty and security of persons with disabilities, paras 6-9. Available [here](https://www.google.com/search?q=http%3A%2F%2Fwww.ohchr.org%2FDocuments%2FHRBodies%2FCRPD%2FGC%2FGuidelinesArticle14.doc&sourceid=ie7&rls=com.microsoft:en-GB:IE-SearchBox&ie=&oe=&safe=strict&gws_rd=ssl). [↑](#footnote-ref-30)
31. Mead, S. and Copeland, ME., ‘What recovery means to us: Consumers' perspectives’ (2000) 36(3) *Community mental health journal* 315;

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    from severe mental illness: an intrapersonal and functional outcome definition’ (2002) 14(4)

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