CASE STUDY 1

Community Mental Health Advocacy delivered by seAp

BACKGROUND HISTORY
(client category, nature of referral, other useful information to inform the reader of the needs of the client)

A approached Kent Advocacy asking for support regarding an ESA Appeal Tribunal which was only three weeks away.

The advocate made contact with A and they arranged to meet to discuss the situation, at a mutually convenient location.

The advocate met A and had a long discussion regarding her case. Both ESA and PIP had been stopped about two months previously but the upcoming Tribunal was not a Tribunal at all but an assessment for Universal Credit, which is being trialled in A's part of Kent.

An appeal had been submitted already regarding the ESA and it was unclear at this point if that would need to go ahead or not, as the UC Assessment may supersede it.

CLIENT ISSUES & DESIRED OUTCOMES:
(what were the issues for the client and what did they want to achieve?)

A wanted her money to be re-instated as she was struggling to manage with no income. She desperately wanted to work, but due to a catalogue of incidents and health issues, was unable to do so. Her health issues included PTSD (from a number of violent assaults, one of which had caused a brain injury), paranoia, claustrophobia, hypothyroidism and 6% disability due to an industrial injury, which meant that she could no longer pursue the career for which she had trained. A was also terrified of meeting strangers.

Her main issue in dealing with all the above in the Tribunal/Assessment setting was communication – how to explain everything to strangers in a way that made sense to them and how to deal with her own fear and perceived loss of dignity in needing to do so.

CHALLENGES
(what were the challenges to dealing with the issue, supporting the client, or for you as the advocate?)

The advocate found that the main challenges were in preparing herself and A for the UC Assessment and gathering the evidence that would support A's case. This involved a lot of liaison with A's GP and other professionals known to her. A knew what was needed but needed the advocate to articulate to the professionals and explain the urgency. The advocate was then able to support A at the assessment.

Shortly afterwards it became clear that the DWP were insisting that A attend an Appeal Tribunal for the ESA to cover the time from when it had finished until the date from which UC was being considered. This was a period of three months.

A heard about the (positive) outcome of the UC assessment and was very optimistic about the upcoming Tribunal - she did not fully understand that she would still need to put a good case forward at the Tribunal. The Advocate gleaned enough information to ascertain which descriptors were going to be relevant at this Tribunal and concentrated on getting to know A and her complex issues.

On the day of the Tribunal, minutes before the hearing was due to start the Clerk to the Tribunal announced to A, the advocate and B (a friend) that the DWP had sent a presenting officer for this case and that she had brought three trainee colleagues with her, to observe how a Tribunal works. This seemed totally inappropriate, given A's mental health issues, fear of strangers and claustrophobia. The advocate and B both protested politely as A became upset.

The Chair of the Tribunal sent word that she wished to see the Advocate supporting A and the DWP Presenting Officer alone just before the hearing. With A's permission the advocate went in to meet the panel and the DWP person and was able to explain how inappropriate an audience would be in this particular case. The Chair had clearly read the paperwork, because she completely agreed and advised the DWP person that she was using her powers as Chair of the Tribunal to insist that the observers be excluded. The DWP person accepted this without arguing and we proceeded to the Tribunal.

WHAT DID THE ADVOCATE DO AND HOW?
(What support was given to the client? Highlight examples of good practice or innovation that can inform the work of your peers. Please give details of any specialist communication techniques used or methods used for improving accessibility)

The advocate's role in the Tribunal was a supportive one, mostly reminding A of the particular examples of her needs and issues that she had wanted to highlight, but struggled to remember with clarity. An example of this was when she was describing her 6% disablement from the industrial injury and how this had impacted on her ability to work. A explained that it was her thumb that was affected, but that she had completely forgotten to tell the Industrial Injuries assessors about the loss of hearing that occurred. If she had remembered this then she would have got more than 6%. She had not thought about this until later, and was frightened of doing the same here.

The advocate encouraged A to keep talking and mentioned a couple of examples that she had noticed during her short acquaintance with A – particularly of her paranoia, fear and lack of insight into how her behaviour or speech impacted others. A, B and the advocate had all discussed this beforehand and A was prepared to hear both B and the advocate say a couple of things that she perhaps would not normally want to hear (who likes being described as paranoid!). The earlier discussion had resulted in A trusting her advocate to elaborate on this important issue to the Tribunal panel, as it was one of the very significant reasons that she was unfit for work.

WHAT WENT WELL

The UC assessment and the ESA Tribunal both went well, due in large part to the supportive role of the advocates and the trust they had been able to build with A. Having them "watching her back" gave her

more courage to speak more candidly than she might otherwise have done. This was what she needed to do in order to "pass" these two "tests", although it involved divulging deeply personal information.

The DWP Presenting Officer not only withdrew her challenge to the appeal but advised that she would mark A's case as one to which Rule 35 applied. This meant that she would not be automatically recalled for a yearly reassessment for the UC, but would be left in peace to continue her slow recovery from a number of traumas. She suggested this herself and did not need to be pushed to it by the panel who were in full agreement once she mentioned it.

WHAT WAS THE OUTCOME OF ADVOCACY SUPPORT?
(what did you support the client to achieve, did it meet the client's expectations – if not why?, how did they feel about it?)

A very vulnerable client was able to get her benefits reinstated and the DWP admitted that this was a case to which a special rule applied.

A was pleased and very relieved. By the time HT had returned to her desk that day A had called the Contact Centre to express her appreciation for the support of both advocates in achieving her goal.

CASE STUDY 2

Independent Mental Health Advocacy delivered by seAp

BACKGROUND HISTORY
(client category, nature of referral, other useful information to inform the reader of the needs of the client)

I was approached by G while undertaking the weekly IMHA drop-in at Thanet Mental Health Units / QEQM Hospital Margate.

G recognised me from years before when I supported her in the community with other Advocacy issues. She had attended hospital on a voluntary basis due to concerns about her mental health, but, when she had tried to discharge herself from the ward, had been sectioned by the psychiatrist (section 2)

G has mental health difficulties as well as physical mobility problems and learning difficulties. She is in her early 60s.

CLIENT ISSUES & DESIRED OUTCOMES:
(What were the issues for the client and what did they want to achieve?)

G was very distressed and angry because she did not want to be in hospital, could not understand why she was not allowed to leave or go home, and blamed her family as they had asked her to go into hospital because of her behaviour.

G wanted to know what a section 2 was, why she could not go home, and to have information about why she was being held in hospital. She said that the ward staff had not spoken to her about why she could not leave and that the psychiatrist talked in a way that she did not understand and she felt stupid because of this.

CHALLENGES
(What were the challenges to dealing with the issue, supporting the client, or for you as the advocate?)

G was in a very manic state, one minute she would be crying hysterically then the next minute screaming and shouting. In between the high and low moods she kept repeating that there was nothing wrong and she should not be in hospital.

The challenge was trying to explain the information regarding section 2 and the restrictions to the client (mainly due to capacity issues around clients learning difficulties and her emotional state).

The information / literature that I had on me, was very in depth and not very easy to read or understand so I needed to find another way of explaining to the client why she was in hospital and what a section 2 was.

WHAT DID THE ADVOCATE DO AND HOW?
(What support was given to the client? Highlight examples of good practice or innovation that can inform the work of your peers. Please give details of any specialist communication techniques used or methods used for improving accessibility)

I supported the client to speak to her consultant psychiatrist and named nurse during ward round and explained to her what the doctor was telling her in relation to her restrictions / rights / treatment etc. This meant that I kept asking the doctor to change or think about what he was saying to the client, because the client kept saying she did not understand.

The doctor found this rather difficult to do, so we agreed that he would say what he needed to say first, and then I would simplify what he had said - this would hopefully help the client understand.

I also provided the patients section 2 information, in a way that the client could hopefully understand a little better, sitting with the client, going through the information, simplifying words and constantly checking with the client that she understood what I was saying and, if not, rewording what I had said.

WHAT WENT WELL
(And why do you think so?)

I think that challenging the psychiatrist in relation to the way he relayed information to the client worked well as he did try to put the information in a way that the client could understand, although I still had to change / simplify certain phrases etc. so that the client could understand what was being said to her by the doctor.

Checking with the client constantly that she understood what was being said.

WHAT WAS THE OUTCOME OF ADVOCACY SUPPORT?
(What did you support the client to achieve, did it meet the client's expectations – if not why? how did they feel about it?)

I supported and helped the client to understand her rights / restrictions better, while she was being detained in hospital and provided vital information in relation to appealing against her section, which G told me she did not understand when the ward staff had spoken to her on admission to the ward.

Although G had a better understanding in relation to her rights and restrictions while she was detained in hospital, she still refused to appeal against her section and would constantly demand to leave the ward.

G has now been discharged from hospital but did say to me before she left, that she would contact the advocacy service again if she needed support.