VoiceAbility

Reforming the Mental Health Act (MHA)

The impact of opt-out advocacy

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VCSE health & wellbeing alliance

Reforming the Mental Health Act

In June 2022, the government published a draft Bill to reform the Mental Health Act (MHA) which they describe as including "a wide range of changes to shift the balance of power from the system to the patient, putting service users at the centre of decisions about their own care."[1]

The role of Independent Mental Health Advocates (IMHAs) in supporting people to participate in decision-making over their care and treatment is intended to be even more significant under these reforms.

Independent Mental Health Advocacy

IMHAs were formally introduced as part of the 2007 MHA reforms so that everyone detained under the Act is entitled to support from an IMHA. Detention in hospital can involve severe restrictions on personal liberty (for example physical, chemical or mechanical restraint) and IMHAs are an important and independent support for people in these challenging circumstances.

The role of IMHAs, according to the MHA Code of Practice, is to "support patients to exercise their rights and ensure they can participate in the decisions that are made about their care and treatment."[2] This might include supporting people to engage with clinical professionals and informing them of their rights to apply to the Mental Health Tribunal (an independent judicial body that hears appeals against detention).

However, it is estimated that only half[3] of the over 50,000[4] people who are detained under the MHA each year currently get support from an IMHA. The legal duty on healthcare providers to inform people about advocacy is relatively weak and access to advocacy services can be overly dependent on the attitude of individual staff or culture of wards or healthcare providers. For example, in its 2019/20 MHA monitoring

[1] assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1085872/draft-mental- health-bill-explanatary-notes.pdf p.4
[2] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF p.54
[3] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1085873/draft-mental-health-bill-impact-assessment.pdf p.79
[4] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures

report, the Care Quality Commission (CQC) "found wards where staff did not routinely refer any eligible patients to an IMHA".[5]

Opt-out advocacy

Improving access to advocacy services is vital to deliver the MHA reform objectives of a more person-centred and less coercive mental health system. To address this issue, the government intends to legislate for an opt-out IMHA service. Opt-out advocacy was one of the recommendations of the independent review of the Mental Health Act.[6] It has also been recommended by several House of Commons Select Committee reports[7] and is also being legislated for in other parts of the world such as Victoria, Australia.[8]

In an opt-out system, everyone is automatically referred to an IMHA by the hospital or healthcare provider. The IMHA then contacts each person to explain the service and the person can then decide whether to proceed or not.

The impact of opt-out advocacy

To help develop and share understanding of how opt-out might work, VoiceAbility has led a small project to identify examples of IMHA services who have been voluntarily trialling an opt-out approach. This report summarises how opt-out has been working in five locations in England. They range in scale from whole local authority approaches in Bradford, Herefordshire and Worcestershire, and Wiltshire to smaller scale approaches relating to a specific service or ward in Sheffield and Colchester.

All five case studies demonstrate that opt-out leads to a significantly higher uptake of IMHA services. This is due to those advocacy services being informed and aware of everyone who is detained in a particular healthcare setting. Advocates can then make direct contact with every person and provide an explanation of the service themselves, rather than the current reliance on healthcare professionals who may not have a strong understanding of advocacy and are also managing other priorities. This also enables advocates to respond directly to any queries and

[5] https://www.cqc.org.uk/sites/default/files/20201127_mhareport1920_report.pdf p.53
[6] https://assets.publishing.service.gov.ac.uk/government/uploads/system/uploads/attachment_data/file/778897/Modernising_the_Mental_Health_Act_-_increasing_choice__reducing_compulsion p. 94
[7] https://publications.parliament.uk/pa/cm201314/cmselect/cmhealth/584/584.pdf p.16
https://committees.parliament.uk/publications/8153/documents/170201/default/ p.43
[8] https://www.legislation.vic.gov.au/bills/mental-health-and-wellbeing-bill-2022

concerns and, even if the service is declined initially, check whether they would like to take up the offer at a later point in their hospital stay.

In Bradford, there were beneficial outcomes for three individuals Ryan, Steve and Raffia, who would have been unlikely to access advocacy without the opt-out system. In each of the three real-life examples, advocacy helped the person to identify and achieve their personal objectives more quickly. It also helped to reduce their length of stay in hospital and consequently an earlier discharge from costly inpatient mental health services.

In summary, the benefits of opt-out are that it:

- ensures that every individual who is eligible for support receives a visit from an advocate and an explanation of the service (including those who may not otherwise come into contact with the service: for example, if they have been placed in seclusion or segregation and are not visible on the ward)
- significantly increases uptake of IMHA services and ensures referrals are not dependent on variables outside of the patient's control (such as the attitude of staff or healthcare providers to facilitating access to advocacy)
- enables more people to have a greater voice in their care and treatment which leads to improved outcomes for them, and for the wider health and care system, if people are not kept in hospital for any longer than they need to be
- supports people to advocate for themselves and be discharged sooner when they can be better supported in the community, reducing strain on in-demand inpatient mental health services

Evidence

We collected evidence from five different settings in England where opt-out advocacy was already being provided.

Bradford

These three cases of opt-out IMHA services provided by VoiceAbility demonstrate beneficial outcomes for people.

Herefordshire and Worcestershire

The uptake of IMHA services provided by Onside Advocacy almost doubled with benefits for patients, but also presented resource challenges for the advocacy service, and was less effective in the community.

Wiltshire

The Advocacy People's opt-out IMHA service benefited from a proactive approach from the NHS Trust.

Sheffield

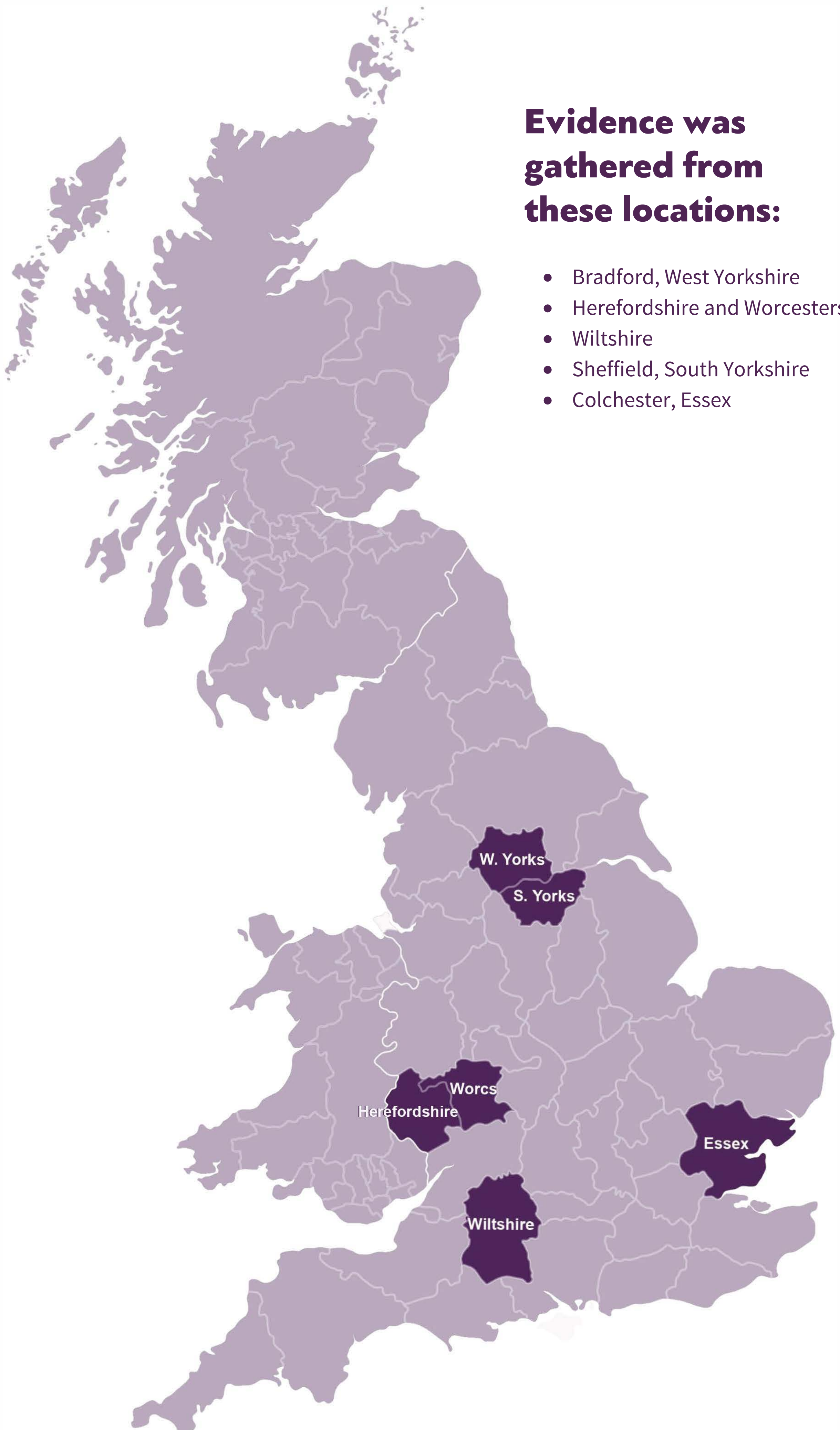
This long-running children's and young people’s service provided by Sheffield Advocacy Hub effectively provides for detained and informal patients.

Henneage Ward, King’s Wood Centre, Colchester, Essex

Opt-out IMHA services provided by Rethink Advocacy demonstrate that older adults, including those who are assessed as lacking capacity, benefit from independent advocacy.

Evidence was gathered from these locations:

- Bradford, West Yorkshire
- Herefordshire and Worcestershire
- Wiltshire
- Sheffield, South Yorkshire
- Colchester, Essex



Bradford

VoiceAbility provides IMHA services in Bradford, primarily at Lynfield Mount Hospital and the Airedale Centre for Mental Health which are part of Bradford District Care NHS Foundation Trust.

An opt-out IMHA service was introduced with the onset of the coronavirus pandemic and IMHA referrals have significantly increased as a result from 204 in 2018/9 to 416 in 2021/22. All eligible patients are automatically referred for advocacy with referral information provided to VoiceAbility around twice a week.

Below are three real-life stories (with names changed) which demonstrate how opt-out has enabled the advocacy service to support people it would not otherwise have reached and the beneficial outcomes for those people.

Ryan

Ryan was admitted and sectioned on a mental health ward during the initial coronavirus pandemic lockdown. As well as his mental health condition, Ryan was HIV positive but this was well managed with medication.

Ryan was referred to the advocacy service under the opt-out system and contact was initially made by telephone as advocates were not able to visit the ward in person. Following an introduction to the service, Ryan initially declined the offer of support but was provided with contact information for future reference.

Due to his HIV positive diagnosis, the hospital ward made the assumption that Ryan was at particular risk of coronavirus due to a heightened risk of coronavirus on the ward generally. As a result, they asked Ryan to remain in his room on the ward and not to access communal areas. He was also refused leave of absence from the ward, which is an important step towards discharge from hospital, despite no concerns regarding his mental health or behaviour.

After the decision regarding leave, Ryan became concerned about his rights and contacted the advocacy service to ask if an advocate could support him. Ryan and the advocate discussed the circumstances. The advocate researched the facts around HIV, coronavirus and risk levels and was able to identify that, because his HIV was well managed with medication, he was no higher risk than any other person on the ward. At Ryan's request, the advocate communicated these facts with ward staff

and requested an urgent review. Following the review, Ryan was allowed leave of absence from the ward.

Providing an introduction to the advocacy service via an opt out mechanism was particularly important in supporting Ryan. As he was essentially detained in his room, even if an advocate had been able to visit on the ward it is unlikely they would have met him and been able to offer help.

As the advocacy service was aware that Ryan was on the ward, it was able to make contact (over the phone) and provide an introduction and contact details. Although Ryan decided not to take up the initial offer, he was empowered and able to make contact with the advocacy service when he needed support to challenge the decision regarding leave of absence from the ward.

Steve

Steve was detained on a male acute mental health ward but preferred to stay in his room, not coming into the communal areas and not eating his meals with others. He wanted only to be in his own space.

Due to these preferences, it is very unlikely the advocate would have met Steve through visiting the ward and drop-in sessions. Staff on the ward were not proactive in supporting people to access advocacy, and would not have identified him as someone who had requested advocacy - because he had not asked for an advocate himself.

However, due to a referral through the opt-out system the advocate was able to make a request to staff to visit Steve. The advocate was escorted to his room, explained their role including support with tribunal processes and liaising with a solicitor if needed. Steve clearly wanted to go home but had not yet contacted a solicitor. The advocate was able to ensure the tribunal paperwork was completed, and as a result Steve was discharged.

Steve was clear that being in hospital was only making his mental health worse and firmly believed that if he was at home he would get well more quickly. He did not

want to do some of the things that the doctors were asking him to do, such as going out in the hospital grounds or visiting a shop. He did not want to have to “jump through the hoops” and just wanted to go home.

Without the opt-out system, Steve would have missed out on advocacy, as he was not wanting to “make a fuss” and it is unlikely he would have sought out the IMHA support he was entitled to despite desperately wanting to be at home.

Raffia

Raffia was detained on a female acute mental health ward after becoming unwell. Her son and daughter-in-law had been caring for her for over 10 years without assistance but had been struggling more recently.

When Raffia was first admitted to hospital, she felt beleaguered and isolated. Raffia is Muslim and cleanliness is an important part of prayer. She needed access to a bidet and prayer mat, Qu'ran and cutting off her nails for Jummah prayers on Friday was important to her. Raffia had always only eaten her own culturally South-Asian diet.

Raffia was unlikely to have proactively requested support from an advocate. However, after their first meeting, her advocate was able to quickly build a trusting relationship with Raffia. The advocate communicated with Raffia in her mother tongue, Punjabi, and was sensitive to her cultural needs.

The advocate requested for Raffia to have her cultural food and have access to the prayer mat, Qu'ran and to have her nails cut. Raffia said this had all made a massive positive difference to her well-being.

When Raffia was ready to be discharged from hospital, the advocate also helped to secure a residential placement that was better able to meet her needs. In contrast to the local authority’s original proposal, it had many staff and residents who spoke Punjabi and a better understanding of her cultural needs including religion and diet.

Raffia’s daughter-in-law said:

“When we decided to put Mum in a care home, the advocate really helped us understand the process and included us and listened to my mother-in-law.

“We know the advocate worked very hard to get my mother-in-law’s voice heard and made sure her cultural needs weren't ignored or minimised. She spent time with my mother-in-law, built a good relationship with her and really understood her needs.

“We are very sure that the process and result would have been very different, and much more confusing and stressful for my mother-in-law and us if the advocate hadn’t picked up the case. A huge thank you and God bless. I say this with no exaggeration: you and this cultural advocacy service is literally saving lives.”

Herefordshire and Worcestershire

Onside Advocacy provides IMHA services in Herefordshire and Worcestershire, primarily in hospitals which are part of the Herefordshire and Worcestershire Health and Care NHS Trust.

Onside were concerned about the low proportion of people accessing advocacy and that many were refusing advocacy at the point of admission, or soon after, as this is not the best time to understand and decide about advocacy support.

IMHAs were also spending significant amounts of time trying to access patients and facilitate referrals, impacting on the time available to provide advocacy support.

They approached the Trust about introducing opt-out and a pilot was launched in May 2021. In its first year of operation, the opt-out pilot has successfully increased the number of people accessing advocacy from 298 to 583.

Referral information is provided once a week to Onside Advocacy, including the person's name, date of birth, ward or location, MHA section type and section start or end date, and IMHAs visit the wards once per week.

When opt-out was first established, consideration was made to adopting a "3 attempts to engage/contact" prior to closing a case. In reality, this did not work as each person's needs are individual to them and it can take varying amounts of time to engage, gain their trust and support them depending on what stage they have reached in their journey. Therefore, the advocacy service now keeps a case open for the length of time a person is under section and on a ward. One IMHA said that the risk if we close a referral prematurely due to lack of engagement is that the patient could "slip through the net" and not have the support they want at a later date.

Onside have identified the following benefits of the opt-out pilot. IMHAs can:

- immediately access eligible patients, speak to ward staff and request an introduction to new patients, through already knowing who is on the ward
- spend less time trying to work out who is eligible, tracking down patients and waiting for staff to provide updates of who is on ward, and therefore have more time with the person they are supporting

- continue to offer support to people easily if they change their mind, following an initial refusal of support, or following other changes (for example, a ward or location change) as a referral has already taken place

Lack of resources

Whilst the opt-out pilot has been very successful in increasing uptake, the lack of additional resources to deliver an opt-out service has had a range of impacts. Firstly, it has led to much higher caseloads for each IMHA, and cases are open for longer. The time taken to conduct visits to wards has significantly increased with IMHAs potentially seeing over 20 people in one day, whereas before the opt-out pilot this may have been fewer than 10. This has also impacted on the time available to support each person, with little flexibility to respond to more immediate and reactionary needs and requests. Higher caseloads have also brought increased administrative demands, including documenting and evidencing of work for commissioners. Overall, the increase in workload for IMHAs has been significant.

Advocacy for people on Community Treatment Orders (CTOs)

The opt-out pilot has had less impact on IMHA uptake for those on Community Treatment Orders (CTOs). The information provided to the advocacy service is often insufficient to make contact with the person. Consequently, a lot of time is spent contacting community psychiatric nurses or sending letters via the hospital's Mental Health Act administrators to offer the IMHA service, but with very little direct contact with and from the person. It is important to note that this was also a difficulty before the opt-out pilot was initiated.

Some advocates have long-standing CTO patients where support is requested when needed. When a person on a CTO is placed in a known residential or supported living placement, IMHAs are able to establish contact via the residential placement. It is more difficult to make contact when a person is on a CTO in their own home in the community. Further discussion is needed on how opt-out can work better for people on CTOs, including the potential for greater disclosure of contact information to advocacy providers.

Wiltshire

The Advocacy People provides IMHA services in Wiltshire, primarily at the Green Lane Hospital in Devizes and at Fountain Way mental health facility in Salisbury. An opt-out IMHA service was introduced in response to the coronavirus pandemic lockdown when advocates had no access to hospital wards, and advocacy referrals were in significant decline.

Following conversations with Avon and Wiltshire Mental Health Partnership NHS Trust, the Trust developed a new protocol, which has since been updated, meaning that everyone sectioned under the Mental Health Act is automatically referred through an opt-out approach.

The referral information provided by the Trust includes the person's name, section, where they are physically located and any information relating to risk that the advocate needs to be aware of before making contact with the person.

Once the referral is received, an IMHA from The Advocacy People visits to explain the IMHA service and ask if they would like support from an advocate. If this initial offer is not taken up, there is a further check with the person in a week or two before the referral is closed.

Opt-out has been working well in Wiltshire and there has been ongoing collaboration between the Trust and The Advocacy People to refine the protocol and processes for sharing information to facilitate referrals.

On one of the wards, hospital staff were not as proactive in operating the opt-out approach, but this has now been largely resolved following feedback provided to the Trust and a reissuing of the protocol by Avon and Wiltshire Mental Health Partnership NHS Trust.

The Advocacy People also provides IMHA services for a 12-bed eating disorder unit at Cotswold House, Marlborough where opt-out is not in place and referrals are lower.

Sheffield

Sheffield Advocacy Hub provides IMHA services at the Becton Centre for Children & Young People, part of Sheffield Children's NHS Foundation Trust. Opt-out has been in place for at least 6 years with automatic referral for both those who are detained under the MHA and those who are there voluntarily as informal patients.

The opt-out system works in exactly the same way for both informal and detained patients. The referral information provided by the Trust includes the person's name, date of birth, legal status (whether an informal patient or detained under section), address, and any information relating to risk that the advocate needs to be aware of before making contact with the person.

Once the referral is received, Sheffield Advocacy Hub makes an introductory visit to the child or young person to ask if they would like support from an advocate. They are also provided with an accompanying letter with further information and contact details for the advocacy service. Some of the young people can be quite unwell when the introductory visit is made and only decide later to access support from the advocate. The opt-out system therefore ensures that everyone is at least aware of the service and has led to more patients ultimately accessing advocacy than would otherwise have been the case.

One of the advocates from Sheffield Advocacy Hub supporting children and young people at Becton commented:

"I think this [opt-out] is particularly relevant to autistic young people as their understanding and processing is often a lot different.

"I can think of examples where I had regular contact with a certain autistic young person but he always said that he was ok, but would acknowledge me every time he saw me and would introduce me to new patients. Then one day he asked to see me, and there was a huge piece of work that I did with the young person after this. It was like it had taken that long for me to build that relationship, and for him to have that understanding of what advocacy meant."

Sheffield Advocacy Hub also provide advocacy services at Riverdale Grange specialist eating disorder hospital where no opt-out system is in place and referrals are proportionately lower. They believe that opt-out would also be beneficial in this setting and would lead to higher number of people accessing advocacy support.

Henneage Ward, King's Wood Centre, Colchester, Essex

Rethink Advocacy provides IMHA services in Essex. An opt-out system is in place on one hospital ward, Henneage Ward at the King's Wood Centre, Colchester General Hospital, part of the Essex Partnership University NHS Foundation Trust. It is a ward for older adults where a significant proportion of people are assessed as lacking capacity to make decisions on whether to access support from an advocate.

There can be an assumption that if people lack capacity to decide then the default is to not make an advocacy referral. The use of opt-out on this ward ensures that all patients have the opportunity to access support from an advocate.

For example, there was a patient on the ward for almost a year who would have been unlikely to ask for an advocate but was referred through the opt-out system. The IMHA began working with them and sought to gain an understanding of their situation, wishes and preferences. The advocate was successful in empowering the individual, particularly in relation to meetings with their care co-ordinator, and securing a placement for discharge that was more suitable to the person's needs than the original options being considered.

Referrals from the other wards in the hospital where opt-out is not in place are much lower.

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To discuss any of the issues raised in this report, or to find out more about VoiceAbility's work, please contact **publicaffairs@voiceability.org.**

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