IMHA Support Project

Key Competencies Of An Effective IMHA Service

Action for Advocacy

This guidance is aimed at IMHAs, health and social care professionals, commissioners of IMHA services as well as regulators such as the Care Quality Commission (CQC). It is not designed to replace existing policy and guidance within the Mental Health Act 1983 or be a detailed best practice guide but rather an overview of key elements of an IMHA service in order to support the delivery and commissioning of services as per advocacy principles recognised within the sector and developed by Action for Advocacy.

The Mental Health Act 1983 details the responsibilities and requirements of an IMHA service:

The Independent Mental Health Advocate (IMHA) must help the patient to obtain information about and to understand:

- their rights under the Act;
- the rights which other people (eg nearest relatives) have in relation to them under the Act;
- the particular parts of the Act which apply to them (eg the basis on which they are detained) and which therefore make them eligible for advocacy;
- any conditions or restrictions to which he is subject by virtue of this Act;
- what (if any) medical treatment is given to him or is proposed or discussed in his case;
- why it is given, proposed or discussed;
- the legal authority under which treatment is, or would be, given; and
- the requirements of this Act which apply, or would apply, in connection with the giving of the treatment to him;
- help in obtaining information about and understanding any rights which may be exercised under this Act by or in relation to him; and

The help, which IMHA services must provide, also includes helping patients to exercise their rights, which can include representing them and speaking on their behalf. But IMHA services are not designed to take the place of advice from, or representation by, qualified legal professionals. However there is

nothing to prevent IMHAs accompanying patients to tribunals and hospital managers hearings and speaking on their behalf.

Key elements of an effective IMHA Service

AWARENESS & KNOWLEDGE OF THE MENTAL HEALTH ACT & CODE OF PRACTICE

IMHAs need a good working knowledge of the Mental Health Act 1983 (MHA) and accompanying Code of Practice in order to be able to inform patients of their rights and discuss options available with regards representation in ward rounds, Care Programme Approach (CPA) meetings/care reviews, Mental Health Tribunals and day to day activity within a mental health unit. This is a key competency and skill of an IMHA service given the expectations as set out within the Act. IMHAs will want to be able to understand and offer:

- Information about detention and supervised community treatment (SCT)
- Information about consent to treatment
- Information about seeking a review of detention or SCT
- Information about the Commission
- Information about withholding of correspondence (where applicable)
- Information about patient rights and how to exercise these which may include advocacy representation
- Information about nearest relative and what their rights are within the Act in relation to the patient
- Information for informal hospital in-patients (many IMHA services will not be commissioned to work with informal patients but it is important their rights are understood)
- Information for those subject to guardianships
- Information about Second Opinion Appointed Doctors (SOADs)
- Awareness of the emergency applications of detention

This list is not exhaustive.

AWARENESS & KNOWLEDGE OF THE MENTAL CAPACITY ACT

The Code of Practice to the MHA 1983 emphasises that those working with people with mental health needs will need to have a good understanding of the Mental Capacity Act 2005 (MCA 2005). IMHA services will want to be familiar with:

- The MCA Code of Practice (including the five principles of the Act and best interests checklist)
- The assessment of capacity within the MCA
- Deprivation of Liberty Safeguards (DoLS) Code of Practice
- Interface between the Mental Health Act and Mental Capacity Act
- The role of the Independent Mental Capacity Advocate (IMCA)

NON-INSTRUCTED ADVOCACY

IMHAs will inevitably work with clients who lack the capacity to instruct or request an IMHA service. This might be because clients are acutely unwell either physically or mentally, they may have dementia and it has begun affecting their memory to the point they can no longer retain or use information to make a decision (which includes instructing an IMHA to represent them). They may have a learning difficulty which impacts on their ability to understand what an IMHA does. For many reasons a person may be unable to instruct an IMHA to represent them.

The Mental Health Act Code of Practice (20.19) clearly states:

"AMHPs and responsible clinicians should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA's visit but is unable or unlikely for whatever reason to request an IMHA's help themselves".

IMHA services will therefore be required to have an understanding and practical working experience of non-instructed advocacy, which will include:

- A non-instructed advocacy policy
- An understanding of non instructed advocacy approaches
- A referral process for clients unable to instruct themselves

- Prioritisation policy that includes those less able to instruct an advocate

- Information for third parties including professionals about non instructed advocacy

AWARENESS RAISING

There is a duty placed on the managers of the hospital a patient is detained in, local authority and the patients responsible clinician (or approved clinician for decisions about ECT) to inform patients about their right to access the IMHA service. It is imperative that hospital staff have a good understanding as to what an IMHA does and how the local service works. IMHA services whilst not required to carry out informal training for hospital staff or awareness raising about their role, it would appear to be best practice/benefit clients if this is carried out to ensure a smooth running and person centred service. IMHAs can carry this out in the following ways:

- Within handover sessions during ward rounds
- As part of the hospital induction programme for staff
- Hospital away days
- Hospital team meetings

SUPERVISION & TRAINING

The nature of the 1:1 relationship in advocacy and the complexities of mental health and the relevant pieces of legislation means that it is vital IMHAs are able to access supervision. The supervision must include case work supervision carried out by someone who has knowledge and experience of the MHA and the role of the IMHA to ensure effective case work supervision that ultimately benefits the patient that accesses the service.

IMHAs should be able to access training that supports them in their role which may include:

- updates on relevant case law;
- aspects of community care law;
- non-instructed advocacy;
- working with children;
- safeguarding (including adults and children) as well as
- refresher training on the Mental Health Act and Mental Capacity Act.

This list is not exhaustive.

INFORMAL PATIENTS

Currently in England informal patients are not entitled to support from an IMHA (there are some specific exceptions to this with regards certain

treatment and under 18's). In Wales all patients in mental health units are entitled to an IMHA.

Some of these patients will be entitled to an IMCA for specific decisions but as a general rule of thumb there is no statutory right to access advocacy for a voluntary capacitated patient. This client group may potentially be the most vulnerable if unable to access independent information and representation from an advocate (albeit clarity as to their rights should always be provided by mental health staff). It should be highlighted that there is no national recording of the number of informal patients in mental health settings.

Whilst this is a commissioning issue it is important that IMHA providers are recording this information when they are approached and are unable to deliver a service; including whether they were able to refer on to a non statutory advocacy service (or IMCA service); the patient was left without a service; or the IMHA supported the patient (be it as part of commissioning arrangements or good will).

PRO ACTIVE APPROACH

IMHA services should ensure they have procedures in place that mean they have a presence on wards and units in order for patients to be able to self refer as well as for hospital staff to be aware which service should be contacted when making a referral.

Trust and consistency are key elements of a patient/advocate relationship and it cannot be expected that patients would want to contact an unknown service (that is a service that does not have a visible presence). The independence of advocacy is also another key element and therefore IMHA providers should ensure that patients are aware of this and consider the methods they will use to convey this. Example of pro-active approaches may constitute the following:

- Information leaflets & posters clearly indicating contact details of the relevant service and methods of referral as well as availability both on the ward/unit and outside of these hours.

- Pro actively approaching patients that may be newly admitted or are preparing for a ward round, CPA, Tribunal etc to explain the IMHA service or clarify if support is required, by the patient.

- Having a weekly presence on the ward or unit so that patients began to recognise and feel familiar with the advocacy service, this is particularly important on units where non-instructed advocacy takes place and allows for IMHAs to approach patients who may lack capacity to instruct an advocate (or appear to) this may include approaching staff to enquire on this issue as well.

- Attending/hosting patient/group meetings

OUT OF AREA PATIENTS

Current commissioning guidance for out of area patients states the following:

Where patients are treated out of area, the patient's responsible PCT will need to make suitable arrangements for an IMHA to be made available.

Such arrangements could include:

- Commissioning an independent advocacy provider contracted to work with patients in the PCT's area to also provide IMHA services for patients placed out of area;
- Commissioning a different independent advocacy provider to provide IMHA services for the patients in question;

- Arranging with another commissioner (for example, another PCT) to commission IMHA services for the patients in question; or

- Commissioning the relevant mental health service provider to arrange IMHA services via an independent advocacy provider.

Access to an IMHA will be much easier for patients and staff if the same IMHA service provider can work with all qualifying patients in a particular ward or hospital.

Commissioners will need to consider which the above when ensuring out of area patients are easily able to access an IMHA service. IMHA providers need to be clear what the current arrangements are and be able to refer on easily on behalf of patients in circumstances that mean they are not the provider for that particular patient.

Cross-border arrangements

The Mental Health Act 1983 applies in both England and Wales. The Secretary of State's – and therefore PCTs' duty – is to arrange IMHA services for all qualifying patients who are considered to be in England for these purposes.[1] The Mental Health Act 1983 itself, and arrangements agreed by the Secretary of State and Welsh Ministers under it, set out whether a particular qualifying patient is to be regarded as being in England or Wales for these purposes:

[1] From April 2013 the statutory duty and funding for **commissioning IMHA services** will transfer to **local authorities.**

Qualifying patients	England or Wales
Patients liable to be detained in hospital	Country where the hospital is situated
Patients on Guardianship	Country where the LSSA is situated
Patients on Supervised Community Treatment	Country where the responsible hospital is situated
Informal patients being considered for section 57 treatment	Country where they live or, if they are in hospital or subsequently go into hospital for treatment for a mental disorder, the country where that hospital is
Informal patients aged under 18 being considered for section 58A treatment	Country where they live or, if they are in hospital or subsequently go into hospital for treatment for a mental disorder, the country where that hospital is

PRIORITISATION POLICY

IMHA services should ensure they are able prioritise their case load to be able demonstrate transparency as well as ensure that patients are seen based on their need and not that of the IMHA service or unit. Factors that can influence the prioritisation of patients may be new admissions, ward rounds, complaints, where there is a need to deliver non-instructed advocacy and this policy can also clarify the factors that may be less of a priority such as Tribunals where the patient is represented by a mental health solicitor. Where IMHA services hold a waiting list due to capacity of being able to deliver it is imperative that this information is recorded and that commissioners and the CQC are kept informed of this. If patients are not able to access the IMHA service for reasons beyond their control i.e. there is not enough funded provision they are effectively being denied their right to a service and this is an issue that should be progressed on their behalf.