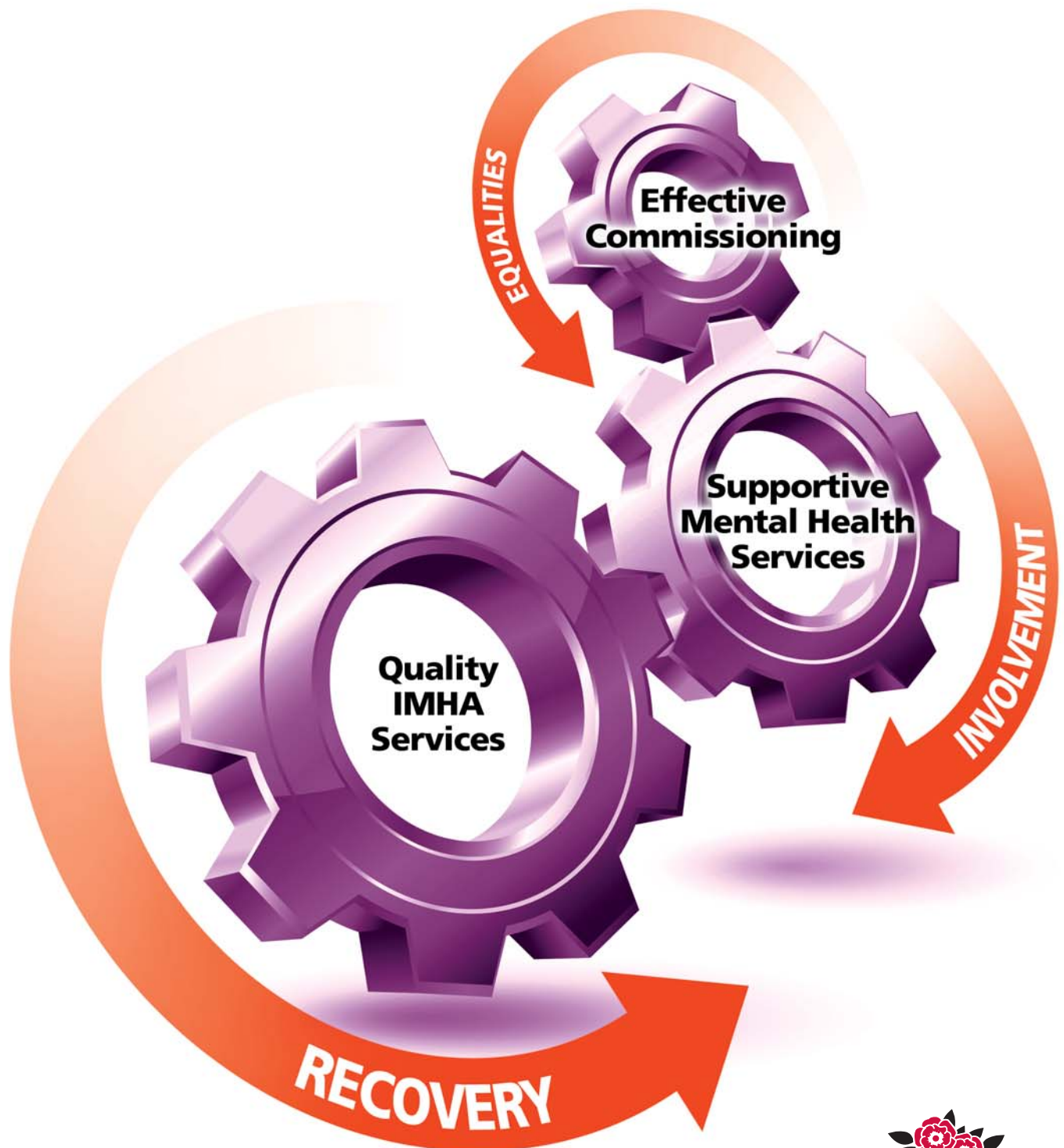


The Right to Be Heard

Review of Independent Mental Health Advocate (IMHA) Services in England



Summary Report
June 2012

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ABBREVIATIONS AND TERMS

| | |
|---|--|
| Advocacy partner or IMHA partner | Qualifying patient using IMHA services |
| AMHP | Approved Mental Health Professional |
| Best interests | Making a judgment, on behalf of someone who lacks capacity, about their best interests |
| BME | Black and minority ethnic |
| Carer | Family member or friend with specific caring responsibilities in relation to a service user |
| CPA | Care Programme Approach |
| CTO | Community Treatment Order |
| DOLS | Deprivation Of Liberty Safeguards: safeguards for people deprived of their liberty but not covered by the Mental Health Act 1983 safeguards |
| Equality analysis | An analysis of the effect of policies on different groups protected from discrimination by the Equality Act 2010 |
| ICAS | Independent Complaints Advocacy Service |
| IMCA | Independent Mental Capacity Advocate: a statutory advocate, introduced by the Mental Capacity Act 2005, to safeguard the interests of people lacking capacity |
| IMHA | Independent Mental Health Advocate/Advocacy |
| LGBT | Lesbian, Gay, Bisexual and Transgender people |
| MDT | Multi-disciplinary Team |
| MH Act | Mental Health Act |
| Nearest relative | This term is used in the MH Act 1983 to define someone who has certain rights and responsibilities to someone detained under the Act |
| NIMHE | National Institute for Mental Health England |
| Non-instructed advocacy | Non-instructed advocacy takes place when the person is unable to instruct or tell the advocate what they want |
| PCT | Primary Care Trusts in the National Health Service in England |
| Qualifying patients | People who are detained under the MH Act who are eligible to use IMHA services |
| Reasonable adjustments | The Equality Act 2010 requires that reasonable adjustments should be made by public services to enable disabled people, including people with mental health conditions, to get the same standard of service as non-disabled people |
| Service user | People who use mental health services, including those who do not qualify for mental health services |

INTRODUCTION

Advocacy is a vital mechanism for ensuring that people can get their voice heard and have their rights protected. It aims to empower people to have greater control and choices in their relationship with services. Self-determination is a fundamental principle enshrined both in law and in health and social care policy. It is reflected in the concept of recovery, shifting the emphasis from diagnosis to wellbeing, hope and personal strengths (Maddock & Hallam, 2010). Like the concept of recovery, advocacy has its origins in the service user movement. It developed in response to negative experiences of the mental health system to enable people with mental health problems to have a voice and determine what happened to them. Current government policy promotes advocacy as a way of ensuring that health and social care users can get their voice heard; have more choice and control over the services they use; and safeguard their rights.

An Independent Mental Health Advocate (IMHA) is a statutory mental health advocate, granted specific roles and responsibilities under the Mental Health Act (MH Act) 2007.

Whilst the concept of independent advocacy is not new, there have been few evaluations of mental health advocacy to help guide commissioners and providers of IMHA services. The Department of Health therefore commissioned a research team at the University of Central Lancashire to undertake a review of the quality of IMHA services in England. The research was undertaken in partnership with Equalities National Council, Aawaz, Manchester African Caribbean Mental Health Services and Comensus, (a service user group at the University). The research team comprised four academic staff and ten service users, one of whom was a member of academic staff. The service user researchers (referred to here as co-researchers) had experience of being detained under the MH Act, including in secure settings.

The overarching aim of the research was to review the extent to which IMHA services in England are providing accessible, effective and appropriate support for the diversity of qualifying patients, and to better understand the factors that affect quality. It was intended that the study would obtain robust evidence to inform the commissioning and delivery of high quality IMHA services.

The study was adopted by the Mental Health Research Network and the research was undertaken between December 2010 and November 2011. Ethical approval for the study was granted by Cambridgeshire 3 Research Ethics Committee and the International School for Communities, Rights and Inclusion Ethics

Committee at the University of Central Lancashire. Site specific authorisation was sought, via the National Institute for Health Research Coordinated System for gaining NHS Permission from the local NHS Trust and, if appropriate, the PCT.

A Plain English summary version is also available on this site and in hard copy on request to University of Central Lancashire.

THE ROLE OF IMHAS

The role of IMHAs is to help qualifying patients understand the legal provisions to which they are subject under the MH Act 1983 and the rights and safeguards to which they are entitled, and to help them exercise their rights through supporting participation in decision-making (summarised in Figure 1). It followed the introduction of another form of statutory advocacy, the Independent Mental Capacity Advocacy (IMCA), which was introduced by the Mental Capacity Act 2005 (implemented in 2007) to safeguard the interests of people lacking capacity.

Mental health service users eligible to use IMHA services

Patients, who are eligible to use IMHA services, i.e. qualifying patients, are those patients:

- Detained under the 1983 MH Act (even if on leave of absence from the hospital).
- Conditionally discharged restricted patients.
- Subject to guardianship.
- Under Supervised community treatment orders (CTOs).

1. Helping patients to obtain information about and understand the following:

- Their rights under the Act.
- The rights which other people (e.g: Nearest Relative) have in relation to them under the Act.
- The particular parts of the Act which apply to them (e.g: the basis upon which they are detained) and which therefore make them eligible for advocacy.
- Any conditions or restrictions to which they are subject (e.g: as a condition of leave of absence from hospital, as a condition of a community treatment order or as a condition of conditional discharge).
- Any medical treatment that they are receiving or might be given and the reasons for that treatment (or proposed treatment).
- The legal authority for providing that treatment, and the safeguards and other requirements of the Act which would apply to that treatment.

2. Helping patients to exercise their rights, which can include representing them and speaking on their behalf.

3. Supporting patients in a range of other ways to ensure that they can participate in the decisions about their care and treatment.

Figure 1: The role of an IMHA
(Source: Department of Health, 2008)

Other patients, who are informal, are eligible for IMHA services if they are:

- Being considered for a treatment to which Section 57 applies (i.e. treatments requiring consent and a second opinion).
- Under 18 and being considered for ECT or any other treatment to which Section 58A applies (i.e. treatments requiring consent or a second opinion).

Patients detained under emergency sections (e.g. Section 4) do not qualify for IMHA services,

although of course may use other advocacy services. Commissioning Guidance published by NIMHE (2008) states that commissioners may wish to extend IMHA support for informal patients, on wards or units where patients are identified as particularly vulnerable.

The NICE Guideline on improving the experience of service users of adult NHS mental health services (National Institute for Health and Clinical Excellence, 2011) and recent policy from the Welsh Government (Welsh Government 2011a) propose extending the availability of advocacy for all psychiatric inpatients.

The role of mental health services

The Code of Practice (Department of Health, 2008) places a duty on hospital managers to inform qualifying patients about IMHA services as soon as is practically possible. In practice, these duties will be delegated to appropriate staff. Approved mental health practitioners (AMHPs) and responsible clinicians should consider requesting an IMHA to visit a qualifying patient if it seems unlikely that the patient is unable or unlikely to make the request themselves. However they should not do so, if they know or strongly suspect that the patient does not want IMHA support (NIMHE, 2008).

Mental health services should enable IMHAs to meet with patients in private. Further, IMHAs must be able to attend meetings between patients and professionals involved in their care and to access mental health notes as appropriate. IMHA services do not:

- Replace other advocacy and support services available to the service user and should work in conjunction with them.
- Affect the individual's rights to seek legal advice and patients have the right not to use an advocate.
- Provide a direct service for relatives or carers, although they may be in contact with families and carers.

Commissioning IMHA services

Primary Care Trusts became responsible for ensuring availability of IMHA services in April 2009, and this passed to local authorities in 2013 as a consequence of the Health and Social Care Act 2012. It was originally estimated that around 42,000 people would qualify for IMHA services (Department of Health, 2009), with the majority being based in hospital and aged over 18. The Count Me In census (CQC, 2011a) of in-patients has consistently found that overall detention rates are higher for specific black and minority ethnic (BME) groups, and the emergent findings from the

AESOP study confirm a picture of poor outcomes and negative experiences of people from Black Caribbean and Black African communities (Morgan, 2012). Thus, these groups are particularly vulnerable (CQC, 2011b), but can also face difficulties in accessing appropriate advocacy (Hakim & Pollard, 2011; Newbigging, McKeown & French, 2011; Newbigging, McKeown, Hunkins-Hutchinson et al, 2007).

PREVIOUS RESEARCH

Previous research into mental health advocacy is fairly sparse and has largely been undertaken in hospital settings, including secure services (Barnes & Tate, 2000; McKeown, Bingley & Denoual, 2002). There has been only one study (Rosenman, Kortjen & Newman, 2000) that has attempted to evaluate the outcomes from mental health advocacy. This study compared the outcomes of hospitalised patients for an experimental model of personal advocacy compared with routine rights-based advocacy. The results indicated better outcomes for the experimental group in terms of risk of further detention, attendance for aftercare, experience of staff and patients of the detention.

Concerns about awareness of entitlement to advocacy and potential shortfalls in advocacy services to meet anticipated needs in relation to mental health legislation have been expressed within a Scottish context (Rushmer & Hallam, 2004; Ridley, Rosengard, Hunter et al, 2009).

The Care Quality Commission (CQC 2010; 2011a) Administrative Justice and Tribunals Council (AJTC & CQC, 2011) and the Mental Health Alliance (Hakim & Pollard, 2011) have flagged up concerns that a significant number of people who qualify for IMHA services in England may not be getting access to them.

In 2010, the CQC found that nearly one in five (18%) wards did not have access to IMHA services and in 2011 that qualifying patients had regular access to an independent mental health advocate (IMHA) on 65% of wards visited (CQC, 2010; CQC 2011b). They also found that some staff, who had a duty to explain the IMHA service to patients, did not understand it. Furthermore, they identified that problems continued with commissioning arrangements for some IMHA services, particularly for patients placed out of the area, and identified an impasse in some instances with no practical IMHA provision for some out of area patients. Further, they found that some commissioners had cut back on non-statutory advocacy and that some IMHA services reported that their funding was inadequate to cover the demands for their services.

The Mental Health Alliance study of the commissioning and provision of IMHA services (Hakim & Pollard 2011) found that the process of introducing IMHA services had felt rushed and many PCTs had continued to contract with existing providers. Continuing with existing advocacy providers meant that BME providers were disadvantaged in this process leading to a noticeable failure in addressing important issues for BME users. The consequence of this combined with inadequate needs assessment has meant that people from BME communities can be disadvantaged in their access to IMHA services.

A small number of studies in relation to BME communities have raised questions about equity of access and style of provision. These studies suggest that people from BME communities are more likely to use advocacy provided by community organisations that are knowledgeable about their specific needs, understand the history of black oppression and negative experiences of mental health services (Newbigging, McKeown, Hunkins-Hutchison et al, 2007).

METHODS

This study used multiple methods to gather information about how IMHA services are working in practice. The study was undertaken in two stages, as illustrated in Figure 2.

This first stage enabled us to develop draft quality indicators for IMHA services. The second stage of the study involved gathering data in eight case study sites (NHS Trust areas) to understand the experience of qualifying patients, and the commissioning and delivery of IMHA services and their relationship with mental health services.

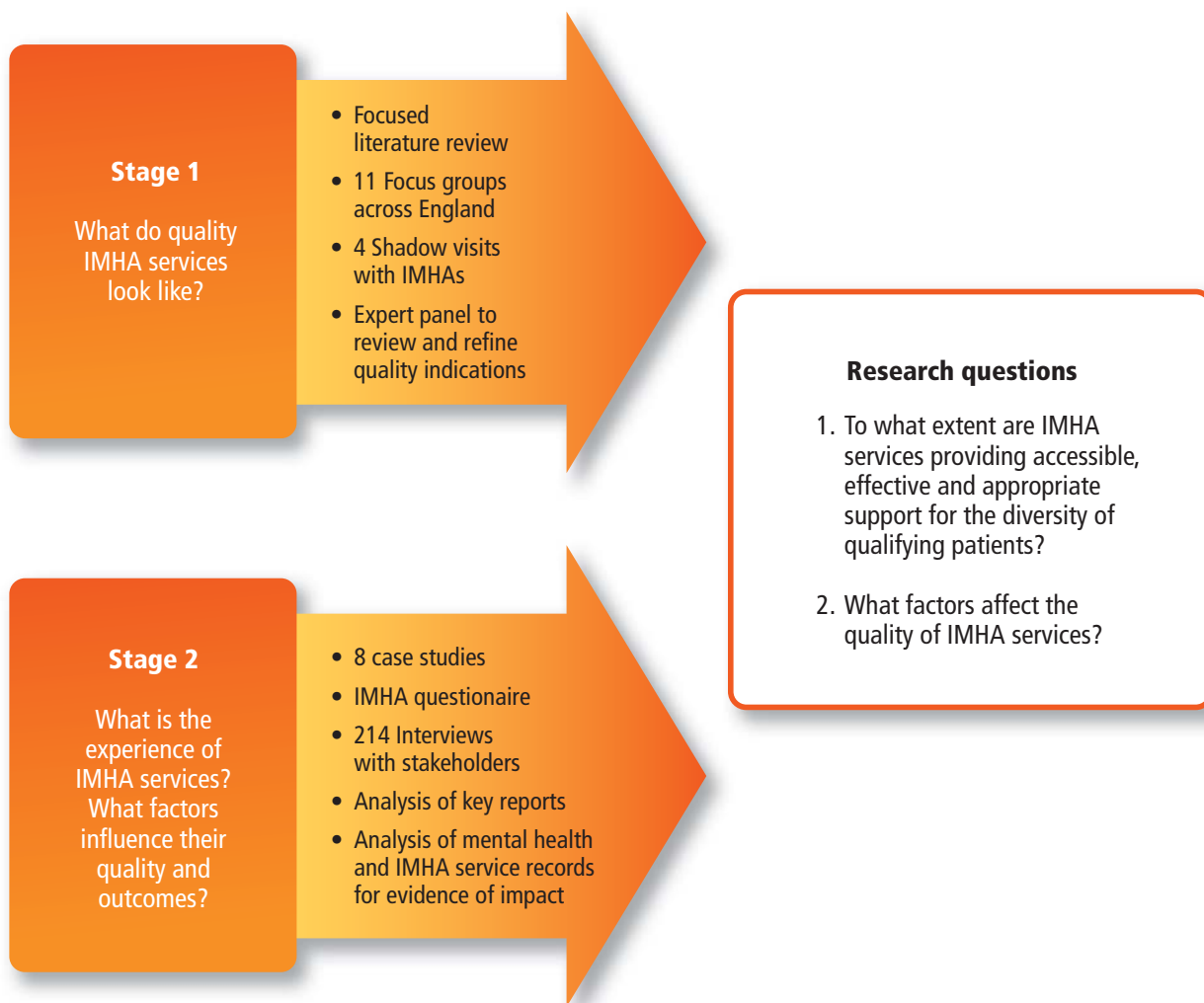


Figure 2: Overview of the study design

The eight case study sites were selected to reflect differences in local populations and the way IMHA services were organised and delivered, and included:

- Two NHS mental health Trusts in inner city locations.
- Two NHS mental health Trusts in urban locations.
- 2 NHS mental health Trusts in a mix of urban and rural, including coastal, areas.
- One independent provider of medium and low secure services for people placed out of area.
- One NHS provider of high, medium and low secure services.

In each of the case study sites a particular focus for IMHA provision was identified and we explored IMHA provision:

- Across the age spectrum.
- For diverse communities.
- For people on Community Treatment Orders (CTOs).
- In settings with different levels of security (from low to high).
- For people placed out of area.

In each case study site the following methods were used to collect data on the experience of IMHA services and how they were working:

- A questionnaire to IMHA providers in the study site.
- Analysis of key documents including service specifications, engagement protocols and reports from the IMHA providers.

- Interviews with qualifying patients (both IMHA partners and non-users); IMHA providers; mental health professionals; commissioners; and professionals involved in the administration of the MH Act.
- Service user questionnaire to obtain demographic information.
- Analysis of the IMHA records and mental health records for a small sub sample of consenting qualifying patients.

We also undertook a brief survey of independent sector providers to clarify what arrangements were being made for people detained in services outside their normal area of residence (i.e. out of area treatments).

There were a number of difficulties recruiting people to take part. This mainly reflected **the lack of routine information being kept and/or shared about who was eligible for and who was using IMHA services**. This is a key finding of the study as it has implications for understanding the access and uptake by different groups of individuals.

The qualitative data from the focus groups and interviews was analysed using standard qualitative data analysis methods and NVivo 9 software was used to support this process. Quantitative data from the service user questionnaire, used in the case study sites, was analysed using descriptive statistics with SPSS 18.

Study Participants

Nearly 300 people in total took part in this study with 75 participating in focus groups, and 214 people participating in stage 2 across eight case study sites. This included a broad range of stakeholders as illustrated in Figure 3.

Mental health professionals interviewed included a range of disciplines, nurses, psychiatrists, professionals involved in the administration of the MH Act (mainly Approved Mental Health Practitioners and MH Act Administrators) and a small number of occupational therapists and psychologists. They were working in a range of settings – secure services, acute inpatient wards, rehabilitation and recovery services, and community settings.

90 qualifying patients were interviewed in the case study sites and this included 29 people who had not used IMHA services to enable us to explore the reasons why not. The sample was made up of 47 men and 43 women.

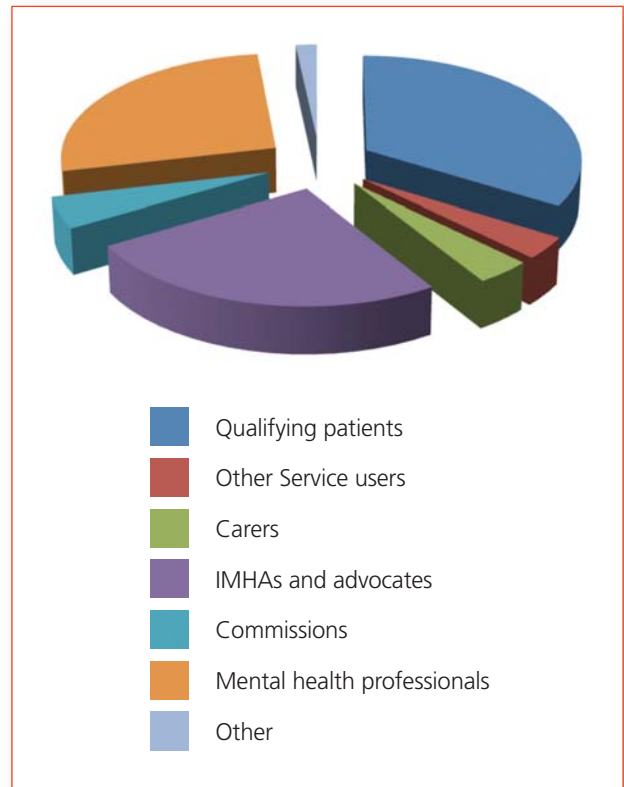


Figure 3: Summary of the study participants

The majority of service users (91%) that we interviewed completed a questionnaire. From this we found that:

- 12% were under the age of 21 and 6% over the age of 65 with the majority aged 21-65.
- 30% were from a BME community, including Black Caribbean, Black African, mixed heritage, South Asian and White Irish.
- 88% identified English as their first spoken language with a range of other languages being spoken including Punjabi, Somali, Thai, French and Patois.
- 8% of the sample completing the questionnaire identified their sexual orientation as gay or bisexual.
- Nearly two thirds (65%) identified having a disability with over a third (35%) identifying this as a mental health condition ranging from loss of confidence to bipolar disorder to psychosis and schizophrenia. A learning disability or Autistic spectrum disorder was identified by 13%.
- Over half (58%) had more than five years contact with mental health services compared with less than ten per cent (9%) with less than a year of contact.

- Half had been sectioned three times or more compared with a quarter (26%) who had been sectioned once.

Patient and Public Involvement

One of the hallmarks of this research has been the partnership with mental health service users. This meant that we had a range of skills and experiences to draw on in gathering and interpreting the data. At the same time we had to think about how this shaped our approach to the research task. It also meant that the research was accountable to people with direct experience of mental health service use and detention.

The involvement of service users as co-researchers was positively evaluated by the qualifying patients that we interviewed. One woman commented that it was inspirational to her own recovery to meet service users undertaking research.

“It made a difference – you understand how I feel.”

Service user participant

The study was also undertaken in partnership with Equalities National Council, Aawaz and Manchester African Caribbean Mental Health Services, who were involved in the Project Advisory Group or the Service User Reference Group. The Project Advisory Group provided guidance to the project and involved mental health service users. A Service User Reference Group was established for the project and this group helped develop the questions we asked and commented on the findings and what they could mean.

KEY FINDINGS

Experiences of the Mental Health Act

The 90 qualifying patients we interviewed came from all walks of life, had a variety of personal circumstances and were using a broad range of mental health services.

Many of the qualifying patients that we interviewed described the process of detention under the Mental Health Act as frightening and disempowering. Several people described instances where force had been used either to admit people to hospital or to administer medication.

“I was hurt when they restrained me and they put your arms behind you and push your head down and take you to a quiet room, I was hurt and I’m still hurt now, I’m receiving physiotherapy for it.”

IMHA partner

Very few people talked about positive experiences of detention under the MH Act or of mental health services, during this time.

“No matter how coherent, how rational, you know how considered my arguments and my explanations for events are, that assumed level of incompetence undermines it because you’re given sub status.”

Non IMHA user

These findings suggest that people with mental health problems, who ordinarily are able to speak up for themselves, find the experience of detention at a time when they are distressed and potentially vulnerable, particularly stressful and difficult.

This confirms the need for IMHA provision to enable people to be heard and to have the opportunity to influence their care and treatment under the MH Act, as consistent with its principles.

Access to IMHA Services

In most of the case study sites, there was no systematic way of recording which qualifying patients are using IMHA services to enable an analysis of differences between diverse groups, across service locations and across IMHA providers. In most sites, IMHA services provided activity monitoring reports but this provided a general picture of trends and it was sometimes unclear how this information was being used to inform service commissioning and provision.

Based on the IMHA questionnaire data, we found variations in the access to and uptake of IMHA services, particularly between qualifying patients in urban and rural sites, and between those in secure services, acute inpatient care and in the community on CTOs.

Overall, with the exception of people in the High Secure service in one of our case study sites, less than half the numbers of qualifying patients were accessing the IMHA service. This was much lower for people on Community Treatment Orders, as illustrated in Table 1.

This data is tentative and needs to be interpreted cautiously but is interesting for indicating general trends.

| Case study area | Number of people using IMHA as % of number of qualifying patients detained in hospital ¹ | Number of people using IMHA as % of qualifying patients on CTO ¹ |
|-----------------|---|---|
| A | 19 | 5 |
| B ² | 32 | 25 |
| C | 48.9 | 0 |
| D | 92 | Not relevant |
| E | 33 | Not available |
| F | 57 | 11 |
| G | 4 | 55 |
| H | 40 | 20 |

Table 1: Percentages of qualifying patients using IMHA services in 2010-2011 compared with total numbers of qualifying patients

There was a strong consensus that those who need the IMHA service the most access it the least.

Participants expressed concern that specific groups of people were not being well served by IMHA services. These included:

- People from BME communities.
- People with learning disabilities.
- Older people with dementia.
- People who are hearing impaired or deaf.
- Children and younger people.
- People on CTOs.
- People placed out of area.

These gaps in provision were confirmed by data from the IMHA questionnaires. Further, none of the PCTs commissioning IMHA services had undertaken a needs assessment that considered the diverse needs of qualifying patients. Furthermore, the issues in relation to the high occupancy rates and higher use of CTOs with some BME groups had not been considered. Indeed, we found that, unless a specific effort was made to understand the needs of these different groups and how they might access IMHA services, qualifying patients may not know about the service or decide that it was not for them. The factors we

identified as influencing access and uptake of IMHA services are:

Availability of IMHA services

As noted earlier, the quality of the information gathered to inform the commissioning and thus availability of IMHA services was generally poor. This was compounded by the lack of systematic recording of who is accessing the services as a basis for evaluating uptake and access and thus being able to determine whether current investment is appropriate.

Understanding of the purpose of IMHA services and the role

Service users and carers did not always understand the purpose of IMHA services or had confused it with Independent Complaints Advocacy (ICAS) or a support worker role. Reasons given by qualifying patients for not using IMHA services largely reflect a lack of awareness or understanding of the service and thus how it can help. This was different from the view of mental health professionals who mainly thought that the reason people did not use IMHA services was out of choice, on the assumption that they had received the information and understood what it was for.

“So the information is there but it tends to get lost, it tends to get lost in a wealth of other information that you’re given that could be really quite frightening when you’re not very well.”

Non-IMHA user

We also found that a small number of service users had a well-developed understanding of the stated purpose and role of IMHA, but were unsure of its real purpose and thought that it might exist to maintain the status quo.

We found that in all of the case study sites; just under half of the mental health professionals were unable to name the service or an advocate, reflecting limited experience of IMHA services, the number of organisations providing IMHA services and recent organisational changes. This was particularly marked for community staff, who often had a poor understanding of IMHA services, the eligibility of service users on CTOs, and their obligation to promote IMHA.

Areas of misunderstanding and confusion for mental health professionals included:

¹ Source: NHS Information Centre (2011): Mental Health Bulletin Annual Returns 2011. The figures have been adjusted to take account of patients on short-term Sections who would not qualify for IMHA services.

² There was data missing for one of the services in this site and thus the figure may be an underestimate.

- Confusion with Independent Mental Capacity Advocacy (IMCA) role.
- Assuming that IMHA services are only for people detained under the Mental Health Act who lack capacity.
- The difference between IMHA and other forms of advocacy, particularly generic mental health advocacy.
- Assuming that they were the patient's advocate.

Furthermore, less than a third of mental health professionals knew that IMHAs could access a patient's notes.

Promotion by mental health services

The sites varied in terms of whether the mental health professionals interviewed understood that they had an obligation to promote the service, with some being completely unaware of this, whereas others were taking steps to actively promote the service.

"They [ward staff] do have a duty to tell the people and they've always been welcoming to us being on the wards and happy to go round and inform everyone that IMHA is here."

IMHA

In other instances, it was evident that mental health professionals were gatekeeping access to the services.

"When it's relevant and the patient's in the right sort of frame of mind, sometimes I'll suggest that they contact the advocate."

Psychiatrist (Secure service)

We found in the majority of case study sites that many professionals had not received training or that it was very brief, usually as part of a general overview of the MH Act. A minority of mental health professionals described more thorough training and these were most likely to be Approved Mental Health Practitioners or working in the High Secure service.

We also found that many mental health professionals, particularly nursing staff, considered that they had an advocacy role. They usually described this in terms of ensuring that the 'best interests' of the service user were being met. This is different from the concept of independent advocacy but a substantial number of mental health professionals we interviewed did not appear to understand this. We found that the understanding of advocacy and the IMHA role by mental health professionals shapes their attitudes and relationships to IMHA services.

Sometimes, this means that they may be reluctant to facilitate access to IMHA services or take extra steps to ensure IMHAs are involved with the service user in key meetings.

Receptiveness of qualifying patients to IMHA services

Trust in, and familiarity with, the service were important and had implications for how qualifying patients found out about IMHA services.

"Well I heard that she was doing a good job, the lady who was here and she's very passionate about her work so... I heard a lot of good things about her so I thought I would give it a try and see if she could help me."

IMHA partner (Low secure unit)

A tangible commitment to equality of access for all

This goes beyond having a statement of equal opportunities to evidencing specific efforts to engage and increase the uptake of different groups of people who might otherwise not use the service.

Practical steps to improve access

Leaflets or posters can be useful but it was clear that relying on promotional materials only is inadequate. Ways of promoting access and uptake of IMHA services need to take practical steps to address the factors that we identify above, including:

- A needs assessment to enable IMHA services to be commissioned so that levels of investment reflect the need and take particular account of the factors that could impede access and uptake: communication, profile of the service, lack of trust and familiarity with the service etc.
- Undertaking an equality analysis to identify whether and how particular groups might be disadvantaged in terms of the current design and provision of services.
- Developing a systematic method for recording and sharing information between mental health and IMHA services to be able to evaluate access and uptake.
- Considering an opt-out rather than opt-in system to overcome gatekeeping.

“Basically it came down to staff attitude. And what we felt was that all staff should have that decision taken away from them, it should be the patient’s decision.”

PCT and Local Authority Commissioner

- Developing information in a variety of formats in partnership with potential IMHA users, using scenarios and examples of issues that IMHAs have helped with to promote an understanding of their role.
- Ensuring that mental health professionals understand their obligations in relation to promoting IMHA services and the purpose and role of the IMHA and that they revisit the opportunity to make qualifying patients aware of this.

“As soon as section is applied and we do it every week, especially because some people don’t always retain the information so they’re told the first day then they’re told like every day for up to 72 hours and then we go every week.”

Ward Manager (Older persons’ ward)

- Providing access to culturally appropriate forms of IMHA. There are a range of ways of achieving this including commissioning community organisations to provide IMHA services, upskilling these organisations and IMHA providers working in partnership with community organisations.
- Provision of bilingual advocates (including British Sign Language) is desirable and access to trained interpreters if not.
- Raising the awareness of service user groups and supporting peer promotion of IMHA services.

Landscape of IMHA Services

Advocacy organisations providing IMHA support tended to be well established. Provision of IMHA services across the research sites varied according to type of advocacy provider; the menu of advocacy provision within the service; the number of IMHA providers in an area; and the number of IMHA within the service. This meant that the interface between advocacy and mental health services in some areas was far more complex as there were multiple IMHA providers, while in others there were just one or two providers. Few services or advocates were offering both IMHA and IMCA. However, it was common for them to also be operating as generic mental health advocates with the main argument for doing so being that this enabled a holistic approach and increased service flexibility.

“I think it’s an advantage to the patients that I can do both because I don’t then have cut off points where I say ‘oh well you’re voluntary now so I’m not advocating for you anymore’... because we do community ... if I’m doing something for somebody and they’re discharged or they leave the unit, I will continue advocating for them until their issues are resolved or they’re happy and satisfied...”

IMHA

The IMHA workforce was predominantly female and white, which does not reflect the diversity of the potential user group. Thus services were generally limited in the extent of choice that could be offered to IMHA partners. However, in general this was not raised as problematic by service users who were more concerned about the effectiveness and professionalism of the advocate than their personal characteristics (e.g. their gender or ethnicity) or previous experience of using mental health services.

IMHA partners were generally positive about the support they received from IMHAs, although it was suggested the quality of IMHAs varied even between advocates in the same service. ‘Good’ IMHAs were approachable and friendly, were prepared to stick with whatever the issue was, were clear in their communications and dependable. Not surprisingly, they were found to be particularly skilled at listening to the perspectives of service users and at communicating. On the whole, IMHAs were considered by qualifying patients and mental health professionals to be highly skilled, experienced advocates, and it was the minority who felt some IMHAs were naïve about diagnostic labels and treatment and needed more training in these areas.

Caseload size of IMHAs varied from six to fifty-five cases, with no clear reason as to why this would be so. Commonly, IMHA cases were kept open for a relatively short period (1-3 months), and the majority of cases were open ended rather than being open only for a fixed time. New referrals were allocated to the next available IMHA unless a particular specialism was called for, and managers aimed to achieve balanced caseloads for IMHAs.

Provision of IMHA Services

In practice IMHAs undertake a plurality of roles, and are involved in a wide range of activities in both hospital and community settings in order to ensure qualifying patients can exercise their rights and that their voice is heard.

Their role is a complex one conducted within a challenging legal and service context. Part of the dilemma for IMHAs is that the statutory role can limit their involvement and thus impede them acting to address broader issues that are critical to a person's recovery.

A number of metaphors were used to describe the role of the IMHA – because they followed through actions they were seen as a “godmotherly person”, “a hammer”, “a lever”; and in respect of the relationship with services, “a diplomat”, “a bridge” and “WD40”.

*“That’s why I’ve described her as WD40
...it’s been necessary for me to have her
to almost smooth over some of this
disjointed problems that occur from
me being shoved around.”*

IMHA partner

IMHAs had an important role to play in providing information in terms of:

- Information about detention and rights under the Mental Health Act such as right to appeal and the right to legal representation.
- Explaining what Tribunals and other systems are and how they work.
- Signposting to other services including benefits and housing advice.
- Facilitating access to information, for example, on the effects of drug or other treatments when requested by patients.

There was firm evidence from both the interviews with qualifying patients and mental health professionals that IMHAs were regularly involved in providing support at various official meetings (such as Tribunals, Hospital Managers’ Hearings, ward rounds and other multi-disciplinary meetings) – often helping their advocacy partner prepare for the meeting, sometimes attending, and debriefing after the meetings to ensure understanding of decisions taken. In some areas they were more likely to support their advocacy partner at ward rounds or multidisciplinary team (MDT) meetings than other kinds of meeting. They were also more likely to be involved in Managers’ Hearings than Tribunals, though this was not the case across all sites.

In terms of IMHA’s right to access patients’ notes, there had been some disquiet, even resistance at first, from mental health professionals. Across the sites, knowledge of this aspect of the IMHA role among mental health service professionals was rather thin. In practice, IMHAs

infrequently accessed patients’ notes. Professionals such as psychiatrists and ward managers expressed concern about third party information, which they would not release to patients, and therefore not to IMHAs either. In some areas there were clear protocols between the NHS Trusts and advocacy services including controlled access to NHS databases.

As a core purpose of IMHA is to enable participation in decision-making, we were interested in ways in which self-determination may have been promoted and the relationship of this with IMHA services. We therefore asked qualifying patients whether they had used an Advance Directive or Advance Statement. Nearly all of the qualifying patients interviewed did not have an Advance Directive, nor did many understand what one was, with several expressing interest when it was explained and asking for further information. None of the IMHAs interviewed affirmed involvement in supporting Advance Directives.

Non-instructed IMHA was uncommon, and several IMHAs were uncomfortable with acting in the absence of instructions from a person and did all they could to establish their wishes and preferences. Nonetheless, the importance of non-instructed IMHA was recognised by some advocates and mental health professionals:

*“Historically a lot of advocacy
organisations wouldn’t actually do it, but
in [name of organisation] there’s always
been the ethos that they’re the people
that probably needed it the most and
therefore we always have.”*

IMHA

In some areas, advocacy services followed a procedure, which included:

- Establishing whether or not the person lacks capacity or is able to communicate their wishes in some way.
- Speaking with ward or community based staff to find out about what the person communicates on a day to day basis and to establish any expressed wishes.
- Looking at case notes relating to a particular issue and looking at what has happened during their stay in hospital and any expressed preferences.
- Observation of the person in their surroundings.
- Speaking to family and or friends to gain a picture of the person’s life, how they came to be detained, what their previous living situation was like, how suitable etc.

- Feeding the results of all information gathering into decision making meetings such as Care Programme Approach meeting.

It was important to IMHAs that non-instructed advocacy did not become “best interest” work.

Experiences of IMHA

IMHA partners were in the main, extremely positive about their relationship with their IMHA. Mental health services staff on the other hand, tended to be more reserved in their appreciation and possibly more cynical about the value of this relationship. Both emphasised the importance of the IMHA being on the person’s side and of making efforts to understand the situation from the person’s perspective. Good trusting relationships between service users and IMHAs took time to develop.

Satisfaction and dissatisfaction with the IMHA was complex and multi-faceted. Positive experiences were associated with the utility of the advocacy and the relationship with the IMHA, while negative experiences were often framed around uncertainty or lack of achievement of desired outcomes, and certain aspects of the way the IMHA service was delivered.

To an extent, variations in positive and negative criticism were affected by recent changes to IMHA service provider or the difference in practice of different named advocates. IMHA partners on the other hand tended to be positive about the relationship building and interpersonal skills of the IMHA, often contrasting this with poor experiences in mental health services. Finally, while some mental health professionals clearly welcomed the IMHA role in protecting patients’ rights under the MH Act, others experienced it as challenging, even irritating and inappropriate.

Meeting the Diverse Needs of Qualifying Patients

The capacity of IMHA services to provide accessible and appropriate services to the diverse range of qualifying patients relies on effective commissioning, based on adequate intelligence about the local population, and the differing needs in relation to IMHA services. We found little evidence in our case study sites that this had been undertaken. Not surprisingly then, concerns were raised by participants as to how well IMHA services were responding to diverse needs.

Children and young people

Overall, we found that the proportion of children and young people accessing IMHA services was relatively low and the variation reflected whether IMHA services were being commissioned for children and young

people and whether dedicated provision had been developed. There are a number of barriers that children and young people may face in accessing advocacy services (Brady, 2011) including understanding the role of IMHAs and the power differential that exists in relation to age, in settings where all the staff will be adults. Thus, the service profile and visibility, in order to build up familiarity and trust, will go some way to addressing these issues. Maintaining the involvement of advocacy as young people move from Child and Adolescent Mental Health Services (CAMHS) services into adult services will be important and measures will need to be in place to ensure that this happens smoothly.

Older adults

Older adults detained under the MH Act may be particularly vulnerable and, as a proportion may have an organic disease, lack the capacity to instruct an advocate. Further, there may be particular issues in relation to safeguarding as older people can be vulnerable to abuse and exploitation.

The uptake of IMHA services by older adults was identified as a major gap. This gap was explained in terms of the development of IMHA services and the relative lack of familiarity or acceptability of non-instructed advocacy as a way of working. Thus, some older adults qualifying for IMHA services may not have the capacity to instruct an IMHA and therefore miss out. There was also the suggestion that IMHAs visit wards for older adults less frequently. Our findings indicate that either staff need to routinely refer all qualifying patients and/or IMHA services need to visit older people’s wards and be ready to provide non-instructed advocacy. Engaging with families and carers, as in other contexts, could increase the uptake of IMHA services.

People from BME communities

People from BME communities may experience specific forms of disadvantage in relation to the mental health system. People from African and Caribbean communities are two to six times more likely to occupy a bed in hospital; have higher rates of detention under the MH Act (CQC, 2011a); more likely to be readmitted within a year of their first involuntary admission (Priebe et al, 2009); more likely to be placed in seclusion and people from Caribbean communities are also likely to stay in hospital longer (CQC, 2011a); have poorer outcomes and more negative experiences of mental health services (Morgan, 2012). Furthermore, the higher occupancy rates for certain BME groups are reflected in the disproportionately high numbers on CTOs (CQC, 2011b; NHS Information Centre, 2011).

This points to the need to tailor IMHA provision for specific communities in order to address these issues

and advocacy has been highlighted as a mechanism to potentially change this experience. Overall, we found a relatively limited awareness across the mainstream IMHA providers and commissioners as to the specific needs of local BME communities and few efforts appeared to have been made to establish these. Most IMHA providers reported that anyone could access their services and that they had clients from BME communities and thus it was not a major issue. Furthermore, the issue for BME communities was often construed by mainstream IMHA providers in terms of language, with access to interpreters being seen as critical. The advocates from BME communities were likely to stress the importance of a culturally appropriate services, which included an in-depth appreciation of the negative experiences of people from BME communities of mental health services and wider society as well as a good understanding of a person's background and cultural expectations.

Culturally appropriate forms of advocacy often developed in response to the lack of appropriate provision.

“ I think historically the understanding of what has been, what has happened and the reason for this place to be set up and how people have been treated in the past, how it effects people, how medication can be over-used, the side effects of that to people, how it's disabling in certain things.”

BME advocate from a community advocacy organisation

The picture is one where mainstream advocacy organisations may receive the funding for IMHA provision but not be attractive to, or have the skills and knowledge to provide culturally competent services for qualifying patients from BME communities. There are two possible solutions to this. First, IMHA providers working in partnership with BME community organisations. However, we found little evidence of this, with the current climate of competition cited as a potential barrier to this. The second solution is to invest in capacity building and upskilling grass roots community groups to help to fill this very evident gap in the service (Centre for Social Justice,2011). Similarly, we found no evidence that this was taking place.

Gender sensitive provision

The staffing profile of IMHA services – predominantly female – may limit the choice of IMHA on the basis of gender. However, we found that women were more likely to express a preference for an advocate of the same gender, reflecting cultural issues or concerns about relational security. Having an advocate of the same

gender does not guarantee that issues to do with culture or a previous history of abuse will be well understood. IMHA services should consider the arrangements that they have in place, including training and supervision, to take full account of gender sensitivity in provision.

Lesbian Gay Bisexual and Transgender (LGBT) people

No specific provision was identified in any of the case study sites for LGBT people nor was this raised by any of the participants, although the sample included people who identified as gay or bisexual. It was notable that IMHA services were less likely to record an individual's sexual orientation, than other equality strands, and therefore it was harder to evaluate the uptake or issues for this population.

People with learning difficulties

Any service that relies on patients understanding enough to request services is inherently discriminating to those who lack capacity in various aspects of their life. People with learning difficulties have struggled to receive appropriate mental health services with mental health professionals sometimes lacking the appropriate skills. Thus the provision of IMHA services can be viewed, for this and indeed other groups, as a reasonable adjustment to enable qualifying patients to participate in decisions about their care and treatment.

Access to IMHA services can be positively influenced by experience of other forms of advocacy. However, we identified that commissioning arrangements in some instances were disadvantaging access for people with learning difficulties, where advocacy for this group was commissioned separately from commissioning for IMHA services.

People with physical disabilities and/or sensory impairment

The physical accessibility of IMHA services was not raised as an issue because IMHAs tend to visit people on the wards, in mental health service and occasionally at home. Partnerships with organisations that have particular knowledge and skills in the area of disability could also prove fruitful:

“We can provide easy read literature from our service, we also have someone who can provide ... she works for the Blind Society, she would do anything you know in terms of looking at our literature for somebody who's visually impaired.”

IMHA manager

The main issue we identified was appropriate provision for hearing impaired and deaf people, who are inpatients in one of the national specialist units, provided by the NHS or in the independent sector. The same issues existed as for people in relation to people from BME communities in terms of appropriate promotional materials and access to interpreters (British Sign Language). Most importantly cultural competence and an understanding of or identity within the deaf culture was highlighted.

The development of IMHA services is based on a model of instructed advocacy provided by mainstream advocacy providers. As our findings show, this may inadvertently disadvantage qualifying patients who have specific needs that may have not been considered in the development of this model. IMHA services tend to be confident about their capacity to respond to the diversity of qualifying patients but our findings suggest that they need to review their practice and critically examine whether this is actually the case.

Furthermore, commissioners need to undertake a thorough needs assessment to ensure that the diversity of need is properly reflected in the service specification and the contract with IMHA providers. Both commissioners and IMHA providers should be undertaking an equality analysis in order to highlight particular groups that may be disadvantaged and to enable them to commission and provide services for everyone that might need to use them. There is also a need to recognise that there may be relevant knowledge and expertise in small community-based organisations. Commissioners need to consider the implications of this when commissioning IMHA services whilst IMHA services need to explore working in partnership with these organisations. Both need to look at how to resource these organisations to meet gaps in provision for diverse groups. Furthermore, the training for IMHAs needs to be reviewed to strengthen the emphasis on responding to diversity.

IMHA and Mental Health Services

Mental health professionals have a central role to play in promoting access to IMHA services. They can practically support the advocacy service through making IMHAs feel welcome on to the ward, making sure rooms are available or a quiet space for meeting service users, and generally keeping alert to the safety of the advocate, such as communicating basic information about wellbeing or risk prior to IMHAs seeing particular service users. Furthermore, they can alert IMHA services to qualifying patients, help IMHAs access notes, as necessary, and organise meetings so that IMHAs are able to attend.

“When the IMHA just comes to the ward the ward staff will go out of their way to assist them with what they need because they’ll need access to certain things and information from us as well. In these cases, mental health services staff will feel obliged to take steps to support advocacy and this can make a positive contribution to relationships.”

Ward manager

There was a broad consensus around the need for a positive working culture between advocates and mental health services. This can be developed through the commissioning process or in agreeing an engagement protocol. However, relationships at a grass-roots level will be worked out largely on the basis of whether there is mutual understanding and realistic expectations of each others’ roles.

Mental health professionals who can appreciate the link between effective expression of service users’ views and their subsequent wellbeing or recovery value the involvement of IMHAs:

“When they’ve worked well they’ve worked alongside primarily the nursing team and I think they can provide a conduit for information going both ways whereby they can allow patients obviously to express their wishes, also allow patients to understand the position they’re in regarding the Act, or medication.”

Psychiatrist

Where there are positive working relationships, advocacy is understood and appreciated and any challenges to practitioner staff are dealt with equanimity.

“The person I work with personally seems very much on the ball and very challenging which is good, I mean it’s what we’re here for, we should be challenged, we need to be challenged, we should always be challenging the system for the benefit of the patient, we need to be kept on our toes.”

AMHP

Balancing the desirability of having constructive working relationships with mental health services posed challenges for individual IMHAs, and advocacy services, who may come to be seen by service users as no longer independent and too close to mental health staff. As one IMHA commented “slowly but surely we are becoming part of the statutory regime”. Attention to boundaries and maintaining an independent relationship is therefore important.

On occasion, there was evidence of resistance and conflict, which can lead to complete fractures in working relationships and to lip service being paid to advocacy.

“I don’t think they like advocacy ... this is the impression I’m getting ... Well you know the way they didn’t want me to go ahead with the tribunal and they don’t tell people here that they can get advocacy, I don’t know why, it’s very obvious.”

IMHA partner

Reports of conflict in the relationships between mental health professionals and IMHAs were not uncommon, and often reflected various ways in which professionals failed to appreciate advocacy and the IMHA role. Not surprisingly, IMHAs also described resistance and the sense that some professionals see them as interfering and were aware that they added to the workload of staff. In the extreme, IMHAs are an irritant to service provider staff and their professionalism is called into question.

As well as understanding the role, previous experiences and history of advocacy involvement with services, often predating the introduction of IMHA, could be influential in the way services have responded to IMHAs. These different views on the relationship between IMHAs and mental health professionals reflected different dispositions towards advocacy and different understandings of IMHA.

Our analysis indicates that these can be broadly grouped into four different types of response, organised along two interlocking dimensions; disposition to advocacy and understanding of advocacy and the IMHA role in relation to their own role. This is illustrated in Figure 4.

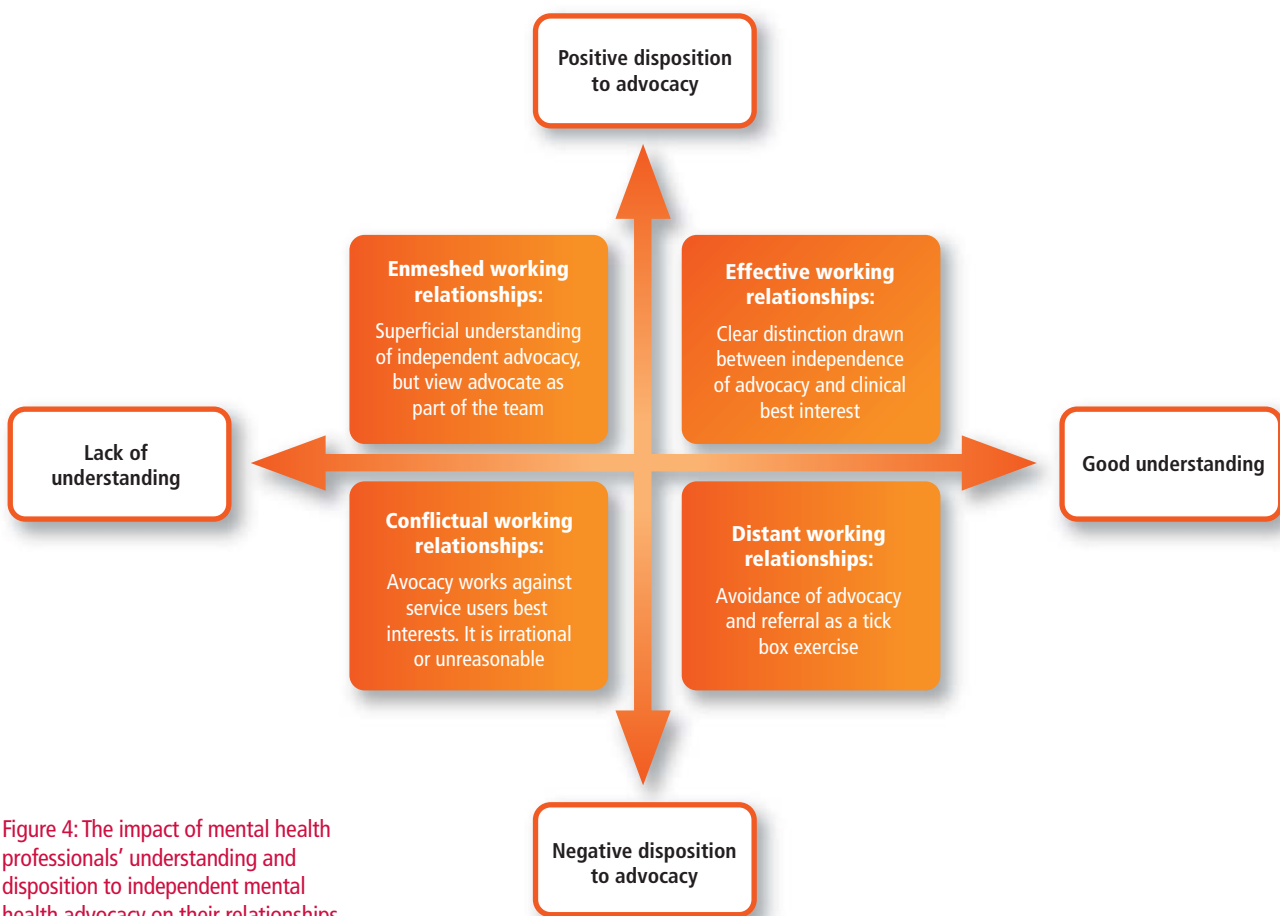


Figure 4: The impact of mental health professionals’ understanding and disposition to independent mental health advocacy on their relationships with IMHA services

Making a Difference

Both service users and mental health professionals recognised the main benefit from IMHAs was ensuring service users had a voice. As expected, IMHA had empowered service users to exercise their rights by, for example, appealing the Section, accessing legal representation, and participating in CPA, Managers' hearings, ward round meetings and Tribunals. Some service users were more accepting of the status quo because the IMHA had helped them understand that this was the way to achieve the outcome they wanted.

Similar to other studies, this research found a key distinction between the impact of IMHA in terms of the process and tangible (action orientated) outcomes, with most impact being identified in relation to the process. While a concrete outcome (such as changing the level of restriction, or lifting the Section) might not be what was always achieved, there was a high level of service user satisfaction with the process of IMHA. Further, while there were examples of IMHA impacting on individuals' care and treatment, it was less likely overall to be thought to increase participation in decision making.

A minority of service users and some mental health professionals identified minimal or no impact from IMHA. In some of these cases, there was a lack of appreciation of the impact (on process for instance) or lack of knowledge about what constitutes a recognisable outcome of advocacy.

"It's not changed anything that's happening here at all... [But] it's made me feel better within myself because people are treating me as a human being and not a bit of dirt under their feet... It gives you confidence within yourself."

IMHA partner

Proxy or crude measures of outcome to assess the effectiveness of IMHA would be unhelpful. Any measurement needs to take account of the complexity and incorporate measures of both process and outcome. These will include individual service user defined outcomes – for example, the IMHA partner feeling that they know more about their rights or have been able to participate in decision-making more fully – as well as aggregated outcomes – for example an increase in the number of successful appeals. These measures will rely on a variety of both quantitative and qualitative data, developed with IMHA partners, and could include:

- Quantitative data (through case note audits or analysis of routine data) on the changes in unlawful

detentions; the number of people exercising their rights for example to appeal against a Section, and changes in their care and treatment under the MH Act.

- Qualitative measures (through surveys, interviews and routine feedback from service user groups or through questionnaires) on the quality of appeals: changes in qualifying patients' knowledge and understanding of their rights; changes in the service user's confidence and ability to self-advocate; assessment of involvement in decision-making about care and treatment; satisfaction with the IMHA service, both the process and the impact.

Commissioning IMHA Services

The critical role that participants considered commissioning plays in the development of good quality IMHA services was clear, from all the data sources.

It was evident that PCTs had been poorly prepared for the introduction of IMHA services in 2009, with some extending contracts on a short-term basis with existing providers. Since then approaches to commissioning IMHA services had become more systematic with a number of PCTs testing the market in the past year. Most had detailed service specifications, based on the National Institute for Mental Health England (NIMHE) guidance, although these differed in terms of whether they focused on IMHA services only or included IMHA as an element of a more comprehensive approach to advocacy provision.

There was little evidence of commissioning based on needs assessment and equality impact assessment, and there was evidence in the case study sites that specific needs had not been given much consideration. In particular, gaps in relation to people from BME communities, people with learning difficulties, older people, and children and young people were highlighted. Further, it was evident that generally service users, particularly qualifying patients, were not being directly involved in the commissioning process or in monitoring contracts.

The basis for the level of investment was thus typically unclear. From the data we have, 50,000 people a year qualify for IMHA services. This is 16% higher than the original estimate, reflecting increasing numbers of people subject to the MH Act. On the basis of our evidence, the current level of investment in IMHA services appears to be inadequate, and relies too heavily on some qualifying patients not taking up the service and/or on IMHA services or mental health services gatekeeping access.

Commissioning arrangements for people placed out of area were confused and commissioners, mental health providers and IMHAs requested clarity. We identified a number of instances where independent sector providers, were commissioning the IMHA service, which is clearly inappropriate but an expedient solution to promoting access.

Concerns were expressed by IMHA services about the practice of spot purchasing as it threatens the financial viability of IMHA services and compromises strategic planning. Tendering processes can privilege larger organisations over smaller ones and this can inadvertently disadvantage smaller community based organisations, which may be particularly well placed to respond to specific diverse needs.

Our findings have a number of implications for the future commissioning of IMHA services. The move from PCTs to local authorities in 2013 creates an opportunity for local authority commissioners to learn from their PCT colleagues and to remedy the shortcomings in arrangements that this research identified. In particular, local authorities can use this opportunity to:

- Ensure there is a proper needs assessment in relation to IMHA provision, building on the Joint Strategic Needs Assessment and engagement with community groups.
- Review the level of investment and ensure that it is appropriate for the level of potential demand.
- Engage with qualifying patients, mental health service users and carers to co-design IMHA services.

- Clarify the arrangements for IMHA provision for people placed out of area, so that arrangements are in line with the Health and Social Care Act 2012 and ensure that IMHA services are not being commissioned by independent sector providers.
- Clarify the interface with specialist commissioning for IMHA provision to national specialist services.
- Consider the potential of small local organisations that have particular skills, knowledge and networks that could support the development of access to appropriate forms of IMHA provision for potentially disadvantaged groups.
- Establish an agreed information system to be able to evaluate access and uptake.
- Develop meaningful outcome measures, in partnership with qualifying patients, mental health service users and carers.

One of the major challenges that local authorities may face is knowledge of the mental health services context and it will be vital for them to work in partnership with health commissioners to ensure that the context within which IMHA services are operating is a supportive one.

THE QUALITY OF IMHA SERVICES

A key finding from this study was that in addition to well organised and properly managed IMHA services, quality IMHA provision depends upon good quality commissioning and supportive mental health services (See Figure 5).



Figure 5: A framework for the quality of IMHA services

A quality IMHA service is easily **available**; one in which the service user has **confidence and trust**; enables them to **express their views and be heard** and thus **potentially influence decisions** about their care and treatment under the MH Act and thus ultimately **is likely to support their journey to recovery**. This reflects the fundamental purpose of IMHA services – that people detained under the MH Act have a right to be heard.

Our findings enabled us to identify a number of domains that determine the quality of IMHA services. These quality indicators have been organised around eight themes, which reflect our key findings. Further detail about the indicators can be found in the full report. In short these were:

- Effective commissioning for IMHA services.
- Availability and accessibility of IMHA services.
- IMHA Service Characteristics.
- Organisation and management of IMHA services.
- The IMHA role.
- Meeting diverse needs.
- Monitoring and outcomes of IMHA services.
- The role of and relationship with mental health services.

These indicators provide a basis for commissioners and IMHA providers together with mental health services to review the quality of local provision.

DISCUSSION

Independent Mental Health Advocacy has three overlapping dimensions: to provide a safeguard of individuals' rights under the MHA; to support and/or represent an individual to get their voice heard and to promote and enhance participation in decision-making. The ideal is an individual able to speak for themselves as a consequence of support from an IMHA, and a care team that is open to hearing and involving that person in decisions about their care and treatment. The guiding philosophy underpinning IMHA services was consistent across provider services with a central commitment to the value of upholding individual's rights, person centred support, independence of advocacy, and the service being free of charge. Ultimately, this ethos is all about empowering people such that they have a voice in challenging circumstances. Almost invariably we were

impressed with the way in which practising IMHAs could articulate these values and describe examples in their work demonstrating their application.

IMHA has a central role to play in an individual's recovery through offering a degree of control and self-determination in a context where limits on freedom have been imposed. It has the potential to emphasise strengths and reconnect with hope, control and opportunities (Repper and Perkins, 2003). Beyond the individual journey, advocacy in general, and IMHA provision in particular, contributes to the development of mental health services that have a recovery focus. Advocacy can help shift the balance of power in the relationship between service users and mental health professionals, which is a crucial step in the journey towards recovery-oriented services (Shepherd, Boardman and Slade, 2007).

Our findings confirm that there is a role for IMHA and that this role is valued by IMHA partners. However, this opportunity is not being used to its full potential.

Accessibility of IMHA services

The basis for evaluating access to and uptake of IMHA services requires attention. Our experiences of recruiting study participants gave us an insight into the nature and quality of the information that is currently being kept and access to this. We found in the majority of our case study sites that mental health services do not share information about the population of qualifying patients with IMHA providers, and conversely, IMHA providers are not under obligation to share information about who has accessed or is using their service with mental health service providers. Indeed some advocates would argue that this is confidential information and should not be shared. While IMHA use may be recorded in an individual's case notes, there is a lack of systematically recorded data to facilitate a review of access and uptake of IMHA support.

Overall, we found that less than half the numbers of people qualifying for IMHA services appear to be accessing them, with the exception of the site with a High Secure Unit, where the IMHA provider was routinely notified of any new admissions. Although our data is tentative, we found the percentage of qualifying patients accessing IMHA services ranged from as low as 19% to 57%, apart from secure services. Concern was expressed both by IMHA providers and commissioners about the levels of uptake in general and for specific groups, particularly groups with specific needs, and people on CTOs. This was more problematic in the inner city areas we studied, which is likely to reflect the nature of the acute in-patient wards with high occupancy rates and

a more frequent turnover of patients, possibly with higher levels of need. It is not surprising that access is less of an issue for secure services where the population is more static and thus the relationship with the IMHA service more established.

The proportion of people on CTOs accessing IMHA services was even lower, ranging from 5% to 55%. IMHA services will not necessarily be aware of who is eligible unless they have been working with the person prior to discharge from hospital or the mental health provider informs them. It was suggested by mental health staff that people on CTOs are making less use of the IMHA service because the MH Act is less of an issue for them, but we have no evidence that people were being routinely informed of their right to access the IMHA service. This was further compounded by the lack of awareness that we identified amongst community-based mental health staff as to the role and purpose of IMHA services and of eligibility criteria.

Participants' accounts suggested a paradox: those who require IMHA services the most may be making the least use of them. This was usually expressed in terms of an individual's personal characteristics, i.e. being articulate, their educational level, their mental health status – with people with a diagnosis of personality disorder identified as most likely to access the service – or their understanding or previous experience of advocacy. Concerns were raised about qualifying patients with specific needs who are less well served by IMHA services: in particular, people from BME communities, particularly those who do not speak English; people with communication difficulties, particularly hearing impairment; and older people, particularly those with dementia.

We found little evidence of outreach strategies for these particular groups or of partnership working with or upskilling community organisations to facilitate better access and uptake. IMHA providers however, indicated that people from these groups were accessing IMHA services and appeared confident that their person-centred approach enabled them to respond flexibly to a diverse range of needs. This finding resonates with that of Hakim and Pollard (2011) whose findings suggested that although IMHA providers were aware they did not fully cater for the needs of BME communities that they were fairly comfortable with this. We found that IMHA services tend to construe the needs of BME communities in relation to access in terms of language and not take account of other factors including negative perceptions of mental health services or specific cultural issues. Further, we found little evidence of strategic planning to address these specific needs in the current commissioning of IMHA services. For example, none of the commissioners in our study had considered the Count Me In Census data (e.g. CQC, 2011a) to

understand the disproportionate rates of occupancy by people from specific BME communities and the implications of this for IMHA provision. There is a potential risk in that the introduction of IMHA services will jeopardise local advocacy groups and networks that wish to adopt a community-based user-led model (Simpson, 2011). This may have particular consequences for BME organisations, who may be disadvantaged in the tendering process (Hakim & Pollard, 2011) and who have developed a distinct model of community advocacy; valued and trusted by service users, who might be less likely to use mainstream IMHA provision. Careful thought is required by commissioners to consider how they can build on this, invest in these organisations, and upskill them to provide IMHA services.

The availability of IMHA services is directly linked to the level of local investment for IMHA provision. We estimate that the numbers of people requiring IMHA services is approximately 50,000, reflecting an increased trend in the number of detentions under the MH Act. We found little in the way of strategic needs assessment in order to inform the potential need for IMHA services locally and to help determine appropriate levels of resourcing. Further, our findings suggest that basing commissioning on demand is unreliable because of the factors that we have identified that impede access and uptake and this strategy is likely to perpetuate existing inequities in access. The quality of commissioning has improved in the time since IMHA services have been introduced, with most commissioners having detailed service specifications in place.

Case load sizes vary markedly as do the areas or numbers of wards (i.e. potential numbers of qualifying patients) covered by individual advocates. The statistics describing rates of compulsion under the MH Act are important for making a continuing case for the need for high quality IMHA. The data collated by the NHS Information Centre indicates that the number of people subject to restrictions under the MH Act continues to rise, with an increase by 5% in the number of people subject to the MH Act in March 2011, compared with the previous year. This reflects an increase by 29% of the number of people on CTOs (NHS Information Centre, 2011). These trends need to be directly reflected in the needs assessment for IMHA services.

We found a lack of awareness of and confusion about IMHA services among potential IMHA partners. Over two thirds of qualifying patients that we interviewed who had not used the service did not know what it was for, had confused its purpose with complaints advocacy or did not know what the service could do for them. This contrasted with the explanations offered by mental health professionals as to why people were not using the service. They

generally attributed this to the person exercising a positive choice, which we found to be the exception. This does not necessarily rule out numbers of service users who may choose not to use IMHA because they are relatively satisfied or confident in their own agency; though we did not locate such individuals. Other reasons such as the individual's mental state could also impede access and carers suggested that they could have an important role in such instances.

Not surprisingly, how and when the IMHA service is promoted emerged as critically important to influencing access. The quality of promotional materials that we saw tended to be rather limited, often giving basic details about the service. Potential IMHA partners wanted more detail including pictures of the local IMHAs so they could recognise them on the ward, and examples of how an IMHA could help them. It was evident that relying solely on written materials was an inadequate strategy for promoting access.

Accounts of the difficulties in engaging with IMHA services as a consequence of mental health status, circumstances surrounding admission and the sheer information overload people experience when being detained under the MH Act, all point to the need for there to be a more visible advocacy presence. This is particularly so on inpatient wards, and for mental health staff to repeatedly ensure that the person has understood the purpose of IMHA, their entitlement and how to access it. There are, of course, resource implications to be considered in areas where advocacy services receive insufficient funding to commit to such a presence. We did find evidence of IMHA services that had cut this aspect of their activities to prioritise direct IMHA work.

At the moment, responsibility for identifying who and how to access the services lies somewhere between the IMHA service, the mental health service and the qualifying patient. The Code of Practice puts explicit duties on certain mental health professionals or the statutory organisations. Staff are willing and do refer, particularly on inpatient wards. However, this is reliant on understanding that access to IMHA service is a right and being predisposed towards advocacy and IMHA services. IMHAs expressed uncertainty about the quality of information that mental health services provide to qualifying patients and whether this is treated as a one-off exercise. On the other hand, mental health services were uncertain how qualifying patients used the information provided, with both groups viewing self-referral as consistent with advocacy principles.

Our findings on access to IMHA services are consistent with the findings from the CQC (2010; 2011b). Access

for many qualifying patients appears to be problematic and may be impeded by lack of understanding and, occasionally, active resistance on the part of mental health professionals. We have also identified that it may be the case that those people who need their rights protecting the most may be the least likely to access IMHA services. Furthermore, mental health professionals can act as gatekeepers to IMHA services making judgments about who might need to be referred to an IMHA or make most use of it. This does not sit comfortably with the spirit of the 2007 MH Act that promotes access to IMHA services as a right and thus should be universally available to qualifying patients.

There are two potential remedies to the issue of inequities and potential gatekeeping of access to IMHA services. The first is for all qualifying patients to be automatically referred to IMHA services on detention or discharge to CTO, giving them the opportunity to opt out rather than opt-in. If such a development were to be adopted across the board, serious attention would have to be given to the capacity of advocacy organisations to cope with a subsequent increase in the volume of referrals.

A second option is to strengthen the overall advocacy presence, particularly on inpatient wards, in line with the recent NICE guideline (National Institute for Health and Clinical Excellence, 2011). Having an advocate or service user presence on the ward to provide information in terms that qualifying patients understand would not only promote access but also facilitate access to the most appropriate form of advocacy. The way in which the service is promoted appears to significantly influence uptake with service users preferring an informal approach from the advocate. Thus, peer support and service user or community-led initiatives have an important role to play in increasing access.

Appropriate support from IMHA services

The starting point for considering appropriateness lies with examining the suitability of IMHA services for the population of qualifying patients. On the whole, IMHA partners were especially satisfied and appreciated many aspects of the independent support they received from IMHAs. For those who accessed IMHA services, therefore, the support appeared to be relevant and suitable to most individuals.

We found little evidence, however, that IMHA providers had comprehensively addressed the diverse needs of the qualifying population. Indeed we found scant evidence of the involvement of IMHA partners in the design or delivery of IMHA services, nor of IMHA providers consistently working in partnership with community

organisations. This may well reflect the demands on their time but is clearly a shortcoming. The sites in our study were undertaking equalities monitoring, although this was largely restricted to gender, age and ethnicity and needs to be further extended. Any unease about capturing data on sexual orientation needs to be addressed and could usefully be taken forward in collaboration with LGBT organisations.

Similar to the results of the advocacy workforce survey undertaken by Action for Advocacy (2008), we found that approximately three quarters of the advocates were white women, making the provision of choice of advocate in a context of diversity a potential challenge to deliver on. However, most users of advocacy services emphasised the quality and effectiveness of the advocacy support as opposed to the personal make-up of the advocate. To some extent, this finding is supported by our previous research into advocacy for African and Caribbean men (Newbigging, McKeown, Hunkins-Hutchison et al 2007; see also Newbigging, McKeown & French, 2011). In this study, the ethnicity of the advocate was important in terms of initial recognition and trust and, hence, was influential in some service users' decisions whether to engage with the advocate in the first place.

Similar to the present study, once a relationship was established the ethnicity of the advocate was usually secondary to their effectiveness and other qualities. However, it is important to note that the number of people from BME communities in this study overall was relatively small and they represented diverse communities. Indeed, our earlier study, and other work has highlighted the importance of different models of advocacy to meet culturally diverse needs, including approaches that are much more embedded within communities and concerned with interdependence, with families for instance, than the defined model of independence embodied in IMHA (Mir & Nocon, 2002; Rai-Atkins, Jama, Wright et al, 2002). This has not been explored within the current study but these previous studies and supporting commissioning guidance (Newbigging, McKeown, Habte-Mariam et al, 2008) provide resources for commissioners, IMHA providers and community organisations to develop appropriate IMHA services.

Another dimension of appropriateness is whether the appropriate type of IMHA is available i.e. instructed or non-instructed. One of our key findings is that there was relatively little non-instructed advocacy taking place in our case study sites, creating a gap in provision, particularly for older people with dementia. There was the suggestion that IMHAs can be ambivalent about non-instructed advocacy and therefore may not be recognising or responding to the need. It is clearly a different style of advocacy and this

has training implications for IMHA services as well as supervision and operational policies to support good practice. However it is also important to recognise that the need for non-instructed versus instructed advocacy is not always clear cut and may change over a relatively short period of time. Our findings suggest that the co-location of IMHA services and IMCA services, and dual trained advocates, mean that IMHA services may be more confident and comfortable with providing non-instructed advocacy to qualifying patients and be able to respond flexibly to changing needs.

The IMHA role is a particular form of advocacy and it is clear that there is an important interface with generic advocacy, as people often need support in expressing their views on other issues that do not pertain directly to the MH Act but are relevant to their mental health issues, their recovery journey and broader health and social needs. We found evidence both that IMHAs experienced dilemmas in relation to this and felt that the introduction of the statutory role created boundaries to their practice, which can be an impediment to pursuing a more holistic form of advocacy. Further, for some advocates there was a sense that generic advocacy has been squeezed in the implementation of IMHA, with those service users not subject to compulsion missing out. We had limited data on this but our sense was that those IMHA services that also provided generic mental health advocacy interpreted the role in terms of a function, which also sat comfortably alongside an IMCA or Deprivation of Liberty Safeguards (DOLS) role, as well as retaining a broader focus on the health and general needs of people. This is within the spirit of the law and the guidance so that IMHA services form part of the broad spectrum of advocacy provision. However, there are implications for commissioning and for how IMHA services are organised, which need to be considered at a local level.

Whether or not the role of IMHAs in Tribunals and managers' meetings was always appropriate was raised both by IMHAs and mental health staff. There was a suggestion that, to some extent, IMHAs were becoming quasi legalistic in relation to these activities and this, arguably, was not a positive development. Rather, IMHAs were at times substituting for legal representation as a result of changes in legal aid entitlement, and this was, by default, changing Tribunal chairs and panels' expectations and understanding of the role IMHAs.

Effectiveness of IMHA services

The study reports routine collection of monitoring information including satisfaction with IMHA services. Such endeavours are arguably crucial to making sense of the overall impact of advocacy, appraisal of its

quality and supporting an effective commissioning process. Our study found there was a distinction between process and outcomes of IMHA provision, with many service users commenting favourably on the process and with less tangible evidence of outcomes. This reflects the distinction between benefits arising from the process of advocacy and those resulting from the outcomes of the process made by Townsley, Marriott & Ward (2009). Further, the outcomes may not always be perceived as benefits, even when the process is evaluated positively.

Approaches to measuring impact represent interesting thinking on outcomes and service evaluation and are clearly part of a broader process of professionalising the organisation of advocacy, of which IMHA is an important part. There remains, however, a case for a more thorough review of different approaches to measuring the effectiveness of advocacy and the possibility of devising a standardised approach to IMHA evaluation that would address geographic variation in quality and render the commissioning process more meaningful and insightful. Both equality analysis and developing user-defined outcomes could form a significant element of this approach.

We found that advocacy is appreciated when it has a tangible impact and the service user is empowered to get the outcome they want. One feature of the service user experience of IMHA, however, that links process and outcome is the often remarked upon scenario wherein people don't get exactly what they want but feel better having experienced advocacy or perhaps arriving at a compromise solution or an approximation of what they were asking for. As we have observed, the process of delivering IMHA can on occasion be viewed as validating detention and, therefore, as a method of social control. Similarly, there is a view that an outcome of advocacy involvement may be that some service users make better-informed choices not to exercise their rights. This suggests that advocacy is not always thought of as working on behalf of qualifying patients but can be seen as part of a pacification process, assisting them to adapt to perceived wrongs rather than challenge them. The extent to which participants in the operation of advocacy are consciously aware of these possibilities will affect their appraisal of quality of the service.

The reported lack of impact of advocacy by some service users is cause for concern. Our study was not designed to track the impacts of advocacy interventions case by case, though we have mapped relevant influential factors. Hence, issues around lack of outcomes may be either because of an individual advocate who is ineffective, or the mental health service might be highly effective and not need advocacy or may be so poor that any impact is difficult

to achieve. Further inquiry could usefully afford analysis of advocacy case work in more detail.

Further the question of the effectiveness of statutory advocacy in comparison to generic mental health advocacy remains unanswered though previous studies from Australia have suggested that a restricted focus on legal advocacy may be less effective than a model that attends to broader health and life issues (Rosenman, Korten & Newman, 2000; Beaupert, 2009). These studies reinforce the importance of locating statutory advocacy within a system of well resourced, well organised and ongoing advocacy services.

The critical nature of the relationship with mental health services

Advocacy will have different impacts, for different people, at different times in different contexts. In one sense, advocacy can be seen to be an important catalyst for opening up the discursive space of psychiatric practices and institutions, empowering individuals to be more actively involved in decisions about their care and recovery. Where this makes a progressive contribution to the democratising of these spaces, then advocacy can be seen to have something of a transformative or emancipatory role. In other regards, advocacy might be seen as a conservative force, merely helping individuals to adapt to the oppressive or liberty-limiting features of psychiatric regimes.

We might wish to distinguish between the readiness of various locations or care teams to engage with advocacy: different mental health settings will represent different sorts of social space for involvement (Spandler 2009). Quirk, Chaplin, Lelliot et al, (2011) note the degree to which psychiatrists, for example, can put pressure on service users to agree to treatment plans or prescriptions that are seen to be in their best interests. Encounters could be described in terms of a three-way typology: they were either open, where decision making was freely negotiated with full user participation; or they were largely directed by the practitioner, with the service user co-operating, but being gently led towards the position preferred by the practitioner in the first place; or they were pressured where the psychiatrist more or less badgers the service user into accepting the practitioner point of view. Our study shows that many service users, and to a lesser extent mental health professionals, recognise that the presence of an advocate in such encounters or collective meetings can alter the tone and arguably shift the decision making towards the more open end of the decision-making continuum.

Service users in our study have remarked upon the extent to which advocacy practice can be seen to open up clinical environments to scrutiny and greater

transparency. The very presence of an advocate is felt to alter staff behavior towards a more respectful or empowering stance to service users. Care teams who are open to greater levels of service user participation arguably adopt a more democratic milieu to start with, and they may already have systems and processes in place that foster these ideals; we might consider these convergent spaces where the wishes of service users and staff for more open, participatory decision-making coincide. The relations between service users and staff in a context of compulsion into care are often not so cosy and, despite the rhetoric of participation, they may be characterised in terms of contention rather than convergence, strengthening the case for independent advocacy.

We should not lose sight of the extent to which advocacy and progressive mental health practices can promote and enhance the personal agency of individuals, supporting hope and recovery in a context of debilitating life circumstances (see Shepherd, Boardman & Burns 2010; Maddock & Hallam 2010). If the idea of mental health recovery is conceived of in terms of 'hope, control and opportunities' then arguably this describes an element of what IMHA do – offer some sense of control in a situation where control and agency are taken away. In this sense, advocacy can highlight opportunities and a way forward, and consequently offer hope for people. In any event, with growing numbers of individuals subject to compulsion it would be foolhardy to dismiss advocacy wholesale as a mere palliative. Rather, it would be more appropriate to take a clear-eyed view of its limitations and seek to strengthen its role in empowering individuals to be active agents in their own care as much as possibly can be achieved. To some extent, the standpoint taken on this by services will depend on context and willingness of staff to accommodate the challenge of advocacy.

PRACTICE AND POLICY IMPLICATIONS

Advocacy has a role to play in improving the experience and outcomes of service users detained under the MH Act, and can contribute to an organisational approach becoming recovery focused. The principles of respecting and promoting self-determination and improving opportunities for choice and control are central strands of current thinking on personalising health and social care. They also underpin the MH Act, current mental health policy (HM Government, 2011) and NICE guidance (National Institute for Health and Clinical Excellence, 2011) to improve the quality of mental health care. Our findings shows that advocacy is valued and can lead to tangible benefits for mental health service users, even if these are not always well

documented. It is also clear from our study that steps need to be taken to ensure full implementation of IMHA and that its introduction does not become a paper exercise, or that IMHA exists mainly to ensure detained people conform to professional views or demands.

This has two major implications. First, ensuring that the investment in IMHA provision reflects the level of local need and is based on a good understanding of the diverse needs of the local population for IMHA provision. Second, mental health services need to review their practices, such as ward rounds, to ensure that they are creating an environment within which the IMHA contribution can be optimised. For those in mental health services committed to developing a recovery-based approach, they will already be some way along this journey.

One of the difficulties with the introduction of statutory advocacy is the shift towards professionalisation of advocacy and away from its roots as a service-user led initiative. Statutory advocacy, thus, has to be seen as one form of advocacy and the provision of IMHA needs to be considered in the context of the different forms of advocacy and initiatives to strengthen service user involvement and peer support. Furthermore, there is considerable scope for the co-production of advocacy and IMHA services with mental health services users. Qualifying patients may prefer to have an IMHA who has a service user background and, from our findings, certainly value the opinion of their peers on the IMHA's qualities and effectiveness.

The NICE guideline on improving the experience of adult mental health care (National Institute for Health and Clinical Excellence, 2011) and recent policy from the Welsh Government (Welsh Government 2011a) propose extending the availability of advocacy for all people admitted as psychiatric inpatients. The Welsh Government (2011b) also promotes universal access to advocacy for all children and young people. Further, the Centre for Social Justice (2011) has proposed that people from BME communities have a right to advocacy before detention.

Our findings indicate that there are concerns about the rights of people who are informal and maybe 'de facto' detained and that the introduction of IMHA services may have compounded this by prioritising resources to be spent on advocacy for detained patients. We believe that consideration should now be given to extending the opportunity to access advocacy to informal patients in hospital and those at risk of detention as part of a broader approach to strengthening service user involvement and opportunities for peer support. In practice, when IMHAs also provide generic mental health advocacy they are able to respond flexibly, both to the changing needs of individuals

and also to the potential need for advocacy from non-qualifying patients. Investment in advocacy services needs to recognise this and ensure that IMHA services also have the capacity to provide generic mental health advocacy to informal patients.

There remains work to be done on the experience of people from BME communities in respect of mental health services and appropriate models of advocacy. Further, there is a need to look at the place of non-instructed advocacy, particularly for older people and people with a learning difficulty who lack the capacity to instruct an advocate. This points to a need for the development of policy for advocacy in mental health more generally to pull these and other strands, i.e. IMCA and DOLS, together.

Advocacy has developed at a rapid pace since the introduction of statutory advocacy and this is an opportune time to review and develop a whole system of advocacy and realise its full potential. The shift of responsibility for commissioning IMHA services to local government provides such an opportunity. It would be helpful if this could be supported by the development of government policy.

The transfer of commissioning responsibility from PCTs to the local authority could, however, also be problematic for IMHA service development, particularly if adequate resources are not ring fenced for this purpose. Furthermore, it will be important for local authorities to build on the progress and positive development of IMHA services that has taken place over the last three years. In addition, the importance of the mental health services context in determining the quality of IMHA provision needs to be recognised and, thus, local authority commissioners will need to work in partnership with health service commissioners to provide the necessary conditions for the successful operation of IMHA services.

FUTURE RESEARCH

Future research is needed to:

- Explore the many gaps in the evidence base for mental health advocacy and follow up some of the key findings of this study in more detail.
- Investigate the impact of IMHA services and the influence of contextual factors, particularly organisational models for delivery.
- Conduct service evaluations that provide information about access and uptake of IMHA in specific contexts.
- Explore the role of advocacy in promoting empowerment of individuals as opposed to pacifying unease with compulsion into services.
- Review the different forms of training and to evaluate the impact on IMHA practice and mental health professionals' understanding and disposition to advocacy.

Conduct action research or appreciative inquiry approaches to develop and enhance the relationship between advocacy services and mental health staff being cognisant of the problems identified in this study.

RECOMMENDATIONS

The full report contains a number of detailed recommendations from our research, which we summarise here. These recommendations are particularly important given that responsibility for commissioning IMHA services moved to local authorities in 2013. This process of transition needs to build on learning from the implementation of IMHA services and identified best practice.

Recommendations for Government

1. A re-emphasis of the core values and principles underpinning the MH Act of self-determination and participation in decision-making needs to be supported by investment in values-based practice.
2. Through full policy implementation, the government needs to continue to recognise the value of advocacy.
3. Access to IMHA services need to be clearly understood and framed as a right.
4. There is a need to consider IMHA advocacy in relation to other forms of advocacy given the changing context.
5. The provision of IMHA services has not yet reached its full potential. Measures are needed to further improve access and ensure adequate investment.
6. Systematic information requirements should be introduced across England to capture data on numbers of qualifying patients and referrals to IMHA services.
7. Consideration should be given to establishing an opt-out rather than an opt-in system to promote access to IMHA services.
8. There is a need to clarify the arrangements for commissioning and providing IMHA services for people placed out of area, in the independent sector and in NHS services that have a national catchment area.
9. Although there is variation in the quality of IMHA services, it is important that existing good practice is recognised and IMHA networks supported to enable this.

Recommendations for the Care Quality Commission

1. We propose that the CQC further refine the draft quality indicators to provide a basis for reviewing the quality of local IMHA services.
2. It would be helpful if mechanisms could be established for IMHA providers to highlight a clear breach of an entitlement under the 1983 MH Act and have reached the limits of local resolution.

Recommendations for Commissioners

1. Commissioners need to undertake systematic needs assessment to determine the local needs for and required configuration of IMHA services.
2. Investment in IMHA services needs to provide a sustainable basis for delivery and in line with good practice guidance, we recommend that this is for a minimum of three years to enable IMHA services to develop to their full capacity.
3. The investment in IMHA provision should include adequate infrastructure costs and the costs of training, support and development for staff.
4. There needs to be an agreed and standardised system for capturing information on both the impact of process and on outcomes.
5. Commissioners play an important role in facilitating access for under-served groups through commissioning small local providers and facilitating collaborative working with community organisations.
6. Commissioners should involve a range of IMHA partners in the commissioning process.
7. Requirements in relation to the role of mental health services should be included in contracts for mental health providers.

Recommendations for Mental Health Services

1. Mental health services need to take steps to ensure that all relevant staff understand that access to IMHA services is a right and are aware of the purpose and role of IMHA and are knowledgeable about local services.
2. Mental health services need to consider providing a more supportive context within which IMHA services can operate effectively.

3. MH Act administrators, as well as ward and community based staff, should ensure they have up to date information about IMHA services in their area especially where there are multiple providers.
4. Mental health professionals working with those on CTOs should receive training about their obligation to inform qualifying patients about IMHA, and protocols for referral need to be developed and implemented as a matter of priority.
5. The variable relationships between MH Act administrators, mental health staff and advocacy services should be noted and steps taken to optimise learning from good practice.

Recommendations for IMHA services

1. IMHA services and mental health services need to agree a systematic method for recording and evaluating uptake.
2. IMHA services should be consistent in recording equalities data to enable them to properly monitor and improve uptake by different groups.
2. Proactive strategies should be developed for improving access and provision for under-served groups, including those on CTOs.
3. Information about IMHA services should be promoted and disseminated through service user and carer networks.
4. Advocacy services should review promotional materials – posters, leaflets, DVDs – ensuring these are accessible and effective, and should involve mental health service users in any redesign.
5. Advocacy services could help improve understanding of, and access to, IMHA by publicising anonymised case studies demonstrating the use and impact of IMHA (including by those on CTOs and non-instructed advocacy).
6. IMHA services should review and ensure a systematic approach to non-instructed advocacy through training and learning from each other through advocacy networks and sharing best practice.
7. Review and ensure that the quality of record keeping is in line with current good practice and enables the service to identify outcomes for IMHA partners.

8. Training and preparation of the future generation of IMHAs is needed and consideration of opportunities for career progression in order to retain and develop high calibre staff.

Recommendations for Service User, Carer and Community organisations

1. Service user, carer and community organisations could create and respond to opportunities to engage in consciousness raising amongst service users around human rights in mental health services.
2. Self organised user groups need to consider the nature of alliances with advocacy organisations.
3. We hope these organisations will critically engage with the reflections from this study about the balance between the potential for advocacy to promote personal agency and the peril that it acts as another form of social control.

Recommendations for Higher Education and Training providers

1. It is recommended that pre-registration training explicitly addresses the meaning of advocacy in the context of the professional role for health and social care professionals.
2. Consider the development of an academic focus for advocacy which would develop the theory and practice of advocacy and build capacity of advocates to lead their own research agenda.

CONCLUSION

This research has found that the IMHA role is highly valued and appreciated by service users, although its potential is not fully realised. This study has identified key factors that influence the quality of IMHA services. It is clear from the study that action to strengthen this has to be three pronged:

1. Through improving commissioning so that the investment reflects the diversity of need and potential demand.
2. By developing supportive mental health contexts, primarily through training and fostering constructive working relationships between IMHA providers and mental health staff.
3. By strengthening the capacity of advocacy services and partner organisations to provide IMHA services to deliver high quality IMHA support to the full range of qualifying patients, including those who require non-instructed advocacy.

These developments will be facilitated by investment in raising the awareness of service users, carers and health and social care professionals in relation to individuals' right to IMHA services, and developing a rights-focus that maximises the potential for self-determination in the context of the legislative framework.

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Further information on the study can be found at:

www.uclan.ac.uk/research/environment/projects/the_right_to_be_heard.php

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