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Getting to know you: reflections on a specialist independent mental health advocacy service for Bexley and Bromley residents in forensic settings

David Palmer, John Nixon, Simone Reynolds, Anastasia Panayiotou, Antje Palmer and Ruth Meyerowitz

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Abstract

Purpose – This paper aims to discuss an audit evaluation of a specialist independent mental health advocacy service based in the London Borough of Bexley.

Design/methodology/approach – The audit included qualitative interviews with ten service users, resident in two specialist forensic mental health and challenging behaviour units. All participants were long-term in-patient residents. A number of ethical issues required consideration, in particular respondent confidentiality and informed consent.

Findings – Findings indicate that the service's approach, which combines formal advocacy methods with a proactive ethos, had a positive impact on engagement. The importance of trust in the relationships between advocates and service users was also highlighted by the study and is discussed here. The audit also indicates a significant increase in self-reported wellbeing, self-efficacy and empowerment for participants. Given that enhancing personal empowerment is one of the primary objectives of the advocacy service, the positive wellbeing outcomes reported are encouraging.

Research limitations/implications – The paper relies on a small number of individuals. There is no attempt to claim representativeness or endeavour to generalise from the findings.

Originality/value – It is recommended that, in the absence of a comprehensive national evidence base, the advocacy needs of patients in forensic and specialist settings be constantly reviewed. Additionally, further action research, to inform educational material and guides for advocacy in specialist settings, may be beneficial and timely.

Keywords Independent mental health advocacy, Forensic, Engagement, Trust, Mental health services, Bexley and Bromley, Intergroup relations

Paper type Research paper

Introduction

From April 2009, statutory access to an Independent Mental Health Advocate (IMHA) has been available to patients subject to certain aspects of the Mental Health Act 1983 (Steven and Symington, 2009). The regulations stipulate that patients detained under the act have a statutory right to advocacy. IMHAs exist to help and support patients to understand and exercise their legal rights. This paper reports on a specialist IMH Advocacy service, which is provided by Mind in Bexley. The service is commissioned by Bexley Care Trust for children and adolescents, older age people, those between the ages of 18 and 65 years on acute psychiatric units, clients with mental health and learning disabilities and Bexley residents in secure forensic settings. The IMHA service is also commissioned by Bromley Care Trust to work with residents from Bromley detained within forensic settings.

Forensic psychiatry gives rise to particular challenges as both the needs of individuals and the requirements of the judicial system must be met. Statutory independent advocacy

The authors are grateful to all participants who gave them the privilege to share their experiences of advocacy. For further information on this study contact: info@mindinbexley.org.uk

is available in all special hospitals and medium secure units across the UK. It is primarily concerned with supporting and safeguarding vulnerable people who, because of perceived risks in relation to their history, may experience discrimination. The imposed restrictions and loss of liberty experienced (Rutherford and Duggan, 2007) further increase the importance of advocacy for this group.

The statutory requirement for advocacy represented an opportunity for Mind in Bexley to develop an innovative specialist advocacy service, working pro-actively with a vulnerable group resident in forensic settings. This article is based on an audit study on the specialist service and was undertaken with in-patients at the Bracton Centre, Dartford and on two in-patient units at Memorial Hospital, Greenwich. The Bracton Centre provides a range of specialist forensic mental health and challenging behaviour services for people aged 18-65 years living in the London boroughs of Bexley, Bromley, Lewisham and Greenwich, as well as some patients from other parts of the UK. The two units at the Memorial Hospital are low secure units for males aged 18-65 years with challenging behaviour, from these boroughs and other areas of the UK.

The practice of undertaking professional evaluation and audit studies has become widespread in health over the last 20 years (Glover, 1990). Changes in the health funding and commissioning environment are elevating the expectations for project evaluations and undertaking an audit study raises opportunities to consider changes to the operation of projects. The audit presented here examines the accessibility of the advocacy service in forensic settings. The initial aim of the audit study was to assess the advocacy service model and its impact, with an ultimate goal of improving the quality of our advocacy service for those in forensic settings. Important ethical issues arise when conducting an audit of mental health services. There are also, as highlighted by Glover (1990) significant technical matters to consider, such as the standardisation of evaluations and decisions around participation.

The advocacy team undertook the audit as part of their everyday advocacy work. The integration of the audit process with advocacy practice had developmental value, encouraging individual and team reflection. This had additional benefits in terms of developing and improving patient/service user care. A review of the literature showed that no research has been published on how an advocacy service, based on a proactive model of engagement, may be initiated and supported in a forensic setting. There is a lack of clear definition about what "proactive advocacy support" means for those involved. It is hoped that this small-scale audit study will improve care for those accessing the advocacy service and add to wider understandings and further research.

Approaches to advocacy

Although it has been given increasing prominence in recent central and local UK government policy, a fixed definition of advocacy across a range of health care settings has yet to be arrived at. Some "key factors" to successful advocacy have been identified by Henderson and Pochin (2001). These relate to the "process of identifying and representing people's views and concerns, in order to secure enhanced rights, undertaken by someone who has little or no conflict of interest" (Henderson and Pochin, 2001, p. 1). O'Brien (1987) describes advocacy in similar terms, whilst additionally emphasising the importance of empathy and the particular approach adopted by the advocate as key elements in the process. The advocates "create(s) a relationship with a person who is at risk of social exclusion and choose one or several ways to understand, respond to and represent that person's interests as if they were the advocate's own . . ." (O'Brien, 1987, p. 3). A recent definition produced by the advocacy charter offers a more comprehensive view. "Advocacy is taking action to help people say what they want, secure their rights and obtain services they need. Advocates and advocacy schemes work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice" (Advocacy Across London, 2002, p. 2). This definition more clearly defines advocacy and its objectives. It also highlights the inter-relationship between process and outcomes, a relationship reflected in this audit study.

A number of different models of advocacy including legal, citizen, professional/formal casework, and self-advocacy can also be identified from the literature (Teasdale, 1998; Henderson and Pochin, 2001; Walmsley, 2002; Gray and Jackson, 2002). As it responds to a wide range of individual circumstances and needs, the Mind in Bexley IMHA service does not correlate directly to one model. It comes closest, however, to a combination of formal casework and citizen or self-help advocacy.

Professional or formal casework advocacy has developed in mental health services from the Dutch “patients advocate” approach. This model uses paid advocates (Klijnsma, 1993) who are, typically, accredited. It is task based and in most cases involves short-term partner relationships (Henderson and Pochin, 2001). Formal casework mental health advocacy has developed in the UK over the last 20 years, as a means of challenging the discrimination faced by those who are, or have been, engaged with the mental health system. There is a clear role for the full range of formal advocacy under the Mental Health Act 1983 (MHA). “Qualifying patients” are entitled to access help and support from IMHAs (Steven and Symington, 2009). A person is deemed a “qualifying patient” where they have been detained under the MHA (Sections 2, 3 and forensic sections) for longer than 72 hours. People living in the community under MHA guardianship, conditional discharge and supervised community treatment are also eligible.

In our experience, patients in forensic settings often need long-term support. The formal advocacy provided by Mind in Bexley’s IMHA service tends, therefore, to be longer term. This provides opportunities for advocates to engage with, and empower, users over an extended period of time with an ultimate aim of encouraging citizenship or self-advocacy. This long-term self-advocacy approach, according to Gadow (1980), encourages personal choice, helps individuals select information and enables them to voice their own views.

Audit methods

This explorative audit study was qualitative with a focus on the views of participants. There is a large and detailed body of literature which documents the characteristics and respective advantages of quantitative and qualitative approaches (Denzin and Lincoln, 1994). A qualitative audit was deemed the most appropriate method considering the time frame of the project and the vulnerability of the target group which “naturally lend themselves” to qualitative methods (Strauss and Corbin, 1990, p. 17). The focus is on the perceptions of a small number of individuals rather than collective behaviour. There is no attempt to claim representativeness or endeavour to generalise from the findings.

The methodology for the audit was very carefully considered, the interviews needed to be appropriate for the participant group and flexible in order to allow for inquiries into emerging topics. They were, therefore, based on an open-ended topic guide in which the participants were encouraged to give considered responses. This method produces descriptive data – people’s own words – and replication of the findings is not an aim (Denzin and Lincoln, 1994). This method was chosen in preference to other established methodologies such as structured “formal” questionnaires as these were deemed unsuitable in respect of both process and outcome. In contrast, the informal interview approach allowed for greater clarification of questions and responses, which is particularly important when dealing with literacy barriers and issues of trust.

It was important to pilot the topic guide enabling the interviewer to apply and develop their interviewing skills. The pilot consisted of the first two interviews. Following this, the interviewer met with the advocacy team to discuss and reflect on the process. This resulted in some changes to the topic guide and assured the approach and the data collected were appropriate to the aims and objectives of the audit. The interviewer and team members were careful to locate themselves in terms of the service and their own interests, positions and concerns without attempting to influence the content or course of the conversation. Participants were given detailed information on the audit well in advance of the interview, so that they had an opportunity to consider their involvement. They were also invited to interview at a time convenient for them.

All interviews were undertaken by one of the advocates (Simone Reynolds) and the study was written up by the Chief Executive of Mind in Bexley in conjunction with the advocacy team.

Sampling

Respondents for the audit were selected from Bexley and Bromley patients in forensic settings, who had accessed the advocacy service. All those who had accessed the service were approached to take part in the audit study. Not all patients wished to take part in the study and as a result the sample was self-selecting. Among the reasons given for not wanting to participate were suspicion of the interview process and its motives, feeling unwell or not interested. From a total of 21 patients, ten agreed to take part in the audit study. Although the sample was small, this did allow the interviewer to spend more time with each participant, establishing rapport with them and thereby encouraging engagement with the audit study.

All participants were long-term in-patient residents. A number of important ethical issues, therefore, required consideration, in particular respondent confidentiality and informed consent. Care was taken to ensure confidentiality during recruitment and participation and written consent was obtained from all participants. Participants also had the option of opting out at any stage throughout the project. The project guaranteed anonymity from the onset and all names have been changed in order to protect the identity of participants. Information on the study was sensitively worded to gain participants' confidence and to communicate the integrity of the project. Participants could elect to respond through either a self-completed questionnaire or personal interview, conducted using a topic guide. The interviews aimed to gain information about individual experiences of, and perspectives on, advocacy in a forensic setting. The majority (8/10) of the participants opted for a personal interview. Data collected were analysed using thematic content analysis. The recording sheets were thematically analysed to produce coherent and presentable evidence (Bowling, 2002). It was not considered necessary by the interviewees to use a statistical computer package, as the sample size was relatively small.

The majority of participants were male ($n = 8/10$); however, as this is not a randomly selected sample it cannot be interpreted as representing the true ratio of male to female residents in the Bracton Centre. The age of participants at the time of interview ranged from 18 to 65. The majority of the ten participants (six) were from Black Minority Ethnic (BME) communities with the remaining classified as White British. Of the ten participants, five had Bexley connections and five were the responsibility of Bromley.

Findings: advocacy and developing trust

I saw the advocate walking on the ward. Seeing the advocates faces meant that I got to know them (Marie).

Research suggests that trust is vital to quality healthcare and effective outcomes. This is particularly relevant in the treatment of mental illness, where feelings of vulnerability and uncertainty may be heightened (Brown *et al.*, 2009). For people experiencing severe mental illness, such as those in forensic settings, a sense of trust can be a determining factor. The presence or absence of trust may influence whether an individual approaches a service, how openly they disclose their concerns and their continued cooperation with agreed treatment options (Brown *et al.*, 2009).

Trust and trustworthiness are emphasised in the social capital literature as key to the formation of positive professional relationships (Schieman, 2005). Trusting individuals expect that they can depend on the other, they believe in the integrity of the other and they have faith and confidence in them (Ross *et al.*, 2001). If they are to reap the benefits of a service such as specialist forensic advocacy, individuals, in this case service users, must have opportunities to form such relationships with the advocate. Building trust is therefore of primary importance. The responses of all participants in our study highlighted this:

They are like a mini solicitor. I need to get to know an advocate to trust them, to form a professional relationship between two parties. Getting to know a person on a friendly basis (Benjamin).

Raising the profile of patients with mental health needs is integral to the Department of Health's (2011) *No Health Without Mental Health*, which sets out standards for the promotion of mental wellbeing, the treatment of illness and the provision of effective, accessible mental health services. The strategy also supports a holistic approach to mental health and stresses the importance of building and maintaining positive relationships with patients, their carers and families. The specialist forensic service was funded to provide a proactive approach to advocacy, in order to develop such relationships. Psychiatric liaison is heavily influenced by the medical model and includes little provision for ongoing support and advice. Mind in Bexley's proactive advocacy service aims to address this gap in care. Advocates provide weekly sessions on the units, irrespective of whether appointments have been made. This regular, visible presence communicates a level of commitment which may be particularly valuable to patients (service users) who might otherwise feel unable to approach and/or access services. This proactive approach has clearly been beneficial:

They get things moving . . . I needed to get to know them. The advocate visits every Thursday and . . . they even leave information for me when I was asleep (James).

Frequent face-to-face communication builds trust and rapport between the advocate and the users and this was highlighted by Tom:

I got used to seeing the advocate's around the place and started talking to them. I got some trust doing that (Tom).

Trust and satisfaction are also bound together (Scheufele and Shah, 2000). Trust in others has been found to increase general happiness (Scheufele and Shah, 2000). Theoretically, the greater the trust established the more diverse are the opportunities accessible to the individual, which in turn has positive implications for their overall health and wellbeing. The findings from our audit study suggest that the proactive approach to advocacy has resulted in higher levels of trust and, therefore, higher levels of participation in the service. The association we have observed is that trust developed over time increases the rapport between the service user and the advocate:

I find it easier to speak to the advocate than the doctors . . . It has given me hope that things will get better for me (James).

Another participant, Darren stated:

It's about . . . seeing them on a regular basis. Patients always have reasons to speak to an advocate in improving the wards. I found it easy talking to her as she was there regularly (Darren).

Most participants revealed a limited understanding of IMH advocacy. Despite extensive advertising through leafleting and educational workshops for ward staff, many participants reported having little knowledge of the available services prior to meeting with advocates. This lack of knowledge demonstrated by participants may also be relevant to understanding the low national participation rates, especially if services are not proactive. This issue was clearly highlighted by one participant:

The advocate approached me, introduced themselves and explained about the advocacy service. Without that I wouldn't have spoken to them . . . It helps patients by showing them that there are people, real people out there who have their interests at heart (Liam).

The majority of participants did identify more positive aspects of the initial engagement process; these included continuity, familiarity and consistency.

These features of the advocates' working practices were acknowledged as key to the success of the project. Accordingly, continuity was consciously developed to enhance the quality of the relationship between users and advocates and to positively influence help seeking behaviour:

Easy to speak to. I like to speak face to face and let the advocate know how the weeks been. If something has happened then the advocate could help me sort it out. Talking is good (Marie).

As highlighted above, most participants consulted made positive comments related to the efforts the advocacy staff made to engage with them.

Some also recounted that, generally, nursing staff were well informed about the scheme and although it is clear that the roles are distinct, participants reported that staff were committed to the service, assisting in making appointments and referrals for users. Throughout the study, it was also apparent that there is awareness among nursing staff of the positive support provided by a specialist advocacy service.

Another important issue in relation to engagement and access was highlighted by one participant who expressed concerns about perceived inequalities or power relations between staff and users. They were worried that this may restrict or put off users from accessing the service:

Patients are often reluctant to call Advocacy. There is always a fear that this may be seen as anti-staff (Kevin).

Another participant stated:

I can talk to the advocate, I'm not judged and there is no hidden agenda. I can't trust the nurses (Lee).

Whilst another, Dee, highlighted the importance of the advocates' independence:

I find them pleasant and professional . . . because they are independent from the NHS, it calms people down (Dee).

This is a complex issue. It is important to contextualise the thoughts and feelings expressed in relation to this issue, acknowledging that responses may vary according to an individual's mental health diagnosis, personal choices and experiences and not all participants may respond positively to, trust or engage with clinicians. However, it is nevertheless important to address these concerns through staff training and continued work with participants, if they are to approach the service confidently and without fear of negative repercussions.

Advocacy and diversity

Although the profile of the advocates does not reflect the diversity of residents, the project has done much to have reciprocal arrangements with an advocacy scheme from a neighbouring borough, whereby advocates could be recruited from a wider ethnic base if specified by the service user. However, many of the individuals interviewed during the audit did not prioritise ethnic background when considering appropriate advocates. The preferences expressed when considering advocates were to have someone who was well established and professional, with sufficient knowledge to navigate them through the system. Therefore, whilst it would be desirable to have advocates from a wide range of ethnic origins, it is not according to participants essential for the effectiveness of the scheme. This is, however, an area which needs to be explored further.

Advocacy and wellbeing

Advocates ensured that the measurement of successful outcomes prioritises a focus on proactive support and engagement, the nature of the service user-advocate relationship and the personal achievements gained from accessing the scheme.

This is an important focus since in many cases "moving forward" is not measured by hard indicators but rather by more holistic evidence relating to greater confidence and/or personal empowerment. To this end, outcomes are recorded using the action for advocacy outcome measures. These recognise the complexity of advocacy and capture achievements, which are realistic for the individual.

Findings from the audit indicate a significant increase in self-reported wellbeing, self-efficacy and empowerment for participants. Given that enhancing personal empowerment is one of the primary objectives of the advocacy service, the positive wellbeing outcomes reported is encouraging. It is important, however, to acknowledge limitations in the sample size

and the extent to which responses may be influenced by factors such as participants' mood, temperament and tendency to give perceived desired responses. However, the results of the audit study suggest that the more flexible discursive interview approach functioned well. Additionally, the study itself became a means of promoting personal empowerment as it was from service users' responses that priorities for action were identified and recommendations to the service were made. The process then establishes that it is the "client" who is the "expert" and creates the potential for this expertise to be acknowledged and acted upon in a meaningful way.

To introduce the topic of wellbeing in the audit, participants were asked to tell us which phrases they associated with the advocacy service and its impact on their mental wellbeing. Participants chose phrases including: feeling relieved, making life easier, the ability to deal better with challenges, a sense of belonging, being accepted and not regarded as an "outsider". Key qualities identified by participants about the advocates included: maintaining a person-centred approach, independence, confidence building between advocate and user and a capacity to listen.

Feedback from participants pointed to improved confidence which allows them to function more effectively and independently as patients within a forensic setting:

I feel more confident to ask for things when I need them (Lee).

One participant also highlighted that advocacy promotes hope for recovery:

It's given me hope that things will get better for me (Benjamin).

Participants also reported improved social connections and reduced isolation, having developed a sense of trust in the advocate:

It nice, I can contact them if I have an issue. I can approach them without worrying, I've got to know them from being on the wards I would like the advocates to come more than twice a week (Liam).

Others felt the project has had a positive impact on many different aspects of their lives. Some said that it had helped them to better interact with others and supported them in their ability to voice concerns and make practical suggestions:

It has strengthened my confidence and argument of my case. The support and encouragement of an advocate can also be a catalyst to feel motivated to do things (Darren).

Participants reported increased self-respect and self-worth. This was highlighted by Dee:

I have someone there if I need them. It makes me feel better. I feel supported, respected, stronger and more empowered (Dee).

The range of mental health problems encountered in forensic settings is broad and flexible responses are required if advocacy needs are to be met effectively. The ongoing presence of advocates on the ward provides service users with regular opportunities to access the service. It also allows advocates to respond promptly and effectively to individuals' needs as they arise, providing the potential for real improvements to be made to long-term wellbeing:

It feels good to have someone to go to if I have problems. It makes me feel positive that I can get in touch with them if I have a problem (James).

Conclusion and recommendations

IMH advocacy is an area of rapid growth, change and improvement. The accounts provided in this study raise and address issues relating to advocacy for those in forensic settings. Although they are a very small contingent their specific case deserves special attention not least because of its capacity to highlight issues and knowledge that other studies on advocacy have so far failed to illuminate.

The advocacy scheme reported on has proved to be a crucial adjunct to therapeutic and other interventions for individuals. The Mind in Bexley project is unique in its approach and offers timely responses to the provision of advocacy services in specialist settings.

The project's impact has been evident on several different levels. All those interviewed reported significant gains from the relationships developed with the advocates. They regarded them as trusted and independent professionals, which has in turn yielded positive, self-reported well-being benefits and outcomes. Results also highlight the need for appropriate, sensitive and innovative approaches to working with vulnerable individuals resident in forensic settings. All service users interviewed expressed appreciation for the innovative approach of this service, which combined the values and methods of formal advocacy with a pro-active ethos. This approach was highlighted as having a significant impact on engagement.

The audit study also highlights the importance of developing trusting relationships, not least as it is positively related to engagement with the scheme. Trust as it relates to mental healthcare has become a key concern for policymakers and researchers. However, despite the importance of trust in the provision of advocacy, there are no known studies available which explore this concept and the issue warrants further research. The fact that the project appears to be successfully engaging with this complex and vulnerable client group is also due to the advocates' commitment, the effective support process and the overall management of the project.

It is evident that the service is a robust and "visible" voice for participants; however, it must be acknowledged that there are gaps in this study due to the small number of participants interviewed. To implement meaningful changes, further partnership work needs to be undertaken in developing and fully engaging with individuals, particularly from BME communities. It is recommended that the advocacy needs of patients in forensic and specialist settings is constantly reviewed, due to the lack of a national evidence base of issues, concerns and needs. It is imperative that research continues and that needs and outcomes are reviewed and evaluated within a time-bound framework at regular intervals. In addition, further action research to develop appropriate education material for other service providers and a guide for advocacy in specialist settings would be beneficial and timely.

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