

VISIT AND MONITORING REPORT

The Right to Advocacy

A review of how local authorities and NHS
Boards are discharging their responsibilities
under the Mental Health (Care and
Treatment) (Scotland) Act 2003

March 2018

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Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Executive summary

About this report

The Mental Health (Care and Treatment) (Scotland) Act 2003 imposed a duty on local authorities and health boards to collaborate to ensure the availability of independent advocacy services in their area. The Act gave everyone with mental illness, learning disability, dementia and related conditions the right to access independent advocacy support. The Mental Health (Scotland) Act 2015 builds on the right in the 2003 Act to independent advocacy support, by requiring health boards and local authorities to tell the Mental Welfare Commission how they have ensured access to services up to now, and how they plan to do so in the future.

This report is based on information the Commission collected from health boards and local authorities, and from the new health and social care partnerships (HSCPs). We asked about services they have made available in their areas, and how they were planning for the future provision of advocacy services and to improve access to advocacy. We received responses covering 29 of the 31 HSCP areas, no information from two HSCP areas, and incomplete information for five of the HSCPs. From the information we received, we had no details about the actual independent advocacy services commissioned in five HSCP areas.

We also asked local authorities to tell us if their integrated children's services plans covered the provision of independent advocacy services for children and young people with mental illness, learning disability or related conditions. We received responses covering 31 of the 32 local authority areas.

Current service planning

The Scottish Government's expectation, set out in *Independent Advocacy: Guide for Commissioners*, published in December 2013, is that local strategic advocacy plans should be developed. We asked for information about local planning activity, and received copies of only five up to date plans. Two of these were due to run out at the end of 2017, but we were told that they were in the process of being revised and updated. There are 31 HSCP areas in Scotland, and the plans received cover only nine of these. Twelve HSCPs told us that they were in the process of developing a plan, while in 10 areas we received no information about any activity to develop a plan.

We were aware that local authorities may commission specialist advocacy services for children and young people, and we therefore asked local authorities to tell us if their integrated children's services plans covered the provision of independent advocacy services for children and young people with mental illness, learning disability, or related conditions. Only nine local authorities told us that their plan did so.

Actual service provision

There are different types of advocacy, but generally the types of advocacy support available will be individual advocacy, with one-to-one support provided by an advocate; collective advocacy, where people will speak as a group about issues which are important to them; and non-instructed advocacy, where an individual's capacity to instruct an advocate is limited. The map of service provision across Scotland is complex. Not all services provide all types of support. Some services are generic and will work with all age ranges of adults, with a small number also working with children and young people. Some services support people with specific conditions, most commonly adults with learning disability, or dementia, or mental illness.

It is difficult to identify clearly gaps in provision from the information we received. We can say that individual advocacy support is available across all areas in Scotland, that there is some collective advocacy provision, and that non-instructed advocacy is widely available, although not for every group of people in all areas. It is also clear from the information we received that there are issues in relation to the actual advocacy support available.

- The majority of services were prioritising referrals for people subject to compulsory measures under the 2003 Act, although only two mentioned any concern as to the potential impact of this on other clients. The Commission is clear in its view that limiting advocacy provision to people subject to compulsory measures was never the policy intention when the right to advocacy was introduced in the 2003 Act. We would therefore expect the provision of services locally to be sufficient to ensure that every person who has the right to access advocacy support is able to get support.
- Only three areas told us that the budget for advocacy services had increased in the past two years, and three quarters of responses said that budgets had not changed in this period. If service providers have standstill budgets, this is likely to mean that there could be an actual reduction in service provision, or that it is increasingly necessary to prioritise referrals to manage demand for advocacy support.
- We received information from local authorities about a range of dedicated services for children and young people. However a number of these services were not independent advocacy services. For example, we were told about children's rights officers employed by authorities. Almost all of the services also had very restricted eligibility criteria, generally being commissioned to provide advocacy support for children or young people who are looked after, or have experienced abuse or trauma. We also heard, where a service is available for children and young people, that it is often the case that it is restricted to those who are subject to compulsory measures under the 2003 Act. Our information suggests therefore that there are significant gaps in service provision for children and young people.

Monitoring and reviewing services

Not all advocacy planners reported having strategic outcomes for the provision of an advocacy service. Many told us about outcomes at provider level, or it was unclear whether their outcomes were overarching or for providers. In relation to children and young people, some responses told us about outcomes for advocacy services for looked after and accommodated children and young people, but did not address mental health and learning disability.

Most described one or more regular mechanisms to monitor the quality of services, and most, but not all, also described measuring the satisfaction of people using advocacy services as part of this. In relation to children and young people in particular, several areas said they were developing ways to measure satisfaction better. However, there has been very little independent evaluation of advocacy services.

We asked about monitoring unmet need for advocacy. Most, but not all, ask services to provide information, for example about waiting lists. However most responses did not provide information on current waiting lists: only three provided numbers and a further five said they had no current concerns.

Fewer than half of the areas had carried out an equality impact assessment, and, while most asked providers to report equalities data, only eight respondents provided any specific information about actions to address equalities issues.

Developing awareness of advocacy rights and provision

There was a patchwork of responses in relation to how advocacy rights and services are promoted. Some areas appeared to rely on providers to promote their own services, but 15 areas described a more strategic approach to ensuring that people who might benefit from advocacy are aware of it, understand what it is, and are able to access it. More than a dozen mechanisms were mentioned but most areas used no more than two or three, implying that there is scope for development in most areas. One in five areas had taken no specific actions to promote the use of advocacy among health and social care staff.

For children and young people's advocacy, staff such as children's rights officers, social workers, education staff and health workers were key to making children and young people and their families aware, and there were some innovative examples of strategic level promotion.

Future planning

Sixteen responses confirmed there was a current planning group, a further four said a plan was being developed, and two more already had a current plan. Two areas had no planning group and no plans to produce a plan. Only 16 NHS board or HSCP responses

gave some information about work being done locally to assess projected need for services, and not all were collating information to identify gaps in provision.

Within children's services planning processes, 16 local authorities said they did not have an advocacy planning group. In some areas, where there is a strategic advocacy planning group the needs of adults, and children and young people may be being addressed together by the one group. However our information suggests that the issue of advocacy support for children and young people with mental illness, learning disability and related conditions will not be addressed in children's services planning processes, and may not be addressed even where there is a wider strategic advocacy planning group in place.

Recommendations

Given the role and remit of Integration Joint Boards (IJBs), and their responsibility for planning integrated arrangements, for strategic planning and for the delivery of services, we would expect that responses to our recommendations are discussed at the IJB itself in each area.

NHS chief executives and HSCP chief officers should:

- Ensure that there is clarity about which organisation will be responsible for co-ordinating the preparation of strategic advocacy plans for their area.
- Ensure that strategic advocacy plans are in place by the end of December 2018.
- Ensure that strategic plans are developed based on a local needs assessment, and information about unmet need and gaps in local provision. They should be developed in partnership with people who use or may use services, and with service providers. Barriers people may be experiencing accessing advocacy support, including barriers created by prioritisation criteria and people being placed outwith their home areas, should be addressed in plans.
- Ensure that advocacy planners carry out equalities impact assessments and develop approaches to monitoring and enabling access to advocacy which cover all the protected characteristics.

Specific recommendations relating to services for children and young people

HSCP chief officers and local authority chief executives should:

- Ensure there is clarity about where the responsibility lies for planning and commissioning independent advocacy services which are accessible for all children and young people under 18 with a mental disorder. This includes children and young people receiving care and treatment on an informal basis, or in placements outwith their home area.
- Ensure that arrangements for planning for the provision of independent advocacy services for children and young people include processes for assessing the projected need for these supports.

Why did we produce this report?

The Mental Health (Scotland) Act 2015 created new responsibilities for health boards and local authorities to demonstrate that they are discharging their legal responsibilities in relation to independent advocacy services. Boards and local authorities must give the Commission information about what they have done in the previous two years, and what they intend to do in the next two years (or a longer period if the Commission requires it) to ensure that independent advocacy services are available for people with a mental illness, a learning disability, dementia, or a personality disorder, in their area, and that people are able to access these services.

The Commission decided it would produce a strategic advocacy plan template which could be used by relevant organisations in preparing advocacy strategies, setting out how they intend to develop and improve access to advocacy services in their areas. This template was created in consultation with advocacy planners, and has been provided to the new joint integrated boards, which will lead on advocacy.

The Commission also decided to build on the existing map of advocacy services prepared every two years by the Scottish Independent Advocacy Alliance (SIAA).¹ We decided we would produce a report every two years, analysing the availability of advocacy and the plans to develop provision across Scotland, and looking at whether we feel public bodies are doing enough to live up to the requirements and principles of the mental health legislation.

This is the first report the Commission has produced since the 2015 Act created the new duties on information about advocacy services.

¹ The Scottish Independent Advocacy Alliance (2017) A Map of Advocacy across Scotland 2015-16 edition https://www.siaa.org.uk/wp-content/uploads/2017/09/SIAA_Advocacy_Map_2015-16-1.pdf

Independent Advocacy

Why is it important?

Independent advocacy, in all its forms, seeks to make sure people are able to have their voice heard on issues which are important to them, and have their views and wishes genuinely considered when decisions are being made about their lives. It is an important part of the process of safeguarding rights. It is a particularly important safeguard for people with a 'mental disorder', who may find that their views and wishes are not always taken seriously, or may not be fully involved in decisions about their care and treatment.

The Scottish Government guidance, *Independent Advocacy: Guide for Commissioners (2013)*² talks about how 'people can be treated unfairly as a result of institutional and systemic barriers as well as prejudice and individual, social, and environmental circumstances that make them vulnerable...' The guidance also states clearly that independent advocacy is important 'to ensure the individual's views are heard and understood and that they receive support to ensure their rights are not infringed...' Advocacy is therefore clearly seen as a crucial part of the process of making sure that peoples' voices are heard and their rights are protected.

Policy and legislative context

There is nothing new about the idea of people speaking up for themselves or others. Organised forms of advocacy only started to develop in the 1960s, with the first advocacy scheme in the UK set up in the early 1980s. Since then though the need for independent advocacy in mental health care has become increasingly clear, and increasingly acknowledged in policy and legislation.

The Millan Committee was set up in 1999, to review mental health law in Scotland. The report, *New Directions, a Report on the Review of the Mental Health (Scotland) Act 1984*³, was published in 2001. The report recommended there should be greater access to advocacy, and that 'all mental health service users should have a right to obtain access to an advocate...(and that)it should be a joint duty of health services and local authorities to ensure those advocacy services are available and that service users are informed of the services' (Paras 101 and 102). The report also said explicitly that most people receive care and treatment on an informal basis, and that everyone receiving care and treatment, whether on a compulsory or informal basis, should have access to advocacy support, to make sure they are involved as fully as possible in decisions about their care. The report therefore recommended that a new mental health act 'should give a right to all mental health service users to obtain access to an advocate' (Chapter 14, Recommendation 14.1). The 2003 Act follows this

² The Scottish Government (2013) *Independent Advocacy: Guide for Commissioners*
<http://www.gov.scot/Resource/0044/00441045.pdf>

³ Scottish Executive (2001) *New Directions: Report on the Review of the Mental Health (Scotland) Act 1984* https://www.mhtscotland.gov.uk/mhts/files/Millan_Report_New_Directions.pdf

recommendation, and states (Section 259) that anyone with a mental disorder, whether or not they are subject to compulsory measures under the Act, has a legal right of access to independent advocacy. The 2003 Act also confers a duty on each health board and local authority to work collaboratively to ensure that independent advocacy services are available, and that people are able to access services. The 2015 Act builds on this duty, by requiring local authorities and health boards to give the Commission information about how they are arranging for the provision of independent advocacy services in their area.

The importance of independent advocacy services has been recognised in other recent legislation and policies. Better Health, Better Care: An Action Plan (2007) which set out a new vision for the NHS in Scotland, recognised the need for advocacy support. The Patient Rights (Scotland) Act 2011, which aims to improve patients' experiences of using health services and to support people to become more involved in their health and health care, established a patient advice and support service. It says that this service, where appropriate, should make people aware of and direct them to advocacy services (Section 18). This act also required the Scottish Government to publish a charter of patient rights. The charter was published in 2012, and said that a patient using health care 'may ask to have an independent advocate to help you give your views', and that if you have a mental health disorder you have a right to support from an independent advocate. The Social Care (Self-directed Support) (Scotland) Act 2013 refers to the provision of information about advocacy services (Section 9 (d)).

Several national strategies also refer to advocacy provision. The Keys to Life 2013, the learning disability strategy launched in 2013, has a recommendation (Recommendation 32) about improving the delivery and uptake of independent advocacy services at local levels. Caring Together: the carers strategy for Scotland 2010-15, has a specific chapter, Chapter 17, which confirms the importance and value of advocacy for carers in their own right. National policy and legislation is therefore emphasising consistently the positive benefits of independent advocacy support.

In addition to the references to advocacy services in legislation other than mental health legislation, and in various national strategies, the Scottish Government has, as mentioned above, published Independent Advocacy: Guide for Commissioners in 2013. This guidance emphasises the importance of advocacy, the statutory duties which are set out in the 2003 Act to ensure that people can access independent advocacy, and the fact that this right applies to everyone with a mental disorder, and not only those who may be detained in hospital. The guidance also says that a strategic advocacy plan should be developed in local areas, on the basis of a needs assessment, scoping exercises, and consultations.

New arrangements for integrating health and social care have been put in place, with Integration Joint Boards set up to oversee integration, and 31 health and social care partnerships (HSCPs) formed to deliver adult social care and primary health care services which health boards and local authorities have agreed will be integrated in their

areas. The Commission was therefore collecting information about advocacy services at a time of very significant change in the way adult care services were being planned and delivered.

How we gathered information for this report

Monitoring the provision of advocacy services in local areas is a new role for the Commission. In preparation for this new duty we undertook a number of consultation exercises. This included holding a workshop at the SIAA AGM in November 2015, having several meetings with the SIAA, and having a meeting with a small group of planners and commissioners from statutory organisations. We produced a draft questionnaire to use in a survey, along with a draft template for strategic advocacy plans, and sent the drafts out in an email consultation. We then held a further workshop with planners and commissioners, to get views about the revised questionnaire and template.

Following the consultation process, we sent questionnaires out in July 2017. The questionnaire asked for information about current planning and service provision in local areas; about monitoring and reviewing arrangements with current advocacy providers; about actions taken locally to make people aware of advocacy service provision; and about future plans for developing services locally. We also asked respondents to provide us with a copy of their local strategic plan or action plan for advocacy services if one was available, and to complete an attachment giving us information about the actual services commissioned in local areas, to provide advocacy support to people with a mental illness (including dementia) or a learning disability.

Requests for this information were sent to all 14 health board chief executives and all 31 HSCP chief officers. This was because we were aware, following consultation, that planning structures and arrangements were different in different local areas. However, we emphasised that we expected to get one single response from each HSCP or health board area, depending on the local planning arrangements. We also sent a similar request for information to all chief social work officers in the 32 local authorities, asking for details of any specialist advocacy services commissioned for children and young people with a mental illness or learning disability. We sent this request out separately because we knew that health and social care integration only applies to adult services, and that local authorities may independently commission advocacy services for children and young people.

Advocacy provision for adults

Responses received

We received 25 responses providing information from all the 14 health board areas in Scotland. Arrangements for planning and commissioning advocacy services are different in different local areas though. In some areas responsibility for planning and commissioning is now undertaken within the HSCP area, while in certain areas this is still undertaken on a health board wide basis. We only received partial information about current advocacy provision in one health board area, Greater Glasgow and Clyde.

Six health board areas in Scotland are coterminous with the new HSCPs; these are NHS Borders, Dumfries and Galloway, Fife, Western Isles, Orkney and Shetland. We have information from all these areas. We have received one single response from four health board areas, which each cover several HSCP areas, but where the response includes all the separate HSCPs in that health board area. These responses are from NHS Lanarkshire, Forth Valley, Highland, and Grampian. In four health board areas – NHS Ayrshire and Arran, Lothian, Tayside, and Greater Glasgow and Clyde - we have been told that HSCPs are responsible for planning and commissioning advocacy services now. We have received information from each of the HSCPs in Ayrshire and Arran, Lothian, and Tayside, but we did not receive responses from two HSCP areas in the Greater Glasgow health board area – from East Dunbartonshire and Inverclyde.

Current planning and service provision

Responsibility for strategic planning for independent advocacy services

We asked for information about whether planning for the provision of advocacy services was undertaken on a health board wide basis, or within HSCP areas.

In three areas, NHS Grampian, NHS Lanarkshire, and NHS Highland, advocacy planning is carried out on a health board wide basis, covering all the HSCPs in the health board area. In six areas in Scotland health board and HSCP boundaries are coterminous, and we were told that planning responsibility in all these areas lies with the HSCPs. In the NHS Forth Valley area it has been agreed that responsibility for planning for advocacy services across the whole area will lie with one of the two HSCPs. In all the other areas in Scotland planning responsibility sits with the new HSCPs.

This means that in 10 health board areas in Scotland strategic advocacy planning is effectively undertaken on a health board wide basis, either because the HSCP covers the entire health board area, because one HSCP has identified responsibility for planning for the whole area, or because the NHS is retaining responsibility for co-ordinating planning across all the HSCPs in the area.

The other four health board areas in Scotland are NHS Ayrshire and Arran, Tayside, Lothian, and Greater Glasgow and Clyde. In Ayrshire and Arran, and Greater Glasgow and Clyde, the HSCPs have told us that advocacy strategic planning will be carried out

at an HSCP level. In the NHS Tayside and NHS Lothian areas though the picture is confusing, from the responses we received. There are four HSCPs in the NHS Lothian area. Two of these HSCPs (Edinburgh and West Lothian) have indicated in their responses that planning is undertaken at an NHS wide level. Midlothian and East Lothian HSCPs though have told us that planning responsibility is being passed to the HSCPs, and Midlothian has also told us that they expect to have a local plan, covering the HSCP, in place by December 2017. NHS Tayside has three HSCPs and the information we have received suggests that there had been an NHS wide approach to planning advocacy provision. However, that there are no current local arrangements in place either for an NHS wide approach to continue, or for the HSCPs to take on the responsibility in each of their areas.

Current strategic plans

The advocacy commissioning guidance published in 2013 by the Scottish Government states that 'a strategic advocacy plan should be developed based on the information gathered from a needs assessment, scoping exercise and consultations.' The SIAA map of advocacy report, 2015-16 edition, provided information about the overall picture at July 2016. At that point there were five up to date strategic plans, covering NHS Fife, Highland, Lanarkshire, Lothian and Western Isles. The plans for Fife and Highland run until the end of 2017, while the plans for the other three areas ended in 2016. The SIAA report also said that there were no plans in place in four NHS areas, NHS Ayrshire and Arran, Forth Valley, Greater Glasgow and Clyde, and Orkney. In three areas, NHS Borders, Dumfries and Galloway, and Grampian, plans were under review. In two areas, Shetland and Tayside, plans had ended and there was no information about plans being reviewed or updated.

We asked authorities to tell us if they had a current strategic plan covering their area. Eight of the 24 respondents said they had an advocacy plan, and sent us copies of documents, but in three of these responses the documents received were not up to date strategic plans. We received copies of five up to date plans, from Dumfries and Galloway (covering from 2015 to 2018), from Fife (covering 2014 -2017), from Grampian (2016 -2018), Lanarkshire (2016-2020), and from Highland (2014 -2017). We also received a copy of advocacy plans from NHS Greater Glasgow and Clyde, covering from 2011 -2014, and from Lothian, covering from 2012 -2016. South Ayrshire sent us a copy of their Adult Community Mental Health Strategy for 2017 -2022, which has some references to advocacy provision but is a general community mental health strategy. We therefore only received current strategic plans covering five health board areas in Scotland, and these plans cover nine HSCP areas.

Plans in development

NHS Fife and Highland both told us they had current strategic advocacy plans in place, and sent us copies of the plans. In both cases the plans run out in 2017, but both areas confirmed that the plans are in the process of being revised and updated. NHS Highland

also said clearly that a plan covering from 2018-21 is due to go to the board by the end of 2017.

In 12 HSCP areas we were told that there was no strategic plan in place, but that a plan was in the process of being developed. In five of these areas there was a clear timescale for a plan being completed, later in 2017. In two areas the timescale for completion was later, with Renfrewshire HSCP indicating that a plan 'will be developed as part of the review of the HSCP Strategic Plan in 2019.' Responses from three other areas, while indicating that a plan was to be produced, were vague about when a plan would be in place.

In four HSCPs, we were told that there was no plan in place, with no plan to produce one. In three areas, we were told there was a plan in place, but the reference was to a plan which was clearly out of date, with no indication that work was being done to prepare a new plan. Three HSCPs did not submit a response, and taken together this means that in 10 HSCP areas there is no current plan in place, and no information suggesting that a plan will be produced

Advocacy planning by HSCP area, October 2017

HSCPs with a current plan in place	9
HSCPs with no plan, but in process of developing a plan	12
HSCPs with no current plan and no plans to develop one	4
HSCPs with an out of date plan, and no plan to update this	3
No returns	3
Total:	31

Recommendations

- NHS chief executives and HSCP chief officers should ensure that there is clarity about which organisation will be responsible for co-ordinating the preparation of strategic advocacy plans for their area.
- NHS chief executives and HSCP chief officers should ensure that strategic advocacy plans are in place by the end of December 2018.

Involvement in planning

We asked respondents to tell us how advocacy provider organisations and people using advocacy services were consulted and involved in the development of a strategic plan.

Unsurprisingly, we received detailed information from those areas which had a current advocacy plan in place. In Lanarkshire we got responses from NHS Lanarkshire and South Lanarkshire HSCP, and together they described how there were a series of focus groups hosted by advocacy providers, with input from people using advocacy support,

and how draft versions of the plan were shared with the local advocacy network for discussion on several occasions.

In Fife, we heard about a mapping exercise which was undertaken, and about two stakeholder events which involved people using services, and aimed 'to capture the recent experiences of the people who were using the existing services, share examples of good practice, identify what elements of advocacy currently worked well, and identify the future expectations and needs of local service users.'

In Grampian, we were told how providers are core members of the Grampian Independent Advocacy Steering Group, which has the responsibility for producing a three year plan and reviewing this annually. Also, that the views of people using services are fed in to planning processes through independent advocacy providers, and through NHS Grampian consultation processes led by public involvement networks in NHS Grampian, with the final plan reviewed and approved by the NHS Grampian Engagement and Participation Committee.

In Highland, we heard how advocacy providers have recently been involved in a consultation exercise, and have completed a questionnaire to input into the development of a new plan. The questionnaire has included questions about unmet need and key challenges and priorities, and providers have been involving members and service users in completing this. The draft plan will be circulated to services for final comment/amendment prior to the final version going to the NHS Board by the end of the 2017.

In Dumfries and Galloway, we were told that people using advocacy services were consulted on the development of the wider Health and Social Care Plan for Dumfries & Galloway 2016 – 2019, as well as on the advocacy plan. It is not clear how providers were involved in the early stages of preparing a draft plan, but Dumfries and Galloway has told us that 'updated drafts of the refreshed document were shared with providers. This resulted in discussion between commissioners and provider organisations and these helped significantly in shaping the current plan.'

Responses we received from areas where we were told the process of plans being developed were variable. Three responses gave quite specific details about how consultation was being undertaken. Clackmannanshire and Stirling HSCP, which provided a response for the whole of NHS Forth Valley area, described how a series of open consultation events has been held, 'to discuss current advocacy provision in Forth Valley, eligibility criteria, any barriers to advocacy provision and to provide any further feedback on local advocacy services.' People using services could attend the open consultation meetings, but one facilitated service user only event was also held. A questionnaire was also widely circulated, with 123 responses, including 15 from people using advocacy supports. East Ayrshire HSCP told us that advocacy providers have responsibility for co-producing a plan, along with a lead officer, and that specific consultation days, which will involve people using services, were scheduled to take

place shortly after we got their response. Other responses told us how advocacy providers are core members of planning groups, or referred to scoping exercises, consultation sessions, and/or the use of questionnaires.

Four responses provided no information about how provider organisations and people using services were involved in preparing plans. In one of these four areas we were told a plan would be completed by December 2017, but in the other three areas no work is being undertaken at present to prepare a plan. A number of responses had vague information about how engagement would take place –for example saying that this will be built in to the development process, or will be considered, or that there will be consultation, without giving more explicit details of how this will be undertaken. Three responses referred to specific consultation events which had taken place, but these related to the production of a previous strategic plan which was out of date, and not to the production of a current plan.

Action plans and reference to mental health/learning disability services in other plans

In the questionnaire we sent out, we asked if there was an action plan for the development of mental health and learning disability services, and for information about actions in relation to these services which may be in other plans. We asked these questions for specific reasons. We thought that if there was a strategic advocacy plan in place, there may be a separate action plan which set out action to be taken to implement a strategy. We had also been told, when we had consultation meetings with planners and commissioners that the planning landscape is complex, and that reference may be made to developing advocacy services in a number of local plans, and not simply in one single strategic advocacy plan.

We received 25 responses to the question about whether there was an action plan in place, and only five of the responses said there was. A few responses did acknowledge the difference between a strategic plan, which is to achieve longer term goals, and an action plan, which we would expect to focus on shorter term actions and goals. The response from Clackmannanshire recognised this, saying ‘the action plan is in draft format and will be finalised on the completion of the Strategic Advocacy Plan.’ In many cases though, where more information was provided about an action plan, this was seen very much as part of the process of producing a strategic plan.

With regard to plans for the development of advocacy services which may be in other local plans, one response, from Renfrewshire HSCP, did say that the strategic plan for advocacy service provision will be included as part of the review and development of a wider HSCP strategic plan in 2019. One response, from South Ayrshire HSCP, indicated that there was no plan to develop a strategic advocacy plan, but that details about advocacy provision and planning will be included in individual care group plans, such as the mental health and the learning disability strategies.

Several other responses did indicate that there will be references to advocacy service provision in care group specific strategic and commissioning plans, including mental health and learning disability plans. Where this was stated though, the response generally said that the information would also be in a general strategic advocacy plan, and that an advocacy plan was in place or being developed. The response for example from Clackmannanshire and Stirling HSCP was very clear – it said that actions from the Strategic Advocacy Plan, currently being finalised, ‘will be consistent with the local delivery plans of both HSCPs and the NHS Forth Valley healthcare strategy.’ Other responses simply clarified that information about mental health and learning disability advocacy provision is or will be included in the general strategic advocacy plan for an area. Five responses provided no answer to this question.

The information we received indicated therefore that where strategic plans are in place, or are in the process of being developed, the general plan will contain the information about mental health/learning disability advocacy services, although this information may also be incorporated into care group specific plans.

Actual services commissioned

We asked responders to complete an attachment giving us information about the actual independent advocacy services commissioned in their area, to provide support for people with mental health problems/learning disabilities. We also asked for information about whether services were generic or supported specific groups or age ranges of people, and what type of advocacy support they provided.

On top of the two areas which did not respond to the survey four respondents did not provide information about the services commissioned in their area. The responses with the missing information were from Edinburgh, Midlothian, South Ayrshire and Angus. Although, Angus did send us a link to the SIAA Advocacy Map for 2015/16, which has details of the one independent advocacy service commissioned in the Angus HSCP in that year, which we know is still operating.

The information we have received indicates that generic individual advocacy services are available to adults with mental health problems/learning disability in all the areas which provided details. In the six HSCP areas which did not provide current information, the SIAA Advocacy Map 2015/16 says that individual advocacy services were also available in that year.

From the returns sent to the Commission there was information about 54 commissioned independent advocacy services. We asked responders to provide us with some further information about these services –about whether the services were to support specific groups, about the age range of people supported, and about the type of advocacy, provided.

The information we got about whether services were generic or targeted at supporting specific groups of people is difficult to summarise. Some responses said an individual

service was a generic service for all age groups, or a generic service for people either up to or over 65. While some responses would say a particular service was not generic, tick boxes to suggest that the service targeted every group were selected, and therefore could be seen as a generic one. The information does indicate, as mentioned above, that individual advocacy services are available in all areas for people with mental health problems, with learning disability, and with dementia. The information also says that:

14 services are generic services, covering all groups of people

18 services support people with a mental health problem

20 services support people with learning disability

14 support people with dementia

15 support people with autistic spectrum disorder

10 support mentally disordered offenders

15 support people who are homeless and have a mental disorder

10 support asylum seekers with a mental disorder

22 support people with other conditions

It is difficult to draw firm conclusions from this information. If a service is seen by commissioners as a generic service, then it could be assumed that the service will support any of the specific groups we asked about, even if this is not explicitly stated in a response. We would certainly hope for examples that a service which is a generic service does not exclude people who are homeless, or asylum seekers, who also have mental health problems, learning disability, or dementia. However, as this is the first time the Commission has tried to gather information about advocacy services, in line with our new duty, we can look at how we collect information, and the questions we ask, when we repeat this exercise in the future. Where responses indicated that the advocacy service supported people with other conditions, and identified conditions, these included frail older people, people with a brain injury, people with physical disabilities, or people with substance misuse problems.

We also asked respondents to tell us the age range the services commissioned will support. Four services were said to be providing support to all ages, which we would take to include children and young people. Some services support adults of any age, while 35 services support adults up to 65, and 27 support adults over 65. Twelve services were said to provide support to young people under 18, but in most cases this support is explicitly for young people, who are looked after and accommodated, for young people from 16 -18, or in one case for young people of any age who are subject to compulsory measures under the 2003 Act.

We asked what type of advocacy support is provided by individual services. The 2003 Act does not specify what type of independent advocacy services should be available in

health board and local authority areas, and simply says that people should have a right of access to independent advocacy. There are a number of different types of advocacy, and the Scottish Government guidance for commissioners listed three forms of advocacy support – individual advocacy, collective advocacy, and non-instructed advocacy. We asked responders to tell us what type of advocacy provision was offered by the individual services they commissioned. They reported that:

44 services provided individual advocacy support

24 provided collective advocacy

13 provided citizen advocacy

35 provided non-instructed advocacy support

Some independent advocacy services will provide all the above types of support, while some services are commissioned to provide one form of support. A service may also be commissioned to provide one type of advocacy support to one specific group. As an example, we were told that People First Scotland provides collective advocacy support for people with learning disability in South Lanarkshire.

Non-instructed advocacy

The Commission recently reviewed and updated our good practice guidance, *Working with independent advocates* (September 2017), in which we said that when a person lacks the capacity to direct their advocate, the advocate can still have an important role to play, and indeed that people who lack capacity may be more in danger of having their views ignored. We are pleased to see that in 23 out of the 25 HSCP areas who provided information, non-instructed advocacy is available. West Lothian has no non-instructed advocacy provision, and no information was provided by the Western Isles, while in North Lanarkshire we were told that non-instructed advocacy is available for adults up to 65, but not older adults.

Prioritisation and rationing

In relation to services commissioned we asked if independent advocacy services are required to apply a limit to the amount of advocacy support any one person can receive, and if they have to prioritise referrals for advocacy support. We were pleased to hear that there was only one area, the Western Isles, where the service is expected to apply a limit to the amount of provision, as we feel that advocacy support should continue to be provided as long as someone needs this support to express their views.

The information we received about prioritising referrals indicates that there is a variable approach to this issue across the country. Eight responses (32%) said that services were not required to prioritise referrals, while 17 responses (68%) specified that certain referrals should be prioritised. Three of these 17 responses (from Dundee, Perth and Kinross, and the Western Isles) gave no further information about how services were expected to prioritise referrals, while three responses (Renfrewshire, Scottish Borders

and NHS Lanarkshire) simply said that details about prioritisation were included in service specifications or contracts. All the other responses said services would be expected to prioritise referrals for advocacy support for people subject to compulsory measures. The main priority mentioned was people subject to measures under mental health legislation, although several responses also mentioned cases where there are interventions under the Adults with Incapacity (Scotland) Act 2000 or the Adult Support and Protection (Scotland) Act 2007. In a few responses, prioritisation criteria are also more extensive. For example in Edinburgh, criteria includes any adult potentially at risk of harm, and children and young people accessing mental health services. While in East Ayrshire priority is given to statutory work but also to cases which meet criteria on the basis of need risk or urgency. Two responses also said that priority is given to referrals for anyone with a mental disorder as defined in legislation, which is a very broad criterion. Angus and North Ayrshire told us that a very clear timescale is set for advocacy to respond to a referral where someone is detained, which is within three working days.

We also asked separately if commissioners were aware of services prioritising support to people subject to compulsory measures. 18 of the 23 respondents who answered this question said they were. Only two mentioned any concern as to the potential impact of this on other clients. NHS Lanarkshire said it was discussed at monitoring and East Lothian HSCP said that, 'Risk of loss of liberty and time scales which need to be adhered to result in those clients subject to compulsory measures having to be prioritised. This has not resulted in a waiting list having to be created.'

Four told us providers were not prioritising people subject to compulsory measures. Glasgow City said 'whilst we do not prioritise there is a needs based criteria system in place'. Fife told us that advocacy services for older people had previously been contracted only for older people with dementia, or subject to compulsory measures under the Mental Health (Care and Treatment) (Scotland) Act 2003. However, that the new contract now included any older person meeting the eligibility criteria, as for [younger] adults. Shetland said that numbers were so low that prioritisation had not been required.

The increasing demand generally for health and social care services means that in many areas services are prioritised on the basis of need. We can understand that commissioners will want to make sure that peoples' views are heard when statutory interventions are being considered. The 2003 Act though makes it clear that anyone with a mental disorder should have the right to access advocacy support. While priority is given in many areas to providing support to people who are subject to the 2003 Act, people who are not subject to compulsion may be equally vulnerable, and may be experiencing significant problems having their views heard, or accessing appropriate supports. We would hope that even when priority is given to providing advocacy support to people who are subject to compulsory measures, services also have capacity to provide support to people who are accessing services on a voluntary basis, or indeed

are having difficulty accessing services at all. We would expect all advocacy planners to require information from providers about waiting lists, and effectively monitor unmet need and any impact on other clients where people subject to compulsory treatment are being prioritised.

Budgets

As well as asking for information about services commissioned, we asked if the commissioning budget had changed over the past two years. 18 responses (72%) said there had been no change. Since the SIAA advocacy map gathered information in 2015/16, this would indicate that in these areas the actual funding is as set out in the map. Seven responses (25%) said that the budget had changed, and in three of these areas (Orkney, Dundee, and North Ayrshire) we were told the budget had increased. This was because there had been a straightforward percentage increase in Orkney, while in North Ayrshire there was an increase in the level of identified need. In Dundee, there was investment in a specific service for young people. South Ayrshire did not specify how their budget had changed, but in the other three areas (Glasgow, Perth and Kinross and South Lanarkshire) there are reported reductions, to achieve efficiency savings, or in line with reduced costs because of new arrangements for service provision, and in Perth because one specific service is no longer funded.

Provision for marginalised groups

We asked if dedicated services were commissioned in each area for people who are in prison, for people who are homeless, and for asylum seekers and have mental health issues, learning disability or dementia. Eleven of the 25 HSCP areas said they had a prison in their area. Where there is a prison there was only one area (Perth and Kinross) where advocacy support is not provided. We were told that plans are almost finalised there to commission a service. Of the other 10 areas, a dedicated service is in place in prisons in Edinburgh, West Lothian and East Ayrshire, while in Forth Valley, which has three national prison units, there is a limited ring fenced budget, presumably added to the budget of the generic service, for advocacy support in the prisons. In the other areas with prisons advocacy support for prisoners, it will be provided by the generic advocacy service for the area.

With regard to people who are homeless there is no service commissioned in any area specifically for this group of people. North Ayrshire told us that they do have a housing advocacy project, which is not specifically for people with mental health problems/learning disability or dementia, but is for any person needing advocacy support in relation to housing or complex debt issues. Other areas said that generic advocacy services in their areas are expected to support people who are homeless. Two areas told us that people would be referred to specialist services, such as the national Shelter advocacy service (with NHS Lanarkshire saying that they provide a small amount of funding to Shelter).

With asylum seekers again there is no service specifically commissioned for this group of people in any area in Scotland. Where respondents provided further clarification in response to this question, they said that current generic services are available to anyone with a mental health problem, including asylum seekers. Although we did not ask for information about communication needs, two responses also clarified that interpretation services or support to meet specific communication needs would also be available.

Out of area placements

In relation to current services commissioned, we asked how patients placed in private healthcare facilities outwith their home health board area can access advocacy support. Twelve responders said that they didn't know, or didn't answer this question. Only two responses, from Orkney and Angus, said they would expect their home advocacy service to provide support. We would imagine this could have a significant impact on advocacy services in Orkney if they are expected to provide support to someone who is a patient in a hospital a considerable distance away on the mainland. The other 11 responses said they would expect a local service, in the area the person was placed, to provide advocacy support. The response for the West Lothian area said that they did explicitly provide advocacy support to an independent hospital in their area, which can have patients from across Scotland, and indeed from other countries in the UK. Two areas, Shetland and East Ayrshire, said they would make decisions on a case by case basis. Shetland said they would commission a specific service from the local area as needed, and East Ayrshire will make decisions based on the proposed length of stay outwith their home area. Several other responses, which indicated they would expect a local service in the area where a patient had been admitted outside their own health board to provide support, said that this is what would happen in their area, i.e. that their local services would support any patient in a healthcare facility or in any care facility who happens to have been placed there from their own home area.

From the number of don't know responses to this question, there does seem to be a lack of clarity about who will provide advocacy support when people are receiving care and treatment in independent hospitals outwith their home health board area. This suggests that service specifications for advocacy services should be clear about how support will be provided to people who may be placed in a facility outwith their home area, particularly an independent hospital.

Carers

We asked if current services commissioned included services for carers of people with mental health issues, learning disability, or dementia. Eight responses provided no information. From the 17 responses received nine said that carers are able to access the generic service in their local area, with several replies saying this is explicitly stated in the service contract. Three responses said that there was a dedicated service for carers. In Highland this is a separate carers' advocacy service, while in two other areas

there is a designated worker in a generic service. Four responses said that support will be provided by the local carers' centre, with Renfrewshire telling us that their carers centre is explicitly funded to provide advocacy support. The response from South Ayrshire said that a separate HSCP wide carer's strategy was in the process of being developed.

Monitoring and reviewing services

Outcomes and monitoring

We asked about the outcomes advocacy planners are seeking to achieve and how they monitor these. We expected to hear about the strategic outcomes advocacy planners set for the provision of an advocacy service, against which success will be measured.

Ten respondents provided overarching outcomes for advocacy in their areas. Some of these also referred to specific outcomes set with providers. For example, North Ayrshire HSCP told us about their current set of outcomes and about the outcomes within the current recommissioning of advocacy services, which are:

- People have a greater awareness, and understanding, of advocacy
- People are more involved in decision making processes that affect their lives
- People are more able to advocate for themselves
- People are more aware of, and able to access, their rights and entitlements
- People who use the service are involved in shaping the service and central to the development of a Quality Assurance Framework which is used to obtain stakeholder experiences of advocacy
- People from all backgrounds and circumstances are able to access advocacy

Six of the areas had similar sets of overarching outcomes about access to independent advocacy, the voices of those using advocacy being heard, and service users' involvement in service improvement. East Ayrshire included as an outcome, 'Service users who engage in partnership with independent advocacy will have progressed to their identified goals'. Angus' were 'Increased participation; Increased confidence; Better access to services; Wider networks'. East Lothian's were 'To enable statutory duties to be met Improve participation Increase/improve choice, self-determination, independence and control ensure project is accountable to all stakeholders'.

Clackmannanshire and Stirling, for the Forth Valley area, provided a detailed outcomes framework which linked outcomes of the service user to local outcomes, such as 'Self-

management of health and wellbeing', and national outcomes such as 'Healthier living' and 'reduce inequalities'. They plan to develop performance measures on advocacy against the outcomes outlined in the contract.

Three areas noted a single high level outcome, to provide independent advocacy services.

NHS Lanarkshire provided their strategic advocacy plan, which says that the advocacy planning group will undertake further work in partnership with service providers and service users to agree board-wide outcomes and develop outcome-focussed reporting.

Fife HSCP said their outcomes are the nine health and social care outcomes.

In some areas the outcomes given were explicitly at provider level. In some cases it was not clear whether the outcomes were overarching or for providers.

Not all these respondents said how they monitor outcomes, but for those that did, monitoring was through provider monitoring reports and monitoring visits. Both Dundee and Edinburgh said they request anonymised case studies to assess whether individual outcomes are achieved.

Some areas made use of external frameworks, including Glasgow City, who said 'The provider is asked to show how they will provide advocacy in line with the Principles and Standards set by the SIAA'. South Lanarkshire and East Renfrewshire said providers follow Talking Points outcomes, a framework of outcomes important to individuals.⁴

Shetland HSCP gave no strategic outcomes or outcomes for providers but said that outcomes are decided on an individual level, and that they measure 'successful cases' as described by the service provider.

Monitoring quality

We asked about the arrangements in place for monitoring the quality of independent advocacy services, including independent evaluation. We consider that effective monitoring should include monitoring against clear agreed outcomes, rather than solely hours and types of advocacy provided. It should also include analysis of the nature of referrals, waiting times and unmet need.

Most respondents described one or more regular mechanisms to monitor providers, including monitoring forms or returns (5), monitoring reports (9), monitoring meetings (8), monitoring visits (4) and annual reports (5), annual reviews (2) and annual monitoring (1).

Midlothian and Renfrewshire and one of the three Grampian providers quoted in NHS Grampian's response told us that monitoring was in line with their contract monitoring

⁴ <http://www.jitscotland.org.uk/wp-content/uploads/2014/01/Talking-Points-Practical-Guide-21-June-2012.pdf>

arrangements. For example, Midlothian said, 'The services are monitored and evaluated in accordance with the Service Specification, the Council's Monitoring and Review procedures and where relevant National Care Standards. Specific service requirements are set out in each individual service level agreement (SLA) covering outcomes, targets, criteria, availability, quality assurance and standards. We liaise with the Provider to apply appropriate contract monitoring methods to assess the quality of the service delivered.'

Two areas mentioned scrutiny. Dumfries and Galloway outlined a system of scrutiny by the planning and commissioning team in line with their Quality Assurance Contract Monitoring Framework and East Ayrshire said the quarterly outcome returns are signed off by the Head of Service and scrutinised by elected members at the grants committee.

Measuring the satisfaction of people using advocacy services

We sometimes hear from people we speak to that they are not happy about the quality of advocacy they have experienced. Measuring their satisfaction is an important part of measuring the quality of a service, and we asked about this.

Eight respondents said that they require providers to survey clients at the end of their advocacy input. Nine were less specific but said that satisfaction is measured by providers as part of their contract. As well as collecting end of service comments, Edinburgh required providers to survey clients annually, and East Ayrshire HSCP said that providers conduct a survey of referring partners and service users every two years. Shetland and West Lothian HSCPs also reported customer satisfaction surveys. Two areas told us how this information feeds in at a strategic level. East Ayrshire's consultation and engagement with service users forms part of strategy developments, and Fife said that there is service user representation on the Advocacy Strategy Implementation Group.

NHS Lanarkshire told us that in addition to client surveys they use more formal focussed group based reviews which form part of the service reviews. Other feedback mechanisms mentioned included pre- and post-intervention questionnaires to measure specific strategic outcomes, telephone interviews, outcome and evaluation tools, face-to-face feedback and the Patient Opinion online feedback service.

North Ayrshire told us, 'The current advocacy provider utilised the Scottish Recovery Indicator (SRI2) in 2016 to gather feedback about their service. This has enabled them to measure areas of their service based on feedback from people who use advocacy and develop an action plan for improvement as a result. They also record satisfaction within case diary notes for each individual using the service. If dissatisfaction is indicated, this would be handled as an informal complaint and information provided accordingly.'

Dundee HSCP said that they are currently exploring a mechanism with providers. East Lothian said they had no arrangements to measure satisfaction, and Orkney, and Perth and Kinross did not provide information.

Independent evaluation

There has been very little independent evaluation of advocacy services. The SIAA carried out an advocacy quality assurance pilot project⁵ in 2015 in which six advocacy providers were evaluated independently based on SIAA's Independent Advocacy: An Evaluation Framework⁶ and Principles and Standards for Independent Advocacy.

The pilot evaluations looked at:

- the advocacy relationship and impact
- recruitment, training and support of advocates and other staff (paid and unpaid)
- managing the organisation
- external relationships, independence and conflicts of interest, and
- funding and commissioning.

Only Glasgow City HSCP and one of the providers in NHS Grampian (Advocacy Service Aberdeen) made reference to this pilot. Most respondents had neither had independent evaluation of providers carried out, nor made provision for this in the future.

Glasgow City HSCP said that further independent evaluation will be agreed with the current provider. North Ayrshire told us they have made provision for independent evaluation in year two of a recommissioned contract. Clackmannanshire and Stirling HSCP, on behalf of the NHS Forth valley area, said they include in the provider contract that the service can be open to independent evaluation from the SIAA or any other relevant party.

Information from providers about the number of cases of people accessing advocacy support

All respondents said they get information from each organisation about the number of cases of people accessing advocacy support. However, not all respondents provided figures, and the information provided was for a range of different periods and therefore not comparable.

Unmet need

Through our advice line and visiting work, the Commission is aware that individuals are sometimes unable to access advocacy when they need it, and of the difficulties this can cause for people.

Eighteen of the 22 who responded to this question said they ask services to provide information about unmet need, for example about waiting lists. We asked for up-to-date information about this, but only eight areas provided further comment. Five of them had no current concerns about waiting lists. East Renfrewshire, Shetland, East Lothian and

⁵

http://www.scottishhealthcouncil.org/publications/evaluation_reports/siaa_quality_assurance_pilot.aspx#.WfCWjmb6uxA

⁶ <http://www.siaa.org.uk/resources/publications-list/evaluation-framework/>

Highland said there is at present no-one on a waiting list for adult advocacy. West Lothian said all their providers aim to operate without a waiting list and any unmet need is discussed at annual contract monitoring reviews, but did not detail whether providers succeeded in this aim.

Only three respondents provided numbers on waiting lists. North Ayrshire provided the number waiting at the start of each month during 2016-17, which fluctuated between six and 18. Glasgow City reported a managed waiting list of approximately 168 people. Grampian provided mixed information from its three providers: one has a 'zero waiting list policy', one had 41 people waiting at the end of March 2017 and one did not provide details.

Fife HSCP told us that grant funded voluntary sector providers do not have requirements under their service level agreements to report on unmet need, but they are developing monitoring. However, they also commission via a contract and unmet need is reported on and discussed.

Complaints monitoring

We would expect contracts and SLAs to set out requirements for providers to report complaints and outcomes as part of regular monitoring reports and meetings, with immediate notification of a serious complaint.

Six of the 25 who responded to this question said they receive annual monitoring data from providers, and a further 12 more frequently, as part of regular monitoring reports and/or meetings.

Edinburgh said they have a system of immediate notification within a week of receipt of all complaints, and West Lothian expects immediate notification by the provider of all formal complaints. North Ayrshire and Borders monitor quarterly but also expect immediate notification of any serious complaint.

East Lothian told us that complaints about advocacy services are dealt with under Council complaints procedures, which is their policy for all third sector providers.

South Lanarkshire told us that complaints would be monitored through their normal complaints procedures. But, that providers also manage their own complaints and advise us any issues at monitoring and liaison meetings.

NHS Orkney said they have no specific process for advocacy, but that as the numbers are very small, they would investigate every complaint for learning, and complaints are reported as part of the reporting framework.

Developing awareness of advocacy rights and provision

We asked about how each area raises awareness and delivers public information about the availability of mental health/learning disability advocacy services. We would expect that in addition to requiring provider organisations to promote their services, advocacy planners would have a strategic approach to ensuring that people who might benefit from advocacy are aware of it, understand what it is, and are able to access it.

Fifteen respondents described their own approach to raising awareness at a strategic level, in most cases as well as advocacy services' own promotional work. Examples of strategic-level promotion included:

- Edinburgh, Shetland and West Dunbartonshire and Orkney mentioned social work and NHS staff promoting advocacy when working with people
- NHS-Board-wide leaflets in Lothian, Tayside and Ayrshire which provide details of local providers
- Several areas said that they include information about advocacy in other leaflets produced by the HSCP, such as leaflets about Adult Support and Protection, or on HSCP, NHS and council websites
- East Ayrshire include information about advocacy in guidance and audit materials for staff
- Glasgow City said medical records issue information via all appointment letters
- Shetland uses newspaper adverts
- Edinburgh and East Lothian make information available on the staff intranet
- In East Lothian advocacy workers attend social work and health staff team meetings to raise awareness
- Edinburgh said there is promotion of advocacy by funded collective advocacy groups
- Highland told us about a staff survey in preparation for the next advocacy plan, followed by information on how staff could find out about local services
- Fife said that the Advocacy Forum is the lead for general awareness raising
- East Lothian mentioned advocacy being represented in strategic planning

Not all of these approaches were taken in every area; most respondents mentioned only two or three at most.

Seven respondents mentioned only provider organisations' responsibility for promoting their own services.

Responses varied in the level of detail, with some simply saying that awareness-raising formed part of the contract or SLA with provider organisations, and others providing more detailed information. Other than the standard materials such as leaflets and posters, distributed electronically and/or on paper, methods mentioned included:

- Presentations to NHS, HSCP, social work services and third sector organisations
- Presentations to service user and carer groups
- Events such as holding a public event for potential referrers and information event in a hospital
- Community engagement, such as attending community events; talks to care home residents
- Information stalls at community and/or professional events and conferences
- Location of an advocacy service in accessible shop-front location in town centre
- Providing information about advocacy and their service provision within training courses for health and social care staff (such as Adult Support and Protection training)
- Providing materials to lecturers for a health & social care degree course including advocacy in their course material and resources
- Networking and local contacts
- Press articles

Nineteen (79%) of the 24 who responded said there had been specific actions to promote the use of advocacy among health and social care staff, but five (21%) said there had not been. We would expect advocacy planners to consider the need for raising staff awareness, and to put in place approaches such as staff training, information on paper and online, and prompts in relevant forms and electronic processes to ensure advocacy is mentioned during assessment and at other key points.

Equality

We asked how planners ensure that services are available to equality groups, and how they measure this. We would expect that planners would carry out equality impact assessments, ensure that equalities data is monitored and reported by providers, and work with providers to ensure that there is a strategy for reaching under-represented and hard-to-reach groups.

We were disappointed that only 10 (42%) of the 24 respondents who answered the question had carried out an equality impact assessment.

Sixteen respondents told us providers monitor equality data about service users and report this. One of these areas was NHS Grampian, which provided separate

information from its three providers: one reported the use of interpreters in hospital, and recorded clients' ethnicity but not sexual orientation. Neither of the other two said they monitored equality data.

Seven respondents told us that their advocacy services were open to everyone, but provided no information on how they ensured awareness among, and accessibility to groups such as ethnic minority or LGBT people. Only four of these seven said that equality monitoring information was collected. We consider that it is not adequate to assume that saying a service is open to all will make this the case.

Only eight respondents provided any specific information about actions to address equalities issues, and in most cases this was that they discuss any data with providers to address any barriers.

North Ayrshire said the provider use voluntary equality monitoring forms and use census and other local demographic information to compare with this, and gave a specific example of an area where equality monitoring has highlighted an issue. 'This enables them to identify any groups who are overrepresented as well as any groups that are not accessing the service and take steps to address this. For example, the service is aware that the number of people who are transgender who utilise the service is greater than would be anticipated from the amount of people identifying as transgender living in the local community. This highlights the level of need for advocacy within that specific group.'

East Ayrshire HSCP said that their independent advocacy services operate an open referral system, and that removal of barriers to referral is the means by which advocacy services are made available to all members of a community, including equality groups. 'Independent advocacy services are linked in with the Council's Equalities Officer and attend various community based groups attended/ organised by people in equalities groups. An Equalities Impact Assessment is being completed as part of the development of the new Plan.'

Four other areas mentioned ways of reaching out to some equalities groups, including interpreter services and working with partner agencies to raise awareness of advocacy services. Angus HSCP said that a citizen advocacy program provides outreach to hard to reach groups.

East Lothian, Dundee and West Dunbartonshire recognised equalities as an area for development. East Lothian HSCP noted that, 'Identified support is available to equality groups through other services provision, and it is recognised that they would take on an advocacy role, but this would not be independent advocacy.'

We did not ask specifically which equality groups advocacy planners consider, although we would expect planners to consider all the protected characteristics.⁷ Our question

⁷ The protected characteristics are age, disability, gender, gender reassignment, pregnancy and maternity, race, religion or belief and sexual orientation.

made reference to LGBT people and ethnic minority groups as examples. Most respondents did not list equalities groups, but it was notable that in the two who did, explicit reference was made to a range of equalities groups but not to LGBT people.

Future planning

The Commission's new duty to gather information about advocacy service provision covers how services have been provided, and also how local authorities and health boards intend to fulfil their duties over a period of at least two years in the future. We therefore asked responders to tell us about their future planning, about how they were assessing gaps in service provision and unmet need in their areas, and about any plans they had to promote awareness of the availability of advocacy services locally.

We asked first of all whether there was an advocacy planning group in each area, and for further information about plans in the process of being developed. One response, from Perth and Kinross, had no information, and eight responses said there was no current planning group, while 16 responses confirmed there was a current planning group. Of the eight responses which said there was no current local planning group four said a plan was still in the process of being developed, which does raise questions about how planning is being taken forward in these areas. Two responses were from areas where a current plan has actually been developed, which may suggest that there is simply no ongoing planning at present. In the other two areas, Angus and East Renfrewshire, there is no planning group and no plans to produce a plan.

Sixteen responses said there was a local planning group in place. These areas included Fife, Lanarkshire, and Grampian, where up to date strategic plans are in place. The situation in the NHS Lothian area, as we have said above when discussing current plans, is confusing. Midlothian HSCP has told us that they have a local planning group, and that responsibility for planning is moving from an NHS wide group to the HSCPs.

East Lothian HSCP though said they have representation on a Lothian wide advocacy steering group, and that 'dialogue is underway as to consider local and Lothian agendas, and how they can complement each other.' This suggests that all HSCPs in Lothian may not be assuming responsibility for the planning of advocacy services on a local basis. In Tayside, we were told that there had previously been an NHS wide group with responsibility for advocacy services, but that this has not met for over a year.

Angus HSCP acknowledged in their response that nothing has been put in place locally in their area. They have no planning group and no plans to develop a strategy. Perth and Kinross provided no information. Dundee did tell us they had a planning group and that advocacy commissioning intentions will be outlined in the wider HSCP strategic plan, but that commissioning intentions have not been agreed yet.

We asked about how the projected need for mental health/learning disability services were being assessed. There was no information from Perth and Kinross, and four other areas said they were not currently assessing projected need. One of these responses

was from Fife, which is just completing the process of revising their current plan. East Lothian told us this will be addressed in a local review of services, and Renfrewshire and the Scottish Borders had no specific plans. The other 20 responses said that projected needs were being assessed. Four responses gave no details about how this was being tackled, but 16 responses gave some description of what was being done locally. North Ayrshire for example said a recent scoping exercise included details of projected need, various responses referred to using demographic data and information from current providers, and East Ayrshire said they use existing HSCP data and information from locality profiling. Current advocacy providers seem to be involved in the process of assessing projected need in a number of areas, by providing information from their services, and being involved with commissioners in Dundee in a local audit.

We asked if areas had information about current identified gaps in provision for future planning purposes. Five responses said that this information was not currently being collated, one response missed this question, and two responses said that information was collected, but gave no details about this. Seventeen responses said information was collected and gave some additional information. A number of the responses referred to the previous question, and the information provided about unmet need. In areas where there is a current strategic plan, several references were made to gathering information during consultations about the plan. In several areas information from providers is part of the process, either gathered from contract monitoring processes, or as Midlothian told us, gathered from the annual reports of advocacy provider organisations. Several areas also gave us examples of specific gaps in provision which had been identified. These included the provision of support to children and young people who are not looked after, to carers, to the LGBT community, and to people who also have addiction problems.

We asked responders to tell us about specific actions planned to promote awareness of local services over the next two years. Ten responses acknowledged that they had no plans in place to promote awareness. Fifteen responses said that they did have some plans, and 13 of these gave us some examples of their plans. In a number of areas providers will be expected to promote the services available, but several areas described having stakeholder events to promote advocacy. South Lanarkshire told us they have an advocacy pathway which is to be circulated. A few responses spoke about disseminating information through the HSCP and wider health workforce. Edinburgh described a number of actions, including issuing guidance to staff in the HSCP partnership and leaflets to the public, and awareness raising through Advocating for Advocacy Week, a week-long series of events.

Recommendations

- NHS chief executives and HSCP chief officers should ensure that strategic plans are developed based on a local needs assessment, and information about unmet need and gaps in local provision. They should be developed in partnership with people who use or may use services, and with service providers. Barriers people

may be experiencing accessing advocacy support, including barriers created by prioritisation criteria and people being placed outwith their home areas, should be addressed in plans.

- NHS chief executives and HSCP chief officers should ensure that advocacy planners carry out equalities impact assessments and develop approaches to monitoring and enabling access to advocacy which cover all the protected characteristics.

Advocacy provision for children and young people

Responses received

We sent requests for information to all 32 chief social work officers in Scotland. We received 24 complete responses, and three responses which either just had a contact name, or very minimal information.

Of the five local authorities which did not complete the questionnaire two did send us information about services commissioned (Dumfries and Galloway and South Ayrshire). We had received information about advocacy services which children and young people could access in the adult services response from another two authorities (Perth and Kinross and Western Isles). Looking at the combined information from the adult and young people returns, we therefore have no information from only one local authority area, East Lothian.

Current planning and service provision

Planning

We asked local authorities to tell us if their current integrated children’s services plan covered the provision of independent advocacy services, and to give us more details. We got 25 responses to this question.

References to the provision of independent advocacy in children’s services plan

Yes, including young people with “mental disorder”	9 (36%)
Yes, but not including young people with “mental disorder”	3 (12%)
No	3 (12%)
Other	10 (40%)

Total 25

We did not ask for copies of children’s services plans, but nine authorities said very clearly that their plan did cover the provision of advocacy support for children and young people, including people with mental illness or learning disability and related conditions. Three other authorities said their plan did not mention this group, and that this was because the strategic plan for advocacy services covered this issue. However, in each

of these areas (East Dunbartonshire, East Renfrewshire, and Midlothian) other information we received indicates there is no current strategic advocacy plan in place. Three authorities said very clearly there was no reference to advocacy in their plan, although one of these responses added that there was a clear commitment to ensuring the 'meaningful participation and engagement of children and young people.'

Ten responses did not say yes or no, but gave us further information. Several responses said that while there is no specific mention of independent advocacy in their plan, there is a commitment to 'giving children a voice in matters that affect them', or to the Getting it right for every child (GIRFEC) principles. GIRFEC is the national approach in Scotland to improving outcomes and supporting the wellbeing of children and young people. Other responses referred to advocacy service being commissioned for children who are looked after, or are on the child protection register.

Current service provision for children and young people

Of the 27 responses we received, three were incomplete and had no information about current services provided, while two responses did not provide details of actual services commissioned. Of the five authorities which did not respond to the questionnaire, two did send the attachment we had asked them to complete, giving details of actual services available for young people (Dumfries and Galloway and South Ayrshire). We therefore had information about services in 24 areas, and two of the group which had not provided any response at all, had also given us details of provision which was available for young people in their adult service response.

Comparing the information in the adult and young person responses there were some duplications. For example, Aberdeen and Orkney had both told us in their adult response that their generic independent advocacy service supports adults, but will also support young people. This was confirmed in the separate young person service response from each area. The responses we received though did tell us about a range of advocacy support services provided across Scotland and targeted specifically to meet the needs of children and young people.

While we did get a picture from local areas that a variety of advocacy services are in place the information also suggests that there are issues with the provision of independent advocacy for children and young people. Several authorities described services which are not independent advocacy services. For example a children's rights officer employed by the authority, or services which are not commissioned to provide advocacy but will mediate or promote the child's view.

Many responses also listed services which are explicitly targeted at certain groups of children or young people. Who Cares Scotland, as an example, is commissioned to provide support in 22 of the 24 areas we received information from, but almost all the responses clearly said their support is for looked-after children and young people. This group will certainly include young people with mental illness or learning disability, but the eligibility criteria will exclude young people who are not looked-after. Other

advocacy services for young people also had well defined eligibility criteria, which could include being available for young people on the child protection register or who had experienced abuse, or had additional support needs or had experienced trauma.

There were very few areas where a generic young person's advocacy service can be accessed by any child or young person, which would clearly include any young person who should be entitled to access advocacy support under the 2003 Act.

We have looked at the information about specific advocacy services for young people and at the details we got from our adult returns, which told us that in some areas, generic advocacy support services will support adults and also young people. This does raise an issue about whether a generic adult service which will also support young people should have a dedicated worker, if it is felt that specific skills and knowledge are needed to communicate with and support a young person. A more significant issue though is that in many areas where there are specialist advocacy services for young people, or where a generic service will support adults and young people, there are gaps in service provision. The information we have tells us that often generic services are commissioned to provide support to young people over 16, or who are subject to compulsory measures under the 2003 Act, and that many services exclusively for young people have very precise eligibility criteria and can only support certain groups, such as looked-after children.

Budgets

At the same time as we asked about actual services provided for children and young people, we also asked if the budget for these services has changed over the past two years. Twenty-two responses answered this question, and 14 (64%) of the responses said there had been no change. Only three responses told us that the commissioning budget had increased. In two cases this is because there has been a small (1%) uplift, and in one case a new service had been commissioned. From the number of responses missing or saying there has been no change, it is probably reasonable to assume that advocacy services are having to manage the same budget constraints that local authorities are dealing with more generally, and that in most areas funding will have been stand-still, or budget increases have been very small.

Out of area placements

With regard to existing services we asked local authorities how any child or young person placed outwith their local area would receive advocacy support. Of the 22 responses received 14 (64%) said this would be provided by a service from their home area. The other eight said that support would be provided by a local service, wherever they were placed. While the number of young people in this situation may be small, it would be very likely that a young person placed in secure residential care, or in one of the three units providing in-patient care and treatment for young people, would be placed outwith their home area.

Local authorities which said a home area service would provide advocacy support included Orkney, Shetland, and Highland Council, and there would be very practical problems if the advocacy service from Orkney, for example, had to provide support to a young person in the in-patient unit in Dundee. The obverse of this is that authorities which said a local service, wherever a young person is placed, would provide support, would be dependent on a local service agreeing to support a young person who is in a placement out of their home area. Many services may be willing to do this, but this highlights that the needs of young people for advocacy support, when in a placement outwith their home local authority area, should be addressed both on an individual case-by-case basis, and in planning and commissioning services.

Recommendation

- HSCP chief officers and local authority chief executives should ensure there is clarity about where the responsibility lies for planning and commissioning independent advocacy services which are accessible for all children and young people under 18 with a mental disorder. This includes children and young people receiving care and treatment on an informal basis, or in placements outwith their home area.

Monitoring and reviewing services

Outcomes and monitoring

We asked about the outcomes advocacy planners are seeking to achieve in relation to advocacy services for children and young people with mental illness or learning disability, and how they monitor these.

Seventeen respondents provided information. Overall, there was a mixed picture. Not all respondents were clear about outcomes for advocacy services for children and young people with mental illness or learning disability. In a number of cases they told us about outcomes for advocacy services for looked after and accommodated children and young people, but did not address our focus of mental health and learning disability.

Some provided broad overarching outcomes for advocacy for this group in their areas. For example, Falkirk Council's was 'We want an independent advocacy service for vulnerable groups, to improve their life chances and ability and improve outcomes'. Their commissioned services cover children with mental health or disability issues, care experienced children, those subject to child protection processes and those in the youth justice system.

West Lothian Council were clear that their commissioned service covers looked-after and accommodated young people and aims to encourage and facilitate their participation in care planning. They did not mention outcomes relating to anything other than the care planning process.

Some referred to broader outcomes not specific to advocacy, in their strategic children's services planning. For example, Angus Council told us that a specific target in the

Tayside Plan for Children, Young People and Families, 2017-2020 is 'to increase the percentage of plans for children with complex and enduring needs which demonstrate that their views and the views of their parents/carers have been heard.' Midlothian Council said that their outcome was set out in strategic children's services planning, 'that the experiences of young people using services inform and influence service design'. They did not specify whether or how this related to individual mental health or learning disability advocacy, but noted that their GIRFEC board has agreed the need for a stand-alone mental health group.

Some areas listed or referred to the outcomes set out in the provider service specifications.

In relation to how outcomes are monitored, most responses did not address this separately from monitoring of providers' service quality.

Monitoring quality

We asked about arrangements for monitoring the quality of children's mental health and learning disability advocacy services, including independent evaluation. Stirling Council and East Renfrewshire HSCP told us that commissioned organisations are monitored against SHANARRI⁸ indicators and in Stirling, relevant components of the Children's Services Plan.

Many areas told us about regular monitoring arrangements, such as quarterly monitoring meetings and regular monitoring returns. In Falkirk, meetings include partner agencies such as health, education and the voluntary sector. In East Ayrshire, there are six-weekly meetings between the social worker, service manager and advocacy worker, with quarterly formal reporting and monitoring. East Renfrewshire said that they are reviewing arrangements to strengthen quality, overall impact and feedback from children.

South Lanarkshire said that many of their providers build in regular evaluation into their service, but did not specify what this involved. They said that 'funding of independent evaluation is difficult during a time of efficiency and budget constraints'. They told us that Children's Services were inspected by the Care Inspectorate and Health Information Scotland during 2014, however, it does not appear that this report looked at advocacy service quality.

Stirling Council told us that the Children's Rights Officer works alongside commissioned organisations to ensure the needs of individuals are appropriately met and that they use feedback from service users in the review of commissioned organisations and strategic planning.

⁸ Eight well-being indicators (Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included) which are part of Getting it right for every child (GIRFEC), the national approach in Scotland to improving outcomes and supporting the wellbeing of our children and young people
<http://www.gov.scot/Topics/People/Young-People/gettingitright>

West Dunbartonshire said that at an individual level the impact of any supports including independent advocacy 'would be reviewed at the team around the child meetings' and that at a service level the delivery of independent advocacy would be reviewed through three multi-agency improvement groups, which report to the Children & Families Delivery Group.

Fife Council said that the provider, 'seeks evaluation through professional/external evaluation forms on an annual basis' in addition to user feedback, and that strategic overview of advocacy services is on the agenda of the Joint Strategic Advocacy Planning Group.

The only area reporting an independent evaluation of a service was Orkney Health and Care, where the provider was evaluated by SIAA in 2015. They also carried out an Advocacy Plan survey in 2016, which included feedback from the provider and other third sector and statutory services.

Measuring satisfaction

We asked about arrangements to measure the satisfaction of children and young people with mental illness, learning disability or related conditions using advocacy services. Eighteen areas gave a response.

Six respondents said that they require providers to use exit questionnaires, feedback forms or surveys of children and young people at the end of their advocacy input. Scottish Borders Council also said that contract monitoring often includes case studies and user quotes. Four were less specific but said that satisfaction is measured by providers as part of their contract. South Lanarkshire said that they have established a participation and engagement sub group of their Corporate Parenting Group, and that children and young people are engaged in regular forums and discussions to find out their views.

Several areas said they were developing ways to measure satisfaction better:

- East Renfrewshire said that this should be incorporated in to the child's assessment/wellbeing indicators plan but that they have identified a need to develop this further.
- West Dunbartonshire told us about a recently-introduced electronic tool to capture young people's views about all the supports they receive and the impact on individual outcomes: 'The tool will enable the team around the child to assess the success and satisfaction of the supports currently in place for the young person and help identify any additional supports that may be required, including advocacy.'
- Glasgow City said, for NHS Greater Glasgow and Clyde, that a provider has representation on two SIAA working groups, Measuring the Impact of Independent Advocacy (to develop evaluation tools) and Children & Young People's Advocacy (to widen access to more children and young people).

Information from providers about the number of cases of people accessing advocacy support

Twelve of the 16 respondents who answered this question said they get information from each organisation about the number of cases of children and young people accessing advocacy support. However, not all respondents provided figures, and the information provided was for a range of different periods and therefore not comparable.

The other four said that where an independent service was provided for looked-after children and young people, the information received did not include information on the number with mental illness or learning disability. One said that this was because outcomes were specific to the child, and one that the issues facing young people were complex. The other two said that they intended to seek this information in future.

Unmet need

Eleven of the 16 areas which answered this question said they ask providers for information on unmet needs for advocacy, for example waiting lists, and a further three did gather some information. In Clackmannanshire the provider reports on waiting times. Midlothian said that they 'tend to have a lot of information' about their partners. Scottish Borders Council said that although there is not a specific requirement to report on unmet needs, this is always explored at contract monitoring meetings.

East Renfrewshire said that the fact that there is no waiting list may be due to insufficient referrals and they intend to promote uptake.

West Dunbartonshire said that this information is contained within individual assessments and plans for young people, which means that it is not possible other than manually to know the total numbers.

West Lothian Council said that information around unmet needs does not relate directly to mental illness, learning disability or related conditions but to capacity issues within the caseload, such as the advocacy worker being unable to attend all children's hearings.

Complaints monitoring

We would expect contracts and SLAs to set out requirements for providers to report complaints and outcomes as part of regular monitoring reports and meetings, with immediate notification of a serious complaint.

Ten of the 18 who responded to this question said they receive regular monitoring data from providers or receive information on complaints as part of regular monitoring reports and/or meetings, or are otherwise required to report them. Two of these also referred to council complaints procedures. Orkney Health & Care, and Fife Council, each said that complaints would be handled according to the organisation's complaints policy, but did not specify how they monitor this.

Some areas did not refer to complaints received by providers. East Renfrewshire HSCP said that complaints are investigated in line with council or NHS procedures as soon as they are received, and are communicated between the Commissioning and Contract Monitoring Team and Children and Families Team to identify if there are patterns or ongoing issues with the provider. East Ayrshire HSCP said that any complaints are passed to the contract administrator for investigation.

We are concerned that in areas which referred only to council or NHS complaints procedures, there may be a risk that complaints made direct to providers may not be monitored. Indeed, Edinburgh Council said that monitoring complaints about independent advocacy would not be their role unless it impacted on the contract or service level agreement.

We consider that monitoring complaints forms an important part of monitoring service quality.

Developing awareness of advocacy rights and provision

We asked about how each area raises awareness and delivers public information about the availability of advocacy services for children and young people with mental illness or learning disability. We would expect that in addition to requiring provider organisations to promote their services, advocacy planners would have a strategic approach to ensuring that children and young people who might benefit from advocacy are aware of it, understand what it is, and are able to access it.

Twenty three respondents answered this question. Many mentioned leaflets and/or posters and websites. Sometimes these were produced by the provider and sometimes at the council or HSCP level, and in some cases it was unclear.

Some respondents described their own approach to raising awareness at a strategic level, in most cases as well as advocacy services' own promotional work. Generally this involved staff such as children's rights officers, social workers, education staff and health workers making individual children and young people and their families aware and assisting them to access independent advocacy services.

Examples of innovative strategic-level promotion included:

- South Lanarkshire HSCP has designed an Advocacy Pathway
- Stirling Council said their children with disability team hold information days and monthly drop-ins to provide information about services available
- Stirling and Angus Councils promote advocacy to foster carers
- Aberdeenshire Council said children with any kind of additional need would be signposted to Enquire (the Scottish advice service for additional support for learning), and that advocacy needs would be considered as part of looking at support needs for individual children and young people as part of the Child's Plan

and review process. Their Additional Support Needs Team provides advice to schools on advocacy services.

Aberdeen City, Glasgow and East Ayrshire HSCPs and Midlothian, Highland, West Lothian and Angus councils outlined routes into advocacy for looked-after children and young people. For example, children's rights officers and Who Cares? Scotland staff making direct contact, promotion at young people's reviews, welcome packs for looked-after children or Who Cares? Scotland print and online information. However, these did not apply to children and young people with mental illness or learning disability who are not looked-after.

Methods used by providers, besides leaflets and websites, included:

- Angus Council has a provider which supports parents and also offers advocacy to children and young people, which they highlight to parents who are referred. They also have a Facebook page.
- East Renfrewshire HSCP said providers attend service and team meetings and events in HSCP, Council, NHS and third sector organisations, and also participate in integrated children's services planning groups where they promote their service to partner agencies.

Promoting advocacy amongst staff

Seventeen (85%) of the 20 who responded in relation to promoting the use of advocacy among staff said there had been specific actions.

Some described activities such as briefing staff, involving advocacy staff in multi-disciplinary groups and meetings and promoting staff awareness of advocacy services through training events and advocacy forum events.

North Lanarkshire HSCP said that the advocacy service participates in strategic groups, such as Corporate Parenting sub-groups 'which helps raise both profile and purpose'. They have also involved advocacy staff in training to all children and families staff about new questionnaires to engage with children and young people and to gain their views.

Some areas did not appear to feel there was a need for promoting advocacy to staff. Aberdeen City HSCP said, 'All staff are fully aware of their responsibility to ensure children are afforded their rights and have access to advocacy services', and City of Edinburgh Council said staff were aware of local agencies. Renfrewshire Council also felt staff were aware via publicity materials and advocacy staff attendance at team meetings, and said there is a high uptake of advocacy services. Falkirk Council told us, 'The Children's Rights Service role is specifically advocacy and there is an expectation that council staff use the service'. It should be noted, however, that this is not independent advocacy.

Conversely, a number of areas recognised the need to do more, and had some proactive plans. Midlothian noted the Year of Young People in 2018 as an opportunity to

look at how to promote advocacy to local groups, such as the Midlothian Youth Platform and Mental Health GIRFEC subgroup. East Renfrewshire HSCP recognised a training and development issue for staff and providers in relation to children's rights, and will be revisiting this under their new children's plan and the legal duty to publish a Children's Rights report. Stirling Council are considering developing training on children's rights, including understanding advocacy, for multi-disciplinary staff groups, as well as web-based information.

Some areas referred only to services commissioned for looked-after children and to work with residential service staff and foster carers or via corporate parenting activities. In the case of West Lothian Council, with Children's Panel members, legal and court staff.

We would expect advocacy planners to consider the need for raising staff awareness, and to put in place approaches such as staff training, information on paper and online, as well as more innovative approaches.

Future planning

We asked whether children's services planning structures included an advocacy planning group, and whether the projected need for independent advocacy services for children and young people with mental illness, learning disability, or related conditions was being assessed.

When we asked if current children's services plans included any mention of advocacy support for this group of young people only nine areas said there was reference to advocacy. Three responses relating to the above questions about future planning confirmed there was an advocacy planning group in their local planning structure. Eight responses skipped this question, and 16 responses said there was no specific planning group.

Of the eight responses which did not answer the question about whether they had a local planning group, four did provide further information. Two of these said their planning structure was currently being revised, and two told us that there was a strategic advocacy planning group in their area which looked at the need for advocacy support for adults and children, including gaps in provision.

Of the 16 responses which said they did not have an advocacy planning group three provided some further information about how the projected need for advocacy supports will be addressed. One local authority confirmed that they have a general advocacy planning group which looks at the needs of adults and children, and in two areas we were told that while there is no specific advocacy planning group other groups with a wider remit (groups looking at additional support needs more generally, and at mental health and emotional wellbeing) will consider the need for advocacy support to be available.

From the limited information we received, about future planning and assessing projected need, it is not clear that the planning structures and processes for children's services in many local authority areas will include a focus on assessing the need for independent advocacy services, and ensuring supports will be available for those young people who should be able to access services, because of mental illness or learning disability.

Recommendation

- HSCP chief officers and local authority chief executives should ensure that arrangements for planning for the provision of independent advocacy services for children and young people include processes for assessing the projected need for these supports.

Conclusions

Strategic planning

At the point when we asked for information to be provided, there were five current strategic advocacy plans in place. In two areas covered by plans, the health boards and the HSCPs were coterminous, and in the other three areas planning had continued to be undertaken on a health board wide basis, including all HSCPs in the area. In all these five areas there seemed to be clear arrangements in place both to produce plans, and to review and revise them when necessary.

In all the other areas in Scotland responsibility for planning for the provision of advocacy services lies at the HSCP level, although in four of these areas the boundaries between health boards and HSCPs are coterminous. We have received five responses telling us that there is no strategic plan in place, and no plan being developed. We have received other responses which indicate that there is a clear timescale for producing a plan within an HSCP, and some responses which indicate that a plan will be produced, without any firm timescale.

We have also received conflicting information, suggesting that in two specific health board areas there is a planning vacuum, with some HSCPs stating that planning will still be undertaken at an NHS board wide level, while other HSCPs are clear that they will be responsible for planning. There is therefore a need for clarity in all HSPCs about who is responsible for co-ordinating the preparation of strategic advocacy plans, and for arrangements to be agreed to prepare plans, with a clear timescale, where there is a planning vacuum.

The lack of clarity in some areas about where responsibility lies for strategic planning for the provision of advocacy support is matched by the fact that in eight areas we were told there is no planning group in place. In some areas, where there is no planning group, we were also told that a plan is being developed, which raises questions about how a plan is being prepared if there is no identified planning group. There is a need to identify not only where responsibility will lie for preparing plans, whether at a health board wide level or at the HSCP level. Also, to have a planning group to take responsibility for the production of a plan and to make sure there is appropriate involvement from all stakeholders in this process. Plans should contain strategic outcomes for the provision of independent advocacy, and be clear about how these outcomes are monitored. They should also consider equalities issues.

Engagement and involvement

We received detailed information in a number of responses, telling us how advocacy providers and people using advocacy services had been involved in discussions about strategic plans. Though, there was a lack of clarity in several responses about how involvement in planning would be achieved, and some responses provided no information about this issue. The meaningful involvement of providers and people who

may use services in planning is vitally important in making sure that services commissioned respond to what people need and want. It is consistent with the wider duties NHS boards have to involve people not only in decisions about their own treatment but the development of local services. It is also in line with the Scottish Government guidance for commissioners, which says that services should be developed 'in partnership with other agencies and the people who need them.' (Guidance, para 9.3) In many areas in Scotland, where plans are in the process of being developed, or where there are no current plans to prepare a strategic advocacy plan, there is no evidence of a clear and structured approach to engaging providers and people who use or may use advocacy support in the production of a plan.

Types of advocacy support available

There is considerable variation in the types of advocacy support accessible in different areas across Scotland. There are very few areas where all the types of advocacy referred to in the Scottish Government guidance for commissioners are available. In some health board areas, people will be able to get one type of advocacy support if they live in one HSCP area, but not if they live in a neighbouring HSCP.

Legislation does not explicitly state what forms of independent advocacy support should be made available. However, people may ask for and may benefit from different types of advocacy support at different times. The Scottish Government guidance for commissioners says that they should think about where advocacy is needed in their local area, about what approach to advocacy works best in different places, and about whether particular groups of people experience barriers accessing advocacy support. It also says that plans should be informed by information from needs assessments, scoping exercises, and consultations, and plans should be equality impact assessed.

In many HSCP areas planning is underway to develop a strategic advocacy plan. As part of the planning process needs assessments and consultations should take account of the different ways advocacy supports can be provided, so that decisions about the types of support to be commissioned are informed by information about local needs and the types of support which would meet these needs best.

In most HSCP areas independent advocacy services are expected to prioritise referrals relating to people who are subject to compulsory measures under the 2003 Act. While we can understand why this group of people should be a priority for advocacy support, the legislation explicitly states that advocacy support should also be available for people who are not subject to compulsion, who are accessing services on a voluntary basis, or may be having difficulties getting services. Also, people that may be vulnerable and need advocacy support. We feel it is important therefore that HSCPs, in conducting needs assessments and preparing strategic plans, look at the capacity of local services to meet the needs of all the people who have the right to access advocacy support, including people who are not provided with care, treatment and support on a compulsory basis.

Services for children and young people

All local authorities and their relevant health boards have a duty to prepare an integrated children's services plan. The majority of current plans do not contain any reference to the provision of independent mental health advocacy services for children and young people.

Current service provision is very variable across the country. In a few areas, generic independent advocacy services are commissioned to provide support to adults and children. Although, these services are often restricted to young people over 16, or to any young person who is receiving mental health care and treatment on a compulsory basis. There are a range of advocacy services commissioned specifically for children and young people, covering all local authority areas we received responses from. However a large majority of these services have explicit eligibility criteria, most commonly that they support young people who are looked after, subject to compulsory measures under the children's hearing system, or are on the child protection register. This means that in many areas young people will not be able to access mental health advocacy support unless they are detained under the 2003 Act, or they meet other criteria.

With regard to future planning, the situation is similarly variable. Very few local authority areas have an advocacy planning group in their children's services planning structure. In some areas a wider strategic advocacy planning group has responsibility for planning services for both adults and children. While in a few areas we were told that a children's services group, with a broader planning remit, will consider the need for advocacy services as part of its remit. This suggests that in the majority of local authorities the need for independent mental health advocacy services for children and young people will not be featuring on children's services planning agendas.

The Scottish Government guidance on commissioning independent advocacy services is very clear in stating that it is important that there is ease of access to advocacy services, and that strategic plans should be developed based on needs assessments, scoping exercises, and appropriate consultation. It also says that the duty to ensure access applies to children and young people as well as to adults. The information we have received would suggest this is not being taken account of in children's services planning.

Appendix 1

The full text of the responses we received is available as a separate appendix.

Responses to Mental Welfare Commission survey - Mental Health (Scotland) Act 2015 advocacy duty, Adults, were received from:

Angus Health and Social Care Partnership (HSCP)

Borders NHS & Borders Council

City of Edinburgh HSCP

Clackmannanshire & Stirling HSCP

Dumfries & Galloway HSCP

Dundee HSCP

East Ayrshire HSCP

East Lothian HSCP

East Renfrewshire HSCP

Fife HSCP

Glasgow HSCP

Grampians NHS

Highland HSCP

Lanarkshire NHS

Midlothian HSCP

North Ayrshire HSCP

Orkney HSCP

Perth & Kinross HSCP

Renfrewshire HSCP

Shetland HSCP

South Ayrshire HSCP

South Lanarkshire HSCP

West Dunbartonshire HSCP

West Lothian HSCP

Western Isles (Eilian Siar) HCP

Appendix 2

The full text of the responses we received is available as a separate appendix.

Responses to Mental Welfare Commission survey - Mental Health (Scotland) Act 2015 advocacy duty, children and young people, were received from:

Aberdeen City Health and Social Care Partnership (HSCP)

Aberdeenshire Council

Angus Council

Argyll & Bute HSCP

City of Edinburgh – Edinburgh Council

Clackmannanshire Council

Dundee City Council

East Ayrshire HSCP

East Dunbartonshire

East Renfrewshire HSCP

Falkirk Council

Fife Council

Glasgow City HSCP

Highland Council

Inverclyde HSCP

Midlothian Council

Moray Council

North Ayrshire HSCP

North Lanarkshire HSCP

Orkney Health and Care

Renfrewshire Council

Scottish Borders Council

Shetland

South Lanarkshire HSCP

Stirling Council

West Dunbartonshire HSCP

West Lothian Council





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