



Mental Health Alliance

Briefing Paper 3

Independent Mental Health Advocacy

Rezina Hakim and Tom Pollard, Mind Policy and Campaigns Unit

The Mental Health Act 2007 made important changes to mental health and mental capacity legislation in England and Wales. The Mental Health Alliance, which came together in 1999 to work for humane and effective mental health legislation, is currently assessing the impact of these changes. The right to Independent Mental Health Advocacy (IMHA) is an important safeguard introduced by the legislation. This paper assesses the commissioning of IMHA services in England only, where the new right did not come into effect until April 2009 in order to give primary care trusts time to introduce the necessary services.

Key messages

- Independent Mental Health Advocacy is an entitlement under the Mental Health Act, the purpose of which is to support patients to understand and exercise their legal rights.
- IMHA providers report being underfunded and overstretched in the face of the demand for their services, while there is still a lack of awareness about it among service users and mental health staff.
- A rushed commissioning process has meant that many IMHA services were not put out to tender and this has led to a failure to provide adequately for black and minority ethnic (BME) service users who are disproportionately affected by the Mental Health Act.
- There is also evidence of good commissioning and providers striving to deliver quality services.
- Commissioners need to carry out IMHA needs assessments and put new contracts out to tender so that comprehensive services are provided and BME service users' needs are properly catered for.
- Mental health service providers should ensure that service users are made fully aware of their rights to an IMHA.

Introduction

The Independent Mental Health Advocacy (IMHA) service came into effect in England in April 2009 as part of a new statutory provision in the revision to the 1983 Mental Health Act passed in 2007. The revised legislation provides a safeguard and right to advocacy for 'qualifying patients' detained under the Act. The main purpose for an IMHA is to help and support patients in understanding and exercising their legal rights.

Responsibility for commissioning IMHA services lies with each primary care trust (PCT). Ideally commissioning decisions are based on specific guidance developed by the Department of Health. Commissioning guidance for IMHA detailed a variety of recommendations for conducting a full assessment of local need. A significant portion of the guidance focuses on how IMHA services should be tailored to meet the particular needs of minority ethnic communities.

When commissioning IMHA, PCTs must, as far as reasonably practicable, have regard to the diverse circumstances (including, but not limited to, the ethnic, cultural and demographic needs) of qualifying patients (DoH, 2008b). Guidance recommends that issues of diversity are integrated from the start of the commissioning process as part of the initial needs assessment.

Examples of the different ways that an IMHA service provider may meet the specific needs of qualifying patients include:

- joint-working with other services that have specific skills and/or experience of working with particular groups of people (for example, with BME communities)
- employing (sessional) workers with specific skills and knowledge.

The IMHA service provider may also build informal links with other local services that have levels of experience in particular areas, such as refugee and asylum groups. These informal relationships and joint-working links can include sharing best practice, or referring patients on to other advocacy services that are better placed to meet these needs.

The commissioning guidance also recommends that commissioners seek to address some of the issues presented by the experiences of BME mental health service users, particularly in supporting them to access advocacy services. These cases can then be used to ascertain how tailored the IMHA service will need to be in order to fulfil the needs of BME patients.

This report explores the extent to which PCTs have been successful in commissioning IMHA services and, in turn, how well service providers have managed to implement it. Sets of data obtained from both PCTs and providers will be examined under four headings; 'commissioning', 'functioning', 'black minority ethnic (BME) context' and 'monitoring standards'.

Methodology

Mind sent Freedom of Information (FOI) requests to all 152 PCTs in England. The request focused on the following six areas of work pertaining to IMHA service commissioning:

1. Documents and communications relating to the assessment of local needs undertaken prior to inviting tenders for IMHA contracts (or prior to awarding the contract without tender), including the title of the individual responsible for commissioning and reference to the specific needs of black and minority ethnic (BME) communities within the assessment.
2. Service specification and invitation to tender for the IMHA contract (or service agreement if no tender was undertaken).
3. Documents and communications pertaining to the number of providers that applied for the IMHA contract.
4. Documents and communications relating to whether the National Advocacy Qualification and the Quality Performance Mark were required as part of the IMHA contract.
5. Documents and communications pertaining to how the quality of the service is being monitored.
6. Monitoring of the uptake of the service, including monitoring of the ethnicity of those making use of the service.

Alongside this request, services providing IMHA were also asked to respond to a survey asking the following questions. The intention was to compare the PCT's commissioning obligations with the service provider's experience of IMHA delivery:

- What is the name of your organisation and which PCT do you provide IMHA for?
- Do you have any issues with the IMHA contract with the PCT (such as insufficient resources for the need, or the boundaries of the service)?

- What are your perceptions of levels of awareness of the IMHA services among: i) mental health services staff; and ii) service users?
- Have you had any issues with patients not being referred efficiently to the IMHA service? If yes, please give further details.
- How significant are the 'Principles'* in securing people's access to the right services and greater say in treatment?
- Do you also provide general mental health advocacy services?
- If yes, are these commissioned by the PCT and does this raise any issues?
- Are any parts of your IMHA services tailored specifically for local BME communities?
- Are you required to provide BME-specific services as part of your IMHA contract?
- Do you believe your IMHA services fully cater for the needs of local BME communities?
- In your role as IMHA provider, have you worked with other, BME-specific, local advocacy providers?
- How is uptake of the service being monitored and how is ethnicity being recorded as part of this process?
- How effective do you think your service has been so far, in terms of helping individuals to access the right services and have a greater say over their treatment?

Around 10 per cent of IMHA service providers responded to the survey, which yielded 35 survey responses. For each, we also selected their PCT FOI response. We also selected an additional 15 PCT FOI responses on the basis of the depth/scope of information submitted by the PCT. The following analysis is based on these responses.

The number of responses from FOI, and survey responses far exceeded our expectations. Therefore we have additional data available, which can be used in the future for a fuller analysis to complement this interim report.

* The 2008 revisions to the Code of Practice to the Mental Health Act 1983 added a new statement of guiding principles including 'respect': "People taking decisions under the Act must recognise and respect the diverse needs, values and circumstances of each patient, including their race, religion, culture, gender, age, sexual orientation and any disability." (DoH, 2008a)

Commissioning

In addressing the relationship between the service provider and their PCT, over two-thirds of survey respondents reported hitches with their IMHA contract and the PCT.

The following is a general overview of the more common issues the respondents cited:

- Underfunding of the service is the major complication that service providers face. The PCTs have been slow to predict the uptake of the service and hence funding has either been minimal or services are expected to use existing funding for non-statutory services to deliver IMHA.
- Resources are stretched with staff being diverted away from other duties and spending voluntary extra hours meeting the demand for IMHA.
- Many IMHA providers lamented that their service is being delivered as a 'spot purchase' with no official contract having been issued by the PCT.
- There have been some issues with out-of-boundary patients using IMHA and this is causing extra pressure on the limited numbers of advocates currently available.

Our FOI requests revealed that 78 per cent of responding PCTs did not put the IMHA contract out to tender. Many of the PCTs attributed this decision to the short turnaround from when the commissioning guidelines were issued to when IMHA legislation came into place, making timescales too limited for effective tendering. To ensure PCTs delivered IMHA on time, they found their most feasible option was to contract with existing mental health service providers. Although guidance for commissioners did not come out until December 2008, four months before the service started, PCTs were aware of the impending IMHA regulations from when the service was accepted on to the statute books in July 2007.

Many PCTs suggested that due to the short turnaround from receiving the commissioning guidelines to when IMHA legislation came into effect, they were not in a position to put the service to tender and therefore felt it necessary to collaborate with existing advocacy services. Yet, those PCTs who did put the service to tender were also the ones who conducted a full assessment of needs, suggesting these PCTs were better able to respond to the fact that waiting for commissioning guidelines at a later date would likely result in a hastily commissioned, poorly matched service. By way of comparison, the 11 PCTs that did put the IMHA contract out to tender, received anything from three to 13 bids.

The Equalities Impact Assessment reiterates the commissioning guidance recommendations that where tendering has been carried out, the provider should demonstrate they have sufficient knowledge and experience in meeting the needs of diverse ethnic communities. This might involve employing effective tools where English is not a patient’s first language. It could be argued that the absence of effective tendering for early IMHA contracts has resulted in a missed opportunity to locate IMHA services within a setting already tailored to meet the needs of particular ethnic groups.

More than half of the PCTs had undertaken a needs assessment, necessary to scope the type and scale of IMHA service provision in their area. However, from the information provided, it was often unclear whether this was conducted specifically for IMHA, or based on previous data from existing mental health services. Also, service provider responses gave a clear indication that issues with the contract made the implementation of the IMHA framework particularly difficult. Such issues include limited resources and ‘spot purchasing’ giving rise to low numbers of contracted staff. The shortfall in advocates and in number of hours available to meet demand for the service has led to an increased reliance on the good will of non-IMHAs within services working to facilitate IMHA provision.

Functioning

Service providers were asked whether they had experienced any issues with patients being inappropriately referred to IMHA, to which 86 per cent affirmed they had (Fig. 1).

Among the issues cited was the lack of understanding or awareness among hospital staff and GPs of access to the IMHA service. Staff responsible for referring patients to the

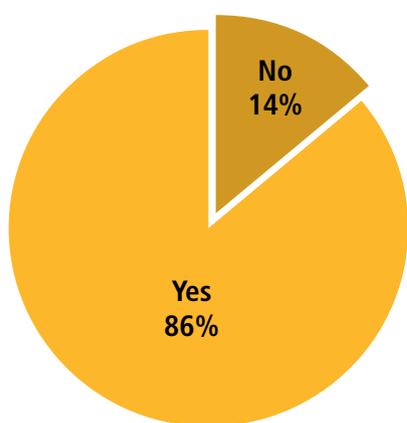


Fig 1. Do you have issues with inefficient patient referrals to IMHA?

service were often unsure of the process for IMHA referrals, were therefore not well placed to encourage the patients to use the service. There was a noticeable lack of communication between service providers and hospital staff. This is clearly problematic, as hospital staff tend to be gatekeepers determining access to services. Without knowledge of IMHA among such staff, referrals are less likely to occur. That said, questions about service providers’ perceptions of the level of IMHA awareness among mental health staff revealed a more complex picture. Although levels of awareness were noticeably higher among hospital staff than service users, comments suggested that knowledge of the nature and function of IMHA was still lacking, even though hospital staff were aware of its availability.

In attempting to remedy this, some providers thought it necessary to address the issue of awareness among staff through training. They have since seen an increase in referrals, although it is difficult to definitively measure this change as it would require acknowledgement by existing staff of their lack of awareness of a service to which their patients are entitled.

It was clear from some of the responses that there was an absence of comprehensive engagement by health professionals, also a degree of confusion over the juncture between IMHA and existing advocacy services. Staff were unsure whether qualifying patients were aware of their right to an IMHA, as information for the service was seldom being filtered to those who were entitled. Despite such challenges, there was a general sense among providers that the IMHA framework was still getting off the ground and, given time, all staff would make a concerted effort to raise the service’s profile.

IMHA and black and minority ethnic (BME) communities

The guidelines for commissioning IMHA suggest an assessment of local needs can be carried out prior to commissioning. This should yield better understanding of the type of IMHA service most appropriate to the local population. Over half of our sample of PCT respondents had undertaken an assessment of their local area (Fig. 2). The commissioning guidelines recommend that “issues of diversity are integrated from the start of the commissioning process as part of the initial needs assessment.” Based on this recommendation, our FOI results showed 54 per cent of the PCTs had not made any reference to responding to an ethnically diverse population.

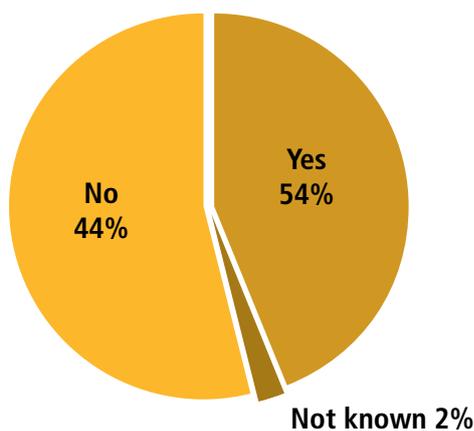


Fig 2. Assessment of local needs

Explanations of this position focused primarily on the fact that all PCTs have established equal opportunity frameworks. New services are automatically subjected to PCT – or in some cases local authority – equality and diversity audits.

Some PCTs regarded their local community to be less ethnically diverse than others. Undertaking a needs assessment, or providing BME-tailored services was therefore regarded as unnecessary. A problem with this approach is that it tends not to be based on a rigorous mapping of the current local population. Numbers of patients from BME communities may well be overlooked due to historically low levels of contact with services, which feeds the belief that such populations do not exist locally. Even where there are relatively low numbers of BME people in a particular area, where (as seems to be the case) decisions on service-type are based primarily on the scale of need assessed against population size, rather than magnitude of need among individuals and local groups, it is likely that the needs of minority sections of the local community will be overlooked. The absence of a BME-focused assessment led to the vast majority of IMHA services not being tailored to engage with diverse ethnic groups.

In general, service providers expressed a belief that the current IMHA contracts are not best suited to meet the needs of BME communities. When asked to expand, they gave the following reasons:

- Owing to limited funding it is not always possible to employ an advocate to cater for different languages or dialects of the local community.
- A lack of requirement, and consequently resources, prevents services from fully engaging with BME communities and addressing these needs would require a discrete project focus.
- Some providers had little or no contact with BME patients

and felt the demographic of their community did not require a BME-focused service.

The implication is that services are unable to respond to the diversity of needs in their area. Alongside the provision of translation and interpreting services, there are also potentially wider impacts. As with all person-centered advocacy provision, in seeking to meet the client’s needs, IMHA services should take account of people’s unique circumstances. Ethnicity and culture are core components of people’s identity and can shape the way they live their lives.

Although IMHA providers seemed to understand that their service did not fully cater for BME communities, they seemed reasonably comfortable with this position.

Monitoring standards

In terms of monitoring IMHA, PCT responses showed increased activity when providing information against pre-set standards. Unsurprisingly, where there were no such standards (such as for tailoring services for BME communities) monitoring data was not provided. It can be surmised from the comments made by the providers that they often had little choice in the way they monitored quality:

- Quarterly reports are produced by the provider which are then fed back to the PCT in board meetings or filtered through to management.
- Databases are used to record referrals, age, gender, ethnicity, issues which advocates helped with and which section patients are detained under.
- Some providers continued to use their ‘standard’ monitoring process which is used for all their services and not designed specifically for IMHA.

IMHA providers have robust methods of monitoring levels of engagement, and profiles of all qualifying patients. Some IMHAs explained they actively encouraged their patients to provide feedback on the service they had received, with a few providers displaying their surprise at how significant the IMHA uptake had been in their local area.

Looking at standards of training and qualification levels attained, 30 out of the selected 50 PCTs said specific qualifications were necessary for an IMHA to be fully recognised and qualified to deliver the service. The guidelines suggest the National Advocacy Qualification (NAQ) should be completed by the end of the first year the IMHA enters the post, or in this case, since the roll-out of the service. Common answers

emerging from the FOI requests were consistent with these guidelines and almost all IMHAs had successfully completed their qualification. Where extenuating circumstances, such as sickness or maternity leave occurred, reasonable time adjustments were made (permitted in the commissioning guidelines). This achievement has served the providers well, as they have mostly striven to reach this qualification or make provisions to ensure partly qualified advocates either complete their training or continue current courses.

Other sources and concerns

The Care Quality Commission's 2009–10 annual report on the Mental Health Act confirmed concerns about gaps in access to IMHA, reporting that 18 per cent of all wards visited did not have access to IMHA services (CQC, 2010). People on community treatment orders are also entitled to IMHA but being based in the community raises different issues about access. Referring to people on community treatment orders, the Care Quality Commission report states that "Patients often questioned whether advocacy services were available to them in any practical sense, even though they had a legal entitlement to them." (CQC, 2010)

Gender is another equalities concern and an under-resourced 'standard' IMHA service will not be able to meet the needs of women who may need more time to build sufficient trust in their advocate. Many people detained under the Mental Health Act are treated in the private sector where Alliance member concerns suggest that commissioning guidance needs to be strengthened. There are difficulties reported where the same service has IMHAs from different areas and in raising funding for IMHA training.

NHS commissioning is changing fundamentally with the planned abolition of primary care trusts. Responsibility for commissioning IMHA is being transferred to local authorities. It is essential that the responsibility is unambiguous and supported by adequate funds.

Conclusion

Certain common issues became apparent as each FOI and provider response was analysed. The tight timescales faced by the PCTs meant the implementation of IMHA was a rather rushed affair. In order to meet the statutory start date, a large proportion of PCTs failed to put the service out to tender, thereby hastily imposing IMHA on existing mental health advocacy providers in their area. This has led to a noticeable failure in addressing key issues for BME users, and may have impacted negatively on the quality of both IMHA provision and general mental health advocacy across all ethnic groups.

The disproportionate application of mental health legislation to BME groups is well documented in publications such as the *Count Me In* survey (CRC, 2009) and it affects those discharged on to Community Treatment Orders as well as detained patients. Consequently, such groups are likely to make greater use of IMHA. By failing to put IMHA services out to tender, the possibility of responding to this through advocacy services with a history of catering to diverse ethnic groups has been severely curtailed. As a consequence, despite specific examples of effective practice, on the whole, IMHA is failing to fully engage with and thus adequately provide for BME communities. Perhaps more worrying is the low number of hospital staff making qualifying patients fully aware of their rights to access IMHA. Although some PCTs are trying to rectify this via training sessions, a more robust response may be required.

The Mental Health Alliance therefore recommends that:

- primary care trusts – and future commissioners of IMHA – conduct needs assessments for IMHA services which are sufficiently focused and thorough as to identify the needs of diverse communities and take full account of the demographic profile of people liable to be detained under the Mental Health Act
- as IMHA contracts come to an end, PCTs put new contracts out to tender and ensure that the tenders take into account the needs of BME service users, ideally including procurement of services directly from providers which specialise in catering to BME communities, and via joint bids between larger-scale and smaller community-based 'grass-roots' providers
- the Department of Health remind all mental health hospitals of the duties of relevant persons to inform qualifying patients of their rights to IMHA

- trusts providing mental health services ensure that all relevant staff are made aware of the role of IMHAs and qualifying patients' rights to access their services, both inpatients and those in the community
- the Tribunal Service include information about IMHA in its guidance and information materials
- the Government ensure that changes to NHS commissioning are unambiguous and robust vis-à-vis responsibilities for commissioning IMHA and that this includes a BME focus
- the Care Quality Commission continue to monitor closely the implementation of IMHA and take any necessary action where qualifying patients are denied access to this statutory safeguard.

References

Care Quality Commission (2009), *Count Me In*

Care Quality Commission (2010), *Monitoring the use of the Mental Health Act in 2009/10*, p.58

Department of Health (2008a), *Code of Practice, Mental Health Act 1983*

Department of Health (2008b), *Independent Mental Health Advocacy: Guidance for Commissioners*, p.22

Mental Health Alliance members

Afiya Trust; Black Mental Health UK; British Association for Counselling and Psychotherapy; British Association of Social Workers; Caritas Social Action; Ethnic Health Forum North West; Hafal; Institute of Mental Health Act Practitioners; King's Fund; Manic Depression Fellowship; Mental Health Foundation; Mind; National Autistic Society; NUS; Witness; Rethink severe mental illness; Revolving Doors Agency; Richmond Fellowship; Royal College of Psychiatrists; SANE; Centre for Mental Health; SIRI; Together; Turning Point; UK Federation of Smaller Mental Health Agencies; UKAN; UNISON; United Response; Voices Forum; YoungMinds; The 1990 Trust; African Caribbean Community Initiatives; Age Concern England; Alcohol Concern; Association of Directors of Social Services; AWAAZ (Manchester); AWETU; British Medical Association; BME Mental Health Network; Carers UK; Church of England Mission and Public Affairs Council; Confederation of Indian Organisations; Democratic Health Network; Depression Alliance; Drugscope; East Dorset Mental Health Carers Forum; Family Action; Footprints (UK); General Medical Council; Haldane Society of Socialist Lawyers; Having a Voice; Homeless Link; Imagine; JAMI; Justice; Law Society; Liberty; Local Government Association; Manchester Race and Health Forum; Mencap; Nacro, NHS Confederation; Race on the Agenda; RADAR; Refugee Action; Royal College of General Practitioners; Sign; Social Action for Health; Social Perspectives Network; Somali Mental Health Project; Supporting Carers Better Network; UK Council for Psychotherapy; West Dorset Mental Health User Forum; WISH.

Acknowledgements

The Mental Health Alliance is very grateful for the assistance of Martyn Cooper at City and Hackney Mind, Martin Coyle at Action for Advocacy, Karen Newbiggin at the University of Central Lancashire and all the service providers who took part in the survey.

For enquiries about this report, contact:
m.vige@mind.org.uk

For enquiries about the MHA, contact:
Mental Health Alliance
c/o Richmond Fellowship, 80 Holloway Road, London N7 8JG

For general enquiries about IMHA contact:

MindinfoLine

MindinfoLine is able to provide information on a range of topics including types of mental distress, where to get help, drug and alternative treatments and advocacy. We are able to provide details of help and support for people in their own area.

T: 0845 766 0163 (local call rate)
Monday to Friday, 9.00am–5.00pm
e: info@mind.org.uk
w: www.mind.org.uk

MindinfoLine
PO Box 277
Manchester
M60 3XN

Rethink

The Rethink Advice and Information Service is a source of detailed advice covering a wide range of mental health problems. We can provide advice and information on a wide range of mental health issues including treatment, second opinions, money and debt, the law and rights, criminal justice issues, information for carers and help with court hearings.

T: 0845 456 0455
Monday–Friday 10.00am–2.00pm
e: advice@rethink.org
w: www.rethink.org

Action for Advocacy (A4A)

A4A is the central point for information on independent advocacy and has a range of publications to raise awareness of and support the development and delivery of effective advocacy.

T: 020 7921 4395
e: info@actionforadvocacy.org.uk
w: www.actionforadvocacy.org.uk

The Oasis Centre
75 Westminster Bridge Rd
London SE1 7HS



Mental Health Alliance