



Subject: Mental Health Act advocacy provisions  
To: Adam Holloway MP  
From:  
Reference: 2007/7/132-SPS  
Date: 23 July 2007

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I understand that you would like to know what is happening about advocacy provision and the Mental Health Bill by tomorrow.

The new (amending) *Mental Health Act 2007* received the Royal Assent on 19 July 2007. Government provisions on advocacy were introduced with support from both the Liberal-Democrats and the Conservatives at the Report Stage of the Bill in the House of Commons on 18 June 2007. They are now contained in Section 50 of the 2007 Act, which introduces new sections 130A-D in the *Mental Health Act 1983*. These are reproduced below:

*30 Independent mental health advocates*

(1) Part 10 of the 1983 Act (miscellaneous and supplementary) is amended as follows.

(2) Before section 131 insert—

*"130A Independent mental health advocates*

(1) The appropriate national authority shall make such arrangements as it considers reasonable to enable persons ("independent mental health advocates") to be available to help qualifying patients.

(2) The appropriate national authority may by regulations make provision as to the appointment of persons as independent mental health advocates.

(3) The regulations may, in particular, provide—

(a) that a person may act as an independent mental health advocate only in such circumstances, or only subject to such conditions, as may be specified in the regulations;

(b) for the appointment of a person as an independent mental health advocate to be subject to approval in accordance with the regulations.

(4) In making arrangements under this section, the appropriate national authority shall have regard to the principle that any help available to a patient under the arrangements should, so far as practicable, be provided by a person who is independent of any person who is professionally concerned with the patient's medical treatment.

(5) For the purposes of subsection (4) above, a person is not to be regarded as professionally concerned with a patient's medical treatment merely because he is representing him in accordance with arrangements—

(a) under section 35 of the Mental Capacity Act 2005; or

(b) of a description specified in regulations under this section.

(6) Arrangements under this section may include provision for payments to be made to, or in relation to, persons carrying out functions in accordance with the arrangements.

(7) Regulations under this section—

(a) may make different provision for different cases;

(b) may make provision which applies subject to specified exceptions;

(c) may include transitional, consequential, incidental or supplemental provision.

### **130B Arrangements under section 130A**

(1) The help available to a qualifying patient under arrangements under section 130A above shall include help in obtaining information about and understanding—

(a) the provisions of this Act by virtue of which he is a qualifying patient;

(b) any conditions or restrictions to which he is subject by virtue of this Act;

(c) what (if any) medical treatment is given to him or is proposed or discussed in his case;

(d) why it is given, proposed or discussed;

(e) the authority under which it is, or would be, given; and

(f) the requirements of this Act which apply, or would apply, in connection with the giving of the treatment to him.

(2) The help available under the arrangements to a qualifying patient shall also include—

(a) help in obtaining information about and understanding any rights which may be exercised under this Act by or in relation to him; and

(b) help (by way of representation or otherwise) in exercising those rights.

(3) For the purpose of providing help to a patient in accordance with the arrangements, an independent mental health advocate may—

- (a) visit and interview the patient in private;
- (b) visit and interview any person who is professionally concerned with his medical treatment;
- (c) require the production of and inspect any records relating to his detention or treatment in any hospital or registered establishment or to any after-care services provided for him under section 117 above;
- (d) require the production of and inspect any records of, or held by, a local social services authority which relate to him.

(4) But an independent mental health advocate is not entitled to the production of, or to inspect, records in reliance on subsection (3)(c) or (d) above unless—

- (a) in a case where the patient has capacity or is competent to consent, he does consent; or
- (b) in any other case, the production or inspection would not conflict with a decision made by a donee or deputy or the Court of Protection and the person holding the records, having regard to such matters as may be prescribed in regulations under section 130A above, considers that—

- (i) the records may be relevant to the help to be provided by the advocate; and
- (ii) the production or inspection is appropriate.

(5) For the purpose of providing help to a patient in accordance with the arrangements, an independent mental health advocate shall comply with any reasonable request made to him by any of the following for him to visit and interview the patient—

- (a) the person (if any) appearing to the advocate to be the patient's nearest relative;
- (b) the responsible clinician for the purposes of this Act;
- (c) an approved mental health professional.

(6) But nothing in this Act prevents the patient from declining to be provided with help under the arrangements.

(7) In subsection (4) above—

- (a) the reference to a patient who has capacity is to be read in accordance with the Mental Capacity Act 2005;

(b) the reference to a donee is to a donee of a lasting power of attorney (within the meaning of section 9 of that Act) created by the patient, where the donee is acting within the scope of his authority and in accordance with that Act;

(c) the reference to a deputy is to a deputy appointed for the patient by the Court of Protection under section 16 of that Act, where the deputy is acting within the scope of his authority and in accordance with that Act.

**130C Section 130A: supplemental**

(1) This section applies for the purposes of section 130A above.

(2) A patient is a qualifying patient if he is—

(a) liable to be detained under this Act (otherwise than by virtue of section 4 or 5(2) or 4) above or section 135 or 136 below);

(b) subject to guardianship under this Act; or

(c) a community patient.

(3) A patient is also a qualifying patient if—

(a) not being a qualifying patient falling within subsection (2) above, he discusses with a registered medical practitioner or approved clinician the possibility of being given a form of treatment to which section 57 above applies; or

(b) not having attained the age of 18 years and not being a qualifying patient falling within subsection (2) above, he discusses with a registered medical practitioner or approved clinician the possibility of being given a form of treatment to which section 58A above applies.

(4) Where a patient who is a qualifying patient falling within subsection (3) above is informed that the treatment concerned is proposed in his case, he remains a qualifying patient falling within that subsection until—

(a) the proposal is withdrawn; or

(b) the treatment is completed or discontinued.

(5) References to the appropriate national authority are—

(a) in relation to a qualifying patient in England, to the Secretary of State;

(b) in relation to a qualifying patient in Wales, to the Welsh Ministers.

(6) For the purposes of subsection (5) above—

(a) a qualifying patient falling within subsection (2)(a) above is to be regarded as being in the territory in which the hospital or registered establishment in which he is liable to be detained is situated;

(b) a qualifying patient falling within subsection (2)(b) above is to be regarded as being in the territory in which the area of the responsible local social services authority within the meaning of section 34(3) above is situated;

(c) a qualifying patient falling within subsection (2)(c) above is to be regarded as being in the territory in which the responsible hospital is situated;

(d) a qualifying patient falling within subsection (3) above is to be regarded as being in the territory determined in accordance with arrangements made for the purposes of this paragraph, and published, by the Secretary of State and the Welsh Ministers.

***130D Duty to give information about independent mental health advocates***

(1) The responsible person in relation to a qualifying patient (within the meaning given by section 130C above) shall take such steps as are practicable to ensure that the patient understands—

(a) that help is available to him from an independent mental health advocate; and

(b) how he can obtain that help.

(2) In subsection (1) above, "the responsible person" means—

(a) in relation to a qualifying patient falling within section 130C(2)(a) above (other than one also falling within paragraph

(b) below), the managers of the hospital or registered establishment in which he is liable to be detained;

(b) in relation to a qualifying patient falling within section 130C(2)(a) above and conditionally discharged by virtue of section 42(2), 73 or 74 above, the responsible clinician;

(c) in relation to a qualifying patient falling within section 130C(2)(b) above, the responsible local social services authority within the meaning of section 34(3) above;

(d) in relation to a qualifying patient falling within section 130C(2)(c) above, the managers of the responsible hospital;

(e) in relation to a qualifying patient falling within section 130C(3) above, the registered medical practitioner or approved clinician with

whom the patient first discusses the possibility of being given the treatment concerned.

(3) The steps to be taken under subsection (1) above shall be taken—

(a) where the responsible person falls within subsection (2)(a) above, as soon as practicable after the patient becomes liable to be detained;

(b) where the responsible person falls within subsection (2)(b) above, as soon as practicable after the conditional discharge;

(c) where the responsible person falls within subsection (2)(c) above, as soon as practicable after the patient becomes subject to guardianship;

(d) where the responsible person falls within subsection (2)(d) above, as soon as practicable after the patient becomes a community patient;

(e) where the responsible person falls within subsection (2)(e) above, while the discussion with the patient is taking place or as soon as practicable thereafter.

(4) The steps to be taken under subsection (1) above shall include giving the requisite information both orally and in writing.

(5) The responsible person in relation to a qualifying patient falling within section 130C(2) above (other than a patient liable to be detained by virtue of Part 3 of this Act) shall, except where the patient otherwise requests, take such steps as are practicable to furnish the person (if any) appearing to the responsible person to be the patient's nearest relative with a copy of any information given to the patient in writing under subsection (1) above.

(6) The steps to be taken under subsection (5) above shall be taken when the information concerned is given to the patient or within a reasonable time thereafter. "

(3) In section 134 (patients' correspondence), in subsection (3A), for paragraph (b) substitute—

"(b) "independent advocacy services" means services provided under—

(i) arrangements under section 130A above;

(ii) arrangements under section 248 of the National Health Service Act 2006 or section 187 of the National Health Service (Wales) Act 2006; or

(iii) arrangements of a description prescribed as mentioned in paragraph (a) above. "

The debate on the Government amendments on 18 June 2007 and is reproduced below. Rosie Winterton was then the Government Minister with responsibility for mental health.

Ms Winterton: It is a pleasure to report back from the Committee after our extensive debates. It is particularly pleasurable to start with this group of amendments, as the

amendments that we have tabled on advocacy are in response not only to what was said in the other place and in the detailed discussions that we had in Committee, but to the many representations that we received from organisations that have an interest in people with mental health problems having access to advocacy.

Government new clause 3 and Government amendment No. 66 provide for advocates to be available to patients detained in hospital for assessment or treatment, to community patients and to patients subject to guardianship. In the other place and in Committee, the issue was raised of specialist advocacy for black and minority ethnic patients, child patients and patients with learning disabilities. My hon. Friend the Member for Hackney, South and Shoreditch (Meg Hillier) spoke in Committee of the great benefit of specialist advocacy for patients for whom English is not their first language. The need for specialist advocacy is the reason that we have included a regulation-making power that will allow us to make different provisions for cases when it comes to the training requirements for advocates.

As was pointed out in Committee, patients must know that they have a right to advocacy. We have provided for them to be told orally and in writing. In addition—I know this will interest the hon. Member for Tiverton and Honiton (Angela Browning)—Government amendments Nos. 52 and 61 amend the Mental Capacity Act 2005 and give the person deprived of liberty or their representative the statutory right of access to an independent mental capacity advocate to explain to them the authorisation for the deprivation of liberty and to provide support with a review or with an application to the Court of Protection. Again, these Government amendments, which reflect representations made to us, also ensure that both the person and their representative are told about the IMCA service.

Mr. David Kidney (Stafford) (Lab): My right hon. Friend mentions the existence of independent mental capacity advocates under the 2005 Act; now we are to have independent mental health advocates. Can she assure the House that they will effectively be the same bodies of advocates, with common training and arrangements?

Ms Winterton: My hon. Friend is right to raise that important issue. We believe that there is scope for advocates, if they wish, to receive training in both areas. Naturally, some people will perhaps wish to specialise. He is probably aware that the pilot training for IMCAs is already under way, but there would not necessarily be any problem with people being able to specialise in both areas.

Mr. Edward Gamier (Harborough) (Con): I apologise for coming late to the subject. I was not a member of the Public Bill Committee, so this matter may have been discussed already, but will the advocates be funded from the Minister's budget or from the Ministry of Justice's budget, or will they be paid for by the people for whom they will provide representation? It seems a little unclear.

Ms Winterton: I can assure the hon. and learned Gentleman that they certainly will not be paid for merely by the people who need to use them. They will be paid for by the supervisory body - whether that is the local authority or health authority will depend on the IMCAs and, in a sense, those for whom they are to be used. In the case of mental health advocates and mental capacity advocates, individuals will not be expected to pay for them.

Mrs. Madeleine Moon (Bridgend) (Lab): I have today received an e-mail from Mental Health Matters, a charity in Bridgend that provides a community advocacy service. One of the things that it welcomed was this provision and this change on the part of

the Government. In particular, it has written to say that it is an important change, which it welcomes, but that it is having difficulty in getting the local trust and the local authority to fund its community advocacy service. Does my right hon. Friend agree that it is important that the voluntary sector is approached in providing such services, as it gives confidence to many users of mental health services that advocacy is independent and works in their best interests?

Ms Winterton: My hon. Friend is right. During debates on the Mental Capacity Bill, we were able to give assurances that we saw an important role for the voluntary sector in such instances because that sector often has such expertise. One thing that we hoped would flow from our taking statutory powers in this sense would be the ability to ensure that a number of voluntary organisations would have access to some of those streams of funding, particularly because such organisations are often seen as independent and as having quite a lot of expertise already. There is no point in reinventing the wheel in some of these cases, but we need to ensure that the organisations have proper training. That is why, through some of the IMCA pilot sites, we have been ensuring that that takes place.

Angela Browning (Tiverton and Honiton) (Con): Will there be a statutory right for the patient to see the independent advocate in private?

Ms Winterton: We would like to ensure that the advocacy services are delivered in the most appropriate way. If there is a need for privacy to form a part of the service, that would be expected to be the case. I take on board what the hon. Lady says. However, we would have to be careful not to give the impression that every interview had to be held in private in case that was not appropriate for an individual, for example if it caused them distress. It is right to say that we should think about ensuring that privacy is provided wherever possible. Perhaps we could take the subject away and consider it in respect of such issues as the code of practice in both instances, as well as the importance of training in that area.

Meg Hillier (Hackney, South and Shoreditch) (Lab/Co-op): It seems to me implicit in new clause 3 that an advocate should be able to speak with the patient, and should perhaps therefore be able to speak another language. Will my right hon. Friend explain her views on bilingual advocacy? It is not the same as having advocates with translations. I appreciate that it would be difficult to make an open-ended commitment to ensuring provision in every language spoken by people in my constituency, but for an advocate truly to understand the case - and this is stressed by Derman, a Turkish and Kurdish advocacy service in my constituency—they need to understand the cultural implications of someone's background.

Ms Winterton: That is exactly why, as I have said, we have included in the power relating to regulations the ability to consider the issue of specialist advocacy; that will cover exactly those points. Hywel Williams (Caernarfon) (PC): Further to what the Minister has said, would advocates in Wales be treated as working for a public body, as defined by the Welsh Language Act 1993?

Ms Winterton: That is something that the hon. Gentleman will need to take up with the National Assembly for Wales. Obviously, some of those matters will be devolved. The Bill enables powers to be taken, but some of the implementation, particularly with regard to specialist advocacy, may well be covered by the Assembly.

Section 40 of the Mental Capacity Act 2005 provides that an IMCA is not required to be appointed in certain specified situations. Government new clause 5 and Government amendments Nos. 62 to 64 and 68 would limit the exceptions under

section 40. Where someone has been appointed for matters related to property and affairs, the appointment will no longer preclude an IMCA from being instructed for health and social care matters.

I want now to turn to the amendments tabled by the hon. Member for Romsey (Sandra Gidley), which would make changes to the Government new clause requiring advocates to be made available to patients who had not yet been detained for the purposes of assessment or treatment, and for child in-patients who were not subject to detention. I completely understand her concerns, but we need to target resources at the most vulnerable. We do not agree that it is necessarily either appropriate or workable to provide advocates to people who have not yet become subject to an application for detention, or who are not being treated under the Mental Health Act 1983, except in the specific and limited circumstances that we have set out. We must prioritise, and we believe that we have identified the priority group.

There are also links between some of the nearest relative provisions and our intentions in introducing advocacy; I know that my hon. Friend the Member for Birmingham, Selly Oak (Lynne Jones) sees the nearest relative as being, in a way, the patient's representative. The aim of new clause 17 and amendments Nos. 104 and 105, tabled by my hon. Friend, is to provide patients with the opportunity to have their carer appointed as their nearest relative, and to extend the grounds on which they can apply to displace a nearest relative.

That is an issue about which there were lengthy debates in the other place, particularly about whether a patient should be able to choose their nearest relative. Those debates continued in Committee. I considered the matter extremely carefully, because I can understand the intuitive sense that it is the right approach.

Having looked at it, however, I came to believe that it would be inappropriate to make the kind of changes that my hon. Friend the Member for Birmingham, Selly Oak is suggesting—so that someone could choose a nearest relative in the same way as they would choose a direct representative or a next of a kin. We need to start from the position that the nearest relative has very particular powers under the Bill, some of which are quite specific, in respect of preventing detention and applying for discharge.

In some of the earlier discussions on this Bill, and on previous Bills, we talked about nominated representatives, but carers groups expressed concerns particularly about the displacement of a nearest relative, which could have an effect on carers that many of us know all too well. When a person becomes extremely ill and feels that the nearest relative has the power to block detention or to discharge, it becomes too easy for that person to think that that is precisely what they should be doing. That can put many people in a difficult position. We need to realise that this is a sensitive issue.

Chris Bryant (Rhondda) (Lab): I hope that the Minister realises that the issue is also very sensitive in the other direction. Many "revolving-door" patients of mental health institutions—that is not a very nice term, but it is one that we grew used to in Committee—sometimes feel that they want to change their nearest relative without having to go to the court and give lengthy and complex arguments why they should be able to do so. I hope that the Minister understands that, too.

Ms Winterton: Of course I understand that, and I know that my hon. Friend is concerned about this particular issue. As I said, I examined it very closely and asked my officials to see whether there was a way of trying to accommodate that

development. Let me set out some of the reasons why we decided that there was a real difficulty with such a provision.

If we allowed an automatic right to appoint the nearest relative in advance, to comply with the European convention on human rights it would be necessary to set up a system by which nominations could be ratified by an independent process with a suitable mechanism for appealing decisions. There is no existing body that could do that; we would have to set up a new body, whereas at the moment we take such issues to the county courts. We would still need a process by which to make that happen. For example, we would need to be able to allow a nearest relative who was being displaced to appeal if they felt that it was the wrong approach.

I understand the argument that it would be possible for someone to nominate a person in advance when they were not subject to the legislation—that is, when they were not in a detained situation—in anticipation of being detained, but for ECHR compliance it would be difficult to have one system for people who were not detained and a completely different system, under which people had no access to that right, when they were being detained. Restricting the provisions to carers alone would also have particular problems.

Amendment No. 105 would add another ground on which applications could be made to displace the nearest relative—

"that in the reasonable opinion of the patient the person is not appropriate",

and would also amend ground (e) in clause 23(5). I understand the concerns expressed about the Bill's new ground of being "not suitable". For the first time, patients can apply on those grounds and say that they believe that their current nearest relative is not suitable. Concerns have been expressed about whether the provision would cover situations where patients have no real relationship with their nearest relative. Although it is important that the courts look at each case on its merits, we intend the idea of unsuitability to cover situations where there is no effective relationship between the patient and their nearest relative, or where the relationship has broken down irretrievably.

Given the other changes that we are making, we believe that our proposals cover some of the problems highlighted by my hon. Friend the Member for Birmingham, Selly Oak in amendments Nos. 104 and 105. We shall continue to hold consultations about the code of practice and I am happy to include my hon. Friend in them, as I know she is particularly concerned.

Angela Browning: Will the right hon. Lady give way?

Ms Winterton: I will in a second.

The changes we are making to the Bill give patients a new right to apply to the court for displacement. They will then be free to nominate anyone they want as their replacement nearest relative. As long as the court finds that person suitable and they are willing to act, they will be appointed. As well as that new right, we have provided that the involvement of carers and others with the patient must be addressed as part of the fundamental principles. That meets the fear that people might be excluded. Based on the principles, the code will make it absolutely clear that the nearest relative is not meant to replace the patient's next of kin, so their appointment does not prevent other people nominated by the patient from being contacted or appropriately involved in decisions about care and treatment.

The Mental Health Act 1983 provides that hospital managers have a duty to advise patients of their rights, including providing all patients with information about how to apply to the county court. I think that my hon. Friend the Member for Birmingham, Selly Oak, and some members of the Committee, were concerned that people would have to go through a cumbersome process, so we shall ensure that patients are advised of their rights and training is given to ensure that those who inform and advise patients understand the new rights properly. In our meetings with the new mental health coalition, concerns were raised about the provisions, so we have looked at matters closely and considered production of a user-friendly guide to applying to the county court.

New clause 15 relates to the three-month rule under section 58 of the Mental Health Act 1983, and would reduce to two months the period after which the section applies. The section requires that if a patient refuses consent, or cannot give consent, a SOAD—second opinion appointed doctor—should certify that the treatment is appropriate and should be given. My noble friend Lord Hunt said in the other place, and I reiterated in Committee, that we continue to believe that the three-month period remains appropriate. The 1983 Act contains a power, in section 58(2), to reduce the period by order, so we can already go forward on that basis. However, we feel it would be more appropriate to do so after consultation, so that we can proceed based on evidence, and at a manageable and sustainable pace. At this stage, we do not think it right to change that existing power without undertaking proper consultation and without ensuring that we can deliver on it.

Tim Loughton (East Worthing and Shoreham) (Con): To pre-empt the new clause that I shall propose in a minute, may I ask the Minister: has not the power to vary the term been in the Act since 1983? The Government said that they would look at it, but nothing has been done for 24 years. Why is the Minister so convinced that the three-month term remains appropriate? She has not made the case.

Ms Winterton: There is no evidence to support the proposition that the period is too long. Of course, I am aware of comments made by the Mental Health Act Commission and the Joint Committee on Human Rights, but those opinions do not constitute evidence that three months is not the most appropriate period for the SOAD to assess a patient's medication for the first time and, with the approved clinician in charge of treatment, to identify whether changes should be made to the ongoing treatment plan. As I said in Committee, the High Court has recently refused leave for a judicial review of the compatibility of the three-month period with the European convention on human rights, so it is not outside the ECHR. We do not believe that there is evidence for changing the period, and that is why we do not accept the need to do so.

Most of all, the power exists already, and we would use it only after proper consultation with clinicians and others to decide whether it was an appropriate time to use it. Otherwise, it could become a completely unmanageable and unsustainable change.

Tim Loughton Will the Minister give way?

Ms Winterton: I will give way to the hon. Gentleman, but I am sure that we will hear his arguments in full before too long.

Tim Loughton: Absolutely, and I shall try to make them brief.

If the Minister is to be consistent, why was it appropriate in the 2004 draft Bill to set up the tribunal system, which has now been dropped, which would have reviewed the case after not three months or two months, but 28 days?

Ms Winterton: As the hon. Gentleman knows, a number of changes were suggested in the draft Bill, but it was rather heavily criticised by the pre-legislative scrutiny Committee, of which he was a member, for being lengthy and complex, and for making many commitments that would involve financial considerations that could not necessarily have been delivered. We responded to many of the Committee's points by introducing a short amending Bill to amend the 1983 Act.

If the hon. Gentleman is happy to enter such a commitment, involving a number of changes and commitments, both managerial and financial, I am sure that his Front Bench will be behind him. However, I urge him, when talking to his shadow Chancellor and the rest of the gang, to make it clear what such a commitment would mean. I also urge him to ensure that he is absolutely convinced that the right evidence exists to make such a commitment. We do not believe that it does.

John Bercow (Buckingham) (Con): I apologise to the right hon. Lady that I was not here for the start of her remarks. I have no wish to be curmudgeonly or uncharitable, but I am conscious that new clause 3(2) and (7) refer to the order-making power and the different regulations that will flow from that. Can the right hon. Lady assure me that we will have sight of at least a draft of the intended regulations before the ultimate passage of the Bill? Otherwise, with the best will in the world, we are being asked to opt for, and to be content with, a pig in a poke. We need to see the detail before we vote for the legislation.

Ms Winterton: I am astonished that the hon. Gentleman refers to our Bill, which has been through such distinguished discussions, as a pig in a poke. I am sure that his Front Bench will have something stern to say about that. I hope that I can reassure him that we will continue to consult fully on the Bill, particularly on some of the regulation-making powers, not only through the procedures of the House but with clinicians and others who have shown an interest. We are anxious that the implementation be effective, so we will continue to discuss that.

I stress that the advocacy amendments were tabled by the Government very much in response to points made in the other place, in Committee and by a number of organisations about this important issue. I am glad that we have been able to debate those as part of the first group of amendments, and I urge the House to support them.

I ask the hon. Member for Romsey not to press her amendments, because it is important that we consider where our resources are best used, and her proposals would not be practical. My hon. Friend the Member for Birmingham, Selly Oak is right to raise the issues that she does, as they are important, but to try to make some of the changes proposed would involve real problems. I undertake, however, to consider some of the issues in relation to the code of practice, and I hope to address the concerns raised. I urge the hon. Member for East Worthing and Shoreham (Tim Loughton) to withdraw his new clause, for the reasons that I have outlined.

Tim Loughton: I want to comment on two aspects of this group. First, I want to pose some questions to the Minister about advocacy. Clearly, that part of the Bill is completely new. It is a welcome new addition, but it is a reappearance, because advocacy services were promised by the Government in the 2004 draft. That was very much welcomed by the pre-legislative scrutiny Committee, which raised practical questions with the Minister about it. She has now included the provision, but it could

have been included in the first place, which would have enabled the Committee to consider the finer print, and saved us further debate here.

Advocacy is essential in three main areas: to ensure a statutory right to an independent mental health advocate for all patients subject to compulsory powers; to make patients aware of that right, which the Minister has touched on; and to ensure, as my hon. Friend the Member for Tiverton and Honiton (Angela Browning) pointed out, that patients have a right to meet their advocate in private. Those are fundamental human rights that should be made available as part of the service.

The advocates will be essential, providing support to vulnerable people in exercising their rights to appeal against decisions made for their treatment or confinement: for example, as a way of communicating their interests when they may lack capacity to do so for themselves. That service should be provided, particularly for the most vulnerable patients, and prioritised at the point of crisis. The issue of the availability of culturally competent advocacy has also been raised. In particular, the black and minority ethnic mental health communities have pointed to the importance of suitable advocacy for their members.

The pre-legislative scrutiny Committee questioned the Minister's estimated costings. The regulatory impact assessment estimated the whole-time equivalent of 140 advocates at a cost of approximately £5 million. We seriously questioned whether the Minister had made a very conservative and inadequate estimate. We need to be convinced that the service will be workable, viable and sustainable, not just a token effort to make available a few—but not nearly enough—advocates. Has the Minister reviewed the costings?

Mr. Kidney: I raised the issue of common advocacy standards, training and arrangements with independent mental capacity advocates because I hoped that that would enable us to ensure that the costs were proportionate and affordable.

Tim Loughton: The hon. Gentleman has raised that issue before, and has been a big advocate of advocates for some time. The point he makes is right. It also touches on how the advocates should be overseen and quality-controlled. Again, the pre-legislative scrutiny Committee suggested that the Mental Health Act Commission should be engaged to set the standard for the advocates. If we are to have advocates, we need to ensure that they know what they are doing, and are of a sufficient standard to do what can be a technical job dealing with technical parts of the law, as all of us who have been involved with the Bill for some years, and on the Committee for the past few weeks, know.

What has been learned from the Mental Capacity Act 2005 about the use of advocates? I know, from when the Minister and I discussed a statutory instrument to extend the pilot for advocates provided under that Act, that they have gone down well. At that time I raised the great inconsistency: if they worked well for people covered by that Act, why on earth were we not having them in this legislation—as we now are? I should like to hear some comments on that. We support what the Government are introducing, and merely question whether the measure is sufficiently resourced and structured for it to be as successful as we all want it to be. However, I certainly commend the Government for introducing it.

The Minister pre-empted some of my comments on new clause 15, although she did not answer my questions about it, which I fear was also the case when we raised the subject in Committee. This is important because it is all about respecting the wishes of vulnerable patients and considering the effect of treatment on them, giving them an

opportunity to engage in their treatment, and ensuring that there are thorough checks and balances so that people with serious medical conditions get the right medical treatment. Given the serious effects of medication and the possibility of patients being given too high a dose without their consent, even despite their active opposition to medication, we must ensure that we get it right.

As the Minister said, the new clause would amend section 58 of the Mental Health Act 1983 by reducing from three months to two the time before a second medical opinion is required for medication. The Joint Committee on Human Rights—its Chairman is not in the Chamber, but I am sure that he will be joining our deliberations because he has tabled later amendments—proposed that the time should be reduced from three months to one. We are proposing a compromise, as we did in Committee, to reduce it from three months to two months in stages. The Joint Committee had serious concerns, which again the Minister has not allayed.

The second opinion appointed doctor will assess types of medication, the doses of medication and the combination of different medications. We are talking about powerful chemical cocktails. They have the capacity to bring about serious side effects, such as obesity, diabetes, impotence and movement disorders. It is essential that we take the patient's feelings into account and ensure that we have good practice.

We also made the case in Committee that patients in that condition should be subject to more regular physical health checks for their own benefit, simply because of the physical effects that many of the powerful drugs have on them. We are joined in that request by the Mental Health Act Commission, which has raised on several occasions, and in at least two of its reports, its concerns about how the period of three months works in practice. In its last biennial report, for 2003-05, it said:

"Too many patients feel that they are excluded from decision making and the exercise of choice in their hospital treatment and unable to discuss their subjective experiences of therapeutic effect or adverse side-effects. This is likely to exacerbate the likelihood of non-compliance after discharge and may contribute to the problems of revolving-door re-admissions".

It is not good for patients' therapy or recovery to feel excluded in that way.

The MHAC says that when visiting hospitals it has found that medical treatment is a key issue for patients, and it often receives complaints about it. In its most recent report it listed complaints about, for instance,

"No record of discussion with patient regarding proposed treatment... No record of assessment of patient's capacity to consent to treatment... Patients telling visiting Commissioners that they are not happy taking their medication".

As the Minister knows, a patient's diagnosis is not straightforward and may change several times over a period of detention. We think that three months of being treated without consent, or with a lack of capacity to consent to treatments that may be causing harm, is simply too long. In 2004-05, 18 per cent, of patients' plans were changed as a result of SOAD intervention, but as the MHAC reported, that is not an accurate indicator of the importance of the role.

There is an extra incentive for doctors to get it right. As the MHAC says,

"the SOAD provides a check on the RMO's practice"

—"RMO" stands for "registered medical officer—

"and by the very nature of the oversight provided by the Second Opinion ensures that RMOs give careful thought to their decisions. We believe that if this provision had not been available there would have been no check on the appropriateness of treatment, and many more treatment plans could have been the subject of formal complaint. "

The Minister has already taken up my point that the 1983 Act provides a power, under order, to vary the time. We have had 24 years in which to do that, but it has not been done. The MHAC says "We believe that the current Act provides insufficient protection to patients in the first three months of their treatment under detention, when they may be forcibly given medication in doses or combinations that are outside of product guidelines and recommendations without the oversight of a Second Opinion Appointed Doctor. Some RMOs appear to share our unease: we receive... occasional requests for statutory Second Opinions in relation to such patients".

The Minister addressed that point a moment ago without answering it, or at least, she answered it completely the wrong way. She said that the Government agreed with those concerns, and that that was why tribunals that they had intended to establish under the draft Mental Health Bill of 2004 would have had power to step in after 28 days. This is nothing to do with cost-effectiveness, or with our practical complaints that people were not available to man the tribunals. The principle was that the conditions should be examined after 28 days. Our complaint was that the mechanics would not be practicable. If the principle was right then, why are the Government reverting to a three-month period? That is the question that the Minister has not answered.

In Committee, the Minister said that the system would be too bureaucratic and might involve up to 8, 000 more SOAD hours. There would be a big cost and resource implication. Mat Kinton is undertaking further research for the MHAC, which is not yet finished but is soon to be published. We have been given permission to quote from it. Mr. Kinton conducted a survey of the 14, 574 patients detained at 31 March 2006, just over a year ago. He was able to examine just over 81 per cent, of them in detail. Working on the Government's figures, he established that if the three-month rule had been a two-month rule, 3, 598 patients, or 30. 5 per cent, of the total number admitted to hospital under Mental Health Act powers, could have received a second opinion. That is an additional 337 opinions and an increase in second-opinion activity of slightly over 10 per cent., which amounts to nothing like 8, 000 additional SOAD hours.

I believe that the Government's estimates are woefully wrong. I am surprised that the Minister has not been contacted the MHAC, given the serious concerns that it has raised on a number of occasions. The Minister's figures are wrong; but, more importantly, the principle that someone should not be forced to wait for three months on medication that may not be appropriate—regardless of the physical, let alone the mental effect—is fundamentally wrong.

Our suggestion is not radical; it is a compromise solution—to reduce the period from three months to two months. Many people think that the period should be shorter than that. It is a practical suggestion and, more importantly, it addresses the principle of respecting the wishes of people with mental illness. It makes sure that they are engaged properly in their treatment, rather than potentially cut adrift from having any say in it for three months until a SOAD is appointed. On that basis, I am minded to

press our new clause to a Division at the appropriate time, rather than to withdraw it as the Minister requested.

Mr. Kidney: In speaking on advocacy, I should declare an interest. I am honorary president of the Advocacy Services in Staffordshire, or ASIST.

I warmly congratulate the Minister on the work she has done on advocacy between the Committee and Report stages. She gave an assurance in Committee that she would bring this matter back to the House and she has done so; that is welcome. I said in Committee that it was untenable for us not to have a system of advocacy for mental health patients when we have now accepted advocacy for mental capacity cases. The wording of the new clause closely follows the wording on advocates in the Mental Capacity Act 2005, which shows that synergy. My earlier intervention on the Minister was intended to be helpful. I said that there might be common standards, training and systems of maintaining advocates in order to keep the costs of both systems at a reasonable level.

Advocacy is to be welcomed because patients can find it disempowering enough to have to face the panoply of the mental health system when in need of help, but when faced with professionals such as a consultant psychiatrist or a range of people with other mental health expertise—perhaps social workers, too—it can also seem that the balance of power is wrong. The beauty of the advocacy system is that it enables someone to stand shoulder to shoulder with the patient in putting their case. It can enable the patients themselves to say exactly what they want, and if they are unable to do so it enables the advocate to speak up on their behalf and to make sure that their voice is heard in deliberations and planning.

Dr. Ian Gibson (Norwich, North) (Lab): Does my hon. Friend agree that advocacy is not just about helping the patient from a health point of view, but that there might also be legal implications which it is important that somebody present addresses in order to prevent the patient from ending up unprotected in a court situation?

Mr. Kidney: I agree, but as we found in debating and amending Acts such as the original 1983 Act, legal issues can be difficult and complex. The advocates we are talking about are citizens' advocates rather than lawyers, who are advocates who understand the law. Sometimes, an important part of an advocate's role is to make sure that the legal interests of a patient are presented and studied by an independent lawyer.

I especially welcome the Minister saying that when the advocacy system is in place there will be full information for patients about the availability of the scheme, and full training on advocacy for staff in mental institutions and in the community who provide mental health services so that they can make sure that people receive their entitlements and rights.

This is such an important change from the Bill in its original form that I hope that it will also help us to overcome some of the objections raised in the other place about other parts of the Bill. When we are sure that patients are as protected as possible by a system of advocacy, some of the objections debated in the other place can fall away.

My right hon. Friend the Minister said that she was not minded to agree to amendments to new clause 3 to do with children and advocacy. That is disappointing, and I hope that the Minister will say that she will at least keep the door open for that to happen later.

On another area of law, I chair the all-party group on looked-after children and care leavers, and I know just how vital it is for those vulnerable children to have access to advocacy. They do not yet have universal access—access is provided only in certain specified circumstances—and I want to argue for their having it. Similarly, children who are patients in the mental health system are particularly vulnerable, and I hope that they, too, can have universal access to advocacy.

Dr. Gibson: Does my hon. Friend agree that many of the people who suffer from anorexia and bulimia are often quite young and need support, which has not been forthcoming? We should therefore consider them just as seriously, because this is a somewhat new area of endeavor.

Mr. Kidney: Indeed, and as I explained on Second Reading, a hospital in my constituency specialises in eating disorder cases, and some of the children who attend it are extremely young. In Committee, we debated age-appropriate facilities for children, and learned of a child as young as 10 who was in very inappropriate accommodation when receiving in-patient hospital treatment. So yes, those children can be very young and very vulnerable.

I want to say a little about nearest relatives and carers. Between consideration in Committee and today, my right hon. Friend the Minister and I corresponded on this subject, and I am disappointed at not having made any progress. There is one issue that I would like to bring to the head of my wish list: I want the Minister at least to look again at the definition of a carer. At the moment, we are reliant on the 1983 Act, which says that a carer is somebody who has been caring for five years, which then gets them on to the nearest relative list. If they are living with the patient at the time that such services are required, they can go to the top of that list. However, the position of carers has moved on a long way since 1983. Since then, there has been a Labour Government—since 1997—and we have the country's first ever national strategy for carers and the first dedicated funding for carers, rather than for the people whom they care for. We have also established for the first time an entitlement for a carer to have an assessment of their needs, rather than of the person whom they care for.

So the definition of a carer today is very different from simply being someone who has lived with a person for five years. Of course, many carers do not live with the person whom they care for, even though they are their full-time carer, so I would argue that we still need to look at the definition of carer. I understand why my right hon. Friend the Minister is not attracted to new clause 17, but it does at least bring up to date the definition of a carer, in line with the legislation introduced in 2000, which is the latest to deal with carers.

I turn to my final point on the ability to nominate someone to be the nearest relative. I have read the correspondence that my right hon. Friend sent to me and I accept all the arguments, but I ask whether there is one last option—one quite similar to that given in a briefing that we received from the Law Society. Here, I should declare another interest as a non-practising solicitor. If the person in question could nominate from a closed list, rather than an open one, would that get round the problems associated with the European convention on human rights that my right hon. Friend mentioned? If the closed list could simply be the nearest relative list with an updated definition of a carer included, could not the person in question—when they are not subject to the powers under the 1983 Act—at least nominate somebody from that list in order to bring them to the top of it, rather than somebody who is completely outside that list? That is my last suggestion for the Minister, and I hope that it is of some help.

Sandra Gidley (Romsey) (LD): It would be churlish of me not to welcome the Government new clauses and amendments. As the Minister suspected, amendments (a) to (c) to new clause 3 are an attempt to see whether she can be pushed just a little further. I take on board the points made about resources. Indeed, a briefing from the NHS Confederation, which most Members present today will have received, raises concerns about the resourcing of this service, and points out that patients have to know about its availability. So I take on board the point that we should see how things progress and then potentially go further.

I shall briefly outline why it was important to table the amendments. I am sure that the Minister is aware that a disproportionate number of black and minority ethnic people are sectioned. It is a particular problem for the Afro-Caribbean community, which experiences more instances of over-medication, mis-diagnosis and control and restraint. They are more likely to be detained as long-term patients, which increases the need for access to advocates before sectioning. That is the driver behind amendments (a) and (c).

In Committee, the Minister glossed over my comments about a race equality impact assessment for the Bill. It is not enough to assume that all will be treated equally under the Bill, because that does not happen at the moment and there is nothing in the Bill to suggest that it will change matters. If one section of society has different outcomes, that is a problem that needs to be addressed in some shape or form and the amendments are an attempt to address it.

There has been a history of misunderstanding and discrimination against black and minority ethnic people, resulting in the death of several Afro-Caribbean service users under the care of the mental health system. The most famous case is that of David "Rocky" Bennett, which was the subject of an independent inquiry by Norfolk, Suffolk and Cambridgeshire health authority. The inquiry's report made 22 recommendations. The key underpinning theme of those recommendations was that there should be ministerial acknowledgement of the presence of institutional racism in the mental health services and a commitment to eliminate it. It is never pleasant to have to admit something like that, but the figures speak for themselves.

A study has also found that there are circles of fear that stop black people from engaging with services. They do not access help early because they are concerned about what will happen to them. The study found that Afro-Caribbeans were often not treated with respect and the services were not accessible, welcoming, relevant or well integrated with the community. The way in which Afro-Caribbean people enter mental health services is problematic and influences the nature and outcomes of treatment.

Most importantly, different models of description of mental illness and other people's philosophies or world views are not understood or even acknowledged. That is a double-edged sword, because the flipside is that the concept of culture has been used to attempt to address some of those issues, but it can also divert professionals from looking at the patient as an individual, with their own characteristics, history and needs. Assumptions can be made on the basis of race, and that is wrong.

Those and other findings were supported by the "Inside Outside" report and the "Breaking the Circles of Fear" report. A recent Mental Health Act Commission census also backed them up. The amendments attempt to address some of the problems, because if advocacy is available at the beginning of the process, an appropriate advocate could be found who could ensure fairer treatment.

The Minister was concerned about the overall financial impact of the amendments, but if she is serious about addressing the problems of racism, she could consider a pilot scheme in a relevant area to see whether structured access to advocacy services and greater cultural awareness help to break down some of the barriers and reduce the statistics. I hope that the Minister will look into that—

Dr. Gibson: As the hon. Lady will know, Rocky Bennett was in a certain unit in my constituency. How would advocacy have helped in the situation on that Saturday night?

Sandra Gidley: I do not want to go into individual cases. The example that I cited was not the best example of the effect of a lack of advocacy services at the beginning because there was clearly a mental health problem in that case. I raised that case, however, because of the report that highlighted the problems experienced by many service users. It is fair to say that several Afro-Caribbeans would not be sectioned or subjected to electro-convulsive therapy if there was more understanding of their culture and needs.

I will not press amendments (a) and (c) to new clause 3 to a Division because of the wider implications, but I hope that the Minister will take on board nature of the specific problem and bring something forward to move us in a fairer direction in the longer term.

Amendment (b) to Government new clause 3 would do something similar for children by extending the terms of the measure to make mental health advocacy available for all children who are voluntary patients, rather than just children liable to detention, or for whom ECT is being contemplated. I do not buy into the Minister's argument about resources because estimates show that the measure would probably affect only 650 children a year, or one in each constituency. The numbers are not high, yet we should provide an extra safeguard for those children. It must be terrifying for a child to be admitted to an in-patient unit, especially, as is frequently the case, if their relationship with their parents has broken down. An advocate would be someone other than a parent, carer or clinician who could not only communicate with the child, but communicate that child's interests and ensure that there was a right of appeal.

Children can overturn parental responsibility only through a court order, so the system is completely stacked against them. We are talking about only a small number of people, yet they are vulnerable and at a crucial time of their lives, so although the Bill does much to improve conditions for children, I urge the Minister to think again on this matter. Given that I have heard supportive comments from Labour Members, I am minded to press amendment (b) to new clause 3 to a Division.

Lynne Jones (Birmingham, Selly Oak) (Lab): Like everyone who has spoken, I warmly welcome the Government new clauses and amendments and the increased safeguards for vulnerable people that will be introduced through the arrangements for advocacy. The new clause and amendments that I have tabled would improve the arrangements by which the nearest relative could be displaced, if necessary. The Bill contains a measure that allows for that, but it is problematic because it requires a patient to go to court and due to the grounds set out on which a nearest relative may be displaced.

New clause 17 is based on an amendment tabled in Committee by my hon. Friend the Member for Stafford (Mr. Kidney). It would avoid court proceedings by allowing a patient to give an advance directive of the name of the nearest relative. As my right hon. Friend the Minister said, the appointment of the nearest relative is extremely

important. However, as my hon. Friend the Member for Stafford pointed out in Committee, there is all too often no nearest relative who is willing to perform that role. If someone suitable is available, it is thus important that it is as easy as possible for a patient to appoint that person as the nearest relative.

My new clause differs somewhat from the original measure tabled by my hon. Friend because I have attempted to address several concerns expressed by the Government. I realise that it would not be appropriate to allow frivolous changes or appointments of the nearest relative, so my amendment would confine the appointment or changed appointment as the nearest relative to the carer. As my hon. Friend the Member for Stafford pointed out, a carer is someone who is not living with the patient, but who has their best interests at heart, spends a great deal of time with them and knows their case, and is someone whom the patient There are times when advocacy is perhaps more relevant than it is at other times. I suggest that immediately or very close to the point at which a person has been admitted to hospital under a detention order, they should be made aware of their rights to advocacy—subject, of course, to their being aware and well enough to understand that information. Early intervention and notice of advocacy and access to an advocate are extremely important.

Mr. Kidney: Before everybody loses sight of the fact, I point out that proposed new clause 130B(3)(a) in new clause 3 says that the independent mental health advocate may

"visit and interview the patient in private".

Angela Browning: I appreciate that, but I felt that the Minister was praying in aid the code of practice in her response to me, and I just wanted some clarification on that issue. Finally, I want to pick up on a point made by the hon. Member for Birmingham, Selly Oak (Lynne Jones): when we consider the nearest relative and carer, we should remember that they are often one and the same person, and that is quite a difficult situation, not least in the situation that she identified. Sometimes, if the patient lives with their nearest relative, or their nearest relative is also their primary carer, a situation develops in which that relative becomes personally involved in assisting the medical profession to section someone close to them. That can trigger a reaction on the part of the patient. I hope that the Minister will consider those situations and will be flexible enough to identify them on a case-by-case basis.

However, the Minister faces a dilemma, because it is not an easy issue to resolve. In the Bournemouth case, the nearest relative of HL—an autistic adult who was detained—did not have day-to-day knowledge of HL's condition. It was actually the paid professional carer who had that knowledge, and it would have been much more helpful if the carer had been involved at a much earlier stage. I appreciate that it is a difficult point for the Minister, but I hope that the system will be robust, yet flexible enough to allow difficult circumstances to be built into the changes that she is introducing.

Meg Hillier (Hackney, South and Shoreditch) (Lab/Co-op) rose—

Mr. Deputy Speaker (Sir Michael Lord): I call Kitty Ussher. I beg your pardon—I mean Meg Hillier.

Meg Hillier Thank you, Mr. Deputy Speaker; I am glad to know that it is not just me who makes that kind of slip occasionally. I welcome new clause 3, which is comprehensive and which goes quite a long way towards tackling some of the issues

that cause me concern. I look forward to seeing the regulations, and I know that the Hackney organisations with which I am involved will want to contribute to the process, particularly with regard to issues of language and cultural awareness, which were raised by the hon. Member for Romsey (Sandra Gidley). Those are huge issues in a constituency such as mine, where 300 languages are spoken, and where all the inequalities that affect the mental health of people of many different ethnic groups are highlighted to an extreme. I hope that new clause 3 and the regulations will help to pave the way for greater advocacy for people, both pre-detention and post detention. I raised that matter through probing amendments in Committee. The new clause sets out a good way forward for extending rights of advocacy.

I cannot end without touching on the issue of resources, because under the Mental Capacity Act 2005, the whole of Hackney—not just my constituency, but that of my hon. Friend the Member for Hackney, North and Stoke Newington (Ms Abbott), too—received £40, 000 for support for those who are unbefriended. I hope that in our debates on that subject we realistically consider the issue of resources. It is worth reminding Members that 12 of the top 20 users of accident and emergency services at my local hospital, Homerton University hospital, were known to mental health trusts; they were the most frequent users of those accident and emergency services, so the advocacy issues are important for a number of reasons. I have highlighted some of the issues that I have already discussed in Committee, so I will not detain the House any further.

Hywel Williams: I, too, welcome the proposals on advocacy, but I am concerned to ensure that advocacy services in Wales are widely available in both Welsh and English. The reason why I intervened on the Minister earlier and asked whether advocates would be assumed to be working for a public authority is that public bodies in Wales are subject to the Welsh Language Act 1993, and must produce language schemes. That might ensure that help was available in Welsh or English, as required. My second point is that if advocates are employed by a public authority, the system should be set up on an entirely bilingual basis. I refer the Minister to the way in which the post of Children's Commissioner for Wales was set up by Peter Clarke. That started out properly on a bilingual footing.

I refer the Minister to the recent speculation in Wales that the new Welsh Assembly Government might seek a legislative competency in mental health. One of the reasons for that would be to ensure that the service was available in Welsh. Commenting on that, the First Minister, Rhodri Morgan, said that although he was sympathetic to the proposal, he was concerned about whether undeveloped aspects of legislation could be disentangled. Some subjects are properly the concern of Parliament, but some are properly the concern of the Assembly. That may be resolved by new clause 3(2), which states:

"The appropriate national authority shall make such arrangements as it considers reasonable"

to enable people to act as advocates. Will the Minister confirm that, to her mind, that requires whoever sets up the advocacy system in Wales to ensure that the system is bilingual from the outset?

Ms Rosie Winterton: I will respond briefly to the points that have been made. First, on the issue raised by the hon. Member for East Worthing and Shoreham (Tim Loughton) and by my hon. Friend the Member for Hackney, South and Shoreditch (Meg Hillier), we have taken on board the points made during pre-legislative scrutiny about the estimates for advocacy. We are still working on the costings, but when the

Bill hopefully completes its passage through the Commons, we will be able to produce an updated regulatory impact assessment before the Lords consider the Commons amendments. I hope that that will improve the position outlined by the hon. Member for East Worthing and Shoreham.

Turning to the point that the hon. Member for Tiverton and Honiton (Angela Browning) made about privacy, proposed new section 130B already includes provisions for an advocate to meet the patient in private, and I assure the hon. Lady that we will expand on that in the code of practice. I thank my hon. Friend the Member for Stafford (Mr. Kidney) for his comments, as I know that he is concerned about the issue, particularly the question of advocacy and the nearest relative. I can assure him that proper information about rights will be made available. We always keep those issues under consideration. As for the position of the nearest relative, anyone living with the patient for five years will be placed on the list, as he knows, and anyone living with, or caring for, a patient will be moved to the top of the list. We have therefore tried to make sure that carers are properly defined and treated in the same way that they are treated under other legislation.

The hon. Member for Romsey (Sandra Gidley) rightly raised the issue of black and minority ethnic patients. As I have set out, we have taken a series of actions under "Delivering race equality in mental health care" but, as I tried to stress at the outset, we are considering specialist advocacy for people from BME communities. I reiterate that it is important to confine advocacy to the groups that have been set out. I very much welcome the comments of my hon. Friend the Member for Birmingham, Selly Oak (Lynne Jones) about the fact that we need to make sure that, when we look at the issue of the nearest relative, we involve the relevant people to ensure that the code of practice is right. I thank her for her understanding of the issues that we have tried to tackle. As I have said, I wanted to see whether there was anything further that we can do, but I am convinced that with the exception of the question of looking at the code of practice and so on—I will keep in touch with her on that—we have found the right way forward. I will write to the hon. Member for Caernarfon (Hywel Williams) about the issue of the Welsh language. As I have said before, essentially, this is a question about devolving the issue to the Welsh Assembly. As he said, it is about the Welsh language, too, but I will make sure that Ministers in Wales are aware of his comments.

Finally, I welcome the support given during the debate to our proposals on advocacy. I regret that I still cannot agree to the new clause tabled by the hon. Member for East Worthing and Shoreham because I do not think it is practical and we already have the power that we need to make the changes. Of course I will look at the evidence from MHAC, but we would have to be clear that the proposal was properly evidence based. For that reason I ask the House not to support the new clause if the hon. Gentleman decides to press it to a vote later.

Question put and agreed to.

The *informal memorandum* issued by the Government on the amendments that it had introduced in the Commons, published for the debates in the House of Lords after 20 June 2007, said of the advocacy provisions:

Independent mental health advocacy: Commons Amendments 29 and 100

29. Commons Amendment 29 inserts a new clause in the Bill which in turn inserts new sections 130A to 130D in the 1983 Act. The effect is to place a duty on the

appropriate national authority to make arrangements for help to be provided by independent mental health advocates (IMHAs). IMHAs must be made available to certain "qualifying patients" subject to the powers or safeguards in the Bill, to provide support in the ways specified in the provisions.

30. Qualifying patients will be informed that they are eligible for the services provided by an IMHA as soon as is practicable. An IMHA will meet with a patient on the request of the patient, the nearest relative, the responsible clinician or an AMHP.

31. Where a patient has the capacity to consent and does so, an IMHA has a right to see any hospital or local authority records relating to the patient. If a patient lacks the capacity to consent, the record holder can still allow access to such records if it is appropriate and relevant to the help the IMHA will provide to the patient. IMHAs have a right to meet patients in private and to visit and interview anyone professionally concerned with the patient's medical treatment.

32. The appropriate authority can make regulations setting out, for example, the standards and qualifications that will need to be met by an individual in order to be approved as an IMHA. These regulations can make different provision for different cases. This will allow them to take account of the different needs of different groups of patients. This amendment also ensures that hospital managers cannot block correspondence between patients and their IMHA under section 134 of the 1983 Act (correspondence of patients. )

33. Commons Amendment 100 makes transitional provision to ensure that IMHAs are made available to patients who are already 'qualifying patients' when the provisions come into force, in the same way as they will be to patients who become 'qualifying patients' after that date.