Evaluation of the Advocacy in Wirral's Independent Mental Health Act and Psychiatric Liaison Advocacy Services

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Applied Health and Wellbeing Partnership

The Applied Health and Wellbeing Partnership
The Applied Health and Wellbeing Partnership is an initiative of NHS Wirral Research & Development Team and Liverpool John Moores University Centre for Public Health. The Partnership supports the development, delivery and evaluation of the Wirral Health and Wellbeing Strategy, through the innovative generation and application of evidence for effective and sustainable health and wellbeing commissioning.

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Executive Summary

In the UK, 22.8% of the total burden of disease is attributed to mental ill-health, with the total annual cost of mental health problems in England estimated to be £105.2 billion. Mental ill-health is associated with increased risks of cancer, cardiovascular disease, diabetes, alcohol misuse and smoking. Unemployment, low income, debt, violence, stressful life events, inadequate housing, and fuel poverty are all known risk factors for mental ill-health. Advocates can play a fundamental role in supporting people with mental health problems by promoting awareness and choice, and providing practical support to assist them to function in society.

Advocacy in Wirral (AiW) is a peer-led service which provides support, information and representation to people experiencing mental ill-health. AiW work across a range of areas, including community advocacy, welfare benefits, primary care advocacy, drug and alcohol advocacy, Independent Mental Capacity Act advocacy, and hospital advocacy. Hospital advocates provide advice and practical support regarding a range of issues, including welfare benefits, housing, employment, debts and legal issues. Hospital advocates can also attend ward rounds, accompany clients to meetings, and represent clients at local and regional meetings, helping to promote the needs of their client and bring about changes to the support and care of the client. Two elements of the AiW hospital advocacy service, Independent Mental Health Act (IMHA) advocacy and Psychiatric Liaison (PL) advocacy, have been evaluated to explore effectiveness and identity impacts and outcomes.

A range of qualitative and quantitative methods were used in triangulation, including an evidence review of cost-effectiveness and service provider experiences of hospital advocates, analysis of AiW hospital advocacy service data, thematic analysis of case study data, and analysis of mental wellbeing data.

Findings revealed that almost one in six Wirral patients identified on clinical registers as having a mental health problem were seen by an AiW IMHA advocate, and almost one in four patients referred to Wirral Mental Health Services were seen by an IMHA advocate. The age of IMHA advocacy users were representative of local mental health prevalence. However, gender use was not representative, with more males than females accessing this service, despite a higher prevalence of mental health problems amongst females. This supports previous findings that more women than men use mental health services, but more men than women are treated as inpatients, and suggests that men do not access services until they reach a crisis point. Ethnicity of clients using IMHA and PL advocates was predominantly white British suggesting a potential gap in support to other ethnic groups.

Patients were referred to the IMHA and PL advocacy services from a range of sources, demonstrating a wide recognition of the services. There was an increase in self-referrals following a primary episode, particularly in users of psychiatric liaison services, which resulted in a reduction in inpatient appointments and an increase in home appointments. As expected, mental health diagnosis differed amongst users of IMHA and PL advocacy services. However key risk factors (benefits, housing and debt) were the same for users of both services, suggesting that using hospital advocates to address risks associated with mental health problems will reduce inpatient admissions regardless of patients' primary diagnosis. The majority of IMHA and PL advocacy patients required two or three contacts before their case was resolved, although some patients required a much higher number of contacts.

A number of barriers and challenges to the delivery of hospital advocacy were identified in a recent review of IMHA advocacy services in England. For example, health professionals viewed themselves as advocates but described their advocacy role as less in-depth than the

support provided by IMHA and PL advocates, highlighting a potential conflict between health professionals and advocates.

AiW IMHA and PL advocates provide an effective service for patients with mental ill-health, addressing risk factors and contributing to a reduction in hospital admissions. Recommendations for future delivery of AiW IMHA and PL advocacy services include reviewing capacity to ensure advocates can offer provision to all patients in need; ensuring service provision includes costs for staff training, support and development; ensuring all population groups (particularly BME) have equal access to services; and improving reporting and data capture.

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1. Introduction

"Mental health is the largest single source of burden of disease in the UK"
(Royal College of Psychiatrists (RCP), 2010)

1.1 Risk Factors for Mental Ill-Health

Mental ill-health affects physical health and risk behaviours, and is associated with increased risks of obesity, cancer, cardiovascular disease, diabetes, alcohol misuse and smoking (RCP, 2010). People with schizophrenia and bipolar disorder die approximately 25 years earlier than the general population, which is largely attributed to physical ill-health. Schizophrenia is associated with a two-fold increase in CVD death rates, a three-fold increase in respiratory disease death rates, and a four-fold increase in infectious disease death rates (RCP, 2010). Poor physical health increases the risk of mental illness (RCP, 2010). Risk factors for mental ill-health in adulthood are unemployment, lower income, debt, violence, stressful life events, inadequate housing, fuel poverty and other adversity. Mental ill-health is also associated with increased likelihood of risk taking behaviour, such as smoking and alcohol misuse (RCP, 2010).

Unemployment is a risk factor for mental ill-health, due to associations with low self-esteem and financial difficulties. Employment for people with mental ill-health has been shown to promote recovery and have a positive impact, and working towards a reduction in sickness absence and promoting an early return to work are important strategies in treating mental ill-health (RCP, 2010). However, employment has been identified as a risk factor for mental ill-health, where low pay, insecure jobs, and stress lead to poor physical and mental health (NICE, 2009). It is therefore important to ensure that people with mental ill-health are supported into employment in roles that promote quality of life and low stress (RCP, 2010).

1.2 The Cost of Mental Ill-Health

In 2010, the RCP published 'No Health Without Mental Health – A Case for Action', which highlighted that, in the UK, 22.8% of the total burden of disease was attributed to mental ill-health, compared to 16.2% for cardiovascular disease and 15.9% for cancer. The cost of mental ill-health predominantly falls upon the people experiencing mental health problems and their families, but also affects businesses and tax payers. Data regarding the economic and social costs of mental ill-health in 2009/10 show that the total annual cost of mental health problems in England was £105.2 billion. Of this, 20.2% was attributed to health and social care costs, 28.8% to output losses in the economy due to people's inability to work, and 53.6% on human costs due to negative impact of mental ill-health on quality of life (Centre for Mental Health, 2010). The annual cost of depression is £7.5 billion, anxiety £8.9 billion, schizophrenia £6.7 billion and dementia £17 billion (RCP, 2010). The annual cost of work-related mental health problems is £30.3 billion, of which two-thirds are due to lost productivity (RCP, 2010). Mental illness is the most common reason for people receiving incapacity benefits, with 43% of people receiving long-term health-related benefits having a mental or behavioural illness as their primary diagnosis (Department for Work and Pensions, 2010).

1.3 Mental Health Advocates

Advocacy has been described as the activity of an individual to pursue and act in the interests of another (NHS Executive and Social Services Inspectorate, 2001), returning the decision-making authority to the individual and empowering them to play a more central role in their own care, treatment, rehabilitation, and life choices (Stylianos & Kehyayan, 2012). In mental health settings, advocates alleviate the vulnerability of people with mental ill-health, promoting positive systematic change and eliminating barriers to social inclusion (Funk, Minoletti, Drew, Taylor & Saraceno, 2005). Advocates play a fundamental role in ensuring clients are aware of the choices available to them within their care, treatment and life, and

provide practical support to assist them to function within society, including advice regarding debt, housing and employment (Stylianos & Kehyayan, 2012).

A wide range of benefits have been associated with advocates, including a reduction in stigma (Sylianos & Kehyayan, 2012), improvements in patient outcomes (Berk, Berk & Castle, 2004), and empowering patients, which is deemed to be central to the recovery process (Ontken, Durmont, Ridgway, Dorman & Ralph, 2002). Corrigan (2002) stated that advocates improve mental health through treatment strategies that promote collaboration between health care providers and their clients, rather than professionally driven, unilateral decision making. Despite the advantages, researchers have cautioned that the short-term nature of advocacy contact may be a disadvantage for some clients, and that advocates need to be flexible and adaptable to working with a wide range of population groups (Ridley, Rosengard, Hunter & Little, 2009).

1.4 Cost-Effectiveness of Advocacy Support

NICE (2008) highlights that advocacy is an effective and cost-effective intervention for promoting mental wellbeing. Knapp, Bauer, Perkins and Snell (2010) have examined the effectiveness and cost-effectiveness of interventions which impact on health and social care, capturing public and independent sector budgets alongside the unpaid time of family and carers, and issues such as employment and housing. Knapp, et al., (2010) describe advocates as 'navigators' who reach out to vulnerable groups to provide emotional, practical and social support and skills, and who help people in range of situations, such as debt, benefit, employment or housing problems. The estimated economic benefits of advocates are outlined by Knapp, et al., (2010) as £900 per person per year. These calculations take into consideration the more appropriate use of support pathways to ensure patient needs are met, reduction in GP visits and hospital admissions, and improved mental and physical wellbeing. The RCP (2010) caution the economic cost of not providing mental health services, and state that interventions that support even a small percentage of people with mental health problems will result in considerable cost savings.

1.5 Advocacy in Wirral

Advocacy in Wirral (AiW) is a service which provides support, information and representation to people experiencing mental ill-health, delivered by service users of mental health services. AiW was established in 1992 by a group of mental health service users, who identified a need for practical and emotional support provided by other service users, outside of traditional services. AiW provides support to empower people with mental ill-health to express their personal needs and preferences, and provides representation for clients where required. AiW provide support across a range of areas, including community advocacy, welfare benefits, primary care advocacy, drug and alcohol advocacy, Independent Mental Capacity Act advocacy, and hospital advocacy. The hospital advocacy element of AiW is the focus for the current evaluation.

Hospital advocates provide advice and practical support regarding a range of issues, including welfare benefits, housing, employment, debts and legal issues. Hospital advocates can also attend ward rounds, accompany clients to meetings, and represent clients at local and regional meetings, helping to promote the needs of their client and bring about changes to the support and care of the client. The AiW Hospital Advocacy Project comprises five separate elements; Adult in-patient advocacy at Springview and Clatterbridge, providing support for patients at Springview, a mental health centre based at Clatterbridge hospital; Older people's advocacy at Springview and in the community, assisting with discharge management; Independent Mental Health Act (IMHA) advocacy, a statutory requirement provided by AiW; Psychiatric Liaison (PL) advocacy services, based at Arrowe Park Hospital; and a general advocacy service to support in-patients at Arrowe Park Hospital with their social care and support needs.

1.6 Evaluation

The Applied Health and Wellbeing Partnership were requested by the Programme Manager at Cheshire, Warrington and Wirral Commissioning Support Service to conduct an evaluation to specifically explore the AiW IMHS and PL advocacy services. Key evaluation questions for exploration were:

Quality and Performance
How many initial appointments were resolved at first interview?
How many clients have initial contact on day of referral?

Value and Impact
How does mental health advocacy impact on hospital admissions and costs?
Do AiW services contribute to a reduction in recurrent inpatient admission?
Does the service increase wellbeing?
How satisfied are clients?
What are the perceptions of service providers?

The evaluation framework includes triangulation of various quantitative and qualitative tools to provide a broad measure of the impact of AiW IMHS and PL advocacy services on a range of stakeholders.

2. Evaluation Methodology

A range of quantitative and qualitative methods were employed to assess the effectiveness of the AiW IMHS and PL advocacy services. In order to answer the evaluation questions, data were analysed by service use, admissions and waiting times, and service impact. The methods used are outlined below.

Review of Evidence
An evidence review of the cost-effectiveness of advocacy services has been undertaken to determine how advocacy can impact on hospital admissions and costs. The search strategy included searching several databases included PubMed, Medline, Cochrane Reviews and grey literature.

The perceptions and experiences of service providers were highlighted by commissioners as important factors for exploration. Initially, qualitative insight work was proposed to be undertaken with health professionals involved in the IMHA and PL advocacy services. However, during the evaluation, a large scale review of IMHA advocacy services in England was published (June 2012) (Newbigging, Ridley, McKeown, et al., 2012). This review explored all of the areas that were important to commissioners using a very detailed and in-depth methodology. Newbigging, et al., (2012) used eleven focus groups with a mix of stakeholders covering all areas of England, shadow visits to four services, and eight case studies across England covering urban and suburban areas. This comprehensive review has been explored, and all transferable issues have been included for the purposes of this evaluation.

Quantitative Analysis
AiW collect routine monitoring data for each of the five hospital advocacy services they provide, which were analysed to understand the quality and performance of the IMHA and PL advocacy services.

NHS Wirral Performance and Intelligence Department receive AiW data regarding primary care advocacy, therefore the AiW IT and Data Manager provided the evaluation team with the AiW Hospital Advocacy service data (which included the IMHA and PL advocacy service data). All patient identifiable information was removed from the dataset by the AiW IT and Data Manager before datasets were shared.

AiW collect data on patient age, gender, service type, ethnicity, disability, benefits, patients' primary and secondary diagnoses, referral sources, number of patient contacts and patient waiting times. AiW also collect free text outcome data for each patient and denote where three-month follow-ups have been completed. The quantitative data were cleaned, coded and analysed using the Predictive Analytics Software (PASW) (formally known as Statistical Package for Social Sciences (SPSS)) Version 18.0.

As part of their contract, AiW are required to collect data on all patients who use the Hospital Advocacy services, recording data at each single patient admission, and giving every patient a new hospital identification number, regardless of whether they have been assigned one during a previous admission. This method does not capture any information regarding the readmission of individual patients or the patient journey with AiW. Thus, for the purposes of the evaluation, this data analysis aimed to identify those patients who had one admission to the hospital advocacy service, along with those patients who had more than one admission to the hospital advocacy service, to allow further exploration of recurrent inpatient admissions.

To enable identification of patient episodes, data were matched according to all constant patient characteristics: date of birth, ethnicity, gender and GP Practice. Each patient was then allocated a service identification number, which identified the number of advocacy admissions per patient. Due to the high volume, data were analysed according to primary admission (first admission to AiW) and subsequent admissions (any admissions that followed). Primary and subsequent AiW admissions were identified by using the PASW 'duplicate' function and defining matching cases by the service identification number. These data were then sorted by date of referral, where the first case in each patient admission group was identified as the primary admission, and the remaining cases identified as subsequent admissions. Once the cleaning, matching and coding had been completed the data and understandings of field descriptions were checked with the AiW IT and Data Manager. The data were then explored to identify the value and impact of the AiW IMHA and PL advocacy services.

In order to determine service quality and performance, the AiW data were analysed to explore characteristics of PL and IMHA advocacy service use, patient diagnoses, referral sources, appointment sites, number of patient contacts, and patient waiting times. In addition to providing in-depth understanding of service use, this analysis provided insight into the number of initial appointments resolved at first interview, recurrent inpatient admissions, and the number of clients having initial contact with AiW on the day of referral. These data were then analysed with reference to local mental health prevalence data and hospital episode data, to determine comparisons of service use.

Qualitative Analysis

Due to the high volume of data, the free text outcome data collected for each AiW hospital advocacy patient were entered into the qualitative data analysis software package NVivo (version 9) and analysed using word frequencies, rather than being individually coded and thematically analysed.

High users of IMHA and PL advocacy services (those who had a high number of subsequent episodes and contacts) were explored in depth, to provide an understanding of their journey. This descriptive analysis provides a summary of each patient episode with AiW, exploring issues such as whether their diagnoses and outcomes were related to their previous admissions. This information provides further evidence of the impact and efficiency of the AiW service.

Between March 2011 and March 2012, AiW collected case study data from 25 patients using Hospital and Older People in the Community Services. Each month, two advocates were requested to complete a case study, written from the advocate's perspective detailing their experiences with particular clients. These case studies do not identify individual patients and so cannot be matched to the IMHA and PL advocacy datasets, however these data were included in this evaluation to further explore the impact of Hospital Advocates, and to verify the quantitative and qualitative findings. Content analysis was used to explore the case studies.

Analysis of Wellbeing Data

AiW used the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) to measure mental wellbeing in a number of case study participants, collected at the beginning and end of the hospital advocacy intervention. WEMWBS is a validated and widely used measure of mental wellbeing, which comprises a 14-item scale covering subjective wellbeing and psychological functioning (Stewart Brown & Janmohamed, 2008). WEMWBS provides a measure of actual wellbeing, not the determinants of wellbeing. Again, these do not identify individual patients so cannot be matched to the IMHA and PL advocacy datasets, but have been included to further evidence the impact of the service.

The WEMWBS tool is free to use but is copyrighted and permission must be sought prior to use, and appropriate reference to the tool will be used throughout this report. The WEMWBS user guide (Version 1) states that any report using WEMWBS should include the text: *"The Warwick-Edinburgh Mental Well-being Scale was funded by the Scottish Government National Programme for Improving Mental Health and Well-being, commissioned by NHS Health Scotland, developed by the University of Warwick and the University of Edinburgh, and is jointly owned by NHS Health Scotland, the University of Warwick and the University of Edinburgh."*

3. Results

3.1 Service Use

The AiW database provided non-identifiable patient data for referrals to the hospital advocacy services between 4th April 2009 and 30th May 2012. Although the IMHA and PL advocacy services are the primary focus of the current evaluation, the whole hospital advocacy service data were explored initially, to enable understanding of service use in comparison to the other hospital advocacy services.

Advocacy in Wirral characterise each individual patient episode by a hospital identification number. The data were cleaned[1] and any anomalies checked with the IT and Data Manager at Advocacy in Wirral. Initial analysis of the data showed there were 3277 separate patient entries coded into five service categories: adult inpatient and IMHA; older people, inpatient and IMHA; EMI (elderly mentally infirm) community; Arrowe Park mental health advocacy; and psychiatric liaison (Table 1).

Table 1 Hospital Advocacy Service Use

Hospital Advocacy Service	Frequency	
	n	%
Adult inpatient and IMHA	1485	45.3
Older people, inpatient and IMHA	294	9
EMI community	519	15.8
Arrowe Park mental health advocacy	417	12.7
Psychiatric liaison	562	17.1
Total	3277	100

Further analyses showed that the 3277 separate patient episodes were made by 1806 patients, who were admitted to one of the AiW hospital services on either one occasion, or more than one occasion[2] (Table 2a). A total of 605 patients were seen by the advocacy service on more than one occasion, ranging between having two and 37 repeat episodes per patient (Table 2b).

Table 2a Hospital Advocacy Service: Total Sample Patient Episodes

All patients	1806
Total number of patient episodes	3277
Average episodes per patient	1.82 ± 2.01
Min	1
Max	37

Table 2b Hospital Advocacy Service: Total Sample Patients with 1+ Episode

Patients with more than one episode	605
Total N of repeat episodes	2077
Average N of episodes per patient	3.43 ± 2.85
Min	2
Max	37

[1] Record 319 was duplicated, one of which was removed; two hospital IDs had not been used = 2909 and 2744; two different patients had been given same ID number = 2991; one of the patients with number 2991 was replaced with number 2744; hospital ID 2909 was left unused.

[2] Patient data were matched according to date of birth, ethnicity, gender and GP Practice. This information was corroborated with the IT and Data Manager at Advocacy in Wirral, who also checked any anomalies for accuracy (e.g. patient with 37 episodes).

For the purposes of the evaluation, every patient's first contact with AiW has been labelled 'primary episode' (regardless of whether the patient has just the one, or more than one, contact), and any patient contact after this has been labelled 'subsequent episode'. Due to the high volume of data, and high number of subsequent episodes, these are not disaggregated further.

The focus for the current evaluation is the IMHA and PL advocacy service use, therefore the EMI community and Arrowe Park mental health advocacy data were excluded from the dataset. The IMHA and PLS advocacy service data represented 2341 of the 3277 total recorded patient episodes (average 1.84 ± 2.09 episodes per patient, ranging between one and 30 episodes). A total of 399 IMHA and PLS patients were seen on more than one separate occasion, ranging between two and 30 episodes per patient (average 3.68 ± 3.01).

3.1.1 Service Use: IMHA Advocacy

A total of 1779 separate entries were made for patients seen by the IMHA service between 4th April 2009 and 8th May 2012. Of these, 1485 were categorised by Advocacy in Wirral as 'Adult inpatient and IMHA' and 294 as 'Older people, inpatient and IMHA' (see Table 3 for sample characteristics).

The Advocacy in Wirral dataset provides three full financial years worth of data (April 2009 – March 2012); over this time period the number of separate IMHA patient episodes has remained stable[3] (Apr 2009 – Mar 2010 n = 540; Apr 2010 – Mar 2011 n = 577; Apr 2011 – Mar 2012 n = 574).

Data show that 16.08% (1691/10,511) of patients recorded on Wirral GP registers as having mental health problems were seen by IMHA advocates between 2009 and 2011 (NHS Wirral Joint Strategic Needs Assessment 2012 (JSNA)).

A review of NHS Wirral Mental Health Service shows that in the financial year 2010-11, 7502 patients were referred to Wirral primary care mental health services, and 23.7% of these (1779/7502) were seen by the IMHA advocacy service.

Table 3 Advocacy in Wirral IMHA: Whole Database Sample Characteristics

		n	%
Age (years)	Range	17 – 94	-
	Mean	47.13 ± 15.81	-
Gender	Male	994	55.9
	Female	785	44.1
IMHA	Adult inpatient and IMHA	1485	83.5
	Older people, inpatient and IMHA	294	16.5
	N patients single episode	534	62.5
	N patients repeat episodes	320	37.5
Ethnicity	White British	1723	96.9
	Asian or Asian British	20	1.2
	White Irish	13	0.7
	Black or Black British	10	0.6
	Chinese	2	0.1
	Other	11	0.5

[3] Dates of referral and first contact was missing for one patient.

Disability	Yes	1503	84.5
	No	273	15.3
	Not stated	3	0.2
Receiving benefits	Yes	1528	85.9
	No	247	13.9
	Not stated	4	0.2
Statutory sick pay	Yes	47	2.6
	No	1719	96.6
	Not stated	13	0.7

The age of service users reflects local prevalence of mental health problems, with the majority of people with mental health problems recorded on Wirral clinical systems between 2009 and 2011 being aged between 35-49 years (32.09, 3373/10,511) (NHS Wirral Joint Strategic Needs Assessment (JSNA), 2012).

The gender of service users does not reflect mental health prevalence in Wirral, where the NHS Wirral JSNA (2012) showed that more females than males (66.4%, 6989/10,511) had mental health problems recorded on clinical systems between 2009 and 2011.

The 1779 individual patient entries were matched using the same method as for the whole sample database[2], which revealed that the entries were made by 854 patients, 320 of which were seen on more than one occasion by an IMHA, ranging between 2 and 30 episodes per patient (average 3.89 ± 3.24).

AiW IMHA Advocates
A total of nine AiW advocates provided IMHA advocacy support between 4th April 2009 and 8th May 2012 (Apr 2009 – Mar 2010 n = 7; Apr 2010 – Mar 2011 n = 4; Apr 2011 – Mar 2012 n = 7). Advocate contacts range between 1 and 908 patient episodes per year, which does not include the individual contacts required per episode.

IMHA Advocacy Patient Diagnosis
In the database, all patient entries include a primary diagnosis referring to the mental health diagnosis made for each patient, and a secondary diagnosis referring to the practical problems that each patient requires IMHA support with. These practical problems are risk factors for mental ill-health and have been termed 'action required' for the purposes of this report.

The most common primary diagnosis for patients with only one IMHA advocacy episode was schizophrenia (23.4%), followed by bipolar affective disorder (12.9%) and psychosis (12.4%). These were also the most common primary diagnoses in patients with more than one IMHA advocacy episode (Table 4). There was an increase in the number of patients diagnosed with schizophrenia at second episode, suggesting that patients who were initially diagnosed with a generic condition at first episode (such as generalised anxiety disorder or depressive episode) were now given a more specific diagnosis (Table 4). The patients whose first diagnosis had been disappearance/death of family member or eating disorders had been given a different diagnosis at their second episode, which may have contributed to the increase in unspecified mental disorders (Table 4).

Table 4 Patient primary diagnosis by episode

Primary Diagnosis	N Patients					
	Patients with only 1 episode		Patients with > 1 episode			
			First episode diagnosis		Second episode diagnosis	
	n	%	n	%	n	%
Schizophrenia	125	23.5	89	27.8	99	30.9
Bipolar affective disorder	69	12.9	61	19.1	59	18.4
Psychosis	66	12.4	45	14.1	44	13.8
Mental disorder, not otherwise specified	63	11.8	31	9.7	36	11.3
Depressive episode	53	9.9	27	8.4	23	7.2
Dementia	43	8.1	10	3.1	11	3.4
Mixed anxiety and depressive disorder	41	7.7	20	6.3	19	5.9
Recurrent depressive disorder	22	4.1	13	4.1	10	3.1
Generalised anxiety disorder	19	3.6	8	2.5	4	1.3
Eating disorders	17	3.2	7	2.2	6	1.9
Mental & behavioural disorders due to alcohol use	10	1.9	5	1.6	5	1.6
Agoraphobia with/without history of panic disorder	2	0.4	0	0	1	0.3
Post-traumatic stress disorder	1	0.2	0	0	0	0
Somatoform disorders	1	0.2	2	0.6	2	0.6
Specified (isolated) phobias	1	0.2	0	0	0	0
Disappearance/death of family member	0	0	1	0.3	0	0
Obsessive compulsive disorder	0	0	1	0.3	1	0.3
Total	533	100	320	100	320	100

Individual patient journeys were explored for those patients who had more than one IMHA advocacy episode. Analysis included the most common primary diagnoses for patients' first six episodes.

Schizophrenia

Of the patients diagnosed with schizophrenia at first episode, all but nine (10%, 9/89) were diagnosed with schizophrenia at second episode. The remaining diagnoses were for unspecified mental disorders (n=4), psychosis (n=3), depressive episode (n=1) and bipolar affective disorder (n=1). The box below outlines the individual journeys for patients diagnosed with schizophrenia at first IMHA advocacy episode, and demonstrates that the majority of patients' diagnoses do not change.

Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	Episode 6
89 Schizophrenia →	*73 Schizophrenia* →	*48 Schizophrenia* →	*32 Schizophrenia* →	*18 Schizophrenia* →	*12 Schizophrenia*
	4 Unspecified →	*2 Unspecified* →	*2 Unspecified* →	*2 Unspecified*	
	3 Psychosis →	*1 Psychosis* →	*2 Psychosis* →	*1 Psychosis* →	*3 Psychosis*
	1 Bipolar →	*1 Bipolar* →	*1 Bipolar* →	*2 Bipolar* →	*1 Recurrent Depression*
	1 Depressive episode	*1 Mixed anxiety*			
		1 General anxiety			
		1 Eating disorder →	*1 Eating disorder*		

Bipolar Affective Disorder

Of the patients diagnosed with bipolar affective disorder at first episode, the majority (18%, 49/61) were diagnosed with this at the second episode. The remainder were diagnosed with schizophrenia (n=8), depressive episode (n=1) or were unspecified (n=1). The remaining patient journeys for these patients are outlined below, and again demonstrate that patient diagnosis remains stable throughout.

Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	Episode 6
61 Bipolar →	*49 Bipolar* →	*28 Bipolar* →	*20 Bipolar* →	*12 Bipolar* →	*11 Bipolar*
	8 Schizophrenia →	*1 Schizophrenia* →	*1 Schizophrenia* →	*1 Schizoprenia* →	*1 Schizophrenia*
	1 Depressive episode →	*1 Depressive Episode* →	*1 Depressive Episode* →	*1 Eating Disorder*	
	1 Unspecified →	*1 Demetia* →	*1 Dementia*		

Psychosis

The majority of patients diagnosed with psychosis at first episode were also diagnosed with this at second episode (35/45). The remaining patients were diagnosed with schizophrenia (n=4), depressive episode (n=2), bipolar (n=1) or were unspecified (n=3). The remaining patient journeys are outlined below, again demonstrating the stability of patient diagnosis.

Episode 1	Episode 2	Episode 3	Episode 4	Episode 5	Episode 6
45 Psychosis →	*35 Psychosis* →	*17 Psychosis* →	*14 Psychosis* →	*7 Psychosis* →	*7 Psychosis*
	3 Unspecified →	*2 Unspecified* →	*3 Unspecified* →	*1 Unspecified*	*1 Bipolar Affective Disorder*
	4 Schizophrenia →	*3 Schizophrenia* →	*2 Schizophrenia* →	*3 Schizophrenia*	
	2 Depressive Episode →	*1 Bipolar* →	*1 Bipolar* →	*1 Depressive Episode*	
	1 Bipolar	*1 Recurrent Depression*			
		1 General Anxiety			

The average age of IMHA patients differed across the diagnoses (Figure 1). Patients diagnosed with specified isolated phobias were, on average, older than patients with other diagnoses (mean age 80.64). Patients diagnosed with eating disorders were, on average, younger than patients with other diagnoses (age 29.16 ± 12.16). As may be expected, patients diagnosed with dementia were significantly older (mean age 73.63 ± 1.42) than those with a different primary diagnosis (mean age 45.94 ± .36) ($t(1756) = 15.967$, $p < .000$).

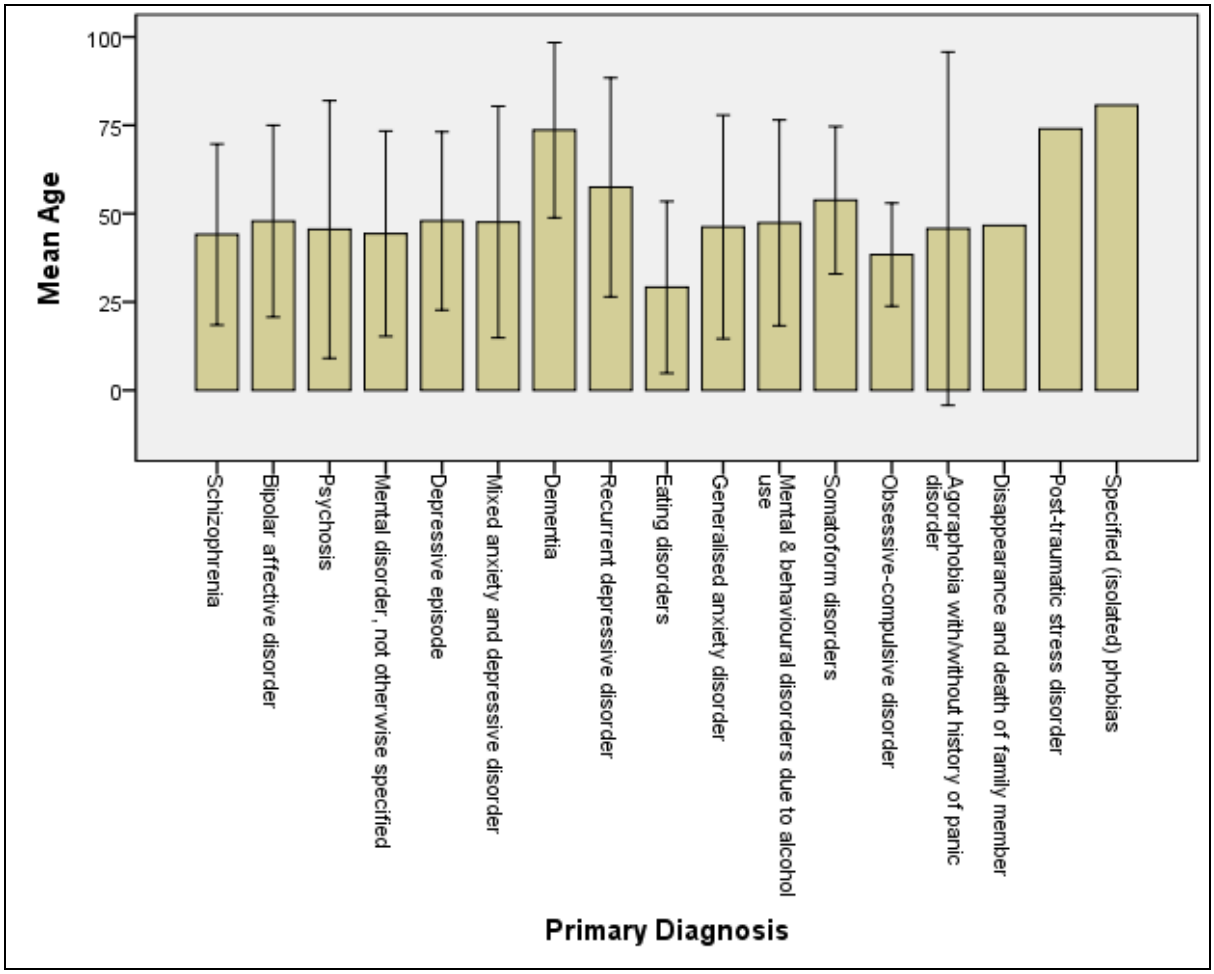


Figure 1 Average Age of IMHA Patient by Primary Diagnosis (ordered by numerical size of group)

The most common action required for patients with only one IMHA advocacy episode was regarding benefits (36.14%), followed by IMHA representation (30.34%) and housing (9.93%). These were also the most common actions required for patients who had more than one episode with IMHA advocacy, however, the most common action required at primary episode was regarding IMHA representation. This reduced considerably at the second episode, where there was an increase in the support required around benefits, debts, financial services, and legal support in second episodes, suggesting that patients requiring IMHA representation now required support in these areas (Table 5).

Table 5 IMHA Advocacy Action Required by Patient Episode

	N Patients					
	Patients with only 1 episode		Patients with > 1 episode			
			First episode diagnosis		Second episode diagnosis	
Action Required	n	%	n	%	n	%
Benefits	193	36.1	112	35	120	37.5
Representation Mental Health Act (IMHA)	162	30.3	128	23.9	93	29.1
Housing	53	9.3	31	9.7	32	10

Debts	48	8.9	20	6.3	30	9.4
Other	30	5.6	14	4.4	18	5.6
Financial services and products	15	2.8	3	0.9	8	2.5
Health and community care	15	2.8	3	0.9	6	1.9
Relationship and family	8	1.5	3	0.9	2	0.6
Employment	3	0.6	1	0.3	1	0.3
Legal	3	0.6	1	0.3	6	1.9
Travel, transport and holidays	3	0.6	3	0.9	4	1.3
Education	1	0.2	0	0	0	0
Utilities	0	0	1	0.3	0	0
Total	534	100	320	100	320	100

Individual patient journeys were explored in those patients who had more than one IMHA advocacy episode. Due to the range of potential actions required and the number of patient episodes, the first five episodes for the most common actions were explored. Of those patients who required IMHA representation at their first episode, only 39% (50/128) required this action at their second episode and instead 32.8% (42/128) now required support regarding benefits. Of the IMHA advocacy patients who required action regarding benefits, 42.6% (52/112) also required this at their second episode. A wide range of other actions were required at the second episode, including IMHA representation, debts and housing, demonstrating a potential overlap between some of the actions required. This was also the case for patients requiring housing support at first episode, who were more likely to require benefits support (48.4%, 15/31) rather than housing support (19.4%, 6/31) at second episode.

Patients with problems relating to utilities were on average the oldest IMHA advocacy patients (mean age = 65.28 ± 6.89), and patients with problems relating to education were, on average, the youngest IMHA patients (mean age = 19.18) (Figure 2).

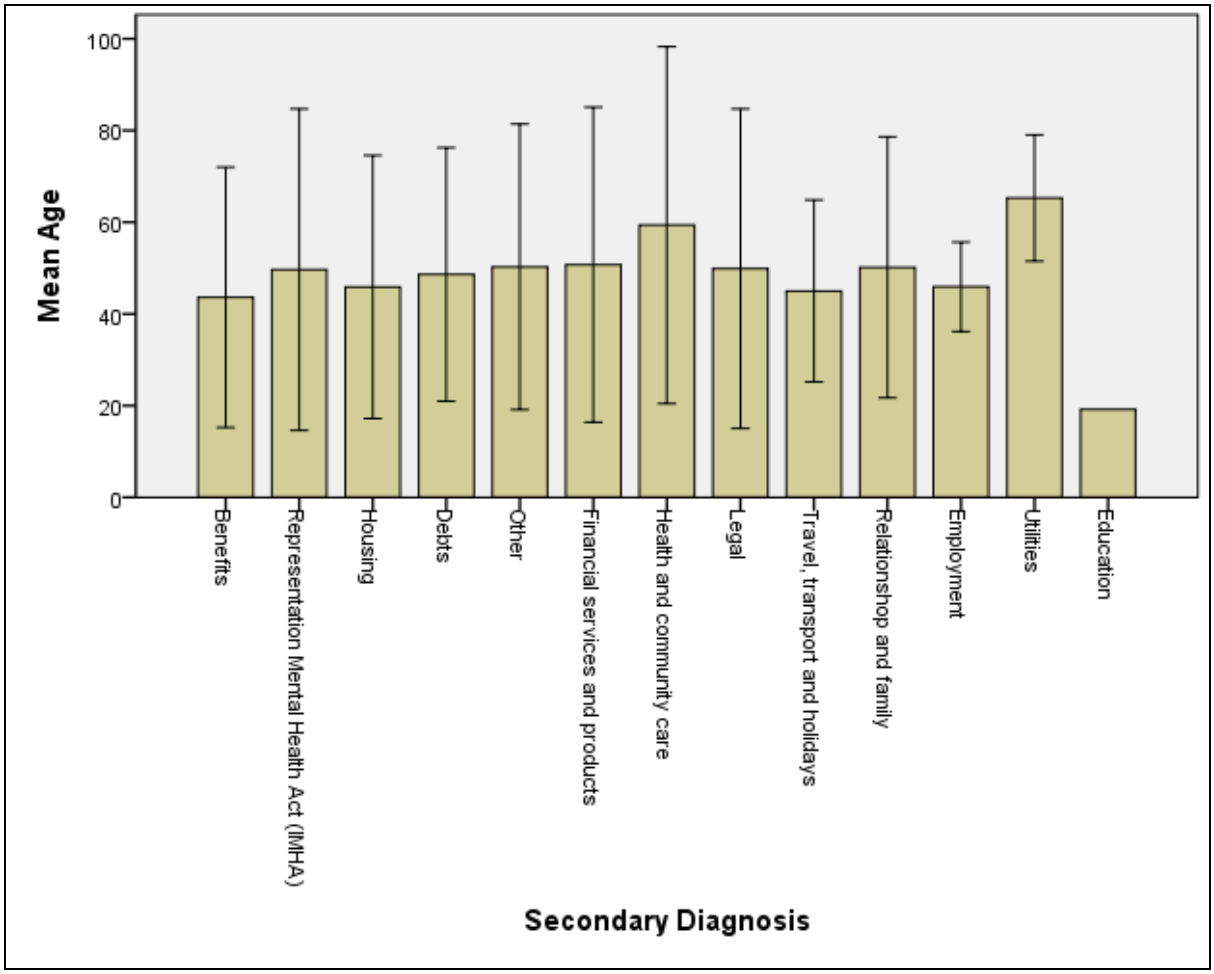


Figure 2 Mean Age of IMHA Patients by Secondary Diagnosis (ordered by numerical size of group)

3.1.2 Service Use: PL Advocacy

A total of 562 separate entries were made for patients seen by the PLS between 24th June 2009 and 18th May 2012 (see Table 6 for sample characteristics). There was a difference between the number of separate patient episodes over the three full year dataset (Apr 2009 – Mar 2010 n = 157; Apr 2010 – Mar 2011 n = 133; Apr 2011 – Mar 2012 n = 239).

Data show that 5.03% (529/10,511) of patients recorded on Wirral GP registers as having mental health problems were seen by PL advocates between 2009 and 2011 (NHS Wirral JSNA, 2012), and that 7.49% (562/7502) of patients referred to Wirral primary care mental health services in the financial year 2010-11 were seen by the PL advocacy service.

Table 6 Advocacy in Wirral PLS: Whole Database Sample Characteristics

		n	%
Age (years)	Range	17 – 82	-
	Mean	42.16 ± 13.95	-
Gender	Male	278	49.6
	Female	283	50.4
Ethnicity	White British	554	98.6
	White - Other	5	0.9
	Asian or Asian British	2	0.4

	Other	1	0.2
Disability	Yes	199	35.4
	No	362	64.4
	Not stated	1	0.2
Receiving benefits	Yes	428	76.2
	No	133	23.7
	Not stated	1	0.2
Statutory sick pay	Yes	14	2.5
	No	547	97.3
	Not stated	1	0.2

As with IMHA advocacy services, the age of PL advocacy service users reflects local prevalence of mental health problems, with the majority of people with mental health problems recorded on Wirral clinical systems between 2009 and 2011 being aged between 35-49 years (32.09%, 3373/10,511) (NHS Wirral JSNA, 2012).

The gender of service users does not reflect mental health prevalence in Wirral, where the NHS Wirral JSNA 2012 showed that more females than males (66.4%, 6989/10,511) had mental health problems recorded on clinical systems between 2009 and 2011.

The 562 individual patient entries were matched using the same method as for previous data matching[2], which revealed that the entries were made by 435 patients, 80 of which were seen on more than one occasion by the PLS, ranging between 2 and 11 episodes per patient (average 2.48 ± 0.99).

AiW IMHA Advocates

A total of six AiW advocates provided IMHA advocacy support between 24th June 2009 and 18th May 2012 (Apr 2009 – Mar 2010 n = 3; Apr 2010 – Mar 2011 n = 2; Apr 2011 – Mar 2012 n = 5). Advocate contacts range between 2 and 428 patient episodes per year, which does not include the individual contacts required per episode.

PL Advocacy Patient Diagnosis

The most common primary diagnosis for patients with only one PL advocacy episode was mixed anxiety and depressive disorder (14.9%), followed by recurrent depressive disorder (7.3%) and unspecified mental disorder (4.5%) (Table 7). These were not the three most common diagnoses in patients with more than one PL advocacy episode, where unspecified mental disorder was diagnosed in just one patient. This suggests that patients who have more than one PL advocacy episode have a specified diagnosis.

Table 7 Primary Diagnosis of PLS Patients by Episode

	N Patients					
	Patients with only 1 episode		Patients with > 1 episode			
			First episode diagnosis		Second episode diagnosis	
Action Required						
	n	%	n	%	n	%
Mixed anxiety and depressive disorder	53	14.9	19	23.4	17	21.3
Recurrent depressive disorder	26	7.3	6	7.5	6	7.5

Mental disorder, not otherwise specified	16	4.5	1	1.3	1	1.3
Mental & behavioural disorders due to alcohol use	15	4.2	5	6.3	7	8.8
Generalised anxiety disorder	13	3.7	2	2.5	1	1.3
Disappearance and death of family member	5	1.4	1	1.3	0	0
Schizophrenia	5	1.4	1	1.3	1	1.3
Psychosis	4	1.1	0	0	0	0
Somatoform disorders	4	1.1	0	0	0	0
Bipolar affective disorder	3	0.8	0	0	1	1.3
Post-traumatic stress disorder	3	0.8	1	1.3	1	1.3
Eating disorders	1	0.3	0	0	0	0
Specified (isolated) phobias	1	0.3	2	2.5	2	2.5
Total	355	100	80	100	80	100

Individual patient journeys were explored for those patients who had more than one PL advocacy episode. Analysis included the most common primary diagnoses for all patient episodes. The diagnoses for PL advocacy patients appeared more changeable than those for the IMHA patients, where potentially overlapping conditions such as mixed anxiety, depressive episodes and recurrent depression were cited.

Mixed Anxiety and Depressive Disorder

Episode 1	*Episode 2*	*Episode 3*	*Episode 4*	*Episode 5*	*Episode 6*
19 Mixed Anxiety →	*17 Mixed Anxiety* →	*4 Mixed Anxiety* →	*3 Mixed Anxiety* →	*1 Mixed Anxiety* →	*2 Recirrent Depression*
		2 Depressive Episode →	*1 Depressive Episode* →	*1 Recurrent Depression*	
		1 Recurrent Depression →			

Patients diagnosed with mixed anxiety and depressive disorder were all diagnosed with this at second episode, and following this patients were diagnosed with depressive conditions. This was also the case for patients diagnosed with recurrent depressive disorder.

Recurrent Depressive Disorder

Episode 1	*Episode 2*	*Episode 3*	*Episode 4*
6 Recurrent depression →	*6 Recurrent depression* →	*2 Recurrent depression* →	*1 Depressive Episode* →
		1 Mixed Anxiety →	*1 Mixed Anxiety* →

All patients diagnosed with mental and behavioural disorders due to alcohol use were diagnosed with this at all subsequent episodes (up to three episodes). The remaining patients were all diagnosed with the same condition at subsequent episodes, with one patient with specified (isolated) phobias having the most (n=11) separate episodes.

The average age of PLS patients differed across the diagnoses (Figure 3), where patients diagnosed with disappearance or death of a family member were, on average, older than patients with other diagnoses (mean age 47.31 ± 23.1).

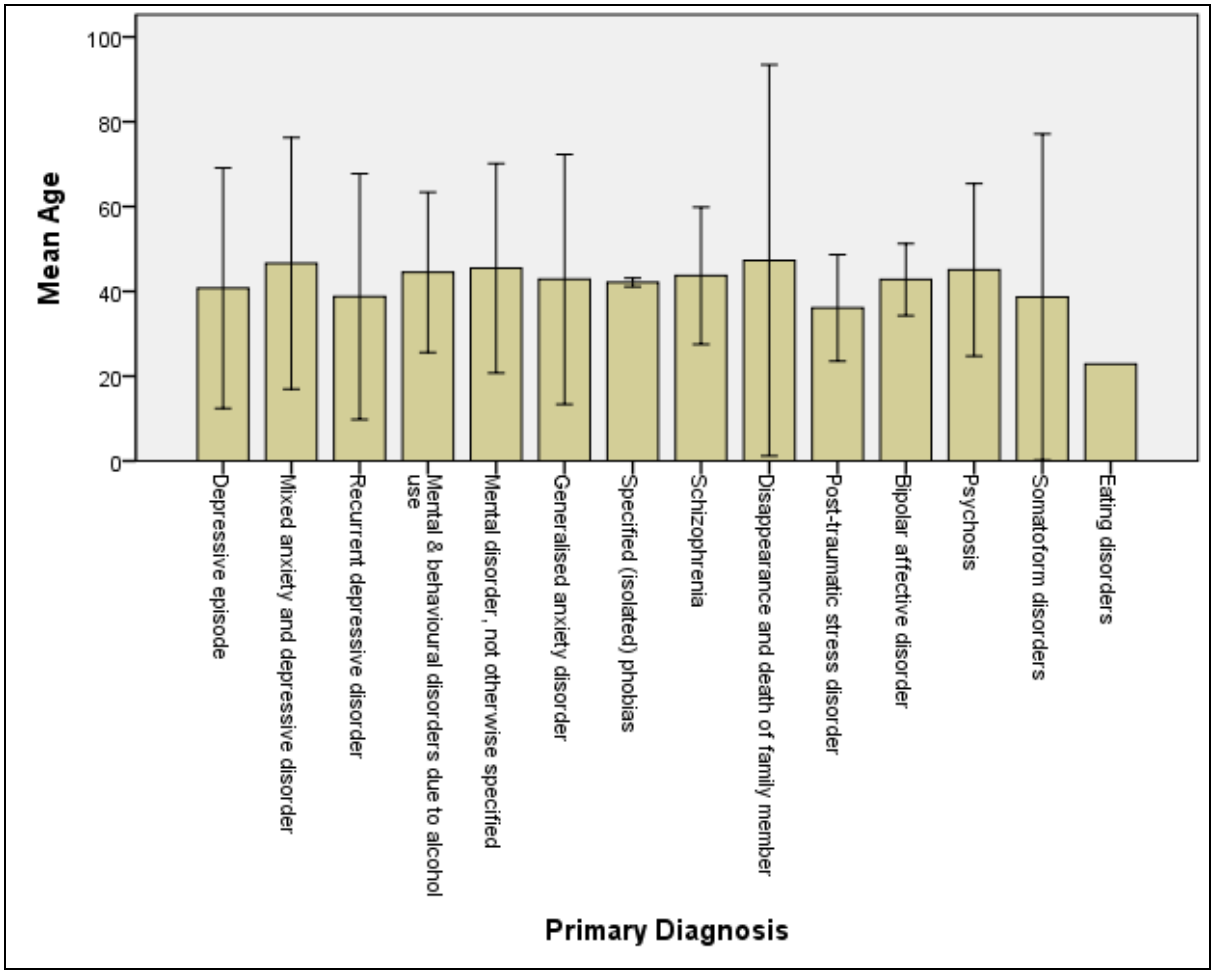


Figure 3 Average Age of PLS Patient by Primary Diagnosis (ordered by numerical size of group)

The most common action required for patients with only PL advocacy episode was regarding debts (37.7%), which was closely followed by housing (24.5%) and benefits (20%). These were also the most common action required at the first episode of patients who required more than one PL advocacy episode. However, there was a notable decrease in housing problems and debts at patients' the second episodes, suggesting these problems had been addressed, where the number of patients reporting benefits problems at second episodes increased (Table 8).

Table 8 Secondary Diagnosis of PLS Patient

	N Patients					
	Patients with only 1 episode		Patients with > 1 episode			
			First episode action		Second episode action	
Action Required	n	%	n	%	n	%
Debts	134	37.7	28	35	23	28.8
Housing	87	24.5	22	27.5	11	13.4
Benefits	71	20	20	25	24	30

Other	19	5.4	5	6.3	11	13.4
Health and community care	13	3.7	4	5	4	5
Relationship and family	8	2.3	0	0	0	0
Legal	7	1.9	0	0	0	0
Employment	6	1.7	0	0	2	2.5
Financial services and products	5	1.4	1	1.3	1	1.3
Education	4	1.3	0	0	1	1.3
Utilities	1	0.3	0	0	1	1.3
Consumer	0	0	0	0	1	1.3
Travel, transport and holidays	0	0	0	0	1	1.3
Total	355	100	80	100	80	100

Individual patient journeys were explored in those patients who had more than one PL advocacy episode, amongst the most common actions required. Of the patients who required help with debts at their first episode (n=28), ten of these (35.7%) required support with debts at the second episode. Nine patients required support with benefits, and others required support in housing (n=2), education (n=1), financial services and products (n=1), consumer (n=1), and health and community care (n=1), with three people being classified as requiring 'other' support. Four of these patients had a third episode, requiring benefits regarding benefits and health and community care, and two patients had a fourth episode, requiring debt support.

Out of the 22 patients who required support regarding housing at first episode, only four required this at second episode. Instead, patients required support regarding debts (n=5) and benefits (n=6). Other patients required support regarding health and community care (n=2) or were unclassified (n=4). Eight patients had a third episode, requiring support regarding benefits (n=4), housing (n=1), travel, transport and holidays (n=1) or were unclassified. Three patients had a fourth episode (requiring support regarding benefits, housing and 'other'), and the patient with benefits problems had five episodes.

Finally, patients who required benefits support at first episode (n=20) were explored, and six of these still required benefits support at second episode. Instead, patients needed support for debts (n=6), housing (n=5), employment (2), with the remainder unclassified. Six of these patients had a third episode, and needed support for benefits (n=3), housing (n=1), debts (n=1) or 'other' (n=1). Four of these patients had five episodes, requiring support for benefits, health, debts and travel, and one patient had six episodes, needing continued support for benefits.

Patients with problems relating to health and community care were on average older than other PL advocacy patients (mean age = 51.40 ± 16.32), and patients with problems relating to education were on average the youngest (mean age = 23.06 ± 3.59) (Figure 4).

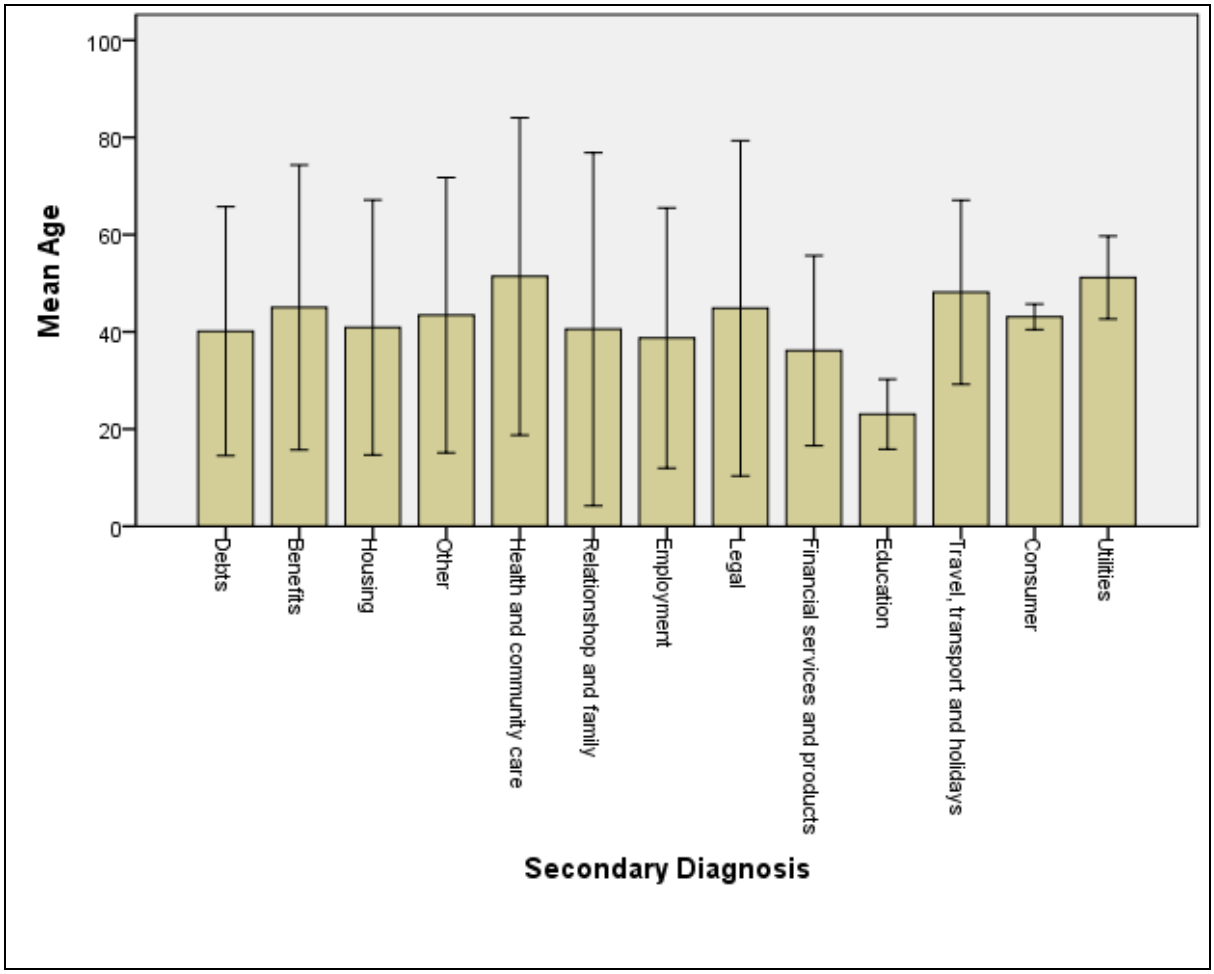


Figure 4 Average PLS Patient Age by Secondary Diagnosis (ordered by numerical size of group)

3.2 Admissions and Waiting Times

3.2.1 Admissions and Waiting Times: IMHA Advocacy

IMHA Advocacy Referrals
Patients are able to refer themselves to the IMHA service, or can be referred by a number of sources. Hospital staff were the most frequent source of referrals for all patient episodes, representing 57.3% for patients with only one advocacy episode, 66.9% for the first episode in patients with more than one episode, and 60% for the second episode in patients with more than one episode (Table 9).

Of patients who only had one IMHA advocacy episode, 12.7% self-referred, suggesting an awareness of the service in patient who had not used it. For patients who had more than one advocacy episode, self-referrals increased from 9.6% in patients' first episodes to 16.3% in second episodes (Table 9). This finding was reflected in a decrease in referrals from hospital staff and other mental health professionals.

Table 9 Referral Source for Patient Episodes

Referral Source	N Patients		
	Patients with only 1 episode	Patients with > 1 episode	
		First episode	Second episode
Hospital staff	306	214	193
Self	68	31	52
Community mental health professional	61	25	28
Consultant psychiatrist	41	21	23
Inpatient mental health professional	21	14	8
Family/friends	17	6	10
Other	14	6	5
Psychiatric liaison team	6	3	1
Total	534	320	320

For primary episodes, the most common communication method to patients was 'visit' (543/854, 63.6%), followed by 'other' (264/854, 30.9%). For secondary episodes, the most common communication method to patients was also 'visit' (491/925, 53.1%), followed by 'other' (369/925, 39.9%).

The majority of advocacy appointments took place at the inpatient ward (Table 10), this was the case for patients with only one episode, and patients with more than one episode. For patients who had more than one IMHA advocacy episode, those who were seen at the inpatient ward were also seen here at their second episode. The number of home visits increased for second episodes, as reflected in the decrease of second appointments at the Advocacy office, hospital, and community venue. There was a decrease in the proportion of patients who required three episodes who were seen in the inpatient ward (from 88.4% at second episode to 85.5% at third episode), and an increase in these patients who were seen at home (from 6.3% at second episode to 7.3% at third episode) (Table 10).

Table 10 IMHA Advocate Patient Appointment Site by Episode

Referral Source	N Patients			
	Patients with only 1 episode	Patients with > 1 episode		
		First episode	Second episode	Third episode
Inpatient ward	445	283	283	153
Home visit	38	11	20	13
Advocacy office	34	20	16	8
Community venue	15	3	1	5
Hospital	2	3	0	0
Other	0	0	0	0
Total	534	320	320	179

A review of NHS Mental Health Services (2012) showed that in 2010-11, 523 people were discharged from Adult and Older People Inpatient wards. The Advocacy in Wirral data show

that 281 patients were seen by the IMHA advocacy service in 2010-11, who had a total of 577 separate patient episodes (range = 1-26, mean = 2.05 ± 2.29). In 2010-11, a total of 255 separate IMHA advocacy patients were seen in the in-patient ward (representing 48.75% 255/523, of all patients discharged from the Adult and Older People Inpatient wards) (Table 11).

Table 11 IMHA Advocate Patient Appointment Sites 2010-11

Appointment Site	Primary Episode	Subsequent Episodes	
		Number of patients	Number of episodes
Inpatient ward	146	109	346
Advocacy office	6	18	34
Home visit	14	5	21
Community venue	1	13	6
Hospital	0	2	2
Other	0	1	1
Total	167	148	410

IMHA Advocacy Patient Contacts

The majority of IMHA cases required two (41.5%, 739/1779) or three (20.5%, 365/1779) contacts before they were resolved (Table 11). Patient contacts ranged up to 70 for patients with one episode, and 22 for patients with more than one episode. The majority of cases required up to 15 contacts, therefore the three patients who required 16, 22 and 70 contacts were removed from analysis of mean contacts.

The average number of contacts was higher for patients with only one episode (31 ± 55.7) than patients who had more than one episode (average contacts for first episode 18.9 ± 32.2, average contacts for second episode 18 ± 40.1), however the central tendency was much lower for second episode of patients with more than one episode (Table 11).

Table 11 IMHA Advocacy: Number of Patient Contacts Required

	N Patients		
	Patients with only 1 episode	Patients with > 1 episode	
N Contacts		First episode	Second episode
1	62	21	23
2	193	113	143
3	106	65	66
4	36	27	22
5	22	14	7
6	8	5	9
7	5	7	2
8	1	4	0
9	1	2	1
10	3	1	0
11	0	1	0
12	1	1	1
14	0	3	0

15	2	1	1
16	0	1	0
21	0	0	0
22	0	1	0
70	1	0	0
Total	441	267	275
Median	4	4.5	1

The higher number of contacts between the patients and their advocates were amongst patients with a diagnosis of schizophrenia, depressive episodes, psychosis, recurrent depressive disorder and bipolar affective disorder.

IMHA Advocacy Patient Waiting Times

The majority of all new patients were contacted by AiW on the day of their referral (95.5%, 815/854), with 98.3% (835/854) of patients being contacted within 48 hours. Similarly, the majority of all patient subsequent episodes (98.5%, 911/921) were contacted by AiW on the day of referral, with 99.3% (919/925) of patients being contacted within 48 hours. There were marked, but not significant differences between the number of days between referral and first contact at the primary and subsequent episodes ($t(1768) = .962$, $p = .336$), and the time from referral to commencement of advocate support at the primary and subsequent episodes ($t(1768) = -.295$, $p = .768$). There was a significant difference between referral and outcome date (in days) between primary and subsequent episodes ($t(1359.32) = -5.180$, $p < .000$) (Table 11).

Table 11 IMHA Patient Waiting Times

	Primary episode			Subsequent episodes		
	N	Range	Mean	N	Range	Mean
Time from referral to first contact (days)	849	0 - 4	0.02 ± 0.18	921	0 - 61	0.08 ± 2.02
Time from referral to commencement (days)	849	0 - 158	0.26 ± 5.44	921	0 - 61	0.20 ± 2.15
Time between referral and outcome date (days)	706	0 - 1067	118.79 ± 202.69	833	0 - 809	69.36 ± 165.54*

*Denotes a significant difference at the $p < .005$ level

The data show that three monthly follow-ups were completed for 70.6% (194/273) of patients' primary episodes between April 2009 and March 2010 (Year 1). The AiW database did not show any three monthly follow-ups completed between April 2010 and March 2011 (Year 2), or April 2011 and March 2012 (Year 3). Three monthly follow-ups were completed for 82.4% (220/267) of subsequent episodes between April 2009 and March 2010 (Year 1). Again, the database did not show any three monthly follow-ups completed in Years 2 or 3.

In primary episodes, 83.5% (713/854) of cases were recorded as closed, with 5.9% (50/854) of patients signposted to other agencies (18/50, 36% to other AiW services, and 32/50, 64% to external agencies).

In subsequent episodes, 90.4% (836/925) of cases were recorded as closed, with 5.5% (51/925) of clients signposted to other agencies (7/51, 13.7% to other AiW services, and 44/51, 86.3% to external agencies).

3.2.2 Admissions and Waiting Times: PL Advocacy

PL Advocacy Referrals
Patients are able to refer themselves to the PLS service, or can be referred by a number of sources. The majority of patients were referred by the Psychiatric Liaison Team, accounting for 93.5% of referrals for patients with only one episode, 96.3% of referrals for the first episode of patients with more than one, and 92.5% of referrals for patients' second episodes. This reduction is reflected in the referral from the hospital staff, inpatient mental health professional (Table 12).

Table 12 Referral Source for PLS Advocacy Patient Episodes

	N Patients		
	Patients with only 1 episode	Patients with > 1 episode	
Referral Source		First episode	Second episode
Psychiatric liaison team	332	77	74
Hospital staff	11	1	2
Self	8	1	1
Community mental health professional	3	0	0
Consultant psychiatrist	1	1	1
Inpatient mental health professional	0	0	1
Other	0	0	1
Total	355	80	80

The most common communication method to patients was visit (306/562, 54.4%), followed by telephone (196/562, 34.9%), letter (34/562, 6%), and other (26/562, 4.6%).

The proportion of patients with only one PL advocacy episode who had their appointment in hospital (inpatient ward or hospital) was 79.2%, with 11.8% of these seen at home. There was a decrease in the proportion of patients with more than one episode, who had their appointment at hospital; 75% of these patients had their first episode appointment at hospital, 71.3% had their second, and 47.6% had their third episode appointment at hospital. This is reflected in the increase in home appointments, with 17.5% of patients with more than one episode having their first episode appointment at hospital, 18.8% of patients' second, and 47.6% of patients third episode appointments at home (Table 13).

Table 13 PL Advocacy Patient Appointment Site by Episode

	N Patients			
	Patients with only 1 episode	Patients with > 1 episode		
Appointment site		First episode	Second episode	Third episode
Inpatient ward	198	42	39	7
Hospital	83	18	18	3
Home visit	42	14	15	10
Advocacy office	26	4	5	1

Community venue	6	2	3	0
Total	355	80	80	21

A review of NHS Mental Health Services (2012) showed that in 2010-11, 523 people were discharged from Adult and Older People Inpatient wards. The Advocacy in Wirral data show that 119 patients were seen by the PL advocacy service in 2010-11, who had a total of 133 separate patient episodes (range 1-2, mean = 1.06 ± 0.23). In 2010-11, a total of 92 PL advocacy patients were seen in the in-patient ward (representing 17.59%, 95/523 of all patients discharged from the Adult and Older People Inpatient wards) (Table 14).

Table 14 PL Advocate Patient Appointment Sites 2010-11

Appointment Site	Primary Episode	Subsequent Episodes	
		Number of patients	Number of appointments
Inpatient ward	87	5	8
Advocacy office	9	1	1
Home visit	14	3	5
Community venue	1	0	0
Hospital	8	0	0
Total	119	9	14

PL Advocacy Patient Contacts

The PLS patients required a range of contacts before they were resolved, with the majority requiring two (14.2%, 80/562) or three (12.5%, 70/562) contacts.

Patient contacts ranged up to 73 for patients with one episode, and 73 for patients with more than episode. The average number of contacts for patients with only one episode was 6.2 ± 12.8, whereas average contacts for all patients who had more than one episode was lower (average contacts for first episode 1.1 ± 1.6, average contacts for second episode 1.0 ± 1.8).

The higher number of contacts within the first fifteen contacts, when the remaining were removed the average number of contacts was much higher for patients with one episode (13.9 ± 17.6), in comparison to patients who had more than one episode (average contacts for first episode 2.1 ± 2.1, average contacts for second episode 2.3 ± 2.2), and supported in central tendency findings that for patients with one episode had median 6.5 contacts, compared to 1 for first of multiple episodes and 1.5 for the second of multiple episodes.

The higher number of contacts between patients and their advocates were amongst patients with a diagnosis of mixed anxiety and depressive disorder, depressive episodes, mental and behavioural disorders due to alcohol use and recurrent depressive disorder.

PL Advocacy Patient Waiting Times

The majority of all new PLS patients were contacted by AiW on the day of their referral (91.7%, 399/435), with 98.1% (421/435) of patients being contacted within 48 hours. Similarly, 91.3% (116/127) of all patient subsequent episodes were contacted on the day of referral, with 96% (121/127) of patients contacted within 48 hours. There was a significant difference between the number of days between referral and first contact at the primary and subsequent episodes ($t(125.063) = 1.999$, $p = .048$). There were no significant differences between time from referral to commencement of advocate support at the primary and subsequent episodes ($t(553) = -.821$, $p = .412$), and referral and outcome date (in days) between primary and subsequent episodes ($t(349) = -.026$, $p = .979$) (Table 15).

Table 15 PLS Patient waiting times

	Primary episode			Subsequent episodes		
	N	Range	Mean	N	Range	Mean
Time from referral to first contact (days)	429	0 - 88	0.39 ± 4.52	126	0 - 921	27.91 ± 154.52*
Time from referral to commencement (days)	430	0 - 88	0.49 ± 4.60	125	0 - 5	0.15 ± 0.661
Time between referral and outcome date (days)	282	0 - 790	98.75 ± 153.66	69	0 – 843	98.19 ± 189.19

*Denotes a significant difference at the $p < .005$ level

The PLS data show monthly follow-ups were completed for 10.34% (45/435) of patients' primary episodes between April 2009 and March 2010 (Year 1). The AiW database did not show any three monthly follow-ups completed between April 2010 and March 2011 (Year 2), or April 2011 and March 2012 (Year 3).

Three monthly follow-ups were completed for 23.6% (30/127) of subsequent episodes between April 2009 and March 2010 (Year 1). Again, the database did not show any three monthly follow-ups completed in Years 2 or 3.
In primary episodes, 65.7% (286/435) of cases were recorded as closed, with 4.1% (18/435) of patients signposted to other agencies (8/435, 1.8% to other AiW services, and 10/435, 2.3% to external agencies).

In secondary episodes, 54.3% (69/127) of cases were recorded as closed, with 7.9% (10/127) of clients signposted to other agencies (2/127, 1.6% to other AiW services, and 8/127, 6.3% to external agencies).

3.3 Impact

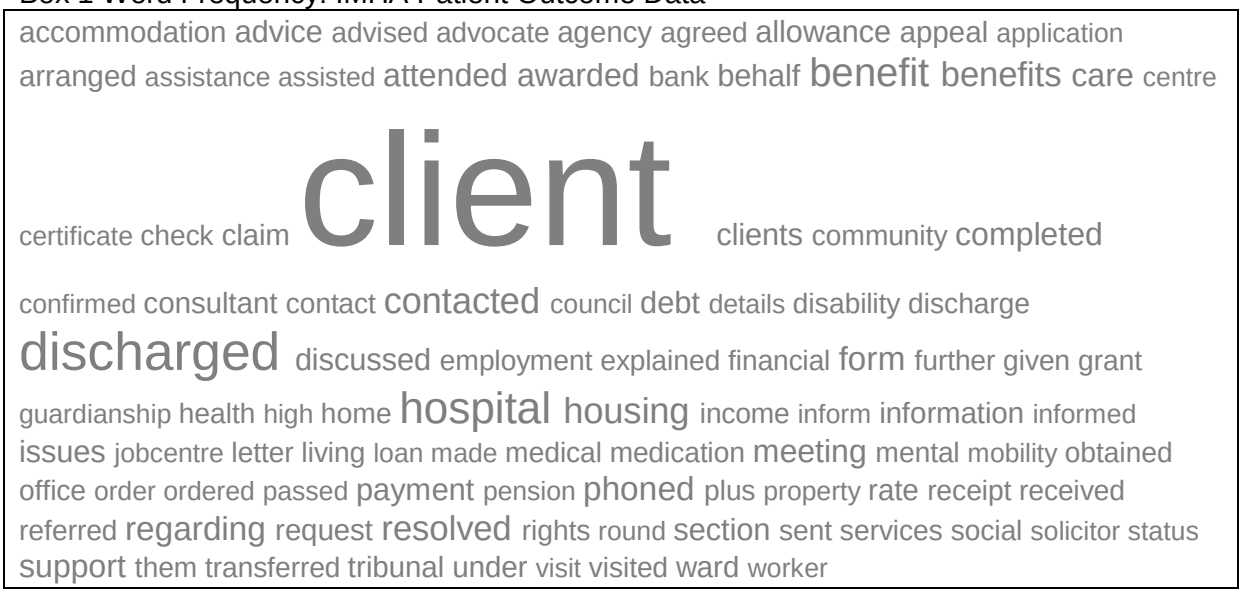
3.3.1 IMHA Advocacy Outcome Data

Patient outcome data are recorded in the AiW database as free text entries. Outcome data were available for 87.2% (1551/1779) of all IMHA patient episodes recorded between 4th April 2009 and 30th May 2012 (primary episodes = 83.5%, 713/854; subsequent episodes = 90.6%, 838/925). The free text data for IMHA patient outcomes were analysed using NVivo 9. A word frequency was generated for primary and subsequent outcomes to demonstrate the most frequently used words to describe the patient outcomes and to determine any differences between primary and subsequent episodes[4].

Box 1 shows that the most frequently used words for all IMHA patient outcomes recorded in the AiW database were 'client', 'discharged', 'hospital', 'benefit' and 'housing'. The word frequency information also indicates the range of support provided by IMHAs, as demonstrated by the frequency of words such as 'contacted', 'resolved', 'phoned', 'attended', 'completed', 'confirmed', 'contacted', and 'explained'.

[4] The 100 most frequent words with a minimum of four letters were included and only nouns, adjectives, verbs and adverbs were included (e.g. conjunctions such as 'and' and prepositions such as 'in' were removed.

Box 1 Word Frequency: IMHA Patient Outcome Data



The words ‘able’, ‘creditors’, ‘engage’, ‘file,’ ‘further’, ‘guardianship’, ‘help’, ‘Jobcentre’, ‘referred’, and ‘representation’ were present in the word frequency for patients’ primary episode outcome information, but did not appear in the word frequency for patients’ subsequent episode outcome information. Words such as ‘further’ and ‘referred’ suggest that the patient required further support which was not required when the patient was seen on subsequent occasions.

More nouns than verbs were present in the word frequency for patient’s subsequent episode outcome information, with the words ‘certificate’, ‘card’, ‘council’, ‘credit’, ‘grant’, ‘loan’, ‘mobility’, ‘pension’, ‘property’, ‘telephoned’, and ‘Wirral’ not appearing in primary episode data. This information is more specific, and may suggest that patient’s subsequent IMHA episodes may be for a more specified than general issue.

The words ‘advice’, ‘debt’ and ‘section’ appeared in the top 20 most frequent words recorded in the primary episode outcome information, but did not appear in the top 20 for the subsequent episodes, indicating these were not issues for patients on subsequent occasions. Action-oriented words such as ‘attended’, ‘meeting’, ‘awarded’, ‘request’, and ‘behalf’ were present in the top 20 most frequent words recorded in subsequent episode outcomes, but did not appear in the primary episode outcomes, suggesting that the initial episode may require advice and support pertaining to debt, housing and benefits, and subsequent episodes require the Advocate to attend meetings, request information, and act on the client’s behalf.

IMHA Advocacy High User Case Studies

A random selection of high users of the IMHA service (those who had a high number of subsequent episodes and contacts) were explored in depth, to provide an understanding of their journey.

IMHA case study 1

Characteristics: 51 year old, single female with the primary diagnosis noted as schizophrenia, bi-polar affective disorder and mental disorder on different referral occasions.

Referral information: Referred 24 times between February 2010 and December 2010 with between one and five separate contacts with an advocate per referral. The initial and majority of the referrals were made by hospital staff, but on a few occasions the patient self-referred (6 times). Other referrers included a community mental health professional and consultant psychiatrist. The main mode of contact for this patient was via hospital or home

visits and telephone calls. The patient was contacted by an advocate on the day of referral each time.
Support details: The patient required support for mainly money-related issues including benefit claims and assistance with debts. Outcomes included: support with claiming for bereavement benefits and funeral grant; general advice regarding what support and benefits were available for the patient and assistance filling in forms; and contacting utility companies, council tax and creditors on patient's behalf to resolve debt problems. Most outcomes appeared to have been completed the same day as referral; however, there were a few occasions where the outcomes appeared to have taken over a year to resolve. It is uncertain if this is a real time lapse or administration error. Four of the referrals were noted to have had a three-month follow up (the first four referrals); however, the patient was in regular contact with AiW through the year 2010.

IMHA case study 2
Characteristics: 47 year old, single female with the primary diagnosis noted as schizophrenia, psychosis and depressive episode on different referral occasions.
Referral information: Referred nine times between August 2010 and October 2011 with between two and four contacts with an advocate per referral. The initial contact was a self-referral and the patient self-referred on one subsequent occasion; however, the majority of the referrals were by hospital staff. The patient was either visited at home or hospital or received a phone call. The patient was contacted by an advocate on the day of referral each time.
Support details: The patient required support mainly with benefits, but they were also assisted on one occasion each with housing, debts, health and community care and representation of Mental Health Act. Outcomes included: arranging and contacting benefits agencies to ensure patient benefit entitlement resumed on discharge from hospital and liaising with utility companies on patient's behalf. Most outcomes were completed the same day as referral; however, there were two occasions where the outcomes appeared to have taken over a year to resolve. It is uncertain if this is a real time lapse or administration error. No three-month follow up details were noted for this patient.

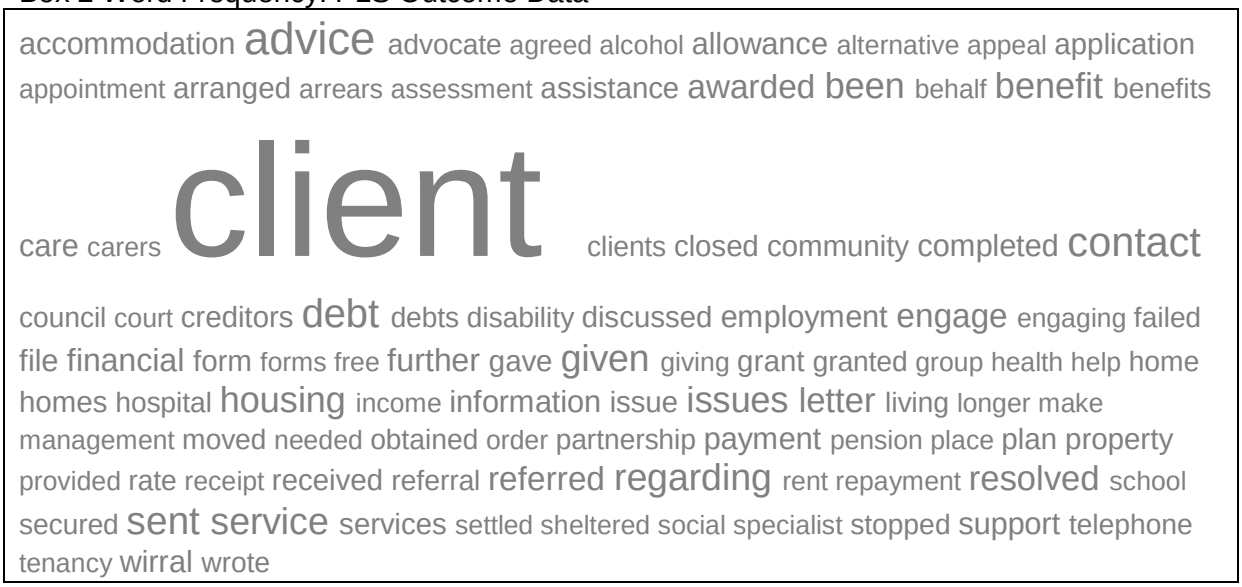
IMHA case study 3
Characteristics: 21 year old, single male with a primary diagnosis of psychosis, mental disorder and schizophrenia on separate referral occasions.
Referral information: The patient initially self-referred and was referred a total of five times between March and April 2010 with between two and four contacts with an advocate per referral. Subsequent referrers included a community mental health professional and hospital staff. The patient was mainly seen in hospital by an advocate, but received one phone call. The patient was contacted by an advocate on the day of referral each time.
Support details: The patient required support with a range of issues such as housing, benefits and financial services/products. Outcomes included: assistance with finding secure housing; liaising with community psychiatric nurse to inform patient they were to be assessed for supported living; and assistance with the re-instating of income support for the client. Most outcomes were completed the same day as referral; however, there were two occasions where the outcomes appeared to have taken over two years to resolve. It is uncertain if this is a real time lapse and administration error. Two of the referrals were noted to have had a three-month follow up (the first four referrals).

3.3.2 PL Advocacy Outcome Data

Free text outcome data were available for 63.2% (355/562) of all PL advocacy service patient episodes recorded between 24th June 2009 and 18th May 2012. As with the IMHA advocacy data analysis, a word frequency was generated for primary and subsequent outcomes to highlight the most frequently used words to describe the patient outcomes and determine any differences between primary and subsequent episodes[4]. Box 2 shows that

the most frequently used words for all PL advocacy outcomes were ‘client’, ‘advice’, ‘contact’, ‘debt’ and ‘sent’. The word frequency also demonstrates the range of support provided by the PL advocates, as demonstrated by the frequency of the words ‘contact’, ‘referred’, ‘resolved’ and ‘sent’. Unlike the IMHA advocacy outcomes, there were no clear differences between the outcome data recorded for the primary and subsequent episodes.

Box 2 Word Frequency: PLS Outcome Data



PL Advocacy High User Case Studies

A random selection of high users of the PL advocates (those who had a high number of subsequent episodes) were explored in depth, to provide an understanding of their journey.

PL Advocacy case study 1

Characteristics: 42 year old, divorced female with the primary diagnosis being specified phobias.

Referral information: Referred on numerous occasions on one day in June 2009 by a consultant psychiatrist and a community mental health professional; a subsequent referral was made in October 2009 by psychiatric liaison team. The June referral resulted in multiple contacts with an advocate via visitation at hospital, letter and one phone call. Some occasions had the mode of contact noted as ‘other’ but it is uncertain what this contact is. The majority of the contacts were made on the day of referral; however there four recordings of long delays of up to 921 days (30 months), but the dates inputted for initial contact appear to coincide with the date of referral. Therefore, the number of days between referral and initial contact for these occasions may be administration error.

Support details: The patient required support mainly with benefits but also isolated one-off assistance with legal issues, relationship and family problems and housing. Outcomes included: support with applying for Community Care Grant; referral to local agencies to ensure client has care package in place; contact with Young Carers on behalf of client’s child to ensure they are provided with support; and information and advice provided regarding local solicitor’s details. Whilst some outcomes were completed quickly (within one day), others took longer depending on the support required. The longest took 166 days, which is approximately five months. All referrals had a three-month follow up completed.

PL Advocacy case study 2

Characteristics: 45 year old, single male with primary diagnosis noted as mental and behavioural disorders due to alcohol use, mixed anxiety and depressive disorder and recurrent depressive disorder on separate referral occasions.

Referral information: Referred five times between December 2009 and December 2010 with between three and 15 contacts with an advocate per referral. Each referral was made via psychiatric liaison team and the patient was contacted by either home or hospital visits. The patient was contacted by an advocate on the day of referral each time.
Support details: The patient was supported with a range of issues and outcomes included: a referral to Young Carers support agency so that the client's child could be provided with support; the client being offered money through Social Fund; application for free school meals being granted; and the client being awarded a travel pass. According to the database referrals took between six and 482 days (approximately 16 months) to resolve; however, this could be administration error. Two of the referrals resulted in a three-month follow up being completed.

PL Advocacy case study 3
Characteristics: 37 year old, single female with a primary diagnosis of general anxiety disorder.
Referral information: Referred twice by psychiatric liaison team between October 2009 and March 2010 with multiple contacts with an advocate per referral (12 contacts for the first referral and five contacts for the second). Contact by an advocate was made on the same day as the referral each time via hospital visits and phone calls.
Support details: The patient was supported with benefits and housing such as assisting with having the patient granted with an urgent needs status for housing and their disability living allowance being reviewed. Outcomes were noted to have taken between 64 and 563 (approximately 18 months) to resolve. One three-month follow-up was completed.

3.3.3 AiW Hospital Advocacy Case Studies

Between March 2011 and March 2012, AiW collected case study data from 25 patients using Hospital and Older People in the Community Services. Each month, two Advocates were requested to complete a case study[5], written from the advocate's perspective detailing their experiences with particular clients. These case studies do not identify individual patients and so cannot be matched to the IMHA and PL advocacy datasets, however these data have been included in this evaluation to further explore the impact of hospital advocates, and to verify the quantitative and qualitative findings. Content analysis was used to explore the case studies, and although it was clear that people had very different histories and reasons for using AiW, four key themes emerged as representative of the data: explanation, relationships, finance and accommodation. These themes are not discrete, as clients often faced issues which spanned across all four themes.

Explanation
The case studies detail the uncertainty and fear that patients' feel when they are suffering mental ill-health and are in need of support, and these feelings are further compounded when patients do not understand the situation they are in. A clear role for AiW is that of explaining processes and procedures to vulnerable individuals.

> *"[I wanted the client] to at least understand the severity of her situation and explain the alternatives to her without upsetting her"*

> *"I was eventually able to explain to the client that she was under a section and was entitled to apply for a Tribunal which she wanted to do."*

> *"AiW was able to explain the process of compulsion under the Mental Health Act 1983 and the safe guards enshrined within the Act. We also explained what his*

[5] One case study was collected in November 2011, therefore a total of 25 were collected

rights were and the process of appeal if he wanted to contest his sectioning under the Act"

"[I] explained the details of the section to her, the appeal procedure, and the fact that I could contact a solicitor to represent her at the tribunal"

These explanations helped the Advocate to build a rapport with the clients, which led to the Advocates representing clients at tribunals and ward rounds, arranging Best Interest Meetings, and assisting the client to be removed from Guardianship.

Relationships
Many of the clients seen by AiW faced relationship problems, most commonly with their spouse, and sometimes with their siblings or children. There were situations where relationship problems had contributed to the mental ill-health, or occurred as a result of the mental ill-health.

"When [client] decided that he did want help from AiW he explained that he and his wife were on the verge of breaking up….and felt that his life was falling apart. [The client's wife] had asked him to leave the family home and his two children had not been speaking to him"

"Since coming in to hospital and becoming ill [the client] and her husband had separated. She was unsure where to start in sorting out her problems and consequently left all her bills and debts without opening the envelope."

"[The client] was concerned that she would have nowhere to live on discharge as her marriage had broken down"

"[The client's] brother was very low in mood and at first was refusing for [the client] to return home"

"[The client's] method of payment had always been by cash at the bank, but since the recent death of her husband and due to her mental ill health she was unable to manage these issues now, and didn't fully understand the alternative payment methods."

In these instances, AiW were able to assist by finding suitable accommodation for clients, liaising with Solicitor's to arrange mediation, liaising with creditor's to organise financial repayments, and organise appropriate benefits.

Finance
Financial pressures were often mentioned as either contributing to or happening as a result of mental ill-health. Debts, benefits and pensions were commonly mentioned in the case studies.

"There were also multiple debts; we made a referral to an associated debt management project which immediately made an arrangement to see the client at the hospital. The debt project was able to stop the client's home being repossessed and a payment plan was put into place to manage the client's debts."

"I completed a benefits check and after noting that [the client] was not claiming benefits that he was entitled to I advised him and assisted him in submitting the appropriate claims. The benefits were subsequently granted."

"We were able to have some debts written off and those that remained were arranged onto a repayment plan."

"I then made a debt referral to the Money Advice project, arranging an appointment for a debt adviser to visit the client which she did. I had helped the client to gather all her letters concerning debt and we handed these to the debt adviser. I asked the client's consultant for a letter of support to add to our request for favourable terms when paying back any debts. The letter was then forwarded to the debt adviser and the process of negotiation is ongoing"

"AiW were able to take away the pressure of all debts by agreeing to contact all her creditors and acting on her behalf to liaise with them and sort out repayment agreements. As the letters from the creditors would now come straight to AiW [the client] felt that was a huge weight off her mind."

Financial arrangements such as those highlighted here prevented clients from having their homes repossessed, and resolved any financial issues that may have been contributing towards clients' mental ill-health.

Accommodation

Many clients seen by an Advocate had accommodation problems, including living in unsuitable accommodation *"client is suffering an enduring mental health problem as well as being physically disabled…she had been placed into a block of flats on the sixth floor, she was unable to get out of the flat and felt she was trapped",* unsuitable locations *"[the client] told me that he no longer wanted to live and was over whelmed by anti-social behaviour, youths and attacks on him in the area that he lived. [The client] felt unable to return to his home"*, or having no accommodation to return to at all *"[the client] eventually returned to the Wirral where she was found by the Police begging for food on the streets of Birkenhead*."

These interventions resulted in all of the Advocacy clients being placed in appropriate accommodation.

"As [the client's] condition stabilised I was able to arrange for her to view a number of properties with the assistance of her Community Psychiatric Nurse, and the approval of her consultant"

"We were able to secure for our client a small one bed roomed flat without the need for a deposit from a landlord we have worked with many times."

"We told [the client] that we would be able to assist him with finding some accommodation at least temporarily whilst he and his wife decided if the split was permanent or not. We were able to contact a local landlord who offered our client a one bed roomed furnished flat for six months"

3.3.4 Mental Wellbeing

The AiW Hospital Advocacy case study information includes a measure of mental wellbeing, collected at the beginning and the end of the Hospital Advocacy intervention, using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS). Due to the low sample size, a non-parametric test (the Wilcoxon Signed-Rank Test) was used to determine changes in the pre- and post-interventions scores. Findings revealed significant differences between the pre and post scores of all 14 WEMWBS items (Table 16).

Table 16 Mental Wellbeing Pre- and Post-Hospital Advocate

	Pre-Score		Post-Score		Z Score	
	Mean	±	Mean	±		
I've been feeling optimistic about the future	1.16	0.37	3.56	0.51	4.493	*
I've been feeling useful	1.56	0.51	3.44	0.58	4.522	*
I've been feeling relaxed	1.56	0.51	3.60	0.58	4.449	*
I've been feeling interested in other people	1.36	0.49	3.68	0.63	4.424	*
I've had energy to spare	1.60	0.50	3.56	0.71	4.431	*
I've been dealing with problems well	1.60	0.50	3.44	0.51	4.440	*
I've been thinking clearly	1.80	0.41	3.84	0.55	4.477	*
I've been feeling good about myself	1.56	0.51	3.84	0.47	4.465	*
I've been feeling close to other people	1.52	0.51	3.72	0.46	4.484	*
I've been feeling confident	1.40	0.50	3.64	0.49	4.506	*
I've been able to make up my own mind about things	1.52	0.51	3.72	0.46	4.457	*
I've been feeling loved	1.48	0.59	3.88	0.44	4.451	*
I've been interested in new things	1.64	0.49	4.00	0.41	4.540	*
I've been feeling cheerful	1.76	0.44	3.80	0.41	4.520	*

** Denotes significance at p < .000 level*

4. Discussion

4.1 Service Use

Data show that a relatively large proportion of all Wirral patients identified on clinical registers as having a mental health problem were seen by AiW IMHA advocates (16.08%), with almost a quarter of all patients referred to Wirral Mental Health Services being seen by an IMHA advocate. Although the age of IMHA advocacy users were representative of local mental health prevalence, it was interesting to find that gender use was not representative, with more males than females accessing this service, despite a higher prevalence of mental health problems amongst females. This supports previous findings that more women than men use mental health services, but more men than women are treated as inpatients, and suggesting that men do not access services until they reach a crisis point (NHS Information Centre, 2009).

A small number of AiW advocates dealt with the IMHA and PL advocacy patients, with just one or two advocates providing the majority of support. This may become a capacity issue, particularly with the PL advocacy patients who require a large number of contacts per episode.

It was unsurprising that patient primary diagnosis differed for IMHA and PL advocacy service users, with more generic diagnoses (depressive episodes, mixed anxiety and depressive disorders, and recurrent depressive disorder) being the most frequent primary diagnosis for IMHA advocacy patients, and more specific diagnoses (schizophrenia, bipolar and psychosis) the most frequent primary diagnosis for PL advocacy patients. However, a key finding from the evaluation was that despite the differences in primary diagnosis, there were no differences in the actions required for IMHA and PL advocacy service users. Benefits, housing and debts were all the most frequent actions required for patients. This finding is important for service delivery, suggesting that using hospital advocates to tackle risks associated with mental health problems will reduce inpatient admissions regardless of patients' primary diagnosis.

Black and ethnic minority groups are at higher risk of suffering mental ill-health, and interventions must promote and support mental wellbeing within these groups (RCP, 2010). Ethnicity of clients using IMHA and PL advocates was predominantly white British suggesting a potential gap in support to these groups. A large scale review of IMHA advocacy services in England identified that there had been little commissioning of advocacy services on the basis of need and equality, with particular gaps in BME communities (Newbigging, et al., 2012). The findings from this review showed the investment in IMHA advocacy services was inadequate and was not meeting the needs of the people who could benefit from this service (Newbigging, et al., 2012).

4.2 Admissions and Waiting Times

The evaluation demonstrates the range in referral sources to AiW, which come not only from health care professionals but through self-referral and family/friends, highlighting that patients are signposted to advocacy resources. A key finding related to this is that of an increase in self-referrals following a primary episode. This finding suggests that patients recognised when they required the help of an advocate, which resulted in an increased number of home-based appointments and a reduction in hospital inpatient appointments.

The majority of IMHA advocacy patients required two or three contacts before cases were resolved, with fewer contacts required for subsequent episodes. This finding is important for service delivery as, although service users are returning, a high proportion are recognising the problem, self-referring, and not requiring a large amount of support to resolve the issue. Similarly, although PL advocacy patients required a higher number of contacts than IMHA advocacy patients before an outcome was reached, findings suggest that returning service users recognise the problem, self-refer to AiW, and are treated at home before they reach a crisis point, thus preventing a hospital admission.

The majority of patients were contacted by AiW within 48 hours of referral to either the IMHA or PL advocacy services. There were a small number of patients who had a long time between referral and commencement, and referral and outcome date, and it is unclear whether this is a true reflection of service performance or an administrative error in entering the data. Similarly, the lack of three month follow-ups completed for both advocacy services in 2010-11 or 2011-12 requires further exploration to determine whether this is a true reflection of service performance or an administrative error in entering the data. A number of those patients' whose cases were closed were signposted on to other services, including AiW services and other external agencies, and suggesting the hospital advocates are aware of, and actively signpost to, other support.

4.3 Impact

Similar to other research, the evaluation findings suggest that the impact of IMHA and PL advocates was more related to the process rather than the outcome of the intervention (Townsley, Marriott & Ward, 2009). Although many patients required repeat contacts and episodes with the advocates, suggesting an outcome had not been achieved, the process of being supported by an advocate improved patient wellbeing. Mental wellbeing contributes to quality of life and productivity, and is not just the absence of mental ill-health, but a positive mental health (RCP, 2010). Factors associated with mental wellbeing include socioeconomic status, demographic characteristics, income, emotional and social literacy, participation, community cohesion, and purposeful activity (RCP, 2010). Findings from this evaluation demonstrate how and where IMHA and PL advocates contribute to the promotion of these factors, by supporting safe housing, debt management, employment and relationships. These findings are further supported by the WEMWBS survey, which showed that every person had a significant improvement in their mental wellbeing following the support they received from AiW.

Benefits and debts were the most common reasons for clients seeking support from IMHA and PL advocates, which are known risk factors for mental ill-health (RCP, 2010). Improved financial circumstances are known to support a reduction in health inequalities, where debt advice improves mental health, and good financial status reduces depression and anxiety (RCP, 2010). Moving from low to average financial capacity has been shown to improve mental wellbeing by 5.6% and reduce the risk of anxiety and depression by 14.7% (Forum for Mental Health in Primary Care, 2009). IMHA and PL advocates were able to support clients by ensuring they were being awarded the correct benefits, and contacting creditors to arrange repayments or clearing of debts. Advocates also supported clients in employment matters, whether contacting the clients' current employers, or supporting clients back into employment. Promoting and facilitating return to work can reduce depression, support clients' financial status, and reduce levels of sickness absence (RCP, 2010).

Inadequate housing is a risk factor for mental ill-health, and the provision of housing support and house improvements has been shown to reduce hospital admission rates (RCP, 2010). The prevalence of housing problems amongst the IMHA and PL advocates patients supports the literature (RCP, 2010), with housing being the third most common secondary diagnosis for IMHA advocacy patients, and the second most common for PL advocacy patients. Advocates were able to support clients in a number of ways, finding accommodation for those without any, or relocating clients where their current housing was inappropriate. Evidence shows that good housing can reduce anxiety and depression and improve independence and social contact (RCP, 2010).

4.4 Costs

The impact of mental ill-health on employment is associated with huge costs to the economy, where effective management of mental health in the workplace could result in annual savings of up to £8 billion. Re-admission into hospital can be reduced by 52% by supporting employment in people with mental ill-health (Burns, Catty, White, et al., 2009; RCP, 2010) The evaluation findings show that advocates provide a wealth of employment support to clients who require it, whether it be advising current employers of clients' current situations, or support clients back into employment, thus contributing to the reduction in hospital admissions outlined in the study by Burns, et al., (2009).

The case for action outlined by the Royal College of Psychiatrists (2010) outlines the strong evidence base demonstrating the cost-effectiveness of mental health intervention strategies. Cost-benefit analysis demonstrates the cost savings associated with investment in a number of mental health interventions, many of which are provided by AiW in the IMHA and PL advocacy services. Early interventions to improve housing problems have shown a reduction in hospital admissions, leading to cost savings (McCrone, Knapp & Dhanasiri, 2009) and debt advice interventions have demonstrated cost-effectiveness (RCP, 2010).

It is accepted that advocacy services provide value for money, yielding a large return for relatively low cost in respect of mental health service budgets. The National Survey of Investment in Adult Mental Health Services revealed that in 2011/12, advocacy services in England were valued at £20,143.60K, which was 0.37% of the Grand Total £5,946613.31K Direct Costs. The Support Services Group of which it is part amounted to 1.21% of the Grand Total for Direct Costs and 1% of the Grand Total of Working Age Adult Investment.

The National Survey of Investment in Mental Health Services for Older People revealed that in 2011/12 advocacy services in England were valued at £2739K which was 0.10% of the Grand Total £2,408,351K Direct Costs. The Support Services Group amounted to 0.45% of Direct Services Investment.

The findings from this evaluation show that patients accessing the AiW IMHA and PL advocacy services with repeat episodes have a reduction in hospital inpatient appointments and an increase in home based appointments . If AiW IMHA and PL advocates reduced each patient hospital stay by just one night, through either early discharge or prevented readmission, they would have saved the NHS a total of £526,725 (PLS advocacy = £126,450K, IMHA = £400,275K since April 2009), based on the cost of £225 for one bed day cost (NHS Institution for Innovation and Improvement, 2012).

4.5 Service Provider Perceptions of Advocates

A large review of IMHA advocacy services in England explored the relationship between mental health professionals and advocates, which highlighted a number of key and transferable issues (Newbigging, Ridley, McKeown, et al., 2012). Here, many health professionals viewed themselves as having an advocacy role that was encouraged in their both training and as a result of their developing relationships with patients. Nurses in particular viewed themselves as advocates, but described their advocacy role in terms of providing information, persuing complaints, helping patients to understand service information, and signposting to other services (Newbigging, et al., 2012). Evaluation findings show that IMHA and PL advocates provide practical support to patients that is more in-depth than that described by the health professionals in the Newbigging, et al., (2012) report, and this highlights a potential issue of conflict between health professionals and advocates.

Another key finding in the Newbigging, et al., (2012) report was the need for advocates to maintain their independent position, with advocates reporting that boundaries between advocates and health care professionals could become blurred. This was particularly an issue where health care professionals and advocates worked closely together which resulted in patients questioning the independence of advocates. Service users need to be able to identify the difference in roles between advocates and health care professionals, and trust that advocates are independent of health care professionals. Newbigging, et al., (2012) suggest that a visible presence on the ward is required so that health care professionals can developing a working relationship with advocates, and caution that if staff and advocates do not work closely together it will affect their working relationship and have a negative effect on the impact of advocacy. All mental health professionals in the IMHA review (Newbigging, et al., 2012) reported being aware of this issue and is something that should be monitored by service commissioners.

4.6 How do AiW IMHA and PL advocates contribute towards policy recommendations?

In 2006, the Disability Rights Commission published a formal investigation into health inequalities experienced by people with learning disabilities and mental health problems, which found that there was a lack of support for these individuals. The paper recommended that accessible and appropriate support be available to promote healthy living, including improving physical health conditions and treatments (Disability Rights Commission, 2006). Evaluation findings show that AiW provides an accessible service which provides support for known risk factors for mental ill-health, including housing, debt and employment. This support promotes physical and mental health, improves living conditions, and ensures patients understand the treatment choices available to them.

In 2011 the Government published ‘No Health Without Mental Health’, a cross-government mental health strategy for England, and in July 2012 the Implementation Framework for this strategy was published. The 2012 Implementation Framework outlines that improvements in mental health and wellbeing should be measured via three outcomes frameworks: self-reported wellbeing, reducing excess under-21 mortality in adults with severe mental illness, and increasing the proportion of people reporting that using mental health services have made them feel safe and secure. AiW routinely collect measures of wellbeing, using the

validated WEMWBS tool, and collect case study information to determine client experiences of using the services.

The 2012 Implementation Framework outlines that Clinical Commissioning Groups and the NHS Commissioning Board will be required to improve the commissioning of mental health services to ensure that outcomes for people with mental ill-health are improved, and reduce costs of untreated or unidentified mental health problems. The Implementation Framework (DH, 2012) outlines actions to support commissioning which includes ensuring effective transition and integration between services. Evidence from the AiW IMHA and PL advocacy services demonstrates how advocates play a vital role in liaising between services on behalf of the client, and ensuring services work together to create a positive outcome for the client (for example, liaising between NHS and social services). The Implementation Framework (DH, 2012) also suggests that, where possible, commissioners ensure people have a choice of provider and treatment. Again, evidence from the IMHA and PL advocacy services demonstrate how the advocates support patients to ensure they fully understand the choices and options available to them, and liaise with and represent patients' needs (where necessary) to ensure this choice is exercised. The Implementation Framework (DH, 2012) also suggests that innovative service models, such as Primary Liaison Services, be implemented to improve mental health. Wirral already provide a Primary Liaison Services, and also provide an advocate within this service, thus ensuring that Wirral meets commissioning requirements.

The Implementation Framework (DH, 2012) outlines how providers of mental health services should focus on choice, recovery and personalisation, and that this should include advice on housing, benefits, debt, employment support, training and education. Evidence from AiW demonstrates how advocates provide effective practical support and advice in all of these areas, thus meeting the requirements of the mental health strategy.

The Implementation Framework (DH, 2012) suggests that primary care providers should ensure people with mental ill-health problems have a choice in the treatment they receive, and state how this should include signposting to advocacy support wherever necessary. The range in referral sources to AiW, not only from care providers but through self-referral as well, demonstrates patients are signposted to advocacy resources. The AiW evaluation findings further demonstrate the range of support that the IMHA and PL advocacy provides, including ensuring that patients understand their rights in choosing treatment options.

The Implementation Framework (DH, 2012) outlines how the Government is working towards improving mental health, including increasing patient involvement and choice in their care and treatment. A number of actions are outlined in the paper, including a number which are specifically supported in the work of AiW IMHA and PL advocacy. Employment is one central factor outlined by the Government, in terms of both contributing to mental health problems, but also assisting clients back into employment. The findings from this evaluation show that employment is a key area where AiW hospital advocates provide support. The measurement of wellbeing is also highlighted as a key Government aim, which is supported in the work of AiW, where WEMWBS data are collected in from PLS advocacy and IMHA clients pre- and post-advocacy intervention.

4.7 Recommendations

- The IMHA and PL advocacy services are delivered by a small number of AiW advocates, with just one or two advocates providing the majority of support. Commissioners should consider whether this could become a capacity issue, particularly regarding the PL advocacy service and the high number of contacts required per patient episode.

- In order to ensure health professionals are fully aware of the role advocates, investment in provision for IMHA and PL advocacy services should ensure costs of training, support and development for staff (health professionals and advocates) are included.

- Ethnicity of clients using IMHA and PL advocates was predominantly white British, suggesting a potential gap in support to BME groups. Commissioners should ensure that the IMHA and PL advocacy services meet the needs of the local population, potentially via a needs assessment and/or equality impact assessment. Services should be reconfigured if required to ensure all population groups have equal access to the services.

- More women than men are treated in the earlier stages of mental ill-health, but more men are treatment as inpatients, therefore mental health services should promote early intervention to support men identified with mental health problems (perhaps as recorded on Wirral clinical systems).

- IMHA and PL advocates should continue to support patients and tackle risks associated with mental health problems, regardless of patients' primary diagnosis.

- There were a small number of patients who had a long time between referral and commencement, and referral and outcome date, and it is unclear whether this is a true reflection of service performance or an administrative error in entering the data. The IMHA and PL advocacy services should ensure process data is accurately captured by AiW, particularly around referral times and outcome times.

- Providers should consider capturing data at individual patient level to enable accurate monitoring of service use and service impact.

- It would be beneficial change the outcome data field (in the AiW hospital advocacy dataset) from an open field to a coded field, to enable accurate analysis of outcome data.

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