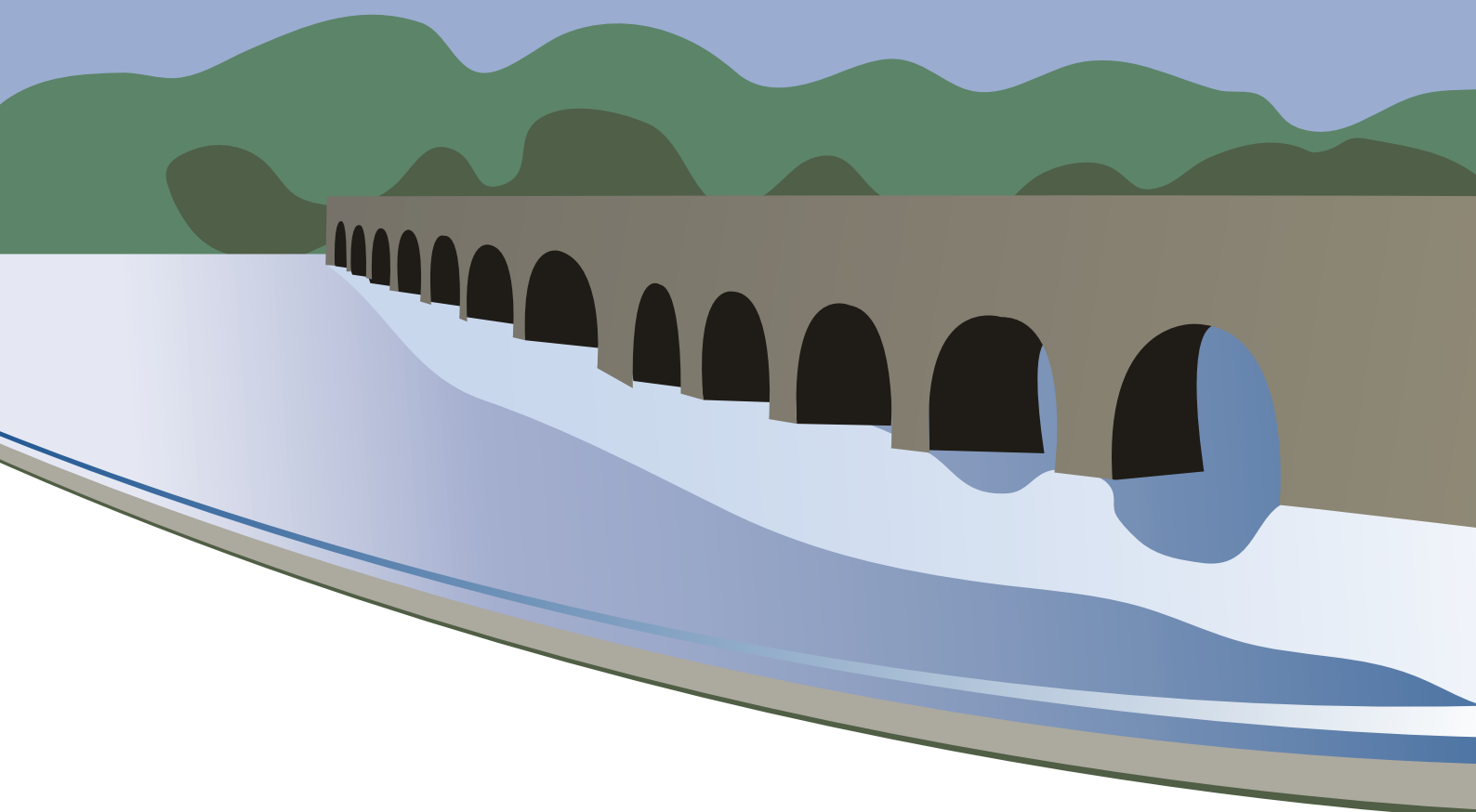




Llywodraeth Cymru  
Welsh Government

[www.cymru.gov.uk](http://www.cymru.gov.uk)



Delivering the Independent Mental Health  
Advocacy Service in Wales:

---

# Guidance for Independent Mental Health Advocacy Providers and Local Health Board Advocacy Service Planners

December 2011



# CONTENTS

<b>Part 1 – Introduction and overview</b> .....	<b>3</b>
Introduction.....	3
Overview of the Guidance .....	1
Funding for the expanded independent mental health advocacy scheme .....	2
<b>Part 2 – Background to the development of the independent mental health advocacy scheme</b> .....	<b>3</b>
Introduction.....	3
Different types of mental health advocacy .....	4
Legislative framework .....	5
<b>Part 3 – Overview of the independent mental health advocacy provisions in the 1983 Act</b> .....	<b>7</b>
Introduction.....	7
Duty to arrange advocacy services (section 130E).....	7
Eligible patients (sections 130I and 130J) .....	8
Principle of independence (section 130E(4) and (5)).....	9
The role of IMHAs (sections 130F and 130G) .....	10
Right of IMHAs to visit patients (section 130H(1)) .....	11
Duty of IMHAs to visit patients (section 130H(3) and (4)).....	11
Right of IMHAs to interview professionals and other persons, and look at records (section 130H(1) and (2)).....	12
Duty to inform patients about the availability of advocacy services (sections 130K and 130L) .....	13
Information for nearest relatives (sections 130K and 130L).....	13
<b>Part 4 – Operational considerations</b> .....	<b>15</b>
Introduction.....	15
Independence.....	15
The role of the IMHA.....	16
Independent mental health advocacy for informal/voluntary patients .....	19
Making a request for an IMHA .....	20
The healthcare service provider’s role in facilitating and supporting IMHAs .....	21
Patient choice .....	21
Providing support to qualifying patients who cannot instruct the advocate .....	22

Advocacy standards and the National Advocacy Qualification .....	22
<b>Part 5 – Suggested model of delivery.....</b>	<b>24</b>
Introduction .....	24
Scope of services .....	24
Building on existing independent mental health advocacy services and making use of local expertise.....	25
Assessing increased demand resulting from the expanded independent mental health advocacy scheme .....	26
Developing independent mental health advocacy as part of wider advocacy services .....	27
Service specifications and the tendering process .....	28
<b>Contact information .....</b>	<b>31</b>
<b>Glossary of terms and abbreviations .....</b>	<b>32</b>
<b>Further reading.....</b>	<b>33</b>
<b>Annex A – Extract of sections 130A to 130L of the Mental Health Act 1983 .....</b>	<b>34</b>
<b>Annex C – Guidance on developing a service specification .....</b>	<b>36</b>
<b>Annex D – Model Service Specification .....</b>	<b>48</b>
<b>Annex E – Example of an Engagement Protocol.....</b>	<b>57</b>

# Part 1 – Introduction and overview

## Introduction

1. Independent mental health advocates (“IMHAs”) have provided an important safeguard for patients treated under the compulsory powers of the Mental Health Act 1983 (“the 1983 Act”) since the scheme was introduced in Wales in 2008.
2. The scope of the independent mental health advocacy scheme under the 1983 Act is expanded in Wales, by Part 4 of the Mental Health (Wales) Measure 2010 (“the Measure”) to patients detained under certain short term sections of the 1983 Act and to informal (i.e. non-detained) inpatients receiving assessment or treatment for mental health problems in hospitals in Wales.
3. The expanded service will continue to be known as the Independent Mental Health Advocacy scheme, and will build upon the current arrangements for the provision of the service. The expanded scheme will continue to support patients under the compulsory powers of the 1983 Act (which will now include patients detained under certain short term sections), but will also act as important safeguard for patients receiving assessment or treatment for mental ill-health in hospital who have been admitted without recourse to the 1983 Act.
4. The expanded independent mental health advocacy scheme will provide help and support to all qualifying patients, irrespective of age or diagnosis, in relation to the care and treatment they receive for their mental disorder.

## Purpose of the guidance

5. This Guidance is provided to Local Health Boards (LHBs) and independent mental health advocacy providers to advise them on how they should proceed in the planning and provision of independent mental health advocacy services under the 1983 Act as amended by the Part 4 of the Measure.
6. The Guidance will also be useful to other advocacy providers, including those who would wish to provide independent mental health advocacy services in the future.

## Status of the guidance

7. This Guidance replaces the *Mental Health Act 1983 IMHA Guidance: Commissioning the Independent Mental Health Advocate service* which was issued to services by the Welsh Government to support the launch of the original independent mental health advocacy scheme in 2008.

## Overview of the Guidance

8. The Guidance is divided into five Parts, and in addition to this overview Part, provides details on:

- a. the background to the development of the independent mental health advocacy scheme (Part 2);
  - b. the main provisions of the 1983 Act and associated secondary legislation as they will stand when the majority of the amendments made by the Measure take effect (Part 3);
  - c. the duties and responsibilities of LHBs and independent mental health advocacy service providers in relation to the independent mental health advocacy scheme in Wales. It will be particularly relevant to those managers whose responsibilities include planning, procuring and monitoring the delivery of mental health advocacy services and those independent advocacy providers and individual advocates who are employed in the delivery of the expanded service. This is set out in Part 4 of the Guidance.
  - d. a suggested model of delivery, and an outline procurement process, designed to ensure that high quality independent advocacy services continue to be provided to qualifying patients. It includes advice for LHBs and independent advocacy providers in relation to the requirements which an advocacy organisation providing an independent mental health advocacy service will be expected to meet under the scheme in Wales, and in bidding for independent mental health advocacy contracts with LHBs (Part 5 of the Guidance).
9. There are associated Annexes to each of the Parts of this Guidance. In summary these are –

Annex A – Extracts of sections 130A to 130L of the 1983 Act

Annex B – The 2011 IMHA Regulations

Annex C - Guidance on developing a service specification

Annex D - Model Service Specification

Annex E - Example of an Engagement Protocol

### **Funding for the expanded independent mental health advocacy scheme**

10. The Welsh Government will continue to make funding available annually to LHBs to support the expanded independent mental health advocacy service, and LHBs will receive notification of resource allocations from the Welsh Government on an annual basis.

## Part 2 – Background to the development of the independent mental health advocacy scheme

### Introduction

11. Users of mental health services can experience difficulty negotiating with mental health professionals and ensuring that their own point of view is acknowledged. These difficulties apply both to the practical activities of daily life as well as help with their mental health problems. Service users sometimes have insufficient information about their mental ill-health and the various alternatives which may be available to them in relation to their treatment and care. Advocacy seeks to address this imbalance by ensuring that the service user's voice is heard, that they are able to make informed choices, and that their rights are safeguarded.

12. Evidence shows that advocacy can lead to an improved experience of mental health services for individuals, including *“the potential for advocacy to secure basic rights; create choice; improve the identification and understanding of mental health needs; promote self-advocacy and involvement in decision making; challenge discrimination; and promote access to complimentary ways of healing and practical help”*<sup>1</sup>.

13. The Welsh Government is committed to working with services to ensure that advocacy is available for individuals at times when their mental health and usual support mechanisms may be breaking down, leaving them vulnerable when key decisions about treatment and support may need to be made.

14. Whilst the Independent Mental Health Advocacy scheme introduced in November 2008 established statutory advocacy arrangements for many detained patients in Wales, it did not provide equivalent legal provisions for individuals detained in hospitals under the ‘short term’ sections of the Mental Health Act 1983 (“the 1983 Act”), or those receiving inpatient services for mental health problems on a voluntary basis in Wales.

15. The Mental Health (Wales) Measure 2010 (“the Measure”) included provisions which amend the 1983 Act, so as to expand the scope of the independent mental health advocacy scheme in Wales. The scope of the scheme will now include individuals detained in hospital under certain ‘short-term’ sections of the 1983 Act, and those in inpatient settings in Wales receiving assessment or treatment for mental ill-health on a voluntary or informal basis. The Measure also amended the 1983 Act to provide a form of independent mental health advocacy in Wales which is broader in scope – the range of help and support that an independent mental health advocacy in Wales can provide is wider than originally set out in the legislation.

16. By expanding statutory advocacy services so that access is available to the majority of inpatients receiving treatment for mental ill-health, whether subject to compulsory powers or not, the Welsh Government is seeking to ensure that the rights of this often vulnerable group of patients are safeguarded. The expanded

---

<sup>1</sup> Newbigging, K et al (2007) *Mtetezi: Developing mental health advocacy with African and Caribbean Men* London: Social Care Institute for Excellence

independent mental health advocacy scheme will assist inpatients in making informed decisions about their care and treatment, and support them in getting their voices heard.

## **Different types of mental health advocacy**

### **Professional or representational advocacy**

17. The model of advocacy discussed in relation to independent mental health advocacy services is that of independent professional or representational advocacy. In this model, advocates have paid employment with an independent advocacy service. Advocates may support individuals or groups, but their support will be time-limited and focused on dealing with specific issues or problems. Wherever possible, advocates will support individuals to develop the skills and confidence to advocate for themselves, but when asked to do so, advocates will represent the views of those they are supporting.

18. The reasons why this model of advocacy is appropriate for independent mental health advocacy provision are:

- Advocates will be paid employees;
- Advocates will be required to complete specified training and undertake continuous professional development;
- Advocates will maintain a clear focus on the advocacy task;
- Advocates will be held accountable to their manager for delivering advocacy to agreed policies and procedures and to an agreed code of practice (if one is in place);
- Advocates will be required to attend supervision and undergo regular appraisal.

### **Instructed and non-instructed advocacy**

19. Wherever possible, advocates will take instruction from the person that they are supporting. An advocate may help an individual to obtain information, explore options and carry out action but, throughout this process, the advocate will be directed by the individual and only act on their behalf. The advocate's role is to make sure the wishes of the individual are expressed and heard.

20. However, advocates also work with people who are unable to express their wishes clearly, or at all, because of a lack of mental capacity to instruct, or communication difficulties of some kind. These people are often very vulnerable and in need of an independent presence in decision-making, to safeguard the wishes and feelings that they are unable to express. Historically, other people tend to make decisions on the behalf of such individuals, and although they may be surrounded by very skilled and caring professionals and members of their family, there is a risk that the individual's wishes and preferences will be overlooked.

18. When in receipt of care and treatment, people who lack capacity can experience significant disadvantage. For example, they may lack the ability to:



- Refuse treatment;
- Engage with the development of their care plans;
- Decide who will be involved in delivering their care;
- Decide where and with whom they will live;
- Instruct other parties such as advocates, next of kin, solicitors etc in making decisions that affect them.

19. Some of the benefits of non-instructed advocacy are:

- Providing a safeguard against abuse of rights;
- Ensuring that services address every aspect of the person's care and treatment;
- Ensuring parity between people who can instruct advocates and those who cannot;

20. Advocates have developed a range of approaches to providing this non-instructed support which may involve:

- getting to know the individual over time and learning how to communicate with them;
- learning about their past;
- observation;
- scrutiny of case notes;
- talking with paid carers, families and friends

21. The Independent Mental Capacity Advocate (IMCA) created by the Mental Capacity Act 2005, is another form of statutory advocacy which protects people who lack capacity in specific situations. Importantly, not all qualifying patients with mental health problems who lack capacity will qualify for the IMCA service. Therefore, knowledge of the interface between the Mental Health Act 1983 and the Mental Capacity Act 2005 will be important both for IMCAs and IMHAs.

## **Legislative framework**

The Mental Health Act 1983

22. The Mental Health Act 1983 governs the compulsory treatment of certain people who have a mental disorder in England and Wales. In 2007 the UK Parliament made a number of amendments to the 1983 Act. One of the key amendments was the addition of sections 130A to 130D, which introduced the independent mental health advocacy scheme in England and Wales.

23. In Wales, the independent mental health advocacy provisions came into effect in November 2008. Since that time LHBs have been required to make provisions for independent mental health advocacy services to be available to provide support for certain categories of qualifying patients who are receiving assessment or treatment under the 1983 Act.

24. Part 4 of the Mental Health (Wales) Measure 2010 amends the 1983 Act, so as to provide an expanded statutory scheme of independent mental health advocacy, both for the majority of patients subject to the powers of the 1983 Act, and those receiving inpatient treatment for mental disorder in hospital on an informal - or voluntary - basis (i.e. not subject to the powers of the 1983 Act).

25. An overview of the relevant provisions of the 1983 Act, as amended, is set out in Part 3 of this Guidance.

### **Subordinate legislation (the “IMHA Regulations”)**

26. The Mental Health (Independent mental Health Advocates) (Wales) Regulations 2011 were made by the National Assembly for Wales in 2011. These set out certain arrangements and requirements in relation to independent mental health advocacy within Wales.

27. The regulations set out that LHBs will continue to be responsible for commissioning IMHA services for their areas, that individuals acting as advocates must have appropriate experience and training, and that they must be independent of any person involved with the medical treatment of the client and of the LHB which commissions the service.

### **The Mental Health Act 1983 Code of Practice for Wales**

28. The *Mental Health Act 1983 Code of Practice for Wales*<sup>2</sup> was prepared and issued under section 118 of the 1983 Act by the Welsh Ministers in 2008. It was provided as guidance to certain practitioners (including doctors, approved clinicians, approved mental health professionals and hospital managers) on how they should proceed when undertaking functions and duties under the 1983 Act.

29. The Welsh Government is currently considering the implications of the Measure for the current Code of Practice for Wales. It is intended that the Code will be revised and issued for consultation during 2012.

---

<sup>2</sup> Welsh Government (2008)

## **Part 3 – Overview of the independent mental health advocacy provisions in the 1983 Act**

**NOTE: This Part of the Guidance is not intended as a complete description of every aspect of the relevant sections of the Mental Health Act 1983 and must not be relied on as a definitive statement of the law. It is not a substitute for consulting the Act itself or for taking legal advice.**

### **Introduction**

33. This section of the guidance describes the provisions in the Mental Health Act 1983 (“the 1983 Act”) relating to independent mental health advocacy services in Wales.

34. Part 4 of the Mental Health (Wales) Measure amended the 1983 Act in relation to independent mental health advocacy in Wales. The effect of the amendments was to separate the elements of the 1983 Act dealing with independent mental health advocacy in Wales from the related elements dealing with the scheme in England. This required the amendment of certain sections of the 1983 Act to apply in relation to England-only, and the addition of a number of additional sections which deal solely with arrangements in relation to Wales.

35. An extract of the 1983 Act showing the effect of the amendments made by the Mental Health (Wales) Measure in respect of sections 130A to 130L is included in Annex A to this guidance.

### **Timescales**

36. The provisions of the 1983 Act that are currently in force (section 130A to 130D) will continue to remain in force until the new provisions (sections 130E to 130L) commence in relation to Wales.

37. The new provisions will come into force in two stages:

- a. the first stage, relating to compulsory patients, will come into force on 3 January 2012;
- b. the second stage, relating to informal patients, will come into force on 2 April 2012.

38. The remainder of this part of the guidance is written to explain the provisions in relation to Wales as though they are already in force.

### **Duty to arrange advocacy services (section 130E)**

39. Section 130E enables the Welsh Ministers to make such arrangements as they consider reasonable to ensure that IMHAs are available to help eligible patients. Eligible patients fall into two groups:

- a. Welsh qualifying compulsory patients; and,
- b. Welsh qualifying informal patients.

### **Arrangements for independent mental health advocacy services**

40. In practice, advocacy services are arranged locally, rather than directly by the Welsh Ministers. The IMHA regulations set out requirements in relation to the provision of the service, with Regulation 3 placing responsibility upon LHBs to make IMHAs available to qualifying patients within their area. LHBs may make arrangements with advocacy providers for the provision of services and Regulation 4 requires them to be satisfied that any individual acting as an IMHA has appropriate experience or training and is of integrity and good character, whilst Regulation 5 requires IMHAs to be independent of any person concerned with the medical treatment of the patient, or any person who has made the request for an advocate. Regulation 5 also states that LHBs may not appoint a member of their own staff as an IMHA.

### **Eligible patients (sections 130I and 130J)**

41. Individuals are eligible for independent mental health advocacy services if they fall within the meaning of a Welsh qualifying compulsory patient (set out in section 130I of the Measure) or the meaning of a Welsh qualifying informal patient (set out in section 130J of the Measure).

### **“Welsh qualifying compulsory patients”**

42. A Welsh qualifying compulsory patient is a person who is:
- a. detained under the 1983 Act (which includes patients on leave of absence from hospital) in a hospital or registered establishment situated in Wales;
  - b. conditionally discharged;
  - c. subject to guardianship and the responsible local social services authority is situated in Wales; or
  - d. subject to supervised community treatment (SCT), the responsible hospital for them is situated in Wales.
43. This includes patients who are:
- a. detained for assessment on the basis of an emergency application (section 4); or
  - b. detained under the “holding powers” in section 5 of the 1983 Act.
44. It does not include a person detained in a place of safety under section 135 or 136 of the 1983 Act.
45. Other patients are eligible as Welsh qualifying compulsory patients if they are:

- a. being considered for a treatment to which section 57 applies (“a section 57 treatment”) whether they are detained under the 1983 Act or not; or
- b. under 18 and being considered for electro-convulsive therapy (ECT) or any other treatment to which section 58A applies (“a section 58A treatment”), again whether they are detained under the 1983 Act or not.

46. Patients who qualify because they are being considered for one of these treatments remain eligible until the treatment is finished (or stopped), or it is decided that they will not be given the treatment for the time being.

*Note: When determining whether a patient is a Welsh qualifying compulsory patient on the grounds of the treatment provisions (set out in paragraph 45 above), regard must be had to any arrangements made and published by the Secretary of State and the Welsh Ministers. At the time of publication of this guidance no such arrangements have been made.*

### **“Welsh qualifying informal patients”**

47. A Welsh qualifying informal patient is a person who is:

- a. an in-patient in a hospital or registered establishment<sup>3</sup> situated in Wales;
- b. is receiving treatment for, or assessment in relation to, mental disorder at that hospital or registered establishment; and
- c. is not subject to powers under the 1983 Act who would render them liable to be detained.

### **Inpatients with a learning disability**

48. The Welsh Government's position in relation to individuals with a learning disability who are receiving assessment, care or treatment for that learning disability whilst an inpatient (i.e. as a Welsh qualifying informal patient) is that such individuals would qualify for support from an IMHA - provided that their learning disability is of the type or degree which is viewed as a mental disorder.

49. Part 4 of the Measure makes provision for the expanded IMHA scheme in Wales by inserting new sections into the 1983 Act. This means that the definition of "mental disorder" relied on for the purposes of these new sections is the definition of 'mental disorder' provided at section 1(2) of the 1983 Act i.e. "a disorder or disability of the mind".

### **Principle of independence (section 130E(4) and (5))**

50. When making arrangements for advocacy, the Welsh Ministers must have regard to the principle that IMHAs should, so far as is practicable, be independent of

---

<sup>3</sup> 'Registered Establishment' means an establishment in respect of which a person is registered under Part II of the Care Standards Act 2000 as an independent hospital in which treatment or nursing (or both) are provided

the professionals currently involved in the medical treatment of the patient they are helping<sup>4</sup>, and any other persons specified in regulations.

51. In this context, people are not considered to be professionally concerned with a patient's treatment if their only involvement with that treatment is acting as an advocate for the patient in connection with the treatment. "Advocate" here includes independent mental capacity advocates (IMCAs) helping people under the Mental Capacity Act 2005.

52 Regulations 4 and 5 of the IMHA regulations require that any person acting as an IMHA be independent from those providing medical treatment to the patient, and must not be an employee of the LHB where they are providing the service.

53 As patients detained section 4 of the 1983 Act are able to request support from an IMHA under the expanded scheme, Regulation 5 also states that the IMHA must be independent of the AMHP or nearest relative who made the section 4 application, and the doctor who provided the section 4 medical recommendation.

### **The role of IMHAs (sections 130F and 130G)**

54 The help which independent mental health advocates are to provide must include helping all eligible patients to obtain information about, and understand:

- a. what (if any) medical treatment is being given to the patient or is being proposed or discussed in the patient's case;
- b. why such treatment is being given, proposed or discussed;
- c. the authority under which it is, or would be, given.

55 IMHAs can also help eligible patients:

- a. to become involved, or more involved, in decisions made about their care or treatment specifically, or more generally, decisions about care and treatment;
- b. to complain about their care or treatment;
- c. to receive information about other services which are or may be available to them.

56 In giving this help, the IMHA may represent the patient and speak on their behalf. But independent mental health advocates are not designed to take the place of advice from, or representation by, qualified legal professionals about such matters.

---

<sup>4</sup> The 1983 Act describes this as being independent of "any person who is professionally concerned with the patient's medical treatment".

57 For Welsh qualifying compulsory patients, in addition to the help and support outlined above, the IMHA may provide help to the patient in obtaining information about and understanding –

- a. their rights under the 1983 Act (and the IMHA may help the patient exercise those rights);
- b. the rights which other people have in relation to them under the 1983 Act (e.g. any right their nearest relative has to discharge them);
- c. the particular parts of the 1983 Act which apply to them (e.g. the basis on which they are detained) and which therefore make them eligible for advocacy;
- d. any conditions or restrictions to which they are subject (e.g. as a condition of leave of absence from hospital, of a community treatment order or of conditional discharge).

### **Right of IMHAs to visit patients (section 130H(1))**

58 IMHAs may visit and interview the patients they are helping in private. Anyone who prevents them doing so without reasonable cause would be guilty of the offence of obstruction under section 129 of the 1983 Act.

### **Duty of IMHAs to visit patients (section 130H(3) and (4))**

59 IMHAs must comply with any reasonable request to visit and interview a Welsh qualifying compulsory patient, if the request is made by:

- a. the patient themselves;
- b. someone the IMHA believes to be the patient's nearest relative;
- c. the patient's responsible clinician (if they have one);
- d. an approved mental health professional (AMHP);
- e. a registered social worker who is professionally concerned with the patient's care, treatment or assessment;
- f. the managers of the hospital (or a person duly authorised by them) where the patient is liable to be detained (if this is the grounds for the person being eligible for independent mental health advocacy);
- g. the patient's donee or deputy (if they have one).

60. In respect of Welsh qualifying informal patients, the duty on IMHAs to visit and interview the patient is the same, but is only engaged if the request is made by:

- a. the patient themselves;
- b. the managers of the hospital or establishment (or a person duly authorised by them) where the patient is an in-patient;
- c. someone the IMHA believes to be the patient's carer;
- d. the patient's donee or deputy (if they have one).

- e. a registered social worker who is professionally concerned with the patient's care, treatment or assessment;

61. In this context, a carer is an individual who provides (or intends to provide) a substantial amount of care on a regular basis for the patient. This meaning does not include any individual who provides, or intends to provide, this care because of a contract of employment, other type of contract, or as a volunteer.

62. In relation to donees and deputies, the duty on the IMHA only arises if the request made is within the scope of the authority of the donee or deputy to make it.

63. In all cases, although the IMHA is under a duty to visit and interview the patient, the patient may refuse to be interviewed and does not have to accept help from an IMHA if they do not want it.

### **Right of IMHAs to interview professionals and other persons, and look at records (section 130H(1) and (2))**

64. IMHAs have the right to visit and interview any person who is currently professionally concerned with a patient's medical treatment, provided it is for the purpose of supporting the patient.

65. For patients detained under section 4 of the 1983 Act, the IMHA also has the right to visit and interview the AMHP or nearest relative who made the application for detention, and the doctor who gave the medical recommendation on which the application for detention was founded (where such persons are not also professionally concerned with the medical treatment of the patient).

66. IMHAs may also request sight of records relating to a patient's detention, treatment or assessment in any hospital or registered establishment, or after-care services provided under section 117 of the 1983 Act, as well as any records made or held by a local social services authority (LSSA) which relate to the patient.

67. But if the patient has capacity to decide whether the advocate should see the records, IMHAs may see them only if the patient has consented.

68. Otherwise, where patients cannot consent (because they lack the capacity or, in the case of a child, the competence to do so), IMHAs may access the records only if:

- a. it would not involve anyone going against a decision made on the patient's behalf in accordance with the Mental Capacity Act 2005 by a donee of lasting power of attorney or a deputy, or a decision of the Court of Protection; and
- b. the person holding the records (the "record-holder") thinks that the records are relevant to the help which the advocate is providing to the patient and that it is appropriate to let the advocate see them.



## Duty to inform patients about the availability of advocacy services (sections 130K and 130L)

69. Certain people (known in the 1983 Act as the “responsible person”) have a duty to take whatever steps are practicable to ensure patients understand that help is available to them from independent mental health advocacy services and how they can obtain that help (as set out in the table below). This must include giving the relevant information both orally and in writing.

Type of patient	Steps are to be taken by	as soon as practicable after
Detained patients	the managers of the hospital in which the patient is liable to be detained	the patient becomes liable to be detained
Guardianship patients	the responsible LSSA	the patient becomes subject to guardianship
SCT patients	the managers of the responsible hospital	the patient becomes an SCT patient
Conditionally discharged patients	the patient's responsible clinician	the patient is conditionally discharged
Informal patients receiving particular treatments (under section 57 or 58A)	the doctor or approved clinician who first discusses with the patient the possibility of them being given the section 57 or 58A treatment in question	this discussion (or during it)
Informal patients	the managers of the hospital to which the patient has been admitted	the patient becomes an in-patient

70. If the legal status of a patient changes after the responsible person has provided information on the advocacy service to them, for example the patient was an informal patient but subsequently was detained in the same hospital under section 3 of the 1983 Act, the duty on the responsible person arises again. This remains the case where there is also no change in who the responsible person is.

### Information for nearest relatives (sections 130K and 130L)

71. The responsible person for a Welsh qualifying compulsory patient, must also take whatever steps are practicable to give a copy of the written information to:

- a. the person they think is the patient's nearest relative;
- b. a donee of a lasting power of attorney; and
- c. a deputy appointed by the Court of Protection.

72. The responsible person for a Welsh qualifying informal patient, must also take whatever steps are practicable to give a copy of the written information to:

- a. the person they think is the patient's carer;
- b. a donee of a lasting power of attorney; and
- c. a deputy appointed by the Court of Protection.

73. In all cases this information should be given unless the patient requests otherwise. In the case of a donee or deputy, the information should only be given where the scope of the donee or deputy's authority includes matters relating to the care and treatment of the patient.

74. The information can be given to the nearest relative, carer, donee and/or deputy either when it is given to the patient or within a reasonable time afterwards.

75. The duty to give information to nearest relatives will not apply to informal patients or to patients (whether restricted or unrestricted) who are liable to be detained on the basis of an order or direction under Part 3 of the Act (e.g. a hospital order or transfer direction), including those who have been conditionally discharged. It does apply to patients subject to guardianship orders under Part 3, patients who are considering treatment under sections 57 or 58A of the Act, and to SCT patients who were formerly detained under Part 3.

## Part 4 – Operational considerations

### Introduction

76. This Part of the Guidance provides information on the some of the operational considerations which LHBs and independent mental health advocacy service providers need to consider in relation to the delivery of the scheme in Wales.

### Independence

77. At the heart of independent mental health advocacy is the concept of independence: this is clearly stated in both the 1983 Act and the associated subordinate legislation.

78. The independent mental health advocacy service is designed to provide safeguards for patients and it is imperative that the advocates providing the service should be free to support qualifying patients, without any conflicts of interest, and to appropriately challenge service providers on the patient's behalf.

79. The subject of such challenge may be very broad and can include:

- decisions made about a patient's care and treatment;
- the upholding of a patient's mental health and legal rights;
- the quality of care and treatment being provided.

80. Advocates are partial in that they will support a patient in whatever action that patient decides to take. An advocate will help a patient to understand his or her rights and the choices of action that are available, but ultimately, any decisions taken will be the patient's own.

81. Often the support provided by advocates will be similar to that provided by mental health or social care professionals in the course of their work, but there are some important differences of approach:

- a. Such professionals owe patients a legal duty of care and will use their professional judgement to assess how a patient is and how a patient's illness might be impacting on their actions. Using this judgement, staff are required to act in a patient's best interests. The role of the IMHA, by contrast, is to support the patient's own views or wishes, even where these may be different to, or conflict with, the best interests of the patient as perceived by the mental health or social care professionals;
- b. Health and social care professionals are required to act according to the policy and procedures of their employers. Hence they have to work within policy and financial constraints and may not be able to promote or offer what is being requested by the patient.

82. For advocates to be effective they need to be able to work outside these constraints and within the framework of their own professional practice. However, this independence is not always understood by mental health or social care professionals. Therefore, it is very important that the principle of independent advocacy is clearly acknowledged and supported by those procuring services and mental health and social care providers and practitioners with whom the advocates will be working.

83. The 1983 Act and the IMHA regulations state that IMHAs must be able to act independently of any person who is professionally concerned with the patient's medical treatment, and able to act independently of any person who makes a request for an IMHA to visit or interview a patient. The IMHA regulations also require that an IMHA must not be an employee (i.e. employed under a contract of service) of the LHB where they are providing an advocacy service.

84. Independence should be built into all stages of independent mental health advocacy provision, including:

- a. the service level agreement and/or engagement protocol entered into between the LHB and the advocacy provider;
- b. the establishment of appropriate feedback arrangements so that the independent mental health advocacy service can report concerns to the healthcare provider on both a regular and urgent basis, while maintaining the anonymity (where necessary) of qualifying patients;
- c. independent mental health advocacy service governance arrangements which reinforce the independence of its management.

85. Independent mental health advocacy providers should also ensure that independence is maintained through appropriate:

- a. work practice;
- b. appropriate relationships with mental health staff and professionals;
- c. publicity material;
- d. agreed patient confidentiality policies.

### **The role of the IMHA**

86. Independent advocacy is regarded as an important safeguard for those individuals who are receiving care and treatment for mental health problems. At one level, independent advocates provide the kind of support that individuals might ordinarily receive from partners, friends or family members, with whom dilemmas might be discussed and whom individuals might ask to accompany them to difficult meetings or consultations.

87. However, individuals receiving care and treatment for mental health problems often do not have easy access to this kind of informal support. For example, they may be in inpatient care, living away from home, or have difficulty sustaining

relationships because of their mental health problems. In some circumstances, perhaps within a secure mental health facility, an independent advocate may be the only person a patient has ready access to who is not employed by the hospital or involved in the patient's care and treatment.

88. Even where patients are able to access informal support networks, family members or friends may on occasions encourage the patient to agree to treatments or approaches proposed by health professionals which the patient themselves may not wish to undertake. In such situations, the fear of upsetting or alarming friends or relatives may prevent patients from revealing their true state of health, their fears or their wishes regarding treatment. It is in circumstances such as these that the full benefits of independent and non-directive mental health advocacy are often realised.

89. In providing support to qualifying compulsory and informal patients, the IMHA will:

- a. ensure that the voice of the patient is heard, by supporting the patient to articulate their views and to engage with the multi-disciplinary team;
- b. help patients to access information, and to understand better what is currently happening and what is being planned, and to understand better the options available to them;
- c. support patients in exploring options, making better-informed decisions and in engaging with the development of their care plans;
- d. support the patient to ensure that they are valued for who they are;
- e. support the patient to counteract any actual or potential discrimination.

90. Key points at which IMHAs may be able to provide support for qualifying compulsory and informal patients might include:

- a. as soon as is practicable after the patient's arrival in an inpatient unit, to provide support and understanding of the situation from an independent person who is familiar with the hospital environment and mental health system;
- b. as soon as is practicable after any patient who was initially admitted for a reason other than a mental health problem has been informed that they will be receiving assessment or treatment for a mental health problem whilst an inpatient;
- c. prior to meetings or ward rounds at which the patient's care and treatment is discussed, to prepare what they want to say and explore alternatives to the proposed treatment;
- d. at meetings or ward rounds, either to provide support, or to attend in place of the patient to represent their views;
- e. when the patient is concerned about their care or treatment, for example their medication, and would like the support of an IMHA to

arrange a meeting with their doctor (or in the case of compulsory patients, their responsible clinician);

- f. when their initial care and treatment plan is being developed and agreed with the patient's care coordinator, or during any review or revision of the patient's care and treatment plan;
- g. when the patient wants support to access relevant records, including their own health or social care records;
- h. when the patient wants to express concern about any aspect of their hospital experience or access the complaints process;
- i. when they want support in accessing other services;
- j. prior to discharge, so that they can explore all their options and raise concerns about appropriate after-care.

91. In addition, in relation to qualifying compulsory patients, the IMHA may also be able to provide support in the following situations or circumstances:

- a. as soon as is practicable after the patient has been admitted or transferred to the hospital under the assessment or treatment provisions of the 1983 Act, or held in that hospital under section 5(2) or 5(4), to provide support and understanding of the situation from an independent person who is familiar with the hospital environment and mental health system;
- b. when the patient is to be visited and examined by a Second Opinion Appointed Doctor;
- c. when applying for a Hospital Manager's hearing;
- d. when applying for a Mental Health Review Tribunal for Wales hearing, obtaining legal representation, having support at a hearing or help in understanding the directions made by the Tribunal;
- e. when plans are being made for leave of absence under section 17 of the 1983 Act;
- f. when plans are being made for a patient's discharge onto Supervised Community Treatment (SCT);
- g. when they are subject to recall;
- h. when considering their rights in relation to their nearest relative, including their right to seek to displace their nearest relative through the County Court.

92. The nature of the IMHA role can also sometimes bring difficulties for those individuals delivering the service. On occasions, advocates may find themselves supporting qualifying patients when they think an action is unwise or may not be in the patient's best interests - for example, taking a minor issue through the formal NHS complaints procedure at the patient's request when the advocate is certain that the matter could be cleared up faster and more effectively through local resolution, or seeking early discharge from a hearing by the Mental Health Review Tribunal for Wales. Whilst the advocate would be perfectly correct to suggest a more

appropriate course of action in such instances, the advocate's ultimate role is to support the patient's decision.

93. There can also be occasions when potential conflicts of interest might arise for an IMHA. Situations of this nature need to be informed by the independent mental health advocacy provider's Conflicts of Interest policy.

94. Save for exceptional circumstances, advocacy services cannot choose when, or when not, to support a patient. If the request for the support is reasonable, and an advocate agrees to support a patient, they will provide this support and/or representation even if they do not agree with the action decided on by the patient. Exceptional circumstances may include safety issues for the advocate, or the advocate knowing the patient personally. Any exceptional circumstances should be immediately reported to the appropriate Local Health Board where the advocacy service is not able to provide a service. The Local Health Board will look to resolve such issues to ensure that the patient receives appropriate independent mental health advocacy support.

### **Independent mental health advocacy for informal/voluntary patients**

95. As well as broadening the scope of the independent mental health advocacy scheme in relation to individuals detained under the 1983 Act, the Measure expands the advocacy scheme to make statutory independent advocacy available for all inpatients who are receiving assessment or treatment for mental disorder in Wales, including those in non-mental health settings (i.e. general wards). Patients who fall within this category are referred to in the 1983 Act, and in this Guidance, as 'Welsh qualifying informal patients'.

96. The independent mental health advocacy service is available to hospital inpatients of all ages who are being assessed or given treatment for a mental disorder. This includes patients for whom assessment or treatment for a mental disorder is not the primary purpose for which they have been admitted (for example, an older person admitted to a general hospital for hip replacement surgery, but who is also suffering with dementia, may receive support from an IMHA in relation to any care and treatment provided in hospital in response to needs arising from the dementia).

97. A Welsh qualifying informal patient will be entitled to the support of an advocate as soon as they are admitted to a hospital, and will continue to be eligible for that support for as long as they are being assessed or receiving treatment for a mental disorder as an inpatient.

98. If further support is required following discharge, the patient should be referred on to existing non-statutory community advocacy services.

99. The support provided by the IMHA will only be in relation to issues connected to care and treatment of the patient's mental disorder. This applies even where the primary purpose for the individual's admission was not for a mental health condition, or where the patient is receiving care or treatment for co-occurring physical health problems.

## **Making a request for an IMHA**

100. Under the 1983 Act, IMHAs are under a duty to respond to reasonable requests made by particular persons for them to visit and speak with the patient (more information is given in Part 3 on this). However even where requests are made by persons other than those named in the Act, the IMHA should still consider attending and meeting with the patient.

101. Operation of the independent mental health advocacy scheme since 2008 has shown that a number of requests for support also originate as a result of IMHAs proactively making themselves known to qualifying patients. Healthcare providers should therefore ensure that this practice is facilitated, as it ensures that support is made available to qualifying patients who may lack the confidence, or feel unable to request support from an advocate for other reasons.

## **Responding to a request for an IMHA**

102. In response to referrals, IMHAs will visit and interview the patient, but they will only work with qualifying patients who wish to see them. The engagement protocol agreed between the LHB and the advocacy provider should set out the minimum standards required in terms of response times, but it is recommended that the service specification should require that all referrals (except those relating to detentions under sections 4, 5(2) or 5(4), for which see paragraph 103 below) will receive an appropriate response within 5 working days.

103. Requests made in relation to qualifying compulsory patients who are detained under sections 4, 5(2) or 5(4) of the 1983 Act should be prioritised by both the responsible person making the request and the independent mental health advocacy service provider responding to the request. As these sections are of a short duration – a maximum of 6 hours in the case of section 5(4) and 72 hours in the case of sections 4 and 5(2) - it is important that the advocacy provider be promptly informed of any such requests, and that they respond to such requests as soon as is reasonably practicable. The aim in such cases should be to ensure that, wherever possible, the patient is visited by the IMHA during the period of their initial detention.

## **Risk and Safety**

104. When responding to requests or visiting qualifying patients, either in community or inpatient settings, advocates should always check with relevant staff whether there are any issues of risk which they should be aware of, including any potential risks relating to the personal safety of the advocate, the patient themselves, or any other person.

105. Advocates will respond appropriately to any information provided to them by relevant staff concerning matters of safety or risk.



## **The healthcare service provider's role in facilitating and supporting IMHAs**

106. The model service specification and engagement protocol appended to this guidance recommends that independent mental health advocacy providers and healthcare service providers work together to ensure that the principles of the scheme are disseminated to, and understood by staff on general wards, as well as mental health units, so that those staff can ensure that patients are able to access independent mental health advocacy services (including by passing on requests from patients in a timely manner).

107. Healthcare service providers who are responsible for the assessment, care and treatment of qualifying patients should make provisions to ensure that the IMHA is able:

- a. to see a patient in private, unless the patient is under close observation or in seclusion, or clinical staff advise against it for reasons of the advocate's or the patient's safety;
- b. to attend relevant meetings at the request of the qualifying patient;
- c. to visit patients based in the community at the place where they are resident, subject to good practice, or in appropriate settings such as at the local community mental health team premises;
- d. to meet with professionals involved with the patient's care in order to promote the patient's involvement in his/her care and treatment. The IMHA can talk to the professional without the patient's permission but, unless the patient requests it, the professional will be unable to disclose any confidential information;
- e. to access, in accordance with the provisions of the 1983 Act, those parts of a patient's health records relevant to detention, treatment or after-care;
- f. to access, in accordance with the provisions of the 1983 Act, the patient's social care records.

### **Patient choice**

108. Patients who qualify for the independent mental health advocacy service should be informed that they have choices. For example, when the responsible person is making the patient aware of their entitlement to an IMHA, they should also let them know that at any future point they are able to request an advocate other than the individual who may be initially appointed to act on their behalf, if they so wish.

109. Similarly, service providers should ensure that they inform the patient they are able to request an alternative advocate to act on their behalf if they are not satisfied with the support which is currently being provided to them.

110. More widely, it should be made clear to all qualifying patients that the involvement of an IMHA does not affect their right to access legal aid or seek advice from a solicitor. However, in circumstances where a patient has indicated that they

do not wish to be supported by an IMHA, or that they wish to be supported by someone else who will act as an independent advocate for them, it should be explained to both the patient and any such advocate that the rights and duties given to the IMHA can only be exercised by those commissioned to provide the independent mental health advocacy service. Other independent advocates or representatives will not enjoy the same legal rights or powers as an IMHA.

### **Providing support to qualifying patients who cannot instruct the advocate**

111. Wherever possible, IMHAs will take instructions directly from the patient whom they are supporting. Where this is not possible, because the patient is unable (for whatever reason) to instruct an advocate, the role of the IMHA is to:

- a. Support the patient to participate as fully as possible in any relevant decision;
- b. Ascertain what alternative courses of action are available in relation to the patient;
- c. Ensure the patient's rights are respected.

112. In such circumstances, the IMHA should have a sound knowledge and understanding of the principles of the Mental Capacity Act 2005 as this relates to qualifying patients who may lack capacity, including the guidance contained in the *Mental Capacity Act 2005 Code of Practice*<sup>5</sup>.

113. Where a patient lacks capacity, or cannot, for any reason clearly say whether or not they would like an IMHA, the responsible person and other staff working with the patient should consider how an IMHA might be involved and whether or not the patient might benefit from the involvement of an IMHA. In doing so, staff should pay particular attention to the views of people supporting the patient and any views the patient has previously expressed.

114. The nearest relative, donee or deputy of a Welsh qualifying compulsory patient and the carer, donee or deputy of a Welsh qualifying informal patient are also able to request an IMHA to engage with a patient, as per paragraphs 60 to 63 above.

115. Health or social care professionals involved with the patient may wish to discuss the benefits of requesting an IMHA with the patient's nearest relative, carer, donee or deputy (as the case may be).

### **Advocacy standards and the National Advocacy Qualification**

116. The IMHA regulations enable Welsh Ministers to set standards and requirements in guidance in relation to those persons who will be delivering the independent mental health advocacy service in Wales.

117. The Welsh Government expects that, in developing service specifications and agreeing engagement protocols for the expanded scheme, LHB service planners

---

<sup>5</sup> Department for Constitutional Affairs (2007)

and advocacy providers should have regard to the Quality Indicators of the Action for Advocacy Quality Performance Mark<sup>6</sup>..

118. These indicators provide a widely-recognised and accepted benchmark against which service specifications should be planned and monitored.

119. It is expected that those independent mental health advocacy services who provide IMHAs on behalf of LHBs in Wales should also have either attained, or be working towards achieving, the Action for Advocacy Quality Performance Mark (QPM)<sup>7</sup>.

120. In addition, advocacy service planners and providers should ensure that all individuals who are delivering the independent mental health advocacy scheme in Wales have either attained, or be working towards, the City and Guilds Level 3 Certificate in Independent Advocacy.

121. All IMHAs should, as a minimum requirement, have successfully completed the IMHA specialist Level 4 unit of the Qualification, or have attained this unit within 18 months of their appointment as an IMHA.

122. Where an IMHA is likely to be providing advocacy services to individuals below the age of 18, that advocate should also have attained, the Independent Advocacy with Children and Young People Level 4 specialist unit, or have attained this unit within 18 months of their appointment as an IMHA.

123. These requirements should be clearly set out in the service specification issued by LHBs and in any engagement protocol agreed between the LHB and the advocacy service provider.

---

<sup>6</sup> <http://www.actionforadvocacy.org.uk/articleServlet?action=display&article=1445&articletype=60>

<sup>7</sup> <http://www.actionforadvocacy.org.uk/articleServlet?action=display&article=1445&articletype=60>

## **Part 5 – Suggested model of delivery**

### **Introduction**

124. In advance of the introduction of the expanded independent mental health advocacy scheme in Wales, LHB advocacy service planners will either wish to renegotiate their existing independent mental health advocacy contracts, or enter into additional arrangements with other independent advocacy providers where this is felt to be more appropriate, to ensure that there is sufficient capacity available to deal with the increased demand which is likely to arise as a result of the broader range of patients who will in future be eligible for the service.

### **Scope of services**

125. Local Health Boards will continue to be responsible for the procurement of independent mental health advocacy services in Wales. Each LHB will be responsible for ensuring that IMHAs are available to:

- a. all qualifying compulsory and informal patients receiving treatment in hospitals or registered establishments in the LHB area;
- b. any qualifying patient subject to guardianship or supervised community treatment who is present in the LHB area;
- c. any patient in the LHB area for whom section 57 or section 58A type treatments are being proposed.

### **Partnership working**

126. As with the original independent mental health advocacy scheme, LHB service planners should give consideration to whether it would be appropriate to enter into arrangements with local authority partners within their geographical boundaries to jointly commission the service. This is recommended for the following reasons:

- a. the provision of certain types of care and treatment provided under the powers of the 1983 Act is the responsibility of both health and social services bodies.
- b. the configuration of mental health services at primary and secondary level is often cross-discipline and cross-boundary. For example, community mental health teams usually include staff from health and social care bodies.

127. LHB service planners should also consider whether experience and evidence from earlier independent mental health advocacy (or IMCA) commissioning exercises indicates that joint procurement would have been an appropriate arrangement.

## **Wider provision**

128. In preparing for the introduction of the expanded independent mental health advocacy scheme, and making arrangements for the further provision of mental health advocacy within their LHB area, service planners may find it useful to take a strategic view of all advocacy provision which is commissioned by the LHB. As well as IMHA and IMCA, service planners may wish to consider what arrangements are in place for other statutory advocacy services in their locale, including NHS complaints advocacy. Consideration should also be given to any non-statutory advocacy services which are commissioned or part funded by the LHB, including children and young person's advocacy.

129. In considering how best to meet the additional demand which is likely to arise from the introduction of the enhanced independent mental health advocacy scheme in their area, advocacy planners should be mindful of the need to ensure that the different types of advocacy – both statutory and non-statutory – that they commission are planned and delivered in a way which minimises overlap and delivers, as far as is practicable, seamless and co-ordinated advocacy services.

130. Service planners should aim to ensure that there is as much continuity for individuals accessing advocacy services as possible. For example, a service user moving from an IMHA to an IMCA, or from detained status to informal inpatient status or to community treatment, may find it disruptive to switch from one advocate or advocacy service to another when their circumstances or legal status change.

131. The Welsh Government recognises that it will not always be possible for LHBs to ensure that all advocacy services are delivered in a complimentary manner, but suggests that service commissioners be mindful of this principle when planning, tendering, and entering into arrangements for future services.

132. The practice of 'spot-purchasing' is not considered suitable in the majority of cases for the provision of independent mental health services and should be avoided unless required by exceptional circumstances (see sections b & c of Annex D for examples of such circumstances).

## **Building on existing independent mental health advocacy services and making use of local expertise**

133. As IMHA and non-statutory mental health advocacy services are already provided in many inpatient wards, psychiatric units, independent hospitals and within some community settings, it is anticipated that the expanded independent mental health advocacy scheme will build on existing services wherever possible, and that it will be delivered by established local advocacy services. Locally developed services can bring a number of advantages, such as:

- a. Knowledge of local networks or services which may contribute to a patient's care when they are discharged from inpatient treatment or go onto a community treatment order;

- b. Accountability to local service users; often exercised through service user participation in the management of the advocacy service, feedback on the support received, or through action on commissioning groups or forums;
- c. Working to a remit that is wider than the IMHA brief – for example the provision of local community advocacy services - which enables the advocacy service to support qualifying patients through a whole episode of illness.

### **Assessing increased demand resulting from the expanded independent mental health advocacy scheme**

134. The expanded independent mental health advocacy service will be available to all qualifying compulsory and informal patients within the LHB area.

135. In assessing the requirement for future independent mental health advocacy services, the following factors should therefore be considered:

- a. The current and potential number of qualifying compulsory and informal patients cared for in the LHB area, and related demographic information (including age, gender, language needs, ethnicity and culture);
- b. the nature of the care and treatment provided to these individuals, and the average length of time spent in inpatient settings or, in the case of qualifying compulsory patients, the average length of time spent under the provisions of the 1983 Act;
- c. the locations, sizes and types of units the independent mental health service would be required to cover in the LHB area, including general hospitals and also specialist services such as forensic units, learning disability units or CAMHS units;
- d. who provides the services identified (i.e. NHS or the independent sector);
- e. any planned changes or developments within the LHB area which may impact on the future need for independent mental health advocacy services (i.e. the development of new inpatient units, or secure facilities).

136. In calculating its funding allocations for the expanded service, the Welsh Government has made use of available data on detentions under the 1983 Act and the numbers of admissions for inpatient mental health services in each LHB area (which is published on the Stats Wales website<sup>8</sup>). These figures can provide a useful baseline for service planners and advocacy providers in estimating the increased demand which may arise in their area as a result of the introduction of the new independent mental health advocacy scheme and in calculating the additional number of advocates that may be required to deliver this service in their area.

<sup>8</sup> <http://statswales.wales.gov.uk/index.htm>

137. As a starting point in estimating future take-up of the expanded scheme, service planners are advised to seek to identify the number of qualifying patients in their area who have taken up the original independent mental health advocacy scheme per year since introduction (this information should have been collated and regularly reviewed as part of existing service arrangements). In addition, the number of uses of sections 4, 5(2) and 5(4) of the 1983 Act per LHB area over recent years can also be identified. These figures, which are available on the Stats Wales website, can be used to extrapolate estimates of the future potential take-up of the expanded scheme for qualifying compulsory patients.

138. In relation to the expansion of the independent mental health advocacy scheme to informal (or non-detained) inpatients, the numbers of patients who have been admitted each year for inpatient treatment for mental health problems is also available on the Stats Wales website. These figures can be broken down by LHB area and can be used as a starting point in estimating the potential number of informal patients who may wish to make use of the scheme in future (the Welsh Government does, however, recognise that the data available on Stats Wales does not include patients who have been admitted for reasons other than mental disorder, but who have received treatment for mental health problems whilst in hospital – service planners are advised to seek local LHB data on this category of patient).

139. As with the original independent mental health advocacy scheme, areas with a greater concentration of qualifying patients, such as where there is a secure facility or an independent hospital, may require a higher number of advocates than an area where more limited inpatient services are delivered.

### **Developing independent mental health advocacy as part of wider advocacy services**

140. As mentioned above, it is recommended that the independent mental health advocacy service be developed in a way which is complimentary to the wider advocacy provisions which are delivered within the LHB area, and that in commissioning the expanded service, a strategic view be taken of where independent mental health advocacy fits into existing statutory and non-statutory advocacy services which are available in the locale.

141. In undertaking any such comprehensive assessment of existing advocacy services, and in planning for future provision, service planners may wish to consider the following issues:

- a. What statutory and non-statutory advocacy provision already exists in the LHB area?
- b. Who provides these advocacy services?
- c. Where does funding for the existing advocacy services come from?
- d. How many advocates are employed by these services?
- e. How is the existing independent mental health advocacy service provided?
- f. How is IMCA provided?

- g. How is Complaints Advocacy provided?
- h. How is advocacy for children and young people provided?
- i. What advocacy is available for adults and children with learning disabilities?
- j. What do these advocacy services aim to achieve?
- k. What is known about the outcomes of these services?
- l. Where are the gaps?
- m. How well are diverse needs being met?
- n. Do service users have a choice of advocate?
- o. What has worked well, and not so well, in delivering the independent mental health advocacy service to date?

142. This review should be carried out in liaison with local advocacy providers, service users and carers, and families. A review of the strengths and weaknesses of current provision will provide an opportunity to develop a greater understanding of local advocacy services, their capacity and potential.

143. However, the Welsh Government appreciates that time pressures on service planners may mean that the expanded independent mental health advocacy service will need to be commissioned quickly to ensure that services are in place to meet statutory requirements when these come into force, and without a comprehensive review of local advocacy provision. Where this is the case, this section of the guidance can be used as the basis for a strategic review of advocacy provision across the LHB at a future date.

144. The objective in undertaking such a review should be the development of a comprehensive strategy for advocacy within the LHB. A strategy of this sort should include the range of client groups and types of advocacy which are being delivered, and seek to achieve delivery of these services in a rational, coordinated and complimentary manner. Such a strategy should make clear the expected contribution each advocacy service will be expected to make, and identify the financial resources which are being provided to support the various aspects of the service.

### **Service specifications and the tendering process**

145. As with the original independent mental health advocacy scheme, a detailed service specification should be drawn up by the LHB. This must take into account the particular requirements and demography of the population of the LHB area, including (but not limited to) ethnic, cultural and demographic needs. Demographic needs can include age, gender and disability. Issues of geography and rurality, and the likely demand for the provision of services in the patient's language of choice or need should also be considered.

146. Guidance on developing a service specification is included for reference at Annex D.



147. Comprehensive tendering guidance should be prepared to ensure that advocacy providers are clear about what information is required from them in these and other areas in relation to any bids they would wish to put forward.

148. As previously, in order to maximise available resources, LHB service planners and advocacy providers must consider whether services might best be delivered on a collaborative or regional basis in order to pool resources and expertise. Such partnership arrangements might be appropriate either jointly between LHBs (and potentially local authorities), or between advocacy providers themselves.

149. There are successful precedents of joint commissioning in delivering both the IMCA scheme in Wales, and the original independent mental health advocacy service. Therefore, where appropriate and cost effective, such arrangements should be considered in relation to the expanded scheme.

150. In considering procurement arrangements, LHB mental health advocacy planners may also wish to have regard to the principles of the Procurement Route Planner produced by Value Wales<sup>9</sup> for social care and housing related services. Whilst this guidance is aimed primarily at those who purchase services for local authorities, service planners may find its principles helpful in relation to the procurement of mental health advocacy services.

151. Service planners might wish to consider extending invitations to tender to the following:

- a. Existing IMHA, IMCA and non-statutory advocacy providers;
- b. Local advocacy services not currently involved in the provision of statutory schemes but which have experience of working with appropriate client groups, including non-detained inpatients, children, older people, or people with learning disabilities;
- c. Mental health advocacy services that work in neighbouring localities;
- d. Regional mental health agencies which provide advocacy amongst their services and have appropriate experience to set up a new or expanded scheme.
- e. In all cases, the LHB should revisit its existing service level agreement and/or engagement protocol for delivery of the independent mental health advocacy service in its area to consider whether these should be revised.

152. Given that the process of commissioning for the expanded service is likely to take several months, preparation should commence as soon as possible. Service planners are encouraged to follow the commissioning approach they employed in establishing the original independent mental health advocacy scheme for their area where this was successful.

---

<sup>9</sup> <https://www.buy4wales.co.uk/PRP/social-care/contents/index.html>

153. As with the existing service, LHBs should ensure that robust monitoring and review procedures are in place to ensure that all services commissioned achieve and maintain minimum quality standards which should accord with the standards set out in the agreed service specification.

154. Detailed guidance on developing a service specification is attached at Annex D, along with a model service specification and engagement protocol at Annexes E and F, for those service planners and advocacy providers who would find these useful.

## Contact information

For further information in relation to this Guidance, please contact:

Mental Health Legislation Team  
Welsh Government  
Cathays Park  
Cardiff  
CF10 3NQ

Telephone: 029 2082 3294 or 029 2082 6988

Email: [mentalhealthlegislation@wales.gsi.gov.uk](mailto:mentalhealthlegislation@wales.gsi.gov.uk)

## **Glossary of terms and abbreviations**

### **Healthcare service provider**

This guidance uses the term healthcare service provider to describe those persons or organisations which deliver services to qualifying compulsory or informal patients whilst they are in hospital or the community, which include services for the patient's mental health problem. Depending on the patient's circumstances such service providers could include an NHS hospital or mental health unit, an independent hospital, or a local social services department.

### **Independent advocacy provider**

An organisation which employs, manages and trains mental health advocates.

### **Independent mental health advocacy service provider**

An independent advocacy provider who has been contracted by a Local Health Board to provide an independent mental health advocacy service in accordance with the requirements of the 1983 Act.

### **Staff and professionals**

When reference is made to staff and professionals this refers to health and social care staff (including paid carers) that provide care and treatment for qualifying patients. Employees of advocacy services are referred to as advocates.

### **Welsh qualifying informal patients**

Those patients who are not subject to the powers of the 1983 Act, but qualify for support from an IMHA because they are receiving assessment or treatment for a mental health problem whilst an inpatient at a hospital or unit in Wales.

### **Welsh qualifying compulsory patients**

Those patients entitled to the support of an IMHA because they are subject to certain of the compulsory powers of the Mental Health Act. It also includes other categories of qualifying patients, who whilst not detained, are also entitled to the support of an IMHA.

## Further reading

The Mental Health (Wales) Measure (2010) and Explanatory Memorandum  
<http://wales.gov.uk/topics/health/nhswales/healthservice/mentalhealthservices/?lang=en>

The Mental Health (Independent Mental Health Advocates) (Wales) Regulations 2011 and Explanatory Memorandum

<http://www.assemblywales.org/bus-home/bus-business-fourth-assembly-laid-docs.htm?act=dis&id=221840&ds=9/2011>

[SUB-LD8671-EM - The Mental Health \(Independent Mental Health Advocates\) \(Wales\) Regulations 2011 - Explanatory Memorandum](#)

Action for Advocacy (2006) *Quality Standards for Advocacy Schemes and A Code of Practice for Advocates*

<http://www.actionforadvocacy.org.uk/articleServlet?action=list&articletype=23>

Welsh Government (2003) *National Standards for the Provision of Children's Advocacy Services*

<http://wales.gov.uk/topics/childrenyoungpeople/publications/nationalstandardsadvocacy/?lang=en>

Welsh Government (2005) *A Study of Advocacy Services for Children and Young People in Wales Advocacy Services*

<http://wales.gov.uk/topics/childrenyoungpeople/publications/advocacystudy/?lang=en>

## **The following documents have also been published in relation to the independent mental health advocacy scheme in England:**

National Institute for Mental Health in England (2008) *Independent Mental Health Advocacy: Guidance for Commissioners*

<http://www.library.nhs.uk/commissioning/ViewResource.aspx?resID=302119>

National Mental Health Development Unit (2009) *Independent Mental Health Advocacy: Effective Practice Guide*

<http://www.nmhdunit.org.uk/silo/files/independent-mental-health-advocacy-effective-practice-guide.pdf>

**Annex A – Extract of sections 130A to 130L of the Mental Health Act 1983**

## **Annex B – The Mental Health (Independent Mental Health Advocates) (Wales) Regulations 2011**

# **Annex C – Guidance on developing a service specification**

## **SERVICE SPECIFICATIONS**

### **Developing a service specification**

Service specifications are key tendering documents which outline what commissioners expect from services they are seeking to procure.

Many LHB service planners and managers will already have standard specifications for commissioning services from the independent and/or voluntary and community sectors, along with the service specification they developed for the original independent mental health advocacy scheme in their area. Where the latter is the case, service planners are required to reconsider their existing independent mental health advocacy service specification to ensure that it reflects the expanded scheme within the Mental Health Act 1983, as introduced by the Mental Health (Wales) Measure 2010.

As with the original independent mental health advocacy service, the Welsh Government recommends that service specifications for the expanded scheme be drawn up in consultation with key stakeholders, including service users, advocacy organisations and healthcare providers.

In redesigning the independent mental health advocacy service specification it will be important to consider whether the service should be broader than the minimum requirements of the Measure. As set out in paragraphs 128 to 132 of the Guidance, service planners will wish to give consideration to how the service will fit within the wider advocacy services that are provided in their LHB and/or local authority areas, bearing in mind that such services should wherever possible be complimentary.

### **Required content of a service specification**

As with the independent mental health advocacy scheme introduced in Wales in 2008, the Welsh Government recommends that the following issues be included in any service specification:

#### **a. Model of service**

Independent mental health advocacy services are required to be provided by independent, paid, qualified advocates who will be trained to support individual qualifying patients. IMHAs will respond to referrals, and minimum response times will be specified.

#### **b. Timing of the contract**

The expanded independent mental health advocacy service for Welsh qualifying compulsory patients is intended to commence in October 2011. Whilst the scheme for Welsh qualifying informal patients is intended to commence in January 2012.



Discussions with independent mental health advocacy service planners and providers have confirmed that contracts lasting for a minimum of 3 years, subject to satisfactory performance, are to be recommended.

An agreement of this length will enable a newly-appointed independent mental health advocacy provider adequate time to become fully established and embedded with services in their area, and for staff to enjoy some security of employment.

Where a contract is already in place for the provision of an existing independent mental health advocacy service to an LHB, and both parties wish to extend these arrangements to include the expanded advocacy provisions which are being introduced in 2011 and 2012, existing contracts should be renegotiated and extended as appropriate.

Where an LHB has some time left to run on an existing independent mental health advocacy contract, but does not wish to renegotiate or extend its arrangements with its current provider, it is acceptable for that LHB to supplement its existing service by entering into a separate contractual arrangement with another advocacy provider to deliver additional capacity until such time as they are able to retender for the full independent mental health advocacy contract. Such an arrangement is likely to create practical delivery issues and is not recommended, although the Welsh Government accepts that there may be reasons why an LHB may wish to make such arrangements in the shorter term.

Where an existing contract may be coming to an end and the LHB wishes to re-tender or renegotiate its existing contract, then sufficient time should be factored in to the commissioning cycle to ensure that new contractual arrangements are in place to provide the expanded service in a timely manner.

It is also suggested for the purposes of business planning and commissioning cycles that any new contractual arrangements be synchronised with the financial year.

**c. Purpose of the service**

The purpose will be to provide the independent mental health advocacy service as required by the 1983 Act.

It may be of use, however, to clarify in the service specification the type of support which IMHAs will be expected to give to qualifying informal and compulsory patients.

For all qualifying patients this might include:

- Accessing information in relation to, and developing understanding of, their treatment and rights;
- Engaging in decisions being made about their care and treatment;
- Contributing to their care and treatment plan and discharge plan;

Whilst for qualifying compulsory patients, this might also include:

- Preparing for a Mental Health Review Tribunal, and understanding any decisions made by the tribunal;
- Obtaining legal representation where required;
- Support in relation to Hospital Managers' Hearings
- Raising concerns or making complaints on behalf of the patient.

If specialist psychiatric services are provided (whether in NHS or independent settings), such as forensic services, CAMH services or services for adults with learning disabilities, a separate independent mental health advocacy contract might be considered for those settings. This would enable advocates with specialist skills and experience to be contracted to deliver a more targeted service.

#### **d. Principles of the service**

This section provides an opportunity to reinforce the importance of certain principles and also the need for independent mental health advocacy services to recognise they are delivering a statutorily required function. The principles to be specified may include:

- the need for independence;
- advocacy principles which must be adhered to when delivering both instructed and non-instructed advocacy, in particular around confidentiality;
- meeting the diverse needs of qualifying patients;
- working in partnership with agencies involved in the care of qualifying patients and their aftercare;
- meeting the standards of independent advocacy required in the Measure and Regulations, and in this guidance.

#### **e. Availability and coverage**

It is expected that, as a minimum, independent mental health advocacy services should be available for all qualifying patients during business hours on weekdays (i.e. 9.00am – 5.00pm, Monday–Friday, excluding public holidays).

In relation to requests made for IMHA support from qualifying compulsory patients detained under sections 4, 5(2) and 5(4) of the 1983 Act, independent mental health advocacy providers will be expected to provide prompt responses to such requests. As these sections of the 1983 Act last from only 6 to 72 hours, independent mental health advocacy providers will be expected to ensure that any such requests made outside business hours are prioritised and responded to in a timely manner.

Service specifications should also be clear as to how the independent mental health advocacy service will be expected to:

- Support qualifying patients detained in hospital and those on supervised community treatment;
- Cover inpatient units in different specified locations;
- Cover specialist provision, such as forensic or CAMHS units, or services for people with learning disabilities and mental illness;
- Respond to referrals within specific response times from point of referral (see Model Engagement Protocol at Annex D).

**f. Interface with mental health service providers**

The independent mental health advocacy service will have to remain independent from, but work within, hospitals and units caring for qualifying patients. To clarify the ways the IMHA will work with healthcare providers, an engagement protocol should be negotiated and approved by those procuring the service, the healthcare providers who will utilise the services, and the independent mental health advocacy provider(s) who will deliver the service.

The engagement protocol should be drawn up within two months of the service becoming operational.

Other expectations of the independent mental health advocacy service provider that could be specified include:

- the training of healthcare service providers' staff and professionals to raise awareness about the expanded independent mental health advocacy service;
- the provision of publicity materials and the formats in which these should be available.

**g. Issue resolution and complaints**

The role of IMHAs in supporting qualifying patients to resolve issues, concerns and complaints should be described, and expectations made explicit.

**h. Appropriately skilled and trained IMHAs**

A requirement should be included that the independent mental health advocacy service provider ensures that any individual made available to act as an IMHA meets the appointment requirements set out in the regulations. It is intended that these regulations stipulate that individuals delivering the independent mental health advocacy service to patients should be of integrity and good character, appropriately experienced and trained, and that consideration has to be given to standards set in guidance by Welsh Ministers.

This guidance requires that all individuals who are delivering the independent mental health advocacy scheme in Wales have either attained, or be working towards, the City and Guilds National Advocacy Qualification level 3 Certificate in Independent Advocacy, and as a minimum requirement should have successfully completed the IMHA specialist level 4 unit of the Qualification within 12 months of appointment.

Any IMHA who is working with individuals below the age of 18 should also have attained (or if in post for less than 12 months, be working towards) the Independent Advocacy with Children and Young People level 4 specialist unit.

**i. Security checks**

The IMHA Regulations will require IMHAs to be subject to enhanced Criminal Records Bureau checks. Additionally, checks should be made against the Protection of Vulnerable Adults (POVA) list and the Protection of Children Act (POCA) list where an IMHA will be working with children under the age of 16.

**j. Diversity**

The independent mental health advocacy service should be expected to make every reasonable effort to appoint a staff team that reflects the ethnic diversity, cultural make up or language requirements of the qualifying patient population. Where teams are small, or recruitment is difficult, independent mental health advocacy services should be requested to explain the arrangements they intend to establish with other services to redress any imbalance.

**k. IMHA management and supervision requirements**

Individuals delivering the independent mental health advocacy service to patients will be managed by, and primarily accountable to, the advocacy organisation that recruits and employs them. This will help to ensure the independence of advocates. In addition, the advocacy provider must ensure that it undertakes appropriate monitoring, management and supervision arrangements for all advocates it employs.

**l. Case and activity recording**

It is important that advocacy providers keep comprehensive records of patient contacts that can be shared with the patient concerned. All independent mental health advocacy services should have a policy and procedure for the setting up, maintenance, storage, archiving and destruction of case records, and this should be regularly reviewed. Independent mental health advocacy services may also be required to record other activity such as enquiries that do not lead to case file being opened, or training and awareness-raising sessions that they have undertaken with healthcare providers.

**m. Patient involvement and feedback**

LHB independent mental health advocacy service planners should be required to take qualifying patients' views into account when commissioning and reviewing the service.

**n. Outcomes and quality monitoring**

Targets and performance indicators should be stipulated and agreed between the independent mental health advocacy service and the service procurer and should form part of the service specification. Some suggested key indicators are included in the 'Monitoring and Review' section on developing an engagement protocol below.

**o. Finance**

independent mental health advocacy services should be required to demonstrate sound financial management and to provide detailed costings of the proposed service.

**p. Accountability**

The independent mental health advocacy service will be accountable to the LHB which has commissioned it, and quarterly contract review meetings are recommended during the first year of any newly appointed service, to monitor delivery and identify and resolve any problems. Thereafter ongoing six-monthly or annual review meetings are recommended.

A model independent mental health advocacy Service Specification is provided at Annex C.

## **TENDERING AND SELECTION**

### **Tendering process**

Tendering for the original independent mental health advocacy scheme in 2008 will have provided LHB service commissioners with much valuable experience which can be drawn upon when undertaking the procurement of the expanded independent mental health advocacy service.

Before tenders for the expanded independent mental health advocacy services can be issued, commissioning arrangements will need to be in place (including any partnerships between LHBs, or between LHBs and local authorities) and detailed service specifications agreed. Although LHBs will continue to lead on the process, if there is strategic benefit to joint arrangements the subsequent tendering process should be carried out jointly, either between LHBs, or by health and local authority partners.

As with the original independent mental health advocacy scheme, service planners are advised to engage with service users during the tendering process. Where they are requested to help, service user representatives should be involved throughout the process, including drawing up the tender documents, short listing and

interviewing, and selection. In order to participate fully in the process, service users may need to be given training and financial recompense.

Tender documents will set out, for those independent advocacy providers who wish to tender, the information that service commissioners will require in order to judge their bids. A suggested checklist is provided below.

As with the original scheme, those bidding for contracts should also be asked to provide a case study or scenario which illustrates how they provide (or would provide, if they are not currently a contracted service) advocacy services to individuals. The case study should demonstrate the use of core advocacy values and principles, some of the dilemmas advocates face, and the approach the advocate took to resolve the issue. The information provided will be important in evaluating the principles of the advocacy service, its experience in handling difficult situations and its understanding of the IMHA role.

National advertisement of the independent mental health advocacy tenders is encouraged (unless there are well established tender arrangements based on preferred partner status). This will enable a wide range of organisations to see the advertisements.

### **Costing the tender**

As set out in paragraphs 140-144 of the main guidance, LHB advocacy service planners will have financial and statistical information available to them from the provision of the existing independent mental health advocacy service, and will be able to use this as a starting point in estimating the costs of the expanded independent mental health advocacy scheme. The costs will need to include, as previously:

- Costs associated with running the advocacy organisation, including accountancy and legal fees;
- Access to specialist advice such as mental health lawyers;
- Inclusion costs (BSL, translation and interpretation costs).

In addition, LHB service planners may also wish to factor-in the following considerations when costing the expanded service if they are intending to renegotiate with an existing independent mental health advocacy service provider:

- Direct and indirect costs incurred by advocacy providers in advertising, interviewing and appointing additional advocates who may be required to deliver the expanded service;
- Short term costs incurred in providing cover for existing staff who may be involved in interviewing, recruitment and training of new advocates;
- Salaries for the additional advocates who will be required to deliver the expanded service;

- Training costs for new advocates, including attaining the National Advocacy Qualification;
- increased management costs, including line management and supervision arrangements for new advocates;
- Potentially increased costs of absence cover;
- Costs of further awareness-raising training for mental health service providers;
- Additional administration costs;
- Potential increases in office rent and charges;
- Additional stationary and equipment, including IT and telephones;
- Increased travel costs where additional advocates are being employed (these will continue to be particularly significant in rural areas);
- Printing of publicity materials for expanded service;
- Security checks for new staff (including CRB, POVA and POCA as applicable).

### **Tendering requirements**

In submitting a tender, an advocacy provider should be asked to:

- Provide information on its size, organisational structure and experience (and constitution and code of practice, if it has one);
- Provide three business references;
- Demonstrate experience of providing advocacy, and which client groups it mostly works with;
- Either demonstrate its experience of providing mental health advocacy, or explain how it will develop this skill;
- Provide information on how often its advocates receive supervision and whether they have personal/ professional development plans;
- Show experience of working in partnership with statutory agencies;
- Illustrate experience of providing a service which demonstrates an active commitment to equal opportunities;
- Demonstrate their commitment to being locally accountable if outside their usual geographical area of working;
- Show experience of working with users from ethnic minorities; those who do not have Welsh or English as their first language; those who need specialist communication tools and those who communicate through informal methods;

- Demonstrate compliance with the Welsh Language Act 1993. Additional requirements to provide services in Welsh and bilingual information may be determined by service planners locally;
- Confirm that it employs staff in a manner that ensures they are fit for purpose: this will include the provision of enhanced CRB, POVA and POCA checks;
- Demonstrate sound financial management, including an annual report together with financial accounts for the last financial year, as well as details of its public and employers' liability insurance (if it has any);
- Provide information on methods of working, and on whether and how often case work is shared and discussed;
- Provide a summary of the number of mental health advocacy cases they dealt with in the previous 12 months (indicating, where appropriate, how many of these were IMHA-qualifying patients);
- Provide any policy documents relating to mental health advocacy;
- Specify the number of advocates the service proposes to train and manage as IMHAs (within the stated budget), and whether these are/would be full time or part time;
- Describe proposed internal monitoring arrangements;
- Identify what indicators and methods would be used to provide evidence that individual and service outcomes have been achieved;
- Attach a copy of their confidentiality policy, or show a willingness to develop one;
- Provide a detailed annual budget for the 3 years the contract will run.

## **ENGAGEMENT PROTOCOLS**

### **Negotiating an engagement protocol**

Once an LHB has chosen and appointed an advocacy provider to deliver the expanded independent mental health advocacy service in their area, an engagement protocol will need to be developed.

An engagement protocol, or procedure, confirms the three-way relationship between those procuring the service, the healthcare service provider(s) who will utilise the service, and the independent mental health advocacy provider(s) who will deliver the service.

It sets out service delivery and practice requirements for the provision of the independent mental health advocacy service in particular settings and clarifies the working relationship between the advocacy service and the healthcare service provider(s). It also includes details on what the independent mental health advocacy service provider will provide, how these services will be provided and monitored,



what boundaries the IMHAs will work within, and how advocates will relate to the healthcare service providers' staff and professionals.

It further sets out what the independent mental health advocacy service provider(s), and qualifying patients, can expect from the healthcare service provider(s) and what arrangements are in place for regular meetings with those who have commissioned the service. In addition, in settings where particular security arrangements are in place, the ways these will affect the day-to-day working of the independent mental health advocacy service can be spelled out.

The independent mental health advocacy service provider usually takes a lead in drawing up the engagement protocol, but it should be drafted with input from the other partners. In all cases, all of the partners will be required to agree the final document. It should then become an openly available document that healthcare staff and advocates can refer to when they wish to check agreed arrangements and responsibilities.

### **Engagement protocol content**

LHB mental health advocacy service planners will already have access to the engagement protocol which will have been agreed in relation to the provision of the existing independent mental health advocacy service in their area. However, attached at appendix 2 is a model document which can be tailored to specific local circumstances where required.

Key sections of engagement protocols should include:

- The scope and geographical range of the independent mental health advocacy service;
- independent mental health advocacy service principles;
- Provision of information about the independent mental health advocacy service and who will be responsible for providing it;
- How referrals should be made and responded to (including arrangements in relation to patients detained under sections 4, 5(2) and 5(4));
- Arrangements for IMHAs' access to wards and meetings with qualifying patients who are in the community;
- Arrangements for obtaining patient consent to an IMHA acting on their behalf;
- Arrangements for IMHAs' attendance at meetings concerning care and treatment;
- Access to patient records;
- Confidentiality policies;
- Case recording;
- Issue and problem resolution;

- Arrangements for supporting qualifying compulsory patients on SCT and guardianship;
- Supporting qualifying compulsory patients on longer term section 17 leave;
- Incident management and reporting;
- Complaints procedures;
- Arrangements regarding review meetings between the independent mental health advocacy provider(s) the service commissioner(s) and the mental health service provider(s).

### **Monitoring and review**

Service commissioners will want to ensure that the independent mental health advocacy service they procure is delivering in a satisfactory manner, and should include monitoring and review arrangements in the contract they draw up with the independent mental health advocacy provider.

Possible Key Indicators for inclusion in engagement protocols could include the following:

#### ***a. Providing a responsive independent mental health advocacy service***

- The number of qualifying patients who have received support from an IMHA during the reporting period within the agreed timescales for response (potentially broken down by patient type (ie, section type, community, informal) and/or location);
- The number of service users who requested, but did not receive a visit from an IMHA within the agreed timescales, because of lack of availability of advocates;
- The number of IMHA cases concluded and closed having achieved a satisfactory outcome;
- Any notable case studies.

#### ***b. The provision of independent mental health advocacy by a trained professional workforce***

- The number of IMHAs delivering the service, by age, gender and ethnic origin;
- Details of the qualifications and experience held by those advocates delivering the service, including ongoing training;
- Number of supervision sessions held between IMHAs and line managers, with agreed action plans, together with two examples of agreed action plans (anonymised as case examples)

- Copies of (anonymised) personal development plans for those IMHAs delivering the service;

**c. *An independent mental health advocacy service that values the comments of service users and mental health professionals***

- The number and types of compliments, and complaints, received by the advocacy provider during the reporting period and any outcomes relating to these;
- Outcomes/changes resulting from any feedback or comments received by the advocacy provider;
- Outcomes resulting from any consultation or evaluation undertaken by the advocacy provider during the reporting period.

**d. *An independent mental health advocacy service which is financially sound***

- A summary of the independent mental health advocacy service's income and expenditure for the reporting period;
- Details of any temporary or permanent variation from budget, with explanations of any such variations.

## **Annex D – Model Service Specification**

(Note: This draft specification sets out some basic requirements for an independent mental health advocacy service, and can be used by LHB service planners as a basis for the development of their own documentation. However, LHBs should adapt it to reflect their style of commissioning and standard documentation as appropriate)

**## Local Health Board[s] (LHB[s]) [and ## Local Authority[ies] (LA[s]), if applicable]**

**Specification for Independent Mental Health Advocacy Service for Welsh qualifying compulsory and informal patients**

### **1. Introduction**

1.1 *The Mental Health Act 1983, as amended by the Mental Health (Wales) Measure 2010, requires the provision of independent mental health advocacy for qualifying compulsory and informal patients in Wales.*

1.2 *xxx LHB[s] [and xxx LA[s]] wish[es] to ensure that independent mental health advocacy services are made available for all qualifying patients within xxx Local Health Board/local authority area[s].*

1.3 *The independent mental health advocacy service will be fully compliant with the Mental Health Act 1983 Code of Practice for Wales. For the avoidance of doubt, if anything is contained within this service specification that conflicts with the Code of Practice, then the Code of Practice takes precedence.*

### **2. Commissioning of independent mental health advocacy services**

2.1 *Independent mental health advocacy will be commissioned by xxx LHB[s] [and xxx LA[s]] for those qualifying patients within xxx LHB/LA area[s].*

2.2 *This specification focuses on the advocacy requirement for qualifying patients under the Mental Health Act 1983.*

2.3 *The future advocacy service provider's contractual relationship will be with xxx LHB[s] [and xxx LA[s]]. They will be responsible for monitoring, reviewing the service via quarterly or six-monthly contract monitoring meetings, and for negotiating the operation of the service as required within xxx inpatient facility(ies), xxx Independent hospital(s) and xxx community services.*

### **3. The independent mental health advocacy service**

3.1 *xxx LHB[s] [and xxx LA[s]] require that the advocacy service provider for this contract should have at least two years experience of the provision of mental health advocacy to people receiving care and treatment in a psychiatric setting.*

3.2 *The advocacy service provider will make available professional mental health advocacy services at xxx [location(s)]. This will be available during office hours*

*Monday-Friday with flexibility for evening/weekend sessions if required. This will consist of direct advocacy service provision to all qualifying patients being made available within 5 working days, except for those patients detained under sections 4, 5(2) and 5(4) of the 1983 Act.*

*3.3 The advocacy service provider will also make advocacy available to patients detained at xxx under sections 4, 5(2) or 5(4) of the 1983 Act as soon as is reasonably practicable, ensuring that such requests are prioritised and dealt with in a timely manner.*

*3.4 The advocacy service provider will promote understanding and awareness about advocacy amongst health service and social care staff and qualifying patients to facilitate and encourage access to the independent mental health advocacy service, via training sessions and publicity materials (eg, information leaflets).*

*3.5 The advocacy service provider will be required to be a properly registered and regulated company/charity, or a distinct and independently functioning subsidiary.*

*3.6 The advocacy service provider will be expected to provide on request by xxx LHB[s] [and xxx LA[s]] evidence of their advocacy service provision experience to date, including:*

- annual reports, staffing/managerial/supervisory structure;-*
- their skills/experience base;*
- examples of training pro-forma, etc,*
- current qualitative, quantitative outcome measures, financial accounts, policies, procedures and references.*

#### **4. Confidentiality**

*4.1 The advocacy service will be bound by its own confidentiality policy, which it is expected will be legally accurate. The service's policy will accommodate and reflect the need for all case work to be regarded as being confidential within the advocacy service, and not exclusively to individual advocates. The service should also comply with the Data Protection Act 1998.*

*4.2 The advocacy service will also be bound by the confidentiality requirements set out in the Engagement Protocol.*

#### **5. Location of Advocacy Service**

*5.1 Given the geographical area which the independent mental health advocacy service will cover, the advocacy organisation will be responsible for providing office accommodation, which will include a secure storage area, where the advocacy service will be able to safely store case records. The office will be equipped with telephones, and have facilities for the installation of computers.*

## **6. Model and Type of Mental Health Advocacy Service Required**

6.1 *The advocacy service will provide a service which channels, rather than filters, qualifying patients' views, facilitating qualifying patients in self advocacy where this is feasible.*

6.2 *An advocacy service provider is being sought that can provide a model of professional mental health advocacy that is proactive, by ensuring that each referral for IMHA support for qualifying patients is dealt with within 5 days (except in relation to qualifying patients detained under sections 4, 5(2) or 5(4) of the 1983 Act, in relation to whom see paragraph 6.3).*

6.3 *Whilst the advocacy service is not expected to provide 24 hour, 7 day a week response to requests, it will be expected to prioritise and respond as soon as is reasonably practicable in relation to requests made in relation to qualifying patients detained under sections 4, 5(2) and 5(4) of the 1983 Act.*

6.4 *Not all qualifying patients at xxx [location] will be able to instruct advocacy services. The advocacy service will therefore have in place policies that address the delivery of non-instructed advocacy, and prioritisation of those individual qualifying patients who may lack capacity and who fall outside the scope of the IMCA service.*

6.5 *The advocacy service will not be required to act within the commissioned service as an "expert witness" or to function as an "appropriate adult" under the Police and Criminal Evidence Act, 1984.*

6.6 *It is expected that the advocacy service will take account of the weekly routines of qualifying patients. Therefore an ability to work flexibly will be expected.*

6.7 *It is expected that advocacy will be delivered mainly on an individual basis with qualifying patients. Resources allowing, the advocacy service will be available to support qualifying patients' individual expression within group meetings.*

6.8 *The advocacy service will set out a clear process for monitoring collective concerns across the service, and will negotiate with XXX Trust/Independent Hospital/Community service managers a protocol for dealing with collective issues. The work to develop this protocol will be facilitated by XXX LHB[s] [& LA[s]] and is expected to be in place within two months of the commencement of the service.*

6.9 *The advocacy service will be expected to provide regular and ongoing advocacy awareness training to health and social care staff and qualifying patients. The advocacy service will be required to maintain records of training given and numbers of staff /qualifying patients who have attended. The training should cover general awareness about advocacy, as well as specific training about the particular independent mental health advocacy services which they provide, utilising suitably anonymised case work illustrations.*

6.10 *xxx LHB[s] [and LA[s]] are commissioning advocacy services to ensure that all qualifying patients within xxx LHB[s]/LA[s] area[s] will have access to professional advocacy support. This will not prevent individual qualifying patients from making*

*their own arrangements for mental health advocacy support. To assist qualifying patients in having a choice, the advocacy service will update and maintain a library resource of other known advocacy services, concentrating on those that support people from different ethnic or cultural backgrounds.*

*6.11 The advocacy service will have achieved, or be working towards achieving, the Action for Advocacy Quality Performance Mark.[this requirement will have already been discussed with advocacy planners/providers as part of main guidance]*

## **7 Issue Resolution/Complaints**

*7.1 Issues raised with the advocacy service by qualifying patients can often be effectively resolved at a local level through informal negotiation with the individuals directly concerned. Advocacy has a very important role in supporting qualifying patients in achieving this. A complaint may emerge if the patient is unhappy with the outcome of this process and wishes to take the matter further, verbally or in writing. Qualifying patients may seek advocacy support in taking such complaints forward. The advocacy service should be able to provide evidence of experience in dealing with such situations.*

## **8 Advocates' Competencies and Skills**

*8.1 It is expected that all advocates will be skilled and competent for the task, and will be willing to undertake further training and development if required. All individuals who are delivering the independent mental health advocacy scheme in Wales have either attained, or be working towards, the City and Guilds National Advocacy Qualification level 3 Certificate in Independent Advocacy, and as a minimum requirement should have successfully completed the IMHA specialist level 4 unit of the Qualification, or have attained this unit within 18 months of their appointment as an IMHA.*

*8.2 Where an IMHA is likely to provide support to individuals below the age of 18, that advocate should also have successfully completed the Independent Advocacy with Children and Young People level 4 specialist unit, or have attained this unit within 18 months of their appointment as an IMHA.*

*8.3 The advocacy service provider will be able to demonstrate awareness of current best practice in skills and competencies for professional mental health advocates.*

*8.4 The Advocacy Service Provider notes that all advocacy staff working at the XXX Hospital[s]/Unit[s]/Independent Hospital[s]/Community setting will have to undertake their annual refresher training in health, safety, security, and other areas as deemed necessary in order to work safely within these settings.*

*8.5 All advocates will have undergone the necessary clearance checks, including enhanced criminal records bureau checks and POVA and POCA checks. It will be a matter for agreement between the LHB and the advocacy provider to decide whether any formal entries which appear on relevant checks will automatically act as a bar or*

*disqualification to advocacy employment. Any discretion retained should be specifically stipulated and reasons given.*

## **9 Patient involvement and Feedback**

*9.1 The advocacy service will be required to show evidence of having taken account of qualifying patients' views about the service they provide, particularly in respect of accessibility and impact. The advocacy service provider will be expected to negotiate with the XXX LHB[s] [& LA[s]] and XXX Hospital[s]/Unit[s]/Independent Hospital[s]/Community services on the methods to be used to obtain this feedback. Advocacy services will be required to set out their plans for ensuring this requirement is met.*

*9.2 Part of any service proposal submitted needs to describe how service user views will be gained and used.*

## **10 Delivery of the Advocacy Service**

*10.1 A protocol for establishing the way in which advocacy services will be delivered will be agreed between the XXX LHB[s], XXX Hospital[s]/Unit[s]/Independent Hospital[s]/Community services within two months of the commencement of the service. It is envisaged that the advocacy service will be accountable for operating at all times within this protocol and will participate in an annual review of it within quarter 3 contract monitoring meeting between XXX LHB[s], XXX Hospital[s]/Unit[s]/Independent Hospital[s]/Community services.*

*10.2 Once a protocol has been agreed then any breach of its terms and conditions will be regarded as a breach of contract and will be subject to immediate review by the XXX LHB[s], which could result in the withdrawal or suspension of the advocacy service.*

## **11 Supervision, Continuous Professional Development & Performance Appraisal**

*11.1 Supervision and professional development are seen as an essential component of the service. The advocacy service provider will be expected to hold regular, not less than monthly team meetings at which casework is shared and discussed. This will be seen as a critical activity ensuring quality and consistency of service provision. XXX LHB[s] will pay particular attention to ensuring that this happens.*

*11.2 Each advocate will receive not less than six-weekly individual management supervision with their line manager.*

*11.3 Each advocate will have a personal/professional development plan that is assessed, implemented, and evaluated on an annual cyclical basis.*

*11.4 Reporting on the delivery of supervision, uptake by advocates, and the generation of individual personal development plans will form part of the reporting*



*requirement to XX LHB[s] annually within the last quarter contract monitoring meeting.*

*11.5 The advocacy service provider will describe their practices around staff training and appraisal.*

## **12. Advocacy Service Staffing Profile**

*12.1 The advocacy service at XXX [location] will consist of ... (e.g. one dedicated advocacy caseworker per X qualifying patients).*

*12.2 The advocacy service provider will be expected to make every reasonable effort to ensure that the makeup of the advocacy service closely reflects the ethnic and cultural diversity of the patient population.*

*12.3 However, it is recognised that the advocacy service may not be able to employ a sufficient number of advocates to meet the range of requests for advocates from specific ethnic, cultural, religious or other groups. Therefore it is expected that links will be built with other specialist advocacy services within the locality, to increase the choice of support that can be made available to qualifying patients.*

*12.4 When recruiting staff, the advocacy service provider will ensure that it takes into account the range of communications skills and abilities of the patient population. This will ensure that no patient is excluded from accessing the advocacy service. The advocacy service may be required to have access to signers and language interpreters, and have information available in other forms than just written Welsh and English.*

## **13. Case Records and Case Record Storage**

*13.1 The advocacy service will be required to keep comprehensive records of patient contact. Record keeping should focus on enabling quantitative and qualitative analysis, and on producing a record which is open and accessible to qualifying patients. It is expected that the advocacy provider will produce and operate to a policy that accommodates these requirements and reflects that, in limited circumstances, these case records may be subpoenaed by the courts.*

*13.2 The advocacy service will have policies and procedures for making and maintaining records of engagements with qualifying patients. These policies and procedures will be expected to detail standards for recording patient information, internal audit and quality monitoring, storage, cataloguing, archiving, and destruction. There will also be a procedure for handling and storage of third party information.*

*13.3 The advocacy service provider will be expected to keep records about all advocacy awareness training sessions delivered, including attendees. These records will form the basis for reports as required below in section X.*

## **14. Service Outcomes and Quality Monitoring**

14.1 All service outcomes will be derived from, and related to, the overall service aim of ensuring advocacy is provided to support qualifying patients in making known their wants, views and experiences arising from either being subject to compulsion, or in receipt of care and treatment as an inpatient at XXX [location[s]].

14.2 All ward-based and relevant community staff, other clinical team members, and service managers will be offered advocacy awareness training on no less than a 12 monthly basis. The advocacy provider should describe how they will meet this requirement, providing supporting evidence of previous experience.

14.3 The advocacy provider will be expected to be committed to reflective and evolving practice. Evidence of this will be demonstrated through the service having an ongoing programme of audit of service delivery, through which service deficits are identified and plans are set in place to address them. This will lead to the service having a regularly reviewed development plan.

14.4 XXX LHB[s] [& LA[s]] will regularly monitor the quality of advocacy service provision. The conclusions of this ongoing monitoring will be made known at the quarterly or six-monthly review meetings and formally presented in advance of the annual review.

14.5 Quality monitoring will be based on reports submitted to XXX LHB[s] [& LA[s]] by the advocacy provider. Monitoring should include activity profiles across the quarter, patient feedback, and random sampling of advocacy case work, encompassing interviews with advocates, qualifying patients, and staff.

14.6 XXX LHB[s] [& LA[s]] will initially discuss the findings of its quality monitoring with the advocacy service provider.

14.7 XXX LHB[s] [& LA[s]] will expect to be informed about pre-planned staff/patient advocacy awareness training sessions and will reserve the right to attend these.

## **15. Managing the Advocacy Service Provision**

15.1 As stated above, the advocacy service will be directly accountable for its operations and performance against the specification and contract to XXX LHB[s] [& LA[s]]. The contract and service will be subject to annual review. In advance of annual review, the advocacy service provider will be expected to provide an annual report covering:

- A quantification and description of the activities of the last year, including the number of qualifying compulsory and informal patients it has assisted;
- Information on the gender/ethnicity/language requirements of qualifying patients it has assisted;
- A summary of the individual issues raised by qualifying patients and outcomes;
- A summary of any collective issues raised by qualifying patients and outcomes;

- Evidence of, and reflection on, service achievements;
- A report of their annual accounts.

15.2 This annual report will be presented in such a way that it is fit to be circulated to service providers and made public (including to qualifying patients and patient representative organisations).

15.3 The annual report process will include formal discussion of the report between XXX Hospital[s]/Unit[s]/Independent Hospital[s]/ Community services and the advocacy service provider. Once agreed, the report will be formally presented to the XXX LHB[s] [& LA[s]].

15.4 In addition to the formal annual report, three or six-monthly meetings will be held between XXX LHB[s] [& LA[s]], the relevant managers of XXX Hospital[s]/Unit[s]/Independent Hospital[s]/Community services, and the advocacy service provider. There will be a standing agenda for these meetings and the advocacy service provider will be expected to provide progress and state of service reports.

15.5 XXX LHB[s] [& LA[s]] will encourage the advocacy service provider manager and relevant managers of XXX Hospital[s]/Unit[s]/Independent Hospital[s]/Community services to meet on a regular basis (quarterly initially, and then six-monthly thereafter) to discuss operational matters and to raise issues on behalf of qualifying patients.

## **16. Arbitration**

16.1 XXX LHB[s] [& LA[s]] would expect that the majority of issues arising from operational practice will first be addressed through the regular meetings held between the advocacy service manager and the appropriate manager within the Hospital/Unit/Independent Hospital/Community service. Where matters cannot be resolved in this way, XXX LHB[s] [& LA[s]] expect[s] that the matter will immediately be brought to its [their] attention by either party, but preferably both. If resolution then cannot be achieved, XXX LHB[s] [& LA[s]] will appoint an independent person/body to investigate and arbitrate.

16.2 XXX LHB[s] [& LA[s]] will not have a role in arbitrating on individual patient issues unless they specifically come within commissioning core responsibilities. For qualifying patients whose services are commissioned by other NHS or local authority agencies, XXX LHB/LA will act as the first point of contact for the advocacy service provider, and facilitate their contact with the appropriate service thereafter.

## **17 Contract terms**

17.1 The service will commence from the X/X [month/year] and will be of three years duration, with the option for a further period subject to satisfactory performance. The service will be reviewed annually. It is possible that further changes will be made to the specification in future years if required by subsequent legislation or Welsh Government guidance.

## **18 Funding**

*18.1 In order to achieve the aims of this service a sum not exceeding £\_\_\_\_ has been made available for this project on a recurring basis. This will be payable quarterly in advance/arrears.*

*19.2 It should be noted that bidders are challenged to demonstrate value for money and that, in accordance with the Procurement Process, the successful tender shall be determined on the basis of a cost per point of value.*

## **Annex E – Example of an Engagement Protocol**

### **Protocol for the Engagement of Independent Mental Health Advocacy Service Delivery**

#### **1. Context**

This document details the protocols agreed to by [the service procurer], [the healthcare service provider] and [the independent mental health advocacy service].

#### **2. Purpose**

The purpose of these agreements is to make clear to all parties how the independent mental health advocacy service provider will be enabled to provide its services to individuals who qualify for the independent mental health advocacy scheme under the Mental Health Act 1983. The agreement forms an integral part of the commissioning process.

#### **3. Introduction**

This protocol sets down service delivery and practice requirements for the provision of the independent mental health advocacy service, and clarifies the working relationship between the advocacy service and the healthcare provider. It sets out those services the independent mental health advocacy service will provide, how these services will be provided and monitored, what boundaries the advocates will operate within, and how advocates will relate to staff of the providers of statutory services. It further sets out what the independent mental health advocacy service, and its qualifying patients, can expect from the statutory healthcare providers.

#### **4. Scope and Breach of Protocol**

These protocols will apply to all engagements undertaken by the advocacy service. Any noncompliance with these protocols by the advocacy service will be liable to investigation by the LHB advocacy service manager/planner. The outcome of which could result in suspension of all, or part(s), of the advocacy service until a full and detailed investigation has been conducted. This will be made clear to all parties at the time.

#### **5. Review**

These protocols may be subject to formal review and may be liable to amendment in light of operational experiences.

#### **6. The Scope of independent mental health advocacy**

The independent mental health advocacy service provides an independent, free, confidential advocacy service for all qualifying patients under the 1983 Act. The independent mental health advocacy service will work on a casework basis, with the advocate's activities instructed by the patient, except in circumstances when the patient is unable due to lack of capacity to do so. When a patient lacks capacity to

instruct an advocate the independent mental health advocacy service will deliver non-instructed advocacy in accordance with the agreed protocol.

## **7. The delivery of independent mental health advocacy services**

Independent mental health advocacy will be commissioned and provided in accordance with guidance set out in the Mental Health Act 1983 Code of Practice for Wales and the Welsh Government's Guidance for Independent Mental Health Advocacy Service Planners and Providers.

Independent mental health advocacy services will be expected to deliver advocacy services in accordance with published good practice guidance, including; the Action for Advocacy Quality Standards for Advocacy Schemes and Code of Practice for Advocates and the Welsh Government's National Standards for the Provision of Children's Advocacy Services.

In addition, it is likely that further authoritative documents will be published on mental health advocacy in future. The advocacy service provider is expected to take account of these as they emerge, and critically reflect on its advocates' ability to meet any additional statutory requirements or practice guidelines.

The independent mental health advocacy service providers own policies, procedures, protocols and guidelines should include the following:

- An Advocacy Charter
- Confidentiality Policy
- Complaints Policy
- Whistle blowing Policy
- Health & Safety Policy
- Quality Assurance Policy
- Equal Opportunities Policy
- Health Care Standards
- POVA/POCA Policy

## **8. Information given to qualifying patients**

The independent mental health advocacy service provider will make information available on its service in accessible formats, including leaflets explaining the role of an IMHA, information about the service's confidentiality policy and complaints policy, and how qualifying patients can contact their advocate.

In delivering the independent mental health advocacy service:

- Advocates should at all times aim to provide balanced information to qualifying patients, so that the patient can make informed choices.

- Advocates will support qualifying patients to access information about, and understanding in relation to, their rights; including rights under the 1983 Act where the patient is detained under the provisions of that legislation, and will support them in exercising those rights.
- Advocates will assist qualifying patients in accessing information regarding their care and treatment, and will help them to gain understanding about the reason any treatment is proposed or given.
- Advocates will assist the patient to obtain other information that may be needed, and will signpost qualifying patients to appropriate agencies and services who provide specialist advice and information as appropriate.
- Advocates will not give qualifying patients advice on any topic, nor will they state a preference for a particular course of action.

## **9. Training and Qualifications**

All members of the independent mental health advocacy service provider's staff, paid or voluntary, will be adequately trained to carry out their particular role(s).

All IMHAs must have appropriate skills and competencies, and should be willing to undertake further training and development if required. *All advocates delivering the independent mental health advocacy service will be expected to already possess, or be working towards, the National Advocacy Qualification, and all should have successfully completed the IMHA module of the Qualification within 18 months of appointment.* Documentary evidence of this may be requested by the procurer of the independent mental health advocacy service.

All advocates will have adequate training in matters relating to mental health, in particular the legal and social issues which may affect individuals with mental health problems.

## **10. Referrals**

Referrals to the independent mental health advocacy service will be made by qualifying patients directly or through a third party (e.g. hospital managers or ward/nursing staff to whom authority to make referrals has been delegated, responsible clinicians, approved mental health professionals, the local social services authority, registered medical practitioner or approved clinician).

All referrals made to the independent mental health advocacy service will receive an appropriate response within 5 working days, except for those referrals made by or on behalf of patients detained under sections 4, 5(2) or 5(4) of the 1983 Act, which will be prioritised by the independent mental health advocacy service provider and responded to as soon as is reasonable practicable.

The independent mental health advocacy service reserves the right to withdraw advocacy support from a patient, if:

- an advocate is threatened either verbally or physically by the patient;
- the support requested by the patient could be more appropriately carried out by another agency;
- the support requested falls outside of the scope of work the service undertakes;

The independent mental health advocacy service will make available a copy of their referral policy on request, which will include how the service prioritises responses to referrals.

## **11. Information about the service**

The independent mental health advocacy service is required to provide, and make widely available, publicity material providing qualifying patients and others with details on how they may contact the service.

The independent mental health advocacy service is required to promote and advertise the service in whatever way is most effective. It will also be required to produce leaflets which are to be readily accessible to patients, carers and relatives explaining the IMHA role, information about the service's confidentiality and complaints policies, and how the advocacy provider can be contacted. All such information will be available in an accessible format wherever possible.

## **12. Advocates visiting qualifying inpatients**

The independent mental health advocacy service will negotiate an appropriate mechanism to enable advocates to visit individual wards and units, whether this is by advanced warning or by open access.

When an advocate enters a ward or unit s/he will notify a senior member of the ward staff, and will also inform them when they leave the ward or unit.

In undertaking such visits, advocates will ask the ward or unit staff if there is anything they should be aware of concerning issues of safety or risk. Advocates will respond appropriately to information or requests made by ward or unit staff concerning matters of safety or risk.

Advocates will make themselves known to qualifying patients on the ward or unit and there may be local protocols in place to provide routine introductions where consent has been given.

If the advocate wishes to see a particular patient, then they will ask a member of the ward or unit staff to inform the patient that the advocate is there to see them.



Advocates will meet qualifying patients in private in a designated interview room. If it is not possible for advocates to meet the patient in private, due to them being under observation, in seclusion, or if they pose a risk to the advocate, then the advocate will meet with the qualifying patient in the presence of a member of the ward staff, as long as the patient agrees to this.

### **13. Advocates meeting patients in the Community**

Independent mental health advocacy services will have a policy regarding meeting patients in the community, which will include guidance in relation to lone working.

IMHAs will arrange to meet patients in the community in a way that fits into the patient's lifestyle and their care and treatment plan.

Issues of accessibility, practicality, suitability, patient agreement and the safety of the IMHA will all be considered.

IMHAs will ask the care team if there is anything they should be aware of concerning issues of safety or risk, and will respond appropriately to such information.

### **14. Meetings between advocates and qualifying patients**

The advocate will first ensure that the patient is happy to meet with the advocate, especially if the referral was made through a third party. No pressure should be placed upon a patient by the advocate, or by a third party, to engage with the service.

The advocate will explain to the patient the role of an IMHA, and what they can and cannot do. They will also explain that the service is free and independent of the statutory services they are receiving for their mental health disorder.

The advocate will explain the service's confidentiality policy, including the circumstances when confidentiality can be broken, and ensure that, as far as possible, this is understood.

Advocates will ensure that they work in a way that adheres to the patient's wishes, empowers the patient, and remains issue-based and outcome-focussed. The advocate will work to a broadly circular process:

- Listen
- Discuss options
- Agree action
- Research and gather information
- Review options in light of information
- Confirm action
- Provide support through the action requested
- Review outcome

- Try other option if planned outcome not achieved
- Close case issue.

## **15. Consent to act**

The advocate will always obtain written consent from a patient to act on their behalf if possible. A consent form will be completed which sets out specifically what the patient authorises the advocate to do on their behalf. This should be signed by the patient.

A copy of this consent form will be shown to any third party the advocate contacts when carrying out the patient's wishes.

If, for reasons other than lack of capacity, it is not possible to obtain a patient's written authority, the advocate will ensure that a written record is kept of the fact that the signature was requested and refused, along with the reason(s) for any such refusal.

## **16. Confidentiality**

The independent mental health advocacy service will have a transparent confidentiality policy.

All matters relating to a patient are confidential within the independent mental health advocacy service (except for matters of significant risk to others, or illegal acts).

Information regarding a patient will not be divulged to any third party without the informed consent of the patient.

Advocates will not request information regarding a patient from a third party without the informed consent of the patient.

## **17. Complaints about an advocate**

The independent mental health advocacy service will have a comprehensive complaints policy and procedure.

Complaints will be dealt with within the service. However, if the complainant is not satisfied with the result of their complaint, or the way it was handled they will have the right to refer their complaint to XX.

## **18. The IMHAs relationship with staff of statutory health or social care agencies**

IMHAs will be expected to behave professionally at all times. They will attempt to form constructive working relationships with the staff of the health or social care providers with whom they will engage.

Only in exceptional circumstances will an IMHA express any comments about members of staff to qualifying patients. These exceptional circumstances may be

where an advocate needs to express or imply a view in order to explore a patient's views if the advocate has witnessed inappropriate behaviour by a member of staff. Any such departures must be reported as soon as possible to the advocate's line manager.

Advocates will not allow their personal feelings about a member of staff, or their actions, to influence their working relationship with that member of staff.

Any problems which may develop between an advocate and a member of staff will be dealt with through the appropriate complaints procedure.

## **19. Incident Management & Reporting**

Any incidents involving the advocacy service are to be reported verbally, and backed up in writing, to XX within 24 hours of the occurrence, or immediately whenever possible. The recording of any such incidents will be in accordance with the healthcare provider's Incident Reporting Protocol.

The advocacy service will be expected to participate in any post-incident review that is deemed necessary, and will also be expected to conduct their own in-service review. Any such occurrences must also be considered at the next quarterly or six-monthly monitoring meeting between the advocacy service provider, the service commissioner and the healthcare provider(s), unless the incident is of such magnitude that the continued delivery of the advocacy service is compromised, in which case the advocacy service manager will call an extraordinary meeting.

Lessons learned from any such incidents or reviews should be reported back to the Welsh Government so that relevant information can be incorporated into future advocacy guidance or training.

## **20. Case recording**

IMHAs will keep a record of all work undertaken on behalf of a client, subject to being able to destroy closed case files after 6 years.

Patient's advocacy records should be divided into sections which relate to each discreet issue pursued. Dates when the advocate first started supporting a client on a particular issue should be recorded, as well as the time taken, and the date on which work relating to that issue was completed.

All statistical data will be recorded onto an approved computerised database, using standard categorisation of issues. This monitoring data may from time to time be made available to regulatory bodies on request.

## **21. What the IMHA can expect from Healthcare Providers**

### ***Raising awareness of IMHAs***

The healthcare provider must undertake to ensure that all relevant staff attend awareness-raising sessions on the expanded independent mental health advocacy

scheme. The independent mental health advocacy service is expected to either lead, or participate in, these sessions.

Ward or unit managers will be responsible for making staff aware of this protocol, a copy of which will be made freely available.

### ***Access to qualifying compulsory and informal patients***

Staff of the healthcare provider will, on all occasions, enable qualifying patients to have reasonable access to an advocate, and vice versa, except when access would place the advocate or others at risk, or where there is some other valid reason. A decision to refuse access will be subject to appeal to a senior member of the healthcare provider's management.

A room will be made available on a regular basis for advocates to meet with qualifying patients. The advocate will also have reasonable access to a telephone and photocopier.

Staff will ensure that the patient is able to meet with the advocate in a reasonable place of the patient's choosing, if there is a valid reason for the patient not wishing to use the designated room.

Staff will respect the right of the patient to speak to the advocate confidentially.

No pressure will be put on qualifying patients to meet with, or not meet with, an advocate.

Members of staff will alert qualifying patients when an advocate is on the ward or unit, or when they are expected to be there.

An advocate will be allowed to speak with qualifying patients who have not requested support to ensure that they are aware of the independent mental health advocacy service, their rights, and any other information relevant to their detention.

## **22. Information about the advocacy service**

Where a patient is either admitted for assessment or treatment of a mental health problem, is assessed or treated for a mental health problem whilst already an inpatient receiving care or treatment for a condition other than a mental health problem, or their status changes from informal to formal, the patient will be informed verbally and in writing of the independent mental health advocacy service by a member of staff who has responsibility for making relevant patients aware of the independent mental health advocacy service and asked if they wish to make use of the service.

The patient's response will be recorded on their notes.

If the patient requires advocacy support the member of staff will contact the independent mental health advocacy service to inform them of the request.

Facilities will be given to publicise the advocacy service on the ward.

If appropriate, places to display posters will be made available in prominent positions.

Leaflets will be made available to any patient who requests one, and if appropriate a leaflet will be left in qualifying patients' wards, units, or rooms.

All qualifying patients should be made aware that they are entitled to have an advocate present at any formal meeting, e.g. at a ward round meeting, a care commissioning meeting, etc.

When a qualifying compulsory patient is eligible for a Mental Health Review Tribunal they will be informed of their right to have the support of an advocate.

### **23. Attendance at meetings**

Wherever possible or practicable, staff will allow an advocate to attend, with or without the patient, any meeting that a patient would normally be expected to attend. If the advocate is attending without the patient they will do so only with the informed consent of the patient and with their signed authority.

Seating at meetings will be such that the advocate is able to sit with the patient.

When an advocate attends a meeting on behalf of a patient, they will only speak on issues that they have been authorised so to do by the patient.

Staff will understand that the advocate will faithfully report back to the patient anything said at a meeting when the patient does not attend. Unless to do so is forbidden by law or the advocate is advised formally that it would put the patient at risk to inform them of a particular issue. Such departures must be reported as soon as possible to the IMHA's line manager.

### **24. Complaints about services provided by the health or social care provider**

IMHAs will assist qualifying patients to make complaints about any part of the service provided by the healthcare provider through the appropriate channels. This may include taking complaints to democratically elected representatives.

If a patient is unhappy with any part of the care or treatment they are receiving, the advocate will provide information on the options available to them. Options might include; instigating a complaint under the NHS or LSSA complaints procedure or finding another way of addressing the concerns, for example through informal negotiation or local resolution.

Subject to the patient's consent, advocates will seek to resolve issues at the lowest level possible in the first instance, escalating matters through formal mechanisms where resolution cannot be achieved informally.

When an advocate assists a patient in making a complaint this should not be seen as in any way reflecting the personal views or attitude of the advocate towards any member of staff implicated in the complaint.

The independent mental health advocacy service may become aware of issues that relate to more than one patient, or that are raised by groups of qualifying patients. In such cases the advocacy service is expected to bring these, via the advocacy service manager, to the attention of the healthcare provider. Appropriate methods for bringing these collective issues to the attention of the healthcare provider should be developed.

## **25. Confidentiality**

Anything told to an advocate by the patient will remain confidential, unless the advocate is instructed by the patient to divulge information, or where there is good evidence of potential significant self harm, risk to others, or illegality.

Advocates will not attempt to find out any information that could be regarded as confidential about a patient, unless they have been asked to do so by the patient, and have a signed consent form from the patient to that end.

Staff will not divulge any confidential information regarding a patient to an advocate, unless asked to do so by the patient, or on receipt, or sight, of a copy of a signed consent form from the patient authorising specific disclosure.

Staff will inform advocates if there is a potential risk to the advocate from a particular patient, but this will not necessarily be a reason for the advocate not to meet with the patient.

If staff divulge any information about a patient to an advocate then the advocate is obliged to report it to the patient.

## **26. Health and social care providers policies and procedures**

The health or social care provider will make available to the independent mental health advocacy service all of their relevant policies and procedures, and agree that the independent mental health advocacy service may make these policies and procedures available to qualifying patients.

The health or social care provider will ensure that the independent mental health advocacy service is made aware of any changes to any such relevant policies or procedures.

## **27. Equal opportunities**

The independent mental health advocacy service will have an equal opportunities policy.