

National Advocacy Conference Group

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Dear Professor Sir Simon Wessely

We are writing to contribute comments to the ongoing Independent Review of the Mental Health Act particularly in relation to Independent Mental Health Advocacy and also more broadly where appropriate. Our comments are divided into issues that we consider should apply directly to the Mental Health Act and others to be included in the Mental Health Act Code of Practice when it is next revised.

The points attached to this letter were drawn up at a meeting held on 26/10/18 at The Arden Hotel Birmingham following the National Advocacy conference. Present at the meeting were the following:

Susan Eades, Independent Advocacy Services Manager, Broadmoor Hospital (SEAP), Crowthorne

Peter Edwards, Human Rights Lawyer and Director, Peter Edwards Law, Hoylake

Diana Evans, Blackpool Advocacy Hub Manager, Blackpool

Jacqui Jobson, Director, Advocacy Centre North, Newcastle-upon-Tyne

Helen Sloan, IMHA (Forensic), West London Mental Health Services (The Advocacy Project), Southall/Assessor and Facilitator, Kate Mercer Training

Thelma Thomas, IMHA, Middlesbrough Citizens Advice Bureau

Kate Mercer of Kate Mercer Training provided a venue and context for the meeting and is involved in contributing to the points in this letter. Our group represents decades of experience in the delivery of Independent Mental Health Advocacy and Human Rights Law and in working with Service Users and Carers who have been affected by the Mental Health Act 1983 (2007).

A further meeting was held at The Advocacy Project London on 7/11/18 with contributors from that organisation (see Appendix A) and further meetings online to ensure consensus across the group (see Appendix B). We have also been distributing these comments as an open letter for others in the sector to add their signature to and will be sending a list of names who support our comments down to you before the mid-December. However, given our understanding of your timeframe for the final report from the Review, we felt it important to send our comments as soon as possible.

We hope that you will find our comments of interest and look forward to hearing from you.

Yours sincerely

National Advocacy Conference Group

Advocacy Practice and the Mental Health Act Review

IMHA (Independent Mental Health Advocacy) referral process

In 2012 UCLan¹ published the first national evaluation of IMHA services and identified gaps in provision for people from seldom heard groups accessing advocacy support. The evidence collected by local advocacy services shows an opt out service increases referrals to up to 98% of qualifying patients who actually see an IMHA before deciding whether to use advocacy. The research made recommendations (accepted and supported by Department of Health at the time) that IMHA support should be offered on an opt-out basis (services such as Blackpool Advocacy Hub already do this as standard). This is of particular importance for people who lack the capacity to instruct an IMHA and rely on staff to refer on their behalf. Introducing a mandatory opt out system reduces the risk of the most vulnerable people missing out on this important safeguard. This approach would have an impact on the referral process and how it is organised. Of course, working in partnership with an IMHA would remain the decision of the service user.

At our meeting on 26/10/18, discussion took place around the best time to refer a patient to IMHA services. On reflection and discussion, the group felt that further consultation was needed with service users. The proposals that were made however were:

- a) IMHAs should be offered for opt out on admission to hospital whether detained or informal patients (see below)
- b) IMHAs should be able to attend Section 12 assessment meetings should the client request it in or out of hospital (clients should be made aware that they have a right to an IMHA at assessment and it is already mentioned in the current MHA Code of Practice 14.53 p122)² and that the opt out arrangement begins for patients on admission to hospital whether detained or informal. If the client agrees, the assessment report should be made available to the IMHA as part of the first referral.

Since the introduction of the Mental Health (Wales) Measure 2010, IMHA support has been extended to informal patients and those held under emergency sections. We have seen the successful rollout in Wales with increased numbers of people being able to receive support to understand their rights and increased participation. We therefore believe IMHA services in England should be available to informal patients in hospital as a matter of course.

Monitoring and recording

Advocacy databases should record similar information and we believe there is significant need for Department of Health and Social Care to support the advocacy sector with national monitoring and research – similar to the database the Department of Health managed and reported on with the introduction of IMCA (Independent Mental Capacity Advocacy). This should be researched to find a national standard which also takes into consideration data collection and outcome measure around

¹ Newbigging, K et al., (June 2012) The Right to be Heard: Review of the Quality of Independent Mental Health Advocate (IMHA) Services in England, Research Report, University of Central Lancashire (UCLan)

² Mental Health Act 1983: Code of Practice (2015), Department of Health, TSO, Norwich

impact³ The advocacy sector should be involved in the development of this initiative to ensure it is fit for purpose.

Databases should reflect the needs of the service users and advocates, as well as providing data for commissioning.

Mental Health Act Code of Practice: It was suggested that the models of advocacy code of practice, person centred planning and self-determination theory for databases should form the basis of this entry in the code of practice. The Advocacy Project reported that their database was based on the advocacy code of practice developed by NDTi (National Development Team for Inclusion) and from that point of view worked well.

Information gathered from standardised databases would be very useful for monitoring from CQC and Department of Health from the point of view of the standard and impact of service delivery.

Clarity around advocacy standards

The group recognised that advocacy training is not consistent across the country and that this needs to be addressed and clarified. The main challenge in this is ambiguity about what training IMHAs actually require with different services adopting local training instead of using Department of Health developed national qualifications in Independent Advocacy.

The qualifications were last reviewed in 2013 and are in need of updating to reflect changes in the law (particularly within mental capacity legislation) and key findings within 'A Right to be Heard' research by UCLan⁴

Items for standardisation would be:

Training – Kate Mercer Training, working with other training providers, would be committed to updating and repurposing training and standards

Equal Provision across regions (IMHA should not be a postcode lottery) – The existing lack of provision across regions is partly due to the commissioning process and the lack of ability for different services to discuss their mutual work and workload since they are constantly in competition.

The Mental Health Act Review should state that IMHA should be provided to an equal extent around all regions of England and that Local Authorities have the responsibility to provide suitable resources to commission adequate service provision to meet needs, including contracting with neighbouring advocacy service provider if there are capacity issues.

Mental Health Act Code of Practice: A professional culture should be developed to allow for exchange of ideas and across different advocacy services and advocacy practitioners. The National

³ [Susan Eades](#), (2018) "Impact evaluation of an Independent Mental Health Advocacy (IMHA) service in a high secure hospital: a co-produced survey measuring self-reported changes to patient self-determination", *Mental Health and Social Inclusion*, Vol. 22 Issue: 1, pp.53-60, <https://doi.org/10.1108/MHSI-12-2017-0054>

⁴ Newbigging, K et al, *op cit*

Advocacy Conference is a vehicle for this exchange but more needs to be done outside of conference season.

Some Local Authorities have not ring-fenced statutory advocacy which makes it hard to implement IMHA and other statutory advocacy services consistently. As a statutory service, funds need to be ringfenced for IMHA.

It was pointed out at this juncture that the statutory right to an advocate in the Mental Health Act should not be changed based on inconsistent practice resulting from not implementing the existing law and that access to a statutory right should be monitored and regularly reviewed.

Clarity around advocacy role in Mental Health Review Tribunals and Managers' Hearings

There is an inconsistency in practice about IMHA attendance at Mental Health Reviews and Managers' Hearings. IMHA's should be given the right to attend and participate fully in tribunals if the client requests it or if the advocate uses Non-Instructed Advocacy they should be able to make the judgement about whether to attend or not. While the Code of Practice states that 'IMHAs may, if appropriate, help the patient to exercise their rights by assisting patients to access legal advice and supporting patients at Tribunal hearings' (6.14, p.56), it is not clear what 'appropriate' means and should be changed to 'IMHAs should have the right to if the patient requests it'⁵

There are few statutory criteria with Managers' Hearings and currently a solicitor is not paid to attend Managers' Hearings so they rarely participate. Clarity around the role of the IMHA in this setting would be very useful. It was acknowledged that Service Users find the option of a Managers' Hearing positive and empowering in terms of having their voice heard and so it should remain but that as a process it might be more useful to all involved.

IMHA's should have the option to speak, and clarity should be given on when this should be both in the context of MHRTs and MHs

Collaborative working with Mental Health Solicitors (and other solicitors when appropriate)

Details around legal advocates and IMHAs working in tandem should be available in the Mental Health Act Code of Practice. We all agreed that if this was the norm, it would save time, money and repetition of work. Currently this is not clear and collaborative working between solicitors and IMHAs is not consistent across regions and services. It was suggested that solicitors should also be briefed and trained on the potential for working with IMHAs.

Databases (see Monitoring and Record Keeping)

Advocacy and the discrepancy between Section 117 of Mental Health Act and provision of an advocate.

IMHA ceases on discharge and is not provided as a matter of course for people in receipt of Section 117 aftercare. There should be provision of a minimum of one visit from an IMHA post discharge.

⁵ Mental Health Act 1983, Code of Practice (2015), Department of Health, TSO, Norwich *op. cit.*

While the Care Act provides advocates for people in receipt of Section 117 aftercare, it only provides for those people who have substantial difficulty and/or no one appropriate to support them. The Mental Health Act should allow for IMHA provision for people under Section 117 aftercare more fully.⁶

Advocacy and Equal Opportunities – Inclusion of BAME communities and LGBTQ communities

It was felt that different services represent different demographics across the country. In our group, one service reported having a strong representation of Somali clients while another service said that their client base was predominantly white British.

Representation of advocacy needs to work on a matrix reflecting demographics of particular communities. Different case studies were discussed and the group was cautious of developing models under the Mental Health Act under a 'one size fits all' approach. Advocacy Centre North provides one of the few specific BAME Advocacy projects nationally and reported that community advocates including bi-lingual advocates from the BAME communities work well alongside trained IMHAs as an example of a model.

It was felt above all that cultural competency across all aspects of equality and diversity needed to be fostered and promoted and that systems and facilities needed to be in place to enable this. Further research is needed to ensure that lessons are learnt from BAME Communities' experience of IMHA services and applied to other groups with protected characteristics under the Equality Act 2010 who also have mental health needs.

Jacqui Jobson reported that she had been awarded a Winston Churchill Fellowship to explore LGBTQ mental health and advocacy in relation to health inequalities in Canada and Australia and lessons that could be learnt in UK.⁷

Further considerations will be provided by The Advocacy Project (TAP), an organisation based in London and with a very diverse client base and workforce and Jacqui Jobson of Advocacy Centre North as an appendix to this letter. (See Appendix A)

Training for clinicians about IMHA

Training about the role of IMHA should be mandatory for clinicians and should be a part of Section 12 training.

Members of the group reported that there was ongoing variation of understanding of IMHA in clinical teams. Some clinicians think that IMHAs have a legal right to follow 'duty of care' and best interests advocacy for patients. The Royal College of Psychiatrists in their 2012 College report acknowledge this and explain the differentiation between 'duty of care' best interest approaches

⁶ Care Act Statutory Guidance (July 2018) 7.23 p.103 <https://www.gov.uk/government/publications/care-act-statutory-guidance>

⁷ Jacqui Jobson, Research Report (2017), Winston Churchill Memorial Trust, <https://www.wcmt.org.uk/fellows/reports/lgbtq-mental-health-exploring-advocacy-approaches-health-inequalities>

and the work of IMHAs.⁸ This variation of understanding needs to be changed by proper training of clinicians around the role of IMHAs. The UCLan 'A Right to be Heard'⁹ research identified that the success of the IMHA service was impacted upon by staff understanding and support. We need to ensure that clinical teams understand the IMHA role and do not develop enmeshed, conflictual or distant working relationships.

General Mental Health Act

Relationship between Mental Health Act and Mental Capacity Act

Mental Health Act and its relationship with the Mental Capacity Act must be looked at. This is particularly important with regard to DoLS and recent proposed changes to the Mental Capacity Act which are still to be resolved.

If a person is in a hospital ward receiving treatment for a mental disorder and they lack capacity to understand their treatment, the Mental Health Act should be used and not the Mental Capacity Act (or DoLS). It is not appropriate to use DoLS in a setting for treatment of mental health disorders. This needs to be stressed and implemented

There was some concern around whether the proposal to apply DoLS when a person who lacked capacity did not object to being detained in hospital was appropriate.

It was also felt that as there were proposals to amend both Mental Health Act and Mental Capacity Act that were taking place without resolution of one or the other, it might be prudent to discuss both the Acts together to make sure that they have legal relevance to each other.

Acknowledging stigma in the Mental Health Act

Acknowledgement of day to day living with stigma for people with mental health disorders should be incorporated into the Act.

Discussions took place at The Advocacy Project about the inter-relationship between stigma applied to mental health and stigma associated with race (see Appendix A)

Coping with stigma as part of a care plan should be in the Mental Health Act Code of Practice

Access to services for all written into the Mental Health Act

It was discussed that the original intention of the Mental Health Act was to include early intervention. The use of the phrase 'nature or degree' implies that health is the baseline rather than any particular benchmark for warranting treatment.

⁸ Independent Advocacy for People with Mental Disorder, (Feb 2012), Royal College of Psychiatrists College Report, CR171 p. 10

⁹ Newbigging et al, *op cit*

Currently the Mental Health Act appears to be being reviewed on the basis of detention. It does not however acknowledge the people who are denied access to services when they have requested them.

A possible approach to amendment would be to adopt the approach in Wales whereby there is a right to self-referral to specialist services.

Nearest Relative

The Nearest Relative role should be replaced with a right to appoint a “Nominated Person”, this in keeping with principles of autonomy and respecting wishes and views of the person. An interim nominated person could be appointed for those who are deemed to lack capacity but need to reviewed immediately the person regains capacity.

Service User involvement and Co-production

Co-production of Care Plans, Discharge Plans and Risk Assessments between clinical professionals and service users should be written in to the MHA. Inclusion of Advanced Decision Making into the care planning process was also supported.

The Mental Health act should include principles on the face of the Act which would support decisions made under the Act and agree that principles of Empowerment, Involvement and Co-production, Individuality, Autonomy, Equality and Diversity should be key components.

Supported decision making, autonomy over decisions about care and treatment and self determination are important to be put at the centre of this approach.¹⁰

For further general discussion at TAP (The Advocacy Project) on 07/11/18 and subsequent discussion among The National Advocacy Conference Group, see Appendix B.

¹⁰ An interesting discussion on findings from the recently introduced Australian model of IMHA indicate that decisions over care and treatment by the patient should be further focused on rather than emphasis on decisions being made for the patient by the Responsible Clinician. See Bennetts et al, (2018), The ‘Tricky Dance’ of Advocacy: A Study of Non-Legal Mental Health Advocacy, International Journal of Mental Health and Capacity Law, no. 24 pp 12 - 51

Appendix A of National Advocacy Conference Group Letter (Focus on BAME and marginality)

Notes from TAP (The Advocacy Project) meeting on Mental Health Act Review 7/11/18, TAP, St Charles Square, London W10, 13.00 – 15.00

Present: Asiya Elgady(AG), Elroy Gray (EG), Joshua Kyene (JK), Odug Mohamed (OM), Toby Morrison (TM), Helen Sloan (HS)

Further comments from: Shifaa Ali (SA), Alice Asuquo (AA) and Judith Davey (JD) (TAP); Jacqui Jobson (JJ) (Advocacy Centre North)

Information about The Advocacy Project (TAP)

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

The Advocacy Project is a charity based in London which helps marginalised communities to speak up, understand their rights and make choices. Stigma, isolation and inequalities are some of the biggest challenges faced by people with learning disabilities, mental health problems, dementia and eating disorders. TAP is working with people to address these challenges. TAP believes everyone has the right to influence decisions affecting their lives and offers free, independent advocacy and user involvement services to people in London. TAP stands with its service users for rights and supporting people to have a say in the issues that matter to them.

It was noted that there was a wealth of experience of representation of marginalised communities across TAP. TAP holds regular CPD sessions, guest lectures and meetings to discuss practice and better ways of delivery with its core values above as the starting point.

Meeting Notes

HS introduced the slides from Alex Ruck Keene's lecture at TAP on 16/10/18 and also the letter drafted from the proceedings of the meeting held 26/10/18 after the National Advocacy Conference, Birmingham. She proposed that because TAP has such a diverse client base, range of experience and workforce that it might be good to focus on the BAME proposals in the Mental Health Act Review. However, the meeting was to air all concerns about the Mental Health Act Review.

Mental Health Review and BAME communities

It was noted that the Mental Health Act Review was not very helpful in that given its proposed emphasis on BAME communities, it only had two special topic groups a) Black and Caribbean and b) Asian and other ethnic minorities. It was felt that this would be adding to the problem rather than the solution by not representing the diversity of the broader community in a representative way.

Research needs to be done to be more extensive and detailed and to reflect the communities that are present in England as represented by Mental Health Act.

Group discussion

Changes required to improve Mental Health Services for BAME Communities based on TAP's experience of working on the ground

Providing adequate research into BAME communities to deliver mental health services equally for all

It was discussed that the Mental Health Act Review, while acknowledging the magnitude of the issue, had a methodology that was not inclusive or extensive enough to do anything other than maintain the status quo. For real change to be made, detailed and extensive research must be made regularly and consistently. We began to scope out the beginnings of a research methodology that could be incorporated into Mental Health legislation:

Annual research as part of mental health services and built into Mental Health Act Code of Practice (possibly Mental Health Act)

Quantitative Research

Statistics should be gathered on an annual basis and the range of those statistics should be more detailed and focused. This might be based on central data from NHS but it is important to distinguish more fully across ethnicity eg to say that someone is Black African is not enough – there are 52 countries in Africa and they represent diverse culture both socio and economic.

The way that data is collected is important and it should be the responsibility of a specific research group within each health service provider.

Qualitative Research

Focus groups to be facilitated to collect qualitative anecdotal data based on experience from specific ethnic communities. These groups may focus on the following questions:

What are the prevailing attitudes towards mental health in the culture being discussed?

What are the barriers to maintaining mental health and accessing services if needed?

What would the participants like to suggest could be done to make mental health services better and/or more accessible?

These basic principles to be brought into a research project designed by consultation with researchers and focus groups.

Training

Training for Police

Discussion was had about appropriate and robust training of the police in relation to mental health generally and in the context of BAME communities.

Training for advocates

Training should be available in cultural competency based on the demographic of a local area. As suggested in the draft letter it should work on the basis of a matrix approach.

Who should provide the training?

Emphasis should be made on training to be provided by members from the community that was being discussed. A presence of people from the relevant community at least should be in attendance in a training capacity.

Incorporating religious beliefs and spirituality in care pathways

People are sometimes considered to be ill due to strongly held religious beliefs. While in some cases, religion can contribute to a person's illness, in a secular Mental Health Sector or one that is mostly driven by Christian held beliefs and values under the current provision some beliefs can be held as outside of healthy thinking when actually the thinking is very much part of a patient's culture. More awareness and training in religion and spirituality should be looked at before concluding that the beliefs are contributing to a person's illness.

Acknowledgment of and specialist treatment for trauma

Increasingly, England has people resident who are refugees of torture and/or war zones. Specialist treatment and acknowledgment of a person's background in these contexts is erratic within services from the experience of the advocates. Access to treatment for these patients needs to be researched and provided.

Diversity across Clinical Staff in Mental Health Sector and IMHAs

While Mental Health has a diverse work force, it does not always reflect the demographic of the people it serves. Training should at least be provided (based on findings of research – see above) for all staff in cultural competency on at least ethnic and religious grounds.

(See the end of this document for a list of references provided by participants in the meeting and further discussion)

Addressing stigma

Stigma is not only present for people with mental health issues but is also present around race. This often impacts on mental health and again a Mental Health Sector that has been predicated on white Christian ethics can be alienating and provide stigma in itself. This needs to be addressed at the point of discussing the Mental Health Act and BAME communities.

EG feels that a measurement of wellness that is currently biased towards measurement of cognition may be key and he favours an emphasis on emotional cognition instead (see references)

Jacqui Jobson, Director of Advocacy Centre North comments

(<http://www.advocacycentrenorth.org.uk/>) :

My experience comes from both providing a BAME Community Advocacy service which works closely with IMHA's within the same organisation and managing a Hate Crime Advocacy service which as well as case advocacy, includes a training element through a community partnership involving our local Health and Race Equality Forum, Show Racism the Red Card, LGBT organisation, Trans organisation Disability User Group and Mental Health User Group.

Our BAME advocacy model is not perfect and we have a different demographic in Newcastle and Gateshead to Inner City London for example. We have a model of Community Advocates who are a mixture of bi-lingual and advocacy trained (some have IMHA qualification but don't formally act as an IMHA regularly), we focus on skilling up community members where possible, but also ensuring that the advocacy training they receive is the same as other advocates within the team. We find that sometimes where a community member's strength is being closely aligned to their community, they may need some additional support regarding the IMHA role and so they will work in tandem with an IMHA to ensure that the person is getting a high standard of culturally competent IMHA support. Each person's situation is assessed individually as to whether they need a community advocate or an IMHA. We regularly carry out outreach into minoritised communities, work hard to maintain our visibility in the communities (although there is always more work can be done) and have been invited by communities to work in partnership as a "trusted organisation". We were recently awarded "Outstanding Service" at the National Advocacy Awards, partially in recognition of our partnership working.

I have also recently written a report LGBTQ mental health: Exploring advocacy approaches to health inequalities as a Churchill Fellow, following my travel fellowship to Australia and Canada.

<https://www.wcmt.org.uk/fellows/reports/lgbtq-mental-health-exploring-advocacy-approaches-health-inequalities> (see Note 7 in main letter for full reference).

My report recommends that:

1. Independent advocacy is ideally placed to champion the rights of minority groups, especially those experiencing multiple discrimination, on both an individual and systemic level.
2. The concept of Minority Stress should inform practice including with those accessing mental health services. This would include training for health and social care professionals as well as advocates. Minority stress was originally used around BAME Communities but has been adapted to include the LGBTQ+ communities. The theory addresses the impact that discrimination has on mental health and places the emphasis on societal change and advocates creating trauma informed environments which take account of the trauma created by minority stress.
3. Cultural Competency and Cultural Safety (including awareness, training, policy change and review of practice) needs to be a priority. Mental health prevention should also be included in this as people's mental health is often made worse by inappropriate, ill-informed and discriminatory interventions and attitudes.
4. Attention must be paid to intersectionality and supporting those who are affected by multiple systemic discrimination.

Judith Davey, CEO of The Advocacy Project (TAP) comments:

We work in 10 highly diverse London Boroughs, and strongly support the concept of Cultural Competency and Cultural Safety (including awareness, training, policy change and review of practice) as a priority. As Jacqui Jobson says above, mental health prevention should also be included in this as people's mental health is often made worse by inappropriate, ill-informed and discriminatory interventions and attitudes.

Our workforce is highly diverse, reflecting the communities in which we work. We also have LGBTQ advocates and have worked hard to address the recorded increase of suicide rates in these communities through our projects. Our model is to build the capacity of communities and community groups to advocate for themselves and others. By opening up our National Advocacy Qualification accredited training to community groups, offering mentoring and pathways to employment, we can ensure that non-statutory advocacy is conducted to the same standard as formal statutory advocacy and is delivered in a culturally appropriate way.

As an example, we are working with London Borough of Hackney to create a lasting legacy. We have opened up our Continuing Professional Development training schemes to local organisations such as an orthodox Jewish organisation, Muslim community centres, and the BAME Health Forum to help them deliver statutory and non-statutory advocacy to improve practice. We have also invited staff in local community-based organisations to train as statutory advocates alongside our own staff. Stronger more resilient communities with a deeper understanding of advocacy, benefits everyone.

We're collaborating with people and organisations across London in developing alternative forms of advocacy, such as citizen advocacy, peer advocacy and group advocacy, as well as exploring new delivery mechanisms. There will always be a role for individual face-to-face interactions, but we are also embracing new ways of ensuring that people have easier access to high quality advocacy. We have piloted use of technology-enabled advocacy across care groups, such as people with learning disabilities, offering different choices about how to engage with us. It has worked well, and we are now rolling these approaches out more broadly.

A selection of existing literature and research drawn from articles provided by group participants

Dahaba Ali Hussen, (4/11/18), Somali Refugees are too often left out of mental health discussions – here's why I want that to change, *Independent* - <https://www.independent.co.uk/voices/mental-health-somali-community-civil-war-islam-muslim-a8616796.html>

Grey, T et al., Mental Health Inequalities Facing UK Minority Ethnic Populations: Causal Factors and Solutions, *Journal of Psychological Issues in Organisational Culture*, 3:1, 2013

Meeting the Public Sector Equality Duty at South London and Maudsley NHS Trust, (2017), *Lambeth Ethnicity Information*

Mental Health and Cultural Diversity International Conference: Exploring Transformative Practices, De Montfort University, Leicester, 2017

<https://dora.dmu.ac.uk/bitstream/handle/2086/12252/MHCD%20International%20Conference%20Programme%2022nd%20%2024th%20June%202016.pdf?sequence=1&isAllowed=y> (2016)

Highlights from AE relating to Leicester conference material:

- a) "Cultural insensitivity of our Health and social care services leads to a lack of service engagement with users. Indeed the barriers for service access, utilisation and ways of promoting better outcomes for BAME communities has been well researched and a considerable body of evidence exist for improving culturally appropriate and acceptable services. However, the lack of a comprehensive and joined up synthesis of evidence to influence service change leaves our policy makers and service providers continually articulating the disparities in BAME mental health." P.30
- b) "This call for action for developing cultural competency and this presentation will focus on developing cultural competency in our health and social care workforce." P.30
- c) "Because of the acute lack of quantitative and qualitative data about the health and social care needs of BAME communities, and how they are best met, training to improve cultural competency in services is difficult. Whilst training for basic Asian language communication skills is useful, the diversity both between and within BAME communities also needs to be addressed." P.35
- d) "cultural competency refers to an understanding of diversity and represents a value-based perspective that recognises individuality – similar to that of person-centred care." P.35

Forrester-Jones, R et al (2018) Including the 'Spiritual' Within Mental Health Care in the UK from the Experiences of People with Mental Health Problems, *Journal of Religion & Health* 57(1) pp 384 – 407
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5762776/>

Kendra Cherry, IQ vs EQ: Which One is More Important?, *Verywellmind Online*, 12/11/18,
<https://www.verywellmind.com/iq-or-eq-which-one-is-more-important-2795287>

Appendix B to letter from National Advocacy Conference Group (Additional Points outside of meetings)

Points made by members of TAP (The Advocacy Project) and National Advocacy Conference Group Meeting in response to the core meetings on 26/10/18 and 7/11/18

- 1) Gender and Ageism** - It was noted that the older women (often white) who provide advocacy should not be forgotten for their skills, empathy and experience. Older women can often be marginalised by society and yet have a lot of experience and reassurance to offer.
- 2) Issues on the wards that often go undetected and ways to pick them up**
 - Spot checks on wards and checking through a 'secret shopper' approach to see what really happens on some of the wards
 - Ensure that complainants on the ward are not penalised for raising concerns. Patients have said that they have faced negative repercussions on wards after raising concerns with measures such as an increase in medication, leave suspension, and being labelled as a trouble maker
 - Patients to be given the rules of the hospital on admission, to know what is happening to them and about their care plans. It is not enough to get patients to sign section papers that they often do not fully understand. Some patients do not know what plans and timescales are scheduled and this has an impact on recovery. Plans and the rules of the hospital need to be explained clearly.
- 3) Lack of Section 17 leave** - because a patient is deemed a risk can be a violation of a person's human rights. It should not be possible to prevent a patient from leaving a hospital at any cost due to risk as outdoor areas are limited in hospitals. It has been noted by some patients that prisoners have more rights than they do in terms of being able to access outside spaces.
- 4) Early intervention** – more options should be available to people before they hit crisis point and have to be sectioned. Access to services (see letter is important) eg OTs, talking therapies in the community (see main letter)
- 5) Concern about the term 'compliance'** – Does that mean that a patient follows what the clinical team says without question? This seems to contravene the idea of empowerment and involvement in care and treatment.
- 6) Treatment of those people who have experienced trauma eg domestic abuse, war zones, torture, veterans, terrorist attacks etc.**- Specialist support is needed for these patients. Their conditions do not always appear to be considered in tandem with their experiences in a hospital environment as experienced by IMHAs in the group.
- 7) Stigma** - should be looked at in its broadest sense and should include any form of stigma that can involve discrimination and have an impact on mental wellbeing (see also main letter and appendix A)
- 8) Consideration of the Deaf and BSL communities** – At the National Advocacy Conference it was noted how isolating it can be for deaf people with Mental Health issues. It was requested that this be taken into consideration when reviewing the act. This leads to ensuring that a full audit of what constitutes marginalised communities is made before approving revisions to the Mental Health Act.