

Consultation on Independent Advocacy – Guide For Commissioners

Independent Advocacy

A Public Consultation on the Guide for Commissioners

Responses are invited by 19 July 2013

**Chief Nursing Officer, Patients, Public and Health Professions Directorate,
Scottish Government Health and Social Care Directorates**

Covering Letter

Dear Sir/Madam

CONSULTATION ON INDEPENDENT ADVOCACY – GUIDE FOR COMMISSIONERS

Responding to this consultation paper

We are inviting written responses to this consultation paper by 19 July 2013. **Please send your response with the completed Respondent Information Form (see "Handling your Response" below) to:**

Independent Advocacy - Guide for Commissioners
FREEPOST RLXC-UYZU-HXHG
Mailpoint 1
Person-centred Team
St Andrew's House
Edinburgh
EH1 0BR

Or

E-mail to: advocacyguideforcommissioners@scotland.gsi.gov.uk

If you have any queries please contact Alison McLoughlin on 0131 244 3363.

We would be grateful if you would use the consultation questionnaire provided as part of the Respondent Information Form or could clearly indicate in your response which questions or parts of the consultation paper you are responding to as this will aid our analysis of the responses received.

This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages of the Scottish Government website at <http://www.scotland.gov.uk/consultations>.

The Scottish Government has an email alert system for consultations, <http://register.scotland.gov.uk>. This system allows stakeholder individuals and organisations to register and receive a weekly email containing details of all new consultations (including web links). It complements, but in no way replaces Scottish Government distribution lists, and is designed to allow stakeholders to keep up to date with all Scottish Government consultation activity, and therefore be alerted at the earliest opportunity to those of most interest. We would encourage you to register.

Handling your response

We need to know how you wish your response to be handled and, in particular, whether you are happy for your response to be made public. Please complete and return the Respondent Information Form attached to this letter as this will ensure that we treat your response appropriately. If you ask for your response not to be published we will regard it as confidential, and we will treat it accordingly. All respondents should be aware that the Scottish Government are subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

Next steps in the process

Where respondents have given permission for their response to be made public and after we have checked that they contain no potentially defamatory material, responses will be made available to the public in the Scottish Government Library, and on the Scottish Government consultation web pages by **16 August 2013**. You can make arrangements to view responses by contacting the Scottish Government Library on 0131 244 4552. Responses can be copied and sent to you, but a charge may be made for this service.

What happens next?

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us consider the way forward. We aim to issue a report on this consultation process along with our response to it in the autumn 2013.

Comments and complaints

If you have any comments about how this consultation exercise has been conducted, please send them to the address given above.

Yours sincerely

Sandra Falconer

Person-Centred Team

Electronic publication and additional copies:

This consultation paper is available via the internet at:

<http://www.scotland.gov.uk/Consultations/Current>

You can use this link to find out more about the consultation; ask questions; submit your views; and view submitted responses.

Or if you want additional paper copies of the consultation paper, or if you or someone you care for require this paper in a different format or language, please contact us at:

Independent Advocacy - Guide for Commissioners
FREEPOST RLXC-UYZU-HXHG
Mailpoint 1
Person-centred Team
St Andrew's House
Edinburgh
EH1 0BR

Or e-mail to: advocacyguideforcommissioners@scotland.gsi.gov.uk

Copies of the documents mentioned in this paper can also be obtained from these addresses.

This consultation is being conducted in line with the Scottish Government's consultation process Consultation: Good Practice Guidance¹

This consultation, and all other Scottish Government consultation exercises, can be viewed online on the consultation web pages at <http://www.scotland.gov.uk/consultations>. You can telephone Freephone 0800 77 1234 to find out where your nearest public internet access point is. There will be no charge for this call.

¹<http://www.scotland.gov.uk/Resource/Doc/1066/0006061.pdf>

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Part 1

Background

1. Advocacy has 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 also provides 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 that might limit what the advocate can and cannot do. 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.
2. In this consultation we are seeking views on a revision of the Guide for Commissioners originally published by the Scottish Executive Health Department in 2001 and subsequently revised and reissued by the Scottish Independent Advocacy Alliance in 2010.
3. Since the publication of the Guide for Commissioners in 2010 there have been several developments. For example the publication of the NHS Healthcare Quality Strategy in 2010; the provision of joint Scottish Government and COSLA Guidance on Procurement of Support and Care Services in 2010; the introduction of the Patient Rights (Scotland) Act 2011; the introduction of the Children's Hearings (Scotland) Act 2011; publication of the Carers and Young Carer's Strategy in 2010; and the publication of the Patients Charter of Rights and Responsibilities in October 2012.
4. Extensive work has also been undertaken with the Scottish Government Directorate Children and Families Steering Group which looked at the provision of advocacy for children and young people and the principles and standards and special considerations that should apply. We will consult separately on supplementary material focussing specifically on advocacy for children and young people. That material will be designed for use in conjunction with the Guide for Commissioners.
5. The draft guide has been updated to reflect these and other relevant developments. It has also been updated to reflect Commissioners' statutory responsibilities for the provision of independent advocacy and the principles and standards they should apply when commissioning advocacy services.
6. We are keen to hear your views on the content of the draft Guide to Commissioners prior to finalising this for issue.

**Independent Advocacy
Guide for Commissioners**

Draft

Foreword (to be inserted following consultation)

Guide for Commissioners

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1. Introduction

1.1 The importance of advocacy

1.1.1 The Scottish Government recognises the important role that advocacy plays in enabling 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 their care.

1.1.2 Advocacy:

- safeguards people who are vulnerable and discriminated against or whom services find difficult to serve
- 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.

1.1.3 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.

1.1.4 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. Further reference material is listed in Appendix 3.

1.1.5 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. However, some people in society are much more likely than others to be treated unfairly, either because of other people's prejudice or because of their own vulnerability, or both.

1.1.6 Factors which put people at risk or make them vulnerable include age, physical frailty, gender, ethnic origin, sexual orientation, impairment (cognitive, psychological, motor, sensory), reputation, dislocation, abuse, family breakdown, caring and young caring responsibilities, and social isolation. Some people have to rely on powerful service systems for help with all aspects of their life - 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.

1.1.7 Individuals who rely on these service systems often have limited personal power and resources to argue their case. This is especially true for people who do not use words to communicate, for children and young people, for people 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.

1.1.8 If these individuals do not have well-motivated and capable family and friends to speak up for them, they are at risk of not receiving the treatment they need. 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 and friends may not be able to ensure that the individual's views are taken into account.

1.1.9 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.

1.1.10 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 and 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.

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, 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.

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.

2.2 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. Both are available from the SIAA and will help commissioners gain an insight into how advocacy can improve an

individual's quality of life and provide a better understanding of how the different types of advocacy work in practice.

3. The importance of Independent Advocacy

3.1 Advocacy becomes an organised activity because:

- Some people in our society are more likely than others to be treated unfairly, either because of other people's prejudice, or their own vulnerability or both
- Some people have no connections to family or friends or the wider community who could support them
- For some people family and friends are part of the problem
- 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 completely on someone's side in this way, to support them to claim their rights and safeguard their individuality, 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 The Mental Health (Care & Treatment) (Scotland) Act 2003 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. 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. The Act also identifies the need for independent advocacy organisations to have policies in place to identify and manage/minimise the risk of any conflict of interest.

3.5 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. There are different models of one to one 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.'

3.6 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 applied when commissioning other types of advocacy support.

3.7 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 care or 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.

3.8 Non-Independent Advocacy

3.8.1 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 in the monitoring and evaluation of non-independent advocacy services and to identify the potential conflicts of interest, ways of managing these conflicts and also take action to enhance independence.

3.8.2 Commissioners should give consideration to the unique role of unpaid carers as care providers and equal partners in care when commissioning advocacy services. In order to avoid potential conflict of interest between carers and the people they care for, advocacy services for carers should be distinct from those provided to service users. This may be achieved through commissioning local carer organisations to provide a carer advocacy service, or by the appointment by an independent advocacy organisation of dedicated carer advocacy workers. Commissioners should also seek to encourage the use of the guidance for carer advocacy in the commissioning, monitoring and evaluation of carer advocacy services available from autumn 2013.

4. The Scottish Independent Advocacy Alliance

4.1 The Scottish Independent Advocacy Alliance (SIAA) is a membership organisation responsible for promoting, supporting and defending 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. Links to material developed by SIAA is included in Appendix 4. These can also be accessed through the SIAA website at: <http://www.siaa.org.uk/>.

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.”

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.”

5.2 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.

5.3 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 and not solely those who are detained under the Act’s powers.

6. Principles and Standards for Independent Advocacy

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 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.” (Para 99)

6.3 The Code of Practice Volume 1 further expands on the 2003 Act definition of independent advocacy to give the following guidance:

“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. (Para 108)

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. (Para 109)

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.” (Para 110)

6.4 Commissioners should therefore ensure that advocates and advocacy organisations commissioned to provide independent advocacy services in their area under the Act comply with the Principles and Standards included in Appendix 1 to ensure the provision of good quality advocacy.

6.5 The Principles are the core beliefs about independent advocacy. These are the ideas that guide everything that advocates and advocacy organisations do.

6.6 Commissioners must pay particular attention to Principle 3² 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 welfare, care or 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

Question 1: Are you content with the level of detail given in relation to the statutory responsibilities and that the information is clear?

Yes

No

If no, what additional information do you think should be included?

6.7 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.

6.8 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 conflicts of interest and minimises the restrictions on the work of advocates and the organisation.

² Standards 3.1 and 3.2 associated with Principle 3 above reflect the definition of independent advocacy in the Mental Health Act (Care & Treatment) (Scotland) Act 2003 and differ from the standards used by the advocacy movement in the SIAA Principles and Standards.

6.9 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, it's part of being a decent human being. But they aren't and can't be independent. To be on someone's side, 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.

6.10 Independence doesn't mean being right all the time. Independent advocates are no more virtuous than service providers. They just stand in a different place and see things from a different perspective.

6.11 Independent advocates do not have the same potential conflicts of interest as professional workers who are expected to make judgements about who is most deserving or most eligible for a service. 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.

6.12 Professional workers who advocate strongly on behalf of a particular individual or group may be seen as acting unprofessionally or as being critical of their employing organisation. This entails personal risks, and can also put the professional worker in a situation where their views on this and other issues are discounted.

6.13 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.

6.14 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.

6.15 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.

6.16 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
- *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
- 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.

6.17 Appendix 2 contains examples of situations Commissioners may find useful to consider in identifying and minimising potential conflicts of interest.

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 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

7.6.1 Advocacy supports the development of person-centred services because it is involved with 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.

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 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. And – as with all commissioning – this thinking has to be done aloud and in partnership with other stakeholders.

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.

8.5 It may be difficult, for example, to establish a new advocacy organisation for people from LGBT communities. In some cases organisations that already provide services to LGBT groups may feel that they are the most appropriate organisation to provide advocacy for their service users. Service users may prefer to access advocacy support from an organisation that they are already familiar with and trust but which also provides other services.

8.6 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 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. 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.

8.7 An individual may face multiple layers of discrimination in wider society based on perhaps their age, gender, 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.

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. 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.

10. Commissioning Independent Advocacy

10.1 Public bodies should ensure that their procedures for procurement of care and support services (which includes advocacy) comply with the public procurement rules and reflect the guiding principles contained within the joint Scottish Government and COSLA Guidance issued in 2010. The guidance highlights the need for engagement with service users prior to and during commissioning processes and is available at <http://www.scotland.gov.uk/Resource/Doc/324602/0104497.pdf>.

10.2 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.

10.3 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 should remember that the advocacy organisation is an independent organisation and therefore there needs to be clear boundaries which are respected.

Question 2: Are you content that the level of detail given in Section 10 on the Commissioning of Independent Advocacy is appropriate?

Yes No

If not, why not?

10.4 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.

10.5 There is a statutory duty under the Equality Act 2010 for NHS Boards and Local Authorities to provide other support services which may arise depending on the specialist needs of the client group, such as BSL sign language interpreters, interpretation or translation services.

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. A web-based resource to aid third sector and health board engagement is also available at: www.discoverthethirdsector.org.uk.

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.

11.5 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.

11.6 Support for volunteer management

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

11.7 Support for co-operations, networking and renewal

11.7.1 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.

11.7.2 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'.

11.7.3 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.

11.7.4 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).

11.7.5 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?

11.7.6 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.

11.8 Getting the relationship right

11.8.1 Commissioners have a duty to clarify expectations and lines of accountability. It is easy to impose 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.

11.8.2 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.

11.8.3 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.

11.8.4 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?'

11.8.5 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.

11.9 Training, Expertise and Resources

11.9.1 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
- 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

11.9.2 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.

11.9.3 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.

11.9.4 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.

11.9.5 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.

11.9.6 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.

11.9.7 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

11.9.8 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.

11.10 Keep support under review

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

11.10.2 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 organisation 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 good 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 should be made available to funders, advocates and 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**'. The framework 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 1³.

12.6.8 There are three sections to the 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 and 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

³ Please note that Standards 3.1 and 3.2 associated with Principle 3 reflect the definition of independent advocacy in the Mental Health Act (Care & Treatment) (Scotland) Act 2003 and differ from those in the SIAA Principles and Standards.

- 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 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.

Question 3: Would you support a programme of evaluations based on the pilot model of evaluation set out in paragraph 5 of Part 2 of the consultation paper?

Yes No

If not, why not?

Appendix 1

Principles and Standard for Independent Advocacy Reflecting Commissioners' Statutory Responsibility⁴

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 welfare, care or provision of other services to the individual for which they are 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.

⁴ Please note that Standards 3.1 and 3.2 associated with Principle 3 reflect the definition of independent advocacy in the Mental Health Act (Care & Treatment) (Scotland) Act 2003 and differ from those in the SIAA Principles and Standards. The remaining Principles and Standards i.e. Principles 1, 2 and 4 and the associated standards set out in above are consistent with the SIAA Principles and Standards.

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. Of course, where individuals and organisations are involved in the delivery of non-independent advocacy, they will not be in a position to satisfy some of the standards.

Identifying and minimising conflicts so interest

Situation	Impact?	What action could be taken to m minimize any conflict?
<p>A service user approaches an advocacy organisation because they want support to make a complaint. The complaint concerns an individual who is employed by a large national organisation that hosts* the advocacy service.</p>		
<p>A person with a learning disability has used a service from a care providing organisation in the past. That organisation now also has an advocacy project. The person needs an advocate.</p>		

Situation	Impact?	What action could be taken to minimize any conflict?
<p>An advocate is supporting a person who wants to change their home support from their current provider but doesn't know what options are open to them. The advocate works for an advocacy project hosted by an organisation that has contractual links with other home support providers in the area.</p>		
<p>A woman with dementia is getting a good home support service from a care providing organisation. The organisation also provides advocacy. The woman's son would like an advocacy worker to start working with his mother while she is still able to express her views and wishes. It turns out that the only suitable advocacy service in the area is managed by the same organisation that provides the home support service.</p>		

Situation	Impact?	What action could be taken to minimize any conflict?
<p>An organisation that supports children and young people is involved in the Multi-Disciplinary Team that assesses patients for admission to the local Child & Adolescent Mental Health Service Unit. This organisation also provides advocacy.</p>		
<p>The carer or the young carer is supported by their local carer organisation and is content with the support. The organisation also provides advocacy. The carer/young carer reaches a crisis/emergency situation with a potential for breakdown in the caring situation. Who should provide advocacy?</p>		

Situation	Impact?	What action could be taken to m minimize any conflict?
<p>A collective advocacy group is supported by an advocacy worker who is employed by an advocacy project, which is linked to a large organisation which also provides care services. The collective advocacy group is campaigning for changes to local services that may impact on contracts held by the parent organisation*. The parent organisation has a consortium agreement with a number of other agencies in other areas. The proposed changes to local services may have impact on other consortium members.</p>		

*parent or host organisation = an organisation that employs and or manages the staff of a discreet project

Question 4. Do you think it is useful to highlight situations (such as those given in Appendix 2) that commissioners should be mindful of in order that consideration is given to how these would be avoided/handled/resolved?

Yes No

Are there any others you would add/remove?

We would welcome your thoughts on what the impact of each of these situations would be and also your views on what action should be taken to minimise conflict. We will consider the responses and add as part of the guidance.

Further Reference Material/ Useful links

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>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

Adult support and Protection (Scotland) Act (2007)	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.”	http://www.legislation.gov.uk/asp/2007/10/contents
The Road to Recovery (2008)	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.	http://www.scotland.gov.uk/Resource/Doc/224480/0060586.pdf
Dementia Strategy (2010)	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.	http://www.scotland.gov.uk/Resource/Doc/324377/0104420.pdf
Caring Together - Carers Strategy for Scotland (2010)	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.	http://www.scotland.gov.uk/Resource/Doc/319441/0102104.pdf
Getting it Right For Young Carers Strategy (2010)	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.	http://www.scotland.gov.uk/Resource/Doc/319441/0102105.pdf

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
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
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
Discover the Third Sector (2012)	This online resource has been set up to help partnership working between the statutory and third sectors.	http://www.discoverthethirdsector.org.uk/

<p>Charter of Patient Rights and responsibilities (2012)</p>	<p>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. This reflects a patient's right to be treated with dignity and respect; to have their privacy and confidentiality upheld; the right that the NHS services they receive take into account their individual needs, abilities and circumstances; the right to information and communication that helps them participate and make informed choices and decision about their health care; the right to give feedback, comments, concerns and complaints. The Charter states that:</p> <p>“You have the right to request support when making decisions about your health care.</p> <p>- 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.”</p>	<p>http://www.scotland.gov.uk/Resource/0040/00407723.pdf</p>
<p>A Fairer Healthier Scotland (2012)</p>	<p>This strategy sets out the role, direction and priorities of NHS Health Scotland for the next five years.</p>	<p>http://www.healthscotland.com/documents/5792.aspx</p>
<p>The Engagement Matrix (2013)</p>	<p>A tool and guidance for improving engagement between health boards and the third sector.</p>	<p>http://www.vhscotland.org.uk/wp-content/uploads/2013/02/Engagement_Matrix_finished_WEB_version_VHS_110213.pdf</p> <p>http://www.vhscotland.org.uk/wp-content/uploads/2013/02/Engagement_Matrix_Template_Editable_Word_Version_VHS_110213.doc</p>
<p>Social Care (Self Directed Support) (Scotland) Act (2013)</p>	<p>The Act 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)).</p>	<p>http://www.legislation.gov.uk/asp/2013/1/contents/enacted</p>

<p>The National Person-Centred Health and Care Programme</p>	<p>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.</p>	<p>http://www.scotland.gov.uk/Topics/Health/Policy/Quality-Strategy</p>
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Question 5. Do you find the information on additional reference material in Appendix 3 helpful?

Yes No

Are there any others you would add?

Are there any you would remove?

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 \(2010\)](#)

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'.



**The Scottish
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Riaghaltas na h-Alba

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