

Perceptions of Advocacy in Mental Health Services: Essential or Irrelevant

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ABSTRACT

Purpose – The purpose of this paper is to collate information from available literature on the impact of advocacy on service users based in a psychiatric unit and who should provide them with advocacy.

Findings – The review found two main themes the first being that there is an agreement amongst professionals and governments that advocacy can benefit people and to a greater or lesser extent this can be provided by an independent advocate but also in certain circumstances by a nurse or social worker. The second theme is the continuing lack of awareness of advocacy not only with service users but also professionals affect the opportunity for services users to access the service.

Originality/value -Researchers have looked at the three professions mainly in isolation and their contribution to advocacy but few have focused on the interaction between an independent advocate, nurse and social worker and how this can benefit the service user.

Keywords – advocate, social worker, nurse, empowerment, voice, control, mental health, service user's views.

ACRONYM

AMHP - Approved Mental Health Professional

ASW - Approved Social Worker

BASW – The Professional Association for Social Work and Social Workers

CCETSW – Central Council of Education and Training in Social Work

CPA - Care Programme Approach replaced by Community mental health framework

DoH – Department of Health

IMCA – Independent Mental Capacity Advocacy

IMHA – Independent Mental Health Advocacy

IPA - Independent Professional Advocacy

MHA – Mental Health Act 1983

NOS – National Occupational Standards

PCF – Professional Capability Standards

UKAN - United Kingdom Advocacy Network

UKCC - United Kingdom Central Council

1. INTRODUCTION

This dissertation will explore if advocacy can deliver change from the perspective of qualifying patients placed in a psychiatric unit under the Mental Health Act 1983 and asks the question should it be provided by a social worker, nurse, or advocate. This is considering the perceived dilemma by the different professions as to who should be delivering advocacy as demonstrated in the book *Effective Advocacy in Social Work* by Jane Dalrymple and Jane Boylan where in the introduction it is noted the dilemma for social workers.

‘that social workers recognise advocacy as an important feature of contemporary practice, they may feel less sure about how to translate the concept into action’

Dalrymple and Boylan (2013 pp. X)

Also in a field study of the role of nurses in advocating for safe practice in hospitals the author muses over a similar dilemma in nursing.

The modelling of expert nurses and team-based learning emerged as essential factors facilitating the development of nurses' advocacy role and practices. The state of ‘limited advocacy’, as characterized by the adoption of disempowering and coercive measures to ensure patient safety, clearly indicates a need to re-examine the concept of advocacy in contemporary health care

Choi *et al* (2014 pp 1584).

Whilst Newbiggin *et al* argues for the role of advocacy within mental health services but that the role of an independent advocate is misunderstood.

We begin by addressing the claim for an advocacy role on the part of mental health service staff themselves, and how these, despite well meaning intentions, can not replace truly independent advocacy. Furthermore, we suggest that it is a naïve view of advocacy and confusion over who can take on an advocacy role in this provider context that contributes to strained working relationships and negative views about independent advocacy.

Newbigging *et al* (2015, pp. 245)

In an article *Advocacy in Practice* there appears to be a conflict between nurses and social workers over who's role it is to advocate with nurses feeling ‘if this did arise it was with nursing staff’ Carver N. & Morrison J. (2005 p. 82) and also noted by Atkinson & MacPherson (2001 pp 590) ‘there are also some difficulties in negotiating

boundaries between advocacy and nursing or social work practice’. The United Kingdom Central Council (UKCC) remarked in regard to the role of a nurse as an advocate ‘suggesting in most circumstances an independent advocate could provide more objective support to a patient than a nurse’ (UKCC 1988). But it appears there is an on going discussion within the three professions as to where and by whom advocacy is best provided and this dissertation will look further into this subject and the contrasting information as to whether advocacy should be the sole or shared responsibility of one of these professions.

Contexts of Study

A literature review will be undertaken as a preliminary investigation and looking at contrasting arguments as to whom should provide advocacy to people within a psychiatric unit. Consideration will be given as to the perceptions of staff and service users have of how advocacy works in a Mental Health setting. This review is to establish a basis and a critical account of the literature available regarding the need for advocacy.

There are 3 further sub-questions which will be explored in this study, these are:

- Who should be providing advocacy Independent Mental Health Advocate v Social Worker v Nurse?
- Does a Social Worker, Nurse or advocate have a conscious or unconscious bias when delivering advocacy?
- Service user opinion on effective advocacy?

Initially existing material and techniques used will be explored which will be brought together through this Literature Review that will assist in expanding the knowledge and understanding of this subject area.

This literature review won’t be a full systematic review but it will be comprehensive and will follow the recommendation in the Literature Review as a Research Method.

‘which is one that attempts to incorporate a systematic approach to literature searching, appraisal and re-analysis, even though the final review might fall short of a full and detailed systematic approach’.
Aveyard (2019 pp. 3)

The results and discussion section at the end will summarise the findings of the literature review regarding the involvement of nursing and social work in advocacy and how the professionalisation of advocacy affects their role. Also highlighted will be the recognition from authors and Governments that advocacy has a role to play in the care and well being of patients in a psychiatric setting.

The final conclusion will highlight the main themes and their limitations emanating from the various literatures reviewed. The recommendations will reflect on the main themes and suggest actions if carried out that might improve the understanding between professions that can only benefit the service user.

2. LITERATURE REVIEW

2.1. Introduction

According to Keyes et al (2009 pp 91) there are several different therapies available that will assist people with a variety of mental health illnesses. Most of these treatments remain ephemeral and is only partly effective and the unfortunate situation persists that mental health issues remain as a factor that affects in a disabling manner not only individuals but families and communities.

This literature review will look at initially at some important historical aspects of how people were looked after and treated for their mental health through the ages. The next part of the review will then look at how the three professions, social worker, nurse and independent advocate role exists and interacts with patients located on a psychiatric ward and their role in advocating for patients. The final part will then look at how advocacy as a profession has developed and the effect statutory legislation has had on professionalisation of the independent advocacy role and what effect this might have on the role of a social worker, mental health nurse and patients.

2.2. Mental Health in the 21st Century

According to Roffe D. and Roffe, C. (1995, pp1708) even as far back as the late 13th century congenital ‘idiots’ were protected by law.

Care of lunatics, by contrast, was primarily the responsibility of the family. However, where the family could not or was unwilling to provide, provision was made by the crown. Through the instrument of the inquisition, the diagnosis and social circumstances of each case were determined by commissioners in consultation with a local jury and all interested parties, including the subject himself or herself. The best interests of the subject remained a prime concern, and the settlement that was ordained was tried and enforced in law.

Roffe D and Roffe, C (1995, pp 1708)

It is also clear that even back in the 13th Century the person seen as suffering from mental health, an ‘idiot’ had a right to have a voice in decisions made about them.

According to Wright (2010) The English state has a long history of providing welfare to, and regulating the property of, idiots and imbeciles of the Realm. The Poor Laws as established in Elizabethan times, parishes in England and Wales were responsible for looking after and assisting people who were not well off in society. Overseers of the Poor were people that were obliged to support the ill and disabled of their district.

This system prevailed up to the Victorian era,

The Old Poor Law did not function as a unitary system: its implementation varied according to the problems, priorities, and wealth of each of more than 10,000 parishes. However, by the end of the 18th century certain patterns of parochial care and accommodation were beginning to emerge as officials dealt more frequently with those suffering from mental disability: idiots or imbeciles.

Wright (2010, pp. 11)

During the second half of the eighteenth century according to Wright (2010) Poor Law Overseers supplemented their general assistance by purchasing admissions to charitable (non-profit) 'lunatic asylums', such as Bethlem, St Luke's Hospital, and the Manchester Asylum. Another was the appearance of for profit 'trade in lunacy', where 'madhouse keepers' accepted the poor and those that could pay but with different level of payments sought depending on the person's background. Some parishes used such places but later on built their own asylums. Again, as stated by Wright (2010) other 'madhouses'—or to give them their official name at that time 'licensed houses' like the Droitwich and Camberwell asylums, tailored their policies to accept pauper inmates from parishes at a reduced price. But it was rare for parishes to use these places as it was easier and less costly to use the 4,000 workhouses and alms-houses that were located around the country to dispose of their pauper idiots.

Throughout the 19th century some 20–25% of all known pauper lunatics in England and Wales were accommodated in workhouses. Early on, the lunacy commissioners considered that all pauper lunatics should be admitted to asylums and were highly critical of the conditions under which they were kept in workhouses. As the century progressed the lunacy commissioners were forced to compromise because of the lack of

space in asylums and diminishing confidence in the results of asylum treatment. By the end of the century the lunacy commissioners were reconciled to the accommodation of feeble-minded, imbecile, idiot, chronic psychotic and demented paupers in workhouses, but held to the view that the acute pauper insane should be admitted to asylums. Myers, E. (1998, pp 575).

At the beginning of the 20th Century there was considerable debate about improving the lot of people suffering from mental health. This was led by the Eugenics Society who believed in what today would be regarded as an immoral theory of “racial improvement” and “planned breeding,” but which gained considerable support in early 20th century (National Human Genome Research Institute). According to Matthew Thomson (1998) frustrated by the government’s inaction in introducing a Bill in Parliament, the Eugenics Society drafted their own ‘Feeble-Minded Control Bill’ but this failed to gain sufficient support. Under pressure from different groups within the Parliament the Government eventually brought forward a Mental Deficiency Bill which was eventually passed in 1913 with an overwhelming majority of 358 to 15. The main thrust of the Act was to make arrangements for dealing with those considered to be ‘mentally defective’: ‘idiots’, ‘imbeciles’, ‘feeble-minded persons’ and ‘moral imbeciles’ (Education in England) and it is principally concerned with the provision of appropriate accommodation for them.

The 1913 Mental Deficiency Act drew on a trend away from heterogeneous asylum populations towards sophisticated models of classification and segregation.
Dale (2003 pp 406)

Thomson (1998) commented in *The Parliamentary Politics of Mental Deficiency* that the British legislature avoided seriously addressing the problem again until Mental Health Act 1959

The 1959 Mental Health Act and the 1962 Hospital Plan presaged the rundown of the asylums and the assimilation of psychiatric care into the wider hospital system. Services thereafter developed against a background of serial reorganisations of the NHS and local government.

Turner *et al* (2015 p 602)

Turner *et al* (2015, pp 602) goes on to explain that in the broadest of terms, the mental health service in 1950 compulsorily detained most of its users for long periods in large asylums, attended by nurses under the supervision of doctors.

After the introduction of the Mental Health Act 1959 and the subsequent Act of 1983 and 2007 there were several other changes to mental health treatment as can be seen in Appendix 6.3. The context to these changes according to Turner *et al* (2015 pp 602), as has already been alluded to, was the rundown of the asylum system into the wider hospital system. This was against the background of several reorganisations of the NHS and local government. Governments in power again according to Turner *et al* (2015 pp 603) from both left and right during the 70's acknowledged the need for more resources for mental health services but very little was done to address the issue. The article by Hamilton in the British Medical Journal in May 1983 also gives a summary of mental health treatment from the 19th Century onwards but also the background to the introduction of the 1983 Mental Health Act.

Public concern over the standards of care in psychiatric hospitals has been fired by allegations of neglect and ill treatment in the string of public inquiries in the 1970s. In 1969 mentally handicapped patients in Ely Hospital were found to have been neglected and ill treated by incompetent staff. The report on Ely was followed by those on Farleigh and the Whittingham Hospital in 1972, where allegations of severe ill treatment, inadequate medical and nursing care, defective management policy, and suppression of complaints were found to be true.

Hamilton (1983, pp 1721)

Hamilton goes on to list other allegations of cruelty and inadequate care at South Ockendon 1974, Normansfield 1978 and Rampton Hospital in 1980. At the time there was nobody to oversee the work of mental health practices except for the multidisciplinary team within the social work service of the Department of Health and

Social Services. This team was not empowered according to Hamilton to investigate individual complaints or to comment on matters of clinical judgment.

The main thrust of the new Act according to Hamilton was to establish if a new overarching commission was required and if patients needed to give consent before treatment.

Psychiatrists were pleased to see that the government accepted the proposal to establish a Mental Health Act Commission but disappointed that the new proposals on consent to treatment.... The particular issues were which forms of treatment should be subjected to which procedures, who should give second opinions on consent, and whether or not treatment should be given.... On the one hand some psychiatrists thought that they must be free to give treatment, certainly medication, to any patient whenever they considered that appropriate..... On the other hand, certain members of parliament expressed the view that in no circumstances whatsoever should a patient be forced to have treatment against his will..... Eventually the government scrapped its original proposals and a compromise package passed into law. Psychiatrists won the battle that only doctors could give a second opinion but their opponents were successful in having introduced a nonmedical element in deciding whether the patient was capable of consenting and had consented.

Hamilton (1983, pp 1723-4)

The Act also provided several other provisions such as the change of terminology of mental health classification from “mental subnormality” to “mental impairment”. Welfare Officers were replaced by approved Social Workers appointed by local authorities. Admission could be made by the nearest relative or approved social worker and signed off by two doctors but with a right to appeal by the patient within 28 days of admission.

Crucially a mental health nurse could as stated in the article by Hamilton have the power to detain an informal patient in hospital for up to six hours to enable a doctor to be found to sign a section 30 order that would retain that person in hospital.

The new legislation according to Cummins (2020) was being driven by two potentially conflicting and contradictory concerns.

The first is the role of the state and state agencies in wider public protection. In this discourse, the “mad” both individually and collectively pose a threat. The state requires a range of professionals to manage this potential threat and mental health legislation encodes the powers of these groups – psychiatrists, mental health social workers, psychiatric nurse and the police. The second is a concern with and a recognition of the need to protect the civil rights of those who are subject to such legislation.

Cummins (2020 pp. 217)

Cummins went on to explain that the 1983 MHA Act made it clearer when consent should be sought for treatment thus giving further say for individuals held under the Act in situations where they might be treated against their will. The 1983 Mental Health Act gave a stronger role to the Approved Social Worker as explained by Cummins (2020) in that they would provide a social perspective in the MHA assessment which included

not only ensuring that the views of the person being assessed were taken into account but also exploring all alternative and community-based options to a formal MHA admission.

Cummins (2020 pp. 2020)

The 2007 Mental Health Act would see further changes and reform including the replacement of the ASW by an Approved Mental Health Practitioner which according to Rapaport an AMHP:

will have the same duties as the ASW but while the ASW is always a social worker, the new role of AMHP will be available to non-medical mental health professionals such as mental health nurses, occupational therapists and psychologists.

(Rapaport, 2006 pp. 37)

The change came about due to the lack of ASWs (Huxley *et al*, 2005 pp 1063-1079) and changes in service configuration, but mainly because large number of ASWs were moved from social services to new multi-disciplinary community mental health teams

(CMHTs) operating under jointly managed or integrated health and social care partner trusts Rapaport (2005).

There were further significant changes under the 2007 Act such as Responsible Clinician/Approved Clinician replacing the Responsible Medical Officer where an RC does not always need to be a doctor (Medical Health Law Online) with further details of changes listed on their website. In relation to the issue under observation in this piece of work the other significant change is the introduction of the Independent Mental Health Advocate. The new Act under Regulation 2008 not only specifies that patients have right to access an advocate it sets out legal structures to support the role of an advocate:

99. Section 30 places a duty on the appropriate national authority to make arrangements for help to be provided by independent mental health advocates (IMHAs). IMHAs must be made available to certain "qualifying patients" subject to the powers or safeguards in the 1983 Act as amended, to provide support in the ways specified in the provisions.

100. Qualifying patients will be informed that they are eligible for the services provided by an IMHA as soon as is practicable. An IMHA will meet with a patient on the request of the patient, the nearest relative, the responsible clinician or an AMHP.

101. Where a patient has the capacity to consent and does so, an IMHA has a right to see any hospital or local authority records relating to him. If a patient lacks the capacity to consent, the record holder can still allow access to such records if it is appropriate and relevant to the help the advocate will provide to the patient. IMHAs have a right to meet patients in private and to visit and interview anyone professionally concerned with the patient's medical treatment.

102. The appropriate national authority can make regulations setting out, for example, the standards and qualifications that will need to be met by an individual in order to be approved as an IMHA. These regulations can make different provision for different cases. This will allow them to take account of the different needs of different groups of patients.

103. Section 30 also amends section 134 of the 1983 Act, to ensure that hospital managers cannot withhold correspondence between patients and their advocates.

Medical Health Law Online (2020)

In Wales a further step has been taken by the Welsh Senedd, or Assembly as it was called in 2010, by putting in further provisions in addition to what was incorporated into the 1983 and 2007 Acts. The legislation passed by the Welsh Senedd is the Mental Health (Wales) Measure 2010. The 1983 and 2007 Mental Health Acts focus on compulsory powers and how patients are admitted into hospital and then subsequently discharge, the new Welsh Measure is more about supporting the individual and what should be available to those suffering from mental health issues regardless of where they live in Wales.

As described above the Measure's intent and the intention of the Senedd is to make sure that wherever mental health services are provided, they focus on people's needs as well as the process. There are four main areas to the Measure with each area focused on new responsibilities for Health Boards and Local Authorities with the desired effect eventually of having improved service delivery. The four areas are as follows.

- Local Primary Mental Health Support Services
 - Care Coordination and Care and Treatment Planning
 - Assessment of people who have used specialist mental health services before
 - Independent Mental Health Advocacy
- Llywodraeth Cymru / Welsh Government (2012)

A better concise description of what each point means is given Hafal, a mental health charity, on their Mental Health Wales website.

Part 1 seeks to ensure more mental health services are available within primary care.

Part 2 gives all people who receive secondary mental health services the right to have a Care and Treatment Plan.

Part 3 gives all adults who are discharged from secondary mental health services the right to refer themselves back to those services.

Part 4 offers every in-patient access to the help of an independent mental health advocate.

Part 4 of the Measure is the section that is relevant to the role of an IMHA and it extends access to an advocate to anyone admitted to hospital for treatment for their mental health including those on a shorter-term, emergency sections of the Act (principally Sections 4 and 5), but more specifically to those entering the hospital on their own free will and not subject to the Mental Health Act which would include restrictions on that patient being able to leave the hospital of their own choice.

2.3. History of Advocacy

Societies across the world have their own values and beliefs, but potentially it could be a case that humans as individuals want to speak up for each other when they see someone not being treated fairly and this can be regarded as someone advocating for another person. Some have suggested that ‘most of us want to find ways to voice and act on our values’ (Gentile 2019), however, on the flip side of this there can be an element of fear is speaking up for others and this can prevent some individuals from stepping forward to confront injustice because of the fear of rejection.

People fear rejection in any form of human interaction. Rejection piggybacks on physical pain pathways in the brain. In fact, the same pathways are activated when we are rejected as when we experience physical pain.

Glaser (2018, para. 4)

Speaking on behalf of yourself can sometimes be more difficult than speaking up for others be those individuals or groups and this is the main thrust of advocacy as defined in the Oxford Dictionary.

The Concise Oxford Dictionary’s definition of advocate is also interesting. It reads: ‘one who pleads for another, one who speaks in favour of . . .

Bateman (1995 pp.17).

Examples of people advocating for other can be found in early documented history but usually only recordings of people in authority were kept rather than deeds of ordinary individuals. An example of someone from the early part of Welsh history advocating for a group of individuals was Hywel Dda who ruled most of Wales and advocated for women equality in the Cyfraith Hywel Dda (Edwards, 1929) He was one of the first Welsh rulers to set laws in place for how society should operate and even by today standards they would not be thought as giving true equality between sexes but in the Medieval period they were not welcomed by the established Church as they were different and gave stronger rights to women in comparison with women's rights in Anglo-Saxon England and continental Europe.

Throughout our early history and even up until relatively recently in historic terms openly trading in humans as slaves was common practice. The first Norman King, William the Conqueror cannot be regarded as a truly just person and he committed many atrocities following his invasion of England, but he did not support slavery and in his Laws prohibited the practice.

'I prohibit the sale of any man by another outside the country' says the ninth law in the list 'on pain of a fine to be paid in full to me'
Morris (2013 pp 235).

The signing of the Magna Carta was arguably the first step in establishing what today is regarded as our fundamental rights. One of the key aspects of the document was the right to justice and a fair trial. The principles within the document can be argued have been the basis of other landmark documents around the World establishing common rights which support advocacy principles today.

Some of Magna Carta's core principles are echoed in the United States Bill of Rights (1791) and in many other constitutional documents around the world, as well as in the Universal Declaration of Human Rights (1948) and the European Convention on Human Rights (1950) Brea, Harrison (British Library 2014).

According to Ridley *et al* (2015 pp 56) in their book *The Right to be Heard* quotes Jugessur and Iles (2009) the possible origins of the language of advocacy can be traced back to the fourteenth century and to the word 'Advocacie' where 'Advocacie' is translated as pleading for or supporting. It goes on to quote the definition of advocacy which originated in the legal system as:

stating a case to influence decisions, getting better services, being treated equally, being included, being protected from abuse, redressing the balance of power and becoming aware of the exercising rights
Jugessur and Iles (2009, p. 188)

One of the earliest self-advocacy documents on record is the *Petition of the Poor Distracted People in the House of Bedlam* in 1620 (Brandon 2000). More than two hundred years later, in 1845, Richard Paternoster established the *Alleged Lunatic's Friend Society*. One of the first recruits was John Perceval, who, after three years' incarceration, wrote vociferously about his maltreatment. They discussed matters that still happen today: 'demands for a voice in decisions about care, campaigning for change and alignment with radical politics' (Hervey 1986). This group possibly could be regarded potentially as the forerunners of consumer / self-advocacy groups and their objectives were:

to reduce the likelihood of illegal incarceration and improve the condition of asylums, to offer help to discharged patients, and to convert the public to an enlarged view of Christian duties and sympathies
Hervey (1986 pp 245).

In more recent history it has become more common for groups to advocate on specific injustices such as rights fought for by the Chartists (Black, 2012). In the 60s and 70s

advocacy concepts started to be recognised through self-advocacy and by Wolf Wolfensberger (Bateman 1995), working with parents of children with disability, who developed citizen advocacy.

By 1972 the Scottish Union of Mental Patient was formed with the 'Foundation Members' of SUMP being patients in locked ward 7 along with three patients from the locked wards 8 and 10 whom created a petition that was 'smuggled out' (Gallagher 2017). This was followed by Mental Patients Union in London with membership only open to patients or ex-patients who together sought to have conditions in psychiatric hospitals improved. Even though these unions did not call or regard themselves as advocacy groups at the time they certainly were examples of collective self-advocacy by those personally using mental health services (Dalton and Carlin 2002 pp 21).

In the 80s the Advocacy Alliance was formed which supported the introduction of independent citizen advocacy (Dalton and Carlin 2002 pp 21). The concept of citizen advocacy can probably best be defined by John O'Brien, Learning from Citizen Advocacy Programs.

A valued citizen who is unpaid and independent of human services creates a relationship with a person who is at risk of social exclusion and chooses one or several of many ways to understand, respond to, and represent that person's interest as if they were the advocate's own thus bringing the partner's gift and concerns into circles of ordinary community life
O'Brien (1987, pp. 3).

There are several reasons that can be argued as to why advocacy during the 90's was able to gain momentum as a right for people to access rights and this is illustrated by Dalton and Carlin (2002 pp 21) but probably best described by Campbell (2009) who suggests:

that it was the confluence of policies promoting consumerism, retracing the asylum system and extant criticism of psychiatry and psychiatric services that was favourable for the growth of a survivor or service user movement, and that this in turn, was instrumental in promoting advocacy in its various forms and ultimately, securing rights to independent advocacy

Campbell (2009 pp. 46-52).

Without any kind of framework or set of principals in place advocacy could be regarded as any kind of support be that verbal or action that is carried out by a friend, relative or professional on behalf of a person irrespective of whether that person has even been consulted. This was one of the reasons that The United Kingdom Advocacy Network (UKAN) was founded in the 1990's following a national users conference was organised and out of that conference grew the concept of a national body to represent the various advocacy groups that then existed Dalton and Carlin (2002 pp 21). UKAN went on to develop the Advocacy Code of Practice which was first published in 1994 and since then has been developed into the code of practice that is in existence today and forms part of the Advocacy Quality Performance Mark Code of Practice which is overseen by the National Development Team for Inclusion (NDTi) and was last updated in May 2018. The code is a fundamental part of everyday working practise for any advocate and a summary of the code is below with the full set to be found in Appendix 6.4 and online at National Development Team for Inclusion (2018).

Clarity of purpose is in regard to awareness raising where the advocacy providers need to ensure they people wanting to access the service be they individuals, professionals or organisations are of the service, know what advocacy stands for. That the advocacy service is independent at all times, remaining independent from statutory services and therefore free from conflict of interest. Advocates will be person-led, putting them first and follow their instructions in a non-judgmental

manner. The advocate will endeavour to support the person being supported to self-advocate through empowerment of information and choice. The person being supported will dictate what level of support they will want from the advocate and the advocate will support the person with different communication tools to enable them to participate in discussions about their care and treatment.

The code emphasises that correct policies and procedures such as equality, diversity and accessibility are in place and that the service is free of charge.

The code also highlights the need for advocates to be supported through training, supervision and opportunities to upskill plus access to legal advice when required. That the service itself is well managed with effective systems in place to allow the recording, monitoring and evaluation of the service.

The Code stresses the need for the service to inform and respond to feedback and complaints. Confidentiality is another factor of the Code and give guidelines on process that should be undertaken to always protect confidentiality except in exceptional circumstances. The advocates will have a thorough knowledge of safeguarding issues and how to inform people they support about their Human Rights. The Advocacy Code can be regarded as the cornerstone of any advocacy service and how it should operate but how an advocate should act when interacting with the people is espoused by Henderson (20005) that the advocate represents his/her partner's views '*as if they were the advocate's own*' which is reenforced by Dalton and Carlin (2002 pp21) that the advocate will offer neither opinion or advice and will not judge either the service user or what they want to say.

But how does an advocate operate. According to Henderson he explains how an advocate receives instructions:

First s/he needs to receive instruction from the service user. This can be done formally via a letter of authorisation, or informally in conversation.
Henderson (2005 pp. 202)

In an article in 2005 by Carver and Morrison who conducted semi-structured interviews with ten advocates to understand their perspective of how an advocate should act. All the advocates that took part had a personal belief that *'they only acted on what a client asked of them, and they did not act to influence a client'*. As one advocate put it:

If a psychiatrist is talking to me, for all intents and purpose he's talking to the patient. Advocacy was not then: ...a fight the system thing.
Cavern & Morrison (2005, pp 77)

It is generally recognised by the turn of this century that advocacy is there to be the voice of the person being supported but also there to try and empower the user to speak up on their own behalf. As described by Harrison and Davis in their article Advocacy: time to communicate (2009 pp.57-64) the central tenet of advocacy in healthcare is that service users should be enabled to speak up on their own behalf and empowered to take a lead in the decision-making process. They also go on to claim that potentially advocacy can be of assistance to that person's mental health by helping them understand what is happening around them, that what they wished to say can be heard, and that the person is at the centre of decision making.

The World Health Organisation goes as far as to state that advocacy can change government policy.

'Advocacy is an important means of raising awareness on mental health issues and ensuring that mental health is on the national agenda of governments. Advocacy can lead to improvements in policy, legislation and service development'
(World Health Organization 2003: front cover)

Due to the recognised need for advocacy, there has been an introduction of statutory advocacy in both England and Wales. The first statutory advocacy service to be introduced was the IMCA service under the Mental Capacity Act 2005.

IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person.

Social Care Institute of Excellence (2010)

Even though the Mental Health Act was passed in 1983 it was not until 2007 under an amendment to the Act that an IMHA service was introduced, and this was most likely due to the direct campaigning and organising by the Mental Health Alliance (Ridley *et al* 2015 pp 68), and the commissioning of the service did not take place until November 2008 in Wales and April 2009 in England (Harrison and Davis 2009 pp.57-64). The IMHA service in England could only be provided for patients sectioned under the Act but in Wales there was an additional Measure (2010) to the Act which allowed informal patients to access the advocacy service with informal being regarded as non-detained, patients receiving assessment or treatment for mental disorder in hospitals in Wales within the scope of the IMHA service (Mental Health Act Code of Practice Wales). There have been other statutory advocacy services introduced since then such as in Wales the Independent Professional Advocate (IPA) (Social Services and Well Being Act [SS&WBA] 2014) but the focus of this paper will be on the interaction between nurses, social workers and the IMHA service and how advocacy can benefit patients in a psychiatric setting.

2.4. Mental Health and Independent Mental Health Advocacy: Policy and Practice

As proposed by Barnes et al (2002 pp2) the definition of IMHA in the 2007 Act describes it as a distinct form of advocacy for people detained under the legislation and it can only be provided for qualifying patients, in Wales this was extended to informal patients as well. As described by Ridley *et al* (2015 pp149) qualifying patients cover patients detained under the MH Act 1983, including people on CTOs, but excluding people on emergency section (i.e. Section 4 and 5). Informal patients in Wales also have the right to access an IMHA service unlike in England but this is potentially going to change under the review of the Mental Health Act by the Westminster Government.

Why should we differentiate between informal and formal because somebody who is informal could quite easily actually meet the criteria for being sectioned and so just the fact that they've gone in as a formal patient means they're not entitled to an IMHA and I think everybody should.
IMHA quoted in Newbigging *et al* (2012, pp.134)

The core standards for a future IMHA service were also looked at in 2002 by Durham University, written by Di Barnes and Toby Brandon with Tricia Webb, the Independent Specialist Advocacy in England and Wales: Recommendations For Good Practice report which was commissioned by the Department of Health in London. The report indicates as to what principles the advocacy service should adhere to, but they are not as comprehensive as today's principles but do draw on those developed by UKAN and does include that an advocacy service should be independent, empowering, inclusive, impartial, confidential and free to all service users.

The report also sets out who can access the service in accordance with the Mental Health Act 1983 and how the service should be delivered. It goes on to recommend what records should be kept, the different policies that should be in place, the governance of the service and that service users should be involved in the development of the service. In staffing the service, the report is quite clear that

people with experience of using the service should be encouraged to apply for positions of advocates, that they should receive adequate training with regular supervision and should reflect the gender and ethnic make-up of the service users they are supporting.

Royal College of Psychiatrists London produced a report in 2012 called independent advocacy for people with mental disorder and on page 31 and 32 the authors set out what they regard as what an advocacy is and is not. Possible this could be regarded as precursor or alternative code of practice for advocacy as set out by NDTi (Appendix 6.4) which has been touched on earlier. There are many cross overs between the two such as advocacy is empowering, accessible, about standing alongside people who are in danger of being pushed to the margins of society, about standing up for and sticking with a person or group and taking their side, listening to an individual or a group and trying to understand their point of view but then report goes further than the principles of advocacy to give a more in-depth reasoning for what is advocacy:

- Assertive
- Non-judgemental
- Non-directive
- A process of working towards natural justice
- Finding out what makes them feel good and valued
- Understanding their situation and what may be stopping them from getting what they want
- Offering the person or group support to tell other people what they want or introducing them to others who may be able to help
- Helping the person or group to know what choices they have and what the consequences of these choices might be
- Enabling a person or group to have control over their life but taking up issues on their behalf if they want you to

Unlike the principles of advocacy this report tries to give a definition of what advocacy is not such as making decisions for someone, providing mediation, counselling or a befriending service. The report goes on to give other examples of what advocacy should not be such as telling or advising someone what the advocate

thinks they or solving all of someone's problems. Also the report clear states that advocacy should not be an occasion for advocates to speaking for people when they want to speak for themselves, filling all the gaps in someone's life. A further list is provided:

- Pursuing the advocate's own agenda
- Agreeing with everything a person says and doing anything a person asks you to do
- Acting in a way that prioritises the need of anyone other than the individual
- Overly emotionally involved
- Creator of dependency
- Breaker of confidentiality
- Giver of false hope
- Allied to any professional standpoint

The Code of Practice relating to Mental Health Act as revised in 2016 mirrors some of the main aspects of the report prepared by Durham University and Royal College of Psychiatrists London report but goes into more detail about the role of an IMHA. The section relating to the role of an IMHA in chapter six, pages 30 to 39, Code of Practice for Wales. It is not the intention here to record the whole section, but it is important to pick out some elements to highlight the role of an IMHA. On pages 30 to 31 it lays out what an IMHA will do such as help the patient to understand their rights under the Act, that the patient has a voice, to access information, explore options and to counteract any prejudice. It sets out how an IMHA will supports a patient in attending meetings, to explore alternatives to proposed treatments, to understand what is happening to them, to support in raising concerns and accessing records. It sets out how an IMHA will support a patient that lacks capacity by enabling them to participate as much as possible, find out '*what alternative course of action are available*' and make sure the '*patient's rights are respected*'.

Not only does the Cope of Practice set out what an IMHA will do it also records a patient's rights, on pages 33 and 34, to access an IMHA. According to the Code this

should be done as soon as possible after the patient arrives at the hospital, when the patient might have made a complaint, when discussing their care or treatment or in any meetings attend by the patient regarding any assessment or treatment they might be receiving.

The Code also sets out who is responsible for informing the patient about their right to an IMHA for example if a patient is detained then it is the manager of the hospital. These persons would be regarded as the ‘responsible person’ and they have a duty to inform the patient of the support available from an IMHA.

On pages 37 and 38 the code specifically sets out the rights of an IMHA to speak in private with the patient except in certain circumstances, the right to interview professionals ‘*concerned with the patient’s medical treatment*’, have access to the unit where the patient is detained and that the IMHA can access records that are relevant about ‘*the patient’s detention or treatment*’.

The Code of Practice (Appendix 6.4) reinforces the fact that an IMHA service is a statutory role which is in agreement with Ridley (2015, p 168) ‘*IMHA is a form of statutory advocacy with a clearly defined role*’.

To underline the competency of advocates to carry out their role as IMHAs commissioners of the service now require the IMHA service provider to ensure all their advocate obtain the Independent Advocacy Practice qualification. In a recent procurement process for the IMHA service in Wales the procurement document in point 14.7 clearly states that:

As of 1st September 2020, there is a new City and Guilds National Advocacy Qualification level 4 ‘Professional Practise in Independent Advocacy’ this replaces the previous City and Guilds National Advocacy Qualification level 3 ‘Certificate in Independent Advocacy’.
NHS Wales Shared Services Partnership (2022 pp. 15)

Initially the requirement was for an IMHA to obtain the City & Guilds 3610 Independent Advocacy Qualification. The advocate was required to complete core modules, Unit 301 Purpose and principles of Independent Advocacy, Unit 302 Providing Independent Advocacy support, Unit 303 Maintaining the Independent Advocacy relationship, Unit 304 Understand the social context of Independent (SCIE, 2015) plus two additional modules with one being 306: Providing Independent Mental Health Advocacy (IMHA) which was a Level 3 award.

This changed in 2020 in both England and Wales following a recommendation from NICE that advocacy services should ensure that advocates should complete the National Qualification in Independent Advocacy (NICE, 2020). It recognises the need for independent advocates to be trained and assessed across their knowledge and practice skills to a level 4 standard. With the new qualification the advocate would be required to study the subject in more depth with three mandatory units Unit 401 Principles and practice of independent advocacy, Unit 402 The legislative framework which impacts upon the independent advocacy role and Unit 403 Entitlements to independent advocacy (City and Guilds, 2023) with one additional unit in the case of an advocate working towards being an IMHA they would be required to take Unit 405 Independent mental health advocacy.

2.5. Advocacy and Social Work practice

In their introduction to their book *Effective Advocacy in Social Work* Jane Dalrymple and Jane Bolan (2013) argue that that advocacy has traditionally been a key element of social work and that it is identified as a central skill by the Central Council of Education and Training in Social Work (CCETSW) in 1995 as well as by the British Association of Social Workers in 1996. They go on to state that as service users have battled to gain recognition for the need for an independent advocacy and that the

consequence of this is that advocacy within social work has been overtaken by the role of independent advocacy services. But they argue in their introduction that social workers and other health professionals have a role in promoting rights, participation and service user involvement and that they should reclaim their advocacy role.

Sheafor and Horejsi (2003 pp57) also agrees that advocacy has been described as ‘at the heart of social work’ and as a key function of social work practice where it can be of assistance to both people being supported and carers being independent from service providers.

The definition of social work by international standards as set out by the International Federation of Social Workers is shown below:

The social work profession promotes social change, problem-solving in human relationships, and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behaviour and social systems, social work intervenes at the points where people interact with their environments. Principles of human rights and social justice are fundamental to social work.

Hare (2004 pp. 409)

Dalrymple and Bolan (2013 pp13) in their book note that promoting change can be challenging for social workers if employed in a statutory setting ‘because of the tension in the social control elements of social work’. But they go on to state that empowerment and liberation involves the use of relationships and interpersonal skills to help the personal growth of people who are having a particularly difficult time and may be disadvantaged (Dalrymple and Bolan pp 14). Brandon and Brandon (2001, pp 3) bring to our attention that the idea of advocacy within social work is not a new concept noting that ‘there is widespread delusion that advocacy in social care is of recent origins’.

The Barclay Committee which was established in 1980 according to Dalrymple and Bolan (2013 pp 29) with the role ‘to review the whole task of social worker in local

authority social services department and related voluntary agencies in England and Wales and to make recommendations' (Barclay, 1982: vii) and identified an important advocacy role for social work. Stating that Social Workers would:

failing in their duty if they did not speak out in light of personal knowledge and the evidence amassed from contact with such (poor and disadvantaged) people, challenging policy decision or the way resources were allocated
Barclay (1982, pp. 9)

Towards the end of the last century it was becoming clear that policy and legislation was recognising that people receiving services and their carers to have a say in the way they receive services and according to Dalrymple and Bolan (2013 pp 31) this was leading to independent advocacy being taken seriously by all four nations of the UK.

According to Scourfield (2021) Social workers in England were first brought into statutory professional regulation in 2001, when the General Social Care Council (GSCC) was established. The Social Care Register was opened in 2003 and only those on this register could use the title of 'social worker'. In Wales the statutory regulation only came in under the Social Services and Wellbeing Act 2014 and the establishment of Social Care Wales in 2016. The principals of the Act are:

Voice and control – putting the individual and their needs, at the centre of their care, and giving them a voice in, and control over reaching the outcomes that help them achieve well-being.

Prevention and early intervention – increasing preventative services within the community to minimise the escalation of critical need.

Well-being – supporting people to achieve their own well-being and measuring the success of care and support.

Co-production – encouraging individuals to become more involved in the design and delivery of services.

(Social Care Wales 2023)

The first principle of the Act mirrors closely one of the main principals of the advocacy code of practice (Appendix 6.4). Social Care Wales on its website gives the first agreed definition of a Social Worker in Wales:

Social work is a profession that supports, empowers and safeguards the most vulnerable adults and children in society
(Social Care Wales 2023)

It goes on to describe on its website what it expects a social worker to be including to act as an advocate for vulnerable people and children.

Guidance issued by the Department of Health in England created new National Occupational Standards (NOS), which set out the requirements for qualification for social workers (Department of Health, 2002). The NOS were organised around 6 ‘Key Roles’ and 21 Units (TOPSS, 2002). Key Role 3 which was about supporting ‘individuals to represent their needs, views and circumstances’ stated that social workers should be able to:

- Advocate with and on behalf of, individuals, families, carers, groups and communities.
- This was elaborated in Unit 10 which stated that social workers should be able to:
- 10.1 Assess whether you should act as the advocate for the individual, family, carer, group and community
 - 10.2 Assist individuals, families, carers, groups and communities to access independent advocacy
 - 10.3 Advocate for, and with, individuals, families, carers, groups and communities
- (Department of Health 2002)

Scourfield (2021) reflects on Unit 10.1 in that he finds it is interesting as there is a requirement for a social worker to consider if they should advocate in relation to the people they are supporting. He emphasises that the Unit 10.1 makes the important point that social workers should not assume that they will always take on the advocate role. He does raise the question that the guidance does not give clear guidance for a social worker as to when they should or should not act in the role of advocacy leaving

it to the professional discretion of the practitioner. In Unit 10.2 identifies that as well as practising advocacy, social workers is required to direct a person being supported to access independent advocacy. Scourfield (2021) points out that the guidance is unclear under which circumstances a social worker should or should not direct a person to independent advocacy. He does point out that the guidance was formulated before the time statutory advocacy was created in legislation, but the fact that advocacy and guidance for social workers is included confirms that the efforts of service user groups to have their voices heard had been recognised.

The NOS were replaced by the Professional Capabilities Framework in 2012 and it appears that there is recognition that statutory advocacy has been established and that potentially social workers have less of a role to play in advocacy as there is very little reference to ‘advocacy’ in the domain descriptor according to Scourfield (2021) only that social workers should ‘where appropriate, set up and/or enable access to effective independent advocacy’

However, the references to promoting human rights, challenging inequality and injustice and promoting strengths and agency strongly imply an advocacy role for social workers. Arguably, in order to ‘promote’ to ‘challenge’ and to ‘address’ it requires some form of advocacy. Given the emphasis the PCF gives to promoting rights, challenging inequality and addressing oppression, it might have been more explicit about how these goals are expected to be achieved. In this respect the PCF is less explicit about social workers acting as advocates than the NOS

Scourfield (2021, pp 57)

The only other apparent pointer to advocacy is in domain seven of PCF states that social work students should ‘communicate information, advice, instruction and opinion to advocate, influence and persuade others’ (BASW, 2018).

In 2019 Social Work England (SWE) replaced the Health and Care Professions Council in regulating social work in England. The PCF remains in place but, SWE published its own standard with specific reference to advocacy:

Social workers support people to be in control of their own lives and advocate for themselves. Sometimes however, people are not able to represent their own interests. In such a scenario, social workers should work with the person to agree a way forward, which could include advocacy by the people in the person's life, including relatives or friends, or non-statutory independent advocacy, and advocacy by professionals..... Social workers can act as advocates on behalf of people to support them to say what they wish and/or to access services. This can be an invaluable role, supporting people to make their voice heard, to exercise their rights and to gain access to the information, services or resources they need.

(Social Work England pp4)

In the above quote regarding different types of advocacies according to Scourfield is a clear indication from SWE and in comparison to other professional guidance the by far,

the most clear about the 'invaluable' advocate role that can be played by social workers themselves. Therefore, taken together, the PCF, QAA Benchmark Statement, KSS and SWE guidance set out (either explicitly or implicitly) a clear mandate for social workers to undertake case advocacy where necessary. It is also prescribed that social workers enable access to independent advocacy where appropriate.

Scourfield (2021 pp 59)

The regulatory body in Wales, Social Care Wales (2022), also has similar copies of practice, regulation, education and training standards but does not give a definition of the role of advocacy in social work.

Advocacy and Nursing Practice

According to the Article in Mental Health Nursing (2014) by Mick McKeown *et al* they argue that interest by nurses in advocacy dates back to the Crimea war and Florence Nightingale. Nelson goes on to state that:

Advocacy has moved from a posture of interceding for clients to acting as guardian of the client's rights to autonomy and free choice. In spite of

counterforces, such as perceived loyalty to an employer, nurses have been able to serve as advocates to clients as individuals and as groups.
Nelson (1988 pp.136-41)

Holmes (2001) argues that the role of the nurse as an advocate goes unrecognised but should be realised as part of an '*intellectual and political commitment to ensure that the most disadvantaged voices, subject to surveillance and control are properly heard*'.

According to Mick McKeown (2014) there is a connection between the embracement of caring values and the principles of empowerment by the nursing professional. In a study carried out in Australia in an inpatient location for those with mental health needs found

'nurses articulated a clear personal philosophy of advocacy and attempted to structure nursing interactions to promote client autonomy and informed choice'
Clearly (2004, pp. 56)

The comment from Clearly demonstrate that there is an understanding by nurses about the concept of advocacy which aligns closely to the principles of advocacy.

The claim that nurses should be patient advocates is a questionable one according to Bernal (1992), especially when it is mixed in with the professional issue of nurses' freedom to practice. He goes on to express a view that a less combative, more cooperative model of the profession would serve nurses better.

The view of mental health professionals, particularly nurses, according to Newbigging *et al* (2012) is that they, nurses, have an advocacy role. Newbigging *et al* goes on to state

This is usually framed as best interests advocacy linked to their duty of care and is fundamentally different from the concept of independent advocacy. A substantial number of mental health professionals we interviewed did not appear to understand this. In such instances, staff can view the IMHA role as

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

Newbigging et al (2012, pp. 5-6)

In the report Newbigging *et al* did go on to explain that the above approach was not universal across the profession and that some mental health professionals believed that they did have a good understanding of the difference between their nursing role and that of an advocate and that some professionals with a clearer understanding of an IMHA role went on to promote the service and create an environment that was conducive to creating a space that allowed an independent advocacy to thrive.

As part of their report *The Right to Be Heard - Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England* Newbigging *et al* (2012) interviewed many people including advocates, mental health service users, IMHA partners, carers and mental health professionals. During the conversations with professionals working within the field of mental health aspects about advocacy was raised about the nature and purpose of advocacy. A number of nurses and social workers pictured themselves as having a defined advocacy role and that this role was reinforced during their training period and the professional codes of conduct they were taught.

In the Review on pages 104 to 105 to emphasise the above point Newbigging *et al* (2012) quoted the responses made by some of those participating in the interviews.

“It’s integral as the role of the nurses to advocate for our patients and I regularly do when we’re in meetings. We do ward rounds and CPA’s and I’ll regularly put the point across that the patient might want to ask, you know having discussed the various issues and we quite often try and also bring in the point of view of the patient as well because I think that’s absolutely essential.”

Ward Manager (Learning difficulties ward)

“I mean I’d see myself as being an advocate and I have done on many occasions, like, you know, especially around complaints. If patients make

complaints I'd seek to rectify the complaints in the first instance if they were, you know, locally resolvable.”
Modern Matron (Secure services)

Many, especially nurses participating in the review expressed a view that due to their position within mental health units that they had an advocacy role to play as they were a key worker or care coordinator, that includes having a good relationship with the person being supported and through knowing them well and learning about their whole well being they were better placed to advocate for them.

“A relationship between a nurse and a patient is quite close, that's what we try to make it therapeutic. We try and really understand their emotions and their needs. Sometimes it's difficult to separate other things from that because you become close with that person, now an Advocate doesn't have that emotional bond with the patient because they don't spend that length of time and they're not trained to do that.”
Staff Nurse (Acute ward)

The nurse in the above example is trying to put forward that due to a more intense relationship with people being supported that this cannot be achieved by an advocate and thus by building this relationship the person being supported can discuss their worries with them. According to Newbigging *et al* (2012) this was not an isolated view held by nurses they interviewed.

Carver and Morrison (2005) in their article in Journal of Psychiatric and Mental put forward in their findings, which they believed would be of particular interest to mental health nurses who wished to increase their knowledge of advocacy and gain a fresh perspective on inpatient care

that the finding reveal difficulties inherent in advocacy practice as well as the nature and importance of good working relationships between advocates and clinicians. Despite acknowledging such relationships frequently exist, advocates can still encounter ignorance of their role and opposition to their presence. The clearest implication of the findings is the need for greater training of nurses and other clinicians in the role of the advocate.

Carver and Morrison (2005, pp. 75)

Carver and Morrison continue in their article to quote the Department of Health who argued that mental health nurses had a critical role in ensuring advocates are welcomed and listened to. DoH (1994).

The Professional Standards of Practice and Behaviour for Nurses, Midwives and Nursing Associates (2018) does not specifically mention advocacy within their code but in section 2 Listen to people and respond to their preferences and concerns to work in partnership with people to make sure you deliver care effectively nurses and midwives should understand and respect people's wishes when they want to have an input into their own care, to encourage and empower to contribute their thoughts about treatment they are receiving and at what level they want to contribute, to respect the fact that some people may want to decide to accept but also refuse treatment. These principles are closely linked to those of advocacy and can potentially lead to an understanding why nurses feel they can advocate for a patient.

2.6. Mental Health and Professional Advocacy: Policy and Practice

There are several reasons why an Independent Mental Health Advocacy was finally proposed and added to the Mental Health Act 2007. As has already been touched upon the direct campaigning by organising such as the Mental Health Alliance put pressure on the Government to include advocacy in the 2007 Act. There are other examples of why eventually the Government of the day eventually included an IMHA requirement into the Act.

One of these was call for reform and delivery of race equality in mental health care, an Action Plan for reform and the Government's response to the independent inquiry into the death of David Bennett. The report delivering race equality an independent inquiry into the death of David Bennett in mental health care was published by the

Department of Health on 11 January 2005. This followed an inquiry into David Bennett's a 38-year-old African-Caribbean patient who died on 30 October 1998 in a medium secure psychiatric unit after being restrained by staff and recommendations made following his death.

As well as Delivering Race Equality, this document contains the Government's formal response to all the recommendations made in the report of the inquiry into David Bennett's death. The responses are overwhelmingly positive and, taken together with the action plan in DRE, comprise a coherent programme of work for achieving equality of access, experience and outcomes for BME mental health service users. (DoH 2005, pp. 3)

There are numerous recommendation that the Government accepts including the following.

3.62 Providers and commissioners should also make sure that there are culturally and linguistically appropriate independent advocacy services, if necessary using strategies such as joint commissioning to ensure adequate investment and coverage.

3.63 The draft Mental Health Bill (2004) provides for independent Mental Health Act advocacy to be available to everyone treated under powers of compulsory detention, and to the nominated person appointed to help them. The advocate will help patients (and nominated persons) to obtain and understand information about: • their medical treatment; • the legal authority under which they are detained; • which requirements of the Act apply to their treatment; and • their rights and how to exercise them – for example, by applying to the tribunal for discharge. (DoH 2005, pp. 49)

Prior to the 2007 Act being given Royal assent the Durham reports which were split into two documents, core standards and recommendation for good practice in advocacy. In the Recommendation for Good Practice it sets out the purpose, scope and model for an advocacy service. Under purpose on page two and three of the report it sets that the advocacy is there to safeguard the rights of service users and to empower the people being supported about the care they receive, to get their views heard without the advocate giving their own opinion. Further to this it states that

advocates should assist a person being supported with matters that concern them, to make informed decisions and to feed back on matters affecting the person being supported to service providers to enable them to improve the service. The last statement today would go against the Confidentiality policy in the principles of advocacy which can be found above on page 23 where information should not be shared unless consent is given by the person being supported.

The report then goes on to describe on page three the scope a specialist advocacy service in that the service provided should be focused on the individual, should only relate to that person's mental health treatment, should be only on certain matters relating to their mental health treatment and time limited and that the service can respond in adequate time to requests for support. The report specifies the response time this being three days but only within normal office hours and the advocate should not work on behalf of relatives as well as the person being supported.

Again, on page three the report suggests that the model proposed should be:

that of professional advocacy – a service provided by trained paid advocates. Volunteers may make a valuable contribution and add value to the service, but the core specialist work should be provided by paid employees. The service must be independent and therefore free from conflicts of interest.

Barnes *et al* (2002, pp. 3)

This report goes into further detail highlighting the pay structure that should be available for a specialist advocate and team leader.

for a specialist advocate SO1/2, or NJC points 29-32,
for a team leader SO2/PO1 or NJC Scale Points 33-36

Barnes *et al* (2022, pp. 4)

The above payrates today if the NJC recommendation had been implemented would give a salary for specialist advocate (IMHA or IMCA) for points 29-32 (West Sussex County Council 2023) between £37,336 and £40,221 going up to £41,418 to £4425

for a team leader. A search for IMHA post on the internet on the 20 January 2024 shows that salaries today do not match the recommendations in the Durham report. A post in Somerset for an IMHA had a range of £21,255 to £22,255, an IMHA based in Kingston upon Hull £24,000 and an IMHA based in Bangor, North Wales was advertised at £23,401 to £24,793. An example of a job advert can be seen in Appendix 6.5 drawn from the internet on 20 January 2024. Salaries of an advocate do not appear to reflect the professionalisation of its service with salaries ranging between £21,255 and £24,793 which is considerably lower than what was recommended in the Durham report (2002). This is in comparison to an average starting salary for a social worker at £27,000 and with experience as much as £43,000 (nursing.co.uk) with a nursing starting salary of £28,407 but with an average salary ranging between £33,000 and £35,000 (nursing.co.uk)

The Core Standards documents goes into more specific details. It highlights the principles that the advocacy service should adhere to these being independence, empowerment, inclusive, impartial, confidential and free. Today's set of principles as set out by NDTi duplicating these but also expands on these core standards (Appendix 6.4).

The document touches on how advocacy should be delivered which is also included in the Recommendation of Good Practice but also highlights how an advocate should keep records of the work carried out.

Advocates should be required to keep brief accurate records of their interaction with service users.

Records should be securely stored to ensure the confidentiality of the advocacy relationship. Service users should have access to their records at all times. Records are required to be stored for 7 years after the last contact with a service user for public liability insurance purposes, but should then be destroyed. Specialist advocacy services should comply with the requirements of the Data Protection Act 1998.

Barnes et al (2002, pp. 4)

The report also gives details of how an advocate should be supported and supervised.

Advocates should be required to keep brief accurate records of their interaction with service users. Records should be securely stored to ensure the confidentiality of the advocacy relationship. Service users should have access to their records at all times. Records are required to be stored for 7 years after the last contact with a service user for public liability insurance purposes, but should then be destroyed. Specialist advocacy services should comply with the requirements of the Data Protection Act 1998.

Barnes et al (2002, pp. 4-5)

The report also gives examples of good practices as to what policies should be enacted, what training that should be available and what governance and accountability should look like.

The report does not give examples of the type of case load an advocate should carry but there does appear to be a definitive guide as to the caseload an IMHA should carry at any one time in research carried out by Newbigging *et al* in 2012

The average caseload size of individual IMHAs in these services was around 25 cases, but this masked wide variation between different IMHA services. In some advocacy services, IMHAs were reported to have a caseload of eight while others reported a caseload of 55.

Newbigging (2012, pp.126)

Newbigging et al (2012) conclude that in the absence of further contextual information from the services this anomaly is difficult to interpret accurately. They went on to summarise that the caseload did not equate to the number of advocates employed or whether for a definitive length of time or to a fixed timescale. They compared the caseload of an advocate that worked purely as an IMHA with those that carried generic casework and found that the IMHA casework was only 65% of those with non-IMHA casework. It was found that casework was only open for a period of one to three months but there were examples of some services having casework open for up to six months whilst a couple of services had cases open for up to a whole year.

The findings also showed that most cases (87%) were not fixed to a certain amount of visits but remained open as the need was required. It was only in one service where advocates worked to a tighter schedule of four hours for involvement in CPA and six hours for Tribunal work. Another service fed back that their service visited a ward with a minimum of two visits per week, but all clients were seen pre-CPA meetings for six monthly reviews.

This compares to figures published by the Government on its website in February 2023 that an average caseload (per FTE) 16.6 case per social worker in England in 2022 which is up from 16.3 in 2021 but down from 16.9 in 2019 (Gov.uk 2023).

The eligibility criteria for an IMHA are slightly different in England and Wales as both compulsory and informal patients can access the service in Wales whilst at present only compulsory patients in England can access an IMHA. Below the focus will be on how the Mental Health Act 1983 Code of Practice for Wales Revised 2016 (Welsh Government, 2016) describes the role of an IMHA and the responsibility of others to make patients aware of the service.

6.4 of the Code of Practice explains how and IMHA with support a patient to better understand how the legislation works, patient's rights under the Act and any safeguards. 6.5 explains what the IMHA will do such as making sure they have a voice, supporting them to access information, looking at different options, that the person being support is valued and any prejudice against that person does not occur.

An important element of the IMHAs role is ensuring the patient is able to take part in decisions about their care and treatment which is covered in 6.6. This can include the IMHA attending meetings, looking at alternative treatments, understanding their rights, supporting applications to Mental Health Reviews Tribunals and assisting patient to understand decisions made. 6.6 goes on to explain how patients can obtain

legal representation, raising concerns, accessing relevant records, what after care they provision should be available.

As with any code it is important to point out what can and can not be done and what should and should not be provided. Point 6.7 of the Code of Practice is a clear illustration of this point as points out that having an IMHA does not disqualify a patient from seeking their own separate legal advice or entitlement to receive legal aid. It goes on in 6.8 to explain that IHAs even though they are there to give a patient a voice they should not be used as a translation or interpreter.

Some of the patients receiving support from an IMHA will lack capacity and the Code address this issue in points 6.9 and 6.10. The Code explains that the IMHA should be instructed by the patient when possible but in circumstances where this is not possible due to a person lacking capacity the IMHA should not assume the patient can not instruct and that the IMHA should make every effort to assist the patient to participate fully in decisions that affect them. Where a person appears to lack capacity then the IMHA needs to use their own judgment in coming to a conclusion whether that patient has the ability to instruct or not. Points 6.11 to 6.18 clearly defines which patient is eligible for the IMHA service including compulsory, informal and those with learning disabilities. It is not intended to go into detail here about eligibility but details of which can be seen by accessing the document online on the Welsh Government website.

Point 6.19 explain when a patient has a right to see an IMHA and defines in 6.26 which professional should be directing patients to an IMHA service. The Code in 6.19 gives a list of examples as to when a patient may consider wanting an advocate:

- as soon as practicable after their arrival in hospital under one of the relevant sections of the Act
- before the initial discussion with their clinician about the proposed care and treatment plan

when the use of electroconvulsive therapy (ECT) is being considered
 when an application has been made or is being considered to the MHRT
 for Wales or to the hospital managers
 when they choose not to be legally represented at a MHRT for Wales
 hearing
 when they want to make, or have made, a complaint
 when they want to discuss any aspect of their care or treatment
 when they want to apply to displace their nearest relative (see Chapter 5)
 when they are consulted about the conditions to be attached to a CTO
 when a CTO is renewed, revoked or its conditions are revised
 when a meeting is held to discuss after-care.
 (Welsh Government 2016)

In 6.21 to 6.25 the Code goes into some detail as to when an IMHA should visit and interview a patient if a request is made for a visit. This would naturally include the patient but also their nearest relative as set out in Chapter 5 of the Code. There is a list of professionals that also make a request for a visit such as the responsible clinician, AMHP, social worker, manager of the hospital or patient's attorney or deputy. The list is slightly different for an informal patient and only includes the patient, hospital manager, the patient carer, patient attorney or deputy and social worker.

Point 6.26 sets out in table format who is the 'responsible person' who should inform the patient about the role of an IMHA and the code states that this should be done as soon as it is practicable but does not give a timescale.

Further to this 6.27 to 6.34 expands on the role of the 'responsible person'. It sets out that information should be provided to the patient in verbal and then written format, and how that support can be obtained. It also makes clear that the 'nearest relative' should be provided with the same information, as long as the patient does not object. More than just providing information the 'responsible person' should also ensure that facilities are available to the patient to contact and meet with the IMHA. A record

should be kept in the patients notes of the steps taken to inform the patient of an IMHA.

Advocacy is about choice and a patient might decline to have contact with an IMHA and in point 6.34 the Code notes this but emphasises that a note should be made in the patients notes that the service has been declined but that at a later date it is offered again.

Points 6.35 to 6.39 highlights what information needs to be provided to nearest relative, attorneys or deputies and as this section does not include reference to the IMHA it is not discussed here. Points 6.40 and 6.14 is in regard to confidentiality. AS with any service that deals with patients or sensitive information confidentiality is paramount and a meeting between and IMHA and patient is no different and this is reinforced in the Code and in the Advocacy Code of Practice. Any information shared with an IMHA has to remain confidential unless there is a perceived risk to the patient or others and the advocate feels they have to disclose the information. Likewise any information shared with the IMHA by a professional the IMHA is obliged to share it with the patient but in exceptional circumstances professionals feel that information should not be shared with a patient, consideration should then be given to whether the information is shared with the IMHA.

The final section of the chapter describes the rights IMHA's have including the right to interview professionals at to look at records. These are covered in 6.42 to 6.52 and starts with the fact that an IMHA has a right to see the patient in private but there are exceptions when the patient is under close observation, held in seclusion or when the IMHA receives advice from a professional that there is risk to meeting the patient in private. When circumstance don't allow the IMHA to meet in private the IMHA can cancel the meeting or with the patient consent to have the meeting in an area where

others might hear some of the conversation. The code in this section does highlight in bullet point form the what relevant staff must do and know which is being aware the duties place upon local authorities and health boards and the legal requirement of an IHA service, how to access an IMHA, when to give information to patients, when to keep detailed records of the involvement of the IMHA service, pass on information to others when an IMHA is working with a patient and makes sure an IMHA is informed if there are changes that might affect the support they can provide.

Under the Act IMHAs can access a patients record and this is covered in 6.50 to 6.52 as long as it is relevant to the treatment the patient is receiving and where consent is given. When the person does not have capacity that it is in the best interest of the patient for the IMHA to access the records.

2.7. Conclusion

As far back as the 13th Century as indicated by Roff D and Roff C (1995 pp1708) people with mental health illness were protected by law and had a voice about decisions made about them. During Victorian times 'licence houses' were established as stated by Wright (2010) but most parishes preferred to use workhouses. Changes happened under the Mental Deficiency Bill passed in 1913 with focus on providing proper accommodation for those considered 'mentally defective'. It was not until 1959 that a further Mental Health Act was passed which brought mental health treatment into the wider hospital system (Turner *et al* 2015 pp 603). A further Act was passed in 1983 (Hamilton 1983) due to the apparent ill treatment of patients and the new Act gave patients the right to consent before treatment as well as other safeguards.

Under the 1987 and 2007 Mental Health Act social workers were given a more prominent role and until the introduction of an IMHA service being introduced in the

2007 Act it could be argued that a social worker had a stronger claim between these two Act to claim an advocacy role (DoH 2002, CCETSW 1995, British Association of Social Work 1996)

The Welsh Government (2012) recognised under the additional Measure to the 2007 Act that one of the main priorities was an IMHA service where every patient had a right to access an IMHA service if they wished (Mental Health Wales 2023).

The history of advocacy explains that the concept of advocacy has been around for a considerable amount of time with the origins of the word possible originating in the fourteenth century (Jugessuer and Iles 2009). Self-advocacy can be first recorded potentially in Petition of the Poor (Brandon 2000) with forerunners of self-advocacy groups in 1845 with the 'Alleged Lunatics Friends Society (Harvey 1986). During the twentieth century advocacy gained momentum and according to Campbell (2009) it was due to change in attitude, policies and criticism of treatment that brought the call for independent advocacy.

As has been touched on already the 2007 Act introduced the IMHA service and Harrison and Davis (2009 pp.57-64) pointed out the central tenant of advocacy in health care is for people to be supported through empowerment and having a voice.

Even before the 2007 Act was introduced Barnes *et al* (2002 pp2) gave specialist advocacy a definition as a distinct form of advocacy for people detained under legislation. The Durham report (2002) set out recommendations of good practice for specialist advocacy including how records should be kept, policies that should be in place and good governance. The Royal College of Psychiatrists (2012) gave a description of what an advocate is and isn't with the Mental Health Act Code of Practice (2016) going into considerable detail of the role of an IMHA and what they can and can not do and what statutory powers they have. The NDTi (2018) sets out

the expected standards that an advocacy service should reach to qualify for its Quality Mark and NICE (2020) sets out the new Level 4 City and Guilds qualification advocates should achieve to continue practicing which could argue potentially puts IMHA on a professional standing as was envisaged in the Durham report.

Dalrymple and Bolan (2013) state in relation to social workers that advocacy is an integral part of their work as does CCETSW (1995) and British Association of Social Work (1996). The NOS (DoH 2002) clearly states that advocacy should be part of a social workers remit. Scourfield (2021) points out that a social worker should not assume that they will take on an advocacy role and the NOS guidance is unclear on this point, but Scourfield also points out that a social worker should direct a person towards an Independent Advocate. The PCF (2012) which replaced the NOS gives very little reference to the role of a social worker in advocacy, but Scourfield argues even though advocacy is not highlighted by indicating a social worker should be promoting human rights that this is an advocacy role. The SWE (2019) as a regulatory body does give a role for social workers but this is not replicated by the Welsh regulated body SCW (2022)

Mick McKeown *et al* (2014) puts forward a case that advocacy goes as far back as the Crimean war and Nelson (1988) expresses a view that nurses can act as advocates but does suggest that there could be a conflict with their employer. Clearly (2004) notes that nurses felt they had an advocacy role, but Bernal (1992) disagrees that advocacy should be part of a nurse's role when mixed in with the professional issues of nursing. Newbigging *et al* (2012) also found that nurses felt they had an advocacy role but this was framed more around their duty of care which differed from the concept of advocacy. Newbigging *et al* did point out that it was not universal across the nursing profession and that some nurses felt they understood the difference between nursing

and advocacy whilst others due to their position within a mental health setting had an advocacy role to play.

Direct campaigning by the Mental Health Alliance helped to get advocacy onto the agenda as well as changes in public opinions especially after the death of David Bennett (DoH 2005) is a secure psychiatric unit.

Previous to that initial guidelines for a specialist advocacy service were set out in the Durham report (2002) into expected standards and practice as well as expected salary levels. Barnes *et al* (2002) gives an indication of how and why an advocacy service should store records and for how long. Newbigging *et al* (2002) touches on casework but does not give clear guidelines as to how many cases an advocate should carry. The Code of Practice (2016) goes into detail about the various aspect of an IMHA role as to when they can and can not advocate for a person.

3. RESULTS AND DISCUSSION

3.1. Introduction

The result of the literature review finds that social workers are more inclined to feel that they still have a role to play in advocating (Dalrymple and Bolan 2013, CCETSW 1995, British Association of Social Work 1996, Sheafor and Horejsi 2003, Haynes and Mickelson 2006) but that there is more of a disagreement regarding whether nurses should (Holmes 2001, Mckeown 2014) or should not (Bernal 1992) have a role in advocacy. Advocacy has become more prominent as a role since the turn of this century especially in statute with not only the introduction of the IMHA under the Mental Health Act 2007 but also an Independent Mental Capacity Advocacy under the Mental Capacity Act 2005, Independent Professional Advocate under the Social Services and Well-being (Wales) Act 2014 and in England the introduction of an Independent Advocate under the Carers Act 2014.

3.2. Result

Under the above Acts advocacy is recognised more as a profession than ever before with statutory rights in some cases, such as an IMHA for example, able to request to see a patient records or to meet with other professionals to discuss the persons they are supporting's case. An IMHA is also expected to work to a Code of Practice (Appendix 6.4) and to obtain a Level 4 City and Guilds advocacy qualification. At present in Wales regulation of advocacy only applies to advocacy services for children (Llywodraeth Cymru 2019) and it does not appear that any part of advocacy is regulated in England unlike social workers (Social Work England and in Social Care Wales) and nurses (Nursing and Midwifery Council) that fall under their own regulated bodies, code of practice and required qualifications to practice. Salaries of an advocate do not appear to reflect the professionalisation of its service with salaries

ranging between £21,255 and £24,793 considerably lower than what was recommended in the Durham report (2002) and lower than salaries offered to social workers and nurses.

Nursing and Social Workers have a longer standing relationship with people that use their service compared to advocacy that might not be as established in the minds of professionals and service users. Also, Nurses and Social Workers as a provider of services can potentially be compromised as they can have a power relationship with service users being decision makers in services that person receives. Dalrymple and Bolan (2013 pp 157) also note the potential for independent advocacy to be a tool that can be used to challenge the differential power relations experienced in relationships between users and providers of services and by including an advocate it gives service users some independence from providers of different services.

3.3. Conclusion

By the introduction of a statutory IMHA service under the Mental Health Act 2007 the UK and Welsh Government recognise that there is a role to play for advocacy in in making sure patient's wishes and feelings are being heard in decisions being made about their care and that the independent advocate should be professionally trained, qualified and employed to carry out the role. It might be argued as the IMHA has a specific role defined under the act they are unable to carry out generic advocacy under their remit and therefore there still exist a role for social workers and nurses to carry out some generic advocacy work.

Bernal (1992) argued that nurses should not be involved with advocacy whilst a counter argument about this is made by McKeown (2014). Dalrymple and Bolan, even though they feel social workers have a role to play in advocacy do state:

Th role of the independent advocate as a specialist in now clearly established A key role for social worker is to understand when they are

unable to advocate for a person they are working with and how to link them to a relevant independent advocacy service.
Dalrymple and Bolan (2013 pp 147)

The problem arises due to the fact there are notable differences but also similarities and some cross overs between all three professions in that all three services are looking to support the service user, to listen to their concerns and improve their wellbeing and therefore a role in advocacy. Therefore, especially for social workers they still feel they can advocate for a person, but it should be noted that the three professions also have a clear defined role to play in supporting a person and especially a social worker has to recognise that they are not an independent advocate but on the same level an independent advocate has to recognise they are not a social worker.

Newbigging et al (2012, pp101) in their research found that one of the fundamental problems for the IMHA service is awareness of the service amongst qualifying patients and an understanding of the role amongst other professionals and throughout the literature review for this paper there was little or no apparent recommendation for more training to be given for all three professions to understand each other's role. Newbigging *et al* (2012, pp 104) also pointed out the limited training that most mental health professionals had received can affect how the advocacy service is perceived by them to deliver change from the perspective of qualifying patients placed in a psychiatric unit which can lead to referrals to the IMHA service not being made that can lead to them having less of an independent voice in care and treatment they would receive.

4. CONCLUSION AND RECOMMENDATIONS

The main theme to come out of the literature review is that it is accepted that an independent advocacy service is required not only by Governments but by most professionals and for that service to be a voice for people receiving services but that there is still a role to play for nurses and social workers potentially at a lower more generic level of advocacy.

There was evidence in academically reviewed documentation as highlighted in this paper is available for the need of advocacy but there was a lack of qualitative and quantitative evidence to support the view that if advocacy can deliver change from the perspective of qualifying patients placed in a psychiatric unit under the Mental Health Act 1983. It was difficult to find quantitative evidence of referral levels to the IMHA, or other statistical evidence supporting the use of the IMHA service as overall annual statistics for England and Wales do not appear to be published but Newbigging *et al* (2012 pp 247) estimated that potentially up to 50,000 per annum could have a need to access the IMHA service. The qualitative evidence was more available but not in abundance but publications that includes McKeown, Ridley, Newbigging, Machin, Poursanidou, and Cruse (2012, 2014, 2015) gives some insight into feedback received from people (IMHA Partner) using the IMHA service and what it meant for them to have that support:

He made me understand a lot of things... he explained a lot of things all the time, he made me understand why I was in hospital. He made me understand my rights and my voice and everything..."

IMHA partner

"He [IMHA] made me realise what expectations the doctor wanted from me and the nurses and all the staff and that's I think ... without him I suppose, you know it was like coming to my senses to realise what they wanted from me.

IMHA partner:

"Very, very useful because they told you how to set about doing this and giving you all the legalities and how you had a right to... and even which

laws to use and which bit to quote and all the rest of it which was very, very useful.”

IMHA partner (Acute ward)

The additional theme to come out of the literature review is that there remains a lack of knowledge amongst professionals as highlighted in Newbigging *et al* (2012) report and people that should be accessing the service about the role of an advocate. This could potentially be down to the need for more training for professionals and awareness raising amongst people that might need the service but generally with the wider public.

- Recommendation 1: A more comprehensive quantitative annual report detailing the number of people requiring the IMHA service should be published regionally and nationally to ascertain the need for the MHA service. The report could include for example age, sexuality, location, language, ethnicity, section used to detain (in Wales how many informal patients), length of detention, average time spent by IMHAs on each case.
- Recommendation 2: Qualitative methods should be developed to measure outcomes from the involvement of the IMHA that can demonstrate the effectiveness of the service involvement. This should be a standardised method to enable comparisons in delivery across England and Wales.
- Recommendation 3: A review of the training provided to professionals in mental health settings regarding the IMHA role and should be framed to emphasise the benefits of an independent advocacy but also that it is a right for a patient to access that service.
- Recommendation 4: Advocates should receive training of the role of a mental health nurse and social worker in a mental health setting, this could include shadowing sessions that would lead to a better understanding of the roles.
- Recommendation 5: Investment in the IMHA service should be increased to ensure that adequate funding is available for the delivery but also remuneration of advocates up to the level recommended by the Durham report.
- Recommendation 6: All locations where a person is detained under the Mental Health Act should have information available to all patients as to how to access and professionals within those services should receive regular awareness session about the importance to support a patient to access the IMHA service.
- Recommendation 7: A wider awareness raising events outside of the psychiatric units should be initiated within all regions with related organisation that come in touch with people suffering from mental

health issues to raise awareness of the IMHA service and the benefits it can bring to people who might need access to an IMHA.

This review has demonstrated that advocacy can deliver change from the perspective of qualifying patients placed in a psychiatric unit through the examples given of feedback from patients and professionals working within these settings. For this to work better there does appear to be a need for each of the three professions, independent advocacy, social worker and nurses to work closely together and for a better understanding to exist between each profession of each other's role.

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6. APPENDICES

6.1. Proposal Form

Institute of Education and Humanities/
Yr Athrofa Addysg a'r Dyniaethau

**MA Dissertation Approval Form/
Ffurflen Gymeradwyo Traethawd Hir MA
ECGE7002Q**

Student Name/ <i>Enw Myfyriwr</i>	Elfed Williams
Degree Scheme/ <i>Cynllun Gradd</i>	MA Equality and Diversity
Start date/ <i>Dyddiad cychwyn</i>	20 September 2022

I have completed/ about to complete* Part 1 of my degree.

*Please delete as appropriate.

Yr wyf wedi/ ar fun cwblhau Rhan 1 o fy ngradd

** Dileu fel sy'n briodol*

• Title of Dissertation: • <i>Teitl eich Traethawd Hir</i> ○ Does Advocacy Work in a Mental Health Setting • Research Question • Cwestiwn Ymchwil ○ To explore if an IMHA service can deliver change from the perspective of qualifying patients placed in a psychiatric unit under the Mental Health Act 1983 and how this can be measured.
Aims and Objectives: <i>Nodau ac Amcanion</i> • Introduction ○ The aim of the research would be to explore through a literary review how an IMHA service can make a difference to the voice of the service users in decision making process. The research will also look at the current format for gathering personal outcomes and if this truly reflect the thoughts of those accessing the service. • Literature Review

- Theme

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- Theme - Legislation

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 - information gathered and what use will be made of any data. The researcher will be versed in working in a confidential manner and it will be made clear to all participating that confidentiality will be preserved at all times.
- Reliability/Validity/Transferability/Trustworthiness etc
- Conclusion
 - It is estimated that this research project will take 8 months to be completed with an initial report published

Short Introductory Bibliography: <i>Llyfryddiaeth rhagarweiniol byr</i> See above
Proposed Supervisor: <i>Goruchwyliwr awgrymedig</i>

Please indicate whether ethical approval for project is needed – **YES**/NO
Nodwch a oes angen cymeradwyaeth foesegol ar gyfer y prosiect - OES / NAC OES

Please indicate whether sufficient resources are available for the project – **YES**/NO
Nodwch a oes digon o adnoddau ar gael ar gyfer y prosiect - OES / NAC OES

The above topic, proposal, and supervisor have been agreed:
Cytunwyd ar y pwnc, y cynnig a'r goruchwyliwr uchod:

Signed : Programme Director/
 Llofnod Cyfarwyddwr y
 rhaglen

Date:.....
 Dyddiad

Please return this form to your Programme Director.
Dychwelwch y ffurflen hon at eich Cyfarwyddwr Rhaglen.

6.2. Ethics Form

APPLICATION FOR ETHICAL APPROVAL

In order for research to result in benefit and minimise risk of harm, it must be conducted ethically. A researcher may not be covered by the University's insurance if ethical approval has not been obtained prior to commencement.

The University follows the OECD Frascati manual definition of **research activity**: "creative work undertaken on a systematic basis in order to increase the stock of knowledge, including knowledge of man, culture and society, and the use of this stock of knowledge to devise new applications". As such this covers activities undertaken by members of staff, postgraduate research students, and both taught postgraduate and undergraduate students working on dissertations/projects.

The individual undertaking the research activity is known as the "principal researcher".

Ethical approval is not required for routine audits, performance reviews, quality assurance studies, testing within normal educational requirements, and literary or artistic criticism.

Please read the notes for guidance before completing ALL sections of the form.

This form must be completed and approved prior to undertaking any research activity. Please see Checklist for details of process for different categories of application.

SECTION A: About You (Principal Researcher)

1	Full Name:	Huw Elfed Williams			
2	Tick all boxes that apply:	Member of staff:	☐	Honorary research fellow:	☐
	Undergraduate Student	☐	Taught Postgraduate Student	☒	Postgraduate Research Student
3	Institute/Academic Discipline/Centre:	Institute of Education and Humanities			
4	Campus:	Ysgol Prifysgol Cymru: Y Drindod Dewi Sant/University of Wales: Trinity Saint David. Caerfyrddin/Carmarthen.			
5	E-mail address:	1916610@student.uwtsd.ac.uk			
6	Contact Telephone Number:	07901547049			
For students:					
7	Student Number:	1916610			
8	Programme of Study:	MA Equity and Diversity			
9	Director of Studies/Supervisor:	Associate Professor Dr Caroline Lohmann-Hancock Supervisor - Phillip Morgan			

SECTION B: Approval for Research Activity

1	Has the research activity received approval in principle? (please check the Guidance Notes as to the appropriate approval process for different levels of research by different categories of individual)	YES	☐	NO	☐
					Date
2	If Yes, please indicate source of approval (and date where known): Approval in principle must be obtained from the relevant source prior to seeking ethical approval	Research Degrees Committee	☐		
Institute Research Committee		☐			
P Morgan		☒			

SECTION C: Internal and External Ethical Guidance Materials

	Please list the core ethical guidance documents that have been referred to during the completion of this form (including any discipline-specific codes of research ethics, location-specific codes of research ethics, and also any specific ethical guidance relating to the proposed methodology). Please tick to confirm that your research proposal adheres to these codes and guidelines. You may add rows to this table if needed.	
1	UWTSD Research Ethics & Integrity Code of Practice	☒
2	UWTSD Research Data Management Policy	☒
3	<i>CBritish Sociological Association</i>	☒

SECTION D: External Collaborative Research Activity

If there are external collaborators then you should gain consent from the contact persons to share their personal data with the university. If there are no external collaborators then leave this section blank and continue to section E.

1	Institution	Institute of Education and Humanities				
2	Contact person name	NA				
3	Contact person e-mail address	NA				
4	Is your research externally funded?	YES	☐	NO	☒	
5	Are you in receipt of a KESS scholarship?	YES	☐	NO	☒	
6	Are you specifically employed to undertake this research in either a paid or voluntary capacity?	Voluntary	YES	☐	NO	☒
7		Employed	YES	☐	NO	☒
8	Is the research being undertaken within an existing UWTSD Athrofa Professional Learning Partnership (APLP)?	If YES then the permission question below does not need to be answered.	YES	☐	NO	☒

9	Has permission to undertake the research has been provided by the partner organisation?	(If YES attach copy) If NO the application cannot continue	YES	☐	NO	☒
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Where research activity is carried out in collaboration with an external organisation

10	Does this organisation have its own ethics approval system?	YES	☐	NO	☒
	If Yes, please attach a copy of any final approval (or interim approval) from the organisation (this may be a copy of an email if appropriate).				

SECTION E: Details of Research Activity

1	Indicative title:	<i>Advocacy in Mental Health Services: Essential or Irrelevant</i>		
2	Proposed start date:		Proposed end date:	
	Introduction to the Research (maximum 300 words per section) Ensure that you write for a <u>Non-Specialist Audience</u> when outlining your response to the points below: • <i>Purpose of Research Activity -</i> • <i>Proposed Research Question</i> • <i>Aims of Research Activity</i> • <i>Objectives of Research Activity</i> Demonstrate, briefly, how <u>Existing Research</u> has informed the proposed activity and explain • <i>What the research activity will add to the body of knowledge</i> • <i>How it addresses an area of importance.</i>			
3	Purpose of Research Activity The purpose of this 'pilot' research project is to establish if advocacy work in a Mental Health setting actually works and to act as a baseline for further research. (this box should expand as you type)			
4	Research Question ○ Does Advocacy Work in a Mental Health Setting'? ▪ Who should be providing advocacy IMHA v SW v Nurse ▪ Does a SW, Nurse or advocate have a conscious or unconscious bias when delivering advocacy ▪ Service user Opinion on effective advocacy ▪ At what point of a person's recovery does advocacy work become effective?			

	(this box should expand as you type)
5	Aims of Research Activity 1. The aim of the research is to establish if advocacy services in a Mental Health psychiatric facility necessary, valued and acknowledged as being needed and who is based placed to deliver the advocacy provision 2. It will be used as a pilot project to establish the basis for a much larger scale piece of research into the subject area, Wales wide. 3. To explore if an IMHA service can deliver change from the perspective of qualifying patients placed in a psychiatric unit under the Mental Health Act 1983 and how this can be measured. (this box should expand as you type)
6	Objectives of Research Activity ○ Establish a frame of reference in support of a much larger scale piece of research into this subject area, i.e., this is a pilot project. ○ To establish the perceptions of advocacy as necessary, valued and acknowledged by: ▪ Social Worker ▪ Nurse ▪ Advocate ▪ Service user ○ Develop a methodology that supports effective data gathering and provides a credible platform from which to develop useable and useful information in practice. (this box should expand as you type)
	Proposed methods (maximum 600 words) Provide a brief summary of all the methods that may be used in the research activity, making it clear what specific techniques may be used. If methods other than those listed in this section are deemed appropriate later, additional ethical approval for those methods will be needed. You do not need to justify the methods here, but should instead describe how you intend to collect the data necessary for you to complete your project.
7	Literature Review
	Location of research activity Identify all locations where research activity will take place.
8	(this box should expand as you type)
	Research activity outside of the UK If research activity will take place overseas, you are responsible for ensuring that local ethical considerations are complied with and that the relevant permissions are sought. Specify any local guidelines (e.g. from local professional associations/learned societies/universities) that exist and whether these involve any ethical stipulations beyond those usual in the UK (provide details of any licenses or permissions required). Also specify whether there are any specific ethical issues raised by the local context in which the research activity is taking place, for example, particular cultural and/or legal sensitivities or vulnerabilities of participants. If you live in the country where you will do the research then please state this.

9	Not applicable (this box should expand as you type)
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10	Use of documentation not in the public domain: Are any documents NOT publicly available?	NO	☒
		YES	☐
11	If Yes, please provide details here of how you will gain access to specific documentation that is not in the public domain and that this is in accordance with the current data protection law of the country in question and that of England and Wales. (this box should expand as you type)		

	Does your research relate to one or more of the seven aims of the Well-being of Future Generations (Wales) Act 2015?	YES	NO
12	A prosperous Wales	☐	☒
13	A resilient Wales	☐	☒
14	A healthier Wales	☒	☐
15	A more equal Wales	☐	☒
16	A Wales of cohesive communities	☒	☐
17	A Wales of vibrant culture and thriving Welsh language	☐	☒
18	A globally responsible Wales	☐	☒
19	If YES to any of the above, please give details:		
	(this box should expand as you type)		

SECTION F: Scope of Research Activity

	Will the research activity include:	YES	NO
1	Use of a questionnaire or similar research instrument?	☐	☒
2	Use of interviews?	☐	☒
3	Use of focus groups?	☐	☒
4	Use of participant diaries?	☐	☒
5	Use of video or audio recording?	☐	☒
6	Use of computer-generated log files?	☐	☒

7	Participant observation with their knowledge?	☐	☒
8	Participant observation without their knowledge?	☐	☒
9	Access to personal or confidential information without the participants' specific consent?	☐	☒
10	Administration of any questions, test stimuli, presentation that may be experienced as physically, mentally or emotionally harmful / offensive?	☐	☒
11	Performance of any acts which may cause embarrassment or affect self-esteem?	☐	☒
12	Investigation of participants involved in illegal activities?	☐	☒
13	Use of procedures that involve deception?	☐	☒
14	Administration of any substance, agent or placebo?	☐	☒
15	Working with live vertebrate animals?	☐	☒
16	Procedures that may have a negative impact on the environment?	☐	☒
17	Other primary data collection methods. Please indicate the type of data collection method(s) below.	☐	☒
	Details of any other primary data collection method: (this box should expand as you type)		

If NO to every question, then the research activity is (ethically) low risk and **may** be exempt from **some** of the following sections (please refer to Guidance Notes).

If YES to any question, then no research activity should be undertaken until full ethical approval has been obtained.

SECTION G: Intended Participants

If there are no participants then do not complete this section, but go directly to section H.

	Who are the intended participants:	YES	NO
1	Students or staff at the University?	☐	☒
2	Adults (over the age of 18 and competent to give consent)?	☐	☒
3	Vulnerable adults?	☐	☒
4	Children and Young People under the age of 18? (Consent from Parent, Carer or Guardian will be required)	☐	☒
5	Prisoners?	☐	☒
6	Young offenders?	☐	☒
7	Those who could be considered to have a particularly dependent relationship with the investigator or a gatekeeper?	☐	☒
8	People engaged in illegal activities?	☐	☒
9	Others. Please indicate the participants below, and specifically any group who may be unable to give consent.	☐	☒

	Details of any other participant groups:		
	(this box should expand as you type)		

	Participant numbers and source Provide an estimate of the expected number of participants. How will you identify participants and how will they be recruited?		
10	How many participants are expected?	N/A	
		(this box should expand as you type)	
11	Who will the participants be?	N/A	
12	How will you identify the participants?	N/A	

	Information for participants:	YES	NO	N/A
13	Will you describe the main research procedures to participants in advance, so that they are informed about what to expect?	☐	☐	☒
14	Will you tell participants that their participation is voluntary?	☐	☐	☒
15	Will you obtain written consent for participation?	☐	☐	☒
16	Will you explain to participants that refusal to participate in the research will not affect their treatment or education (if relevant)?	☐	☐	☒
17	If the research is observational, will you ask participants for their consent to being observed?	☐	☐	☒
18	Will you tell participants that they may withdraw from the research at any time and for any reason?	☐	☐	☒
19	With questionnaires, will you give participants the option of omitting questions they do not want to answer?	☐	☐	☒
20	Will you tell participants that their data will be treated with full confidentiality and that, if published, it will not be identifiable as theirs?	☐	☐	☒
21	Will you debrief participants at the end of their participation, in a way appropriate to the type of research undertaken?	☐	☐	☒
22	If NO to any of above questions, please give an explanation			
	(this box should expand as you type)			

	Information for participants:	YES	NO	N/A
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24	Will participants be paid?	☐	☐	☒
25	Is specialist electrical or other equipment to be used with participants?	☐	☐	☒
26	Are there any financial or other interests to the investigator or University arising from this study?	☐	☐	☒
27	Will the research activity involve deliberately misleading participants in any way, or the partial or full concealment of the specific study aims?	☐	☐	☒
28	If YES to any question, please provide full details			
	(this box should expand as you type)			

SECTION H: Anticipated Risks

	Outline any anticipated risks that may adversely affect any of the participants, the researchers and/or the University, and the steps that will be taken to address them.		
	If you have completed a full risk assessment (for example as required by a laboratory, or external research collaborator) you may append that to this form.		
1	Full risk assessment completed and appended?	Yes	☒
		No	☐
2	Risks to participants For example: sector-specific health & safety, emotional distress, financial disclosure, physical harm, transfer of personal data, sensitive organisational information		
	N/A (this box should expand as you type)	How you will mitigate the risk to participants: N/A. (this box should expand as you type)	
3	If research activity may include sensitive, embarrassing or upsetting topics (e.g. sexual activity, drug use) or issues likely to disclose information requiring further action (e.g. criminal activity), give details of the procedures to deal with these issues, including any support/advice (e.g. helpline numbers) to be offered to participants. Note that where applicable, consent procedures should make it clear that if something potentially or actually illegal is discovered in the course of a project, it may need to be disclosed to the proper authorities		
	(this box should expand as you type)		
4	Risks to the investigator For example: personal health & safety, physical harm, emotional distress, risk of accusation of harm/impropriety, conflict of interest		
	Risk to the investigator: Low	How you will mitigate the risk to the investigator: The Investigator is aware of the	

	(this box should expand as you type)	support available to students should any issues arise as a result of the Literature Review (this box should expand as you type)
5	University/institutional risks For example: adverse publicity, financial loss, data protection	
	Risk to the University: Low (this box should expand as you type)	How you will mitigate the risk to the University: Risk to the University will be mitigated by the use of Regular Supervision session and reference to appropriate policies. (this box should expand as you type)
6	Environmental risks For example: accidental spillage of pollutants, damage to local ecosystems	
	Risk to the environment: Low (this box should expand as you type)	How you will mitigate the risk to environment: There will be no use of chemicals in this process. Use of vehicles to travel to and from the interviews will be kept to a minimum to reduce carbon footprint. (this box should expand as you type)

	Disclosure and Barring Service			
	If the research activity involves children or vulnerable adults, a Disclosure and Barring Service (DBS) certificate must be obtained before any contact with such participants.	YES	NO	N/A
7	Does your research require you to hold a current DBS Certificate?	☐	☐	☒
8	If YES, please give the certificate number. If the certificate number is not available please write "Pending"; in this case any ethical approval will be subject to providing the appropriate certificate number.			

SECTION I: Feedback, Consent and Confidentiality

1	Feedback What de-briefing and feedback will be provided to participants, how will this be done and when?
	N/A (this box should expand as you type)
2	Informed consent Describe the arrangements to inform potential participants, before providing consent, of what is involved in participating. Describe the arrangements for participants to provide full consent before data collection begins. If gaining consent in this way is inappropriate, explain how consent will be obtained and recorded in accordance with prevailing data protection legislation.

	N/A <i>(this box should expand as you type)</i>
3	Confidentiality / Anonymity Set out how anonymity of participants and confidentiality will be ensured in any outputs. If anonymity is not being offered, explain why this is the case.
	N/A

SECTION J: Data Protection and Storage

	Does the research activity involve personal data (as defined by the General Data Protection Regulation 2016 “GDPR” and the Data Protection Act 2018 “DPA”)?	YES	NO
1	“Personal data” means any information relating to an identified or identifiable natural person (‘data subject’). An identifiable natural person is one who can be identified, directly or indirectly, in particular by reference to an identifier such as a name, an identification number, location data, an online identifier or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person. Any video or audio recordings of participants is considered to be personal data.	☐	X
	If YES, provide a description of the data and explain why this data needs to be collected:		
2	<i>(this box should expand as you type)</i>		
	Does it involve special category data (as defined by the GDPR)?	YES	NO
3	“Special category data” means sensitive personal data consisting of information as to the data subjects’ – (a) racial or ethnic origin, (b) political opinions, (c) religious beliefs or other beliefs of a similar nature, (d) membership of a trade union (within the meaning of the Trade Union and Labour Relations (Consolidation) Act 1992), (e) physical or mental health or condition, (f) sexual life, (g) genetics, (h) biometric data (as used for ID purposes),	☐	X
	If YES, provide a description of the special category data and explain why this data needs to be collected:		
4	<i>(this box should expand as you type)</i>		

	Will data from the research activity (collected data, drafts of the thesis, or materials for publication) be stored in any of the following ways?	YES	NO
5	Manual files (i.e. in paper form)?	☐	☒
6	University computers?	☐	☒
7	Private company computers?	☐	☒

8	Home or other personal computers?	☐	☒
9	Laptop computers/ CDs/ Portable disk-drives/ memory sticks?	☒	☐
10	"Cloud" storage or websites?	☐	☒
11	Other – specify:	☐	☒
12	For all stored data, explain the measures in place to ensure the security of the data collected, data confidentiality, including details of backup procedures, password protection, encryption, anonymisation and pseudonymisation:		
	Any data stored on a laptop will be password protected and covered by a cyber essential certificate <i>(this box should expand as you type)</i>		

	Data Protection		
	Will the research activity involve any of the following activities:	YES	NO
13	Electronic transfer of data in any form?	☐	☒
14	Sharing of data with others at the University outside of the immediate research team?	☐	☒
15	Sharing of data with other organisations?	☐	☒
16	Export of data outside the UK or importing of data from outside the UK?	☐	☒
17	Use of personal addresses, postcodes, faxes, emails or telephone numbers?	☐	☒
18	Publication of data that might allow identification of individuals?	☐	☒
19	Use of data management system?	☐	☒
20	Data archiving?	☐	☒
21	If YES to any question, please provide full details, explaining how this will be conducted in accordance with the GDPR and Data Protection Act (2018) (and any international equivalents, where appropriate):		
	NA <i>(this box should expand as you type)</i>		
22	List all who will have access to the data generated by the research activity:		
	N/A <i>(this box should expand as you type)</i>		
23	List who will have control of, and act as custodian(s) for, data generated by the research activity:		
	N/A <i>(this box should expand as you type)</i>		
24	Give details of data storage arrangements, including security measures in place to protect the data, where data will be stored, how long for, and in what form.		

	Will data be archived – if so how and if not why not.		
	Any data stored on a laptop will be password protected and covered by a cyber essential certificate. Data will be stored on the laptop for the duration of the dissertation period and then deleted. (this box should expand as you type) <i>(this box should expand as you type)</i>		
25	Please indicate if your data will be stored in the UWTSD Research Data Repository (see https://researchdata.uwtsd.ac.uk/). If so please explain. <i>(Most relevant to academic staff)</i>		
	Not applicable <i>(this box should expand as you type)</i>		
26	Confirm that you have read the UWTSD guidance on data management (see https://www.uwtsd.ac.uk/library/research-data-management/)	YES	☒
27	Confirm that you are aware that you need to keep all data until after your research has completed or the end of your funding	YES	☒

SECTION K: Declaration

	The information which I have provided is correct and complete to the best of my knowledge. I have attempted to identify any risks and issues related to the research activity and acknowledge my obligations and the rights of the participants. In submitting this application I hereby confirm that I undertake to ensure that the above named research activity will meet the University's Research Ethics and Integrity Code of Practice which is published on the website: https://www.uwtsd.ac.uk/research/research-ethics/	
1	Signature of applicant:	Date:

For STUDENT Submissions:

2	Director of Studies/Supervisor:	Ken Dicks	Date: 26/09/2023
3	Signature:	Ken Dicks	

For STAFF Submissions:

4	Academic Director/ Assistant Dean:		Date:
5	Signature:		

Checklist: Please complete the checklist below to ensure that you have completed the form according to the guidelines and attached any required documentation:

☒	I have read the guidance notes supplied before completing the form.
☒	I have completed ALL RELEVANT sections of the form in full.
☐	I confirm that the research activity has received approval in principle
☐	I have attached a copy of final/interim approval from external organisation (where appropriate)
☒	I have attached a full risk assessment (where appropriate) ONLY TICK IF YOU HAVE ATTACHED A FULL RISK ASSESSMENT
☒	I understand that it is my responsibility to ensure that the above named research activity will meet the University's Research Ethics and Integrity Code of Practice.
☒	I understand that before commencing data collection all documents aimed at respondents (including information sheets, consent forms, questionnaires, interview schedules etc.) must be confirmed by the DoS/Supervisor, module tutor or Academic Director.

RESEARCH STUDENTS AND STAFF ONLY

All communications relating to this application during its processing must be in writing and emailed to pgresearch@uwtsd.ac.uk, with the title 'Ethical Approval' followed by your name.

You will be informed of the outcome of your claim by email; therefore it is important that you check your University and personal email accounts regularly.

STUDENTS ON UNDERGRADUATE OR TAUGHT MASTERS PROGRAMMES should submit this form (and receive the outcome) via systems explained to you by the supervisor/module leader.

This form is available electronically from the Academic Office web pages:
<https://www.uwtsd.ac.uk/academic-office/appendices-and-forms/>

6.3. Key dates in mental health policy since 1959

Turner *et al* (2015 p 603) - The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research

Mental health services before the establishment of the National Health Service were governed by the 1890 Lunacy Act, which set the terms for certification and compulsory detention, and the 1930 Mental Treatment Act, which allowed hospitals to treat mentally ill patients without certification. The Board of Control acted as a central inspectorate. Mental hospitals were incorporated in the National Health Service in 1948, but the Board of Control survived.

1959: *Mental Health Act* – implementing the *Report of the Royal Commission on the law relating to mental illness and mental deficiency* (the Percy Report, 1957) – finally repeals the 1890 Act, and abolishes the Board of Control.

1961: Enoch Powell's 'Water tower speech' signals a policy of closing the large asylums.

1968: *Report of the Committee on Local Authority and Allied Personal Social Services* Cmnd 3703 (The Seebohm Report) leads to the creation of an integrated social work profession.

1971: Creation of the *Royal College of Psychiatrists* from the former Royal Medico-Psychological Association.

1974: NHS re-organisation integrates mental health services with general medical and hospital services into a unified NHS organised in districts coterminous with Local Authorities.

1975: *Report of the Committee on Mentally Abnormal Offenders* Cmnd 6244 (The Butler Report).

1975: *Better Services for the Mentally Ill*, Cmnd 6233.

1983: *Mental Health Act*, strengthening protection for the civil rights of mentally ill patients.

1988: *Community care: agenda for action* (the Griffiths Report), which led to the 1990 NHS and Community Care Act.

1991-1996: Introduction of NHS Trusts, including separate Mental Health Trusts.

1992: *Review of health and social services for mentally disordered offenders and others requiring similar services* Cm 288 (The Reed Report).

1992: *Health of the Nation*, Cm 1986, includes specific mental illness targets.

1998: *Modernising Mental Health Services* White Paper.

1999: *National Service Framework* (NSF) for adult mental health.

2003-2009: *New Ways of Working* initiative for mental health professions.

2004: *National Service Framework for children, young people and maternity services* (incorporating guidance on child and adolescent psychiatric services).

2006: *Everybody's business: integrated mental health services for older adults* (the first integrated policy statement on mental health services for older adults).

2007: *Mental Health Act*, following a long-fought battle between the government and the *Mental Health Alliance*.

6.4. Advocacy Code of Practice

Clarity of purpose

Advocacy Providers ensure that the individuals they advocate for, referrers, health and social care services and funding agencies all receive information that helps them understand the advocacy service and the role of the advocate, including its benefits and boundaries. The Advocacy Providers objectives and activities must align with the principles set out in this Charter.

Independence

The Advocacy Provider is independent from statutory organisations and all other service delivery and is free from conflict of interest, both in design and operation of advocacy services. The Advocacy Provider's culture supports Advocates to promote their independence with individuals, professionals and other stakeholders; Advocates will be free from influence and conflict of interest so that they can represent the person for whom they advocate.

Person-led

The Advocacy Provider and Advocates will put the people they advocate for first, ensuring that they are directed by their wishes and interests. Advocates will be non-judgmental and respectful of people's needs, views, culture and experiences.

Empowerment

The Advocacy Provider will support people to self-advocate as far as possible, creating and supporting opportunities for self-advocacy, empowerment and enablement. Advocates support people to access information to exercise choice and control in their lives and the decisions affecting them.

People will choose their own level of involvement and the style of advocacy support they want. Where people lack capacity to influence the service, the Advocacy Provider will ensure the advocacy remains person led and enable those with an interest in the welfare of the person to be involved. People receiving advocacy will be involved in the wider activities of the organisation up to and including the Board.

Equality, diversity and accessibility

The Advocacy Provider will have an up to date Equality and Diversity Policy that recognises the need to be pro-active in tackling all forms of inequality, discrimination and social exclusion so that all people are treated fairly. Advocates time will be allocated equitably.

Advocates make reasonable adjustments to ensure people have appropriate opportunity to engage, direct and benefit from the advocacy activity.

Advocacy will be provided free of charge to eligible people. The Advocacy Provider will ensure that its premises (where appropriate), policies, procedures and publicity materials promote full access for the population that it serves. Advocates will provide

information and use language that is easy to understand and accessible to the person

Supporting advocates

The Advocacy Provider will ensure that Advocates are suitably trained, supported and supervised in their role and provided with opportunities to develop their knowledge, skills and experience, including access to legal advice where necessary.

It will create a supportive culture that enables Advocates to undertake their role in line with this Charter

Accountability

The Advocacy Provider is well managed, with appropriate governance arrangements in place, meeting its obligations as a legally constituted organisation.

People accessing the service will have a named Advocate and a means of contacting them. The Advocacy Provider will have systems in place for effective recording, monitoring and evaluation of its work, including identification of the impact of the advocacy service and outcomes for people supported.

Complaints.

In addition, it will be accountable to people who use its services by obtaining and responding to feedback and complaints.

Confidentiality

Information held by the advocacy service about individuals will be kept confidential to the advocacy service. The Advocacy Provider will have a Confidentiality Policy that reflects current legislation. It will be clear about how personal information held by the Advocacy Provider will be kept confidential, under what circumstances it may be shared, the organisation's approach to confidentiality in the delivery of Non-Instructed Advocacy and how the organisation responds if confidentiality is breached. Advocates will ensure that information concerning the people they advocate for is shared with these individuals unless there are exceptional circumstances, when a clear explanation will be recorded. Advocates must also be aware of situations that require making a child or adult safeguarding alert..

Safeguarding

As part of supporting people to realise their Human Rights, the Advocacy Provider will have a thorough understanding of safeguarding responsibilities and processes as set out in law and best practice guidance.

The Advocacy Provider will have clear, up to date policies and procedures in place to ensure safeguarding issues are identified and acted upon.

Advocates support people to have their rights upheld and will be supported to understand and recognise different forms of abuse and neglect, issues relating to confidentiality and what to do if they suspect an individual is at risk (National Development Team for Inclusion, 2018).

6.5. IMHA advert on website Conwy and Denbighshire Mental Health

Advocacy Service 20 January 2024.

Independent Mental Health Advocate (Adult Apprenticeship) – West

Independent Mental Health Advocate (Adult Apprenticeship)
30 hours per week

The successful candidate will need to undertake the Level 4 apprenticeship qualification in Independent Advocacy

<https://www.gcstraining.co.uk/level-4-independent-advocacy-new>

CADMHAS has been operating since 2007 and provides community advocacy, statutory advocacy (Independent Mental Health and Independent Mental Capacity Advocacy) and Relevant Person Representative services across North Wales and Powys.

We are looking to appoint an IMHA (Independent Mental Health Advocate) to join our apprenticeship scheme. Our apprenticeship scheme is open to applicants of all ages (over the age of 16) and will require the successful candidate to follow a Level 4 Independent advocacy course (attending college virtually 2 days per month.) The remaining time will be split between completing coursework and practical casework. We are looking for one person to work primarily in Gwynedd and Anglesey.

Responsible The Principal Advocate, who is responsible to the Director of Services

To:

Working with: Staff, volunteers, and clients of CADMHAS

Location: Based at home - Gwynedd and Anglesey

Hours of work: 30 hours per week

Area of work: Primarily in Gwynedd and Anglesey, but required to work throughout the region to provide cover when required

Aims of the To work as a statutory Independent Mental Health Advocate (IMHA) in line with the

post: definition of the role under the Mental Health Act 1983 (as amended, most recently by the Mental Health Act 2007)

Remuneration: The starting salary for the post is £23,401 pro rata per annum, moving to £24,793 pro rata when the Diploma in Independent Advocacy is achieved. The cost of this will be borne by CADMHAS.

CADMHAS will contribute the equivalent of 3% of the salary towards the Government Pension Scheme once the probation period has been completed. Travel expenses and subsistence will be paid in line with CADMHAS agreed rates.

Hours: A full-time working week is 37 hours, this post is for 30 hours per week (excluding lunch hours). Overtime is not payable but time off in lieu may be taken at a mutually convenient time. Very occasional evening and weekend work may be necessary

Annual Leave: Holiday entitlement is 37 days per annum pro rata, inclusive of all Bank Holidays.

There will be a probation period of 3 months commencing from the first day of employment. The post will be subject to an enhanced DBS check

Job Description – Independent Mental Health Advocate (Adult Apprenticeship)

Main Duties:

To work as an Independent Mental Health Advocate in Gwynedd and Anglesey for CADMHAS. Work will be carried out from a variety of locations as identified by the Director of Services.

This will include:

- Providing an advocacy service, which is free, independent, and confidential.
- Ensuring service users are aware of their rights under the Mental Health Act.
- Providing representation for clients in a wide variety of settings.

- Supporting clients who wish to represent their own interests.
- Collecting data and relevant information for the monitoring of the service.
- Providing balanced information about relevant issues.

The duties outlined above serve as a guide to the major responsibilities of the post. They may need to be reviewed during the lifetime of the post. Any changes will be in consultation with the post holder.

General:

The post holder will be expected to either already hold, or to have achieved within 12 months, the Diploma in Independent Advocacy including the IMHA specialist modules. The post holder will be expected to attend such training events identified as being of value to their role either by the Director of Services or themselves through supervision and appraisal. This post will be home-based with travel to different locations within Gwynedd and Anglesey.

Person Specification

The following are considered to be **essential** criteria for this role:

- An understanding of advocacy
- Understanding of issues faced by people with a mental health problem
- A positive, non-judgemental attitude to, and empathy with, people with mental health problems
- An understanding of, and commitment to, the involvement and empowerment of those using the service
- The ability to work in a way that empowers people
- Self-motivated and organised – able to manage your time and carry your case-load
- The ability to communicate effectively with a wide range of people
- The ability to liaise with personnel at all levels of management structures
- Negotiation skills
- The ability to work independently and in conjunction with others
- Report writing/record-keeping skills – able to write clearly and concisely in letters and reports
- Basic word processing/computer skills/Ability to utilise a database
- Car owner/driver.

The following are considered to be **highly desirable** criteria for this role:

- Experience in the field of mental health in a paid/voluntary capacity or as a carer or user of services
- Achieved the Diploma in Independent Advocacy
- The ability to communicate in both Welsh and English
- Experience in advocacy work
- Experience in the voluntary sector

Applications:

- A CV will not be accepted. Applications forms will need to be requested from CADMHAS office by emailing us at admin@cadmhas.co.uk or by phoning the office on 01745 813999
- Closing date for applications is 30th January 2024. The applications can be emailed to admin@cadmhas.co.uk or posted to CADMHAS, 94 Bowen Court, St. Asaph Business Park, Denbighshire, LL17 0JE

