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Advocacy processes in mental health: a qualitative study

Norman Stomski[a], Paul Morrison[a], Martin Whitely[b], and Pip Brennan[b]

[a]Murdoch University, School of Health Professions, Murdoch, Australia; [b]Health Consumers Council, East Perth, Australia

ABSTRACT
Advocates perform an important role in representing the rights of mental health consumers, especially since mental health consumers are often marginalized. Little is known about the processes advocates use to assist mental health consumers in navigating the health care system. This study details the manner in which advocates work together with mental health consumers and health professionals through presenting a qualitative synthesis of 60 case records. Four main themes emerged: negotiating on behalf of consumers during meetings with health professionals; liaising between consumers and health professionals outside of meetings; supporting consumer decision making without the involvement of health professionals; and involvement in legal processes. The findings of this study demonstrated that advocates were primarily oriented toward the protection of negative rights, but they also promoted positive rights.

KEYWORDS
Advocacy; consumer; mental health; participation

Background

A recent systematic review of Australian mental health care services reported that the rights of consumers were often transgressed (Griffiths, Carron-Arthur & Mendoza 2015). Such violations include neglecting to provide information about rights, lack of privacy, and inappropriate use of seclusion, restraint, and detainment. Also, in the majority of cases consumers are not involved in the development of care plans and rarely receive a copy of their care plan (Auditor General Western Australia 2009). The prioritization of coercive, paternalistic focused mental health care, over recovery-oriented support, underlines advocacy's importance in ensuring that consumer rights are respected (National Mental Health Commission 2014).

Australian mental health care is most commonly delivered in community settings. In regard to community-based care, an issue of notable concern involves the sustained use of community treatment orders (Hickie, McGorry & Christensen 2014). In part, this concern owes to the ongoing escalation in the rate of Australian community treatment orders, which is high compared to other developed countries (Light et al. 2012). Moreover, systematic reviews

CONTACT Norman Stomski ✉ N.Stomski@murdoch.edu.au 90 South Street, Murdoch, Western Australia 6150, Australia.

have concluded that the use of community treatment orders result in consumers experiencing no improvement in numerous outcomes, including social functioning, quality of life, and service use (Kisely & Campbell 2015; Maughan et al. 2014). Hence, there is often no robust justification for the use of community treatment orders because they constrain civil liberties while offering little benefit to the mental health consumers involved.

There has been a recent shift toward reducing the use of community treatment orders in Australia, as evidenced by the enactment of legislation that significantly restricts the criteria for coercive treatment in several jurisdictions (Ryan, Callaghan & Peisah 2015). At present, the effect of such legislation has only been evaluated in one of these jurisdictions. That evaluation was less than promising since the use of community treatment orders had increased by 10% after legislation was introduced (O'Donoghue et al. 2016).

The other main form of coercive mental health treatment used in Australian settings involves involuntary detainment. Between 2009 and 2014 in Australia, there was a year-on-year increase in the rate of specialized psychiatric inpatient admissions, of which about one-third were involuntary (Australian Institute of Health and Welfare 2015). This increase was contrary to recommendations for a greater proportion of mental health consumers to be treated in community settings, especially since the prevalence of psychiatric disorders remained stable (Kirkbride et al. 2012; National Mental Health Commission 2014). In light of the increase in involuntary inpatient admissions and the previously noted high rate in use of community treatment orders, there is apparently an overreliance on coercive treatment in the delivery of Australian mental health care, which underlines the need for accessible advocacy services.

Mental health consumers use several key forms of advocacy. Self-advocacy involves consumers advocating on their own behalf (Lawton 2006). In contrast, individual advocacy involves an advocate working with a consumer on a one-on-one basis to inform them about their rights and to develop and work through a plan of action that addresses clearly defined goals (Australian Institute of Health and Welfare 2016; Townsley, Marriot & Ward 2009). Both self-advocacy and individual advocacy aim to ensure that the consumer's needs and choices are heard (Stewart & MacIntyre 2013). On the other hand, systemic advocacy seeks to change legislation, policies, or practices that lead to mental health consumers experiencing marginalization, neglect, or exploitation (Smith & Gridley 2006).

Limited research has been undertaken in the field of mental health advocacy. Studies in the United Kingdom have consistently found that mental health consumers stated that advocacy was inaccessible (Care Quality Commission [CQC] 2010; Grant 2004; Newbigging et al. 2015a). The use of advocacy was also constrained by not understanding advocacy's purpose or the benefits that could be gained through using advocacy (Newbigging et al. 2015a). This limited understanding was associated, in part, with health professionals failing to provide information about advocacy (CQC 2014; Newbigging et al. 2007, 2012).

The inability of consumers to access advocacy may detrimentally impact recovery. In particular, when consumers have gained the assistance of advocacy services, they report improvements in empowerment, self-efficacy, and wellbeing (Mind 2006; Palmer et al. 2012). These improvements are further enhanced when advocates proactively maintain in-person contact (Foley & Platzer 2007; Newbigging et al. 2012).

Scant research has been conducted in an Australian setting about advocacy for mental health consumers. In a study that examined the effect of a person-centered advocacy model, mental health consumers' reported increased satisfaction with care during detainment, and after discharge attended more follow-up consultations and were less likely to be involuntary detained (Rosenman et al. 2000). In the only other study of Australian mental health advocacy, a review was undertaken of the strategic focus of advocacy organizations (Gee, McGarty & Banfield 2015). That study concluded that these organizations prioritized: enhancement of consumer agency and recognition; working to refocus mental health systems on consumer needs; facilitation of effective collaboration and partnerships; and consolidation of organizational capacity.

With this background in mind, it is evident that the types of mental health cases advocates handle and the manner in which advocates address issues arising from these cases remain unexamined. This study bridges the literature gap through detailing how advocates use an individual advocacy model in working together with mental health consumers and health professionals in resolving issues that consumers encounter in navigating the health care system.

Methods

The Murdoch University Human Research Ethics Committee granted ethical approval for this study (2015/149). Data were collected from the Health Consumer's Council WA (HCC) advocacy case database. The HCC is an independent, not-for-profit, community-based advocacy service operating in Western Australia. It employs three professional advocates, who use an individual advocacy approach, whereby health consumers are supported to participate, engage and partner with the Western Australian health system as result of their interactions with the HCC. Case records are written or updated by advocates after each consumer contact in order to assist advocates in following up complaints about health services. These records capture standardized details that include consumer demographic information, consumer case history (medication and diagnosis details), consumer contact with health provider or health service, and contact with other complaint resolution agencies. Each year the HCC handles the cases of about 600 consumers, about one-third of whom are mental health consumers.

Sampling

The advocacy service de-identified all case records and assigned an anonymous identifier to each case record before provision to the research team. The data were extracted from 60 cases drawn from the 2014 and 2015 calendar years that detailed issues for which mental health consumers sought advocacy. Purposive sampling was used to select the case records (Braun & Clarke 2006). Initially, the advocacy service selected 20 case records, which the advocates viewed as exemplary consumer issues that the service commonly addressed. Two of the research team members multiple coded the 20 records and developed a preliminary thematic framework. The research team then requested additional 20 case records that detailed staff neglect of consumer needs excepting medication issues and detainment and case records that noted instances in advocacy did not result in the outcome consumers initially sought. After coding that set of records, the research team requested 20 further records that detailed cases in which advocates discussed care options with health professionals during meetings, which was the most underdeveloped theme. At this point, the themes were theoretically saturated and no additional records were sought (Braun & Clarke 2006).

Data analysis

An inductive coding approach was used to identify emergent themes. We first used line-by-line coding, whereby each individual line of the case records was assigned initial codes that explained small components of the data (Charmaz 2014). These codes were succinct, precise, and active, which remained close to the data and assisted in identifying processes. Focused codes were then developed by using constant comparison to group together similar initial codes. The most incisive, salient focused codes were used to sort and elucidate larger sections of data (Charmaz 2014). These focused codes then formed the basis of themes that articulated important advocacy processes for mental health consumers.

Findings

Participant characteristics

In about three-quarters of the case records, advocacy support was sought for female mental health consumers. Consumers initiated the majority of contacts with the advocacy service, whereas carers initiated less than one-quarter of the contacts. More than half of the consumers were located in the community, and about three-quarters were of voluntary status.

Primary themes

Four main themes emerged from the inductive analysis, each of which reflected a broad, general process that advocates used to support mental health consumers. Hence, this article is a distillation of the advocates' accounts of the consumer issues and what was done to address them from their advocacy service perspective.

Extracts from the case records, each of which has been assigned a unique identifier, have been provided to further delineate the themes, which are presented below in the following sections.

Assisting consumers during meetings with health professionals

The advocates on certain occasions acted primarily as a supportive presence during meetings between health professionals and either mental health consumers or carers [1C1; 4C5; 24C35]. One consumer noted that the presence of an advocate resulted in a psychiatrist acting in a "far friendlier and less pushy" manner than in previous consultations [4C5]. The psychiatrist's shift in attitude was also evident in accepting the consumer's preference for a particular type of medication, which relieved the anxiety that the consumer had experienced. Another consumer, who was pregnant, asked an advocate to attend a meeting with public sector psychiatrists [24C35]. At the subsequent meeting, the psychiatrists stated that it might be necessary to admit the consumer after the birth of the child, primarily because the psychiatrists believed that her argumentative manner was suggestive of re-emerging illness. However, the consumer disagreed and noted that "she was arguing with him because she did not trust him." That decision was supported by an advocate and private sector psychiatrist, and the consumer and infant were both thriving at home, without any hospitalization episode, when the advocate last made contact. The final case in the supportive presence section involved meetings between health professionals and a carer seeking to reduce the medication dosage and manner in which it was administered to their elderly partner [1C1]. At that meeting, and several subsequent meetings that the advocates also attended, the staff agreed to taper the medication dosage and eventually withdraw it, along with ensuring that only trained staff could administer the medication.

In addition to providing a supportive presence, the advocates often negotiated with health professionals during meetings at which consumers were also present [2C3; 5C7; 13C24; 38C49; 47C58; 50C61; 60C71]. Most of these negotiations revolved around medication issues. On some occasions, voluntary consumers asked advocates to attend meetings as they were reluctant to comply with suggested medication regimes but were anxious about being made involuntary if they did not follow the directions of health professionals [5C7; 38C49]. In one of these cases, the health professionals persistently and strongly insisted on the consumer receiving the recommended injection [38C49]. This coercive type of manner prompted the advocate to “clarify that [the consumer] was a voluntary patient and reinforced that it was therefore [the consumer’s] choice,” which enabled the consumer to discontinue the medication. In the other case, at the outset of the meeting the advocate gently noted that the consumer was very anxious about complying with the proposed medication regime [5C7]. The health professionals then stated that the medication could reduce the anxiety, after which the consumer hesitantly agreed to adhere to the medication regime. Subsequently, the consumer mentioned to the advocate that “the staff had eased off and seemed friendlier.”

Concerns about medications were also raised by an involuntary consumer [13C24] and carer of an involuntary consumer [60C71]. In the former case, the advocate and health professional reviewed together information about the medication [13C24]. The advocate then confirmed to the consumer that the dosage recommended by the health professional was below the typical therapeutic dosage. After the meeting, the consumer noted that the advocate’s advice was reassuring and had changed their intention to challenge a community treatment order. In the other case, the advocate attended a meeting between health professionals and the carer of a consumer who experienced moderate dementia [60C71]. The carer was concerned that a lack of exercise had contributed to a recent myocardial infarction At the meeting, the advocate negotiated with the carer’s “psychiatrist and cardiologist where it was agreed to taper the dose downwards and enable a private physiotherapist, paid for by [the carer], to work with [the consumer] in the hospital.”

The other main issue that advocates discussed at meetings with consumers and health professionals involved modifying care plans [2C3; 47C58; 50C61]. In one instance, a visually impaired adult consumer was concerned about continuity of care as they transitioned from care delivery by a public mental health team to a general practitioner’s care [2C3]. At the advocate’s suggestion, the health professionals agreed to provide one of the consumer’s parents with all future relevant medical documentations, which would enable them to subsequently discuss ongoing care in light of prior treatment. Another case concerned a morbidly obese, voluntary inpatient consumer who was “feeling pressured to have bariatric surgery, as losing weight is one of the conditions she must meet in order for her to have the support of her treating team to live outside the public residential psychiatric clinic” [50C61]. The advocate clarified that the consumer could refuse the surgery, and had the treating team agree to work together with the advocate in obtaining independent accommodation for the consumer. The final case in this section involved an advocate attending a meeting between health professionals and a consumer concerned the transfer of care to health professionals in another state [47C58]. The consumer was reluctant to raise this issue, and the advocate on the consumer's behalf clarified that their medical records could be provided to the new treatment team.

Liaising between consumers and health professionals outside of meetings

Liaising between consumers and health professionals outside of meetings was perhaps the most common form of advocate intervention. Such intervention typically concerned either unlawful detainment [21C32; 22C34; 30C41; 35C46], concerns about being classified as an involuntary patient [3C4; 10C18; 11C20; 59C70], obtaining medical records [20C31; 23C34; 33C44; 41C52; 42C53], or gaining access to medical care [16C27; 17C28; 46C57; 56C67].

Of the cases involving unlawful detainment, health care staff recognized that it was unlawful in only one instance [35C46]. The staff in the remaining cases stated that the consumers were unable to leave without permission, despite their voluntary inpatient status [21C32; 22C34; 30C41]. The advocates arranged the release of all of the consumers through two main forms of intervention. Consumers were typically allowed to leave after the advocates had persistently discussed the issue with staff at the facilities [21C32; 30C41; 35C46], but in one case the advocates had to raise the unlawful detainment with the chief psychiatrist's office before the consumer was discharged [22C34].

In the cases where advocates liaised with health professionals about the possible enactment of community treatment orders, all of the consumers reported considerable anxiety about the prospect of it occurring [3C4; 10C18; 11C20; 59C70]. This anxiety resulted from wanting to reduce the dosage of medication [59C70], health professional home visits [11C20], treatment review meetings [3C4], or simply intending to contact health professionals [10C18]. In all of these cases, the advocates contacted the relevant health professionals, confirmed that the consumers would not be placed on community treatment orders and then informed the consumers, which alleviated the consumers' anxiety.

There were various decisions about care options for which advocates liaised with health professionals on behalf of consumers [16C27; 17C28; 46C57; 56C67]. Some cases involved access to care issues, whereby one consumer wanted to receive electroconvulsive therapy as an outpatient [17C28], and another consumer sought admission to a facility because of suicidal thoughts [46C57]. The advocates resolved the former issue, but were unsuccessful in addressing the latter issue. Another case involved an inpatient consumer who about to be discharged despite lacking accommodation [56C67]. In this instance, the advocate collaborated with a social worker at the facility to organize suitable accommodation. The remaining case involving care options concerned a consumer who “was upset about being denied access to a phone to talk to [the consumer’s] children before their bedtime by a nurse on her ward” [16C27]. The advocates were able to arrange phone access the following day after discussing the issue with staff.

The remaining main issue for which the advocates’ primary role was to facilitate communication between consumers and health professionals involved concerns about medical records. Some cases related to consumers disputing statements in medical records, and in these instances the advocates assisted in drafting letters that detailed the concerns, which were then forwarded to senior management staff [41C52; 42C53]. The other cases involved the advocates assisting consumers in gaining access to medical records [23C34; 33C44]. The advocates in one of these cases were provided with the records after informing staff that they could be obtained through a freedom of information request [23C34], and in the other case the records were only provided following the lodgment of a formal written request [33C44].

Supporting consumer decision making without the involvement of health professionals

The advocates often provided general advice about care to mental health consumers or carers without involving health professionals. Such advice most commonly concerned information about medications [1C1; 8C14; 29C40; 36C47; 40C51]. In some instances, voluntary consumers asked whether they needed to comply with prescribed medication regimes, which the advocate noted was a discretionary decision since the consumers were not subject to treatment orders [29C40; 40C51]. Advocates also provided carers with information about medication side effects [8C14], advice regarding the possibility of gradually reducing medication dosage [1C1], and that carers could not be involved in medication decisions without the consumer’s consent [36C47].

Mental health consumers also asked advocates for information about care issues that were not concerned with medication. One case involved a consumer who “was seeking admission to a privately run mental health facility to support her through a proposed change to her medication regime. However, staff at the facility said she could not be admitted as she was not mentally ill” [57C68]. An advocate advised the consumer to ask their psychiatrist to discuss the issue with staff at the inpatient facility, which subsequently resulted in the consumer gaining admission. Another case concerned a voluntary inpatient consumer with a history of self-harm, who “expressed [their] wish to leave the hospital, but had been informed [they] would be made involuntary if [they] did” [31C42]. The advocate informed the consumer that the staff would likely use the history of self-harm to reclassify them as an involuntary patient. Hence, it would be best to presently comply with the staff's recommendations and maintain their voluntary status, which would enable them to exercise their own will in leaving the facility once their condition had stabilized.

Clarifying the meaning of mental health treatment forms was the final type of issue that advocates and consumers resolved without the involvement of health professionals. In such cases, the advocates notified consumers that the forms related to either the termination of an involuntary treatment order [9C17] or authority to detain and transport to hospital for psychiatric assessment [19C30].

Involvement in legal processes

Mental health consumers and carers often contacted the advocacy service for assistance with legal or quasi-legal processes. One of the more common legal processes detailed in the case records involved contesting community treatment orders [12C21; 25C36; 28C39; 54C65]. The enforcement of the community treatment order in one instance was especially concerning since the consumer was required to comply with an antipsychotic medication injection regime, despite experiencing neuroleptic malignant syndrome, a potentially life threatening adverse reaction [12C21]. In two of the other cases, the consumers challenged the orders because of a perceived lack of medication efficacy coupled with unpleasant adverse effects [25C36; 28C39]. The remaining case involved a consumer who contested the order as it was enacted without any explanation [54C65]. The advocacy service assisted in challenging the community treatment orders through either engaging legal support [12C21; 25C36; 54C65] or preparing applications to the Mental Health Review Tribunal [28C39]. The community treatment orders were discontinued in all but one of these cases.

Some of the case records detailed instances in which carers were seeking advocacy support in contesting the guardianship of mental health consumers [7C12; 39C50]. In one of these cases, the advocacy service assisted in preparing a successful legal application, which resulted in the consumer's preferred carer becoming their guardian [7C12]. The other case involved a carer who sought to assume guardianship of his or her intellectually disabled sibling because the carer believed that high dosages of antipsychotic medication had caused tardive dyskinesia [39C50]. The advocacy service suggested that contesting guardianship on such grounds could be counter-productive since it may be perceived as "challenging the experts." This advice appears to have been judicious as the carer stated feeling "portrayed as a caring but interfering in [the consumer's] treatment and this was the primary reason [they were] unsuccessful."

One of the other legal issues for which consumers sought the assistance of the advocacy service concerned challenges to involuntary inpatient admissions in mental health facilities [11C20; 14C25]. In the first case, a consumer was still held in a locked ward one week after having been reclassified as a voluntary patient, apparently because a key staff member was on sick leave [14C25]. The advocacy service liaised with the Council of Official Visitors, who then arranged the immediate release of the consumer. The second case involved the advocacy service contacting health professionals on behalf of a consumer to determine whether the consumer might be classified as an involuntary patient [11C20]. On the advice of the health professionals, the advocacy service informed the consumer that there were no such plans. However, a few days later the consumer rang the advocacy service and "informed them [that they] had been made an involuntary patient and given an injection against [their] will. The HCC advocate immediately rang the Council of Official Visitors (COOV)…The COOV advocate followed up and [the consumer] was made a voluntary patient and then discharged."

Assisting in the preparation of compensation claims was the final type of legal process that the advocacy service helped consumers to undertake [27C38; 32C43; 49C60]. One of these cases was especially troubling since it involved a child who had attempted suicide on several occasions [27C38]. These attempts had occurred after the consumer had begun taking three different medications concurrently, all of which were associated with an increased risk of suicide. At no point in time were the consumer's parents informed of such risk. Another case involved the breach of a consumer's confidentially, which ensued when a psychologist in a small regional town distributed a notice through email without blinding the approximately 30 recipients [49C60]. The final compensation case concerned a consumer who experienced considerable side effects after commencing antipsychotic medication, which ceased after the medication was discontinued [32C43]. In all of these compensation cases, the advocacy service facilitated meetings with lawyers, and in two of the cases complaints were lodged with the Australian Health Practitioner Regulation Agency [27C38; 49C60].

Discussion

The advocates in this study undertook several different activities. In most instances, the activities accorded with the mental health consumers initial directions, and took the form of attending meetings and providing a supportive presence, actively collaborating with consumers during negotiations with health professionals, or engaging with health professionals on the behalf of consumers without the consumers' immediate involvement in the interaction. However, on some occasions the advocates suggested that the consumers' initial directions might be contrary to their best interests and proposed alternative approaches to addressing the issues. The consumers in most cases followed the advocates' advice, but when the consumers wanted to proceed against advice the advocates in at least one instance adhered to the consumers' directions.

The manner in which advocates in certain instances suggested that alternative approaches, which differed from original instructions, might result in the promotion of the consumer's best interests was similar to the approach described in a previous study of advocacy (Rosenman, Korten & Newman 2000). In that study, when the consumer's directions diverged from their best interest, the advocate developed an understanding of the consumers' values and reached a decision about what the consumers would choose if they had insight into their own best interest. Such an understanding was then used to attempt to arrange treatment that the consumer considered to be acceptable. This model of advocacy resulted in increased satisfaction with care and reductions in subsequent cases of involuntary detention (Rosenman et al. 2000). Nonetheless, in using this approach, there is the potential that advocates could shift from a collaborative partnership to a paternalistic stance, whereby they believe they know what's best and not adequately take consumers' views into account. Hence, advocates should carefully reflect on beliefs or attitudes that may influence their own judgment when suggesting approaches that differ from the instructions put forward by consumers.

In many of the case records it was evident that the advocacy service promoted consumer involvement in decision making. At times, the mere presence of advocates appeared to strengthen a consumer's position in negotiations with health professionals, as health professionals were more inclined to accommodate the health care preferences of consumers even when advocates attended meetings without contributing to the discussion. More typically, however, the advocates actively engaged with health professionals, especially through reinforcing the rights of consumers, which then led the health professionals to incorporate consumer preferences in health care decisions. This active advocacy role has been conceptualized as a "lever," "bridge," or "hammer" in a previous U.K. study of advocacy services (Newbigging et al. 2015a). The other main approach the advocates used to enhance the agency of consumers in decision making was through providing information that enabled them to reach informed decisions. Such information typically concerned their rights as voluntary or involuntary consumers, generally in relation to medication, detainment, or access to care.

Another frame through the provision of advocacy can be understood involves considering how it influences negative and positive rights. Negative rights have been conceptualized as the protection of individual freedom against excesses of the state, whereas positive rights are based on the promotion of dignity, equality, and antidiscrimination (Spandler & Calton 2009). In terms of mental health care, negative rights often revolve around coercive treatment issues, and positive rights commonly concern access to health care, housing, and welfare (Newbigging et al. 2015b). The findings of this study demonstrated that the advocacy service tended to be oriented toward the protection of negative rights, with many of the case records involving coercive treatment. However, numerous case records detailed issues about access to care, and one case record involved the service finding accommodation for a consumer, which showed that the advocacy service also supported positive rights.

It was unsurprising to find that many of the cases in this study concerned consumers seeking to challenge coercive treatment involving either community treatment orders or involuntary detainment. Several studies have reported that consumers' experience of coercive treatment is intensely distressing (Gibbs et al. 2005; Light et al. 2014; Morrison et al. 2015, 2016; O'Reilly et al. 2006; Wyder et al. 2015). However, the distress arising from coercive treatment can be mitigated by the approach health professionals use to implement the treatment (Light et al. 2014; Wyder et al. 2015). In particular, strategies that alleviate distress include explicit explanation of the order, engaging consumers in decisions about their care, demonstrating an empathic understanding of mental illness, and improving access to mental health services and other support services (Light et al. 2014; Wyder et al. 2015). Importantly, delivering health care in such a manner should not be viewed as an aspiration but rather as a reciprocal obligation given the constraint on civil liberties imposed through coercive treatment (Brophy 2013; Dawson 2008; McDougall 2004; Morrison & Stomski 2015).

It was concerning to find that the cases commonly detailed instances in which voluntary consumers were informed that coercive treatment would be enacted if they did not comply with recommended treatment. These types of directives may reflect a deliberative orientation, involving a transition from persuasion to coercion in light of perceived best interests (Feiring & Ugstad 2014). However, several studies found that the predisposition toward imposing coercive mental health treatment stems mainly from paternalistic attitudes, which hold that consumers lack insight and are incapable to make informed decisions (Diseth, Bogwald & Hoglend 2011; Emanuel & Emanuel 1992; Feiring & Ugstad 2014; Pelto-Piri, Engstom & Engstrom 2013). Such attitudes should be reconsidered since they are likely to impair mental health consumers' recovery and quality of life (Hungerford et al. 2016).

All records may have elements of bias since they are shaped by the record taker's subjective views and extent to which consumers disclose relevant information. Therefore, several procedures were used to mitigate bias through enhancing the rigor of this study. First, purposive sampling was used to reduce selection bias, particularly through seeking deviant cases (Harding & Gantley 1998). Second, two researchers developed the thematic framework through multiple coding involving two researchers (Barry et al. 1999). Finally, respondent validation was undertaken by distributing the results to advocates at the service at which this study was conducted and requested that they confirm that the material reflected the manner in which cases were addressed (Torrance 2012).

Conclusion

This analysis of advocacy case records furthers an understanding of the experience of consumers in navigating the mental health care system and the manner in which advocacy services can assist consumers. Our findings indicate that advocates typically resolved the concerns for which consumers sought support, thereby maintaining the rights of individuals who may be vulnerable and marginalized. The resolution of most concerns demonstrates that they were usually valid and unrelated to illness symptoms or lack of insight. Further research would be especially beneficial to identify particular advocacy processes that most effectively address the concerns of mental health consumers. Also, the findings of this study reflected the perspectives of advocates, and it would be worthwhile to undertake studies with mental health consumers to understand their views about the manner in which advocacy can protect and promote their rights.

Notes on contributors

Norman Stomski holds a PhD in the health sciences and works as a postdoctoral researcher at Murdoch University. Norman has undertaken research across a broad range of areas, including mental health, chronic pain, and Indigenous health. He has a particular interest in understanding how the interactions between health professionals and consumers influence health outcomes.

Paul Morrison is the Dean of Health Professions at Murdoch University. He has experience in health care and university settings in Ireland, the United Kingdom, and Australia. He worked as a mental health nurse and general nurse before completing tertiary studies in psychology (BA, PhD), education (PGCE), and counseling (GradDip). Paul is an experienced teacher, researcher, and writer. He is also a registered psychologist, a member of the Australian Psychological Society (MAPS), a Chartered Psychologist (CPsychol), and an Associate Fellow of the British Psychological Society (AFBPsS).

Dr. Martin Whitely is a mental health advocate, researcher, author and former politician. While a Member of the Western Australia Legislative Assembly (2001–2013) he influenced Attention Deficit/Hyperactivity Disorder prescribing practices within Western Australia, contributing to a 50% fall in child prescribing rates between 2002 and 2010. A focus of Martin's advocacy has been exposing and reducing what he asserts is "regulatory capture," primarily by the pharmaceutical industry, of research, treatment guidelines, and prescription drug licensing and safety monitoring processes. He has also been prominent in highlighting concerns about "diagnostic creep"—the loosening of the diagnostic criteria of psychiatric disorders, potentially leading to inappropriate labelling and harmful over-medication. His book *Speed Up and Sit Still—The Controversies of ADHD Diagnosis and Treatment* was published in 2010 (UWA Publishing). He has also written numerous shorter items on

ADHD and mental health. He completed his PhD thesis ADHD Policy, Practice and Regulatory Capture in Australia 1992–2012 at Curtin University in 2014.

Pip Brennan has worked in the community sector for the last 15 years. Inspired by her own experiences of the confusing maternity care system, Pip initially volunteered as a maternity consumer representative in a range of roles. She began her paid health career as an Advocate working at the Health Consumers' Council (HCC) from 2006. She then moved to the Office of Health Review (now the Health and Disability Services Complaints Office) in 2007 and took up a position as a Conciliator of Health Complaints. In 2009 she began working at Community Midwifery WA (Now The Bump WA), while also working on a pilot project in the victim support services sector, Reclaiming Voices. In 2010 she took on the role of Manager of CWMA until 2013. She spent 2014 working at WACOSS on outcomes based contracting in the health not for profit sector project before returning to HCC to take on the role of Executive Director. Pip sits on the Executive Board of the WA Health Translation Network and works closely with the Consumer and Community Engagement Network. This has evolved from the Involving People in Research Project, for which Pip is an Ambassador.

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