



Llywodraeth Cymru
Welsh Government

**City & Guilds 7566
Level 3 Certificate in Independent Advocacy (IMHA)
Learning Support Resource**



306: Independent Mental Health Advocacy (IMHA)

Interim Learning Support Resource for the City & Guilds 7566 Independent Advocacy Qualification, Unit 306 Independent Mental Health Advocacy (IMHA) clarifying the changes to the Legislation in Wales since the qualification was accredited by QCA in 2009.

This resource is to be used by both training providers and learners in the period between September 2011 and September 2012 when the qualification review will be completed.

Please note that all references to legislation, the Code of Practice, etc. are specifically related to Wales. This resource has limited value to IMHAs outside of Wales.

The resource is not intended as a complete description of every aspect of the legislation and must not be relied on as a definitive statement of the law.

This is a revised, simplified and amended version of the original NMDHU support materials.

The Independent Mental Health Advocacy Services were introduced in Wales on the 1st November 2008 as an additional safeguard for patients who are subject to the Mental Health Act 1983.

Independent Mental Health Advocates are specialist advocates who are trained to support patients who are subject to the Mental Health Act. The Mental Health (Wales) Measure 2010 significantly increases the role of the Independent Mental Health Services in Wales.

Advocacy Consultancy Training and Supervision Ltd (ACTS) has produced this resource for the Welsh Assembly Government, with consultation with City & Guilds, to support training providers when they are teaching the underpinning knowledge for City & Guilds 7566, Independent Advocacy Qualification, and also for Independent Mental Health Advocates (IMHAs) when providing portfolio evidence of their skills and knowledge for the Independent Advocacy Qualification IMHA unit 306.

More information can be obtained from ACTS@advocacyqualification.co.uk

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Introduction to Unit 306

Learning Support materials for Unit 306

The Level 3 Certificate in Independent Advocacy

Introduction to the learning, assessment process and criteria for this unit

Learning Support materials for Unit 306

Welcome to this interim resource for the City & Guilds Level 3 Certificate in Independent Advocacy. This 'specialist pathway' Unit provides the opportunity to demonstrate the practical skills and underpinning knowledge that an Independent Mental Health Advocate (IMHA) practicing in Wales requires to work effectively across a range of settings.

Objectives

Thus support material is designed to identify the underpinning knowledge and principles of practice needed to complete the Level 4 306 Unit. This includes:

- information about the MHA 1983 as amended by the Mental health Act 2007 and the Mental Health (Wales) Measure 2010;
- the wider legal and ethical frameworks that impact on the work of an IMHA;
- the particular competencies – practical skills – you will require to practice effectively and safely as an IMHA.

How to use this resource

These support materials relate to the assessment criteria that are linked to the required **learning outcomes** for the unit. The learning outcomes and assessment criteria focus on discrete areas of learning.

General points

1 This resource is not intended as a reference guide for the legislative framework governing IMHAs. References to other more detailed sources of information are included.

2 It is suggested that primary sources are used when preparing training sessions or researching or gathering information (e.g. the MHA 1983, the Mental Health (Wales) Measure 2010 and the Code of Practice) rather than secondary sources

3 Read the most up-to-date and appropriate key documents when using them as a reference.

The Level 3 Certificate in Independent Advocacy

The Level 3 Certificate in Independent Advocacy is a Qualification Credit Framework competency-based qualification. This means that those registering for it must demonstrate their skills and knowledge in undertaking a range of advocacy-specific activities in their workplace.

The qualification is made up of four core units which are assessed at Level 3 and focus on the 'core' requirements for advocacy. There are also specialist pathway units, including this unit for Independent Mental Health Advocacy (IMHA), which are assessed at Level 4.

The different levels recognise a learner's ability to perform tasks to these standards and to demonstrate their knowledge, understanding and awareness of the tasks and consequences.

The Level 3 Certificate in Independent Advocacy requires the four mandatory core units plus Unit 306:

- Unit 301 Purposes and principles of independent Advocacy;
- Unit 302 Providing independent Advocacy Support;
- Unit 303 Maintaining the Independent Advocacy Relationship;
- Unit 304 Responding to the advocacy needs of different groups of people.

The qualification is accredited by the Qualifications and Curriculum Authority (**QCA**) at Level 3 of the Qualification and Credit Framework. Each unit can be taken and be assessed separately to allow a learner to work at their own pace along a flexible route to this or another qualification recognised within the or England and Wales.

Certificates of Unit Credit

Certificates of unit credit (CUCs) will be issued for each successfully completed unit, even if the full qualification is not attempted.

Candidates who do complete a full qualification will receive, in addition to their full certificate, a CUC for each Unit achieved.

Introduction to the Learning, Assessment Process and Criteria for Achievement of Unit 306

This summarises and adapts the comprehensive assessment requirements for this Unit set out in the City & Guild's Handbook for the qualification.

The requirements for the achievement of the 306 Unit, and the portfolio of evidence, knowledge requirement and learning outcomes are all established by City & Guilds. The credit value for this unit is 7 credits at Level 4. The number of Guided Learning Hours is 35 Hours. The hours are divided between the taught component and the performance element within the workplace.

Assessors

An assessor, who must have expertise in the field of independent mental health advocacy, is the person appointed by the training provider to give support through the process of building portfolio evidence. They have a responsibility to visit the workplace, assess the portfolio evidence, meet with the Expert Witness and carry out a Professional Discussion which will elicit underpinning knowledge, gain explanations of how to deal with contingencies and can provide opportunities for you to clarify or expand on evidence presented in your portfolio. A summary of the areas covered and the outcomes of the discussion must be recorded. If audio or visual recording is used it must be of a good enough quality to be clearly heard/seen. Tapes must be referenced and marked to allow verifiers quick access to the evidence they have planned to sample. The evidence must be trackable and accessible.

Knowledge and Performance evidence requirements

You will be required to demonstrate knowledge theory, but performance will be evidenced from real work practice, some of which must be observed. Product evidence is also likely to be significant in providing evidence for this unit. Regardless of the evidence source, assessment method and means of recording, the legal requirements and best practice in relation to maintaining the confidentiality and rights to dignity and privacy of the clients must be upheld.

Range of assessment methods or evidence sources

In addition to observation by line managers, expert witnesses and witnesses, assessors will negotiate the most effective and appropriate mix of methods/evidence sources to ensure all requirements are met. These can include projects/assignments, exercises, work products and reflective accounts. They can ask questions to confirm understanding and/or cover any outstanding areas. Questions may be asked orally or in writing but, in both cases, a record must be kept of the questions and responses.

Data protection and confidentiality

Data protection and confidentiality must not be overlooked in meeting the learning outcomes and other requirements of this unit.

Protecting identity

It is extremely important to protect the identity of the individuals encountered in the work setting, e.g. patient's confidential information must not be included in the portfolio or assessment records. Confidential information should remain in its usual location, and a reference should be made to it in the portfolio or assessment records.

Learning Outcomes for the 306 Unit

The 306 Unit requires evidence of six learning outcomes and the assessment criteria laid down for each of them.

1. Know how Mental Health legislation affects Independent Mental Health Advocacy qualifying patients;
2. Provide Independent Mental Health Advocacy;
3. Respond to requests for Independent Mental Health Advocacy support;
4. Engage with professionals;
5. Respond to individuals who have diverse needs;
6. Work safely.

Outcome 1: Know how Mental Health legislation affects Independent Mental Health Advocacy qualifying patients

Assessment criteria:

- 1.1 Explain key principles of Mental Health legislation
- 1.2 Analyse powers within the Mental Health Act 1983 as amended by the Mental Health Act 2007
- 1.3 Use the Mental Health Act 1983 as amended by the Mental Health Act 2007 to explain the process of compulsion
- 1.4 Research a range of safeguards enshrined within the Mental Health Act 1983 as amended by the Mental Health Act 2007

Outcome 2: Provide Independent Mental Health Advocacy

Assessment criteria:

- 2.1 Use the Mental Health Act 1983 to identify when an individual is entitled to receive IMHA support
- 2.2 Analyse the roles and responsibilities of an IMHA
- 2.3 Summarise rights afforded to an IMHA within the Mental Health Act 1983
- 2.4 Prioritise a range of case work
- 2.5 Assess a range of potential dilemmas which IMHAs can face in practice
- 2.6 Resolve practice dilemmas
- 2.7 Summarise and respond to a range of common advocacy issues for qualifying patients
- 2.8 Understand treatment options available to an individual who is subject to compulsion under the Mental Health Act 1983
- 2.9 Signpost qualifying patients to other services
- 2.10 Identify a range of information that should and must be recorded
- 2.11 Work within different environments
- 2.12 Understand how physical environments can impact on individuals

Outcome 3: Respond to requests for IMHA support

Assessment criteria:

- 3.1 Identify a range of people who can refer to the IMHA service
- 3.2 Use referral processes
- 3.3 Implement and review referral processes
- 3.4 Respond to referrals
- 3.5 Know when to refer to a range of advocacy services

Outcome 4: Engage with professionals

Assessment criteria: you can

- 4.1 Research and identify a range of people and services the IMHA is likely to come into contact with
- 4.2 Communicate the IMHA's role to a range of people
- 4.3 Use strategies to negotiate with professionals
- 4.4 Respond to dilemmas and challenges which may be faced

Outcome 5: Respond to individuals who have diverse needs

Assessment criteria:

- 5.1 Describe how having mental health needs can impact on daily living
- 5.2 Offer support to individuals who have mental health needs
- 5.3 Use a range of methods to communicate with people who have mental health needs
- 5.4 Respond to the cultural and spiritual needs of an individual
- 5.5 Identify dimensions of diversity
- 5.6 Signpost a range of specialist support services that a qualifying patient may wish to access
- 5.7 Evaluate how the personal and cultural identity of an IMHA can impact on the advocacy relationship

Outcome 6: Work safely

Assessment criteria:

- 6.1 Identify situations that present potential risks
- 6.2 Respond to risk
- 6.3 Summarise adult (or) child protection procedures
- 6.4 Commit to using supervision

Achievement of this Unit

Assessment is Pass or Fail only (no grades)

If the Assessor is unable to sign the assessment and verification document, he or she will provide feedback and will identify the outstanding evidence.

Outcome 1: Know how Mental Health legislation affects Independent Mental Health Advocacy qualifying patients

1.1 Explain key principles of Mental Health Legislation

The Welsh Assembly Government's Mental Health Strategy *Adult Mental Health Services for Wales* established nine guiding principles, grouped together under three broad headings. These underpinning principles are to guide everybody involved in planning, commissioning, managing, working in and using mental health services.

The principles are:

The empowerment principles

1. Patient well-being and safety should be at the heart of decision-making
2. Retaining the independence, wherever practicable, and promoting the recovery of the patient should be central to all interventions under the Act
3. Patients should be involved in the planning, development and delivery of their care and treatment to the fullest extent possible
4. Practitioners performing functions under the Act should pay particular attention to ensuring the maintenance of the rights and dignity of patients, and their carers and families, while also ensuring their safety and that of others

The equity principles

5. Practitioners must respect the diverse needs, values and circumstances of each patient
6. The views, needs and wishes of patients' carers and families should be taken into account in assessing and delivering care and treatment
7. Practitioners should ensure that effective communication takes place between themselves, patients and others

The effectiveness and efficiency principles

8. Any person made subject to compulsion under the Act should be provided with evidence based treatment and care, the purpose of which should be to alleviate, or prevent a worsening of, that person's mental disorder, or any of its symptoms or manifestations.
9. Practitioners should ensure that the services they provide are in line with the Welsh Assembly Government's strategies for mental health and learning disability

While these principles were explicitly set out in the strategy for adults (including older adults), they are sufficiently broad to provide headings for ordering the guiding principles which will inform decision making under the Act across all ages and client specialisms.

However, the principles set out in the *Statement on Policy and Practice for Adults with a Learning Disability*, as well as those included in the Child and Adolescent Mental Health Services (CAMHS) strategy *Everybody's Business*, should also be noted.

Using the principles

The principles inform decisions - they do not determine them. Although all of the principles must inform every decision made under the Act, the weight given to each principle in reaching a particular decision will depend on the context. It may be that in making some decisions a greater weight should be given to some principles over others.

The Code of practice states "All the chapters of this Code of practice should be read in the light of these principles."

1.2 Analyse powers within the Mental Health Act 1983 as amended by the Mental Health Act 2007

- Detaining powers
- Treating powers
- Holding powers
- Police powers
- Court powers
- Guardianship
- Community treatment orders

Detaining Powers

Criteria for detention

The MHA 1983 lays down the criteria which have to be met before an application for detention can be made. Before any application is made the professionals involved in the assessment need to consider whether there are alternative ways of providing the care and treatment the patient needs.

The criteria for section 2 are that:

- the patient is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
- they ought to be so detained in the interest of their health or safety or the protection of others.

The criteria for section 3 are that:

- the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital;
- it is necessary for their health or safety or for the protection of others, that they should receive that treatment;
- treatment cannot be provided unless they are detained under section 3;
- appropriate medical treatment is available for them.

Patient

“Patient” is defined in the MHA 1983 (section 145) as someone who is, or appears to be, suffering from mental disorder. This means that the Act uses patient where in practice other terms, such as service user or client, may be used. For simplicity, this resource uses the term patient, as does most official information about the MHA 1983. But it is important to remember that it is just a legal term – it is not saying anything about that person’s status or their relationship with professionals or anyone else.

Mental disorder

“Mental disorder” is defined for the purposes of the MHA 1983 (in section 1) as any disorder or disability of the mind. However, dependence on alcohol or drugs is specifically excluded. In addition, a learning disability counts as a mental disorder for the purposes of some aspects of the MHA 1983 only where it is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

Nature or degree

Case law has established that ‘nature’ refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient’s previous response to receiving treatment for the disorder.

Degree refers to the current manifestation of the patient’s disorder- in other words the intensity with which the patient is experiencing the symptoms.

(R v Mental Health

Review Tribunal for the South Thames Region Ex P. Smith (1999))

It is important to appreciate that a mental disorder may be **either** of a nature **or** of a degree that warrants action under the Act.

Section 2 or three?

In deciding whether a person should be detained in hospital under the Act, careful consideration must be given to which section, if any, would be the most appropriate, particularly bearing in mind the principle of least restriction. Professional judgement must be applied in making this decision.

The Code of Practice sets out some pointer to help the decision

Section 2 pointers:

- An inpatient assessment must be carried out in order to produce a treatment plan.
- A judgement is required on whether the patient will accept treatment on a voluntary/informal basis after admission.
- A judgement has to be made on whether a proposed treatment, which can only be administered to the patient under Part 4 of the Act, is likely to be effective.
- The condition of a patient who has already been assessed, and who has been previously admitted compulsorily under the Act, is judged to have changed since the previous admission and further assessment is required.
- The diagnosis and/or prognosis of a patient’s condition is unclear.
- It has not been possible to undertake any other assessment in order to formulate a treatment plan.

- The patient has not previously been admitted to hospital and has not been in regular contact with the specialist psychiatric services, and it has not been possible to formulate a treatment plan.

Section 3 pointers:

- The patient is considered to need compulsory admission for the treatment of a mental disorder, which is already known to his or her clinical team, and has recently been assessed by that team.
- The patient is detained under section 2 and assessment indicates a need for compulsory treatment under the Act beyond the existing period of detention.
- In such circumstances an application for detention under section 3 should be made at the earliest opportunity and should not be delayed until the end of the existing period of detention.

Effect of detention

Detained patients may not leave the hospital without permission.

Within the hospital, there will normally be restrictions on their movement, for instance, when they can leave their own ward, when they can use communal facilities. There will be other rules that patients are expected to follow – e.g. about where they keep their possessions, not having anything that might be dangerous, when and where they can see visitors. These rules are up to the hospital, but they must be reasonable.

Except in the high security hospitals (Broadmoor, Rampton and Ashworth) hospitals cannot withhold post from patients, and they can only stop patients sending post if the person to whom it is addressed has asked them to do so. (Section 134 of the Act).

Responsible clinicians

Every patient will have a responsible clinician – who is the doctor, or other professional with overall responsibility for their case.

Responsible clinicians must be approved clinicians. Approved clinicians are senior professionals who have been specifically approved by the Local Health Board as having the competencies necessary to carry out key functions under the Act.

Leave of absence

A patient's responsible clinician can give them leave of absence under section 17 of the Act ("section 17 leave"). Leave can either be short or long term. It covers everything from a brief trip to the local shops to a sustained period where the patient returns home, or lives in other accommodation away from the hospital.

Before granting leave for more than 7 days (or extending it so that it lasts more than 7 days in total), responsible clinicians must think about whether it would be more appropriate to discharge the patient onto supervised community treatment (SCT) where that is a possibility. But, if the responsible clinician decides against SCT, there is nothing to stop leave of absence being for more 7 days. SCT is explained later in this section of the workbook.

Leave of absence is often subject to conditions, e.g. about where the patient must or must not go, or (for long term leave) where the patient should live. These conditions are for the responsible clinician to decide.

Sometimes leave is “escorted leave” – which means that the patient must stay in the company of a member of staff (or another specified person).

“Ground leave” usually means permission to leave the ward and move around the hospital and its grounds. It is not technically section 17 leave because the patient does not leave the hospital.

If patients leave the hospital without permission they are considered to be “absent without leave” (AWOL) and can be taken into custody and brought back to the hospital. The same applies if they don’t return from leave when they are told to, or if they abscond from their escort while on escorted leave.

Transfer between hospitals

Most detained patients can be transferred from one hospital to another within England and Wales by agreement between the managers of the respective hospitals. This is normally done under section 19 of the Act.

Transfers outside England and Wales require the approval of the Secretary of State.

Renewal of detention

Detention under section 3 lasts initially for up to six months, but can be renewed by the patient’s responsible clinician for a further six months and then for a year at a time.

Before renewing the detention, the responsible clinician must examine the patient and decide whether the criteria for continued detention set out in section 20 of the Act are met. These criteria are essentially the same as the criteria for the initial application for detention. Another professional (from a different profession) who has been involved in the patient’s treatment must sign a form to say they agree with the responsible clinician’s decision.

Detention under section 2 cannot be renewed. If detention needs to continue, an application under section 3 has to be made. That is done in the normal way, even though the patient is already in hospital.

Discharge from detention (also see section on safeguards)

Under section 23, a patient’s responsible clinician can discharge them from detention under section 2, 3 or 4 at any time. As a result, responsible clinicians should always be thinking about whether the patient needs to remain detained.

The patient’s nearest relative can also discharge them, unless their responsible clinician completes a form (sometimes called a “barring order”) under section 25 saying they think the patient is likely to act dangerously if discharged. To give the responsible clinician time to think about this, the nearest relative has to give the hospital managers at least 72 hours’ notice of their intention to discharge the patient.

The hospital managers can also discharge the patient. In practice, these decisions are taken on their behalf by “managers’ panels” of three or more people, who aren’t actually part of the management team of the hospital.

Patients can ask a managers' panel to consider discharging them at any time. This is often called asking for a managers' hearing. A managers' panel must also always consider the patient's case if their section 3 detention is renewed by their responsible clinician. Patients (and sometimes their nearest relatives) can also ask a Tribunal to discharge them.

Treating Powers

Medical treatment under the MHA 1983 – general

Compulsion under the MHA 1983 exists primarily to ensure that people with mental disorders get the treatment and care they need to prevent harm to themselves or to other people.

Under the common law, people who have the capacity to decide for themselves whether to consent to treatment cannot be given it unless they do, in fact, consent. In some cases, the MHA 1983 over-rides this general rule in common law, and allows professionals to treat patients without their consent for their mental disorder.

The rules about when detained patients can be treated without their consent are set out in Part 4 of the Act.

Rules about treatment of SCT patients are mainly in Part 4A of the Act.

There are also some rules about certain special kinds of treatment for mental disorder which apply to all patients, whether or not they are detained or otherwise subject to the Act. Those rules are also in Part 4.

The rules in the Act about treatment are only about treatment for mental disorder. It does not deal with treatment for other health issues.

“Although the Mental Health Act permits some medical treatment for mental disorder to be given without consent, the patient’s consent should still be sought before treatment is given, wherever practicable. The patient’s consent or refusal should be recorded in their notes, as should the treating clinician’s assessment of the patient’s ability to consent”

Treatment for detained patients

Part 4 of the Act deals mainly with the treatment of people who have been detained in hospital.

For these purposes “detained patients” includes SCT patients who have been recalled to hospital. But it does **not** include patients:

- detained under section 4 (unless or until the second medical recommendation is received) or section 35;
- held under the “holding powers” in section 5(2) and 5(4);
- being detained in a place of safety under sections 135 and section 136;
- temporarily detained in hospital as a place of safety under section 37 or 45A while waiting for their final hospital place to become available;
- on conditional discharge. For these patients, there are no special rules about their treatment. They are in the same position as patients who are not subject to the Act at all, and they have exactly the same rights to consent to and refuse treatment.

Rules about treatment which apply to patients whether or not they are detained or on SCT

Although the MHA 1983 is mainly about patients subject to some form of compulsion, there are two rules about treatment which apply to patients whether or not they are detained, on SCT, or subject to any other kind of compulsion.

The treatments are:

- for patients of all ages, neurosurgery for mental disorder and other treatments covered by section 57 of the Act; and
- for patients aged under 18, ECT and other treatments covered by section 58A of the Act.

Patients who are being considered for these treatments are eligible for help from an IMHA, whether or not they would otherwise qualify.

Treatments requiring consent and a second opinion under section 57

Section 57 is about neurosurgery for mental disorder (sometimes called “psychosurgery”) and surgical implantation of hormones to reduce male sex drive. In practice, these treatments are very rarely used.

Where section 57 applies, the treatment can be given only if all three of following requirements are met:

- the patient consents to the treatment
- a SOAD (and two other people appointed by the Care Quality Commission) certify that the patient has capacity to consent and has done so; and
- the SOAD also certifies that is appropriate for the treatment to be given to the patient.

The effect is that someone who lacks capacity to consent to a section 57 treatment cannot be given it. Nor can anyone be given it against their will.

In theory, section 57 does not apply in emergencies when treatment is immediately necessary. But, in practice, it is inconceivable that these treatments would ever be immediately necessary.

Treatment without consent – section 63

Section 63 of the Act means that detained patients (as defined above) may, in general, be given medical treatment for their mental disorder without their consent, provided the treatment is given by or under the direction of the approved clinician in charge of the treatment in question.

Holding powers

The Act includes a number of short- term powers of detention, which are mainly to allow a person to be detained for a short time while arrangements are made to have them assessed by an AMHP and one or more doctors to see if an application for detention should be made.

These short-term powers cannot be renewed and do not allow the patient to be given treatment without their consent.

Section 4

Section 4 allows emergency detention for a purpose of assessment for a duration of up to 72 hours.

The application can be made by the nearest relative or an Approved Mental Health Professional (AMHP) and must be supported by one doctor. The doctor must have examined the patient within the previous 24 hours.

The recommendation should indicate the urgent nature of the application, such that detention under section 2 would involve unacceptable delay.

A second medical recommendation from an approved doctor, under section 12 of the Act, received within 72 hours will allow further detention under section 2.

Duration is for not more than 72 hours, and renewal is not possible. But by means of a second recommendation, which must be signed and received by the hospital managers within three days of the admission, section 4 can be converted into section 2.

Section 5

In certain circumstances, hospital inpatients can be detained temporarily pending an assessment to decide whether an application for their detention needs to be made under the Act.

Section 5(2) can be used by the doctor or approved clinician in charge of a patient's treatment (or their deputy), where they believe that an application for detention should be made. As a matter of good practice, the assessment should take place as soon as possible, but section 5(2) allows the patient to be detained for a maximum of 72 hours while that happens.

Section 5(4) is sometimes referred to as the 'nurses' holding power' and can be used where there is no appropriate doctor or approved clinician available to use the power under section 5(2). It allows certain nurses to authorise a patient's detention, if they believe that the patient is suffering from mental disorder to such a degree that it is necessary either for the patient's own health or safety or the prevention of harm to others that the patient should be prevented from leaving the hospital. The holding power lasts for up to 6 hours or until a doctor or approved clinician arrives with the power to use section 5(2) arrives. It cannot be renewed. Unlike the holding power in section 5(2) it can only be used for inpatients who were already being treated for mental disorder.

The Code of Practice states:

"As section 5 may only be used for an informal patient in a hospital, hospital managers should be able to clearly identify what is meant by "informal inpatient". For the purposes of this Code, an informal inpatient is a patient who has come to the ward and who has not acted to resist (verbally or physically) the admission procedure. A patient remains an inpatient until they have removed themselves (or been removed) from the hospital."

Police Powers

Section 136

Section 136 gives a police officer the power to detain a person who is in a public place and who they believe to be suffering from mental disorder and in need of immediate care and control. It enables the police to take the person to a place of safety to be assessed by an AMHP and a doctor.

The assessment at the place of safety should take place as soon as possible after the arrival of the person at the place of safety, but section 136 allows the person to be detained for a maximum of 72 hours. During that period, they can be moved from one place of safety to another.

Places of safety can include both psychiatric and other hospitals. They can also be police stations, although that is meant to be the exception, rather than the rule.

Section 135(1)

Under section 135(1), a magistrate can issue a warrant in response to an application made by an AMHP. The warrant gives a police officer the right to enter premises (by force if necessary) where there is believed to be a person who has mental disorder and who is not receiving proper care.

The police officer must be accompanied by an AMHP and a doctor. The person may be taken to a place of safety to enable them to be assessed by an AMHP and a doctor. In some cases, the AMHP and the doctor(s) may be able to complete the assessment without the need to remove the person to a place of safety. As with section 136, people taken to a place of safety can be detained for a maximum of 72 hours.

Place of safety

The Code of Practice states:

“In choosing the place of safety, the professionals should consider the impact that the proposed place of safety may have on the person held and on the examination and interview. Therefore, a police station should be used either in the exceptional circumstances outlined above or when it is considered the safest option for the person, other patients or staff.”

Court Powers

Some patients are detained in hospital under the MHA 1983 instead of being in prison or some other kind of custody. The rules about this are mainly found in Part 3 of the Act - these patients are therefore sometimes called Part 3 patients. They are also called “forensic patients”, and the relevant parts of the Act “forensic sections”.

Hospital orders (section 37)

The most common type of Part 3 detention is a hospital order under section 37. A hospital order means that a court has ordered that an offender with a mental disorder should be detained in hospital, rather than being sent to prison or given some other kind of punishment.

A hospital order is not a form of punishment, but an alternative to it.

Hospital orders can either be “restricted” or “unrestricted”. They are restricted if the court also makes a restriction order under section 41, because it is concerned the patient poses a risk of serious harm to other people. Patients subject to restricted hospital orders are often called “section 37/41” patients.

For the most part, unrestricted hospital order patients are treated the same as section 3 patients, although there are some differences in when they can apply to the Tribunal. Also, they cannot be discharged by their nearest relative – although the nearest relative may be able to apply to the Tribunal instead.

Restricted hospital order patients are also treated broadly like section 3 patients, but there are more differences. In particular:

- restricted patient's detention does not have to be renewed – it lasts until they are discharged, or the restriction order ends;
- restricted patients cannot be given leave of absence, or be transferred to another hospital, without the agreement of the Secretary of State for Justice;
- restricted patients cannot be discharged by their responsible clinician or the hospital managers unless the Secretary of State for Justice agrees. This means that, unless the Secretary of State agrees, they can only be discharged by the Tribunal;
- restricted patients are the only patients who can be conditionally discharged;

People sometimes refer to 'Part 2' and 'Part 3' patients as shorthand for describing patients to whom these Parts of the Act apply.

Part 2 The part of the Act which deals mainly with detention, guardianship and supervised community treatment for civil (non- offender) patients.

Part 3 The part of the Act which deals mainly with detention, conditional discharge and guardianship for mentally disordered offenders and defendants in criminal proceedings.

Part 2 and Part 3 of the MHA 1983

Restricted patient's hospital order can specify a particular unit (e.g. a ward), rather than a whole hospital. If so, they need leave of absence to leave that unit, even if they remain within the hospital; additionally restricted patients do not have a nearest relative for the purposes of the MHA 1983 – so, by definition, their nearest relative has no say over their discharge, and no right to apply to the Tribunal.

In practice, each restricted patient has a caseworker in the Ministry of Justice's Mental Health Unit (MHU). The MHU is responsible for managing restricted patient's cases on behalf of the Secretary of State for Justice.

The Secretary of State can lift a restriction order at any time, and in a few cases it will end automatically after a fixed period. If the patient is still detained when the restrictions are lifted, they then become an unrestricted patient instead.

Hospital and limitation directions (section 45A)

In certain cases, a court can pass a prison sentence and give the equivalent of a restricted hospital order at the same time. This is known as hospital and limitation directions – the hospital direction is the equivalent of the hospital order, and the limitation direction is like the restriction order.

Patients on hospital and limitation directions are treated largely as if they were subject to a restricted hospital order. The main difference is that, if they no longer need to be in hospital, they can be moved to prison to serve any time left on their prison sentence.

If they are still detained in hospital when they would have been released from their prison sentence, the limitation direction ends, and they are then treated, in effect, as if they were on an unrestricted hospital order.

Transfer directions for sentenced prisoners (section 47)

People serving prison sentences can be transferred to detention in hospital instead if they need treatment for a mental disorder. This is done by the Secretary of State for Justice issuing a transfer direction under section 47 of the Act.

Like hospital orders, transfer directions can either be restricted or unrestricted. They are restricted if the Secretary of State also issues a restriction direction under section 49. In practice, most transfer directions are restricted when they are first made.

For the most part, transfer direction patients are treated like restricted or unrestricted hospital order patients (as the case may be). The most important difference is that, if they no longer need to be in hospital, restricted transfer direction patients can be returned to prison to serve any time left on their prison sentence.

If restricted transfer direction patients are still detained in hospital when they would have been released from their prison sentence, the restricted direction ends, and they become unrestricted patients. This is sometimes called a “notional section 37” (because, in practice, the patient is then treated in the same way as an unrestricted hospital order patient).

Transfer directions for un-sentenced prisoners (section 48)

The Secretary of State can also issue a transfer direction to transfer an un-sentenced prisoner to hospital if they need treatment urgently. Un-sentenced prisoners include people on remand awaiting trial or sentence, civil prisoners and people detained under immigration legislation.

The effect of a transfer direction is largely the same as for sentenced prisoners, except that the transfer direction ends automatically when the person would otherwise no longer be on remand etc. At that point, the patient can only be kept in hospital if they are detained in some other way (e.g. the court has decided to give them a hospital order, or they are detained in the normal way by an application by an AMHP).

Other powers of the courts (sections 35, 36, 38 and 44)

Instead of remanding a defendant in a criminal case in custody, the courts can remand them to hospital under the MHA. There are two types of remand:

- under section 35, someone can be remanded to hospital so that a report can be prepared on their mental health;
- under section 36, someone can be remanded to hospital for treatment.

Under section 38, if they are considering whether to give an offender a hospital order, the courts can give an interim hospital order detaining the patient in hospital. The order can be for up to 12 weeks initially and can be renewed by the court periodically for up to a year in total.

For most purposes, patients detained under section 35, 36 or 38 are treated like other detained patients. But there are some important differences. In particular:

- because they are, in effect, still under the control of the court, only the court can discharge them or end the order. This means, for example, they cannot apply to the Tribunal and that responsible clinicians cannot give them leave of absence;
- as with restricted patients, the provisions in the Act about nearest relatives do not apply to them;
- patients detained under section 35 cannot be given treatment without their consent (although in practice they sometimes can because they are also detained under section 3).

Because magistrates' courts cannot make restriction orders themselves, they sometimes send offenders to the Crown Court for sentencing if they think the offender should be given a restricted hospital order. Under section 44, they can order the patient to be detained in hospital until the Crown Court makes its decision. Patients detained under section 44 are treated, for most purposes, as if they had already been given an unrestricted hospital order.

Conditional discharge

Conditional discharge means that a patient is discharged from detention by the Tribunal or the Secretary of State for Justice, subject to the possibility of recall to hospital by the Secretary of State if necessary.

Only restricted patients can be conditionally discharged (and restricted patients cannot be discharged onto SCT instead).

Conditionally discharged patients are expected to comply with conditions set either by the Tribunal or the Secretary of State. In practice, there is always a condition that they accept clinical supervision by their responsible clinician (e.g. a consultant psychiatrist) and social supervision (e.g. from a social worker or probation officer). There may also be other conditions, e.g. about where they should live, or places or people from whom they must stay away.

Responsible clinicians have to make periodic reports to the Ministry of Justice on their conditionally discharged patients.

The Secretary of State can recall a conditionally discharged patient to hospital at any time if he thinks it necessary. If recalled, the patient goes back to being a restricted detained patient, under the same section of the MHA 1983 as before their conditional discharge.

There is no direct sanction for breaking the conditions of conditional discharge, but it will be one of the factors the Secretary of State will take into account in deciding whether a patient needs to be recalled to hospital for further treatment.

To recall a patient, the Secretary of State issues a recall warrant. As soon as that warrant is issued, the patient is considered to be AWOL and can be taken to the hospital in question against their will, if necessary.

Unlike in SCT, there is no separate concept of revocation. A recall warrant effectively revokes the conditional discharge. If he recalls a patient, the Secretary of State must refer their case to the Tribunal.

Conditionally discharged patients cannot be given medical treatment without their consent, unless they are recalled to hospital.

Only the Tribunal or the Secretary of State can discharge a patient from conditional discharge. That is called an absolute discharge, and means that the patient is no longer liable to be recalled to hospital.

Guardianship

The purpose of guardianship is to help enable vulnerable people with a mental disorder to receive care in the community when it cannot be provided without the use of compulsory powers.

There are two main routes into guardianship. Normally, a person becomes subject to guardianship on the basis of an application for guardianship made under Part 2 of the Act (section 7) by an AMHP or (less commonly) their nearest relative. However, an offender can also be given a guardianship order by a court under section 37 in Part 3 of the Act as an alternative to a hospital order or any kind of punishment.

You may hear guardianship under section 7 referred to as a “guardianship order”, but technically only guardianship imposed by a court under section 37 is an “order”. In practice, it makes little difference. The criteria for a guardianship application under section 7 are that:

- the patient is suffering from mental disorder of a nature or degree which warrants their reception into guardianship;
- it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received.

The effect of a guardianship application or order is to appoint a guardian for the patient. The guardian is almost always a local social services authority, although it can also be a private individual (known as a “private guardian”) approved by such an authority.

Guardians have three specific powers:

- to require a patient to live at a specified place;
- to require the patient to attend for treatment, work, training or education at specific times and places (but they cannot use force to take the patient there); and
- to require that access be given to any doctor, AMHP or another specified person at the place where the person lives.

The powers of the guardian are conferred on them to the exclusion of anyone else. In other words, no one else may take a decision on these matters which goes against a decision of a guardian.

Guardianship patients who do not go voluntarily to the place their guardian requires them to live are considered to be AWOL, and can therefore be taken there against their will, if necessary. Similarly, they can be returned to that place if they absent themselves from it (e.g. by going to live elsewhere) without the guardian’s permission. But this does not allow the guardian – or anyone else – to detain the patient there, or anywhere else. Nor does guardianship give anyone the power to treat the patient without their consent.

Patients have the same rights to consent to or refuse treatment as anyone else. If they lack capacity to consent to treatment, then (as with anyone else) it may be possible to treat them in accordance with the Mental Capacity Act 2005 (MCA).

Guardianship lasts for up to six months initially. It can be renewed for a further six months and then for a year at a time under section 20. Normally, it is for the patient's responsible clinician to decide whether to renew the guardianship (if the patient has a private guardian, then the decision falls to the doctor who has been appointed by their guardian as the patient's "nominated medical attendant").

In this context of guardianship, "responsible clinician means an approved clinician appointed for the purpose by the relevant local social services authority."

Guardianship can only be renewed if the criteria for continued guardian in section 20 are still met. These are effectively the same as the criteria for a guardianship application.

Patients can be discharged from guardianship at any time by:

- their responsible clinician;
- their nearest relative (unless they are subject to a guardianship order under section 37) – this cannot be blocked by the responsible clinician or anyone else;
- the relevant local social services authority.

In practice, discharge decisions are made on behalf of the local social services authority by a panel of three or more people authorised by the authority. They must consider discharging a patient when the patient's guardianship is renewed.

Patients (and in the case of people on guardianship orders under section 37, their nearest relatives) can also apply to the Tribunal for their discharge from guardianship.

Supervised community treatment

Supervised community treatment (SCT) is a way in which patients can be discharged from detention in hospital, subject to the possibility of being recalled to hospital for further treatment if necessary.

Its purpose is to allow suitable patients to be safely treated in the community rather than in hospital, and to provide a way to help prevent relapse and any harm (to the patient or to others) that relapse might cause. It is intended to help patients maintain stable mental health outside hospital and to promote their recovery. SCT is the newest form of compulsion under the Act. It was introduced in November 2008.

Criteria for SCT (section 17A)

SCT is for patients who are detained for treatment under section 3. It can also be used for patients detained under sections 37, 45A, 47 or 48, but only if they are unrestricted.

Only the patient's responsible clinician can discharge them from detention onto SCT. The responsible clinician does that by making a community treatment order (CTO).

A CTO is the means by which SCT is implemented. This guidance uses the term “SCT patient”, but other people may use “CTO patient”. The Act itself uses the term “community patient”.

Five criteria must be met before a CTO is made:

- the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for the patient to receive medical treatment;
- it is necessary for the patient’s health or safety or for the protection of other persons that the patient should receive such treatment;
- subject to the patient being liable to recall ... such treatment can be provided without the patient continuing to be detained in hospital;
- it is necessary that the RC should be able to exercise the power ... to recall the patient to hospital;
- appropriate medical treatment is available for the patient.

A responsible clinician cannot make a CTO unless an AMHP agrees in writing that these criteria are met and that it is appropriate for the patient to become an SCT patient.

The effect of a CTO is to discharge the patient from detention in hospital, subject to certain conditions and to the possibility of being recalled to hospital for further treatment. It can be thought of as suspending the patient’s liability to be detained in hospital.

Setting conditions in the CTO (section 17B)

All CTOs must include a condition that patients must make themselves available for examination:

- by the responsible clinician, when the responsible clinician needs to decide whether the CTO should be extended at the end of the first six months and periodically thereafter; and
- by a SOAD (second opinion appointed doctor) who is deciding whether to issue a certificate authorising the patient’s treatment (there is more about the SOAD later).

In addition to these two compulsory conditions the responsible clinician may include other conditions which they think are necessary or appropriate for one or more of the following purposes:

- ensuring the patient receives medical treatment;
- preventing risk of harm to the patient’s health or safety; or
- protecting other people.

The AMHP has to agree these conditions. But the responsible clinician can vary or suspend any of these conditions after the CTO has started, without the agreement of the AMHP.

Responsible hospital

Every SCT patient has a “responsible hospital”. Initially, that is the hospital in which the patient was detained before they were discharged onto SCT. But responsibility can be assigned to another hospital by agreement between the respective managers.

The managers of the responsible hospital have various powers and duties in relation to the SCT patient. For example, it is the managers of the responsible hospital who must ensure that the patient is given information about SCT and their rights and who must make sure that the proper procedures for SCT are being followed.

However, the patient won't necessarily be receiving treatment at the responsible hospital.

Recall to hospital (section 17E)

The responsible clinician can recall an SCT patient to hospital at any time, if:

- the patient needs to receive treatment for mental disorder in hospital; and
- there would be a risk of harm to the health or safety of the patient or to other persons if the patient were not recalled.

They can also recall a patient who breaches one of the two compulsory conditions requiring them to make themselves available for examination.

The patient not complying with the conditions of their CTO (apart from the compulsory conditions) on its own does not justify recall. However, it is one of the factors that the responsible clinician may take into account. Also, if the criteria for recall are met, the patient can be recalled even if they have complied with all the conditions of their CTO.

To recall a patient, the responsible clinician must complete a written notice of recall to hospital. The power to recall the patient will become effective only once the notice is served on the patient (either by being given to the patient in person, or being left at or posted to their usual or last known address).

The effect of a recall notice is that the patient has to return to hospital and can be detained there for up to 72 hours. If the patient does not come to the hospital voluntarily, they are considered to be AWOL and can be taken there against their will if necessary.

Hospital in this context can mean a clinic within the hospital grounds, and the hospital to which the patient is recalled does not have to be their responsible hospital.

Revocation (section 17F)

Recall only allows the patient to be detained for a maximum of 72 hours from when they arrive at the hospital (or from when the notice was served, if they are already in hospital). In many cases, recall will be much shorter than that, and won't necessarily involve the patient being admitted again as an in-patient.

The responsible clinician can release the patient at any time during the 72 hour period, and should do so as soon as it is no longer necessary to keep the patient in hospital. If released, the patient remains on SCT as before.

If the responsible clinician thinks the patient needs to be detained for more than 72 hours, the CTO will need to be revoked.

The responsible clinician can only revoke the CTO if:

- the RC believes that the criteria for detention under section 3 are met; and
- an AMHP agrees with that opinion and states that it is appropriate for the CTO to be revoked.

If the CTO is revoked, the patient ceases to be on SCT and becomes detained again under section 3 (or whichever section they were detained under prior to going onto SCT).

Where that happens, it is taken as the start of a new period of detention – meaning it lasts for up to six months initially and can then be renewed in the normal way for another six months and then for a year at the time. The hospital managers must also automatically refer the patient's case to the Tribunal.

The Code of Practice says:

'Recall to hospital should not become a regular or normal event for any patient on SCT. If recall is being used frequently, the responsible clinician should review the patient's treatment plan to consider whether it could be made more acceptable to the patient, or whether, in the individual circumstances of the case, SCT continues to be appropriate'

Note, too, that:

- Patients can be recalled even if they are already in hospital having been admitted informally. SCT does not prevent informal admission;
- Patients need not be recalled to the same hospital that they were discharged from or which is now their responsible hospital.

Extension of SCT (section 20A)

The CTO lasts for six months from the date specified on the CTO. The responsible clinician can extend it for a further six months and then for a year at the time.

As with renewal of detention, the responsible clinician must first examine the patient and decide whether the criteria for continuing SCT are met. In addition, an AMHP must state in writing their agreement that the criteria are met and that it is appropriate for the CTO to be extended.

Discharge from SCT (section 23)

A patient's responsible clinician can discharge them from SCT at any time.

For patients who were previously detained under section 3, the patient's nearest relative can also discharge them, unless their responsible clinician completes a form (sometimes called a "barring order") saying they think the patient is likely to act dangerously if discharged. As with detention, to give the responsible clinician time to think about this, the nearest relative has to give the hospital managers at least 72 hours' notice of their intention to discharge the patient.

Nearest relatives cannot discharge patients who were detained under Part 3 of the Act before going onto SCT – but they have rights to apply to the Tribunal instead.

The managers of the responsible hospital can also discharge the patient. As with detention, in practice, these decisions are taken on their behalf by managers' panels of three or more people who aren't actually part of the management team of the hospital.

Patients can ask a managers' panel to consider discharging them at any time. A managers' panel must also always consider the patient's case if their CTO is extended by their responsible clinician. Patients (and sometimes their nearest relatives) can also ask a Tribunal to discharge them. Discharge from SCT means that the patient is no longer subject to the CTO and no longer liable to recall to hospital.

Treatment for SCT patients

Although SCT is designed to help ensure that patients continue to receive the treatment they need and stay in touch with mental health services, it does not allow professionals to treat

patients forcibly without their consent, unless they have been recalled to hospital. The only exception to this is where the patient lacks capacity to consent and it is an emergency.

Once discharged onto SCT patients are no longer subject to Part 4 of the MHA 1983 and are instead subject to Part 4A.

This means they cannot be treated for mental disorder by force, unless they are recalled to hospital (except in emergency situations where they lack capacity to consent).

It also means that, for the most part, they cannot be given medication (or ECT) unless it is covered by a SOAD certificate (even if they consent).

Authority to treat SCT patients who have not been recalled to hospital

SCT patients who haven't been recalled to hospital can only be given treatment for mental disorder where Part 4A of the Act says there is "authority to treat" them. This includes SCT patients who are back in hospital voluntarily, rather than having been recalled.

Specifically:

- if the patient has capacity to consent to the treatment, it can only be given if they consent to it;
- if the patient lacks capacity to consent, but someone else has the authority to consent on their behalf, then they can be treated if that person consents. Only the donee of a lasting power of attorney, a deputy appointed by the Court of Protection under the Mental Capacity Act or the Court of Protection itself would be able to do that;
- otherwise, a patient who lacks capacity to consent can be treated provided the treatment is given by, or under the direction of, the approved clinician in charge of the particular treatment, unless:
 - (in the case of a patient aged 16 or over) it would conflict with a decision that their donee, deputy or the Court of Protection has the authority to take on their behalf;
 - (in the case of a patient aged 18 or over) they have made an advance decision refusing the particular treatment in question;
 - (in the case of a patient any age) they object (in any way) to being treated and force would have to be used to administer the treatment.

If it is an emergency (because the treatment is immediately necessary), these restrictions on treating patients without capacity don't apply, provided that any force used is proportionate to the risk to the patient. The definition of when treatment is immediately necessary is the same as for detained patients.

Patients with capacity to consent cannot be treated without their consent, even if it is an emergency. This is true even if it is a condition of their SCT that they take the treatment in question. If it is necessary to treat an SCT patient who can't be treated under these rules, they have to be recalled to hospital.

Part 4A Certificates

Part 4A also spells out the "certificate requirements" for SCT patients.

Unless it is an emergency, SCT patients cannot be given medication (or ECT) unless it has been approved by a SOAD on a “Part 4A certificate” (also called Form CTO11). This applies even if the patient is consenting. However, a certificate is not needed for medication:

- during the first month following the patient’s discharge from detention onto SCT, or
- if less than three months have passed since the patient was first given medication while under compulsion (either while still detained or after being discharged onto SCT).

Nor is it needed in an emergency for treatment which is immediately necessary.

SOADs can make their approval subject to conditions. SOADs can also use Part 4A certificates to approve treatment to be given if the patient is recalled to hospital (see below).

Treatment of SCT patients on recall to hospital

SCT patients recalled to hospital are treated like detained patients.

That means that they can be treated for their mental disorder without their consent while recalled to hospital, subject to the normal rules about treating detained patients.

However, a SOAD certificate under section 58 or 58A is not required if a SOAD has already said on a Part 4A certificate that the treatment may be given on recall to hospital (or if no SOAD certificate is yet required because the patient has been on SCT for less a month). That enables the patient to be treated swiftly when recalled to hospital, without having to wait for a new Part 4 certificate to be obtained.

That continues to apply if the patient’s SCT is revoked – and so they go back to being detained – but only for as long as it takes to get a new SOAD certificate.

1.3 Use the Mental Health Act 1983 as amended by the Mental Health Act 2007 to explain the process of compulsion

Forms of compulsion under the MHA 1983

IMHA services exist primarily to help and support patients who are subject to compulsory measures under the MHA 1983. This section gives an overview of the four different forms of compulsion to which qualifying patients may be subject, namely:

- detention;
- supervised community treatment;
- conditional discharge;
- guardianship.

Main civil powers of detention

Detention in hospital is the most common form of compulsion under the MHA 1983.

Applications for detention

The majority of people who are detained under the MHA 1983 are detained because an approved mental health professional (AMHP) has completed an application for them to be detained.

An AMHP is a mental health professional with specialist training in mental health assessment and legislation. AMHPs are approved by the local social services authority (LSSA). An AMHP can be a nurse, social worker, occupational therapist or psychologist – although at present AMHPs are normally social workers. That is because AMHPs only replaced approved social workers (ASWs) in November 2008. It is therefore possible that the term ASW is still used when AMHP should be used.

An application can also be made by the patient's nearest relative, but that is unusual.

Two medical recommendations are required to support an application. One must be from a doctor who is approved under section 12 of the Act as having special expertise in the diagnosis or treatment of mental disorder (often called a "section 12 doctor"). If practicable, at least one of the doctors should have previous acquaintance with the patient (all doctors who are approved under the Act as approved clinicians are automatically treated as section 12 approved).

There are two main kinds of applications. An application under section 2 is called an application for admission for assessment. It allows a patient to be detained in hospital for assessment (or assessment followed by medical treatment) for up to 28 days.

An application under section 3 is called an application for admission for treatment. It allows a patient to be detained in hospital for medical treatment. Detention for treatment under section 3 is for up to six months initially and can be renewed for another six months and then for a year at time.

An emergency application for admission for assessment can be made under section 4 on the basis of only one medical recommendation. Section 4 can only be used where the urgency of making the application outweighs the desirability of waiting for a second doctor, e.g. where there is risk or serious or immediate harm to the patient or other people. Detention under section 4 lasts for up to 72 hours, unless the second medical recommendation is completed during that period. The receipt of a second medical recommendation effectively "converts" it into a section 2 application.

Criteria for detention

The MHA 1983 lays down the criteria which have to be met before an application for detention can be made. Before any application is made the professionals involved in the assessment need to consider whether there are alternative ways of providing the care and treatment the patient needs.

The criteria for section 2 are that:

- the patient is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and
- they ought to be so detained in the interest of their health or safety or the protection of others.

The criteria for section 3 are that:

- the patient is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital;

- it is necessary for their health or safety or for the protection of others, that they should receive that treatment;
- treatment cannot be provided unless they are detained under section 3;
- appropriate medical treatment is available for them.

Nature or degree?

Case law has established that 'nature' refers to the particular mental disorder from which the patient is suffering, its chronicity, its prognosis, and the patient's previous response to receiving treatment for the disorder.

Degree refers to the current manifestation of the patient's disorder- in other words the intensity with which the patient is experiencing the symptoms. (*R v Mental Health Review Tribunal for the South Thames Region Ex P. Smith (1999)*)

It is important to appreciate that a mental disorder may be **either** of a nature **or** of a degree that warrants action under the Act.

Effect of an application

A properly completed application, supported by the required medical recommendations, allows the applicant to take the patient to the hospital where they are going to be detained, or to arrange for someone else to do so.

Sometimes the patient will already be in the hospital when the application is made. A properly completed application is also what gives the hospital managers – i.e. the organisation that runs the hospital – the legal authority to detain the patient.

1.4 Research a range of safeguards enshrined within the Mental Health Act 1983 as amended by the Mental Health Act 2007

- The Nearest Relative
- Second Opinion Appointed Doctor (SOAD)
- Mental Health Review Tribunal
- Hospital Managers Panels
- Healthcare Inspectorate Wales

Nearest relative

The MHA 1983 confers a number of rights and powers upon patients' nearest relatives (if they have one). In particular:

- nearest relatives can make applications for patients to be detained (although this is unusual – most applications are made by AMHPs);
- they can require a local social services authority to ask an AMHP to consider making an application for detention (and if the AMHP decides not to make an application, the nearest relative has to be told why in writing);
- AMHPs must take steps to inform the nearest relative, either beforehand or as soon as practicable afterwards, if they make an application for detention under section 2 or 4;
- AMHPs must take steps to consult the nearest relative before making an application for detention under section 3 or an application for guardianship. The application cannot be made if the nearest relative objects;

- in many cases, the nearest relative has the right to discharge a patient from detention or SCT (although this may be blocked by the patient's responsible clinician);
- nearest relatives always have the right to discharge people from guardianship (unless the patient is on a guardianship order imposed by a court under section 37). Discharge from guardianship cannot be blocked;
- in some circumstances, nearest relatives can apply to the Tribunal for a patient's discharge;
- generally, nearest relatives will be told when the patient has applied to the Tribunal, unless the patient requests otherwise;
- unless the patient requests otherwise, nearest relatives generally have to be given a copy of written information that hospital managers or local social services authorities are required to give patients about their rights (etc) under the Act;
- unless they ask not to be told, or the patient requests otherwise, nearest relatives generally have to be told if the patient is discharged from detention or SCT, preferably seven days in advance.

Identification of the nearest relative (section 26)

A patient cannot choose their nearest relative. The Act itself sets out a so-called "hierarchical list" in section 26 to determine who the nearest relative is.

1. husband, wife or civil partner
2. son or daughter
3. father or mother
4. brother or sister
5. grandparent
6. grandchild
7. uncle or aunt
8. nephew or niece

The basic rule is that the person who comes highest in the list is the nearest relative. If two or more people come in the same position, the nearest relative is the older or oldest (regardless of gender).

However, there are many significant exceptions to these rules. In particular:

- people who have lived together for at least six months as if they were husband and wife or civil partners are normally treated as if they were, in fact, the patient's husband, wife or civil partner;
- people who have lived together for at least five years are treated as relatives, whether or not they are actually related. They start at the bottom of the hierarchical list;
- relatives (including people treated as relatives) who live with, or care for, the patient generally take precedence over those who do not.

There are other exceptions to these basic rules. Before talking to patients about who their nearest relative is, it is worth studying section 26 of the Act carefully. (It is also worth looking at chapter 33 of the Reference Guide.)

Changing the nearest relative

Nearest relatives can delegate most of their powers by authorising someone else in writing to act on their behalf. They can also withdraw this authorisation to act any time they wish. If the

nearest relative wants to appoint someone to act in this way it is important that it is done in writing. This is set out in regulations under the Act, rather than in the Act itself. The nearest relative must tell the patient if they have delegated their powers to someone else in this way (or have taken their powers back).

Patients cannot choose their own nearest relative. But it is possible for a patient – and certain other people – to apply to the county court for the appointment of an acting nearest relative in place of whoever would normally be the nearest relative. This is sometimes called “displacing” the nearest relative.

Section 29 sets out five grounds for this:

1. the patient has no nearest relative as far as can be determined;
2. the nearest relative is incapable of acting as such;
3. the nearest relative unreasonably objects to the making of an application for detention or for guardianship;
4. the nearest relative has exercised the power of discharge without due regard to the interests of patient or other persons, or is likely to do so;
5. the nearest relative is otherwise not a suitable person to act as such.

The third ground is sometimes used when a nearest relative objects to an AMHP making an application for detention under section 3, or an application for guardianship. If the AMHP thinks that the nearest relative is being unreasonable, they may decide to apply for the nearest relative to be replaced by someone else. If the patient is detained under section 2 at the time, their detention under that section can be extended until the court case is finally resolved.

The procedures for making an application to the county court for an order appointing an acting nearest relative, and for subsequent discharge or variation of such an order are set out in sections 29 and 30 of the Act. If a patient is considering making an application, they would probably benefit from advice from a qualified lawyer.

Second opinion appointed doctor (SOAD)

Section 58 – treatment requiring consent or second opinion

Section 58 is about medication for mental disorder, but it only applies once three months have passed from the day on which any form of medication for mental disorder was first administered to the patient during the patient’s current period of detention under the Act.

This three month period applies even if the section under which the patient is detained changes, or they go onto SCT.

Detained patients cannot be given medication to which section 58 applies unless:

- the approved clinician in charge of the treatment, or a SOAD, certifies (on Form T2) that the patient has the capacity to consent and has done so; or
- a SOAD certifies (on Form T3) that the treatment is appropriate and either that:
 - the patient does not have the capacity to consent; or
 - the patient has the capacity to consent but has refused to do so.

A SOAD is an independent psychiatrist appointed by the Healthcare Inspectorate Wales to decide whether to authorise treatment under the MHA. They are independent of the

professionals responsible for the patient's care. Before deciding whether to issue a certificate, SOADs visit and examine patients. They also talk to professionals involved in their treatment.

Section 58A – electro-convulsive therapy etc

Section 58A is about electro-convulsive therapy (ECT) (and the medication which is administered as part of ECT).

Detained patients who have capacity to consent may not be given treatment to which section 58A applies unless they consent. In other words, they have the right to refuse ECT, even though they are detained (unless it is an emergency – see below). The approved clinician (or a SOAD) must certify the patient's consent.

A patient who lacks the capacity to consent may not be given treatment under section 58A, unless a SOAD certifies that the patient lacks capacity to consent and that:

- the treatment is appropriate;
- no valid and applicable advance decision has been made by the patient under the Mental Capacity Act 2005 refusing the treatment;
- No suitably authorised attorney or deputy objects to the treatment on the patient's behalf; and
- the treatment would not conflict with a decision of the Court of Protection which prevents the treatment being given.

In addition, no patient aged under 18 can be given section 58A treatment unless a SOAD has certified that the treatment is appropriate (even if they consent).

Exceptions in emergencies – section 62

Section 62 says that sections 58 and 58A do not apply in emergencies. An emergency is where treatment is immediately necessary to:

- save the patient's life;
- prevent a serious deterioration in the patient's condition, so long as the treatment is not irreversible: or
- (except for ECT) to alleviate serious suffering, so long as the treatment is neither irreversible nor hazardous
- prevent the patient from behaving violently or being a danger to themselves or others, so long as the treatment is neither irreversible nor hazardous and represents the minimum interference necessary

Because sections 58 and 58A do not apply where treatment is immediately necessary in these terms, the treatment can be given without a SOAD certificate.

It also means that ECT which is immediately necessary to save the patient's life or prevent a serious deterioration in their condition can be given without a detained patient's consent, even though that would not normally be allowed.

ECT for patients aged under 18 – section 58A

No patient under the age of 18 may be given treatment to which section 58A applies – principally ECT – unless a SOAD has certified that it is appropriate.

The SOAD must also certify that:

- the patient has the capacity to consent and has done so; or
- the patient lacks the capacity to consent.

For patients 16 or over, the SOAD would also have to certify that no suitably authorised deputy objects to the treatment on the patient's behalf and the treatment would not conflict with a decision of the Court of Protection.

If the SOAD certifies that the patient lacks capacity to consent, the SOAD certificate, by itself, is not sufficient to allow the treatment to be given, unless the patient is a detained patient. In any other case, there would still have to be another legal basis for giving the treatment. For SCT patients, there would be legal basis if there is "authority to treat" under Part 4A. For other patients – i.e. those who are neither detained nor SCT patients - guidance is given in chapter 36 of the Code of Practice (paragraphs 36.55 to 36.62).

Section 58A does not apply in an emergency where treatment is immediately necessary to save the patient's life or prevent serious deterioration of their condition. So in those cases, treatment could be given to a patient aged under 18 without a SOAD certificate.

Mental Health Review Tribunal Wales

The role of the Tribunal

Most patients subject to compulsion under the Act have the right to apply to the Tribunal. The Tribunal is an independent and impartial judicial body, which has the power to end their compulsion by discharging them.

The Tribunal system in Wales is different from that in England, where there is a two tier tribunal system.

The Tribunal is important because it gives patients the chance to have their case considered by a panel which is completely independent of the people who are detaining them or keeping them subject to any other form of compulsion.

People sometimes refer to this as an "appeal". But, in fact, the Tribunal is not reviewing whether the original decision was correct. Its job is to decide whether the patient should remain subject to compulsion on the present facts of the case.

Applications by patients

Applications have to be signed by the person making them (e.g. the patient) and be sent in writing to the Tribunal. Hospitals normally have systems for helping detained patients do this.

Patients detained under section 2 (or 4) must apply within the first 14 days of their detention. The day on which they are detained counts as the first of these 14 days. So if they are admitted to hospital on 1 March, their application must reach the Tribunal no later than 14 March. If the application is late, the Tribunal is not allowed to accept it.

Generally speaking, other detained patients can apply once during every period of their detention. So a patient detained under section 3 can apply once during the first six months, once in the next six months if their detention is renewed, and then once in each subsequent year.

However, Part 3 patients detained directly by a court (i.e. those given hospital orders or hospital and limitation directions) cannot apply during the first six months. That is because a court has already decided that they need to be in hospital. They can apply once during the second six months and then once in each subsequent year. The restriction on applying during the first six months does not apply to patients transferred from prison under section 47 or 48.

SCT patients can apply once during the first six months they are on SCT, then once during the second six months if their SCT is extended, and then once in each subsequent year. (But if they were originally detained by a court, they can't apply until they would have been able to apply if they were still detained – i.e. six months from when they were detained.)

SCT patients cannot apply to the Tribunal to be released from recall, but being recalled to hospital doesn't affect when SCT patients can apply for discharge from SCT itself.

If their SCT is revoked, they can apply once during the six months following the revocation, then once during the next six months and then once in each subsequent year. (But, again, if they were originally detained by a court, they can't apply until the end of the six months from when they were originally detained.) The hospital managers must also automatically refer a patient's case to the Tribunal if their SCT is revoked (see below).

Conditionally discharged patients cannot apply until they have been on conditional discharge for a year. They can then apply once in the next year, and then once in every subsequent two year period.

If conditionally discharged patients are recalled to hospital, the Secretary of State has to be refer their case to the Tribunal automatically. After that, they can't apply themselves until they have been detained again for six months, but can then apply once during the next six months and then once in each subsequent year.

Guardianship patients can apply once during the first six months they are on guardianship, then once during the second six months if their guardianship is renewed, and then once in each subsequent year.

Applications to the Mental Health Act Tribunal can be addressed to:

The Mental Health Review Tribunal for Wales
4th Floor, Crown Buildings, Cathays Park, Cardiff CF10 3NQ
Tel. 029 2082 5328 Fax. 029 2082 6331

Applications by nearest relatives

In some cases, nearest relatives can apply to the Tribunal as well.

Nearest relatives of section 3 patients and section 3 patients who have gone onto SCT, can apply to the Tribunal if they have tried to discharge the patient, but the discharge is blocked by a "barring order" from the responsible clinician. They have to apply before the end of the 28 days starting on the day they are told about the barring order.

Nearest relatives of unrestricted Part 3 patients (e.g. those on unrestricted hospital orders) – including those who have gone onto SCT - can apply once during every period in which the patient themselves can apply (except that nearest relatives of guardianship order patients can only apply once in the first year).

Also, nearest relatives who are displaced by the county court (i.e. replaced with acting nearest relative) can apply once in each year their displacement continues. But this only applies if they were displaced because they objected unreasonably to the patient being detained or put on guardianship, or because of the way they used (or were likely to use) their power of discharge.

Automatic referrals to the Tribunal

To make sure that no-one who is detained or on SCT goes without their case being considered by the Tribunal for an excessively long period, there are certain times when patients' cases have to be automatically referred to the Tribunal.

The hospital managers must refer the case of patients detained under section 2 or 3 (including those who have since gone onto SCT) after six months from when they were first detained. Managers don't have to do this if there has already been an application (by the patient or anyone else) or a referral while the patient was on section 3 or SCT (but they have to ignore applications and referrals made while the patient was on section 2 or 4). The overall effect is that no-one who is detained under section 2, 3 or 4 should go for more than six months without having their case brought to the attention of the Tribunal for the first time.

Hospital managers must also refer patients' cases to the Tribunal if they have gone for three years without having a Tribunal hearing (for patients under 18, the period is one year). This doesn't apply to restricted detained patients – but instead the Secretary of State has to refer them if they haven't had a hearing for three years.

Hospital managers must also refer patients whose SCT is revoked. Likewise, the Secretary of State must refer restricted patients whose are recalled from conditional discharge.

Referrals don't stop patients themselves also making any application they are entitled to make. There are no automatic referrals for guardianship patients or for people who are on conditional discharge.

The Welsh Ministers also have the discretion to refer cases to the Tribunal.

Tribunal Hearings

When the Tribunal receives an application or a referral, the secretariat arranges a suitable time and place with the key people (e.g. the hospital, the patient's lawyers).

Hearings in section 2 cases have to be listed to take place within 7 days. There is normally a longer wait for hearings in other cases.

For detained patients, Tribunal hearings take place in the patient's hospital. For other patients, they may take place elsewhere.

The panel hearing the case is made up of three people – the Chairman (who is a lawyer), the medical member (usually a psychiatrist) and a third person who is neither a lawyer nor a doctor (sometimes called the "lay member").

Before the hearing, the medical member will talk to and examine the patient, so that they can give their professional opinion about the patient's condition to the other members.

The members of the tribunal will also have seen reports from the “responsible authority” – the hospital managers for detained and SCT patients, the local social services authority for guardianship.

These include a report from (or on behalf of) the patient’s responsible clinician, and a social circumstances report from a social worker or AMHP. For patients in hospital, there will normally be a nursing report as well. And for restricted patients, there will also be a report from the Secretary of State.

The patient – and the patient’s lawyer (if they have one) – will normally also have seen these reports (although the Tribunal can agree to parts of reports being kept from patients in certain circumstances).

Hearings normally take place in private. Patients are entitled to attend the hearing (although they cannot be forced to attend if they do not want to).

Patients are entitled to a representative at the hearing. Their representative can (but does not have to be) a lawyer. Patients (or their representative) have to tell the Tribunal and the other people involved in the case (e.g. the hospital) in advance who their representative is. Their representative can’t be another patient from the same hospital, or another patient who is subject to compulsion under the Act.

Patients are also entitled to be accompanied by someone else to help and support them at the hearing. But that person can only speak for the patient at the hearing with the Tribunal’s permission.

Normally patients can be present throughout the hearing, unless one of the parties (e.g. the hospital) requests otherwise, and the Tribunal accepts that the presence of the patient at a particular stage will adversely affect the patient’s health or the welfare of the patient or others. The patient’s representative will however be entitled to be present throughout the hearing.

Decisions

The Tribunal normally makes its decision at the end of the hearing after a short adjournment and tells the patient (or their representative) immediately. The decision is normally followed up with written reasons a few days later.

If the Tribunal decides that the patient should be discharged from compulsion, that normally happens straight away. That means, for example, that a detained patient would be free to leave hospital immediately. In some circumstances, the Tribunal can delay discharge from detention or SCT to a particular future date (but this is unusual).

There is a special arrangement for restricted patients where the Tribunal thinks that conditional discharge would be appropriate, provided the necessary arrangements (e.g. for after-care and supervision) can be put in place to support the conditions the Tribunal intends to impose. This is called “deferred conditional discharge”.

In effect, the Tribunal makes a provisional decision to conditionally discharge the patient – but suspends the final decision until it is satisfied that the necessary arrangements are in place. Once the arrangements are in place, the Tribunal makes a final decision to discharge. If the arrangements aren’t put in place within a reasonable time, the Tribunal has to reconvene and

decide what to do next. Depending on the circumstances, that might mean changing the conditions, discharging the patient absolutely (i.e. without the possibility of recall) or deciding the patient cannot, after all, be discharged from detention

The way the Tribunal works is governed by the Tribunal Rules – formally, the Mental Health Review Tribunal for Wales Rules 2008

The judges at the head of the Tribunal also issue “practice directions” about more detailed aspects of the way cases are dealt with – including, for example, what needs to be included in reports for the Tribunal.

Note:

For restricted patients who would otherwise be in prison (those subject to hospital and limitation directions under section 45A, or transferred from prison under sections 47 or 48), the Tribunal cannot actually discharge them into the community unless the Secretary of State for Justice agrees. Normally, the Secretary of State will decide to transfer them to prison instead to complete their sentence (or equivalent). However, if the Tribunal thinks the patient is eligible for conditional discharge, it can recommend that the patient remains in hospital rather than be transferred to prison. If it does so, the patient remains detained in hospital as before.

The Tribunal cannot discharge someone from detention onto SCT. But if it decides not to discharge a relevant patient from detention it can recommend that the responsible clinician thinks about SCT as an option. Similarly, the Tribunal can recommend that a detained patient be given leave of absence, or be transferred to another hospital, with a view to making the patient's discharge in future more likely.

The Tribunal cannot insist that its recommendations are acted on. But if they are not, the Tribunal can reconvene to consider the patient's case further, without the patient having to make a new application.

Legal representation at Tribunals

Patients are entitled to free legal representation in connection with Tribunals under Legal Aid arrangements. Unlike most legal aid, this is not means-tested (i.e. eligibility does not depend on the patient's income or other financial resources).

Hospitals keep details of local law firms who do mental health work and the Law Society's website offers a find a solicitor service. The Solicitors Regulation Authority runs an accreditation scheme for lawyers who specialise in Mental Health Act Tribunal work.

While there is nothing to prevent IMHAs representing patients at Tribunals, patients need to be careful to make sure that patients understand that IMHAs are not lawyers – and that they are entitled to free legal representation at Tribunals, even if you are also helping them.

Legal representation for appeals to the Upper Tribunal is not automatic, and is means tested. The patient's lawyer will be able to explain the detail.

Patients who cannot apply to the Tribunal

Patients detained under the holding powers in section 5, or in a place of safety under section 135 of 136, cannot apply to the Tribunal.

Nor can patients who are effectively still under the control of the courts because they have been remanded to hospital under section 35 or 36, or given an interim hospital order under section 38. They have various opportunities instead to apply to the court itself to end their detention in hospital.

Hospital Managers' Hearings

Hospital managers' powers to discharge

Detained and SCT patients who can apply to the Tribunal can also be discharged by the relevant hospital managers (except that restricted patients can only be discharged with the agreement of the Secretary of State for Justice).

For detained patients, the relevant hospital managers are the managers of the hospital in which they are detained. For SCT patients they are the managers of their responsible hospital.

Hospital managers can discharge people from detention and SCT, but they cannot discharge detained patients onto SCT. Like the Tribunal, they can discharge patients even if the responsible clinician does not agree.

Managers' panels

Technically, the hospital managers are the body which runs the hospital – e.g. the Local Health Board or the company which owns an independent hospital. But, in practice, discharge decisions are made by “managers panels” of three or more people who aren't, in fact, part of the management team of the hospital.

Some of these people may be non-executive directors of the body. But more often they are people who have been specially recruited for the purpose. These latter people are sometimes called “associate hospital managers”.

Asking for a hospital managers' hearing

Patients can ask the managers to consider discharging them at any time. You may hear this referred to as “applying for a managers' hearing” or “appealing to the hospital managers”.

Hospitals should have their own arrangements for patients asking for a hearing. An IMHA will need to find out what these arrangements are.

In addition, the managers must always consider discharging the patient whenever they get a report from the responsible clinician renewing the patient's detention, or extending their SCT. Patients should be asked whether they want a managers' hearing whenever this happens - some hospitals hold hearings automatically.

There are no restrictions on when patients can ask for a managers' hearing. But, in practice, the managers will probably not hold a hearing if they have only recently considered the case, or the patient has either just had a Tribunal hearing or is due to have one shortly.

Managers' hearings

Managers' panels try to keep hearings as informal as possible. There is no prescribed procedure for the conduct of managers' hearings. However the Code of Practice sets out the general principles in accordance with the rules of natural justice:

- they must adopt and apply a procedure which is fair and reasonable
- they must not make irrational decisions, that is, decisions which no body of hospital managers properly directing themselves as to the law and on the available information, could have made
- they must act in good faith and without bias, giving everyone the opportunity to state their case adequately
- they must not act unlawfully.

The patient will have a chance to explain why they think they should be discharged, and the panel will also want to hear from key people responsible for the patient's care.

IMHAs can help patients ask for and prepare for managers hearings. They can also support and represent them at the hearing, if the patient wants.

Patients can also have a legal representative. But, unless it is part of the work the lawyer is already doing in connection with an application to a Tribunal, legal aid for representation at managers' hearings is not automatic, and is means-tested.

Managers' hearings and Tribunals

Although managers' panels try to reach their own, independent decision and cannot be told what to decide by the actual management of the hospital, they are not an independent and impartial judicial body in the same way as the Tribunal.

It is important for IMHAs to help patients understand that there is a difference between managers' panels and the Tribunal – and that neither asking for a managers' hearing, nor the outcome of any such hearing, has any affect on their right to apply to the Tribunal.

Healthcare Inspectorate Wales

Healthcare Inspectorate Wales is the independent inspectorate and regulator of all healthcare in Wales. HIW's primary focus is on:

- making a significant contribution to improving the safety and quality of healthcare services in Wales.
- improving citizens' experience of healthcare in Wales whether as a patient, service user, carer, relative or employee.
- strengthening the voice of patients and the public in the way health services are reviewed.
- ensuring that timely, useful, accessible and relevant information about the safety and quality of healthcare in Wales is made available to all.

HIW's core role is to review and inspect NHS and independent healthcare organisations in Wales to provide independent assurance for patients, the public, the Welsh Assembly Government and healthcare providers, that services are safe and good quality. Services are reviewed against a range of published standards, policies, guidance and regulations. As part of this work HIW will seek to identify and support improvements in services and the actions required to achieve this. If necessary, HIW will undertake special reviews and investigations where there appears to be systematic failures in delivering healthcare services, to ensure that rapid improvement and learning takes place. In addition, HIW is the regulator of independent

healthcare providers in Wales and is the Local Supervising Authority for the statutory supervision of midwives.

HIW carries out its functions on behalf of Welsh Ministers and, although part of the Welsh Assembly Government, protocols have been established to safeguard its operational autonomy. HIW's main functions and responsibilities are drawn from the following legislation:

- Health and Social Care (Community Health and Standards) Act 2003 Care Standards Act 2000 and associated regulations
- Mental Health Act 1983 and the Mental Health Act 2007
- Statutory Supervision of Midwives as set out in Articles 42 and 43 of the Nursing and Midwifery Order 2001
- Ionising Radiation (Medical Exposure) Regulations 2000 and Amendment Regulations 2006

HIW works closely with other inspectorates and regulators in carrying out cross sector reviews in social care, education and criminal justice and in developing more proportionate and co-ordinated approaches to the review and regulation of healthcare in Wales.

HIW is also responsible for appointing the SOADs (second opinion appointed doctors) who authorise treatment under the Act.

Under the Act itself, one of the HIW's powers is to investigate complaints about the way the Act is used.

IMHAs can, of course, contact HIW on behalf of qualifying patients.

Patients can also complain to HIW if they think that a health or social care provider registered with HIW is not complying with its registration requirements. Until 2010 (when the registration system will be changed and apply equally to public and private providers), this is most likely to be relevant to independent hospitals.

Mental Health Act Reviewing

What is the Review Service for Mental Health for?

- The role of the Review Service for Mental Health, within Healthcare Inspectorate Wales, is to keep the use of the Mental Health Act 1983 under review and check that the Act is being used properly The Review Service for Mental Health is independent of all staff and managers of hospitals and mental health teams
- Mental Health Act Reviewers include doctors, nurses, social workers, lawyers, psychologists, service users and other people with knowledge of the Act and mental health services
- Reviewers visit all places where patients are detained under the Mental Health Act, and meet with them in private
- In certain circumstances, the Review Service also arranges for an independent doctor to provide a second opinion if a patient is not able or willing to consent to their treatment
- The Review Service may investigate certain types of complaints
- The Review Service publishes a report of its activities and findings every year.

How do the Reviewers do it?

Reviewers visit all wards where patients are detained under the Mental Health Act 1983 and may also visit other settings to meet with patients subject to Guardianship or Supervised Community Treatment (SCT) to check:

- that such patients are lawfully detained and well cared for
- that such patients are informed about their rights under the Act
- that such patients are given respect for their qualities, abilities and diverse backgrounds as individuals, and that account is taken of their needs in relation to age, gender, sexual orientation, social, ethnic, cultural and religious backgrounds
- that the Mental Health Act Code of Practice for Wales is being followed
- that the right plans are made for patients before they are discharged from hospital.

During visits, Reviewers meet and talk to detained patients in private.

Reviewers also meet with managers and other staff to talk about things that affect patients' care and treatment, and to raise issues on behalf of patients.

What the Review Service for Mental Health cannot do

The Review Service:

- cannot discharge patients from their section under the Mental Health Act 1983
- cannot discharge patients from hospital
- cannot arrange for patients to have leave
- cannot transfer patients to another hospital
- cannot offer individual medical advice
- cannot offer individual legal advice
- cannot help informal patients

Outcome 2: Provide independent Mental Health Advocacy

2.1 Use the Mental Health Act 1983 as amended by the Mental Health Act 2007 to identify when an individual is entitled to receive IMHA support

Independent mental health advocacy was introduced to provide, for the first time in Wales, a statutory source of independent help and support for people subject to the MHA 1983. For most people, making their own decisions and choices, is a matter of some considerable importance.

Being part of decision making processes is not only a route where self identity is expressed but it is also an important aspect of personal freedom. However, a number of barriers can prevent people from actively taking part in decisions which affect their lives and can affect an individual's ability to speak up for themselves. For patients with mental health problems their ability to be involved in making decisions may be affected by the effects of the mental disorder. For patients subject to the MHA 1983 this may have additional significance. Choices may have been made

on their behalf over which they have little or no control, they may feel that they are no longer in control of other aspects of their life and may feel disempowered.

Services exist to give them access to dedicated, reliable, independent support in getting the information they need to understand what is happening to them and what their choices and rights are, and in getting their voice heard and listened to.

Patients subject to compulsion under the MHA 1983 often require support to help them understand what is happening to them, to find out what choices and options are available, how to express their views and secure their rights.

Patients qualifying for IMHA services

A patient who is eligible for the support of an IMHA service is described in the Act as a **'qualifying patient'**.

Under the Mental Health (Wales) Measures there are two types of eligible patients:

A Welsh qualifying compulsory patient is one who is:

- a. Detained under the Act (even if they are currently on leave of absence from hospital) in a hospital or registered establishment situated in Wales;
- b. Detained for assessment on the basis of an emergency application (section 4) until the second medical recommendation is received;
- c. Under the holding powers in section 5;
- d. Conditionally discharged;
- e. Subject to guardianship, and the responsible local social services authority is situated in Wales;
- f. On supervised community treatment (SCT), the responsible hospital for them is situated in Wales;
- g. Being considered for a treatment to which the special rules in section 57 of the Act apply;
- h. Under 18 years of age and being considered for treatment to which the special rules in section 58A of the Act apply.

A Welsh qualifying informal patient is one who is:

- a. an in-patient of a hospital or registered establishment situated in Wales;
- b. receiving treatment for, or assessment in relation to, a mental disorder at that hospital; and
- c. not subject to powers under the 1983 Act which would render them as liable to be detained.

A patient does not qualify for an IMHA service by being detained:

- In a place of safety under section 135 or 136.

2.2 Analyse the roles and responsibilities of an IMHA

The Mental Health Act 1983 (Independent Mental Health Advocates) (Wales)

Regulations 2008 came into force on 3rd November 2008. They set out the appointment requirements people must meet to act as an IMHA and specify who must check that an IMHA meets these requirements.

These regulations have now been amended by the Mental Health (Wales) Measures 2010

No person may act as an IMHA unless that person is approved by the Local Health Board or is employed by a provider of advocacy services to act as an IMHA.

In addition, the person or organisation appointing the IMHA must check that they meet certain appointment criteria set out in the IMHA regulations.

Under the IMHA regulations, a person may only act as an IMHA if they:

- have appropriate experience or training or an appropriate combination of experience and training. Guidance on what constitutes appropriate experience and training for this purpose has been published by the Secretary of State for Health. The guidance includes an expectation that IMHAs will normally have completed the IMHA Unit of the independent advocacy qualification by the end of their first year of practice;
- are a person of integrity and good character;
- are able to act independently of any person who is professionally concerned with the qualifying patient's medical treatment. An IMHA is not regarded as 'professionally concerned' with a patient's medical treatment if their only involvement in that treatment is that they are currently representing the patient as an advocate, or have represented them as an advocate in the past. But if they currently have any other professional involvement with the person's treatment then they will not be able to act as an IMHA for that patient; and
- are able to act independently of any person who requests that person to visit or interview the qualifying patient.

Section 130A of the MHA 1983 requires that the appropriate authority makes arrangements for Independent Mental Health Advocates to be available to support patients qualifying for this service in England and Wales. IMHAs will help patients understand and exercise their legal rights under the Act.

The role of an IMHA

An IMHA is a specialist advocate who provides a statutory service to qualifying patients under the MHA 1983. The IMHA must work within the legislative framework of the MHA 1983 which defines the rights and duties of an IMHA.

The Mental Health (Wales) Measures have now extended the role of an IMHA.

An IMHA can support qualifying patients in a range of ways to help them to understand their rights under the MHA 1983 and to ensure they can participate, as fully as possible, in the decisions that are made about their treatment and care.

The help which IMHAs are to provide must include helping all eligible patients to obtain information about and understand:

- a. What (if any) medical treatment is being given to the patient or is being proposed or discussed in the patient's case;
- b. Why such treatment is being given, proposed or discussed;
- c. The authority under which it is, or would be, given.

IMHAs can also help eligible patients:

- a. To become involved, or more involved, in decisions made about their care or treatment specifically, or more generally, decisions about care and treatment;
- b. To complain about their care or treatment;
- c. To receive information about other services which are or may be available to them.

In giving help, the IMHA may represent the patient and speak on their behalf. But IMHAs are not designed to take the place of advice from, or representation by, qualified legal professionals about such matters.

For Welsh qualifying compulsory patients, in addition to the help and support outlines above, the IMHA may provide help to the patient in obtaining information about and understanding:

- a. their rights under the Act (and the IMHA may help the patient exercise those rights);
- b. the rights which other people have in relation to them under the Act (e.g. any right their nearest relative has to discharge them) ;
- c. the particular parts of the Act which apply to them (e.g. the basis on which they are detained) and which therefore make them eligible for advocacy;
- d. any conditions or restrictions to which they are subject (e.g. as a condition of leave of absence from hospital, of a community treatment order or of conditionally discharge);

For Welsh qualifying informal patients the support an IMHA may give has to be connected to care and treatment for the patient's mental health disorder.

The IMHA would need to refer a informal patient to an existing non-statutory advocacy service on their discharge from hospital.

Underpinning practice, IMHAs should:

- place qualifying patents at the centre of their activities;
- draw on the best of current practice in mental health advocacy;
- demonstrate a commitment to diversity and promoting equality for qualifying patients.

IMHA roles will include:

- supporting the patient to participate as fully as possible in any relevant decision;
- finding out what options are available for them;
- understanding their wishes and feelings;
- ensuring the patient's rights are respected and upheld;
- providing a safeguard against abuse of rights;
- ensuring parity between people who can instruct an advocate and those who cannot;
- exploring what alternative courses of action are available in relation to the patient;
- ensuring the patient's rights are respected.

The Measures identify situations where an IMHA may be able to support qualifying compulsory patients:

- as soon as is practicable after the patient has been admitted or transferred to the hospital under assessment or treatment provisions of the 1983 Act, or held in that hospital under section 5(2) or 5(4), to provide support and understanding of the situation from an independent person who is familiar with the hospital environment and mental health system;
- when the patient is to be visited and examined by a Second Opinion Appointed Doctor;
- when applying for a Hospital Managers hearing;

- when applying for a Mental Health Review Tribunal for Wales hearing, obtaining legal representation, having support at a hearing or help in understanding the directions made by the Tribunal;
- when plans are being made for leave of absence under section 17 of the 1983 Act;
- when plan are being made for a patient's discharge onto Supervised Community Treatment (SCT);
- when they are subject to recall;
- when considering their rights in relation to their nearest relative, including their right to seek to displace their nearest relative through the County Court.

The IMHA's role in meetings may include:

- meeting with a qualifying patient beforehand to clarify the issues they wish to raise and to inform them of their rights, entitlements and choices, including requesting a review and making a complaint;
- support the patient to prepare for the meeting by accessing relevant information, undertaking research, clarifying choices and options and rehearsing what they want to say;
- at the qualifying patient's request, call a meeting or attend a meeting with professionals: e.g. the patient's responsible clinician;
- at the qualifying patient's request, attend the meeting with the patient or on their behalf; review and follow up to ensure that the agreed action points from the meeting have been implemented and the qualifying patient has been kept informed of progress;
- meet with the qualifying patient to check they are happy with the outcome and
- where appropriate close the case.

In fulfilling these roles, the IMHA will:

- respond to and represent the patient's views, wishes and interests, where appropriate;
- ensure that where a patient has deliberately stated their wishes in advance about a variety of issues, including their medical treatment, the steps that should be taken in emergencies and what should be done if particular situations occur, that such wishes are given the same consideration as wishes expressed at any other time;
- where appropriate take into account the views of people who know the patient well about what the patient would want.

It is not the role of the advocate to offer their own views or opinions as to what is in the patient's best interest or to determine a particular course of action.

What an IMHA service or an IMHA is not

An IMHA service is not:

- a service offering impartial advice to all parties;
- befriending, 'buddying' or social support activity;
- a lobbying or campaigning organisation or activity;
- a substitute for other services that are not effective;
- a complaints service;
- a patient-led organisation;
- working in the 'best interest' of qualifying patients;
- a legal advocacy service (replacing lawyers).

Obtaining consent to act for a qualifying patient

Where a patient has the capacity to instruct an IMHA, the IMHA should only act on the patient's behalf with their consent.

As good practice it is recommended that IMHAs obtain written consent from a qualifying patient to act as their advocate, where this is applicable. Where a qualifying patient lacks the capacity to give consent the IMHA should follow local policies and procedures in place.

2.3 Summarise rights afforded to an IMHA within the Mental Health Act 1983**The rights of an IMHA**

An IMHA, has certain rights under the Act:

- meeting the patient in private;
- accessing the patient's records, under certain circumstances;
- visit and interview anyone who is professionally concerned with the patient's medical treatment
- attend appropriate meetings

The right of the IMHA to visit and interview the patient in private:

- under the Act, IMHAs have the right to visit patients in private;
- local arrangements will determine where an IMHA meets a qualifying patient in hospital and in the community;
- IMHAs and IMHA services will need to consider the needs of patients in different settings when agreeing where and when to meet patients;
- in certain circumstances IMHAs will also need to consider the individual circumstances of the patient at the time of the meeting. For example the patient may be under close observation or in seclusion, or clinical staff may advise against the meeting for reasons of the IMHA's or the patient's safety.

Anyone who prevents them doing so without reasonable cause would be guilty of the offence of obstruction under section 129 of the 1983 Act.

Rights of IMHAs to access records

The Act gives IMHAs the right to access records relating to qualifying patients, under certain circumstances, for the purpose of providing help to the patient in question. Information concerning an IMHA's right to see patients' records was enhanced by the publication by the Department of Health of 'Supplementary guidance on access to patient records under section 130B of the Mental Health Act 1983'.

An IMHA's right to access records is only for the purpose of providing help as an IMHA to the patient in question.

An IMHA, has the right to see any clinical or other records relating to the patient's detention or treatment in any hospital, or relating to any after-care services provided to the patient.

IMHAs have a similar right to see any records relating to the patient held by a local social services authority.

Where the patient has the capacity to instruct, the IMHA should agree with the patient beforehand which records will be accessed. Subject to the patient's consent these records should be directly relevant to the help the IMHA is providing to the patient. If the IMHA is helping a patient who lacks capacity they should only ask for the records that are relevant to the help they are providing to the patient.

Where the patient does not have the capacity (or in the case of a child, the competence) to consent to an IMHA having access to their records:

- the holder of the records must allow access if they think that it is appropriate and that the records in question are relevant to the help to be provided by the IMHA;
- records must not be disclosed if that would conflict with a decision made on the patient's behalf by the patient's attorney or deputy, or by the Court of Protection.

The Code of Practice states that:

"When seeking access to records for a patient who is not capable of consenting, the advocate will be asked to declare why they are seeking access and the nature of the information being requested.

Record holders should bear in mind the principle of respect for the patient's past and present wishes and feelings, when considering the request for access to records."

An IMHA's rights to meet with and interview professionals

IMHAs have a right to visit and speak to any person who is currently professionally concerned with a patient's medical treatment, provided it is for the purpose of supporting that patient in their capacity as an IMHA.

This would include for patients detained under section 4 of the 1983 Act the right to visit and interview the AMHP who made the application for detention, and the doctor who gave the medical recommendation on which the application for detention was founded.

In practice, the IMHA will need to contact the person concerned and arrange a meeting at a mutually convenient time. It is expected that the professionals will make themselves available in good time.

Supporting patients in meetings

The Code of Practice says IMHAs should be allowed to attend any meeting that patient would be expected to attend, either with or without the patient

Where the patient has the capacity to instruct an IMHA, the IMHA should only attend meetings and speak on issues with the agreement of the patient. Where the patient does not have this capacity, the IMHA can attend the meeting to speak on the patient's behalf, if the IMHA thinks it is appropriate.

Where an IMHA attends a meeting with the patient, they can help:

- support the patient to feel confident;

- remind the patient of what they wanted to say;
- speak for the patient, if the patient does not wish to self-advocate;
- reflect with the patient after the meeting what was said.

Where the IMHA attends a meeting without the patient, the IMHA can help:

- represent the patient's views and wishes;
- feed-back to the patient what was said in the meeting.

2.4 Prioritise a range of case work

No resource is provided for this assessment criteria

2.5 Assess a range of potential dilemmas which IMHAs can face in practice & 2.6 Resolve practice dilemmas

Practice dilemmas and challenges

IMHAs practice in a range of very complex situations with a number of interacting factors affecting their day to day work. Accordingly, they will encounter a range of technical, ethical and legal dilemmas and challenges which the IMHA have to manage and try to resolve.

An IMHA, has the responsibility to ensure that the qualifying patient's view is heard or represented rather than that of others, including the IMHA's own.

Generally the qualifying patient's particular situation determines what course of action the IMHA takes. However, occasionally the IMHA will have to choose one of two or more unsatisfactory alternatives and this may generate controversy and disagreement among key stakeholders. While it is a qualifying patient's 'voice' that is always primary in such cases, there may be many other distinct views offering different opinions on which is the best course of action.

This can be challenging for an IMHA, particularly if challenges effect their personal and professional values. Part of the skill of effective practice is the ability to distinguish between dilemmas that are resolvable and those requiring action but which cannot be resolved, as well as living with the fact that at times wrong decisions are made.

This section explores dilemmas and challenges that the IMHA may face and provides guidance on recognising, managing and resolving such issues.

Patients changing their mind or being inconsistent

There may be times when the patient instructs an IMHA about an issue and then subsequently changes their mind. This can be for a number of reasons such as their state of mind at the time of instruction, the effect of their illness or medication, or change in circumstances or heart. Everyone has the right to change their mind but the IMHA should also be aware that patients can feel under pressure by family/carers and professionals to agree to courses of action that they do not actually want, which can cause them to subsequently change their minds.

IMHAs may also support patients with fluctuating capacity or whose illness affects their decision making and choices and it can be difficult for the IMHA to be clear about what a patient wants when the patient changes their mind.

When the IMHA has agreed a course of action with the patient or is representing the patient during a meeting and the patient changes their mind, this can be a source of frustration to the IMHA and can at times be embarrassing or make the IMHA look mistaken, particularly if the IMHA make a request at a meeting which the patient then challenges.

In instances where the IMHA believe the patient's preferred outcomes are being affected by their disorder or medication, the IMHA should take great care to ensure that they pursue a course of action that the patient actually wants. In order to this the IMHA may need to keep checking this with the patient.

In all cases where the IMHA is unsure, they should seek advice from their advocacy supervisor and reflect on their approach and ensure that they do not make judgements about a course of action or go down a path which they feel is more appropriate for the patient and may reflect their own view rather than that of the patient.

Acting on third party information

The IMHA will come into contact with a wide variety of people who know the patient including professionals, carers, friends and family. This could be as a result of working with professionals to collect information or to represent the views of the patient to others. The IMHA may find that other people offer information about the patient and ask the IMHA to act on this information. The IMHA should be very clear who they are instructed by and resist the pressure to respond to any such request.

Taking action on poor practice

In the course of their work an IMHA may witness instances of poor practice by health and social care staff or organisations. As a result there may be occasions when the IMHA feels the need to report their concerns without receiving any instruction from a patient.

Concerns could include:

- witnessing poor practice such as seeing a staff member being physically abusive toward a patient;
- general concerns that the IMHA has been made aware of by different patient. This could include a number of patients complaining about the same issue over a period of time – for instance property on the ward going missing and staff not taking action to address theft;
- instances of discrimination and inequality: e.g., ageism, sexism, racism or homophobia.

It is best if the IMHA raises their concerns with their supervisor or manager, so that where appropriate the IMHA service raises the concerns rather than the individual IMHA. The IMHA service will then make a decision on how best to raise these concerns whilst upholding the confidentiality of patients who have used the IMHA service.

Maintaining boundaries with qualifying patients

While the IMHA's role may be similar to other support services, it is distinct from them and should not seek to replace them. It is also not an impartial advisory role, lobbying or campaigning role and clearly not a 'befriending' role. However, establishing and maintaining an open, informal and trusting relationship with qualifying patients is likely to lead to positive outcomes for the patient and a positive experience of advocacy for them.

Patient wants support with issues outside the IMHA's remit

Patients may want the IMHA to do more for them than the role allows either in terms of the depth of relationship or type of advocacy issues. For example, the patient may want the IMHA to advocate for them in relation to issues beyond the scope of their responsibilities as an IMHA (e.g. noisy neighbours, welfare benefits or employee/employer grievances) or may want to retain the services of the IMHA for longer than is necessary.

In these circumstances the IMHA needs to be able to clearly explain the scope and limitations of their role to the patient, and be prepared to signpost them to other services as appropriate. This may include a referral to non-statutory advocacy services.

Patient wants advice, not advocacy

There are many agencies whose job it is to offer advice and the IMHA should provide information and support to help qualifying patients to find out about these, facilitate access to the appropriate service available and support the person to weigh up the information or advice given. For example someone may need advice about the law from a solicitor or lawyer; information about appropriate welfare benefits they are entitled to from a benefits advice agency such as Citizens Advice Bureaux; or help with a medical matter when they would need to talk to an appropriately trained medical professional. With all the above mentioned agencies, the patient may need support from an advocate to help them understand what is being said or written by those who are advising them.

An IMHA may assist a patient in making a choice or decision by discussing the consequences of taking certain actions or the availability of a number of options. This is not the same as giving advice.

Confidentiality, Disclosure and Information Sharing

Respect for confidentiality is a key advocacy principle as patients often do not feel able to speak freely and explore options unless they can do so in confidence. There are times, however, when confidentiality cannot be maintained or upheld and disclosure with or without the consent of the qualifying patient may be necessary.

The limits of a qualifying patient's right of confidentiality ought to be clearly set out in any confidentiality policy provided by the IMHA's employing organisation. Any such policy must make clear that whilst information disclosed to IMHAs in connection with each patient's care and treatment will be treated as confidential, there are circumstances in which the IMHA may be required to disclose such information. The policy should explain when such circumstances may arise and what action the IMHA should take in those cases.

The IMHA has a responsibility to make sure that they are familiar with any confidentiality policy in operation in their service.

Duty of confidentiality

In common law, a duty of confidence arises when one person discloses information to another in circumstances where it is reasonable to expect that the information will be held in confidence. Certain situations, such as discussions with a health professional or social worker, are generally presumed to be confidential. Qualifying patients can expect the same of their discussions with IMHAs.

Disclosure of information to the IMHA

Information may be disclosed to an IMHA only in line with the law. The normal rules on patient confidentiality apply to conversations between professionals and IMHAs even when the conversation is at the patient's request. While the IMHA has the right of access to patient's records in certain circumstances professionals should otherwise only be sharing confidential information with the IMHA where the patient has consented to the disclosure or the disclosure is justified on normal grounds.

IMHAs duty of confidentiality

An IMHA, in carrying out their responsibilities under the Act, will have access to a range of confidential information. This is because the IMHA may:

- have access to wards and units on which patients are resident;
- meet with patients in private;
- attend meetings between patients and professionals involved in the patients care and treatment;
- speak to any person who is professionally concerned with a patient's medical treatment.

Accordingly, the IMHA must understand the duty of confidentiality and the circumstances in which confidential information may be disclosed to third parties even if the person concerned does not consent. Information can be shared without breaching the common law duty of confidentiality if:

- information is not of a confidential nature (advice should be sought if it is not clear whether information is of a confidential nature or not); or
- the person to whom the duty of confidentiality is owed has given explicit consent; or
- there is an overriding public interest in disclosure (such as to protect a person from serious harm or prevent a crime); or
- sharing is required by a court order or other legal obligation.

The 'public interest' is not the same as what might be of interest to the public. Where confidential patient information is involved, public interest justifications for overriding confidentiality could include (but are not limited to) protecting other people from serious harm and preventing serious crime.

Common law does not normally permit disclosure of confidential patient information solely in the person's own interests, where they have the capacity to consent to the disclosure but refuse to do so.

A person's right to have their privacy respected is also protected by Article 8 of the European convention on human rights. The disclosure of confidential information may be a breach of that right unless it is a necessary and proportionate response to the situation.

Many of the qualifying patients with whom IMHAs work are considered by statutory organisations to be 'vulnerable persons'. IMHAs may also sometimes work with children. All local authority areas have safeguarding children and adult procedures. An IMHA will need to be familiar with these procedures.

Access to information in patients' records that would be withheld from the patient

Because IMHAs have a right to access patients' records, they may be shown information which would be withheld from the patient if they requested access themselves under the Data Protection Act 1998. This could be information that would be withheld because:

- it is provided by, or relates to another identifiable individual (a third party) who has not consented to its disclosure to the patient (“third party information”);
- a health professional has decided that disclosing it would risk causing serious harm to the mental or physical health or condition of the patient or any other person.

If the IMHA does not want to be given this sort of information, they should make that clear to the record-holder when they request access to the patient’s records.

Before the IMHA asks to see records which might include information that would not be disclosed directly to the patient, they should explain to the patient that such material might exist, and specifically ask the patient whether they consent to the IMHA seeing it, if it does. In doing so, the IMHA should explain to the patient that they will generally not be able to pass that information on, or even tell them that it exists.

In deciding what records the IMHA asks to inspect in cases where the patient lacks capacity to consent, they need to consider how this will affect their ability to provide help and support to patients in accordance with the Act. On the one hand, being in possession of information that cannot be shared with the patient may cause difficulties in the relationship of trust with the patient. On the other hand, there could be circumstances in which not accessing all the available information could restrict the IMHA’s ability to help the patient as fully as possible.

Record-holders should tell the IMHA if there is information in the records they show the IMHA which should not be disclosed to the patient because of the risk of serious harm to the patient or others. If the IMHA suspects there is other information that might fall into this category, it is best to ask for confirmation. The Department of Health’s advice is that the IMHA must not share information of this kind with the patient, because (amongst other reasons) the IMHA are under an implicit obligation to respect the opinion of the health professional who decided it was too risky to be disclosed.

Ideally, record-holders will tell the IMHA if the records they are being shown include third party information which would be withheld from the patient. But the IMHA cannot rely on this, so they need to treat any third party information in the records in the same way as the IMHA would treat information from or about third parties which came into their possession by any other means.

If the information is not actually about the patient and is confidential, then it is unlikely to be permissible to share it with the patient without the third party’s consent.

If the information is about the patient and comes from the patient’s health records, and the third party is a health professional who has compiled or contributed to the health records or been involved in the patient’s care, then the information can be disclosed to the patient. Otherwise, if the information is of a confidential nature, generally speaking the IMHA should not disclose it to the patient without the third party’s consent, even though it is about the patient.

But this is not an absolute rule – there may be particular cases in which it would be reasonable in all the circumstances to disclose it to the patient. That can only be decided on the facts of the particular case. If in doubt, advice should be sought.

If the IMHA decides that they should not disclose third party information, which is about the patient, they should still consider what (if anything) they could tell the patient without directly or indirectly identifying the third party or enabling the patient to do so.

Confidentiality and Sharing Information: Children and Young People

The right to confidentiality applies to all children and young people. Where they are able to make decisions about the use and disclosure of information they have provided in confidence, the views of children and young people should be respected in the same way as adults. However, this right to confidentiality can be qualified or limited in certain circumstances. For example: where child abuse or serious harm is suspected.

Where child abuse or serious harm is suspected, the public interest may justify disclosure.

The guidance 'Working Together to Safeguard Children' available at:

www.everychildmatters.gov.uk/workingtogether/

states:

"In deciding whether there is a need to share information, professionals need to consider their legal obligations, including whether they have a duty of confidentiality to the child. Where there is such a duty, the professional may lawfully share information if the child consents or if there is a public interest of sufficient force. This must be judged by the professional on the facts of each case. Where there is a clear risk of significant harm to a child, or serious harm to adults, the public interest test will almost certainly be satisfied. However, there will be other cases where practitioners will be justified in sharing some confidential information in order to make decisions on sharing further information or taking action – the information shared should be proportionate.

The child's best interests must be the overriding consideration in making any such decision; including in the cases of underage sexual activity ... Any decision whether or not to share information must be properly documented. Decisions in this area need to be made by, or with the advice of, people with suitable competence in child protection work, such as named or designated professionals or senior managers". (5.21-5.22)

An IMHA is unable to achieve what the patient wants

IMHAs cannot be expected to have all the answers or to know exactly what those they advocate for want and desire, just because they have the title 'advocate'. IMHAs are however, in a unique position because their only concern is for the person they are advocating for and ensuring they have a voice in the process. The IMHA has to work at finding out exactly what it is that the person wants the them to say on their behalf.

It is important to recognise that there will be times when the IMHA is not successful in achieving the desired outcome for the people on whose behalf they are advocating. There may be a number of different reasons for this including:

- the decision is beyond the IMHA's control;
- non-compliance by another party.

At these times the person should be given an explanation and the reasons why the IMHA cannot achieve what they want. The IMHA has not failed in these circumstances and the patient needs to understand that there are limitations to the IMHA's role, and what the IMHA is able to achieve on behalf of the person they are supporting. The IMHA's role is then to support the person in understanding and coming to terms with this decision. The IMHA might also work with them to retain as much control as possible of the situation.

Advocating for something the IMHA doesn't agree with

An important advocacy principle is that advocates should strive to be non-judgmental and respectful of peoples' views and experiences.

Non-judgmental in this context means that the IMHA should not impose their own views on the person, nor should they seek to alter the perspective of the person other than through the provision of information which enables the person to make informed choices. Inevitably, however, this will mean that sometimes the IMHA does not agree with the particular course of action that the person wishes to pursue.

It is not always possible to put aside one's own spiritual and religious beliefs and personal values. If the tensions are significant for the qualifying patient and the IMHA, it is best to seek support from a senior colleague with the authority to make decisions should be sought to reflect on the situation. Sometimes it may be the right decision to change IMHAs but this should be put into effect with great care as it may be perceived by the patient as a rejection or reaction to something else.

2.7 Summarise and respond to a range of common advocacy issues for qualifying patients

No resource is provided for this assessment criteria

2.8 Understand treatment options available to an individual who is subject to compulsion under the Act**Different perspectives on mental health**

It is important to recognise that there is a wide variety of perspective on mental health that may be different and even opposed to each other. Within this wide variety of perspectives mental health is usually defined broadly in two ways; as either:

- an absence of an objectively diagnosable mental illness or disorder that significantly interferes with a person's cognitive, emotional or social abilities e.g. 'clinical depression, anxiety, schizophrenia; or
- a state of mental wellbeing that, together with other factors, enables children and adults to attain independence, be productive and participate in personally fulfilling ways in society.

Medical treatment

"Medical treatment" is defined (in section 145) as including nursing, psychological intervention, and specialist mental health habilitation, rehabilitation and care, as well as what would normally be considered "medical treatment" (e.g. medication). In other words, it covers a wide range of treatment and care.

Where the MHA 1983 refers to "medical treatment for mental disorder", section 145(4) says it means medical treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations. Symptoms and manifestations include the way a disorder is experienced by the individual concerned and the way in which the disorder manifests itself in the person's thoughts, emotions, communication, behaviour and actions. In other words, medical treatment proposed under the Act must have the purpose of

improving, or at least prevent a worsening of, the person's mental disorder or its effect. The MHA 1983 cannot be used if the treatment is not for that purpose.

An IMHA is not expected to be an expert on treatment for mental disorder, but they may be asked to support patients with issues relating to treatment. The IMHA will need to be familiar with the main types of treatment. There are many sources of information on different treatments available for professionals and the public. Good sources of information for the public include:

Mind:

<http://www.mind.org.uk/Information/>

Royal College of Psychiatrists:

<http://www.rcpsych.ac.uk/mentalhealthinfo/treatments.aspx>

NHS Choices:

<http://www.nhs.uk/Conditions/Pages/bodymap.aspx?r=1&title=Health+Encyclopedia>

There are also many published guidelines on best practice, including those published by the National Institute for Clinical Excellence (NICE)

<http://www.nice.org.uk/Guidance/>

2.9 Signpost qualifying patients to other services

No resource is provided for this assessment criteria

2.10 Identify a range of information that should and must be recorded

Effective recording

General guidelines for good record keeping are:

- reports should be factual and accurate;
- reports should be dated and signed so that everyone knows who wrote them;
- use straightforward, simple language and make sure it is legible. It can be easy for another person to make mistakes about what is recorded because they cannot read it easily. A record needs to be concise and to the point. It does not need to contain lots of unnecessary words;
- do not use words which make a value judgement about the person e.g. 'stubborn', 'refused', 'uncooperative';
- the style should always be respectful;
- when recording someone's reaction to an activity or event, it is really important to record what is observed and then what this made you decide about that person's communication i.e. be explicit that it is your interpretation or opinion and not a fact.

A fact is something you know to have happened or to be true.

An opinion is a belief or judgement held without actual proof.

Think about why you are recording the information

- What is the purpose?

- Who is going to read it?
- Is it relevant and do you really need to record it?
- Does it contain adequate information to record what happened?
- Does it contain any personal judgements?

If possible and practicable, reports/records should be written with the person they are about being present (or actually in their own words) even if this simply means telling them what you are writing.

Recording, reporting and sharing information is key to safe and effective IMHA practice. An IMHA's records should be:

- in the standard format used within your employing organisation;
- up to date and written in a way that is not discriminatory or biased;
- clearly written and differentiate between facts, your opinions and the views of those involved; also identify any conflict of views or wishes and say how these were addressed and by whom;
- in a form that assumes that they may be used for supervision, auditing purposes, inspection and in a Court of Law.

2.11 Work within different environments

2.12 Understand how physical environment can impact on individuals

No resource is provided for these assessment criteria

3: Respond to requests for IMHA support

3.1 Identify a range of people who can refer to the IMHA service

The Mental Health (Wales) Measures states that IMHAs must comply with any reasonable request to visit and interview a Welsh qualifying compulsory patient, if the request is made by:

- the patient themselves;
- someone the IMHA thinks is the patient's nearest relative;
- the patient's responsible clinician (if they have one);
- an approved mental health professional (AMHP);
- a registered social worker who is professionally concerned with the patient's care, treatment or assessment;
- the managers of the hospital (or a person Duly authorised by them where the patient is liable to be detained (if this is the grounds for the person being eligible for independent mental health advocacy);
- the patient's done or deputy (if they have one).

In respect of Welsh qualifying informal patients, the duty on IMHAs to visit and interview the patient is the same, but only engaged if the request is made by:

- the patient themselves;
- the managers of the hospital (or person duly authorised by them) where the patient is an in-patient;
- someone the IMHA thinks is the patient's carer;
- the patient's done or deputy (if they have one);

- a registered social worker who is professionally concerned with the patient's care, treatment or assessment.

Timeframes for responding to referrals should be agreed locally.

Staff and other professionals should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA's visit but is unable or unlikely for whatever reason to request an IMHA's help themselves.

Before requesting an IMHA to visit a patient, however, they should, wherever practicable, first discuss the idea with the qualifying patient, and give the patient the opportunity to decide for themselves whether to request your help. They should not refer the patient to the IMHA service if they know or strongly suspect that patient does not want the help of an IMHA.

When might a qualifying patient seek the support of an IMHA service?

A qualifying patient may request the support of an IMHA service at any time after they become a qualifying patient. It can be helpful to think about occasions when patients are most likely to request the support of an IMHA and what kind of help the patient might ask for. These occasions include:

- soon after arrival in an inpatient unit to obtain reassurance and understanding of their situation within the hospital environment and mental health system;
- when they know that their care and treatment is going to be discussed in a meeting or ward round and they want help in preparing for the meeting, or support or representation at the meeting itself;
- when they are concerned about particular aspects of their care or treatment and wish to meet with their doctor/responsible clinician;
- when they are going to be examined by a second opinion appointed doctor;
- When they want to express concern about any aspect of their hospital experience or access the complaints process;
- when applying for or attending a hospital manager's hearing;
- when applying to the Tribunal for a hearing, obtaining legal representation, needing support at a hearing or help in understanding the decisions made by a Tribunal;
- when they have questions about their rights in relation to their nearest relative;
- why they need help to understand, apply to and obtain legal representation for County Court hearings about changing their nearest relative;
- when they are being considered for supervised community treatment (SCT);
- when they are talking to their guardian about requirements the guardian is imposing on them (e.g. about where they should live);
- when they want support to access medical or social services records;
- prior to a discharge planning meeting to explore all their options and raise concerns about appropriate after-care;
- when they want support in accessing other services.

A qualifying patient's right to refuse help from an IMHA

While a qualifying patient has a statutory right of access to an IMHA service they have a right not to accept help from an IMHA or seek alternative services. They can also choose to end the support they are receiving from an IMHA at any time. This means:

- that although the IMHA has a duty to comply with any reasonable request from an AMHP, the patient's nearest relative or responsible clinician to visit and interview them, the patient has a right to refuse to be interviewed;
- the patient has the right to choose an alternative service or person to act as an advocate for them, where available. This may be another independent advocate or a legal professional; or they may nominate a relative, friend or other informal supporter. However, these representatives do not have the same statutory powers and duties as an IMHA.

It should be explained to the qualifying patient and any advocate they choose to use that the IMHA's legal rights and duties can only apply to advocates from an organisation commissioned to provide IMHA services.

Statutory rights and duties of an IMHA do not apply to other advocates

3.2 Use referral processes

3.3 Implement and review referral processes

3.4 Respond to referrals

The referral stage

IMHAs need to respond to staff, professionals and other agencies wishing to make a referral to the service, in line with local referral policies and procedures.

Each IMHA service will have its own policies and procedures for responding to referrals and opening cases, which the IMHA will need to understand and follow.

The Mental Health (Wales) Measures makes it clear that referrals made in relation to qualifying compulsory patients who are detained under section 4, 5(2) or 5(4) of the 1983 Act should be prioritized by both the responsible person making the request and the independent mental health advocacy service provider responding to the request. As these sections are of a short duration – a maximum of 6 hours in the case of section 5(4) and 72 hours in the case of sections 4 and 5(4) – it is important that the advocacy provider be promptly informed of any such request, and that they respond to such requests as soon as is reasonably practicable. The aim in such cases should be to ensure that, wherever possible, the patient is visited by the IMHA during the period of the initial detention.

IMHAs will have to be able to respond to referrals at different levels of complexity. This will require them to carry out assessments of what is required, including different levels of risk management that may be involved.

Introductions

An IMHA will need to apply the standard procedures of their employing organisation for opening a case. Where the referral comes from someone other than the patient part of the response will be informing a qualifying patient of their rights to decline to use the service should they wish.

Clear and respectful introductions are important: including asking the qualifying person how they wish to be addressed (e.g., first name, surname or family name).

A qualifying patient may request help in a variety of issues. The IMHA will need to explain to the patient what the specific role of the IMHA is and the areas in which they can provide support, such as:

- understanding their rights under the MHA 1983 and the rights which other people have in relation to them;
- information about any medical treatment they are receiving or might be given and reasons for it;
- applying for discharge including Tribunals and managers hearings;
- requesting leave of absence;
- making complaints;
- improving communication with staff including accessing interpreters;
- care planning including discharge planning;
- help in applying for the nearest relative to be displaced.

Interview

In an interview with a qualifying patient, the IMHA should not only concentrate on what they think they need to know, but also try to make sure that the patient gets what they want out of the interview.

In conversation with the qualifying patient this includes:

- communicating in a way they can understand (including alternative formats);
- actively listening to the patient and checking that you have understood;
- formulating and framing questions in a way that the qualifying patient understands and ensure their objectives are met;
- observing non-verbal communication and checking out their validity, especially where it appears to contradict what is being said;
- sensitivity to the culture, gender, religious, faith, age and any disability issues of the qualifying patient;
- feeding back your understanding of the objectives and outcomes of the interview;
- checking agreed responses and actions in a way that can be accurately recorded.

(Adapted from Bateman, Neil. *Practicing Welfare Rights (Social Work Skills)* (2006) Chapter 4)

3.5 Know when to refer to a range of advocacy services

No resource is provided for this assessment criteria

Outcome 4: Engage with professionals

4.1 Research and identify a range of people and services the IMHA is likely to come into contact with

IMHAs will need to understand, navigate and engage with the mental health system in order to provide effective support to qualifying patients. This section explains the roles of a range of professionals and public bodies that IMHAs are likely to come into contact with.

Local Health Boards (LHBs)

(LHBs) are responsible for planning, designing, developing and securing delivery of primary, community, secondary care services, and specialist and tertiary services for their areas. There are 7 LHBs in Wales

Community Health Councils across Wales will:

- provide help and advice if an individual has a problem or complaint about the NHS services;
- ensure that individuals views and needs influence policies and plans put in place by health providers in their area;
- monitor the quality of NHS services from users points of view;
- provide information about access to the NHS

Primary Care Trusts (PCTs)

PCTs are at the centre of the NHS. Their main functions are:

- improving the health of their population. This includes reducing health inequalities, protecting health and emergency planning;
- commissioning NHS services. Including primary care (e.g. GP services) as well as hospital and other specialist services;
- directly providing services, where it is in the patients' interests and is value for money.

PCTs are responsible for getting health and social care systems working together for the benefit of patients. They are required to work with local authorities and other agencies to ensure that local community health and social care needs are met.

PCTs are required to act as commissioners of IMHA services in England.

Strategic Health Authorities (SHAs)

SHAs are responsible for managing the NHS locally and acting as a conduit between NHS organisations and the Department of Health. Their main functions are:

- strategic oversight of Primary Care Trusts (PCTs) to ensure capacity and competition;
- helping develop and evaluate national policy;
- devising overarching local plans for the NHS to improve services and the health of their population.

NHS Trusts

NHS trusts earn their income through providing healthcare commissioned by or on behalf of PCTs. They must work in partnership with other NHS organisations, local authorities and the voluntary sector. Trusts are obliged to meet national targets and standards of care, as well as deliver national priorities. Trusts are largely self-governing organisations.

NHS foundation trusts

NHS foundation trusts are similar to NHS trusts, but with greater autonomy. They are independent public benefit organisations, modelled on co-operatives but remaining part of the NHS. Local people have a say in running them by becoming members or governors. Like NHS trusts, NHS foundation trusts must reach national targets and standards, but they have more freedom in deciding how they do this.

Like NHS trusts, NHS foundation trusts primarily earn their income through providing healthcare commissioned by PCTs and practice-based commissioners. NHS foundation trusts have been given much more financial and operational freedom than other NHS trusts.

All types of NHS trusts can apply to become a NHS foundation trust should they wish, including acute trusts and mental health trusts.

Acute Trusts

An 'Acute Trust' generally means an NHS trust or an NHS foundation trust which manages hospitals, to ensure that they provide high-quality healthcare and spend their money efficiently. They also develop strategies for service improvement within those hospitals.

Acute trusts employ a large part of the NHS workforce, including nurses, doctors, pharmacists, midwives and health visitors, as well as people doing jobs related to medicine – for example, physiotherapists, radiographers, podiatrists, counsellors, and psychologists.

There are also many non-medical staff employed by acute trusts, including receptionists, porters, cleaners, managers, and domestic and security staff.

Some acute trusts are regional or national centres for more specialised care. Others are attached to universities and help to train health professionals.

Mental Health Trusts

Mental health trusts are similar to acute trusts, but specialise in providing health and social care services for people with mental health problems. They normally provide both hospital and community mental health services. Some also provide social services for people with mental health problems on behalf of the social services authority.

Care trusts

Care trusts are organisations that work in both health and social care. They may provide a range of services, including social care, mental health services or primary care services.

Care trusts are set up when the NHS and local authorities agree to work together, usually where it is felt that a closer relationship between health and social care is needed or would benefit local care services.

Independent Hospitals

There are many independent sector hospitals which provide mental health services (often for NHS patients). All independent hospitals have to be registered with the Care Quality Commission.

Local Social Services Authorities (LSSA)

Local authorities (councils) are responsible for providing and commission social services for adults and children, including services specifically for people with mental health problems.

Not all local authorities have social services responsibilities. Those which do are referred to in the MHA 1983 – and in related guidance – as local social services authorities (LSSAs). There is normally a Director of Adult Social Services in charge of social services for adults, including people with mental health problems.

LSSAs don't necessarily provide all their services themselves. Some services are provided in partnership with the NHS, or by an NHS body on their behalf. Other services may be provided by private providers (e.g. private care homes) or by voluntary organisations.

LSSAs are also responsible for approving people to be approved mental health professionals (AMHPs) under the MHA. When AMHPs take decisions under the MHA, they must be acting on behalf of an LSSA (although it won't necessarily be the one which approved them). Acting on behalf of an LSSA doesn't mean the LSSA can tell the AMHP what decision to reach in an individual case – but it does mean that the LSSA is responsible for the quality of the services AMHPs provide.

People who have specific statutory functions under the MHA 1983

IMHAs work with a range of professionals- in particular mental health professionals- when helping qualifying patients. A reminder is given below of some of the people with specific responsibilities under the Act that IMHAs are likely to encounter.

Approved clinician (AC)

A mental health professional is approved by Local Health Boards to act as an approved clinician for the purposes of the Act. Some decisions under the Act can only be taken by people who are approved clinicians. An AC can be a doctor, nurse, occupational therapist, psychologist or social worker who has undertaken specific training. In practice, SHAs (or PCTs) approve ACs on behalf of the Secretary of State.

Responsible clinician (RC)

A responsible clinician is normally the approved clinician with overall responsibility for the patient's case. Certain decisions can only be taken by the responsible clinician for example renewing the patient's detention, or placing the patient on supervised community treatment.

Section 12 Doctor

Doctors who approved under section 12 of the Act as having special expertise in the diagnosis or treatment of mental disorder. One of the two medical recommendations in support of an application for detention or guardianship under the Act has to be made by a section 12 doctor. In England, section 12 doctors are approved by SHAs on behalf of the Secretary of State. Most section 12 doctors are psychiatrists, but there are also GPs and other doctors who are section 12 approved. Doctors who are approved clinicians are automatically treated as section 12 approved as well.

Approved mental health professional (AMHP)

Approved mental health professionals are mental health professionals with specialist training in mental health assessment and legislation. They are approved by the local social services authority (LSSA). An AMHP can be a nurse, social worker, occupational therapist or psychologist, provided they have undertaken specialist training and are approved. An AMHP is one of the required persons needed to complete an assessment for detention under sections 2, 3, 4, or for supervised community treatment or guardianship.

Guardian

The person on who certain powers are conferred in respect of a patient received into guardianship. In the majority of cases the guardian will be the Local Social Services Authority (LSSA), but there may be a private guardian for example a relative of the patient. They are normally consultant psychiatrists.

Second opinion appointed doctor (SOAD)

Is a doctor appointed by the Care Quality Commission to provide an independent second opinion on whether it is appropriate for certain types of medical treatment for mental disorder to be given to patients under the Act.

Nearest relative

A nearest relative is not a professional but has an important role in relation to patients under the Act. It is important to note that the nearest relative is not the same as their next of kin; a patient's nearest relative is defined in section 26 of the Act. Nearest relatives have various rights under the Act.

Hospital managers

The organisation (or individual) responsible for the operation of the Act in a particular hospital.

In England, NHS hospitals are managed by NHS trusts, NHS foundation trusts and primary care trusts. For these hospitals, the trust themselves are defined as the hospital managers for the purposes of the Act. In an independent hospital, the person or persons in whose name the hospital is registered are the hospital managers.

It is the hospital managers who have the authority to detain a patient under the Act. They have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as the Act allows, that their treatment and care accord fully with its provisions, and that they are fully informed of, and are supported in exercising, their statutory rights.

In practice most of the decisions of the hospital managers are actually taken by individuals (or groups of individuals) on their behalf. In particular, decisions about discharge from detention and SCT are taken by panels of people ("managers panels") specifically selected for the role.

Key mental health services

Qualifying patients maybe receiving services in a number of different specialist settings. IMHA will need to be familiar with the services which operate in their local area and where they may be asked to provide an IMHA service. IMHAs should also be aware that patients based in specialist services may have very different needs and circumstances to patients in general mental health settings and in practice the IMHA service may be provided by specialist IMHAs. The way that mental health services are organised and described vary from place to place. But the following section outlines some of the key services IMHAs are likely to come across.

Services for different age groups and client groups

The organisation of mental health services is often divided on an age basis:

Child and adolescent mental health services (CAMHS) promote the mental health and psychological wellbeing of children and young people, and provide multidisciplinary mental health services to all children and young people with mental health problems and disorders to ensure effective assessment, treatment and support, for them and their families.

CAMHS are often divided in Tiers, and IMHAs are most likely to be involved with tier 3 -4 (specialist services) which provide specialist support to children and young people with the most serious mental health problems and will include day units, highly specialised outpatient teams and in-patient units. These can include secure forensic adolescent units, eating disorders units, and other specialist teams.

They often serve more than one district or region.

Adult services normally work with adults of working age, sixteen to sixty-five.

Older people services normally work with adults over the age of sixty-five. Many older people will have similar mental needs to adults of working age, but they may also experience other illness such as dementia. Mental health services for older people are provided in community, day services and inpatient wards. Not all patients will automatically be transferred to a service for older people when they are 65 in cases where they have been receiving services in an adult mental health service this may continue as appropriate to the individual.

Services for people with learning disabilities and substance misuse services

These services are often separate – which can cause difficulties for people who have needs in more than one area. Currently there is a growth in ‘dual diagnosis’ services for people with both substance misuse and mental health problems.

Specialist services for particular groups for patients

Within these general areas, services for some particular groups may be organised as specialist services, e.g.

Eating disorders services – provides a range of services to people with a range of eating disorders including anorexia nervosa and bulimia nervosa. Services are provided in community, out-patient and in- patient settings and day services;

Forensic services provide mental services for patients whose behaviour, as a result of mental disorder, has brought them, or might bring them, into contact with the criminal justice system, i.e. Courts and Police. Forensic services are provided in the community and in hospital settings.

Types of community mental health services

Most areas have a range of different types of teams delivering specialist mental health services for people in the community. These tend to include:

Community mental health teams (CMHTs) - These are generally multi- disciplinary teams consisting of doctors, nurses, social workers, psychologists and support workers who provide

mental health services to adults of working age with mental health needs. They will often be the initial point of referral from primary care and will offer both short term and long term support, they may include the AMHP service.

Assertive outreach team - These are generally multi-disciplinary and provide a service to severely mentally ill patients who have complex needs. Assertive outreach teams provide more intensive input that can generally be offered by other services.

Crisis resolution and home treatment teams - Offer a crisis response and assessment for patients suffering a mental health crisis in the community. The team will generally work with people in their own homes until the crisis is resolved, often without hospital admission. Crisis resolution teams also provide a gateway for hospital admission. The team generally provides a multi-disciplinary service.

Early intervention teams - Provide a multi-disciplinary team approach to working with people experiencing their first episode of psychosis. Early intervention services provide a service to people between the ages of 14 and 35.

Types of in-patient services

Hospitals – and wards- are often classified according to the level of security they provide.

Acute admission wards - People detained under the Act by an application by an AMHP are typically admitted to an acute inpatient ward. These wards also provide care and treatment to informal patients;

Psychiatric intensive care units (PICUs) are for patients compulsorily detained under the Act usually in secure conditions, who are in an acutely disturbed phase of a serious mental disorder, which is associated with loss of capacity for self control and a corresponding increase in risk, which prevents their safe, therapeutic management and treatment in a general open acute ward. Length of stay depends on clinical need and assessment, but would ordinarily not exceed eight weeks;

Low secure services deliver treatment and care for patients who demonstrate disturbed behaviours in the context of a serious mental disorder and who require the provision of security. These units aim to provide a homely secure environment which has occupational and recreational opportunities and links with community facilities. Patients will be detained under the Act and in need of rehabilitation usually for up to 2 years;

Medium secure services are for patients considered to pose a serious danger to the public;
High secure services are for patients considered to present a grave and immediate danger to the public if they were at large, who could not be safely contained within the security available in a medium secure unit. There are three high secure hospitals in England - Ashworth, Rampton and Broadmoor.

Other services include:

- Clinical psychology departments providing specialist psychological therapies (including specialist services for adult mental health, learning disability, elderly, children and adolescents, forensic) providing specialist therapies;
- Counselling including bereavement, psycho-sexual (including post sexual assault and sexual abuse) etc;

- Substance abuse service;
- Self-harm service;
- Services for people with autism;
- Services for people who also have a condition affecting the brain such as multiple sclerosis (MS) or brain injury.

Community services include:

- Hostels and supported living usually for working age adults with mental health issues and people with learning disabilities;
- Nursing homes and care homes;
- Day centres.

4.2 Communicate the IMHA's role to a range of people

Methods of providing information on IMHA services

Information on IMHA services may be provided in a range of ways: verbally and in writing, audio-tapes, websites. IMHAs need to be familiar with the ways in which information about your service is made available.

How does a qualifying patient find out about an IMHA service?

Section 130D places a duty on a 'responsible person' to provide verbal and written information about IMHA services to qualifying patients. This may be a hospital manager, responsible clinician, local services social authority, the patient's doctor or approved clinician.

Responsibility for informing patients of IMHA service

Qualifying patient	Person responsible for informing the qualifying patient (the 'responsible person')
Patient liable to be detained	The hospital managers
A patient who is liable to be detained but has been conditionally discharged	The responsible clinician (for the patient)
Patient subject to guardianship	The responsible local social services authority
A community patient	The hospital managers (for the responsible hospital)
A patient for whom treatment under section 57 is proposed, if they do not already fall under one of the categories above	The registered medical practitioner or approved clinician with whom the patient first discusses
A patient under 18 years for whom treatment	The registered medical practitioner or

the possibility of such treatment under section 58A is proposed, if they do not fall under one of the categories above	approved clinician with whom the patient first discusses
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The Code of Practice explains the responsible person duties:

- They must ensure that they tell the patient, both orally and in writing, that support is available to them from an IMHA, and how they can obtain that support.
- That if a patient has a nearest relative, the responsible person should, unless the patient requests otherwise, provide a copy of the same information, in writing, to the nearest relative.
- As well as telling people about the availability of independent mental health advocacy, the responsible person must also ensure that the patient has the opportunity of making use of IMHA support.
- If the patient would like an IMHA, the responsible person should support them in making contact - for example, they might make arrangements for the patient to meet the IMHA if the patient would otherwise be unable to do this, but they should not at this stage disclose any personal information about the patient to the IMHA service.
- They should record in the patient's medical records the steps taken to tell that patient about IMHA support. Other people who support the patient should also be informed about whether the patient would like support from an IMHA, and any follow-up action required, if the patient has agreed to such information being shared.
- If a patient has been fully informed about IMHA support, and chooses not to involve an advocate in their case, the responsible person should:
 - record in the patient's medical records that the patient was informed about independent mental health advocacy and did not want it
 - check with the patient again at a later date in case they have changed their mind
 - tell the patient that legal representation is available and how to access it.

Informing the patient of their right to an IMHA and how are people referred to IMHA Services

Anybody can make a referral to an IMHA service including the qualifying patient, hospital managers or members of the hospital or community mental health staff. However, the IMHA service only has a statutory duty to respond to any reasonable referrals made by people specified in the Act. IMHA services should also respond to any direct referral from the patient themselves. A policy on responding to non-statutory referrals – for example from family members or nursing staff should be agreed locally.

As a matter of good practice, the IMHA service should:

- Make available a copy of their referral policy on request (where this is available);
- Respond appropriately to the request within agreed timeframes.

4.3 Use strategies to negotiate with professionals

How any one of us thinks and feels about power depends on a number of factors: our childhood experiences, differences such as race, ethnicity, gender, faith and religion, sexual orientation,

age and ability; where we live, how we have been educated, the identities we have chosen for ourselves, life events that have shaped our understanding of why the world is as it is. All of these factors come into play in any exchange of views on power, empowerment and safeguarding the rights of qualifying patients.

When helping to uphold the rights and aspirations of qualifying patients, it is important for the IMHA to recognise how they conceive power and its links to their practice. They also need to be aware of how qualifying patients and those with whom they work understand and translate their ideas on power into their lives or practice. This involves seeing the similarities and differences of forms of power and their impact on the patient; understanding the influence of professional structures and affiliations, and the constraints of hierarchies and physical, emotional, cultural and political distances between key stakeholders.

For example, some mental health staff and professionals work within hierarchical bureaucratic structures and ascribed relationships of power and authority that do not fit neatly and easily with an IMHA's role of developing a partnership of equals with qualifying patients. Also, there are status differentials between and within professional groups which also determine expectations of power and define working relationships. Whatever the difference in their understanding of power and unequal relationships of power, an IMHA is expected to share a common desire with staff and professionals to help qualifying patients to safeguard and uphold their rights under the Act and so have complementary and supportive roles where possible.

The general experience of mental health advocates suggests that where staff and professionals have witnessed a positive impact of advocacy, they are likely to welcome the existence of IMHA services; not least because their role is to protect and safeguards the rights of patients under the Act with whom IMHAs also work.

Nonetheless, there are times when tensions and strains will occur that have to be managed and negotiated. This requires being alert to problems, avoiding labelling and stereotyping others and seeing the potential need for support in a dispute or conflict that may have serious consequences for a qualifying patient.

Changing the language and ways of communicating unequal power

In many cases the communication between qualifying patients and professionals is an unequal encounter. The extent to which professionals are prepared to establish equal participation opportunities across language differences and ability varies considerably.

The ways of communicating that indicate unequal power relations are not limited to verbal exchanges. Non-verbal behaviour can be a very powerful tool for communicating power: e.g. not making eye contact, seating arrangements, looking at the clock continually as someone is speaking, sighing or shaking one's head.

Where little effort is made to facilitate a patient's ability to communicate, a qualifying patient may be reduced to silence, nervous laughter or verbal hostility. Apart from the opportunity for misunderstanding because the patient is made powerless and assumed to be unable to participate, they are also likely to feel humiliated, excluded and discriminated against.

As part of the advocacy process, the aim of an IMHA would be to find ways through which the inequality of power relations between the professional(s) and patient could be mitigated or changed. This might be a simple matter of challenging jargon and official language that is alien

to a qualifying patient; or involve suggestions (including the offer of training) on the use of innovative and alternatives ways of communicating that does not exclude or diminish patients.

Typical forms of power

The following simple descriptions of power can be usefully related to the experience of qualifying patients and how to address the problems they face.

- Power over: is imposed and relational. It may operate through threat or fear, or be consented to as when a person has authority over their life or that of others and is often about social action;
- Power to: is the capacity to have an effect, bring about change or get things done;
- Power with: refers to developing common ground among different interests particularly where people have little or no power;
- Power is knowledge: the ability to construct meaning to what is happening and the power relations that shape our lives;
- Power structures: the means by which power is embedded in society, particular institutions and establishments.

Explaining and mediating qualifying patients' views and choices

While qualifying patients may have little or no power because they are a vulnerable and voiceless group, they can operate a 'reverse' personal power which may be accepting or hostile towards professionals and other stakeholders.

They may welcome the power they perceive professionals to have in their treatment and care and show an attitude of acceptance or passivity to that power and what can be achieved through it. Conversely, they may express hostility or resistance by disregarding appointments, rejecting meetings offered, being guarded in responses or demonstrating condescending attitudes towards the ability of particular professionals.

As it is likely that the frustration and disappointment of professionals will be shared with an IMHA, and they will have to strike a balance between supporting the qualifying patient's rights in these circumstances and explaining to a qualifying patient the possible consequences of their actions.

Changing perceptions of the IMHA role

However positive the IMHA's working relationships may appear, it is possible for staff and professionals to have a negative perspective on what an IMHA is trying to achieve. This may be a matter of style (clothes, manner of speaking, perceived lack of respect and structure). It may be justified in terms of previous bad experiences or the IMHA role may be perceived as adversarial and 'anti-professionals': e.g. when a qualifying patient wants to question decisions that have been made or make a complaint about a particular professional. More generally, some professionals may resist the need for an IMHA in the belief that they are the best people to advocate for a patient. They may also be suspicious of the independent approach taken by IMHAs particularly when they judge the support given to a patient to be risky and harmful to them. Where it is possible, it is worth IMHAs working in both formal and informal situations to (re)building a trusting a respectful relationship by exploring the reasons for the negative perspective and showing how it can be different. Where there is a culture of resistance which is

too difficult to change at practitioner level and is having a negative impact on qualifying patients, it may be necessary for IMHAs to seek support from other more senior colleagues on both sides.

Maintaining boundaries with mental health professionals

The IMHA has some similarities with other professional roles and responsibilities; it is possible that the differences will not always be understood by people working in other services and this could lead to difficulties for a qualifying patient. IMHAs, therefore, need to be able to clearly explain the scope and limitations of their role to the patient, staff and professionals in other agencies.

Perceptions of the relationship between IMHAs and professionals can, however, be subtle and difficult to untangle. For example, there may be times when the nature of this relationship is problematic for qualifying patients. The relationship may even appear intimidating and threatening to them.

For example, it may seem to a patient that decisions are being made secretly and they may perceive appearances of friendly relations between IMHAs and professionals as confirmation of collusion on this. Whatever the IMHA's intentions, it may appear that their ability to challenge professional decisions in public and the promised independence of the advocacy role is undermined or compromised.

At the other extreme, there may be few opportunities for contact between IMHAs and professionals and working relations are built on a limited contact in meetings. This may prevent the development of shared ideas necessary for the professional's and IMHAs common purpose of meeting the needs of qualifying patients and it may lead to suspicion and resentment.

For example, professionals may find it difficult when a qualifying patient disagrees with decisions on their treatment and care and wants to question them. It may appear that the IMHA role is antagonistic and critical. An IMHA, when supporting or representing a patient will need to demonstrate that they are not putting forward their own opinion nor judging decisions made by professionals. IMHAs will need to make it clear that they are supporting a patient to express their views on what they want and their concerns about their medical treatment and care.

Negotiating unequal power relations

The dilemmas about an IMHA's unequal power relations with a qualifying patient and professionals may be stressful but if it is ignored the IMHA may run the risk of acting in a way that may be damaging to the qualifying patient. It may also leave the IMHA feeling burnt out by the pressures and with a sense of helplessness and despair. When this happens they should seek support from colleagues or supervisors where available.

Negotiating unequal power relations for the benefit of a qualifying patient is, however, a fundamental part of an IMHA's role and it requires confidence and an ability to be appropriately assertive rather than abrasive or aggressive. It is important to recognise that attempts to change power relations are not simple - not least because it usually involves someone giving up power. Issues and difficulties, therefore, must be addressed with care and thoughtfulness and an understanding of what it means to people involved.

Negotiating successfully is an acquired skill – even where someone appears to have a knack for it. Some negotiations to bring about change are direct and other indirect and some are

successful and others do not work. At one extreme IMHAs are negotiating with a professional with clinical or other authority to make decisions; at the other, it involves the creation of an informal working relationship with staff and professionals in other agencies.

It may be that it is necessary to involve others with greater expertise, including legal support where disputes could lead to conflict.

Basic negotiating skills include:

- being clear about the purpose of the negotiation and checking out that those the IMHA is negotiating with have a shared idea of its purpose;
- identifying possible equality issues, cultural and professional differences that might arise;
- establishing the most appropriate method of negotiating: direct and simple communication or indirect and complex styles and methods;
- identifying who is involved and what is at stake for them;
- the willingness and ability of all parties to compromise, take risks, divulge information and tolerate uncertainties in a proposed way to bring about change in the power relations;
- knowing how to build on agreements on outcomes and find ways forward.

4.4 Respond to dilemmas and challenges which may be faced

Retaining independence

The IMHA will need to develop courteous and professional relationships with health and social care staff. However, the IMHA will need to balance their co-operation with staff with their need to be independent of health and social care services. In particular, the IMHA needs to consider how patients will perceive their interaction with staff and professionals; an overly familiar relationship could be perceived by patients as breaching the confidentiality of the advocacy relationship.

The role of the IMHA is to act on behalf of the patient. In some circumstances this may bring them into conflict with professionals, particularly where there is a lack of understanding of their role. This conflict may be construed as obstructive or interfering with the actions of professionals, or that the IMHA is acting of their own volition and not on behalf of the patient.

The main challenge for an IMHA is the extent to which a balance between their need to be independent and the need to co-operate with others can be struck and the IMHA's practice still deemed to be effective and safe. The issues may include:

- a patient's perception of the IMHA's interactions with staff and professionals as breaking the confidentiality of the IMHA's relationship;
- keeping boundaries clear on the distinction between the IMHA role and that of others;
- information sharing; and
- limits of action that the IMHA can take or be involved in which the patient has not requested.

To demonstrate independence, mental health advocates have developed the following strategies:

- only go into the staff office when necessary;
- wherever possible, meet with staff in the presence of the qualifying patient;

- if it is necessary to speak to staff on the patients behalf, ensure that the patient knows what the IMHA is discussing and provide feedback quickly;
- not mingling, being familiar or closely associating with the clinical team and others;
- associate with the patient and avoid taking the perspective of the staff team.

Conflicts with health and social care staff

Conflicts can particularly arise where:

- a patient wants to question decisions that have been made about their treatment or care;
- a patient wants to make a complaint; or
- a patient has asked an IMHA to advocate for something which staff judge to be risky or harmful.

The IMHA should always be clear to staff that they are acting on behalf of the patient and their wishes. However, if conflict arises then the IMHA should try to resolve the conflict at the lowest level, either talking to the member of staff directly or with the member of staff's manager. The IMHA should report back any conflicts to the IMHA service provider, who may be required to take up the issue on the IMHA's behalf.

Promoting a course of action that is perceived by others to be risky or not in the best interests of the patient

An important part of the IMHA's role is to support qualifying patients to be independent of the views of others and make their own informed choices, even where the patients view or wish is challenged by other people, including staff or family members. This role is supported by the general advocacy principles that advocacy is client led, non-judgemental and values diversity and equality.

Patients may choose a course of action or take decisions which others deem to be risky or not in their best interests. The IMHA may even be concerned that what they have been asked to do by a qualifying patient is contrary to the patient's recovery/treatment or may indeed be harmful to them. Nonetheless, the role of an IMHA includes respecting the choices and wishes of the patient they are supporting even when the IMHA do not understand this choice or agree with it.

Where the consequences of the decision being made by a patient are potentially serious the IMHA should seek the support of a senior colleague within their employing organisation to reflect on the dilemma and the available options. The IMHA should not support the patient if the proposed course of action would put the patient, the IMHA or anyone else in danger or if the action is against the law.

Practice Example

Sofira asks the IMHA to support her in her discharge CPA meeting. She tells the IMHA she finds the psychiatrist intimidating and wants her IMHA to explain to him that she doesn't like being in hospital as she doesn't find it therapeutic. She thinks she is much better now and sees no reason why she should still be in hospital. She wants to be discharged.

She asks the IMHA to tell the psychiatrist she won't take her medication when she goes home because she doesn't like the side effects and she doesn't want to see anyone from the mental health team as this will just remind her of being unwell.

When the IMHA presents this information during the CPA meeting, the psychiatrist cannot understand why the IMHA doesn't see that this is not in Sofira's best interests. He thinks the IMHA should try to persuade Sofira that she should take her medication when she is discharged or at the very least to engage with the mental health professionals. The psychiatrist says 'Sofira is clearly well enough to be discharged but I'm concerned that it is too risky to discharge her if she won't comply with the care plan'.

The IMHA makes it clear to the psychiatrist that it is not the IMHA's role to assess the risk or make clinical decisions and reminds the psychiatrist that the IMHA is there to support Sofira to say what she wants to say.

5 Respond to individuals who have diverse needs

UK anti-discriminatory laws relevant to IMHA services

This section outlines the main UK anti-discriminatory legislation and the considerations for IMHAs in relation to it.

Disability Discrimination Act 1995

The Disability Discrimination Act 1995 (DDA) came into force in 1996. It has been significantly extended by subsequent legislation, including the Disability Discrimination Act 2005.

The DDA makes it unlawful to discriminate against disabled people in a range of areas including employment; education and access to goods, facilities and services. It requires employers and providers of goods and services to make 'reasonable adjustments' to their usual practices and procedures to avoid discriminating against disabled people.

Definition of disabled person

The DDA defines a 'disabled person' as someone 'with a physical or mental impairment, which has a substantial and long-term effect on his or her ability to carry out day-to-day activities'. The definition covers a wide range of disabilities and includes people who have had a disability previously. Most (although not necessarily all) patients eligible for IMHA services are likely to be covered by this definition.

Disability Equality Duty

The Disability Discrimination Act 2005 amended the DDA so that it now places a duty on all public authorities, when carrying out their functions, to have due regard to the need to:

- promote equality of opportunity between disabled persons and other persons;
- eliminate discrimination that is unlawful under the DDA;
- eliminate harassment of disabled persons that is related to their disabilities;
- promote positive attitudes towards disabled persons;
- encourage participation by disabled persons in public life; and
- take steps to take account of disabled persons' disabilities, even where that involves treating disabled persons more favourably than other persons.

The overarching goal of this duty (the "disability equality duty") is to promote equality of opportunity.

The disability equality duty applies to a range of public bodies including schools and colleges, NHS agencies, police forces, central and local government.

IMHAs and the Disability Equality Duty

The DDA does not define a public authority but this term includes 'any person certain of whose functions are functions of a public nature'. This means that, as with the Human Rights Act 1998 (see above) individuals exercising statutory functions under the MHA 1983 will be considered to be public authorities and will therefore need to comply with the disability equality duty. **This will include IMHAs.**

Disability Equality Schemes

In addition to the disability equality duty, the DDA requires specified public authorities to publish a 'Disability Equality Scheme' which will need to include points such as an action plan, setting out the steps that the authority will take to comply with the disability equality duty. **IMHAs are not subject to this duty.**

Race Relations Act 1976

The Race Relations Act 1976 (as amended) (RRA) prohibits race discrimination in a range of areas including employment, education, housing and the provision of goods, facilities and services. It is unlawful for a person to discriminate against another person on racial grounds.

The RRA defines racial grounds as including race, colour, nationality or ethnic or national origins.

Duty to promote race equality

Following the Inquiry into the murder of Stephen Lawrence, the Government announced its intention to amend the Race Relations Act 1976 to put public authorities under a statutory duty to promote race equality. This was introduced by the Race Relations (Amendment) Act 2000 (RR(A)A) places a statutory duty on all public authorities to promote race equality. It has extended the scope of the legislation outlawing racial discrimination in all functions of public authorities.

The definition of 'function' relates to anything that a public authority does in the course of its duties. It is important to note that the duty to promote race equality covers all aspects of an organisation's activities – policy and service delivery, as well as employment practices. This duty is in two parts, the general duty and specific duties (see below).

General Duty

The RRA places a general duty on a wide range of public authorities to promote race equality.

The authorities that are subject to this general duty are listed in Schedule 1A of the RRA.

The authorities listed in the Schedule include NHS agencies, police authorities and local councils.

IMHAs are not included in this list.

The public authorities subject to the general duty must have due regard to the need to:

- eliminate unlawful racial discrimination;
- promote equality of opportunity; and
- promote good relations between people of different racial groups.

The duty aims to make the promotion of race equality central to the way public authorities work.

Specific Duties

To assist in developing the general duty, specific duties have been imposed on specified public authorities (including NHS agencies, police authorities and local councils, the Housing Corporation and the London Development Agency). These detail specific actions public authorities need to take in order better to comply with the general duty. This includes the preparation and publication of Race Equality Schemes in which the public authority sets out how it intends to meet its obligations under the general duty and any other specific duties to promote race equality which are relevant to it.

Other Equality Legislation

Sex Discrimination Act 1975 and Gender Equality Duty

The Sex Discrimination Act 1975 prohibits sex discrimination against individuals in employment, education, and the provision of goods, facilities and services. It also provides protection for transgender people.

The Gender Equality Duty came into force on 6 April 2007. It is an amendment to the 1975 Act by the Equality Act 2006. It reinforces the 1975 Act by placing a legal obligation on public authorities to promote equality of opportunity between men and women, and actively demonstrating that men and women are treated equally and fairly in the exercise of public functions. The Equality Act 2006 was designed to ensure that a wide number of authorities are subject to the gender duty in relation to the performance of public functions.

So the way it defines public authority is similar to the approach in the Disability Discrimination Act 2005 and the Human Rights Act 1998. Public authorities covered by the general gender duty are not individually listed, but 'public authority' is defined as including any person who has functions of a public nature. **IMHAs will therefore be subject to this general gender equality duty.**

Specified public organisations are required to publish a Gender Equality Scheme which identifies gender equality goals and proposed actions to achieve the goals, in consultation with employees and stakeholders. This **does not include IMHAs**.

Religion and belief

Part 2 of the Equality Act 2006 sets out provisions prohibiting discrimination on grounds of religion or belief in the provision of goods, facilities and services, education, the use and disposal of premises and the exercise of public functions by public authorities- **including IMHAs**. There is separate legislation prohibiting discrimination in education and vocational training.

Sexual orientation

The Equality Act (Sexual Orientation) Regulations 2008 similarly sets out provisions prohibiting discrimination on grounds of sexual orientation in the provision of goods, facilities and services, education, the use and disposal of premises and the exercise of public functions by public authorities – **again including IMHAs**. Again there is separate legislation prohibiting in education and vocational training.

5.1 Describe how having mental health needs can impact on daily living

5.2 Offer support to individuals who have mental health needs**5.3 Use a range of methods to communicate with people who have mental health needs**

No resources are provided for these assessment criteria

5.4 Respond to the cultural and spiritual needs of an individual

IMHAs will need to use a combination of communication skills to ensure that they establish the person's wishes, preferences and values including their religious and cultural beliefs, including:

- raising the profile of the patient's wishes, preferences and values and, as such, promoting a person-centred approach to the service delivery and decisions made on their behalf;
- being aware of and taking action to ensure the patient's rights are upheld. This includes making sure the person is not subjected to any unnecessary risk, ill treatment, neglect or discrimination;
- ensuring that the patient is valued and has a comparable quality of life to their peers; including access to appropriate services and leisure activities;
- providing representation through questioning and seeking justification for decisions and actions taken on the patient's behalf;
- ensuring the patient is as involved in decisions as possible and has the support to be as independent as possible.

Sensitivity and appropriate communication skills are needed at all times. They are particularly important where it may be that a patient chooses to express themselves in non-verbal or unconventional ways. Even if that increases the possibility that the patient will be misunderstood by others, they should still be supported to articulate their views, wishes and concerns if at all possible. This requires the IMHA to consider and establish:

- what level of communication does the patient have?
- does the patient have the capacity to reason and make sense of the issue and any relevant information?
- does the patient have the capacity to make a decision about a specific issue?
- is the patient able to consent to the advocate working with them?

An IMHA supporting a qualifying patient should demonstrate cultural sensitivity and competence by:

- undertaking training (where available) focused on the discrimination and inequalities that patients may face in areas such as diagnosis, compulsory detention and treatment: i.e., not just a generic focus on cultural difference or diversity;
- keeping in mind that patients may demonstrate cultural differences in customs, manners and behaviour;
- not using colleagues or patients from the same cultural background as 'race experts';
- exercising caution about the use of official and accepted terms used to refer to a patient's identity (e.g. ethnicity). Where possible, check with the patients themselves the definitions and descriptions they prefer.

Cultural competence - implications for effective IMHA practice

- An IMHA should find out the most effective way to give the patient information – this may mean asking the patient what suits them;
- Make sure that communication needs identified are met; this may mean arranging sign language interpreters;

- Information needs to be relevant to the person's life so that it is easier to understand – relevant to their age, culture, etc;
- The IMHA may need to collect information or be available to help the person make sense of information they receive from other sources.

Some information is best given directly by another person, other than the advocate, for example information of a technical nature, outside the expertise of the advocate. The advocate can help to make sure the person can understand it. This can be important where a professional (for example a doctor or solicitor) gives complicated information. The advocate can take notes, or record the information in another way.

5.5 Identify dimensions of diversity

Working with Qualifying Patients with Diverse Needs

IMHAs will need the appropriate knowledge of the law and the skills to practice effectively with qualifying patients across a wide range of patient groups, including patients experiencing different types of mental disorders and patients from different cultural backgrounds.

This does not mean that IMHAs are expected to be expert in every area of the qualifying patient's particular individual needs. Depending on local arrangements in certain cases they may need to link with specialist groups and organisations to provide a service. This might include services within hospital settings, externally from services within the statutory and independent sectors, local faith groups or service user-led support groups.

A person typically experiences their identity through the interaction of many factors including class, race, age, disability, sexuality and gender.

To deliver an effective, ethical and safe advocacy service to qualifying patients, IMHAs will need to recognise, value and manage diversity.

Embedding diversity and equality in IMHA practice

Effective IMHA practice requires an understanding of the diverse needs of qualifying patients. To do this IMHAs will need to recognise, value and manage individual differences. They should also recognise and value diversity among immediate colleagues and people working in other organisations.

Effective practice also requires an understanding of marginalisation, isolation and exclusion. This includes understanding the significance of stigma, labelling and unequal chances that people may experience through negative stereotyping of known or perceived differences.

Understanding diversity and equality can require IMHAs to examine their personal and professional assumptions about values and principles. They will also need to recognise, manage and solve practice dilemmas about diversity and equality as they arise.

Definition of stereotyping

A fixed, simplified, usually negative view of how a certain group or category of people live and behave.

Diversity

Diversity focuses on maximising the potential of all patients, professionals and staff by valuing the different ethnic, religious and social backgrounds, genders, sexual orientations, ages, skills, and experiences of individuals. It recognises that 'one size does not always fit all' in terms of patient needs and interests.

There are different definitions of diversity and it can take many forms. In the context of an IMHA's work, it is likely to concern variety and differences in terms of a person's age, religion or physical ability, race and sexual orientation. It might also be about differences in terms of their background experiences, skills and professional specialisation; values, culture and class.

In practice, diversity is about more than just being aware of differences; it is about valuing the wide variety of individuals among qualifying patients and actively engaging with their experience of discrimination and inequality. It also values the diversity of immediate colleagues, staff and professionals in different settings.

One of the key ways an IMHA can promote and support diversity is by promoting the use of language that is appropriate inclusive, and is not offensive.

The Code of Practice tells mental health professionals that:

- everything possible should be done to overcome barriers to effective communication, which may be caused by any of a number of reasons – for example, if the patient's first language is not English. Patients may have difficulty in understanding technical terms and jargon or in maintaining attention for extended periods. They may have a hearing or visual impairment or have difficulty in reading or writing. A patient's cultural background may also be very different from that of the person speaking to them.
- those with responsibility for the care of patients need to identify how communication difficulties affect each patient individually, so that they can assess the needs of each patient and address them in the most appropriate way. Hospitals and other organisations should make people with specialist expertise (e.g. in sign language or Makaton) available as required.

Equality

Equality is the prevention, elimination or regulation of discrimination between people on grounds such as sex, transgender, marital status race, nationality, disability, age, sexual orientation, language or social origin, or of other personal attributes including beliefs or opinions such as religious belief or political opinions.

It is most commonly used to ensure that disadvantaged groups have access to opportunities and positive outcomes available to others with the same needs. It is not about treating everyone identically, but recognising that their needs may be the same or different and may need to be met in different ways. It is supported through legislation and policy but it is everyone's responsibility and right. This includes challenging inequality, disadvantage and systematic unfair discrimination.

Diversity should not be used interchangeably with equality as they both have distinct meanings. Diversity is a much wider concept and may be used to demonstrate the limitations of a 'one size fits all' approach to equality issues. Where one is the primary focus at a particular time, however, the other may be one desired outcomes.

The legal framework for equality

Discrimination

In general terms, discrimination is recognised in four ways under law:

- **Direct discrimination** is less favourable treatment on the grounds of membership of a particular equality group in circumstances which are the same or not materially different, e.g. refusing to offer a woman a job because she is pregnant;
- **Indirect discrimination** is when an apparently neutral requirement or condition impacts adversely or has a disproportionate effect on a particular equality group, e.g. a company which has a strict dress requirement could be indirectly discriminating against people from particular religious groups;
- **Victimisation** is where a person receives less favourable treatment because he or she has complained about discrimination or supported someone who has;
- **Harassment** is conduct which is unreasonable, unwelcome and offensive, and which creates an intimidating, hostile or humiliating environment.

Institutional racism is defined by the McPherson report on the inquiry into the death of Stephen Lawrence as “the collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviours which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people”.

Under the Sex Discrimination and Race Relations Acts positive discrimination is not legal. In certain specified cases, however, positive action may be taken legally.

Positive action through training and encouragement for under-represented groups can be lawful. For example, if over the previous twelve months no women, or people from a particular racial group, have been doing a certain type of work then it is lawful to offer training only for women or the racial group. Another example of positive action is advertising to encourage candidates from a particular group to compete for jobs.

Positive discrimination, or affirmative action, is not lawful in the UK. It occurs if a person is given additional assistance or favourable treatment, or given a job specifically because of certain attributes, e.g., ethnic status, gender, age or connections regardless of whether they have needs or relevant skills and qualifications.

Mainstreaming equality and diversity in an IMHA's practice

Equality and diversity should be central to the work of an IMHA, rather than being seen as an optional 'added extra'.

Promoting diversity and challenging inequality in practice

Recognising, valuing and responding to the diverse needs of qualifying patients and the inequalities in service provision can be complex. To fully embrace diversity and equality in practice, an IMHA needs to:

- be confident that they understand diversity and have the relevant knowledge about the sources of prejudice and stereotyping and the impact on qualifying patients;
- have the skills to tackle difficult situations as they arise;
- understand the IMHA's role in promoting diversity and challenging inequality;
- be open to reflecting on their own attitudes, behaviours and beliefs and where necessary address these prejudices and change their behaviour.

Issues of equality and difference

The following brief summaries focus on differences of age, disability, gender, sexual orientation, race and ethnicity, religion or spiritual belief. IMHAs should be aware of the various forms of inequality and discrimination that may arise from them separately or together.

Women and gender sensitive practice

Rates of mental health issues do not vary significantly between men and women.

However, there are clear variations in the rates of specific conditions and possible reasons for these differences cover a spectrum of social, economic, physiological and emotional factors.

There are differences in the family and social context of women's and men's lives. Differences include the experience and impact of life events, the character of their mental ill health and therefore their mental health care and treatment needs. The link between women's mental ill health and the impact of childhood sexual abuse and domestic violence, for example, is widely documented.

Gender - implications for effective IMHA practice

IMHAs supporting female qualifying patients should:

- recognise that women with mental health problems who have been physically or sexually abused in childhood or as adults, have particular needs for care, treatment and support;
- support women to gain protection from any form of harassment or abuse, whether physical, sexual or psychological. (This is often a high priority for women who are inpatients on mental health hospital wards);
- facilitate access to a female IMHA if asked or obviously appropriate. Understand the implications of this not being a possibility;
- be aware of the reports by women of an over-emphasis on biological causes of mental disorder, rather than social and personal factors such as poverty, social exclusion and experiences of physical and sexual abuse.

Sexual orientation

There are many myths and misconceptions about people's sexual orientation and its link to mental health. Also people who are lesbian, gay, bisexual and transgender (LGBT) are still vulnerable to attempts to pathologise their lives, behaviour and experiences. Many find, for example, that they and their relationships are often also defined solely in terms of their sexual orientation rather than love, friendship, work and interests.

LGBT qualifying patients may have endured stigma and discrimination, which may have contributed to the problems which brought them into contact with the mental health system. Moreover, where they fear stigma and discrimination within the service, they may keep silent about their sexual orientation even though it could be detrimental to their recovery.

Sexual orientation - implications for effective IMHA practice

IMHAs supporting LGBT qualifying patients should:

- ask questions in such a way that heterosexuality is not assumed e.g. that they have any opposite sex partner;
- be clear on qualifying patient's view on disclosure of their sexual orientation to staff and other professionals;
- recognise that, while the terms lesbian, gay or bisexual are now in general use within services, a qualifying patient may not use these terms to define themselves or be comfortable with them.

Addressing diversity and equality on grounds of race and ethnicity

Inequalities between people from different ethnic groups in the mental health system are widely recognised, though the reasons for them are not fully understood. The issues facing people from black and minority ethnic (BME) communities, according to the Report, 'Inside Outside', are so profound and widespread that:

"There does not appear to be a single area of mental health care in this country in which black and minority ethnic groups fare as well as, or better than the majority white community. Both in terms of service experience and outcome of service intervention, they fare much worse than people from the ethnic majority do." (Sashidharan, (2003). Inside Outside: Improving mental health services for black and minority ethnic communities in England, London, Department of Health)

Specific issues facing people from BME communities can include:

- facing a negative relationship with mental health services, resulting in a lack of inclination to seek help or comply with treatment;
- being confronted regularly by a lack of understanding of cultural norms and beliefs, and a denial or ignorance of the racism and exclusion they face;
- being stereotyped, and as a result mistrusting mental health services.

Evidence also suggests that people who are black and who have mental health problems face further discrimination. For example, there have been studies in which they have been shown to be less likely than white people to receive psychotherapy, psychological treatments, counselling or other alternative treatments.

Delivering Race Equality in Mental Health Services

The Delivering Race Equality in Mental Health programme (DRE) is a five-year action plan, set up in 2005 by the Department of Health. It is designed to reduce inequalities in how people from black and minority ethnic communities access, experience and achieve outcomes from mental health services in England.

The DRE action plan is based on three building blocks:

- more appropriate and responsive services - achieved through action to improve mental health care for BME patients, developing a more culturally capable workforce, and finding new pathways to care and recovery;

- community engagement - achieved by engaging communities in planning services, and supported by 500 new community development workers and the expertise of independent sector BME service providers;
- better information - from improved monitoring of ethnicity, better dissemination of information and good practice, and by improving knowledge about effective services. This includes the new regular census of mental health patients covering their ethnicity, faith, legal status and more.

Race & Ethnicity - implications for effective IMHA practice

IMHAs supporting qualifying patients from BME communities or groups should:

- provide a safe and secure relationship within which the feelings of isolation and consequences of stigma associated with mental disorder and racism can be addressed;
- respond appropriately to the language and cultural needs of the patient;
- visibly demonstrate they are free from prejudice and stereotypes;
- provide advocacy built on an understanding of cultural values and beliefs;
- actively promote practice that is socially inclusive;
- encourage BME mental health patients to define their own identity and needs;
- read, use and contribute to policies in place for diversity, equality and anti-discriminatory practice.

Asylum seekers and refugees

Research into the mental health needs of asylum seekers and refugees suggests an increased likelihood of experiencing poorer mental health as well as higher levels of exclusion and vulnerability than native populations. Pre-migratory, migratory and post-migratory experiences and difficulties all contribute to a high level of mental health need.

Refugee communities are diverse and each group has its own language, history, cultural norms and religious beliefs, as well as perception of health and illness. Where this is not recognised misdiagnosis may occur, and mental distress arising from ordinary problems of living may be mistaken for mental pathology – or vice versa.

IMHAs supporting qualifying patients who are (or have been) asylum seekers or refugees should:

- understand that refugees and asylum seekers may have experienced war, persecution or inter-communal conflict, as well as multiple losses including family, friends, home, status and income;
- be informed of particular issues facing asylum seekers and refugees.

Age

While the importance of age-appropriate mental health services is widely recognised, age discrimination in mental health services is an issue that affects all age groups but particularly children, young people and older people. It occurs when age is used to define a person. It is particularly significant when assumptions about a person's performance, potential and concerns are made on (positive and negative) stereotypes of a particular age rather than the competence of the individual or the reality of their life at the time.

An IMHA supporting qualifying patients who are older should:

- be respectful: e.g. check how they wish to be addressed;
- be clear in giving information and be prepared to repeat it;
- actively listen and check the patient's view of their capabilities;

- be prepared to use non instructed advocacy and instructed advocacy interchangeably;
- avoid ageism in their interpersonal relationship with the patient;
- be open to the concerns of carers, relatives, and professionals while keeping in mind that their perspective or plan may not be the same as that of the patient.

People with learning disabilities

The definition of mental disorder in the MHA 1983 includes learning disability, even though learning disability is quite different from, say, mental illness. But in practice people are rarely detained, or made subject to other forms of compulsion under the Act, just because of their learning disability.

Indeed, the Act cannot be used to detain someone in hospital for medical treatment (rather than assessment) or make them subject to guardianship solely on the basis of a learning disability, unless that learning disability is associated with abnormally aggressive or seriously irresponsible conduct on the part of the person concerned.

But it is important to remember that people who have a learning disability may also experience mental ill health.

The Code advises professionals working under the Act with people with learning disabilities to bear in mind the following general points:

- people with learning disabilities may use non-verbal communication rather than spoken language. This nonverbal communication may include behaviour, gestures, posture and body language, ways of moving, signing, noises and pointing. It is important to recognise people's communication in all its forms and to avoid assuming that people's behaviour is a symptom of their mental disorder, when it may be an attempt to communicate feelings or physical pain or discomfort;
- people with learning disabilities may find new environments, such as a medical setting, frightening. All "reasonable adjustments" (as required by the Disability Discrimination Act 1995) need to be made to adapt and respond to each individual's needs. This may mean offering a quiet space, for example, or having one link person assigned who speaks with the person;
- the most appropriate method of communication for each person with learning disabilities should be identified as soon as possible, and the help of a speech and language therapist should be sought wherever appropriate. It is helpful to identify a specific person who will undertake this task;
- some people with learning disabilities may prefer to have written material in simple language with images or symbols to assist, and this could be reinforced orally, through personal contact or other means. It can be helpful to repeat information and leave a record of the information that has been passed on, so that the person can consult it and ask others to clarify anything that is difficult to understand;
- it is important to set aside sufficient time for preparation of suitable information and for preparation before meetings. Meetings should be held in an environment that is not intimidating, in order to allow the patient every chance to understand the information given.
- People with learning disabilities may also encounter problems in:
 - understanding what is being explained to them and communicating their views (in situations that increase their levels of anxiety they may find it even more difficult to understand what is said to them); and

- in being understood, particularly where lack of spoken language makes it hard for them to provide explanations of pain or other symptoms that might aid diagnosis of physical or mental illness. (COP, 34.13)

People with sensory or physical impairment

According to a recent report of people's experiences by the Rowntree Foundation (Morris, J. One Town for My body, Another for My Mind: Services for people with physical impairments and mental health support needs, 2004 www.jrf.org.uk), many said they found difficulty accessing mental health services because of their physical impairments.

They characterised in-patient experiences by inaccessible physical environments and a lack of assistance for even simple things. There was also a reported lack of understanding of the assistance that people needed, and staff were often too busy to provide it.

Medication required for a physical condition was said to be commonly withdrawn on admission to a psychiatric ward and was not always available when needed. This caused considerable distress, particularly when the medication was required for the control of pain. People also had difficulty using physical disability services because of inadequate recognition of their mental health needs and negative attitudes amongst staff towards mental health issues.

An Example: Deaf people and Mental Health services

It has been estimated that around 40% of people who are deaf and hard of hearing in the UK will experience a mental health problem at some point in their lives. (Executive briefing mental health services for deaf and hard of hearing people - SIGN and the Mental Health Foundation).

In England, however, only three specialist NHS units are available for deaf people with mental health support needs. This can lead to patients remaining in hospital for up to four times longer than a hearing person. Because of their longer stay, patients may become institutionalised and find it difficult to return to independent lives.

An IMHA supporting a qualifying patient with learning disabilities should:

- have the skills to communicate creatively and flexibly in ways that patients understand;
- recognise that people with a learning disability may have been victims of abuse or violence;
- be aware that challenging behaviour is normally the product of individual and environmental factors interacting together.

Communication is essential to understanding and treating mental health problems and deaf and hard of hearing people need specialised support. However, because there are only a limited number of specialist units patients can often be placed in mainstream NHS services, which these services don't always meet the communication needs of deaf and hard of hearing people.

The Code of Practice recognises the specific problems of deaf people who are being assessed and suggest special arrangements be made to ensure that they are not discriminated against on grounds of deafness. (COP, 4.106-110). A key concern is to prevent a deaf person being wrongly assessed as having a learning disability or another mental disorder.

Sensory Impairments - implications for an IMHA's practice

An IMHA supporting a qualifying patient with sensory or physical impairments should:

- acquire the knowledge and skills for working with patients for whom this is the case;
- undertake deaf awareness training (where available), including basic training in issues relating to mental health and sensory or physical impairments;
- be prepared to link to other people with specific knowledge and skills;
- avoid reliance on unqualified interpreters or professionals with limited communication skills for a particular purpose;
- avoid reliance on family members in place of a professional interpreter;
- have awareness of how mental health problems present in pre-lingually deaf people;
- take account of cross-cultural misunderstandings that may arise because of a patient's limiting situation.

Cultural sensitivity and respecting different religions and faiths

The cultural contexts in which people live influence the way they define and experience mental health and mental disorder. Cultural factors can influence whether people seek care for their symptoms, what kinds of care they seek, and where they seek care including primary care providers, mental health providers, traditional healers or family members.

There are many approaches to and definitions of culture. Within different cultures, religions and faiths encompass a wide range of spiritual beliefs, traditions and customs. It is important not to generalise about the culture or religious beliefs and practices of any one person from short definitions or statements: e.g. a one- word classification of ethnicity or religion given on an official form.

‘Spiritual beliefs’: is often used as an umbrella term covering all faiths and religions and its use makes no assumptions about personal convictions.

‘Religion’: is used in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community.

Being culturally aware requires having an understanding and sensitivity towards ethnic, religious and cultural groups other than our own. This can involve:

- developing cross-cultural knowledge;
- learning about different religions and faiths;
- avoiding value judgments;
- avoiding stereotyping religions, faiths and cultures.

A lack of cultural sensitivity to people who have mental health problems and their particular religion and faith is acknowledged as one of the key problems for mental health services embedding diversity and equality in their policies and practices.

5.6 Signpost a range of specialist support services that a qualifying patient may wish to access

5.7 Evaluate how the personal and cultural identity of an IMHA can impact on the advocacy relationship

No resource is provided for these assessment criteria

Outcome 6: Work Safely

6.1 Identify situations that present risks

6.2 Respond to risk

Assessment and management of risk

An awareness of risk assessment and management are part of working with 'qualifying patients' in mental health settings.

It is important to note that most qualifying patients IMHAs will visit will not pose any risk to them or anyone else.

But IMHAs need to be aware of circumstances in which there may be a risk to their safety.

IMHA will need to be aware of potential risks in different settings. In addition to the protocols of the IMHA service for which they works, they will need to be aware of any relevant policies operating in the settings they are visiting.

Safe working

IMHAs need to be aware of the times they should safeguard themselves in advocacy situations that can be risky.

IMHAs need to be aware of potential risks and hazards in their work and assess their severity and likelihood before and during any involvement with a patient. If a risk is present, the IMHA must take steps to minimise the potential impact of the risk; this can be done with the use of risk assessment tools. Qualifying patients can feel stigmatised if they are labelled as a risk.

IMHAs should, therefore, take care to ensure a proportionate response is made to the presence of risk. This will include:

- the extent and nature of the risk;
- the factors which contribute to the risk;
- the causes of the risk;
- the changes necessary to eliminate or control the risk.

Factors to consider when making a risk assessment

In order to provide an independent and confidential service, IMHAs will be required to meet patients on their own. IMHA service providers must therefore have protocols that an IMHA follows to ensure their personal safety: e.g., notice of whereabouts, opportunities to debrief and reflect on issues faced in particular situations

Inpatient and residential setting

IMHAs need to have an awareness of environmental factors which might exacerbate situations. For example patients who are detained on a ward and are not able to leave may find the ward environment stressful.

If the IMHA is concerned about their safety they should explore alternative meeting spaces – such as having the meeting in a room with clear windows so that they can be observed whilst maintaining a confidential environment. They could ask another advocate or manager to be present in the room instead of a member of the clinical team. In all these circumstances the

IMHA need to be clear with the patient why they are meeting with them under such circumstances.

Sometime the IMHA may be asked to support patients in hospital who have been restrained or are secluded. In such circumstances, the IMHA must follow any policies and procedures of the IMHA service employing them and the protocols of the mental health service provider. Even with structures in place, the referral may pose a dilemma for the IMHA, as the patient may have been placed in seclusion because their behaviour has become violent or aggressive. For this reason, the IMHA may not be able to visit the patient alone nor hold a confidential meeting. This will need to be explained to the patient unless alternative arrangements may be made e.g. the IMHA is accompanied by a colleague.

Community settings

IMHAs should arrange the visit somewhere mutually acceptable and preferably where other people are available (for example: community centre, café, day centre, etc.).

However, if it is considered that it is appropriate for a home visit to take place, due consideration should be given to the health and safety of both the patient and the IMHA.

Working in the community may present different risks for the IMHAs from those they may encounter in inpatient or residential settings. The IMHA service's risk assessment protocol should include agreed arrangements for visiting qualifying patients in the community. It is the responsibility of the IMHA and the service for which they are working to ensure that any particular factors in making visits in the community are addressed.

This might include:

- undertaking a risk assessment prior to making any planned community visit;
- consulting and discussing concerns with colleagues;
- when visiting a person for the first time, or when an IMHA feels there may be a risk, they should make sure that another person knows where they are;
- there should be an agreed return time and if the IMHA has not made contact by the agreed time, there should be a previously arranged process to raise the alarm to check a person's safety;
- if an IMHA has any concerns about meeting a person, or someone they may be associated with, they should make sure the meeting does not take place in an isolated area and that there are others around should they be needed;
- IMHAs must not agree to meet people in areas or venues that are considered to be dangerous or risky;
- IMHAs should remove themselves from any situation as soon as they feel it is becoming uncomfortable or threatening, particularly if their presence is making a situation worse. Remember that an advocate is client led – if the person doesn't want the IMHA there, then leave;
- it is good practice for an IMHA to ensure that they are able to leave the scene of a meeting quickly, for example sit close to a door where no one can restrict the exit;
- it is important not to panic in situations and to keep a calm exterior. IMHAs should avoid raising their voice and remain calm, polite and objective. Facial expression and body language is important so they should try to establish eye contact without staring;
- avoid being confrontational, sit if possible and remain seated. Do not become involved in an argument and withdraw if the situation is becoming tense.

6.3 Summarise adult or child protection procedures

No resource is provided for this assessment criteria

6.4 Commit to using supervision

Reflecting and learning as a development activity

When an IMHA faces a difficult question, or dilemma they have to be able to transfer knowledge, general principles or practice and skills used in similar situations. IMHAs may have to judge what has to be done at the time or reflect on the judgments they made later. Reflective practice means taking time to think about the way the IMHA has completed a project that was successful and what they might have done differently. It offers a useful way for the IMHA to build their understanding; to inform their practice, to detect and correct errors and look for other more effective strategies.

Part of the skill of reflecting on practice is the ability to discern the appropriate core knowledge, principles and values that are appropriate in the light of experience. It also involves deciding on which should be given priority and the extent to which a balance can be struck between contradictory or conflicting claims of the IMHA role whilst maintaining safe and effective practice.

IMHAs may reflect on their practice immediately and alone, or may wait until sometime has elapsed and they are in a different room or building and then reflect. They may also reflect by relating the events to a colleague back at the office or by writing a report that can be used for monitoring and evaluation purposes in supervision and for auditing the quality of the service provided.

The IMHA service employing the IMHA will have a number of policies and procedures to guide them in the accountability in the IMHA's practice and the IMHA should have a good working knowledge of these. At the same time the IMHA is expected to have the skills to monitor and evaluate their practice for quality assurance purposes. A useful short checklist for this is to answer:

- What outcome(s) in this case demonstrates the IMHA's intervention was **effective and efficient within an appropriate time frame**?
- What indicator(s) are there to show that the advocacy was **responsive, safe** and the outcome of the intervention **sustainable**?

Personal and professional development as an IMHA

An IMHA's continuing professional development is a shared responsibility between them and their employer. This reflects the IMHA's commitment to keep up with new developments in mental health advocacy, including research to provide the best level of advocacy possible for qualifying patients.

Supervision

Regular supervision is an expectation of many professions. It is likely that the IMHA organisation employing the IMHA will have a supervision policy and it will be important for the

IMHA to be familiar with the policy and adhere to its requirements. Regular supervision enables a discussion of case management issues and for the IMHA to seek appropriate support with individual cases, it also provides an opportunity to consider their own personal development needs and how these may be addressed.

Some of the potential benefits of good supervision for IMHAs are listed below.

- It promotes high quality work;
- It increases accountability;
- It recognise the emotional impact of the work and offer support;
- It monitor the IMHA's case loads;
- It ensure the IMHA adheres to the statutory requirements of the role;
- It ensure work is appropriately recorded;
- It identify training and development needs;
- that the organisation employing the IMHA ensures that they meets an acceptable standard of professional practice.

Principles of practice underpinning these competences

There are a range of principles that IMHAs can use to guide their practice. These can be found on a range of sites focusing on particular models of advocacy and it is important that IMHAs get into the habit of searching these sites and using them appropriately.

The following list of principles of advocacy practice, drawn up in the Advocacy Charter developed by Action for Advocacy (2002), have been widely adopted by advocacy services and are applicable to IMHA services. A Code of Practice for Advocates, linked to the Charter, offers a set of guidelines aimed at providing clarity, support and boundaries of an advocate's practice. It also describes what is and what is not expected of an advocate in their day to day work with service users.

- **Clarity of purpose:** The advocacy scheme will have clearly stated aims and objectives and be able to demonstrate how it meets the principles contained in this Charter. Advocacy schemes will ensure that people they advocate for, service providers and funding agencies have information on the scope and limitations of the schemes' role.
- **Putting people first:** The advocacy scheme will ensure that the wishes and interests of the people they advocate for direct advocates' work. Advocates should be non-judgmental and respectful of people's needs, views and experiences. Advocates will ensure that information concerning the people they advocate for is shared with these individuals.
- **Empowerment:** The advocacy scheme will support self-advocacy and empowerment through its work. People who use the scheme should have a say in the level of involvement and style of advocacy support they want. Schemes will ensure that people, who want to, can influence and be involved in the running and management of the scheme.
- **Equal opportunity:** The advocacy scheme will have a written equal opportunities policy that recognises the need to be proactive in tackling all forms of inequality, discrimination and social exclusion. The scheme will have in place systems for the fair and equitable allocation of advocates' time.

- **Accountability:** The advocacy scheme will have in place systems for the effective monitoring and evaluation of its work. All those who use the scheme will have a named advocate and a means of contacting them.
- **Accessibility:** Advocacy will be provided free of charge to eligible people. The advocacy scheme will aim to ensure that its premises, policies, procedures and publicity materials promote access for the whole community.
- **Confidentiality:** The advocacy scheme will have a written policy on confidentiality, stating that information known about a person using the scheme is confidential to the scheme and any circumstances under which confidentiality might be breached.
- **Independence:** The advocacy scheme will be structurally independent from statutory organisations and preferably from all service provider agencies. The advocacy scheme will be as free from conflict of interest as possible both in design and operation, and actively seek to reduce conflicting interests.
- **Supporting advocates:** The advocacy scheme will ensure advocates are prepared, trained and supported in their role and provided with opportunities to develop their skills and experience.
- **Complaints:** The advocacy scheme will have a written policy describing how to make complaints or give feedback about the scheme or about individual advocates. Where necessary, the scheme will enable people who use its services to access external independent support to make or pursue a complaint.

Guiding Principles set out in the Advocacy Charter

In addition, the IMHA service may specify a range of values that should underpin the IMHA's practice. These will generally include:

- A commitment to social justice and inclusion for qualifying patients;
- A qualifying patient's right to self-determination when expressing their views and participating in decision making;
- A non-judgmental relationship between an IMHA and the qualifying patient;
- Empathy; understanding and acceptance of the patient's view as they express it.

Practical skills informed by these principles and values

An IMHA needs to be able to:

- listen to the problem presented by a qualifying patient;
- identify the issues and what is to be changed;
- clarify, negotiate and set objectives with qualifying patients;
- choose advocacy approaches, tasks and activities;
- understand the context and identifying key stakeholders and actors;
- understand the time frame available;
- identify the targets to meet a qualifying patient's objectives;
- identify allies who will work with the IMHA and the qualifying patient;
- assess what resources are needed;
- draw up an action plan.

Information for patients about the Act and their rights

Section 132 of the Act places a duty on the hospital managers to take steps to ensure that detained patients understand certain information about the section under which they are detained, the effects of being detained and about their rights including their rights to apply to the Tribunal.

This must be done as soon as practicable after the patient is detained in the hospital. Information must be given both orally and in writing, but it is not enough for the managers just to provide information. The Act says that the managers must take such steps as are practicable to ensure that the patient understands what they are being told.

These responsibilities are invariably delegated to the ward and other staff, who are expected to use all possible means to ensure that the patient has both been provided with the relevant information and that they have understood it.

Hospitals and their staff have a responsibility to ensure that patients continue to understand the information given to them about their rights. Mental health providers will often have policies, procedures and processes on recording how and when patients are provided with information about their rights.

There is a similar duty in section 132A for the managers of the responsible hospital to provide information and take steps to ensure that SCT patients understand the effect of being on SCT and their rights to apply to the Tribunal.

Local social services authorities have a duty to provide information to guardianship patients about the Tribunal. (That duty is in regulations made under the Act, rather than in the Act itself).

Unless the patient requests otherwise, the hospital managers or local social services authority (as the case may be) must, if practicable, also give a copy of the written information to the patient's nearest relative (if they have one).

This is all in addition to the duties that hospital managers and other people have to inform patients (and their nearest relatives) about their right to help from an IMHA.

Section 117 after-care

Section 117 of the Act puts a duty on primary care trusts and local social services authorities to provide after-care for patients who have been detained under sections 3, 37, 45A, 47 or 48. (It does not apply to people who have only been detained for assessment under section 2.)

After-care services must be provided until the bodies responsible are satisfied that the patient no longer needs them. They must always be provided for SCT patients as long as they remain on SCT (and may still be required after they have been discharged from SCT).

So, by definition, all SCT patients will be receiving some kind of section 117 after-care. In practice, conditionally discharged patients are also likely to be receiving some kind of section 117 after-care as long as they remain conditionally discharged. Guardianship patients will only qualify if they have previously been detained under one of the relevant sections.

The courts have said that the duty to provide after-care services also applies to people who are on leave of absence from detention under one of the relevant sections.

The Act does not define after-care, but in practice it can include a wide range of health and social services, including medical treatment, residential accommodation and day and domiciliary services.

While section 117 after-care must be provided free of charge, even if local social services authorities would normally charge for equivalent services.

Section 117 places a duty on the NHS and social services to provide after-care services; it does not place any obligation on patients to accept the services. (Although accepting some or all of the after-care services on offer could be a condition of SCT or conditional discharge.)

Organisation of IMHA service

Engagement Protocol

IMHA services are likely to have an engagement protocol. This is a document drawn up by the IMHA service in partnership with the mental health provider whose patients they support and the commissioner of the IMHA service to confirm the three-way relationship between them. IMHAs should be familiar with their local engagement protocols, where these exist.

Information which an engagement protocol might include:

- Service delivery and practice requirements for the provision of the IMHA service in particular settings;
- The working relationship between the service and the mental health provider;
- What the IMHA service will provide;
- How these services will be provided and monitored, what boundaries the IMHAs will work within;
- How IMHAs will relate to mental health staff and professionals;
- What an IMHA service and its qualifying patients can expect from mental health providers and commissioners;
- The impact of particular security arrangements on the day to day working of the IMHA service.

The commissioning guidance recommends that once agreed, the protocol should be openly available so that mental health staff and IMHAs can refer to it when they wish to check agreed arrangements, rights and responsibilities.

Policies and procedures of the IMHA Service

An IMHA's practice will need to reflect the policies and protocols required where they work. Accordingly, they should ensure that they are familiar with and adhere to all relevant policies required by the IMHA service.

The policies and protocols that IMHA services develop for advocacy service should be informed by nationally recognised quality standards for advocacy schemes, professional codes of practice. In addition the commissioning guidance recommends that services should consider reflecting the guiding principles set out in the Code of Practice to the MHA 1983 when establishing their service.

To implement a framework for delivering services, it is good practice for an IMHA service to have operational policies that are available at all times to staff, qualifying patients and carers for inspection. These operation policies should reflect:

- A duty of care for the safety of IMHAs and qualifying patients;

- Accountability for operations and performance of the service;
- Commitment to equality and diversity in meeting the needs of qualifying patients;
- Processes and procedures with respect to:
 - health and safety;
 - data protection;
 - child safeguarding procedures;
 - adult safeguarding procedures; and
 - complaints.

IMHAs should ensure that they are familiar with and adhere to the requirements of all relevant policies required by their employing organisation.

The Commissioners Guide recommends that the policies IMHA services develop should include:

- Confidentiality Policy;
- Complaints Policy;
- Whistle Blowing Policy;
- Health & Safety Policy;
- Quality Assurance Policy;
- Equal Opportunities Policy.

Principles of the IMHA service

The IMHA service employing an IMHA is delivering a statutory service required by legislation and informed by wider advocacy principles of practice. This requires an IMHA to:

- Help qualifying patients understand their legal rights, in accordance with the IMHAs statutory role;
- Understand and be able to apply the principle of independence;
- Use advocacy principles to deliver both instructed and non-instructed advocacy;
- Work with people and agencies involved in the treatment and care of qualifying patients.

Minimum requirements for effective practice

The IMHA's statutory role is set out in the MHA 1983 and IMHA regulations. The legislation establishes the legal basis for the IMHA's tasks and responsibilities, and places boundaries around their interactions with qualifying patients, their nearest relatives, staff and mental health professionals. While an IMHA's practice must comply with the legal framework, their everyday activities will also be impacted on by the requirements of the IMHA service that employs them, hospital rules and their own personal values and experiences.

At times, an IMHA is likely to face complex and perplexing ethical issues and dilemmas in which their choice of alternative actions might result in unwanted or adverse outcomes. The IMHA cannot resolve all of these issues but they need to recognise and address them.

The 'voice' of the qualifying patient is always primary and the IMHA is expected to be able to demonstrate an understanding of the patient's personal knowledge and particular values. It is only by learning what a patient values, and knowing what clashes of values exist around them that the IMHA will be able to advocate for them effectively.

The IMHA needs to be able to make judgments about issues arising in every day practice. The judgments they will have to make will be at different levels of complexity depending on the issue presented by a qualifying patient. The need to make judgments is particularly significant when working with qualifying patients whom for whatever reason do not have the capacity to instruct.

The Principle of independence in an IMHA's practice

In accordance with the MHA 1983 and the IMHA regulations, the role and practice of an IMHA is underpinned by the principle of independence. This recognises that:

- the ability of an IMHA to demonstrate their independence from people involved in the patient's medical treatment may increase the confidence of a qualifying patient and the likelihood that they will ask for the IMHA's help;
- an important part of an IMHA's role is creating ways of working which enhance a qualifying patient's independence and gives them the best chance of taking control of their own lives and as far as it is possible.

Independence:

- Enables an IMHA to be free to support and represent the views of patients without any conflicts of interest or threat to the independence of their working practices;
- Assists an IMHA to support a qualifying patient in whatever decision or action they decide to take. This does not preclude the advocate helping a patient understand his or her rights and the choices of action available but the decision must be the patient's own;
- Supports an IMHA to gather information and have access to advice and support independent of the people and services providing care or treatment for the qualifying patient.

IMHA practice

Presentation of the issues, setting objectives and agreeing action

For a variety of reasons, a qualifying patient may not be able to present their issues clearly and in order and may find it hard to work in partnership with the IMHA. It is therefore important that IMHAs formulate questions in a way that the qualifying patient can understand in order to have the best chance of eliciting the key information.

To do this effectively the IMHA needs to recognise any environmental or social factors which shape the way the patient prioritises or presents their problems. They should consider whether the patient could benefit from a specialist advocate or interpreter to help make their wishes known.

A trusting relationship with the qualifying patient with whom the IMHA is working is essential to successful advocacy. Trust takes time to grow and once it is lost is hard to regain. The IMHA's role is task orientated and time limited and this may be a constraint on getting to know the patient over a long time to build trust and confidence in the relationship.

Accepting the limits of the role, trust requires that the IMHA treats what the patient says in a serious and respectful manner, and is completely honest about the support the IMHA is able to give and then deliver what has been agreed.

Where a qualifying patient, for whatever reason, finds it difficult to or does not have the ability to convey their wishes and feelings (e.g. as a result of a disability, a reluctance to trust because of previous experiences, or their age), it is important for the IMHA to explore other ways of eliciting their wishes. This might include the use of assisted technology, interpretation, art or play.

Obtaining consent to act for a qualifying patient

The commissioning guidance included a model service specification which recommended that as good practice local arrangements should ensure that:

- A consent form should be completed which sets out specifically what the patient authorises the advocate to do on their behalf, and is signed by the patient;
- A copy of this consent form can then shown to any third party the advocate contacts when carrying out the patient's wishes;
- If, for reason other than lack of capacity, it is not possible to obtain a patient's written authority the advocate should ensure that a written record is kept that the signature was requested and refused, and the reason for the refusal.

Information gathering, reviewing and applying the evidence

Once the advocacy objectives are clear, the IMHA may need to consult several types of information resources. They may need to seek background information because the issues raised by the qualifying patient are outside their expertise. These resources are usually available in text books, journals or on the internet.

At other times, the IMHA may need to consult a specialist resource (e.g., a lawyer specialising in mental health). The conclusions from this research still needs to be checked and evaluated for appropriateness with the qualifying patient and their view of the problem(s) they are raising.

Evaluations

Some of the problems presented to an IMHA by a qualifying patient will be very complex and The IMHA will need to be able to evaluate different levels of complexity and risk. An inadequate evaluation may result in poor response to the needs, views and wishes of the patient.

Where an evaluation is inadequate it may also lead to unsafe working and could jeopardise current and future collaboration with a nearest relative, carer or staff, mental health professionals, or other health and social care agencies.

Meetings

At times, it will be necessary for the IMHA to attend formal meetings either with a qualifying patient or at their request to represent their views, wishes or concerns. The IMHA's role will vary depending on the level of formality of the meeting, its status and purpose. For example the IMHA's role may be to:

- promote **self-advocacy** in which The IMHA's role in the meeting is to support qualifying patients to communicate their views, wishes and complaints directly to staff and professionals even where they are unable to speak for themselves;
- undertake **Representational Advocacy** in which the IMHA's role is to represent the patient's wishes, views and rights. When using representational advocacy, the advocate

speaks on the patient's behalf, using their words where possible, so that the patient's voice is heard as they would wish it to be heard. Any decision will be the patient's own and the representational advocacy stops as soon as the meeting ends.

Representational advocacy can be used in a number of settings, ranging from one-to-one support in the presentation of a specific problem of ordinary living through to professional support in formal settings where a qualifying patient may be expected to submit evidence to support their viewpoint.

Closing a case

An IMHA should follow local policies and procedures when closing a case. It is not always easy to close a case and it is important that the IMHA is clear in explaining their reasons for doing so to the patient in a way that they can understand. Closing a case can be personally stressful and the IMHA should make use of any support offered by your employing organisation.

The reason for closing the case should be recorded in individual records and address the following:

- have the advocacy objectives been met?
- have the identified outcomes been achieved?
- if not what were the reasons and were all reasonable attempts made?
- is there anything else an advocate can do?
- has the client decided they no longer want an advocate, if so record reason?
- was the client satisfied with the work of the advocate?
- were other interested stakeholders satisfied with the advocate?
- is there anything to be learned from the case?

Practice Example

Ending an advocacy partnership can be tricky. Sometimes the ending is very clear cut and an individual will ask you to support them on a particular issue, you do it and the advocacy is over. Sometimes I agree to do follow-up work once a person is discharged from hospital to the community. I said to Meg to contact me if she needed further advocacy support - she said she would - then didn't. I ask myself does that mean everything is ok? Is she struggling - if she is should I contact her? Then there is Abigail - she was discharged from hospital and I know she is really ok. She keeps contacting the project for information and I keep providing her with contacts - how long should this go on for? The ending isn't always satisfactory - then I use supervision to get clarity or just for reassurance that I am not missing anything.

Working with qualifying patients who lack capacity to instruct an IMHA

There may be times when it is not possible for an IMHA to obtain consent from the qualifying patient to act for them or to obtain a clear sense of their wishes or feelings in relation to the particular issue at hand. This section addresses the skills and knowledge that an IMHA needs to work with these patients.

Non-instructed advocacy principles

As part of the IMHA's role, at times they will work with qualifying patients who are unable to express their wishes clearly (or at all) or who otherwise lack the capacity either temporarily or permanently to instruct or direct an advocate.

In these circumstances, IMHAs will work according to **‘non-instructed’ advocacy principles** which in some important respects differ from those underpinning instructed advocacy. IMHAs should be prepared, however, to use a combination of instructed and non-instructed advocacy as the person may be able to instruct the IMHA about some issues and not others.

When using instructed advocacy the advocate works towards developing an open and trusting relationship where goals and outcomes of the advocacy can be explored and clarified by the person giving the instruction. The advocate can readily represent the person’s wishes and views and review and evaluate progress. The whole process is person-centred and person-led, and the advocate is entirely accountable to the person.

Non-instructed advocacy is different to instructed advocacy because the person either cannot instruct their advocate or because the advocate is unable to clearly ascertain what the individual wants. In these instances, the advocate relies on alternative strategies to find out what the person wants or is likely to want or works in a way which promotes their human rights. The advocacy still remains person-centred, but less person-led.

There are a number of recognised approaches to non – instructed advocacy. These include person-centred, the watching brief and rights approach. They are distinct from each other and may be used separately but they are also complementary and share common ground with each other. All the approaches depend on putting the qualifying patient’s perspective at the centre of practice.

Each approach draws on a deeper theoretical base with specific methodological conditions that apply when used in other practice contexts. The challenge for an IMHA is to know which approach or mix of them is appropriate to a qualifying patient’s circumstances under the law and how to apply them.

The ‘watching brief’ is the best known approach to non – instructed advocacy. It centres around 8 quality of life domains which are used as the basis for a series of questions that the advocate can put to the decision maker. ‘Watching brief’ places the client at the centre of thinking about the best way to support them to live their life in a way which reflects their own preferences and values, and reflects generic ordinary life principles.

As with all non-instructed advocacy approaches it should be used only when IMHAs have taken all reasonable measures to establish ways of communicating that is meaningful to a qualifying patient and is clear that the patient is not making a choice to remain silent.

The eight domains to a quality life “*Watching Brief*” developed by Asist Advocacy

Domain definition focus avoidance

1: Competence to have a level of skill and be able to be as independent as possible learning and developing skills which lead to a greater independence or allowing minimal support, minimizing dependence and inactivity having to rely on others, not taking risks or allowing people to do things by themselves.

2: Community presence having a sense of belonging to a local area by means of access and use encourage a high frequency of use and involvement in local public facilities and amenities using segregated services or not using local facilities enough.

3: Continuity having a past, present and future with key people and events in your life
Meaningful relationships which last over time planning out your life's hopes and ambitions
stagnation and loss, no past and no future, only the present.

4: Choice and influence being able to determine the course of events, looking at situations from your perspective self determination, self advocacy, making your own decisions and choices because you want to. Domination, over protection, no involvement in the way your life is directed.

5: Individuality a unique person in your own right individual needs and wishes, support that is responsive to individual demands grouping and labelling.

6: Status and respect having value in the eyes of others raising others expectations and the removal of social stigma and prejudice, engagement in activity that is valued by others not placing value on a person by degrading them by age, culture or activity.

7: Partnership and relationships having meaningful interaction with other people valuing interaction and friendship, promoting social networks having no one in your life who is important, only associating with other devalued people.

8: Well-being having a state of physical, psychological and social health to maintain a balance between all health needs, both physical and psychological, to promote health accepting illness and disability, not securing appropriate health support and treatment

There is an important distinction between advocating for a qualifying patient where all reasonable attempts to obtain instruction have failed, and simply speaking for the person without consent.

In other words, non-instructed advocacy is not an excuse for failing to engage with the patient; nor is it a way of short-cutting the engagement process.

An IMHA's role with children and young people

The eligibility of children and young people for IMHA services is broadly the same as that for adult patients. This entitlement will now increase with the Mental Health (Wales) Measures, as any child or young person who is an in-patient will be entitled to IMHA support. Usually children and young people are not subject to compulsion under the Act, but are in hospital under parental responsibility. It is therefore crucial that IMHA's are aware of the differences in practice between supporting and adult and supporting young people.

Section 58A

Patients who are under 18 and are being considered for electro –convulsive therapy (ECT) or any other treatment to which section 58A applies are eligible for IMHA services, whether or not they are subject to any form of compulsion under the Act. In practice, the use of ECT with children and young people is rare.

The types of treatment to which the special rules in Section 58A apply for patients under 18 (whether or not they are detained) are:

- Electro-convulsive therapy (ECT);
- Medication administered as part of ECT;
- Other treatments specified in regulations (none currently specified).

In practice, the use of ECT with children and young people is rare.

Age appropriate accommodation

The Act stipulates that in future hospital managers will have to ensure that patients under 18 admitted for mental health treatment must be accommodated in an environment which is suitable for someone of their age (subject to their needs).

This will apply to all young patients, whether or not they are subject to any kind of compulsion under the Act, It is intended to prevent children and young people being placed inappropriately on adult wards.

It is already policy that NHS patients aged under 16 should not be placed on adult wards, unless this is unavoidable.

Particular powers and provisions

IMHAs will need to be aware of the particular powers and provisions that are relevant to children and young people under the MHA 1983 as well as any separate legislation relating to children and young people, such as the Children Acts.

The Code sets out some general considerations for mental health professionals taking decisions about the care and treatment of children and young people. It says that when taking decisions under the Act about children and young people, the following should always be borne in mind:

- The best interests of each child must always be the primary consideration.
- Each child's views, wishes and feelings should always be ascertained and taken into account, bearing in mind their age and understanding.
- Children should always be kept as fully informed as possible, and should receive clear and detailed information about their care and treatment.
- Children have the right to share in decisions about their care and treatment by expressing their views, if any.
- Any intervention in the life of each child that is considered necessary because of their mental disorder should be the least restrictive and least stigmatising option consistent with effective care and treatment.
- Any intervention in the life of a child, considered necessary because of their mental disorder, should result in the least possible separation from family, carers, friends, community and education as is consistent with their well-being.
- All children should receive appropriate educational provision.
- The dignity of all children should be respected.
- the privacy and confidentiality of all children should be respected, unless it is necessary to protect them or others from significant harm.
- Additionally, the functions of all NHS bodies and the services for which they contract are subject to section 11 of the Children Act 2004 and this means they must be carried out having regard to the need to safeguard and promote the welfare of children.

General considerations for working with children and young people

Children (under 16 years old) may need to be considered separately to young people (16 or 17 years old) because different provisions may apply to decisions about their admission, their care and treatment.

The Code of Practice (Chapter 33) sets out some of the considerations as to when the MHA 1983 or the Children Acts should be used and some of the key factors that need to be borne in mind and their interconnections; as well as providing guidance on particular issues arising in relation to working with children and young people.

Additional resources can be found on the Headspace Toolkit web site:

<http://www.headspacetoolkit.org/>

The Mental Capacity Act 2005

The Code of Practice to the MHA 1983 emphasises that those working with people with mental health problems will need to have a good understanding of the Mental Capacity Act 2005 (MCA 2005). This will be particularly true now that IMHAs will be more likely to be working with in-patients who lack capacity and are in hospital under the authority of the Mental Capacity Act, rather than the Mental Health Act. Additionally some patients will be in hospital under Deprivation of Liberty Safeguards., rather than the Mental Health Act.

This section provides a summary of the key concepts and highlights areas of interface between the MCA 2005 and the MHA 1983.

Principles

Section 1 of the MCA 2005 incorporates five principles. These are set out below.

Mental Capacity Act Principles

1. A person must be assumed to have capacity unless it is established that he lacks capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

Purpose and Scope

The MCA 2005 establishes a legal framework for acting and making decisions on behalf of adults (16 years and over) who lack capacity to make such decisions for themselves. It came fully into force in October 2007. The Code of Practice to the Mental Capacity Act 2005 (the MCA Code) provides detailed guidance on the implementation of the MCA 2005.

Ministry of Justice www.justice.gov.uk/guidance/humanrights.htm

Department of Health:

www.dh.gov.uk/en/Managingyourorganisation/Equalityandhumanrights/Humanrights/index.htm

The MCA Code emphasises the scope and importance of this legislation:

“Everyone working with and/or caring for an adult who may lack capacity to make specific decisions must comply with this Act when making decisions or acting for that person, when the person lacks the capacity to make a particular decision for themselves. The same rules apply whether the decisions are life-changing events or everyday matters.” (MCA Code 1.1)

In April 2009 the deprivation of liberty safeguards (MCA DOLS) were introduced. These are intended to protect the rights of people who lack capacity to consent to particular treatment or care when the provision of such care may involve depriving them of their liberty in a hospital or care home. There is a separate Code of Practice on Deprivation of liberty safeguards, which supplements the main Mental Capacity Act 2005 Code of Practice and which provides further information and guidance on these provisions.

Although the main provisions of the MCA 2005 apply to individuals aged 16 or over, the MCA DOLS apply only to individuals aged 18 or over.

Mental Capacity Act 2005: Summary

The main areas covered by the MCA 2005 are as follows:

- **Capacity and test to ascertain if person lacks capacity**

Individuals are presumed to have capacity to make their own decisions unless it is established otherwise;

The MCA 2005 includes a definition of, and test for, establishing whether a person lacks capacity to take a particular decision (see below).

- **Best Interests**

Anything done for, and any decision made on behalf of, a person without capacity should be done or made in the ‘best interests’ of that person;

Those making decisions on behalf of a person who lacks capacity must consider a checklist of factors. These include the person’s past and present wishes and feelings, ‘so far as ascertainable’.

Section 4 of the Mental Capacity Act explains how to work out the best interests of a person who lacks capacity to make a decision at the time it needs to be made.

This section sets out a checklist of common factors that must always be considered by anyone who needs to decide what is in the best interests of a person who lacks capacity in any particular situation. This checklist is only the starting point: in many cases, extra factors will need to be considered.

When working out what is in the best interests of the person who lacks capacity to make a decision or act for themselves, decision-makers must take into account all relevant factors that it would be reasonable to consider, not just those that they think are important. They must not act

or make a decision based on what they would want to do if they were the person who lacked capacity.

Very broadly, a decision on a person's best interests should take into account:

- the options available;
- any evidence of their previously expressed preferences, including an advance statement;
- knowledge of the patient's background, such as cultural, religious, or employment considerations;
- views about the patient's preferences given by a third party who may have other knowledge of the patient, for example the patient's partner, family, carer;
- which option least restricts the patient's future choices, where more than one option (including doing nothing) seems reasonable in the patient's best interest.

• **Informal decision making**

Individuals (professionals and informal carers) can take actions in connection with the care or treatment of a person lacking capacity to consent to a particular action without the need to obtain any formal authority.

The action must be taken in the best interests of the person who lacks capacity;

There are limitations on such actions, for example:

- restraint can only be used if the person taking the action reasonably believes that the restraint is necessary to prevent harm to the person who lacks capacity and the restraint used is proportionate to the likelihood and seriousness of harm (section 6 MCA 2005);
- treatment cannot be given if the person has made a valid advance and applicable decision to refuse treatment in relation to the treatment proposed (section 26 MCA 2005).

• **Formal decision making powers**

The Lasting Power of Attorney (LPA) will enable individuals (aged 18 years or over) to appoint another person to make decisions on their behalf if in the future they lack the capacity to do so themselves. The LPA can cover welfare (including healthcare) and/or financial matters. In the MCA and MHA 1983 Codes of Practice those people who have been appointed to act under an LPA are referred to as 'an attorney' (although in legislation they are referred to as the 'donee').

The Court of Protection has authority for a range of areas of decision-making for adults who lack capacity, including the power to make declarations in relation to individuals' capacity to make certain decisions. The Court will also be able to appoint deputies to make decisions on welfare (including healthcare) decisions as well as financial matters.

• **Advance Decisions to Refuse Treatment**

Where a person (aged 18 or over) makes a valid and applicable advance decision to refuse treatment this must be upheld if at a later date the person no longer has the capacity to make such decisions.

Advance decisions to refuse treatment have the same effect as if the person had retained the capacity to make such decisions.

Assessment of capacity

A person lacks capacity in relation to a particular decision if they are unable to make that decision 'because of an impairment of, or disturbance in the functioning of, the mind or the brain'. An assessment of a person's capacity must be based on their ability to make a particular decision at a particular time – in other words they are always decision specific".

When assessing a person's capacity a two stage test should be used.

1. **Does the person have an impairment of, or disturbance in the functioning of their mind or brain?** If not the person will not lack capacity within the meaning of the MCA 2005.
2. **Does the impairment or disturbance mean that the person is unable to make a specific decision when they need to?** The impairment or disturbance of their brain must affect the person's ability to make the specific decision at that particular time. People must be given all practical support to help them make a decision for themselves – see the second principle of the MCA 2005.

A person is unable to make a decision if they cannot:

- understand the information about the decision to be made;
- retain the information in their mind;
- use or weigh that information as part of the decision-making process;
- communicate their decision (by talking, using sign language or any other means).

An assessment that a person lacks capacity to make a decision must never be based simply on his or her age, appearance, assumptions about the person's condition or any aspect of his or her behaviour (section 2(3) MCA 2005).

The Mental Capacity Act and the Mental Health Act 1983

The Code of Practice to the MHA 1983 identifies specific areas in which the MCA 2005 and the MHA 1983 interact. These include:

• **Information:** professionals should take steps to find out whether patients who lack capacity to take particular decisions for themselves have an attorney or deputy appointed under the MCA 2005 with authority to take the decision on the patient's behalf. In such cases the attorney or deputy should be informed in the same way as the patients themselves about matters within the scope of their authority.

• **Mental health assessment and informal admission:** detention under the MHA 1983 is a last resort. Where a patient lacks capacity to make their own decisions, consideration always needs to be given to whether it would be sufficient to rely on the provisions of the MCA 2005 (including the deprivation of liberty safeguards, where relevant) to make sure they care the treatment and care they need, without detaining them (or keeping them detained) under the MHA.

• The MHA Code of Practice provides more guidance on this. There are some cases where it will not be possible to use the MCA, either for practical or legal reasons. (COP, 4.13 – 4.24)

• **Effect of the MHA 1983 on the powers of attorneys and deputies:** This is described in Chapter 9 of the MHA 1983 Code of Practice. In general the fact that a person is subject to the

MHA 1983 does not affect the validity or scope of the authority of any lasting power of attorney. However attorneys and deputies:

- may not consent on the patients behalf to treatment regulated by Part 4 MHA 1983 (i.e. treatment for mental disorder which can be given to detained patients without their consent, and section 57 treatments for anyone)
- may not make decisions about where a person subject to guardianship is to live,
- nor can they take other decisions that conflict with those decisions that a guardian has a legal right to make (COP, 9.3)

• **Advance decisions:** where the MHA 1983 allows detained and SCT patients to be treated without their consent, unless it says otherwise, it also means that they can be given the treatment even though they have made an advance decision to refuse it.

• **Wishes expressed in advance:** Chapter 17 of the MHA 1983 Code of Practice provides guidance on advance statements and how they relate to compulsory treatment under the MHA 1983.

• **Treatment of Supervised Community Treatment patients who have not been recalled to hospital:** the powers to treat such patients are set out in Part 4A. The MCA 2005 may be relevant, because where the SCT patient lacks capacity to consent to the treatment:

- the patient's attorney/deputy may consent to treatment on their behalf;
- the patient's attorney/deputy and the Court of Protection may object to treatment being given (in non-emergency situations);

in non-emergency situations, treatment cannot be given to an SCT patient if this would be contrary to a valid and applicable advance decision to refuse of treatment.

• **Capacity and consent:** guidance on this and the application of the MCA 2005 is given in Chapter 23 of the MHA 1983 Code of Practice, 23.27 – 23.29.

• **Interface between Parts 4 and 4A of the MHA 1983 and the MCA 2005:** the table in Chapter 23 of the MHA 1983 Code of Practice, 23.52 sets out the situations in which the MCA 2005 may not be relied upon to provide treatment for mental disorder to a patient who lacks capacity to consent to treatment.

• **Electro-convulsive therapy (ECT):** Section 58A of the MHA 1983 sets out the circumstances in which ECT may be given. Save for where treatment is immediately, ECT may not be given if this conflicts with a valid and applicable advance decision to refuse ECT or the patient's attorney or deputy (authorised to make such decisions) objects to the ECT being given.

• **Deprivation of liberty while on Supervised Community Treatment, on leave or subject to guardianship:** Code of Practice, 28.7 – 28.10, explains in what circumstances deprivation of liberty safeguards may be applied to patients in the community while subject to guardianship, SCT or on leave of absence.

Independent Mental Capacity Advocates (IMCAs)

The role of Independent Mental Capacity Advocates (IMCAs) is described in the MCA Code as follows:

"The purpose of the IMCA service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions."

IMCAs will work with and support people who lack capacity, and represent their views to those who are working out their best interests.” (MCA Code, chapter 10)

IMCAs are independent of the person making the decision; they provide support for the person who lacks capacity and represent that person in discussions to work out whether what is being proposed is in the person's best interests. This includes raising questions or challenging decisions which appear not to be in the person's best interests. The information provided by the IMCA must be taken into account by the decision makers when deciding what is in the person's best interest. (MCA Code, 10.4)

IMCAs must be instructed whenever decisions are being made about serious medical treatment or a long term change in accommodation in relation to person who lacks capacity and has no one else to support them (other than paid staff). (But this does not apply where the decisions about being made under the MHA 1983.)

They may also be instructed to support someone who lacks capacity to make decisions concerning care reviews (where no one else is available to be consulted) or in adult protection cases (whether or not family, friends or others are involved).

IMCAs must also be instructed where a person is being deprived of their liberty and there is no one (other than a person engaged in providing care and treatment in a professional capacity or for remuneration) to consult when determining what would be in the patient's best interests. (For these purposes, deprivation of liberty means deprivation of liberty under the MCA – it does not include detention under the MHA 1983.)

A person deprived of their liberty under the MCA and their representative (who is not a paid professional representative) both have a statutory right of access to an IMCA. The role of the IMCA is to represent the person, including assisting the person, and their representative, understand the provisions affecting the patient, what rights the patient has and how to exercise them.

Mental Capacity Act Code of Practice

<http://www.dca.gov.uk/legal-policy/mentalcapacity/mca-cp.pdf>

MCA DOLS Code of Practice

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/MentalCapacity/MentalCapacityActDeprivationofLibertySafeguards/index.htm>

The Public Guardian's Office ex.htm <http://www.publicguardian.gov.uk/mca/mca.htm>

Care Programme Approach

In all mental health settings the Care Programme Approach (CPA) or equivalent is used in planning and provision of mental health services to patients with complex needs. As an IMHA you will need to be familiar with the CPA and other similar systems.

The CPA describes the approach used in secondary mental health care to assess, plan, review and co-ordinate the range of treatment, care and support needs for people in contact with

secondary mental health services who have complex characteristics. It includes an assessment, a care plan and a care co-ordinator. It is used mainly for adults of working age, but the principles should apply to any individual receiving care regardless of their age. There are also similar systems for supporting other groups of individuals, including children and young people (Children's assessment framework), older adults (Single assessment process) and people with learning disabilities (person centred planning).

The CPA (and its equivalent) should be integrated with relevant decision-making under the Act. For example, in practice the planning and implementation of section 117 after-care is integrated into the CPA process.

Making a complaint

The right to complain

Patients who are detained, or subject to any other form of compulsion under the Act, have just as much right as anyone else to complain about their treatment or the services they receive.

Some complaints can be resolved quickly and informally, simply by having a conversation with the right person. Others need to be dealt with through a formal procedure, to ensure they are properly investigated and considered.

An IMHA, can help patients understand the relevant complaints procedures, and what they can expect from them. They can also help them make complaints and support them through the process.

NHS complaints procedures

Every NHS organisation must have its own complaints procedure, which is in line with national regulations. Independent hospitals must also have local complaints procedures.

NHS patients who have complaints about the service they are receiving can either raise it with the organisation (e.g. the trust or independent hospital) providing the service, or with the primary care trust (PCT) which commissions the service.

An IMHA should be familiar with the complaints procedures of the organisations whose patients they support. The exact procedures may vary, but • every hospital and NHS organisation should be able to provide information about its procedures in a form which patients can understand:

- complaints normally have to be made within 12 months of the date of the event being complained about or as soon as the matter first came to the complainant's attention. (The time limit can be extended sometimes, so long as it is still possible to investigate the complaint, e.g. in situations where it would have been difficult for the person to have complained earlier);
- the complainant should receive an acknowledgement of their complaint, be kept informed about the progress of the investigation and be given a full written response once the investigation is complete.

If the complainant is not satisfied with the response, they have the right to ask the Health Service Ombudsman to consider the matter. (Until April 2009, the complaint had first to ask the Healthcare Commission for an independent review – but that part of the system has now been abolished.)

IMHAs (like any other representative) can make relevant complaints on the patient's behalf, if the patient asks them to do so, or if the patient lacks the capacity to decide and the IMHA thinks making the complaint is in the patient's best interests.

An IMHA can help patients get information about the NHS complaints system and help them use it. But they should also bear in mind that there are other sources of help and support for patients. In particular:

- **Community Health Councils Wales** who will provide help and advice if a person has problems with or wishes to complain about NHS services.

The exact arrangements vary from place to place, but an IMHA will find it helpful to be familiar with them.

As the IMHA's role is focused on the MHA 1983, where a patient has a complaint that is nothing to do with the Act, then the IMHA will probably need to refer patients to one of these, or another relevant source of support.

Social services complaints procedures

All local authorities which are responsible for adult social services must also have a complaints procedure, which also has to be in line with national regulations.

Again, an IMHA, will want to be familiar with the relevant local authorities' procedures, so that they can advise and help qualifying patients where necessary.

Guardianship patients tend to have most contact with local social services authorities, but many other qualifying patients may well come into contact with such authorities in various ways. For example, they will be interviewed by an approved mental health professional if they are being considered for detention under section 3 or for SCT. A social worker from the local authority may be responsible for writing social circumstances reports about them for the Tribunal. Many will be eligible for section 117 after-care from a social services authority.

People unhappy with the response they get from those local procedures also have the right to ask an ombudsman to look into the matter – but in this case, it is the Local Government Ombudsman.

Sources of further information

NHS complaints procedures. Department of Health website

www.dh.gov.uk/en/Managingyourorganisation/Legalandcontractual/Complaintspolicy/NHScomplaintsprocedure/DH_376

Social services complaints procedures. Department of Health website

www.dh.gov.uk/en/Managingyourorganisation/Legalandcontractual/Complaintspolicy/Socialservicescomplaintsprocedure/index.htm

Healthcare Inspectorate Wales

<http://www.hiwi.org.uk/>

Health Service Ombudsman

www.ombudsman.org.uk/

Local Government Ombudsman

www.lgo.org.uk/

The Structure of the Mental Health Act 1983

The Mental Health Act is a complex piece of law which is divided into 10 Parts with 149 specifically numbered sections (paragraphs).

Part	Sections	Heading	Particularly deals with
1	1	Application of the Act	Definition of mental disorder
2	2 to 34	Compulsory admission to Hospital and Guardianship	Detention in hospital Supervised community treatment (SCT) Guardianship (including procedures for admission, renewal, transfer and discharge for each of the above) Nearest relatives – definition and displacement
3	35 to 55	Patients Concerned in Criminal Proceedings or Under Sentence (also Schedule 1)	Powers of the courts to remand defendants to hospital while awaiting trial or sentence Powers of the courts to detain convicted offenders in hospital or make them subject to guardianship Transfer of patients from prison to hospital (and their return) Special restrictions on certain patients ("restricted patients") Conditional discharge of restricted patients by the Secretary of State
4	56 to 64	Consent to Treatment	Treatment for mental disorder without consent of patients detained in (or recalled to) hospital Safeguards for detained (and other) patients in respect of particular forms of treatment (e.g. medication, electro-convulsive therapy)
4A	64A to 64K	Treatment of Community Patients Not Recalled to Hospital	Safeguards for supervised community treatment (SCT) patients in relation to treatment for mental disorder while not recalled to hospital
5	65 to 79	Mental Health Review Tribunals (also Schedule 2)	The establishment of Mental Health Review Tribunals Rights for patients (and nearest relatives) to apply to the

			Tribunal for discharge Powers and duties of other people to refer cases to Tribunals Powers of Tribunals
Part	Sections	Heading	Particularly deals with
6	80 to 92	Removal and Return of Patients Within the United Kingdom, etc	Transfer of patients between England and Wales and Scotland, Northern Ireland, the Isle of Man and the Channel Islands Removal of patients to places outside the UK, the Isle of Man and the Channel Islands Patients who go absent across borders
7			No longer applicable
		Miscellaneous Functions of Local Authorities and the Secretary of State	Approval of approved mental health professionals (AMHPs) Duty to provide after-care services Code of Practice Mental Health Act Commission
9	126 to 130	Offences	Specific offences under the Act, including ill-treatment or neglect of patients
10	130A to 149	Miscellaneous and Supplementary	Independent mental health advocacy Informal admission of patients to hospital Children and young people admitted to hospital Duties of hospital managers to give information to patients and nearest relatives Patients' correspondence Warrants to enter premises Detention in places of safety by the police Legal custody, conveyance and absconding Interpretation (i.e., definitions)

Wider Framework of Legislation

This section offers an overview of the legislation other than the MHA 1983 that impact directly and indirectly on the IMHA role. IMHAs do not necessarily have to understand all the details of the different laws but awareness of them, how to access them and understanding which Act should be used helps them to advocate effectively for qualifying patients.

The Mental Health Act 1983

The MHA 1983 is largely concerned with the circumstances in which a person with a mental disorder can be compulsorily detained for assessment or treatment for that disorder without his or her consent, or be made subject to other forms of compulsion. It sets out the processes that must be followed and the safeguards for patients.

The Act has been amended many times over the years. The most important recent amendments are those made by the Mental Health Act 2007, most of which came into force either in November 2008 or April 2009. The amendments made by the Mental Health Act 2007 include the introduction of IMHA services. As well as the MHA 1983 itself, there is a range of regulations and other kinds of secondary legislation which support the MHA 1983. In particular:

The Mental Health (Hospital, Guardianship, Community Treatment and Consent to Treatment) (Wales) Regulations 2008	These regulations deal with a variety of mostly procedural issues (including setting out the statutory forms which must be used for making and recording certain important decisions under the Act).
Mental Health Act 1983 Approved Clinician (Wales) Directions 2008.	These directions deal with the approval of professionals as approved clinicians for the purposes of the Act.
The Mental Health (Approval of Persons to be Approved Mental Health Professionals) (Wales) Regulations 2008	These regulations deal with the approval of professionals as approved mental health professionals (AMHPs) for the purposes of the Act.
The Mental Health (Conflicts of Interest) (Wales) Regulations 2008	These regulations set out cases where people must not apply for the detention or guardianship of a patient under the Act, or give medical recommendations in support of such an application, because they have a potential conflict of interest.
The Mental Health (Mutual Recognition) Regulations 2008 (No. 1204)	These regulations say when people approved under the Act in England are also to be treated as approved in Wales (and vice versa).
The Mental Health (Nurses) (Wales) Order 2008	This order sets out which nurses may use the so called “holding power” in section 5(4) of the Act to temporarily detain hospital in-patients.
The Mental Health (Independent Mental Health Advocates) (Wales) Regulations 2008	These regulations deal with the establishment of IMHA services. They also set out the minimum requirements that people must meet if they are to act as IMHAs.

The legislation itself - versions of all UK Acts of Parliament, incorporating later amendments, are now available from the UK Statute Law Database at www.statutelaw.gov.uk (but note that there is often a lag between amendments being made and them being incorporated into the

version on the database). A version of the MHA 1983 showing the changes made by the Mental Health Act 2007 is available on the Department of Health's website. The Department's website also has links to the secondary legislation listed above.

Other reference works - there are a number of commercially published reference works on the Act which provide more detailed information and commentary. They include Richard Jones *Mental Health Act Manual* published by Sweet and Maxwell and Bartlett and Sandland's *Mental Health Law – Policy and Practice*, published by Oxford University Press, and *Mental Health – the New Law* by Phil Fennel published by Jordans.

The IMHA should bear in mind that, from time to time, there may be further amendments either to the MHA 1983 or to the secondary legislation.

Human Rights Act 1998

The Human Rights Act 1998 (HRA 1998) came into force in October 2000. It incorporates the main rights and freedoms set out in the European Convention on Human Rights (ECHR) into UK domestic law.

HRA 1998 and public bodies

The HRA 1998 requires that public authorities (which include NHS agencies and local authorities) act in manner that is that is compatible with ECHR rights. This means that public bodies must take into account the rights set out in the ECHR when they are carrying out their functions such as the delivery of services to the public. Individuals working for public authorities must ensure that they understand the ECHR rights and take them into account when carrying out their day to day work.

Public authorities will not have acted unlawfully under the HRA 1998 if as result of a provision set out in primary legislation (for example, the MHA 1983) it could not have taken a different course of action. In such cases the higher courts, such as the High Court and the Court of Appeal, may make a 'declaration of incompatibility'. This does not affect the legislation itself but confirms that the ECHR right has been breached and provides the Government with the power to use a special procedure to amend the legislation quickly.

If a person considers that their rights have been infringed by a public body they may take legal action before the national courts. Before the HRA 1998 came into force individuals had to pursue a complaint to the European Court of Human Rights (often a lengthy process).

The importance of the HRA 1998 to the role of IMHAs

IMHAs will need to have a good understanding of the HRA 1998 and how this impacts upon their work because:

- IMHAs must act in accordance with the HRA 1998 when undertaking functions under the MHA 1983: Individuals carrying out statutory functions under the MHA 1983 are considered to be public authorities for the purpose of the HRA 1998. This includes responsible clinician (RC) and approved mental health professionals (AMHPs) as well as IMHAs;
- IMHAs will need to be able recognise where a decision or action being considered may impact upon a patient's rights.

The HRA 1983 and the MHA 1983

The Code emphasises the importance of the HRA 1998, stating that all decisions about a course of action under the MHA 1983 must be 'lawful and informed by good professional practice. Lawfulness necessarily includes compliance with the Human Rights Act 1998' (COP, 1.7).

ECHR Articles of particular relevance to mental health care

All the rights under the ECHR will apply to individuals receiving care and treatment under the Act. Three important points to bear in mind when considering the application of the ECHR rights to mental health care are as follows:

- **Positive obligations:** Many of the rights under ECHR not only require that public bodies refrain from interfering with individuals' rights but in some circumstances will also place a positive obligation on them to take action to protect an individual's rights;
- **Proportionality:** Any interference with a right under the ECHR must be no more than necessary to achieve the intended objective. It must not be arbitrary or unfair. In other words, public authorities must not "use a sledgehammer to crack a nut". Thus before a public body interferes with an individual's right, consideration must be given as to whether there are other options available which would be less intrusive to the individual concerned. This is likely to be an important factor in relation to actions such as seclusion or restraint;
- **The ECHR is a 'living instrument':** The European Court of Human Rights interprets the ECHR in the light of present day conditions and will be influenced by the developments and commonly accepted standards of the member States.

Set out below are some ECHR articles that are likely to have particular relevance to mental health care and the work of IMHAs.

Article 3 (freedom from torture or inhuman or degrading treatment or punishment)

The European Court of Human Rights considers that Article 3 enshrines one of the most fundamental values of democratic societies. It states:

"No one shall be subjected to torture or to inhuman or degrading treatment or punishment"

Article 3 is an absolute right. This means that there are no exceptions to this article – there are no circumstances justifying torture or to inhuman or degrading treatment or punishment. To fall within Article 3, the treatment must attain a 'minimum level of severity', but this will depend on the circumstances of the case such as the duration of the treatment, its physical or mental effects and, in some cases, the sex, age and state of health of the victim (*Selmouni v France*, 1999).

Usually it is necessary to show that there was an intention to 'humiliate or debase' the person concerned. However, in *Price v United Kingdom* (2001) the European Court of Human Rights held that there was a violation of Article 3 even though there was no evidence of such an intention. This case concerned the treatment of a disabled woman while she was detained (she was imprisoned for 7 days having been found to be in contempt of court). The Court found that the failure on the part of the police and the prison authorities to provide facilities adequate to cope with her severe level of disability, constituted inhuman and degrading treatment and a violation of Article 3.

Article 3 may be relevant when considering complaints arising from the conditions of detention, seclusion and restraint. In principle it may also be relevant to treatment without consent.

The Code of Practice says:

Clinicians authorising or administering treatment without consent under the Mental Health Act are performing a function of a public nature and are therefore subject to the provisions of the Human Rights Act 1998. It is unlawful for them to act in a way which is incompatible with a patient's rights as set out in the European Convention on Human Rights ("the Convention").

In particular, the following should be noted:

- compulsory administration of treatment which would otherwise require consent is invariably an infringement of Article 8 of the Convention (respect for family and private life). However, it may be justified where it is in accordance with law (in this case the procedures in the Mental Health Act) and where it is proportionate to a legitimate aim (in this case, the reduction of the risk posed by a person's mental disorder and the improvement of their health);
- compulsory treatment is capable of being inhuman treatment (or in extreme cases even torture) contrary to Article 3 of the Convention, if its effect on the person concerned reaches a sufficient level of severity. But the European Court of Human Rights has said that a measure which is convincingly shown to be of therapeutic necessity from the point of view of established principles of medicine cannot in principle be regarded as inhuman and degrading.

Scrupulous adherence to the requirements of the legislation and good clinical practice should ensure that there is no such incompatibility. But if clinicians have concerns about a potential breach of a person's human rights they should seek senior clinical and, if necessary, legal advice. (COP, 23.39-23.41)

Article 5 (the right to liberty)

Article 5 provides that everyone has right to liberty. However, it is a limited right. This means that in specific circumstances this right can be restricted. The 'lawful detention of persons of unsound mind' is one of the six specific situations in which a person's right to liberty can be restricted. Article 5 is therefore of direct relevance to the powers and procedures for compulsory admission to, and discharge from, hospital under the MHA 1983.

Minimum grounds for detention under the ECHR

The European Court of Human Rights has held that, save in emergencies, the following three minimum conditions have to be satisfied in order for detention on the grounds of mental disorder to be lawful under this article:

- a true mental disorder must be established on the basis of objective medical expertise;
- the mental disorder must be of a kind or degree warranting compulsory confinement;
- the validity of continued confinement depends on the persistence of such a mental disorder.

These are sometimes known as the 'Winterwerp criteria' after the case in which the courts first set them out.

Provision of information on arrest/detention

Article 5(2) requires that everyone who is arrested or detained shall be informed promptly, in a language which he understands, of the reasons for this and 'of any charge against him'. The European Court of Human Rights has stated:

“Any person who is entitled to take proceedings to have the lawfulness of his detention decided speedily cannot make effective use of that right unless he is promptly and adequately and adequately informed of the reasons why he has been deprived of his liberty.” (Van der Leer v the Netherlands, 1990)

Section 132 of the MHA 1983 concerns the duty of hospital managers to give information to detained patients (orally and in writing). It requires that patients are informed of the provisions under which they are detained and their rights to apply to the Tribunal. The Code states that patients should be told the reasons for their detention, adding that they should be told ‘the essential legal and factual grounds for their detention’:

“For the patient to be able to effectively challenge the grounds for their detention or SCT, should they wish, they should be given the full facts rather than simply the broad reasons. This should be done promptly and clearly.” (See COP, 2.11 – 2.15)

Article 5(2) requires that individuals are given the information in a language they understand. The Code states that where an interpreter is needed, every effort should be made to find an interpreter appropriate to the patient’s gender, religion, language dialect, cultural background and age.

Review of Detention

Article 5(4) provides that individuals who have been detained are entitled to ‘take proceedings’ to decide on the lawfulness of their detention and to be released if ‘the detention is not lawful’.

In most cases, the MHA 1983 provides for this review to be undertaken by the Tribunal. The Tribunal considers the cases, and can direct the discharge, of patients who are detained (not including those detained under sections 4, 5, 35, 36, 38, 135 or 136), those who are conditionally discharged, or who are on guardianship or SCT.

Article 8 (The Right to Respect for Private and Family Life)

Article 8 covers ‘the right to respect for his private and family life, his home and his correspondence’. It is a very broad right, for example the right to private life means individuals can live their own lives and enjoy personal privacy.

Article 8 is a ‘qualified right’. Such rights require a balance between the rights of the individual and the needs of the wider community. This means that in some circumstances interference with the right will be justified. However, the interference will only be justified under Article 8 if it is:

- in accordance with the law; and
- necessary in a democratic society (this requires the interference to fulfil a pressing social need, pursue a legitimate aim, and to be proportionate to the aims pursued); and
- falls within one of the following specific aims set out in Article 8:
 - in the interests of national security, public safety or the economic well-being of the country;
 - for the prevention of disorder or crime;
 - for the protection of health or morals; or
 - for the protection of the rights and freedoms of others.

Article 8 will be relevant to a wide range of areas concerning the care and treatment of patients subject to the MHA 1983, such as: visiting policies, access to clinical records, access to fresh air, the use of seclusion and treatment without consent.

For example, the Code recognises that all patients have the right to be visited by anyone they wish to see, but states that this is 'subject to carefully limited exceptions', the principle grounds being clinical or security concerns. The Code adds that the decision to prohibit a visit is a 'serious interference with the rights of the patient' and such exclusions should be exceptional and 'any decision should be taken only after other means to deal with the problem have been considered and (where appropriate) tried'. (COP, 19.9 – 19.11)

Article 14 (Prohibition of discrimination in the enjoyment of ECHR rights)

Article 14 provides that the rights set out under the ECHR must be guaranteed without discrimination. It states:

"The enjoyment of the rights and freedoms set forth in this Convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status."

"The list of grounds on which discriminatory practice is prohibited is non-exhaustive – and 'other status' could include people with mental disorder or detained patients."

Article 14 is not a free-standing right - it can only be relied on in connection with one of the other set out in the ECHR, for example Article 8 (right to private and family life).

However there does not have to be a violation of the substantive right for a violation of Article 14 to be established.

Article 14 will be infringed if there has been a difference in treatment between persons in analogous or relevantly similar positions and there is no objective and reasonable justification for such treatment. Furthermore, Article 14 may also be breached where, without an objective and reasonable justification, a public body fails to treat people differently where their situation are significantly different (*Thlimmenos v Greece* 2000).

The Mental Health (Wales) Measures Brief Factsheet

This can be downloaded from:

<http://wales.gov.uk/docs/dhss/publications/policy/100707mentalhealthfactsheeten.pdf>

Glossary of some Central Terms and Definitions

Advance decision to refuse treatment

A decision, under the Mental Capacity Act, to refuse specified treatment made in advance by a person who has capacity to do so. The decision will then apply at a future time when that person lacks capacity to consent to, or refuse the specified treatment. Advance decisions are only concerned with the refusal of medical treatment.

Advance statement of wishes and feelings

Some patient may wish to state in advance their wishes in advance about a variety of issues, including their medical treatment, the steps that should be taken in emergencies and what should be done if particular situations occur. These advance statements are not binding but should be given the same consideration as wishes expressed at any other time.

After -care

Community care services following discharge from hospital; especially the duty of health and social services to provide after-care under section 117 of the Act, following the discharge of a patient from detention for treatment under the Act. This duty applies to SCT patients and conditionally discharged restricted patients, as well as those who have been fully discharged.

Appropriate medical treatment

In the MHA, references to 'appropriate medical treatment' in relation to a person with a mental disorder, are references to medical treatment which is appropriate in his or her case and takes into account the nature and degree of the mental disorder and all other circumstances of his or her case.

BME: Black and Minority Ethnic (BME) Community

This description is used to refer to a range of different communities, including African and Caribbean communities. It clearly does not accurately reflect the diversity of these communities and it is not universally accepted as a defining term. It is used here because it makes it possible to include a wide range of people who constitute a distinct ethnic group who may identify themselves on the basis of skin colour or their culture and who may face inequality, economic and social exclusion and discrimination on grounds of both.

Carer

The Carers (Recognition and Services) Act 1995 defines a carer as anyone who provides 'substantial care on a regular basis' There are currently an estimated 5.7 million unpaid carers in Britain with approximately 7 per cent of this number caring for people with mental health problems.

Someone who provides voluntary care by looking after and assisting a family member, friend or neighbour who required support because of their mental health needs.

Consent

Agreeing to allow someone else to do something to or for you. Particularly consent to treatment. Valid consent requires that the person has the capacity to make the decision (or the competence to consent, if a child) and they are given the information they need to make the decision and they are not under any duress or inappropriate pressure.

Court of Protection

The specialist court set up under the Mental Capacity Act to deal with all issues relating to people who lack capacity to take decisions for themselves.

Deprivation of Liberty

A term used in Article 5 of the European Convention on Human Rights(ECHR) to mean the circumstances in which a person's freedom is taken away. Its meaning in practice is developed through case law.

European Convention on Human Rights

The European convention for the protection of human rights and fundamental freedoms. The substantive rights it guarantees are largely incorporated into UK law by the Human Rights Act 1998.

Learning Disabilities

For the purposes of the Act, a learning disability is defined as “a state of arrested or incomplete development of the mind which includes significant impairment of intelligence and social functioning” Relatively few people with learning disabilities are detained under the Act, and where they are, it is not usually solely because of their learning disability itself. (MHA, COP, 34.2-5).

Medical treatment

Medical treatment under the Act does not just mean medication but includes nursing, psychological therapies, and specialist mental health habilitation, rehabilitation and care.

Mental Capacity Act

The mental Capacity Act 2005. An Act of Parliament that governs decision-making on behalf of people who lack capacity, both where they lose capacity at some point in their lives, e.g. as a result of dementia or a brain injury, and where the incapacitating condition has been present since birth.

Mental Disorder

Mental disorder is defined for the purposes of the Act as “any disorder or disability of the mind”.

Mental Health Review Tribunal (see Tribunal)**Patient**

Throughout this document, mental health service users are referred to as patients. This mirrors the terminology used in the MHA 1983 In practice other terms such as ‘client’, ‘partner’, ‘service user’ are often used in preference to ‘patient’

Qualifying patient

This refers to those patients entitled to the support of an IMHA

Regulations

Secondary legislation made under the Act. In relation to IMHAs this mostly refers to the **Mental Health Act 1983 (Independent Mental Health Advocates) (Wales) Regulations 2008**

Staff and professionals

When reference is made to staff and professionals this refers to mental health and social care staff (including paid carers) that provide care and treatment for qualifying patients. Employees of advocacy services are referred to as advocates.

Tribunal

The First- Tier tribunal, the independent judicial body which has the power to discharge patients from detention or other compulsory measures under the MHA 1983. The body that previously did this was known as the Mental Health Review Tribunal.

Contacts, Links and Resources

Age Concern: <http://www.ageconcern.org.uk>

The UK's largest charity, working with and for older people.

Alzheimers Society: <http://www.alzheimers.org.uk>

The UK's leading charity on care and research for people with dementia, their families and carers.

British Association for Counselling and Psychotherapy: <http://www.counselling.co.uk>

The Association exists to serve its members and the psychological therapies, as well as increasing awareness and respect for the profession among the general public.

Care Quality Commission: <http://cqc.org.uk/>

Department of Health Mental Health Section:

<http://www.dh.gov.uk/policyandguidance/healthandsocialcaretopics/mentalhealth/fs/en>

The aim of the Department of Health (DH) is to improve the health and wellbeing of people in England.

Depression Alliance: <http://www.depressionalliance.org>

Depression Alliance is the leading UK charity for people affected by depression.

Ex-Services Mental Welfare Society: <http://www.combatstress.org.uk>

Rebuilding the lives of veterans who suffer from injury to the mind.

Foundation for People With Learning Disabilities: <http://www.learningdisabilities.org.uk>

Promotes the rights, quality of life and opportunities of people with learning disabilities and their families. Search for and Access information on the Healthcare Commission's assessment of local mental health services - including community care and in-patient care for people with acute mental health problems.

Inquest: www.inquest.org.uk

INQUEST provides a free legal and advice service to bereaved families and friends on the inquest system. It offers specialist advice to bereaved people, lawyers, advice agencies, policy makers, the media and the general public on contentious deaths and their investigation, with a particular focus on deaths in custody.

Kings Fund: <http://www.kingsfund.org.uk>

The King's Fund is an independent charitable foundation working for better health, especially in London. They carry out research, policy analysis and development activities, working on our own, in partnerships, and through funding.

Legal Services Commission (LSC): <http://www.clsdirect.org.uk>

Free high-quality legal information to help you deal with your legal problems.

Matthew Trust: <http://www.matthewtrust.org>

A small registered charity providing last-stop support & care for people aged 8 years old & upwards, living in all communities of our society throughout the UK, who have a mental health problem of any kind (caring for the mentally distressed and victims of aggression)

MDF - The Bipolar Organisation: <http://www.mdf.org.uk>

A user led charity working to enable people affected by Bipolar disorder / manic depression to take control of their lives.

MENCAP: <http://www.mencap.org.uk>

The UK's leading learning disability charity working with people with a learning disability and their families and carers.

Mental Health Foundation: <http://www.mentalhealth.org.uk>

A leading UK charity that provides information, carries out research, campaigns and works to improve services for anyone affected by mental health problems, whatever their age and wherever they live.

Mental Health Media: <http://www.mhmedia.com>

Reducing discrimination on mental health grounds by promoting the diversity, visibility and credibility of people with experience of mental distress.

MIND: <http://www.mind.org.uk>

The leading mental health charity in England and Wales. We work to create a better life for everyone with experience of mental distress.

Ministry of Justice mental Health Unit: <http://www.justice.gov.uk/about/mentallydisordered-offenders.htm>

NACRO: <http://www.nacro.org.uk>

Working to give ex-offenders, disadvantaged people and deprived communities the help they need to build a better future.

National Autistic Society: <http://www.nas.org.uk>

The National Autistic Society exists to champion the rights and interests of all people with autism and to ensure that they and their families receive quality services appropriate to their needs.

Open Up Toolkit:

http://www.openuptoolkit.net/know_your_rights/human_rights_act_and_mental_health.php

Open Up helps people with experience of mental distress and madness

Rethink: <http://www.rethink.org>

Rethink, the leading national mental health membership charity, works to help everyone affected by severe mental illness recover a better quality of life.

Richmond Fellowship: <http://www.richmondfellowship.org.uk>

Helps thousands of people to gain a new sense of purpose and fulfilment in lives that have often been devastated by mental health problems, sometimes associated with sexual abuse or drug and alcohol misuse.

Royal College of General Practitioners: <http://www.rcgp.org.uk>

The academic organisation in the UK for general practitioners. Its aim is to encourage and maintain the highest standards of general medical practice and act as the 'voice' of general practitioners on education, training and standards issues.

Royal College of Nursing: <http://www.rcn.org.uk>

The RCN represents nurses and nursing, promotes excellence in practice and shapes health policies.

Royal College of Psychiatrists: <http://www.rcpsych.ac.uk>

The professional and educational body for psychiatrists in the United Kingdom and the Republic of Ireland.

Sainsbury Centre: <http://www.scmh.org.uk>

Improving the quality of life for people with mental health problems by influencing policy and practice in mental health services.

SANE: <http://www.sane.org.uk>

SANE is one of the UK's leading charities concerned with improving the lives of everyone affected by mental illness.

Star Wards: www.starwards.org.uk

Star Wards is a project which works with mental health trusts to enhance acute inpatients' daily experiences and treatment outcomes.

The Health and Social Care Concordat (England):

<http://www.concordat.org.uk/homepage.cfm>

The Concordat is a voluntary agreement between bodies that regulate, audit, inspect or review elements of health and healthcare in England

Together: <http://www.together-uk.org>

The UK's leading social care organisation. They provide services for people with complex needs, including those affected by drug and alcohol misuse, mental health problems and those with a learning disability.

Turning Point: <http://www.turning-point.co.uk>

UK Federation of Smaller Mental Health Agencies: <http://www.ontheside.org/ukfed> The Federation is a membership-based Charity set up to support its locally based and independent Members who develop and provide mental health services in their community.

Young Minds: <http://www.youngminds.org.uk>

Young Minds is the national charity committed to improving the mental health of all children and young people

Key to Abbreviations

Abbreviations of key terms are used in the document. A list of the short forms and descriptions you will need to recognise and understand - is given below.

AMHP	Approved Mental Health Professional
ASW	Approved Social Worker
AWOL	Absent without leave
BME	Black and Minority Ethnic (Community)
CMHT	Community mental health team
COP	Code of Practice to the Mental Health Act 1983

CPA	Care Programme Approach
CTO	Community treatment Order
DH	Department of Health
ECHR	European convention of Human Rights
GP	General Practitioner
IMHA	Independent Mental Health Advocacy/Advocate
IMHA Service	Independent Mental Health Advocacy Services
IMCA	Independent Mental Capacity Advocacy/Advocate
Informal patient	Someone who is being treated for a mental disorder and who is not subject to any kind of compulsion under the Act. Sometimes known as a voluntary patient'
LA	Local Authority
LSSA	Local Social Services Authority
MCA	Mental Capacity Act (2005)
MHA	Mental Health Act (1983 and 2007)
NIMHE	National Institute for Mental Health in England
NSF	National Service Framework
NVQ	National Vocational Qualification
PCT	Primary Care Trust
PoCA	Protection of Children Act
POVA	Protection of Vulnerable Adults
Qualifying patient	A patient who is eligible for IMHA Services
RC	Responsible Clinician
s	Section of an Act
SCIE	Social Care Institute for Excellence
SCMH	Sainsbury Centre for Mental Health

SCT	Supervised Community Treatment
Tribunal	Formerly known as the Mental Health Review Tribunal (MHRT) an independent body which reviews compulsion under the Act
SCAD	Second Opinion Appointed Doctor