

Independent Advocacy

Guide for Commissioners



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The Charter of Patient Rights and Responsibilities brings together, in one place, a summary of the rights and responsibilities that patients have when using NHS services in Scotland.

Published by the Scottish Government in September 2012 the Charter includes:



Access: you have a right to request support to access NHS services



Communication and Participation: you have a right to request support when making decisions about your health care



Respect: you have a right to be treated as an individual and with dignity and respect

Foreword



This revised Guidance aims to capture the many developments since the publication of the original Guide to Commissioners in 2001 by the then Scottish Executive Health Department and the subsequent revision and publication by the Scottish Independent Advocacy Alliance (SIAA) in 2010. Importantly it seeks to clarify Commissioners' statutory responsibilities under the Mental Health (Care & Treatment) (Scotland) Act 2003.

The Scottish Government recognises the important role advocacy plays in helping to safeguard people who may be at risk of being treated unfairly as a result of individual, social, and environmental circumstances that make them vulnerable. Advocacy helps ensure people's rights are not infringed and makes it easier for them to exercise those rights.

Of course we all have the right to be involved in decisions about our care and treatment and for most of us this will not be an issue as we know we can effectively convey our views. However, even the most confident among us may find ourselves in a situation at some point in our lives where we need support to ensure our voice is heard and our views are taken into account in decisions or actions that affect our lives. Advocacy should therefore be available to anyone who needs it.

Advocacy should provide an environment in which people can confidently raise issues knowing that it is as free from conflicts of interest as it can be. Commissioners should therefore ensure that the Principles and Standards set out in Appendix 1 are applied in the commissioning of independent advocacy services. Whilst it is acknowledged that not all non-independent advocacy providers will be in a position to meet the Standards in Appendix 1, Commissioners are encouraged to also apply the four core Principles where appropriate and possible in the commissioning of non-independent advocacy services.

Lastly I would like to say a personal 'thank you' to Jo McFarlane for allowing us to use some of her poems from AWOL (Absent without Leave Invisible When Here) to demonstrate how important advocacy is and how it can improve an individual's quality of life.

A handwritten signature in black ink, appearing to read 'Alex Neil', enclosed in a thin black rectangular border.

ALEX NEIL

Cabinet Secretary for Health and Wellbeing

Guide for Commissioners

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1. Introduction

1.1 The importance of advocacy

1.1.1 Advocacy plays an important role in supporting people to express their views and in providing a source of support which gives them the confidence to speak out. Advocacy is vital in nurturing trust and effectively supporting people to ensure their views are taken into account and that they are heard. It should also provide an environment in which they can confidently raise any concerns they may have with their advocate in the knowledge that there are no conflicts of interest.

1.1.2 Advocacy enables people to be involved in decisions which affect their lives. It helps them to express their views and wishes, to access information, to make informed choices and to have control over as many aspects of their lives as possible.

1.1.3 Advocacy:

- Safeguards people who can be treated unfairly as a result of institutional and systemic barriers as well as prejudice and individual, social, and environmental circumstances that make them vulnerable
- empowers people who need a stronger voice by enabling them to express their own needs and make their own decisions
- enables people to gain access to information, explore and understand their options, and to make their views and wishes known
- speaks up on behalf of people who are unable to do so for themselves.

1.1.4 Advocacy has two main themes:

- Speaking up for and with people who are not being heard, helping them to express their views and make their own decisions and contributions
- Safeguarding individuals who are at risk.

1.1.5 Advocacy is a crucial element in achieving social justice. It is a way to ensure that everyone matters and everyone is heard – including people who are at risk of exclusion and people who have particular difficulties in making their views known. The importance of advocacy is reflected in a range of recent legislation and policy guidance and we have included further useful reference material and links (which is not an exhaustive list) in Appendix 3.

1.1.6 Advocacy is part of everyday life. It is an ordinary activity. Many of us will at some point in our lives look to the support of someone we trust to help us speak up for ourselves to get our voice heard about decisions or actions that affect our lives. The most confident and articulate among us can feel less able to cope when ill, stressed or feeling under pressure. In these circumstances it can be difficult to ask questions about concerns. It is at these times that the support of an advocate can make all the difference to someone's quality of life.

1.1.7 However, some people in society are much more likely than others to be treated unfairly because of other people's prejudice and/or because of individual, social and environmental circumstances that make them vulnerable. Factors which might put people at risk include age, physical frailty, disability, gender, ethnic origin, sexual orientation, impairment (cognitive, psychological, motor, sensory), reputation, dislocation, abuse, family breakdown and social isolation.

1.1.8 Some people have to rely on powerful service systems for help with all aspects of their life – health and wellbeing, housing, personal assistance, decision-making, income, occupation, mobility. This can happen particularly when people have been immersed in the service system since childhood, and when they have no strong allies outside institutions. Support services can affect every aspect of someone's life and can have long term consequences.

1.1.9 Individuals who rely on these service systems often have limited personal power and resources to argue their case. This is especially true for example for people who do not use words to communicate, for children and young people, for people who have learning disabilities or those who cannot read or write in the language of the system, for people who have a negative reputation within the system, for people who are physically frail and for people who are regarded as incapable of making decisions.

1.1.10 If these individuals do not have well-motivated and capable family, carers and friends to speak up for them, they are at risk of not receiving the treatment or social care and support that is appropriate to meet their needs. They may not have their own views, wishes and feelings taken into account properly, as is their right. They are also the least likely people to exercise their right to make a complaint. Even capable and positive family, carers and friends may not be able to ensure that the individual's views are taken into account.

1.1.11 The Guidance will apply equally to advocacy for those under 16, whether they live in the community, are detained or are "looked after". However, there are some key factors that need to be taken into account and supplementary guidance specifically in relation to advocacy for children and young developed in consultation with key stakeholders will be available in Spring 2014. Advocacy for children often necessitates a fairly close working relationship with the parents (unless that is not appropriate). Advocates should be clear (with themselves and others) that they are advocating for the child, not the parent, though their views may be similar.

1.1.12 Commissioners may find it helpful to refer to:

- A Voice Through Choice – a book of stories about independent advocacy and A Voice to Trust on DVD (2008) produced by the Scottish Independent Advocacy Alliance (SIAA)
- AWOL (Absent without Leave Invisible When Here) – a book of poems in celebration of advocacy by Jo McFarlane published by the Scottish Independent Advocacy Alliance in 2013.

1.1.13 We have used a few of the poems from AWOL in this Guide. Hopefully these and the Voice through Choice material, which are available from the SIAA, will help commissioners and others gain an insight into how advocacy can improve an individual's quality of life and provide a better understanding of how different models of advocacy work in practice. Further information on the different models of advocacy is given in Section 2 of the guidance.

1.1.14 Individuals may also be unaware of their rights. The [Charter of Patient Rights and Responsibilities](#) launched on 1 October 2012 provides a summary of rights and responsibilities when using NHS services. This includes the patient's right to have their needs taken into account when receiving NHS services; the right to be involved in decisions about their care and treatment; and the right to request support when making decisions about their health care.

1.1.15 The Patient Advice and Support Service (PASS) was established in April 2012 to provide advice and support and will also raise awareness of patients' rights. PASS does not provide advocacy but can signpost people to the support services available to them and this includes providing advice on the availability of advocacy. Further details about the service can be found at: <http://www.cas.org.uk/patientadvice>. NHS Boards have a responsibility to raise awareness of the support services available and should also seek to ensure PASS has information on the advocacy services available in their respective area and how these services can be accessed.

Stand By Me

When I was broken, on my knees,
silenced by the weight of living,
on the brink of giving up,
an advocate came by
and deftly opened up my voice
by listening, simply listening.
Soon the cage became a key,
the words ran free
and hope took root within me.

Together we unraveled all the knots,
sought clarity in breaking down the problem,
put the jigsaw back together in a workable solution.

Ready now to voice my vision
to the doctors and nurses looking after me,
I asked my advocate to stand beside me
as I still felt vulnerable and small,
faced with an impenetrable wall
of professional power.

We walked into the meeting, took our places.
I saw respect light up the faces of my gaolers
as I spoke the words, tentative at first,
then full of confidence, conviction
as they soon began to listen.
My advocate sat quietly by my side,
didn't have to interject
but for the blanks in memory
caused by the haze of medication.

We came to a solution
which I felt I could accept with grace.
I didn't get discharged as I had hoped for
but in the course of being listened to
my gaolers had become my carers
and the treatment plan became a contract
which empowered me.

By standing with me on the journey
my advocate had helped to set me free.
I left the ward soon after with my head held high
because the roots of confidence and hope
she planted in me now had grown into a tree.
(Jo McFarlane, AWOL, 2013)

2. Different Models of Advocacy

2.1 The aim of all models of advocacy is to help individuals gain increased confidence and assertiveness so that, where possible, they will feel able to self-advocate when the need arises. The different models are:

2.1.1 One to one or individual advocacy

2.1.1.1 This includes professional or issue based advocacy. It can be provided by both paid and unpaid advocates. An advocate supports an individual to represent their own interests or represents the views of an individual if the person is unable to do this themselves. They provide support on specific issues and provide information but not advice. This support can be short or long term.

2.1.1.2 Another model of one to one advocacy is citizen advocacy. Citizen advocacy happens when ordinary citizens are encouraged to become involved with a person who might need support in their communities. The citizen advocate is not paid and not motivated by personal gain. The relationship between the citizen advocate and their advocacy partner is on a one-to-one and is normally but not always on a long term basis. It is based on trust between the partner and the advocate and is supported but not influenced by the advocacy organisation. The advocate supports their partner using their natural skills and talents rather than being trained in the role although they should have access to relevant training where appropriate.

2.1.1.3 Peer advocacy is also individual advocacy. Peer advocates share significant life experiences with the advocacy partner. The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates use their own experiences to understand and have empathy with their advocacy partner. Peer advocacy works to increase self-awareness, confidence and assertiveness so that the individual can speak out for themselves, lessening the imbalance of power between the advocate and their advocacy partner.

2.1.2 Group or Collective advocacy

2.1.2.1 Collective Advocacy enables a peer group of people, as well as a wider community with shared interests, to represent their views, preferences and experiences. A collective voice can help reduce an individual's sense of isolation when raising a difficult issue. A collective voice can be stronger than that of individuals when campaigning and can help policy makers, strategic planners and service providers know what is working well, where gaps are and how best to target resources. Being part of a collective advocacy group can help to reduce an individual's sense of isolation when raising a difficult issue. Groups can benefit from the support of resources and skilled help from an independent advocacy organisation.

2.1.3 Non-instructed Advocacy

2.1.3.1 Most one to one advocacy is instructed however there are occasions when non instructed advocacy may be required. Non-instructed advocacy happens when a person who needs an independent advocate cannot tell the advocate what they want. This may be because the person has complex communication needs or has a long term illness or disability that prevents them from forming or clearly stating their wishes/desires. This usually takes place with people who have dementia or profound and/or severe learning difficulties. The advocate will take time to get to know the person and relatives/friends and look for alternative methods of communication which will enable the person to express their views and wishes to ensure their rights are upheld. The advocate will challenge service providers in order to promote a person-centred independent approach.

Advocacy NOW!

In the future
when it's fashionable to listen
Everyone will have a voice –
the disadvantaged, disillusioned
All will have a voice

Not just to say what's wrong
or could be better,
but to celebrate what's good right now

In the future
people won't be threatened by dissent.
We'll welcome opposition to the status quo

In the future
when all voices speak as one,
we'll challenge the hegemony.
We'll seek the truth that speaks its name
regardless of authority or strength in numbers

In the future
we'll drown out the volume,
separate the essence from the noise

In the present
we'll keep fighting for a future
in which ALL shall have a voice
(Jo McFarlane, AWOL, 2013)

3. The importance of Independent Advocacy

3.1 Advocacy becomes an organised activity because:

- people can be treated unfairly as a result of institutional and systemic barriers as well as prejudice and individual, social, and environmental circumstances that make them vulnerable
- some people have no connections to family, carers or friends or the wider community who could support them
- For some people family, carers and friends may have conflicts of interest
- some people may only have professional paid workers involved in their lives. No matter how good the relationship may be, or how well supported they may feel, situations can arise when the person's wishes are not what the paid worker may feel is the right way forward
- a paid professional may be constricted by their role, their legal responsibilities or by their employer.

3.2 In order to be able to ensure the individual's views are heard and understood and that they receive support to ensure their rights are not infringed, it is important for advocates to be as free as they can be from conflicts of interest.

3.3 Advocates, whether paid or unpaid, must be clear that their loyalty lies with the person who needs advocacy, not to the agencies providing or involved in that person's care or to other significant people.

3.4 It is vital that anyone who might benefit from using an advocate feels confident about making that contact, without any real or perceived worries about conflicts of loyalty on the part of the advocate.

3.5 The Mental Health (Care & Treatment) (Scotland) Act 2003 (Part 17, Chapter 2, Section 259) identifies that every person with a mental disorder (as defined under section 328 of the Act) has a right to independent advocacy. The Act places a duty on local authorities and the NHS to ensure that such services are available. (See provisions set out in Section 5 and 6)

3.6 For the purposes of the Act, independent advocacy is advocacy provided by persons other than a Local Authority or a Health Board responsible for providing services in the area where the patient is to receive care or treatment, or a member of those bodies or any other person involved in their care or treatment or in providing services to them.

3.7 The Code of Practice Volume 1 for the Mental Health (Care & Treatment) (Scotland) Act 2003 provides additional clarification and states that provision of independent advocacy may be for one to one or group or collective advocacy. The Code further states that: 'Any or all of the various types might be appropriate depending on the circumstances and personal preferences of the patient concerned.' In addition it identifies the need for independent

advocacy organisations to have policies in place to identify and manage/minimise the risk of any conflict of interest.

3.8 This guidance is designed to support Local Authorities and NHS Boards to ensure that they understand and comply with their duties and obligations under the 2003 Act. The guidance can also be used in relation to the provision of advocacy support for anyone within their area who needs it. Appendix 3 provides links and references to other pieces of legislation and material which recognise the importance of the provision of independent advocacy for people who need it.

3.9 There are key factors which underpin good independent advocacy:

- advocacy groups should be firmly rooted in, supported by and accountable to a geographical community or a community of interest
- advocacy groups and those involved as advocates should be constitutionally and psychologically independent of local and national government
- advocacy groups should not be involved in the delivery of care services or the provision of other services to the individual who requires advocacy
- different approaches to independent advocacy are needed; there is no best model
- advocacy groups should maintain a clear and coherent focus of effort
- advocacy groups should undergo regular independent evaluation of their work, and commissioners should provide financial support for this.

3.10 Non-Independent Advocacy

3.10.1 It is important that whatever the setting advocates work in a clear, accountable and transparent way. Commissioners should also therefore seek to encourage the use of this guidance and the application of the principles given in Appendix 1 as appropriate and where possible in the commissioning, monitoring and evaluation of any advocacy services and to identify any potential conflicts of interest, ways of managing these conflicts and also take action to enhance independence. Links and references to legislation and material which provide further advice and guidance are given in Appendix 3.

3.10.2 Commissioners should give consideration to the unique role of unpaid carers as care providers when commissioning advocacy services. A practice guidance for carer advocacy has been produced and will be available in 2014. It will be of interest to everyone involved in working with and supporting unpaid adult carers to provide a wide understanding of the role and boundaries of advocacy for carers. It demonstrates the benefits of advocacy for adult carers and gives guidance on best practice in planning, commissioning and delivery of advocacy services.

4. The Scottish Independent Advocacy Alliance

4.1 The Scottish Independent Advocacy Alliance (SIAA) is a membership organisation, which promotes, supports and defends independent advocacy in Scotland. It has the overall aim of ensuring that independent advocacy is available to any person in Scotland. The SIAA provides information and support, gathers and distributes information, represents advocacy organisations at various levels and raises awareness and understanding of independent advocacy across Scotland. The SIAA works to influence legislation, policy and practice in relation to independent advocacy.

4.2 Links to material developed by SIAA are included in Appendix 4. All of the SIAA materials can also be accessed through the SIAA website at: <http://www.siaa.org.uk/>.

4.3 This SIAA material includes the SIAA Principles and Standards for Independent Advocacy (2008) developed by the advocacy movement in consultation with other stakeholders over many years and aspired to by the SIAA member organisations. These Principles and Standards were referenced in the previous version of the SIAA Guide to Commissioners issued in 2010 and it is open to Commissioners to use them in the commissioning of advocacy services if they wish and some do. The Principles, which represent the core beliefs about independent advocacy and outlined within the SIAA document are as follows:

Principle 1: Independent advocacy puts the people who use it first

Principle 2: Independent advocacy is accountable

Principle 3: Independent advocacy is as free as it can be from conflicts of interest

Principle 4: Independent advocacy is accessible

4.4 These Principles have been widely accepted and are supported as relevant and appropriate in the provision of quality independent advocacy services and have been adopted in this Guide. However, the standards detailed within SIAA Principle 3 do not strictly reflect Commissioners' statutory responsibilities under the Mental Health (Care & Treatment) (Scotland) Act 2003 and this has caused some confusion. The Standards associated with Principle 3 set out in Section 6 and Appendix 1 of this guidance therefore reflect the provisions within the Mental Health (Care & Treatment) (Scotland) Act 2003 and its supporting Code of Practice detailed in Section 6.

5. Commissioner's Statutory Responsibilities

5.1 The Mental Health (Care & Treatment) (Scotland) Act 2003 Section 259 states that:

“Every person with a mental disorder shall have a right of access to independent advocacy; and accordingly it is the duty of—

- (a) each local authority, in collaboration with the (or each) relevant Health Board; and
- (b) each Health Board, in collaboration with the (or each) relevant local authority, to secure the availability, to persons in its area who have a mental disorder, of independent advocacy services and to take appropriate steps to ensure that those persons have the opportunity of making use of those services.”

5.2 The Code of Practice (Volume 1, Chapter 6, para 140) which supports the Act states:

“Where a patient has a degree of incapacity, or cannot for any reason clearly say whether or not they would like an independent advocate, an MHO/hospital managers/appropriate person should consider how an independent advocate may be involved.....The right of access to independent advocacy is for each patient and is not limited only to those who are best able to articulate their needs.”

5.3 This right applies to everyone who has a mental disorder, and to all types of independent advocacy. The term mental disorder includes any person with a mental illness, a personality disorder or a learning disability. People with dementia and acquired brain injury are also covered by the Act. People do not have to have a medical diagnosis to access independent advocacy.

5.4 Commissioners thereby have a legal duty to ensure that everyone with a mental disorder in their NHS Board or Local Authority area can access independent advocacy. This duty applies to children and young people as well as adults. It also applies to people living in the community with a mental disorder who may be supported by a wide range of care providers in community settings and also prisoners and is not solely those who are detained under the Act's powers.

Committed

Stripped of pride and dignity
we've struggled for this day
The law to mandate patient power,
our right to have a say

A long time in the coming
Too soon to count the cost
of sanity held ransom
and the lives of friends we've lost

Tired of being overlooked
Sick of being mad
We're standing up for reason
and the rights we've never had

The power of lock and key
they've wielded, drugs and ECT,
must now be balanced
with the check of reciprocity

The principles enshrined in law
our welfare to protect,
and those to come who're subject to
the judgement of this Act

We've advocated wisely,
we're victors to the cause
We've stood up to insanity
and now WE'VE GOT A VOICE!
(Jo McFarlane, AWOL, 2013)

6. Principles and Standards for Independent Advocacy Reflecting Commissioners' Statutory Responsibility

6.1 The Mental Health Act (Care & Treatment) (Scotland) Act 2003 defines independent advocacy in section 259 as follows:

(5) For the purposes of subsection (1) above, advocacy services are “independent” if they are to be provided by a person who is none of the following—

- (a) a local authority;
- (b) a Health Board;
- (c) a National Health Service trust;
- (d) a member of—
 - (i) the local authority;
 - (ii) the Health Board;
 - (iii) a National Health Service trust,

in the area of which the person to whom those services are made available is to be provided with them;

- (e) a person who—
 - (i) in pursuance of arrangements made between that person and a Health Board, is giving medical treatment to;
 - (ii) in pursuance of those arrangements, is providing, under the National Health Service (Scotland) Act 1978 (c. 29), treatment, care or services for; or
 - (iii) in pursuance of arrangements made between that person and a local authority, is providing, under Part II of the Social Work (Scotland) Act 1968 (c. 49) (promotion of social welfare) or any of the enactments specified in section 5(1B) of that Act, services for the person to whom the advocacy services are made available;

6.2 The Code of Practice Volume 1 for the Mental Health (Care & Treatment) (Scotland) Act 2003 (Para 99) states that:

“Independent advocacy organisations may provide individual or group advocacy. The Act is not specific about the type or types of independent advocacy services to which a patient should have a right of access. Any or all of the various types may be appropriate depending on the circumstances and personal preferences of the patient concerned.”

6.3 The Code of Practice Volume 1, Chapter 6 (Paras 108, 109 and 110) further expands on the 2003 Act definition of independent advocacy to give the following guidance:

“108. Independence is key in the patient’s right to advocacy, because it is vital that the role of independent advocacy is not compromised in any way. Independence ensures that the advocacy services provided are divorced from the interests of those persons concerned with the patient’s care and welfare. Conflict might occur for

example, if a person providing advocacy services was also a care provider and a patient wanted to raise issues about their care. It is clear that in those circumstances, the advocate's ability to support that patient would be severely compromised.

109. The Act therefore, makes specific provision that to be "independent", the advocacy services must be provided by persons other than a local authority or a Health Board responsible for providing services in the area where the patient is to receive care or treatment, or a member of those bodies or any other person involved in their care treatment or in providing services to them. Any independent advocacy organisation should have policies in place to identify and manage/minimise the risk of any conflict of interest.

110. Independent advocacy should be provided by an organisation whose sole role is independent advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy. If the independent advocacy service or advocate has a conflict of interest, they should inform all relevant parties of this, and should withdraw from acting for the patient."

6.4 These requirements are now reflected in the Principles and Standards included as Appendix 1 to this Guide. Commissioners should therefore ensure that advocates and advocacy organisations commissioned to provide independent advocacy services in their area under the Act comply with these Principles and Standards.

6.5 Commissioners should pay particular attention to Principle 3 which states – "Independent Advocacy is as free as it can be from conflicts of interest." In relation to this principle and in line with the requirements set out above commissioners have a duty under the Mental Health Act is to ensure that the following standards are met when commissioning independent advocacy:

Standard 3.1 - Independent advocacy providers cannot be involved in the delivery of welfare or care services or in the provision of other services to the individual for which it is providing advocacy.

Standard 3.2 - Independent advocacy should be provided by an organisation whose sole role is independent advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy.

Standard 3.3 – Independent advocacy looks out for and minimises conflicts of interest

6.6 An organisation providing independent advocacy should be able to demonstrate that the advocacy services it provides meet the standards set out above and are as free as they can be from conflicts of interest. Standards 3.1 and 3.2 above differ from the standards within the [SIAA Principles and Standards for Independent Advocacy](#) (mentioned earlier at paragraph 4.4) but do not stop Commissioners from applying the SIAA standards if they wish.

6.7 Advocacy should be provided by an organisation which operates independently from other service providers involved in the treatment and care of the individual. This reduces potential conflicts of interest and minimises the restrictions on the work of advocates and the organisation. Appendix 2 provides further advice in relation to the requirement to have policies in place to identify and manage/minimise the risk of any conflict of interest.

6.8 Nurses, social workers, care staff, doctors, teachers and other professionals look out for and speak up for the people they serve. It's their job, it is part of their professional code of conduct but they are not independent.

6.9 Independent advocates do not have the same potential conflicts of interest as professional workers who are expected to make decisions based on an individual's clinical needs and on the most efficient way to use NHS resources. Because advocates do not have this sort of power over people and do not control access to resources they are in a better position to see things from the person's point of view rather than the system's point of view. They can focus on representing the interests and wishes of the people who need an advocate, and be clear that this is their role. Independence doesn't mean seeking the 'best interest' of a client but in helping a client to express their wishes and preferences.

6.10 In order to be able to ensure the individual's views are heard and understood and that they receive support to ensure their rights are not infringed, advocates have to be structurally and psychologically independent of the service system. Independent advocates – whether paid or unpaid – are clear that their primary loyalty and accountability is to the people who need advocates, not the agencies providing health and social services, and not to the government.

6.11 Psychological independence - independence of mind - is even more important than structural or financial independence. Some independent agencies are funded in part or wholly by statutory agencies and therefore have a responsibility to account to their funders for how they are spending the money.

6.12 But independent-minded advocates do not ask the funders for permission to disagree with them. Instead, they challenge agency policy and practice where these are compromising the well-being of the people they represent. They do not expect to be popular with everyone, but they do seek to ensure they are respected for the quality and integrity of their work.

6.13 Good advocacy agencies do not seek confrontation but they maintain the principle of primary accountability to the people they serve. Good commissioners welcome this spirit of independence, even if it makes their life harder.

6.14 Ideas on how to ensure independence

- Be committed as commissioners to this essential component of good effective advocacy.
- The advocacy organisation should work within the Principles and Standards set out in Appendix 1 of this guide and have policies in place to identify and manage/minimise the risk of any conflict of interest (See appendix 2 for suggested areas for consideration and inclusion in this policy.)
- *Ensure that projects have security of funding for periods of at least three years, allowing time to grow and confidence to challenge.*
- Encourage advocacy organisations to diversify their funding streams, while remembering that NHS Boards and Local Authorities still have statutory duties.
- Respect the advocacy organisation's policies, especially referral policies and procedures and confidentiality policies recognising that difficulties may arise during monitoring processes where characteristics are noted and advocacy partners may not feel comfortable with this.
- In conjunction with the advocacy organisation draw up working protocols for referrals.
- Make sure your own staff can have the opportunity to understand the role of independent advocates and involve advocacy organisations, or organisations like the Scottish Independent Advocacy Alliance, in training on the role of independent advocacy.
- Make sure service information includes clear statements not only about your commitment to advocacy but also stresses the independence from Local Authority and Health Board services.
- Have a clear agreement on what will happen if there are difficulties that cannot be resolved between you as the commissioner, and the advocacy organisation.

7. What do NHS Boards and Local Authorities get from Independent Advocacy?

7.1 Better outcomes for people

7.1.1. Advocacy makes a difference to what happens to people. It leads to a better understanding between individuals and service providers and can lead to greater self-help and independence and better decisions about treatment and services. People feel better about themselves and their situation. People get out of places where they are unhappy, get included in places where they want to be. Advocacy can also have a preventative role, ensuring that the interests of vulnerable individuals are not forgotten so that problems and crises for that person do not arise. Group or collective advocacy can provide information to support commissioners and planners to make sure that support services are targeted, that planning leads to the most efficient use of available resources leading to better outcomes for groups and individuals.

7.2 Intelligence and feedback

7.2.1 Advocacy organisations can provide an alternative source of constructive intelligence and feedback about how well services are meeting the needs of the most vulnerable groups, and inform future needs and priorities while protecting the confidentiality of individuals. This can assist the systems of clinical governance within NHS Boards and of best value within Local Authorities. As well as highlighting quality and problems in current service provision, independent advocacy can inform joint planning for the future.

7.3 Added value

7.3.1 A relatively small investment in independent advocacy can yield significant results. Advocacy organisations engage the skills and commitment of ordinary members of the public. They empower people who are being ignored, giving people the support and information they need to make their own decisions and take more control of their own life. Advocacy organisations also have an interest in avoiding dependence on a single agency, so core funding from statutory sources may be extended through other grants and fundraising activity.

7.4 Constructive challenge to service providers

7.4.1 Advocacy organisations provide a constant challenge to service providers to improve what they do. This challenge may be at least as effective in achieving higher quality as the more formal processes of standard-setting, inspection and regulation.

7.5 Keeping the focus on people who are most at risk

7.5.1 By concentrating on people who are most likely to fall through the net, independent advocacy helps the formal service system to improve the quality of what is provided for people who are hardest to serve. This is the acid test for any service system, and independent advocacy helps keep this on the agenda.

7.6 Designing person-centred services and supporting greater choice and control for users of services

7.6.1 Advocacy supports the development of person-centred services because it involves people whose circumstances do not readily fit standard arrangements. By testing the limitations of current services, advocacy can help professionals to redesign and refine the system so that it works better for everyone. Advocacy helps to support greater choice and control for people who use services by providing a voice to individuals at all stages in their support.

7.7 Enabling Carers to be respected as equal partners

7.7.1 Advocacy organisations can support carers to be heard as equal partners with other professionals in the delivery of care and, collectively, in the development of services and support that affect them or the person they care for. Whilst the views of the service user are central, this means that, in line with legislation, the views of carers should be heard and their experience respected by professionals involved. They are a key part of providing support and the term equal partner recognises not only their critical role in sustaining and supporting individuals to remain in their own homes and communities but also their unique knowledge and experience. By supporting carers to be heard and to manage and understand the often

complex systems surrounding health and social care, advocacy can help sustain the caring role reduce crisis and deliver better outcomes.

8. Planning for Independent Advocacy

8.1 It helps to think of investing in advocacy as a way of building community capacity, rather than simply as buying a service. Independent advocacy is not something which the local authority or NHS Boards could provide directly. By definition, independent advocacy operates at arm's length from the provision of local authority or NHS Board services.

8.2 NHS Boards and local authorities fund independent advocacy to meet statutory obligations and because they recognise the contribution it makes to the overall health and responsiveness of the service system and to wider issues of equality and inclusiveness in the community.

8.3 Investing wisely in independent advocacy means thinking carefully and in partnership with other stakeholders about the places where advocacy is needed, about what are the needs that are specific to the area e.g. rural or urban areas, population size etc., about what approach to advocacy would work best on those different places, and how public money could best be used to encourage and sustain these approaches.

8.4 Commissioners need to be aware of barriers and obstacles in the development of independent advocacy for certain groups. For members of groups who are marginalised and face discrimination in the wider world it is particularly important that they have ease of access to independent advocacy. In some cases organisations that already provide services may feel that they are the most appropriate organisation to provide advocacy for their service users and service users may prefer to access advocacy support from an organisation that they are already familiar with and trust. In these circumstances it is of course open to the service user to choose but they should be made aware of their right to access independent advocacy where this is appropriate.

8.5 This dilemma raises a number of issues that need to be addressed whilst ensuring that advocacy, which is independent of those involved in the person's treatment and care and is free from conflicts of interest, should be available for all who need it. Local Authority and NHS Board commissioners need to be aware of their duties under a number of different policies and legislation (additional useful references and links are given in Appendix 3 – this is not an exhaustive list). Whilst it is vital that particular duties are adhered to it is also important that additional obstacles and barriers are not inadvertently created making it difficult to meet the needs of the group whilst also following the principles of independent advocacy.

8.6 An individual may face multiple layers of discrimination in wider society based on perhaps their age, gender, disability, ethnicity, mental health, sexuality or substance dependency and might experience similar barriers in accessing existing advocacy provision. It is important to remember that advocacy organisations should be accessible to all and that

information on the availability of advocacy services in each area should also be made available.

9. Developing the Strategic Advocacy Plan

9.1 A Strategic Advocacy Plan should be developed based on the information gathered from a needs assessment, scoping exercises and consultations. In relation to this NHS boards should bear in mind that responsibility for health care for prisoners transferred to NHSScotland in November 2011 and the needs assessment should take this into account. See Section 10 for advice on Commissioning of Advocacy Services.

9.2 The Strategic Advocacy Plan should be Equality Impact Assessed (EQIA) and signed off by senior management in both the NHS Board and corresponding Local Authorities. The Plan should clearly explain what independent advocacy is and outline the development and investment in advocacy over a minimum three-year period. The Plan may also cover other aspects of advocacy provision being commissioned in your area.

9.3 The NHS Reform (Scotland) Act 2004 placed a duty on all NHS Boards to involve the public (i.e. patients, carers or members of the public from a range of groups' perspectives) in the planning and design of health care services and policies. The Charter for Patients' Rights and Responsibilities published in October 2012 reaffirms the patients right to be involved, directly or through representatives in the planning, design and provision of services in their area. NHS Boards therefore need to ensure that people have a say in decisions not only in relation to their own care and but also in the development of local health services. The Participation Standard produced by the Scottish Health Council is a way of measuring how well NHS Boards do this. One of the criteria within the Standard Section 1, which relates to Patient Focus includes "Independent advocacy services are provided and developed in partnership with other agencies and the people who need them."

Consultation and Involvement

We asked them to contribute
and they cared enough
to tell us what they thought.

They sought the simplest things:
a place to be that held their dignity,
support of self and family,
fulfilling things to do,
respect and being listened to.

We took their big ideas on board,
took small steps forward to achieve
what seemed impossible to us.
Budget cuts, practical logistics,
cultural resistance,
all the barriers we faced along the way.

And then one day,
a revolution happened in our thinking:
let's take the consultation further,
ask the people *how* they think we can
achieve the changes that they want to see.

The answer came like manna from the gods. They said:
Involve us, Don't just listen.
Let us be the architects, the builders
and the artists of our vision.
Give us tools, resources,
and the hope to realise our ambition.
Don't just talk to us,
walk *with* us the road that leads to change"

We found that soon
the labels *service users* and *providers*
were redundant.
We were partners now,
working in pursuit of common goals.
(Jo McFarlane, AWOL, 2013)

10. Commissioning Independent Advocacy

10.1 In commissioning advocacy services Commissioners should ensure that their procedures for procurement comply with the public procurement rules as appropriate and reflect the guiding principles contained within the joint Scottish Government and COSLA Guidance on the procurement of care and support services, which was issued in 2010. The guidance is available at <http://www.scotland.gov.uk/Resource/Doc/324602/0104497.pdf>.

10.2 Jointly published by the Scottish Government and COSLA the detailed guidance includes advice in relation to the European Convention on Human Rights (ECHR) which recognises individuals' freedom to control their own lives and effectively take part in decisions made by public bodies which impact upon their rights. The fundamental rights and freedoms contained in the ECHR are given legal effect in Scotland by the Human Rights Act 1998 and the Scotland Act 1998.

10.3 The Guiding Principles in Chapter 2 of the joint guidance include the need to involve service users and carers as active partners in defining their needs and the outcomes they require. Section 6 of the joint guidance outlines 'Key Considerations' and the 'Personalisation of health and social care services'. Paragraph 6.8 suggests:

"6.8 Public bodies should consult widely on any proposals for new services; where decisions have to be taken about the continuation of existing services, there will be a need for more focussed engagement with people receiving the services. Public bodies should take account of the views expressed by service users and carers at the analysis stage when:

- establishing individual needs and intended outcomes;
- analysing existing arrangements for delivering the service; and
- deciding if a service should be provided in-house, under a shared service arrangement or by grant funding, or if it should be procured from an external service provider."

10.4 Guidance in relation to Option Appraisal is contained in Section 7 of the joint guidance and advises that information gathered during the 'analysis' stage should inform public bodies' appraisal of the options for service delivery, which might include in-house provision; shared services; grant funding; and procurement. Paragraph 7.15 explains that the decision on whether a service is delivered under contract or grant funded will depend on the nature of the service to be provided and the relationship the public body wishes to have with the service provider. It provides examples of when grant funding might or might not be appropriate and suggests that public bodies should seek legal advice on the distinction between a contract and grant funding where they consider that grant funding may be an option.

10.5 Commissioners may find the 'Decision-making flowchart in relation to the continuation of an existing service' included in Chapter 8 of this guidance useful in helping to determine which procurement route is appropriate.

10.6 NHS Boards and Local Authorities should fund advocacy jointly and guarantee a realistic level of funding for a minimum of three years, albeit that funding is reviewed annually, to the independent advocacy providers. Funding should include costs to cover an external independent evaluation. Significant resources were given to local government and health boards as part of the implementation of The Mental Health Act (Care & Treatment) (Scotland) Act 2003, and since 2004 there has been £18 million in the system to implement the Act, of which independent advocacy is an important part.

10.7 Commissioners should recognise that the primary accountability of any advocacy organisation is to the person receiving the service. The organisation is accountable to commissioners for how it spends public money, and should be expected to report fully on this. But commissioners should remember that the advocacy organisation is an independent organisation and therefore there needs to be clear boundaries which are respected.

10.8 Secure long term funding will:

- allow advocacy organisations to plan for their development
- allow advocacy organisations to manage change rather than respond to crisis
- allow trust to develop between commissioners and advocacy organisations
- provide continuity for advocacy partners
- allow for greater staff retention.

10.9 There is also a statutory duty under the Equality Act 2010 for NHS Boards and Local Authorities to provide services that are equitable and accessible ensuring that any barriers to services are addressed (e.g. communication, mobility, sensory, gender and cultural support).

Respect

Respect

Such a little word
two syllables
replete with meaning,
infinite of possibility

I take the time to listen,
get to know you,
understand the shoes you walk in,
all the miles you've travelled,
the companions
and the stumbling blocks
you've met along the way

You take the time to tell me
all the colours of your journey,
how the meeting place of cultures
didn't happen overnight

I am richer, wiser for your story
so I listen with respect,
come to know you as a friend,
share with you my story
till we grow
in understanding of each other

Soon that little word *respect*
becomes a way of life
(Jo McFarlane, AWOL, 2013)

11. Supporting Independent Advocacy

11.1 There is now a much greater emphasis on partnership between commissioners and providers of services, and a greater recognition that commissioners and planners are responsible for enabling and facilitating the work of service providers, not just negotiating and paying for it. Advocacy organisations will benefit from support in various aspects of their work.

11.2 The Engagement Matrix http://www.vhscotland.org.uk/wp-content/uploads/2013/02/Engagement_Matrix_finished_WEB_version_VHS_110213.pdf is a tool launched in February 2013 for health boards and third sector organisations to use together to map and improve engagement between them.

11.3 While it is entirely healthy and desirable for advocacy organisations to secure their funding from a number of sources - including charitable trusts and local communities - it is essential that organisations have reliable core funding. This should run for at least three years.

11.4 Development and Problem Solving Assistance

11.4.1 Initial support may be needed to get the advocacy organisation off the ground. This is traditional community development work - getting people together round the table and finding common cause; clarifying values, aims, methods and relationships; putting together a constitution for the organisation and drawing up a plan of action.

11.4.2 Commissioners should encourage organisations to adopt and maintain good management practices, perhaps by linking them with generic agencies such as councils for voluntary service or with schemes which provide secondments from larger private or public sector organisations. Particularly where only one post is funded, it is worth budgeting for external management supervision in the early years of the organisation.

11.5 Support for volunteer management

11.5.1 For those organisations using volunteer advocates commissioners should ensure that they have sufficient resources for effective volunteer management and development.

11.6 Support for co-operations, networking and renewal

11.6.1 Advocacy organisations benefit from exchanging ideas and providing mutual support. There is also scope for more formal joint work through joint training, concerted efforts to promote advocacy locally and through jointly-managed projects.

11.6.2 Everyone benefits from some form of local networking and information exchange, but this does need to be facilitated. Where there is not already an effective local network, it is worth commissioners providing some modest funding for this through a suitable and acceptable local 'honest broker'.

11.6.3 The essential requirement here is acceptability; the network needs to be owned by the people/organisations involved, and they have to decide which organisations they trust to take on a facilitating role.

11.6.4 Commissioners should also encourage advocacy organisations to spend time on renewal. Organisations may need opportunities to reflect on their work and reconnect with what they are trying to achieve. This may include: review days, development days, team building, regular planning sessions and review of the management arrangements of the organisation. Independent external facilitation may be helpful for some of these areas. Regular timescales for these events could be built into the Service Level Agreement (SLA).

11.6.5 Revisiting and renewing the connections between advocacy organisations and their impact on the service systems may also be beneficial for existing advocacy organisations. Are the projects still connected in the best way to the decision making processes on future services? Are staff in the organisation responding to the issues the organisation is taking forward?

11.6.6 Commissioners can support this process by:

- building in funding for this purpose
- providing information on maintaining good management practice and reviewing policies and procedures
- listening and responding when organisations call for change in the agreements or their own structure as a result.

11.7 Getting the relationship right

11.7.1 Commissioners have a duty to clarify expectations and lines of accountability and should avoid imposing onerous reporting and accountability requirements on small advocacy organisations - they need the money and may agree to unrealistic targets to get it. Commissioners should encourage organisations to be realistic, especially in the first year.

11.7.2 Above all, commissioners should recognise that the primary accountability of any advocacy organisation is to the people it serves. The organisation is accountable to commissioners for how it spends public money, and should be expected to report fully on this. But commissioners do not own the organisation and should do what they can to encourage the organisation to maintain its independence.

11.7.3 Commissioners should not seek to control the advocacy organisation but should take the lead in establishing a relationship of mutual respect where both sides recognise that the other one has a valid and different role.

11.7.4 It is valuable to have regular meetings where the organisation presents a face-to-face report on what they have been doing. This allows genuine concerns about performance to be discussed at an early stage, on the basis initially of 'what can we do to help you?'

11.7.5 Commissioners should not expect the organisation to behave like a direct service project, and especially not like a direct service within a big structure like the NHS. It should be recognised that advocacy organisations will operate in slightly different ways to meet the needs of the individual.

11.8 Training, Expertise and Resources

11.8.1 Commissioners may be able to help or suggest local sources of help with issues such as:

- training for management committee members/Directors/Trustees
- training for paid and unpaid advocates
- training in people's rights including the rights of children and responsibilities in terms of adult and child protection
- developing policies - for example on equal opportunities, complaints handling, confidentiality, recruitment and selection of staff and volunteers
- dealing with allegations of abuse
- setting up office systems and computers
- setting up systems of financial management, and providing training

11.8.2 Commissioners should work in partnership with advocacy organisations to provide training about advocacy. It is imperative that commissioners make sure that the role of advocacy is understood by statutory sector staff. Many statutory sector staff see themselves as the 'natural advocate' for their clients, however this would not be considered independent advocacy. It is important that staff understand the difference.

11.8.3 Commissioners should ensure that statutory sector staff are briefed about the advocacy organisations working in their area and how to make a referral to the advocacy organisations.

11.8.4 Training should also be provided to senior planners and directors to highlight the benefits of advocacy and how it fits in with the wider national policy and legislative context.

11.8.5 Commissioners may also be able to provide or suggest sources for premises, equipment, photocopying, graphic design, promotion/public relations etc. This may be particularly helpful in the first year.

11.8.6 Commissioners should be aware when people need advocates to negotiate what should be routine encounters with service system, and should raise these issues with service providers.

11.8.7 Commissioners are also in a position to help negotiate protocols between advocacy organisations and service providers, for example on:

- **access:** some advocacy organisations find people who need advocates simply by going into institutional settings and meeting people who are particularly isolated and at risk

- **complaints:** if staff of the service provider have a complaint or a concern about the conduct of an advocate, where do they go?
- **confidentiality:** what can the advocate say about the person who needs advocacy, and to whom?
- **access to information:** who decides who can see what sort of information about a patient?
- **handling conflict:** where advocates are representing someone's serious concerns

11.8.8 Commissioners can help to raise the profile of advocacy by ensuring that it gets a mention in wider policy documents and debates. Commissioners can ensure that the role of advocacy is understood by staff that will come into contact with schemes and projects, by assessing training on advocacy.

11.9 Keep support under review

11.9.1 Check out with local organisations what support they need and want - both individually as part of the review cycle and collectively.

11.9.2 There are several ways in which commissioners can support the development of new advocacy organisations:

- providing access to appropriate training for all staff.
- funding for external support and supervision for the coordinator of the organisation
- help in adopting and maintaining good management practice and developing policies and procedures. This can be provided by other bodies such as the local council for voluntary organisations
- support networking with useful organisations. Funding could be provided to support a local advocacy network
- funding should be invested in creating an infrastructure for advocacy and awareness raising

12. Monitoring and Evaluating Advocacy

12.1 Both commissioners and advocacy groups have an investment in knowing that advocacy is effective. Public agencies have a duty to ensure that public money is being used well. Advocacy groups which seek public funds to help them do their work recognise their accountability to the public for how they use this money.

12.2 Advocacy groups know better than most that good intentions do not always lead to good outcomes. They know that this applies to their own work as well as to services, and welcome regular scrutiny.

12.3 Commissioners and advocacy organisations should be clear from the outset that as part of the Service Level Agreement there will be an agreed process for monitoring and evaluation. The SLA should also cite timescales for regular review meetings between the advocacy organisation and commissioners. However, the methods used for monitoring and evaluating the work of independent advocacy organisations must be credible both to the advocacy organisations themselves and to funders and should not impose a disproportionate burden on a small organisation.

12.4 Defining Quality

12.4.1 Different approaches to advocacy are needed for different people at different times and in different contexts, there is no one best model. Similarly, the evaluation method and criteria must be matched to the specific approach.

12.4.2 While advocacy organisations may differ in their approaches and beliefs, advocacy organisations have more similarities than differences and the core principles set out in Appendix 1 are therefore the same for all.

12.5 Monitoring

12.5.1 Monitoring is the process of checking continuously how things are going. From the outset, advocacy organisations should set up systems for gathering the routine information they need so they know how they are doing. For example, in the first few months the organisation and the funders might agree to monitor 'setting up' tasks such as getting the advocate recruitment procedures in place or providing training for the Management Committee or Board of Directors.

12.5.2 Commissioners can advise advocacy organisations on what information to collect and this information will be useful in discussions between the organisation and commissioners. However, advocacy organisations should see monitoring as primarily something which benefits them, not as a chore to please the commissioners. This means limiting the information collected to the useful minimum. In order to protect the confidentiality and anonymity of the advocacy partners, the information passed on to commissioners should not contain any identifying detail.

12.5.3 As well as routine monitoring, many advocacy organisations undertake periodic reviews of their work. These reviews may be purely internal, that is, undertaken by some combination of staff, management committee, advocates and people who need advocacy.

12.6 Evaluation

12.6.1 Evaluation involves a planned process of gathering information, reaching conclusions and making recommendations. An evaluation of an advocacy organisation will seek to take into account the perspectives of all those with a stake in the work: people who need advocacy, paid and unpaid advocates, staff and Management Committee/Board of Directors, members, funders, referrers and so on.

12.6.2 Evaluation means making a judgement of how effective something is, not just whether or not it has complied with a funding specification. It means looking at outcomes as well as activities, at relevance as well as numbers, at what could have been done as well as what was done.

12.6.3 Evaluating advocacy is complicated. It means thinking carefully about the purpose of the organisation, and different stakeholders often have varying accounts of this. It means listening carefully to what people say about the difference it has made to people's lives. Sometimes the people whose lives have been affected most are not able to articulate this. It means balancing the visible stories of success with the invisible work of preventing worse from happening. It means putting a value on relationships as well as results. It means assessing how much impact advocacy has had on policies and practice in the service system, both in relation to individuals and more generally.

12.6.4 Commissioners and advocacy organisations should invest in regular independent external evaluation. The reports from these independent evaluations will belong to the Commissioners and the advocacy organisation but can be shared as appropriate with others.

12.6.5 Evaluation should be a constructive but challenging process - not an ordeal, but equally not simply a mechanism for encouragement and renewal. For this reason, it is important for advocacy organisations to undertake other renewal activities.

12.6.6 The SIAA has published [Independent Advocacy: An Evaluation Framework](#), which offers ideas for processes and tools that can be adapted by individual advocacy organisations to help them to evaluate and monitor their work.

12.6.7 In order for the evaluation to be effective, the independent advocacy organisation needs to demonstrate, through practical examples, how it meets all of the Principles and Standards set out in Appendix 1¹.

¹ As explained in paragraph 4.4 the Principles and associated standards set out at 1, 2 and 4 are consistent with the SIAA Principles and Standards. Standards 3.1 and 3.2 reflect the definition of independent advocacy in the Mental Health Act (Care & Treatment) (Scotland) Act 2003. It is open to Commissioners to apply the SIAA principles and standards, which are more restrictive, if they wish.

12.6.8 There are three sections to the SIAA Framework. The first considers gathering and analysing numerical data and 'soft' outcomes, the second is a tool which can be used by organisations to measure their work against the Principles and Standards for Independent Advocacy in Appendix 1 of this guidance or where appropriate the SIAA Code of Practice. The third section is a tool which can be used by an external independent consultant when undertaking an evaluation.

12.7 Commissioning an independent evaluation

12.7.1 It is useful to draw up a clear specification for any evaluation, setting out the scope of the work, who is doing it, how it will be done, why it is being done, who wants it done, who is paying for it to be done, who will get the report and what sort of actions might be taken as a result of the evaluation.

12.7.2 For example, in planning one evaluation the following scope and focus was agreed by advocacy organisations and commissioners:

- Developmental - using a partnership approach, to highlight what is working well and where improvement and development is needed in future
- Service user-focused - exploring the relationship between partners and advocates, the experience of partners, the issues which have been important to partners and advocates and the roles advocates have taken up
- Organisation-focused - the work of the office and co-ordinator, the training and support given to volunteers
- Management-focused - management arrangements and the role of the Management Committee or Board of Directors
- External support - what support has been provided from commissioners and others, how this helps or hinders, how it could be improved
- Relationship with providers - how the project is perceived, what impact it has had on providers.

12.7.3 As well as considering current outcomes, an external evaluation should pay attention to the accountability, robustness and sustainability of the organisation. This might include, for example, issues such as:

- the composition and renewal of the Management Committee/Board of Directors. How well does the membership of the Committee/Board reflect the organisation's constituency? Are new people being recruited to the Committee/Board?
- the extent to which the organisation is addressing the needs of the most marginalised people within its constituency - for example, people from ethnic minorities, people who do not use words to communicate, etc.
- the reputation of the organisation within its community
- the match between the advocacy needs of the people the organisation serves and the skills and resources held within the organisation.

12.7.4 The SIAA [Independent Advocacy: An Evaluation Framework](#) includes details of areas for assessment in an external evaluation. The framework has been designed to allow it to be used in evaluating different models of advocacy. There are also recognised tools designed for evaluating citizen advocacy.

Principles and Standards for Independent Advocacy Reflecting Commissioners' Statutory Responsibility²

Principle 1

Independent advocacy puts the people who use it first.

- Standard 1.1** - Independent advocacy is directed by the needs, interests, views and wishes of the people who use it
- Standard 1.2** - Independent advocacy helps people to have control over their lives and to be fully involved in decisions which affect them.
- Standard 1.3** - Independent advocacy tries to make sure that people's rights are protected
- Standard 1.4** - Independent advocacy values the people who use it and always treats people with dignity and respect.

Principle 2

Independent advocacy is accountable.

- Standard 2.1** - Independent advocacy is accountable to the people who use it
- Standard 2.2** - Independent advocacy is accountable under the law
- Standard 2.3** - Independent advocacy is effectively managed.

Principle 3

Independent advocacy is as free as it can be from conflicts of interest.

- Standard 3.1** - Independent advocacy providers (individuals or organisations) cannot be involved in the delivery of welfare or care services or in the provision of other services to the individual for which it is providing advocacy.
- Standard 3.2** - Independent advocacy should be provided by an organisation whose sole role is independent advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy.
- Standard 3.3** - Independent advocacy looks out for and minimizes conflicts of interest

Principle 4

Independent advocacy is accessible.

- Standard 4.1** - Independent advocacy reaches out to the widest possible range of people, regardless of ability or life circumstances.

² As explained in paragraph 4.4 the Principles and associated standards set out at 1, 2 and 4 are consistent with the SIAA Principles and Standards. Standards 3.1 and 3.2 reflect the definition of independent advocacy in the Mental Health Act (Care & Treatment) (Scotland) Act 2003. It is open to Commissioners to apply the SIAA principles and standards, which are more restrictive, if they wish.

These principles and standards are designed to support commissioners and advocates in ensuring the provision of high quality advocacy which meets the needs of advocacy partners.

Whilst the principles and standards focus on the delivery of independent advocacy under the Mental health (Care & Treatment) (Scotland) Act 2003, much of what they say reflects good practice in relation to advocacy more generally. Where individuals and organisations are involved in the delivery of non-independent advocacy, they may not be in a position to fully satisfy all of the standards but should seek to apply the four principles as far as possible. It is vital that anyone who might benefit from using an advocate feels confident about making that contact without any real or perceived worries about conflicts of loyalty on the part of the advocate.

Policy to identify and manage/minimise the risk of any conflict of interest

1. The Code of Practice Volume 1, Chapter 6 (Para 109 and 110) expands on The Mental Health (Care & Treatment) (Scotland) Act 2003 definition of independent advocacy and states that:

“Any independent advocacy organisation should have policies in place to identify and manage/minimise the risk of any conflict of interest.

Independent advocacy should be provided by an organisation whose sole role is independent advocacy or whose other tasks either complement, or do not conflict with, the provision of independent advocacy. If the independent advocacy service or advocate has a conflict of interest, they should inform all relevant parties of this, and should withdraw from acting for the patient.”

2. To support best practice, Commissioners therefore need to be satisfied that organisations involved in providing independent advocacy have robust policies and protocols in place to ensure that appropriate action is taken to address and resolve any potential conflict of interest. The action necessary will depend on the nature of the conflict of interest and whether this relates to an individual advocate or the organisation as a whole. The policy should set out what action will be taken when perceived and/or actual conflicts are identified and include seeking, recording and taking the views of the service user into account.

3. It is important to remember, that even the perception of a conflict of interest can have a negative impact on how people view the organisation and how confident and comfortable they would be with that organisation providing them or a relative with advocacy support.

4. Policy Statement – points for inclusion

4.1 It would be anticipated that issues identified below in relation to the Board of Volunteer Directors, the staff, advocacy workers and volunteers would be considered for inclusion in the organisation’s Conflicts of Interest Policy and associated procedures.

4.1.1 For volunteer Directors the organisation should be ensuring that:

- any other role, financial or business interest held by the Director would not, or would not be seen to, conflict with the delivery of independent advocacy
- each Director completes a Register of Interest declaration on appointment and that this is reviewed annually
- Board meetings include ‘Conflict of Interest’ as a standing agenda item.

4.1.2 For all its staff, advocacy workers and volunteers the organisation should:

- ensure individuals complete a 'Register of Interests' declaration on joining the organisation and that they understand that this is subject to on-going review and that they should provide periodic updates. The Register of Interest should be reviewed at least annually and should include any outside activities, financial interests or relationships of staff members that may pose a real or potential conflict of interest.
- provide regular support, advice and supervision. This should include advice in relation to avoiding actions or relationships, that might conflict or appear to conflict with their role or the interests of the organisation. This would include discussion in advance of any proposals to accept a position as an officer or director of a business concern or other organisation or serving on the board of directors of a bona fide charitable, educational or other non-profit organisation.
- ensure that staff, advocacy workers and volunteers are aware that in some instances the conflict of interest may be such that it is necessary for the advocacy worker or the organisation to withdraw from the provision of advocacy for certain individuals or groups. In such circumstances guidance on alternative arrangements for advocacy provision should be available.

This list is not exhaustive and there may be additional issues that are relevant to specific organisations that will also need to be considered and included.

4.2 Potential conflict of interest scenarios

4.2.1 These may include:

- An advocate discovers they have a personal connection to their advocacy partner or another person in their advocacy partner's life.
- The advocate or organisation is involved in providing another service to the individual in addition to their advocacy role.
- The advocate is involved, in a second job, in providing a different service to the advocacy partner.
- An advocate or organisation taking part in any business decision which involves a company or organisation that employs the advocacy partner's spouse or family member.
- An advocate has a second job where that other employment creates a conflict of interest.
- An advocate or organisation receiving personal benefits from advocacy partners or other service providers.

4.2.2 This is not an exhaustive list of situations to avoid. Where there is any doubt an issue or situation must be carefully considered in relation to potential for conflicts of interest.

Further Reference Material/ Useful inks

Appendix 3

<p>The Adults with incapacity (Scotland) Act (2000)</p>	<p>Amended by the Adult Support and Protection (Scotland) Act 2007 which states “In determining an application or any other proceedings under this Act the sheriff shall.....take account of the wishes and feelings of the adult who is the subject of the application or proceedings so far as they are expressed by a person providing independent advocacy services.”</p>	<p>http://www.legislation.gov.uk/asp/2000/4/contents</p>
<p>The Mental Health (Care & Treatment) (Scotland) Act (2003)</p>	<p>Section 259 states that “Every person with a mental disorder shall have a right of access to independent advocacy; and accordingly it is the duty of— (a) each local authority, in collaboration with the (or each) relevant Health Board; and (b) each Health Board, in collaboration with the (or each) relevant local authority, to secure the availability, to persons in its area who have a mental disorder, of independent advocacy services and to take appropriate steps to ensure that those persons have the opportunity of making use of those services.”</p>	<p>http://www.legislation.gov.uk/asp/2003/13/contents</p>
<p>Code of Practice Volume 1 The Mental Health (Care & Treatment) (Scotland) Act (2003)</p>	<p>Chapter 6, para 140 of the Code of Practice which supports the Act states: “Where a patient has a degree of incapacity, or cannot for any reason clearly say whether or not they would like an independent advocate, an MHO/hospital managers/appropriate person should consider how an independent advocate may be involved.....The right of access to independent advocacy is for each patient and is not limited only to those who are best able to articulate their needs.”</p>	<p>http://www.scotland.gov.uk/Publications/2005/08/29100428/04289</p>
<p>Partnership for Care (2003)</p>	<p>Extended the principles of the Fair for All approach across the NHS to make sure that ‘our health services recognise and respond sensitively to the individual needs, background and circumstances of people’s lives’.</p>	<p>http://www.scotland.gov.uk/Resource/Doc/47032/0013897.pdf</p>

National Health Service Reform (Scotland) Act (2004)	The Act states that NHS Boards have a duty to involve patients, and the public, in the planning and development of health services and in decisions which will significantly affect the operation of those services.	http://www.legislation.gov.uk/asp/2004/7/contents
Education (additional Support for learning) (Scotland) Act (2004)	The Act states “Where, in connection with the exercise of an education authority’s functions under this Act in relation to any child or young person, the relevant person wishes—..... another person (referred to as an “advocate”) to— (i) conduct such discussions or any part of them, or (ii) make representations to the authority, on the relevant person’s behalf, the education authority must comply with the relevant person’s wishes”	http://www.legislation.gov.uk/asp/2004/4/contents
Having your say? The same as you? The National implementation report of the advocacy sub group (2006)	<p>Made several recommendations:</p> <ul style="list-style-type: none"> • Commissioners should ensure that there is choice in the advocacy available thus requiring that there is a choice of advocacy organisations available. • The needs of people with learning disabilities and autistic spectrum disorders should be taken into consideration when commissioning services and people should be involved in the advocacy planning process. • Local advocacy plans for each area should state how people can get advocacy support in issues such as housing, transport and the other issues that people in that area say are important. 	http://www.scotland.gov.uk/Resource/Doc/113519/0027513.pdf
Better Health, Better Care: An Action Plan (2007)	<p>The Plan made a commitment to ‘a mutual NHS where patients and the public are confirmed as partners rather than recipients of care’. It also signaled the development of a Participation Standard for the NHS, the development of which was led by the Scottish Health Council. In relation to advocacy, the standard covers the following criteria:</p> <ul style="list-style-type: none"> • ‘Independent advocacy services are provided and developed in partnership with other agencies and people who need them’ • ‘An individual’s need for advocacy is assessed, recorded and provided where necessary’ 	http://www.scotland.gov.uk/Resource/Doc/206458/0054871.pdf

<p>Adult support and Protection (Scotland) Act (2007)</p>	<p>Amended The Adults with incapacity (Scotland) Act (2000) and states “In determining an application or any other proceedings under this Act the sheriff shall.....take account of the wishes and feelings of the adult who is the subject of the application or proceedings so far as they are expressed by a person providing independent advocacy services.”</p>	<p>http://www.legislation.gov.uk/asp/2007/10/contents</p>
<p>The Road to Recovery (2008)</p>	<p>Documents the Scottish Government’s approach to tackling Scotland’s drug problem, building the capacity of advocacy services, to help service users choose the treatment that is right for them, is part of this approach.</p>	<p>http://www.scotland.gov.uk/Resource/Doc/224480/0060586.pdf</p>
<p>Education (additional Support for learning) (Scotland) Act 2009</p>	<p>The Education (Additional Support for Learning) (Scotland) Act 2009 adds to the Education (Additional Support for Learning) (Scotland) Act 2004, and states: “14A Provision of advocacy service: Tribunal (1) The Scottish Ministers must, in respect of Tribunal proceedings, secure the provision of an advocacy service to be available on request and free of charge to the persons mentioned in subsection (2). (2) The persons are— (a) in the case of a child, the child’s parent, (b) in the case of a young person— (i) the young person, or (ii) where the young person lacks capacity to participate in discussions or make representations of the type referred to in subsection (3), the young person’s parent. (3) In subsection (1) “advocacy service” means a service whereby another person conducts discussions with or makes representations to the Tribunal or any other person involved in the proceedings on behalf of a person mentioned in subsection (2).”</p>	<p>http://www.legislation.gov.uk/asp/2009/7/contents</p>

<p>Guidance on Looked after Children (Scotland) Regulations 2009 and the Adoption and Children (Scotland) Act 2007</p>	<p>Provides guidance on the requirement to consider the views of the child. The underpinning principle is summarised as follows: children and young people should not be passive in decision making processes. They have the right to input into decisions about their lives and the services provided to them.</p>	<p>http://www.scotland.gov.uk/Publications/2011/03/10110037/0</p>
<p>Dementia Strategy (2010)</p>	<p>This strategy was devised reflect the importance and also to build on the significant work which was already underway in Scotland in key areas such as early diagnosis, improving care pathways, and public awareness of dementia.</p>	<p>http://www.scotland.gov.uk/Resource/Doc/324377/0104420.pdf</p>
<p>Caring Together - Carers Strategy for Scotland (2010)</p>	<p>Recognises carers as equal partners in the delivery of care in Scotland and fully acknowledges carers' expertise, knowledge and the quality of care they give. With appropriate support, especially support delivered early to prevent crisis, caring need not have an adverse impact on carers. <i>Caring Together</i> sets out 10 key actions to improve support to carers. The focus is on improved identification of carers, assessment, information and advice, health and wellbeing, carer support, participation and partnership.</p>	<p>http://www.scotland.gov.uk/Resource/Doc/319441/0102104.pdf</p>
<p>Getting it Right For Young Carers Strategy (2010)</p>	<p>Recognises that many young people can benefit from providing care to a relative or friend affected by illness, disability or substance misuse. However, we are committed to ensuring that young carers are relieved of inappropriate caring roles and are supported to be children and young people first and foremost. The strategy also endorses an approach which organises services around the child or young person so that all the needs of the child or young person will be identified and addressed, including the impact of caring on their health, wellbeing and education.</p>	<p>http://www.scotland.gov.uk/Resource/Doc/319441/0102105.pdf</p>

NHS Healthcare Quality Strategy (2010)	NHSScotland Quality Strategy - putting people at the heart of our NHS	http://www.scotland.gov.uk/Publications/2010/05/10102307/0
The Equality Act (2010)	Provides a legal framework to protect the rights of individuals and advance equality of opportunity for all. The Act restated and simplified 116 separate pieces of earlier equality legislation into one Act, the bulk of which came into force in October 2010.	http://www.healthscotland.com/equality/equalityact.aspx#duties
National Guidance for Child Protection in Scotland (2010)	The guidance provides a national framework within which agencies and practitioners at local level – individually and jointly – can understand and agree processes for working together to safeguard and promote the welfare of children. It sets out expectations for strategic planning of services to protect children and young people and highlights key responsibilities for services and organisations, both individual and shared.	http://www.scotland.gov.uk/Resource/Doc/334290/0109279.pdf
National Strategy on Self-directed Support (2010)	<p>The National self-directed support strategy states that “in agreeing to opt for a direct payment or an individual budget, it is important that...adequate support and advocacy is in place to support people to manage, drawing on the experience of those who direct their own support.”</p> <p>The strategy also states that progress towards greater choice, control and empowerment for social care users should be recognised via a number of routes and these include a “sustainable network of advocacy and peer support organisations that support individuals to exercise choice and control.”</p>	http://www.scotland.gov.uk/Resource/Doc/329971/0106962.pdf
Forced Marriage etc. (Protection and Jurisdiction) (Scotland) Act (2011)	Summary of the multi-agency practice guidelines. These are aimed at front line practitioners who are supporting victims of forced marriage.	http://www.scotland.gov.uk/Topics/People/Equality/violence-women/forcedmarriage/Guidance

The Patient Rights (Scotland) Act (2011)	The Act raises the status and focus of patient's rights and aims to improve patients' experience of using health services. The Act placed a responsibility on Scottish Ministers to publish a Charter of Patient Rights and Responsibilities by 1 October 2012.	http://www.legislation.gov.uk/asp/2011/5/contents
The Children's Hearing (Scotland) Act (2011)	The Act introduces a requirement to ensure that children and young people going through the Children's Hearings system will, for the first time, be able to get advocacy support. The 2011 Act defines advocacy support as, "services of support and representation for the purposes of assisting a child in relation to the child's involvement in a children's hearing.	http://www.legislation.gov.uk/asp/2011/1/contents
Dementia Standards (June 2011)	These standards have been developed to help people with dementia and their carers understand their rights, and how these rights can help make sure that they receive the support they need to stay well, safe and listened to.	http://www.scotland.gov.uk/Resource/Doc/350188/0117212.pdf
Getting it right for every child (Getting it right) (2012)	Building on what the United Nations Convention on the Rights of the Child says, makes clear reference to the central importance of the child's voice and the involvement of children and young people in decision making. It also recognises that sometimes children might need support if their feelings and opinions are to be shared. That is why good quality advocacy support – which helps children and young people to be 'respected' and 'included' – is a significant part of the Getting it right approach.	http://www.scotland.gov.uk/Topics/People/Young-People/gettingitright
Charter of Patient Rights and responsibilities (2012)	The Charter sets out a summary of the rights and responsibilities of patients using the NHS in Scotland , and of people who have a personal interest in such patients' welfare. The Charter states that: "You have the right to request support when making decisions about your health care. - You may ask (and if you have a mental health disorder you have a right) to have an independent advocate to help you give your views. NHS staff can help you arrange this."	http://www.scotland.gov.uk/Resource/0040/00407723.pdf

A Fairer Healthier Scotland (2012)	This strategy sets out the role, direction and priorities of NHS Health Scotland for the next five years.	http://www.healthscotland.com/documents/5792.aspx
The Engagement Matrix (2013)	A tool and guidance for improving engagement between health boards and the third sector.	http://www.vhscotland.org.uk/wp-content/uploads/2013/02/Engagement_Matrix_finished_WEB_version_VHS_11_0213.pdf
Social Care (Self Directed Support) (Scotland) Act (2013)	The Self-directed Support Act 2013, which applies to children, adults and carers, states that: The authority must give the person— (d)in any case where the authority considers it appropriate to do so, information about persons who provide independent advocacy services (within the meaning of section 259(1) of the Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)).	http://www.legislation.gov.uk/asp/2013/1/contents/enacted
The National Person-Centred Health and Care Programme	A framework to support the delivery of the person-centred aims and ambitions of the NHS Health Care Quality Strategy, using a focused improvement approach to support the testing, reliable implementation and spread of interventions and changes that are known to support health and care services and organisations to be truly person-centred. The high level aim of the Programme is that, by 2015, health and care services are more person-centred as demonstrated by improvements in care experience, staff experience and in co-production.	http://www.scotland.gov.uk/Topics/Health/Policy/Quality-Strategy
Participation Standard	NHS Boards need to ensure that people have a say in decisions about their care and in the development of local health services. The Participation Standard is a way of measuring how well NHS Boards do this. The criteria within Standard Section 1 relates to Patient Focus and one of the criteria includes “Independent advocacy services are provided and developed in partnership with other agencies and the people who need them.”	http://www.scottishhealthcouncil.org/patient_public_participation/participation_standard/participation_standard.aspx

<p>Carers Advocacy Guidance (winter 2013)</p>	<p>Provides guidance in relation to the provision of advocacy for carers. The Carers Strategy for Scotland 2010 – 2015 recognises that: ‘Some carers, especially the most vulnerable, benefit from independent advocacy support to help them in many different ways, including supporting them in their dealings with health and social care and other professionals.’</p>	
<p>UN Convention on the Rights of the Child (UNCRC)</p>	<p>The United Nations Convention on the Rights of the Child was developed in 1989 and sets out the basic human rights of children. The Convention consists of 54 Articles which encompass civil, political, economic, social and cultural rights of children and young people. These Articles form a framework against which to evaluate legislation, policy and decision-making structures. Article 12 of The Convention says that children and young people have the right to speak up and have their opinions listened to and taken seriously by adults. Implementation of the Convention is overseen by the UN Committee on the Rights of the Child, who also play an important role in interpreting its content. The Committee recognises the importance of ensuring that children are properly supported to express their views on matters which affect their lives.</p>	<p>http://www.unicef.org.uk/Documents/Publication-pdfs/UNCRC_PRESS200910web.pdf</p>

Scottish Independent Advocacy Alliance (SIAA) material:

Standards and Guidelines

[SIAA Principles and Standards for Independent Advocacy \(2008\)](#) : This document sets out the advocacy movement principles and standards that underpin good advocacy practice. They can be applied to all advocacy practice.

[SIAA Code of Practice for Independent Advocacy \(2008\)](#) : This document details how independent advocates and independent advocacy organisations should work to meet the advocacy movement Principles and Standards for Independent Advocacy.

[Mental Health Tribunal Guidance for Advocates \(2012\)](#) : This companion guide to the Code of Practice provides guidance for advocates when supporting service users through a Mental Health Tribunal process.

[Elder Abuse Advocacy Guidelines \(2008\)](#) : This is also a companion guide to the Code of Practice. It details issues that an independent advocate might encounter when working with an older person experiencing abuse.

[Non-Instructed Advocacy Guidelines \(2009\)](#) : This is a companion guide to the Code of Practice. It details why and how advocates and organisations can advocate for someone who lacks the capacity to instruct the advocate.

[Independent Advocacy: An Evaluation Framework \(2010\)](#)

Publications

[Towards the Future](#)

[AWOL – Poems in Celebration of Advocacy](#)

Leaflets

[The Work of the SIAA](#)

[Professional Advocacy](#)

[Citizen Advocacy](#)

[Collective/Group Advocacy](#)

[Peer Advocacy](#)

[Self Advocacy](#)

[Non-Instructed Advocacy](#)

[A guide to independent advocacy for service providers](#)

[A guide to independent advocacy for older people](#)

[A guide to independent advocacy for families and carers](#)

Glossary

Advocate

An advocate helps people express their views and make informed decisions. An advocate helps people to find out information, explore options and decide for themselves what they want. Advocates can be a voice for the person and encourage them to speak out for themselves.

Advocates will never tell people what to do, or allow their own opinions to affect the support they provide.

Independent advocates are as free from conflicts of interest, as possible.

Advocacy

The process of standing alongside another, speaking on behalf of another and encouraging the person to speak up for themselves. Advocacy can help address the imbalance of power in society and stand up to injustice. It safeguards rights, and helps people safeguard their own rights. There are different kinds of advocacy, though they all share things in common. All advocacy tries to increase confidence and assertiveness so that people can start speaking out for themselves.

Advocacy partner

The person who uses advocacy. Some advocacy organisations use the term 'client' or 'service user'.

Commissioner

Usually representatives from the Local Authority or Health Board who fund advocacy.

Conflict of interest

Anything that could get in the way of an advocate being completely loyal to their advocacy partner. For example, it would not be appropriate for an advocate volunteering for a mental health advocacy organisation to also work in the local psychiatric hospital, because this would affect their ability to be on the side of the advocacy partner. It would also affect their relationships with hospital staff. Other conflicts of interest could include relationships as well as financial investments.

Funding contract

The agreement, usually between Local Authority or NHS Boards and the advocacy organisation, which outlines how much funding the organisation receives, which geographical areas will be covered, who the advocacy is for and how long the funding is for. (Also see Service Level Agreement).

Honest Broker

A person who is considered to be neutral and able to mediate between two or more parties

Non-instructed advocacy

Non-instructed advocacy happens when a person who needs an independent advocate cannot tell the advocate what they want. This may be because the person has complex communication needs or has a long-term illness or disability that prevents them from forming or clearly stating their wishes/desires. This usually takes place with people who have dementia or profound and/or severe learning difficulties.

Service Level Agreement

The agreement, usually between the Local Authority or NHS Boards and the advocacy organisation, which outlines how much funding they receive, which geographical areas will be covered, who the advocacy is for and how long the funding is for.

Service provider

A person or organisation involved in giving support or care services to an individual.

Service User

The person who uses advocacy. Some advocacy organisations use the term 'client' or 'advocacy partner'.



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