



**Non-instructed Advocacy**  
**& the IMHA Role**  
**Best Practice Guidance**



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## PREFACE

Action for Advocacy's IMHA Support Project aims to develop best practice and improve the quality and effectiveness of Independent Mental Health Advocacy (IMHA) services in England.

At the start of the IMHA Support Project we ran a survey to provide a snapshot of the support needs of the IMHA sector. Responses were received from just under half the IMHA providers in England and identified a number of common areas of concern and resource need. The delivery of non-instructed advocacy within the IMHA role was identified by respondents as an area in need of further clarification.

Concern has been raised that many people who cannot request the support of an IMHA are not being referred. 18% of respondents to the IMHA Support Project's survey said that they received few or no referrals for those qualifying patients in their contractual area without capacity or with fluctuating capacity.

This means that there is potentially a large number of extremely vulnerable qualifying patients that are being denied their statutory right to advocacy as they are unable to ask for it themselves.

The Mental Health Act Code of Practice clearly states that

*AMHPs and responsible clinicians should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA's visit but is unable or unlikely for whatever reason to request an IMHA's help themselves.*

This document aims to provide clear guidance on the IMHA role when working with individuals who lack the capacity to instruct. It aims to ensure a consistent and best practice approach to non-instructed advocacy across the IMHA sector to ensure that all people who are eligible to support from IMHA are able to access that support.

I would particularly like to thank the participants of the advisory group for their significant contribution to the content of this guidance.

**Collette Byrne**  
**IMHA Support Project Manager**

## INTRODUCTION

Prior to the introduction of the IMHA role in April 2009 many mental health advocates were already providing good quality non-instructed advocacy. The 2007 amendments to the 1983 Mental Health Act introduced a statutory right for some detained patients to access an Independent Mental Health Advocate (IMHA). The client group of an IMHA is any 'qualifying patient', i.e. anyone who is detained under the Mental Health Act (except the holding powers of Sections 4, 5, 135 or 136), anyone subject to guardianship, conditional discharge or a community treatment order and some informal patients.

**The IMHA service is available to people who are subject to compulsory powers of the act, whether or not they have the capacity to instruct.**

As such, an IMHA can find themselves working with a range of people who lack the capacity to instruct an advocate. This can include some people with learning disabilities, dementia, acquired brain injury, sensory impairment, autistic spectrum disorder, Huntington's Disease or those in an acute phase of their mental health problem to name but a few.

## GUIDANCE TO DATE

Previous guidance covering the IMHA role such as the MHA 1983 Code of Practice, the Department of Health's Independent Mental Health Advocates Supplementary guidance on access to patient records under section 130B of the Mental Health Act 1983, the National Mental Health Development Unit's (NMH DU) IMHA Effective Practice Guide and the National Institute for Mental Health in England's IMHA Guidance for Commissioners make it clear that IMHAs need to be able to provide non-instructed advocacy to those qualifying patients that lack the capacity to instruct an advocate. Previous guidance has not, however, detailed how or when that non-instructed advocacy might be provided.

The National Institute for Mental Health in England's (NIMHE) IMHA Guidance for Commissioners gives IMHAs a clear mandate to work with people who are unable to instruct, stating that:

***IMHAs may also provide non-instructed advocacy when helping patients who are unable to express their wishes clearly, or at all, because they lack the mental capacity to instruct or have difficulties communicating. When providing non-instructed advocacy, the IMHA will represent the patient's wishes (as far as those wishes are known) and ensure the patient's rights are respected<sup>1</sup>***

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<sup>1</sup> <http://www.nmhd.org.uk/silo/files/independent-mental-health-advocacy-guidance.pdf> section 5.3

## WHAT IS NON-INSTRUCTED ADVOCACY?

Non-instructed advocacy is used where people do not have the capacity to instruct an advocate. An IMHA will need to use his or her own judgement in deciding whether a qualifying patient has the capacity to give them instructions about a particular issue or not. It is important to remember that someone's capacity to instruct or lack of it is not simply defined by their diagnosis or age.

Previously non-instructed advocacy was defined as a form of advocacy to be used with people who had limited or no communication but the introduction of the Mental Capacity Act in 2005 brought further clarity to the concept of capacity which has resulted in a more accurate definition:

***“Non-instructed advocacy is taking affirmative action with or on behalf of a person who is unable to instruct an advocate due to issues of capacity e.g. comprehension or communication issues<sup>2</sup>.***

***The non-instructed advocate seeks to uphold the person's rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for all relevant factors which must include the person's unique preferences and perspectives.”***

*Action for Advocacy 2011*

## INSTRUCTED OR NON-INSTRUCTED ADVOCACY?

The MHA Code of Practice gives AMHPs and responsible clinicians the specific responsibility of requesting an IMHA to visit a qualifying patient if they think that the individual might benefit from an IMHA's visit but is unable to request an IMHA's help themselves. However, health & social care staff have a general responsibility to assess if an individual has the capacity to request to see an IMHA and to refer them to the IMHA service if they cannot do so themselves. It is then up to the IMHA to decide whether an individual has the capacity to instruct them about a particular issue and whether to use an instructed or non-instructed approach for that issue.

When deciding whether someone has the capacity to instruct them about a particular issue the IMHA should be able to show that all practical and appropriate steps were taken to enable them to instruct. Factors that the IMHA should consider are:

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<sup>2</sup> An individual might be able to express what they want, e.g. to go home or a view of what they like or dislike, but may lack the capacity to instruct an advocate as to the action to take regarding a particular issue.

- Would the person have a better understanding if information was explained or presented in another way? E.g. large print, BSL signing, pictorial information.
- Are there times of the day when the individual's understanding is better?
- Are there locations where they may feel more at ease?
- Do they need some specific support with communication, e.g. an interpreter, a hearing aid etc?
- Might the individual regain the capacity to instruct an IMHA? Might the need for non-instructed advocacy be short-term? e.g. someone who is in an acute phase of their mental health problem; someone whose capacity fluctuates; is the individual under the influence of alcohol or drugs?

Following the guidance in the MCA Code of Practice<sup>3</sup> the IMHA is specifically looking to see if the qualifying patient can:

- **Understand** information regarding the advocacy role
- **Retain** that information
- **Use** or weigh up that information *and*
- **Communicate** their decision as to whether to engage with an IMHA or not (by talking, using sign language or any other means).

It is crucial that an IMHA does not confuse capacity with the ability to communicate. Therefore, the advocate must ensure that they explore a variety of means of communication as the person may be able to instruct the advocate using their preferred method of communication.

It is equally important that the IMHA does not equate an individual's lack of capacity to make a particular decision with a lack of capacity to instruct them. An individual may have been assessed by their care team as lacking the capacity to make a particular decision but they may have the capacity to instruct an IMHA.

An IMHA may find that an individual might be able to express what they want, e.g. to go home or a view of what they like or dislike, but may lack the capacity to instruct the IMHA as to the action to take regarding this care or treatment issue.

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<sup>3</sup> Mental Capacity Act Code of Practice Chapter 4

## NON-INSTRUCTED ADVOCACY APPROACHES

There is a long history of advocates providing non-instructed advocacy and a number of different approaches have been developed and used successfully. They are the Rights Based Approach, the Watching Brief, the Questioning Approach, the Person Centred Approach and the Witness-Observer Approach.

These approaches aim to ensure that the individual is kept at the centre of all discussions and that decisions are made taking the individual's wishes, where known, into consideration.

The methods used may depend on a number of factors, the time available to build the advocacy relationship, the issue(s), any timescale regarding a decision, how many other people an IMHA can gain information from etc. and therefore an IMHA needs to be able to use their own judgement as to where and when each of these approaches is most appropriate. Ideally a non-instructed advocate is looking to mix and blend the following approaches.

*In non-instructed advocacy "the advocate may observe, identify communicative behaviour, aim to establish some form of communication, gather information, ask questions and challenge opinions."<sup>4</sup>*

## RIGHTS BASED APPROACH

This approach begins with the premise that we all have certain fundamental rights that can be clearly defined. These rights may be legislative, ethical or human rights. The IMHA represents the individual to ensure that in any decision or action proposed their rights are taken fully into account.

This approach may be useful in ward rounds or CPAs, where decisions about an individual's care and treatment may be being made, in order to raise the issue of an individual's rights and to ensure they are kept at the heart of decision making. It is this approach that an IMHA is using when obtaining legal representation for an individual in relation to an appeal or alerting the appropriate bodies if they witness abusive or illegal activity.

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<sup>4</sup> <http://www.sense.org.uk/Resources/Sense/Help%20and%20Advice/advocacy-toolkit.pdf>

## THE WATCHING BRIEF

‘Watching Brief’ was devised by advocates from Asist (Advocacy Services in Staffordshire). This approach centres around 8 quality of life domains which are used as the basis for a series of questions that the advocate can ask regarding the proposed course of action and the likely outcome for the individual. [See Appendix A.](#)

## THE QUESTIONING APPROACH

As with the Watching Brief the core of this approach is the IMHA asking questions of the professionals’ rationale for proposed treatment and care and how this might impact on the qualifying patient. This approach is not as structured an approach as the Watching Brief as it does not use the quality of life domains. Instead the IMHA asks any questions that might be relevant to the individual they are working with as they are unable to ask them themselves.

## PERSON CENTRED APPROACH

This approach is based on a long-term, trusting and mutually respectful relationship between the advocate and the individual being supported. In spending time with the individual the advocate builds up a picture of their lifestyle, preferences and needs which is aided by the advocate’s independence from service systems. The advocate is in a unique position to describe and, where necessary, represent the individual’s views. In doing so the advocate is putting forward the individual’s unique perspective, and as such is promoting a person-centred approach to service delivery and decision making.

## WITNESS-OBSERVER APPROACH

There is a real value in the advocate’s role in being an observer or witness to the ways in which services interact with the individual. The advocate may see or hear things that are unacceptable or which pose a threat to the individual’s well being. Conversely, the advocate may also pick up on the individual’s preferences and pleasures, which can in turn be used to enhance positive relationships.

The witness-observer approach does not require the advocate to make judgements or assumptions, merely to report on the facts of his or her observations. In doing so, the advocate may be bringing to the attention of service providers or decision makers factors that they had not previously been aware of or taken into account, e.g. a lack of stimulation, dislike of certain people, foods or activities; appropriateness of routines and systems; the communication function of key behaviours or actions etc.

## CASE EXAMPLE 1

Simon is a 33 year old man with a diagnosis of learning disability and schizophrenia.

He is detained on a section 37/41 in a medium secure learning disability unit where he has been detained for the last 5 years. Any decisions relating to discharge or leave are therefore to be decided ultimately by the Ministry of Justice.

Simon can verbally communicate but says very little, his attention span is minimal and he will usually only stay in any room within the unit for 5 minutes at most. He demonstrates his trust in and desire for friendship from others by trying to hold their hand or standing very close to them but at times he has hit other patients and staff when doing this.

He is in regular contact with his father mostly via the telephone. His father has his own health problems and finds it difficult to make the long journey to visit Simon on public transport.

He has had a long-standing relationship with advocacy. He understands that she is not a member of staff and doesn't work for the hospital. He appears to understand the basic concept of what an advocate does (that they speak to the Doctor whenever she's there to tell her what patients would like to happen – some of this is because he picks up on conversations the other patients have and because of what staff tell him as well as the advocate herself). He appears to understand that staff tell the Doctor about how he's been in the last week as the Doctor always mentions this so this is different to what the advocate does. The Doctor also asks the advocate whether she'd like to say something for Simon.

In terms of verbal communication Simon only ever tells the advocate he "wants to go home" when she speaks to him. He is unable to articulate what he means by home or exactly what he'd like to be achieved e.g. home leave, discharge out of hospital, to see his father or other family members. He nods when she asks if he'd like the Doctor to know this but this is the only level of conversation they have. Simon's other communication is varied and difficult to understand, and it has been assessed that he is probably hallucinating or hearing voices.

Simon is unable to tell the advocate he wants her to go to ward rounds although nods when she asks this. Simon doesn't fully understand his detention in terms of the Ministry of Justice involvement but he does know that he is not allowed off the unit unless staff say he can go out and he is always with a member of staff when he goes out anyway.

The advocate therefore acts as a non-instructed advocate as Simon does not ask for advocacy support, he does not attempt to engage with advocacy but he will sit with the advocate for 5 minutes when she asks him. He doesn't ask for any support on issues but rather repeats the same sentence whenever they talk. The advocate always asks Simon whether he knows she will tell the Doctor what he's said and he nods. She also asks Simon whether he understands she will try to help him get what he wants by doing this and he nods.

The advocate therefore asks in ward round whether Simon can have home leave. The advocate arranges to maintain contact with Simon's social worker. The social worker will discuss the issue with Simon's father as well as asking whether he'd be happy for the advocate to speak to him.

There are a range of issues that come out of this - concerns that Simon won't return to the unit if he goes home as he will believe he's back for good and that returning home will be distressing for Simon and/or his family; communicating with Simon to ensure he can understand as best he can about the length of time for approval and restrictions and the issue that Simon's offence was committed near to his home and the implications of this on him.

All of these discussions take place over a period of months and the advocate attends all ward rounds to ask questions on behalf of Simon with regards to concerns, action plans, risk assessments, Simon's rights under the Mental Health Act, as well as communicating regularly with ward staff, Simon's father and his social worker. The advocate also begins to ask about how contact can be improved in general given it is apparent Simon is asking on some level for more contact with his home life, wherever that will be, and asks whether there are support systems Simon's father can access to ensure he can visit Simon without it being a lengthy or tiring journey. This subsequently leads to improved communication with the social worker and father as well as with ward staff. It also leads to a care plan being set up specifically for this issue and a compromised system set up that means Simon's father will be picked up by the social worker once a fortnight to visit Simon as well as using a carer's 'taxi service' that is available in his local area.

Throughout this time the advocate conveys to Simon that she keeps asking the Doctor about his request to go home and explains the Doctor is working to sort this out, she also gives a general overview about further contact with his father although others involved in Simon's care also do this.

The issue ends with a request for home leave being submitted by Simon's RC with supporting evidence from the social worker that includes a thorough care plan and risk assessment. Simon's leave is approved.

This issue started because Simon told the advocate he "wanted to go home" and throughout this very lengthy period, this is all he ever conveyed.

## NON-INSTRUCTED ADVOCACY & THE MENTAL CAPACITY ACT

The Mental Capacity Act 2005 (see Appendix B) provides a statutory framework for assessing whether an individual has capacity and (if they are assessed as lacking the capacity to make a specific decision) for the process of making a best interests decision on behalf of that individual.

That best interests decision is made using the Best Interests Checklist<sup>5</sup> the purpose of which is to enable anyone to try to find out what the individual would have wanted, what they would have considered and what they have previously expressed.

<sup>5</sup> Mental Capacity Act Code of Practice Chapter 5

The MHA provides the legal framework for treating detained patients so a person's rights under the MCA are superseded; however the principles of the MCA can help guide good practice. The Best Interests Checklist is a useful tool that an IMHA might use in their non-instructed advocacy to ask questions on behalf of an individual to ensure that their past and present wishes, feelings, beliefs and values are taken into account and that the individual is at the centre of the decision-making process carried out by the mental health professionals on their behalf.

## SPECIFIC ISSUES

### THE APPEALS PROCESS

Where a qualifying patient does not have the capacity to instruct an IMHA but, through perhaps a repeated request to go home or attempts to leave the ward, makes it clear that they do not wish to be on the ward, it is important to consider the individual's right of appeal under the Mental Health Act.

Hospital managers have a responsibility to refer the cases of certain individuals to a 1<sup>st</sup> Tier (Mental Health) Tribunal<sup>6</sup>. Typically references must be made if an individual's case has not been heard by the Tribunal within 6 months of the individual being detained or in the last 3 years (1 year if the patient is under 18).

Further, the hospital managers must undertake a review if an individual's detention is renewed and should consider holding a review where a Nearest Relative's order for discharge is barred<sup>7</sup>.

There are also a number of ways in which an IMHA can support an individual to appeal their detention where the individual lacks the capacity to instruct them to do so:

- In the majority of cases it is suggested that the IMHA refers the individual to a Law Society Mental Health Review Tribunal Panel solicitor with experience of representing individuals with capacity issues. The Law Society's guidance note Representation before Mental Health Tribunals<sup>8</sup> clearly reminds the legal representative that they 'must assume your client has capacity unless the contrary is established and that the threshold for litigation capacity is a low one....'

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<sup>6</sup> [Reference Guide to the Mental Health Act](#) Chapter 23

<sup>7</sup> MHA Code of Practice 31.11

<sup>8</sup> <http://www.lawsociety.org.uk/productsandservices/practicenotes/mentalhealthtribunal/3386.article>

It would be useful for the IMHA provider to collate a list of solicitors with experience of working with individuals with capacity issues.

- **1<sup>ST</sup> TIER (MENTAL HEALTH) TRIBUNAL**

With reference to s67 MHA the Code of Practice states:

**30.39 The Secretary of State for Health may at any time refer the case of most detained patients, and all SCT patients, to the Tribunal. Anyone may request such a reference, and the Secretary of State will consider all such requests on their merits.**

**30.40 Hospital managers should consider asking the Secretary of State to make a reference in respect of any patients whose rights under Article 5(4) of the European Convention on Human Rights might otherwise be at risk of being violated because they are unable (for whatever reason) to have their cases considered by the Tribunal speedily following their initial detention or at reasonable intervals afterwards.**

**30.41 In particular, they should normally seek such a reference in any case where the patient lacks the capacity to request a reference.**

The Secretary of State for Justice has a similar power to refer the case of a restricted patient to a Tribunal under s.71 MHA.

As anyone may request a referral, an IMHA could write directly to the Department of Health with information in support of the request<sup>9</sup>. In practice, the CQC suggests that the IMHA take their case to the Mental Health Act Administrator to request they submit an application for appeal.

- **HOSPITAL MANAGERS' HEARINGS**

MHA Code of Practice states that hospital managers may undertake a review of whether or not a patient should be discharged at any time at their discretion. An IMHA could approach the hospital managers through the Mental Health Act Administrator detailing their evidence for the individual's lack of capacity to appeal.

Unlike 1st Tier (Mental Health) Tribunals the hospital managers do not need to convene a panel to hear the appeal but at least one panel member needs to meet with the qualifying patient. However it is suggested that where an individual has capacity issues and their case has not been previously or recently reviewed a review rather than a hearing would not satisfy the public law duties of fairness, reasonableness and lawfulness<sup>10</sup>.

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<sup>9</sup> [Section 67 of the Mental Health Act 1983 - references by the Secretary of State for Health to the First Tier Tribunal](#)

<sup>10</sup> MHA Code of Practice 31.23

**CASE EXAMPLE 2**

John, 66 and with a diagnosis of vascular dementia, had been living at home with his wife until his condition deteriorated to the point that she felt unable to care for him on her own.

John was admitted to hospital and placed on a s2 of the MHA while his mental health was assessed and alternative accommodation was sought for him.

During a weekly surgery the IMHA approached John to tell him about the service. John was friendly and welcoming to the IMHA but seemed not able to fully understand who she was and what her role might be.

John expressed his frustration at not being able to leave the ward and spoke of his wish to return home to live with his wife. John was unable to explain to the IMHA why he could not leave the ward but just that 'they wouldn't let him.'

When the IMHA suggested that she and John ask the nurses why he couldn't leave the ward John readily agreed. The IMHA asked to speak to John's Primary Nurse who explained that she had already spoken to John at length and had informed him that he was detained under a s2 and that he shouldn't worry about it as the Consultant was working with John's wife to find a nice place for him to live. At this point John became very distressed and the IMHA was asked to leave.

Over subsequent visits to the ward it became clear to the IMHA that John's ability to instruct her fluctuated but he was consistent in his expressed wish to both leave the ward and to return home to live with his wife. The IMHA spoke to a solicitor about John's case and arranged for him to come and meet with John.

The solicitor met with John and the IMHA on the ward. The solicitor then contacted the Mental Health Act Administrator and Responsible Clinician regarding John's appeal which was subsequently heard by the Hospital Managers.

## IMPORTANCE OF OUTREACH/STAFF AWARENESS-RAISING

The Mental Health Act Code of Practice (20.19) clearly states:

*AMHPs and responsible clinicians should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA's visit but is unable or unlikely for whatever reason to request an IMHA's help themselves.*

Concern has been raised by IMHA providers that many people who cannot request the support of an IMHA are not being referred. 18% of respondents to the IMHA Support Project's survey said that they received few or no referrals for those qualifying patients in their contractual area without capacity or with fluctuating capacity.

This means that there is potentially a large number of extremely vulnerable qualifying patients that are being denied their statutory right to advocacy as they are unable to ask for it themselves.

## BEST PRACTICE FOR IMHA PROVIDERS CARRYING OUT OUTREACH

Through discussions with IMHA providers at Regional Forums and from the results of the IMHA survey it is clear that outreach remains an essential component of IMHA provision. A pro-active approach results in an improved awareness and understanding of the IMHA role and of qualifying patients' statutory right to access an IMHA service amongst both staff and those individuals who are eligible for such a service. It is suggested that:

- Regular outreach is carried out across all units where the IMHA service is commissioned including older people and learning disability units/wards.
- All qualifying patients are provided with information to ensure that they are aware of their right to access the service. This includes those who may lack the capacity to self refer.
- IMHA providers ensure that, when providing staff awareness sessions to mental health providers, their responsibility to refer those patients to the IMHA service who are unable or unlikely to refer themselves is made clear.
- Several IMHA organisations have negotiated an agreement with their local mental health provider that all qualifying patients without the capacity to instruct an IMHA are automatically referred as an additional safeguard.

It could be argued that getting IMHA support for an individual is in keeping with the Participation principle of the Mental Health Act<sup>11</sup> as it can facilitate an individual's involvement in the planning, developing and reviewing of their own treatment and care.

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<sup>11</sup> MHA Code of Practice Chapter 2.

## CONSENT

People need to make a decision whether or not to have an IMHA. How this decision is made is therefore governed by the Mental Capacity Act<sup>12</sup>.

*“AMHPs and responsible clinicians should consider requesting an IMHA to visit a qualifying patient if they think that the patient might benefit from an IMHA’s visit but is unable or unlikely for whatever reason to request an IMHA’s help themselves. Before requesting an IMHA to visit a patient, they should, wherever practicable, first discuss the idea with the patient, and give the patient the opportunity to decide for themselves whether to request an IMHA’s help.”<sup>13</sup>*

Where someone lacks the capacity to make the decision to access an IMHA the decision to request an IMHA to visit the patient should be made in accordance with the Mental Capacity Act 2005 (MCA) and this provides the safeguard for the advocate as it may be deemed to be in the individual’s best interests to have an advocate’s support as well as supporting their right to an IMHA under the Mental Health Act.

It is however good practice to remain mindful of consent when working with all clients/partners. Consent can never be assumed and, as with all individuals, consent should be sought and evidenced; it should be seen as an ongoing process and not a one off action. An individual may lack the capacity to make the decision to work with an IMHA so an indication that an individual does not want to speak to or spend time with an IMHA should not necessarily be taken as a final informed decision.

If the individual is unable to sign a consent form or it seems inappropriate to ask them to do so then consent can be clarified by regularly checking with them both verbally and by checking their body language that they are happy to have the IMHA present and with any action being taken. It would also be important for the IMHA to ascertain what the individual’s past wishes were regarding advocacy.

Knowing how an individual communicates will help the advocate to determine consent. This evidence should then be included in the individual’s IMHA case notes.

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<sup>12</sup> Detailed information about the Mental Capacity Act can be found in Appendix B.

<sup>13</sup> Mental Health Act Code of Practice 20.19 & 20.20

## **ACCESS TO RECORDS**

This issue will be covered more fully in further IMHA Best Practice Guidance but it is important to note what current guidance exists – see Appendix D

As with all requests to record holders to access an individual’s records an IMHA must be mindful of the Data Protection Act (1998) and be very clear what information they need to access and the reasons for doing so. It may be particularly useful when working with an individual who is unable to instruct to have access to their notes to get a clearer picture of who the individual is and what they might have wanted if they could instruct an IMHA. However the notes should add to the picture of the individual the IMHA gathers by spending time with them and should not be a substitute for facilitating the individual’s own expression of their views, wishes and values.

ROUTES INTO NON-INSTRUCTED IMHA

Ward staff identify that the individual is unable or unlikely to request an IMHA's help themselves due to capacity issues.

They refer to IMHA

IMHA contacts the referrer to:

Obtain information regarding the individual's situation

Clarify eligibility

Suggest alternative advocacy provision if individual is ineligible for IMHA

Find out how the individual communicates

Clarify any safety issues the IMHA needs to be aware of with regard to meeting in private with the individual.

Qualifying patient identified by IMHA service through outreach.

Where necessary the IMHA contacts ward/unit staff to:

Find out how the individual communicates

Clarify any relevant safety issues the IMHA needs to be aware of with regard to meeting in private with the individual.

Qualifying patient self-refers to IMHA service

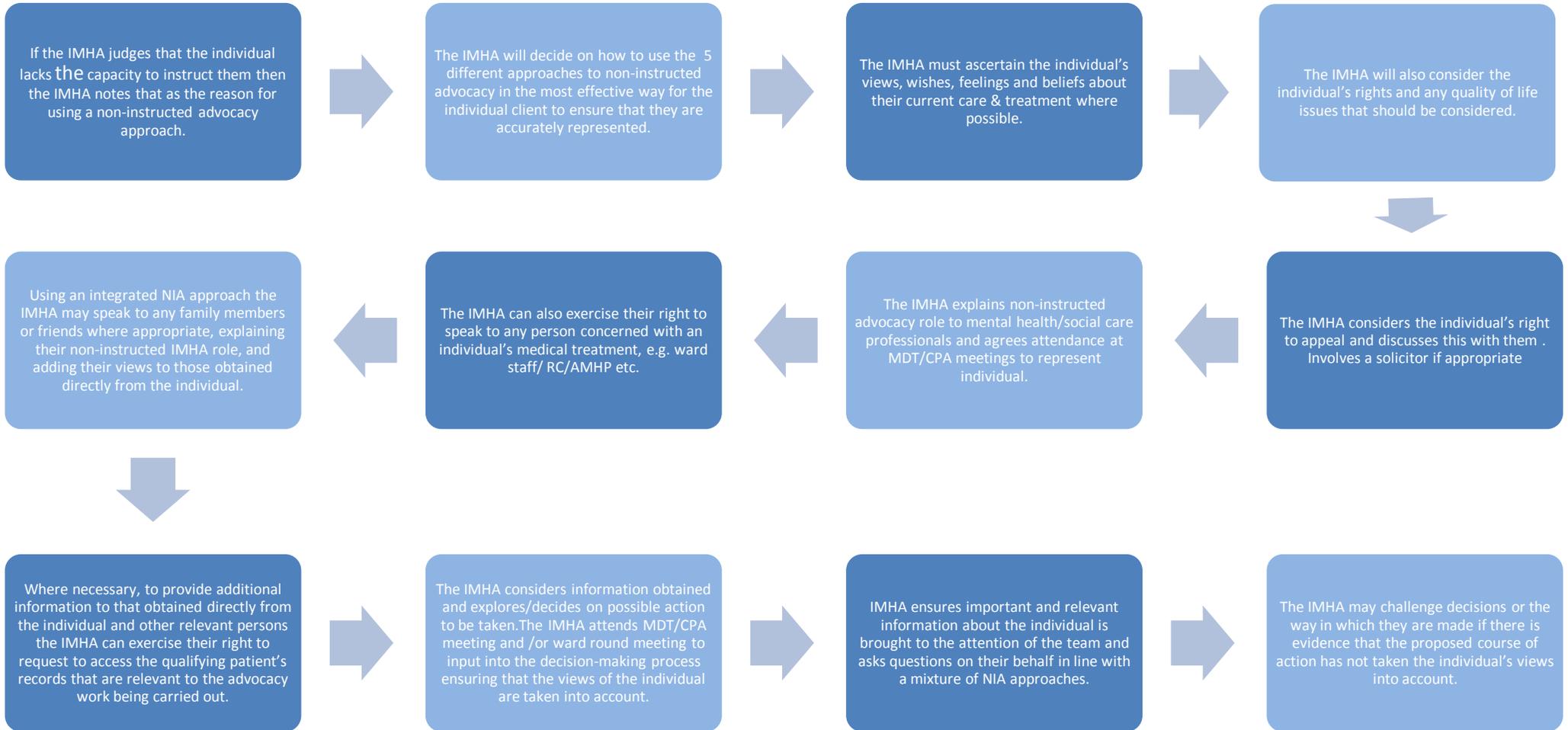
IMHA contacts ward/unit staff to clarify any relevant safety issues the IMHA needs to be aware of with regard to meeting in private with the individual.

IMHA meets with the individual and, using the individual's preferred method of communication, decides whether they have the capacity to instruct them by explaining their role and seeing if they can understand that information, weigh & balance it and communicate their decision to work with the IMHA

**NB: If the IMHA can obtain instructions then they follow those instructions as in any instructed casework.**

**PROVIDING NON-INSTRUCTED ADVOCACY –**

A pathway for IMHA providing Non Instructed Advocacy



It is vital to have a clearly defined and structured process or framework for working with someone who cannot instruct. This process should be detailed in the organisation's Non-instructed Advocacy Policy (see Appendix D for template) which should be available to all mental health provider staff where the organisation is contracted to provide a service.

The process should detail how the IMHA will:

- Represent & support an individual without the capacity to instruct
- Find out the individual's wishes, beliefs, feelings & values
- Find & evaluate information
- Consider alternative courses of actions
- Detail in the case notes what actions have been taken
- Explain their role to family & friends where appropriate.
- Explain their role to professionals and seek attendance at MDT/CPA meetings to represent individual
- Move from providing non-instructed advocacy to instructed advocacy if the individual regains the capacity to instruct an IMHA

Advocacy case notes on the individual should record the process of working out what the qualifying patient would have wanted if they could instruct for each relevant decision. The case notes should include:

- Actions the IMHA took
- Current and previous views of the individual
- Communication methods
- Views of others (where appropriate and applicable), notes etc
- How decision was reached
- What the reasons for reaching the decision were
- Who was consulted
- What factors were taken into account

It is also important non-instructed advocacy scenarios are covered in all of an organisation's relevant policy areas such as confidentiality, access to records etc.

Chapter 7 of Sense's Capacity to Communicate: Training Toolkit<sup>14</sup> includes very practical strategies for communication and information gathering which are aimed at IMCAs but apply just as well to the IMHA role when working with people who lack the capacity to instruct an IMHA. Similarly Asist's Non-Instructed Advocacy Standards<sup>15</sup> provide a reminder of the advocacy role in the provision of non-instructed advocacy.

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<sup>14</sup> <http://www.sense.org.uk/Resources/Sense/Help%20and%20Advice/advocacy-toolkit.pdf>

<sup>15</sup> <http://www.asist.co.uk>

CASE EXAMPLE 3

Molly is a 34 year old former banker who, as a result of a serious car crash which resulted in brain damage, has developed severe mood swings and exhibits periods of paranoia and aggression towards her family. She has been admitted to hospital and detained under s2 of the MHA as a result of a particularly aggressive assault on her husband.

A referral is made to the IMHA service as the staff on the ward do not feel that Molly has the capacity to make the decision to access an advocate. The IMHA visits Molly a number of times and finds that sometimes Molly will sit and talk with her but that sometimes she is very clear that she doesn't want to. Over the space of a number of days the IMHA sees that Molly is more approachable in the morning than after lunch when she seems more tired and lower in spirits. The IMHA also sees that Molly seems more relaxed during the craft sessions that take place just before lunch each day on the ward. The IMHA starts to meet with Molly just as those craft sessions are finishing.

The IMHA sees that Molly is having trouble sitting on some chairs seeming to prefer softer ones and will wander about until she finds one. When the IMHA asks Molly about her medication Molly becomes quite distressed; shaking her head repeatedly and rubbing her hip. The IMHA asks Molly if she could talk to the doctor about her medication but though Molly is unable to instruct her as to what action to take regarding her medication she is consistent in the distress she expresses whenever her medication is mentioned.

The IMHA asks the Responsible Clinician questions about the reasons for Molly's medication and alternatives. The IMHA explores the issue of Molly's medication further with Molly's husband by asking about the side effects Molly has exhibited.

The IMHA encourages Molly to attend her care review meetings, which she ensures are held just after Molly's morning craft sessions but Molly consistently expresses an unwillingness to attend by moving away from the IMHA.

Through the IMHA's input Molly's medication is reviewed and she is given it in the form of tablets that dissolve on her tongue rather than by depot injection, which causes Molly less discomfort.

### Best Practice Checklist

- Define your organisation's view of NIA
- Develop a NIA policy
- Ensure all IMHAs are aware of NIA policy & practice and are confident in using a mixture of approaches
- Ensure that all relevant health & social care staff are aware of NIA policy
- Encourage IMHAs to attend specialist dementia training
- Encourage IMHAs to attend training in communication techniques such as Talking Mats, Dementia Mapping
- Collate list of solicitors with experience of working with individuals with capacity issues.

**APPENDIX A - THE WATCHING BRIEF<sup>16</sup>**

## The eight domains to a quality life

Domain	definition	focus	avoidance
<b>1: competence</b>	to have a level of skill to be able to be as independent as possible	learning and developing skills which lead to a greater independence or allow minimal support dependence and inactivity	having to rely on others, not taking risks or allowing people to do things by themselves
<b>2: community presence</b>	having a sense of belonging to a local area by means of access and use	encourage a high frequency of use and involvement in local public facilities and amenities	using segregated services or not using local facilities enough
<b>3: continuity</b>	having a past, present and future with key people and events in your life	meaningful relationships which last over time planning out your life's hopes and ambitions	stagnation and loss, no past and no future, only the present
<b>4: choice and influence</b>	being able to determine the course of events, looking at situations from your perspective	self determination, self advocacy, asking your own decisions and choices because you want to	domination, over protection, no involvement in the way your life is directed
<b>5: individuality</b>	a unique person in your own right	individual needs and wishes, support that is responsive to individual demands	grouping and labelling
<b>6: status and respect</b>	having value in the eyes of others	raising others expectations and the removal of social stigma and prejudice	not placing value on a person by degrading them by age, culture or activity
<b>7: partnership and relationships</b>	having meaningful interaction with other people	valuing interaction and friendship, promoting social networks	having no one in your life who is important, only associating with other devalued people
<b>8: well-being</b>	having a state of physical, psychological and social health	to maintain a balance between all health needs, to promote health	accepting illness and disability, not securing appropriate health support and treatment

<sup>16</sup> <http://www.asist.co.uk/watching.htm>

Some examples of the sorts of questions based on the quality of life domains in the watching brief an IMHA might ask:

How will the proposal:

**Competence**- promote the individual's independence?

**Community presence** - reduce social isolation?

**Continuity**—maintain continuity in their life?

**Choice & influence**—involve the person in decision making?

**Individuality** – address the person's preferences?

**Status & respect** – value the person in a way consistent with their age, gender, cultural needs etc?

**Partnerships& relationships** – provide opportunities for interaction with others?

**Well being** – recognise and address health issues?

## APPENDIX B - THE MENTAL CAPACITY ACT

The Mental Capacity Act states that people must be given all appropriate help & support to enable them to make their own decisions or to maximise their participation in any decision-making process. Mental Capacity Act 2005 4(4)

### Principles of the Mental Capacity Act

- A person must be assumed to have capacity unless it is established that they lack **capacity**.
- A person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success.
- A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
- Any act done or decision made under the MCA for or on behalf of a person who lacks capacity must be done, or made, in his **best interests**.
- Any act or decision made must be the least restrictive of the person's rights and freedom of action.

These principles aim to protect people who lack capacity and help them take part as much as possible in decisions that affect them. They aim to assist and support people who may lack capacity to make specific decisions, not to restrict or control their lives.

Some people may need help to be able to make a decision or to communicate that decision but this does not mean that they cannot make that decision. Anyone who believes that a person lacks capacity should be able to prove their case.

### Capacity

The MCA Code of Practice defines a person's capacity as being decision and time specific: a person may have capacity about some things but not others; their capacity to make a particular decision may change with time.

Someone's capacity to make a serious or complex decision at a particular time is often formally assessed with a 2-stage capacity test while day to day decisions don't need a formal assessment every time they are carried out.

The capacity test looks at the following 2 factors:

1. Does the person have an impairment of the mind or brain, or is there some sort of (temporary or permanent) disturbance affecting the way their mind or brain works?
2. If so, does that impairment or disturbance mean that the person is **unable to make the decision** in question at the time it needs to be made?

### Best Interests Checklist

As 'best interests' covers every day events to life changing decisions MCA Code of Practice s4 sets out some common factors that must always be considered and evidenced when making a decision for someone who lacks capacity to make that decision themselves. Quick Summary from Chapter 5 MCA Code of Practice :

- Encourage participation
- Identify all relevant circumstances
- Find out the person's views
- Avoid discrimination
- Assess whether the person might regain capacity
- Consult others
- Avoid restricting the person's right
- If the decision concerns the provision or withdrawal of life-sustaining treatment, do not be motivated by a desire to bring about a person's death.

Best interests decisions can only be made on behalf of a person who lacks capacity if that person does not have an Attorney with the appropriate decision making powers or a Court-appointed deputy or has not made an advance decision to refuse treatment applicable to the particular decision in question.

## APPENDIX C - EXAMPLE NON-INSTRUCTED ADVOCACY POLICY

This is an example of the wording of a policy that IMHA providers should draw up that describes how they will advocate for those qualifying patients who lack the capacity to instruct them. It is advisable that this policy be shared with health & social care staff where appropriate.

### Somewhere Independent Mental Health Advocacy (IMHA) Service Non-instructed Advocacy Policy

#### 1. Context

Somewhere IMHA Advocacy Service aims to provide an independent, free and confidential advocacy service to all those detained patients defined as qualifying under the Mental Health Act 2007, i.e. anyone who is detained under the Mental Health Act (except the holding powers of Sections 4, 5, 135 or 136), anyone subject to guardianship, conditional discharge or a community treatment order and some informal patients.

Somewhere IMHA Advocacy Service provides a statutory safeguard to qualifying patients by supporting them to understand and exercise their rights with regard to their care and treatment. IMHAs may support qualifying patients in a range of ways to ensure that they can participate in the decisions that are made about their care and treatment.

#### 2. Purpose

This policy details how Somewhere Advocacy Service will provide non-instructed advocacy to those qualifying patients who lack the capacity to instruct an IMHA.

#### 3. Introduction

IMHAs will, wherever possible, take instructions from qualifying patients, but where the IMHA finds that the qualifying patient lacks the capacity to instruct them they will provide non-instructed advocacy in accordance with this policy.

#### 4. The Process of Non-instructed Advocacy

- 4.1 Where health & social care staff assess a qualifying patient as lacking the capacity to refer themselves they will refer the individual to the IMHA service.
- 4.2 The IMHA will liaise with the referring staff member to find out how the individual communicates, to clarify the individual's eligibility for the IMHA service and any current relevant safety issues regarding the individual that the IMHA needs to be aware of.

- 4.3 If information regarding the individual's preferred method of communication is not available the IMHA will ensure that they explore a variety of means of communication with the qualifying patient as the person may be able to instruct them using their preferred method of communication.
- 4.4 When deciding whether the qualifying patient has the capacity to instruct them the IMHA will specifically look to see if the qualifying patient can:
- **Understand** information regarding the advocacy role
  - **Retain** that information
  - **Use** or weigh up that information
  - **Communicate** their decision as to whether to engage with an IMHA or not (by talking, using sign language or any other means).
- 4.5 The IMHA will record the evidence gathered for deciding that the qualifying patient lacks the capacity to instruct them and will then provide them with non-instructed advocacy using a blend of approaches.
- 4.6 The IMHA will explain their non-instructed role to the individual's friends and family members where appropriate and to those staff involved in the provision of the individual's care & treatment.

## 5 Non-instructed Advocacy Approaches

There is a long history of advocates providing non-instructed advocacy and a number of different approaches have been developed and used successfully. They are the Rights Based Approach, the Watching Brief, the Questioning Approach, the Person Centred Approach and the Witness-Observer Approach.

These approaches aim to ensure that the individual is kept at the centre of all discussions and that decisions are made taking the individual's wishes, where known, into consideration.

### 5.1 The Rights Based Approach

This approach begins with the premise that we all have certain fundamental rights that can be clearly defined. These rights may be legislative, ethical or human rights. The IMHA represents the individual to ensure that in any decision or action proposed their rights are taken fully into account.

### 5.2 The Watching Brief

'Watching Brief' was devised by advocates from Asist (Advocacy Services in Staffordshire). This approach centres around 8 quality of life domains which are used as the basis for a series of questions that the advocate can ask regarding the proposed course of action and the likely outcome for the individual.

### 5.3 The Questioning Approach

As with the Watching Brief the core of this approach is the IMHA asking questions of the professionals' rationale for proposed treatment and care and how this might impact on the qualifying patient. This approach is not as structured an approach as the Watching Brief as it does not use the quality of life domains. Instead the IMHA asks any questions that might be relevant to the individual they are working with as they are unable to ask them themselves.

### 5.4 Person Centred Approach

This approach is based on a long-term, trusting and mutually respectful relationship between the advocate and the individual being supported. In spending time with the individual the advocate builds up a picture of their lifestyle, preferences and needs which is aided by the advocate's independence from service systems. The advocate is in a unique position to describe and, where necessary, represent the individual's views. In doing so the advocate is putting forward the individual's unique perspective, and as such is promoting a person-centred approach to service delivery and decision making.

### 5.5 Witness-Observer Approach

There is a real value in the advocate's role in being an observer or witness to the ways in which services interact with the individual. The advocate may see or hear things that are unacceptable or which pose a threat to the individual's well being. Conversely, the advocate may also pick up on the individual's preferences and pleasures, which can in turn be used to enhance positive relationships.

The witness-observer approach does not require the advocate to make judgements or assumptions, merely to report on the facts of his or her observations. In doing so, the advocate may be bringing to the attention of service providers or decision makers factors that they had not previously been aware of or taken into account, e.g. a lack of stimulation, dislike of certain people, foods or activities; appropriateness of routines and systems; the communication function of key behaviours or actions etc.

- 6 By listening to the expressed views of the qualifying patient and using a combination of these approaches to non-instructed advocacy the IMHA can build up a more complete picture of the views, wishes and wants of the individual regarding their care and treatment.
- 7 The IMHA can then ensure that the individual's views, wishes and wants are at the centre of the mental health professionals' decision-making process.

## APPENDIX D -EXISTING GUIDANCE ON ACCESS TO RECORDS

### The Mental Health Act Code of Practice states that :

- 20.26 Where the patient does not have the capacity (or in the case of a child, the competence) to consent to an IMHA having access to their records, the holder of the records must allow the IMHA access if they think that it is appropriate and that the records in question are relevant to the help to be provided by the IMHA.
- 20.27 When an IMHA seeks access to the records of a patient who does not have the capacity or the competence to consent, the person who holds the records should ask the IMHA to explain what information they think is relevant to the help they are providing to the patient and why they think it is appropriate for them to be able to see that information.
- 20.28 The Act does not define any further what it means by access being appropriate, so the record holder needs to consider all the facts of the case. But the starting point should always be what is best for the patient and not (for example) what would be most convenient for the organisation which holds the records.
- 20.29 In deciding whether it is appropriate to allow the IMHA access, the holder of the records needs to consider whether disclosure of the confidential patient information contained in the records is justified.
- 20.30 The key consideration will therefore be whether the disclosure is in the patient's best interests. That decision should be taken in accordance with the Mental Capacity Act 2005 (MCA) (or, for children under 16, the common law), like any other decision in connection with the care or treatment of patients who cannot make the decision for themselves.
- 20.31 Record holders should start from a general presumption that it is likely to be in patients' interests to be represented by an IMHA who is knowledgeable about their case. But each decision must still be taken on its merits, and the record holder must, in particular, take into account what they know about the patient's wishes and feelings, including any written statements made in advance.
- 20.32 Records must not be disclosed if that would conflict with a decision made on the patient's behalf by the patient's attorney or deputy, or by the Court of Protection.
- 20.33 If the record holder thinks that disclosing the confidential patient information in the records to the IMHA would be in the patient's best interests, it is likely to be appropriate to allow the IMHA access to those records in all but the most exceptional cases.

### The Department of Health's Supplementary guidance on access to patient records under section 130B of the Mental Health Act 1983 states:

5.4 In deciding what records they ask to inspect in cases where the patient lacks capacity to consent, IMHAs need to consider how this will affect their ability to provide help and support to patients in accordance with the Act. On the one hand, being in possession of information that cannot be shared with the patient may cause difficulties in the relationship of trust with the patient. On the other hand, there could be circumstances in which not accessing all the available information could restrict their ability to help the patient as fully as possible.

## USEFUL RESOURCES

### **Mental Health Act (1983) Code of Practice**

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_084597](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084597)

### **Mental Capacity Act 2005 Code of Practice**

<http://webarchive.nationalarchives.gov.uk/+/http://www.dca.gov.uk/legal-policy/mental-capacity/mca-cp.pdf>

### **Reference Guide to the Mental Health Act 1983**

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_088163.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_088163.pdf)

### **Working with the Mental Health Act, 3<sup>rd</sup> Edition, Richards S. Mughal A.**

[www.matrixtrainingassociates.com](http://www.matrixtrainingassociates.com)

### **Mental Health Act Manual, 13<sup>th</sup> Edition, Jones R. Sweet & Maxwell (2010)**

### **Working with the Mental Capacity Act 2005, 2<sup>nd</sup> Edition, Richards S. Mughal A.** [www.matrixtrainingassociates.com](http://www.matrixtrainingassociates.com)

### **When Communication Gets Tough: A Guide to Non-instructed Advocacy, Scope**

<http://www.advocacyresource.org.uk/gen2-file.php?id=108>

### **A Voice of Their Own: A Toolbox of Ideas and Information for Non-instructed Advocacy,** Lawton A. BILD Publications(2006)

### **Capacity to Communicate: Training Toolkit By Lee-Foster A. SENSE (2008)**

[http://www.sense.org.uk/help\\_and\\_advice/research\\_practice\\_development/advocacy\\_capacity\\_communicate.htm](http://www.sense.org.uk/help_and_advice/research_practice_development/advocacy_capacity_communicate.htm)

### **The Watching Brief, Asist**[www.asist.co.uk](http://www.asist.co.uk)

### **Developments in Dementia Advocacy. Wells S.** [www.advocacyplus.org.uk](http://www.advocacyplus.org.uk)

### **IMHA Guidance for Commissioners - National Institute for Mental Health Excellence**

<http://www.nmhdu.org.uk/silo/files/independent-mental-health-advocacy-guidance.pdf>

### **IMHA Effective Practice Guide - National Mental Health Development Unit**

<http://www.nmhdu.org.uk/silo/files/independent-mental-health-advocacy-effective-practice-guide.pdf>

### **Giving Patients Information about IMHA Services & Making Referrals, NMH DU**

<http://www.nmhdu.org.uk/silo/files/imha-services-flowchart.pdf>

### **IMHA Supplementary Guidance on Access to Patient Records**

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_098829.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098829.pdf)

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