An independent mental health advocacy service was introduced in England in April as part of the changes to the Mental Health Act. Kay Steven and Jim Symington examine the implications

The role of independent mental health advocates

KEY WORDS

Mental Health Act
Advocacy
Patient rights

Independent mental health advocacy (IMHA) is not new. However, for the first time, the provision of mental health advocacy is required by revised mental health legislation. This report sets out how the system works and, in a second section, the training requirements for advocates.

The new arrangement means that certain people detained under the Mental Health Act and called 'qualifying patients' (see Who qualifies for advocacy services? box 1, below) are now entitled to the support of an advocate to provide information about their rights under the act and any aspect of their care or treatment under compulsion.

For example, if a detained patient does not agree with the medication prescribed, they may be advised of their right to have a second opinion from an independently appointed doctor, and they may be supported in obtaining information about the benefits, side effects or risks of treatments given.

Mental health professionals must inform detained patients of their entitlement to an IMHA service and make relevant parts of their records available to the advocate. They may also find that the patient wishes an advocate to represent them at decision-making meetings.

We are now in the first weeks of the new advocacy services, which became available on 1 April.

Only someone who is formally employed as an advocate by either a commissioner (a primary care trust or local authority) or an organisation that has a contract with a commissioner for IMHA services can act as an advocate under the act.

In addition, the person or organisation appointing the advocate must check that they meet regulated appointment requirements. These requirements state that an advocate must:

- have appropriate training or experience or a combination of both
- be a person of integrity and good character
- be able to act independently of any person who requests an advocate to visit and interview the patient
- be able to act independently of any person who is professionally concerned with a patient's medical treatment.

Who becomes an advocate?

The advocates undertaking this new formal role are from a variety of backgrounds. In some cases, they will have a formal professional qualification. They may be a mental health nurse or social worker, for example. Others may have a range of life skills, including past experience of mental distress. A background of experience and understanding of the

BOX 1 : Who qualifies for IMHA services?

Under Section 30 of the Mental Health Act (2007), independent mental health advocates must be available to offer support to qualifying patients. The act describes patients who are eligible for IMHA services as 'qualifying patients'. A qualifying patient is a patient who is one of the following:

- a detainee under the Mental Health Act (1983) (even if they are currently on leave of absence from hospital)
- a conditionally discharged restricted patient
- subject to guardianship
- a supervised community treatment patient.

In addition, informal (voluntary) patients qualify for an IMHA service if they are either:

- being considered for a Section 57 treatment
- are under 18 years of age and being considered for a Section 58A treatment.

However, a patient does not qualify for an IMHA service if they have been detained under one of the following sections:

- on the basis of an emergency application (Section 4) until the second medical recommendation is received
- under the holding powers in Section 5
- in a place of safety under Sections 135 or 136.

AUTHORS

Kay Steven is lead for mental health act advocacy, National Mental Health Development Unit

Jim Symington is head of improved care pathway programmes, National Mental Health Development Unit

Contact:
jim.symington@nmhdu.org

principles of advocacy is common to the pioneers in this field.

Advocates will need to have a detailed understanding of the Mental Health Act and the Code of Practice, something that was not previously required of an advocate.

Advocates are all employed by independent organisations, mainly in the third sector, that have been able to demonstrate a track record in the provision of advocacy. Critically, 'independent' in this context means being completely independent of an NHS trust or other provider organisation that is detaining the 'qualifying patient'. The service is funded by primary care trusts (PCTs), which are the commissioning and purchasing organisations responsible for the care of service users.

PCTs have followed guidance published by the National Institute for Mental Health in England (NIMHE) in December 2008 to ascertain the numbers of detained patients in their area (see www.nmhdu.org.uk). On the basis of this data, they estimated the scale of the services they need to have commissioned. These specifications are based on identified needs, as well as the ethnic make-up and cultural diversity of their detained patient population.

Training is a key issue in developing knowledge, skills and competencies within advocacy services and also in increasing understanding among mental health professionals of the services available. Training requirements have been agreed by the City and Guilds Institute, and courses are being established in the higher education sector to meet the national requirement for IMHA services to provide a trained workforce by April 2010, as described below (see Training as an advocate: the National Advocacy Qualification).

This new advocacy role under the act is primarily informed and shaped by legislation and statutory regulations. However, it also builds on learning that comes from years of mental health advocacy practice.

Prior to the introduction of the act, the National Institute for Mental Health advocacy team, commissioned by the Department of Health, worked with existing advocacy services and other stakeholders to develop ideas on how these services should be provided, staffed, commissioned and delivered. Some of these ideas have been developed into a web-based resource on advocacy for detained patients (www.goodadvocacypractice.org.uk), which uses stories to describe advocacy practice and includes examples of organisational policies.

This article focuses on the challenge of marrying the legislative requirements with the day-to-day experience of advocates on the ground. It also reflects the authors' own learning experience in how best to equip advocates to work effectively with qualifying patients. This has involved the development of an accredited learning framework and an effective practice guide for advocates.

Meeting the challenge

The primary challenge for advocates is clarifying what is expected of them. While the legislation and policy directives set out the duties, responsibilities and rights of an advocate, in practice, their role and responsibilities require a range of communication and engagement skills. Advocates provide an important new safeguard for qualifying patients. They also support a qualifying patient in navigating their way through the system more effectively and accessing information more quickly and effectively.

Both patients and mental health professionals expect advocates to be familiar with a range of issues related to the policies and procedures of the particular setting in which they are working, for example awareness of the local care programme approach, complaints procedures or ward routines, and to have knowledge of services that may support an individual's recovery.

PCT commissioners require those providing IMHA services to work to the guiding principles of the act and to be aware of existing advocacy standards. Moreover, their practice will also be governed by the policies of their employing agency, generally a third-sector organisation, which would have been in place well before the legislation came into force in April. Good practice will also be informed by the need to build confidence in IMHA services within the user movement and to reflect the experience of carers. Advocates will also need to build the confidence of those working within health and social care by showing that they act professionally in the support they provide to qualifying patients.

Within this complex environment, advocates will need to know how to deal with those issues arising that are not specified under the act as being their responsibility – for example, shortfalls in service provision. The new *Effective Practice Guide*, published by NIMHE's successor, the National Mental Health Development Unit (www.nmhdu.org.uk) has been welcomed by advocates because it addresses the knowledge and skills needed to meet service user needs, the technical and ethical issues advocates may face and the importance of enhancing their practice.

Traditionally, mental health advocates have worked to advocacy principles that are informally agreed, have benefited from the experiences of their peers, supervision and from the feedback from patients – highlighting, for example, the importance of working with others.

Learning from past experience

During our consultation process, one advocate told us about her approach to the task:

'I work with a lot of detained patients, so I keep up to date with relevant legislation. I provide individuals with copies of the Mental Health Act and highlight the parts of the act relevant to them. I go through their rights with them and make sure they understand why they are in hospital and what will happen next. If the patient asks me a question I can't answer there and then, I go back to the office and check appropriate websites and also contact local colleagues with expertise in specific areas to see if they can help.'

The *Effective Practice Guide* aims to give advocates additional ideas about effective ways to fulfill their specialist role and responsibilities. It sits alongside

Training as an advocate: the National Advocacy Qualification

In order to provide an effective knowledge, values and skills framework, a national advocacy qualification has been developed that will involve both taught and self-directed learning and assessment. The programme is modular in structure so that learners can engage with it at different levels. The modules have been designed to develop practical skills and to provide the underpinning knowledge that advocates will frequently use and rely upon. Over time, the qualification will raise the capacity of the advocacy sector, skill the workforce and help provide advocates with opportunities for progression.

All advocates must undertake formal training in independent advocacy in their first year. This is a regulatory requirement under the Mental Health Act, and feedback from the advocacy sector, service users, commissioners and government demonstrates strong support for this. Advocates wanted the City and Guilds qualification that is now available to them. This training concentrates on developing practical skills and provides portable evidence of the advocate's expertise and knowledge. Advocates also want to show other professionals that they have reached a high standard and are competent and qualified, and also that they provide a robust service.

One advocate told us: 'Psychiatrists always ask, "What qualification do you have?", which makes me feel intimidated. A qualification would give me that confidence and make me know my rights.'

Service users agreed that qualifications would instill more confidence in the new advocacy services. A number of users told us that they want to access trained and competent advocates:

'You wouldn't want to see an unqualified doctor would you? So why would I want to see an unqualified advocate?'

'I presumed there was an [advocacy] qualification. I would have more respect for them if they're qualified.'

Commissioners, who are concerned with quality assurance, have welcomed the nationally approved training for advocates. Many commissioners view the qualification as an important way of raising standards and achieving consistency in the provision of IMHA services. One said:

'An independent advocacy qualification will help to professionalise advocacy and increase both commissioners' and service users' confidence in providers.'

The qualification is one of the first in the newly announced Qualifications and Credit Framework (QCF), and it concentrates on the real life skills an advocate will need to use. There are four units available at Level 3, exploring generic advocacy skills, what advocacy is and how to provide advocacy to individuals in different settings with diverse needs. Each unit can be taken in isolation or together and will provide successful learners with accreditation.

These units are also available to people working with advocates who want either to learn more about independent advocacy or would like to develop additional advocacy skills themselves. Additional specialist units have been created at Level 4 that address the specific functions. These include not just the independent Mental Health Act advocate, but independent mental capacity advocates, children's and adults' advocates and advocacy managers.

'You wouldn't want to see an unqualified doctor would you? So why would I want to see an unqualified advocate?'

The specialist module in independent mental health advocacy is now available. To become a qualified independent Mental Health Act advocate you must complete both the core modules and the specialist IMHA module.

The IMHA module is heavily informed by the experience of mental health advocates who have worked with patients and within mental health services. The specialist unit develops advocates' competency in undertaking a range of advocacy-specific tasks, such as providing information, listening to an individual's wishes and feelings, and representing people.

A significant feature of providing independent advocacy is working with people on a one-to-one basis and, wherever possible, assessment includes observation of the advocate working with people. Assessment of this unit is, therefore, based on practice. It requires the production of a portfolio that demonstrates the use of practical skills and knowledge. Where appropriate, assessors will invite those who have used the advocacy service to contribute to the assessment process.

The qualification is an important step forward in raising quality within advocacy and ensuring that qualifying patients receive consistently high levels of support. Having a nationally recognised accreditation enhances the credibility and confidence in the service. Commissioners and other professionals can be confident that those providing support have attained good standards.

We hope that all these developments will go some way towards ensuring qualifying patients in England now have access to, and are benefiting from, quality advocacy services.

the legislation and regulations, while building on the general principles and values of advocacy as well as the experience of advocates. The guide attempts to bridge the gaps and overcome some of the tensions arising from the need for advocates to follow the requirements of the law, use different theories and work with the reality of a particular patient's life experience or problems.

Advocates have been responsible for self-publicising their service to patients for a long time and this learning is being applied to raise awareness of advocacy services.

One mental health advocate told us how he promotes advocacy: 'I build up a good working relationship with staff by meeting them at team meetings to tell them about the service, and I sometimes do a presentation on advocacy at staff inductions. However, the best way is to keep talking with people individually.'

The Mental Health Act places a duty on the 'responsible person' to provide information about IMHA services to patients. The 'responsible person' includes managers of the hospital, the responsible clinician, local social services authority and the registered medical practitioner or approved clinician. The Code of Practice specifies who provides the information and when (see for reference, Code of Practice 20:12).

This is a major shift for the provision of mental health advocacy services. In particular, it places a new emphasis on mental health professionals, IMHA services and their commissioners working in participation and partnership in the interest of the qualifying patient. For example, under the act, the advocate has the right to access the patient's records, subject to certain conditions. Where the patient consents, the advocate has a right to see any clinical or other records relating to the patient's detention or treatment in any hospital or relating to any after-care services provided to the patient. They have a similar right to see any records relating to the patient held by a local social services authority.

A collaborative approach

A major challenge for new IMHA services is adopting a collaborative approach when engaging with mental health service providers, yet at the same time clearly maintaining their independence from the trust or hospital detaining the patient. A mental health advocate explained how she acts in a non-aligned way when she works with ward staff: 'As a hospital advocate, I constantly have to reinforce my boundaries and explain to ward staff where my advocacy role begins and ends. I am not a member of staff – ward staff have their job to do and I have mine. I will work alongside professionals and am professional in my approach, but I am independent from the team.'

All advocacy starts from the service user's view of their needs, interests and issues. It ensures that their voice is heard and that their wishes and rights are respected. Advocates therefore need to understand how to promote and put into effect the skills of self-advocacy for a qualifying patient.

For example, one mental health advocate described how they prepare a patient for their attendance at a care programme approach (CPA) meeting:

'As an advocate, when I am working with an individual I always encourage them to do some aspects of the advocacy. When I first suggest this, they often back off, saying that they don't feel able to do anything. I explain that I am not asking them to act on their own and I will support them. Then they are more open to sharing the task. Recently, I spent time with Jay, preparing for her CPA meeting. We wrote down a list of questions and in the meeting she read out the questions and I took notes. She told me that she was very nervous to start with, but once she got into it she got more confident and was glad to actively participate in the meeting.'

One of the key learning points for the authors has been developing an appreciation of the specific type of support that advocates need to offer. They need to build new understandings to inform their practice, to detect and correct error and to look for other more effective strategies in their work. This has implications for professional development, peer support and supervision, as described by two experienced advocates:

'I think it is important to reflect on my practice. I look over the paperwork and review what I agreed to do with or for a patient. I look at what I did. I also consider whether I could have approached the work in a different way. I do ask the patient for feedback too – sometimes they are very direct, sometimes not.'

'I find that every case is different. No matter how much I have learnt I am never fully prepared for what a client will tell me. Sometimes when the client tells me what they are going through I freeze and feel completely overwhelmed. I am fortunate enough to have good peer support and get regular supervision from an experienced practitioner. Advocacy can be isolating enough but some of what you hear from patients can be really harrowing. I can't stress enough how important it is to have good supervision and time to reflect.'

However, the knowledge, values and skills base required for reflective practice are not generally well developed, and there are different views among advocates on what skills are essential to enable them to reflect on their practice.

At this early stage of implementation, the way that knowledge, values and experiences come together in IMHA services is still being debated. For example, while values are often treated as universal and timeless, in practice, they are context-specific and make different demands on the practitioner, and different problems are attached to the use of each. However, the framework of principles set out within the Mental Health Act Code of Practice encourages a balanced approach to decision-making and intervention for everyone acting under the legislation, regardless of their role. These principles need to be applied and balanced on a case-by-case basis. There is no simple way to prioritise them in practice, or to resolve contradictions and conflicts in their on-going use perfectly.

Dealing with difficult issues

Issues that will arise in advocacy will include inequality, discrimination and stigma associated with mental illnesses and disorders, which the principles within the Code address under the term 'respect'. It is clear that many service users face discrimination on the grounds of age, sexuality, race and culture, gender, and spiritual and religious beliefs, as well as because of their mental condition. Currently, the misunderstanding, inequality and discrimination in the use of compulsory powers against patients on the basis of their skin colour, culture or religious faith is seen as a major issue for the development of IMHA services.

For example, black groups are up to 44% more likely to be detained under the Mental Health Act compared with the average, and the figure is almost double for black Caribbean and black African groups. The risk of being referred to mental health services by police or by the courts is almost double for black Caribbean and black African groups. These groups are also about 50% more likely than average to be secluded, while 8% of inpatients have experienced one or more incidents of control and restraint. The rate was 29% higher than the average for black Caribbean men. black mental health UK figures are taken from the MHAC Mental Health and Ethnicity Census 2005.)

David Bennett's story illustrates the discrimination facing black African-Caribbean service users, as a NIMHE report pointed out:

'David 'Rocky' Bennett was an African-Caribbean man who suffocated to death while being held under control and restraint procedures in seclusion in a mental health institution. A racial taunt from another service user on the ward had led to the incident. David was secluded, although he had complained of racial abuse and the service user who taunted him was allowed to stay on the ward unchallenged. David had repeatedly complained of being the subject of racist abuse and he felt that his medical treatment was inappropriate, predicated on his skin colour rather than his condition. He had no advocacy service to turn to for support.' (NIMHE, 2008: 6)

Now, under the IMHA service, an independent advocate who was sensitive to cultural diversity would be able to provide an additional safeguard to address such unacceptable practice. They would have the power to scrutinise the way the principles to the Code of Practice were applied in this case.

More generally, the different value systems and perspectives of black and minority ethnic (BME) communities tend to challenge the traditional value frameworks of advocacy and the prominence given to independence. The emphasis on autonomy and empowerment of the individual in an advocacy service may not be understood in some cultural contexts. Values may also be prioritised or expressed differently in some communities. Furthermore, from some perspectives, those traditional values are seen to only make sense within an individualistic Western philosophy – one that may differ from many cultures and spiritual beliefs.

In response, the IMHA project, in partnership with the Department of Health's Delivering Racial Equality programme, is developing a pilot project to explore how IMHA services can be accessible and effective in working specifically with black and African-Caribbean men and also patients from BME communities. ■

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