

Evaluation of the Independent Mental Health Advocacy Service (IMHA)

**Final Report
March 2019**



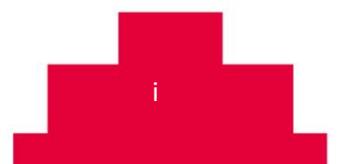
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Suggested citation: Maylea, Chris; Alvarez-Vasquez, Susan; Dale, Matthew; Hill, Nicholas; Johnson, Brendan; Martin, Jennifer; Thomas, Stuart & Weller, Penelope (2019) *Evaluation of the Independent Mental Health Advocacy Service (IMHA)*, Melbourne: Social and Global Studies Centre, RMIT University.





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Acknowledgments

The evaluation team would like to acknowledge the contribution of the consumers who provided feedback about their experience with Independent Mental Health Advocacy (IMHA), the Speaking from Experience Evaluation Subcommittee, IMHA's Senior Consumer Advisor and the consumer evaluators on the evaluation team for their invaluable contribution guiding and shaping this co-designed and co-produced evaluation. Vaanie Krishnan and Flick Grey were essential members of the evaluation team for the first stage of the evaluation. The evaluation team would also like to thank the mental health professionals and other participants who gave frank and fearless feedback, and Victoria Legal Aid (VLA) and IMHA for committing to an independent and transparent evaluation process. The evaluation team also acknowledges the work of previous consultants, VLA and IMHA staff who developed the program logic and objectives used as the basis of this evaluation.

The evaluation team recognises the lived experience of people who have received mental health services, and the good intentions and hard work of those who provide them in the context of contemporary and historical institutional and community settings.

This evaluation was conducted on Aboriginal land, which was never ceded. The Social and Global Studies Centre at RMIT University acknowledges the Australian Aboriginal and Torres Strait Islander peoples of the nations of Victoria, the custodians of this land. We pay our respects to ancestors and Elders, past and present. We are committed to honouring Australian Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society.

Abbreviations and Terms

A# – Advocate Quoted	MHDL – VLA's Mental Health and Disability Law team
C# – Consumer Quoted	MHHREC – Melbourne Health Human Research Ethics Committee
CATT – Crisis assessment and treatment team	MHLC – Mental Health Legal Centre, Victoria
CHEAN – College of Design and Social Context Human Ethics Advisory Network	MoU – Memorandum of Understanding
CRPD – <i>Convention on the Rights of Persons with Disabilities</i>	OCP – Victorian Office of the Chief Psychiatrist
DHHS – Department of Health and Human Services	OPA – Victorian Office of the Public Advocate
FG# – Focus Group Quoted	SDM – Supported decision-making
ECT – Electro-Convulsive Therapy	SH# – Stakeholder Representative Quoted
HREC – RMIT's Human Research Ethics Committee	SPOS – Second Psychiatric Opinion Service, Victoria
IMHA – Independent Mental Health Advocacy	SR# – Survey Respondent Quoted
KPI – Key Performance Indicator	The Act – <i>The Victorian Mental Health Act 2014</i>
MHP# – Mental Health Professional Quoted	The Charter – <i>the Victorian Charter of Human Rights and Responsibilities Act 2006</i>
Mental Health Services – refers to Designated Mental Health Services in s 3 of the Act	The Tribunal – Victorian Mental Health Tribunal
MHAS – Mental Health Advocacy Service of Western Australia	VLA – Victoria Legal Aid
MHCC – Victorian Mental Health Complain's Commissioner	VMIAC – Victorian Mental Illness Awareness Council
	YES Survey – Your Experience of Service Survey



Executive Summary

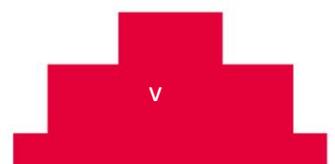
Overall findings

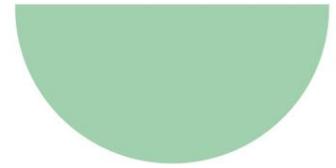
IMHA has proven to be very successful in a challenging context. After three years in operation, it has become an established part of the broader mental health service system. **Consumers highly valued IMHA** because it maintained their rights and because advocates treated them with dignity and respect. Irrespective of whether IMHA advocates achieved the outcome the consumer identified, consumers appreciated an advocate being present. Professionals who had worked with IMHA generally held it in high regard.

To successfully maintain the rights of people subject to compulsory mental health treatment IMHA **must be accessible** to everyone who is eligible for it. This requires the adoption of an **opt-out system** where every person made subject to compulsory treatment is offered advocacy. This will require **increased resourcing** for IMHA to be able to respond to increased demand.

With or without an opt-out system IMHA will require **significantly more resourcing** to ensure equitable access to advocacy via service promotion, and ensure referral pathways. Across the sector, but particularly in community mental health services, awareness of IMHA and understanding of the IMHA model is low. An opt-out system will reduce the need to address this and enable IMHA to focus on providing advocacy services instead of promoting the service.

Achieving IMHA's key objective of maintaining the rights of consumers will require a **whole of system approach** with political and public sector leadership. Oversight and funding bodies, led by DHHS and including VLA, the Office of the Public Advocate, the Second Psychiatric Opinion Service, the Mental Health Complaints Commissioner, the Mental Health Legal Centre, the Victorian Mental Illness Awareness Council, Tandem, the Office of the Chief Psychiatrist and the Mental Health Tribunal, must invest and coordinate with mental health services to ensure that services comply with legislation, are recovery-oriented and least-restrictive in practice, and people are provided with the support they need to make decisions. The evaluation identified an enormous amount of goodwill in the sector, but little in terms of tangible outcomes or improved experiences for consumers. IMHA is working towards this goal but is hindered by inaction and resistance in some parts of the sector. **Sector leadership will be required** to address these systemic issues going forward. The 2019 review of the *Mental Health Act 2014* and the proposed Royal Commission into Mental Health in Victoria provides an ideal opportunity for this.





Key recommendations

IMHA is instrumental to the maintenance of the rights of people who are subject to compulsory treatment. To ensure IMHA's continued success and address system-level issues, four main actions must be taken:

1. Referral to IMHA must be automatic for any person subject to compulsory treatment through an 'opt-out' system
2. IMHA must be adequately resourced to meet demand
3. IMHA must continue to improve sector awareness and understanding of advocacy
4. Oversight and funding bodies must coordinate and adequately invest to ensure that services comply with legislation, are recovery-oriented and least-restrictive, and that consumers are supported to make decisions

Detailed recommendations are included at the end of the report.

Evaluation Overview

IMHA is a non-legal representational mental health advocacy service run by VLA and funded by DHHS. IMHA operates across Victoria, advocating with and for people who are subject to, or at risk of, compulsory treatment under the Victorian *Mental Health Act 2014*. IMHA was launched in August 2015. In 2017, VLA contracted RMIT's Social and Global Studies Centre to evaluate the service in two stages, a midterm review covering the first two years of operation, and a final evaluation covering the first three years of operation. This report details the findings from the final review.

IMHA is centred on realising the rights of consumers and ensuring their voices are heard. Measuring how well this has been achieved and the impact the service has had on the individual consumer has been central to the evaluation. This evaluation employed a mixed-methods approach, combining qualitative thematic analysis of primary and secondary data with descriptive statistical data to help address the evaluation questions.

The main evaluation questions were:

- ~ How is IMHA being implemented, and how does this compare with the logic model and other policy documentation?
- ~ Is IMHA effective?
- ~ Is IMHA efficient?
- ~ Is IMHA sustainable?

This evaluation was co-produced with consumers by an evaluation team comprised of experts in mental health law and service delivery. The evaluation consulted 69 consumers who had used IMHA, 40 consumers who were eligible for but hadn't used IMHA, 9 stakeholder body representatives, 292 mental health professionals, 31 mental health lawyers and 16 IMHA staff. Included in the analysis were consumer files, IMHA documentation and internal data.



Summary of Findings

The IMHA Model

The IMHA model is unique in Australia. To maintain consumers' rights using a **supported decision-making** approach the IMHA model delivers **instruction based advocacy**. IMHA has no statutory powers to ensure access to people in services and in the community, unlike the equivalent services in Western Australia. Without legal powers to ensure access, IMHA relies on a **relational approach**, meaning advocates engage with services and staff to ensure access to and the support of advocacy. This model is informed by the principles of **self-determination** and **recovery** and is designed to improve a consumers' ability to **self-advocate**. While remaining focused on individual advocacy, IMHA also engages in **community education** and **sector reform** advocacy.

Representational advocacy means IMHA advocates listen to and communicate a person's preferences and wishes as expressed by them. They will not make an assessment as to whether a person's instructions might be influenced by mental illness. They also advocate irrespective of whether other people, including the advocate, clinicians, carers or family members agree with a consumer's particular preference. This is in opposition to the 'best-interests' model commonly adopted in mental health services, in which the professional takes responsibility for determining and acting in the best interests of the consumer. To carry out representational advocacy under IMHA's model, advocates use a supported decision-making approach, where people are provided with support to make their own decisions. This means advocates will provide people with information relevant to a decision, such as their legal rights, help them actually make the decision, help them implement the decision, and help them reflect on the decision-making process. This approach is in opposition to the 'best-interests' model commonly adopted in mental health services where the professional takes responsibility for determining and acting in the best interests of the consumer. While supported decision-making is consistent with a representational approach and the *Convention on the Rights of Persons with Disabilities*, its application in the best-interests substituted decision-making framework of the environment of contemporary compulsory mental treatment is the source of many of the tensions and barriers identified during the evaluation.

The IMHA model is **recovery-oriented** and incorporates empowerment principles to improve individual consumer's ability to self-advocate. IMHA is proving successful in building this capacity, however consumers were clear that help from an IMHA advocate may still be necessary for the future, particularly if they were in crisis or where self-advocacy had failed. IMHA has developed a self-advocacy toolkit and resources, which at the time of writing are being reviewed prior to implementation. The evaluation identified opportunities for providing support to family, friends and carers to act as advocates for people who use mental health services.

A third part of the IMHA model is its **relational** aspect. This requires advocates to develop relationships with consumers to enable supported decision-making, and with clinicians to ensure access and opportunities for advocacy. This was necessary for effective advocacy as the power to make treatment decisions lies with the treating team. Participants identified that this was largely successful, with advocates generally maintaining good relationships while advocating strongly for consumers. This was limited by the time advocates could spend building these relationships. IMHA was poorly perceived by mental health professionals when advocates did not have good relationships with services and staff. The adversarial approach adopted by some advocates



was reported to work well for individual consumers but resulted in strained relationships that were seen as having a negative impact on individual outcomes and future advocacy opportunities.

IMHA’s Performance

The **overall findings from the evaluation were overwhelmingly positive**. All participant groups gave positive feedback. The areas for further development that were identified related to systemic issues that were beyond IMHA’s control, such as the identification of new opportunities for increased effectiveness, resource constraints and the newness of the service. The evaluation identified that IMHA was being implemented as intended, and is consistent with the establishing documentation, policies and procedures, program theory and logic model. IMHA is **reaching a broadly representative population**, although it has focused on inpatient settings and is **not easily accessible in the community**. IMHA is exceeding key performance indicators by 357% for high-intensity contacts and 233% for low-intensity contacts.

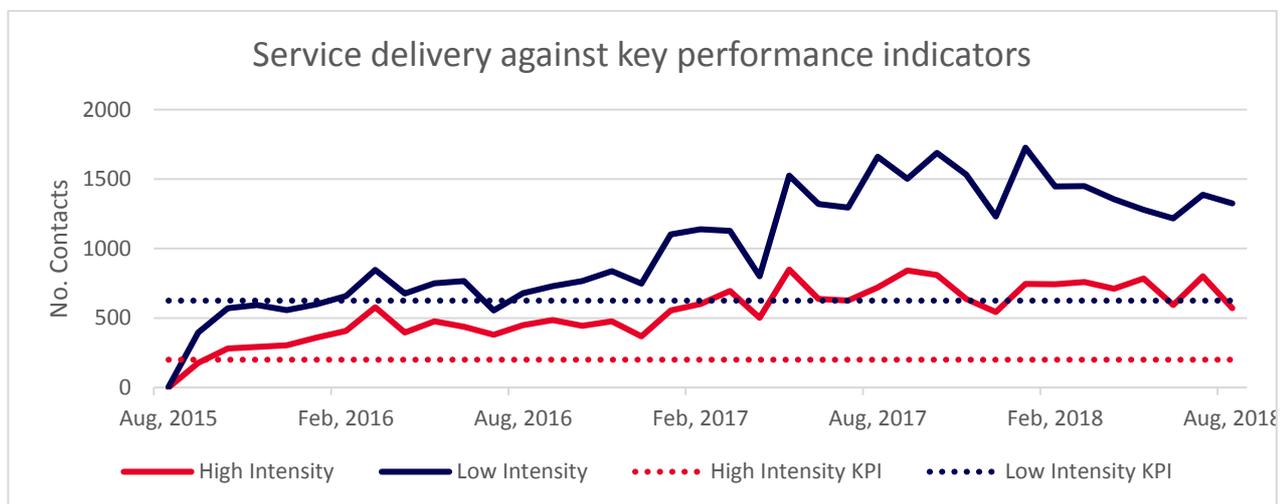


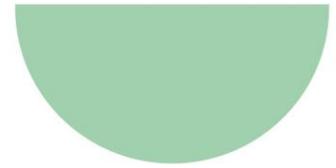
Figure 1 – IMHA Service Delivery KPIs Aug 2015 to Aug 2018

IMHA staff demonstrated consistency with IMHA’s values of integrity, respect, person-centred, curiosity and reflectiveness. The central tenet of IMHA’s service – rights based representational advocacy – was consistently portrayed by advocates and valued by consumers. IMHA advocates supported consumers in a range of areas, primarily around discharge, and participation in decisions around treatment and care. IMHA also provided information and referral to other services, most often legal services, SPOS and the MHCC.

Consumers highly valued IMHA. Consumers appreciated having an advocate present irrespective of whether they were able to achieve the desired outcomes. Mental health professionals who had interacted with IMHA held it in high regard, whereas those who had not had contact (particularly those in the community) held neutral views. The issues regarding IMHA that were raised by mental health professionals largely related to a misunderstanding of the model and occasional examples of IMHA advocates not adhering to the model.

Other Findings

In addition to assessing IMHA’s performance, the evaluation identified specific issues that arose from the data and during the evaluation process. These included challenges related to the mental health context, access issues, questions of IMHA’s scope, IMHA’s role in systemic reform and resourcing.



IMHA must be evaluated in relation to the context that it operates within. The evaluation team heard repeated reports of **breaches of consumers' rights** and **breaches of the Act** by clinical staff. This highlighted the need for an independent advocacy service but also suggested that IMHA is only one part of the solution. Tensions between IMHA's representational model of advocacy and the best-interests approach that dominates contemporary mental health treatment and care were also identified. The evaluation team sought to provide direction to address these by mapping mental health professionals' attitudes to advocacy, finding that while many did not understand representational advocacy, they had positive dispositions to it once it was explained. This suggests that education and promotion have the potential to successfully engage professionals in advocacy.

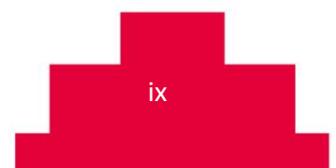
The evaluation highlighted problems in **accessing IMHA** in inpatient units and in the community. Demand for services is much higher than IMHA can currently provide meaning that service promotion and relationship building are unable to be prioritised. This can be resolved through the adoption of an opt-out system which would ensure that all people who are subject to compulsory treatment are referred to IMHA. A corresponding increase in resourcing would be required for IMHA to provide advocacy to all who require it. Although difficult to accurately determine based on limited data, the evaluation team assesses that twice as many advocates are needed to provide advocacy services within inpatient units, and as many again to ensure access in the community.

Issues related to **IMHA's scope** were identified. There was a lack of clarity in how the IMHA model could respond to advocacy needs that did not specifically relate to compulsory mental health treatment and care despite a need being identified by advocates and consumers. The evaluation also identified some difficulties with identifying consumers who are 'at risk' of compulsory treatment. The role of IMHA in relation to the Mental Health Tribunal was also raised by participants and should be considered by IMHA and VLA.

Linked to considerations of scope, IMHA's ability to **engage in systemic and cultural change** was a recurrent theme throughout the evaluation process. System-level reform is focused on reducing the use of restrictive practices, increasing self-advocacy and the reception of self-advocacy by decision makers, increasing the adoption of supported decision-making practices and improving the quality of mental health care and treatment. The sector level data does not indicate immediate success in this area, with rates of restrictive practices including compulsory treatment, seclusion and restraint all remaining static. Much of IMHA's impact at the systemic level has been made by the IMHA Manager, who met regularly with stakeholder bodies, clinical and non-clinical mental health agencies and DHHS. These networks should be formalised to galvanise sector leadership and ensure collaboration with other safeguarding institutions to identify and resolve systemic issues.

IMHA's ability to engage in **strategic reform** through individual advocacy is somewhat limited by the lack of statutory support. In Victoria, consumers have a right to communicate with IMHA advocates, but no other powers. In Western Australia, the advocates are led by a Chief Mental Health Advocate and table an annual report in Parliament. The establishment of a Victorian Chief Mental Health Advocate or other statutory systemic role would give IMHA a formal place amongst other oversight bodies. Granting other statutory powers, including the right for IMHA to access consumer files with consumer consent would improve IMHA's effectiveness.

Hindering IMHA's ability to operate effectively is the **lack of useful sector level data**. The poor quality of publicly available sector level data means that it is not possible to determine how many people are subject to



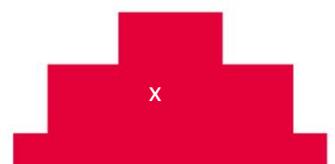


compulsory treatment and therefore eligible for IMHA in Victoria on any given day. To adequately assess service demand and allocate resources accordingly, accurate data on the number of people who are subject to compulsory treatment, including key characteristics such as age, background, gender, type and length of order, needs to be made available to IMHA. This data is already collected by mental health services but not reported or shared with IMHA. IMHA's own data collection processes are inconsistent and difficult to access. IMHA is introducing a new database that will address this issue.

Finally, the evaluation considered issues of **resourcing**. Without clear data on the numbers of people eligible for IMHA's service, the only indication of demand is the demand of consumers who have used IMHA's services. The consistent experience of IMHA advocates is that when they do have the capacity to take on more work, they spend time promoting the service, which leads to an influx in referrals and quickly absorbs their capacity. This process has resourcing implications for community education, capacity building and the system-level reform aspects of IMHA's role. The increase in incoming referrals has also restricted the type of service offered by advocates, with face-to-face advocacy being replaced by telephone advocacy out of necessity. While telephone advocacy has a role, this shift has ramifications for the quality of service IMHA provides. Both consumers and staff identified the importance of being in attendance for treating team meetings and the importance of face-to-face contact for building trust and rapport.

IMHA will only be able to adequately meet the advocacy needs of consumers if the number of advocates is increased. At a minimum, IMHA needs to be present in inpatient units on a weekly basis, which would require **twice as many advocates**. To ensure access in the community within the current opt-in system IMHA would require at least as many advocates again. If an opt-out system was adopted, advocates would be able to spend less time on ensuring access and service promotion. Adopting an opt-out system would require a significant increase in resourcing to meet increased demand. Limited sector data and the variability in opt-out system options mean that exact resourcing requirements will need further consideration.

Each of these issues are covered in detail in the body of the report.





1. Introduction

Independent Mental Health Advocacy (IMHA), run by Victoria Legal Aid (VLA) and funded by the Victorian Department of Health and Human Services (DHHS), provides independent, specialist mental health advocacy to people in Victoria who are subject to, or at risk of being subject to, compulsory treatment under the Victorian *Mental Health Act 2014* (the Act). IMHA was established in August 2015 and operates across Victoria.

In 2017, VLA conducted a formal competitive tendering process to evaluate IMHA. As a result, RMIT University's Social and Global Studies Centre (formerly Centre for Applied Social Research) was contracted to evaluate IMHA in two phases: a midterm review¹ covering the first two years of operation and a final review covering the first three years of operation. This report details the findings from the final review.

1.1. Background

In Victoria, the *Mental Health Act 2014* (the Act) allows for the compulsory treatment and detention of people with a diagnosis of mental illness. In conjunction with a number of other reforms that were inspired by the United Nations *Convention on the Rights of Persons with Disabilities 2008*, the Victorian government announced a new, statewide representational non-legal mental health advocacy service in 2014. After a public tender process, VLA was awarded the initial three-year contract. At the time of introduction it was the first of its kind in Australia, although Western Australia has subsequently introduced a similar service. IMHA services have existed in the UK since 2007.²

IMHA adopts a representational model of advocacy, which means that they attempt to directly represent the views, wishes and concerns of the person, without applying their own views or values. This is distinct from a best-interests approach which continues to dominate within mental health treatment and care practices, despite the Act requiring treating teams to be more inclusive of consumer preferences. In pursuing this approach, IMHA has adopted a supported decision-making model that upholds the right of consumers to be supported to make their own decisions. The Act includes a number of provisions that aim to actively promote consumer participation in treatment decisions and make decisions involving a degree of risk while providing for actual decisions about treatment to be made by authorised psychiatrists when a person is subject to a treatment order. In this context, the provision of representational advocacy recognises that consumers can participate in decision-making processes. Furthermore, it recognises that people may require assistance to articulate and represent their preferences. IMHA advocates provide information, assist in supported decision-making, build individual capacity for self-advocacy, link consumers to other services and provide individual advocacy. This model also aims to contribute to system-level advocacy and system reform.

IMHA is guided by the principles detailed in section 11 of 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

¹ Chris Maylea et al, 'Mid-Term Review of the Independent Mental Health Advocacy Service (IMHA)' (Social and Global Studies Centre, RMIT University, 2018) <<https://sway.office.com/fgJtBnSrMFNTEZYw>>.

² For the report on the evaluation of IMHA in England, see: Karen Newbigging et al, 'Right to Be Heard, A Review of Independent Mental Health Advocacy Services in England' (Research Report, University of Central Lancashire, June 2012) <https://www.uclan.ac.uk/research/explore/projects/assets/mental_health_wellbeing_review_of_independent_mental_health_advocate_research_report_190612.pdf>.



people subject to compulsory treatment to participate in and make decisions about their assessment, treatment and recovery, and respect for their rights, dignity and autonomy. IMHA is informed by the following values: integrity, respect, person-centred, curiosity and reflectiveness. IMHA explicitly adopts a recovery focus. IMHA is also required to comply with the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter).

IMHA has a systemic reform role beyond individual advocacy and coexists with a group of other oversight and systemic advocacy bodies. In Victoria this includes:

- ~ Community Visitors and the Office of the Public Advocate (OPA)
- ~ Victoria Legal Aid (VLA) Mental Health and Disability Law (MHDL)
- ~ Second Psychiatric Opinion Service (SPOS)
- ~ Mental Health Complaints Commissioner (MHCC)
- ~ Department of Health and Human Services (DHHS)
- ~ Mental Health Legal Centre (MHLC)
- ~ Victorian Mental Illness Awareness Council (VMIAAC)
- ~ Tandem
- ~ Office of the Chief Psychiatrist (OCP)
- ~ The Mental Health Tribunal (the Tribunal)

The development and implementation of IMHA have been guided by a logic model. This sets out short, midterm and long-term outcomes, in the areas of IMHA consumers, the IMHA service and the mental health system. This provides a guide for IMHA in implementation and a method for assessing performance. These documents are not made publicly available and are not included in this report.

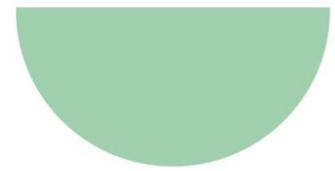
IMHA operates from four VLA offices located across Victoria, in the Melbourne CBD, Dandenong, Geelong and Bendigo. IMHA services are delivered in-person and via the telephone, with ‘outposts’ established in inpatient mental health units. IMHA consists of 19 staff employed at 15 full-time equivalent, and 3 people employed on a casual basis. Each IMHA team consists of a Senior Advocate and Advocates: 2 in Bendigo, 1 in Geelong, 3 in Dandenong and 4 in Melbourne. The staff team includes a Manager, Administration Officer and Senior Consumer Consultant based in the Melbourne office. IMHA is guided by a consumer advisory group, *Speaking from Experience*.

1.2. Evaluation Methodology

1.2.1. Aims and scope

The overarching aim of this evaluation was to detail the extent to which IMHA is providing effective, efficient, sustainable independent advocacy services to eligible consumers. The overall quality of the service delivered was then related to how well each of these factors were achieved, both separately and together. This aim has been achieved by understanding quality from a consumer perspective and engaging with a range of other stakeholders.

The evaluation adopted principles of participatory co-design and co-production, valuing and responding to the lived experience of the people who have previously, currently or may in the future use IMHA. This approach is based on principles of equality, diversity, accessibility, reciprocity and mutuality. Six of the members of the evaluation team have experience as consumers of mental health services and one is currently eligible for IMHA’s services. A subcommittee consisting of five members of *Speaking from Experience* provided guidance and direction at six key points over the course of the project.



For the duration of the evaluation Dr Maylea was located part-time on-site at IMHA. This embedded model facilitated a deeper level of engagement with the IMHA team while maintaining independence and impartiality. All stages of the evaluation were undertaken in close, ongoing consultation with VLA to ensure the evaluation proceeded in line with VLA expectations and the deliverables were appropriate.

All IMHA delivery sites were within the scope of this evaluation, covering the three-year period between 1st September 2015 and 31st August 2018. All IMHA consumers, staff and mental health professionals who work with them were within the scope of this evaluation.

1.2.1. The evaluation team

All members of the evaluation team are committed to the protection of rights of people experiencing mental distress. They bring a diverse blend of skills to the project, including law, criminal justice, sociological, consumer and social work perspectives. The evaluation team consists of Dr Chris Maylea (lead evaluator), Susan Alvarez-Vasquez, Matthew Dale, Professor Stuart Thomas, Professor Penelope Weller and Professor Jennifer Martin. Brendan Johnson and Dr Nicholas Hill joined the team for the final stage of the evaluation. Flick Grey and Vaanie Krishnan were members of the evaluation team for the midterm review.

1.2.2. Key evaluation questions

The questions outlined below were used to inform and guide the evaluation:

- ~ How is IMHA being implemented and how does this compare with the Logic Model, Hierarchy of Objectives and other policy documentation?
 - ≈ Is IMHA being implemented as intended?
 - ≈ For whom, in what ways and in what circumstances? What unintended outcomes (positive and negative) have been produced?
 - ≈ Are consumers being reached as intended?
 - ≈ To what extent is the program achieving the intended outcomes in the short, medium and long-term as outlined in the logic model?
- ~ Is IMHA effective?
 - ≈ How satisfied are consumers? For which consumers?
 - ≈ What were the particular features of the program and context that made a difference?
 - ≈ How has IMHA changed the Victorian mental health service context?
 - ≈ How has IMHA realised the rights of consumers and promoted their voices?
- ~ Is IMHA efficient?
 - ≈ What is currently being done that maintains IMHA's efficiency?
- ~ Is IMHA sustainable?
 - ≈ What, if anything, needs to be put in place to maintain the service benefits?

Over the course of the evaluation, the research team determined that the originating documentation, particularly the Logic Model and Hierarchy of Objectives, had been instrumental in establishing IMHA, but the service had outgrown aspects of these documents. Informed by the establishing documentation, and guided by the key evaluation questions, the team worked with IMHA to develop an assessment framework that incorporated these elements, and which evolved during the course of the evaluation. This report adopts a structure that is reflective of this process.



1.3. Data Collection

1.3.1. Methods

The evaluation employed a mixed-methods approach with a focus on qualitative data. The evaluation was undertaken in two stages: a midterm review from June to September 2017 and a final evaluation from April to September 2018. Data collection consisted of a review of IMHA documentation, an annotated bibliography of relevant literature, a legislative review of other jurisdictions with IMHA equivalents and a suite of participant consultation strategies, including focus groups, interviews and online surveys.

Interviews, focus group and survey questions were developed with reference to the Hierarchy of Objectives. All questions were developed by consumer evaluators and co-produced with the *Speaking from Experience* subcommittee.

Seven stakeholder bodies were consulted:

- ~ Second Psychiatric Opinion Service
- ~ Mental Health Complaints Commissioner
- ~ Office of the Public Advocate
- ~ Department of Health and Human Services
- ~ Victorian Mental Illness Awareness Council
- ~ Tandem
- ~ VLA Mental Health and Disability Law team

The evaluation team visited ten sites across Victoria to conduct interviews and focus groups with professionals and consumers (six metropolitan and four regional):

- ~ Ballarat Hospital (Ballarat Health Service)
- ~ Bendigo Hospital (Bendigo Health Service)
- ~ Bendigo VLA Office
- ~ Broadmeadows Adult (NorthWestern MH)
- ~ Broadmeadows Aged (NorthWestern MH)
- ~ Dandenong VLA Office
- ~ Geelong VLA Office
- ~ Melbourne VLA Office
- ~ Monash Clayton Medical Centre (Monash Health)
- ~ RMIT City Melbourne Campus
- ~ Thomas Embling Hospital (Forensicare)

Table 1 details the number and variety of participants engaged by the method of consultation:

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

Table 1 – Participants by Method of Consultation

A roughly representative range of professions were consulted, shown in Table 2.



	Interview or Focus Group	Online survey	Total
Consultant psychiatrist	11	12	23
Manager	3	4	7
Mental health nurse	29	92	121
Occupational therapist	4	12	16
Peer worker or consumer consultant	1	17	18
Psychiatry Registrar or Intern	4	7	11
Psychologist	2	14	16
Social worker	7	22	29
Other	4	47	51
Total	65	227	292

Table 2 – Breakdown of Mental Health Professionals by profession

All consumer focus groups were led by consumer evaluators. Individual interviews were conducted by both an academic evaluator and a consumer evaluator where possible. Interviews and focus groups were recorded and professionally transcribed. Surveys were distributed via IMHA’s professional networks, social media, and mental health services. Survey invites were also sent to 329 consumers who used IMHA and to all VMIAC members. Consumers who participated in the online survey were invited to leave their details to be contacted for a separate interview. Survey responses were anonymous and are not linked to interviews, IMHA files or any other source.

Recruitment for the consumer focus groups was undertaken by mail out to people who had used IMHA. People who were interested in participating contacted the research team and were directed to a focus group in their area. Consumers who participated in a focus group or an interview were compensated for their time at a rate of \$35 per hour and \$10 for travel in the form of a gift voucher. Consumers who participated in interviews and focus groups were asked if they would like to consent to the evaluation team reviewing their files. Twenty consumers consented to the evaluation team reviewing their files which were then included in the analysis. The experiences of three of these consumers were selected to be developed into de-identified vignettes which will be made available in a forthcoming publication. IMHA staff were also provided with fictional advocacy scenarios and asked to document their responses. Eight staff returned responses.

Quantitative data was provided by IMHA, including data on performance indicator activities, criteria groups, areas of assistance, demographics, referral details and client and caller locations. This data has been used where relevant. Due to difficulties related to IMHA’s database design, the data has been interpreted with caution and guidance from IMHA.

The evaluation team recorded and transcribed 62 hours of audio. Analysed transcripts, survey responses, policy documents and other documentation totalled 961,523 words. Prior to thematic analysis, the raw data was coded to prompting questions, allowing for cross-tabulation of the thematic data. Data was then thematically analysed, first by two consumer evaluators who independently defined the codes using open coding. Academic evaluators then independently coded across each of the groups of sources, axially coding across data sources, which was then combined with the coding conducted by the consumer evaluators. This co-produced process ensured a double handling of the data and thematic analysis led by people with a lived experience of using mental health services and supported by experienced qualitative researchers. Data sources generally triangulated with consistency, with no major inexplicable disagreements between data



sources. The data collected was mapped against the IMHA Logic Model and Hierarchy of Objectives. This informed the structure and focus of this report.

Participant quotes used in this report have been lightly edited for readability and to ensure confidentiality. Some content in this report is reproduced from the Midterm Evaluation Report.³

1.3.2. Limitations

Data collection generally proceeded as planned, although IMHA's priority groups are underrepresented due to a lack of response to invitations to participate in the evaluation. This issue was anticipated in the evaluation plan and mirrors the experience of evaluators on similar projects.⁴ The evaluation team consulted with one of VLA's Aboriginal Community Engagement officers, and IMHA advocates specifically invited consumers from underrepresented groups to participate, however, this was not entirely successful, and the evaluation was not able to fully capture the diversity of IMHA participants.

The evaluation process was consistently hindered by the lack of available sector level data, as discussed below in section 2.3.6. Both service level data provided by IMHA and sector level data was often incomplete, unreliable or inconsistently collected. IMHA and VLA have taken steps to address this issue, with plans for a new IMHA specific database (see Recommendation 14). Without reliable sector level data, it was not possible to accurately determine IMHA's quantitative performance.

1.3.3. Ethics

Ethics approval was obtained through RMIT's College of Design and Social Context Human Ethics Advisory Network (DSC CHEAN) (#A 20975-06/17), RMIT's Human Research Ethics Committee (RMIT HREC) (#20970) and Melbourne Health Human Research Ethics Committee (MH HREC) (#17/MH/394).

The findings of the evaluation are presented in three sections: the IMHA model in practice, IMHA's Performance and Other Specific Findings. Detailed recommendations are included at the end of the report.

³ Maylea et al, above n 1.

⁴ Daniel Van der Pluym, 'Consultation Report - Supported Decision Making under the Mental Health Act 2014 - What Consumers Want' (Consultation Report, Independent Mental Health Advocacy, Victoria Legal Aid, 2016); Newbigging et al, above n 2.



2. Evaluation Findings

2.1. The IMHA Model in Practice

To answer the key evaluation question regarding the implementation of IMHA, this section describes the IMHA model in practice and highlights key aspects and tensions.

The IMHA model is unique in Australia in that it provides specialist advocacy to people subject to, or at risk of, compulsory treatment under the Act. Unlike IMHA services in England, it is a state-wide service covering the entire jurisdiction. Unlike the West Australian Mental Health Advocacy Service (MHAS), it has no statutory powers and is not a statutory body.⁵ Distinct from the Community Visitors run by OPA, IMHA provides ongoing, instruction-based non-legal advocacy. IMHA advocates are specialists in both mental health and in the legislative frameworks which govern compulsory treatment, unlike generalist mental health or disability advocates. IMHA has had to develop a model specific to the Victorian context that does not rely on statutory powers. It delivers instruction-based advocacy using a supported decision-making paradigm and relies on a relational approach. This takes the form of individual advocacy, community education and system-level reform. The model applies a recovery approach and incorporates empowerment principles to support consumers' ability to self-advocate.

2.1.1. Instruction-based Representational Advocacy Using Supported Decision-making

Instruction-based Representational Advocacy

The key difference identified between IMHA and other advocacy provided within the sector was the adoption of a representational approach as a fundamental principle. Representational advocacy is defined by DHHS and adopted into IMHA policy as:

Representational (or instructed) advocacy ensures that people are supported to speak for themselves and have someone 'on their side' who can represent their views, wishes and concerns. Advocates take their instruction from the [Patient] and ensure that they do not take action without the [Patient's] express permission. Representational (or instructed) advocacy promotes what the [Patient] wants for his or herself not what other people think they should have or not have. This is also true in relation to information. Advocates do not keep secrets from [Patients] and will not accept unsolicited information about a person from a service provider or other external source.

In practice, this means that advocates will represent the person's wishes as expressed by them. They will not make an assessment that a person's preferences may be influenced by mental illness, and will advocate irrespective of whether other people, including the advocate, clinicians, carers or family, agree with these preferences. They will share any information they have with a person, without making a judgement about the impact that information might have on a person. Advocates will ask questions as necessary, negotiate and mediate, but will not make decisions on behalf of a person. Consumers may delegate minor decisions to their

⁵ Although consumers have a statutory right to communicate with IMHA. *Mental Health Act 2014* (Vic) s 16(2)(f), *Mental Health Regulations 2014* r 5A.



advocate, such as the drafting a document on their behalf but will have the final say over both the process and the document.

This is linked to and consistent with a rights-based approach, and is informed by the *Convention on the Rights of Persons with Disabilities* (CRPD) which seeks to ensure that people who use mental health services are not discriminated against on the basis of their diagnosis. This is in opposition to the ‘best-interests’ model commonly adopted in mental health services where the professional takes responsibility for determining and acting in the best interests of the consumer. The representational approach was highly valued by consumers, but caused significant tensions with clinical staff, as explored below.

Supported-decision making

IMHA do not apply a capacity test, instead adopting an approach informed by the CRPD. This requires people to be supported to make their own decisions, rather than having their rights to make decisions taken away from them.⁶ This is more sophisticated than simply repeating the consumer’s words, and explicitly incorporates a supported decision-making model. Supported decision-making includes at least three steps:

1. Support to formulate a person’s purposes, explore choices and make decisions
2. Support to engage in decision-making processes and to engage with other parties
3. Support to act on the decision⁷

If decision-making is described as a continuum, with substituted decision-making at one end, and independent decision-making at the other, IMHA occupies a middle position where people are able to make their own decisions and are provided with whatever support they require to do so. This is more structured and implies more support than assisted decision-making, which may simply be the provision of information. Contemporary Victorian compulsory mental health treatment is substituted or shared decision-making. In a supported decision-making approach, the consumer has the final say, both in the decision itself and in the process of deciding.⁸



Figure 2 – A Continuum of Decision-Making⁹

The Act requires, at a minimum, a shared decision-making approach, where consumers ‘should be involved in all decisions about their assessment, treatment and recovery’.¹⁰ It also requires that consumers ‘be supported to make, or participate in, those decisions, and their views and preferences should be respected’. In practice,

⁶ Wanda Bennetts et al, ‘The ‘Tricky Dance’ of Advocacy: A Study of Non-Legal Mental Health Advocacy’ (2018) 2018(24) *International Journal of Mental Health and Capacity Law* 12.

⁷ Gavin Davidson et al, ‘Supported Decision Making: A Review of the International Literature’ (2015) 38 *International Journal of Law and Psychiatry* 61.

⁸ MB Simmons and PM Gooding, ‘Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health’ [2017] *Irish Journal of Psychological Medicine* 1.

⁹ Adapted from Bennetts et al, above n 6.

¹⁰ *Mental Health Act 2014* (Vic) s 11(c).



the evaluation identified that within mental health services a substituted decision-making approach was most commonly experienced by consumers.

The presence of a supported decision-making approach in a shared or substituted decision-making framework is the source of many of the tensions and barriers identified by the evaluation. Examples of advocacy that caused tension included an advocate supporting a consumer to make a complaint about a nurse who they thought was poisoning their food, an advocate who refused to divulge the location of a person who had absconded and when an advocate asked for a change of psychiatrist based on the gender or ethnicity of the psychiatrist. In each of these cases, the advocate followed the instructions of the consumer. Tensions also emerged when advocates refused to divulge information to clinicians about a consumer without the explicit consent of the consumer. These tensions were less pronounced when there was a high degree of understanding of representational advocacy, and there were good relationships between advocates and staff.

Linking individual issues to systemic advocacy

IMHA’s advocacy is mainly at the individual level, but also has a strong focus on amplifying individual issues to contribute to system-level reform and systemic advocacy. The IMHA Manager provides feedback to service executives and some IMHA advocates provide ward level feedback to nurse unit managers or other mid-level managers. Another example of systemic reform is the relationship with VLA’s MHDL team, which has resulted in litigation to protect consumer’s rights under the Act in the Victorian Supreme Court. IMHA also runs supported decision-making training for mental health services. This training requires specific resourcing (Recommendation 4). IMHA is also in the process of developing a self-advocacy toolkit for consumers. This focus on increasing individual self-advocacy skills is key to understanding IMHA’s approach to advocacy and is explored in further detail in the following section.

2.1.2. Building Capacity

An important aspect of the IMHA model is the focus on equipping individual consumers with the skills to engage in self-advocacy and improve their ability and confidence to advocate for themselves. This is based on an emphasis on recovery and empowerment principles and underpinned by an awareness of the problems caused by creating unnecessary dependency on services. Consumers identified that their capacity to self-advocate was improved through working with IMHA. This is shown in the quantitative data in Figure 3. IMHA’s own continuous improvement data supports this, with the majority of consumers strongly agreeing that ‘they had a greater understanding of their rights and were more confident expressing their views and

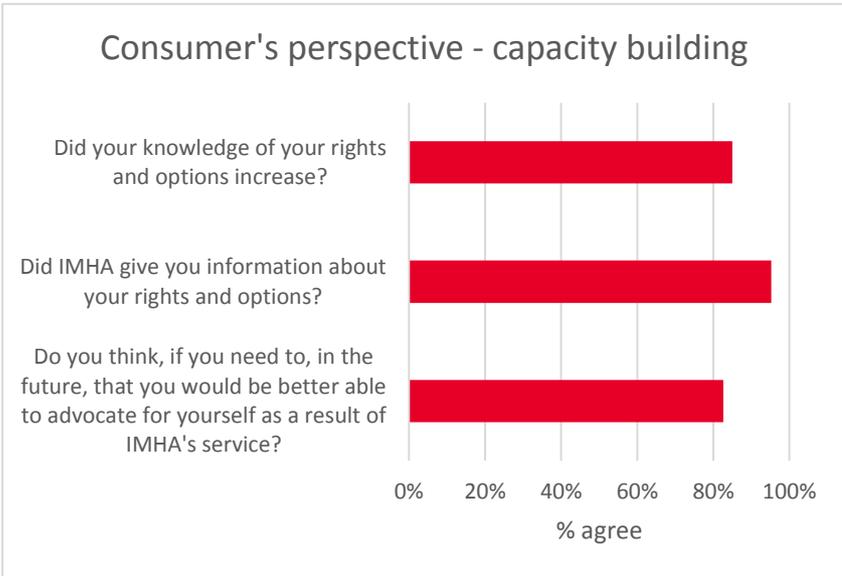


Figure 3 – Consumer's perspective – capacity building (online survey (n=22))



preferences'.¹¹ Qualitative responses offered a more complex story, as some consumers noted that their ability and confidence to self-advocate can vary over time. Others pointed out that it was not just about advocacy skills, but the openness of treating teams to the accommodation of individual preferences. Power and status were important factors in an individual's ability to express their preferences and have those heard by mental health professionals.

This points to a tension between the instruction-based model, supported decision-making and improving self-advocacy skills. In one case it was observed that an advocate had encouraged a consumer to make a complaint on his own, to ensure that it was 'his words' and not those of the advocate. However, this consumer could not undertake this task at that time. Eventually, the complaint was completed using a combination of the consumer's words and the advocate's interpretation of the consumer's preference. This illustrates IMHA's attempt to follow instructions while ensuring it is not encouraging dependence on the advocate. This is consistent with a supported decision-making model that mandates that only as much support as is necessary is provided. Consumers recognised the value of self-advocacy but expressed a preference for representational advocacy in times of crisis and/or distress.

Mental health professionals did occasionally identify IMHA's ability to improve consumers' ability to self-advocate, although this was often difficult for them to assess because of the generally short periods they worked with people. IMHA has developed a self-advocacy model and resources which, at the time of writing, are being reviewed prior to implementation. This has the potential to support self-advocacy beyond IMHA's current reach and should be evaluated following implementation (Recommendation 13.1).

There are opportunities to support family, friends and carers to be advocates for people who are engaged with mental health services. This may give rise to conflicts of interest, as the preferences of carers and family members can often differ to those of the person receiving treatment and care. There is potential value to be found, however, in IMHA promoting the adoption of a rights-based model and supported decision-making by carers and family members. Stakeholder bodies consulted in the evaluation expressed support for extending the focus on self-advocacy to include family and carers. This presents an opportunity for IMHA to build capacity for advocacy within consumers' support networks in circumstances where independent advocacy is unavailable, such as in crisis situations (Recommendation 13.2), and improve awareness of IMHA in the community.

In spite of attempts to improve self-advocacy skills and the ability of interpersonal networks to provide support, it must be noted that independent face-to-face advocacy will remain necessary for many people given the complexities of the current mental health system and the often challenging circumstances they experience.

2.1.3. A relational model of advocacy

The IMHA model is further defined by a strong relational aspect. This requires advocates to develop relationships with consumers to enable supported decision-making, and with clinicians to ensure access and opportunities for advocacy. Advocates indicated that this model was required because the power to make treatment decisions continues to reside with the treating team. There was a tension identified by advocates

¹¹ Independent Mental Health Advocacy, *We're Listening – What Users of Our Services Have Told Us* (6 September 2017) <<http://www.imha.vic.gov.au/about-us/news/were-listening-what-users-of-our-services-have-told-us>>. Ibid.

between the importance of relationships with treating teams and the need to challenge their decisions based on the preferences of the consumer they were advocating on behalf of. There was a concern that this real or perceived conflict with clinicians might limit their ability to advocate for consumers in the future. Advocates indicated that they would generally sacrifice relationships with clinicians to resolve this tension,

which can work both ways, with consumers generally preferring an advocate who has a close working relationship with the treating team. Focus groups were asked about this issue and strongly identified a preference for an advocate who was independent but who had good relationships with the treating team.

The need for advocates to work closely with the treating team was recognised by consumers, who did not identify issues of perceived bias by their advocates. This suggests that, from the consumer perspective at least, advocates have been resolving this tension successfully by clearly advocating on behalf of consumers while maintaining positive relationships with decision makers. This relationship building requires time and consistency of contact and is something that is challenged by the high turnover of staff within services.

For the most part, mental health professionals appreciated the relational model. Both advocates and mental health professionals indicated that within this relational model, advocacy could become quite heated without damaging relationships. Poor relationships, however, appeared to limit the potential for the provision of advocacy because access is dependent on these relationships. The evaluation did identify a number of situations where the relational model had broken down and the advocacy relationship had become adversarial, but it is important to note that while relational advocacy was appreciated by the clinical staff, consumers did not identify negative outcomes as a result of adversarial relationships. In some cases, the opposite was observed, with adversarial advocacy getting results that relation advocacy had not been able to achieve.

One area that the relational model did not extend to was relationships with families and carers. As noted above, the evaluation team identified the potential for IMHA to work with families and carers to facilitate the adoption of supported decision-making practices. This does not indicate a role for IMHA in directly supporting carers but indicates that IMHA might be well-placed to equip carers with tools or approaches. IMHA already has a strong relationship with Tandem, and further opportunities for collaboration exist (Recommendation 13.2).



2.2. IMHA’s Performance

The overall findings from the evaluation are overwhelmingly positive. All participant groups gave positive feedback and where areas for further development exist, they predominately relate to systemic issues which are beyond IMHA’s control, new opportunities for increased effectiveness, and resourcing limitations.

The evaluation found that IMHA was being implemented as intended, consistent with the establishing documentation, policies and procedures, program theory and logic model. IMHA staff demonstrated consistency with IMHA’s values of integrity, respect, person-centred, curiosity and reflectiveness. The central tenet of IMHA’s service – rights based representational advocacy – was consistently portrayed by advocates and valued by consumers. The IMHA model is generally consistently applied in practice across the IMHA regions by staff, with some variance that might be attributable to the professional backgrounds of advocates in those regions. Staff expressed a desire for more opportunities for integration, such as shadow shifts with advocates from different regions (see Recommendation 15.3).

Consumers received advocacy from IMHA around a broad range of issues, as detailed in Table 3. Assistance with discharge, participation in decisions, medication and treatment were most common, with a high demand for support for consumers before the Tribunal. Table 3 also highlights opportunities to increase assistance for consumers to link in with other services and other aspects of the Act, such as advance statements (see Recommendation 13.3).

Discharge	15%
Participation in Decisions	13%
Medication	13%
Treatment	12%
Mental Health Tribunal	9%
Second Opinion	6%
Leave	6%
Complaints	5%
Diagnosis	4%
Nominated Person	1%
Restrictive Intervention	2%
Advance Statement	2%
Change of Clinician	2%
Other	10%

Table 3 – Areas of Assistance – % of consumers

2.2.1. Program Theory and Logic Model

The evaluation process included a mapping of emergent findings against IMHA’s program theory, logic model and hierarchy of objectives, divided between system, service and consumer level objectives. These documents are not publicly available and are not included in this report.

In general, IMHA is performing consistently with this model, although many of the system level objectives are not able to be determined based on currently available data. The evaluation did not identify any areas where IMHA had not meaningfully attempted to achieve an objective, however, these attempts were not universally successful. Some objectives are clearly long-term and would not be expected to be measurable at this time. This was anticipated in the planning and establishment phase of IMHA, as the IMHA Hierarchy of Objectives states that:

The long-term objectives are aspirational and are not the lone responsibility of IMHA. IMHA will be making a contribution to enabling the long-term objectives related to mental health system change.

IMHA is clearly working towards these long-term objectives, but no discernible change in mental health system practice or culture, or a reduction in restrictive practices, or application of recovery-oriented practice could be identified by the evaluation team. IMHA’s objective of contributing to increased consumer satisfaction with public mental health care and treatment was assessed as not achieved on the basis that IMHA often had the



opposite effect, as increasing consumer’s awareness of their rights would decrease their satisfaction with the restrictions imposed as part of their treatment. The barriers to achieving these systemic objectives are central to IMHA’s performance, and as such within the scope of the evaluation and are detailed in this report.

IMHA’s objectives were generally achieved across the service level with key performance indicators exceeded, the development of strong relationships with other services and the successful demonstration of the value and effectiveness of the IMHA model. There is still work to be done in making other services aware of IMHA and ensuring that mental health professionals understand the IMHA model, and IMHA is resolving issues related to data collection.

As a result of contact with IMHA, consumers identified an improvement in their self-advocacy skills, an increased sense of having their views and preferences respected, a greater sense of control over treatment and recovery, and generally felt they had received less restrictive treatment. Where this had not occurred, consumers were quick to locate responsibility with the mental health services and rarely blamed IMHA.

IMHA’s ongoing performance monitoring framework should include the development of an ongoing *Hierarchy of Objectives* and revised logic model (see Recommendation 16.3), and regular transparent reporting to DHHS on performance against those objectives (see Recommendation 16.1).

2.2.2. Key Performance Indicators

As Table 4 shows, IMHA has exceeded key performance indicators for service delivery to date.

Service Type	Key performance indicator	Total Services 1 Sep 2015 to 31 Aug 2016	Total Services 1 Sep 2016 to 31 Aug 2017	Total Services 1 Sep 2017 to 31 Aug 2018
High Intensity <i>(advocacy/Coaching for self-advocacy, debriefing)</i>	2400	4534	6958	8565
Low Intensity <i>(information, referrals)</i>	7500	7647	13048	17486

Table 4 – IMHA Service Delivery by Service Type, 1 Sep 2015 to 31 Aug 2018

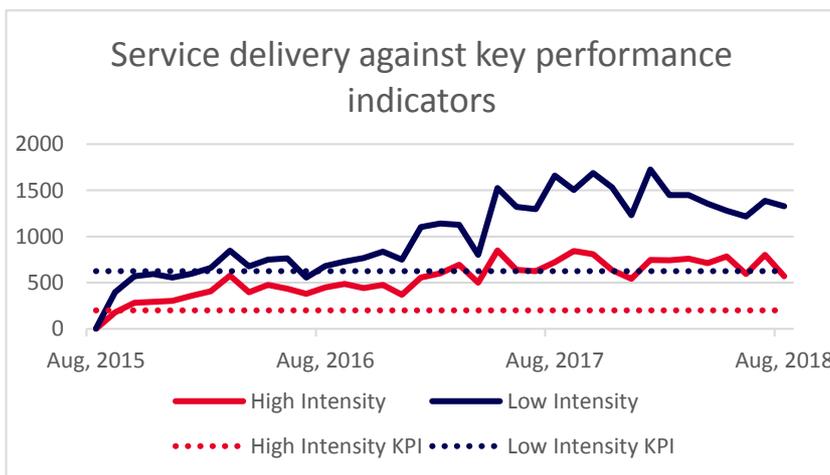


Figure 4 - IMHA Service Delivery KPIs Aug 2015 to Aug 2018

As Figure 4 illustrates, IMHA began to meet these targets in its first few months of operation and has continued to exceed them over time. These targets may have been appropriate for a new service, but now may now be more usefully recalibrated to reflect strategic targets, such as increasing support in the community (see Recommendations 16.1 & 18.1).



With IMHA clearly exceeding its agreed performance indicators, this evaluation has focused on service quality and distribution rather than quantity.

2.2.3. Demographics and representation

What data was available indicated that IMHA has been reaching a demographically representative population. Binary genders were evenly represented, although data was not consistently collected for gender diverse communities.

Figure 5 suggests that IMHA has been reaching adults aged under 65 more successfully than younger or older people. This is likely to be a function of the lower rates of compulsory treatment in those groups. Professionals who worked with older or younger people reiterated the need for advocacy for these groups, and anecdotally it appears that IMHA is responding to this need. Aboriginal and Torres Strait Islander consumers were roughly representative, consisting of 2.3% of mental health services

consumers and 3% of IMHA's consumers, although 35% of IMHA consumers were not asked or did not state if they identified as Aboriginal or Torres Strait Islander. Aboriginal and Torres Strait Islander people constitute 0.8% of the population of Victoria.

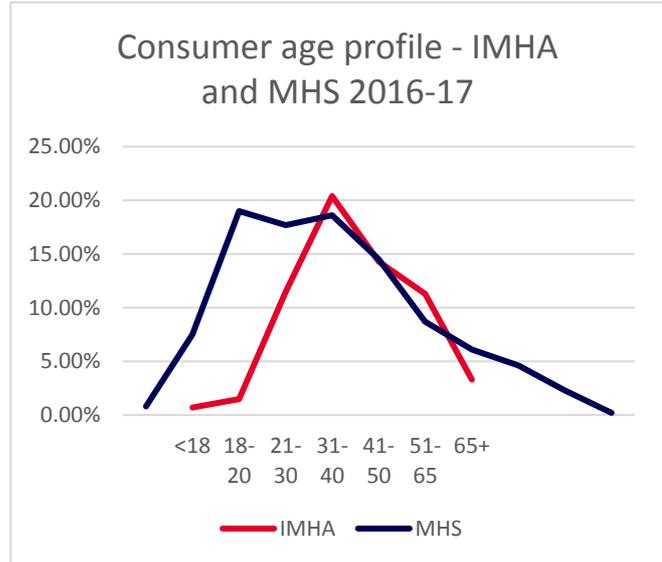


Figure 5 – Consumer age profile – IMHA and MHS 2016-17

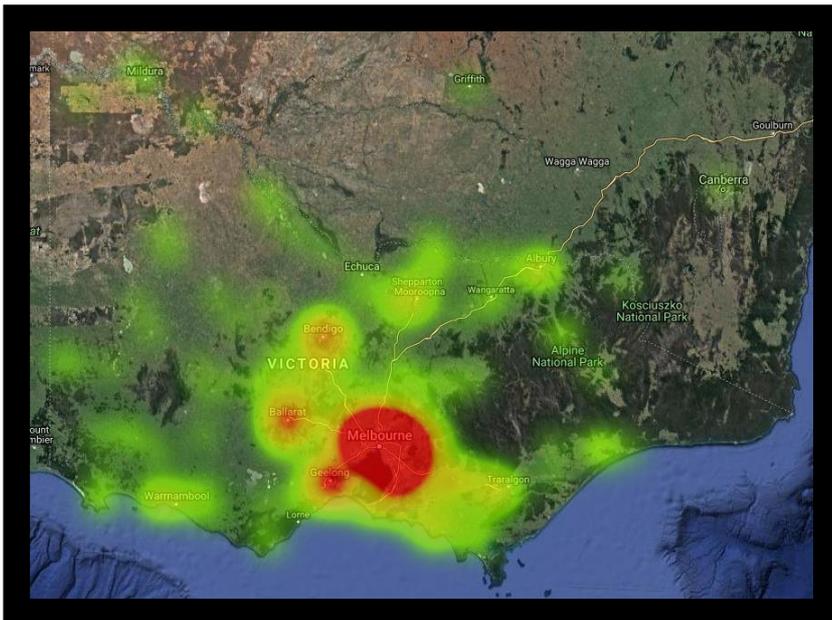


Figure 6 – Geographical spread of people using IMHA (heatmap)

Geographically, IMHA was distributed as expected, clustered around major population centres but with reach across the state, as illustrated in Figure 6. For other specific groups, including people who are homeless, receiving Electro-Convulsive Therapy (ECT), are at risk of family violence or people subject to seclusion and restraint comparative data were not available.

What limited quantitative data was available indicates that IMHA is providing more services than originally expected to a roughly representative consumer population.



2.2.4. Satisfaction with IMHA

All participant groups who had encountered and interacted with IMHA gave overwhelmingly positive feedback to the evaluation team. Consumers gave the most praise of IMHA, with more than one person telling the evaluation team that ‘IMHA saved my life’. One consumer noted:

IMHA, yes, I think in a way they represent some hope. Especially when you’re isolated. And I think that is in itself a good thing. If you have that, you know, that spark there of someone’s listening to me in a rational way. And seems to be wanting to help. Then that’s a big thing. And then of course, if they follow it up and they can help it’s even better. (FG2 C4)

This experience was nearly universal, but there were a few exceptions. One consumer, who was extremely happy with one advocate, was unimpressed by another advocate she had originally been assigned:

The second one, he listened. He tried to understand. I believe that the first advocate dismissed what I was even saying. She just, ‘Oh, you must be crazy. You’re in here’ sort of a situation. That’s what it made me feel like. (C3)

This quote highlights how the representational advocacy model requires unfiltered respect for the person’s perspective. This was only part of what people valued about IMHA’s approach. This consumer shared what made her IMHA experience positive:

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. ... she didn’t make assumptions about what I needed and tell me what I needed. She asked me. ... 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. (C2)

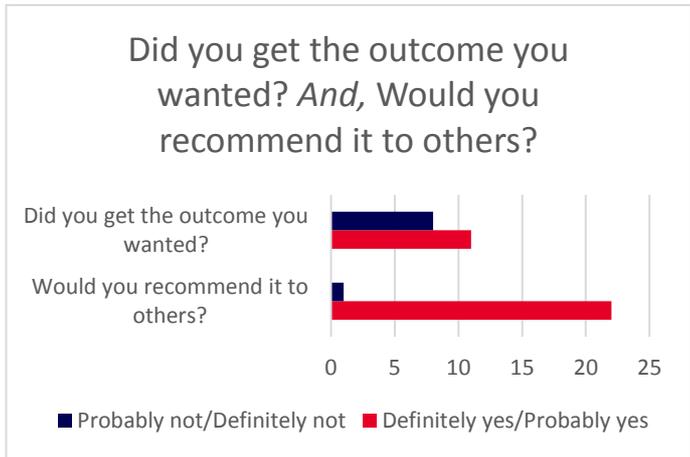


Figure 7 - Did you get the outcome you wanted? And, Would you recommend it to others? (online survey (n=22))

The praise consumers heaped on IMHA seemed unrelated to any actual change in their treatment. This is not to suggest that IMHA did not achieve changes in treatment for consumers, but even when they were unsuccessful their presence was still highly valued by consumers. Irrespective of the outcome, consumers appreciated having an advocate present. Figure 7 illustrates that consumers overwhelmingly would recommend IMHA to others, despite not always getting the outcome they wanted.



The value of IMHA for consumers was also frequently identified by mental health professionals. This overall positive view of IMHA was reflected in the quantitative survey data, shown in Figure 8, although only for mental health professionals who had worked directly with IMHA either by referring someone to IMHA or having direct experience of IMHA’s advocacy. This indicates that IMHA is held in high regard by those who had contact with it, but this reputation does not extend far beyond those individuals.

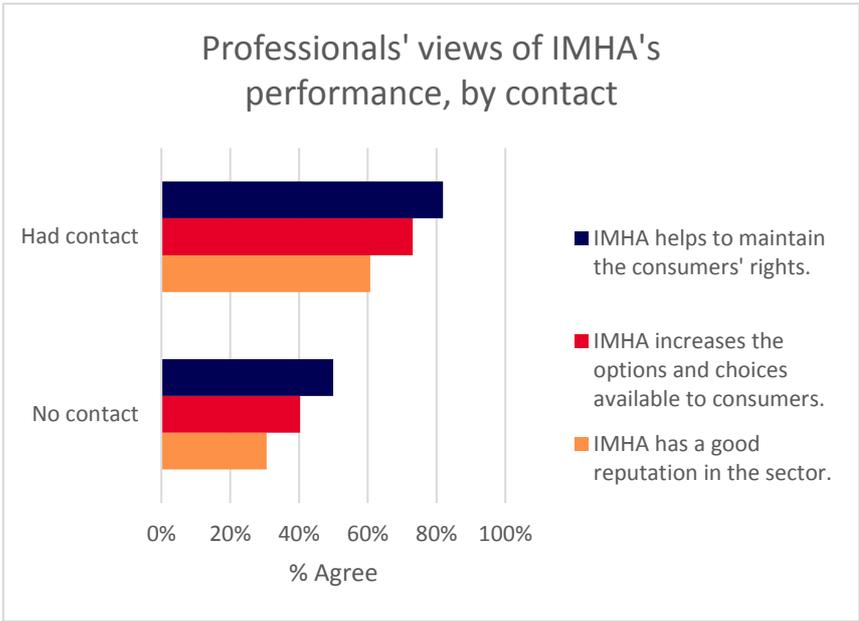


Figure 8 – Professionals' experience, by contact (online survey (n=188))

IMHA cannot be said to have a good reputation amongst professionals in the sector who had not had direct contact with an advocate. Those who had contact with IMHA were twice as likely to agree that IMHA had a good reputation. This is a positive sign, indicating that an encounter with IMHA leads to a positive impression.

Also of note is that while IMHA is recognised as successfully maintaining consumers’ rights, it is viewed as less successful at increasing options and choices.

There were some areas where mental health professionals did not reinforce the positive image outlined by consumers. This includes IMHA’s work to build capacity to self-advocate, as shown in Figure 9, or in the work IMHA does at the systemic level, as discussed below. Ambiguity around capacity building is largely attributable to the viewpoint of mental health professionals, who often did not work with people for long enough to see a change in their self-advocacy skills.

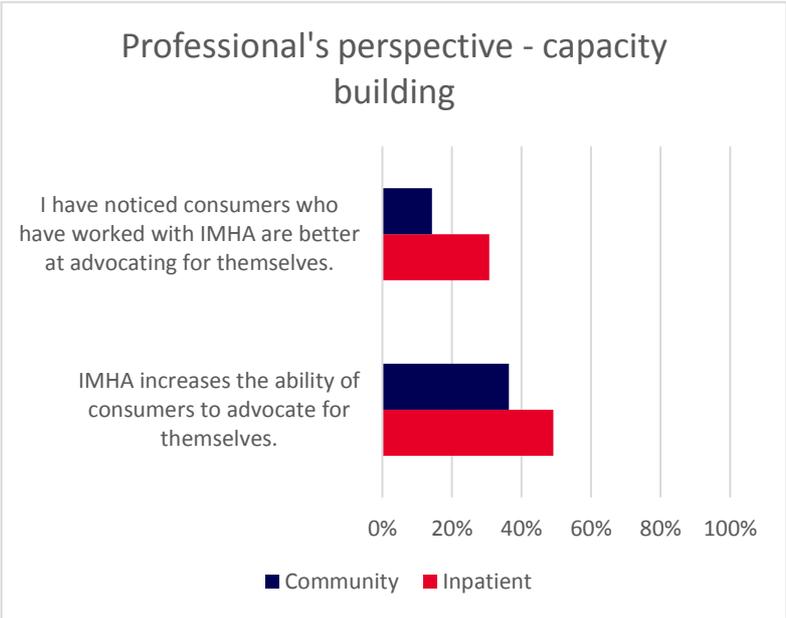
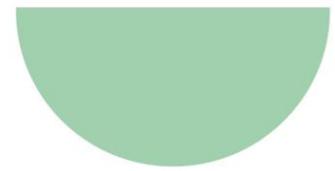


Figure 9 – Professional's perspective – capacity building (online survey (n=188))

Where mental health professionals did raise issues with IMHA, they were mostly related to a misunderstanding of the model or rare examples of the IMHA advocates not complying with the model. For instance, one junior doctor, who strongly supported instruction-based advocacy and had worked well with advocates in other services, reported that one advocate did not allow the consumer to speak, which prevented an assessment of the person’s mental state. This appears inconsistent with the IMHA model, which is focused on



promoting the consumer voice. Alternatively, it may be that the consumer requested the advocate speak on their behalf, which would be consistent with the representational model, and highlight the importance of communicating the nuance of the model so that the doctor had understood this.

A consultant psychiatrist told the evaluation team that when the relational model broke down and the advocate adopted an adversarial stance this caused problems for consumers:

Overall it has been favourable to see consumers being supported with advocacy, and some helping the consumer to better re-frame their difficulties. Unfortunately, on occasion, there has been an adversarial stance taken by consumers on the instigation of an advocate – to the detriment of the therapeutic relationship with the treating team and the mistrust with the support being offered for the recovery journey. Fortunately, these have been isolated events. It will be uniquely enriching for the consumer when advocacy through IMHA support can work collaboratively with the treating team on a consumer’s recovery journey and not take up an adversarial stance. (SR147)

This quotation draws attention to a fundamental difference between the best-interests approaches taken by treating staff and the instructions based approach taken by IMHA. This is the most significant barrier to IMHA’s success and the most important reason for it to be accessible to all who require advocacy. Without IMHA to intervene, many consumers will continue to experience disempowering and discriminatory treatment and care. The reform agenda initiated by the introduction of the Act in 2014 is, as yet, incomplete. Building on and expanding this understanding, the evaluation team considered other specific issues which require action for IMHA to be successful in supporting this reform agenda.



2.3. Other Specific Findings

In addition to assessing IMHA's performance, the evaluation team identified key issues regarding IMHA's ability to succeed and for ensuring the success of IMHA into the future. These issues arose in response to the key evaluation questions of effectiveness, efficiency and sustainability. These include the challenges inherent in the context of the mental health sector, ensuring access to IMHA, IMHA's scope, systemic reform, data and documentation and resourcing constraints.

2.3.1. Challenges of Context

The IMHA model must be considered in the context it operates within. A number of issues were identified in the spaces IMHA is working in, including a disregard for rights, the tension of representational advocacy in best interest services, professionals' attitudes towards advocacy, sector knowledge and understanding of IMHA.

Disregard for rights

The evaluation team identified persistent and consistent breaches of peoples' rights and breaches of the Act, from failure to provide people with Statements of Rights,¹² to failure to involve people in decision-making processes,¹³ and the unlawful detention of consumers who were not subject to an order. The detention of people who were voluntary was commonly acknowledged by mental health professionals and, at times, identified as an issue. Mental health services are required to provide consumers with information about their rights and to explain that information to them.¹⁴ Consumers consistently identified that this was not occurring and when pressed were consistently not able to articulate their rights of appeal or to be involve in decisions. This supports the need for IMHA in this context.

Having established that consumers felt advocacy was necessary, the evaluation team sought to determine attitudes to advocacy amongst mental health professionals.

Situating representational advocacy in best-interests mental health treatment

The evaluation identified the main barrier to the acceptance and success of IMHA was a disconnect between the representational model adopted by IMHA and the best-interests approach dominant in contemporary mental health treatment in Victoria. Many mental health professionals did not see the value in repeating what consumers were saying, as they had already heard what the consumer was saying, sometimes many times. These professionals viewed advocacy as potentially degrading the therapeutic relationship and creating unnecessary work for clinicians. This was central to the issues mental health professionals raised with IMHA. They wanted IMHA to take a 'common sense' approach, and act in the best interests of the consumers. Professionals who raised opposition to IMHA generally did not appreciate how important it was to consumers to have someone to listen to them and act for them without judgement. Even consumers who later agreed that what the advocate supported them with was not in their best interests still preferred the representational model.

IMHA cannot solely be responsible for providing education on the value of representational advocacy and the importance of autonomy as central to the recovery model. Mental health services are responsible for the

¹² *Mental Health Act 2014* (Vic) ss 12-13.

¹³ *Mental Health Act 2014* (Vic) ss 11(c).

¹⁴ *Mental Health Act 2014* (Vic) ss 12, 13.



training and development of staff and must work with IMHA to create environments in which advocacy can flourish with a view to creating environments where it is not required at all (Recommendation 8).

Mental health professionals’ attitudes toward advocacy

The evaluation team sought to chart the cultural and attitudinal barriers of professional mental health staff to IMHA. This was done by mapping understanding and attitudes to advocacy using a model developed through the evaluation of IMHA in England, shown in Figure 10.

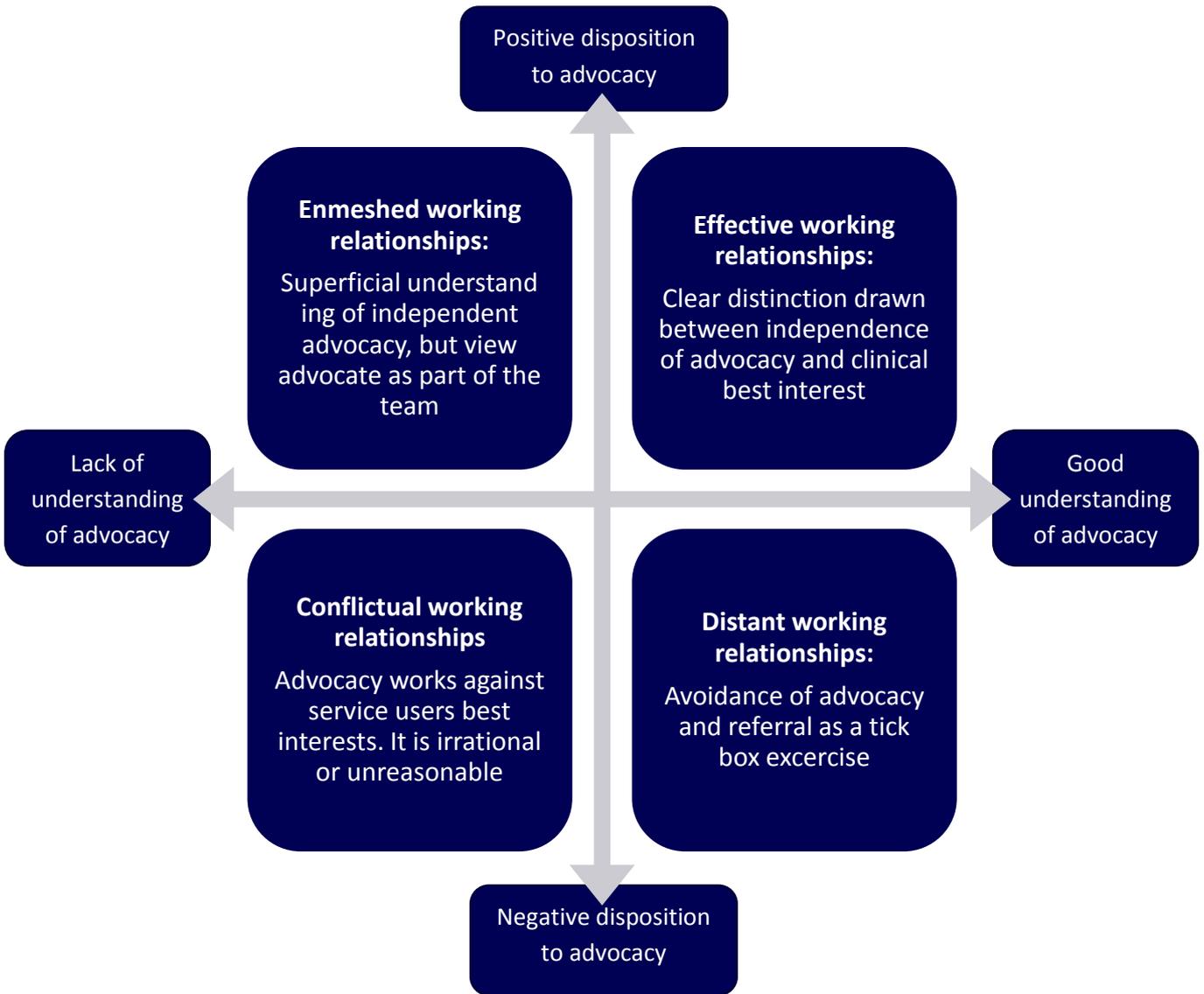


Figure 10 – Understandings of and Dispositions to Advocacy¹⁵

In general, the evaluation team found that advocacy was more successful when clinicians had a good understanding of the representational model. Of the 65 mental health professionals interviewed, there was a significant degree of variability in understandings of advocacy, with the majority of clinicians not comprehending the representational model. Despite this, clinicians overwhelmingly expressed positive

¹⁵ Newbigging et al, above n 2.



dispositions to advocacy. This suggests that change is possible and illustrates the need to provide education about advocacy rather than the more difficult task of changing attitudes. Consistently, the evaluation team found that clinicians were much more positive towards IMHA when they had the model explained to them. Altering attitudes to advocacy will require a cultural and systems-level change, which requires both an increase in advocacy and sector leadership. Compulsory training, particularly around supported decision-making, will address this to some extent (Recommendations 2 & 8).

Some mental health professionals readily accepted IMHA and opted to work with advocates to achieve reform. These staff valued IMHA because they felt they did not have the power to achieve change from within the service. This was particularly the case for allied health professionals who disagreed with the decision of the medical team or legal decision-making body. Nurses, social workers and peer workers all consistently identified using IMHA strategically to support and supplement their own advocacy. A peer worker noted that IMHA had more confidence to 'push back' where they would not be able to:

I have a good working relationship with everybody on the ward no matter what level, but I still don't have the confidence to sort of push back onto huge, big things. ... When someone comes in who does not work on the ward and has those difficult conversations with the doctors and then can walk away again, I think in terms of my professional relationship, I don't know if mine would maintain that. (MHP65)

Other mental health professionals did not share this view of advocacy, such as a psychiatry registrar who felt dealing with IMHA was an imposition on their limited time:

... from the frontline clinician perspective the IMHA appears to be another drain on clinical time, requiring a lot of liaising, and extending the length of interviews. This raises the problem of equitable access – those who have not accessed the IMHA (and carers) are then affected by the increased time I have spent with people who have IMHA involvement. (SR258)

Similarly, a consultant psychiatrist complained about the 'verbatim' nature of representational advocacy, suggesting that an advocate's role was to convince the consumer of the benefits of the proposed treatment. A different consultant psychiatrist told the evaluation team that 'advocacy doesn't add value' as he already knew what the consumer wanted, and that 'advocacy needs to challenge the patient'. This psychiatrist also believed that consumers were well aware of their rights and did not need IMHA to explain them. This opposition or indifference to advocacy was in the minority, although the evaluation team heard this repeated at all services, and from all professional groups.

In general, the evaluation team found that where IMHA was well known and well understood, it was well used and well appreciated. Much more work remains to be done in this area (Recommendation 19). Unfortunately, the evaluation team also found that awareness and understanding of IMHA was uneven across the sector, as shown in the following two sections.



Sector knowledge of IMHA

The evaluation identified that awareness of IMHA across the sector was low. Service promotion in the Victorian mental health sector faces significant barriers, including high rates of staff turnover, fractured and decentralised service provision and a diverse and regularly changing array of similar services. In England, IMHA services were still experiencing promotion issues many years after implementation,¹⁶ therefore this finding was not unexpected. The issue has been compounded by IMHA’s decision to focus on the inpatient setting rather than the community setting. This focus has resulted in much better awareness of IMHA in inpatient units, as detailed below.

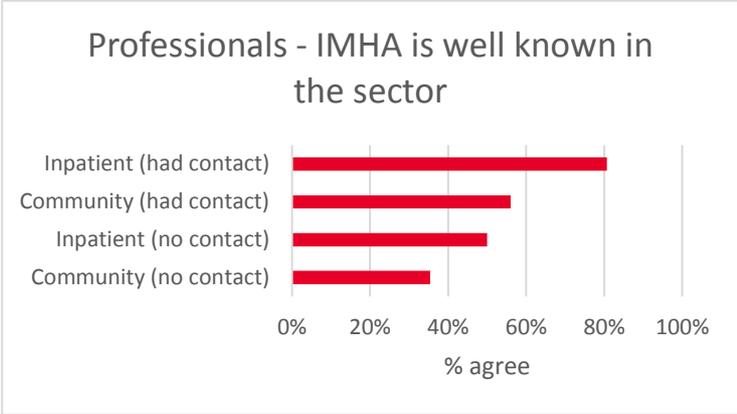


Figure 11 – How well known is IMHA, by contact (online survey (n=188))

Figure 11 indicates that amongst professionals who had interacted with IMHA, it was well known in the sector. The opposite was true of professionals who had not. Knowledge of IMHA is higher in inpatient settings than in the community. This was reflected in the qualitative data, particularly amongst nurses and administration workers who had the most contact with consumers but who would rarely be the target of IMHA advocacy. This appears to be a missed opportunity to increase access (Recommendation 19.2).

This advocate’s assessment correlates with the data in Figure 11, illustrating that this is an important issue for IMHA to address:

Well, I think outpatient you’re looking at probably 30% knowledge, I think it’s lacking. I mean I call people and they say yes I know, but I’m probably calling the same people. Like there are probably clinics out there that don’t know much about IMHA. Inpatient I think would be a lot higher. (A3)

The high turnover in the sector exacerbates this issue, and IMHA is not sufficiently well promoted to ensure that new staff are aware of the advocacy available. The turnover of staff within the sector is a difficult issue for IMHA to address, as it is an unavoidable aspect of the mental health system. IMHA can address this by working with services to ensure that all new staff are briefed on IMHA’s role, and mental health services can ensure IMHA is featured in training for new staff (Recommendation 2). IMHA are included in staff orientation in some, but not all, mental health services.

Sector understanding of the IMHA model

Consumers had an immediate comprehension of the representational model, with all consumers who were asked being able to articulate this, usually as being ‘on my side’. For consumers, it was a very straightforward arrangement. This consumer said:

My expectations were that the advocate would listen to my concerns, and liaise with my treatment team and present my concerns in a cogent manner. They did so, and I was of the

¹⁶ Ibid.

opinion that the treating team was much more receptive to my concerns when they were relayed by the advocate. They also treated me in a more civil and respectful manner when the advocate was present. (SR45)

Despite an understanding that the advocate was on their side, people were not always clear what an advocate was, or what they could actually do. One advocate noted:

Some people might not even know what the word, like what does it mean to have an advocate, you know. I get that question a fair bit. (A3)

Many consumers identified that processing any information while in extreme mental distress was very difficult. This consumer, who had worked with IMHA but had no recollection of it, noted:

I could imagine when I was in the [Unit], if my nurse opened the door – if I was involuntary, which I expect I was at the start – but, like I said, I don't remember – I wouldn't understand what IMHA is. If they told me that, I wouldn't understand whether I needed them or not. (FG1 C1)

When the distress subsided and the effects of medication did not interfere with comprehension, consumers were better able to understand IMHA's role. This comprehension did not extend to clinical staff and other stakeholders, many of whom had passing familiarity but only limited understanding of IMHA's role. One administration worker who had been referring consumers to IMHA for over a year was unable to clearly articulate IMHA's role:

... they're advocates. I don't know that much about IMHA to be completely honest with you. ... I know they're not legal representation. They're an advocate. I do know they help with explaining their rights and give them a lot of resources in relation to that ... I sort of know what to go to an IMHA person for if I need something, but I don't know her exact role, no. I don't know exactly what she does, what she can and can't do. That's a no. (MHP45)

Having someone 'on my side' was consistently identified as vital and important to consumers, but was overlooked by many professionals who would have preferred people to comply with their treatment. Significantly, the evaluation team often found that when professionals' understanding of the model was increased, either by IMHA or through explanation by the evaluation team, their apprehension and opposition to IMHA decreased. Advocates told the evaluation team they had worked hard to improve sector understanding of the model, yet there was still work to do (Recommendations 8 & 19).

2.3.2. Access to IMHA

Currently, consumers can get access to IMHA in three main ways: through inpatient unit ‘outposts’, referrals from mental health professionals or IMHA promotional materials. These three pathways often overlap, such as when services provide promotional material.

IMHA has made significant inroads into the inpatient setting, but in both inpatient and community settings there remains a concern that consumers who are

already best able to advocate for themselves are more likely to come into contact with IMHA, while those who have less developed advocacy skills may not. As Figure 12 illustrates, IMHA is providing support to people who require advocacy. Significantly, there remains a group of people eligible for advocacy who might not be aware of IMHA, may not be able to use the phone to call IMHA, could have a clinician, carer or other person discouraging or preventing access, or are experiencing significant barriers to effective communication. One psychiatrist noted:

... interestingly, a lot of the consumers who ask for IMHA, are also people who are already advocating for themselves. (MHP52)

This means IMHA must continue to work to ensure access, and should be adequately funded to reach those who find accessing support more difficult (Recommendation 3). An opt-out approach would also ensure access for many who are currently not able to do so (Recommendation 1.2).

Access in inpatient units

Advocates and consumers raised issues around the accessibility of IMHA within inpatient units. Advocates conduct outposts in all inpatient units across the state, usually once a fortnight but less often in regional areas. With the average stay in a general mental health inpatient unit being 8-9 days,¹⁷ a large number of consumers will not be present or may be on leave for the duration of the outpost. Advocates frequently reported issues with ensuring continued inpatient access, despite all mental health services signing a MoU or letter of agreement. Advocates and consumers identified issues with access to phones to call IMHA or access to interpreters.¹⁸ Consumers also identified that they often required advocacy out of business hours, or more urgently than is currently possible.

Increasing face-to-face access in inpatient units requires more advocates. Participants suggested that advocates should visit at least once every week, which would require doubling the current number of

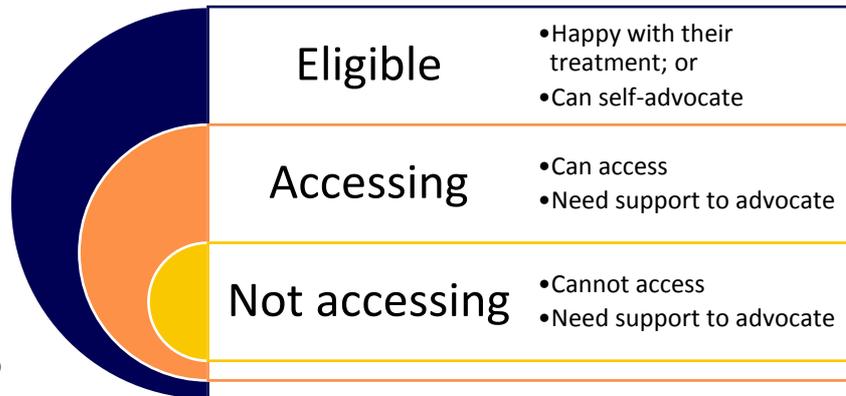


Figure 12 – Three levels of access

¹⁷ DHHS, ‘Victoria’s Mental Health Services Annual Report 2016-17’ (Department of Health and Human Services, October 2017) <<https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report>>.

¹⁸ This has been confirmed by other oversight bodies. See e.g.: OPA, ‘Community Visitors Annual Report 2016-2017’ (Office of the Public Advocate, 2017) <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/strategic-plans-and-annual-reports/community-visitors-annual-reports/442-community-visitors-annual-report-2016-2017>>.



advocates (Recommendation 3). An after-hours crisis line would require the allocation of further resources. (Recommendation 17.3). Access in inpatient units is also facilitated outside of the outpost by referrals from mental health professionals.

Referring to IMHA

Many mental health professionals interviewed regularly referred consumers to the service. The methods of, and reasons for, directly referring and recommending consumers to IMHA varied across sites and amongst professionals. Referring usually involved making IMHA materials available on request, but sometimes extended to warm referrals. Mental health services are commonly displaying IMHA materials, however, consumers reported not being aware of IMHA or IMHA materials until specifically directed to them. Many professionals encouraged consumers to contact IMHA themselves and helped to facilitate that contact. One nurse said:

We really encourage them to take that responsibility to contact [IMHA], [their] number is up on the wall everywhere and we facilitate it if we need to. (MHP1)

Other mental health professionals described contacting IMHA on behalf of consumers or would recommend that the IMHA advocate contact particular patients during an outpost. Some professionals shifted between both methods depending on the needs and concerns of the individual consumer at the time.

Table 5 illustrates that referrals to IMHA are largely self-referrals, with only a limited number of referrals coming from key bodies, such as the MHCC, OPA Community Visitors and the OCP. These figures suggest there is an opportunity for IMHA to work with these organisations to increase referrals. IMHA encourages consumers to self-refer but does not collect data on where consumers first hear about IMHA. It could be that many of the self-referring consumers may be coming from these organisations. This would account for the absence in the data of organisations such as VMIAC and Tandem, who told the evaluation team they regularly refer consumers to IMHA.

Referral source	No. referrals
Self-referred	4087
Public health services	580
VLA	485
Mental Health Complaints Commissioner	31
Office of the Public Advocate	13
Office of the Chief Psychiatrist	1
Other	66

Table 5 – Incoming Referrals 1 Sep 2015 to 31 Aug 2018

Figure 13 indicates that incoming referrals from mental health services vary significantly over time. It is unclear why this is the case.

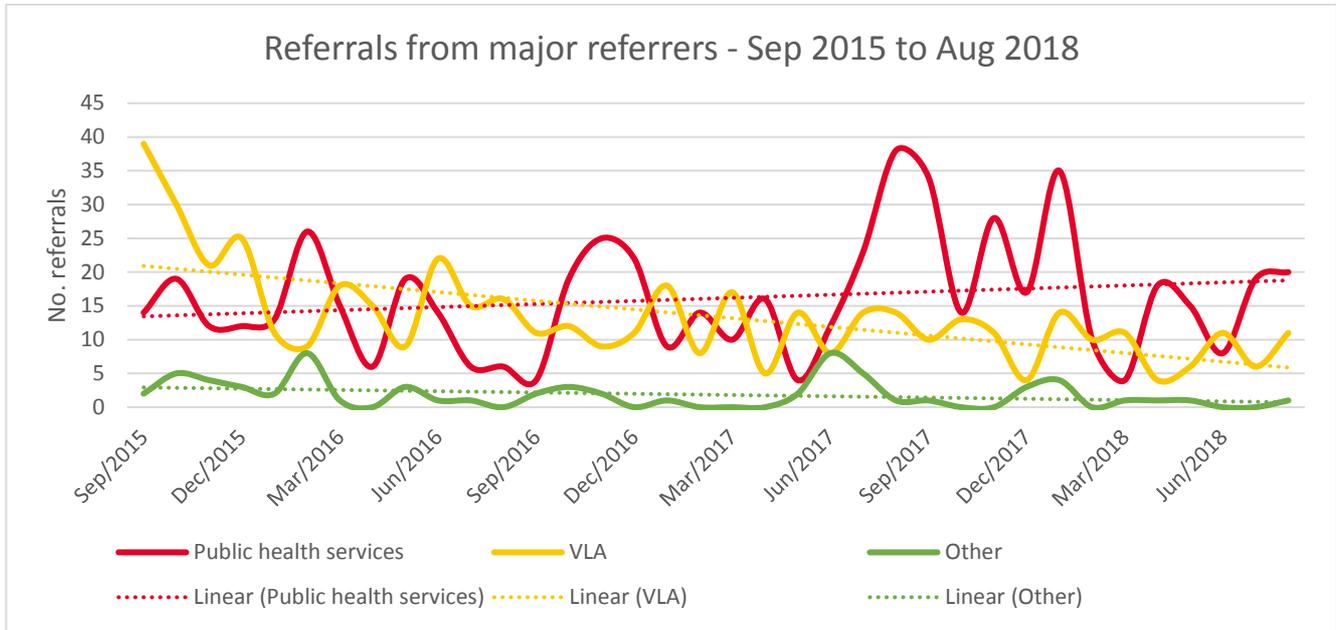


Figure 13 – Referrals from Major Referrers – Sep 2015 to Aug 2018 (excluding self-referrals)

The reasons for recommending and referring consumers to IMHA varied. The most common reason was consumer unhappiness with and concerns about compulsory treatment, wanting to be discharged, distress, lodging a complaint and the need for further support. Consumer concerns and anxiety about forthcoming reviews, Tribunal hearings and discharge also triggered referrals to IMHA.

It was clear that when mental health professionals were aware of and understood IMHA, they actively recommended and referred people. It is reasonable to suggest that raising awareness of IMHA and fostering good working relationships with staff will increase referral pathways and recommendations to IMHA (Recommendations 8 & 19).

Access in the community

Ensuring access to IMHA for people outside of the inpatient setting has proven difficult for IMHA and is a key area for further development. Consumers subject to Community Treatment Orders are less entwined with the system and may only have irregular contact with a case manager. In addition, the MHDL team, who are responsible for many incoming referrals, tend not to represent people at Community Treatment Order hearings due to resourcing limitations. This has created an environment where those who are most in need of advocacy in the community – those who are isolated, unsupported and who lack positive relationships with their treating teams – are those who are least likely to have access.¹⁹ Advocacy also has the potential to achieve more long-term goals post-crisis, when a person is living in the community.

The demand for advocacy within community-based settings was difficult for the evaluation team to measure, however, IMHA advocates identified this as a gap in their service provision. This gap was also evident in IMHA’s internal data. Figure 14 indicates that IMHA has consistently provided more services in inpatient settings, while the provision of advocacy within community-based settings has remained largely static.

¹⁹ This has also been identified as an issue for IMHAs in the UK. See: Newbigging et al, above n 2.

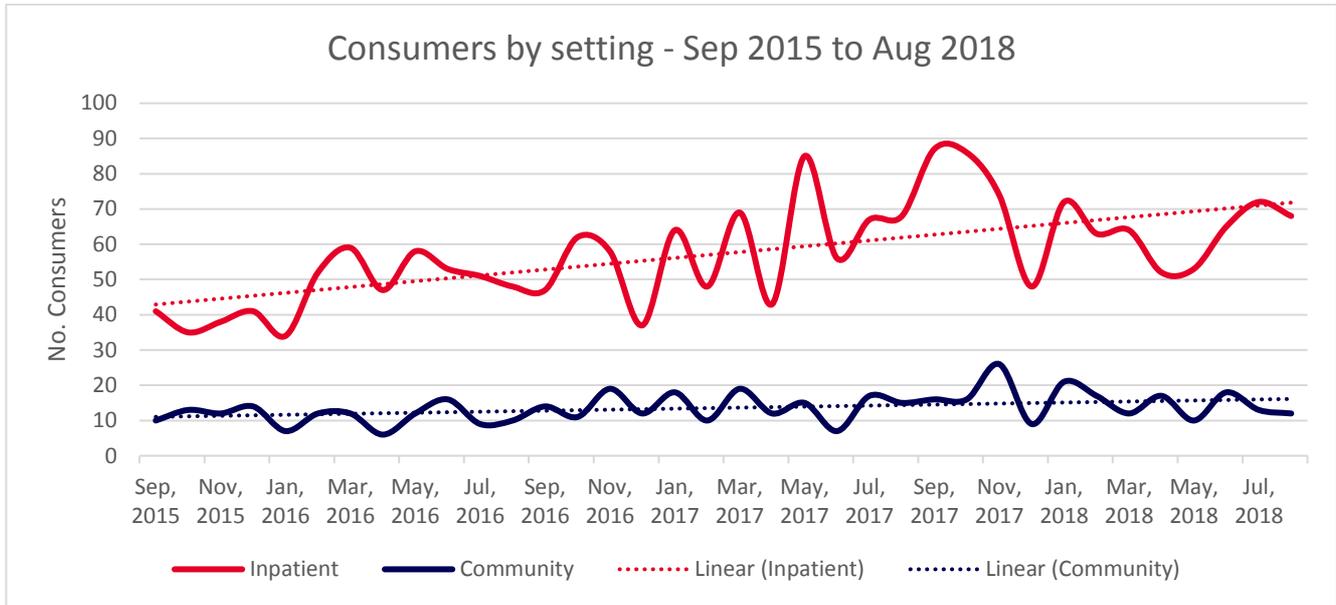


Figure 14 – Consumers by Setting – Sep 2015 to Aug 2018

Without being able to ascertain the number of people on Community Treatment Orders at any one time, it is difficult to assess the extent to which IMHA is meeting demand. Even if this data were available, advocacy needs are different in inpatient units, and providing advocacy in the community is more resource intensive. To determine what level of resources IMHA requires to meet community needs requires the identification and consideration of a number of unknown factors. To address this, the evaluation team employed a *Collaborative Outcomes Reporting* model and assembled a panel of experts,²⁰ including academic experts, a service provider, consumers, and IMHA staff to identify the potential need for advocacy in the community and how IMHA might identify and overcome barriers. It was noted by the panel that Community Treatment Orders are often experienced by consumers as disempowering and limiting choice and agency. The panel identified that people on Community Treatment Orders are in some senses hidden from view, in that they are subject to a level of coercion which is difficult to ascertain and has no physical structure. The experience of Community Treatment Orders as restrictive and disempowering is consistent with the literature examining the lived experience of those subject to such orders.²¹ A representative of a stakeholder body confirmed this:

I think, having worked with people who are on CTOs, they need advocacy... But I think the community sector don't know enough about IMHA because they just – they don't associate IMHA with somebody who is on a CTO. (S7)

²⁰ Jessica Dart and Megan Roberts, *Collaborative Outcomes Reporting* (2014) Better Evaluation <<http://www.betterevaluation.org/plan/approach/cort>>; Alice Roughley and Jessica Dart, 'Developing a Performance Story Report: User Guide' (Department of the Environment, Water, Heritage and the Arts, 2009) <<http://nrmonline.nrm.gov.au/catalog/mql:2162>>.

²¹ Lisa Brophy and David Ring, 'The Efficacy of Involuntary Treatment in the Community' (2004) 2(2–3) *Social Work in Mental Health* 157; K Canvin, A Bartlett and V Pinfold, 'Acceptability of Compulsory Powers in the Community: The Ethical Considerations of Mental Health Service Users on Supervised Discharge and Guardianship' (2005) 31(8) *Journal of Medical Ethics* 457.



The evaluation team consistently heard that advocacy is experienced positively by consumers because they feel heard and are provided with options. The few consumers who participated who were on Community Treatment Orders indicated that advocacy in the community would have similar benefits, although not necessarily outcomes:

I was in the community treadmill, so I'm still in. If they [IMHA] turned up at every meeting that I have with the psychiatrist ... I don't know whether it would be of benefit but I wouldn't mind them being there, to be honest with you, because, as I've said, it's part of witnessing what is occurring. (C3)

Based on the findings of the evaluation, existing literature and the expert panel, it is clear that advocacy for people on Community Treatment Orders would be effective and appreciated. IMHA are aware of this issue and have taken diverse and creative steps to address it. These strategies have included outposts at community clinics, education and information sessions for support workers and clinicians, and agreements with mental health services to include IMHA publications in notifications of Tribunal hearing letters. In the first three years of operation, IMHA completed 550 information sessions to 6692 staff and consumers, including many to senior teams by the IMHA Manager. Many of these have been in the community, or for community clinicians. IMHA have invested heavily in addressing this issue, although ongoing work is needed.

Similarly, IMHA has strong relationships with non-clinical mental health support services such as Neami, Mind Australia and VMIAC, consumer and carer support groups and peer worker networks. Increased engagement with these groups has the potential to increase referrals and knowledge of the service within the sector more generally (Recommendation 18.1). Stakeholder bodies expressed an eagerness to collaborate with IMHA to promote advocacy and increase referral pathways. It is also possible that consumers in the community may be better placed to participate in advocacy training sessions, including advance statement workshops, which could increase IMHA's presence in the community (Recommendation 18.1).

With demand high in inpatient settings and a perceived lower return on investment in the community, there is a strong argument for continuing to focus on inpatient settings, particularly given the potential human rights issues associated with deprivation of liberty. The only response that will maintain IMHA's current work in inpatient settings and improve access in the community is an increase in the number of advocates employed. Regional based staff indicated that additional advocates need to be more widely dispersed than the current IMHA regions, as consumers on Community Treatment Orders are not located in major centres in the way that inpatient units are. These could take the form of fractional appointments in existing VLA offices in Mildura, Shepparton, Horsham, Ararat, Warrnambool, Bairnsdale, Morwell, Ballarat and Sale, as well as existing IMHA offices (Recommendation 3).

Promotion

Despite many clinicians being supportive of and referring consumers to IMHA, there is a concern that clinicians who are least likely to engage in supported decision-making are also those who are least likely to engage with IMHA. Relationships with clinicians are fundamental to IMHA's ability to provide advocacy, but they cannot be relied on as the primary or sole avenue for access.

Current promotional materials such as posters and postcards are not working effectively for IMHA. As one consumer interviewed within an inpatient unit noted:

... it requires to have heard of it and go, 'Oh there's the poster'. 'Great, there's the phone number'. The poster itself isn't sufficient. ... when you're acutely mentally ill, poster on the wall's not enough. You need someone to be able to come to you and say, 'Hey, it looks like you're struggling with this. These are just some services. Here's some phone numbers you can call. Do you want me to get you a phone'? (C1)

Posters are also not guaranteed to stay in place. Four advocates suspected that IMHA posters were being removed by clinical staff, and clinical staff indicated that consumers sometimes remove them. In some services, posters were not permitted for policy reasons. Some consumers who had used IMHA did report that they had found out about IMHA from posters and flyers, so it is clear that this strategy is working for some consumers.

The importance of the timing of the delivery of information about IMHA and the packaging of information are central issues that need to be considered. Participants suggested that information needed to be delivered in different formats and at multiple points within a consumer's journey through the mental health system (Recommendation 18). The existence of multiple services adds to the complexity of the system and can be confusing, particularly when in combination with consumer distress, the effects of medication and possible competing priorities.

In person approaches were viewed as the most effective vehicles for promoting IMHA. Within inpatient units, running workshops with staff and consumers was one way of increasing awareness of IMHA. This strategy would need to be ongoing given the high turnover of consumers and mental health professionals.

Digital resources were another possible avenue for the promotion IMHA. The IMHA website had 34,343 hits in the first three years since launch. Visitors to the site mainly accessed pages outlining consumer rights, or how to access an IMHA advocate. Two-thirds of these visits have been from a computer with the remainder via smartphones and tablets, indicating the potential access in inpatient units. IMHA also has a social media presence and a newsletter, all of which are well positioned to promote the advocacy service further. This digital presence and the largely positive consumer experience of IMHA are significant resources that can be drawn on and should be harnessed in any future promotion of IMHA. Both consumers and mental health professionals felt that testimonials from consumers who had used IMHA would be powerful. Mental health services indicated they would be open to installing a digital display and collaborating with IMHA to produce content.

IMHA has begun developing digital resources, although consumers and advocates both identified further opportunities. Since the midterm review, IMHA has begun to develop videos to help mental health services promote IMHA to consumers, and has created an online referral form to facilitated web access (Recommendations 18.2 & 18.3). Web-based services are still developing an evidence base regarding their ability to facilitate help-seeking. There is some evidence that digital services appeal to people who are experiencing high levels of mental distress and who are in earlier stages of experiencing symptoms.²² These approaches should be viewed as supplementary, rather than replacing effective face-to-face and telephone

²² Debra Rickwood et al, 'Who Are the Young People Choosing Web-Based Mental Health Support? Findings From the Implementation of Australia's National Web-Based Youth Mental Health Service, Eheadspace' (2016) 3(3) *JMIR Mental Health* <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5016625/>>; Sylvia Deidre Kauer, Cheryl Mangan and Lena Sanci, 'Do Online Mental Health Services Improve Help-Seeking for Young People? A Systematic Review' (2014) 16(3) *Journal of Medical Internet Research* <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961801/>>.

strategies. These approaches are not a substitute for an opt-out system and would be required to supplement it.

As noted above, IMHA is currently developing and implementing a self-advocacy resource which will assist in the promotion of IMHA (Recommendation 13.1). This was not able to be included in the scope of this evaluation and should be assessed after implementation.

The responsibility for promoting the advocacy service is one that is shared between IMHA and the mental health services. The evaluation team visited some services where nearly every person was offered IMHA, and others where promotion was largely left to advocates when they arrived for outposts. IMHA must continue to work with services and there are opportunities for closer collaboration. One potential avenue is to formalise the way in which written material is provided by mental health services and the Tribunal (Recommendation 12). Another option would be to encourage services to include a question on access to advocacy in the *Your Experience of Service (YES) Survey* (Recommendation 9).

Compulsory notification

The most direct way to ensure people who are eligible for IMHA are provided with access is through the adoption of an 'opt-out' system, similarly to the model operating in Western Australia. In this model, all people who are subject to compulsory treatment must be contacted by an advocate within a specified timeframe of a treatment order being made. Consumers then have access to an advocate who outlines their rights under the Act and explains the available options to them. After speaking with an advocate, consumers are able to accept or refuse advocacy.

Consumers supported this model and identified access to independent advocacy as more important than privacy concerns. This model has significant resourcing implications. While the exact number of people subject to compulsory treatment at any one time is not made public, the adoption of an opt-out system would increase referrals and would quickly exceed IMHA's current capacity to provide advocacy. It is recommended that an 'opt-out' model be adopted, either legislatively or via the *Mental Health Regulations 2014*, and that IMHA be sufficiently resourced to provide advocacy for all who are eligible for and require it (Recommendations 1.1 & 1.2).

It is important to note that this would significantly increase access to IMHA, but would not capture consumers who are at risk of compulsory treatment or are detained unlawfully, or those who are on very short-term orders. A compulsory notification system would need to balance the importance of providing access to IMHA with pragmatic concerns. This balance would need to determine whether notifications should be made on the basis of Assessment Orders, when orders are varied to inpatient, or when they are renewed.

The most effective strategy would be to provide IMHA advocates with powers similar to Western Australian mental health advocates or Community Visitors in Victoria. These powers include the right to visit persons, inspect any part of a mental health service, make inquiries and copy documents and provide for criminal offences for people who interfere with the exercise of these powers (Recommendation 1.3, 1.4 & 1.5). This should be considered in reference to powers held by Community Visitors and enhance IMHA's current individual representational advocacy approach. IMHA should not replace the Community Visitors nor duplicate their role.

2.3.3. IMHA's Scope

Three key issues relating to IMHA's scope emerged through the consultation process: the ability to engage in non-mental health advocacy, advocacy for voluntary consumers, and the ability for advocates to support consumers at the Tribunal.

Non-mental health advocacy

IMHA currently focuses on advocacy within the clinical mental health system. This is consistent with the *Advertised Call for Submissions*, which stated that a feature of IMHA is that it relates to mental health treatment and care, not general advocacy. IMHA's policy states:

4.1 In addition, IMHA can only provide services where the assistance sought falls within IMHA's scope of service provision, principally being the provision of information, assistance to self-advocate or advocacy in respect of issues relating to a person's assessment, treatment and recovery.

The inclusion of recovery has been used within IMHA to broaden the areas around which advocacy support is provided. The policy also states:

(e) Recovery support services – While IMHA makes referrals to other services that support recovery, IMHA does not deliver recovery support services to Clients. For instance, Advocates will not directly contact landlords on behalf of Clients and will not assist Clients to complete forms to apply for housing or government benefits. Note: Advocates may provide advocacy for a recovery support service, such as a public housing agency, to support a Client to access their service and to actively assist them with a housing issue.

To some degree, this is at odds with consumer-directed representational advocacy that suggests that advocacy should be provided in whatever area consumers require, including housing or other areas. In practice, advocates generally did not advocate outside of the area of mental health when there was another professional able to provide that support. This meant that IMHA advocates would refer consumers to an NDIS advocate or contact a hospital social worker to encourage them to advocate on behalf of a consumer. If IMHA already has a relationship with a person, this process of external referral or indirect advocacy may not be the consumer's preferred option. Expanding the scope of IMHA, however, has negative implications for resourcing and role definition. Ideally IMHA would provide advocacy in line with consumer's needs, rather than being restricted to the mental health sector, however, IMHA's strengths lie in being a *specialist* mental health advocacy service. Any changes to the advocates' role should be considered with a view to increasing IMHA's presence in the community (Recommendation 18.1). This should not be to the extent that IMHA would be supplementing service delivery gaps that should be addressed by other services but may include more integrated relationships with those services to facilitate advocacy.

Advocacy for voluntary consumers

IMHA does provide support to consumers who are 'at risk' of being made compulsory. This is consistent with the evaluation's identification of a large cohort of people who are not subject to a treatment order but are restricted from leaving the inpatient setting. Consumers are presently reliant on mental health professionals identifying the issue, who then contact or recommend IMHA. These consumers are clearly eligible for IMHA's service but are not easy to identify, and would not be picked up by an opt-out system.

In addition to consumers who are 'at risk' of being made compulsory, there is also a clear need for advocacy for those who are voluntary and who simply want a better quality of treatment. The *Advertised Call for Submissions* excludes this group:

The majority of mental health Consumers ... are not in the target group for the IMHAS and will continue to access general support services.

The evaluation did not include the broader mental health consumer population in scope, as they are not eligible for IMHA. VMIAC has recently employed a number of advocates, however, it remains to be seen if they are resourced sufficiently to fill this service gap. Peer workers also provide advocacy to this group and are becoming increasingly common, although the latest available figures indicate only 18 employed in public mental health services across the state.²³ An expansion for IMHA to include voluntary consumers of public mental health services was raised in earlier studies of IMHA,²⁴ however, this is a service gap that should be filled by VMIAC, peer workers and other advocates.

2.3.4. Non-legal advocacy at the Mental Health Tribunal

The third question relating to IMHA's scope relates to the current policy position of IMHA staff not attending the Tribunal other than in exceptional circumstances. IMHA advocates are not lawyers and are not trained in interpreting the Act. Representation at the Tribunal is already very low in this jurisdiction at 15% in 2016/17, down from 19% the previous year.²⁵ IMHA advocates should not be used to fill this gap or replace lawyers at hearings where they are providing representation. This is consistent with the *Advertised Call for Submissions*, which states that:

It is anticipated that advocates would provide support to Patients at the Mental Health Tribunal only in exceptional circumstances. Advocate support should occur earlier with an emphasis on assisting the Patient to self-advocate. Alternatively, the advocate can refer the Patient to Victorian Legal Aid for legal advice and representation.

Despite this, consumers overwhelmingly indicated that they would prefer their IMHA advocate be able to attend hearings with them if they wanted them to. No distinction was made as to whether they would prefer non-legal advocacy to legal advocacy. In general, the responses indicated that consumers wanted more support at the Tribunal. This was reflected in consumer focus groups and in areas of assistance recorded by IMHA staff (Table 3). IMHA advocates, mental health professionals and stakeholder bodies were also generally supportive of IMHA advocates attending Tribunal hearings.

The evaluation identified that people before the Tribunal needed support and that IMHA advocates are well positioned to provide this. Neither the Tribunal nor the Act require advocates at the Tribunal to be legally trained. Staff and consumers suggested that the type and length of contact advocates had with consumers would mean that were well placed to provide advocacy and support at the Tribunal. Furthermore, the Tribunal environment provides opportunities for advocacy that might not be otherwise available, such as the

²³ DHHS, above n 17.

²⁴ Bennetts et al, above n 6.

²⁵ Mental Health Tribunal, '2015/ 2016 Annual Report' (Victorian Mental Health Tribunal, 19 August 2016) <<http://www.mht.vic.gov.au/wp-content/uploads/2016/10/MHT-2015-2016-Annual-Report.pdf>>.



opportunity to have a constructive, facilitated discussion with the treating team and to hold the treating team to account on behalf of the consumer.

Other participants raised concerns regarding the strategic implications of such a move. Replacing lawyers with IMHA advocates gives the impression of minimising the need for legal representation and reduces the strategic attempts by mental health lawyers to enforce legal rigour in Tribunal processes. There are also resource implications, issues around delineation of roles and the risk of engaging in unqualified legal practice. There are also lessons to be learned from the UK context, where the role of IMHA advocates at Tribunal hearings has been explored in depth.²⁶ As the main provider of legal advocacy at the Tribunal, MHDL is central to these considerations and should be included in any review.

An approach that sought to accommodate the widest range of consumer needs and preferences would be that each person appearing before the Tribunal have the option of having both an IMHA advocate and legal representative. Currently, levels of resourcing do not allow for this. Given the overwhelming support from consumers for IMHA advocates to be able to attend Tribunal hearings as standard practice, it is recommended that IMHA consider reviewing this policy and its implications (Recommendation 17.2). Any review of this policy should ensure that IMHA is not simply filling resource gaps left by other parts of the system.

2.3.5. Systemic Reform

A key tension in the IMHA model is the objective of system-level change and reform in the context of individual advocacy. This objective is focused on reducing restrictive practices, increasing self-advocacy skills and the reception of self-advocacy by decision makers, implementing supported decision-making practices and improving the quality of mental health care and treatment. In general, sector level data does not reflect immediate success in this area, with rates of restrictive practices including compulsory treatment, seclusion and restraint all fairly static. Despite this, IMHA is working hard for cultural change and sector reform.

Mental health professionals were asked whether IMHA had achieved systemic change within their three years of operation. Responses varied across inpatient units and professions, with many respondents noting that it was difficult to quantify or find specific examples of IMHA's impact. This difficulty was linked to issues and constraints within the mental health system as a whole. Many respondents highlighted the potential of IMHA to achieve systemic change and appreciated their independence. Raising awareness and education was an area where respondents felt that IMHA could have a positive impact.

This supported decision-making training is a key aspect of IMHA's systemic reform agenda. All executive directors of mental health services have agreed for IMHA to do this training in their services, but IMHA must be properly resourced to continue this work (Recommendation 2).

Many respondents felt that the presence of IMHA had a positive impact on workplace culture and practices, fostering greater accountability, reflexivity and transparency on the part of treating teams. One senior social worker felt that IMHA had made treating teams more accountable:

²⁶ Mental Health Law Online, *Practice Note: Role of the Independent Mental Health Advocate in First-Tier Tribunal (Mental Health) Hearings* (May 2011)

<[http://www.mentalhealthlaw.co.uk/Practice_Note:_Role_of_the_Independent_Mental_Health_Advocate_in_First-tier_Tribunal_\(Mental_Health\)_Hearings](http://www.mentalhealthlaw.co.uk/Practice_Note:_Role_of_the_Independent_Mental_Health_Advocate_in_First-tier_Tribunal_(Mental_Health)_Hearings)>; Mental Health Lawyers Association, 'MHLA Response to Draft Guidance on IMHAS' (11 November 2010) <<http://www.mhla.co.uk/news/mhla-response-to-draft-guidance-on-imhas/>>.

Holding us accountable through an external service. And there's not too much accountability here overall. We can have a patient here who isn't getting any active progress for years, and all of a sudden, once they decide, actually, 'No, I'm sick of this, I'm going to call a lawyer or whatever,' things can start moving pretty quickly. So it's important, I think. (MHP11)

Some professionals noted that IMHA helped improve the decision-making processes of services and treating teams. IMHA advocates were increasingly used by care teams to negotiate between consumers, care teams and management.

There was also evidence that IMHA was tipping the balance of power towards the consumer in some situations, which can be viewed as systemic change. Allied health staff often said they used IMHA's independent status strategically to challenge decisions made by management and consultants. One social worker viewed IMHA as a balancing force:

I certainly do see them as like a balance, like an external check I guess, checks and balances. Sometimes we can get in, working in the system, we can get frustrated with the way the upper management views our patients and the sort of stumbling blocks we get put in our way. I certainly see IMHA as potentially a good way to get around that. (MHP9)

Much of IMHA's impact at a systemic level is made by the IMHA Manager, who meets regularly with senior representatives from stakeholder bodies, clinical and non-clinical mental health agencies and DHHS, raising issues which require escalation by individual advocates. Building on this, there remain opportunities for VLA to engage in collaborative systemic advocacy with other organisations, particularly other oversight bodies. VLA has previously advocated for a group of representatives from each oversight body to be convened by DHHS to collaborate on systemic issues and provide feedback to the department. Other stakeholder bodies were in favour of this proposal (see Recommendation 3). Advocates provided a number of examples where working closely with other oversight bodies such as MHDL or MHCC had led to significant positive outcomes for consumers and changes within the broader system. IMHA has also participated in a range of projects and committees working to address systemic issues in the mental health system and provided advice on the use of supported decision-making, including membership of the SPOS Advisory Group.

Some Nurse Unit Managers identified a missed opportunity to provide feedback at the ward level. They indicated that they would appreciate regular written feedback on issues identified by the advocate during their outposts, similar to the way Community Visitors provide feedback. This feedback is currently provided by IMHA to mental health service executive management but does not appear to be reaching service level managers. A more direct method of feedback at the service level may be more appropriate (Recommendation 11).

IMHA's ability to engage in strategic reform through individual advocacy is limited by the limited legislative recognition of the program. In Victoria, consumers have a right to communicate with IMHA advocates but have no other statutory powers.²⁷ This is in contrast to the system in Western Australia, where the advocates are led by a Chief Mental Health Advocate and an annual report is tabled in Parliament.²⁸ The establishment of a Victorian Chief Mental Health Advocate or other statutory systemic advocacy role would give IMHA a formal place amongst other oversight bodies and increase IMHA's stature when dealing with the media and

²⁷ *Mental Health Act 2014 (Vic) s 16, Mental Health Regulations 2014 (Vic) reg 5A.*

²⁸ *Mental Health Act 2014 (WA) ss 348-378.*



stakeholders in advocating for systemic reform (see Recommendation 1.6). This does not automatically require a separate statutory body; much as the Community Visitors Program sits within OPA, IMHA can remain within VLA.

Statutory mechanisms for system reform

There are some missed opportunities for advocates to provide support to consumers so they are better able to use aspects of the Act that are meant to support systemic change, such as the making of advance statements, second opinions or complaints. The uptake of advance statements across the state is very low, at 2-3% of adult consumers of public mental health services having an advance statement.²⁹ There are also many reasons why a person would not complete an advance statement, such as disagreement about the presence of a diagnosis, levels of distress or the fact that they are not binding.³⁰ Consumers also reported being told by other consumers that advance statements are of no value.

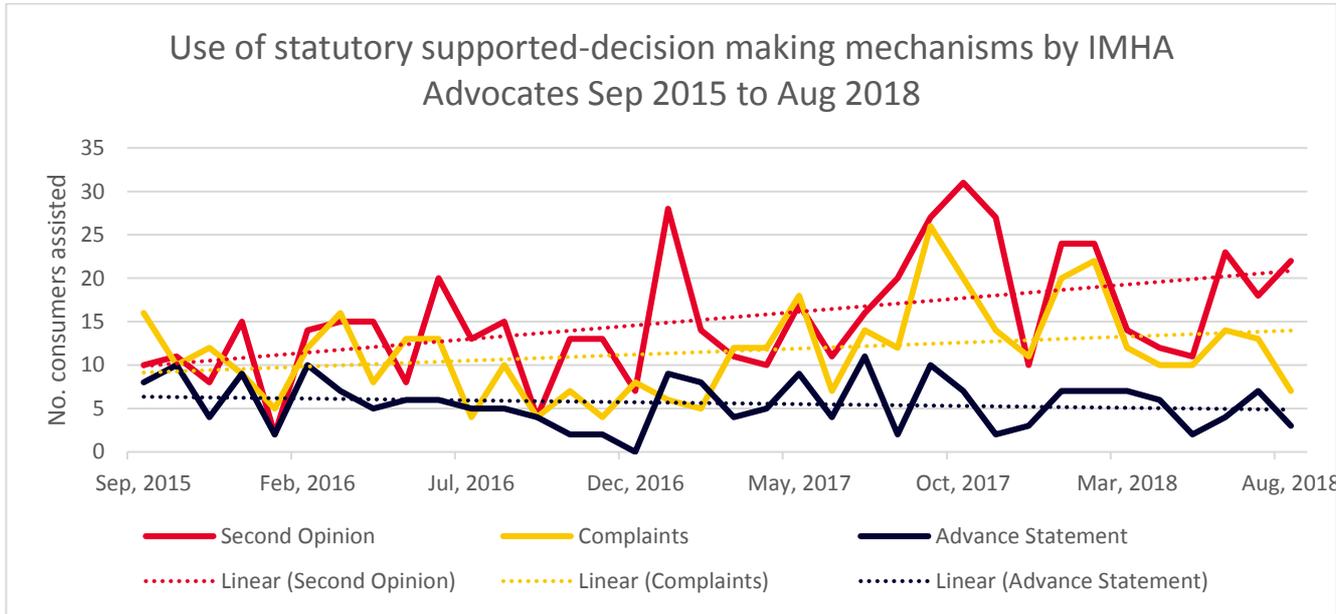
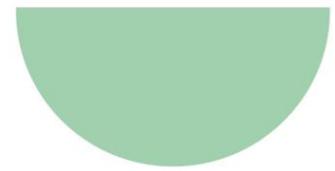


Figure 15 – Use of Statutory Supported Decision-Making Mechanisms Sep 2015 to Aug 2018

Figure 15 shows that while referrals to SPOS and the MHCC have increased over time, assistance with advance statements has decreased. SPOS was not available in all regions for much of the first three-year period, by the end of which 50-60% of referrals to SPOS were from IMHA, indicating good linkages in that area. The missed opportunities in supporting the development of advance statements were also identified in the qualitative data and IMHA files. IMHA consistently passed on information to consumers about advance statements and has developed resources for people to use, but often did not actually provide support to make one. A key aspect of the supported decision-making model is ensuring that people are provided with the supports that are required when they need them. IMHA is well positioned to increase uptake of advance statements if adequately resourced to do so (Recommendations 3 & 13.3).

²⁹ DHHS, above n 17.

³⁰ Maylea, C.; Jorgensen, A.; Matta, S.; Ogilvie, K.; Wallin, P., ‘Consumers’ Experiences of Mental Health Advance Statements.’ (2018) 7, 22 *Laws*; DHHS, above n 17.



Sector contribution to system reform

This evaluation focused on IMHA, however, all participant groups consulted during the evaluation reported that the rights of consumers are not consistently upheld. An experienced consultant psychiatrist, who had practised interstate and overseas, said that he had not received any training about the Victorian Act or been provided with information. This lack of understanding was not limited to decision makers, and included allied health professionals who would be expected to be able to communicate rights information to consumers. This lack of training and subsequent lack of understanding of the rights of consumers may in part explain the apparent disregard for consumers' rights outlined above (see 4.1.1). Addressing or influencing many of these issues is beyond IMHA's control or influence and responsibility must reside with the mental health sector more broadly. For example, in England, all decision makers must complete training on mental health legislation before they can subject a person to compulsory treatment.³¹ It cannot be IMHA's responsibility to provide basic rights and legal education to mental health services staff, yet that is what is currently occurring (Recommendation 2).

As above, the evaluation incidentally identified that the reform agenda of the Act is inconsistently applied in practice. This made assessing IMHA's contribution to that systemic reform difficult. It appeared that the sector was functioning in direct opposition to IMHA's goals. For example, sector reporting against the Mental Health Outcomes Framework requires that 'Services are recovery-oriented, trauma-informed and family-inclusive'.³² The reporting under this outcome has no relevance to recovery as it is defined by policy,³³ and instead focused on clinical recovery outcomes. This means that it is not possible to assess IMHA's objective to contribute to an increase in recovery-oriented practice (Recommendation 6). This not only contributes to the tensions outlined in 4.1.2 and 4.1.3 but means IMHA's attempts to engage in cultural change are stymied while the sector moves in a different direction. It is beyond the scope of this evaluation to map out a strategy for whole of sector leadership, although that is what is required.

2.3.6. Data and Documentation

Sector level data

Sector level data is so poor that it is not possible, using publicly available data, to determine how many people are subject to compulsory treatment in Victoria, and therefore eligible for IMHA on any given day. Previous studies have suggested that Victoria has the highest Community Treatment Order use in the country.³⁴ The IMHA Advertised Call for Submissions indicates that in 2012-13 there were 10,055 compulsory patients in

³¹ *Mental Health Act 1983 (Eng) s 12(2)*.

³² DHHS, above n 17, 48.

³³ Department of Health, 'A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers' (Commonwealth of Australia, 2013) <<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-recovgde>>; Department of Health, 'Framework for Recovery Oriented Practice' (Mental Health, Drugs and Regions Division, Victorian Government Department of Health, 2011) 34 <<https://www2.health.vic.gov.au/Api/downloadmedia/%7B62D4CFBB-6854-4652-ACDC-273D024B7A60%7D>>.

³⁴ Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478.

Victoria, but not how many of them were inpatients and how many were in the community. The Tribunal releases detailed data on orders it makes, however, neither Temporary Treatment Orders nor Assessment Orders are included in this data and no data are available which illustrate how long orders made by the Tribunal stay in force before they are revoked by authorised psychiatrists.³⁵ Departmental data indicates that in the 2016-17 financial year 11% of consumers receiving community mental health services were on a treatment order and 51.5% of inpatient admissions were compulsory, without specifying how many people this percentage relates to.³⁶ Reporting from health services indicates that 14% of adult consumers in the community were on Community Treatment Orders, with a lower percentage for aged consumers and a higher percentage for extended treatment settings, but still no total numbers and no data at all on other types of orders.³⁷ Figures also vary across the state without explanation, with the percentage of people on Community Treatment Orders ranging from 6% to 29%.³⁸ In addition, 2015–16 and 2016–17 public mental health services data collection was affected by industrial activity, specifically impacting community mental health data.³⁹ This makes evidence-based service planning and resourcing recommendations for IMHA very difficult.

Ideally, data would be readily available on the number of people who are subject to compulsory treatment and would include key characteristics such as age, gender, type and length of order etc. This data is collected by mental health services but not reported (Recommendation 7). In addition to reporting already collected data, it would be useful to include a question about access to advocacy on the *YES Survey* to track the commitment of services to ensuring access to IMHA (Recommendation 9).

IMHA internal data collection

As a new, non-legal service located within a legal organisation, IMHA has had to develop bespoke data collection and documentation processes. The new IMHA database promises to address many of the issues related to data collection, although some processes require further review, such as the data is collected inconsistently. For example, mental health services publish data in youth age ranges 0–4, 5–14, 15–24 and IMHA collects data in youth age ranges <18, 18-20, 21-30, making comparisons between demographic groups difficult. Mental health services report the percentage of consumers on an order for more than 12 months, whereas IMHA collects data on people continuously subject to compulsory treatment for more than three orders over the last two or more years. Other data collected by IMHA, such as the list of 1086 client outcomes by location or the list of 179 systemic issues raised with services, have insufficient detail to be usefully analysed (Recommendation 14).

There are also issues in the way data is collected by IMHA. For instance, many consumers do not have their Aboriginal or Torres Strait Islander status recorded. This is not simply a data collection issue. Aboriginal people have extra rights under the Act and under the Charter that IMHA is obligated to uphold. Similarly, gender diverse groups may require specific responses (Recommendation 14).

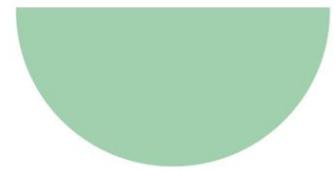
³⁵ Mental Health Tribunal, above n 25.

³⁶ DHHS, above n 17.

³⁷ DHHS, 'Adult Mental Health Performance Indicator Report 2017-18 - Quarter 4' (Department of Health & Human Services, 2018).

³⁸ Ibid.

³⁹ DHHS, above n 17.



IMHA reports quarterly to DHHS as part of its funding agreement and publishes these on its website. It is recommended that these reports are required to be tabled in Parliament, as is the case in Western Australia (Recommendation 1.6), and they are made more easily accessible on the IMHA website.

2.3.7. Resourcing

Without clear and accurate data on the numbers of people eligible for IMHA's service, the only indication of demand is the demand of consumers who have used IMHA's services. IMHA is doubling key performance indicator targets and some advocates are at capacity, yet this does not offer a complete picture of demand. The consistent experience of IMHA advocates is that when they do have the capacity to take on more work, they spend time promoting the service, which then leads to an influx of referrals that quickly absorbs their capacity. This has resourcing implications for community education, capacity building and other system reform aspects of IMHA's role. Another factor is that as IMHA has increased incoming referrals, advocates have by necessity resorted to more telephone advocacy. While telephone advocacy has an important role, relying on it to compensate for an increase in demand has ramifications for the quality of service IMHA provides. Both consumers and staff identified the importance of advocates attending treating team meetings and the value of face-to-face contact for building trust and rapport. Staff identified that providing face-to-face contact was difficult in areas distant from the IMHA offices, due to travel time and other resourcing constraints.

IMHA will only be able to meet the advocacy needs of consumers if the number of advocates is increased (Recommendation 3). At a minimum, IMHA needs to be present in inpatient units on a weekly basis, which would require twice as many advocates. To ensure access requirements in the community IMHA would require at least as many advocates again. If an opt-out system was adopted, advocates could spend less time ensuring access and service promotion. An opt-out system would require a significant increase in resourcing to meet increased demand.

A small number of consumers identified the need for advocacy outside of usual business hours, particularly in the evening and on weekends. This was usually in the context of admissions to emergency departments or attendance from the crisis assessment and treatment team (CATT). A crisis advocacy hotline would be valuable in providing on-demand advocacy to address this issue.

2.3.8. Other Specific Issues

Throughout the course of the evaluation numerous miscellaneous issues were raised by staff and consumers and have been fed back to IMHA management.

Consumers in focus groups indicated that they would have appreciated advocacy around basic items such as clothing and toiletries in inpatient units. This has also been raised as an issue by Community Visitors and offers an opportunity for joint advocacy, oversight and follow-up.⁴⁰

During the midterm review, the MHDL team raised a number of issues specific to their interactions with IMHA. Both MHDL lawyers and IMHA advocates noted excellent outcomes for consumers when they had worked well together. Both teams identified that these relationships were not consistently maintained across all IMHA sites, due to staffing changes and other organisational processes. VLA has implemented processes to ensure that this is addressed.

⁴⁰ OPA, above n 18.

Finally, IMHA's priority groups are too numerous and too unwieldy to provide an effective means of prioritisation and should be reviewed to ensure IMHA is focusing on consumers who are most in need of advocacy. This may require reforming priority allocation mechanisms around actual assessed need, rather than 'vulnerabilities' associated with population demographics (see Recommendation 16.2).

3. Conclusion

In conclusion, IMHA has proven very successful in an extremely challenging context. The evaluation consistently identified that mental health services are not operating in compliance with the Act, and IMHA has proven to be extremely effective at assisting them to do so. Consumers highly valued IMHA in the way it maintained their rights and also in the way advocates treated them with dignity and respect. Stakeholder bodies and mental health professionals who had worked with IMHA generally held it in high regard. For a service in existence for only three years, this is a significant achievement.

For IMHA to continue to be successful in maintaining the rights of people subject to compulsory mental health treatment it needs to be accessible to all who require it. This requires an opt-out system where every person who is eligible is offered advocacy, and an increase in funding to be able to provide services to all those who are eligible for IMHA.

This evaluation has shown that IMHA is essential to the maintenance of the rights of people who use mental health services. This is not IMHA's responsibility alone. In order to ensure that the rights of consumers are maintained, the sector must also take action. The various oversight bodies will need to coordinate and invest to ensure that services are operating in compliance with legislation that mandates recovery-oriented, least-restrictive treatment and care where people are supported to make their own decisions. The evaluation identified an enormous amount of goodwill in this regard, but little in terms of tangible outcomes or an improved experience for consumers beyond those directly supported by IMHA. IMHA is demonstrably working towards this goal but is hindered by inaction in some parts of the sector.



4. Recommendations

These recommendations have been developed in ongoing dialogue with IMHA. They represent the professional opinions of the evaluation team, based on rigorous analysis of evaluation data against the key evaluation questions and program logic model. IMHA is already making progress towards a number of these recommendations following the midterm evaluation report.

Each recommendation is referenced in the text of the report.

Recommendations for the 2019 Review of the Act

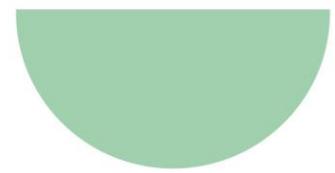
1. The role of IMHA should be legislated, including
 - 1.1. Responsibility for IMHA to contact every person on a Treatment Order (opt-out system)
 - 1.2. Responsibility for mental health services to provide details of every person on a Treatment Order to IMHA (opt-out system)
 - 1.3. Right for IMHA to access individuals
 - 1.4. Right for IMHA to access inpatient units
 - 1.5. Consequences for obstruction of IMHA advocates
 - 1.6. IMHA should have a statutory function for systemic advocacy including a responsibility to table an annual report in Parliament
2. Decision makers under the Act and all designated mental health services staff should be required to undertake regular training to ensure they understand the principles of the Act and their obligations to comply with them, particularly in regard to least-restrictive practice, supported decision-making and supporting recovery.

Recommendations for DHHS

3. Increase IMHA funding to increase the number of advocates to ensure all people who are eligible are able to access IMHA
4. Resource IMHA to provide supported decision-making training to mental health services
5. DHHS to form a formal collaborative network of oversight bodies, led by DHHS and including VLA, OPA, SPOS, MHCC, MHLC, VMIAC, Tandem, OCP and the Tribunal
6. Designated mental health services should be required to report on progress towards a recovery-oriented model of service using a definition of recovery consistent with DHHS policy and the Act
7. Designated mental health services should be required to include reporting of the number of people being compulsorily treated by setting and service including demographic data
8. Designated mental health services should be required to work with IMHA to identify opportunities for cultural change to improve an understanding of the value of representational advocacy
9. The *Your Experience of Service* (YES) Survey should include a question about consumer access to advocacy

Partnership Recommendations

10. Partner organisations and professionals who are not currently regularly referring to IMHA should be encouraged to do so
11. Review the process of IMHA feeding back directly to ward management at the service level
12. Mental health services and other stakeholder bodies should increase efforts to promote IMHA



Recommendations for IMHA policy and practice

Opportunities to increase effectiveness

13. Increase focus on leveraging supported decision-making elements of the Act
 - 13.1. Enhance self-advocacy training for consumers using the advocacy toolkit*
 - 13.2. Continue to explore opportunities to support family and carers to advocate using supported decision-making*
 - 13.3. Directly support consumers to create advance statements
14. Improve internal data collection
 - 14.1. IMHA's data collection categories should mirror those published by DHHS
 - 14.2. Ensure data collected by IMHA is consistent, reliable and complete*
 - 14.3. Collect data on where word of mouth referrals are originating from*
15. Target identified training areas
 - 15.1. Self-advocacy capacity building training for IMHA advocates*
 - 15.2. Training in linking systemic change to individual advocacy*
 - 15.3. Staff to undertake shadow shifts with other staff across regions

Strengthening a new service

16. Review reporting and performance frameworks
 - 16.1. Review number and appropriateness of Key Performance Indicators
 - 16.2. Review number and appropriateness of priority groups
 - 16.3. Develop an ongoing, long-term Program Logic Model and Hierarchy of Objectives
17. Review IMHA's scope and resourcing regarding
 - 17.1. Consistency across sites for advocacy for non-mental health issues
 - 17.2. Non-legal representation before the Mental Health Tribunal
 - 17.3. Demand for an out of hours crisis hotline
18. Increase consumer awareness of IMHA
 - 18.1. Develop strategies for increasing consumer engagement in the community*
 - 18.2. Continue to develop explanatory videos detailing IMHA's services*
 - 18.3. Work with services to provide inpatient access to IMHA videos*
19. Increase mental health professionals' understanding and awareness of IMHA
 - 19.1. Work with mental health services to educate staff on the value of representational advocacy*
 - 19.2. Continue to target and increase focus on mental health service staff who have high contact with consumers, including peer workers, nurses and ward clerks*

*In progress

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