VoiceAbility

Providing advocacy from a distance

This document was written on 17 March 2020 as internal guidance for VoiceAbility staff. It was last amended on 22 June 2020. We are sharing it publicly in the hope that it might be of some assistance to others, especially advocacy organisations, and ultimately to people who rely on the support we all provide. It was written in good faith based on the best information available at a particular point in time. No liability is accepted for any adverse consequences of reliance upon it. We welcome feedback to CV19@voiceability.org

Key messages

Instructed advocacy: consider if you can carry out some of your work by telephone, email or video call.

Non-instructed advocacy: this may be seriously limited but you may still be able to ask questions of decision makers, clients or family members by telephone, email or video call.

In all situations, we must remember that asking to delay a decision, or make a temporary decision, until we can consult fully with our client, is nearly always an option.

Instructed advocacy

Advocates should consider alternative ways to consult with their client, including:

- telephone appointments
- video call
- email or other text-based communication

Whichever method is used, the client should be able to speak to their advocate independently of staff (ideally in a separate room) if they wish to. Advocates should think about how they can communicate most effectively in this setting. This will include confirming whether clients have been allowed, if requested, to speak to them on their own.

IMHA specific

The Mental Health Act Code of Practice requires that “patients should have access to a telephone on which they can contact the IMHA service and talk to them in private” and that IMHAs must be able to “meet with the patients they are helping in private, unless the patient objects or it is otherwise inappropriate.”

Should hospitals be unwilling or unable to facilitate these approaches to providing access to advocacy under the Mental Health Act, this puts clients’ rights at risk. If advocates have any concerns about access to detained patients, they must raise this with their manager. It is appreciated that providers may be working in increasingly difficult circumstances and this should be borne in mind in the way in which concerns are raised.

Non-instructed advocacy

Where advocates are unable to visit, some non-instructed advocacy work can continue. In some situations we will be able to speak with the person by phone or video, but frequently we will not be able to. We might still be able to help their rights and well-being to be considered using for example:

- Watching Brief - asking questions of decision makers using eight key domains
- rights based approach – considering how the options will ensure the client’s rights are upheld
- using knowledge of the person’s previously expressed views and preferences
- using discussions with family and professionals who know the client well to support the above approaches

However, if we have not been able to gain their views directly, the work will be severely limited, and this must be stated in our reports and comments. This is a serious limitation given that the focus of all our work is the client’s own views, wishes and voice.

Delay

In all situations, we must remember that asking to delay a decision, or make a temporary decision, until we can consult fully with our client, is nearly always an option.