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The need for independent advocacy for people subject to mental health community treatment orders

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ABSTRACT

Independent mental health advocacy (IMHA) has been proposed as a way of maintaining peoples' rights in involuntary settings, but little is known about the challenges and opportunities associated with the provision of independent mental health advocacy to those on compulsory treatment orders in the community. In Victoria, Australia, an IMHA service is available to people who are at risk of or subject to compulsory treatment, including those who are subject to Community Treatment Orders. The IMHA service is based on the independent advocacy model developed in the United Kingdom. This paper details the benefits and challenges of providing independent non-legal advocacy to those in the community, drawing on a 15-month independent co-produced evaluation of the IMHA service. With limited publicly available sector level data, the evaluation employed qualitative approaches. Issues raised include the need to better target limited resources in the most effective way and the problem of ensuring timely and adequate access. While advocacy was well received by consumers, tensions specific to the community setting were influenced by the attitudes of clinicians to need, risk and recovery as opposed to a coherent understanding of consumer preference and choice.

1. Introduction

Independent mental health advocacy (IMHA) is a form of specialist advocacy that aims to protect the rights of mental health consumers who are, or may be, subject to compulsory treatment orders (Newbigging et al., 2012). The idea of specialist mental health advocacy was first developed by the consumer movement in mental health, in recognition of the acute vulnerabilities experienced by mental health consumers (Newbigging et al., 2012). Research about independent advocacy services has identified significant benefits (Carver & Morrison, 2005; Ridley et al., 2015). For example, a recent study in an acute forensic service in the United Kingdom, found that 70% of those who received advocacy services reported an increase in self-determination (Eades, 2018). Less attention has been given to the efficacy of advocacy for those who are receiving compulsory mental health treatment in the community. This article examines the work of the IMHA service in Victoria using preliminary data from an evaluation of the serivce (Maylea et al., 2019). The article outlines the theoretical underpinnings of independent advocacy. It provides an analysis of the work of independent advocates and the experience of people using mental health services in Victorian, including those who are or may become subject to compulsory treatment orders (CTOs). CTOs are legal orders made under the Mental Health Act 2014 (Vic) requiring individuals to accept mental health treatment. This article uses the word consumer to refer to people who use mental health services voluntarily and to those who receive treatment when a compulsory order is in place. Whether or not consumers are voluntary or compulsory patients is noted where this distinction is known and has relevance to the analysis. ‘Consumers’ or ‘service users’ are the terms generally used to refer to people who use mental health services in Australia. These terms are used by mental health service providers, in policy and procedural documents and in legislation (Martin, 2017). Consumer is defined in the Mental Health Act, 2014 (Vic):

> ***consumer*** means a person who—
>
> (a) has received mental health services from a mental health service provider; or
> (b) is receiving mental health services from a mental health service provider; or
> (c) was assessed by an authorised psychiatrist and was not provided

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with treatment; or

(d) sought or is seeking mental health services from a mental health service provider and was or is not provided with mental health services (s3 Definitions).

The term consumer is used in the provisions relating to complaints to the Mental Health Commissioner (Part 10). 'Inpatient' means a patient who is detained in a designated mental health service (s3 Definitions). Elswhere in the act, those who are not inpatients are referred to as persons.

This article argues that the demonstrated efficacy of specialist advocacy in inpatient settings warrants the provision of additional resources and specific statutory powers to enable the IMHA service in Victoria to meet community need.

2. Independent mental health advocacy (IMHA)

IMHA is a form of advocacy rooted in a firm appreciation of compulsory treatment as both disabling and disorienting for mental health consumers (Light et al., 2014). Social recognition theory posits that the achievement and maintenance of a person's status as an actor is dependent on patterns of social recognition (Butler, 2015; Honneth, 1996, 2007). In the 1960s, Goffman (1991 [1961]) famously provided detailed accounts of how a person's entry into and exit from mental hospitals negatively impacts self-perception, resulting in the gradual erosion of a person's status as a social actor, which he termed a "moral career" (Goffman, 1991[1961]). Goffman's work was confined to the analysis of "total institutions" but provided a basis for later work. More relevant to contemporary mental health settings is Alex Honneth's (1996) theory of social recognition. He argues that the denial or withholding of recognition is a form of disrespect that has profound consequences for the production and maintenance of self (1996). Honneth (1996) details three forms of disrespect that a person can experience: violation of the body; the denial of rights; and, the denigration of his or her chosen way of life. The experience of these forms of disrespect result in a loss self-confidence, self-respect, and self-esteem respectively (Honneth, 1996, pp. 131–134). As will be discussed below, Honneth's categories of disrespect mirror the reported experiences of mental health consumers who are placed on compulsory treatment orders (Light et al., 2014). Because compulsory treatment limits the ability of individuals to have input into decisions being made about their treatment and care, it undermines their status as autonomous social actors. In turn, this highlights the potential of advocacy to help consumers reclaim agency and a sense of self. Honneth's understanding of disrespect is consistent with the principles of recovery oriented practice as described by Leamy, Bird, Le Boutillier, Williams, and Slade (2011), rights based approaches in mental health law (McSherry & Weller, 2010) and self-determination theory (Eades, 2018). IMHA and other forms of independent advocacy can therefore be understood as interventions that uphold rights, preserve self-determination and personal integrity, work toward recovery and fulfil the obligation to ensure that individuals remain at the centre of decision making (Newbigging et al., 2012; Eades, 2018).

In England and Wales, independent mental health advocates for mental health consumers were introduced with amendments to the Mental Health Act (1983) in 2007. Statutory based independent mental health advocacy services are also operating in Scotland (s 259 Mental Health (Care and Treatment) Act 2003 (Scotland), in Northern Ireland (ss 86, 87 Mental Capacity Act 2016 (Northern Ireland)) and in the Australian state of Western Australia (Mental Health Act 2014 (WA)). In Victoria an independent, non-legal, advocacy service- called the IMHA service was established in August 2015 to complement the reforms introduced by the Mental Health Act 2014 (Vic). The IMHA service does not have a statutory basis, but is recognised in the Mental Health Regulations 2014 (Vic).

3. Rights based advocacy in Victoria

The IMHA service in Victoria was established in 2015 to provide advocacy to individuals who are subject to, or at risk of being subject to, compulsory mental health treatment under the Mental Health Act 2014 (Vic) (Bennetts, Maylea, McKenna, & Makregiorgos, 2018). The Mental Health Act 2014 was proposed as an appropriate response to Australia's obligations under the United Nations Convention on the Rights of Persons with Disabilities The legal framework was also thought to be consistent with the Charter of Human Rights and Responsibilities Act 2006 in Victoria. At the time the Mental Health Act 2014 was adopted by the Victorian Parliament, the then Minister for Mental Health announced the IMHA service as way to enable people and their families: "….to actively participate in decisions related to their care and have a range of choices about the types of support they need to achieve optimal wellbeing" (Victorian Minister for Mental Health, 2014, p. 470). The introduction of advocacy was seen as an important adjunct to the legislative framework. It was envisaged as a mechanism that would ensure that rights were given substance in practice. The IMHA service was subsequently funded as a discrete program operated by Victoria Legal Aid.

The IMHA service aims to support consumers by offering a form of non-legal independent advocacy which is described as "rights based representational advocacy":

> IMHA explicitly adopts a representational model, with a focus on recovery and maintaining the rights of people under the Act. The IMHA model consists of a combination of information provision, referral, advocacy or support for self-advocacy, and is informed by the principles in the Act. These principles include a 'least restrictive' approach; a recovery orientation with a view to full participation in community life; upholding the right of people subject to compulsory treatment to participate in decisions about their assessment, treatment and recovery; and respect for their rights, dignity and autonomy. The IMHA model is also informed by espoused values of integrity, respect, being person-centred, curiosity and reflectiveness, and explicitly adopts a recovery focus (Bennetts et al., 2018, p. 6).

The model of rights-based representational advocacy stands in contrast with best interest models of advocacy that have been previously studied in Australia (see Rosenman et al., 2000). Rights based representational advocacy recognises that respect for self- determination and consumer choice about treatment is essential for personal integrity and recovery (Leamy et al., 2011). The focus on self-determination shifts the emphasis away from diagnosis toward a focus on recovery and the associated aspects of wellbeing, hope and personal strengths (Leamy et al., 2011; Slade, 2009;). The links between social recognition, self-determination and recovery further reinforces the rationale for providing independent advocacy in community settings.

4. Community treatment orders (CTOs) in Victoria

CTOs have been used in Victoria since 1986 when they were introduced with the Mental Health Act 1986 (Vic). CTOs continued in a different form under the Mental Health Act 2014 (Vic). The Mental Health Act, 2014 allows authorised psychiatrists to make Temporary Treatment Orders of up to 28 days. Treatment Orders can be either Inpatient Treatment Orders (ITO) or CTOs, and can be 'varied' to allow community treatment or inpatient treatment. On average, approximately 15% of adults who received public community mental health services in Victoria in 2017–2018 were subject to a CTO (Department of Health and Human Services (DHHS), 2018a, 2018b). In contrast, only 1.1% of young people and 4.5% of older people were subject to a CTO (DHHS, 2018a, 2018b). However, CTO usage varies greatly across the state, from 29% to 6% (DHHS, 2018a, 2018b), although it is not clear why this is the case. A total of 66,445 people used public mental health services in 2016–17, but the exact number of people who were using services in the community, or who are on a CTO at present is not made publicly available (DHHS, 2018a, 2018b).

The vast majority of compulsory treatment orders are temporary treatment orders made by authorised psychiatrists. These may be inpatient or community orders. The authorised psychiatrist may change an inpatient order to a CTO. No data is available to assess how many initial orders are made, or how a many people are moved onto CTOs. Treatment orders longer than 28 days are made by the Mental Health Tribunal. In the year 2016–2017 the Mental Health Tribunal made 3423 CTOs and 2502 ITOs (MHT, 2017). The average duration of a period of involuntary treatment is 64 days, with 12.5% of people being on orders for more than 12 months (DHHS, 2018a, 2018b). Extrapolating from available data it is likely that the number of people subject to involuntary treatment in the community in Victoria in any given year is between 4000 and 7000 a year.

When CTOs were introduced, they were thought to be instrumental in facilitating the shift away from institutional care to community based mental health service provision (Brophy et al., 2018;). They were generally viewed as a positive addition to mental health treatment options, especially because they provided treatment in a less restrictive environment (Brophy, Eden, et al., 2018; Churchill, Owen, Singh, & Hotopf, 2007; Szmukler, 2009; Dawson, 2005;). Despite these intentions, consumers of mental health services have consistently identified CTOs as stigmatising and disempowering (Brophy & Ring, 2004; Canvin, Bartlett, & Pinfold, 2005). Feelings of powerlessness and lack of control are almost universally associated with the experience of compulsion, even when consumers recognise that their mental health is poor, or recognise that CTOs can be instrumental in improving both the quality of care they receive, as well as their access to care (Canvin et al., 2005; Corring, O'Reilly, & Sommerdyck, 2017). The consumer experience of compulsory community treatment is also characterised by problems with communication and understanding (Light et al., 2014). This is most often described as the experience of 'not being heard' (Wyder et al., 2013; Corring et al., 2017, Ridley et al., 2015). The experience of not being heard highlights a central paradox: mental health consumers feel the need for support but experience the 'care and support' while on a CTO as having their rights taken away, not having their issues heard and not having their views on treatment options taken into account (Wyder et al., 2013; Light, Kerridge, Ryan, & Robertson, 2012a, 2012b, Light et al., 2014).

5. Material and methods: the evaluation methodology

This article draws on data from an evaluation of the IMHA service in Victoria. The evaluation was conducted in two stages, with the second stage of the evaluation nearing completion at the time of writing. A report of the findings of first stage of the evaluation has been published (Maylea, 2019). This paper draws on data from both stages of the evaluation specifically relating to the provision of advocacy to people who are placed on compulsory treatment orders. While the question of advocacy in the community was not the focus of the evaluation, it was a salient issue across all aspects of the evaluation.

The IMHA service evaluation employed a co-produced mixed methods approach with a focus on the consumer experience. Co-production is a method of "implementing, delivering and evaluating supports, systems and services, where consumers, carers and professionals work in equal and reciprocal relationships, with shared power and responsibilities to achieve positive change and improved outcomes" (NMHCCF, 2017, p.1). With respect to coproduction, individuals with personal and professional experience of mental health services and mental health advocacy were included in the research team and directly involved with the research design, data collection and analysis. Following the model suggested by consumer advocate Michael Burge, the project sought to foster equal and reciprocal relationships, shared values and collective ownership of the evaluation process (Burge, 2016, p. 4).

Table 1
–Participant groups consulted by method and type.

	Interviews	Focus group	Online surveys	Total
Consumers who had used IMHA service	5	33	31	69
Eligible consumers who had not used IMHA service	2	19	19	40
Stakeholder body representatives	9	–	–	9
Mental health professionals	44	21	227	292
Mental health lawyers	–	8	23	31
IMHA service staff	16	–	–	16
Total	76	81	300	467

The overarching aim of the evaluation was to detail the extent to which the IMHA service has provided effective, efficient, sustainable independent advocacy services to people subject to, or at risk of being subject to, compulsory treatment under the Mental Health Act 2014 (Vic). Relevant participant groups were identified as consumers, mental health professionals, mental health lawyers, IMHA service staff and representatives from sector organisations such as the Mental Health Tribunal, the Mental Health Commission and the Victorian Mental Illness Awareness Council (VMIAC). Participants from these groups were recruited using a purposive sampling method in line with grounded theory (McNeill & Chapman, 2005), as summarised in Table 1:

Sector organisations were identified in conjunction with the IMHA service and asked to nominate representatives to participate. Consumers who had used the IMHA service were sent letters inviting them to participate in focus groups, and emails inviting them to participate in the survey. Consumers who participated in the online survey were invited to leave their details to be contacted to participate in an interview.

The evaluation team visited mental health inpatient units and invited mental health professionals and consumers who had not used the IMHA service to participate in interviews or focus groups. Mental health professionals and consumers who had not used the IMHA service were invited to complete the online survey via email and social media. IMHA service staff and mental health lawyers were invited via their organisations. These approaches resulted in the recruitment of the broadest possible range of perspectives.

Nine focus groups were held in various metropolitan and regional locations across Victoria, both in the community and in inpatient settings; interviews were conducted face-to-face or over the telephone. Online survey data were collected anonymously using Qualtrics Survey Software. Qualitative feedback was triangulated with quantitative data from routine IMHA service client records and related organisational data. Interviews and focus groups were audio recorded, professionally transcribed and transferred into NVivo Qualitative Analysis Software for analysis.

In total, the evaluation collected 62 h of audio, and analysed transcripts, survey responses, IMHA service policy documents and other documentation totalling 961,523 words. Qualitative participant responses were cross tabulated by role, setting (community or inpatient), question response and other relevant variables. The data was then initially analysed by two consumer evaluators who independently defined codes using open coding. Academic evaluators then independently coded the raw data and coded across the groups of sources using axial coding. This ensured double handling of the data, and a process reflective of a consumer perspective under laid with academic rigour. Descriptive quantitative data was analysed by the lead evaluator. Interpretation of the CTO data was augmented by a roundtable discussion or CTO panel, with an expert by experience, a clinician and social work academic with expertise in CTOs.

6. Limitations and ethics

An important focus of this study was consumer attitudes and experience. Identifying and recruiting people subject to CTOs was difficult because they are a largely invisible population and therefore potential vulnerable population. In lieu of this difficulty, three experts (an expert by experience, a clinician and social work academic with expertise in CTOs) were invited to participate in a panel discussion about CTOs, the value of advocacy for this cohort and how this largely invisible group might be targeted. The experts were an expert by experience, a clinician and social work academic who focuses on CTOs, with the panel being comprised of members of the research team and VLA employees.

The main limitation is that the nature of the participant invitation process meant that the participant group was not necessarily representative. A number of specific groups of consumers are underrepresented, including Aboriginal and Torres Strait Islanders, young people, people who were homeless, people identifying as gender diverse and people who use assistance communicating. Attempts to specifically invite people from these groups were not successful.

Secondly, the study was limited by the lack of available sector level data. It is not possible to determine how many people are compulsorily treated in Victoria at any given time, either in the inpatient setting or in the community.

Ethics approval was granted by RMIT University # 20970 and # 20975–06/17, and Melbourne Health Human Research Ethics Committee #17/MH/394.

7. Results: IMHA service in the community

Since August 2015 the IMHA service has provided advocacy, information and referrals to people in the community, but has not made the same headway as it had in inpatient settings. In the first 2 years of operation the IMHA service held over 400 information sessions to over 5000 staff and consumers in the community. The IMHA service distributed flyers, postcards and posters, encouraged word of mouth referrals and engaged with both clinical and non-clinical community based services in an effort to reach people on CTOs. IMHA service records show that the main areas of assistance as support around discharge (15%), participation in decisions (13%), medication (13%), treatment (12%), preparation for the Mental Health Tribunal (9%), accessing a second opinion (6%), getting leave (6%), making complaints (5%) and challenging diagnosis (4%), with a variety of other issues making up the remainder of the IMHA service's work.

Despite the efforts to contact those in the community, the number of consumers in the community who accessed the IMHA service has remained stable over time, while the number of consumers who access the IMHA service in inpatient settings has gradually increased (see Fig. 1).

The distinction between the provision of advocacy in the community and advocacy in the inpatient setting, however, is not always clear. While the majority of people who used the IMHA service initially contacted the service in an inpatient setting, many of those continued to have contact with the service after discharge. Conversely, several of those on CTOs and who were using the IMHA service reported being treated in the inpatient setting, on multiple occasions and for very short periods, usually to enforce medication compliance.

Where the IMHA service has succeeded in providing services in the community, the response from consumers has been overwhelmingly positive. Consumers have reported feeling a sense of relief when they found the IMHA service. The advocacy was deeply appreciated. The small number of consumers ($n = 22$) who had used the IMHA service and who responded to the online survey found it very useful. These respondents reflected on their inpatient experience. Over 90% agreed that IMHA service advocates listened and were “on their side”. They trusted the service, would use it again and would recommend it to others (see Fig. 2).

The similarly positive experience of those who utilised the IMHA service in the community was captured in some of the qualitative data.

7.1. Being listened to

A prominent theme in the interviews was the experience of feeling listened to. For example, one consumer told the evaluation team what they valued about the IMHA service:

> *Their honesty. Their reflective listening skills. They didn’t just listen, they actually listened. And reflected back to you what I’d, back to me what I’d said. But they also sought solutions and suggested a number of different ways and checked in with me which way do you want to go. So they put me in control of what happened next. So they listened, they understood. A lot of people say they’ve got listening skills but they don’t. They didn’t, she didn’t make assumptions about what I needed and tell me what I needed. She asked me. And you might have gathered by now that I can work that out. And checked in that I was okay. Checked herself that I wasn’t, that I was safe. Said are you going to go to your next counselling appointment and I said yes, all been organised and I’ve been. So she did the right thing there but she never took any of the power and control away from me. So she heard, she gave me options, she asked what options, and she didn’t make assumptions about what I needed. And she followed through* (Consumer).

7.2. Facilitating action, resolution and protection of rights

Consumers appreciated the IMHA service support and advocacy because it had facilitated action toward the resolution of an issue. For example:

> *Yeah I mean I was trying to advocate for myself so I was calling PARC*[1] *and trying to get the facts and stuff but no one was listening to me so that’s, and I found that when I spoke to IMHA and I told them and I said to a nurse in ED*[2]*, I’ve spoken to IMHA and I’ve got someone advocating me. That kind of got things moving* (Consumer).

A typical response was appreciation of assistance with referral to a legal service:

> *And so, I was trying to get into a situation where I could feel safe about managing my health issues, which I’d been doing perfectly well. I was perfectly capable of living on my own. And so, I am a resourceful woman, an experienced professional woman and so I looked up the phone book and took it from there. I found IMHA, I had one conversation with them, explained what I was trying to do and why. … the person I spoke to helped me get out of the system and worked with me and didn’t intrude onto what I felt at the time was an important relationship with my GP* (Consumer).

Another prominent theme was being grateful that the advocate spoke up for the consumer's rights:

> *I believe (they helped)... just by being there and backing me up, yes... As I’ve said, I had to plead for my life, basically, not to be injected again, but at least I was grateful that they were saying, “She has the right to do this”* (Consumer).

Another consumer's experience is emblematic of the importance of advocacy in the community. In this case, the consumer needed assistance to access acute mental health care. She had presented herself at the emergency department, where she waited for 6 h to access support, including calling the community based crisis service and the Prevention and Recovery Centre (PARC) she had stayed with before. Eventually, she called the IMHA service. The IMHA service's advocate assisted her

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[1] Prevention and Recovery Centre.

[2] Emergency Department.

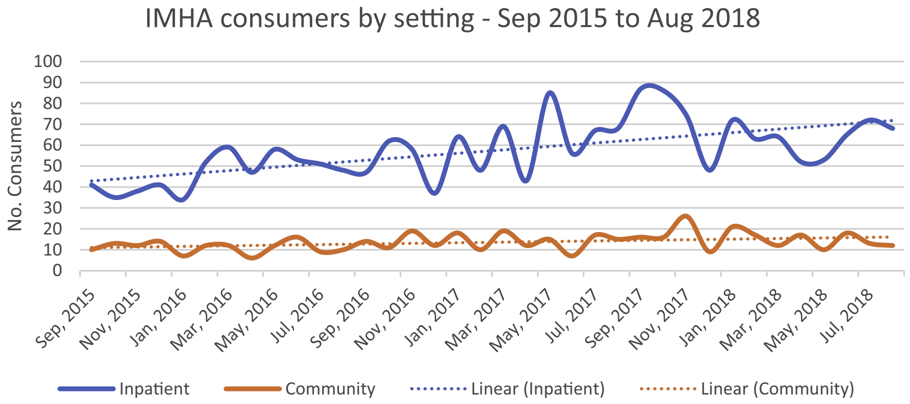

Fig. 1. IMHA service consumers by setting – Sep 2015 to Aug 2018.

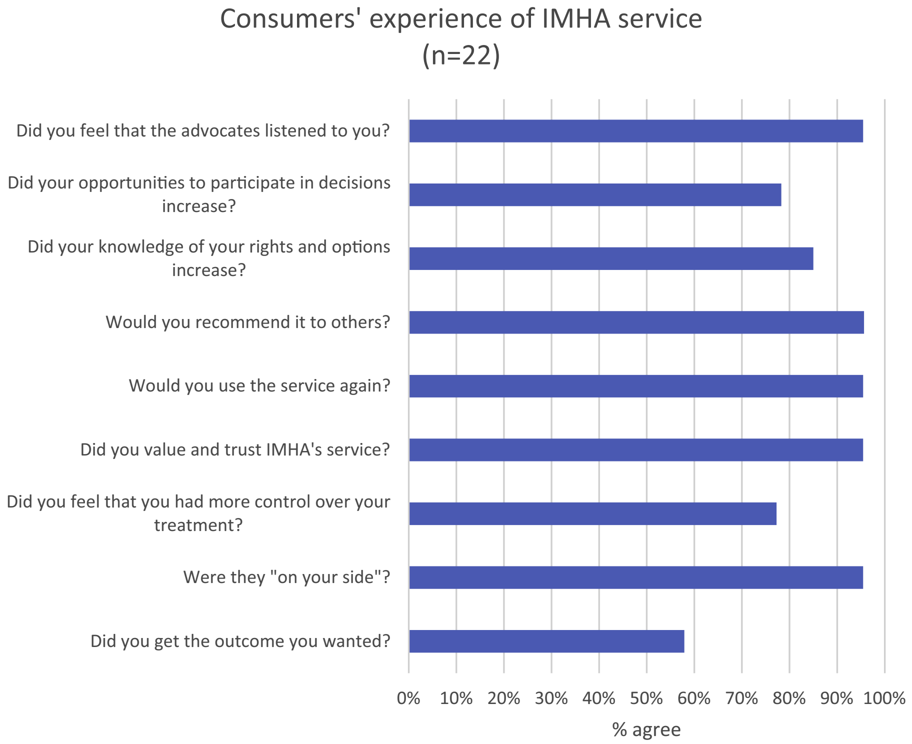

Fig. 2. Consumers' experience of IMHA service.

through the process of admission into the ED, then the inpatient unit, then to a PARC, and later assisted her to make a complaint to the Mental Health Complaints Commissioner. She later told the evaluation team:

> *I can't imagine what my experience would have been like if I hadn't have spoken to them. I don't, I can't imagine. Like it was bad enough. I don't know, it would have been far worse I think. I think that my experience that night would have been worse, in terms of just getting my meds, getting things moving* (Consumer).

One person who participated in the CTO panel contrasted her recent experience of being on a CTO with the support of an advocate with a prior experience where she felt like she was mistreated and not listened to by the treating team. She appreciated feeling listened to by her advocate and being provided with information about her rights, which until this point she had not been advised of. Despite not wanting to be on a CTO and preferring to work with her GP, she felt that she was treated "a lot more carefully" during her recent experience of being on a CTO.

These stories challenge the common assumption that rights based representational advocacy is exclusively about challenging the provision of treatment, and further reinforces the link between recovery and respect for rights. They also suggest the breadth of support that might be associated with independent advocacy for those in the community.

8. Challenges and opportunities

IMHA service advocates reported a number of factors that appeared to limit their ability to provide what they considered to be an optimal level of specialist advocacy in the community.

8.1. Gatekeeping

The first concern was the difficulty of relying on case-managers to make contact with consumers on CTOs. In contrast to the inpatient settings, where consumers could be contacted independently or can be referred by other services who visit the wards, consumers on CTOs are likely to only have regular contact with their case manager, "…there are people everywhere who have been on community treatment orders for donkey's years and unless we manage to present a session to their clinician or their case manager who thinks how would we ever find them?" (IMHA service advocate).

There was a concern raised over the course of the evaluation that where case managers acted as "gatekeepers", few alternatives exist for consumers to learn about and access the IMHA service.

Gatekeeping in the community was associated with equivocal views about the IMHA service, advocacy and rights. Only 36% of mental health professionals who were surveyed and who worked in the community ($n = 74$) agreed that the IMHA service helps maintain consumer's rights. In contrast 78% of those who worked in inpatient settings ($n = 67$) and 69% who worked in both inpatient and community settings ($n = 39$) agreed that the IMHA service helped maintain consumer rights. It is not clear whether the response reflect negative views about the IMHA service or a poor understanding of rights. A number of international authors have observed that the gatekeeping effect is compounded when clinical teams have a negative view about the benefits of advocacy and a poor understanding the rights and entitlements of the consumers (Atkinson, Garner, Gilmour, & Dyer, 2002; Rolfe, Sheehan & Davidson, 2008; Eades, 2018).

Equivocal attitudes about advocacy generally were also prominent theme in the interviews. For example, clinical staff often viewed advocacy as useful only when the consumer's preference aligned with their professional opinion. One consultant psychiatrist who worked in the community setting, told the evaluators that, "advocacy doesn't add value", as he already knew that the consumer wanted to refuse treatment, and he didn't need an advocate to tell him as much. Gatekeeping therefore occurred on two levels: failing to advise people on CTOs of their rights, which includes a right to an advocate; and, obstructing advocates' contact with people.

8.2. Isolation and invisibility

From the consumer perspective, gatekeeping adds to the experience of vulnerability and isolation. For example, one participant who had lived experience of being on a CTO described how word of mouth is limited in clinical settings. She described the experience of being in the clinic with people who may or may not be subject to CTOs like herself. She highlighted that people are not necessarily going to disclose that they are on a CTO, thereby limiting the potential of word of mouth. Finding ways to overcome the invisibility of people on CTOs is a necessary first step if the IMHA service is able to provide services to this cohort of people who can be isolated and particularly vulnerable to not just coercion de jure but also de facto. While community awareness about rights and the IMHA service appears to be growing, isolated consumers in the community may remain unaware of the service.

8.3. IMHA at community clinics

One IMHA service strategy was to offer a regular presence at community clinic to raise awareness about the service, which proved to be unsuccessful:

> *So we've looked at going into a community space to do something like that, our capacity at the time hasn't worked… it has been trialled at a community clinic… It wasn't viable; it wasn't successful in terms of getting new consumers through. So in terms of where I go out to visit to pick up new consumers, it really is only inpatients* (IMHA service advocate).

Consistent with this observation, consumers frequently reported being unaware of IMHA service posters or other promotional material, even when it was clearly displayed in the community clinic, meaning they missed the potential opportunities that were available through the IMHA service.

8.4. Insufficient resources

IMHA service advocates also reported feeling obliged to focus on inpatient consumers, rather than those in the community, because accessing consumers in the community was time consuming and intensive.

> *I've been relatively successful in doing it and I know a lot of people in my team have been very good at spreading the word not just in hospitals but community teams, other networks. But there is definitely a sense that if we had more time we could do more in terms of that [community] space* (IMHA service advocate).

Despite a clear commitment by the IMHA service to work with people on CTOs, easier access to people in inpatient units, coupled with a general assumption in the sector that inpatient settings pose greater risks to people's human rights, resulted in the IMHA service focussing on inpatient advocacy at the expense of community based advocacy. This resourcing was readily conceded by IMHA service advocates interviewed. For example one commented:

> *I personally feel like two advocates could easily do my job – a lot more promotion needs to be doing, a lot more education needs doing and there's a lot of consumers, I think, that [people] probably aren't getting service that need service* (IMHA service advocate).

8.5. You don't know what you don't know

Linked to the difficulties of access and communication was a general lack of understanding of the role and potential benefits of using an independent advocacy service. In the focus group and individual interviews undertaken, it was evident that many service users did not know what an advocate could do for them, or what kind of problems the advocate could assist with. Indeed, many consumers seemed to be unaware of their rights and therefore unaware of the need for assistance. One consumer said:

> *… I've had a lot of issues with community mental health and so I ended up putting a complaint in to them as well about my case manager there. … that would have been helpful but I didn't know the extent of their services I guess. I didn't know that they could help me with that…* (Consumer).

Many consumers had poor awareness of the protections contained in mental health legislation.

8.6. The clash with best interest models

While all of the mental health professionals interviewed supported some version of individual advocacy in principle, many conceptualised this from a 'best interests' perspective. Many did not appreciate the nature of the rights-based representational model used by the IMHA service and most were not aware of supported decision making approaches. Recognition of the value of supported decision making has been prominent in the mental health sector in Victoria since the introduction of the Mental Health Act 2014, which has been described as a supported decision making framework. Supported decision making is an approach which is consistent with recovery oriented practice and is recognised as a critical element in rights protection. The observation that clinicians in the community are unware of this approach points to professional isolation and perhaps a lack of professional development opportunity. The lack of awareness about supported decision making, rights and the IMHA service approach in the community meant that the representational model created friction when applied in practice. For example, clinicians found the way advocates would repeat the preferences of the consumers tedious and became frustrated that the advocates would not filter requests they viewed as unreasonable or irrational.

Table 2
Survey responses from mental health professionals.

	Inpatient	Comm.	Both
IMHA service increases the options and choices available to consumers.	69%	26%	50%
IMHA service increases the ability of consumers to advocate for themselves.	73%	50%	46%
IMHA service has contributed to improvements in your service.	52%	53%	46%
IMHA service has a good reputation in the sector.	59%	41%	46%
IMHA service works for systemic change.	52%	22%	76%
I have noticed consumers who have worked with the IMHA service are better at advocating for themselves.	48%	60%	69%
IMHA service helps to maintain the consumers' rights.	78%	36%	69%

Nevertheless, the overwhelming response form clinicians was positive. Most clinicians, whether they worked in inpatient or community settings or both saw benefit of the IMHA service, although there were significant differences in responses from clinicians who worked in the community. For example, significantly fewer community clinicians thought that the IMHA service increased community choices (26%), that the IMHA service worked for systemic change (22%) or that the IMHA service helped maintained consumer rights (36%). The survey responses from mental health professionals are summarised in the following table (see Table 2).

8.7. Clinical workloads

Advocates also attributed resistance to their work in the community to high clinical caseloads:

> *[In] community clinics I think much more resistance and probably it's a different environment, you know people have really high caseloads,* et cetera*, there's just not a great level of care anyway, and that's not necessarily the workers' fault though some more work could be done there kind of increasing people's knowledge and understanding and therefore like creating some sort of buy-in as well* (IMHA service advocate).

8.8. Confusion about advocacy in the community

Where consumers were seeking support, they were sometimes unable to distinguish IMHA service advocates from the variety of other advocates and services available in the community, even though there are fewer advocacy services offered in the community compared with the inpatient context. Again this meant that some consumers missed out on the specialist advocacy that could be provided by the IMHA service.

9. Discussion

The evaluation of the IMHA service demonstrates the difficulties of accessing people on CTOs in Victoria. Discussing questions of access with respect to marginalised populations in the United Kingdom, Newbigging et al. (2015) argue that independent advocacy is failing to reach those who are "hard to reach and easy to ignore" (2015, p. 129). Hard to reach populations are:

> those in the community, including those with sensory impairments learning disabilities, other disabilities, older people, children and young people women lesbian Gay bisexual transgender people (2015, p.128).

In the Australian context, groups who are overrepresented within CTO numbers, those who speak a language other than English and Aboriginal and Torres Strait Islander people (ATSI) could be added to this list. If the needs of such groups are ignored, the disadvantage and discrimination that they already experienced will be amplified.

The IMHA service study illustrates the difficulty of making contact with those who are isolated and unsupported or have not established positive relationships with their treating teams. These groups are the least likely to access the IMHA service and the most likely to benefit from the service. This study has shown that one of the key difficulties for people on CTOs is their invisibility and isolation. People subject to CTOs are missing from mental health policy documents and aspects of their experience are missing from recovery documents. Their invisibility is compounded be the lack of reliable data about how many people are subject to CTOs at any one time (Light et al., 2012a, 2012b). These observations point to an entrenched, underlying issue. While the apparent rights infringements associated with acute hospital admission are recognised the potential rights infringements of those on CTOs are largely invisible and routinely ignored. Being subject to a CTO can have profound consequences for those who are subject to them undermining their status as autonomous social actors. Rights infringements in the community highlight the need for more intensive IHMA support in the community.

10. Recommendations

These finding point to the following recommendations.

10.1. Legislative change

As is noted above, unlike the IMHA services in England and Wales and in Western Australia, the IMHA service in Victoria lacks legislative footing. One solution to ensuring access to advocacy in the community is a legislative 'opt-out' system, coupled with resources necessary to sustain it. An opt-out system, for example such as that already in place in Western Australia (Mental Health Act 2014 (WA), s 145), requires that every person who is made subject to a treatment order is automatically referred to an advocate. Adopting such a model in Victoria would ensure that all consumers, whether inpatients or community patients under the act, are made aware of the kinds of services and supports that the IMHA service can provide in the community.

10.2. Adequate resourcing

With or without a supporting statutory opt-out framework, there needs to be an adequate number of advocates to provide a service to all of those who are eligible. While there exists such a clear and present need in the inpatient setting, additional resources are necessary to enable the intensive outreach work that seems to be necessary in the community. However, given the continued degree of invisibility of the needs of this community-based population, the extent of this additional service provision remains difficult to quantify.

10.3. Continuity of service

The evaluation also identified missed opportunities for IMHA service advocates to continue working with people after discharge from hospital. For example, there did not appear to be a consistent effort to ensure that consumers who were discharged from hospital were aware that the IMHA service could continue to support them in the community with, for example, referrals to other services or developing self-advocacy skills and building capacity and resilience. Underlying this issue is generally poor discharge and transition planning on the part of mental health services. The IMHA service may need to develop active transition strategies to compensate, especially in instances where consumers may not have functioning email or phone accounts at the time of discharge.

10.4. Systemic advocacy

Finally, there is also an opportunity to develop sector wide understanding both of the importance of advocacy and of the way independent representational rights based advocacy is distinct from the kind of advocacy commonly performed by allied health or case manager roles, and how this alternative approach can be beneficial to consumers across all phases of treatment. This task cannot be achieved by the IMHA service alone. It requires much more than simply informing the sector about advocacy. It points to the need to nurture a system wide awareness of the value of rights based advocacy as the first step to incorporating a rights basis into the system itself. Research that demonstrates the link between self-determination, recovery and clinical benefit may be a valuable tool in motivating system wide change. Providing advocacy in the community might be one way of raising awareness among consumers and clinical staff alike about the shift to the supported decision making model and promoting consumer knowledge of their rights regarding treatment and care.

11. Conclusion

Under the Mental Health Act 2014 independent advocates are an important safeguard mechanism that can ensure that consumer wishes regarding treatment are properly considered by treating teams, who still retain substitute decision making power under the legislation (Knight et al., 2018; Maylea, 2016). Ensuring consumers are heard facilitates their decision making capacities, ensuring they remain actors within their own lives and are able to work toward recovery. While the IMHA service is clearly fulfilling this mandate in inpatient settings, outside the hospital, people on CTOs are largely invisible, vulnerable and isolated. This inability of to access those in the community stems from poor resourcing of mental health services, the slowness of cultural change and the often competing and complex needs of mental health consumers.

International evidence about the efficacy of IMHA coupled with the results of this study, point to the need for active expansion of IMHA services, with particular emphasis on the resources needed to access those living in the community. Current attempts at raising awareness about and providing advocacy supports for people on CTOs are not effective and are not reaching end users. The continued lack of knowledge about the potential opportunities associated with engaging with rights-based representative advocacy services is therefore leading to a significant missed opportunity. Service providers need to take a much more proactive role in ensuring that patient choice and preference is prioritised and omnipresent in care and treatment decisions for people subject to compulsory treatment in the community.

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