KF

Project Paper

NUMBER 59

The advice and legal representation project at Springfield Hospital 1982-1985

An evaluation

THE ADVICE AND LEGAL REPRESENTATION PROJECT

AT SPRINGFIELD HOSPITAL: 1982 - 1985

An evaluation

Prepared by:

The Springfield Advice
and Legal Representation
Project

Social and Community
Planning Research

Printed by G S Litho, London

King's Fund Publishing Office
2 St Andrew's Place
London NW1 4LB

CONTENTS

LIST OF TABLES

I Introduction

The Advice and Legal Representation Project started work in February 1982 as the first legal and advice service for mentally ill people to be based within a psychiatric hospital. The Project offers a free and independent service to hospital-based psychiatric patients. As this was a unique venture, the Project felt it important to record and evaluate its development, both as a general learning resource for workers in the mental health field and, more specifically, as a guide for those wishing to establish similar schemes elsewhere. It was decided that as part of this evaluation there should be an independent study of the service, from the viewpoints of both Project patient clients and staff at the hospital.

This report draws together the views of past and present workers and members of the Management Committee of the Advice and Legal Representation Project at Springfield Hospital, on the setting up and first three years operation of this experimental service for psychiatric patients. It records the Project's day-to-day work, the issues raised and difficulties experienced during that time, and looks at possible future developments.

The report also contains extracts from the the independent study carried out by Social and Community Planning Research in the summer of 1984, when the Project had been in operation for two and a half years. This independent research was funded by the Nuffield Foundation and focuses on two main areas with both patient clients and hospital staff groups; namely the nature and operation of the service provided, and the roles, relationships and boundaries between the Project, patient clients and hospital staff. By addressing these two areas the research meets two objectives. First, it provides a basis from which the Project can evaluate certain features of its past performance in order to feed the lessons learned into its future work. Secondly, it provides a guide to some of the developmental and operational considerations which a similar scheme would need to take into account. Details on the research design and methods of the independent study are contained in Appendix A.

The setting up of the Project and the negotiations between the Project and the hospital, which eventually led to the hospital's acceptance of the scheme, are considered in some detail in the report. It is not, however, suggested that this report is a blueprint for other schemes, as success will depend for the most part on local circumstances and attitudes. But it is hoped that the report will provide useful guidance for those wishing to establish similar advice and legal services elsewhere.

II Background

(i) Springfield Hospital

Springfield Psychiatric Hospital was built in Wandsworth in the 1870s and has grown to cover a 100 acre site. It has a catchment area of half a million people mainly in Wandsworth, Merton, Kensington and Chelsea. There are some 960 beds at Springfield with an admission rate of about 40 people per week.

Springfield Hospital is a reasonably typical psychiatric institution; about one third of its population is comprised of elderly, residential (long-stay) patients; another third of the population are long-stay patients who have rehabilitation potential and the remaining third are short-term (6-8 weeks) acute admissions. The hospital has nearly 40 wards, including about 10 admission wards and a locked ward, the John Meyer Ward. There are two day hospitals, the Jubilee and Cottage, which cater for about 100 day patients. The Jubilee Day Hospital largely deals with elderly psycho-geriatric patients. Out-patients attend Clare House at St. George's Hospital, which is based not far from Springfield. The hospital also has a Regional Deaf Unit and an Industrial Centre, where patients may work in return for a small wage.

(ii) Setting up the Project

The Project was initiated by a group of workers from three Wandsworth Law Centres. The principal aim of setting up the Project was to improve access to advice and legal assistance for individuals in psychiatric hospitals. It was decided that the most effective means of doing this was to institute some form of hospital-based advisory service in the local psychiatric hospital.

No one involved in the Project anticipated that it would take two and a half years from making initial contact with Springfield Hospital to having workers in post. Although this was a frustrating period, it did mean that the Project was set up with a great deal of care. The Project Management Committee developed a strong sense of solidarity and there was time to become familiar with the workings of the hospital and develop a degree of trust with key members of the hospital staff.

Months before any thoughts of having an advice service in the hospital, departmental heads had been approached by Law Centre workers with a view to their approving the distribution of a leaflet giving patients information on advice and legal services in Wandsworth. As a consequence, hospital staff became acquainted with several of the workers in these Law Centres and discussions ensued on the provision of advice services for patients and their limited use of existing community advice services. This was followed by the distribution of a report produced by the Citizen's Advice Bureau in Middlewood Psychiatric Hospital, Sheffield, outlining the range of queries presented to them by patients at Middlewood. The Middlewood report was an important element in persuading hospital staff that an advice service within Springfield Hospital would be of great benefit to patients.

At this point the Project Management Committee was formed and funding was sought for a hospital-based legal advice service. The hospital had agreed

in principle to the establishment of such a service and this was a persuasive factor to prospective funders. The funding application argued the need for the service, drawing on cases from the Law Centres' own experience, and was accompanied by supporting letters from local social services departments, local solicitors, the local MIND group and national MIND, Middlewood CAB and others. Eventually the King Edward's Hospital Fund for London (King's Fund) agreed to finance the scheme for an initial two-year period. However, it was another one-and a half years before workers were in post.

Once funding had been obtained, a formal consultation process was put in train, culminating in the proposed project being put before the Health District Management Team for final approval. The Project's Management Committee prepared a background paper and Code of Practice (see Appendix B) clarifying the Project's terms of reference and operational practices. These documents were used as the basis for the consultation process. Many groups within the hospital were consulted including the trade unions and staff associations and the various professional groups. Some hospital staff expressed considerable anxiety about the proposed project and the Medical Staff committee had to put it to the vote. The creation of the Liaison Committee, where hospital staff could regularly meet the Project Workers to discuss potential problems and iron out everday difficulties, did help to allay some of this anxiety. Undoubtedly, the support of individual hospital staff such as the Hospital Administrator and the Medical Administrator contributed to the successful conclusion of the consultation process.

Several areas proved contentious but compromises were made on both sides and agreement was eventually reached between the hospital and the Project on terms of reference.

(iii) Terms of Reference of the Project

The Project's terms of reference were finally agreed as follows:

(i) The Project would not undertake litigation against any member of the hospital, although it would represent patients at Mental Health Review Tribunals. People who came with complaints about the hospital or about hospital staff would be advised of the hospital complaints procedure and, if appropriate, would be referred to someone who could assist them in pursuing their complaint, such as the Community Health Council, MIND or local solicitors.

(ii) The Project would undertake a wide range of advice and representational work. It would not be limited to advice on the Mental Health Act and Mental Health Review Tribunals.

(iii) The Project would provide a service for hospital staff as well as patients, provided there was no potential conflict of interest with a patient. Staff employment problems would be referred to the trade unions and staff associations.

(iv) The Management Committee would consist of two additional co-options, namely a medical representative and a trade union/staff association representative. In addition, the seat reserved for the Area/District Health Authority representative would be filled by the

Springfield Hospital Administrator rather than someone based outside the hospital. These changes were on the understanding that such Management Committee members would not be involved in the hiring and firing of workers and that they would withdraw from a Committee meeting if their position as hospital staff caused conflict of interest with their position on the Committee.

(iv) Management Committee

The Project was initially set up as a sub office of the Wandsworth Legal Resource Project (WLRP), a local law centre, although the management function was effectively delegated to the Project's own Management Committee from the very beginning. The WLRP provided invaluable advice, support and back-up facilities such as access to their extensive law and welfare rights library and the use of their solicitor when the Project's solicitor was involved in another case, sick or on holiday. The WLRP also provided an important link with the community thereby helping to sustain the Project's independence from the hospital.

The Project is managed by a committee of volunteers representing community groups and organisations involved or interested in advice work and/or mental illness. During its first three years members were appointed from the following organisations:

Wandsworth Legal Resource Project (2 representatives)
Wandsworth Association for Mental Health
Wandsworth Community Health Council
Wandsworth Rights Umbrella Group
Afro-Caribbean Mental Health Association
Area/District Health Authority
The King Edward's Hospital Fund for London

In addition there are a number of co-options including local residents, a community relations worker, WLRP's solicitor, an independent social worker and the hospital's medical representative. It was intended that the management structure should ensure the Project's independence from the hospital and draw a variety of experience to the Project.

Members of the Management Committee have supported the Project workers, most particularly during the first months of work. They have provided expert financial advice, legal help and occasional court representation; information and advice on social work and psychiatric practices, District Health Authority policies, practices and procedures; and a useful knowledge of the catchment area and local organisations. As the Project has become more established and the number of workers increased, members of the Management Committee have become less involved in the Project on a daily basis. This is regrettable although expected. Their input is critical to maintaining an external perspective on the work and it is important that this is sustained.

(v) Funding the Project

The Project's budget for 1985/86 is approximately £48,000, the major expenditure item being salary costs. The hospital subsidises the Project by providing free accommodation, electricity and heat, one telephone line and a

and canteen facilities. The annual budget therefore, does not reflect the Project's full running costs.

The first two years' funding was provided by the King's Fund. This was followed by a third year's grant from the Greater London Council with additional money for a third worker which enabled the Project to complete and document the three-year experimental period and seek more permanent funding.

During 1984, a successful application was made for Joint Finance from the Health Authority and the Local Authority for a period of five years from April 1985. It was the priority given to the application by the District Health Authority that ensured its success, confirming the Health Authority's recognition of the Project's value. Whilst it has always been a goal to obtain funding from the state as part of an overall strategy to achieve advice services for psychiatric patients nationwide, it is important to ensure that the Project's independence is not compromised by receiving Health Authority funding.

(vi) Staffing of the Project

The project is unique in employing a solicitor and not having to rely on referrals or the limitations of the Legal Aid Scheme to provide its clients with a legal service. The employment of a solicitor also provides the Project with a clear ethical code of practice, with its own logic and inherent strength in the face of pressures from the institution and the medical profession. There is no doubt that clients benefit from access to the services of a solicitor at the Project. Cases can be pursued to their conclusion, clients may be represented at short notice or may give instructions over a prolonged period if illness or medication has affected their concentration.

The workers employed during the Project's first three years have had a variety of skills and experience. Formal qualifications are only required by the solicitor who must have held three practising certificates since qualifying. It is obviously an advantage in such a small organisation for the workers to have complementary skills and experience. All Project workers have familiarised themselves with the hospital's catchment area and developed contacts with the local community. This is undoubtedly of assistance to clients and also helps to reduce workers' feelings of isolation within the hospital. Many of the Project's clients do not have strong or easily winnable cases so it is important that the workers are not people who measure their success in terms of cases won, otherwise they will soon become disillusioned. The value of the Project is in its provision of a facility through which people, who would otherwise have no assistance, are able to understand and attempt to deal with the practical difficulties they face and obtain their rights.

The Management Committee has always been concerned to employ people with an ability to listen, understand and deal with clients in a firm but sensitive way. It is essential for the Project workers to have an interest in the civil liberties of people who are mentally ill and experience of work in this field can be an asset. However, it has never been considered necessary or indeed desirable, to employ people with specific experience or qualifications in the care of the mentally ill. The Project has always

emphasised the importance of dealing with clients in the same way as any other clients irrespective of their mental illness. Inevitably, workers acquire a certain amount of information about mental illness and knowledge of the workings of the hospital but are able to perform their duties effectively without formal training in this field.

The Project opened with a solicitor and an advice worker who, between them, undertook advice and casework, training and general administration. They found that they had little flexibility to do work outside the office and experienced real difficulties if one worker was away ill or on holiday.

During the third year, a second advice worker was appointed and the solicitor left and was replaced by two solicitors who shared the post, so that three full time posts were filled by four workers. This has helped to alleviate the problems and has reduced the feeling of isolation. It also means that one of the solicitors is always available.

The "legal" casework generated by the catchment area fluctuates considerably and has sometimes been found to be insufficient on its own to occupy a full-time solicitor. The solicitors in post to date have supplemented their casework by undertaking training sessions, researching specialist areas of law, writing articles, undertaking administrative tasks and taking initiatives outside the office. However, where their interest has been primarily in casework it has caused frustration that this does not fill a five-day week. In future the Management Committee will consider employing solicitors for a three-day week unless the candidate has an interest in pursuing areas of work other than pure casework.

(vii) The Hospital Staff's Reaction

The independent study by Social and Community Planning Research (SCPR) asked hospital staff about the initial setting up period and three points emerged quite clearly.

First, some members of staff thought that by entering into negotiations about the project Springfield had shown itself to be unique. Secondly, staff believed that the period spent discussing and clarifying the Project's terms of reference was an extremely important prelude to their entry into the hospital. Thirdly, it was thought that the amount of time taken by the pre-entry process was evidence of the thicket of institutional practices and procedures that had to be got through. It also demonstrated the necessity of allowing the groups involved to attune themselves to the proposed change.

On this last point, some staff members thought that waiting for final agreement seemed to have taken an excessive amount of time. However, to most it was unavoidable, mainly arising as a consequence of the innovative nature of the scheme and the layers of established institutional practices to be worked through. Administrators and policy-makers at Springfield had had no previous experience to draw on in the setting up of this scheme, either internally or elsewhere. This meant that they had to be extremely careful to work through all possible effects of the Project being located on their site and ensure they did not leave any important issues open, which

could lead to problems in the future. Having said this, negotiations were felt to be both prolonged and prey to professional and institutional pressures.

> 'People wondered quite how that work would fit in with our work - whether we would clash over any issues that involved patients care and legal aspects of their stay. It was simply an unknown quantity.' STAFF

> '..an awful lot of bureaucracy had to be gone through - setting up working party meetings, trying to decide what the Project would do and how it would work; agreeing on terms of reference. It seems to have gone on an inordinate amount of time. Perhaps that's the price you've got to pay for setting-up a unique service.' STAFF

III The service

The Project offers a free, confidential and independent advice and legal representation service primarily for in and out-patients. A service is also offered to patients' relatives and to hospital staff provided there is no potential conflict of interest with patients. The Project will take legal action on behalf of patients, by representing them at courts or tribunals but does not offer legal representation to staff.

It is, therefore, patients who make the most extensive use of the service. This can be seen from the distribution of sources of enquiries over the first three years, listed below. Over two-thirds of enquiries were from patient clients and half were from patients who were actually resident in the hospital at the time of contact.

Table 1: Distribution of client groups 1982-85

	Year 1		Year 1 + 2		Year 1 + 2 + 3	
	1982		1982 + 83		1982 + 83 + 84	
Client Group*						
In-patient	148	48%	275	49%	383	52%
Out-patient	33	11%	72	13%	110	14%
Relative	6	2%	13	2%	15	2%
Staff	90	29%	141	25%	161	22%
Other/Not known	30	10%	60	11%	67	10%

*Notes;

a) The figures in table 1 do not include any cases opened during the period covered by the report that were still being worked on at 1st February 1985.

b) The "number of people seen" and figures relating to that refer to new people only. They do not include old clients returning with new problems.

c) The figures for 1984 do not include clients seen on the Benefits Take-Up Campaign.

The Project offers its patient clients a range of help, including the provision of information or advice, practical help (with letters, phone calls etc), referral to a more appropriate agency and legal representation. It provides advice across a broad spectrum of issues, of which the principal categories are housing, welfare benefits, mental health, family matters (including divorce proceedings and care orders), crime, immigration, employment, consumer, wills and other legal matters. This section looks at

the organisation and advertising of the service and goes on to look in some detail at the principal casework categories. The section concludes by looking at the educational aspects of the Project for patients and the wider community.

Table 2: Representation at Courts and Tribunals 1982-1985

Type of Court/ Tribunal	Year 1 1982	Year 1 + 2 1982 + 83	Year 1 + 2 + 3 1982 + 83 + 84
County Court	6	13	14
High Court	0	11	13
Coroner's Court	1	1	1
Magistrates/Juvenile Court	5	11	16
Crown Court	1	1	1
MHRT	3	9	13
NI Tribunal	0	1	1

(i) Organisation and Advertising

The Project is fortunate in having two offices near to the admissions wards and the patients' cafeteria. Another room is available for waiting and interviewing. Open advice sessions are held on three mornings a week guaranteeing that clients are seen without a prior appointment. Nevertheless, clients call in at any time during the working week and are usually seen when they call. The majority of patient clients come from the admissions wards (ie: are admitted to the hospital for a short period) and from the Cottage Day Hospital and are generally self referred. However, a significant number of patient clients are referred by hosptial staff (usually nursing staff) particularly when the patient is resident on a long stay ward.

Table 3: The ward base of patient clients 1982-85

Ward	Year 1 1982	Year 1 + 2 1982 + 83	Year 1 + 2 + 3 1982 + 83 + 84
Admission	98	181	265
Rehabilitation	12	22	23
Long Stay (dependent)	13	15	15
Psychogeriatric	6	10	11
Locked Ward	5	3	26
Deaf Unit	4	4	6
Day Hospitals (out patients)	22	54	81
Atkinson Morley Hospital	1	1	2
Not known	20	47	64

The Project's main patient client group and ward staff both change constantly, so advertising and publicising the service are seen as vitally important. Various methods are used. A general leaflet and poster are circulated in the hospital and its catchment area and attempts are made to visit all wards at six monthly intervals to ensure that they have an adequate supply of these and to remind staff of the service offered. Staff also learn about the Project through the talks and training sessions organised by the workers. The Patient's handbook, which is issued to every patient, contains a paragraph about the Project and short articles have been written for the staff newsletter and the Patients' magazine. A small colourful leaflet advertising the Project is inserted into the DHSS leaflets given to patients when they are admitted compulsorily.

(ii) Casework

Of the 736 clients seen by the Project three-quarters were patient clients and relative clients. Broadly speaking, the type and breakdown of casework has remained much the same during that time.

Table 4: Breakdown of type of work 1982-85

Type of work	Year 1 1982	Year 1 + 2 1982 + 83	Year 1 + 2 + 3 1982 + 83 + 84
Case taken on	123 24%	203 24%	286 26%
Advice only	273 54%	467 55%	592 54%
Referral	68 13%	117 14%	133 12%
Case taken on and rererred	35 7%	49 6%	62 6%
Cancelled or didn't turn up	11 2%	13 1%	16 2%

a. Housing Casework

Ensuring that patients do not lose their accommodation while in hospital is an important part of the casework. The possibility of eviction has arisen when a client is in rent arrears, has caused a disturbance or been a nuisance to neighbours and where a landlord harasses the tenant or takes advantage of a stay in hospital or a state of health.

Table 5: Types of housing work 1982-85

Type of Housing Work	Year 1 1982		Year 1 + 2 1982 + 83		Year 1 + 2 + 3 1982 + 83 + 84	
Homelessness/eviction	17		21		30	
Security/Possession	23		43		54	
Repairs	7		12		16	
Other	22		34		39	
Total	69	14%	110	13%	139	13%

CASE STUDY - Housing - 1

Mr A lives in a privately rented flat at the top of a house in a street that is becoming very desirable in the area. The other flats in the house became empty some time ago and recently the house was taken over by new landlords. It appears that the new landlords, unaware of the local housing situation, assumed that the Council would give Mr A accommodation so that they would be able to maximise their investment. When they realised that they would not be able to gain vacant possession, they started legal procedings.

Mr A has a protected tenancy,the retention of which is crucial to his welfare. The Project is helping Mr A defend the possession proceedings, which are quite flimsy, and to counterclaim for damages for disrepair.

CASE STUDY - Housing - 2

Mr B is a housing association tenant who fell into rent arrears when he went abroad for a while. He came to the Project at the point when he was about to be evicted. The Project was able to negotiate a substantial back payment of housing benefit, to which he was entitled, and the eviction was averted.

Many clients fail to understand the complexities of the Housing Benefit system. This often results in arrears of rent. Patients suffering from depression may have allowed their financial affairs to deteriorate before admission. Rent is usually the most pressing debt and the Project can often assist in negotiations for payment of rent plus a weekly amount off arrears, or they may represent a client in possession proceedings in the County Court should the matter have gone that far.

Clients faced with landlords requiring them to move while repairs are carried out to their accommodation, or claiming that the tenant has neglected the property and furniture and should leave, or suggesting that the tenant would be better housed elsewhere, have consulted the Project. Intervention in these cases has ensured that landlords act lawfully and that clients' legal rights are protected.

Requests for accommodation or for a transfer are generally referred to the hospital social workers. However the Project has dealt with cases involving the provisions of the Housing (Homeless Persons) Act 1977.

CASE STUDY - Housing - 3

The Project was asked to take on a case where the evidence of the client's vulnerability due to mental illness, provided by medical and social work staff, had been rejected by the Housing Department.

The Project was able to advise the patient's doctor of the criteria necessary to satisfy the conditions of the Act and a supplementary report was submitted to the Housing Department. Subsequently, the client was accepted as being vulnerable within the meaning of the Act and offered accommodation without need for an application to the High Court for a review.

b. Welfare Benefits Casework

Many of the Project's patient clients are dependent on state benefits or live on very low incomes - frequently as a direct result of mental illness. Indeed, managing on a very low income would seem to contribute towards anxiety and ill health in many cases and whilst benefit claimants in general face considerable problems dealing with the system, claimants admitted to hospital face additional problems. The level at which Social Security and National Insurance benefits are paid changes on admission to hospital. It is also dependent on the individual's circumstances and the benefit claimed. This causes confusion for patients, hospital staff and for DHSS staff. Patients allowed home for one or two days during a programme of gradual rehabilitation rarely have their benefit adjusted in advance to ensure that they receive the full rate for the days spent at home.

Delays in the payment of benefits by DHSS are regular occurrences. The Project has come across people who have been without money for weeks, sometimes months. There is often a delay at the DHSS when a person's circumstances change, but someone admitted to hospital may experience further delay caused by the transfer of the DHSS papers to the office local to the hospital. Patients may not be able to pursue claims, perhaps because they are in the locked ward or are unfortunate enough to have their claim dealt with by an officer who takes the view that hospital patients are not a priority because their immediate needs are met by the hospital.

In addition to the general entitlement to benefit, the Project has dealt with a number of cases assisting people to maximise their income through claiming Single Payments and Weekly Additions. People are often unaware of the availability of these benefits and may have accumulated debts by trying to survive without them. Medical reports are often requested in support of a claim for a Single Payment (for essential items of furniture for example),

and in some cases it has been necessary to involve the MP or to make an application to the Supplementary Benefit Appeal Tribunal.

At the end of 1984, the Project began a Benefits Take-Up Campaign, commencing with a pilot scheme on an admissions ward, the Cottage Day Hospital and a long stay ward. The aim was to increase the take-up of benefits among patients; to train ward staff in the basics of the benefits system, to obtain an overall view of the inadequacies of the system and to suggest possible ways of remedying these. At the time of writing, the results of this pilot are being documented and will provide the basis of a discussion with hospital staff and the DHSS.

The Project also attends quarterly liaison meetings at the DHSS, where representatives of statutory and voluntary organisations meet with DHSS managers to discuss problems faced by claimants and to attempt to find solutions.

Table 6: Types of welfare benefits work 1982-85

Types of welfare benefits work	Year 1 1982	Year 1 + 2 1982 + 83	Year 1 + 2 + 3 1982 + 83 + 84
Entitlement to Sup Ben	40	55	75
Other Benefits	15	33	42
National Insurance Benefits	23	43	59
Arrears rent/mortgage	8	11	11
Fuel debts	6	10	12
Other debts	14	27	36
Single payments (Sup Ben)	14	17	26
Weekly additions (Sub Ben)	3	4	7
Access to Finance	2	7	14
Other	5	10	12
Total	130 25%	217 26%	294 27%

c. Matrimonial and Child Care Casework

Matrimonial difficulties often come to a head when a person is admitted to a psychiatric hospital. The Project is regularly asked for advice about divorce, custody and access to children, the financial implications of divorce and the rights to the matrimonial home. In a number of cases clients thought they could do nothing to alleviate their domestic difficulties and had found that admission to hospital afforded an escape. Some have been surprised and relieved when advised that they will not be destitute or homeless if they petition for divorce.

One of the more time-consuming areas of work involves proceedings taken by the Local Authority to have children taken into their care, or to dispense with parents' consent to adoption. The Project has acted for parents faced with these problems. It is the Project's experience that a person diagnosed as suffering from mental illness has to overcome additional problems in proceedings of this kind. A parent is often considered incapable of caring for a child by reason of mental illness and little weight is given to the possibility of recovery. Other members of the family, who may be able to offer support and assist in caring for the child, are often overlooked. Relevant evidence may not have been put before the court if a parent is not represented.

Table 7: Types of matrimonial and child care work 1982-85

Types of matrimonial and child care work	Year 1 1982	Year 1 + 2 1982 + 83	Year 1 + 2 + 3 1982 + 83 +84
Matrimonial proceedings	24	40	56
Custody	8	16	23
Maintenance/property	19	26	32
Domestic violence	10	15	21
Local Authority care proceedings	7	13	15
Adoption	2	4	4
Other	6	8	11
Total	76 15%	123 14%	162 15%

CASE STUDY - Care

Ms S appealed against a Care Order from a Magistrates Court made in respect of her son. At the appeal hearing, evidence was given by the child's grandparents that they could look after him. The Judge, allowing the appeal, said that if the Magistrates' Court had been aware of the existence of grandparents,they would not have made the decision they did.

Medical reports are often requested by the Local Authority in the course of adoption, wardship and care proceedings and frequently have great influence on the outcome. These, together with information given by medical staff to social workers in multi-disciplinary case conferences, often without the knowledge or consent of the patient, cause the Project considerable concern. The issue has been taken up with medical staff on individual cases and raised at one of their monthly seminars. Additionally, the Project encourages clients to discuss the contents of medical reports with their doctors.

d. Mental Health Act and Mental Health Review Tribunal Casework

Table 8: Types of mental health work 1982-85

Types of health work	Year 1 1982	Year 1 + 2 1982 + 83	Year 1 + 2 + 3 1982 + 83 +84
Mental Health Rev. Tribunal	12	28	46
Complaints re conditions	10	17	18
Complaints re treatment	10	15	21
Compulsion/Detention	21	40	55
Negligence/Assault	4	6	6
Other	14	18	18
Total	71 14%	124 15%	164 15%

During the three years covered by this report the Mental Health Act 1959 has been superceded by the Mental Health Act 1983. The most notable change for patients is the extension of the right to apply to the Mental Health Review Tribunal for those detained for assessment under section 2 of the new Act (for up to 28 days). This has, in turn, contributed to an increase in the Project's Tribunal work since October 1983. Applications to the Tribunal from patients detained under section 2, must be made within the first fourteen days of detention and there must be a hearing within seven days of receipt of the application. As a result medical and social work reports are often not available until immediately before the hearing and there is rarely time to prepare independent reports.

Despite these disadvantages, patients detained for up to 28 days now have an opportunity to put their case to an independent Tribunal. Patients detained under longer sections - for example up to six months under section 3 - are now having to wait a considerable time before their cases are heard. One person applied to the Tribunal as soon as she was detained under section 3 and had to wait over five months before her case was heard. Such delays are caused in part by the increase in the number of people applying to the Mental Health Review Tribunal under the new Act, particularly those detained under section 2.

Representation of clients at Mental Health Review Tribunals by Project staff has been the most contentious issue in the relationship between hospital staff and the Project. It is necessary therefore to be clear about the purpose of the Tribunal and the role of the patient's representative therein.

The Tribunal is an independent body which examines the justification for continuing the section at the time of the hearing. Its function is not to challenge the original grounds for compulsory admission to hospital, although it will check that the proper procedures have been carried out.

CASE STUDY - Mental Health Review Tribunal

Mr T was detained under section 2 of the Mental Health Act 1983 for up to 28 days. The application for detention was made by a relative, rather than by a social worker. However, the Act lays down a strict order of priority of who can be the nearest relative. In this case the application had been made by an elder brother when both Mr T's parents were alive and able to act. Mr T's father was next of kin and should have made the application. The section was therefore invalid and Mr T was discharged.

As in any other legal relationship the representative at a Mental Health Review Tribunal acts on the client's instructions and ensures that all relevant material in support of the case is put before the Tribunal. In so doing it may be necessary to question the Responsible Medical Officer and the social worker involved in the case but this should not be seen as challenging professional judgments. Rather it is a means of uncovering the full facts of the case so that the Tribunal can make its own independent decision on the outcome. On occasions the client may request an independent psychiatric or social work report to be presented to the Mental Health Review Tribunal.

About a year after the Project opened a few doctors expressed disquiet about the role of the Project as the representative of the patient at Tribunals, fearing that the situation produced unresolvable conflict. After some debate the Project accepted that in a few particularly sensitive cases it would be more appropriate to instruct a barrister, with experience of Mental Health Review Tribunals, to represent the patient. However, it was agreed that it was important for the Project to continue to prepare all Tribunal cases, whether or not they undertook the representation at the Tribunal itself.

e. Crime Casework

Table 9: The distribution of crime work 1982-85

	Year 1 1982	Year 1 + 2 1982 + 83	Year 1 + 2 + 3 1982 + 83 + 84
Crime	27 5%	61 7%.	79 7%

Criminal matters often require representation in the Magistrates' Court at short notice. A number of cases - usually involving petty offences - have been withdrawn once the police have been made aware of the client's mental state. Medical reports play an important part - in one case a fine of £200 was reduced to £10 when medical evidence was provided on appeal.

The Project has dealt with several serious criminal matters, some more successfully than others.

CASE STUDY - Crime - 1

In the case of Ms P, the stress of impending criminal prosecution for theft from her employer resulted in attempts at suicide. Once the facts had been investigated, the patient's financial circumstances clarified and a settlement reached with the patient's employer, the employer agreed to ask the police not to prosecute and the client was discharged from hospital.

CASE STUDY - Crime - 2

Mr X appealed against the length of a prison sentence in the Court of Criminal Appeal. He had been transferred from prison to Springfield following a severe breakdown in prison. Evidence from two respected forensic psychiatrists showed that information on previous mental illness had come to light since the Crown Court decision, suggesting that his condition may have led to his committing the crime in the first place. Despite this, Mr X's appeal was dismissed.

f) Employment, Consumer and Immigration Casework

Table 10: Employment, consumer and other work 1982-85

	Year 1 1982		Year 1 + 2 1982 + 83		Year 1 + 2 + 3 1982 + 83 + 84	
Employment	30	6%	45	5%	56	5%
Miscellaneous (total)	88	17%	141	17%	162	15%
Consumer	19		25		30	
Wills	10		21		27	
Court of Protection	15		27		30	
Guardian ad Litem/Guardian	2		3		3	
Power of Attorney	4		6		6	
Other (including tort, court and general legal procedures)	38		59		66	
Immigration	11	3%	17	2%	20	2%
Other	8	1%	11	1%	13	1%

None of these areas forms a large part of the Project's work. Employment problems usually arise where a person is threatened with the loss of a job because of their admission to a psychiatric hosptial. If a client is a member of a Trade Union the matter will be referred to the union concerned. Occasionally union representatives have had to be persuaded to take the matter up and not neglect their members because of admission to hospital. Many clients have not been in employment long enough to be protected under employment legislation, but may have rights under their contract of employment entitling them to holiday pay and notice pay.

g) Legal Capacity and the Court of Protection Casework

Mental illness may affect a person's capacity, that is their ability to be involved in legal proceedings, manage their affairs generally and to give proper instructions to a solicitor. It is a question of judgement in each case but where a Project worker is in any doubt, the advice of the Law Society is followed and the client's doctor is asked for an opinion. Whenever a client's doctor is approached, it is with the permission of the client. The question of legal capacity arises in three main areas of the Project's work: legal proceedings, legal documents and Power of Attorney.

If a client wishes to start or defend legal proceedings, then, if the client is not deemed to have legal capacity, a Guardian ad Litem has to be appointed to act on his/her behalf. In practice this is most difficult where the client's condition fluctuates so that he/she appears able to understand fully and give proper instructions on some occasions but not on others. The Guardian ad Litem might be a relative or a friend. In one case the County Court Registrar was appointed. In the High Court it will be the Official Solicitor. The question of who is made Guardian ad Litem should be carefully considered. If it is to be a relative, friend or doctor, it is essential that they should have a knowledge of the law relating to the proceedings or that they should seek legal assistance. The Project has been consulted by hospital staff about their duties and obligations should they agree to become a patient's Guardian ad Litem.

With regard to legal documents such as a will, the worker will ask the client for permission to ask his/her doctor whether he/she has legal capacity and understands the extent of his/her property. If, in the doctor's opinion, the client does have capacity, then a copy of the doctor's letter can be kept with the will in case it should be challenged on the grounds of lack of capacity.

Power of Attorney is normally given when, for example, someone is going to leave the country and knows that there are legal documents which will need to be signed in their absence. If the person giving the Power of Attorney loses the capacity to understand them, the documents become invalid. Where a psychiatric patient has given Power of Attorney to, for example, a relative and then becomes mentally ill and so deemed not to have legal capacity, then that Power of Attorney becomes invalid. This will be altered where Powers of Attorney are made under the Enduring Powers of Attorney Act 1986. The Project has frequently advised on the validity of Power of Attorney; typically it will be relatives, nurses and staff in the hospital administration department seeking advice on the validity of existing Powers of Attorney, where it has been suspected that the Power of Attorney is being abused and the patient unknowingly deprived of their assets e.g. pensions, property and so on.

If a person has an estate worth in excess of £5000 and becomes legally incapable of managing his/her affairs, a Receiving Order may be made by the Court of Protection empowering the Receiver to look after the patient's interests. The nearest relative is usually appointed as Receiver but could also be a friend, a solicitor or doctor. The Project has acted for patients wishing to end existing Receiving Orders and take control of their own affairs. Several problems have emerged with the Court of Protection and Receiving Orders. The Court of Protection is limited and inflexible in the

matters with which it will deal, although improvements are being made. A final area of concern is the situation where the relative appointed as Receiver may be more motivated to maximise their potential inheritance than to ensure that the present needs and comforts of the patient are met.

The Project was set up primarily for patients and to act on their instructions. It has consequently tended to avoid advising relatives in areas like Receivership, on the grounds that there is a potential conflict of interest between the relative and the patient. However, as a result, the Project has done little for long stay and elderly mentally ill patients who are the most likely to be deemed legally incapable and hence unable to instruct the Project. Recently, the Management Committee reviewed the policy and decided that, in an attempt to facilitate more work with this neglected group of patients, the Project would act for relatives or hospital staff on behalf of long stay and elderly mentally ill patients, provided that there was no actual conflict with the patient's interests.

(iii) An Educational Resource for Patients and the Community

As well as offering training to hospital staff (see Section vii) the Project has always regarded it as extremely important that its work with patients should have an educational aspect.

Discussion and information sessions have been held with a number of patient groups in the Cottage Day Hospital and the Occupational Therapy Centre. To date these have focussed on welfare benefits. They are one of the most enjoyable and productive part of the training work. These have been arranged on an ad hoc basis and could perhaps be usefully integrated into formal rehabilitation programmes.

On a broader front community groups and organisations based outside the hospital regularly ask the Project to give talks on their work. Some of the more recent talks have been given to Tooting Action for Pensioners, Wandsworth Day Centre Workers, Wandsworth Association for Mental Health and the staff of a psychiatric unit in a north London hospital. The Project has participated in national conferences organised by MIND, the King's Fund and the British Institute of Mental Handicap. Subjects have included the Court of Protection, the duties of Hospital Managers under the Mental Health Act 1983, patients' money, funding community health projects and citizens' advocates. The volume of requests has been great at times and eventually the Management Committee came to a decision that priority should be given to requests from local community organisations and from groups and organisations involving workers in the health service.

IV Patient clients' and hospital staff's views of the service to patients

This section gives the patient clients' and hospital staff's views and experiences of the service as elicited by the independent study carried out by SCPR. The views were gathered in a series of semi-structured interviews with 50 patients who had been clients of the Project sometime in the preceding two years and 44 members of staff selected from different departments across the hospital. SCPR did not interview hospital staff as clients of the Project; rather they were interviewed from the basis of their position as nurse, social worker, doctor etc. Details of the research design and methods of the study are given in Appendix A.

(i) Contacts and Advertising

The SCPR study reported that patient clients had most commonly first heard about the Project from members of the hospital staff. Other sources through which they had learned of it were, in decreasing order of frequency, posters, fellow patients, the sign on the Project door, Project staff and leaflets. Several clients also mentioned having had longer talks about the Project to other patients and staff at the hospital either before or after their 'contact'. From these conversations they had generally been left with very favourable impressions of the Project's work.

Despite the wide range of sources from which patients had learned about the Project, quite a number of clients felt that the Project was badly advertised within the hospital.

> 'Somehow they should make sure more patients know about it because you're not informed by hospital staff. They should liaise with hospital staff to publicise it and have more posters'. PATIENT CLIENT

> 'There should be better advertising within the hospital by a sort of initial introduction to patients. More awareness on the part of staff, chaplains and plenty of posters or leaflets on the wards. PATIENT CLIENT

The hospital staff's main contact with the Project was through referring patients, joint committees, talks and consultation of the Project for legal advice. Generally , staff felt their communication was informal and largely preferable to more formal liaison. Those individuals who had been involved in setting up the Project and others who had had regular contact with it had extensive knowledge of the Project and its work. However, those further removed from this 'core group' knew a lot less about the Project and felt they should be better informed. More generally it was felt that the Project should maintain, or even increase, its efforts to keep staff and patients in touch with the work they were doing. This, it was felt, would help to maximise use of the Project, either directly to clients or indirectly through staff.

'The booklet and (recent) meeting helped a lot. Before you just knew that they were here and could take on certain things but I knew nothing about them getting here. Even now I'd have to sit and think about a problem before I rang them. It was nice to see all of them together, it sometimes seems like I only speak to one person.' STAFF

'Departments like social work will be very au fait with them because they work together very closely but departments like mine won't. Our contact has been fairly limited ... I think making people aware all the time of the service is probably still important. After the initial campaign you're inclined to think everyone knows they're here - new staff and patients are coming in all the time'. STAFF

(ii) A Hospital Based Service

The majority of patient clients and staff interviewed felt one of the most important features of the Project was its base within the hospital. This was felt to have two particular advantages. First, it made the Project highly accessible for patients who, by virtue of their hospital status or mental health, could not move outside the grounds to use services in the community.

'... you don't have to suffer the pangs of the outside world that you are obviously not fit for. Accessibility is very important, a lot of mentally ill patients are not able to get very far on their own, you knew you were within the safety of the hospital walls and you could always ask a patient where it was'. PATIENT CLIENT

'The mentally ill have difficulty in accessing these centres - unless someone's doing it on their behalf - that's the valuable thing about the Project here - it is in their midst and they're much more likely to make a consultation.' STAFF

The second reason given for the importance of the Project being site-based was its greater understanding of the nature of mental illness and the workings of the hospital. Both clients and staff felt the Project was able to give a better service on this informed basis than they would in an external setting.

'I felt better it being in the hospital - I felt that being in the hospital they would be that bit more understanding.' PATIENT CLIENT

'When I was ill in hospital I was too drugged to give a statement to an articled solicitor - a solicitor is not going to come more than once to get a statement. I was able to go to the Project twice a week when I felt able - I regarded them, at one time, as my best friends.' PATIENT CLIENT

(iii) Offices and Opening Hours:

The interviews conducted by SCPR showed that although patient clients felt it vital for the service to be based within the hospital, clients were fairly critical of the Project's offices and opening hours, both of which they found limited. Project offices were felt to be too cramped, and consequently neither relaxing nor comfortable to be in. It was also felt by some that they were badly located, with a room each side of the corridor. It was thought that the opening hours were too short and should be extended, possibly to include some evening sessions.

Clients generally found the Project workers approachable and receptive, happily spending time to listen and talk through problems. There were, however, a few who mentioned that they did not like their consultation to be conducted across the top of a desk. There were also reservations about the answer phone which some clients found alienating and difficult to use.

(iv) Defining the Problem

SCPR found that the 50 patient clients interviewed had taken a very wide range of problems to the Project. They had gone for a variety of reasons each of which carried different expectations and anxieties. Frequently the contact had taken place at a very stressful period in the client's life. Some clients also found it hard adequately to explain their situation due to the effects of medication they were receiving.

In many cases, therefore, the Project and client had initially spent some time sorting through the clients difficulties before arriving at a point where constructive help could be given. In this way a client may have gone to the Project with one problem and come away with two, eg: they went because they were behind with the rent and it was found that this was because their benefit payments had not been coming through. Several cases of this sort were reported by clients, as were instances where the client had mentioned a second problem during a visit to the Project, with which they had not realised the Project would be able to help.

(v) Patient Clients' Expectations

The independent study looked at patient clients' expectations of the Project. These indicate both what is known about the Project and what motivates individuals to make contact. The interviews revealed that clients approached the Project with widely diverse expectations of the sort of help or advice they would receive. These were in part influenced by factors such as how they arrived at the Project (eg: clients who had been referred by someone else had expectations partly related to the attitude of the person who referred them) but in most cases expectations were more stongly related to their own perceptions of the sorts of help provided and to their own needs.

Some clients had a clear idea of the task they wanted the Project to perform. So, for example, some individuals approached the Project for representation at a tribunal and others for advice on their sickness benefit claim or to ask the Project to write to an employer. Other clients went to the Project because they knew that they would receive some sort of appropriate advice or legal help without any specific idea of what that help

or advice would be. More particularly clients were drawn by the prospect of receiving expert legal advice and help or because they felt the Project would know or be able to access appropriate contacts and facilities to help with their problem.

As well as specific problem-related demands, the Project was approached as a means of relieving worries about health, communication, legal standing and social isolation. These counselling or support needs were a more nebulous expectation of the Project but nonetheless of importance to people who saw the Project as somewhere to talk about their worries and anxieties.

Clients' feelings about their mental state were really of two kinds. Some clients felt that whilst their own ability to cope was impaired by their health, they wanted the Project to assume some responsibility for their problem. Other clients felt they had difficulty in getting attention or help from people who could not see beyond their psychiatric illness and they therefore needed the Project to represent their interests.

These quotes from clients, asked how they thought the Project could help them, illustrate the mixed expectations brought to the Projects' door.

> 'I was ill at the time. Looking back, I thought these people are experts, trained in the law and they would be legal experts. The social worker said they would help me. They would know all the channels to go through. I think it was a link with the outside world. It's bad enough trying to tackle those sorts of things when you are well - it's awful when you are ill.' PATIENT CLIENT

> 'I thought they could help me by advising me about the procedures and what I should know before taking further action - once you're in a mental hospital they don't take much notice of you and I wasn't compos mentis to do anything myself.' PATIENT CLIENT

> 'They'd put me in touch with the right department. They're more versed in that sort of thing than I am and get better results than I would have myself.' PATIENT CLIENT

> 'I didn't have any idea. I suppose I just wanted someone to talk to about it. I went not knowing what they could do.' PATIENT CLIENT

(vi) The Project's response to clients' problems

It became clear from the interviews conducted by SCPR, that the Project's response to a patient client query had varied with the nature and complexity of the problem brought to them and the resources they could use in its solution. This meant that clients had had very different levels of contact with the Project, both in frequency and intensity. Given this, the Project's professional responses to these fifty clients can be divided into four categories - advice, action, advocacy and referral - although their work for any individual client could move between these categories over time.

Advice work could be quite simple and straightforward, such as advice on a benefit entitlement, or more complex, such as advising on employment rights and redundancy agreements. Action taken with, or on behalf of, clients varied across a wide range of activities. It involved anything from making a phone call or writing a letter, to consulting with appropriate bodies or sorting out the legal details of complex cases. Advocacy involved representation of clients at courts and tribunals. This could cover anything from challenging the section under which the client was detained in hospital, to trying to obtain custody of children during divorce proceedings. Referrals were made at various stages in client's contact with the Project and were instituted for one of two reasons. Either the Project had felt that another individual or group, within the hospital or in the wider community, had more appropriate resources to offer; or the client was referred to a community-based advisory service as part of their move away from contact with the hospital.

In describing the type of help the Project gave, the clients also referred to the way in which that help was given. In many cases it was this, rather than the direct professional help, which was important to them. There appear to have been at least four particularly valued features of the Projects' help; these were the Project's receptiveness, demystification of legal jargon, consultation with clients and encouragement of self-help.

(a) Receptiveness

Receptiveness to clients' problems and enlightened treatment of the client were two highly appreciated aspects of the Project's help. Generally, clients found the Project staff approachable and available, allowing them time to talk over their problem and get things clear.

> 'She was interested, she went all into the case and she seemed as if she really wanted to help and get it all settled.
>
> PATIENT CLIENT

> 'They would always talk to you. Half the time I went there I was a bit scatty, a bit high - they never laughed, they were understanding - a nice couple of girls there'.
>
> PATIENT CLIENT

The Project workers also provided a 'normalising' environment for some clients, that is they treated the clients without the patronage of the healthy to the ill. As the majority of clients were in-patients at the time, living in an environment geared to treatment of the sick, the Projects' normalising attitude was of particular value.

> 'I found them very accessible. I found she was easy to talk to, she didn't talk down to me, she gave me concrete advice and treated me like a human being.' PATIENT CLIENT

> 'It was good to know someone thinks you are sane.'
>
> PATIENT CLIENT

'I had somebody sensible to talk to - the girl I spoke to talked to me as though I was a perfectly sane, sensible adult. There seemed to be an atmosphere of totally accepting what you were like - to relate to you in a useful way.' PATIENT CLIENT

(b) Demystification

The Project's ability to demystify confusing and obscure information, practices and legal procedures was mentioned by several clients. This served the purpose of making the complex field of legal rights more accessible; this is of great importance to individuals who may be experiencing difficulties of concentration or side effects of drugs. The only clients who did not feel they understood what was going on were those who mentioned being drowsy due to their medication and unable to absorb or concentrate on what was happening.

'They told me I could put in an appeal so I decided that I would - so they told me what that would involve. I spent quite a lot of time there talking; she filled in the form from what I was saying. I can't remember all the stages. She also told me what my rights were under section - I can't remember details but she went through procedures.' PATIENT CLIENT

'They gave me the facts and figures of supplementary benefit; they gave me a copy of it and explained it to me, so I could understand it.' PATIENT CLIENT

(c) Consultation

Consultation of clients about the way they wished to procede appeared to be an important aspect of the Project's work, although it was not directly mentioned by many clients. To offer a legal service that is non-directive may be seen to have particular value for individuals in an institutional setting who may feel they have lost some control over their own lives.

'They gave me leaflets so that I could decide. They didn't decide for you. You had the chance of asking them to help you and not the other way round. They didn't say "You should do this" or "No, do this". They said "What do you want to do in the circumstances?' PATIENT CLIENT

Most clients for whom the Project was taking some action felt that the Project kept them informed about what they were doing. However, there were one or two worries about the time that sometimes elapsed between contacts. As some of these clients had quite a lot of spare hours on their hands in which to worry about their problems the processes involved in helping them may have appeared mysteriously long. It was important to these individuals that contact was maintained even when it was just to give reassurance that they had not been forgotten.

(d) Self-help

Self-help was the philosophy that the Project used with many of the clients. A lot of clients had been encouraged to take their own action with the support and guidance of the Project; or, if they had problems in helping themselves, to maintain a high profile and level of involvement with the Project.

> 'They advised me to write to (the people concerned), they helped me write the letter and they helped me evaluate the reply I got .. and they advised me about the pros and cons of proceeding further.' PATIENT CLIENT

> 'They suggested I could ring up social services myself, so I did. They gave me a telephone number and I rang up and asked them if a social worker would come down to see me - she came on to the ward.' PATIENT CLIENT

(vii) The Effects of the Project's Help

Patient clients responded to questions on the effectiveness of the service on two levels. Firstly, they evaluated the service in terms of the outcome of the Project's help - that is the direct effects. Secondly, many clients gave answers that showed the Project's help had played a wider role in their lives, it had had indirect effects on their state of mind and general well-being.

(a) Direct effects

The direct effects of the Project's help were very widely spread and they varied according to whether clients had simply had advice from the Project or had had a more prolonged contact. Generally the Project's help had resulted in a tangible improvement in, or removal of, the problem. So that, for example, individual clients had been discharged from hospital; received money they were due; regained custody of their children; come to agreements with employers and creditors; sorted out accommodation problems and solved family difficulties. Those seeking advice on their legal and other rights had usually come away happy and with the information they needed.

The clients who had not managed to work out their problem or get the advice they sought, usually did not blame it on any lack of effort by the Project. Most of these clients said they were satisfied with the help they had received and believed the Project had done all they could for them. Only one or two clients laid the blame for not finding the desired solution to their problem at the Project's door; although it was still the lack of a solution, rather than any identifiable inaction on the Project's behalf, that seemed the main focus of their complaint.

(b) Indirect effects

Many clients recognised that legal, domestic and financial problems could be in some way contributory to mental illness - either as a direct cause of a breakdown or as an additional source of stress in their lives.

'Normally if you're mentally sick and there's a problem and it worries you, you could become more mentally sick; whereas, they can help you with that problem and the pressure is lifted off. Its a general help all round - it's there when you really need someone to talk to.' PATIENT CLIENT

'You get a lot of people in hospital who have various problems, a lot of legal problems. Without a service of that kind they are left with it all stewing inside them - they haven't anywhere to go for advice.' PATIENT CLIENT

The Project was perceived by many clients, therefore, as a means of sorting out difficulties that were adversely affecting their mental health and blocking any possibility of improvements. It was felt that it was not just the type of help the Project gave that aided recovery, nor simply the resolution of problems through them, but rather the way in which that help was given that had indirect benefits. It was the Project's approach of receptiveness, demystification, consultation, and self-help which led to improvements in confidence and self-esteem.

'It gave me a little bit of confidence, it helped me out of the muddle in my mind, they made objective those things that were subjective because they were impartial. I was very appreciative of it, even though they came out zero in my case. It helped to set my mind out a little better, it eased the burden of worry you have while in a mental hospital ...' PATIENT CLIENT

'They've visited me since I got home and I've spoken to them on the phone - helping me in every way. They gave me a lot of advice and also confidence in myself to carry on - I can now speak for myself. They gave me confidence by telling me I could do it myself ...There's nothing wrong with me now.' PATIENT CLIENT

'I went because the doctors said I should - the doctors were trying to treat me but they couldn't really get very far while all this was going on. The Project took over all legal problems and left me with myself, if you know what I mean, left me to get better in myself.' PATIENT CLIENT

The use of the Project as a 'counselling' resource and its effect of removing some anxieties and giving confidence was clearly a highly-valued part of the service received by clients.

(viii) The Gap the Project filled

(a) Staff View

Staff were not entirely sure what had happened to patients' legal, financial and domestic problems before the introduction of the Project. Largely, they were of the opinion that they had previously not been adequately catered for or coped with, although there were three main sources from which they often received some sort of help or advice.

The first line of contact for patients' problems was often the general nursing staff, the medical staff and some members of the administrative staff. Through their day to day contact with patients, the nursing staff often learned of patients' problems but were generally ill-equipped to provide the specialist advice and help needed. Similarly, the patients' accounts section had often given advice on benefit entitlement, but were primarily concerned with ensuring patients supply of money rather than providing an advisory service. Generally, the best advice these staff could give was to suggest to patients that they contact a social worker or an outside agency.

Social workers were the second group who advised and helped patients. The social workers themselves felt that their knowledge was insufficiently specialist, or up-to-date, to provide the most effective help for many of the problems raised. They could use local advice centres and their own legal department at social services for back-up help but these services were not hospital based and required time that was rarely available, given the demands of more pressing case work.

A third possible source of help, before the Project existed, was outside solicitors and advice agencies. Social workers and other staff had sometimes advised patients to use these. However, this necessitated patients having a strength of purpose and freedom of movement that was often lacking due to the state of their mental health.

> 'They got very inexpert advice from nurses, doctors and social workers and would have been encouraged to seek advice outside.'
> STAFF

> 'There are lots of things the Project are dealing with which probably didn't even emerge before - or if they did, people didn't have any way of dealing with them and they got left.'
> STAFF

(b) Clients' view

Clients' feelings tended to confirm the staff view that if the Project had not been there, their problems would probably have remained with them. A number of clients said they would have taken direct action themselves if the Project had not helped. Some also mentioned they would have contacted a social worker or a solicitor outside the hospital. The majority, however, felt they would have taken no action, at least until their time of discharge from the hospital.

> 'I just can't think what I would have done - I would have been perplexed and very anxious and it wouldn't have improved my condition. I don't think I would have got better so quickly. It would have been on my mind all the time and caused me a lot of bother.'
> PATIENT CLIENT

> 'I was worried about it but for some reason I didn't want to go anywhere else - I don't think I was all that well at the time - I think I would have just left it.'
> PATIENT CLIENT

'I don't think I would have got well again because it was when that was out of the way I started to get better again. I don't know what would have happened if she hadn't sorted it out because at that time I was refusing to see it as a problem.'

PATIENT CLIENT

The point that emerges strongly from these clients is that without the Project's help, their recovery might have been delayed; again indicating the recognition of a connection between mental health problems and those of a legal, domestic or financial nature. In this sense the Project was felt to have contributed a very valuable service.

V A resource for hospital staff

(i) Hospital Staff as Clients

When the Project was originally conceived it had been thought most important to offer a service to hospital staff as well as patients. It was felt that a hospital based service would benefit hospital staff who, because of shift work, might find it difficult to use community based services. In addition, some hospital staff were seen to be particularly vulnerable because of their immigration status or because of their extremely low rate of pay.

The original terms of reference agreed that the Project would provide an advice and legal representation service to hospital staff except where there might be a conflict of interest with a patient. However, in the area of employment, the staff member would be referred to the appropriate trade union or staff association. After one year of operating, the Project was so deluged with enquiries that it became necessary to limit its services. It was decided not to offer legal representation to staff clients, because they could more easily use community based facilities. They would be referred to an outside solicitor where representation was required. Nevertheless, the Project continues to offer advice and limited forms of legal action to a substantial number of hospital staff. In the first three years, just under one quarter of the Project's clients were hospital staff, the two largest staff client groups being nurses and auxilliary workers. The types of problems brought by staff clients to the Project cover a wide range from finance, legal documents, crime, housing, matrimonial, consumer to immigration problems. It is clear from the volume of demand that hospital staff use the services of the Project fairly extensively.

(ii) Training and Education

The Project's training work has increased considerably during the three-year period, particularly since the appointment of the third worker at the end of the second year. From the day the Project opened, workers have made it clear to hospital staff that they are available to provide information and training in areas of law which staff consider would be of assistance in their work with patients. This facility has been particularly well used by some staff groups - notably occupational therapists, social workers and student nurses in training at St. George's Hospital School of Medicine. It ranges from welfare and housing benefits training sessions, to training on Mental Health Review Tribunals and patients' rights in general.

Most of the training to date has depended on the initiatives of one or two people and has been run on a rather ad hoc basis. It has become clear, through casework and requests for information, that a greater understanding of certain topics by hospital staff could benefit their patients. Training on some subjects could be provided by Project workers, but others would be more appropriately conducted by outside bodies and professional organisations. In an attempt to rationalise and maximise their training function, Project workers have provided the administration and personnel departments with a list of staffs' possible training needs. They have offered to provide training on two of these subjects, namely welfare benefits and patients' legal capacity, and to assist in finding speakers on other subjects.

Project workers are often approached by members of hospital staff with a request for information on a point of law, or a query about a complex welfare benefits matter. Advice is given provided it will not lead to a potential conflict of interest with a patient. Thus the Project could advise staff generally about the Mental Health Act 1983, but could not answer a query about who was the nearest relative of a particular patient, to apply for admission under a section under this Act. In such cases the Project will explain why assistance cannot be given and will remind staff of other sources of advice. In the above example this may be the Health Authority or Local Authority solicitors.

(iii) The Hospital Staffs' Reactions to the Project as an Educational Resource

It emerged from staff interviews conducted in the independent study that the Project had acted as an educational resource both at a formal and informal level. Formally, the Project workers have given talks on topics such as benefits and the workings of the new Mental Health Act. Some staff members felt this facility had been under-utilised and that the Project could play a much larger role in the formal education of staff in areas of immediate use in their day to day contact with patients. For example, staff who had learned about benefits could pass information on to patients with relevant problems. Under-utilisation was felt to result from a lack of staff awareness and use of the Project rather than from any reluctance on the Project's side. Staff that had attended talks had generally found them both interesting and useful.

The Project had been much more extensively used on an informal basis, as a back up advisory service on legal issues. Certain departments, because of the scope of their work, have used the Project's expertise more frequently. Social workers, for example, had often consulted the Project for advice. Similarly the administration called on the Project a number of times for general advice in interpreting the implications of the new Mental Health Act. These types of help were very highly valued by the staff and were thought to have contributed to the development of a harmonious and effective working relationship with the Project.

Although some found it difficult to disentangle the Project's influence from that of the new Mental Health Act, it was generally felt that staff at the hospital were more aware of the rights of the mentally ill as a result of the work of the Project. Evidence of this was seen in the increased number of tribunals and a greater readiness to discharge patients from compulsory sections under the Act.

> 'Clearly one is aware of someone being there who might have another point of view.... but it does not make any difference to my practice ... I don't know, I don't think so ..... You might be more active taking people off section - signing the necessary form instead of just letting it run out. There is one chap I remember doing that for.' STAFF

'One of the areas that it's highlighting is patients' rights - in terms of hospital treatment and vulnerability to abuse - it's changed staff recognition that patients do have rights and that information should be given to them. Before they didn't have the information and now they know where to send people to get it and I'm sure the instances of patients applying for tribunals has now increased. The situation has changed quite markedly because of the Project and the new Act - it's been an educational process for staff.' STAFF

VI Major issues

(i) Reassessing the Terms of Reference

With the benefit of hindsight gained from three years of operating the service it is worth looking in some detail at the Project's original terms of reference agreed with the hospital.

It is doubtful whether the Project would have got off the ground if litigation against the hospital had been undertaken as this would have introduced open and direct conflict with the hospital. Indeed, the unhappiness expressed by a few members of the hospital staff on the issue of representation at Mental Health Review Tribunals and the ensuing debate on this would suggest that the Project's position would have been untenable if litigation against the hospital had been undertaken as well. However, there may be an argument for reviewing the position now that the Project has been established in the hospital for over three years. Clients do appear to have accepted the Project's restriction on taking up complaints against the hospital and have understood the need to be referred elsewhere in some cases. On a number of occasions clients have been assisted in using the hospital's complaints procedure.

It is clear that offering a general advice and legal representation service to patients has met a real need - over 85% of problems dealt with by the Project were in areas other than mental health. If the Project had limited itself to dealing with the Mental Health Act and Mental Health Review Tribunals, it would have offered an extremely limited service which would only have benefitted a minority of patients in Springfield Hospital. In addition the substantial numbers of hospital staff clients using the Project has shown that the provision of a general advice service to hospital staff is welcomed.

The condition that there should be a hospital presence on the Management Committee was not easily accepted by its members. It was a hotly debated issue, several members believing it would seriously compromise the Project's independence. During the first three years of the Project's life several different administrators and doctors served on the Management Committee and their presence has proved to be beneficial to the workings of the Project. This is certainly due, in part, to the commitment of these individuals to the Project. Possible conflicts of interest have been coped with by such means as dividing the agendas into two so that hospital representatives withdraw when confidential items are discussed in the second half of the Management Committee meetings. Nevertheless, some Committee members still consider that there is inherent conflict in the presence of hospital staff on the Committee although there have been no insurmountable problems to date.

(ii) The Normalising Approach to Clients

As in legal practice, Project workers act on their clients' instructions. This requires informing the client of the procedures involved and the possible outcome of any action he/she may wish to take and leaving the client to decide how or whether to proceed. Occasionally there are difficulties when a client's instructions seem bizarre and so Project workers try to strike a balance between not colluding with any fantasies a client may have and not denying the validity of what a person is saying.

Rather than checking the truth of what has been said with hospital staff or alternatively going along with all the client's demands Project workers try to find a way of dealing with each case depending on the circumstances. For example, one client wanted to sue a food company for the use of his photograph in an advertisement, so he was asked to bring a copy of the advertisement before making a decision on any action. This "normalising" attitude adopted by the Project is particularly valued by patient clients, as is clearly shown by patient clients' comments in section IV (vi).

(iii) Confidentiality

What is said between Project staff and the client is strictly confidential as in any legal practice, and can only be divulged with the client's consent. Project workers found, particularly in the early days of the Project's existence, that some hospital staff found this difficult to appreciate. In the hospital a multi-disciplinary team approach is employed in patient care and an important factor in this approach is the sharing of information and ideas among the various members of the team. The Project, which is bound by Law Society rules, cannot take part in this process, although in many cases clients request, or are happy, that hospital staff should be consulted on matters relating to their case. Conflict with hospital staff has occurred when a client's instructions differ from what is considered to be in their best interests. This happened most often in relation to applications to the Mental health Review Tribunal. Even casual enquiries by hospital staff about the progress of a patient's case can cause difficulties for Project staff, who, in attempting to preserve confidentiality, may have been seen as rude or aloof.

However, the interviews in the independent study of hospital staff showed that most felt the Project's confidentiality to be important as they could recognise this as something also binding the medical profession. But they did think it sometimes prevented the Project from contributing a useful perspective to a patient's case . Furthermore, it was felt that confidentiality could become more of an issue if it were a life or death case.

> 'Confidentiality hasn't so far created problems. It's what solicitors are bound by anyway - so it's no different from what one would expect if patients go to solicitors outside. We're used to working not entirely in the light - patients may choose not to tell us things. There could well be times when the Project workers have information which ought to be shared, to be known by other members of the team but couldn't be for ethical reasons.' STAFF

> 'Confidentiality is always a difficult issue - if a patient tells you confidentially they're going to commit suicide you've got a responsibility to tell people and make sure they don't do it. Unless it was a decision that was going to radically affect that person's life I think - it's pretty much confidential - in the same way that one hopes that any time they go the the solicitor you assume it is - as with the consultant. In that the Project is within the hospital - whatever worker the patient sees has a responsibility to say to the patient - I think your doctor needs to know about this or I am very concerned about this and I would

like to talk to your doctor. If the patient says 'No, I'll do it myself then you're obviously in a terrible professional dilemma.'
STAFF

(iv) Duplication

In interviews with the hospital staff the independent study conducted by SCPR found that duplication of the work of existing hospital departments was largely felt not to have happened. Originally it was thought that the social work department was most likely to be affected by the Project's introduction with both groups offering advice on benefits, housing and other related matters. However, rather than this leading to duplication, staff saw it as resulting in the use of the Project as a specialist resource. Through close liaison between the two groups, social workers felt the Project acted in a complementary way, offering technical and detailed legal advice which they were not sufficiently qualified to provide. Furthermore, they felt the Project's independence was important for patients who wished to consult somebody outside the hospital.

'There are huge overlaps, not so much with legal matters where we are clearly not qualified to give definitive answers, but part of the social work task is to give advice on benefits, housing, divorce, the courts - that is a tremendous overlap. What tends to happen is stuff we're familiar with, we give it. Very often its more complex and we recommend people to use them.' STAFF

'If somebody wants independent advice then our roles can't overlap - if somebody wants the security of talking to someone who is not part of the institution then we can't possibily offer that service. I don't think there is an overlap but if there is it's certainly to the patient's advantage because of the independence and neutrality of the Project.' STAFF

The patient clients interviewed by SCPR largely confirmed this perception of the Project's services as complementary. Specialist knowledge was the principal reason given by clients for consulting the Project rather than anyone else at the hospital. The legal resources of the Project were particulary highly valued by clients, some of whom felt hospital staff could only deal with medical problems and not with legal, domestic or financial matters.

'It wasn't that kind of a problem for them (the hospital staff) to deal with. If you're sick they deal with the sick part, not with domestic problems.' PATIENT CLIENT

The only department where duplication had led to some concern was in patients' accounts, where staff felt they offered similar advice on benefits to that provided by the Project. It was more widely recognised by hospital staff that the role of patients' accounts was to deal with actual claims, while the Project advised on entitlements and claiming procedures. The boundaries between these roles was blurred but had seldom led to a patient not receiving the best possible advice on their benefit problems.

In conclusion, the hospital staff interviewed felt that duplication had largely been avoided by the Project and hospital departments, through a mutual recognition of the strengths that each had to offer in giving patients the most effective service. However, this did not happen overnight and had involved both groups feeling their way over a long period of time, or as one member of staff commented, 'As they've become established the lines of demarcation have become clearer'.

(v) Conflict

Conflict in work interests between the Project and the hospital could have arisen in a number of areas (although some of these were avoided by agreement on the initial terms of reference). The two most likely areas were child care cases and Mental Health Review Tribunals.

From interviews with hospital staff the independent study concludes that, although there is a high awareness of the possibility of conflict over child care cases and the tensions it could cause, conflict has so far been avoided. Neither the hospital staff nor the Project appear to be pretending that conflict is not a possibility and that working relations will always be smooth. Hence potential differences of interest are recognised and false expectations are not tied to the Project's role.

However, open conflict had occurred with doctors on some occasions when the Project had represented patient clients at Mental Health Review Tribunals. There was a view expressed by some hospital staff in the independent survey that the actual Tribunal representation should be undertaken by outside solicitors and not by Project workers.

> 'I think it would be easier if they didn't represent patients because I think it does complicate the relationship with whatever medical member of staff. Particularly from a professional point of view, if the Tribunal went the patient's way and not the doctor's - the doctor could become quite resentful of the Project and I think it could affect whether they refer patients to it in the future. If people need representation at Tribunals, they should recommend an outside solicitor - rather than doing it themselves. It affects how the Project is viewed and used. Medical staff have admitted all their fears were justified - and the workers in the Project are very well respected - and they shouldn't lose that. I think that should be guarded against'.
>
> STAFF

From staff interviews, conducted by SCPR, it emerged that the complexity and sensitivity of the Tribunal situation is complicated by three issues that stem from the Project and staff sharing the same institutional setting, but where the same rules do not apply. The first, and most difficult, issue is the apparent questioning of professionalism that is implicit in the challenge at a Tribunal of a doctors' medical opinion on the state of the patient's mental health. Although any such challenge would only be from an independent medical report by another doctor, and not by the Project worker representing the patient, that challenge is perceived as being put by the Project itself.

The second issue surrounds the Project's independence from the hospital.

The Project is seen to hold a position that lies outside the rules governing the rest of the hospital although it is further perceived as working within an institution in which it has no power. The third issue is that the Project's method of working cannot be incorporated within the 'consensus model' operating in parts of the rest of the hospital because of its procedures concerning confidentiality.

> ...the advocacy model with all its advantages is not one that we use in all the rest of our work. All the rest of our work is by consensus across many disciplines. So, for instance, on a ward round .. there are several doctors there but there are also nurses, social workers, psychologists, the pharmacists come and so on and so on - old Uncle Tom Cobley and all. And very often the patient comes with a grievance - usually it's a medical type not a legal type of grievance - why don't you let me go home, my medicine's not right, it's not me you should have here it's my wife and all this type of thing - and we don't set up a court in which somebody represents the patient and somebody else represents our view and they argue it out. We have a discussion in which the two sides, hopefully, gradually er ...move until they've got a common aim. And all our work is like that. So that when we agreed to accept the Project as guests in the hospital it was in the expectation that we would seduce them into that way of working and indeed they've been very good at it. We've been very pleased to have them as colleagues in that way - in all the work, except the tribunal work, we've worked with them in that way. So when we've been doing that for six months and then suddenly it comes to a tribunal and you sit down in front of the tribunal with the patient and with the Project solicitor as the advocate of the patient not trying to find common-ground but actually nit-picking about all sorts of things about the case made for the patient to remain in the hospital. That's a very different ... departure to make. It must be different for the lawyers too but its their professional skill to do so. We're not trained to make that change and we find it unacceptable.
>
> STAFF

The interviews revealed that for some patient clients however, the availability of legal representation at Mental Health Review Tribunals was very important. These clients tended to see the issue as one of 'sides', where they stood alone against the hospital and, therefore, needed the support of the Project. Hence the Project was expected by a number of clients to fulfil the role of advocate.

The interviews also showed that non-medical staff and doctors who had not been involved in face-to-face advocacy, felt that the doctors had tended to over react to the situation but that it was a delicate area and needed understanding. 'At least', commented one staff member 'it gets aired at meetings', and it was this ability to discuss issues and solve problems as they arose that many staff members felt important to the continued success of the Project.

Although the issue of representation at Mental Health Review Tribunals only concerned a small number of patient clients and doctors, the Project was

concerned to attempt to resolve the issue as it is the sort of problem that does not go away and can lead to major fractures within institutions. It was finally agreed between the Management Committee and the hospital that in a few particularly sensitive cases the Project, whilst continuing to prepare Mental Health Review Tribunal cases, would engage an outside solicitor or barrister to represent the patient at the Tribunal itself.

(vi) Isolation

The Project's independence from the hospital means that it will inevitably be isolated within the institution and must therefore seek professional support from elsewhere. This was one of the reasons for building in the formal link with Wandsworth Legal Resource Project and ensuring that people with a range of experience were represented on the Management Committee. Workers are encouraged to develop links, both formally and informally, with other voluntary organisations to reduce the problems of isolation. Professional isolation must also be seen in the wider context of the Project's unique work and the general lack of interest in the community in the mentally ill, or knowledge of their problems. The appointment of a third worker and the job sharing of the solicitor's post by two part time solicitors greatly eased the feelings of isolation which had been felt by workers early on in the Project's existence.

It was clear from the SCPR interviews with hospital staff that some staff were aware of the double edged position of the Project in being independent but occupying a hospital based site: the advantages of ease of access for clients being weighed against the disadvantages of isolation. Staff saw the workers as suffering both from professional isolation and isolation from hospital life.

(vii) Independence

It has always been considered essential by the Management Committee that the Project should maintain its independence from the hospital so that it could offer an independent advice and legal representation service to clients. To this end, funding for the first three year period was sought from outside bodies and the health representative on the Management Committee was originally from the Area/District Health Authority and not the hospital itself. (This was modified very early on and the hospital administrator and a medical representative have served on the Management Committee, but their presence does not appear to have affected the Project's independence in any real sense).

SCPR asked patient clients and hospital staff about the independence of the Project. Staff did feel it was important that the Project gave an independent service as it offered patients the chance to consult with someone outside the hospital. They were less sure of whether the Project was actually perceived as independent by patient clients and a few thought patients would have difficulty discerning it as such because of its institutional base and apparent integration.

> 'I don't for a moment believe that either the staff or patients see them as independent. I would assume that they're seen as a part of the system... I just find it terribly difficult to

conceive of how the patient would construe the idea that there are these people who talk like, dress like, and behave like all the rest of the staff at the hospital, who are acting in their interests, who have an office in the hospital, who they've been sent to through members of the hospital - and they're independent? What the hell can that mean. I'd say it's a fiction ...' STAFF

In fact, about half of the clients were actually aware of the Project's independence, although this had not influenced many of their decisions to consult the Project and was actually quite unimportant for most of them. However, two things emerged strongly in the patient client interviews. Firstly, it was evident that where independence had been important in initiating contact, it had actually played a decisive role; for example, a client had contacted the Project about a benefit claim he thought false, which he did not wish anybody else to learn about. Secondly, there was a more general feeling amongst clients that independence would have been important if they were consulting about an issue more directly related to the hospital, such as wishing to be taken off a section under the Mental Health Act.

'I felt dubious at first because it was part of the hospital system. I was afraid that anything I told them might have come on my records and would affect me when I got outside. It was a great relief when I realised they were independent.' PATIENT CLIENT

'It was not a very personal problem, otherwise I would have been more wary.' PATIENT CLIENT

'It wasn't a hospital matter that I was dealing with so it didn't matter to me.' PATIENT CLIENT

'- I knew everything you said to nurses got back to consultants and written in notes. And seeing how they'd recommended my section, I didn't think they'd be that helpful in getting me out of it.' PATIENT CLIENT

It was apparent from SCPR interviews that whilst staff felt it important to provide an independent advice service, they were less clear cut about the Project's independence from the hospital structure.

'I suppose they are more independent than most people but they're very much seen as within the hospital, that is, as professional colleagues. I suppose technically they are totally independent. They actually work within the hospital, they see a lot of us, they eat in the same canteen, we have dealings with them - so they are not shut away in some distant part of the hospital - we know who they are.' STAFF

However, the staff were aware that two features of the Project actually distinguished it from 'other hospital departments'. Firstly, the Project was not subject to the same controls from site-based administration and the NHS and secondly , it gave a guarantee of confidentiality to all clients. On the first issue, staff felt that the Project's autonomy from hospital

control allowed the Project greater freedom of operation, without in any way affecting the running of the hospital and this freedom was felt to be essential to the Project's independence as a client service. Nevertheless, staff felt that the Project did have a partnership with the hospital, based on trust and fostered by the sensitivity with which the Project operated in the hospital.

> 'They could have gone in with guns firing in an uncaring way and constantly attacking the system, which heaven knows is full of holes and warts, but they haven't done that. But they also haven't neglected to press where they think it will do good and keep on at it.' STAFF

If the Project had behaved in a less responsible manner it was felt that the hospital would have had ultimate control over its remaining on site because of the hospital's accountability for all site-based activities. Most staff greatly admired the way in which the Project blended independence and institutional awareness.

> 'Our control needs to be that they work within their terms of reference and if there was a complaint about treatment - it would be a breach of their terms of reference and words would be said. Control is almost by default. I respect them as professional people and I expect them as I would my colleagues to do their job. I don't monitor them as they are independent as I wouldn't monitor the National Blood Transfusion Service because it happens to be on the site - it's an independent organisation. They're our guests and they're doing their work - if their individual conduct left something to be desired I would want to have something to say about that as they're on hospital property. It's wrong for us to apply standards to our staff then to turn a blind eye to someone who comes onto the site who doesn't have the same standards. The key is a mutual understanding to what one another are doing. I trust them - I'm not afraid to leave them to get on with their work. I'm not constantly worrying about what they're up to. My experience has demonstrated that there isn't any need to be. They're providing a service for patients we probably are unable to offer - they're not trying to provide a facility that's contrary to the care we're trying to provided - it's intended to be supplementary' STAFF

VII Future development

The independent study by SCPR revealed that most patient clients and hospital staff thought the Project a highly valuable resource and believed it should continue to the benefit of patients, the staff and the hospital. Further to this, several members of staff felt the Project made a positive contribution to the hospital's reputation and was worth continuing on these grounds alone.

> 'If there was no Project there would be a lot of kudos gone for the hospital - I think it's important for Springfield as a hospital to have it - I think it's quite important for staff morale - we're the only place in the country to have this. It does say something about Springfield - it doesn't bury its head in the sand, it will try things. I think a lot of the patients would miss out because I really think we'd just stop thinking about things. There is advice on all sorts of things they wouldn't get - they wouldn't get it accurately if they got it and they wouldn't be channelled in to other places that could also help them.' STAFF

Hospital staff were less sure about the ways in which the Project could be extended in the future. There was a general awareness that their work was already very demanding and that placing further expectations on their time and resources could be self-defeating. The only area in which some staff thought that it was important for the Project to extend was into community based psychiatric care as community-based patients could then benefit both from specific advice and from the Project's wider understanding of the mental health field.

The Project Management Committee, in the short term, envisages a continuation of the present service in the hospital with improvements made in the training function, in work with long stay and elderly mentally ill patients, and in the welfare benefits take-up campaign.

In the long term the Management Committee believes that, with the increasing emphasis on Community Care, advice facilities in the community should be made more accessible to the mentally ill. In the future it seems likely that the overall number of beds in Springfield Hospital will be reduced, but that the hospital will be the administrative core of psychiatric services in the District Health Authority and will provide beds for acute admissions and other specialities. In this case, the Project will continue to have its main base on the present hospital site, whilst anticipating some change in the nature of the service. Negotiations are already underway to establish advice sessions in a psychiatric day centre within the District and this service could be extended to other day centres and small hospital units. Although the ultimate aim would be to encourage day and ex-patients to use existing community facilities, the Project would act as a bridge akin to the role it currently plays for patient clients within the hospital. As well as extending into community-based psychiatric care it would be important for the Project to devote some energy to increasing the awareness of the community advice and legal services, with regard to the particular and additional problems faced by mentally ill people. The Project might also

usefully combine with some community agencies, such as community health councils and special interest groups, to develop educative/preventive programmes and materials.

VIII Conclusion

The Project was originally conceived as a unique experiment which might serve as a possible prototype for a hospital based, independent, advice and legal representation service and which, if successful, could be emulated in psychiatric hospitals up and down the country. To this end it was felt imperative that a thorough, independent evaluation be undertaken to assess the value of the service from the point of view of patient clients and hospital staff; and a detailed record be made of the Project, its background, the service offered and the major issues which arose.

The independent study carried out by SCPR vindicates the existence of an advice and legal representation service within Springfield Psychiatric Hospital. Additional proof that the Project is a valued and needed resource comes from the fact that in 1985, at the end of the three year experimental period, the Project obtained joint funding from the Health and Local Authorities - the first voluntary agency ever to have done so in that area.

It is hoped that this report on the first three years of the Project's life, whilst obviously not a blueprint, will inspire and guide others hoping to set up similar advice and legal services for the mentally ill.

Appendices

A Research Design and Methods of SCPR study

B The Project's Code of Practice

C Past and Present Members of the Management Committee

Appendix A

RESEARCH DESIGN AND METHODS OF SCPR SURVEY

The following provides a brief account of the design, methods and operation of the independent study carried out by SCPR.

The study method

The client interviews were designed to be semi-structured in form both to provide some basic quantification and to allow more open-ended accounts of contact and satisfaction with the Project's service. Staff interviews were treated in a more unstructured way in order to accomodate the range of professional perspectives. The method afforded flexibility to explore issues in different degrees of depth depending on their relevance to the professional group concerned; and to allow staff to raise issues which they felt to be of particular relevance to them.

The Conduct of the study

The client sample was selected from the records of all individuals who had had contact with the Project in the previous two years. Clients who had not been either an in or out-patient at Springfield Hospital at the time of consultation were excluded from the study. Also excluded were individuals who had been directly referred elsewhere or with whom the Project had not had personal contact for other reasons. Of the 561 clients who had made contact with the project in the reference period concerned, 226 were 'eligible' for interview in the terms described above. From this population, a random sample of 150 clients were systematically selected for interviewing, using case records for identification. The sampling was administered by the Project staff because of the confidentiality of the records.

The 150 clients were approached by the Project, either personally or by letter, for their permission to participate in the study. Any clients who were not willing to take part were withdrawn from the sample. An approach was then made to the remaining clients, either in the hospital or at their last known home address. Interviews were carried out during July and August 1984 by five members of SCPR's interviewing panel. The breakdown of response on the various stages of approach was as follows:

Selected sample	150
Found to be ineligible (eg no contact, staff etc)	31
Refusal	11
Selected as eligible	108
Moved, new address not known	21
No contact/untraceable	17
Pilot	10
Total traced sample	60
Refusal	5
Not interested/did not remember contact with Project	5
Productive interviews	50

Fewer interviews than originally anticipated were achieved due to the large number of movers and non-traceable addresses. The mobility of the ex-hospital population proved to be far higher than expected.

The staff sample was selected on four criteria. These were: where their role or activity involved contact with the Project; those who had contact through committees; individuals involved in negotiations to set up the Project; and heads of departments/professions. All six professional groups working within the hospital were included as were a trade union representative and a member of the Area Health Authority. Fifty staff were contacted by a letter from SCPR, and appointments for interview were subsequently arranged. The number of interviews conducted within the specified groups was as follows:

nursing staff	16
medical staff	9
social workers	7
administration	5
occupational therapists	3
psychologists	2
union representative	1
AHA representative	1
	44

Two members of staff refused interviews because they felt they had insufficient knowledge of the Project, three were away for the duration of the study and one had left the hospital. All staff interviews were conducted in staff offices, or in a specially provided room. The interviews took place during July 1984 and were conducted by two members of SCPR's specialist interviewing team.

Copies of the client questionnaire and staff interview topic guide are not reproduced in this volume. They can be obtained from SCPR, 35 Northampton Square, London, EC1V OAX.

Analysis

Analysis was based on 50 semi-structured client questionnaires and 44 taped interviews with staff. At a very early stage it was decided to treat client interviews in a qualitative, rather than a quantitative, way. This was for three principal reasons. Firstly, the open ended data was extensive and rich, affording insight into the clients' attitudes towards the Project. Secondly, it provided more comprehensive material on issues which had initially been covered through structured questions. On the question of the Project's independence, for example, many fewer clients felt independence to be important when asked in a structured way than emerged in the more expansive answers to open-ended questions. Thirdly, the size of the achieved sample makes it difficult to draw any statistical conclusions from the data collected. Analysis was carried out with the two objectives of the report firmly in mind. These were to provide useful feedback to the Project and the hospital, and to act as a learning resource for those planning similar schemes elsewhere. This meant the analysis was geared to extracting important issues rather than providing exhaustive accounts of particular experiences.

Appendix B

ADVICE AND LEGAL REPRESENTATION PROJECT AT SPRINGFIELD HOSPITAL

CODE OF PRACTICE

This code of practice has been drawn up by the Management Committee of the Advice and Legal Representation Project at Springfield Hospital after consultation with staff and staff representatives at the hospital. The code of practice is in two parts:

Part I
1. General Principle
2. Professional Ethics
3. Confidentiality
4. Relationship with Hospital Departments
5. Patients' Access to the Service
6. Patients' Complaints against the Hospital
7. Union Membership
8. Interpretation of the Code of Practice

Part II Staff Access to the Service

Part I

1. General Principle
The Project will provide an independent, free, confidential advice and legal representation service to patients and their relatives, and to a limited extent, to staff.

2. Professional Ethics
The Project will be a sub-office of the Wandsworth Legal Resource Project and as such will be subject to the solicitors' rules in relation to insurance, accounts, confidentiality and procedure. In effect this means that, among other things, all information made known by the client will be confidential; that the Project workers will act on the client's instructions having explained the paths open to him/her and advised on the likely success of any course of action; that the Project workers cannot act for two opposing parties in any one dispute.

The Project acknowledges the sensitive environment in which it will be operating as regards patient care and will therefore seek proper communications with the clinical staff.

3. Confidentiality
The Project recognises the need for the strictest confidentiality. Only the two workers employed by the Project will know the client's name and full details. On the rare occasion when a client's case has to be discussed by the Project Management Committee the anonymity of the client will be preserved. If a member of the Management Committee has a personal involvement or interest in the client being discussed they will be asked to leave the meeting.

4. Relationship with Hospital Departments
The Project workers will become fully conversant with the structure of the hospital and the different professional ethics of the staff. They will want

to make contact with staff in all departments to discuss the service and establish channels of communication and methods of referral. They will familiarise themselves with the work done by the different departments. A formal induction course to introduce the workers to these areas will be arranged. The Project workers will continue to keep all parties informed of the development of the service and the work covered throughout the life of the Project by giving talks, distributing publicity material and running training sessions.

The Project will avoid monitoring the quality of the treatment and help given to patients. Clearly, matters of clinical judgement are not within the Project workers' expertise. It is anticipated that there will be a number of enquiries about patients' status and responsibilities within the hospital and the implications of these, on which the Project will advise. In such cases the Project workers will explain to the patients the nature of their detention, advise them as to what rights they have to appeal, if any, and, where requested, offer advocacy in the form of representation at Mental Health Review Tribunals. Informal patients will be told of their rights over clothing, treatment, etc, when they request this information but when advising the Project will point out the possible consequences of an irresponsible exercising of their rights. In cases that are obviously the responsibility of the patient's psychiatrist (eg. wanting to change wards or wanting alterations in medication) the patient will be referred to the psychiatrist. The Project workers will be happy to discuss the mattter with the patient and help arrange an appointment for the patient with their psychiatrist if so requested.

The Project will make every effort to get to know the nursing staff, particularly the nurses in charge of the wards. When a patient has sought advice from nursing staff on his/her status in hospital, and then seeks advice from the Project on the same matter, the Project workers will advise again although the advice may be exactly the same as that given by the nursing staff. As an organisation independent of the hospital it is thought that the patient may sometimes more readily accept an explanation given by the Project.

The Project would welcome, in appropriate circumstances, communications by the staff about patients whilst recognising the need for staff to preserve the confidences of their relationships with their patients.

Many of the topics covered by the Project will relate to departments already operating in the hospital (eg. the Social Work Department or the Patients' Accounts Department) and the Project will liaise closely to avoid duplication. It would be helpful if there were arrangements in the hospital to allow the Project workers access to basic information such as the patient's legal status, doctor, ward and welfare benefits received. The Project will not have access to clinical, medical or nursing notes about the patient, unless required in the course of litigation on behalf of the patient.

5. Patients' Access to the Service

There will be open, drop-in sessions at regular times in the week (day time and evening) for self-referral by patients and their relatives. In addition, there will be an appointments system. It will sometimes be necessary to visit patients on their wards with the agreement of the ward

staff concerned if the patient cannot make their way to the Project office. The Project recognises that, at times, visits to a patient may be unhelpful at that particular moment and will take advice from the ward staff in these situations.

Patients' relatives can also use the service, but the Project workers will not act for a relative in a case involving a dispute with a patient, because the patient is less likely to be able to obtain independent assistance elsewhere.

6. Patients' Complaints against the Hospital

The Project will not undertake litigation against members of the hospital staff, although it may represent patients in Mental Health Review Tribunals. Such matters will be referred to an appropriate agency using the normal referral procedure of a law centre or advice agency. This procedure involves advising on the appropriate course of action open to that patient, including using the hospital complaints procedure or an outside agency if necesary, and, if the patient decides to pursue the matter, making a referral. For example, this may mean giving the patient the names of several solicitors and encouraging the patient to ring and make an appointment.

Ethically, the Project cannot refuse to listen to a complaint, but once it becomes clear that the problem should not be dealt with by the Project, the matter is referred and the Project will no longer be involved. As it is difficult to draw hard and fast lines about where litigation is a possibility and where a patient has something of substance to pursue, the Project workers will be asked to discuss all such cases with the Management Committee.

7. Union Membership

The Project workers will be expected to join the S.W. London branch of the Association of Clerical, Technical and Supervisory Staffs.

8. Interpretation of the Code of Practice

If there are difficulties or problems between the hospital staff and the Project workers which cannot be sorted out between them, the staff member should contact his/her respective Head of Department. The Management Committee of the Project is ultimately responsible for the conduct of the Project.

Part II

Staff Access to the Service

The Project proposes that it would be valuable to offer some legal advice and representation to hospital staff. The law is becoming increasingly complex and wide ranging and the staff, just like any other members of the community, will have their share of legal problems. However, hospital staff do have more access to advice and legal representation services than patients, both in terms of the services that their own Trade Union or Staff Association offer, or in terms of other services available outside the hospital. Consequently the Project proposes the following model: that the Project offer advice and initial legal representation to staff on urgent legal problems with the exception of employment problems and any other areas

where the Project might duplicate existing or envisaged Trade Union or Staff Association services. Examples of urgent legal problems with serious consequences for the individual where the Project could help are: situations where an injunction is needed to protect someone from domestic violence or to prevent a child from being kidnapped; where someone has been arrested; where someone has a serious immigration problem. The Project will offer advice and initial representation to staff who request such help and then refer them to an appropriate solicitor.

It might be helpful in the future for the Project and the Trade Unions and Staff Associations to meet from time to time to discuss any other areas in which the Project might offer advice.

March 1981

Appendix C

PAST AND PRESENT MEMBERS OF THE MANAGEMENT COMMITTEE

Wandsworth Community Health Council		
Ros Borley	1980 - 1982	
Kate Doggett	1982 - 1984	
Andree Rushton	1984 -	
Wandsworth Association for Mental Health		
Robin and Pat Benians	1980 -	
Wandsworth Rights Umbrella Group		
David Taylor	1980 - 1981	
Rosa Heyes	1981 - 1983	
Wandsworth Legal Resource Project		
Barbara Dwyer	1980 - 1981	
Isobelle Conlon	1980 - 1982	
Sandra King	1982 - 1984	representing Tooting Project from 1983
Marjorie Stevenson	1982 -	
Magi Young	1984 -	
Richard Hallmark	1980 -	co-opted as individual in 1985
Chris Dalton	1983 - 1985	
Afro Caribbean Mental Health Association		
Pat Oakley	1984 - 1985	
Patricia Nanco	1985 -	
Merton MIND		
Shirley Higgins	1985 -	
Unity Helpline		
Doreen Thomas	1985 -	
Tooting Project		
Florence Jackson	1985 -	
Doddington and Rollo Family Centre		
Lois Pollock	1985 -	
King's Fund		
Dr Peter Jefferys	1980- 1985	
Individuals		
Sean Young	1980 - 1985	
Jennifer Rogers	1980 - 1981	
Julia Stallibrass	1980-	
David Dunne	1980 - 1983	
Lester Springer	1982 - 1984	

District Health Authority	
David Harrop	1980 - 1981
David Bennet	1981 - 1982
Neil McKay	1982 - 1984
Eric Flint	1984 -

Medical Committee Representative	
Dr Loic Hemsi	1980 - 1983
Dr Greville Gundy	1983 -

STAFF MEMBERS	
Anne Stanesby	1982 - 1983
Jennifer Rogers	1982 -
Heather Vassie	1983 - 1985
Christine Harman	1984 - 1985
Helen Snell	1983 - 1985
Lorraine Gonzales	1985 -
Katherine Watson	1985-

£4.00