

Independent Specialist Advocacy

Response to the Durham Report

Introduction

These observations and opinions are written from my own perspective and they are not representative of any other individual or organisation.

My background is that of a qualified (CQSW) social work practitioner with 30 years' practice experience in the field of mental health, that paralleled by experience as a Mental Welfare Officer under the Mental Health Act 1959 and an Approved Social Worker under the Mental Health Act 1983. Specifically and intentionally a social work practitioner for the whole of my career, the advocacy role integral to professional social work practice proper has always been to the forefront of my activities, many times resulting in adversarial positions against my local authority employers - service user rights and care and professional values invariably taking precedence over career progression and 'master and servant' blind loyalties.

I was an active proponent of the mental health advocacy movement as it developed through the 1970s onwards (there were elements of organisations such as Case Con and the Community Work movement which contributed to the establishment of early specific mental health advocacy) and was involved, from a professional position, with the development of the East Suffolk Advocacy Network (ESAN) in the early 1990s which became part of the establishment of UKAN. Indeed the UKAN Code of Practice for Advocacy incorporated many of the original concepts and ethics fundamental to professional social work proper some of which have been gradually eroded by the development of what is called social work in the UK today.

I took disability early retirement from local authority work in 1999 and since then have continued to be involved as a freelance voluntary advocate (with a short spell at the end of last year as a paid specialist mental health advocate), writer and commentator - mental health law, policy and practice being one of my continuing fields of interest.

The Report

PREFACE

With the Scottish developments aided by Advocacy 2000, in July and August of last year I was in correspondence with the then DoH and Louis Appleby as to why, despite the 'Reform of the Mental Health Act 1983' White Paper there had been

nothing about advocacy in England and Wales from the Department, especially no mention of advocacy whatsoever in the National Service Frameworks. Eventually, the DoH (seemingly after a lot of head scratching) told me that Durham University had been commissioned to produce a report.

I could find no reference to the report on the Durham University website and eventually sent a request on 24.08.01 via the e mail address: margaret.bell@durham.ac.uk which read:

"Hello.

From a recent query to the Department of Health I had the following reply:

"...the Department of Health has commissioned Durham University to prepare a report on models of advocacy so that we can spread good practice throughout the country".

I can find no reference to such a report or its preparation on your website. Can you please tell me what the position is regarding this report and where I can get information about it?

Please reply to micoxxx@aol.com

Thank you.

Mike Cox."

I have to express my disappointment that the University did not even have the courtesy to acknowledge this request.

That said, please let me congratulate you on a fine, well researched piece of work and a constructive report. I only hope your recommendations do not suffer the same Governmental disregard as the report by the expert committee chaired by Professor Richardson which they commissioned to "take forward the first phase of the review of the Mental health Act" (Reform of the Mental health Act 1983, DoH, Nov 1999).

THE KEY QUESTIONS

Just one amendment: the fifth statement should read: To support, enable and empower service users in seeking resolution to actions, issues and policies which concern and affect them.

The definition at 3.1 is good. However, I would like it noted that I take the view that the Specialist Advocacy which is the subject of this report should be available to ALL users of mental health services, not just those subject to compulsion. That should be covered by the proposed new legislation.

Yes I think a deadline of three days for an initial visit is desirable - the person will have already experienced a gross unannounced intrusion from the proposed "preliminary examination" (Mental Health Bill) and is likely to be experiencing some degree of crisis which in turn will exacerbate any feelings of unreality. The sooner support which is genuine and unconditional is offered the better. But, there are

difficulties: good practice says that person should not experience yet another unannounced intrusion - that is further disempowering. Proper arrangements should be made for the Advocate's initial visit which respect the person's wishes for time, place and conditions. The three day deadline should not be imposed on the service user. Contact (i.e. a letter) within three days might be a better aim.

The advocacy service must sustain its focus on the wishes of the advocacy partner (what you call the "service user" I will use the term advocacy partner with this meaning from now on). That quite simply means if the genuine wishes of the advocacy partner are that they want to work openly and alongside family, friends or 'nominated persons', then the advocate will be able to do that. If the advocacy partner wishes to work privately and confidentially with the advocate then that should be made clear to all others.

Care should be taken that discriminative elements do not creep in by the side door here - for example, the split in some areas into separate mental health services for 'people under and people over sixty five' has clearly led to a two tier service with those over sixty five not having access to some forms of care and treatment. Over-specialisation can bring this kind of disempowering segregation about. The individual advocates should have sufficient skills and a sufficient standard of training and education to deal with all these matters and there should be a sufficient spread of 'special interests' throughout the advocacy team (I would suggest a social work qualification with its study and knowledge of intra-personal, inter-personal and social relationships, including social institutions and law should be the minimum qualification for independent professional advocacy). It should also be urgently noted that child protection advocacy (legitimised by "Working Together 2000", DoH) is often a need arising in everyday mental health advocacy practice and skills in this area should be included from day one. To try to refer the advocacy partner on to another advocacy organisation (which may not exist) or make rules that certain advocacy activities will not be undertaken will be to let the person subject to mental health legislation down badly and defeat the objects of the advocacy proposals.

Comments as above with particular attention to the work done on mental incapacity by the British Association of Social Workers' Mental Health Special Interest Group (Marilyn Tickner et al) and the Law Commission (esp. papers nos. 94, 119, 128, 129 and 130) through the 1990s. Additionally, knowledge and application skills in 'normalisation' and P.A.S.S. (Programme Analysis of Service systems).

I am at one with section 5 of your report but would like to add a suggestion with reference to point 4 at 5.2: one of the best recent references to the structuring of advocacy services I have come across is the work done by Advocacy 2000, Scottish Human Services and some Scots commissioners published by the Scottish Executive as "Independent Advocacy A Guide For Commissioners" in January 2001

and especially the slightly later “Independent Advocacy A Guide for Commissioners: SUPPLEMENT”. The Supplement, recognising that funding sources which include the service providers (as say some local authority social services fund ‘independent’ advocacy services at present) can create impedance to independence, suggests, on their page 6 “IDEAS ON HOW TO ENSURE INDEPENDENCE”. Their text at point two under this heading reads: “Keep funding at arms length by considering SETTING UP AN ADVOCACY TRUST FOR YOUR AREA - by pooling funding from different sources so no one agency holds the significant funding responsibility (my capitals)”. This is expanded on later in the document: “Independent advocacy trusts could: - Provide a mechanism for the arms length funding that contributes to the independence of advocacy schemes - Be inclusive in membership and democratic in practice holding representatives from statutory and voluntary organisations, service users and carers, interested individuals and the wider community - attract some major funders af advocacy along side the statutory bodies - the National Lottery Charities Board & other Charitable Trusts for example”. And I would add the Learning and Skills Councils to this latter list. I think you should add this suggestion to your final report. To respond to the direct question, model 2 (your diagram 1) would best serve the interests of advocacy partners. Firstly for reasons set out in my response to your question 5 and in that case all the necessary skills would be located within the advocacy team. Secondly because, although I am repeatedly told larger organisations bring ‘economies of scale’ my own experience tells me that smaller, more compact organisations respond more effectively, are more accessible, and present a more human, ordinary interface which throws out less deterrents to communication and contact. And thirdly that kind of organisation potentially generates less bureaucracy.

I have one reservation: that too often I have seen volunteer good will grossly exploited and safeguards to that should be built in. Other than that, some people are more comfortable working in a voluntary capacity and make a positive choice to do so, some considering voluntary status preferable and more user friendly than ‘professional’ status. That choice should carry equal weight to that of your proposals for independent professional advocacy. Obviously volunteers would be essential to model 2 above.

I have no expertise to offer on financial calculation or costing. Special comment though about 6.4: the tendering process installs barriers to independence - “if you make too many waves you will be unsuccessful in the next round”!!

This is purely subjective personal opinion based on experience. For me the lessons of the past thirty to forty years are generally that where social care or public service organisations have been restructured to remove them from a neighbourhood or community base for rationalisation into an amalgam of those organisations, there have been serious losses to the users of those services which increase as the organisations get larger. There will be obvious differences in logistics be-

tween urban and rural advocacy services but for reasons as above and already stated elsewhere, I think each distinct specialist advocacy service should seek to serve a population of no more than 20,000 residents. That figure is not arbitrary - it is the average population of small/medium size towns where I have directly experienced social care organisations with a good degree of effectiveness and accessibility.

Active outreach, i.e. surgeries and T groups in the neighbourhood drop ins and day centres.

Accessibility is of crucial importance here; in physical terms - buildings where people can get to them, which have no institutional or stigmatising labels attached and which can be used by advocates and advocacy partners outside set office hours - and resources, including a comprehensive reference library and broadband internet access; in relationship terms - people who are ordinary and who pose no threat, who have no affectations, officious attitudes or class identifiers; and no 'rationing strategies' or 'house rules' which are disempowering or obstructive. Of the latter, there is a pressing need to find ways and means of countering the repressive demands of corporate insurance companies which have led to the growing problem in care services of "That's not my job - our insurance won't permit us to do that." For example, a very simple and extremely common problem experienced by advocacy partners is that of getting from A to B within a particular time scale. In the natural flow of events it is empowering for that to be unfussily side-stepped - "I'm going to the meeting/court/daycentre/hospital so I'll pick you up". Some existing advocacy services (and an increasing number of service providers - i.e. many social workers consider it beneath themselves - "we're not a taxi service!") forbid their advocates to do this citing "we're not insured to carry passengers."

Yes this seems to be pitched about right, but you need to also consider advanced practitioner gradings compatible with management scales.

As I have said in my response to your question 5, I think a professional social work qualification should be the minimum requirement and this would also bring advocates firmly under the registration requirements of the General Social Care Council.

I would again turn to the Scottish Executive publications here which in, conjunction with and alongside their suggestion to establish Independent advocacy trusts, hold constructive comments. I have quoted the 'Guide for Commissioners Supplement' section in full: "LEARNING FROM ADVOCACY - THE BENEFITS. Many service providers genuinely want to learn from independent advocacy on how to improve their services. If there is no mechanism to do this advocates may be seen simply as a source of complaints and aggravation rather than a positive force for change. The benefits of linking advocacy into the decision-making processes include: ° Their ability to link the experiences of their individual service users into common themes ° They can provide feedback on users perceptions of the way they are treated by different services, especially valuable where

service users find it difficult to present this themselves ° They can inform policy and practice in relation to future service provision. It would be useful to build in twice yearly intelligence gathering workshops that involve the advocacy agencies, people who use the advocacy, and the senior planning and operational staff. An external facilitator would be useful for these events. The independence of the advocacy agency and the confidentiality of the people who use the advocacy need to be safeguarded. It would be useful to keep some points in mind when looking at the mechanisms for this feedback: ° Information wherever possible should not be traceable back to individuals. When there is no other option the information should be handled in confidence and the permission sought of the individual/s involved ° Advocacy agencies have a duty to tell it as they see it even if the picture is less positive than the view of the service providers or the commissioners ° Advocacy schemes should try and resolve any issues through the agreed channels first ° Meetings are not to review the work of the advocacy scheme, they are feedback on the advocacy scheme's findings ° The relationship is built on mutual respect rather than confrontation ° The meetings are organised on a basis that makes strategic sense and talks to the right people ° There should be an agreed way in between meetings for the advocacy agencies to raise service related issues with commissioners ° The advocacy agency has a responsibility to record and collate its work in a way that enables them to feedback issues to the decision makers ° Regular short focussed meetings are best. That way the current issues don't get lost and continuity is encouraged ° Commissioners and service providers should ensure that the advocacy agencies are given feedback on the progress of the issues they bring to them".

I have 2 principles here: 1. Monitoring and regulation should itself be properly independent and democratic - not an arm of a local authority; or the health service; or a government department; or a QUANGO, however long. 2. Monitoring should be mainly by mental health service users. Independent advocacy trusts could lend themselves to those principles. There are potential conflicts in that the requirement of a social work qualification for advocates would very definitely involve the GSCC in regulation and may do so even if advocates were otherwise accredited.

THE CORE STANDARDS (your question 17)

3. The service principles:

Add: Openness and honesty - all advocacy services should be founded on "Nolan Rules".

Independence - the word "free" here should explicitly encompass the absence of contractual ties

Empowerment - mainstream advocacy principles specifically exclude some interactive roles and activities. However, it is an unavoidable fact that effective empowerment and enabling sometimes involves some of those banned activities such as education, counselling, casework and cathartic intervention. Providing "balanced information" will inevitably entail expert knowledge of legislation, social systems, how social institutions interact etc. This further supports the proposition that advocates should be qualified as professional social workers.

Impartiality - Everyone unavoidably and largely unconsciously makes judgements. The statement "Advocates should not judge service users" is an impossible exhortation. Special intensive training develops the ability a) to recognise personal bias and judgements; and b) the skill to set these aside. Social workers are trained to do this.

5. Delivering advocacy

Add to 2nd para - but should identify those gaps and poor quality services, providing feedback for improvement.

6. Keeping records

Add to 3rd para - and copies if they wish.

7. Policies and procedures

It is absolutely essential to add WHISTLEBLOWING policies and protocols here.

15. Responsibilities of advocacy commissioners

Add - Commissioners should recognise, respect and uphold these core standards, principles and Code of Practice.

THE CODE OF PRACTICE (your question 18)

I unreservedly agree with this code and would not wish to suggest any changes or additions.

Mike Cox.

27th July, 2002.