

National Assembly for Wales

Health and Social Care Committee

Post-legislative scrutiny of the Mental Health (Wales) Measure 2010

Evidence from Advocacy Support Cymru – MHM 13

Feedback for Health and Social Care Committee assessment of the implementation and operation of the Mental Health (Wales) Measure 2010

Advocacy Support Cymru

We are an independent advocacy service commissioned to provide the statutory Independent Mental Health Advocacy Service in Cardiff & Vale, ABMU, Powys and Cwm Taf Health Board areas. We also provide a community advocacy service.

Theme 1

- 1.1. In general, in both community and adult in-patient settings, our clients have been unhappy with many aspects of the care and treatment provided by secondary mental health services despite the introduction of the Measure. We acknowledge that it may be the case that by nature of the advocacy service we are only going to obtain the views and experiences of service-users who have been dissatisfied with their care and treatment.
- 1.2. IMHAs working with young in-patients report that the Measure has had very little impact with regard to care planning and support. Issues that continue to arise within this setting suggest that young in-patients are no better informed or included in the planning of their care and treatment, and are not provided with tools to enable them to participate fully. E.g. Involvement with one young in-patient identified that no Care and Treatment Plan had been produced several months after admission. Ward staff have been unaware of (and therefore not implementing) a 'Procedure for operational management of Mental Health Measure' which includes Process for Care and Treatment Planning, which has been in place since 2012.
- 1.3. Clients continue to report to us that they don't feel that their wishes and feelings are taken into account sufficiently in care and treatment planning, which is often why they access the advocacy service for support at reviews/meetings etc.
- 1.4. We have also experienced an increase in the amount of clients wishing to pursue complaints about their care and treatment and specifically the lack of completed, up-to-date CTPs.
- 1.5. When CTPs are reviewed and amended, copies aren't always provided to the client in a timely way. Clients report having outdated CTPs and waiting several months for plans to be reviewed and updated.

- 1.6. Clients have reported being unsure of what to do in a crisis as sometimes plans haven't been written in to the CTP and provided to them. Clients who have six monthly appointments with their psychiatrists report being told that only basic CTPs are required regardless of whether or not the client feels that they have needs in other areas.
- 1.7. In many in-patient settings, when accessing patient records, IMHAs often observe blank CTPs that have never been completed although, in some cases, the patient has been in hospital for over six months. Many in-patients report not having been given a copy of the CTP and in some cases are not aware that one exists.
- 1.8. The extension of the IMHA provision has meant that in-patients now have the support they need to address these difficulties.
- 1.9. Our community advocacy service can support people to re-access secondary services under the Measure. However, on occasions it has been difficult to establish whether a client meets the eligibility criteria of being discharged from secondary services within the three year time frame.
- 1.10. Some of our clients have been discharged from secondary services without their knowledge. This has caused some confusion about whether and when they are able to re-access. Clients have been discharged without being informed of their right to re-access or how to do so.
- 1.11. In other cases, there has been confusion about whether service-users have been receiving services under primary or secondary care. Clients have reported believing that they are under secondary services because they have had several appointments with a psychiatrist or psychologist at the CMHT but have then been told that this was part of an assessment process and they haven't always been accepted.
- 1.12. The Measure has undoubtedly made it easier for service-users to access secondary services and once it has been established that they are entitled to so, the process has been relatively straight forward.
- 1.13. The extension of provision of statutory mental health advocacy under the Measure has meant that large numbers of service users are now entitled to an IMHA where they wouldn't have qualified for this service previously.
- 1.14. IMHAs now can also invoke their right to interview professionals and access medical records on behalf of informal patients. Our clients have reported to us that they have found this support helpful in ascertaining their rights to a Care and Treatment Plan, gaining information, being involved in their care and treatment and having their voice heard.
- 1.15. The Measure has also extended the provision of the IMHA service to patients detained under sections 5(2), 5(4) and section 4 of the Mental Health Act 1983. The

organisation has not seen much uptake in terms of referrals for these patients. Where we have seen clients detained under these sections, we have supported them to ask questions and inform them about the processes to be followed.

- 1.16. The extension of the IMHA service for clients in general hospitals has led to a significant increase in the numbers of older people that we see. The involvement of an IMHA means they can be supported and empowered to have their views and wishes listened to on important decisions such as discharge planning. It has also enabled service users to access their safeguards as IMHAs ask questions on their behalf about care and treatment planning and raise concerns regarding potentially abusive situations.
- 1.17. The main barriers to service users in accessing the IMHA service are; the current level of high demand for the service, which may require the implementation of a waiting list, and health and social care professionals awareness of the service users entitlement to statutory advocacy, which means they don't always identify patients who could benefit.
- 1.18. Many of our clients ask for support with issues in relation to their care and treatment. Community advocates and IMHA's are able to use the legislation and related Code of Practice to ensure that our clients are fully involved and have their views listened to in relation to their Care and Treatment Plan, and the domains included in the plan. The Code of Practice has provided clear guidance for professionals to follow in terms of best practice.
- 1.19. IMHAs have received extra training in relation to the interface between the Mental Health Act and the Mental Capacity Act, as many of our clients on general wards have been assessed as lacking capacity in a particular area. This means that IMHAs can ask appropriate question to help ensure that the correct processes are being followed by health staff. This includes use of the Mental Capacity Act where care teams are making best interest decisions for our clients.

Theme 2

- 2.1. In regards to the development of the Part 4 IMHA provision, the dialogue between Welsh Government, commissioners and IMHA providers was very well thought out and the final version of the IMHA provision was developed in partnership with all concerned.
- 2.2. In regards to the scrutiny afterwards, this was not very good in regards to Part 4. None of the IMHA providers or commissioners were consulted as to how best engage service users in giving feedback, as a result there seem to be a number of mechanisms which have been put in place, but which do not appear to have been well thought out. One example is the survey that MIND were commissioned to provide on inpatient units. The survey was long, was not all relevant to IMHA (care and treatment planning was also in the survey) and the patients who have probably

benefitted the most from the extended IMHA service (older non capacious and patients in general hospital) were not able to take part in the survey, as only the IMHA providers would be aware of who had accessed the service.

- 2.3. In regards to the development of the Part 4 IMHA provision, the dialogue between Welsh Government, commissioners and IMHA providers was very well thought out and the final version of the IMHA provision was developed in partnership with all concerned. In regards to the Code of Practice this is currently ongoing but IMHA providers are being consulted in regards to changes to the current code.
- 2.4. As an advocacy service, we have produced leaflets and posters for both professionals and service users in terms of part 4 of the Measure. We have provided a large number of awareness raising sessions to ward staff across all health boards in our area of operation. We have also collaborated with the IMCA provider to formulate and disseminate a flow chart to assist professionals when they are thinking about referral to IMHA / IMCA. This work is ongoing.
- 2.5. IMHAs are reporting that health and social care staff are not aware of the IMHA role both in psychiatric units and general hospitals. Referrals received sometimes reflect this, with IMHA referrals being made when in fact an IMCA is required. This has sometimes led to delays in decision-making for the patient.
- 2.6. Where IMHAs are approached by family members of our clients, they have reported that they were not aware of their relative's right to an IMHA, or what the role is. We received feedback from a family member saying they were very concerned by their relative's referral to IMHA. They felt the IMHA would be making a decision and did not know their relative. Their concerns were alleviated after meeting with the IMHA who explained her role.
- 2.7. Health staff often state that they believe the families of incapacitated clients need to give consent to the referral to the IMHA service and do not understand that it is the statutory right of the patient. In terms of our clients who are able to instruct, staff lack awareness of the fact the client can refuse IMHA involvement if they wish.
- 2.8. Following our experience of raising awareness about IMHA – we have concluded that there should be mandatory training for staff identified as “the Responsible Person” in terms of their legal duty to ensure that all qualifying patients are informed of their right to IMHA.
Although as an organisation we have delivered hundreds of awareness raising sessions we have often had very few people attending, on many occasions less than five people and sometimes none at all.
Although we have arranged many of these sessions during staff handovers on individual wards for the ward staffs convenience, this has made little difference. This has resulted in IMHAs delivering sessions to many unqualified staff, bank/agency staff and nursing students as these are the only groups available to attend at the time. It has been very difficult to reach the qualified nurses and those responsible for carrying out the duty placed upon them by the legislation. This has

resulted in staff being unable to offer advocacy in a meaningful way because they don't know enough about it to explain it to patients.

Theme 3

- 3.1. In regards to Part 4 IMHA provision there are already capacity issues in regards to the amount of IMHAs available. This will only increase as the legislation becomes more widely known in general hospital settings. In addition the recent West Cheshire judgement has implications for the IMHA service, as more and more patients are either detained or subjects to DoLS. Professionals are already more likely to refer patients if they are subject to restraints on their liberty and this will obviously put pressure on the IMHA service as the number of patients subject to restrictions increases.
- 3.2. The amount of money allocated to Powys for Part 4 provision has proven to be problematic in terms of the size of the geographical area in relation to bed spaces
- 3.3. In relation to Part 4 there is already evidence that the service is proving to be value for money. In relation to IMHAs supporting patients to become more involved in their care, there have been a number of past studies that have shown that patients who are working in partnership with their care teams are much more likely to be more satisfied with their treatment and as a result are more likely to continue working with their care teams in the community, resulting in less incidences of re-admission to hospital.
- 3.4. In relation to patients who are deemed by professionals to lack capacity to decide on their discharge destination, the involvement of IMHAs in ensuring that procedures are followed correctly and that least restrictive options are put into place, more people are returning home with packages of care, as opposed to being placed in care settings. This is both more economical for the local authorities and health boards, but more importantly is proving beneficial to patients and their families.

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