

# Independent Advocacy

## A brief look at its past and present. Is its future under threat?

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**Summary:** *The need, in mental health care, for advocacy which is independent of the health care provider is clear and acknowledged but the existence of the schemes which provide it might be seriously threatened by PALS. Principles of independent advocacy have been developed over the last twenty five years. Unfortunately many advocates are unfamiliar with the law affecting their practice and its impact upon those principles, especially in respect of confidentiality. The advocate is the client's agent, owing a duty of care but unable to guarantee confidentiality. It is likely that most independent advocacy schemes have wholly inaccurate and inadequate confidentiality policies and guidelines. If these inadequacies are not addressed independent advocacy will not be able to compete with rival systems and it will be in danger of disappearing.*

Those who receive a diagnosis of mental disorder are thereby placed in a uniquely disenfranchised position. It is recognised that they frequently benefit from the assistance of an advocate and that, since their disenfranchisement is imposed by the service provider and the medical profession, there is an essential role for an advocate who is independent of both and who will seek simply to express the views of the service user.

Psychiatric nurses are taught to regard advocacy for their patients as part of their role<sup>1</sup> but there is an obvious likelihood of conflict between what the client wants and what the mental health team thinks is best for them. In such a situation the “nurse advocate” will almost inevitably bow to the weight of medical opinion and say that the patient must do likewise.

Advocacy in the context of mental health is therefore a manichean concept labouring under two very different principles, the one being independent “client led” advocacy which adopts as its final position the principle that “the service user must be heard”; the other being “profession led” advocacy which adopts as its final position the principle that “the medical profession and the service provider know best”.

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1 See eg “Guidelines for mental health and mental disabilities nursing”; 1998, UKCC

The government has proposed an NHS - wide Patient Advocacy and Liaison Service (PALS)<sup>2</sup> which will provide a “patient advocate team [which] will act as a welcoming point for patients and carers and a clearly identifiable information point” and “build on and support current specialist advocacy services”. The terms in which PALS has been proposed suggest that it will lean very heavily on the model of “profession led advocacy” and in fact will provide a service which is advisory and not advocacy at all. Since PALS will receive government funding there has to be a danger that independent client led advocacy will become a poor relation and gradually disappear. The duality which presently afflicts the concept of advocacy will be resolved when all advocacy, under the auspices of PALS, will be “profession led”.

If independent advocacy does survive and prosper alongside PALS it will be because its practitioners understand both the principles governing their practice and the legal context within which they work. That understanding will provide a firm platform from which they will be able to present arguments justifying their position.

This article (which covers a very wide area and, we acknowledge, only scratches the surface of many subjects which each deserve their own much deeper consideration) addresses issues which we believe must be clearly understood by all independent advocates. The article comes in two halves. In the first half we consider, briefly and broadly, the history of advocacy in the context of mental health, the various types of independent advocacy practised at present and the principles which guide them. In the second half we consider, from a practical point of view, the legal relationship between the advocate and the client and difficulties which arise, particularly in respect of the confidentiality with which the patient/client will expect communications with the advocate to be treated. The issue of capacity has to be briefly considered in this context. We believe that many providers of advocacy services have not addressed these difficulties, which arise from tensions between the law and the ethos of advocacy, and which must be confronted.

Unless the context indicates otherwise the word “advocacy” means “independent advocacy” throughout the rest of the article.

### What is advocacy?

In this context the word “advocacy” is used idiosyncratically. It does not mean conducting or presenting a case before a court, tribunal or assembly but has a meaning very different from that used in common parlance and it is emphatically very different from the advocacy practised by the legal profession.<sup>3</sup>

Advocacy in a mental health setting means assisting service users to express themselves and take an active part in the making of decisions affecting their lives. The assistance may sometimes take the form of speaking on behalf of the service user, but it will more often comprise the provision of information and moral support, as well as being a good listener.<sup>4</sup>

The purpose of advocacy is to ensure maximum preservation of each service user’s personal autonomy and self determination. It follows that the advocate will not offer either opinion or advice and will not judge either the service user or what they want to say.<sup>5</sup>

2 NHS Plan: A Plan for Investment A Plan for Reform; Chapter 10, Changes for Patients

with, rather than for people whenever possible”.

4 *ibid* p.10.

3 *Advocacy - A code for practice: 1994: UKAN* p.4 refers to “... the need for advocates to follow rather than lead [people]”. On p.14 it says “Advocates are there to speak

5 *ibid* p.11: “the giving of advice and the exertion of influence on peoples’ choices are, in effect, breaches of the Advocacy Code of Practice”.

### **History and development of independent advocacy.**

Advocacy has been linked with mental health services as far back as the 17th Century. There is evidence of a campaign for conditions to be improved in Bedlam in 1620<sup>6</sup> and an article written by A.Cruden in 1739 notes that ex-patients were openly complaining about practices in psychiatric hospitals<sup>7</sup>. John Percival has been identified as the first known peer advocate in Britain for the work he did in the mid-nineteenth century<sup>8</sup>.

The modern advocacy movement began to emerge in Britain in the 1970's and 1980's. In 1972 the Scottish Union of Mental Patients was formed, closely followed by the establishment of the Mental Patients' Union in London. Membership was restricted to patients and ex-patients who then campaigned to have conditions improved in psychiatric hospitals and raised issues they felt were of concern. Although the Unions were not then called 'advocacy groups' they certainly were examples of collective self-advocacy by those personally using mental health services.

In 1982 the Advocacy Alliance was formed to introduce independent citizen advocacy. At that time in the Netherlands wide scale independent advocacy was being established in psychiatric services and the work undertaken there influenced pioneering work in Britain. The Nottingham Advocacy Group developed 'patients councils', forums within psychiatric hospitals where patients met to discuss common issues and then tried to resolve them with staff. By the end of the decade many such forums had been established.

In 1990 a national user conference was held to look at the possibility of setting up a national body to represent the numerous advocacy services, patients' councils, and user groups that were by then in existence. The United Kingdom Advocacy Network (UKAN) was founded as a result.

Several writers, including Feenon and Campbell (2001), attribute the growth and expansion of the advocacy movement during the 1980's in part to a raised awareness, in health and social care services, that mental health service users are consumers with the right to have their views aired and to be involved in the services they use. Barnes also notes in her research that the acceleration of the developments in advocacy can be linked to an acknowledgement of the possibilities and existence of abuse and low levels of care, and an awareness of the damaging effects of living in institutions.<sup>9</sup>

In the Netherlands in 1996 legislation was passed which provides that every psychiatric institution is obliged to have a patients' council and that council's approval has to be obtained on such issues as appointments to management and changes in complaints procedures. The effect has been to indicate the value which the legislature attaches to the views of mental health service users. In Britain there has been no similar legislative recognition.

'Advocacy - A Code of Practice', developed by UKAN, was published in 1994. It drew together the existing principles and guidelines for good practice. In the same year the Butterworth Report highlighted the conflict of interest for health providers acting as advocates and said that service users should have access to advocates, who can put forward their views "unreservedly".<sup>10</sup> In 1996 Building Bridges, a guide to inter-agency working for the care and protection of severely mentally ill people identified service users involvement as a fundamental principle in mental health care and spoke of advocacy supporting the process.<sup>11</sup> In 1995 the Patients Charter<sup>12</sup> had given patients the

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6 Brandon, D 1991

7 Mind, 1992

8 Conlon, E in UKAN 1994

9 1.10; Barnes, 2001

10 Department of Health, 1994

11 Department of Health, 1996

12 Department of Health 1995

right to be involved in their own care, and in 1997 the Mental Health Patients Charter<sup>13</sup> stated that service users should be informed of and have access to any local advocacy services. The Mental Health Act Commission referred to advocacy in their biennial reports of 1997 and 1999 and at this time developed the practice of checking on the availability of advocacy services on their visits to psychiatric hospitals.<sup>14</sup> In the Mental Health National Service Framework<sup>15</sup> published in 1999 advocacy is treated as an essential part of mental health services. Now at the turn of the century we have advocacy discussed in the NHS National Plan and in the Mental Health White Paper.

### Models of Independent Advocacy

Over the last twenty years various forms or 'models' of independent advocacy have evolved. Whilst this list must not be regarded as a comprehensive description of all advocacy practised in Britain, it is a familiar list frequently used to describe the main models of advocacy on offer.<sup>16</sup>

**Self-advocacy**, as the name suggests, is individuals acting and speaking for themselves. "Self advocacy is about power - about people regaining power over their own lives".<sup>17</sup> It may be hard for people to speak up in this way; the formation of self-advocacy groups has enabled them to support each other. Survivors Speak Out is perhaps the best known self-advocacy organisation in mental health advocacy.

**Group advocacy** - Group or collective self-advocacy occurs when a specific group of people unites to raise and put forward shared views. Patients' councils and mental health user groups are examples of group advocacy.

**Peer advocacy** is support from a person who is or has been a service user for another who is confronting experiences or difficulties similar to their own. It has been said that the uniqueness of the peer advocacy role is in the advocate's empathy with the client's situation; their experience may have equipped them with valuable skills or qualities and the client may feel that they have a particularly equal relationship with the advocate.<sup>18</sup>

**Citizen advocacy** is an independent, long term, one to one partnership between a volunteer citizen advocate and a person who needs help in representing and defending their interests and rights as a citizen. Citizen advocates are usually part of a scheme (led by a paid co-ordinator) which will recruit, train and support the volunteers. The citizen advocate role is different from other forms of advocacy in that it involves a long-term partnership with one person and involves responding to and representing many concerns or views that their 'partner' may have in different areas of their life.

**Paid/ formal advocacy** - is where a trained, paid worker offers independent, short term, one to one support to a client who wishes to access the service or is a service user. This type of advocacy has often been developed and managed by voluntary organisations.

**'Best interests' (non-instructed) advocacy** - We argue below that there is no legal basis for this type of alleged advocacy which consists of an advocate acting on behalf of someone who is unable to express their views and instruct the advocate. The 'advocate' may act without instruction from their client<sup>19</sup> by representing what they feel the person's wishes would be if they could express

13 Department of Health 1997

14 Mental Health Act Commission Biennial report 1997/1999.

15 p.10, Department of Health, 1999

16 See *Advocacy - A Code of Practice 1994 and The Mind*

*Guide to Advocacy 2000.*

17 *Survivors Speak Out 1990* cited in *MIND* p.9, 1992

18 Conlon, E in *UKAN* 1994

19 Kelley 2001: see also *The Mind Guide to Advocacy 2000* p.5

them. This type of work has been carried out by people working with dementia sufferers who have been unable to communicate clearly to the advocate.

UKAN, among others, has stressed that the ultimate aim is to have people advocate for themselves, yet frequently this is not possible. 'Formal' advocacy has developed out of the recognition that there are times when people are unable to represent their own views and interests.

Principles have evolved which we think are accepted by all providers of advocacy services as governing the advocate/client relationship. Namely, that it is independent, client led, non-judgmental and confidential.<sup>20</sup> These principles have been developed from guidance issued by organisations such as UKAN and from work carried out by organisations that have provided formal advocacy over a period of time.

## **Principles of Independent advocacy**

### *Independent*

The independence of the advocate is of crucial importance if they are to represent the client's view as faithfully as possible. Advocacy is acknowledged as being within the role of mental health professionals but there are limits as to how far they can advocate for the users of their services.<sup>21 22 23</sup> There is the potential for conflict of interest arising from their role of service provider. Ultimately, as mental health professionals, they have power over users of their services and they also have to use their own judgement and assessment of a service user's needs.<sup>24</sup> An advocate must be an independent supporter who is there purely for the 'user' with a loyalty to them alone.

Barnes (2001) and UKAN (1994) note that there are several issues that need to be addressed to ensure that the independence of an advocacy service is not compromised. A clear example is the funding and management of the service. If these are controlled or led by a service provider then there is the danger that the advocate will fail to perform their task to completion because if they were to do so they would be taken to the point at which they would be advocating against the people who pay their wages and supervise their work.

### *Client led*

Independent advocacy aims to be led wholly by the 'client/user'. The advocate will only support a person if they want support and the client will guide the advocate. Kelley offers a clear description of the role; "instructed advocacy – if the person asks for it the advocate does it, if they don't ask for it, the advocate doesn't do it".<sup>25</sup> The purpose of offering advocacy support is to give the control and power to the client and not to take it away by speaking and deciding for them.<sup>26</sup> The advocate should not offer their own opinion nor should they offer advice or tell the client what they should do. The advocate's role is to provide the client with information and the opportunity to discuss concerns and options.

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20 Gathercole 1986 in Butler, Carr & Sullivan, p.2; 1988. UKAN 1994 p.14-16

21 "Guidelines for mental health and learning disabilities nursing"; p.14, 1998, UKCC.

22 Brandon, D in *Professional Social Work*, p13, April 1995

23 Hopton, J; p.3, *Openmind* ed.69, June/July 1994

24 Read and Wallcraft; "Guidelines on Advocacy for mental health workers", p.17; 1994; *Unison/Mind*

25 p.11, *Openmind* Jan/Feb 2001

26 *Royal College of Psychiatrists* 1999, p.6; UKAN 1994, p.14

### *Non judgmental*

The advocate should not make any judgements.<sup>27</sup> The advocate is acting not as a mental health professional but as a messenger for their client. They will therefore not interpret or assess what the client is saying but will work with the client to ensure that what they advocate is what the client is saying.<sup>28</sup> At this point misunderstandings can occur: other mental health workers sometimes think that an advocate is acting against the client's best interests if they seem to be 'supporting the client's delusions'.<sup>29</sup> It is important to remember that the advocate is supporting the client's right to be heard. It is not the advocate's role to decide if the client is capable of putting forward a view nor to analyse what is being said, but to ensure that the client's view is expressed, irrespective of how others may view it. The tensions between this principle and legal considerations of capacity are addressed below.

### *Confidential*

The confidential nature of the advocacy relationship is of great importance but there is a tension between its theory and practice. The UKAN Advocacy Code of Practice states on page 15 that "Advocates will disclose to service users complete details of all communications concerning them, but they will not disclose information about them to others without their express consent". That statement misrepresents the true legal position because neither privilege nor confidentiality apply to the relationship if it can be demonstrated that a third party has a sufficient interest in acquiring information which has been received by the advocate in the course of the relationship. This issue, which also raises the questions of capacity and undue influence, is addressed below.

### **The Challenge Now: To match the principles with the law**

Currently those who practise independent advocacy have no professional or governing body to provide rules and guidance. In view of the government's proposals contained in the NHS Plan it is essential that they now identify and clarify where they stand on fundamental points of ethics and practice. If they do not they may find that a system of ethics and a code of practice which do not reflect their own understanding of their work is forced upon them.

With that in mind we now consider five inter-related questions, which we think must affect, on a daily basis, the practitioners of peer advocacy, citizen advocacy, "best interests advocacy" and especially paid/formal advocacy.

The questions are:

- i) What is the legal relationship between the advocate and the service user?
- ii) Does the advocate owe a duty of care to the service user and if so what does it involve?
- iii) To what extent are communications between service user and advocate privileged or confidential?
- iv) How do the two separate, but often inseparable, issues of capacity and undue influence impact on these questions, and is the advocate ever entitled to raise the issue of capacity?

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27 *Mind guide to advocacy*; p.3; 2000

29 *Read and Wallcraft* 1994, p.16

28 *Curran & Grimshaw*, *Openmind* Jan/Feb 2000

v) In view of the conclusions reached in answering questions iii) and iv) above, how is the client to be protected from the risk of the unpleasant consequences of reporting information to the authorities?

### *Legal Relationship Between Service User and Advocate*

At present the provision of advocacy services by independent schemes has no statutory basis. We are not aware of any schemes which enter into contracts with clients for the provision of advocacy.<sup>30</sup> However, it is clear that a relationship is formed between the service user and the advocate in which the service user relies on the advocate to assist them and speak for them as and when necessary. No payment is made for the service.

Some help is to be found in cases which have been concerned with the provision of a service in a contractual or quasi-contractual situation.

Perhaps agency is the formal legal category which best accommodates the relationship. The advocate is the agent of the service user.

Lord Cranworth discussed the formation of an agency in *Pole v Leask*<sup>31</sup> saying “no one can become the agent of another person except by the will of that other person. His will may be manifested ... simply by placing another in a situation in which ... according to the ordinary usages of mankind, that other is understood to represent and act for the person who has so placed him”. That seems to fully cover the situation in which an advocate, having been asked by a service user to assist and speak up for them does so and is accepted by those to whom they speak as having the necessary authority.

In *Chaudhry v Prabhakar and another*<sup>32</sup> the Court of Appeal held that “a gratuitous agent who offered to [make a purchase] on behalf of another owed [that other] a duty of care to exercise the degree of care and skill which could reasonably be expected of him in all the circumstances, that degree of care and skill being measured objectively and not subjectively”. It is clear from that case that in a very informal situation in which no money passes between the parties and no formality accompanies the arrangement a person who “speaks up” for another, claiming to have sufficient expertise and knowledge to justify their doing so, acts as the agent of the other person and owes a duty of care to that other which renders them liable to be sued if the duty of care is breached.

When one considers “best interests advocacy” the first sentence of the quotation from Lord Cranworth (above) assumes particular importance.

The position was painstakingly spelt out recently by the Employment Appeal Tribunal in *Gloystone and Co Ltd v Martin*<sup>33</sup>. Lindsay J provided “... a brief look at how ostensible authority arises. Putting the point alphabetically, B does not become A’s agent in dealings with C, nor does B acquire authority from A to act on A’s behalf in relation to C by way only of what B says to C. If that was the case, principals could have agents completely unknown to them and over which they had no control. Rather the case is that B becomes A’s agent in dealings with C by reason, in general of what A says to C on the point or whether A conducts himself to C in such a way that reflects on the possibility of B’s agency”.

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<sup>30</sup> *Advocacy - A Code of Practice* p.12 states “There will be no charge for advocacy services”.

<sup>32</sup> [1988] 3 All ER 718

<sup>33</sup> [2001] IRLR 15

<sup>31</sup> (1863) 33 LJ Ch 155 at 161-162

It is also noteworthy that although there is a limited class of case in which a person may be bound by the acts of another, performed without authority on the grounds of urgent necessity, it is extremely doubtful whether a person can be bound by the act of a complete stranger (*Jebara v Ottoman Bank*).<sup>34</sup>

It is difficult to see any lawful justification for the authority which is apparently claimed for an advocate engaging in “best interests” advocacy. In fact, there seems to be a real risk that such an advocate, acting upon limited information, would risk taking steps which would turn out to be inappropriate and leave themselves vulnerable to allegations of negligence. Similarly, any person who incorrectly treated the advocate as having authority which s/he did not have and acted upon incorrect or incomplete communication from the advocate might likewise be vulnerable to such a claim.<sup>35</sup>

### Duty of Care

The circumstances in which advocates employed by independent schemes take instructions from service users necessarily have the appearance of informality but, as the case of *Chaudhry v Prabhakar* indicates, despite those appearances the arrangement is under-pinned by a firm legal framework and it is important that that be recognised.

A service user is entitled to expect that an advocate has received training which enables her/him to understand the difficulties in communication which may arise from the service user’s illness.<sup>36</sup> The advocate comes to the relationship with the authority of the scheme by which s/he is employed. It is clear in those circumstance that the service user is being invited to trust the advocate to understand instructions and the circumstances in which they are received, and to deploy communication and negotiation skills to assist the service user. That is a relationship which is quite simply and clearly covered by the “neighbour test” prescribed by Lord Atkin in *Donaghue v Stevenson*.<sup>37</sup> The advocate owes a duty of care to persons who are so closely and directly affected by the advocate’s act that s/he ought reasonably to have them in contemplation as being so affected when s/he is directing her/his mind to any acts or omissions which might occur during the conduct of the case. It follows that there will have been negligence if the advocate, for want of care or skill, fails properly to understand the instructions given by the service user, or fails properly and accurately to communicate them to others.

The question which then arises is “by what standard is the skill used by the advocate to be tested?” Because advocacy is such a new discipline, and there is at present no body which sets its standards, it is not possible to establish, on the basis of common practice, what is accepted by advocates generally as good practice. Nor is it possible to identify a responsible body of advocates whose opinion on the point might be sought. It is perfectly clear now that in any event the practice and standard which is thought by advocates to be good must stand up to analysis and be reasonable. (*Bolam v Friern Hospital Management Committee* and *Bolitho v City and Hackney HA*).<sup>38</sup>

34 [1927] 2 KB 254

35 Those who lack capacity are represented and protected under the present system by litigation friends, guardians ad litem, the Official Solicitor and Public Trustee, and the procedures of the Court of Protection. Advocacy schemes which provide a “best interests advocacy” service are unauthorised trespassers in the province of

these well entrenched systems.

36 *The Mind Guide to Advocacy*; p.3: 2000 and *Advocacy - A Code of Practice*: chap5.

37 (1932) AC 562

38 [1957] 2 All ER 118 and [1997] 4 All ER 771

It seems that as things stand, if the courts were called upon to decide whether or not an advocate's conduct of a case had fallen below the standard which was to be expected of him/her, and thus amounted to negligence, the advocate's conduct and competence would have to be judged on the particular facts of each case simply against the standard which a reasonable person would expect to be achieved in that case.<sup>39</sup>

Too literal an acceptance of instructions by an advocate may lead to an allegation of negligence. For example, a service user might tell an advocate that s/he intends to perform an act of self harm but insist that that is confidential information which must not be repeated to anyone else. If the advocate were to honour that request for confidentiality and the service user did inflict self injury the service user might subsequently allege that the information given, along with the request for confidentiality, was a "cry for help" influenced by her/his mental state at the time, that the advocate should have appreciated that it was an attention seeking ploy and, despite the words actually used, that the advocate should have understood that a report to the authorities was precisely what was needed, that the failure to report amounted to negligence and that the service user is entitled to damages as compensation for the self inflicted injury.

### *Confidentiality*

It seems fair to say that those who administer many schemes would be well advised to radically redraft their confidentiality policies so that they accurately reflect the law. Quite possibly in the near future they will have policies imposed upon them by the Commission for Mental Health. Those responsible for the drafting will doubtless look to the guidelines which are currently provided for other professions.

Confidentiality and privacy concerning details of our daily lives, which are the business of no one else, are largely governed or protected by the Data Protection Act 1998, and the Human Rights Act 1998, and by the guidelines issued to various professions and referred to below. But advocates will sometimes encounter circumstances in which they are ostensibly asked to keep quiet about situations involving serious personal injury and/or serious crime. Those situations are not granted privilege or confidentiality by statute, common law or guidelines.

First we take the question of privilege: can the service user ever be assured that information will be safe from third parties?

Most of us appreciate that the majority of situations which we deal with in confidence are not privileged, so the confidence would not be protected or respected if we were required to give evidence on the subject. However, it is not widely appreciated just how limited a protection is given to confidential information in general, and in respect of communications concerning medical matters in particular. Blackstone's Criminal Practice 2001,<sup>40</sup> in a passage which covers both civil and criminal law, states the position as follows "at common law no privilege attaches to communications made in confidence except in the case of :-

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<sup>39</sup> *We are not aware of any litigation which has arisen from an allegation of negligence against an advocate. The well known cases of alleged negligence by counsel are of no help, dealing as they do with issues peculiar to the position of counsel in relation to litigants and the court. (see eg Arthur S J Hall & Co v Simons; Barratt v*

*Ansell and others; Harris v Scholfield Roberts & Hill and another [2000] 3 All ER 673; Saif Ali v Sydney Mitchell & Co [1978] 3 All ER 1033; Rondel v Worsley [1967] 3 All ER 993).*

<sup>40</sup> F9.8

- a) Communications between a client and a legal advisor made for the purpose of the obtaining and giving of legal advice; and
- b) Communications between a client or his legal advisor and third parties, the dominant purpose of which was preparation for contemplated or pending litigation”.

Blackstone’s continues:

“Although the courts have an inherent wish to respect the confidences which arise between doctor and patient, bankers and customers, etc, if the question to be put to a witness is relevant and necessary in order that justice be done, the witness will be directed to answer ... Thus, no privilege exists to protect medical records or communications between doctor and patient ... notwithstanding that the rule is regarded as unsatisfactory ... Similarly, there is no privilege for confidential communications between friends”.

It follows that an advocate cannot ever give an absolute guarantee to a service user that information will remain private. Of course, the firm assurance can be given that no communication between service user and advocate will be disclosed unless the law or the policy of the scheme requires it.

Turning to the question of confidentiality: will the advocate ever have a duty to report to a third party information given “in confidence”? It is of interest to look at guidelines in this respect provided to other professions.

The GMC Confidentiality: Protecting and Providing Information, September, 2000 advises doctors that they must respect requests by patients that information should not be disclosed to third parties save in exceptional circumstances. It further advises that even in exceptional circumstances consent to disclosure should be requested where practicable, and the patient should generally be informed before disclosure of the information. However, the guidance does provide that disclosure of personal information without consent may be justified where failure to do so may expose the patient or others to risk of death or serious harm. Examples are given of exceptional circumstances and include “where disclosure may assist in the prevention, detection or prosecution of a serious crime. Serious crimes, in this context, will put someone at risk of serious harm and *usually* be crimes against the person, such as abuse to children” (our italics).

The British Association of Social Workers code of ethics states that a social worker “respects the privacy of clients and confidential information ... gained in his relationship with them ... He will divulge such information only with the consent of the informant except where there is clear evidence of serious danger to the client, worker, other person or the community, in other circumstances judged exceptional, on the basis of professional consideration and consultation”.

The Guide to the Professional Conduct of Solicitors advises solicitors that they may reveal confidential information to the extent that the solicitor believes it necessary to prevent the client or a third party committing a criminal act that the solicitor believes on reasonable grounds is likely to result in serious bodily harm.

The guidance issued to solicitors representing patients at Mental Health Review Tribunals advises that if a client discloses that they intend to do serious harm to themselves or someone else guidance should be sought from the Law Society’s Professional Ethics Division.

These guidelines simply reflect the reasoning of the Court of Appeal in *W v Egdell* which decided that a psychiatrist who is concerned by information acquired in a confidential relationship “is entitled to take such steps as are reasonable ... to communicate the grounds of his concern to the authorities”.<sup>41</sup>

If the reasoning behind these guidelines is applied to the advocate/client relationship it is possible to envisage a policy which denies confidentiality to the communication of information indicating that the service user or anyone else is at risk of serious bodily harm. We suggest that those responsible for the administration of any advocacy service would wish to have in place a confidentiality policy which makes such a provision.

It is a matter worthy of note that the guidelines seem to refer almost exclusively to a risk of serious bodily harm whereas service users are also at risk of being victims of serious economic crime. Some service providers have addressed this issue by producing policies which state that confidentiality will not apply to information indicating a risk of serious crime which is identified by reference to the definition in section 116 of the Police and Criminal Evidence Act 1984.<sup>42</sup> That definition does include theft and makes the point that the degree of seriousness is determined by the effect of the crime upon the victim as much as by the economic value of what is stolen. This is a point to be borne in mind when confidentiality policies for advocacy schemes are being drafted.

Many advocates will think that a difficulty arises if the only person at risk is the service user who has provided the information. If the service user demands confidentiality, they will ask how its refusal can be compatible with the client-led ethos of advocacy? As indicated above, there is a considerable risk that the advocate will be failing in their duty of care to the client if they remain silent. Every advocacy service should protect its advocates from this difficulty by providing a confidentiality policy which puts the issue beyond doubt by requiring that in such a situation the information must be reported by the advocate to the authorities. The policy itself should provide that the advocate must inform the client of its provisions at the commencement of the relationship.

Unfortunately the difficulties do not end there. What of a client who is suffering harm which is not so serious as to come within the contemplation indicated in the guidelines? The harm might be self inflicted or it might be caused by another, possibly someone who is in a position to exert undue influence over the client. If the client demands confidentiality for information concerning that harm, should the advocate be allowed to question whether or not the client has sufficient capacity to make that demand? How does the raising of that question comply with the ethos of non-judgmental client-led advocacy?

### *Capacity and Undue Influence*

A discussion of the notoriously slippery concept of capacity is beyond the scope of this article but the following points must be borne in mind by advocates and those who administer the schemes within which they work.

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41 [1990] 1 All ER 835. *The Supreme Court of California* has gone further and said that such a psychiatrist has a duty to take reasonable steps to protect any identifiable person who is at risk of harm: *Tarasoff v Regents of University of California* (1976).

42 See for example *Surrey - wide Operational Partnership Group Confidentiality Policy Document: Mental Health Services, Appendix 5: 2000 and Worthing Mind “Confidentiality and Use of Information” para 9.*

- The validity of any work done by an advocate arises only from the authority of the instructions received from the client. A service user who lacks capacity cannot give instructions which confer that authority and so, strictly speaking is not a client at all. It follows that if the service user lacks capacity there is no advocate/client relationship and the question of whether or not it is client-led and non-judgmental does not arise.
- The question of whether or not a service user has the necessary capacity to instruct the advocate can arise at any stage of the relationship but the tests for capacity will vary from issue to issue as they arise: see *In re:T.(Adult; Refusal of Treatment)*.<sup>43</sup>
- It is not unusual for doubts as to a client's capacity to arise from facts which also indicate the presence of undue influence: see *In re: T. (Adult; Refusal of Treatment)*.
- *R v Collins and Ashworth Hospital ex parte Brady* <sup>44</sup> seems to lend authority to the proposition of the Richardson Committee that a person with a psychiatric disorder lacks capacity where, although intellectually able to understand and apply information, they nonetheless reach a judgment which they would not have reached in the absence of the disorder.

We suggest that if the question of capacity arises the advocate has no choice but to investigate it. A lack of capacity at the beginning of the client/advocate relationship will prevent the formation of the agency which is the legal foundation of that relationship. In law the advocate and client will be strangers and the advocate will have to make decisions about confidentiality and the client's welfare in the same way as any other well intentioned person who has become aware of the client's predicament. A loss of capacity during the relationship will, we suggest, leave the advocate still owing the client a duty of care which would require her/him to act in the client's best (social and medical) interests and make decisions regarding confidentiality accordingly.

Every scheme providing an advocacy service should have in place a protocol and guidelines to assist the advocate when this situation arises. It is beyond the scope of this article to suggest the detail of what should be the contents of those documents.

### *Protecting the Client in the absence of Confidentiality*

A very simple and practical problem arises when confidentiality is denied.

Service users will request confidentiality essentially for two reasons. They will be afraid that the information which they have communicated will bring upon them unwanted attention from the authorities. They will also be afraid that they will suffer at the hands of those who, as a result of the communication of information, will suffer similar attention. This fear will almost always arise because a criminal investigation has been commenced.

Advocate and client both need help and advice as to what practical protection is available for the client.

If the client appears to be a danger to themselves or others then clearly the authorities must act appropriately and there is nothing to be done to prevent that. Safeguards provided by the Mental Health Act 1983 and the inherent jurisdiction of the High Court are in place to ensure that the authorities act lawfully and proportionately.

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43 [1992] 3 WLR 782

*Journal of Mental Health Law* December 2000.

44 [2000] LLRM 355. See also "Treatment for Mental Disorder - another step backwards": Simon Foster

An advocate who is in the unfortunate position of having to “betray” the confidence of a client who is at risk of violence or harassment will need to know what steps might be taken to protect their client and what assurances might be given. The advocate should be provided with this information by the organisation for which s/he works.

In reality very little real protection will be available and the assurances which can be given are slight.

The following points, which can always be made to the authorities when information is reported to them, may provide some assurance to the client.

- There is a long established rule of law that in criminal proceedings informers should not be identified because the Courts appreciate the need to protect their identity, not only for their own safety but to ensure that the supply of information about criminal activities does not dry up.<sup>45</sup>
- If there is to be an investigation the fact that disclosure came from the service user and the advocate should not be mentioned in the course of that investigation unless it is unavoidable.
- There is a public interest in allowing people to withhold material containing information which would not have been provided if the person who did provide it had believed that it would later be made public. This principle, however, frequently conflicts with the other public interest that justice should be public and seen to be done. Where the conflict arises in an individual case the balance has to be weighed by the Court.
- If at the end of an investigation a prosecution has to be considered the prosecuting authority must also weigh in the balance the public interest and that will include the effect of a prosecution on the service user. It does not have to follow that the detection of a crime will lead to a prosecution.

These principles can be invoked to reduce the risk to the client.

### **In Conclusion**

We suggest that it is beyond dispute that there must be available to all users of mental health services the assistance of a completely independent advocate who will, non-judgmentally, assist the service user to communicate with service providers and others. This has been acknowledged by the government in their proposal regarding PALS but the terms in which that introduction has been made indicate that PALS will not be independent and will not provide advocacy of the kind which we have discussed.

If independent advocacy, which has grown out of the history and developed the principles described in the first part of this article, is to have a chance of survival, its practitioners must fully understand the principles which govern their work and the impact which the law has on those principles. They must also be provided with clear guidance in the form of policies and protocols to assist them when confronted by difficult cases.

If the understanding and guidance for which we are pleading are acquired and put in place they could become the guts and sinew which enable independent advocacy to compete against rival systems and overcome hurdles which will inevitably continue to be put in its way. In their absence, sadly, independent advocacy will not stay the course. It will be left behind by those rival systems and lost from sight. If that happens every aspect of mental health care will be the poorer.

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<sup>45</sup> *Blackstone's Criminal Practice 2001: F9.5*

