

Reforming the Mental Health Act

The advocacy needs of voluntary
patients in mental health hospitals

February 2024



About this research

This research has been undertaken for the UK Government's Department of Health and Social Care (DHSC) as part of the Complex Needs Consortium's work programme for the VCSE Health and Wellbeing Alliance¹.

The purpose of the research was to explore the provision of advocacy services for voluntary patients (also known as informal patients) in mental health hospitals in England.

Voluntary patients are people who have consented to admission to a mental health hospital. In England, they are estimated to make up around half of the 100,000 people admitted to a mental health hospital annually. The remaining half are people who have been detained ('sectioned') under the Mental Health Act 1983 (MHA)². At present, only people detained under the MHA have a legal right to support from an Independent Mental Health Advocate (IMHA). The advocate's role is to support the person and help ensure their voice is heard in decision-making about their care and treatment.

The UK government is undertaking reforms of the outdated MHA so that people admitted to mental health hospitals are supported to make more choices for themselves and to reduce coercive and restrictive practices³. The government's MHA reforms propose two significant changes to advocacy services as follows:

- Opt-out advocacy for detained patients to improve access and uptake (see our previous report 'The impact of opt-out advocacy').
- Extend the legal right to advocacy to voluntary patients (but not on an opt-out basis).

A parliamentary committee scrutinising the government's draft Mental Health Bill has recommended that advocacy for voluntary patients should also be on an opt-out basis⁴.

What we did

This research explores what support voluntary patients need from advocates. It also looks at whether there are any differences that would be a barrier to applying an opt-out model to voluntary patients.

We held nine focus groups with independent mental health advocates across England who all had experience supporting voluntary patients to a greater or lesser extent (depending on what was commissioned by their local authority and other factors). We also gathered evidence from Wales — where voluntary patients already have a right to advocacy — and Jersey.

The research findings are presented in five sections as follows:

- 1) Challenging restrictive practice and 'de facto' detention.
- 2) Increasing awareness of rights.
- 3) Raising safeguarding alerts.
- 4) Engaging with care and treatment decision-making.

5) Access to advocacy and opt-out.

The first four sections focus on voluntary patients' advocacy needs, and the fifth and final section focuses on access to advocacy and the opt-out model. Each section opens with a headline finding and closes with a headline conclusion.

Key messages

- **Voluntary patients often experience 'de facto detention' and are subject to the same rules and restrictions as detained patients but have low awareness of their rights and are sometimes unaware of their legal status.**
- **Voluntary patients need advocacy support for a similar range of issues as detained patients. However, there is a particular need for support around the potential application of MHA holding powers and how to challenge aspects of their care and treatment without access to the formal processes of the MHA (e.g. Mental Health Tribunal).**
- **Safeguarding concerns can apply equally to voluntary patients, and advocates have an important role in supporting people to raise safeguarding alerts. Expanding advocacy to voluntary patients can, therefore, contribute to system-wide initiatives to improve patient safety and outcomes for mental health inpatients.**
- **Advocates described challenges when someone's legal status changed from detained to voluntary and 'access to advocacy suddenly falls away'. Many felt that voluntary patients were 'disadvantaged because of having no advocacy support'.**
- **There was consensus amongst all the focus groups that voluntary patients should have a legal right to advocacy and that this should also be on an opt-out basis.**

1. Challenging restrictive practice and ‘de facto’ detention

The practical experience of voluntary patients in mental health hospitals was described by advocates as ‘de facto detention’ or ‘informal BUT’.

Although they have a different legal status, voluntary patients are accommodated on the same locked hospital wards and often subject to the same rules and restrictions as those detained under the MHA. Advocates highlighted that a risk assessment was often required for a voluntary patient to leave or go off the ward. If a voluntary patient decides to leave without permission, then the MHA’s temporary holding powers might be used by hospital staff to prevent this — with the potential for longer-term detention under the MHA.

An advocate commented that:

“Often people think that a voluntary patient is 100% free to come and go from the ward, and in practice, this isn’t true. If the nurses have concerns about the risk to the person or from the person at the point of exiting the ward, they can action section 5(4) for up to 6 hours until the Psychiatrist/Responsible Clinician is available and he/she can then action section 5(2) to give them 72 hours to sort the section 2 or 3 application.”

Another advocate highlighted that the MHA’s temporary holding powers are used as a management tool if voluntary patients try to ‘push back’ against restrictions. The tone of voice was described as ‘if you do this, we will do that’ and used as a kind of ‘power trip’. Examples were also provided of a voluntary patient being restrained when seeking to leave the ward and another being sectioned when they tried to go off ward to smoke a cigarette. One of the constraints highlighted was a lack of staff to accompany people off the ward.

Case study: Carol

Carol was initially admitted to hospital on a MHA section, but her status changed later to a voluntary patient. With Carol’s consent, the advocate spoke with hospital staff about the nature of her initial admission.

Despite being a voluntary patient, Carol was subject to certain conditions such as having staff present when using internet capable devices and having two staff with her when leaving the ward. Staff explained to the advocate that Carol agreed with these conditions and that the police had put these ‘rules’ in place due to the nature of a previous offence.

Carol was frustrated with her inability to use internet devices whenever she wanted. Staff explained to the advocate that they would set up specific times for Carol to use the internet but she would not be given back access to her internet devices. The advocate highlighted that this could be viewed as a breach of Carol’s rights and asked what legal framework was being used to deprive her of her liberty.

Shortly following this conversation, Carol was given back full access to the internet and could use it unsupervised. Carol was very happy as her games console was a great comfort, helping her get through the day and forge online friendships. Carol also felt empowered by what she could achieve through advocacy and began the process of challenging the conditions around her leave.

Advocacy can support voluntary patients to challenge restrictive practices and circumstances amounting to 'de facto' detention.

2. Increasing awareness of rights

Voluntary patients were often uncertain about their rights, with some completely unaware of their legal status in hospital.

Advocates reported that if a person was not trying to leave and taking medication, they are often assumed to be consenting and, therefore, a voluntary patient (even though they might lack the capacity to decide or have fluctuating capacity).

One older adult ward's process for seeking consent was described as 'cursory' as if a person replied 'yes' to the question 'are you OK to stay in hospital?', there was no further conversation or explanation. In another example, the lack of language or interpretation services meant one voluntary patient was unaware of their legal status in hospital. Once informed by an advocate that they were not legally required to be there, they immediately packed their bags and left the hospital.

Voluntary patients also often found it difficult to challenge aspects of their care and treatment without the formal processes of the MHA available to them, according to many advocates. Many were relieved not to be sectioned — to avoid the perceived stigma — and were wary of that legal status changing. One advocate described how they have to 'walk a difficult line' when informing voluntary patients about their rights, including that if they do try to leave without permission, it may lead to them being sectioned.

An advocate commented that:

"Another issue is medication refusal. As an informal patient, our clients usually believe they can accept or refuse medication freely, but in practice, sometimes the refusal in itself, plus other behaviours, can be construed as lack of capacity and lead to forced administration of meds (under the MCA) which will again impact on the therapeutic relationship and also fulfil some of the criteria for sectioning under the MHA. It can be a big shock for a voluntary patient to actually see their rights eroded. This can be perceived as a breach of rights/heavy handedness/unjustified lack of trust from the Responsible Clinician and nurses, all ingredients of a broken therapeutic relationship as it adds trauma to the situation."

Case study: Kevin

Kevin had become unwell due to heavy cocaine use. He came into the hospital of his own choice and said he felt safer there as he was unable to use cocaine. He wanted more support with his addiction issue, as he said he felt desperate to get his habit

under control. Kevin also raised concerns about not being able to use the electricity supply at his home.

The advocate explained the client's rights as an informal patient and confirmed that Kevin was not under a section (of the MHA). The advocate explained that there were rules on the ward, however, such as the night-time curfew. The advocate also explained that holding powers may be used if the client was thought to be a risk to themselves or others and that this could be used to stop him leaving the ward in certain situations.

As a result of the advocate's support, Kevin had a much better understanding of his rights as an informal patient and the boundaries and limitations of this. Kevin understood why rules were in place on the ward and respected these, returning from leave on time.

Kevin now understood that he could seek medical advice if he wished to leave the ward or discharge himself. He made an informed decision to stay and continue his treatment. Kevin also felt more able to ask questions about his care and treatment at ward reviews and put his views forward.

The advocate highlighted an organisation that provided professional support with drug addictions. Kevin gave consent for the advocate to speak to ward staff on his behalf to request a referral, which was put in motion. Kevin was also offered support from the community team to resolve issues with his electricity at home and ensure he can access utilities.

Kevin said that he felt so much better after talking to an advocate. He said: 'You listened to me, and I feel more positive about things than I did before I spoke to you'.

Advocacy can support voluntary patients to be aware of their legal status in hospital and understand their rights, including around the potential use of MHA holding powers.

3. Raising safeguarding alerts

Safeguarding concerns can apply equally to voluntary patients.

Advocates reported they were often involved in supporting voluntary patients to raise safeguarding alerts. The case studies below demonstrate that, where advocacy has been available to voluntary patients, it has played an important role in supporting those people to raise a safeguarding alert, which has also brought benefits to their care and treatment covering both mental and physical health.

The recent DHSC commissioned rapid review into data on mental health inpatient settings found that "ward visitors, whether unpaid carers, family members, friends or advocates, play an important role in providing feedback regarding the care provided and escalating any concerns"⁵. If advocacy services are only in contact with those detained under the MHA, then it is likely that a significant number of safeguarding issues are currently being missed.

Case study: Stacy

Stacy is 20 years old and is transgender, identifying as female. Stacy was quiet and shy and had difficulty speaking up for herself.

Stacy presented at A&E voicing suicidal intent and was admitted to a male mental health ward as an informal patient. Due to their vulnerability on the ward, Stacy was referred to the advocacy service by ward staff.

Stacy had experienced sexual abuse in the past and felt uncomfortable on the ward as a trans person, as another patient made sexually suggestive remarks towards her. Stacy also told her advocate that she was vegetarian, but her diet was not catered for on the ward, and she was too scared to mention it to staff.

With Stacy's consent, the advocate spoke to the duty nurse about the sexual harassment from another patient and asked what would be done to keep Stacy safe. The duty nurse said the ward was aware of the situation, and the two patients had been separated and would not see each other.

The advocate submitted a safeguarding report to the local authority, and the situation was safely managed on the ward. On future visits, the advocate checked that the safeguarding measures were working and that Stacy felt safe.

The advocate raised the issue of Stacy being a vegetarian with the ward. Ward staff said they were unaware that Stacy was vegetarian, and the duty nurse confirmed that vegetarian and other dietary needs are fully catered for and explained how Stacy could order vegetarian food for mealtimes. The advocate passed this information to Stacy so she could order vegetarian food herself.

Stacy told the advocate: 'Thank you for your support and input; I really appreciate you visiting me and checking in.'

Case study: Beatrice

Beatrice was admitted to an acute ward as a voluntary patient. On one of Beatrice's first days, she experienced discriminatory abuse from a member of staff, who expressed racist views openly during a discussion with Beatrice.

Beatrice had raised these issues with the hospital staff, who had said that they would follow their safeguarding protocols. However, Beatrice was not involved in this process and was unaware how the hospital would respond to the issues raised. Beatrice informed her advocate she would like the concerns raised externally.

Beatrice's advocate supported her in completing a safeguarding alert. Beatrice completed it using her own words and was also able to say what she would like as an outcome of the investigation. Following a (Care Act) section 42 safeguarding enquiry, Beatrice was informed that the member of staff had been dismissed and would not be completing further shifts for the agency they worked for.

Advocacy had supported Beatrice in learning a new system. It taught her how to raise a safeguarding alert, helping her to safeguard herself in future.

Advocacy can support voluntary patients to raise safeguarding alerts and contribute to system-wide initiatives to improve patient safety and outcomes for mental health inpatients.

4. Engaging with care and treatment decision-making

Voluntary patients require advocacy support for a similar range of issues to detained patients.

According to advocates, these include:

- Engagement with clinical decision-making (e.g. medication).
- Time off the ward.
- Contact with family and friends.
- Arrangements for discharge from hospital.

It was reported by advocates in Wales that voluntary patients often became interested in advocacy support when they experienced some form of coercion, including:

- Once they realised that hospital admission can be like de facto detention.
- Wanting to go somewhere (e.g. shops) and being told by staff that they would rather they didn't leave ward or can't leave.
- Change of medication or treatment (with the suggestion that they can't leave hospital until they start taking new/different medication).

The need for advocacy support to help secure discharge from hospital was prominent in most of the focus groups. This included supporting people to have a voice in decision-making about a community placement where the person lacked capacity and/or no family were involved. Advocates described helping voluntary patients to get in touch and follow-up, with care professionals (e.g. social workers, care coordinators), particularly where discharges were delayed due to a lack of available community support. Indeed, one reason for a change of legal status, from detained to voluntary, occurs when the MHA detention criteria are no longer met, but there is also a lack of anywhere to be discharged into the community, so the person remains in hospital.

There was also a sense from some focus groups that voluntary patients might be receiving less support both whilst in hospital and with discharge. Advocates commented that voluntary patients were 'not treated the same' and 'tend to be bottom of the waiting list'. There was even a suggestion that some people's legal status might be changed to voluntary to avoid too much process and paperwork around discharge.

There were also examples provided of voluntary patients not receiving the support they needed in hospital and being sectioned under the MHA as their condition worsened. This could then also lead to breakdowns in therapeutic relationships with hospital staff as treatment shifted from consent to force. It was also suggested that many voluntary patients would benefit from a crisis placement in the community as the ward environment meant they could become more unwell in hospital.

Advocates from Wales also reported that voluntary patients can become stuck in a 'bit of a no-man's land'. This can be due to their lack of entitlement to section 117 after-care under the MHA and the lack of pressure from upcoming MHA Tribunals (who have the power to discharge someone if MHA detention criteria are not being met).

Case study: Ibrahim

Ibrahim was referred by ward staff for advocacy support around his rights as a voluntary patient and his reluctance to talk to professionals. He also had muscular dystrophy which meant he was bed-bound, unable to walk and found it very difficult to talk.

Over a couple of visits, trust was built by explaining the independent nature of the advocate's role and speaking about football — a topic of mutual interest. Once trust was established, Ibrahim asked the advocate to speak to ward staff on his behalf to ask if he could have a bedside table and some reading material. Ibrahim also wanted to know if anything could be done to assist him within his home upon discharge.

The advocate raised this request with the deputy ward manager, and as a result, the occupational therapist spoke to Ibrahim and provided him with a table which could be tilted and easily moved to suit his needs. An assessment was also carried out at his house, and the team spoke to the family about their needs in supporting Ibrahim when he is back home. The occupational therapist arranged for equipment to be delivered to the home as soon as a date for discharge has been agreed.

Without advocacy support, these issues may not have been raised due to Ibrahim's mistrust of mental health professionals.

Advocacy can support voluntary patients to engage with decision-making about their care and treatment. This includes hospital discharge, where they may be disadvantaged by their lack of access to s.117 after-care, Mental Health Tribunals and other statutory processes under the MHA.

5. Access to advocacy and opt-out

Voluntary patients' access to advocacy is currently very limited.

Voluntary patients in England do not currently have a legal right to advocacy, and advocacy services are primarily focused on those detained under the MHA. Some voluntary patients have limited access where a local authority (or healthcare provider) has commissioned additional provisions above the statutory minimum.

One advocate described how the current eligibility criteria 'creates a difficult situation where some are getting something and others are not', and another that voluntary patients were 'disadvantaged because of having no advocacy support'. Another advocate described frustration they are 'not able to get involved at the moment', and the lack of advocacy support for discharge arrangements meant voluntary patients 'can end up in situations they didn't want'. Advocates also described challenges

when someone's legal status changed from detained to voluntary and 'access to advocacy suddenly falls away'.

Some advocates also reported that 'people are dropping between cracks in transition from the MHA to DoLS (Deprivation of Liberty Safeguards)' as DoLS authorisations can be delayed by 8 months or longer. During that period, as the DoLS is not yet in place, the person has no access to advocacy support. This was described as a particular risk for older people and people with a learning disability who were potentially vulnerable to long-term stays in hospital and subject to restrictions but without any access to advocacy services.

Where advocacy services had been commissioned to support voluntary patients, advocates still reported challenges. These included hospital wards only making referrals for detained patients and low awareness and uptake of advocacy amongst voluntary patients. This suggests that inequalities in access to advocacy would likely persist even if eligibility for advocacy was extended to voluntary patients (as currently with detained patients).

The focus groups did not identify any reasons why a system of opt-out advocacy (as proposed for detained patients) could not be applied to voluntary patients. Indeed, there was consensus that opt-out should apply to voluntary patients, and there were some reasons why this would be particularly helpful. For example, there is some evidence that older adult wards and children's wards have a greater proportion of voluntary patients and that these groups of people may also be less likely to request advocacy support proactively. Opt-out would help ensure that advocacy services could reach everyone admitted to a mental health hospital, including those who might need it most (but be least likely to request it proactively).

Advocacy services should be made available to voluntary patients in mental health hospitals on an opt-out basis.⁶

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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.

¹ <https://www.england.nhs.uk/hwalliance>

² <https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures>

³ <https://www.gov.uk/health-and-social-care/mental-health-service-reform>

⁴ <https://committees.parliament.uk/publications/33599/documents/182904/default/>

⁵ <https://www.gov.uk/government/publications/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations/rapid-review-into-data-on-mental-health-inpatient-settings-final-report-and-recommendations#recommendations>