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Older People's Advocacy Alliance (OPAAL) UK

Commissioning Independent Advocacy for Older People

An information and discussion paper from the Older People's Advocacy Alliance (OPAAL) UK

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An Introduction to OPAAL (UK)

The Older People's Advocacy Alliance (OPAAL) UK is the only national strategic organisation promoting the development of independent advocacy with older people throughout the United Kingdom. OPAAL is a registered charity with around 200 members, including local advocacy schemes, national organisations, and individual supporters.

OPAAL defines advocacy as being:

> 'A one-to-one partnership between a trained, independent advocate and an older person who needs support in order to secure or exercise their rights, choices and interests.'

OPAAL believes that there are specific circumstances where all individuals must have a right to the support of an independent advocate to ensure that their own interests and preferences are acknowledged and addressed. As a minimum these services must be available to all older people who are:

- at the point of discharge from hospital
- directly affected by a change in the management or running of their care service
- at the point of accessing continuing care and community care services
- at all reviews affecting care services in hospital and in the community

The grassroots view

A Scottish advocacy user, interviewed by OPAAL in 2006:

> *"The advocate was a friend at my elbow. The advocate steadied my ship against their armada. At one stage [the advocate] stopped the meeting in concern for my well-being. He was a prop – a stabilising influence. ... It helped with a feeling of not being isolated."* (Wright, OPAAL, 2007)

An advocate interviewed by OPAAL in 2001 highlighed the key roles:

> *" The advocate is there alongside the older person. They're in their shoes, so to speak, and standing up for their rights. The advocate takes the time to check what the older person really wants and explains the options and things happening around them in a way that can be fully understood … sometimes the advocate has to say things to the hospital staff that shouldn't have to be said. "* (OPAAL/Help the Aged, 2002)

Commissioning independent advocacy for older people

Background

The position of local authority and health trust officers who have to commission advocacy has received very little support and attention, particularly in relation to older people. This is problematic for commissioners and means that those who don't have a sympathetic appreciation of the aims and conduct of advocacy may not be able to achieve much. Its important that senior managers and commissioners recognise that the commissioning of advocacy for older people requires a principled as well as a practical approach.

Existing sources of support

There are a range of relevant publications on the management and development of advocacy, but little on commissioning. Most recently, in England, the 'Guidance for Commissioners on the Independent Mental Capacity Advocate Service' deals valuably with overlapping territory but its relevance is limited both by its narrow focus and field. By contrast, the Scottish 'Independent Advocacy: A Guide for Commissioners' (Scottish Executive, 2000) offers an informed, principled and pragmatic overview. At a local level, the review of advocacy services recently undertaken by the Better Government for Older People Team in Derbyshire County Council led to the production of 'Taking Older People Seriously' which OPAAL recommends to commissioners throughout England if and when it becomes available.

Locating the policy imperative

The biggest block to commissioning advocacy with older people is the lack of a requirement for it in primary legislation. The commissioner will therefore need an informed understanding to pull together the patchwork of platforms which can be used to support independent advocacy – eg. the Management Guidance for the Community Care Act, the National Care Standards, guidance on Adult Services Complaints, the Hospital Discharge Workbook, Independence Choice and Risk, and Adult Protection policies.

Building support for independent advocacy with older people

The lack of legislation not only makes it more difficult to raise and identify funds for advocacy, it also weakens the requirement for local authorities to make sure that advocacy is available. Advocacy with older people seems not to be a strategic priority for inspection, for example. Although the person in charge of a residential home is required to point users to 'available advocacy', the CSCI does not currently focus on it as a standard. It may therefore require political will and professional support to promote a sympathetic culture and the conditions to make a difference locally.

This will require liaison with care managers, ward-based continuing care coordinators, adult protection teams, complaints managers, welfare rights managers, PALS teams, and the like. A well-informed Champion for Older People may be a valuable ally. Publications produced by OPAAL and partner organisations provide a helpful means of raising awareness about the nature of advocacy, the advocacy needs of older people and the roles of advocates. Counsel and Care's Factsheet 25 'Independent Advocacy' gives a straightforward picture and contains useful case-studies.

Countering negative responses and low expectations

What do commissioners do if they get a negative response to advocacy or discouraging feedback about the quality of current provision? Negative views of advocacy have to be explored, and constructive criticism separated from prejudice. Some professionals are disappointed by what they encounter in advocates, and some are actively hostile. The proper responses involve:

- debating the issues
- diagnosing problem areas
- gathering and analysing data
- promoting understanding of advocacy by focusing on outcomes.

Commissioners will find their task harder when there is a lack locally of disciplined and effective advocacy to demonstrate its positive benefits. Sometimes, for example, schemes become focused on small-scale problem-solving around service-access or benefits claims at the expense of more challenging work, and this can be a real temptation for care-managers who lack the means to offer practical help to many of their clients, and end up trying to co-opt their advocacy partners into a social work assistant role.

It can help to ask colleagues to identify who *is* fulfilling the advocacy role – it may not be a named advocacy service. Commissioners – and advocates – need to accept that empowerment is a broad church. Advocates themselves may have to be challenged if they have developed too much of a bunker mentality. Independent advocacy has needed to place clear water between itself and other related practices but it has done itself no favours when it has claimed to hold a monopoly of integrity or effectiveness. However, formally constituted advocacy schemes can greatly increase the chances of service-users getting a direct response to their requests for help. Both their independence, and their user-directed approach, offers something unique.

Commissioners will need to encourage schemes to gather and analyse data regarding the outcomes and impact of their work.

This will pay off in the longer term, and often lead to improvements in commissioning itself. Commissioners need to move away from contracting for outputs and adopt an approach that commits first and foremost to quality.

This would assist in a fairer evaluation of, and better support to, for example, small schemes where volunteer advocates form long-term partnerships, and to which it sometimes becomes difficult to make new referrals.

Commissioners should be prepared to seek external help, particularly with respect to evaluation, and to consider how to support the implementation of benchmarking agreements where schemes are able to learn from each other. There is a growing focus on measuring outcomes within the advocacy movement itself.

Building a constructive interest in the wider community

Its worth bearing in mind that the advocacy movement with older people has not predominantly been an initiative of older people concerned about rights. Traditionally, pensioner campaigns have focused on income, or on the availability of services, rather than their effectiveness, style and quality. More recently, under the banner of promoting independence, older people have also focused on positive images, new opportunities, and the removal of barriers to participation. With rare exceptions, the availability of independent advocacy does not come high on the shopping-list of demands drawn up by community consultations or through regeneration initiatives. Indeed, the needs of vulnerable older people can sometimes seem to be projected elsewhere, discomforting reminders of dependency, the responsibility of specialised authorities rather than the community as a whole.

> *"Quite rightly, there is much talk about the benefits of the Human Rights Act, but without effective and independent advocacy, the rights promised in the Act are worthless."*
> *(Professor John Williams, Aberystwyth, 2004)*

Commissioners may therefore need to remind their colleagues that advocacy overlaps with three important policy imperatives: citizenship; equalities and inclusion – including independent living; and human rights. Advocacy needs to explain itself well in these contexts, and to make strong alliances with others in the field at local level. Advocacy schemes working with older people are beginning to recognise that both volunteer advocates and satisfied users of advocacy services have an important part to play in debates and promotional campaigns. The trustees of advocacy schemes have a part to play in this, too, while older activists who recognise the importance of advocacy, and can articulate it, are, of course invaluable:

> *"Information is what you need or want to know; advice is being guided on how to go about things; advocacy is a way of acting on that information and advice to get things done"*
> *(Focus group participant, Manchester: Joseph Rowntree Foundation, 2005).*

Setting priorities and dealing with conflicting agendas

A further difficulty is the recent prominence of strategic initiatives which overlap with advocacy, and may even claim to supplant it. Four policy and practice developments in the last fifteen years have altered the policy and practice arenas within which independent advocacy operates:

- user consultation and engagement;
- promoting access and service take-up;
- person-centred working and management
- service brokerage and personalisation.

These have sometimes tempted commissioners to try and co-opt advocacy, and to retreat in frustration when it refuses to be co-opted. Advocates need to recognise that new policy and practice developments can have significant, and sometimes beneficial, impacts. They will also need support in asserting that where old shortfalls remain or new ones emerge, the requirement for one-to-one advocacy partnerships may remain unchanged.

Consulting users and promoting access to services are now major priorities for public bodies, require the direct deployment of their own resources. Because their performance relates to government targets and ratings, there is considerable pressure to achieve, and be seen to achieve.

Meanwhile, person-centred working has been used as a lever to challenge providers of care services to improve their standards and responsiveness, with some beneficial effects. Resources that might once have been ear-marked for external support, like advocacy, are therefore now more likely to be directly invested. At times, developments in these areas have caught advocacy off balance, or have diverted the attention of its supporters, and it will help if commissioners are aware of these trends and pressures.

For example, although prominently identified in the Social Exclusion Unit's report 'A Sure Start for Later Life – ending inequality for older people' independent advocacy with older people has not figured much in the Individual Budget pilots, nor within older people's 'Sure Start' programmes. Commissioners will need to bear in mind that few advocacy schemes will have the development resources to contribute within complex planning initiatives, and will need help to do so. Nor do the appropriate self-advocacy and collective advocacy responses follow seamlessly from delivering one-to-one advocacy partnerships. While schemes might benefit from such developments, they need funding and support to introduce them. This will be equally important for advocacy in adapting to the new localisation agenda.

Service brokerage, and personalisation – direct payments, individual budgets, and so-on – raise different issues. Government has become persuaded that the direct involvement of service-users in the commissioning, design and delivery of their own care is the answer to poor quality and inadequate take-up.

Independent advocacy has been simultaneously invoked and sidelined in the development of these proposals. A strong case can be made that advocacy helps excluded people find their voice, and articulate their wishes. But, equally, in its independence of the care delivery system, advocacy cannot (and should not) be relied on to deliver the outcomes that commissioners require. This is an area that urgently needs credible, independently evaluated, research, and where pro-active commissioners, perhaps working as a group and linking to academic colleagues, could contribute significantly to learning and development.

Minority needs and specialist areas

As long ago as 1991 government guidance drew attention to the need for advocacy on the part of people with dementia, and on the need to focus on the exclusion of people from minority ethnic communities. While independent advocacy works to principles which seek to ensure that advocacy is as broadly available as possible, it also recognises the importance of proactively developing services that are accessible and inclusive. Meeting need in these areas, particularly where existing services are unrepresentative, may involve engaging specialist services, but it may be equally effective and important to challenge generic, broader-based, providers to revise their approach. The primary concern for commissioners should be that advocacy providers keep conflicts of interest to a minimum, and that they are able to demonstrate a focus on principles of empowerment and on the delivery of effective outcomes for individuals. This may require investment in both training and quality standards.

Establishing and maintaining an evidence base

Commissioners need to encourage providers to invest in the evidence base for their work, to promote what they do in an educational and awareness-raising manner, and to consider its implications for social policy more generally. Work is under development by Action for Advocacy and OPAAL (UK) among others to encourage development in these fields. OPAAL would welcome the direct involvement of commissioners in its initiatives.

The Scottish Executive, reviewing what statutory authorities get from independent advocacy, put forward the following categorisations:

- better outcomes for people
- intelligence and feedback
- added value (including public and community involvement)
- constructive challenge to service providers
- keeping the focus on people who are most at risk
- designing user-focused services.

An evidence base that is used to collate data, establish criteria, and, where possible, measure the impact of advocacy against these headings, would provide a valuable counter to crude output measures, and gross unit costings.

Commissioners could use the involvement of an independent evaluator at an early stage to establish a workable self-assessment system. There is currently no cost-based information about the value of advocacy. One prominent local provider in London (WASSR, 2004) commissioned a survey to look at the financial benefits of advocacy: this draws together valuable information, but does not identify a mechanism for cost-benefit analysis.

However, the evidence base around advocacy does not solely concern quality and outcomes. Commissioners need to be aware that there is a serious problem in recruiting advocates, both as volunteers, and as professionals. Commissioners who can draw on funds – particularly from outside health and social care budgets – to assist in tackling this problem will make a major difference. Effective promotional and publicity campaigns – currently few and far between – will rely on sound data.

Generating investment in advocacy

Overall, investment in social care has not kept pace with increasing demand or rising expectations. Much need may go unmet, and many long-term problems will therefore remain unresolved, however much changes to service delivery and developments in personalisation alters their appearance. The Scottish Executive recognised the political case for advocacy:

> *"...small neglects and mistakes by service systems can have huge consequences for the individual. The disparity between the size and power of the service system and the powerlessness of the people most at risk within this system means that further safeguards are needed to reinforce the general protections provided to consumers and to citizens." (Scottish Executive, 2000; Section 1, p7)*

Advocacy has been blighted by underinvestment. Changing this remains as much a problem for commissioners as for advocates. Commissioners, the Scottish Executive argued, must understand why advocacy matters. Such an understanding will underpin their commitment to supporting it; to measuring its effectiveness, learning from it, and investing in it. If commissioners share in convincing others why advocacy matters, it will contribute to generating investment. Having supported advocates to gather and analyse data, commissioners must engage academic and lay colleagues to contribute to its critical examination. Having measured its effectiveness commissioners can then work with advocates, professionals, politicians and community supporters to promote and publicise advocacy. (In some areas statutory bodies have established consultative frameworks and steering groups, which could be assisted to generate wider influence and reach into service systems that would prefer to carry on undisturbed.) Having helped to generate funding and achieved its investment, commissioners must then be prepared to offer, and to engage others in offering, continued endorsement.

John Miles for OPAAL, July 2007

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