

Independent Mental Health Advocacy

Guidance for Commissioners



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Document Purpose Best Practice Guidance

Gateway Reference 10593

Title Independent Mental Health Advocacy: Guidance for Commissioners

Author National Institute for Mental Health in England

Publication Date December 2008

Target Audience PCT CEs

Circulation List

Description This guide outlines the statutory independent mental health advocacy (IMHA) role and discusses good practice for IMHA services and recommended commissioning processes.

Cross Ref Code of Practice, Mental Health Act 1983 as amended

Superseded Docs N/A

Action Required N/A

Timing N/A

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Foreword

It is to be welcomed that for the first time in England and Wales patients subject to certain aspects of the Mental Health Act will have access to an Independent Mental Health Advocate (IMHA).

Consequently, there are significant challenges for all of us involved, including:

- Ensuring that all eligible patients have access to an IMHA;
- Establishing high quality and effective IMHA services;
- Reviewing the current distribution of advocacy provision to ensure that advocacy resources are well targeted; and
- Managing the expectations of this new service with patients, carers and staff.

This guidance is designed to help commissioners to prepare for implementation of this statutory service. It will also support advocacy providers involved in tendering processes, establishing operational arrangements with mental health services and in preparing information for service users and carers. The guidance sets out commissioning and partnership arrangements, alongside the key characteristics of the new service. It also suggests practical steps to complete implementation, monitoring and review, supported by examples of service specifications and engagement protocols.

Over the last twelve months, NIMHE has worked with advocates, community organisation members and local commissioners to focus upon the opportunities that the change to the law offers. From this work and the contributions of many other colleagues, the best available advice has been brought together.

IMHA services have been welcomed by commissioners as a means of ensuring that patients' rights and appropriate support are provided effectively and efficiently. Advocacy can deliver substantial added benefits in helping to promote the quality of very many mental health services. Mental health providers with an established advocacy service often report a type of dynamic tension resulting in the concerns of users and carers being better addressed

issues of diversity and culturally appropriate care being tackled and complaints being reduced. A statutory mental health service builds upon the best of this established practice.

The core task is always to support an individual service user during any particular episode of care. This important new service will focus upon the rights and standards of care provided to qualifying patients. It will also help commissioners and providers to improve continuously the delivery of care to people in the most clinically, legally and ethically complex area of the mental health system.

I believe that commissioners, advocacy providers and mental health services will find this to be a practical and useful guide to developing capable, needs based, mental health advocacy services as a right to which eligible patients in England are entitled.



Jim Symington, National Lead for Legislation
National Institute for Mental Health in England

Executive Summary

The Independent Mental Health Advocate (IMHA) service commissioning guide has been prepared for the introduction of IMHA services on 1 April 2009. The guide outlines the statutory IMHA role, discusses good practice for IMHA services and outlines the commissioning process required to ensure high quality IMHA services are provided for qualifying patients under the Mental Health Act 1983.

The key to provision of IMHA services is effective commissioning. This guidance is designed to support commissioners in preparing for this new statutory service by providing a reference document to the legal and practical issues to be considered when commissioning IMHA services.

This document addresses equality issues throughout. They form an important consideration for those commissioning, delivering and receiving IMHA services.

1. Key messages

1. PCT commissioners will be responsible for ensuring that IMHA services are available for qualifying patients in England from 1 April 2009.
2. IMHA services are a new statutory provision, with specific roles and responsibilities. IMHA services should complement and work with non-statutory mental health advocacy.
3. A consideration of the guiding principles set out in the Code of Practice will provide important guidance to those who are commissioning and delivering IMHA services.
4. IMHA services should be commissioned after an assessment of local need has been carried out, identifying the scope of service needed and any special attributes it should have.
5. The service specification should address how the diverse needs, values and circumstance of qualifying patients will be recognised and reflected, including their race, religion, culture, gender, age, sexual orientation and any disability.
6. Comprehensive guidance should be prepared by commissioners to ensure advocacy providers are clear what information is required from them in their tenders.
7. The tendering process should, wherever possible, involve service users and carers.
8. IMHA service providers should be required to draw up an engagement protocol, setting out the ways in which they will work with mental health service providers. The protocol should be a three-way agreement between the IMHA service provider, the mental health service provider and commissioner.
9. Commissioners should establish robust monitoring and review procedures for the IMHA service provider and move towards outcome-based commissioning.

2. Introduction

2.1 Scope and purpose

Advocacy has been available to support patients in many mental health services for some years, but from 1 April 2009 under provisions introduced by the Mental Health Act 2007, qualifying patients in England will have access to help from an Independent Mental Health Advocate (IMHA). IMHAs are an important new safeguard that will help and support patients to understand and exercise their legal rights.

This guidance builds on learning from years of commissioning of general advocacy and from the commissioning of Independent Mental Capacity Advocacy. It has been produced by the IMHA Project which was set up within the National Institute for Mental Health in England (NIMHE) legislation implementation team.

Note that (unless otherwise stated) this guidance summarises, rather than directly quotes from the legislation or guidance on IMHA services. The relevant legislation and chapter from the Code of Practice are included as an appendix for reference. The guidance relates to the IMHA provisions as they apply in England; the Welsh Assembly Government has produced separate guidance for Wales.

IMHA services are commissioned by PCTs, this process should fit with the **world class commissioning programme** which is the underlying delivery vehicle for many of the objectives of current health policy, including improving mental health services.

The world class commissioning programme particularly supports improving the provision of mental health services as it emphasises engaging public and patients, collaborating with clinicians and promoting innovation and improvement. Further details can be found on the world class commissioning website.

Where IMHA services are commissioned in partnership with local authorities, this process should also fit with the **commissioning framework for health and well-being**, which sets out the eight steps that health and social care should take in partnership to commission more effectively.

2.2 How to use the guidance

This guidance is aimed at commissioners of IMHA services, and provides:

- An outline of the statutory IMHA requirements, and their practical implications;
- A discussion of good practice issues that commissioners could consider when designing an IMHA service;
- A description of the process of commissioning IMHA services;
- Examples of key commissioning documents such as service specifications and tendering requirements;
- Suggestions for indicators that commissioners could use to monitor the quality of service provision and identify improvements;
- Appendices containing:
 - Appendix 1: Guidance on the review of existing advocacy provision
 - Appendix 2: A model service specification
 - Appendix 3: A model engagement protocol
 - Appendix 4: IMHA regulations
 - Appendix 5: Arrangements for 130C(6)(d) patients
 - Appendix 6: COP, Chapter 20 – Independent mental health advocacy
 - Appendix 7: Useful websites.

In addition, the guidance may be useful for IMHA service providers by highlighting quality standards. It can also be used by advocacy networks and providers as a framework to look at service improvement and the development of models of care.

2.3 Terms used in the guidance

Commissioner

This guidance uses the term **commissioner** to refer to the body, individual or group of individuals (or any combination of these) who is making arrangements for an IMHA to be available to help qualifying patients. The commissioner for a patient will be their responsible Primary Care Trust (PCT), unless the PCT has delegated their duties to another body or individual.

Mental health service provider

This guidance uses the term **mental health service provider** to define a person or organisation who provides specialist mental health services for qualifying patients. Depending on the individual circumstances, this could include an NHS Trust, an NHS Foundation Trust, a PCT, independent hospital or local social service authority (LSSA).

Independent advocacy provider

This guidance uses the term **independent advocacy provider** to define an organisation that employs (or engages), manages and trains mental health advocates.

IMHA service provider

This guidance uses the term **IMHA service provider** to define an independent advocacy provider who has a contract with a commissioner to provide IMHA services.

Independent Mental Health Advocates (IMHAs)

The term **Independent Mental Health Advocate** refers to statutory mental health advocates under the Mental Health Act 1983.

IMHA regulations

This guidance uses the term **IMHA regulations** to refer to the Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008.

NHS functions regulations

This guidance uses the term **NHS functions regulations** to refer to the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administrative Arrangements) (England) Regulations 2002.

Qualifying patient

The term **qualifying patient** refers to a patient who is eligible for support from an independent mental health advocate under the Mental Health Act 1983.

Staff and professionals

This guidance uses the term **staff and professionals** to refer to mental health and social care staff (including paid carers) providing care and treatment for qualifying patients.

3. The framework for an IMHA service

This chapter identifies the statutory requirements for the provision of IMHA services and discusses some of the practical considerations in meeting those requirements

3.1 Duty to make arrangements for IMHA services

Section 130A of the Mental Health Act (MHA) places a duty upon the appropriate authority to make such arrangements as it consider reasonable to enable IMHAs to be available to help qualifying patients.

3.2 Who qualifies for an IMHA?

The MHA calls patients who are eligible for the support of an IMHA “qualifying patients”.

Qualifying patients are those patients who are:

- Detained under the MHA (even if they are currently on leave of absence from hospital) apart from those patients detained under sections 4, 5(2), 5(4), 135 or 136;
- Conditionally discharged restricted patients;
- Subject to Guardianship under the Act; or
- On Supervised Community Treatment (SCT).

as well as patients not covered by any of the above but who are:

- Being considered for a treatment to which section 57 applies (“a section 57 treatment”);
- Under 18 and being considered for electro-convulsive therapy or any other treatment to which section 58A applies (“a section 58A treatment”).

(See MHA, 130C (3))

3.3 Who makes arrangements for IMHA services?

The Secretary of State for Health has directed Primary Care Trusts (PCTs) to exercise this duty.

The duty on PCTs to exercise 130A functions is to be exercised under the NHS functions regulations.

The NHS function regulations set out which PCT is responsible for commissioning IMHA services for qualifying patients as follows:

Qualifying patients	Responsible PCT
Qualifying patients registered with an English GP practice	PCT responsible for that GP practice
Qualifying patients not registered with an English GP practice, but who are usually resident in England	PCT for the area in which they are usually resident

Continued

Qualifying patients	Responsible PCT
Qualifying patients present in England who are not covered by either of the above (e.g. people who are usually resident outside England or who have no place of residence). This includes Scottish, Welsh and Northern Irish patients, as well as patients of foreign nationality	PCT in whose area they are present
Qualifying patients in Wales not covered by any of the above, but who are treated as being in England for the purposes of IMHA services because they are liable to be detained in a hospital in England (see 3.5 below)	PCT for the area in which the hospital is located

In broad terms, this means that the statutory duty to make arrangements for an IMHA to be available to help qualifying patients is in line with how the majority of PCTs' functions in relation to specialist mental health services are exercised. Normally, the PCT responsible for commissioning mental health care for a qualifying patient will also be responsible for ensuring that patient has access to an IMHA.

Note, however, that the rules in the NHS functions regulations about responsibility for commissioning continuing care for people placed "out of area" (i.e. in accommodation in a care home, independent hospital in the area of another PCT or a child placed in provided with accommodation in the area of another PCT or Local Health Board) do not apply to IMHA services as IMHA services do not fall within the definition of continuing care. Nor do the rules about commissioning after-care under section 117 of the Mental Health Act.

In cases where it is unclear which PCT is responsible for proving IMHA services for a particular patient, reference should be made to **"Establishing the responsible commissioner"**, which provides guidance on determining commissioning responsibility.

3.4 Out of area patients

IMHAs will need to be available to help the patient where the patient is receiving treatment (in-patients) or is currently resident (patients in the community). In most instances, these arrangements will be straightforward: with the patient receiving treatment or resident in their local area and the IMHA provided by a local independent advocacy provider contracted by

the PCT. However 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.

3.5 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. 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:

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 (see Appendix 6)
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 (see appendix 6)

Where patients are regarded as being in England, commissioning responsibility is determined under the NHS functions regulations.

These arrangements mean that PCTs may sometimes need to arrange IMHA services for people who are in Wales while on leave of absence from a hospital in the PCT's area. However, PCTs are not responsible for IMHA services for patients detained in hospital in Wales but on leave of absence in England.

3.6 Making arrangements for IMHA services

When making arrangements for IMHAs to be available to help qualifying patients, PCTs may:

- Commission IMHA services from independent advocacy providers;
- Provide IMHA services themselves, e.g. directly employ or engage individuals to act as IMHAs.

It is strongly recommended that PCTs commission IMHA services from independent advocacy providers as this offers a number of advantages:

- Qualifying patients will be more confident that IMHA services are genuinely independent if they are provided by an independent organisation;
- Independent advocacy providers already employ people who have valuable knowledge and experience in the advocacy field;
- Independent advocacy providers have often already developed the necessary protocols and procedures for delivering advocacy services safely and efficiently;

- Non-statutory mental health advocacy and statutory independent mental capacity advocates are both generally commissioned from independent advocacy providers.

For the purpose of this guidance, it is assumed that PCTs will choose to commission IMHA services from independent advocacy providers. If PCTs decide to provide IMHA services themselves much of the guidance will still be relevant but may need to be modified in parts.

3.7 Independence of the IMHA service

The independence of the IMHA service is an important consideration for all commissioners. For IMHA services to be meaningful and acceptable to those they are designed to support, they must have patient and public confidence – anything which may appear compromise that independence could undermine that confidence.

In making arrangements for IMHA services, commissioners should have regard to the principle that any help made available to a patient should, as far as practicable, be provided by a person who is independent of any person who is professionally concerned with the patient's medical treatment.

(See 130(A)(4) of the MHA)

For this reason, commissioning arrangements should, as far as possible, ensure that IMHA services are operationally independent of health and social care providers.

PCTs may choose to commission IMHA services in different ways:

- In most cases, it is recommended that IMHA services are directly contracted by the PCT from an independent advocacy provider.
- If PCTs choose to commission IMHA services from a mental health service provider, then these services should be subcontracted by that mental health service provider to an independent advocacy provider. In such

arrangements, the PCT should satisfy themselves that both individual IMHAs and the IMHA service provider are able to operate independently. This may include asking to see a copy of the contract and engagement protocol between the mental health service provider and the IMHA service provider, receiving quarterly reports from the IMHA service provider and obtaining the contact details of the IMHA service provider.

3.8 The role of the IMHA

An IMHA is a specialist type of mental health advocate, granted specific roles and responsibilities under the Mental Health Act.

IMHAs will help qualifying patients understand the legal provisions to which they are subject under the Mental Health Act 1983, and the rights and safeguards to which they are entitled. This could include assistance in obtaining information about any of the following:

- The provisions of the legislation under which s/he qualifies for an IMHA;
- Any conditions or restrictions s/he is subject to for example any arrangements made for s17 leave;
- The medical treatment being given, proposed or being discussed and the legal authority under which this would be given;
- the requirement that would apply in connection with the giving of the treatment;
- their rights under the Act and how those rights can be exercised.

(See MHA, 130B (1))

IMHA will also help qualifying patients to exercise their rights. This help may include:

- Supporting patients in accessing information and better understanding what is happening to them;
- Supporting qualifying patients in exploring options, making better-informed decisions and actively engaging with decisions that are being made;
- Supporting qualifying patients support in articulating their own views;
- Speaking on the patient's behalf and representing them;
- Supporting patients in other ways to ensure they can participate in the decisions that are made about their care and treatment.

(See 130B (2) of the MHA)

3.9 Informing the patient of their right to an IMHA

The MHA places a duty on the "responsible person" to provide verbal and written information about IMHA services to qualifying patients.

(See MHA, 130D)

"Responsible person" includes:

- managers of the hospital,
- the responsible clinician,
- the local services social authority,
- the registered medical practitioner or approved clinician.

The duties are as follows:

Type of patient	Steps to be taken by	As soon as practicable after
Detained patient	The managers of the hospital in which the patient is liable to be detained	The patient becomes liable to be detained
Guardianship patient	The responsible local social services authority	The patient becomes subject to Guardianship
SCT patient	The managers of the responsible hospital	The patient becomes a SCT patient
Conditionally discharged patient	The patient's responsible clinician	The patient is conditionally discharged
Informal patient	The doctor or approved clinician who first discusses with the patient the possibility of them being given the section 57 or 58A treatment in question	That discussion (or during it)

The responsible person must inform the patient of their right to an IMHA. If the patient subsequently decides to access the service, they may request the responsible person to refer them to the IMHA service (see below) or choose to contact the IMHA service directly themselves.

Commissioners will want to ensure that the IMHA service responds to a self-referral from any qualifying patient who directly requests their help. In response to referrals, IMHAs will visit and interview the patient but they will only work with qualifying patients who wish to see them.

3.10 Responding to referrals

IMHAs have a statutory duty to comply with any reasonable request to visit a qualifying patient when a referral is made by any of the following people:

- the patient's nearest relative;
- the patient's responsible clinician;
- an Approved Mental Health Professional (AMHP) acting on behalf of a local social services authority.

(See MHA, 130B (5))

“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.”
(COP, 20.19)

The referral process is important not only because it increases patient uptake of the service, but because IMHAs may receive referrals to work with patients who lack the capacity to make contact with the service or instruct an IMHA directly.

Commissioners will want to ensure the IMHA service provides clear guidance to qualifying patients and staff on how to refer themselves or their patients to the appropriate IMHA service. The guidance should address referrals made in person as well as those made via other routes and informal referrals from other sources such as hospital managers.

It is not expected that IMHA services should function as an emergency service. Consequently, commissioners should set minimum standards required in terms of IMHA response times to all referrals.

3.11 Visiting patients

When helping qualifying patients, IMHAs have the right to:

- To see and interview a patient in private;
- To meet and interview professionals involved with the patient's care.

(See MHA, 130B (3))

These rights mean that, in practice, IMHAs should be able to:

- Have access to wards and units on which patients are resident;
- See patients in private unless the patient is under close observation or in seclusion, or clinical staff advise against it for reasons of the IMHA's or the patient's safety;
- Attend relevant meetings with staff at the request of the patient.

Arrangements over where IMHAs will meet with qualifying patients should be agreed between the commissioner, IMHA service provider and mental health service provider. When making these arrangements, it will be important to consider how IMHA services will fit into a qualifying patient's lifestyle and treatment plan, in both hospital and community settings.

In hospital settings

It is expected that the majority of qualifying patients in hospital will meet an IMHA on the ward or unit where they are resident. Suitable facilities will need to be agreed with the mental health service provider.

In considering suitable arrangements, these should include:

- A private space that the IMHA and patient may access; and
- Access to a telephone on which patients may contact the IMHA and talk to them in private.

In community settings

Issues of accessibility, practicality, suitability, patient agreement and the safety of the IMHA will all affect where a patient in the community can meet an IMHA. Arrangements should specify places where an IMHA may meet a patient and specify who will be responsible for agreeing these arrangements with the patient.

3.12 Access to records

"Where the patient consents, IMHAs have a right to see any clinical or other records relating to the patient's detention or treatment in any hospital, or relating to any after-care services provided to the patient. IMHAs have a similar right to see any records relating to the patient held by a local social services authority."

(COP, 20.25)

(See MHA, 130B (3))

"Where the patient does not have the capacity (or in the case of a child, the competence) to consent to an IMHA having access to their records, the holder of the records must allow the IMHA access if they think that is it appropriate and that the records in question are relevant to the help to be provided by the IMHA."

(COP, 20.26)

(See MHA, 130B (3))

4. Who can be appointed as an IMHA?

This chapter discuss some of the practical implications of meeting the statutory requirements on appointing persons to act as IMHAs, as set out in regulations. A copy of the IMHA regulations can be found at Appendix 4.

4.1 Appointment requirements

The regulations state that a person appointed to act as an IMHA must:

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

In determining if a person is of integrity and of good character, they must have undergone an enhanced Criminal Records Bureau check or, if an enhanced certificate is not required, a Criminal Records Bureau check.

(See IMHA regulation 6)

Only those persons who met these appointments requirement will be allowed to act as an IMHA.

4.2 Appointment processes

The regulations state who must check that an individual meets the appointment requirements before they may act as an IMHA.

- In the case of persons directly employed by the commissioner to act as an IMHA, the commissioner must be satisfied that the individual meets the IMHA appointment requirements.
- In the case of persons employed by an IMHA service provider, commissioners should include a requirement in the agreement with the IMHA service provider, that the IMHA service provider must be satisfied that the individual meets the IMHA appointment requirements.

Only persons made available by the commissioner or by a contracted IMHA service provider can act as an IMHA.

(See IMHA regulation 3(1) and 3(2))

4.3 Appropriate training or experience

All IMHAs should have appropriate experience or training, or an appropriate combination of experience and training.

When determining what constitutes appropriate experience or training or an appropriate combination of experience and training, regard must be had to guidance issued from time to time by the Secretary of State.

(See IMHA regulation 6(2) (a) and 6(3))

The agreement between the commissioner and the IMHA service provider must include a requirement that all IMHAs meet the criteria on appropriate experience and training. In deciding what constitutes appropriate experience and training, the person or organisation appointing the IMHA must have regard to Department of Health guidance. This guidance may be updated from time to time. The current guidance says:

Standards: appropriate experience and training

This is guidance on what constitutes appropriate experience and training for Independent Mental Health Advocates (IMHAs), including an appropriate qualification, referred to in regulation 6 of the Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008.

In deciding what constitutes appropriate experience and training, commissioners should consider:

- Previous experience working in advocacy, particularly mental health advocacy
- Previous experience working with people with mental health needs
- Successful completion of an advocacy qualification, in particular the IMHA module of the National Advocacy Qualification (see below).

National Advocacy Qualification

To achieve national consistency in the way IMHA services are delivered by multiple independent advocacy providers, a national advocacy qualification is being developed. The qualification is to be modular in structure, consisting of four core modules on generic advocacy, and several specialist modules, including an IMHA module. Learners will be able to take any unit in any order, and there will be no requirement to complete the core units before completing a specialist unit.

As it is a competency-based qualification and reliant on practical experience, not all potential IMHAs will be able to complete the IMHA module before starting to practise. However, to ensure that IMHAs are appropriately trained to meet the needs of patients, IMHAs should be expected to have successfully completed the IMHA module by the end of their first year of practice (making necessary adjustments for any maternity leave, long term sickness or other similar absences).

<http://www.dh.gov.uk/en/Healthcare/NationalServiceFrameworks/Mentalhealth/index.htm>

This duty applies directly on the person or organisation appointing the IMHA. However in addition, it is also recommended that commissioners state the level of training and experience which they require in their contracts with the IMHA service provider.

4.4. Independence of the IMHA

An advocate should be able to act independently of any person who is professionally concerned with the patient's medical treatment; and be able to act independently of any person who requests that person to visit or interview a patient.

(See IMHA regulation 6(2)(C) and 6(2)(D))

An advocate is not to be regarded as professionally concerned with a patient's medical treatment if their only involvement in that treatment is that they:

- Are currently representing the patient as an IMHA; or
- Have represented them as an IMHA in the past.

(See IMHA, regulation 7)

The agreement with the IMHA service provider must include a requirement that an IMHA meets these criteria on independence.

5. Engagement Issues

IMHAs may engage with patients in different ways. This chapter discusses some engagement issues for commissioners to consider.

5.1 Engaging with patients

IMHAs have a statutory duty to respond to direct referrals, and a right to visit patients on a one-to-one basis. However, IMHAs may also engage with patients in a variety of other ways. In line with the respect principle of the Code of Practice, commissioners should consider what methods of interaction between the IMHA service and patients would best meet the patients' needs while fulfilling the IMHA's statutory duties. Examples include:

- IMHAs making regular informal visits to a ward so that they can introduce themselves to detained patients and explain what they do. This helps IMHAs to become a familiar face on the ward and become known to individual patients. It also provides an easy way for patients who may otherwise not access the service to contact the IMHA.
- IMHAs running formal drop-in sessions on wards or units, enabling detained patients to know when the IMHA will be on the ward so that they can either talk to the IMHA informally or book individual time with them.
- IMHAs running formal drop-in sessions in the community or out-patient settings, enabling community patients to know when the IMHA will be available and where they can be contacted.
- IMHA service providers publicising their service through use of posters or leaflets in patient settings.
- IMHAs establishing links with community groups who offer support to particular groups of service users, for example, BME communities and community groups for older people.
- IMHAs establishing links with local social services authorities and third sector providers in relation to people on Guardianship.

5.2 Patient choice and representation

IMHAs are not the only people who may support and represent a qualifying patient; patients may

choose to be supported by a general mental health advocate, a family member or friend, or to represent themselves, rather than use the IMHA service.

However, it should be explained to both the patient and the chosen representative that the rights and duties given to an IMHA can only apply to people formally working as IMHAs as part of the service agreed with the relevant commissioner.

“The involvement of an IMHA does not affect a patient’s right (nor the right of their nearest relative) to seek advice from a lawyer. Nor does it affect any entitlement to legal aid.”
(COP, 20.11)

IMHAs are not the same as legal representatives, and should not be expected to perform duties undertaken by solicitors. Qualifying patients will continue to be legally represented in Tribunals as is currently standard practice, and patients should be made aware of their right to access legal aid and/or seek advice from a solicitor.

5.3 Instructed and non-instructed advocacy

Wherever possible IMHAs will take instruction from the person they are supporting. An IMHA may support a person to obtain information, explore options and carry out actions, but throughout this process the IMHA will be directed by the person and act only on their behalf.

IMHAs may also provide non-instructed advocacy when helping patients who are unable to express their wishes clearly, or at all, because they lack the mental capacity to instruct or have difficulties communicating. When providing non-instructed advocacy, the IMHA will represent the patient's wishes (as far as those wishes are known) and ensure the patient's rights are respected.

Where a patient qualifies for both an IMHA and an Independent Mental Capacity Advocate (IMCA), the IMCA will represent the patient in line with the IMCA's statutory role. An example is a qualifying patient who lacks capacity and it is being

considered for cancer treatment: in this case, the IMCA would represent the patient in the decision-making process for this treatment.

5.4 Providing additional support

The legislation sets out the minimum requirements for IMHA services. In addition to this statutory provision, commissioners may want to think about other advocacy needs. Additional services to the IMHA contract could include:

- Broadening the client group to include informal inpatients;
- Broadening the range of issues on which advocates provide support, for example, housing or benefits.

Support for informal patients

In addition to the statutory IMHA service for qualifying patients, some commissioners may choose to extend advocacy provision to support informal patients. They might, for example, help informal patients to access information about their care and treatment, and support them with the care planning process. Support for informal patients could be limited to specified wards or units where such patients are identified as particularly vulnerable.

Support on other issues

The legislation requires the IMHA to provide support to a patient on particular issues. Some commissioners may wish to extend the issues on which IMHAs may provide support. This may include support in addressing particular cultural needs, family issues and money concerns, such as benefits or debts.

Additional services of these kinds are not required under statute, and it will be up to the discretion of the commissioner as to whether they commission these additional services. Where these are included in a contract it will need to be clear that the IMHAs statutory powers only apply to services which fall within the specific role of IMHAs.

6. Commissioning IMHA services

Commissioners will be responsible for making sure that appropriate IMHA services are available for all qualifying patients to access. Nationally, it is expected that different models of IMHA provision will be set up that reflect:

- Different configurations of mental health service provision including large specialist mental health trusts, small providers of psychiatric services and provision for qualifying patients in the independent sector;
- Particular circumstances of the local population, including ethnic, cultural, and demographic needs;
- Individual circumstances which may include race, religion, gender, age, sexual orientation or disability;
- Different group and joint commissioning arrangements;
- An opportunity to involve a range of independent advocacy providers.

6.1 Establishing commissioning partners

To ensure local flexibility, PCTs may commission jointly with or delegate commissioning to other bodies, including other PCTs. They may also enter into partnership arrangements with local authorities.

PCTs cannot delegate commissioning responsibility to NHS Trusts or NHS Foundation Trusts.

(See NHS functions regulation 10(1A))

Partnership arrangements with PCTs

PCTs may commission jointly with or delegate commissioning to other PCTs for the provision of IMHA services.

(See NHS functions regulations)

Reasons why the PCT might want to establish joint or lead commissioner arrangements include:

- In the case of qualifying patients placed in

specialist facilities, such as patients aged under 18 years or forensic patients;

- Where the number of qualifying patients in one PCT is low, or where there are no psychiatric inpatient services in that PCT;
- Where a large mental health provider spans a number of PCTs or an independent advocacy provider spans a number of PCTs.

Partnership arrangements with Local Authorities

A PCT's duties in respect of IMHA services may be included within partnership arrangements with local authorities under section 75 of the NHS Act, subject to all the normal rules about those partnership arrangements.

(See NHS Bodies and Local Authorities Partnership Arrangements Regulations (2000))

Reasons why partnership arrangements might be considered are that:

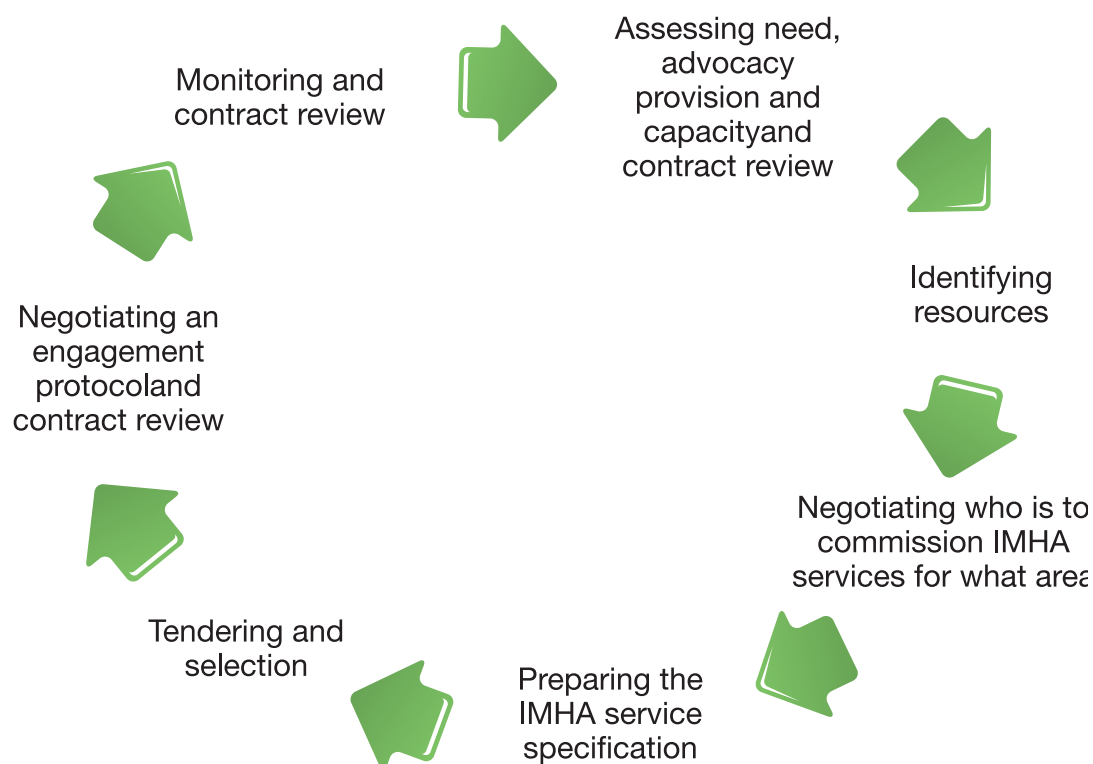
- Local authorities already commission some mental health advocacy services;
- Many qualifying patients will be receiving both health and social services;
- The configuration of mental health services, for example community mental health teams, include staff both from health and social care; and
- There are successful examples of partnership arrangements for IMCA commissioning across England that could be replicated for IMHA commissioning mental health service provider.

PCTs should notify the Department of Health of all intended use of partnership arrangements. Details on how to do this can be found on the Department's website.

6.2 The commissioning process

The commissioning process follows the stages outlined in Figure 1.

Fig. 1: IMHA service commissioning process



The stages include:

- Establishing commissioning partners;
- Assessment of need based on local population
- Identifying resources for the IMHA service;
- Ensuring a reasonable length of contract and realistic costs calculated to take account of full cost recovery by the provider;
- Developing a service specification;
- Developing a tendering process with clear guidelines for bidders on what information is expected, including an adequate timeframe;
- Selecting the IMHA service provider;
- Assisting the IMHA service provider to develop an engagement protocol;
- Monitoring the performance of the IMHA service, and using feedback gained to improve service provision.

It is recommended that service users and carers are involved at all stages of this process.

6.3 Assessing need

The size and nature of the IMHA service required will depend on the qualifying patient population. To assess the advocacy service needed for the local population, it is recommended that the following questions are considered:

- How many qualifying patients are there?
- What was the age and gender distribution of qualifying patients over the last 12 months?
- What was the ethnic make up of the qualifying patient population over the last 12 months?
- Where are qualifying patients cared for that IMHAs would be expected to visit?
- Who provides the care and treatment for qualifying patients?
- Are there qualifying patients in:
 - Forensic services?
 - Learning disability services?
 - CAMHS services?
 - Older peoples services?
- How many patients would you expect to have on SCT in a year?
- How many patients are under Guardianship?
- Are any changes planned that could affect the need for IMHA?

6.4 Meeting diversity

Commissioners must, as far as reasonably practicable, have regard to the diverse circumstances (including but not limited to the ethnic, cultural and demographic needs) of qualifying patients when commissioning IMHA services.

(See IMHA regulation 3(3))

Diversity can include (but is not limited to) issues of race, religion, culture, gender, age, sexual orientation and disability. It is recommended that issues of diversity are integrated from the start of the commissioning process as part of the initial needs assessment. This will enable commissioners to commission an IMHA service that meets these needs, as well as being practicable.

In situations where there are concentrations of patients with particular needs because of the make up of the local population or the provision of specialist services – such as a high

concentration of people from a particular ethnic group – it is recommended that IMHA service providers should be specifically required to provide IMHAs with the appropriate training and experience to meet these needs

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

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

The IMHA service provider may also build less formal links with other local services experienced in working with particular groups of people, for example those with physical disabilities or issues relating to gender or sexual orientation. These informal links can include sharing knowledge or skills or referring patients to these other services. However, only a person approved or appointed by an IMHA service provider will be able to act as an IMHA.

Case scenario 1:

A local IMHA service received a referral from a ward manager. The qualifying patient specifically wanted to meet with an advocate familiar with working with Bengali men. The local IMHA service didn't have an advocate in their organisation who would have met that patient's requirements but the IMHA organisation did have a list of organisations which could provide a range of specialist advocates. The manager of the IMHA service arranged for the IMHA to meet with the patient in the company of another advocate who was familiar with working with Bengali men and could help with the particular issues raised by the patient.

The development of IMHA services present an opportunity to provide support and guidance to service users ensuring they have their needs and views represented. When commissioning IMHA services, it is recommended that commissioners seek to address this through their contracting and performance management processes.

Black and Minority Ethnic (BME) groups

There are a number of ways that commissioners can seek to address some of the issues presented by the experiences of BME mental health service users, particularly in supporting them to access advocacy services. A key issue will be local development of ways to enable BME communities to access IMHA services.

This might combine raising general awareness and targeted work to ensure a more informed understanding of the mental health system and safeguards including advocacy.

Specialist mental health needs

Where IMHAs are to work with patients being treated by specialist forensic, child and adolescent, older people services or learning disability services, commissioners will need to be sure IMHA service providers have arrangements in place to ensure that IMHAs have the necessary experience and training to undertake the role.

7. Developing a service specification

7.1 Introduction

Service specifications are key tendering documents that outline what commissioners expect from services being commissioned. The IMHA service specifications would benefit from being developed in consultation with key stakeholders such as service users, advocates and mental health service providers.

7.2 Content of service specification

A model IMHA service specification is provided in Appendix 2. This sets out the basic requirements for these services and could be used as a starting point for documents tailored to meet local circumstances.

Important content includes the following:

Timing of the contract

The IMHA service is due to commence on 1 April 2009. Good practice suggests contracts should be for a minimum of three years or established as rolling contracts subject to satisfactory performance. This can give new IMHA services time to fully establish themselves, become known by patients and mental health staff and give IMHAs some security of employment.

Purpose of the service

The purpose will be to provide an IMHA service as specified in the Mental Health Act 1983. Commissioners should be clear about any additional services over and above their statutory duties that advocates are expected to perform (see 5.4).

If IMHAs are expected to work in specialist mental health services such as forensic services, CAMHS units or services for adults with learning disabilities, specific requirements may need to be set out in the service specification.

Principles of the service

The principles may include:

- The need for independence;
- Confidentiality;

- Meeting the diverse needs of qualifying patients;
- Working in partnership with agencies involved in the care of qualifying patients.

Availability and coverage

It is expected that IMHA services should be available (at least) during office hours on weekdays but some flexibility could be built into the contract to take account of specific needs or to allow for the weekly routines of patients. The contract should specify to which patients it is providing a service, the kind of service those patients may be receiving and where they are located. For example:

- Qualifying patients in hospital and in community settings;
- In-patient units in different specified locations;
- Specialist provision such as forensic units or services for people with learning disabilities and mental illness.

Interface with mental health providers

To clarify working arrangements between IMHA services providers, mental health service providers and commissioners, an engagement protocol should be negotiated and approved by all three parties. This protocol should be drawn up within two months of the service becoming operational.

Other expectations of the IMHA service provider that could be specified include:

- The training of mental health providers and professionals to raise awareness about the IMHA service;
- The provision of publicity materials and the formats in which these should be available; and
- The development of local protocols agreed between IMHA service providers and mental health providers to address specific issues such as access to records.

Staffing

A requirement must be included that the IMHA service provider ensures that any individual made available to act as an IMHA meets the IMHA appointment requirements set out in regulations.

Training

All IMHAs must meet agreed criteria on appropriate experience and training. In deciding what constitutes appropriate experience and training, the person or organisation appointing the IMHA must have regard to standards in guidance issued by Secretary of State (see 4.3 above). According to current guidance, this may include previous experience working in advocacy, particularly mental health advocacy; previous experience working with people with mental health needs and successful completion of an advocacy qualification, in particular the IMHA module of the National Advocacy Qualification, within one year of starting employment.

In addition, it is also recommended that commissioners state a minimum level of experience or training they require in their contract with the IMHA service provider.

Security checks

IMHAs are required to have undergone either an enhanced Criminal Records Bureau (CRB) check if they qualify for one or, if not, a standard CRB check. In the case of IMHAs working with children aged under 18, checks should be made against the the Protection of Children Act (POCA) list, if applicable. Any other checks required by legislation in future should also be made.

Character

The IMHA must be a person of integrity and good character, and the IMHA service provider must only employ persons to act as IMHAs who they believe meet this requirement. If the IMHA service provider subsequently knows of or suspects any actions on the part of the IMHA that could compromise their suitability to act in the IMHA role, that person should not be allowed to act as an IMHA until these concerns have been resolved.

Independence

The IMHA service provider must not assign an IMHA to a patient if the IMHA has had any professional involvement with that patient's treatment – either past or present – other than acting for them as an advocate.

Diversity

The IMHA service provider should be expected to make every reasonable effort to meet the ethnic and cultural diversity of the qualifying patient population. Commissioners may specify any particular requirements regarding any specific needs of qualifying patients.

IMHA management and supervision requirements

IMHA will be managed by, and primarily accountable to, the IMHA service provider. Commissioners may wish to specify minimum supervision arrangements.

Case and activity recording

A comprehensive record of patient contacts should be kept. It is recommended that all IMHA service providers have a regularly reviewed policy and procedures for the setting up, maintenance, storage, archiving and destruction of case records. IMHA service providers may also be required to record other activity such as enquiries that do not lead to a case file being opened.

Patient involvement and feedback

It is recommended that mechanisms are in place for IMHA service providers to take patients' views into account when planning and reviewing the service.

Outcomes and quality monitoring

It is recommended that commissioners' requirements for the monitoring and review of IMHA services are outlined.

Accountability

It is important that the commissioners set out the performance management mechanisms the IMHA service provider will be required to meet.

8. Tendering and selection

8.1 Tendering process

Before IMHA services can be put out for tender, commissioning partnerships have to be in place and detailed service specifications agreed. While the commissioners of the IMHA service may be different from those involved in commissioning the IMCA service, there may be valuable lessons that can be learnt from that experience.

The tendering process can benefit from the involvement of service users and carers throughout. In order to participate fully in the process, service users may need to be given training and financial recompense.

Tender documents should guide independent advocacy providers who wish to tender on the information that commissioners need in order to judge the bids. A suggested checklist is provided below. It is recommended those bidding are also asked to provide a case study or case scenario that illustrates how they currently provide (or would provide) advocacy to individuals. The case study could demonstrate the use of advocacy principles, some of the dilemmas advocates face and the approach the advocate took to resolve the issue. Such case studies can be very revealing about the value base of the independent advocacy provider, its experience in handling difficult situations and its understanding of the advocacy role.

National advertisement of the IMHA tenders may be necessary unless there are well established local independent advocacy providers or tender arrangements based on preferred partner status. It is recommended that locally those organisations with advocacy skills and experience should be recognised and given every opportunity to tender.

8.2 Tendering requirements

In submitting a tender, it is recommended that an independent advocacy provider is asked to:

- Provide information on its size, organisational structure and experience; its constitution and its code of practice/conduct (if it has one);
- Either demonstrate its experience of providing mental health advocacy or explain how it will develop this skill;
- Provide information on how often advocates

receive supervision and whether they have personal/professional development plans or explain how this will be addressed;

- Illustrate experience of working in partnership with statutory agencies or explain how it will develop this skill;
- Illustrate experience of providing a service which demonstrates an active commitment to equal opportunities;
- Show experience of working with users from ethnic minorities those who do not have English as their first language and those who need specialist communication tools;
- Confirm that it employs staff in a manner that ensures they meet the IMHA appointment requirements set out in regulations, or demonstrate how this will be done;
- Demonstrate sound financial management and provide all financial records required by the commissioner and details of its public and employer's liability insurance (if it has any);
- Provide information on methods of working;
- Provide copies any policies/protocols relating to mental health advocacy;
- Specify the number of advocates the service proposes to train and manage as IMHAs (within the stated budget) and whether these are part-time or full-time posts;
- Identify what indicators and methods would be used to evidence that individual and service outcomes have been achieved;
- Provide a detailed annual budget for the period the contract will run.

In costing IMHA provision to meet local need, it will be necessary to consider the following within the tender application:

Staff costs for:

- Management including line management and supervision;
- IMHAs (there is no nationally agreed pay scale);
- Costs of absence cover;
- Administration;
- Second tier staff/team leaders if the service is large and provides a service in a number of locations/specialisms.

Non-staff recurring costs for:

- Office rent and charges;
- Stationary and equipment, including telephone, faxes and other information technology;
- Travel – particularly significant in rural areas;
- Printing of publicity materials and an annual report.

Set up costs for:

- Job advertisements;
- Equipment;
- Staff security checks.

Training:

- Costs of completing the IMHA module of the National Advocacy Qualification. Training costs will be weighted towards the set-up phase, but a training budget should also be provided annually for the training of new staff;
- On-going training, including continuous professional development;
- Networking.

Governance:

- External supervision for staff to be used when needed to address specific issues on a time-limited basis.

Consultancy:

- Access to specialist advice such as a mental health lawyer;
- Inclusion costs (British Sign Language (BSL), translation and interpretation costs).

Full cost recovery:

- Full cost recovery should be encouraged by commissioners – advocacy providers should not be expected to subsidise the provision of IMHA services from other sources.
- Full cost recovery should include reasonable and justifiable costs to cover risk and speculative investment by the advocacy service.

9. Negotiating an engagement protocol

9.1 What is an engagement protocol?

A key determinant of success will be the three-way relationship in advocacy provision between the IMHA service provider, relevant mental health service providers and the commissioners. In particular, good working relationships between the IMHA service provider and mental health service providers is essential for effective service delivery.

An engagement protocol, or procedure, confirms this three-way relationship between the IMHA service provider, the mental health service provider and the commissioner. It sets down service delivery and practice requirements for the provision of the IMHA service in particular settings and clarifies the working relationship between the IMHA service provider and the mental health service provider. It sets out:

- What the IMHA service provider will provide;
- How these services will be provided and monitored;
- What boundaries the IMHAs will work within; and
- How IMHAs will relate to mental health staff and professionals.

It further sets out:

- What the IMHA service provider and its patients can expect from the mental health service providers; and
- What arrangements are in place for regular meetings with commissioners.

The IMHA service provider will usually take a lead in drawing up the engagement protocol but it should be drafted with the other two partners. All three partners should agree the final document. It is recommended that it then be an openly available document that can be referred to by mental health staff and IMHAs when they wish to check agreed arrangements and responsibilities.

Where the IMHA service provider works with patients receiving treatment in more than one

mental health service provider, the commissioner should consider if:

- There should be one engagement protocol which applies to all the mental health service providers; or
- There should be different engagement protocols, specific to each of the mental health service providers

9.2 Engagement protocol content

An example engagement protocol is attached in Appendix 3 but this is a generic document and it should be tailored to specific local circumstances.

Key sections of engagement protocols include:

- Scope and principles of the IMHA service;
- Provision of information about the IMHA service and who will be responsible for providing it;
- The referral process (how referrals should be made and responded to);
- Arrangements for IMHAs going on to wards and meeting with patients in the community;
- Arrangements for obtaining patient consent to an IMHA acting on their behalf;
- Confidentiality;
- Health and safety;
- Case recording;
- Issue and problem resolution;
- Access to patient records;
- Supporting qualifying patients;
- Incident management and reporting;
- Complaints procedures;
- Review mechanisms.

9.3 Dealing with potential conflict

IMHAs will support patients discuss decisions made by the clinical team or discuss these decisions with clinical team on the patient's behalf. This role should be clearly set out in the engagement protocol so that all parties involved understand that IMHAs act on the behalf of the patient at their request. Conflicts can arise

between mental health service providers and IMHAs where this role is not communicated properly, as the mental health service provider may feel that the IMHA is being obstructive or interfering in their actions, or that the IMHA is acting on, or appears to be acting on, their own volition and not on instruction from the patient.

It is important that clear arrangements for communication are in place to allow the IMHA service provider or the mental health service provider to report any concerns that may arise.

10. Monitoring

10.1 Introduction

Commissioners will want to assure themselves that the IMHA services they commission are meeting the needs of qualifying patients. They should ensure robust monitoring and review procedures for the IMHA service provider and move towards outcome-based commissioning. In order to do this effectively commissioners will have to work in partnership with the IMHA service provider, mental health service providers, patients and carers.

The contract drawn up between the IMHA service provider and commissioners should describe the monitoring and review arrangements. These should also be reflected in the local engagement protocol.

Outlined below are suggested outcomes that might be monitored as part of these arrangements:

10.2 Patient outcomes

Receiving information

- Patients were given information about their rights within the agreed timescales after becoming a qualifying patients;
- Patients are clear about the referral process and know how to access the IMHA service, whether in hospital or the community;
- Patients have access to clear and appropriate information about the IMHA service and how it operates including in accessible formats e.g. in large print or their first language.

Patients are supported to understand their rights

- Reported understanding of provisions of the legislation under which they qualify and any restrictions imposed;
- Reported understanding of treatment being given or proposed under the Act;
- Reported understanding of rights under the Act and how to exercise those rights.

Outcome of involvement with the IMHA service

- Patient were able to see an IMHA within the agreed timescales;
- Patients were able to meet with the IMHA in private;
- An IMHA was available to meet the particular needs of the patient, for example a culturally appropriate service;
- Any issues of accessibility were appropriately addressed – e.g. translation;
- Patients felt their issues were effectively dealt with;
- Patients felt they were appropriately supported at meetings.

10.3 Service outcomes and measures

Service referrals

- Number of qualifying patients referred to IMHA service;
- Number of referrals received from:
 - Qualifying patients
 - Non qualifying patients
 - Nearest relatives
 - Professionals
 - Other sources
- Number of referrals by age, gender and ethnic origin;
- Number of referrals where the qualifying patient lacked capacity;
- Number of referrals/enquires redirected elsewhere;
- Number of IMHA cases closed.

Responsiveness of the IMHA service

- Number of qualifying patients in hospital offered an IMHA service within agreed timescales;
- Number of qualifying patients in hospital – receiving an IMHA service
- Number of qualifying patients in the community (on SCT/Guardianship/ conditional discharge/ s17 leave) receiving an IMHA service;

- Number of qualifying patients the community (on SCT/Guardianship/ conditional discharge/ s17 leave) receiving an IMHA service;
- Number of qualifying patients seen within agreed timescales;
- Number of qualifying patients not receiving an IMHA service (reasons).

Response to comments of service users and professionals

- Number of complaints;
- The IMHA service responses to complaints in line with agreed policy;
- Outcome of any consultation and evaluation of the IMHA service with mental health provider staff, patients, families and carers.

Working with other agencies

- Mental health service providers know how to refer qualifying patients to the IMHA service;
- IMHA service has linked effectively with other agencies as required;
- IMHA availability is well known to referrers and provided reliably.

Operational requirements

- Operational policy is available for inspection;
- An engagement protocol has been negotiated between the IMHA service, the mental health service provider and the commissioner;
- Statutory duties including health and safety, data protection, child and adult protection procedures are complied with by the service at all times;
- Information is available to patients, carers and staff;
- Audited accounts are available for inspection.

Appendix 1: Review of existing advocacy services

1. Introduction

All PCTs must ensure an IMHA service is available to qualifying patients on 1 April 2009. IMHA services should be viewed as an addition to the continuum of advocacy provision and not a replacement for existing services.

2. Whole systems review of advocacy provision

Alongside the assessment of need for IMHA, it is recommended that a comprehensive review of existing advocacy provision is carried out. This review can help ensure IMHA resources are deployed to maximum benefit, and help avoid IMHA services having a negative impact on existing advocacy services. An approach to a systematic advocacy review is proposed in Figure 2.

Fig. 2: Content of a comprehensive review of advocacy provision

Qualifying patients	Responsible PCT
Advocacy capacity and skills	What advocacy provision is there? Who provides the advocacy services? How many advocates are employed?
Provision of statutorily required and policy driven advocacy	How is Independent Complaints Advocacy Service provided? How is IMCA commissioned and provided? How is advocacy for Looked After Children provided and by whom? What advocacy is available for people with learning disabilities?
Recipients of advocacy	Who are the advocacy services targeted at? How well are diverse needs being met? Do service users have a choice of advocate?
Investment in advocacy	Who invests what in advocacy provision?
Impact and outcomes	What do the advocacy services aim to achieve? What is known about the outcomes of services? What has worked well and not so well?
Unmet need	Are there any gaps in advocacy provision? For those who do not have access to an advocacy service, who fulfils the advocacy role? What model of advocacy is needed most? Is anything planned?

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

Appendix 2:

Model service specification

Independent Mental Health Advocacy (IMHA) Services

XXX PCT

Specification for IMHA Services for qualifying patients under the Mental Health Act

The draft specification sets out some basic requirements of such a service. The specification is a starting point for the development of such a service and is not a final document. Commissioners need to adapt it to their style of commissioning and integrate it with existing standard documentation as appropriate. It will also need to be adapted further once the IMHA service goes live, as developing statutory IMHA service is new and will bring to light various challenges for both mental health service providers and IMHAs. Commissioners should see this document as a starting point that will need developing as time goes by.

1.0 Introduction

- 1.1 The XXX PCT wishes to ensure that independent mental health advocacy services are made available for the following groups of qualifying patients: [Describe the groups of patients in question. For example, say whether the contract relates only to patients who are in a particular geographical area, or who are receiving services from a particular mental health service provider, or who are in a particular location. Set out whether it covers all such qualifying patients, or only some patients.]
- 1.2 The IMHA service will be fully compliant with the Mental Health Act 1983 and the Code of Practice (Mental Health Act 1983) for England.

2.0 Overview

- 2.1 The Mental Health Act 1983 requires the provision of effective mental health advocacy made available to qualifying patients under the Act.

3.0 Commissioning of IMHA Services

- 3.1 IMHA services will be commissioned by XXX PCT for those qualifying patients.
- 3.2 The IMHA service provider's contractual relationship is with XXX PCT. The PCT will be responsible for monitoring, reviewing the service via quarterly contract monitoring meetings, and for negotiating the operation of the service as required within XXX in-patient Trust, XXX Independent Hospital and XXX community services.

4.0 The IMHA Service

- 4.1 The IMHA service provider will make available IMHAs at XXXX.
- 4.2 The IMHA service provider and its staff must work in partnership with other agencies: statutory, independent and voluntary. It must assist staff and service managers who are likely to refer their patients and service users in understanding the role of the IMHA service and how to access the service.

5.0 Equal Opportunities

- 5.1 The IMHA service provider will have an equal opportunities policy.
- 5.2 The IMHA service provider shall not discriminate between patients on the grounds of gender, age, ethnicity, disability, religion, sexual orientation or any other non-medical characteristics.
- 5.3 The IMHA service provider shall provide appropriate assistance for patients who do not speak, read or write English or who have communication difficulties (including, without limitation, hearing, oral and learning impairments).
- 5.4 The IMHA service provider shall provide to the PCT such as the PCT may reasonably require:
 - To monitor the equality of access to the services; and
 - To fulfil their obligations under the law.

6.0 Confidentiality

- 6.1 The IMHA service provider will be bound by its own confidentiality policy, which will be legally accurate. The provider's policy will accommodate and reflect the need for all case work to be regarded as being confidential within the IMHA service provider, and not exclusively to individual IMHAs. The IMHA service provider should comply with the Data Protection Act 1998.
- 6.2 The IMHA service provider will also be bound by the confidentiality requirements set out in the IMHA Service Engagement Protocols.

7.0 Location of Advocacy Service

- 7.1 Given the potential geographical area that the IMHA service could cover, the IMHA service provider will be responsible for providing office accommodation for the use of its employees, which will include a secure storage area where case records may be safely stored. The office will be equipped with telephones, and have facilities for the installation of computers.

8.0 Model and Type of Advocacy Service Required

- 8.1 IMHAs will be made available to help qualifying patients understand the legal provisions that they are subject to under the Mental Health Act 1983, and the rights and safeguards to which they are entitled. This may include assistance in obtaining information about any of the following:
- The provisions of the legislation under which s/he qualifies for an IMHA;
 - Any conditions or restrictions s/he is subject to;
 - The medical treatment being given, proposed or being discussed and the legal authority under which this would be given and the requirements that would apply;
 - His/her rights under the Act and how those rights can be exercised.
- 8.2 IMHAs will also be made available to help qualifying patients to exercise their rights. This help may include:
- Supporting patients to access information and better understand what is happening to them;

- Supporting qualifying patients in exploring options, making better-informed decisions and actively engaging with decisions that are being made;
- Supporting qualifying patients to articulate their own views;
- Speaking on the patient's behalf and representing them.

- 8.3 Advocacy will be delivered on an individual basis with qualifying patients. In general, the IMHA service will support the patient in their chosen course of action, unless this course of action puts the patient, the IMHA or others at risk of danger, or the action is illegal.

As not all qualifying patients at XXX will be able to instruct IMHA services, the IMHA service provider will have in place policies that address the delivery of non-instructed advocacy.

- 8.4 Response to the referral for IMHA support for qualifying patients will be dealt with within agreed timescales. The IMHA service provider is not expected to provide 24 hour and 7 day a week response to requests, or react to emergency calls. Neither will the IMHA service provide "expert witness" or be expected to function as "appropriate adults" (Police and Criminal Evidence Act, 1984).
- 8.5 It is expected that the IMHA service provider will take account of the weekly routines of qualifying patients. Therefore an ability to work flexibly will be expected.
- 8.6 XXX PCTs are commissioning IMHA services to ensure that all qualifying patients covered by this service specification will have access to statutory advocacy support. This will not prevent individual patients from making their own arrangements for advocacy support. To assist qualifying patients in having a choice, the IMHA service provider will update and maintain a library resource of other known advocacy services.
- ## 9.0 Issue Resolution/Complaints
- 9.1 The IMHA service will have a complaints procedure.
- 9.2 The IMHA service may become aware of issues that relate to more than one

- patient or that are raised by groups of patients (collective issues). The IMHA service should set out a protocol for handling such issues, which is discussed with XXX Trust, Independent Hospital and Community service managers.
- 9.3 Evidence of understanding and practice consistent with 9.1 is expected to be detailed in the submission accompanying the service proposal.
- 10.0 *Advocates' appointment requirements***
- 10.1 It is the responsibility of the IMHA service provider to check that any individual made available to act as an IMHA meets the legal appointment requirements on training, clearance checks and independence. The failure to do so will be regarded as a breach of contract, and will be subject to immediate review by the XXX PCT which could result in the withdrawal or suspension of the IMHA service.
- 10.2 It is expected that all IMHAs will be skilled and competent for the task, and will be willing to undertake further training and development. This will include successfully completing the IMHA module of the National Advocacy Qualification for all relevant staff as soon as possible and within one year of an IMHA starting employment (making necessary adjustments for any maternity leave, long-term sickness or other similar absences). Documentary evidence of this may be requested by the IMHA service commissioner.
- 10.3 In addition, all IMHAs will have adequate training in matters relating to mental health and the legal and social implications for someone with a mental health condition. The IMHA service provider will be fully aware of current best practice in skills and competencies for mental health advocacy.
- 10.4 All IMHAs will have undergone the necessary clearance checks, including enhanced CRB check or a CRB check and POCA checks where applicable. They will also have undergone any other checks required under legislation in future. Documentary evidence of this may be requested by the IMHA Service Commissioner.
- 10.5 The IMHA service provider will only make persons available to act as an IMHA if they believe them to be of integrity and good character. If the IMHA service provider subsequently knows or suspects of any actions on the part of the IMHA that could compromise their suitability to act in the IMHA role, that person should not be allowed to act as an IMHA until these concerns have been resolved.
- 11.0 *Health and safety***
- 11.1 The IMHA service provider will have a health and safety policy and all IMHAs will have undertaken training in health, safety and security and other areas as deemed necessary to work safely within different settings.
- 11.2 IMHAs seeing patients at XXX premises will be required to undertake the following health and safety training: [insert details]
- 12.0 *Patient involvement and Feedback***
- 12.1 The IMHA service will be required to show evidence of having taken account of qualifying patients' views about the service, particularly in respect of accessibility and impact. The IMHA service provider will be expected to discuss with the XXXX PCT, XXX Trust, Independent Hospital and Community services the methods to be used to obtain this feedback. IMHA service proposals will be required to set out their plans for ensuring this requirement is met.
- 12.2 Part of any service proposal submitted needs to describe how service user views will be gained and used.
- 13.0 *Delivery of the IMHA Service***
- 13.1 A draft protocol for establishing the way in which IMHA services will be delivered will be agreed between the XXX PCT, XXX Trust, Independent Hospital and Community services within two months of the commencement of service. It is envisaged that the IMHA services will be accountable for operating at all times within this protocol and will participate in an annual review of it within quarter 3.
- 13.2 Once a protocol has been agreed then any breach of its terms and conditions will be regarded as a breach of contract and will be subject to immediate review by the XXX PCT which could result in the withdrawal or suspension of the IMHA service.

14.0 *Supervision, Continuous Professional Development & Performance Appraisal*

- 14.1 Supervision and professional development is seen as an essential component of the service. The IMHA service provider will be expected to hold regular supervision sessions agreed in local protocols. This will be seen as a critical activity ensuring quality and consistency of service provision.
- 14.2 Each IMHA will receive not less than monthly individual management supervision with their line manager.
- 14.3 Each IMHA will have a personal/professional development plan that is assessed, implemented, and evaluated on an annual cyclical basis.
- 14.4 Reporting on the delivery of supervision, uptake by IMHAs and the generation of individual personal development plans will form part of the reporting requirement to XXX PCT annually within the last quarter contract monitoring meeting.
- 14.5 The IMHA service proposer will describe their practices around staff training and appraisal.
- 14.6 The IMHA service provider will be expected to keep records about all advocacy awareness training sessions delivered and noting attendees. These records will form the basis for reports as required below (in section 16).

15.0 *IMHA Service Staffing Profile*

- 15.1 it is recognised that the IMHA service provider may not be able to employ a sufficient number of advocates to meet the range of requests for IMHAs from specific ethnic, religious and other groups. Therefore it is expected that links will be built with other specialist advocacy services within the locality to increase the choice of support that can be made available to patients.
- 15.2 When recruiting and training staff the IMHA service provider will ensure that it takes into account the range of communications skills and abilities of the patient population. This will ensure that no patient is excluded from accessing the IMHA service.

- 15.3 The service provided must be appropriate to people's needs, including their disability, race, culture, religion, sexuality, age and gender. The service must also recognise that an individual's needs may change over time and respond accordingly.

16.0 *Case recording*

- 16.1 IMHAs will keep a record of all work undertaken on behalf of a client, subject to being able to destroy closed cases files after six years.
- 16.2 Patient's advocacy support records should be divided into sections on each discrete issue pursued. Dates when the IMHA first started supporting a client on a particular issue should be recorded, as well as the time taken and the date work on that issue was completed.
- 16.3 All statistical data will be recorded onto the approved computerised database, using standard categorisation of issues. This monitoring data will be made available from time to time to regulatory bodies on request.

17.0 *Case Records and Case Record Storage*

- 17.1 The IMHA service provider will be required to keep comprehensive records of client contact. Record keeping should focus on enabling quantitative and qualitative analysis, and on producing a record which is open and accessible. It is expected that the IMHA service provider will produce and operate to a policy that accommodates these requirements and reflects that in limited circumstance the disclosure of these case records may be required by the courts.
- 17.2 The IMHA service provider will have policies and procedures for making and maintaining records of engagements with patients. The policies and procedures will be expected to detail standards for recording patient information, internal audit and quality monitoring, storage, cataloguing, archiving, and destruction. There will be a procedure for handling and storage of third party information.

18.0 *Service outcomes and Quality Monitoring*

- 18.1 All service outcomes will be derived from, and related to, the overall service aim of ensuring advocacy is provided to support patients in understanding and exercising their legal rights under the Mental Health Act 1983 at XXX.
- 18.2 The IMHA service provider will be expected to be committed to reflective and evolving practice. Evidence of this will be demonstrated through the service having an ongoing programme of audit of service delivery, through which service deficits are identified and plans are set in place to address them. This will lead to the service having a regularly reviewed development plan.
- 18.3 XXX PCT/LA will regularly monitor the quality of IMHA service provision. The findings that will be made known at the quarterly review meetings and formally presented in advance of the annual review.
- 18.4 Quality monitoring will be based on reports submitted to XXX PCT by the IMHA service provider. Monitoring should include activity profiles across the quarter, patient feedback and random sampling of advocacy case work encompassing interviews with IMHAs, patients and staff.
- 18.5 XXX PCT will initially discuss the findings of its quality monitoring with the IMHA service provider, and XXX.
- 19.0 *Managing the Advocacy Service Provision***
- 19.1 As stated above, the IMHA service provider will be directly accountable for its operations and performance against the specification and contract to the XXXX PCT. The contract and service will be subject to annual review. In advance of annual review, the IMHA service provider will be expected to provide an annual report covering:
- A quantification and description of the activities of the last year;
 - Above profile by gender/ethnicity;
 - A summary of the individual issues raised by qualifying patients and outcomes;
 - A summary of any collective issues;
 - Evidence of, and reflection on service achievements;
- Report of annual accounts.
- 19.2 The annual report process will include formal discussion of the report between XXX Trust/LA, Independent Hospital and Community services and the advocacy service provider. Once agreed, the report will be formally presented to the XXX PCT.
- 19.3 In addition to the formal annual report, quarterly meetings will be held between XXX PCT, Independent Hospital/Community services, XXX Trust managers and the IMHA service provider. There will be a standing agenda for these meetings and the IMHA service provider will be expected to provide progress and state of service reports.
- 19.4 XXX PCT will encourage the IMHA service provider manager and relevant managers of XXX Trust/LA, Independent Hospital and Community services to meet on a regular basis (monthly) to discuss operational issues and to raise issues on behalf of patients.
- 20.0 *Arbitration***
- 20.1 XXX PCT would expect that the majority of issues arising from operational practice will first be addressed through the regular meetings held between the IMHA service manager and XXX service manager. Where matters cannot be resolved in this way, XXX PCT expects that these will immediately be brought to their attention by either party, but preferably both. If resolution then cannot be achieved, XXX PCT will appoint an independent person/body to investigate and arbitrate.
- 21.0 *Contract terms***
- 21.1 The contract will be awarded to the successful provider for a three-year period, with a break clause after the first year, subject to satisfactory performance and compliance with terms and conditions as set out in the specification and contract.
- 22.0 *XXX PCT Resource***
- 22.1 To enable the delivery of the independent advocacy service XXX PCT/LA have identified annual revenue of XXX (exc. VAT), payable quarterly in advance.

Appendix 3

Appendix 3: Example of an Engagement Protocol

Protocol for the Engagement of Independent Mental Health Advocate (IMHA) Service Delivery

1 Context

This document details the protocols agreed to by the commissioner, the mental health service provider and IMHA service provider.

2 Purpose

The purpose of these agreements is to make clear to all parties how the IMHA service provider will be enabled to provide its services to qualifying patients under the Mental Health Act 1983.

3 Introduction

This protocol sets down service delivery and practice requirements for the provision of an IMHA service, and to clarify the working relationship between the IMHA service provider and the mental health service provider. It sets out what services the IMHA service provider will provide, how these services will be provided and monitored, what boundaries the IMHAs will have, and how IMHAs will relate to staff of the mental health service providers.

4 Scope and Breach of Protocol

These protocols will apply to all engagements of the IMHA service provider. Any non-compliance with these protocols by the IMHA service provider will be liable to investigation by the manager commissioning the IMHA service on behalf of the PCT. The outcome of which could result in suspension of all or part/s of the IMHA service until a full and detailed investigation has been conducted. This will be made clear to all parties at the time.

5 Review

This protocol may be subject to formal review and may be liable to amendment in light of operational experiences.

6 The scope of IMHAs

The IMHA service provides an independent, free, confidential advocacy service for all

qualifying patients under the Act. The IMHA service will work on a casework basis, with the IMHA's activities instructed by the patient, except in circumstances when the patient is unable to do so due to lack of capacity. When a patient lacks capacity to instruct an IMHA, the IMHA service will deliver non-instructed advocacy in accordance with the agreed protocol.

7 The delivery of IMHA services

IMHA service policies and procedures

The IMHA service provider's policies, procedures, protocols and guidelines and should include the following:

- Confidentiality Policy;
- Complaints Policy;
- Whistle Blowing Policy;
- Health & Safety Policy;
- Quality Assurance Policy;
- Equal Opportunities Policy;

8 Information about the service

Subject to the lead role that statutory services have to provide information about how a qualifying patient can access an IMHA, the IMHA service provider will have leaflets explaining the role of an IMHA, information about the service's confidentiality policy and complaints policy and how qualifying patients can contact their advocate. All information will be available in an accessible format wherever possible.

9 Information given to qualifying patients

- IMHAs will at all times aim to provide balanced information to qualifying patients so that the patient can make informed choices.
- IMHAs will support qualifying patients to access information about, and to understand, their rights particularly those covered by the Act; and will support them to exercise these rights.
- IMHAs will assist qualifying patients to gain access to information regarding their care

and treatment, and will help them to gain understanding about the reason any treatment is given.

- IMHAs will assist the patient to obtain other information that may be needed, and will signpost qualifying patients to appropriate agencies and services who provide specialist advice and information as appropriate.
- IMHAs will not give qualifying patients advice on any topic, nor will they state a preference for a particular course of action.

10 Referrals

Referrals to the IMHA service will be made by qualifying patients directly, or through a third party (for example, hospital managers, the responsible clinician, approved mental health professional or the local social services authority).

All referrals will receive an appropriate response within agreed timeframes.

The IMHA service provider reserves the right to withdraw advocacy support from a patient, if:

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

The IMHA service provider will make available a copy of their referral policy on request, which will include how the service prioritises responses to referrals.

11 Advocates visiting qualifying in-patients

- The IMHA service provider will negotiate an appropriate mechanism for advocates to visit individual wards and units, whether this is by advanced warning or by open access.
- When an IMHA enters a ward s/he will inform a senior member of the ward staff, and will also inform them when they leave the ward.
- IMHAs will ask the ward staff if there is anything they should be aware of concerning issues of safety or risk. Subject to patient confidentiality, IMHAs will respond appropriately to information or requests by ward staff concerning matters of safety or risk.

- If the IMHA wishes to see a particular patient, then, they will ask a member of the ward staff to inform the patient that the IMHA is there to see them.
- IMHAs will see patients in private in a designated interview room. If it is not possible for IMHAs to meet the patient in private due to them being under observation, in seclusion or because they pose a risk to the advocate, then the IMHA will speak with the patient in the presence of a member of the ward staff, as long as the patient agrees to this.
- IMHAs will make themselves known to qualifying patients on the ward or unit, and there may be local protocols in place to provide routine introductions where consent has been given.

12 IMHAs visiting patients in the community

- IMHA services will have a policy regarding meeting patients in the community, which will include issues about lone-working.
- IMHAs will arrange to meet patients in the community in a way that fits into the patient's lifestyle and treatment plan.
- IMHAs arranging to meet with patients in the community will always consider the patient's view on where to meet in the context of the IMHA service provider's policy on meeting patients in the community.
- Issues of accessibility, practicality, suitability, patient agreement and the safety of the IMHA will all be considered.
- IMHAs will ask the care team if there is anything they should be aware of concerning issues of safety or risk. Subject to patient confidentiality, IMHAs will respond appropriately to information or requests by the care team concerning matters of safety or risk.

13 Meeting qualifying patients

- The IMHA will first ensure the patient is happy to meet with the IMHA, especially if the referral was through a third party. There should be no pressure put on a patient by the IMHA or third party to engage with the service.
- The IMHA will explain to the patient the role of an IMHA, and what they can and cannot do. They will also explain that the service is free and independent of the statutory service provision.

- The IMHA will explain the service's confidentiality policy, including the circumstances when confidentiality can be broken, and ensure, as far as possible, that this is understood.
- IMHAs will ensure that they work in such a way that adheres to the patient's wishes, empowers the patient and remains issue-focused. The IMHA will work to a broadly circular process:

Listen

Discuss options

Agree action

Research and gather information

Review options in light of information

Confirm action

Provide support through the
action requested

Review outcome

Try other option of outcomes
(if necessary)

Close case issue



14 Consent to act

- The IMHA will always obtain written consent from a patient to act for them if possible. A consent form will be completed which sets out specifically what the patient authorises the IMHA to do on their behalf, and is signed by the patient.
- A copy of this consent form will be shown to any third party the IMHA contacts when carrying out the patient's wishes.
- If, for reason other than lack of capacity, it is not possible to obtain a patient's written authority the IMHA will ensure that a written record is kept that the signature was requested and refused, and the reason for the refusal.

15 Confidentiality

- The IMHA service will have a transparent confidentiality policy which should address issues relating to disclosure of information and patients with capacity and those who lack capacity to consent.

16 Complaints about an advocate

- The IMHA service will have a comprehensive complaints policy and procedure.

17 Independent Mental Health Advocacy Service's relationship with other agencies' staff

- IMHAs will be expected to behave professionally at all times. They will attempt to form good working relationships with staff.
- Only in exceptional circumstances will IMHAs express any comments about members of staff to qualifying patients. These exceptional circumstances may be where an IMHA needs to express or imply a view in order to explore a patient's view if the IMHA has witnessed inappropriate behaviour by a member of staff. Any such departures must be reported as soon as possible to the line manager.
- IMHAs will endeavour to ensure their personal feelings about a member of staff, or their actions, do not influence their working relationship with that member of staff.
- Any problems with a member of staff will, wherever possible, be resolved through local resolution or referred and dealt with through the appropriate complaints procedure.

18 Incident management and reporting

- Any incidents involving the IMHA service are to be reported by the IMHA service, verbally and backed up in writing, to [INSERT] within 24 hours of the occurrence, or wherever possible immediately. The classification of incidents will be as per [INSERT Healthcare providers Incident Reporting Protocol]. The IMHA service will be expected to participate in any post-incident review that is deemed necessary, and will otherwise be expected to conduct their own in-service review. This will then be subject to discussion at the quarterly monitoring meetings, unless the incident is of such magnitude that the continued delivery of the advocacy service is compromised in which case the IMHA service manager will call an extraordinary meeting. Lessons learned from this review should be incorporated into future IMHA training.

19 What the IMHA service provider can expect from mental health service providers

Advocacy awareness raising

- The mental health service provider should undertake to provide all relevant staff with advocacy awareness sessions. The IMHA service is required to participate in these advocacy awareness sessions, if not lead them.
- Relevant managers will be responsible for making staff aware of this protocol, a copy of which will be made freely available.

Access to qualifying patients

- Staff will on all occasions allow qualifying patients to have reasonable access to an IMHA, and vice versa, except when access would place the IMHA or others at risk, or where there is some other valid reason. A decision to refuse access will be subject to appeal to a senior member of the mental health service provider's management.
- A room will be made available for IMHAs to meet with patients. The IMHA will also have reasonable access to a telephone and photocopier.
- Staff will enable the patient to see the IMHA in a reasonable place of the patient's choosing if there is a valid reason for the patient not wishing to use the designated room.
- Staff will respect the right of the patient to speak to the IMHA in confidence.
- The patient's right not to access IMHA services will be respected.
- In in-patient settings, members of staff will inform patients when an IMHA is on the ward, or when they are expected to be there.

20 Other agencies' staff relationships with IMHA staff

- Staff will be expected to behave professionally at all times and to attempt to form good working relationships with IMHA staff.
- Staff will endeavour to ensure their personal feelings about an IMHA or their actions, do not influence their working relationship with that IMHA.
- Any problems with IMHA staff will, wherever possible, be resolved through local resolution or referred and dealt with through the appropriate complaints procedure.

21 Information about the IMHA service

- When a patient becomes a qualifying patient they must be informed verbally and in writing by the relevant person of their rights to access an IMHA service in accordance with the Mental Health Act 1983.
- The patient's response will be recorded on their notes.
- If the patient requests the support of an IMHA, the member of staff who the patient has spoken to will contact the IMHA service to inform them of the request.
- Facilities will be made available to publicise the IMHA service generally, including written information about the IMHA service being made available to all qualifying patients.
- All qualifying patients should be made aware they are entitled to have an IMHA present at any formal meeting, e.g. at a ward round meeting, a care planning meeting, etc.
- When a qualifying patient is eligible for a Tribunal, they will be informed of their right to have the support of an IMHA.

22 Attendance at meetings

- Wherever possible or practicable, staff will allow an IMHA to attend, with or without the patient, any meeting that a patient would normally be expected to attend. If the IMHA is attending without the patient, they will do so only with the informed consent of the patient and with their signed authority.
- Seating at meetings will be such that the IMHA is able to sit with the patient.
- When an IMHA attends a meeting on behalf of a patient, they will only speak on issues they have been authorised to do so by the patient.
- Staff will understand that the IMHA will report back to the patient anything said at a meeting when the patient does not attend.

23 Complaints about services provided by the mental health service provider

- IMHAs will assist qualifying patients to make complaints about any part of the service provided by the mental health service provider through the appropriate channels.
- If a patient is unhappy with any part of the care or treatment they are receiving then the IMHA will provide information on the options

available to the patient to have their concerns addressed. These could include taking no action, informal negotiation or instigating a complaint under the relevant NHS or LSSA complaints procedure.

- It should be understood that when an IMHA assists a patient to make a complaint this should not be seen as in any way reflecting the attitude of the IMHA towards any member of staff implicated in the complaint.
- The IMHA service may become aware of issues that relate to more than one patient or that are raised by groups of patients (collective issues). In these cases the IMHA service is expected to bring these, via the IMHA service manager, to the attention of the mental health service provider. Appropriate methods for bringing these collective issues to the attention of mental health service provider will be developed.

24 Service provider policies and procedures

- The mental health service provider will make available to the IMHA service all of their relevant policies and procedures, and agree that the IMHA service may make these policies and procedures available to patients.
- The mental health service provider will ensure that the IMHA service is made aware of any changes to its relevant policies and procedures.

Appendix 4: IMHA regulations

STATUTORY INSTRUMENTS

2008 No. 3166

MENTAL HEALTH, ENGLAND

The Mental Health Act 1983 (Independent Mental Health Advocates)(England) Regulations 2008

Made – 9th December 2008

Laid before Parliament – 16th December 2008

Coming into force – 1st April 2009

The Secretary of State in exercise of the powers conferred by section 130A of the Mental Health Act 1983(a) and by sections 7, 8, 14, 19, 75, 272(7) and (8) and 273(4) of the National Health Service Act 2006(b), makes these Regulations.

Citation, commencement and extent

1. These Regulations may be cited as the Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008.
 - (1) These Regulations shall come into force on 1st April 2009.
 - (2) These Regulations apply in relation to England only.

Interpretation

2. In these Regulations—

“the Act” means the Mental Health Act 1983;

“commissioning body” means a body, individual or group of individuals (or any combination of these) authorised under regulations 3 and 10 of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002() or regulation 4 of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000() to exercise section 130A functions;

“IMHA” means an independent mental health advocate;

“provider of advocacy services” means a person (including a voluntary organisation) that employs or engages individuals who may be made available to act as an IMHA but does not include a commissioning body;

“section 130A functions” means the Secretary of State’s functions under section 130A of the Act.

Directions in respect of section 130A functions

3. (1) Where a commissioning body, in exercising section 130A functions, enters into arrangements with an individual who may be made available to act as an IMHA the Secretary of State directs that the commissioning body must be satisfied that the conditions set out in regulation 6 are satisfied.
 - (2) Where a commissioning body, in exercising section 130A functions, enters into arrangements with a provider of advocacy services the Secretary of State directs that such arrangements must include a term that the provider of advocacy services is satisfied that the conditions set out in regulation 6 are satisfied.

(a) 1983 (c.20). Section 130A was inserted by section 30 of the Mental Health Act 2007 c.12.

(b) 2006 (c.41).

(c) S.I. 2002/2375; relevant amending instruments are S.I. 2003/1497, 2004/865, 2006/359, 2007/559 and 1818.

(d) S.I.2000/617.

(3) The Secretary of State directs that a commissioning body, in exercising section 130A functions must, as far as reasonably practicable, have regard to the diverse circumstances (including but not limited to the ethnic, cultural and demographic needs) of qualifying patients in respect of whom that commissioning body may exercise those functions.

Amendment of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000

4. In regulation 5(b) (functions of NHS bodies) of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000, for “and 117” substitute “, 117 and 130A”.

Amendment of the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002

5. (1) The National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 are amended as follows.

(2) In regulation 2 (interpretation) after the definition of “prison”, insert—

“qualifying patient” has the same meaning as in section 130C of the Mental Health Act 1983;”.

(3) In regulation 3 (functions of the Secretary of State exercisable by Strategic Health Authorities and Primary Care Trusts)—

(a) at the end of paragraph (7)(a)(i), delete “and”;

(b) after paragraph (7)(a)(ii), add—

(iii) qualifying patients resident in Scotland, Wales or Northern Ireland who are present in its area and who do not fall under the responsibility of another Primary Care Trust under head (i) above; and

(iv) qualifying patients present in Wales who are liable to be detained under the Mental Health Act 1983 in a hospital or registered establishment in its area and who do not fall under the responsibility of another Primary Care Trust under head (i) and (ii) above.”;

(c) after paragraph (11) add—

“(12) In this regulation, “registered establishment” has the same meaning as in section 34(1) of the Mental Health Act 1983.”.

(4) In regulation 10 (arrangements by Primary Care Trusts for exercise of functions)—

(a) in paragraph (1) for “paragraphs (5)”, substitute “paragraphs (1A), (5)”;

(b) after paragraph (1), insert—

“(1A) A Primary Care Trust may not exercise jointly with an NHS trust any functions under section 130A of the Mental Health Act 1983.”.

(5) After the entry relating to section 121 of the Chronically Sick and Disabled Persons Act 1970(a) in Part 2 of Schedule 1 (Secretary of State Functions exercisable by (A) Primary Care Trusts and (B) Strategic Health Authorities for Specified Purposes Only)—

(6) in column (1), add the following entry—

“Mental Health Act 1983— section 130A”;

(a) in column (2), add the following entry—

“Making such arrangements as considered reasonable to enable independent mental health advocates to help qualifying patients”.

Independent Mental Health Advocates: conditions

6. (1) A person may not act as an IMHA unless the conditions specified in paragraph (2) are satisfied.

(2) Those conditions are that the person referred to in paragraph (1)—

(a) has appropriate experience or training or an appropriate combination of experience and training;

(a) 1970 (c.44).

- (b) is a person of integrity and good character;
 - (c) is able to act independently of any person who is professionally concerned with the qualifying patient's medical treatment; and
 - (d) is able to act independently of any person who requests that person to visit or interview the qualifying patient.
- (3) For the purposes of the condition referred to in paragraph (2)(a) regard must be had to standards in guidance that may be issued from time to time by the Secretary of State.
- (4) The standards referred to in paragraph (3) may include any qualification that the Secretary of State may determine as appropriate.
- (5) For the purposes of the condition referred to in paragraph (2)(b) there must be obtained in respect of that person—
- (a) an enhanced criminal record certificate issued pursuant to section 113B of the Police Act 1997(a) (enhanced criminal record certificates); or
 - (b) if the purpose for which the certificate is required is not one prescribed under subsection (2) of that section, a criminal record certificate issued pursuant to section 113A of that Act (criminal record certificates).

Persons not professionally concerned with a patient's medical treatment

7. For the purposes of section 130A(5) of the Act a person is not to be regarded as professionally concerned with a qualifying patient's medical treatment if that person—
- (a) is representing the patient in accordance with—
 - (i) arrangements made for the purposes of section 130A functions;
 - (ii) arrangements made other than for the purposes of that section;
 - (b) has in the past represented the qualifying patient in accordance with arrangements referred to in sub-paragraph (a) and in doing so was not otherwise professionally concerned in that patient's treatment.

Signed by authority of the Secretary of State for Health

Phil Hope

Minister of Health

Department of Health

9th December 2008

EXPLANATORY NOTE

(This note is not part of the Regulations)

Section 130A of the Mental Health Act 1983 (c.20) ("the Act") provides that the Secretary of State shall make arrangements to enable Independent Mental Health Advocates (IMHAs) to be available to help qualifying patients. These Regulations contain provisions about the arrangements for the appointment of IMHAs and as to who can be appointed to act as an IMHA.

Regulation 3 directs that where relevant a commissioning body or provider of advocacy services must ensure that an individual who is appointed to act as an IMHA satisfies the conditions in regulation 6.

1997 (c.50). Sections 113A and 113B were inserted by section 163(2) of the Serious Organised Crime and Police Act 2005 (c.15). Section 113A was amended by paragraph 14 of Schedule 9 to the Safeguarding Vulnerable Groups Act 2006 (c.47), section 78 of the Protection of Vulnerable Groups (Scotland) Act 2007 (asp 14) and section 50 of the Criminal Justice and Immigration Act 2008 (c.4). Section 113B was amended by paragraph 14 of Schedule 9 to the Safeguarding Vulnerable Groups Act 2006, paragraph 149 of Schedule 16 to the Armed Forces Act 2006 (c.52) and section 79 of the Protection of Vulnerable Groups (Scotland) Act 2007.

Commissioning bodies are also directed to take reasonable steps to ensure that the different needs and circumstances of qualifying patients, in respect of whom they may exercise the functions under section 130A of the Act (“section 130A functions”) are taken into consideration.

Regulation 4 amends regulation 5(b) of the NHS Bodies and Local Authorities Partnership Arrangements Regulations 2000 (S.I. 2000/617) to include section 130A functions in the definition of “Functions of NHS bodies”.

Regulation 5 amends the National Health Service (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulations 2002 (S.I. 2002/2375) so that section 130A functions are exercisable by a commissioning body i.e. (1) Strategic Health Authorities, for performance management purposes, and (2) by Primary Care Trusts. Regulation 3 of those Regulations is amended to provide for circumstances where a Primary Care Trust must exercise section 130A functions for the benefit of qualifying patients who are not otherwise within their area or the area of another Primary Care Trust and who are (1) resident in Scotland, Wales or Northern Ireland but are present in its area, and (2) present in Wales, but liable to be detained under the Act in a hospital or registered establishment in its area. A further amendment is made to regulation 10 of those Regulations preventing Primary Care Trusts exercising section 130A functions jointly with NHS trusts.

Regulation 6 provides that a person can only act as an IMHA if he has satisfied certain requirements as to experience, training, good character and independence. That regulation also provides that in deciding whether to appoint a person to act as an IMHA, regard is to be had to guidance issued from time to time by the Secretary of State.

Regulation 7 specifies those who are not to be treated as concerned in the patient’s treatment (a status that would otherwise prevent them from acting as an IMHA).

Appendix 5:

130C(6)(d) arrangements

For the purposes of 130C(6)(d) of the Mental Health Act 1983, a qualifying patient falling within subsection 130C(3)(a) or 130C(3)(b) of that Act is to be regarded as being in the territory where they are resident, unless that person is receiving treatment for a mental disorder as an in-patient in an NHS hospital or an independent hospital, in which case they are regarded as being in the territory where that hospital or independent hospital is situated.

Where there is doubt as to where a person is resident:

- (1) They shall be treated as resident at the address which they give to the registered medical practitioner or approved clinician discussing the treatment with them;
- (2) If they give no such address, then they shall be treated as resident at the address they give as their most recent address;
- (3) Where their residence cannot be determined in accordance with (1) and (2) above, or they are not resident in England or Wales, then they shall be treated as resident in the territory in which they are present.

Explanation of these arrangements

As a result of the Mental Health Act 2007, the Mental Health Act 1983 (the 1983 Act) requires the “appropriate national authority” to arrange for independent mental health advocates to be available to “qualifying patients”. For England, the appropriate national authority means the Secretary of State and for Wales it means the Welsh Ministers. (In practice, both the Secretary of State and the Welsh Ministers can arrange for other people – like the NHS locally – to commission IMHA services on their behalf.)

In most cases, the 1983 Act itself says whether a particular qualifying patient is to be treated as “English” or “Welsh” for these purposes.

- **For qualifying patients who are liable to be detained under the 1983 Act (even if they are currently on leave of absence from the hospital or conditionally discharged):** responsibility for making an IMHA available falls to the national authority for the country in which the hospital or registered establishment

where they are liable to be detained is situated.

- **For qualifying patients under Guardianship:** responsibility for making an IMHA available falls to the national authority for the country where the area of the responsible local social services authority is situated.
- **For patients on supervised community treatment:** responsibility for making an IMHA available falls to the national authority for the country in which the responsible hospital is situated.

However, for patients who qualify under 130C(3)(a) or 130C(3)(b) of the 1983 Act, the Act leaves it to the Secretary of State and the Welsh Ministers to publish a statement setting out the rules as to which of them will be responsible.

Patients qualifying under 130C(3)(a) are informal patients of any age being considered for section 57 treatment (psychosurgery or the surgical implantation of hormones to reduce the male sex drive). Patients qualifying under 130C(3)(b) are informal patients aged under 18 being considered for section 58A treatment (electro-convulsive therapy). “Informal patient” in this context means a patient who is not otherwise a qualifying patient (e.g. as a result of being detained, or on SCT, Guardianship or conditional discharge).

The effect of the statement above is that if a patient qualifies for an IMHA under 130C(3)(a) or 130C(3)(b) of the 1983 Act, responsibility for making an IMHA available falls to the national authority for the country in which the patient lives or, if they are in hospital or subsequently go into hospital for treatment for a mental disorder, to the authority for the country where that hospital is. If it is not clear where a person lives, then they shall be treated as living at the address which they give to the registered medical practitioner or approved clinician discussing the treatment with them, or if they give no such address, then they shall be treated as living at the address they give as their most recent address. If where they live cannot be determined in either of these ways, or if they do

not live in England or Wales, then they shall be treated as living where they are present.

Examples of how these arrangements may work in practice:

If a patient who is being considered for section 57 treatment lives in England, the English authority is responsible for providing them with an IMHA. If that patient subsequently becomes an informal in-patient in a hospital in Wales while still being considered for section 57 treatment, the Welsh authority is responsible for providing them with an IMHA.

If a patient aged under 18 who is being considered for section 58A treatment is an informal in-patient in a hospital in England, the English authority is responsible for providing them with an IMHA. If that patient is subsequently discharged from hospital and goes to live in Wales, while still being considered for section 58A treatment, the Welsh authority is responsible for providing them with an IMHA.

Appendix 6: Code of Practice, Chapter 20 – Independent Mental Health Advocacy.

20.1 This chapter explains the role of independent mental health advocates (IMHAs) under the Act.

Purpose of independent mental health advocacy services.

20.2 Independent mental health advocacy services provide an additional safeguard for patients who are subject to the Act. IMHAs are specialist advocates who are trained specifically to work within the framework of the Act to meet the needs of patients. (1)

20.3 Independent mental health advocacy services do not replace any other advocacy and support services that are available to patients, but are intended to operate in conjunction with those services.

Patients who are eligible for independent mental health advocacy services (qualifying patients)

20.4 Patients are eligible for support from an IMHA if they are:

- detained under the Act (even if they are currently on leave of absence from hospital);
- conditionally discharged restricted patients;
- supervised community treatment (SCT) patients.

20.5 For these purposes, detention does not include being detained:

- on the basis of an emergency application (section 4) until the second medical recommendation is received (see Code of Practice chapter 5);
- under the holding powers in section 5; or
- in a place of safety under section 135 or 136.

20.6 Other patients (“informal patients”) are eligible if they are:

- being considered for a treatment to which section 57 applies (“a section 57 treatment”); or
- under 18 and being considered for electro-convulsive therapy or any other treatment

to which section 58A applies (“a section 58A treatment”).

20.7 The Act calls patients who are eligible for the support of an IMHA “qualifying patients”.

The role of independent mental health advocates

20.8 The Act says that the support which IMHAs provide must include helping patients to obtain information about and understand the following:

- 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 they are subject (eg as a condition of leave of absence from hospital, as a condition of a community treatment order, or as a condition of conditional discharge);
- any medical treatment that they are receiving or might be given;
- the reasons for that treatment (or proposed treatment); and
- the legal authority for providing that treatment, and the safeguards and other requirements of the Act which would apply to that treatment.

20.9 It also includes helping patients to exercise their rights, which can include representing them and speaking on their behalf.

20.10 IMHAs may also support patients in a range of other ways to ensure they can participate in the decisions that are made about their care and treatment.

20.11 The involvement of an IMHA does not affect a patient’s right (nor the right of their nearest relative) to seek advice from a lawyer. Nor does it affect any entitlement to legal aid.

1 Independent mental health advocacy services under the Act are expected to be introduced in April 2009.

Duty to inform patients about the availability of independent mental health advocacy services

20.12 Certain people have a duty to take whatever steps are practicable to ensure that patients

understand that help is available to them from IMHA services and how they can obtain that help, as set out in the following table. This must include giving the relevant information both orally and in writing.

Type of patient	Steps to be taken by	As soon as practicable after
Detained patient	The managers of the hospital in which the patient is liable to be detained	The patient becomes liable to be detained
Guardianship patient	The responsible local social services authority	The patient becomes subject to Guardianship
SCT patient	The managers of the responsible hospital	The patient becomes a SCT patient
Conditionally discharged patient	The patient's responsible clinician	The patient is conditionally discharged
Informal patient	The doctor or approved clinician who first discusses with the patient the possibility of them being given the section 57 or 58A treatment in question	That discussion (or during it)

20.13 The relevant person must also take whatever steps are practicable to give a copy of the written information to the patient's nearest relative, unless the patient requests otherwise (and subject to the normal considerations about involving nearest relatives – see Code of Practice paragraphs 2.27-2.33).

20.14 However, any information about independent mental health advocacy services should make clear that the services are for patients and are not advocacy services for nearest relatives themselves.

20.15 The duty to give information to nearest relatives does not apply to informal patients, nor to patients detained in hospital under Part 3 of the Act (although it does apply to those patients if they subsequently become SCT patients).

Seeking help from an independent mental health advocate.

20.16 A qualifying patient may request the support of an IMHA at any time after they become a qualifying patient. Patients have the right to access the independent mental health advocacy service itself, rather than the services of a particular IMHA, though where possible it

would normally be good practice for the same IMHA to remain involved while the person's case stays open.

20.17 A patient may choose to end the support they are receiving from an IMHA at any time.

20.18 IMHAs must also comply with any reasonable request to visit and interview a qualifying patient, if the request is made by the patient's nearest relative, an approved mental health professional (AMHP) or the patient's responsible clinician (if they have one). But patients may refuse to be interviewed and do not have to accept help from an IMHA if they do not want it.

20.19 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.

20.20 Before requesting an IMHA to visit a patient, they should, wherever practicable, first discuss the idea with the patient, and give the patient the opportunity to decide for themselves whether to request an IMHA's help. AMHPs and

responsible clinicians should not request an IMHA to visit where they know, or strongly suspect, that the patient does not want an IMHA's help, or the help of the particular IMHA in question.

Independent mental health advocates' access to patients and professionals

20.21 Patients should have access to a telephone on which they can contact the independent mental health advocacy service and talk to them in private.

20.22 IMHAs should:

- have access to wards and units on which patients are resident;
- be able to meet with the patients they are helping in private, where they think it appropriate; and
- be able to attend meetings between patients and the professionals involved in their care and treatment when asked to do so by patients.

20.23 When instructed by a patient, the nearest relative, an AMHP or the responsible clinician, an IMHA has the right to meet the patient in private. IMHAs also have a right to visit and speak to any person who is currently professionally concerned with a patient's medical treatment, provided it is for the purpose of supporting that patient in their capacity as an IMHA.

20.24 Professionals should remember that the normal rules on patient confidentiality apply to conversations with IMHAs, even when the conversation is at the patient's request. IMHAs have a right of access to patients' records in certain cases (described below), but otherwise professionals should be careful not to share confidential information with IMHAs, unless the patient has consented to the disclosure or the disclosure is justified on the normal grounds (see Code of Practice chapter 18).

Independent mental health advocates' access to patients' records

20.25 Where the patient consents, IMHAs have a right to see any clinical or other records relating to the patient's detention or treatment in any hospital, or relating to any after-care services provided to the patient. IMHAs have a similar right to see any records relating to the patient held by a local social services authority.

20.26 Where the patient does not have the capacity (or in the case of a child, the competence) to consent to an IMHA having access to their records, the holder of the records must allow the IMHA access if they think that it is appropriate and that the records in question are relevant to the help to be provided by the IMHA.

20.27 When an IMHA seeks access to the records of a patient who does not have the capacity or the competence to consent, the person who holds the records should ask the IMHA to explain what information they think is relevant to the help they are providing to the patient and why they think it is appropriate for them to be able to see that information.

20.28 The Act does not define any further what it means by access being appropriate, so the record holder needs to consider all the facts of the case. But the starting point should always be what is best for the patient and not (for example) what would be most convenient for the organisation which holds the records.

20.29 In deciding whether it is appropriate to allow the IMHA access, the holder of the records needs to consider whether disclosure of the confidential patient information contained in the records is justified.

20.30 The key consideration will therefore be whether the disclosure is in the patient's best interests. That decision should be taken in accordance with the Mental Capacity Act 2005 (MCA) (or, for children under 16, the common law), like any other decision in connection with the care or treatment of patients who cannot make the decision for themselves.

20.31 Record holders should start from a general presumption that it is likely to be in-patients' interests to be represented by an IMHA who is knowledgeable about their case. But each decision must still be taken on its merits, and the record holder must, in particular, take into account what they know about the patient's wishes and feelings, including any written statements made in advance. (For further information on taking decisions in the best interests of people who lack capacity to make the decision themselves, please see the Code of Practice to the MCA.)

20.32 Records must not be disclosed if that would conflict with a decision made on the patient's behalf by the patient's attorney or deputy, or by the Court of Protection.

20.33 If the record holder thinks that disclosing the confidential patient information in the records to the IMHA would be in the patient's best interests, it is likely to be appropriate to allow the IMHA access to those records in all but the most exceptional cases.

Appendix 7: Useful websites

Quality standards for advocacy schemes (2006) Action for Advocacy

<http://www.advocacyacrosslondon.org.uk/>

Good Practice in Advocacy (2005): The Leeds Standards

<http://www.advocacy-network-leeds.org.uk/standard/gpgwelc1.html>

Advocacy Standards: Standards for Advocacy in Mental Health (2004)

Written by Patrick Wood for UKAN. ISBN 0-9537303-4-4

Available from UKAN, 14-18 West Bar Green, Sheffield S1 2DA. Cost £1.50 per copy to cover the cost of post and packaging. <http://www.u-kan.co.uk/publications.html>

National Standards for the Provision of Children's Advocacy Services (2002)

Department of Health.

http://www.dh.gov.uk/en/Consultations/Responsestoconsultations/DH_4017049

World class commissioning, Department of Health

<http://www.dh.gov.uk/en/managingyourorganisation/commissioning/worldclasscommissioning/index.htm>

NHS Act 2006 Partnership arrangements, Department of Health

<http://www.dh.gov.uk/en/Healthcare/IntegratedCare/Healthact1999partnershiparrangements/index.htm>

Readers are advised that all of the above links were correct at the time of going to press. If you have problems accessing the documents through the direct links detailed above, they should be readily located via a search from the relevant site's home page.



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