

Current Law

At present, mental health legislation does not provide a formal individual right to advocacy and there is no duty on the appropriate authorities to ensure the provision of advocacy services.

The National Service Framework for Mental Health states that health authorities should have in place arrangements for the provision of advocacy services.¹ This builds on the Patients Charter Implementation Guidance (1997) which set a basic standard for informing patients of any local advocacy schemes.² It also recognised the importance of independence and of working to instruction, rather than according to 'best interests'.

The Report of the Expert Committee states:

"We are now satisfied that access to independent advocacy will be vital if the fundamental principles which underlie our recommendations are to be achieved." It recommended therefore that *"A statutory right to advocacy be created at the earliest opportunity."*³

The Government recently highlighted the importance of advocacy for people with learning difficulties.⁴ Following the Health and Social Care Act 2000 there are now Independent Complaints Advocacy Services (ICAS)⁵, and there is guidance on the relationship between Patient Advice and Liaison Services (PALS) and independent advocacy.⁶

It also proposed that local authorities and health authorities should be placed under a statutory obligation to produce local advocacy plans. On the issue of monitoring and regulation, rather than an Advocacy Standards Agency, the committee proposed that this function be carried out by the Mental Health Act Commission.

Alliance position

Access to advocacy

The Alliance strongly urges the government to broaden the access of patients to advocacy services

The Alliance believes that advocacy is effective in terms of reducing distress and the use of clinical services. Experience shows that early and on-going support from advocates reduces the need for admission to hospital and involvement with other agencies such as the courts and

¹ Department of Health, 1999. *National Service Framework for Mental Health: modern standards and service models.*

² NHSE circular EL(97)1 16.1.97

³ Expert Committee, November 1999. *Review of the Mental Health Act 1983: Report of the Expert Committee*, para.39, p.9

⁴ Department of Health, March 2001. *Valuing People: A New Strategy for Learning Disability for the 21st Century.*

⁵ Department of Health November 2001. Health and Social Care Act 2001 Section 12; *Involving Patients And The Public In Health Care: Response To The Listening Exercise.*1

⁶ NHSE, AAL, Kings College Hospital, January 2002. *Protocol for PALS and Independent Advocacy Joint Working.*

homelessness services. Advocates can help by limiting the escalation of financial, housing, personal, and medication problems. Advocacy also enhances communications between patients and medical and social care practitioners.

Service users regularly report that they were not aware of important procedures and rights when they were assessed under the Mental Health Act 1983 and/or when they were detained under compulsory powers – either the information was not given to them or they did not receive it in a form they understood.⁷ This can relate particularly to the medication they are being given. It also applies to whether or not they end up as voluntary patients or under compulsion.

The Alliance supports the principles behind the Government's proposal to introduce independent advocacy for people subject to compulsory treatment, either as civil or forensic patients. However, the provisions fall short of providing the individual with a legally enforceable right to an independent advocate. The Alliance considers an enforceable right is essential because access to advocacy at all stages has a crucial role to play in safeguarding the rights of people subject to the new regime.

The Alliance notes that the Scottish Mental Health Act puts a duty on authorities to ensure that independent advocacy is available to all people with a "*mental disorder*" and that they have an opportunity to use it. We support these provisions. The Joint Committee would appear to have endorsed this view in its recommendation that there be a duty in the Bill on the appropriate authority to ensure that independent advocacy is available to all people with a mental disorder, and that they have an opportunity to use the service. This sits well with the Alliance proposal that patients brought for examination should be entitled to an assessment of needs even if they remain as voluntary patients.

In relation to the use of compulsory powers, the Alliance believes that an individual right to independent advocacy is vital for people who are:

- liable to compulsory treatment;
- at the point of 'examination' for assessment;
- under an assessment order;
- undergoing periods of compulsory treatment; or
- subject to aftercare arrangements.

There should be a duty on professionals to remind patients of their right to an advocate, as the Joint Committee agreed.

In order to make the right of access to independent advocacy meaningful, advocates should be able to:

- attend, where practicable, any consultation, interview or meeting about the person's treatment or support;
- have access to the person at any reasonable time;
- correspond or communicate in any other way with the person on any matter relating to their role as an advocate; and
- receive such information as would assist them to perform their role.

In any meeting or negotiation with clinical or social care staff, a patient should have the right to be supported and, at the patient's request, represented by an independent mental health advocate of his/her choice, in the following circumstances:

⁷ Discussion on Mental Health Act at Mental Health Alliance People's Parliament, 9 Nov 2002; Mind Seminars on Mental Health Act, 14 Oct 2004; Maca Annual Conference 16 Sept 2004.

- when s/he is receiving in-patient treatment for mental disorder as a formal or informal patient;
- when s/he is receiving care and treatment in the community, whether on leave of absence or subject to a care and treatment order or a supervision order.

Where a person lacks capacity, an advocate's role would be to help the person to participate in the decision-making process to the fullest extent possible and to make sure that their views are heard. Where a patient may not be able to communicate their preferences in conventional ways, the role of an advocate is to safeguard the basic human rights of the person for whom they advocate and ensure that their treatment meets agreed standards of good practice. It should be remembered that because people's capacity may change over time, an advocate's role in working with that person will also change accordingly.

Carers should also have a right to advocacy

The carer has no access to advocacy unless s/he is also the nominated person. This is in spite of the rights identified under the Health & Social Care Act and the practice guidance of the Carers & Disabled Children Act 2000. This is an important issue as carers frequently complain that their requests for help are ignored on the one hand whilst they are expected to pick up the pieces of professional decisions on the other.

Functions

The specific functions of IMHA Advocates should be decided as part of the Department of Health's proposed stakeholder group and detailed guidance developed in the code of practice.

The Alliance supports the functions of advocates as outlined in the draft Bill and in particular the central role of providing assistance to qualifying patients in obtaining information; however, this function needs to be fully described in accompanying guidance. It is vital that the relevant authorities' duty to provide information is not avoided through a mistaken emphasis on these provisions. It is also vital that IMHA Advocacy support is not defined solely as 'representative', as the key principle of advocacy is that it promotes self-advocacy i.e. it provides support to the qualifying patient to get their voice heard, in the way that they wish to be heard.

Access to records

In general, the Alliance supports the Government's desire to accelerate access to mental health records, as scrutiny by the individual of their records can help to ensure that appropriate and effective treatments are put into place. However, we believe that this would be better achieved by fast-tracking the right of access to records for patients themselves, with the assistance of advocates if they so wish. This access should include social work and nursing records as well as clinical notes.

IMHA Advocates should not be given access to records without the patient's informed consent

Giving advocates direct access to records, or even having 'regard for the wishes and feelings of the patient' in this matter, is open to abuse and works against the principle of self-advocacy and autonomy. Where a person lacks the capacity to decide whether or not they wish themselves or their authorised advocate to have access to their records, the nominated person should be given the right of access. However, it may be appropriate, in some circumstances, for there to be a duty on the hospital authorities to ensure that key information is communicated to the advocate.

Point of access/qualifying patients

The Alliance believes that the Bill should provide the right to access specialist mental health advocacy during the examination stage

The draft Bill proposes that patients should only become entitled to information about their right to access advocacy services after the initial examination has taken place and after a formal decision has been reached that the patient needs to be assessed as a resident or non resident patient. The examination process can take place in a variety of different settings and there is a time limit of 120 hours for the examination to take place. The Alliance believes that people undergoing the examination process should be given the information and the opportunity to contact a mental health advocate if they choose to do so. In extreme emergencies it may not be possible to impart this information in a meaningful way, and occasionally some patients may not be well enough to make use of the information and/or take the opportunity to contact the advocacy service. However, this is also true of some patients when a decision has been taken to undertake the assessment stage. Notwithstanding the condition of the patient, AMHPs are still under a duty to explain the help available from IMHAAs at this point.

Without information about IMHAAs being provided during the examination the patient will be completely isolated. At this time the nominated person will not have been appointed. Hence for five days a person can be examined and administered treatment compulsorily under common law, with no safeguard in place. Providing information at the examination stage will also allow the advocate to be involved at an early stage with patients who are subsequently made liable to assessment. During the first five days, the draft Bill states that the initial care plan must be drawn up, which will allow treatment to be administered without the patient's consent. Delaying giving information about advocacy will inevitably delay meaningful input into this critically important document.

The Alliance cannot see how information about IMHAAs being given at the earliest reasonable opportunity will confuse the detaining/compulsory role, or in any way impede the examination. Providing the opportunity to make contact with advocacy services at this stage will safeguard the patient's rights, assist communication with clinical and care staff at the earliest opportunity, give advocacy services time to ensure patients are seen by advocates sooner rather than later, and may reassure patients at a most distressing time for them. It will also mean advocates can assist in ascertaining who the patient most wants to act as their nominated person, and allow their input into the initial care plan from the outset. It must be emphasised that the proposal is simply to give the patient the option of an advocate not to require an advocate to be present. Nor is it expected that the mental health professionals be required to stall the process unreasonably while an advocate is sought.

Information about advocacy

People should also be informed about advocacy at other key stages of the process

- on admission to hospital;
- whenever special treatments are considered (including electro convulsive therapy (ECT), psychosurgery and the implantation of hormones to reduce sex drive);
- on review of care or treatment;
- at discharge or transfer from hospital or release from compulsion;
- when any other significant decision is being made;

- when a person is in seclusion; and
- when the patient has strong objections to a proposed course of action.

Information about advocacy should be clear and in a format that the patient can understand

Information about independent advocacy organisations must be communicated to people in a way which they can understand and that takes account of any special communication needs they have. This will mean having in mind the needs of people with a visual or auditory impairment, and/or people for whom English is not a first language. In addition, all communication should be written in clear and easily understood language. While it is essential to leave the person with a permanent record of advocacy information, just handing over a leaflet will not be sufficient. Information about advocacy should be displayed in public areas and on wards as well as in a wide range of accessible formats.

Nominated person

The advocacy entitlement of the patient should have primacy over that of the nominated person

The provision of advocacy to both patients and their nominated persons may cause a conflict of interest. The proposed number of advocates will not allow for separate advocates for each. Conflicts may arise where the patient is broadly happy for the nominated person to pursue their role but, where there is a key point of disagreement, the advocate is supposed to continue unless advised by the appointer. The proposals do not reflect the primacy of the wishes/ needs of the qualifying patient.

Ultimately, the point of IMHAA is to act as a patient safeguard. It is not primarily intended to provide support to other safeguarding roles. This should be more accurately reflected in the legislation so that in the event of conflict between the patient and the nominated person, the patient is not left feeling coerced into putting up with a nominated person they are unhappy with for fear of losing their advocacy support. Unless the patient is clear that in the event of conflict it is the patient's entitlement to advocacy which will remain intact, the safeguarding effect of both nominated persons and IMHAAs will be reduced.

Right to meet

The Alliance recommends that the right of patients to meet with their advocate in private is reinstated

The Alliance supports the proposal to enshrine the right of patients to meet with their authorised advocate and is concerned that the right to meet in private, proposed in the 2002 Bill, has been removed. The right should be in line with the rights of Healthcare Commissioners, detailed in particular in Clause 270(3)(a) which enshrines a right to visit, interview or examine in private and 270(3)(b) which requires that commissioners be afforded "*such facilities and assistance...as are necessary to enable him to exercise his powers*". This was supported by the Joint Committee.

Regulation

A code of practice and training standards for IMHA Advocacy should be developed in consultation with people who use mental health services and advocacy workers. A dedicated Advocacy Standards Agency should oversee this work

The Alliance supports the government's proposals to arrange for the regulation of IMHA Advocates. There should be a new agency tasked with overseeing quality measures, ensuring effective scrutiny and overseeing standards setting in mental health advocacy. The agency should be independent but governed by statute and accountable to government.⁸ People who use services and advocacy workers themselves should be involved in developing standards.

The Alliance supports the model of advocacy service proposed by Durham University which proposes that IMHA Advocacy should be embedded in existing Mental Health Advocacy Services and should be run according to professional voluntary sector standards. We do not believe that the Healthcare Commission should be given responsibility for giving advice to the appropriate authority on standards for the appointment, training and monitoring of advocates.

Access to advocacy at a place of safety

The Alliance believes that the Bill should provide the right of access to specialist mental health advocacy when the person arrives at the place of safety, whether it is a psychiatric hospital or police station

Under the Bill, the police will continue to have the power, currently provided under Section 136 of the 1983 Act, to remove a person from a public place to a place of safety for assessment, should they appear to be suffering from a mental disorder and in need of immediate care and control. The Bill also introduces a new power for the police to enter premises without a warrant and remove a person suffering from mental disorder to a place of safety. This must only be based on the evidence of an Approved Mental Health Professional. Furthermore, a person can also be removed to a place of safety where a magistrate has issued a warrant under Clause 400 authorising entry to premises, if need be by force. The place of safety could be a hospital or police station and these powers last for up to 72 hours. We believe that vulnerable people who are detained in these circumstances must have the right to effective safeguards and support. This principle is already recognised under the Police and Criminal Evidence Act 1984 which provides for appropriate adults for vulnerable people who are arrested.

Access to advocacy when Courts issue a Mental Health Order

The Alliance believes that where a Mental Health Order is being considered by the court, there should be provision for patient/advocacy involvement in the creation of the care plan.

The Alliance disagrees with the use of criminal courts to make mental health orders but make its comments on the basis of the current draft Bill. The Bill, does not give any opportunity for patient/advocacy input into the creation of the care plan that must be submitted to the court when it considers issuing a Mental Health Order. The making of a Mental Health Order by the court is conditional upon the preparation and submission to the court of a care plan by an approved clinician. However a patient will only become a 'qualifying patient' when a mental

⁸ This is already happening in Scotland in the form of the Advocacy Safeguards Agency.

health order is in force. Anyone for whom a mental health order is proposed will not have access to advocacy.

Elsewhere in the Bill, Clause 31(a), it is stated that in preparing a care plan for the patient, the clinical supervisor must consult the patient about the medical treatment to be specified in the plan unless it is inappropriate or impracticable. While schedule 5 states that provisions of part 2 do not apply to part 3 unless specified in part 3, the proposal to consult people subject to treatment under statutory powers appears to create a 'spirit' for the act in keeping with provisions of the Care Programme Approach. It is recommended that Clause 248 be extended to those people for whom a care plan under 115(1) is being drawn up, therefore giving access to an advocate to assist in the preparation of the care plan.

Independence

The Bill must establish a truly independent IMHA Advocacy service

The Alliance supports the government's commitment to the independence of advocacy from services responsible for providing care and treatment. Independence is vital so that the ability of advocacy organisations and advocates to carry out their roles is not compromised. Ideally, independent advocacy should be provided by an organisation whose sole role is advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy.

Costs and workforce implications

The Alliance believes that the costing of advocacy under a new Act has been miscalculated and is unrealistic

It is unclear on what basis the government's figure of £5million has been calculated. This needs to be looked at in relation to the funds made available to implement the '*independent mental capacity advocate*' scheme in the Mental Capacity Act 2005 (believed to be £6.5 million). Using the government's figures that 140 whole time equivalent (WTE) advocates will be needed to implement the Mental Health Bill, produces a sum of £35,174 per WTE advocate per annum. This figure is likely to be a substantial underestimate.

Given that there are some 50,000 uses of the Mental Health Act 1983 each year, the figure of 140 advocates with a duty to provide information and representation appears somewhat conservative. We urge the Department of Health to release information on how this figure was calculated and to ensure that further detailed work on this is undertaken in partnership with advocacy providers and other stakeholders.

It is essential that sufficient resources are provided to implement these proposals. The Alliance supports the Government's apparent intention to ensure that IMHAA Advocacy is provided by properly trained advocates. Advocacy under the Act needs to be delivered by people with appropriate levels of skills and a thorough knowledge of mental health legislation. In addition advocates need to be properly supported and supervised and this requires that advocacy services are properly financed and salaries reflect both market rates and the necessary skills.

The Committee recommended that before the Government introduces the Bill to Parliament, it should review the costs of setting up discrete advocacy services and that this should be undertaken with those providing advocacy services. This should reflect detailed and robust costing, and a sensitivity analysis taking account of, for example, possible variations in the

number of persons detained and the provision of advocacy at examination stage, to 'voluntary' patients and to those under compulsion in the community.

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Information sharing

Where a person lacks capacity and cannot consent to information being shared on their behalf, health and social care staff should make available to the independent advocate such information as is necessary for them to do their job as an advocate effectively. As a minimum, it would be expected that advocates are informed when:

- a person is admitted to hospital;
- there is a review of care or treatment;
- any form of compulsion is considered;
- special treatments are considered; and when
- plans for discharge or transfer are being made.

Giving this information to advocates is permissible under the Data Protection Act 1998, which contains a specific exemption from restrictions on disclosure where the reason for disclosure is to protect a person's vital interests.

Advance directives

Advance directives may be used for people to indicate whether they would wish to have an advocate or not. This would enable hospital managers and others to make a referral, if appropriate, where the person lacks capacity to request or consent to an advocate at a later date. Independent advocates may also assist people to write an advance directive and keep it up to date. However, it would not be appropriate for an advocate to be a witness to an advance statement as this would involve making a judgement about the capacity of the person making the statement.

People should have the right to advocacy support when developing and implementing advance directives. Where someone lacks capacity IMHA Advocates should be consulted to determine the existence of any advance directive.

Correspondence

The Alliance agrees that IMHA Advocates should be included in the list of official communicants in Schedule 11 as this will safeguard the patient's right to correspond with his or her representative without interference by hospital or other authorities.

General issues

1. User involvement

The government should include guidance on user involvement in the Code of Practice

User involvement should be central to all advocacy practice, and is essential for the healthy functioning of an advocacy service. The Alliance believes that advocacy services must ensure that there are routes to meaningful involvement at all levels of the organisation.

2. Informal advocacy

People should have the right to choose an untrained advocate/friend in place of or in addition to a specialist advocate if they wish

It is of vital importance that 'informal' advocacy, such as that provided by local support and self-help groups, friends and family is not excluded in favour of professional advocacy. People using mental health services must have the right to bring along a supporter of their choosing to ward rounds, CPAs and other meetings.