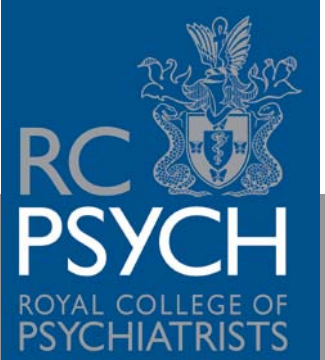


CR171



# Independent advocacy for people with mental disorder

February 2012

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February 2012

Royal College of Psychiatrists  
London

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This report is dedicated to the memory of Winston McCartney who died in 2005. Winston was part of the service user movement in Northern Ireland and contributed greatly to the work of the Royal College of Psychiatrists, including membership of a previous working group on updating the College document on advocacy.

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# Working Group

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\*Mr Shaun McNeil co-chaired the group for the first meeting.

# Executive summary

The Working Group was first convened in April 2010 to update the previous Council Report on patient advocacy published in 1999 (Royal College of Psychiatrists, 1999). The current report is for College members to provide information on what independent advocacy is and why it is needed.

The United Nations Convention on the Rights of Persons with Disabilities in 2006 marked a 'paradigm shift' in attitudes and approaches to people with disabilities. Persons with disabilities are not viewed as 'objects' of charity, medical treatment and social protection; rather, they are viewed as 'subjects' with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society.

People with mental health problems and intellectual disability may face discrimination and marginalisation, and independent advocacy is an excellent way to ensure that an individual's rights are upheld and that the individual receives the care and treatment that they are entitled to. It also has benefits for psychiatrists and can improve the quality of the relationships between people with mental health problems and professionals.

## DEFINITION OF INDEPENDENT ADVOCACY

It is crucial that advocates are independent from the people caring for and treating people with mental health problems and that they do not have any conflicts of interests. Indeed, unlike professionals, advocates may support an individual to do something that is not in their own best interests. In collective advocacy, groups of people speak out to attempt to improve the way their community is treated and included in society. In individual advocacy, the advocate subsumes their own ideas, listens closely to their advocacy partner and articulates what they actually want. Instructed advocates empower service users by only acting on their instructions. In non-instructed advocacy, the advocate takes affirmative action with or on behalf of a person who is unable to instruct an advocate due to issues of capacity.

In collective advocacy, a group of people who are all facing a common problem get together to support each other over specific issues or the group as a whole may campaign on an issue that affects them all.

## KEY PRINCIPLES IN INDIVIDUAL ADVOCACY

The report defines the following principles:

- clarity of purpose

- independence
- putting people first
- empowerment
- equal opportunity
- accountability
- accessibility
- supporting advocates
- confidentiality
- complaints.

## HOW DO ADVOCATES WORK?

In instructed advocacy, advocates will take action as instructed to do so by their advocacy partner.

In non-instructed advocacy, the person lacks capacity to instruct an advocate and is unable to communicate their views and wishes. In this situation the advocate will:

- seek to uphold the person's rights
- ensure fair and equal treatment
- ensure that decisions are taken with consideration for the person's unique perspective and preferences
- make sure that all options are considered.

In collective advocacy, members of the group find common cause and use a variety of techniques to make sure that the varied views of their community are known.

## DIFFERENT TYPES OF ADVOCACY

The advocacy sector is diverse and a variety of approaches to delivering advocacy exist but they all have a guiding set of common principles. There is no 'best' form of advocacy: some advocacy organisations combine different approaches, and some approaches may be more common or suited to specific local need or groups of people. All forms of advocacy encourage and promote self-advocacy.

Carers may also access advocacy. For the most part, their concerns may relate to the person with mental disorder, but they may also require advocacy to articulate their own needs. The benefits of carer advocacy are the same as the benefits of independent advocacy for people with mental health problems.

### *INDIVIDUAL ADVOCACY*

- Issue-based advocacy: this is advocacy for specific issues.
- Citizen advocacy: encourages ordinary citizens to become involved with

the welfare of those who might need support in their communities.

- Peer advocacy: peer advocacy is about individuals who share significant life experiences.
- Self-advocacy: when people stand up for themselves either individually or in a group.

## COLLECTIVE ADVOCACY

Collective advocacy is an attempt to express the voice of a community over the issues that they jointly think are important to them.

## STATUTORY ADVOCACY

The statutory arrangements for advocacy for England, Scotland, Northern Ireland and Wales are discussed.

## ADVOCACY AND EQUALITY

People with mental disorder and intellectual disability may have additional burdens of poverty, unemployment, poor housing, poor physical health and poor educational opportunities. In addition, some groups face discrimination in society for a number of reasons, for example on the basis of ethnicity, gender, disability, sexuality or age. These same groups will also face discrimination in psychiatry and advocacy. It is important that there is recognition of the power imbalance between service users and psychiatrists and that both groups are capable of holding discriminatory or prejudiced views.

Collective advocacy exists as a voice for frequently marginalised people and communities. The motivation of many members of an advocacy group is often the desire to stop discrimination and prejudice and unequal treatment of that community by the rest of society.

## ADVOCACY IN DIFFERENT CLINICAL AREAS

Although the key principles of advocacy do not vary across clinical specialties or settings, the practice of advocacy requires special consideration in certain areas. It is important to remember that advocacy relates to the whole person and should have an impact on all aspects of the person's life which is more than just care and treatment for mental disorder. All the different types of advocacy can be useful in all specialties and settings. The report refers to advocacy in the following clinical areas:

- old age
- rehabilitation and social psychiatry
- learning disability
- forensic psychiatry
- liaison psychiatry
- child and adolescent psychiatry.



# 1 Introduction and context

## WHY DO WE NEED ADVOCACY?

The United Nations' (1991) principles for the protection of persons with mental illness were adopted in 1992. Furthermore, the United Nations' (2006) Convention on the Rights of Persons with Disabilities marked a 'paradigm shift' in attitudes and approaches to individuals with disabilities. People with disabilities are not viewed as 'objects' of charity, medical treatment and social protection; rather, they are viewed as 'subjects' with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent as well as being active members of society. All activities must include the participation of persons with disabilities: 'Nothing about us without us' (Department of Health, 2001).

The discrimination and stigma people with mental health problems and intellectual disability face in society can leave them disempowered, disadvantaged and vulnerable. They can be marginalised by society, often poorly informed as to their rights and excluded from key decisions that are made about their lives. The challenges they face are to have their voices heard, their views respected and their interests defended. Independent advocacy is an excellent way to ensure that an individual's rights are upheld and that they get the care and treatment that they are entitled to. Independent advocates facilitate the process to safeguard people who are vulnerable or discriminated against, or whom services find difficult to support.

Advocacy services not only benefit the person needing support but also have a number of positive side-effects for service providers (and commissioners) of healthcare services. For example, advocacy can prevent crises arising in a person's life that otherwise may result in an intervention that has much greater resource implications. It can also enhance capacity-building at a community and individual level, which can ultimately serve to reduce dependency on other health and social care services. By giving those most at risk a vehicle through which they can have their voices heard, advocacy services can also help service providers (and commissioners) gain a better understanding of the needs of this important group. They can act as a valuable channel for seeking ideas and views on how current health and social care services can be improved to better meet those needs, and to inform planning for future needs and service re-design.

In addition, advocacy has benefits for psychiatrists. When people with mental health problems are able to articulate their needs and wishes, communication with professionals improves. People are empowered, which helps to equalise the power balance inherent in doctor-patient relationships. This improves and deepens the relationship and can also diffuse and reduce confrontation. It is therefore important for psychiatrists to actively promote and engage with independent advocacy.

## 2 Definition of independent advocacy

Advocacy is part of everyday life. Often people turn to those they trust for help or support to express their views or to have their views heard when difficult questions are being asked of them. That person could be a family member, peer, carer or a health and social care professional. Such individuals fulfil a vital informal advocacy function, which should not be undervalued.

Psychiatrists and other mental health professionals as well as informal carers play advocacy roles in a number of ways such as lobbying for changes to services, engaging with policy makers and governmental organisations. Indeed, many consider this task integral to their role. Although this activity is to be encouraged, this report is concerned with only one particular usage of the term: advocacy is an independent service based on principles of equality, autonomy, social justice and citizenship, which aims to support individually or collectively people in hospital or in the community with a non-judgemental listening ear, providing information, using negotiating skills and signposting in order to articulate and achieve their aspirations.

It is crucial that advocates are independent from the people caring for and treating a patient. Effective independent advocates do not have conflicts of interest that might interfere with their ability to voice the concerns of their advocacy partner, for example, about the care and treatment they are receiving. People who are paid to care for or treat an individual have legal obligations that mean that they must work in the best interests of a person. Paid carers may have a duty to defend the actions of the organisation they work for. Unpaid carers may have their own ideas about how a person should be treated and these may conflict with the views of the individual. Therefore this could make it difficult for a carer to be an effective independent advocate.

Sometimes people think that advocacy is about working in the best interests of an individual. In fact, sometimes the advocate is supporting an individual to do something that is not in their own best interests. Advocates do not have a legal duty to make decisions that are in the best interests of an individual. An effective advocate needs to challenge and question professionals when best interests are given as a reason for decisions made about their advocacy partner.

In collective advocacy, groups of people speak out to attempt to improve the way their community is treated and included in society. Often this may involve trying to influence and improve mental health services. Different groups may take different approaches; some may aim for a consensus of their members' views, whereas others attempt to express the broad variety of perspectives held by members of their community. The essence of this sort of advocacy is that the person's/community's experience

and views are of considerable importance when attempting to develop services or improve society.

## INDIVIDUAL ADVOCACY

Advocacy means that the advocate subsumes their own ideas about what might be in an advocacy partner's best interests, listens closely to their advocacy partner and articulates what they actually want, even if it seems not to be what the advocate would advise. Often in the course of a conversation with an advocate, as possible alternatives are discussed, the information provided by the advocate may inform the advocacy partner's decision (Case study 2.1).

### CASE STUDY 2.1

Simon is a 33-year-old man with schizophrenia and intellectual disability and has been living for the past 5 years in a medium secure learning disability unit.

Simon can verbally communicate but says very little, his attention span is minimal and he will only stay in one room for 5min at the most. He demonstrates his trust in others and desire for friendship by trying to hold a person's hand or standing very close to them, but at times he has hit other patients and staff when doing this.

He is in regular contact with his father who lives out of the local area and who finds it difficult to make the long journey to visit Simon on public transport.

Simon has had a long-standing relationship with his advocate. He understands that she is not a member of staff. He appears to understand the basic concept of what an advocate does. He appears to understand that staff tell the doctor how he has been in the last week, as the doctor always mentions this, so this is different to what the advocate does. The doctor also asks the advocate whether she would like to say something for Simon.

In terms of verbal communication, Simon only ever tells the advocate he 'wants to go home' when she goes to speak to him before ward rounds. He nods when she asks if he'd like the doctor to know this and nods again when she asks him if he wants her to attend the ward round. This is the only level of conversation they have. Simon's other communication is varied and difficult to understand, and it has been assessed that he is probably hallucinating or hearing voices.

The advocate therefore acts as a non-instructed advocate, as Simon does not ask for advocacy support, he does not attempt to engage with advocacy but he will sit with the advocate for 5min when she asks him.

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

All of these discussions take place over a period of months and the advocate attends all ward rounds to ask questions on behalf of Simon with regard to concerns,

### CASE STUDY 2.1 (CONTINUED)

action plans, risk assessments, Simon's rights under the Mental Health Act 1983, and communicates regularly with ward staff, Simon's father and his social worker. The advocate also begins to ask about how contact can be improved in general given it is apparent Simon is asking on some level for more contact with his home life, and asks whether support systems for Simon's father can be implemented to improve access. This subsequently leads to improved communication with the social worker and father as well as the ward staff. It also leads to a care plan being set up, whereby Simon's father will be picked up by the social worker once a fortnight to visit Simon as well as using the carers' taxi service that is available in the local area.

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

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

## INSTRUCTED ADVOCACY

Advocates empower their advocacy partner by only acting on their instructions, as they should have the right to determine and define their own needs, by listening to and helping them disentangle their various concerns and by giving them information as to their rights and choices. Advocates support the informed choices that advocacy partners make and give them the confidence to articulate concerns either directly or through the advocate.

## NON-INSTRUCTED ADVOCACY

'Non-instructed advocacy is taking affirmative action with or on behalf of a person who is unable to instruct an advocate due to issues of capacity e.g. comprehension or communication issues. (An individual might be able to express what they want, e.g. to go home or a view of what they like or dislike, but may lack the capacity to instruct an advocate as to the action to take regarding a particular issue.)

The non-instructed advocate seeks to uphold the person's rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for all relevant factors which must include the person's unique preferences and perspectives.' (Action for Advocacy, 2011: p. 5)

## COLLECTIVE ADVOCACY

This is when a group of people who are all facing a common problem get together to support each other (Case study 2.2). Individual members of the

group may support each other over specific issues. The group as a whole may campaign on an issue that affects them all. Some of the benefits of group/collective advocacy are:

- an issue may arise that is to do with the planning of services and their impact on a group of people; the collective voice can be stronger than that of the individual – groups are difficult to ignore
- raising a difficult issue can be an isolating experience for someone – the group experience can reduce isolation and provide support.

#### CASE STUDY 2.2

A collective advocacy group commissions a play with a local theatre company to tour local secondary schools. Its subject is stigma. Members provide awareness training for the actors, help develop the script and accompany the play to the schools. An evaluation of the play shows that 96% of the young people say they will be more tolerant of people with a mental illness having seen the play.

# 3 Key principles in individual advocacy

The key principles of individual advocacy are enshrined in the Advocacy Charter (Action for Advocacy, 2004), which has been broadly accepted throughout England and Wales as a document that informs advocacy practice and training and ensures quality. These principles are similar throughout the UK but may not apply to collective advocacy in Scotland.

In Scotland, the Scottish Independent Advocacy Alliance (SIAA), with the advocacy movement, has created a set of documents that cover all aspects of advocacy commissioning, funding, principles, practice and evaluation. The SIAA has identified four key principles that cover all the work of advocates and apply to the different types of independent advocacy.

- 1 Independent advocacy puts the people who use it first.
- 2 Independent advocacy is accountable.
- 3 Independent advocacy is as free as it can be from conflicts of interest.
- 4 Independent advocacy is accessible.

## CLARITY OF PURPOSE

The advocacy scheme will have clearly stated aims and objectives and be able to demonstrate how it meets the principles contained in the Advocacy Charter. Advocacy schemes will ensure that people they advocate for, service providers and funding agencies have information on the scope and limitations of the scheme's role.

## INDEPENDENCE

The advocacy scheme will be structurally independent from statutory organisations and preferably from all service provider agencies. It will be as free from conflict of interest as possible both in design and operation, and actively seek to reduce conflicting interests.

## PUTTING PEOPLE FIRST

The advocacy scheme will ensure that the wishes and interests of the people they advocate for direct advocates' work. Advocates should be

non-judgemental and respectful of peoples' needs, views and experiences. Advocates will ensure that information concerning the people they advocate for is shared with these individuals.

## EMPOWERMENT

The advocacy scheme will support self-advocacy and empowerment through its work. People who use the scheme should have a say in the level of involvement and style of advocacy support they want. Schemes will ensure that people who want to, can influence and be involved in the running and management of the scheme.

## EQUAL OPPORTUNITY

The advocacy scheme will have a written equal opportunities policy that recognises the need to be proactive in tackling all forms of inequality, discrimination and social exclusion. It will have in place systems for the fair and equitable allocation of advocates' time.

## ACCOUNTABILITY

The advocacy scheme will have in place systems for the effective monitoring and evaluation of its work. All those who use the scheme will have a named advocate and a means of contacting them.

## ACCESSIBILITY

Advocacy will be provided free of charge to eligible people. The advocacy scheme will aim to ensure that its premises, policies, procedures and publicity materials promote access for the whole community.

## SUPPORTING ADVOCATES

The advocacy scheme will ensure advocates are prepared, trained and supported in their role, and provided with opportunities to develop their skills and experience.

## CONFIDENTIALITY

The advocacy scheme will have a written policy on confidentiality, stating that information known about a person using the scheme is confidential to the scheme, and any circumstances under which confidentiality might be breached.

## COMPLAINTS

The advocacy scheme will have a written policy describing how to make complaints or give feedback about the scheme or about individual advocates. Where necessary, the scheme will enable people who use its services to access external independent support to make or pursue a complaint.



# 4 How do advocates work?

## INSTRUCTED ADVOCACY

Fundamentally, advocates will take action as instructed to do so by their advocacy partner. An effective advocate will ensure that a person has all the relevant information they need, including options they may not have thought of themselves. Together with their advocacy partner, the advocate will explore options and ensure that their advocacy partner understands their options and rights as well as possible outcomes and consequences.

Advocates speak on behalf of people who have difficulty speaking for themselves, or choose not to do so. Advocacy is about broadening horizons and widening the options that people have by giving information.

## NON-INSTRUCTED ADVOCACY

If a patient is assessed as not having the capacity to request support from an advocate and they are refusing that support, professionals should attempt to ascertain whether when they had capacity to request help, they would have wanted it. This is to ensure that patients who refuse an advocate but do not have the capacity to understand what they are refusing, have the opportunity for an advocate to be involved and to have independent representation.

Where a person lacks capacity to instruct an advocate and is unable to communicate their views and wishes, the advocate can use non-instructed advocacy. In this situation the advocate will:

- seek to uphold the person's rights
- ensure fair and equal treatment
- ensure that decisions are taken with consideration for the person's unique perspective and preferences
- make sure that all options are considered.

In non-instructed advocacy there are a number of approaches which the advocate may use. ASIST – Advocacy Services in Staffordshire (2011) devised The Watching Brief, which sets out a process where the advocate asks what impact a particular decision will have on a person's whole life and defines eight quality-of-life domains. This approach is similar to the 'questioning approach', where the advocate asks questions relevant to the issue on the person's behalf to find out the rationale behind any proposed course of action and to ensure transparency and that the advocacy partner's

rights are upheld. Advocates should never express their own views or preferences, or make any decisions on behalf of the advocacy partner.

Other approaches include the rights-based approach where an advocate will speak up for a person to ensure their rights are promoted or defended where a person's rights have not been upheld.

The witness-observer approach is where the advocate will spend time observing the person and their interaction with services and other people, including families and friends, to gain an insight into the person's life.

A non-instructed advocate will often use a combination of approaches when supporting and representing their advocacy partner including making reference to advance directives, advance statements and lasting power of attorney. A key factor, regardless of the different approaches used, is that the advocacy partner is always at the centre of the process.

Although this describes what advocates do in instructed and non-instructed advocacy, all advocates work with people to develop their own sense of self-advocacy skills to determine their own lives.

## COLLECTIVE ADVOCACY

In collective advocacy, the advocate is a member of a group who find common cause and use a variety of techniques to make sure that the views of their community are known. Techniques may involve a campaign on a particular issue where lobbying, the media and personal testimony are used in an effort to make changes in society or services. Equally, it can involve participation in policy and service development meetings, the expression of advocacy partners' experiences to challenge stigma, or the creative expression of a community through writing, drama or music to increase awareness or shift attitudes.

# 5 Different types of advocacy

The advocacy sector is diverse and a variety of approaches to delivering advocacy exist but they all have a guiding set of common principles.

There is no 'best' form of advocacy; some advocacy organisations combine different approaches, and some approaches may be more common or suited to specific local need or groups of people. All forms of advocacy encourage and promote self-advocacy.

Carers may also access advocacy. For the most part, their concerns may relate to the person with mental disorder, but they may also require advocacy to articulate their own needs. The benefits of carer advocacy are the same as the benefits of independent advocacy for people with mental health problems.

## INDIVIDUAL ADVOCACY

### *ISSUE-BASED ADVOCACY*

Issue-based advocacy is provided by both paid and unpaid advocates. It happens in relation to specific issues, to:

- support people to represent their own interests
- represent the views of individuals if the person is unable to do this themselves
- provide support on specific issues
- provide information, not advice
- provide short- or long-term support.

Independent advocates can support several people at any time.

## CITIZEN ADVOCACY

This type of advocacy encourages ordinary citizens to become involved with the welfare of those who might need support in their communities. Citizen advocacy:

- is based on trust between the person being supported and the advocate
- means that the advocate's loyalty is to the person being supported
- means that the advocate is not paid

- means that the advocate will support their advocacy partner using their natural skills
- means that the advocacy relationship will be on a one-to-one basis and long term.

## PEER ADVOCACY

Peer advocacy is about individuals who share significant life experiences (Case study 5.1). The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates use their own experience to understand and empathise with their advocacy partner. Independent peer advocacy works to:

- increase self-awareness, confidence and assertiveness so that the individual can speak for themselves
- lessen the balance of power between the advocate and their advocacy partner.

### CASE STUDY 5.1

Stephen is a 49-year-old man who has been in a psychiatric hospital for 7 years and has no current links with his home town 100 miles away. He is due to be relocated to social housing after assessment. He felt terrorised by religious discrimination before being admitted to hospital and this terror kept him silent on the issue. A peer advocate developed an equal relationship with him by sharing a lived experience. In spite of limited alternatives and the assessment system's inflexibility, the peer advocate used listening skills and local area knowledge to negotiate safe, acceptable housing in the community. The services appreciated the benefit of a peer advocate's lived experience, and Stephen learnt to trust others in solving this problem.

## SELF-ADVOCACY

Self-advocacy is when people stand up for themselves either individually or in a group. Self-advocacy groups are a place where people can get better at speaking up for themselves. Self-advocates have control over their own lives and express their views. Self-advocacy groups will:

- ensure that members are aware of their rights
- encourage and support individual members to learn new skills and develop existing ones
- help reduce an individual's sense of isolation when raising a difficult issue.

All types of advocacy aim to support advocacy partners, where possible, towards self-advocacy (Case study 5.2).

## CASE STUDY 5.2

It was a very dark, confusing and frightening time for me. I was struggling to bring up my teenage daughter (with issues of her own), while drowning under reams of paperwork of unmet bills and debts. It was the darkest time, as I was also drowning in that dark and stagnant pitch that is a stultifying concoction of intense anxiety, distress and despair. I had fallen down a deep pit of debt and worry that was full to the brim with such harmful substances, insidious enough to seep into my soul.

I was a shadowy figure, a very dark version of Alice in Wonderland being unwillingly swept away by tide and time into a remorselessly vindictive whirlpool infested with unheard of creatures called loan sharks, which, among the relentless swirl, in favour of direct attack, would come at me in the guise of letters with as sharp a bite into my fragile mind as would make flesh bleed; or otherwise would come down the phone at me with heartless words so cold and indifferent that could freeze my soul.

The potions I was offered just made things worse. However, I at last had found the key that would end up being my salvation. I was no longer Alice, but Dorothy, complete with my very own fairy godmother from a strange and unfamiliar place called the Land of Advocacy. Such a funny word but this was no fairy tale and I definitely was not dreaming, even though my helper radiated with warmth, humanity and hope, as bright as any wand. It no longer seemed as dark, she showed me that I had always been at home. She made me realise that I, like Dorothy and her red slippers, had the power all along. My advocate helped me face my sharks; instead of me alone, we were a team. When I could not even pick up the phone, my advocate would without bemoaning the fact, naturally make that call for me. She was on MY side; she understood how the oppressive forces of depression and creditors had rendered me powerless and afraid.

She did not judge me. She listened to me. She repeated, reinforced and reassured me throughout for as long as I needed. The three R's I call them. During each visit, she took my hand and swam with me through that sea of paperwork, until I was no longer drowning but waving. I witnessed how quietly assertive she was to my creditors who were all the more unreasonable having no understanding of vulnerable people. It was good to witness a professional's surprise at their ignorance. She came to my home no problem and was not surprised by the piles of paperwork, and by order of priority we responded to each outstanding bill.

It was an education for me. A patient and understanding teacher at my side teaching me to ask for help – it is sensible, not a sign of weakness, to prioritise essentials like rent and food, and to always keep in touch with those I owe money to. From watching my advocate in action I have used her as a role model so that when I am well I can be my own advocate, I represent myself – a big milestone on my road to recovery – I have the knowledge. They call this self-advocacy. I know that if I am unable to advocate for myself, I know someone who can, and this in itself is a lifesaver. Advocacy, is not just done to you – it helps you help yourself. How empowering is that!

Tracey, Service Users' Recovery Forum, Royal College of Psychiatrists

Advance directives and advance statements are examples of self-advocacy. Advanced directives are important to the role of advocates whose functions include supporting and representing people, obtaining and evaluating relevant information, and especially in the case of incapacity, ascertaining as far as possible the person's wishes and feelings. Barriers to

the implementation and completion of advanced directives can be overcome through better organisation and clearer policies, and mental health services need to develop a routine practice to implement the right to use advance statements in the most appropriate manner (Jankovic *et al*, 2010).

## COLLECTIVE ADVOCACY

Collective advocacy is an attempt to express the voice of a community over the issues that they jointly think are important to them.

People with similar experiences meet together and through sharing their experiences and opinions, gather their views on the issues within their community that are important to them. Usually they will then speak out on these issues in a variety of ways to attempt to improve the way their community is treated and perceived.

These activities involve members supporting each other over the issues they raise and often sharing common values and goals. By engaging in speaking out and by committing themselves to a dialogue with others, members often find a sense of empowerment and purpose by being part of a mutually agreed cause.

Most collective advocacy groups are run as democratically as possible and are committed to finding out the range of opinions that their members hold.

# 6 Statutory advocacy

## ENGLAND

From April 2009, statutory access to an independent mental health advocate (IMHA) has been available to patients subject to certain aspects of the Mental Health Act 1983. In 2007, amendments were made to the Act that consequently affected the Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008. The results of the 2007 changes were that as of April 2009 a legal right to independent advocacy was enshrined in legislation in England. This right applies to people subject to compulsory treatment or supervisory community treatment; informal or voluntary patients; and people considering life-saving treatment. Placing independent advocacy on a statutory footing was intended to empower and protect individuals and to support patients to understand and exercise their legal rights.

The Mental Capacity Act 2005 also introduced an additional framework for dedicated statutory independent advocacy services for people who lack capacity. This applies to people who are subject to certain provisions in the Act and places an obligation on local authorities to provide an independent advocacy service. An independent mental capacity advocate (IMCA) ensures that people who lack capacity have their views represented when potential life changing health and social care decisions are made. The best interests of the person are paramount when an IMCA is acting and making decisions, along with professionals involved in the care and treatment of the person.

### *INDEPENDENT MENTAL HEALTH ADVOCATE (MENTAL HEALTH ACT 1983 SECTION 130A)*

The 2007 changes to the Mental Health Act gave certain 'qualifying patients' the legal right to access an independent advocacy service. People will qualify for an IMHA if they are:

- detained under the Mental Health Act for assessment and treatment (this does not include people detained on emergency short-term sections, or detained in a place of safety)
- conditionally discharged restricted patients
- on supervised community treatment orders or guardianship orders
- informal/voluntary patients who are discussing the possibility of life-saving treatment (e.g. neurosurgery) for a mental disorder (or electroconvulsive therapy if the person is under 18 years of age).

## *INDEPENDENT MENTAL CAPACITY ADVOCATE (MENTAL CAPACITY ACT 2005)*

An IMCA advocates for people who do not have the capacity to make their own decisions. Independent mental capacity advocates support these people regarding issues of medical treatment or residential care. An IMCA must be involved if the person is deemed to lack capacity to make their own decision about the issue to be decided when:

- the person has neither family members nor friends whom it is appropriate to consult on their behalf
- AND
- the decision to be made is about serious medical treatment provided by the National Health Service
- OR
- it is proposed that the person be moved into residential or nursing care for more than 8 weeks, or hospital for more than 28 days.

## SCOTLAND

The introduction of the right of access to independent advocacy has been one of the most important reforms that the Mental Health (Care and Treatment) (Scotland) Act 2003 has brought in. Section 259(1) of the Act 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'.

It is the duty of all health boards and local authorities to ensure that independent advocacy services are available in their area and they must keep an up-to-date list of advocacy organisations within their area.

The Act makes it clear that there are a number of specific responsibilities in addition to the general right of advocacy. For example, mental health officers must advise patients being subjected to short-term detention or compulsory treatment orders of their right to advocacy, and moreover must assist the person to access advocacy services. These duties also apply if community treatment disorders or compulsory orders are extended or varied. Hospital managers have a responsibility to ensure people subject to civil or criminal orders receive information about advocacy and are given help when accessing it.

General practitioners should also have information about advocacy services and should be able to help those using their services to access advocacy. The Act also makes clear that advocacy must be independent. Advocacy workers should not work in this area if they have any conflict of interest, for example they should not be employed by the local authority or health board.



The code of practice accompanying the Act makes it clear that people should not be discriminated against because they lack the capacity to appoint an advocacy worker. It indicates that those responsible for making advocacy available should consider how to involve advocacy workers in such cases. Consideration should be given to the patient's past wishes, the views of carers and any advance statement he or she may have made (Scottish Executive, 2005; para. 6.44).

Advance statements were introduced with the Mental Health (Care and Treatment) (Scotland) Act 2003. They are a useful way for people with mental disorder to express their wishes in the event that they become ill and need treatment under the Mental Health Act and cannot make decisions themselves.

Annex 1 of the Adults with Incapacity (Scotland) Act 2000 (The Scottish Government, 2011a) makes specific mention of advocacy. It contains a guide to communicating with the person with impaired capacity, stressing that 'the person can use the services of an advocacy project which supplies volunteers or other staff to promote independently the rights, views and wishes of people who have difficulty in expressing these for themselves'.

The Adult Support and Protection (Scotland) Act 2007 places a duty on local authority staff to tell vulnerable adults about advocacy and how it might be able to help them, and how to contact their local advocacy organisation.

The Education (Additional Support for Learning) (Scotland) Act 2009 places a duty on local authorities to tell parents about independent advocacy.

The Patient Rights (Scotland) Act 2011 places a duty on health board staff to tell patients about advocacy and how to contact their local advocacy organisation.

## NORTHERN IRELAND

In Northern Ireland there is a proposal to include a statutory right to advocacy in new legislation, which will replace the existing Mental Health (Northern Ireland) Order 1986 and introduce mental capacity legislation for the first time. Details of the new statutory right to independent advocacy in the proposed Mental Capacity (Health, Welfare and Finance) Bill are still being developed. However, it is envisaged that the right will mainly arise in deprivation of liberty cases where serious health or welfare interventions are being proposed and the person lacking capacity is resisting or objecting to the intervention. It is likely that the precise role of the advocate in these circumstances will be set out in subordinate legislation and will include supporting and representing the person lacking capacity, obtaining and evaluating relevant information, ascertaining as far as possible the person's wishes and feelings and communicating these to the decision maker. The advocate will also be able to challenge the decision maker if they feel that the action proposed is not in the person's best interests (but not ultimately to decide whether the intervention should take place or not). Further detailed guidance on the proposed new statutory right will be issued in late 2013/early 2014.

## WALES

The Mental Health (Wales) Measure 2010 includes provisions that amend the Mental Health Act so as to expand the scope on the independent mental

health advocacy scheme in Wales. The scope of the scheme will now include individuals detained in hospital under certain 'short-term' sections of the Act and those receiving assessment or treatment for mental ill health on a voluntary or informal basis. The Measure also amends the Act to provide independent mental health advocacy in Wales that is broader in scope.

# 7 Advocacy and equality

People with mental disorder and intellectual disability may experience additional burdens of poverty, unemployment, poor housing, poor physical health and poor educational opportunities. In addition, some groups face discrimination in society for other reasons (e.g. ethnicity, gender, disability, sexuality, age). These same groups will also face discrimination in psychiatry and advocacy. It is crucial that we are all aware of discrimination, discriminatory practices and the policies and legislation in place to safeguard the rights of minority groups (e.g. Human Rights Act 1998 and Equality Act 2010<sup>1</sup>). It is important that there is recognition of the power imbalance between patients and psychiatrists, and that both groups are capable of holding discriminatory or prejudiced views. All staff should undergo training on anti-discriminatory practice to enable them to provide the best care and treatment to all groups. Independent advocates should also be trained to ensure they do not discriminate; they should be skilled enough to meet the needs of the advocacy partner and recognise what they need to do or that they may need further assistance to appropriately support that person. Use of interpreters is equally important for the process of advocacy as it is for other aspects of the person's care and treatment.

Collective advocacy exists as a voice for frequently marginalised people and communities. The motivation of many members of an advocacy group is often the desire to stop discrimination and prejudice and unequal treatment of that community by the rest of society. By speaking out, members demonstrate the dignity of their experience and show that they are active members of society. By campaigning, lobbying and using direct experience and the language of social justice, the exclusion members may struggle with is likely to diminish.

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1. The Equality Act 2010 does not apply in Northern Ireland.

# 8 Advocacy in different clinical areas

The key principles of advocacy do not vary across clinical areas or settings, but the practice of advocacy requires special consideration in certain circumstances. It is important to remember that advocacy relates to the whole person and should have an impact on all aspects of the person's life, which is more than just care and treatment for mental disorder. All the different types of advocacy can be useful in all specialties and settings.

## OLD AGE

Some older people are subject to a number of social and cultural disadvantages. Age discrimination is particularly frequent in the field of mental health, as recognised by the Royal College of Psychiatrists. Older people often have relatively low expectations of what can be done to help them or what their potential might be and can accept relatively low and suboptimal levels of care and treatment. During the past 20 years, attitudes to risk have changed very little in the field of older people's mental health, particularly if dementia is present. Where an ethos of risk avoidance predominates, an older person with mental illness might find themselves under pressure to avoid what may be perceived by others as risk-taking. Consequently, they may find themselves agreeing to enter institutional care rather than live alone or to spend longer in hospital rather than return home, or have a level of physical support imposed which they might find detrimental. In these situations, independent advocacy has a huge part to play (Case study 8.1).

## REHABILITATION AND SOCIAL PSYCHIATRY

People who use rehabilitation services have complex and longer-term mental health problems which may affect their cognition, motivation and ability to organise themselves to carry out day-to-day and more complex tasks. These difficulties may also mean that they can be very easily persuaded to do things or agree to things without fully understanding the consequences. As such, they may be vulnerable to exploitation and to having assumptions made about their views and wishes. For these reasons, this group may have a great need for advocacy to ensure their voice is heard. This needs to be offered proactively, since they are less likely than other groups to request an advocate (Case study 8.2).

### CASE STUDY 8.1

In November 1999 I was diagnosed with dementia. I could not do things that I used to take for granted, like driving and counting money – even though I used to work in a bank! I was at a very low ebb. I sat at home depressed, did not go out, did not wash, change clothes or shave. My advocate helped me get my life back on track. She helped me sort out lots of things in my life; and helped me do things I never thought would be possible. Public speaking used to terrify me, my mouth would feel like it had been poured with concrete. Since November 1999 I have spoken at conferences around Scotland, Ireland, the Dominican Republic, and even Beirut.

I am also a member of the Scottish Dementia working group. We have members all over Scotland and we go and give talks to people with dementia, and are involved in responding to government consultations on legislation that affects people with dementia and those that care for people with dementia. In 2002 we produced a help card for people with dementia. People with dementia can use the card to help them explain discreetly why they may need assistance in certain situations, like in shops and on buses. One of the symptoms of dementia is that you lose the ability to count money. This happened to me and I used to find it embarrassing. That is why I wanted to produce the card, so that other people will not need to feel like I did.

### CASE STUDY 8.2

Harry is a 40-year-old man. He has had a disrupted childhood characterised by emotional and physical neglect. His mother abandoned him when he was 2 years old and he grew up in a series of foster homes. He developed a psychotic illness in his 20s and has been diagnosed with schizophrenia. He has a deep distrust of services and would rather live in squalor in a state of severe self-neglect than accept help or treatment. He does, however, have a good relationship with an advocacy worker who has been able to articulate for Harry the issues that are important to him – such as keeping old newspapers in his room. There were concerns that this would be a fire hazard. A compromise was reached between all parties and this process was a step in engaging with Harry, which meant that another compromise could be made, this time in relation to accepting medication.

## FORENSIC PSYCHIATRY

Forensic psychiatry has its own unique challenges, and the competing demands of the judicial system with the appropriate care and treatment of patients can cause difficulties for patients and staff. Independent advocacy is about supporting and safeguarding vulnerable people who, because of possible distorted perceptions of risk in relation to their history, are discriminated against or whom other services find difficult to support. Increased restrictions and loss of liberty stress the importance of advocacy for this group.

Statutory independent advocacy is available in all high-security hospitals and medium secure units across the UK. Advocacy in these settings

should follow the same principles as advocacy in, for example, local hospitals and the community: empowerment, ensuring people's rights are upheld and that they have a say in their care and treatment. Advocacy organisations usually have a contract or service level agreement that will include a working protocol when they work in hospitals, outlining how they work, days and times of availability, and addressing specific safety and security issues. The protocol would outline whether advocates carry keys, when and how they might breach confidentiality, etc.

## LEARNING DISABILITY

People with intellectual disabilities can benefit from the support of independent advocacy in the same way as other groups. Historically, people with intellectual disabilities have faced discrimination and were often separated from their families and society from birth. They lived their lives, grew old and died in long-stay hospitals. Even today, people with intellectual disabilities are marginalised and it is difficult for them to participate fully in society, and other people often have low expectations of what they might be able to achieve. A skilled independent advocate will be able to ensure that their advocacy partner understands the role of the advocate as best as possible. Often, people with intellectual disabilities will require more time to build a trusting relationship with their advocate and may need more time and input to understand complex issues.

## LIAISON PSYCHIATRY

People in general hospitals with mental health problems have a need for advocacy which is often overlooked by both service providers and indeed those who provide advocacy services. There are many individuals in general hospitals who have a mental disorder. Some are subject to detention or receive treatment using incapacity legislation. These include people who self-harm, people with comorbid physical and mental disorders, and people with organic brain syndromes. Many, although not all, will be referred to liaison psychiatry services. The College's Psychiatric Liaison Accreditation Network includes the following as a standard: 'The liaison team can access advocacy services, including PALS [Patient Advice and Liaison Services], Independent Mental Health Advocates, Independent Mental Capacity Advocates and mental health act advocates' (Palmer *et al*, 2010).

In addition, in England and Wales there is an independent mental capacity advocacy service for those who lack the capacity to make decisions for themselves, a situation which is not uncommon in general hospitals. Staff in general hospitals will usually be less aware of the need for advocacy services and indeed of their role, and psychiatrists and other mental health staff clearly have a part to play in addressing this.

## CHILD AND ADOLESCENT PSYCHIATRY

Article 12 of the United Nations Convention on the Rights of the Child enshrines the right of children to have their views and opinions listened to and taken into account.

It is essential that children are able to access advocacy, as often services and professionals are not 'geared up' or used to hearing child service user views and opinions. Advocacy can provide support to children and young people in formal situations such as hearings, tribunals or complaints and help them to understand the processes in which they are involved. It can also allow the child's voice to be heard where it can make a significant difference to their life at home, and in access to services. Advocacy for children and young people should be seen as a specialist area of advocacy. Care should be taken in communicating with the child or young person in an age-appropriate fashion and using age-appropriate language.

When advocacy is provided in a formal setting, the child or young person may by virtue of their mental health difficulties be distressed and have difficulty in retaining information. It is the experience of members of the Faculty of Child and Adolescent Psychiatry that the representative from an advocacy organisation is often seen as yet another person who comes to ask questions and thus their visit may be perceived as an additional stressful experience. There are specialist advocacy organisations providing input for children and young people and it would be best practice for these agencies to be available for all children and young people if advocacy is indicated.

If, however, more generic advocacy services are all that is available in a particular unit, it would be important that advocacy workers have access to skills training or child and adolescent mental health service consultation to upskill their workers in communicating with young people.

It is also important to be clear about the role of advocacy for parents and carers of a child or young person with mental health difficulties. It would be important not to exclude parents/carers from the process as they are key partners in the child or young person's care.

Advocates need to have an understanding of development, context and legal frameworks of children and young people's lives. In England, this would be the Children Act 2004, which states that 'each children's services authority in England must make arrangements to improve the well-being of children'. This includes the physical and mental health and emotional well-being of children.

In Scotland, key provisions within the Children (Scotland) Act 1995 and related regulations and guidance show when children's views must be considered. 'Getting it right for every child' (The Scottish Government, 2011b) advocates an approach to improve outcomes for children and young people. This has been adopted as Scottish government policy to underpin all children's services and put the child at the centre of care.

Concerning Northern Ireland, it is the intention of the Department of Health, Social Services and Public Safety to apply the proposed Mental Capacity (Health, Welfare and Finance) Bill to persons aged 16 years and above who, because they lack capacity, are unable to make decisions for themselves. There will also be need to include a gateway into this new legislation for the small number of children aged under 16 years who require treatment for a mental disorder on a compulsory basis. This cannot be a capacity gateway but rather one based on risk and necessity. It is intended that the safeguards that will apply to a person aged 16 and over, including the right to an independent advocate in certain circumstances, will also apply to those children under 16 years.

# 9 Myth busting

## ADVOCACY IS...

- Assertive
- Non-judgemental
- Accessible
- Empowering
- Non-directive
- About standing alongside people who are in danger of being pushed to the margins of society
- About standing up for and sticking with a person or group and taking their side
- A process of working towards natural justice
- Listening to an individual or a group and trying to understand their point of view
- Finding out what makes them feel good and valued
- Understanding their situation and what may be stopping them from getting what they want
- Offering the person or group support to tell other people what they want or introducing them to others who may be able to help
- Helping the person or group to know what choices they have and what the consequences of these choices might be
- Enabling a person or group to have control over their life but taking up issues on their behalf if they want you to

## ADVOCACY IS NOT...

- Making decisions for someone
- Mediation
- Counselling
- Befriending
- Care and support work



- Just public or group consultation
- Telling or advising someone what you think they should do
- Solving all of someone's problems for them
- Speaking for people when they want to speak for themselves
- Filling all the gaps in someone's life
- Pursuing the advocate's own agenda
- Agreeing with everything a person says and doing anything a person asks you to do
- Acting in a way that prioritises the need of anyone other than the individual
- Overly emotionally involved
- Creator of dependency
- Breaker of confidentiality
- Giver of false hope
- Allied to any professional standpoint

## COLLECTIVE ADVOCACY IS NOT...

- A support group
- A therapeutic group

# 10 Useful contacts

There are many advocacy organisations throughout the UK, but the following three are umbrella organisations and therefore can be contacted about local advocacy services in your area.

## ENGLAND AND WALES

Action for Advocacy  
The Oasis Centre  
75 Westminster Bridge Road  
London  
SE1 7HS

Tel: 0207 921 4395  
Email: [info@actionforadvocacy.org.uk](mailto:info@actionforadvocacy.org.uk)  
Web: [www.actionforadvocacy.org.uk](http://www.actionforadvocacy.org.uk)

## SCOTLAND

Scottish Independent Advocacy Alliance  
69A George Street  
Edinburgh  
EH2 2JG

Tel: 0131 260 5380  
Email: [enquiry@siaa.org.uk](mailto:enquiry@siaa.org.uk)  
Web: [www.siaa.org.uk](http://www.siaa.org.uk)

## NORTHERN IRELAND

Patient and Client Council  
1st Floor, Lesley House  
25–27 Wellington Place  
Belfast  
BT1 6GD

Freephone: 0800 917 0222  
Tel: 028 90 321 230  
Email: [info.pcc@hscni.net](mailto:info.pcc@hscni.net)  
Web: [www.patientclientcouncil.hscni.net](http://www.patientclientcouncil.hscni.net)

# Glossary

Advocacy partner	The person who is being advocated for.
Code of practice	This provides doctors and hospital staff with advice and guidance of how they should proceed when undertaking functions and duties under the various mental health acts. There are codes of practice for England, Wales and Scotland.
Comorbid	The person has more than one mental or physical disorder.
Mental disorder	A psychological disorder of thought or emotion. For the purposes of the document we have used the term mental disorder. Some service users and carers may not be comfortable with this as a term, but this document is primarily aimed at College members and this is the term with which they are most familiar. It is also the term used in mental health legislation.
Organic brain syndrome	An older and nearly obsolete general term from psychiatry, referring to many physical disorders that cause impaired mental function.
PALS (Patient Advice and Liaison Services)	Provide information, advice and support to help patients, families and their carers.

# Appendix: Training and standards

## ENGLAND AND WALES

### *INDEPENDENT ADVOCACY QUALIFICATION*

There are two new national independent advocacy qualifications: the Level 3 Certificate in Independent Advocacy and the Level 3 Diploma in Independent Mental Capacity Advocacy – Deprivation of Liberty Safeguards.

These qualifications have been developed by the Department of Health in partnership with City & Guilds and the Welsh Assembly Government. They have been endorsed by Skills for Care & Development and Skills for Health and are accredited by the Qualification and Curriculum Development Agency.

The Level 3 Certificate in Independent Advocacy consists of four mandatory units and five specialist units. To achieve a full certificate, advocates need to complete the four core units plus one of the following specialist units:

- providing independent mental capacity advocacy
- independent mental health advocacy
- independent advocacy management
- providing independent advocacy to adults
- independent advocacy with children and young people.

The Level 3 Diploma in Independent Mental Capacity Advocacy – Deprivation of Liberty Safeguards consists of four mandatory units plus two specialist units on independent mental capacity advocacy and Deprivation of Liberty Safeguards (DoLS). To achieve the full diploma, advocates need to complete the four core units plus these two specialist units:

- providing independent mental capacity advocacy
- independent mental capacity advocacy – DoLS.

### THE CORE UNITS

#### *PURPOSE AND PRINCIPLES OF INDEPENDENT ADVOCACY*

This unit addresses the development of advocacy, what independent advocacy is, the various models of advocacy, and implementation of values and principles underlying good practice in advocacy, and the roles and responsibilities of an independent advocate.

*PROVIDING INDEPENDENT ADVOCACY SUPPORT*

This unit addresses the practical implementation of advocacy in terms of establishing an effective relationship, creating an action plan, assisting the person to explore options and the possible consequences of these, and acting on their instruction. It will also include supporting the person to self-advocate, and at the end of the work, to review and end the relationship.

*MAINTAINING THE INDEPENDENT ADVOCACY RELATIONSHIP*

This unit aims to develop the skills that an advocate utilises in order to maintain an effective and independent relationship with the person receiving their service, while also examining the limitations of the role of the advocate in this relationship.

Topics covered will include knowing how to respond to practice dilemmas, dealing with conflict, and responding to concerns of abuse. The unit will also cover self-management such as task prioritisation, personal values and making the most of supervision.

*RESPONDING TO THE ADVOCACY NEEDS OF DIFFERENT GROUPS OF PEOPLE*

This unit enables advocates to examine and understand the specific advocacy needs of different groups of people. This includes: ensuring the accessibility of the service to different groups; using non-instructed advocacy; and addressing social inclusion.

## *INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA)*

The Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006 state that no one can be appointed as an IMCA unless:

- a he is for the time being approved by a local authority on the grounds that he satisfies the appointment requirements, or
- b he belongs to a class of persons which is for the time being approved by a local authority on the grounds that all persons in that class satisfy the appointment requirements.

The *Mental Capacity Act 2005: Code of Practice* (Department for Constitutional Affairs, 2007) set the training requirements of attending 'the IMCA training'. This has been superseded by the specialist independent mental capacity advocacy unit of the qualifications in independent advocacy.

To undertake the DoLS roles, experienced IMCAs were expected to undertake further specialised training.

The IMCA commissioning guidance, recently published by the Social Care Institute for Excellence (2009) and supported by both the Department of Health and the Association of Directors of Adult Social Services, does not set the expectation that IMCAs will have completed the full certificate or diploma in independent advocacy.

## *INDEPENDENT MENTAL HEALTH ADVOCATE (IMHA)*

Independent mental health advocates do not need any specialist training before they start practice. However, the Mental Health Act 1983

(Independent Mental Health Advocates) (England) Regulations 2008 require IMHAs to have 'appropriate experience or training or an appropriate combination of experience and training'. It is up to the person or organisation appointing the IMHA to decide whether they demonstrate this. In making this determination, they must have regard to guidance issued by the Secretary of State.

The Department of Health's guidance (2010) about appropriate training and experience states that IMHAs should be expected to successfully complete the independent mental health advocacy unit of the independent advocacy qualification within their first year of practice. This unit enables advocates to understand how mental health legislation affects patients who meet the qualifying criteria for this service, and how to respond to such referrals. The unit also enables advocates to work with a range of people receiving the services and responding to their needs as well as working with a range of professionals.

Independent mental health advocates, like IMCAs, are also required to have enhanced Criminal Records Bureau checks.

## QUALITY PERFORMANCE MARK

Action for Advocacy's Quality Performance Mark is the only national advocacy-specific quality assessment system that applies to all forms of one-to-one advocacy.

The Quality Performance Mark sets out the language of quality for independent advocacy. It provides a framework within which advocacy services can develop. It focuses on how principles and procedures turn into practice and performance by looking at the following eight areas of quality:

- 5 independence
- 6 clarity of purpose
- 7 confidentiality
- 8 equality, accessibility and diversity
- 9 empowerment and putting people first
- 10 accountability and complaints
- 11 supporting advocates
- 12 IMCA specific review.

The Quality Performance Mark is a three-stage process consisting of self-, desktop and site assessment. Each of the seven areas is divided into a list of quality indicators which state what is required to attain the Quality Performance Mark.

## SCOTLAND

The Scottish Independent Advocacy Alliance (SIAA) has produced a suite of documents about good practice in independent advocacy. All advocacy organisations should provide training and induction for new staff and volunteers. Typically, advocacy training will include the following core topics:

- role of the advocate

- advocacy skills
- the principles of independent advocacy
- relevant legislation and policy.

The SIAA has produced an evaluation framework (Scottish Independent Advocacy Alliance, 2010) that provides guidance to advocacy organisations on methods for ongoing review and monitoring as well as an external evaluation that should take place approximately every 3 years. The evaluation framework is based on the *Principles and Standards for Independent Advocacy* (Scottish Independent Advocacy Alliance, 2008a) and the *Code of Practice for Independent Advocacy* (Scottish Independent Advocacy Alliance, 2008b).

The SIAA is developing a system of practice development, whereby a team will carry out evaluations of advocacy organisations and help develop advocacy to address gaps in provision of advocacy.

## NORTHERN IRELAND

The Department of Health, Social Services and Public Safety issued *A Draft Policy for Developing Advocacy Services: A Guide for Commissioners* (2011) for consultation from 27 June to 14 October 2011. The consultation responses are currently being analysed and it is envisaged that the final document will be published late Spring 2012. The aim of the policy guidance is to help develop all health and social care advocacy services by putting in place common principles and standards for their future commissioning and delivery, while recognising that these may need to be tailored to meet the needs of specific groups, such as children and young people. It recognises all models of advocacy, often described as a 'continuum' of advocacy services in the commissioning process. It also recognises independence as a key criterion whatever model of advocacy is being commissioned. The new statutory right will be an important part of that continuum and, when it is introduced, it should ideally complement, not replace, the other elements, such as peer and group advocacy.

### *PEER ADVOCACY TRAINING COURSE IN NORTHERN IRELAND*

This is a 10-week course accredited by the Northern Ireland Open College Network, the first accredited peer advocacy course in Europe. The training is available to anyone who has experienced mental health problems. It aims to educate people how to work as a peer advocate and to offer personal development. Each session covers topics through group discussion, scenarios, role plays, handouts, plus personal learning records (written homework). Topics covered include:

- what is advocacy; role of advocate
- communication; mental distress
- mental health law; keeping safe
- perspectives on mental health difficulties
- advocate's code of practice; mental health resources available locally

- housing and mental health; complementary therapies
- medical model treatments; stigma and empowerment
- welfare rights and benefits; talking therapies
- getting started as an advocate
- course evaluation; preparing personal learning records.

Those who wish to work as peer advocates must also undertake 6 months of voluntary work-shadowing of a peer advocate.



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