

The Mental Health Act 1983

Colin Vines

cvconsulting@btconnect.com

The Mental Health Act 1983

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- The Mental Health Act Code of Practice and the Guiding Principles
- The 2007 Amendments - 9 Key Changes
 - Supervised Community Treatment
 - Independent Mental Health Advocates

Before We Start – What does that mean?

- MHA – Mental Health Act
- IMHA – Independent Mental Health Advocate
- ASW – Approved Social Worker
- RMO – Responsible Medical Officer
- AMHP – Approved Mental Health Professional
- RC - Responsible Clinician
- SCT – Supervised community Treatment
- CTO – Community Treatment Order

The 1983 Mental Health Act

Mental Health Legislation: An Introduction

- The Mental Health Act 1983 provides a statutory framework for the compulsory detention in hospital and medical treatment of patients suffering from mental disorder
- Detention under the 1983 Act is not permitted for any purposes other than assessing or treating mental disorders

Informal Admission

The majority of patients admitted to psychiatric hospitals are 'informed patients'.

Most of these patients have capacity and have consented to their informal admission and treatment

Compulsory detention under the 1983 Act is a measure of last resort

Police powers under the MHA

Section 136

- Police power to detain a person who is in a 'public place' and who they believe suffering from mental disorder and in need of immediate care and control. It enables them to be taken to a place of safety where they can be assessed by a doctor and an AMHP.
- This power lasts for a maximum of 72 hours.

Power to enter premises. . .

Section 135

- A Magistrate's warrant to enter premises where a person with a mental disorder is living and take them to a place of safety for assessment or to return them to hospital if they are AWOL.
- Persons taken to a place of safety can be kept there for up to 72 hours.

Detention in hospital

Section 2

Is for assessment which lasts for up to 28 days. It cannot be renewed and where a patient is thought to need longer term treatment they are placed on section 3.

Criteria for detention (section 2)

- The person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment (or for assessment followed by treatment) for at least a limited period.
- The person ought to be so detained in the interests of their own health or safety or with a view to the protection of other people.

Section 3

Which is for treatment and lasts up to 6 months, it can be renewed for a further 6 months and thereafter for 1 year at a time.

Criteria for detention (section 3)

- A person can only be detained for treatment under section 3 only if the following criteria apply:
- The person 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 the health or safety of the person or for the protection of other persons that they should receive such treatment and it cannot be provided unless the patient is detained under this section

Guardianship

Section 7 is guardianship

- Person has a guardian appointed – usually a local authority.
- Guardian can say where they live and require them to attend for treatment or other activities (e.g. day centre)
- Patient is not detained – but can be taken to the place they are to live, and returned there if they go absent without permission.

The Code of Practice and Guiding Principles

Who is the Code of Practice for?

- for the guidance of **registered medical practitioners, approved clinicians, managers and staff** of hospitals, independent hospitals and care homes and **approved mental health professionals** in relation to the admission of patients to hospitals and registered establishments under this Act and to guardianship and **community patients** under this Act; and
- (b) for the guidance of **registered medical practitioners and members of other professions** in relation to the medical treatment of patients suffering from mental disorder.

“In performing functions under this Act persons mentioned in subsection (1) (a) or (b) shall have regard to the code.”

This means that when reaching decisions, professionals must follow the advice of the code or justify why they are not able to do so.

Introduction to the Principles

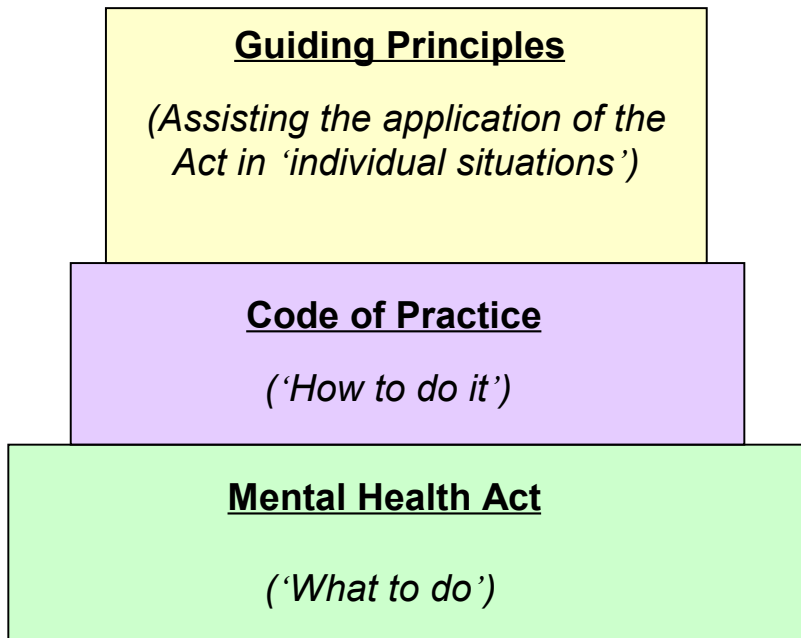
How do the Act, the Code of Practice and the Guiding Principles fit together?

Quite simply:

The Act tells us **What** to do

The Code explains **How** to do it

The Guiding Principles help us to apply the Act in **individual situations**.



The notion is that the principles are a framework of important values which help us focus on the best interest of the individual.

The principles make the practitioner consider the questions, 'Who?' 'How?' and 'Why?'

Principles

S 118 (2A) The code shall include a statement of the principles which the Secretary of State thinks should inform decisions under this Act.

The Code of Practice contains a set of guiding principles

- People taking decisions in respect of detained patients are required to have regard to these principles when making their decisions
- The principles are designed to inform decisions, they DO NOT determine them
- Although all the principles must inform every decision taken, the weight given to each principle will depend on the context
- They are there to safeguard the rights of the patient and also cover the rights of the family and carer who have the right to a fair and sensitive service for their relative

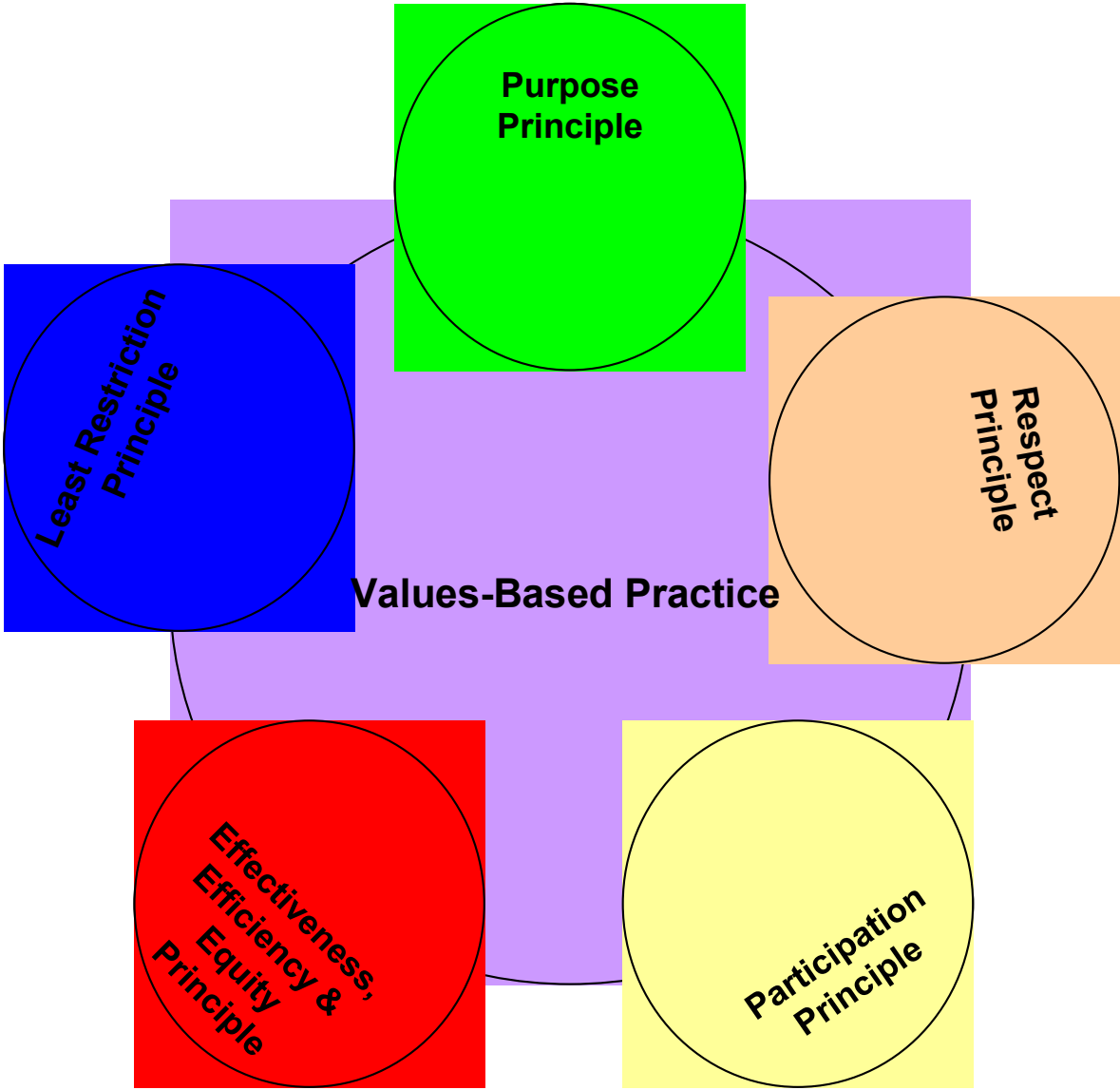
Why are principles needed?

Every decision taken involves unique individuals in unique situations. So, however carefully the law and the Code of Practice spell out what to do and how to do it, they can never cover all situations in sufficient detail. The principles guide us in individual situations by providing a framework of important considerations that should always be kept in mind when making decisions under the Mental Health Act.

(2B) In preparing the statement of principles the Secretary of State shall, in particular, ensure that each of the following matters is addressed:

- a) respect for patients' past and present wishes and feelings,
- c) respect for diversity generally including, in particular, diversity of religion, culture and sexual orientation (within the meaning of section 35 of the Equality Act 2006),
- e) minimising restrictions on liberty,
- g) involvement of patients in planning, developing and delivering care and treatment appropriate to them,

- a) avoidance of unlawful discrimination,
- c) effectiveness of treatment,
- e) patient wellbeing and safety, and
- g) public safety.
- i) views of carers and other interested parties,



Exercise

- What are values
- What individual values do you bring to your organisation
- What do you think are the current values in place in your organisation – and are they different to your personal ones

1. The Purpose Principle

When decisions are made under the Act they must be accounted for at all times. This includes the purpose of any such action taken.

This has obviously got to be in the best interest of the service user.

The well-being (psychological and physical) and safety of the service user is also to be considered at all times. Along with this is the safety and protection from harm of both the service user and the public (which includes carers, family & practitioners).

Decisions should be informed by an assessment of risk and the results of such should be made readily available for all concerned.

2. Least Restriction Principle

The patient must be afforded as much freedom as possible within the realms of safe practice. This means that a balance needs to be made, using thorough risk assessment and management plans, to ensure that the patient rights to freedom are balanced against their own right to be protected from the consequences of their mental disorder, and the rights of others, such as members of the public, so that they are not in danger or harm.

2. Least Restriction Principle (continued)

Creative and collaborative approaches to care for service users can be the most beneficial way of ensuring that restrictions are minimised. For professionals to understand the anxieties which may be present in a person facing a loss of freedom and liberties would be a beneficial and empathic place to start.

3. Respect Principle

The diversity of a population has to be respected and acknowledged by others and this is also true of mental health patients.

An anti-discriminatory approach must be upheld at all time to ensure equitable and fair practice.

Respect must be acknowledged for a patient's age, race, disability, religion, culture gender or sexual orientation.

In essence patients will be afforded the same rights and opportunities that anybody else may receive.

4. Participation Principle

Where practicable patients should be involved in planning and developing their own care in order to assist in this care being appropriate and effective. This involvement should also be extended to encourage carers, family members and other people who have a genuine interest in the patients' welfare, unless there are particular reasons to the contrary. The views of all parties involved should be taken seriously in the overall care management.

(2C) The Secretary of State shall also have regard to the desirability of ensuring:

- c) the efficient use of resources, and
- d) the equitable distribution of services.

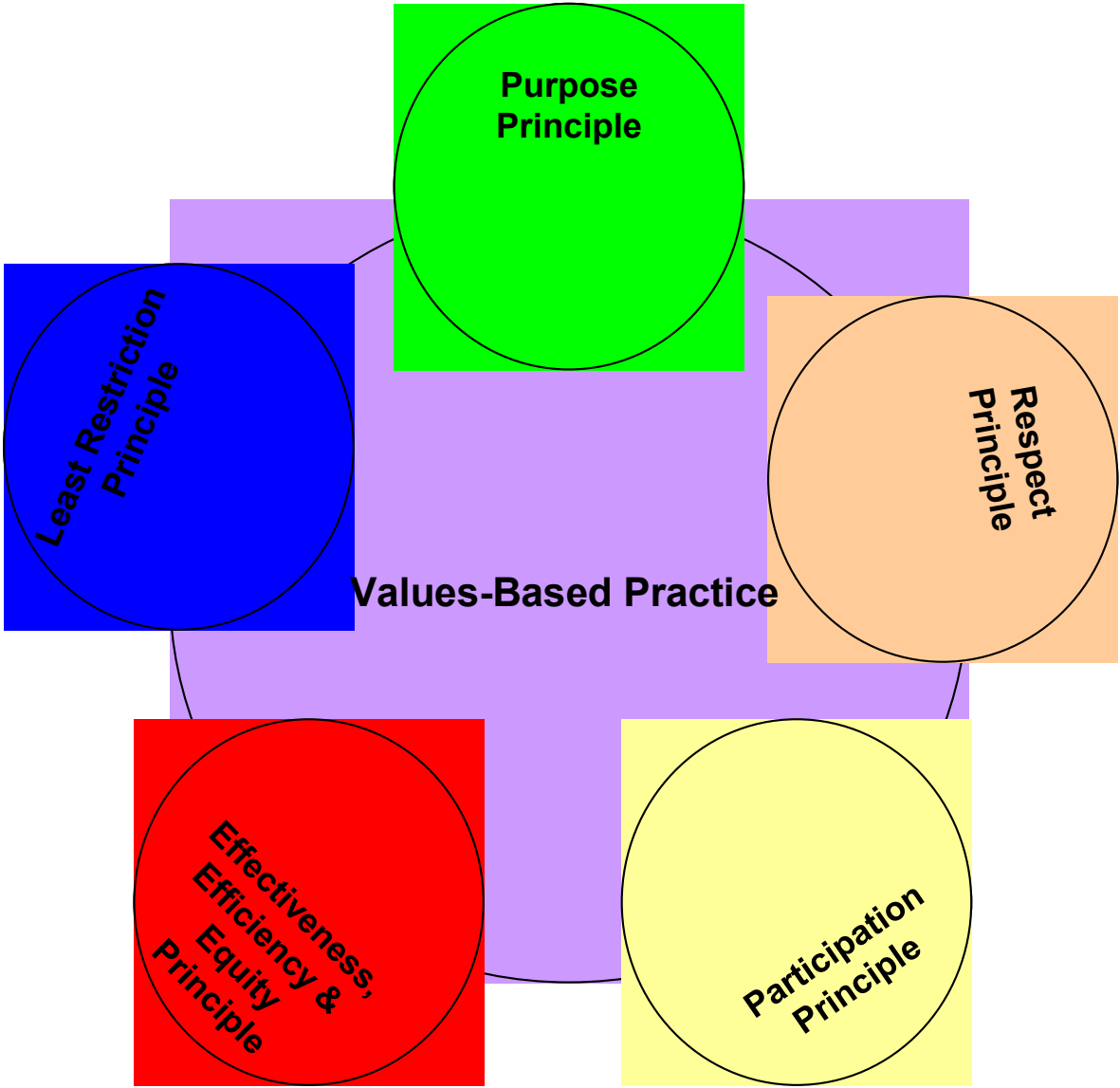
(2D) In performing functions under this Act persons mentioned in subsection (1)(a) or (b) shall have regard to the code.

5. Effectiveness, efficiency and equity principle

People taking decisions under the Act must seek to use the resources available to them and to patients in the most effective and equitable way, to meet the needs of patients and achieve the purpose for which the decision was taken.

In Conclusion

- Guiding principles are to be utilised to inform the decision making process and should be heeded by all practitioners
- The guiding principles should be considered in all cases
- It is vital to remember that none of the guiding principles carry more weight, importance or significance than any of the others
- The guiding principles provide a framework of important considerations that should always be kept in mind when decisions are made under the Mental Health Act, and they may also be used in general practice.



The 2007 Amendments to The Mental Health Act 1983

The 9 Key Changes

Key Changes

1. Single definition of Mental Disorder
2. Criteria for the use of Compulsion
3. Age Appropriate Services
4. Professional Roles
5. Nearest Relative
6. **The Independent Mental Health Advocate**
7. Patients and ECT
8. **Supervised Community Treatment**
9. Mental Health Review Tribunal

Other changes

- Abolishing **Finite Restriction Orders** so that when offenders are given restricted hospital orders (under section 37 and 41) they will always now be without limit of time;
- Amendments to **Sections 135 and 136** so a person detained in a place of safety can be transferred to another place of safety, subject to the overall time limit for detention of 72 hours;
- Changes to the powers of delegation for managers of **NHS Foundation Trusts**;
- Extending the **Rights of Victims** under the Domestic Violence, Crime and Victims Act 2004;
- Changes to the arrangements for **Informal Admission of Patients aged 16 or 17**.

9 Key Changes – 4 Steps

Step 1 – Coming Into Compulsion

Step 2 – Making Decisions

Step 3 – Supervised Community Treatment

Step 4 – Ending Compulsion

Step 1 – Coming into Compulsion

Key Change 1

Definition of Mental Disorder.

For sections of the MHA which apply to assessment under compulsion, the wording of the definition of mental disorder is very similar to that worked with under the existing MHA. It changes from “mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disability or disorder of mind” to: “**any disorder or disability of the mind**”

Step 1 – Coming into Compulsion

Key Change 1

Definition of Mental Disorder.

However, **this wider definition now applies to all sections of the MHA.** The four forms of mental disorder (mental illness, mental impairment, severe mental impairment and psychopathic disorder) have disappeared. This means some people previously excluded from treatment are now included. For example, people with a brain injury who were previously excluded from the use of s3 could now benefit from the protections of the MHA.

Step 1 – Coming into Compulsion

Key Change 2

Appropriate Treatment

Introduces a new “appropriate treatment” test which will apply to all the longer-term powers of detention (for example, section 3 and Supervised Community Treatment). As a result, it will not be possible for patients to be compulsorily detained or their detention continued unless ‘medical treatment’ which is appropriate to the patient’s mental disorder and all other circumstances of the case’ is available to that patient.

Step 1 – Coming into Compulsion

Key Change

²‘Medical treatment’ includes psychological treatment, nursing, habilitation and rehabilitation as well as medicine.

It doesn't have to be the 'perfect' treatment, but it does have to be clear what the treatment will be, and that it will be available in a particular place. Doctors, for example, will be expected to state on their recommendations for s3 what sort of treatment is needed, and in which hospital(s) it will be available to the patient.

Step 1 – Coming into Compulsion

Key Change 3

Admitting young people to suitable environments

The effect of this change is that hospital managers are placed under a duty to ensure that patients under 18 who are admitted to hospital for assessment or for treatment under the legislation, or who are voluntary patients are in an environment that is suitable for their age (subject to their needs).

Step 1 – Coming into Compulsion

Key Change 3

There is flexibility in the amendment to allow for patients under 18 years to be placed on adult psychiatric wards where the patient's needs are better met this way. This is expected to come into force in 2010, by which time it is hoped new services will be available. S140 of the existing Mental Health Act has also been amended, to put a duty on Primary Care Trusts to let Local Social Service Authorities know where services that can admit young people in an emergency are to be found.

Step 2 – Making Decisions

Key Change 4

Broadening Professional Groups

This change widens the group of practitioners able to train to fulfil functions currently undertaken by Approved Social Workers (ASWs) and Responsible Medical Officers (RMOs). It does this by introducing two new roles:

Step 2 – Making Decisions

Key Change

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Approved Mental Health Professionals (AMHP).

Based on the old ASW role, AMHPs are mental health professionals with specialist training in mental health assessment and legislation. The training will be opened up from social workers to also include mental health and learning disability nurses, clinical psychologists and occupational therapists. AMHPs will assess 'on behalf' of Local authorities, who will continue to be responsible for approving AMHPs, and ensuring a 24hr AMHP service is available.

Step 2 – Making Decisions

The final part of this change concerns the **Approved Clinician (AC)**, the professional status a practitioner must obtain before they can become a **Responsible Clinician (RC)**.

The RC is the old Responsible Medical Officer role, which has now been opened up to include social workers, mental health and learning disability nurses, clinical psychologists and occupational therapists.

Step 2 – Making Decisions

The RC has overall responsibility for a patient's case. This change allows more flexibility – for example making it possible to transfer responsibility to professionals from different groups of staff, as the patient's needs change.

Regulations make it clear that all professionals who want to be an RC need to meet particular levels of competence undertake a short course to demonstrate their state of readiness and be approved by Strategic Health Authority as an AC.

Step 2 – Making Decisions

Key Change 5

Nearest Relative

Changes give patients the right to make an application to court to displace their NR and introduces a new ground for displacement where there are reasonable grounds for doing so. The provisions for determining who the NR is are amended to include civil partners on equal terms with heterosexual married couples.

Step 2 – Making Decisions

Key Change 6

Advocates

From April 2009, gives the right for patients who are subject to compulsion to have access to advocacy services.

More detail Later

Step 2 – Making Decisions

Key Change

7

Patients and Electro-Convulsive Therapy

For patients aged 18 and over, the patient may only be given ECT if they have capacity and agree, or if they don't have capacity the ECT must be authorised by a SOAD (except in an emergency).

In other words, this means that a detained patient can *refuse* to have ECT, and this can only be overturned if a SOAD agrees that the patient does not have capacity to make the decision, and that giving the ECT treatment would be appropriate. In this case, the SOAD also needs to be sure that there is not a valid advanced decision refusing the use of ECT.

Step 2 – Making Decisions

Key Change 7

If such an advanced decision has been made, then ECT cannot be given, except in an emergency. In the case of young people, (aged under 18) even if a child with capacity agrees, they may only be given ECT with the additional agreement of a SOAD. These rules apply to young people *whether or not they are detained*. In addition, if a young person isn't detained, and doesn't have capacity to agree to the treatment, as well as the agreement of the SOAD, another authority to treat (for example, from the court of protection) will be needed.

Step 3 – Supervised Community Treatment

Key Change

8

Supervised Community Treatment

Introduces Supervised Community Treatment (SCT) for patients following a period of detention in hospital (mainly those on Section 3 or 37).

More detail Later

Step 4 – Ending Compulsion

Key Change 9

Mental Health Review Tribunal

Changes to the Mental Health Review Tribunal (MHRT) rules have introduced earlier referrals by Hospital Managers of detained patients who have not used their rights of appeal to the MHRT. The six month referral rule must take into account any time that a patient may have been detained under Section 2.

Step 4 – Ending Compulsion

Key Change 9

The annual referral to the MHRT for those under 16 has been raised to those under 18. The Secretary of State has the power to further reduce the period for referral by Hospital Managers in the future. The MHA has also introduced the immediate referral of patients who have had their SCT revoked.

The existing multiple regional tribunals are to be replaced with two tribunals, one for England and one for Wales.

In Summary

Changes in the Mental Health Act	Changes in Best Practice in mental health and social care since 1983
1. Single Definition of Mental Health Disorder	This recognises that certain people were excluded from treatment by the past definitions, and society has increasing expectations of who should be helped by mental health services.
2. Criteria for Detention	This reflects the belief that the treatability test was not deemed in the patient's interest and encourages a move away from the medical model. It also allows for the development of services for people previously deemed as "untreatable".
3. Age Appropriate Services	Recognition that children have been inappropriately detained on adult wards in the past, and that facilities and services appropriate to their age and needs must be made available.

4. Broadening Professional Groups	Direct reflection of the move to multidisciplinary or multi-agency teams as basis of service delivery in mental health and social care.
5. Nearest Relative 6. Advocacy Services 7. Electro-Convulsive Therapy	Recognition of the importance of strengthening the patient's voice.
8. Supervised Community Treatment	Shift to treatment and care for mental health issues in the community rather than in hospital.
9. Earlier Referral to MHRT	Recognition of the need for strengthening protections for patients.

Supervised Community Treatment

- Supervised Community treatment is the name given to the whole ***approach***
- The name of the section that details the requirements and powers is a ***Community Treatment Order s17a*** Mental Health Act 1983 (as amended by the 2007 Mental Health Act)

What is SCT?

- SCT is intended to support patients who have a mental disorder, have been detained for treatment, and are likely to disengage from treatment once they are discharged.
- The order introduces the ability to recall the patient subject to certain conditions

How the COP defines the purpose of SCT

- 25.2 The purpose of SCT is to allow suitable patients to be safely treated in the community rather than under detention in hospital, and to provide a way to help prevent relapse and any harm – to the patient or to others – that this might cause. It is intended to help patients to maintain stable mental health outside hospital and to promote recovery.
- 25.3 SCT provides a framework for the management of patient care in the community and gives the responsible clinician the power to recall the patient to hospital for treatment if necessary.

How does SCT work?

Legally, the effect is to suspend the following requirements of a treatment order:

- the liability *to be detained in hospital*
- the requirement to *take medication under Part 4 of the Act*

Patients on SCT are subject to part 4a, which requires their consent

What are the criteria?

- (a) the patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment;
- (b) it is necessary for his health or safety or for the protection of other persons that he should receive such treatment;
- **(c) subject to his being liable to be recalled** as mentioned in paragraph (d) below, **such treatment can be provided without his continuing to be detained in a hospital;**
- **(d) it is necessary that the responsible clinician should be able to exercise** the power under section 17E(1) **below to recall the patient to hospital;** and
- (e) appropriate medical treatment is available for him.

‘..... The key factor in the decision is whether the patient can safely be treated for mental disorder in the community only if the responsible clinician can exercise the power to recall the patient to hospital for treatment if that becomes necessary’

- COP 25.7

‘the patient is suffering from a mental disorder of a nature or degree’

- With SCT, the nature of a person’s mental disorder is likely to be of more importance than the degree of their disorder

‘it is necessary for the patient’s health, or safety or the safety of others.’

- Risk needs to be considered within the context of the patient’s history of mental disorder (the ‘nature’)
- The risk of deterioration and the possible risks associated with that

Consenting or agreeing to cooperate?

COP: 25.14

‘Patients do not have to consent formally to SCT. But in practice, patients will need to be involved in decisions about the treatment to be provided in the community and how and where it is to be given, and be prepared to co-operate with the proposed treatment.’

Conditions

The following two conditions **must** be applied (under s17b of the MHA):

- that the patient must make himself available for examination of whether his CTO should be extended under s20A
- that if a SOAD doctor needs to see him/her, he must also make himself available

Other conditions may be imposed as long as they are 'necessary or appropriate', for one or more of the following reasons:

- **ensuring that the patient receives medical treatment** *and/or*
- **preventing risk of harm** to the patient's health or safety *and/or*
- it is **necessary to protect** other people

An AMHP must also agree:

that any such conditions are '**necessary or appropriate**'

Recommendations from the MHRT

- The MHRT can recommend that the RC considers the use of SCT
- It is up to the RC whether or not they agree to the use of the order

CPA & the SCT process

- The use of SCT sits within the CPA process as a whole
- Any SCT application needs to be supported by a comprehensive care plan
- Any care plan must be informed by the guiding principles of the Act
- It is important that patient and carers are fully involved in the planning and application process

The SOAD's role

The treatment plan must be agreed by a SOAD within 1 month (or if the patient has only recently come into hospital on s3, the remainder of the 3 month period where treatment is allowed without the patient's consent.)

The effect

No one can be treated
forcibly in the
community, except in an
emergency.

S17 leave or SCT?

If the RC wishes to send someone on s17 leave for more than 7 days, the law now says that they must consider whether SCT would be a better option.

SCT – the protections

- The person isn't subject to Part 4 so cannot be forced to accept medication in the community (? May promote better relations due to better balance of power with care team)
- They can be recalled to hospital to prevent an acute crisis
- A SOAD must check their treatment plan within 1 month
- The person gains a further right of appeal to the MHRT when they start on SCT

Protections - Continued

- Again, if their order is revoked, the hospital managers have a duty to refer them to the MHRT straight away (the patient also has the option to withdraw if they wish to appeal at a later stage within the 6 month period.)
- An AMHP can prevent the use of SCT, it's conditions, renewal and revocation
- They are entitled to an IMHA
- The Nearest Relative has a similar right of discharge to s3

Review at the end of the period

- At the end of the period of compulsion, both the Responsible Clinician and the AMHP have to reassess, and agree that the criteria are met, prior to the order being extended further.
- The AMHP must also agree that the use of the power continues to be ‘appropriate’

Recall and Revocation

- If the compulsory conditions are breached, the RC can recall the patient
- If other conditions set are breached, recall can only happen if the criteria on the following slide are met, however
- If the following criteria are met, the person can be recalled whether or not they have breached their

The RC can recall the patient subject to the following criteria:

- 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.

What this means....

- It is possible to recall the patient at an earlier stage, if it is considered that non-compliance with medication would lead to further deterioration in their mental health
- This will usually relate to the *nature* of their mental disorder, rather than its *degree*
- The advantage of this is not just for the patient's mental health but also avoids the potentially stigmatising effects (such as police involvement) often associated with later intervention

The effect of recall

- Once recalled, the patient becomes subject to Part 62A of the Mental Health Act. This means the person can be forced to take medication
- The recall may last for up to 72hrs
- If the order is revoked, the CTO reverts to its previous status (i.e. s3, s37 etc).
- The Section starts again, 6 months, 6 months and a year for renewal.

How someone is recalled

- The Act says that a patient will become subject to recall once they have received the notice to recall in writing
- Received means *either* physically being given the order *or* it being sent to the last known address of the patient

- In practice, the Code (25.57) suggests that in most cases the recall notice should be given directly to the patient. In this case the power to recall is effective immediately
- Where the recall notice needs to be posted, the notice is deemed to be served on the 2nd working day after posting.
- If the recall notice is hand delivered, it will take the following day
- In either case, if the patient does not comply, they would be deemed to be AWOL

- The liability to be detained therefore comes back into effect
- The 72 hrs only begins once they have returned to hospital
- 'hospital' has a wider meaning to include community treatment centres, where this is deemed to be a more appropriate place for recall.
- The power to enforce treatment starts when the patient arrives at the hospital (as above)
- The patient does not have to be returned to their 'responsible' hospital.

Amending or suspending conditions

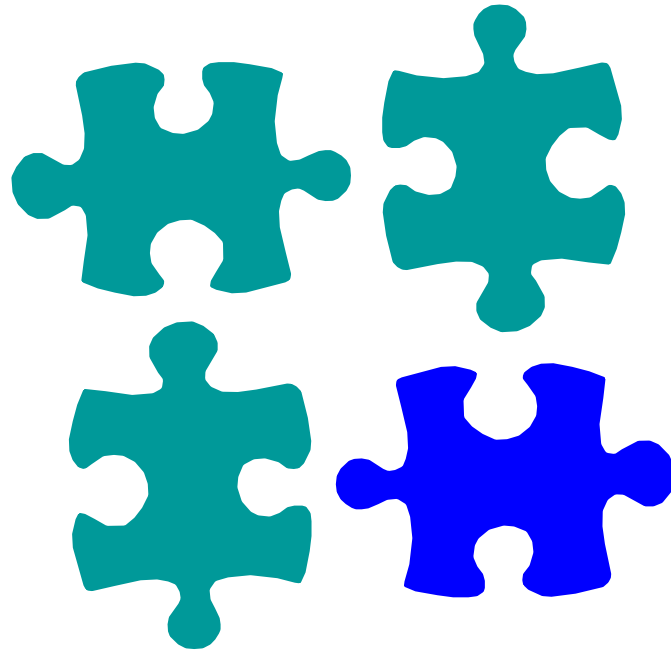
- The Responsible Clinician may amend or suspend conditions imposed on the service user (but it would not be good practice to make changes soon after imposing the order, unless there were a change in circumstances.)
- Any changes must be sent in writing to the service user.

Independent Mental Health Advocates

What is an Independent Mental Health Advocate (IMHA)

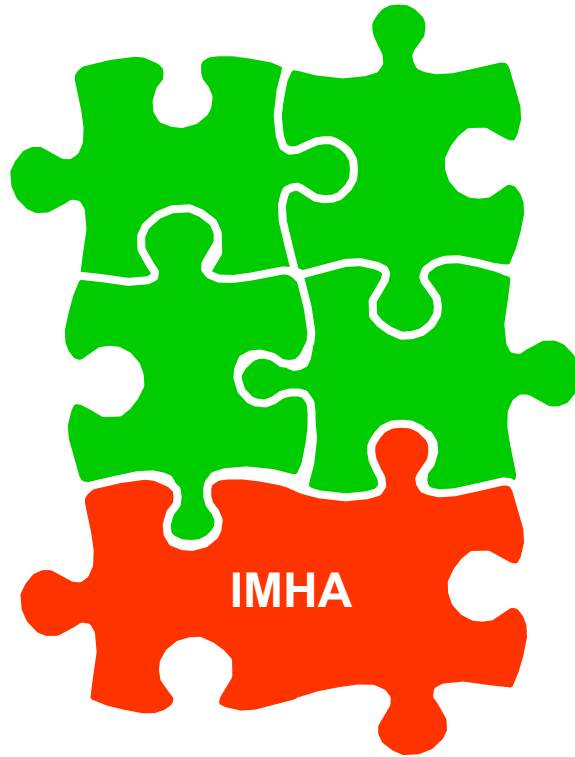
- Specialist advocates who are trained to specifically work within the framework of the Mental Health Act, to meet the needs of detained patients.
- They do NOT replace existing advocacy services or legal representation.

By completing all four modules...



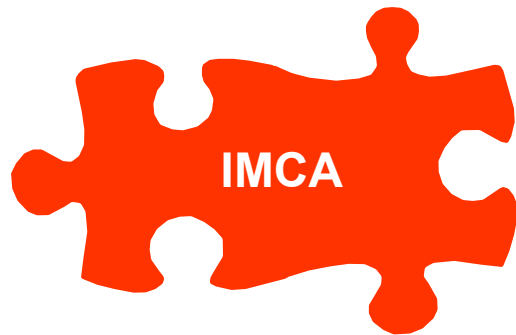
...the learner will
achieve
Level 3 qualification

By completing all four modules a specialist pathway...



...the learner achieves specialist module

The five proposed specialist modules:



A Independent Mental Health Advocacy



Role of the IMHA

Mental Health Review Tribunals

Visiting people who are detained

Mental Health Act 1983 & 2007

Accessing records

Providing information

Rights within mental health legislation

Independent Mental Health Advocacy

IMHAs required to complete the unit within
one year

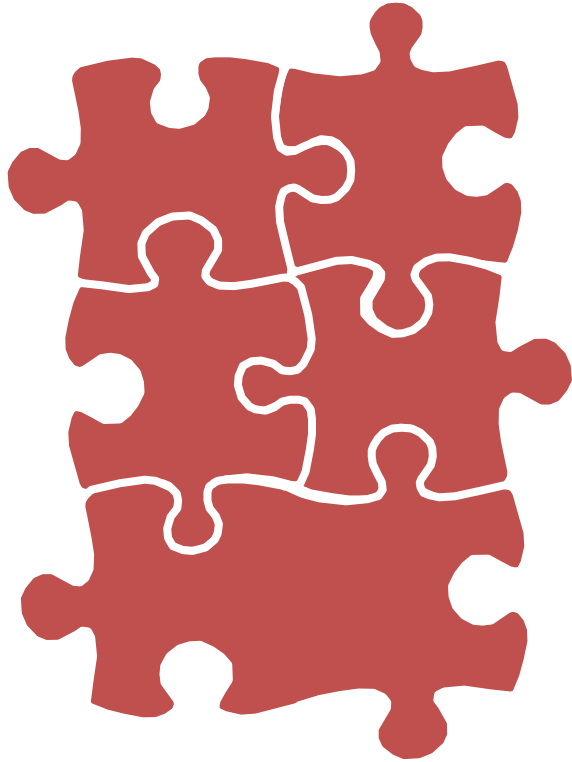
Independent Mental Health Advocacy

Service users involved in its delivery

Based on competence – workplace
assessment

Assessed by portfolio

Flexibility!



The Learner can complete the first four modules in any order

There will be a choice of trainers; you can choose where to take each module

Walk away at any point with certificate(s) for learning completed

Course can be delivered part or full time

Myths and Facts

MYTH

IMHAs aren't any different to non-statutory mental health advocates.

FACT

IMHAs have legal rights and obligations under the Mental Health Act and non-statutory advocates do not.

The right to:

Visit patients in hospital

Interview professionals involved in their care

Access patient's records

MYTH

IMHAs must be present when a patient is assessed under the Mental Health Act to determine if they need to be detained.

FACT

IMHA services are not expected to provide an emergency response service. They are unlikely to be present during most assessments.

MYTH

IMHAs cannot accompany patients to Tribunals or Hospital Managers hearings.

FACT

IMHAs can accompany patients to Tribunals and Hospital Managers' hearings and speak on their behalf.

MYTH

IMHAs will replace legal representation for patients at Tribunals

FACT

IMHAs are not the same as legal representatives and are not expected to take over duties currently undertaken by solicitors and their staff. Qualifying patients will continue to have the right to be legally represented in Tribunals.

MYTH

An IMHA can look at a patient's records even if the patient hasn't consented.

FACT

The IMHA does not have the right to access records where a patient with capacity has not consented.

If the patient is unable to consent because they lack capacity, the holder of the records must allow the IMHA access if they think that it is appropriate and that it is relevant to the help the IMHA will provide.

MYTH

Patients can choose anyone they wish to be their IMHA.

FACT

Only advocates who are employed as an IMHA by a commissioner or by an IMHA service, can act as an IMHA.

MYTH

IMHAs must have completed the National Advocacy Qualification before they can practice as an IMHA.

FACT

IMHAs do not need any specialist training before they start practice. However, they must demonstrate appropriate experience or training, or an appropriate combination of experience and training.

MYTH

IMHAs aren't required to have any previous experience or training, or to undertake any training while practising as an IMHA

FACT

Under regulations, an IMHA must have appropriate experience or training, or an appropriate combination of experience and training. It is up to the person or organisation appointing the IMHA to determine whether they demonstrate this. When making this decision, they should consider:

Previous experience working in advocacy, particularly mental health advocacy

Previous experience working with people with mental health needs

Successful completion of an advocacy qualification, in particular the IMHA module of the National Advocacy Qualification