

Speaking up to Safeguard

Lessons and Findings from the
Benchmarking Advocacy and Abuse Project, 2008-09

MAY 2009

About us

OPAAL UK is the Older People's Advocacy Alliance, the only national strategic organisation throughout the UK promoting independent advocacy with older people. We consider ourselves to be unique, with a member base that focuses on independent advocacy services for older people across the UK.

We have around 200 members: this figure represents advocacy schemes, national organisations with an interest in advocacy such as Help the Aged and Age Concern England, and a small number of individuals, mostly academics and older activists.

We work closely with central and local government, health trusts and others, advising on independent advocacy work with older people, and undertaking development projects and commissions.

Andrew Dunning lectures in Social Policy and is a member of the Centre for Innovative Ageing at Swansea University. He is a founder member of OPAAL UK. His publications on advocacy include *Citizen Advocacy with Older People: A code of good practice* commissioned by the Department of Health and published by the Centre for Policy on Ageing in 1995, and *Information, Advice and Advocacy for Older People: Defining and developing services* for the Joseph Rowntree Foundation, published in 2005.

Action on Elder Abuse works to protect, and prevent the abuse of, vulnerable adults. They are the only charity working exclusively on these issues across the UK.

Action on Elder Abuse,
Astral House, 1268 London Road,
Norbury, London, SW16 4ER
Tel. 020 8765 7000
enquiries@elderabuse.org.uk
www.elderabuse.org.uk

Action for Advocacy is the central point of information on independent advocacy across all client groups. Their activities include campaigning, training, running national projects and publishing a wide range of material on independent advocacy.

Action for Advocacy
PO Box 31856, Lorrimore Square,
London, SE17 3XR
Tel. 020 7820 7868
info@actionforadvocacy.org.uk
www.actionforadvocacy.org.uk

Older People's Advocacy Alliance (OPAAL) UK

Parkfield House, 64 Princes Road, Hartshill, Stoke-on-Trent ST4 7JL
Tel: 01782 844 036 Email: kathryn.parson@btinternet.com
www.opaal.org.uk

Registered charity number 1090182

 Further copies of this report (including appendices) and a separate executive summary can be downloaded at www.opaal.org.uk



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Appendices to this report, including case data forms, are available to download in PDF format at www.opaal.org.uk

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Kath Parson
National Project Manager
Older People's Advocacy Alliance (OPAAL) UK
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* Now the National Mental Health Development Unit

Foreword

The role of independent advocacy in countering the abuse of older people in the UK has a lost history. As long ago as 1995, when the Centre for Policy on Ageing's good practice guide helped consolidate progress in developing the movement, it carried a section on the topic with several thoughtful case studies (Dunning 1995). Fourteen years ago advocacy would have been well-placed to benefit from the rise of attention being paid to adult protection. Regrettably, as government became more directly involved, and safeguarding professionalised, this did not happen: advocacy has found itself marginalised, with much official reporting behaving as though it did not exist.

It is true that there have been one or two high profile gestures – as in the House of Commons Health Committee report (2004) – but these have not then been backed up by research, or through the movement's own literature. The result may have been to discourage advocacy schemes from maintaining their active involvement in the field of advocacy for older people who are experiencing abuse, and it is possible that some expertise and commitment has been lost. Recent efforts, through, for example, the Comic Relief community programme, have offered welcome encouragement to reverse this.

OPAAL and Action on Elder Abuse have collaborated before; in developing a training pack in 2001, and in forming an exploratory partnership under the aegis of Better Government for Older People in 2005. This explored themes based around citizenship with respect to abuse, but limited resources and a lack of attention at the policy level stifled it at an early stage. Through the initiative outlined in this report we have been able to go further and directly involve a group of independent advocacy schemes in working together to explore good practice. We believe this approach cannot be neglected any longer: by definition independent advocacy helps put the victim at the centre of the safeguarding equation, and that commitment challenges all stakeholders to recognise that empowerment is a goal of safeguarding alongside protection.

There are two core elements of advocacy practice which bear upon this issue: the instrumental and the expressive. In their instrumental role advocates may point to a truth that others don't want to acknowledge, or think they can't respond to. In their expressive role advocates must work painstakingly to help an oppressed individual find their voice. There is evidence of both sorts of working practice in this study. The schemes which have contributed (without additional investment) to this programme deserve great praise. They selected themselves, not because they considered that they had the answers, but to share what they are doing, learn from each other, and contribute to change. It is now the turn of researchers, commissioners, and central government to get involved. The case for giving sustained attention to advocacy's contribution to safeguarding older people from abuse is clear. It appears, indeed, to be a matter of some urgency.

John Miles (OPAAL)

Daniel Blake (Action on Elder Abuse)

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Introduction: project background, origins and aims

“Sometimes people can be afraid to speak up. There can be an erosion of individuality and status. Dehumanising. We should be in control but not controlled.”

“They [the advocacy scheme] have made me feel that they are safeguarding me. It saved my life. Everything is perfect.”

(Quotations from older participants’ reflections in *A Voice That Wasn’t Speaking: Older people using advocacy and shaping its development*. Wright, OPAAL 2006)

This report draws upon an exploratory project on benchmarking advocacy and abuse initiated by the Older People’s Advocacy Alliance (OPAAL) UK and undertaken with national partners, local advocacy schemes and other contributors. OPAAL is the national strategic organisation which supports and promotes independent advocacy with older people.

The project was shaped by three broad objectives for learning, research and practice:

- To learn about the impact of advocacy on elder abuse
- To collect information to help develop the evidence-base, and
- To improve practice through joint-working

The specific aims of the project were to:

- 1** Gather data which helps understanding of the impact of advocacy when working with victims of elder abuse
- 2** Learn more about the relationships between advocacy schemes and the Safeguarding Adults teams and processes
- 3** Explore the potential for advocacy schemes to benchmark best practice in working with victims of elder abuse

The project had its roots in a national development programme carried out by OPAAL in 2003-2006 which provided a descriptive review of the range of work being undertaken by advocacy schemes, including responses to abuse (Robinson 2006). National partners and contributors to this timely new project, including Action for Elder Abuse (AEA) and Action for Advocacy, had similarly highlighted a need to further develop this important area of work.

The Benchmarking Advocacy and Abuse project ran from January 2008 to January 2009. The local advocacy schemes involved (known as the ‘benchmarkers’) signed up to gather data about their work and to share it. They also agreed to meet

together and discuss the outcomes of their work, and to explore the scope for adopting reflective practice.

In documenting the main findings of the Benchmarking Advocacy and Abuse project, this report is intended to raise awareness, share learning and support policy and practice development in the crucial area of advocacy.

The report will be of interest to politicians and policy makers, academics, commissioners, safeguarding teams, health and social care and related practitioners, voluntary organisations, older people's groups and advocacy schemes.

The report is set out as follows:

Section Two outlines the context of advocacy and abuse, including key definitions and meanings; the prevalence of abuse as a social problem; the need for independent advocacy as a means of empowerment, prevention and protection; developments in legislation and policy; developments in practice.

Section Three discusses the benchmarking approach; a description of participating advocacy schemes; the methods employed in carrying out the Benchmarking Advocacy and Abuse project.

Section Four presents the project findings and discusses the demographic profile of advocacy partners; aspects of referral; types of abuse experienced and case examples; advocacy goals; approaches to intervention; the outcomes of advocacy undertaken.

Finally, **Section Five** provides a concluding commentary and proposes some next steps for future work.

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Definitions and developments: advocacy and abuse in context

This section provides working definitions of advocacy and abuse used by the project. It outlines the core principles of advocacy and the main roles undertaken by advocates themselves. The need for advocacy as a response to abuse is highlighted. There is then a discussion of some of the key developments in legislation, policy and practice surrounding the project.

Definitions of advocacy and abuse

Definitions of advocacy and abuse are dynamic and sometimes contested. However, for the purposes of this project the following definitions were adopted by the steering group in relation to advocacy and abuse:

The Older People's Advocacy Alliance (OPAAL) UK 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 identifies the core principles of advocacy as being independence, empowerment and inclusion. Advocates should be free of conflicts of interest to ensure that the needs and interests of the advocacy partner remain paramount. Advocacy seeks to enable people to have a voice, to have a say in the decisions that affect their lives and take control of their circumstances. It is also about protecting and promoting citizenship and human rights.

Advocates undertake two main roles – instrumental and expressive. Instrumental roles are essentially about 'doing' by providing practical support as a representative, spokesperson or appointee. Expressive roles are more concerned with 'being there', listening, enabling and providing emotional support. The relationship between the advocate and advocacy partner might be short term and task-specific in its focus. Conversely, advocacy partnerships may need longer to develop, so that the advocate gets to know what is 'normal' for the advocacy partner, establishes trust and finds the best way to represent their needs and interests over a period of time.

Although advocates should be instructed by the older person wherever possible, this may be problematic if the individual lacks capacity in some situations or points in time. The advocacy movement has developed a number of 'non-instructed' approaches to support individuals in such circumstances. These approaches variously focus upon being rights based, person centred and holistic (Action on Elder Abuse / Action or Advocacy, undated). Where a person has impaired communication skills and the advocate is unable to ascertain their views, advocacy support may also be provided by means of a 'watching brief' based upon quality of life domains and a clear set of values and questions (ASIST, 2007).

Action on Elder Abuse (AEA) defines abuse as being:

“A single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.”

AEA goes on to identify the main forms of abuse as being physical abuse, psychological abuse, financial abuse, sexual abuse and neglect. Such abuse might occur in a range of settings, including the person's own home, a carer's home, in day care, residential care, a nursing home or hospital. Both men and women can be at risk of being abused.

According to AEA, the abuser is usually someone well known to the person being abused. They may be a partner, child or relative; a friend or neighbour; a paid or volunteer care worker; or a health or social worker or other professional. The older person may also be abused by someone they care for. Often the people who abuse an older person are exploiting a special relationship. They are in a position of trust, whether through family bonds, friendship or through a paid caring role – and they exploit that trust.

Prevalence of abuse

Whilst abuse is recognised as being a social problem, the scale and detail of the problem is still unfolding. The *Hidden Voices* study of calls to the Action on Elder Abuse helpline over a six and a half year period found that: women were more likely to be the victims of abuse (67% of calls); men were more likely to be the individual abusers (41%); most abuse occurred in people's own homes (64%) but abuse in care homes accounted for 23% of calls – although only 5% of older people live in these settings (Action on Elder Abuse / Help the Aged 2004).

In a prevalence survey of abuse and neglect of older people, O'Keeffe et al (2007) estimated that 227,000 older people in Britain were experiencing neglect or abuse by a person in a position of trust. About 13% of abuse was found to involve care staff, whilst in domestic settings 51% of abuse was by the person's own partner and 49% by other family members.

However, the numbers might be far greater than the survey undertaken by O'Keeffe et al suggests, as only 21% of the older people who responded used any social services. Given the ageing population, the position of people living in institutional care, people living with dementia and in other situations which make reporting difficult, the total figure is likely to be an underestimate and the picture of the perpetrators incomplete. A more accurate and fulsome account of the problem is set to emerge when the findings of a programme of research into abuse and neglect commissioned by the Department of Health and Comic Relief are published in 2011.

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Power, prevention and protection: the need for independent advocacy

Advocacy can be a crucial component in the prevention of and protection from abuse. Older people may have many of the same advocacy needs as people of other age groups and the ageing population is itself diverse.

However, whilst old age in itself does not inevitably equate with vulnerability, a specific focus on abuse and advocacy for older people might be required due to a number of life events and circumstances, including:

- A decline in physical and mental health
- An increase in sensory impairment
- Changes in living arrangements
- Isolation and the decline of social networks
- A greater need for formal and informal care,
- Ageism and other forms of discrimination

Older people have expressed the need for independent advocacy to be available as a means of empowering and safeguarding them. Older People involved in the OPAAL advocacy user engagement initiative (Wright 2006) were asked about what motivated them to use advocacy, and why they needed advocacy in the first place. They gave a range of responses related to:

- Being protected from abuse
- Combating discrimination
- Obtaining and changing services
- Securing and exercising rights
- Being involved in decision making and being heard

These reasons for independent advocacy echoed comments by groups of older people engaged in the development of the National Service Framework for Older People, the Better Government for Older People programme and the Joseph Rowntree Foundation Older People's programme (Dunning 2005). More recently, a local research project on safeguarding adults within the care sector in the Borough of Halton, emphasised user and carer perspectives on the importance of independent advocacy and the need for it to be more readily available in the safeguarding process (Darwin and Pickering 2008). The Pensioners Charter promoted by the National Pensioners Convention calls for older people to have "*advocacy, dignity, respect and fair treatment in all aspects of their lives*".

Developments in legislation and policy

Over the past decade or so there has been a plethora of legislative and policy developments of relevance to the Benchmarking Advocacy and Abuse project. These include:

The Human Rights Act 1998, which has brought issues of representation, participation and protection to public attention and helped to create more citizen-focused responses.

The Care Standards Act 2000 which heralded regulations requiring care providers to make proper arrangements to protect people in their care from risk of harm or abuse.

The Health and Social Care Act 2001 which placed a statutory responsibility on the Secretary of State for Health to make appropriate arrangements for the delivery of independent advocacy services (ICAS) to support people in making complaints against the NHS.

The Domestic Violence, Crime and Victims Act 2004 which made explicit that physical abuse, sexual abuse, harming or causing deliberate cruelty by neglect of an adult (or child) is a criminal offence.

The Mental Capacity Act 2005 which broadly aimed to empower and protect individuals who may not be able to make some decisions for themselves. The Act brought into force new criminal offences of ill treatment and wilful neglect. It also introduced a new statutory service – the Independent Mental Capacity Advocate (IMCA).

The Safeguarding Vulnerable Groups Act 2006 which created the Independent Safeguarding Authority to replace the Protection of Vulnerable Adults (POVA) scheme with a more comprehensive, single agency to vet all individuals working with vulnerable adults in England, Wales and Northern Ireland.

The Mental Health Act 1983 (Independent Mental Health Advocates) (England) Regulations 2008 which direct Primary Care Trusts to make arrangements for independent mental health advocates (IMHAs) to be available to help qualifying patients under the Mental Health Act 1983.

More recent developments are likely to impact on the direction and development of advocacy and abuse. Some of these initiatives are focused on specific groups, including people with learning disabilities and people with dementia. *Valuing People Now* (2009) is a three year strategy for people with learning disabilities which

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builds on the 2001 White Paper *Valuing People*, and maintains a commitment to underlying principles of rights, independence, choice and inclusion – clearly complemented by advocacy. The first ever National Dementia Strategy was also launched in February 2009, aimed at improving care and providing more help and community personal support services, including independent advocacy.

A profound shift in present policy was heralded by *Putting People First: A shared vision and commitment to the transformation of adult social care*, the Ministerial Concordat launched in December 2007. Personalisation is intended to ensure that every person who receives support has choice and control over how that support is shaped for them in all care settings. One of the objectives of the concordat is “a universal information, advice and advocacy service for people needing services and their carers irrespective of their eligibility for public funding”. The *Our Health, Our Car, Our Say* White Paper (2006), the In Control initiative, direct payments and individual budgets can all be seen as part of the new agenda for personalised, public services. These developments bring significant opportunities and challenges for work on safeguarding adults from abuse as well as for the independent representation and protection that advocacy can help to provide for older people in domestic and institutional settings.

Finally, an initiative of direct and fundamental significance to work on abuse and advocacy is that of the review of *No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (Department of Health 2000). The review was being carried out during the course of this project, and a number of project participants have been involved in the consultation process. *No Secrets* provided greater clarity about the roles, responsibilities and arrangements for relevant agencies than had been the case hitherto. Since its publication there have been calls for improvements in the effectiveness of intervention in some areas, greater emphasis on prevention and a more citizenship based approach as well as stronger underpinning legislation. According to the Commission for Social Care Inspection* (CSCI), whatever changes are introduced in safeguarding adults:

“...councils, care providers and regulators all have crucial roles to play in ensuring that the essential elements of prevention and early intervention are in place, namely people being informed of the right to be free from abuse; and supported to exercise these rights, including having access to advocacy”
(CSCI 2008 p9)

* now the Care Quality Commission

Developments in practice

The number of advocacy schemes working for older people has steadily risen since the early 1990's when Wertheimer (1993) identified around a dozen throughout the UK. More recently, a mapping exercise of older people's advocacy schemes commissioned by OPAAL found 136 in England alone (Kitchen 2006).

These schemes have variously been run by voluntary organisations for older people, organisations of older people and as stand-alone bodies. They might be generic or specialist in their nature, focusing on particular groups, settings or situations. However, this apparent growth and diversity of the sector disguises the fragility and patchiness of provision on the ground.

Despite the legislative and policy initiatives discussed above, there is no 'joined up' independent advocacy strategy at national level. Independent advocacy has only acquired legal status and attendant funding in a narrow range of areas – confined to Independent Complaints Advocacy Services in health care settings, Independent Mental Capacity Advocates and Independent Mental Health Advocates. Many local advocacy schemes work with older people who fall outside the criteria for such support. These schemes themselves are subject to uncertain funding and variable commissioning arrangements (Kitchen 2007; Miles 2007).

Even where an advocacy scheme has been established, there can be capacity issues associated with the quantity and complexity of cases. No wonder then that responses drawn from thematic inspection, the CSCI found that access to advocates was variable and that *"care providers reported that it was often difficult to obtain independent advocacy for people using their services"* (CSCI 2008 p30).

Nevertheless, the advocacy movement has not only called for a more comprehensive set of rights to independent advocacy and greater provision, but also endeavoured to work collaboratively towards the development of policy and good practice. Here are some examples of recent work initiated by national voluntary organisations and advocacy groups:

OPAAL's current work includes convening a national forum, a regional development project in the South West of England, a study on commissioning, and an older people's engagement network, as well as benchmarking best practice.

Action on Elder Abuse worked in conjunction with Action for Advocacy to produce an elder abuse advocacy 'toolkit' and has set up a telephone helpline to assist advocates in better addressing issues of abuse.

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Action for Advocacy has developed an Advocacy Charter, Code of Practice, and Quality Performance Mark, and has recently undertaken the Lost in Translation project on advocacy outcomes.

The Beth Johnson Foundation has a long established dementia advocacy scheme and has also initiated a national project to develop support systems for advocacy schemes across England.

Age Concern England has initiated a Mental Capacity Advocacy Project to develop, explore and evaluate a volunteer advocacy service for older people who lack mental capacity through four local Age Concern organisations.

The advocacy movement has worked with central government and other statutory bodies to contribute towards policy initiatives. Recent examples include a feasibility study on the development of a National Strategic Framework for Advocacy undertaken by the Advocacy Consortium UK, the engagement of advocacy organisations in the development of a national advocacy qualification, and involvement in the expert reference group on Independent Mental Health Advocacy.

Whilst the advocacy movement has taken more initiative and responsibility in the promotion and development of policy and practice, there are tensions and difficulties in doing so. Advocacy came into being as a fundamentally grassroots response to abuse, neglect and discrimination (Dunning 1998). As recognition of the need for advocacy grows and new legislation and policy emerges, concerns have been voiced about the possibility of losing the essence of advocacy itself. Greater professionalisation may risk turning advocacy into 'just another service'.

However, it is generally acknowledged that when abused older people need advocacy, it must be good quality advocacy. Moreover, the challenge for the advocacy movement is to ensure that core values and effectiveness of advocacy can be maintained (Dunning 2005). The Benchmarking Advocacy and Abuse project aims to make a small contribution towards that endeavour.

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Project approach and methods

The Benchmarking approach

The project sought to adopt a ‘benchmarking’ approach overall. This would involve advocacy schemes working together to help build up a picture of their practice and then go on to encourage comparative learning, the exchange of constructive criticism, and ultimately the setting of benchmarks to which participants could aspire and measure the quality of their services.

The benchmarking approach has been promoted by the UK Government as a means of delivering wider benefits to public service organisations as well as citizens (www.benchmarking.gov.uk). These benefits may be summarised as:

- Learning from those who have achieved excellence
- Sharing knowledge and insight between organisations about overcoming common problems
- Setting appropriate performance measures, and developing realistic targets for improvement
- Encouraging the involvement of staff in making changes happen
- Introducing collaborative approaches that give rise to better outcomes
- Developing a culture of continuous improvement and a willingness to learn from outside our own organisation
- Introducing new ways of working, and innovative solutions

This approach had previously been proposed in the full report on the OPAAL UK national development project (Robinson 2006). It was now seen to be appropriate to meet the broad objectives of OPAAL UK, Action on Elder Abuse and others involved in the new project to learn about the impact of advocacy in working with abuse, document the evidence and develop the evidence-base, and improve practice through joint-working.

The project steering group

A project steering group was established. This ultimately comprised of OPAAL UK and Action on Elder Abuse with contributions from Action for Advocacy, the National Institute for Mental Health Excellence and Age Concern England. Advice was also sought from academics and other practitioners engaged in research and development work on advocacy, abuse and reflective practice.

The role of the steering group was broadly to support the development of the project in order to achieve its aims. Given the exploratory nature of the project, meetings of the group were an important forum for sharing learning and progress to date as well as shaping direction. The meetings provided an opportunity to respond to findings from the incoming data and any emerging issues. Members of the steering group also worked directly on the project by undertaking a range

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of roles and tasks such as data collection and the facilitation of benchmarkers meetings and reflective practice.

The advocacy schemes: 'benchmarkers'

A general call was made for advocacy schemes to be involved in the project and to become the 'benchmarkers'. This invitation was made through the OPAAL UK website (www.opaal.org.uk), events and e-mailouts. Some schemes became engaged having already expressed an interest during the OPAAL UK national development programme in 2003-2006.

Whilst these schemes were self selecting, they reflected: a diversity of geographical locations; generic and specialist approaches; sizes; multi-service and stand alone organisations. All of the schemes worked with older people (though some also worked with other age groups within their organisation) and all would define themselves as being 'independent'.

A first project meeting of potential benchmarkers held in March 2008 was attended by ten advocacy schemes. Immediately after that meeting, two schemes were unable to commit to the project. Another scheme – the Age Concern Essex Advocacy Scheme – contributed to the early stages of the project but was unable to continue its involvement beyond July 2008. The withdrawal of these schemes was largely attributed to resource issues, staff illness and departures.

A total of seven benchmarking advocacy schemes were fully engaged throughout the proposed lifetime of the project. In October 2008, schemes were asked to commit to a project extension of three months to ensure adequate time to complete the project and conduct telephone interviews with participants. All projects with the exception of WASSR were able to do so.

Fortunately, the diversity of the benchmarkers was maintained throughout. The participating advocacy schemes comprised the following:

Beth Johnson Foundation Dementia Advocacy Project

The Beth Johnson Foundation is a national organisation that seeks to make a positive impact on the lives of older people, and to challenge age discrimination through pioneering initiatives that bring together research, policy and best practice. In 1989 the Foundation set up a pioneering citizen advocacy with older people project, a model subsequently replicated by numerous other organisations. In 1998 the Foundation went on to establish a groundbreaking dementia advocacy project with a co-ordinator and a team of volunteer advocates. In 2001 an evaluation of the project highlighted the significant impact dementia advocates have in ensuring that people with dementia have a 'voice' which is acknowledged when confronted with issues

in their lives. Today, the re-modelled project provides specialist advocacy worker support for older people with dementia in North Staffordshire. The Foundation also runs a National Advocacy Support Project, developing support systems for advocacy schemes across England.

Doncaster Advocacy

Doncaster Advocacy is a local voluntary organisation and registered charity based in Doncaster in South Yorkshire, which has been established since May 1992. It has a staff team of six workers and is supported by 23 volunteers. The organisation offers advocacy support to adults over the age of 18 who have a learning disability and live in the Doncaster Borough. Support is provided via issue based or crisis work; support to four self advocacy groups; citizen advocacy partnerships; support to a User Forum of adults with learning disabilities, and Drop-In sessions at six Day Centres in the Doncaster area (one of which is a specialist provision for older people with learning disabilities). Doncaster Advocacy also has a Communication and Consultation worker, who works primarily with people who have profound and multiple disabilities and do not communicate verbally.

Older Citizens Advocacy York (OCA Y)

Older Citizens Advocacy York (OCA Y) aims to provide an independent, confidential advocacy service to citizens of York aged 50+. In order to achieve this, OCA Y provides a core of trained and supervised volunteers who will be called upon to act for people who do not have suitable family or friends to advocate for them, or who want more detached and independent help; supports and encourages individuals advocating on an individual basis for friends and family, and provides them with information and guidance, and promotes the benefits of and encourages the use of advocates. The scheme grew out of work undertaken as part of the Better Government for Older People national programme. OCA Y is managed by a board of trustees and employs two paid staff, an advocacy manager and an administrator.

Sefton Pensioners Advocacy Centre

The Sefton Pensioners Advocacy Centre (SPAC) is a local voluntary organisation providing one to one casework advocacy and self-advocacy services to older people (aged 60+) in the Metropolitan Borough of Sefton. SPAC provides help in a range of areas, from general advocacy to specialist projects to support people with a variety of needs. The scheme has a diverse funding base together with rising demand and recognition for its work. Originally staffed entirely by volunteers, SPAC now has 9 salaried full and part time staff, along with over 20 volunteers involved in advocacy. The scheme has

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specialist projects working in the following areas: Nursing Fees / Care Packages, Mental Health (Functional) and two Dementia Advocates. SPAC also facilitates the Sefton Older Persons Forum, originally meeting as a group advocacy project but now evolving into a consultative group for both voluntary and statutory agencies. SPAC regularly supports over 500 service users per year.

ENABLE Advocacy (South Yorkshire Centre for Inclusive Living)

ENABLE Advocacy is a free, independent advocacy service. It is one of the services provided by South Yorkshire Centre for Inclusive Living, based in Doncaster, which works with people who have a physical and / or sensory impairment. ENABLE works with disabled people to help them to speak up for themselves, and ensure that their views are heard. The advocacy service also helps people to access information and services which can give them more choice and control in their lives.

The Himayat Project (Subco Trust, London Borough of Newham)

Subco Trust is a specialist service provider for Asian elders and their carers in the London Borough of Newham. It is one of the largest organisations in the country working specifically with Asian elders. Subco aims to offer quality services that are culturally and linguistically appropriate and explores innovative ways of working effectively. It also seeks to assist and empower Asian elders and their carers to advocate for other services to meet their individual special needs. The Himayat Project is an advocacy scheme initiated and run by the Subco Trust. The project offers a particular focus on people with mental health problems. The project worker provides advocacy support for Asian elders aged 55 and above.

Westminster Advocacy Service for Senior Residents (WASSR)

Westminster Advocacy Service for Senior Residents (WASSR) has been established for several years and provides trained volunteer advocates to enable all older people in the London Borough of Westminster to express choices about matters affecting their everyday lives and so achieve a better quality of life. WASSR runs a number of specialist services, including a dementia advocacy service and a housing advocacy service. There is outreach work to hard to reach groups including black and minority ethnic communities and people with challenging behaviours or people with mental health problems. WASSR has also developed and runs the Dementia Advocacy Network, which provides support, networking and learning opportunities to dementia advocates and others working with people with dementia.

The methods

Given its aims and approach, the Benchmarking Advocacy and Abuse Project can be seen to have attempted to combine elements of research, practice development, quality management and collaborative learning. The range of methods employed reflected this wide ranging endeavour and included a literature review, data gathering forms, benchmarkers meetings, reflective practice sessions, sharing advocacy stories, and telephone interviews. These methods are further discussed below.

Literature review

Literature on advocacy, abuse, safeguarding and benchmarking was reviewed in preparation for the project and as it progressed. This included an exploration of relevant academic literature, Government reports and guidance, as well as the 'grey' literature produced by national statutory and non-statutory organisations and local advocacy schemes.

Data gathering forms

Four data gathering forms provided the key components of the research, providing a survey of benchmarkers' perceptions of their casework and a self description of the process of supervision within individual advocacy schemes. The survey was carried out in two stages: retrospective and current.

A case data form (Form 1A) first asked the benchmarker to identify a basic demographic profile of the service user; categorise the source of the referral; to categorise the nature of the abuse. It then went on to ask the benchmarker to categorise: the goals of the intervention (distinguishing the advocates' goals from those of the user, for example); the key elements of the advocates' approach, and the outcomes of the intervention. The overall focus of the questions is on a description of the users' characteristics; the status of the case within or outside safeguarding procedures; the planning of the advocacy response, and the providers' judgements of the outcome.

Firstly, the benchmarkers were asked to generate data for all relevant case-work in the previous calendar year to be included on Form 1A. However, the form was intended for use with both retrospective and current cases. For the purposes of the research the case was 'closed' either when the work concluded, or when the period for data collection came to an end. Once submitted, information from the forms was copied into a database and held by OPAAL.

Secondly, from the beginning of June 2008, the benchmarkers were asked to open a file for all new cases, and then submit two reports on a monthly basis. The first of these (Form 1B) used pre-set categories and a small box with room for comment to capture any movement or progress in the case and was to be submitted by the benchmarker as part of the survey. The second (Form 1C) was to be used by the

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advocate, seen by the benchmarker (if not the advocate), and then submitted in confidence to a member of the steering group guiding the reflective practice. The form asked for a description of activity and then invited the advocate to reflect on changes and learning. It was intended to capture some of the complexity of the work, such as any doubts surrounding the status of the abuse, or to comment on the impact and involvement of relatives and other professionals.

Early in the project, a form was added for the benchmarker and project partners to help prepare the ground for the supervision and reflective practice side of the work (Form 2). This asked about arrangements for supervision, identification of advocate, and case allocation procedures. It also asked for brief feedback on whether the scheme used reflective practice in supervision; whether the benchmarker had undergone training in reflective practice; classification systems for abuse; use of advocacy outcome measures, and support needs for participation in the project.

The benchmarkers were asked to comment on the content and design of Form 1A. The feedback was collated through a one-hour focus group session and then by phone or email. Several revisions were made.

Benchmarkers meetings

The benchmarkers meetings served to share information about the progress of the project itself, discuss emerging issues and results, and feed into the formulation of benchmarks. The meetings also provided an opportunity to present relevant aspects of the work of partner organisations and other contributors, including definitional issues and wider developments in the fields of advocacy and abuse.

“The presentations by AEA and OPAAL and then our discussions in the group were a great help. Getting the definitions right is crucial – even more than I had carried in my head. It gives practice a stronger knowledge base... and brings clarity and confidence in acting and confronting what are after all abusive situations.” (Advocacy Scheme E)

“In the benchmarking group we had a direct relationship with each other. I felt we were all moving through something together – even in the more difficult parts. There was something for everyone to take away, think about or try.” (Advocacy Scheme D)

Reflective practice groups

The reflective practice groups provided a secure forum for benchmarkers to share practice development and deal with ethical issues and dilemmas as well as practical challenges in the day to day work of advocacy schemes working with abuse. This space was valued by the benchmarkers in their feedback on the project.

The benchmarkers were briefed on the nature of reflective practice as a non-managerial or non-mechanistic approach. The need to identify and reflect upon work in which there was an 'unsettling element' was also explained as being a key feature of practice development and action. As John Miles of OPAAL UK noted in his report on the Benchmarking Advocacy and Abuse project reflective practice day, held in June 2008:

"In a way reflective practice involves looking for trouble – problem-finding is sometimes as important as problem solving."

The first reflective practice session involved discussion of a case that had been submitted by one of the schemes. It highlighted the complexity and emotional challenge of the work and opened discussion about the limits of the instrumental and expressive roles of the advocate.

A further session required the benchmarkers to work in pairs and consider an example of their own personal everyday experience of indecisiveness and vulnerability. They were then asked to link this experience to a piece of advocacy with an older person and the supervision process. Using a variation of a model of reflective cycle developed by Gibbs (1988), benchmarkers were guided to ask themselves the following questions:

- What is the situation?
- What are you thinking and feeling about it?
- What is good and bad about not making a decision?
- What sense can you make of your responses / behaviour?
- What else could you now do?
- How will you respond in a similar situation in future?

The process of reflective practice was also linked to entries on Form 1b as described above. Some advocacy managers reported that this had been incorporated into individual supervision with advocates. Further tools included the suggestion that the benchmarkers could keep a reflective practice diary, recording events and using the reflective cycle. Members of the project team also made themselves available to comment and provide feedback on reflective practice in writing, by telephone and in person if needed.

"It pains me to say it but this exercise showed that we fell down on the reflective side of our work both within our organisation and with service users. We were reflective but not reflective enough. I try to choose volunteers sufficiently sensitive to work with abuse – but we need to reflect on our reflective practice!" (Advocacy Scheme C)

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Another important feature of the reflective practice sessions was the use of ‘advocacy stories’, as the benchmarkers were encouraged to tell the story of their advocacy partnerships. This approach follows a longstanding advocacy tradition (Williams 1998; Henderson and Pochin 2001), though the focus was on telling the stories of the benchmarkers themselves rather than their advocacy partners.

“I am very taken with the idea of using advocacy stories. Advocates are not good at telling their OWN stories. They are good at telling the story of the person they represent – the advocacy is not seen to be about themselves. It is good to hear the process the ADVOCATE works through, the connections with their life experience. It’s learning about being alongside another human being, what to do with someone you really cared for.” (Advocacy Scheme B)

Telephone interviews

Follow up telephone interviews were conducted with all six benchmarking advocacy schemes involved until the end of the project. The telephone interviews provided the opportunity to clarify the content of previously submitted data, including any gaps, expand upon the themes discussed within the reflective practice sessions, and enable participants to provide feedback on the project as a whole.

The telephone interviews were conducted using a semi-structured set of prompts and thematic cues. Participants were asked to comment upon:

- The barriers / enablers to working with abuse
- Relationships between their scheme and the local safeguarding group
- Key areas for reflection and the formation of benchmarks
- The strengths and weaknesses of the Advocacy and Abuse Benchmarking project

Advocacy scheme-specific questions were also asked in following up issues highlighted in the data gathering forms and reflective practice sessions.

The limits of the project

As the Benchmarking Advocacy and Abuse project has been exploratory in nature, it is important to highlight some of the main limitations identified in the pilot process. This is intended to capture the experience of stakeholders as well as to inform future work.

Clarity

The project might have benefited from greater clarity of terms of engagement regarding the roles and responsibilities of the steering group, contributors and

advocacy schemes from the outset. This could have helped all stakeholders to understand expectations, plan their involvement and be more explicit about the contributions they would be able to make. A 'benchmarker commitment form' used at the beginning of the project might have been broadened to include the commitment between partners and contributors. The terms might also have been reviewed more formally during the course of the project.

Complexity

At another level, some aspects of the project were perhaps overly complicated. Form 1A, for example, required more guidance for completion by the benchmarkers and further clarification was needed in coding the data for analysis. There was also some confusion about the relationship between different elements of the project – such as the connection between reflective practice and benchmarking – and how these were to be brought together.

“The reporting forms were onerous. A standard format is useful but the forms were too difficult to complete.” (Advocacy Scheme E)

Resources

The project was under-resourced at all levels. This was perhaps most acutely felt in the lack of funding for the involvement of the advocacy schemes themselves. However, the schemes were reimbursed for travel expenses to attend benchmarkers meetings. They also reported that they had derived great benefits from the reflective practice element of the project – and hoped to see more return on their involvement if this project led to further development and progress in the field.

Capacity

This was an ambitious project which placed significant demands on the steering group members and other contributors. Some interested advocacy schemes were unable to either commence or continue their involvement due to lack of organisational capacity, sickness and staff turn-over during the life of the project. The benchmarking advocacy schemes with a relatively large group of paid staff and volunteers – as well as those with a sole advocacy worker who remained involved in the project – similarly voiced concerns about capacity, and of working in a relatively under-resourced sector. This issue clearly needs to be borne in mind in future initiatives.

“It was beneficial to be able to share and to listen to each other about how we work – individually and organisationally. But I could see that some organisations have more time and space in their schemes and for the project than others. It must be particularly difficult for the small one man bands who might benefit the most.” (Advocacy Scheme D)

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Project findings and discussion

This section will begin with a brief outline of the demographic profile of advocacy partners (service users) referred to advocacy schemes involving abuse, and a consideration of the types of abuse being recorded. The section largely then follows the pathway from the referral stage to the results of intervention. The outcomes of advocacy intervention are examined in terms of whether – and to what extent – the goals had been achieved, as well as levels of satisfaction and empowerment. The section draws upon responses to the data collection, benchmarkers meetings, reflective practice work and telephone interviews undertaken during the project. It incorporates findings which are pertinent to each of the main aims of the project regarding the evidence base and impact of advocacy, relationships with Safeguarding Adults teams and processes and the potential to benchmark best practice.

Demographic data

Summary *: In the majority (39%) of cases advocacy partners (service users) were aged 80-89. Almost twice as many women as men had been provided with advocacy support in retrospective cases, but equal numbers of men and women in current cases were receiving support. 12% of advocacy partners were identified as Asian, Black / Black British, Chinese or of other ethnic origin.

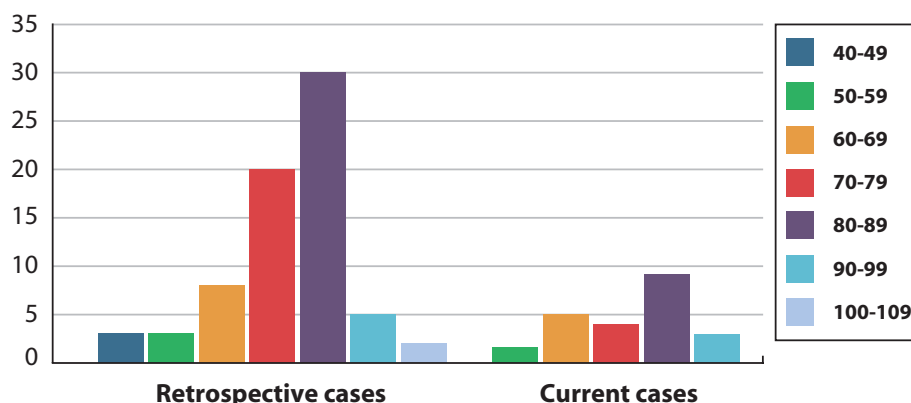
Form 1A called for information on the age, gender and ethnicity of the advocacy partners. The responses provided some basic demographic data on the composition of those people receiving advocacy support from the schemes involved in this project.

The ages of advocacy partners in the retrospective data ranged from 40 to 100+ (Figure 1). Those at the youngest end of the age range were known to advocacy schemes working with people with learning disabilities. Two advocacy partners were aged 100+. A significant majority of advocacy partners in the retrospective and current data were in the 80-89 years cohort (30 and 9 partners respectively).

* The summaries of data findings combine retrospective and current cases, and are based on percentage extrapolations for each question asked in data gathering forms.

Figure 1. Demographic profile

AGE



In the retrospective data there were almost twice as many women as men being provided with advocacy support (50 women and 26 men). At the point at which the current data was collated, exactly the same number of men and women were receiving advocacy support (11). However, further questioning revealed that the advocacy schemes tended to work with women more than men and that this might be attributed to the larger proportion of older women relative to older men within the population as a whole.

The majority of advocacy partners in the retrospective data (64) and all of those identified in the current data (22) were identified as being White. The retrospective data also showed 9 Asian / British Asian, 2 Black / Black British and 1 advocacy partner of Chinese or other ethnic origin. Given that one of the participating schemes focused entirely upon advocacy for Asian elders, it would appear that engaging with black and minority ethnic groups is an area requiring further attention (Rai-Atkins et al 2002; Bowes and Sim 2006).

Referral

Summary: 86% of cases were new referrals, and the referral indicated abuse in 75% of cases. Where abuse was indicated, 75% of referrals were made by social services staff who were not part of Safeguarding Adults, 16% by Safeguarding Adults staff, 10% by hospital based NHS staff, 6% by family members, 5% by GP or primary care based NHS staff, 2% by private sector service providers and 1% by voluntary sector providers. Where abuse was not indicated in the referral, it was subsequently identified by the advocate in 25% of cases, by the older person themselves in 27% of cases, and by someone else (usually care professionals) in 50% of cases. At the point of referral, advocacy schemes were made aware of whether there had been a professional assessment of the person's capacity in 38% of cases, but were unaware in 61% of cases. Independent Mental Capacity Advocates (IMCAs) were involved in 36% of current cases.

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Form 1A explored several aspects of the cases at the point of referral, including:

- Whether the referral was new and previously unknown to the scheme
- Whether abuse was indicated at the point of the referral
- The source of the referral
- Whether the capacity of the person had been known to have been assessed at the point of referral
- Whether an IMCA had been involved at any stage

The retrospective responses showed that 66 of the 76 cases dealt with during the period in question were new referrals. Within the current data, 19 of the cases were new and 3 were already known.

The retrospective data revealed that a referral was made with references to abuse in 60 cases but not mentioned in 16 out of the total 76 cases. In the current data, abuse was indicated in 14 cases but not mentioned in 8 out of 22 cases.

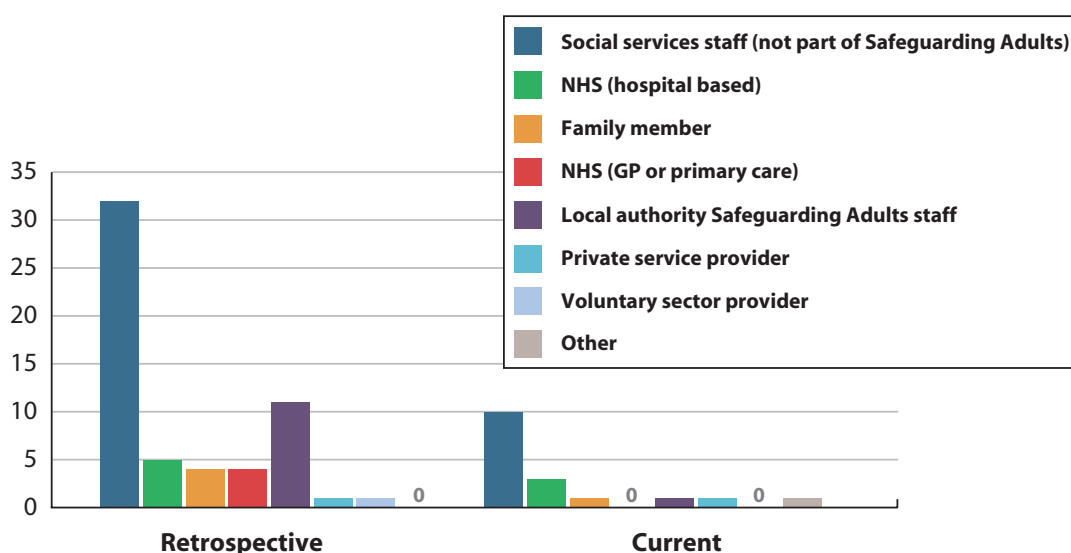
In terms of the source of the referral in which abuse was indicated, the retrospective data showed that the referral was made on behalf of the older person in 57 cases and that the older person approached the advocacy scheme themselves in 7 cases (there were 12 non-responses to this question). In the current data, the referral was made on behalf of the older person in all cases recorded.

In the event of the referral in which abuse was indicated being made on behalf of the older person, the retrospective data showed that the majority of referrals (32) were made by social services staff who were not part of Safeguarding Adults, whilst 11 referrals were made by Safeguarding Adults staff. Hospital-based NHS staff made 5 referrals and GP or primary care based NHS staff made 4 referrals. Family members made 4 referrals and private and voluntary sector service providers made 1 each (see Figure 2).

The current data again showed that the majority of new referrals made on behalf of the older person in which abuse was indicated were made by social services staff who were not part of Safeguarding. Indeed, only 1 referral within the current data set came from Safeguarding Adults staff. NHS hospital-based staff accounted for 3 referrals. There was 1 referral received from a family member and 1 each from a private sector provider and other source.

Figure 2. Source of referral

WHO MADE THE REFERRAL ON BEHALF OF THE OLDER PERSON?



It should be noted that whilst most of the above responses indicated that referrals came from local social services staff (and indeed other professionals) rather than from dedicated Safeguarding Adults sources, follow up questioning revealed that referrals were being made with the knowledge or support of Safeguarding Adults teams.

In the retrospective data, for referrals in which abuse was not indicated, the abuse was identified in support of an overall referral for advocacy in 2 cases and the abuse was identified in support of a request for another service in 7 cases. Within the current data, abuse was identified in support of an overall referral for advocacy in 3 cases.

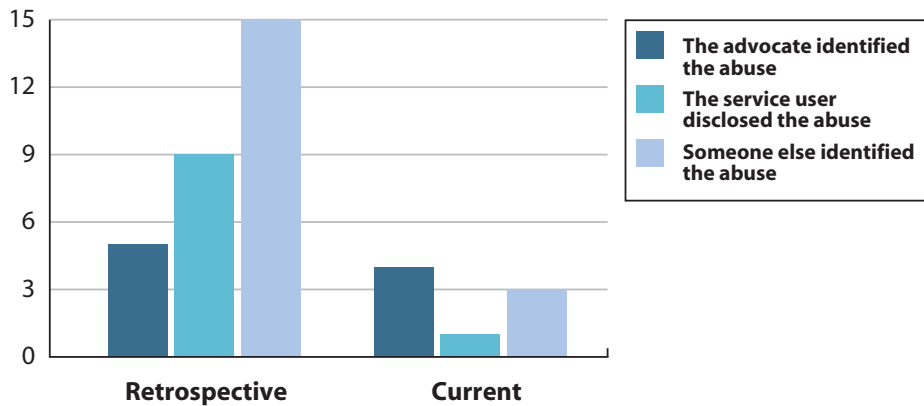
Of the referrals in which abuse was not indicated, the retrospective data shows that: 5 of these were made by social services staff who were not part of Safeguarding Adults; 1 by a family member; 1 by NHS hospital-based staff; 2 from other sources; none came from Safeguarding Adults. Current data identifies just two sources – private service providers (3) and, in one case, a friend.

In cases not referred because abuse was suspected, the retrospective data shows that the advocate subsequently identified the abuse in 5 cases; the service user disclosed the abuse in 9 cases; someone else identified the abuse in 15 cases. Within the current data the advocate identified the abuse in 4 cases; the service user disclosed the abuse in 1 case; someone else identified the abuse in 3 cases. Those named within the category of ‘someone else’ included a local authority housing officer, a registered social landlord officer and day centre staff. (See Figure 3.)

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Figure 3. Source of disclosure

IF THE CASE WAS NOT REFERRED BECAUSE ABUSE WAS SUSPECTED, HOW WAS THE ABUSE IDENTIFIED?

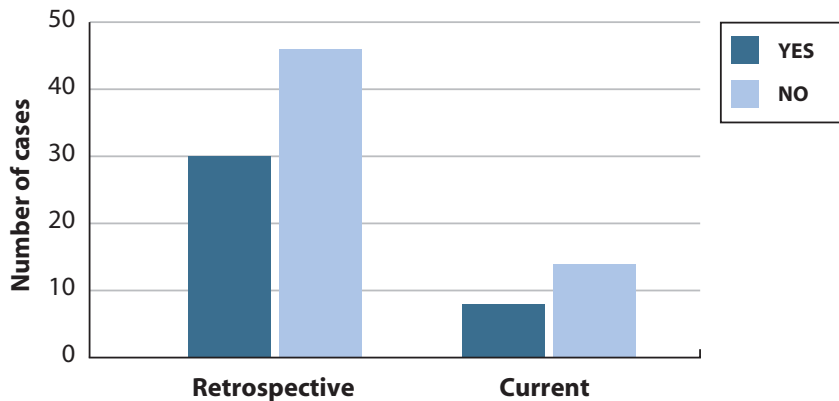


Benchmarkers were also asked questions about the capacity of the older people when referred. At the point of referral, according to the retrospective data, advocacy schemes were made aware whether there had been a professional assessment of the person's capacity in 30 cases, but were not made aware in 46 cases. In the current data, advocacy schemes were made aware in 8 cases and not made aware in 14 cases. Therefore, advocacy schemes were receiving a significant number of referrals regarding people whose capacity was of concern. Moreover, since opening the case after referral, the advocacy schemes had been made aware of a professional assessment of the person's capacity in 2 cases within the retrospective data and in 5 cases within the current data. (See Figure 4.)

The retrospective data shows that an Independent Mental Capacity Advocate (IMCA) had not been involved at any stage up to the point of referral in any of the 75 cases recorded. In the current data, an IMCA had been involved in 8 cases but there was no IMCA involvement in 14 cases. The advocacy schemes subsequently attributed this rise in involvement to the work of IMCA's becoming more established over the period in question. It was also believed that the relationship between IMCA's and non-IMCA schemes was beginning to develop in some areas.

Figure 4. Awareness of a professional capacity assessment

AT THE POINT OF REFERRAL, WERE YOU MADE AWARE WHETHER THERE HAD BEEN A PROFESSIONAL ASSESSMENT OF THE PERSON'S CAPACITY?



The relationship between the advocacy scheme and Safeguarding Adults, as well as statutory health and social services more generally, was seen by benchmarkers to be of significance at the referral stage. It was seen to directly affect the quantity and quality of referrals:

“When the professionals know the advocate’s role it is a better quality of referral. It then gets better working together – it enables the process from the beginning – who is doing what, who needs to know within the Safeguarding system.” (Advocacy Scheme A)

“Referrals are few and far between from Safeguarding – but it has happened. The majority of our referrals are from social workers... The number of abuse cases referred to us over the past couple of years have been small. It worries me that things are not coming to our notice. We need to get closer.” (Advocacy Scheme C)

“Social services recognise that many of their clients in care homes need independent representation. They are referring and looking beyond the boxes – even stretching their criteria to make the referral. That’s been a positive and relationships have improved. But hospitals just seem to see advocacy as a way of getting beds released. It’s very much part of that mindset.” (Advocacy Scheme C)

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Some schemes have taken the initiative to raise awareness about advocacy and their own schemes amongst professionals. Others highlighted the positive difference that the longevity, familiarity and credibility can make:

“It is important to helping professionals who you work with to understand what advocacy is and how to use it properly. We give presentations and provide training on what we do. We have used old cases to work with social workers on what might have happened before referral was made. We also identified cases in which there are multiple issues to deal with and the advocacy would just be a part of a multi-agency response.” (Advocacy Scheme D)

“We have been established for a long time. The role of the independent advocate has clicked with Safeguarding and social services locally. The good ones have a good understanding of what advocacy is about.”
(Advocacy Scheme B)

“The scheme is established and understood. The personalities are known. We are not strangers... we are trusted. Even if the advocate is challenging them, they know we work in a fair way for the right reasons. They are confident that involvement of advocate will improve life chances of the service user so will make the referral. Reputation and respect makes a huge difference.”
(Advocacy Scheme A)

One benchmarker highlighted the need for professionals within statutory services locally to be clear about their own practice in relation to the Safeguarding process when referring to the scheme:

“Much of the work we have done on abuse did not come from POVA [Protection of Vulnerable Adults] directly. Many had social services involvement but the social workers were not ready to instigate POVA procedures until there was independent back up. Social workers have looked to us to instigate proceedings. Perhaps social workers are lacking in confidence to report in their own systems. Is this a consequence of Baby P? Some social workers seem concerned about being the alerter.” (Advocacy Scheme D)

Types of abuse experienced

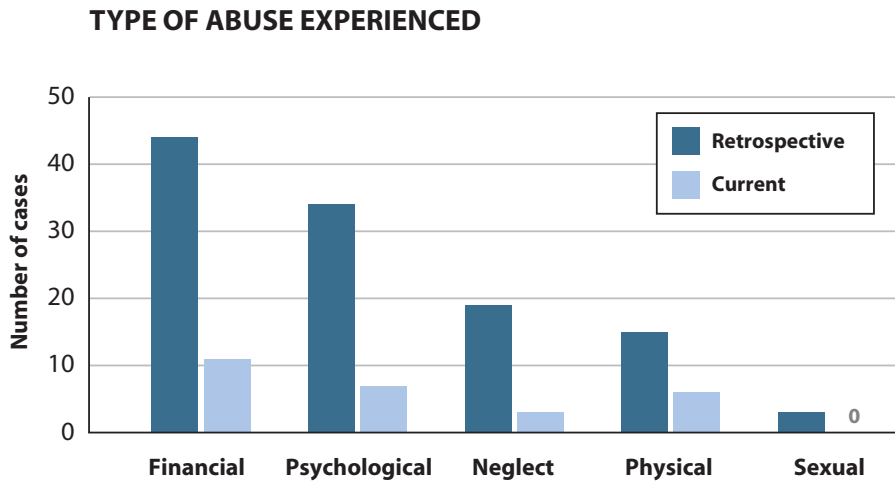
Summary: Financial abuse was experienced by advocacy partners in 38% of cases, psychological abuse in 28% of cases, neglect in 15% of cases, physical abuse in 14% of cases, and sexual abuse in 2% of cases. Examples show that, in some cases, older people paid large amounts of money to their abusers, that they were verbally bullied and threatened or forced to eat, were left without necessary assistance for their personal care or hygiene, had been pushed to the floor or physically assaulted, and raped or subjected to other non-consensual physical or sexual contact. In some cases, older people experienced more than one kind of abuse. The benchmarkers emphasised the importance of clarity of definition for abuse, and for its nature to be more widely recognised by the public and professionals, as well as by advocates and older people themselves.

The advocacy schemes reported working with people experiencing a range of types of abuse – with some people experiencing more than one form. The retrospective cases included instances of financial, psychological, physical and sexual abuse and neglect, with financial and psychological abuse being the most prominent forms accounting for 44 cases and 34 cases respectively. Neglect was identified in 19 cases, physical abuse in 15 cases, and sexual abuse in 3 cases. (Figure 5.)

The current cases showed a similar spread of types of abuse, though sexual abuse was not reported and there were relatively more instances of physical abuse (6) than neglect (3). Financial abuse was again the most recorded form of abuse (11 cases), followed by psychological abuse (7 cases).

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Figure 5. Experience of financial, psychological, physical and sexual abuse, and neglect



Case examples

The nature of abuse brought to the attention of the advocacy schemes is illustrated by the following examples drawn from their casework.

Financial abuse

An 85 year old woman with dementia was referred to the advocacy scheme by the Social Services Department. She reported paying large amounts of money, ostensibly for work to be carried out on her house, without knowing what was being done or how much it was costing. Her step niece would arrive to initiate these payments then go away 'on holiday' for a few months.

An 83 year old man was referred to the advocacy scheme by a family member. He entered a residential care home from hospital before being able to return to his own home. When he got back to his own home he began to pay a care assistant he had met at the care home to provide him with domestic and personal care (she was still employed at the residential care home in which they had met). He reported handing over large sums of money as well as gifts to retain her services. She had also tried to dissuade him from seeking alternative sources of assistance.

Psychological abuse

A 100 year old woman was referred to the advocacy scheme by a family member. The referrer had previously highlighted concern to the carers' agency providing her great aunt with a paid carer. She reported having seen change in her great aunt's outward behaviour. The situation seemed to deteriorate and her great aunt had become very withdrawn. Her great aunt then disclosed that she was being verbally bullied and forced to eat by the paid carer from the agency and that this had been going on for over a year.

A 74 year old woman was referred to the advocacy scheme by the Social Services Department. She disclosed psychological abuse by her son. He had mental health problems and was abusing class A drugs. She had looked after him for many years but he had recently become verbally aggressive and taunted her. He was also demanding money and threatening to sell her personal belongings to get money for drugs if she did not do what he wanted. She reported being scared and spending many hours wondering what to do.

Neglect

A 71 year old woman with learning disabilities was referred to the advocacy scheme by staff at a drop in centre. She lived alone and received weekly visits from a care worker. She reported that she had not been allowed or supported to bathe, shower or wash her hair by her care worker over a matter of months. She was distressed about being unable to manage her personal hygiene and being 'unable to be heard' by the care worker when she tried to express her needs and requirements to be helped.

An 85 year old man was referred to the advocacy scheme by a family member. He lived with his wife in their home. He had several strokes which led to cognitive impairment. He had also suffered from heart failure and incontinence. He had received support from his wife, along with a small package of care via the Social Services Department. However, over a period of 14 months his wife had been turning the carers away. The man was no longer receiving assistance with his personal care, eating, washing and other daily tasks. The referrer stated that the man's wife seemed unable or unwilling to help him in place of the carers.

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Physical abuse

An 88 year old man was referred to the advocacy scheme by the Social Services Department after he had made an allegation of deliberately being pushed to the ground by a member of care staff in a residential care home. A police investigation was apparently dropped at the request of the man. An internal investigation of the incident was being carried out within the care home. The client was fearful of his situation within the setting and in need of support through the investigation process.

A 76 year old woman was referred to the advocacy scheme by Safeguarding Adults staff having been subject to physical assaults by her son. The mother and son each owned a half share of the house in which they both lived. He wanted her to relinquish her share of the property and move out, resorting to physical violence to get her to do so. She was very distressed and had fled to her daughter's house as a temporary measure until the situation could be resolved.

Sexual abuse

A 63 year old woman was referred to the advocacy scheme by Social Services staff. She lived in a group home. She reported that another resident had been going into her bedroom at night and making unwelcome physical and sexual contact. The incidents had happened some time before but she had not reported anything to care staff until now. She liked the group home and wanted to stay, but wanted the abuse to stop.

A 79 year old woman was referred to the advocacy scheme by Social Services staff. She reported having been raped by a volunteer visitor shortly after moving into the residential care setting in which she lived. The police were involved but the alleged perpetrator had disappeared. The woman wished to leave the facility where the alleged attack had occurred to find alternative accommodation.

The benchmarkers also emphasised the importance of clarity of definition and for the nature of abuse to be more widely recognised by the public and professionals, as well as advocates and older people themselves:

“Financial abuse is sometimes indicated in a referral to our scheme, but really the issue is simply about setting up a direct debit. So social workers try to send in the advocate on the premise that there might be abuse and they might get a quicker response to sorting out a practical matter as well as covering all eventualities ‘just in case.’” (Advocacy Scheme D)

“Older people with learning disabilities, for example, do not always recognise abuse as abuse. There is sometimes difficulty in communication – or there can be low expectation. Or there are those who have lived with it for all their lives and it is what it has always been.” (Advocacy Scheme B)

“The benchmarking exercise and the discussions in our meetings really helped us to understand that certain actions of relatives with whom we work are abusive. They didn’t see it as abuse and perhaps we didn’t formally categorise it as such, though we took it seriously.” (Advocacy Scheme E)

Goals of advocacy intervention

Summary: Brief accounts of the goals of the intervention (as identified by both the advocate and the advocacy partner) were provided. These ‘goal setting statements’ were divided into two categories (abuse-focused and non-abuse focused) and cross referenced according to whether they related to the instrumental (‘doing’) or expressive (‘being’) roles of advocacy. There was evidence that both instrumental and expressive approaches had been adopted within the goals set.

The benchmarkers were asked to provide a brief account of the goals of intervention identified by both the advocacy partner and the advocate on Form 1A. This starting point might have heralded a somewhat mechanistic exercise and it was generally acknowledged that the language of ‘goals and outcomes’ felt overly managerial and even alien to some advocates. However, members of the project steering group agreed that among the advantages of goal setting were that it encouraged transparency (the implicit intentions of advocacy are made explicit with the user) and that it kept the advocate’s accountability constantly before them.

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A variety of goal setting statements were made by the advocacy partners and advocates. As the project progressed, the incoming data on these statements was grouped into two cross referenced sets of categories, Firstly, abuse focused and non-abuse focused goal statements. Secondly, a continuum of goal statements that could be related to the instrumental and expressive roles of advocacy.

Advocacy partners' goal statements

For advocacy partners the abuse-focused, instrumental goal statements included: *"neighbour to be prosecuted"* and *"complain to social services about this situation"*. The abuse-focused, expressive goal statements included: *"stop the bullying"* and *"for the abuse to end"*.

Also for advocacy partners, the non-abuse focused, instrumental goal statements included *"to move into residential care"* and *"to get a new care package in place"*. The non-abuse focused, expressive goal statements included *"to improve personal hygiene"* and *"to develop confidence"*.

Advocates' goal statements

For advocates the abuse-focused, instrumental goal statements included: *"to represent the service user at meeting and with permission put their views to Safeguarding Adults team"* and *"to support the client to make a complaint"*. The abuse-focused, expressive goal statements included: *"enable client to feel more positive about care needs"* and *"to increase service user's confidence"*.

Also for advocates, the non-abuse focused, instrumental goal statements included: *"get social worker to arrange a review of her care package"* and *"get benefit check done"*. The non-abuse focused, expressive goal statements included: *"encourage user in their pursuit of personal hygiene"* and *"support partner in confidence building"*.

It was noticeable from this data that whilst advocacy partners and advocates identified instrumental goals, advocacy partners tended to have identified more expressive goals than the advocates. It was also apparent that in a few cases, there was a total divergence of view between the advocate and partner as to setting the goals of intervention. This included examples in which the advocacy partner gave less prominence to addressing abuse (the main goal for the advocate) than the desire to address their living arrangements. The reflective work and interviews with the benchmarkers also highlighted this tension:

"A main barrier can be the person themselves. Enabling them to express their concerns about what's going on and then getting them to agree that it needs to be taken up. It is difficult not to tell them what to do in their best interest – not to lead them to where you think that they should be going... In abusive situations that's what might be needed." (Advocacy Scheme C)

Advocacy in practice

Summary: Having identified intervention goals, benchmarkers reported on how advocates intended to pursue them, using a set of pre-defined categories. 19% of advocates intended to pursue identified goals by making an alert to Safeguarding Adults, 11% by supporting the person without involving local Safeguarding Adults, 31% by representing the person during the multi-agency Safeguarding Adults procedure, 18% by maintaining a 'watching brief', 12% by providing the person with information about rights and choices, and 7% by referring on elsewhere. Accounts of advocacy practice during the project demonstrate the painstaking expressive practice that can enable a person who has been abused to find a voice, and the skill and speed which enables effective instrumental or representational work. There was evidence of increasingly developed relationships with Safeguarding teams and systems (although concerns were raised about length of time and lack of feedback), and most benchmarkers believed that remaining 'one step removed' from the formal Safeguarding structure helped to maintain independent and effective representation. Benchmarkers highlighted the need for good supervision (and the value of reflective practice) in dealing with the ethical, emotional and practical issues confronting advocates working with abuse.

Having identified the goals of intervention, the benchmarkers reported on how advocates intended to pursue them. Data Form 1A provided several pre-determined categories and benchmarkers could indicate their intention to pursue more than one of these if needed:

- By referring on elsewhere
- By making an alert to local Safeguarding Adults
- By providing the person with information about rights and choices
- By representing the person during the multi-agency Safeguarding Adults procedure
- By supporting the person without involving local Safeguarding Adults
- By maintaining a 'watching brief' (e.g. the ASIST model)

In the retrospective data, advocacy schemes reported that the advocate intended to represent the person during the multi agency Safeguarding Adults procedure in 53 cases; maintain a watching brief in 36 cases; make an alert to the local Safeguarding Adults body in 35 cases; provide the person with information about rights and choices in 21 cases; support people without the involvement of local Safeguarding Adults in 19 cases; refer on elsewhere in 12 cases. (See Figure 6.)

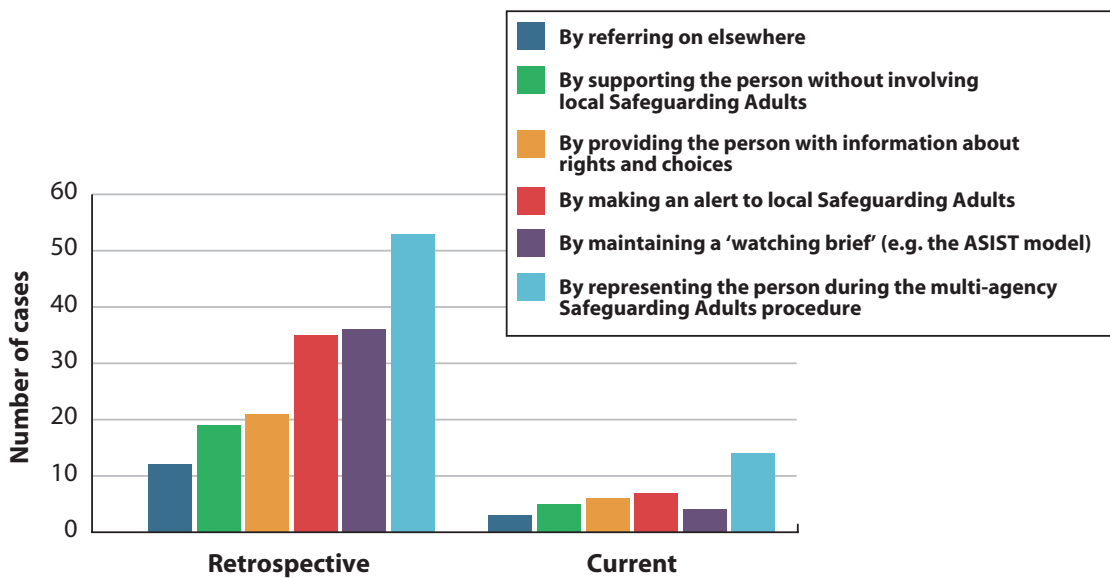
In the current data, the intention to represent the person during the multi agency Safeguarding Adults procedure was again the most frequently recorded response

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(in 14 cases). There was an intention to alert the local Safeguarding Adults body in 7 cases; to provide the person with information about rights and choices in 6 cases; to support people without the involvement of local Safeguarding Adults in 5 cases; to maintain a watching brief in 4 cases; to refer on elsewhere in 3 cases

Figure 6. Methods for pursuing identified goals

HOW DOES THE ADVOCATE INTEND TO PURSUE THE GOALS IDENTIFIED AT THE ORIGINAL REFERRAL?



In working with their advocacy partners, the benchmarkers indicated that advocates employed a range of skills and techniques which manifested both expressive and instrumental roles. The two passages below are used to illustrate firstly, the painstaking expressive practice that can take place to enable a person who has been abused to find a voice and secondly, a more instrumental and intervention in terms of a piece of representational work:

“There can be ambivalence. On the one hand wanting something done about the situation and on the other not wanting to change the situation or allow the advocate to see it through. The client herself – despite her ambivalence – she is accommodating and is happy to listen to all options – though she is not finding it easy to make a final decision. She gives her emotional feelings as well as how things affect her materially. It is an achievement of the project that she is able to express herself and is listened to – a really positive and beneficial ‘interim outcome’ for advocacy. She does not have that relationship with the care staff. Nobody else has got this from her – but it is there.”
(Advocacy Scheme C)

“The woman had Alzheimer’s. The social workers seemed in denial or lacked knowledge that the financial abuse was happening. They seemed to have no idea of how to respond to it or if they or anybody else should get involved with the family. So we did it. We engaged the lady, assessed the situation and made the alert. We got everybody around there who needed to be there. We also made sure that she was represented through the process.”
(Advocacy Scheme A)

The findings and further discussions with the benchmarkers suggested that advocacy schemes were developing relationships with Safeguarding teams and systems. There was evidence of advocates making alerts to the local Safeguarding Adults as well as representing and supporting the person during the multi-agency Safeguarding Adults procedure.

“I will attend a Safeguarding meeting, but will also see the individual first – to let them know I am going and see if there is anything they want me to put across – how they felt – and make sure that their views are represented. Safeguarding know that I need to do that and will try to give me time to do so before I am called in.” (Advocacy Scheme E)

“We are one step removed from the Safeguarding group and that’s a good place to be. We have just had a phone call from them to say that they want our involvement with a person without someone else to speak for them – we can be a watchdog and ensure that a process is carried through.” (Advocacy Scheme B)

Indeed, most benchmarkers believed that ‘one step removed’ from the formal Safeguarding structure might be a good place to be in order to retain independence and represent the advocacy partner effectively. However, it was also stressed that this position must not go against the interests of the advocacy partner:

“If you are too intrinsically involved in Safeguarding you are not in a position to challenge the process – you are the process. But if you are working for the individual and being there you can keep badgering for information and outcomes.” (Advocacy Scheme D)

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“If I sat on the Safeguarding group there could be issues about clarity of role and confidentiality. But in practice it is necessary to be known on the inside, as it were, to ensure protection and support people who are being abused. Hand on heart we do share information and we have had to move out of our advocacy comfort zone if this needs to be done.” (Advocacy Scheme F)

Further areas of concern regarding the relationship with Safeguarding in advocating for older people included the length of time that the process took, and lack of feedback:

“Safeguarding is a lengthy process. Everything is checked and rechecked. For the abused and the alleged abuser this is not helpful – they need somebody to speak up for them and get the process going and the information flowing. The process can be damaging or sometimes even more damaging than the abuse.” (Advocacy Scheme A)

“We are talking about advocating to get the person a good outcome. But by alerting the authorities in Safeguarding, the ‘official’ machine grinds away and it can be lengthy. That might not feel best for the people themselves, either because of the time or because they choose to stay in an abusive setting. It might be too rough a ride. It needs to be managed somehow.” (Advocacy Scheme F)

In discussing the process of advocacy intervention, benchmarkers also highlighted the need for good supervision to deal with the ethical, emotional and practical issues that confronted advocates working with abuse. A connection was also made with the use of reflective practice and the benchmarking project itself, though arrangements varied widely between projects. Two of the strongest schemes in this area of practice commented:

“I am shocked people don’t get opportunities for reflective practice. People who set up our project years ago are still with it on the management committee. People who give support need support and that has been our ethos and ethic from day one. We have good processes and systems for supervision and appraisal with agreed timescales and so on. We have monthly advocacy update meetings, looking at allocation, workload management etc. Individual supervision is to think about ways forward. It is feelings-based and uses reflection. So reflective practice is integral to what goes on – there is an institutional commitment at both levels.” (Advocacy Scheme B)

“Reflective practice is incorporated within individual supervision and group supervision. Staff meetings have been given over to group supervision and a discussion of dealing with issues. Feelings based issues can still be dealt with in individual supervision, but we find that things are being shared more widely.”
(Advocacy Scheme D)

The outcomes of advocacy intervention

Summary: The goals identified by the advocacy partner were reported as having been fully achieved in 36% of cases, partially achieved in 36% of cases, and not achieved in 13% of cases (no response was given in 15% of cases). The goals identified by the advocate were reported as having been fully achieved in 56% of cases, partially achieved in 41% of cases, and not achieved in 2% of cases. In the judgement of the advocacy schemes, the abuse had been stopped in 46% of cases, reduced in 11% of cases, prevented in 17% of cases, had not been substantiated in 19% of cases, and was ongoing in 6% of cases. 44% of older people reported being fully satisfied with the advocacy support they received, 24% were partially satisfied, and one older person was not satisfied (responses were not identified in 30% of cases). 42% of older people considered that they had been informed during the process, 31% that they had been empowered, and 19% that they had been involved. Benchmarkers expressed concerns that a linear ‘contract-process-outcomes’ model might be too mechanistic and miss the more expressive (‘being’) elements of the advocacy relationship; other methods, such as the use of advocacy stories, were felt to have a potential place in validating outcomes.

The benchmarkers were asked to indicate the outcomes of advocacy intervention with regard to:

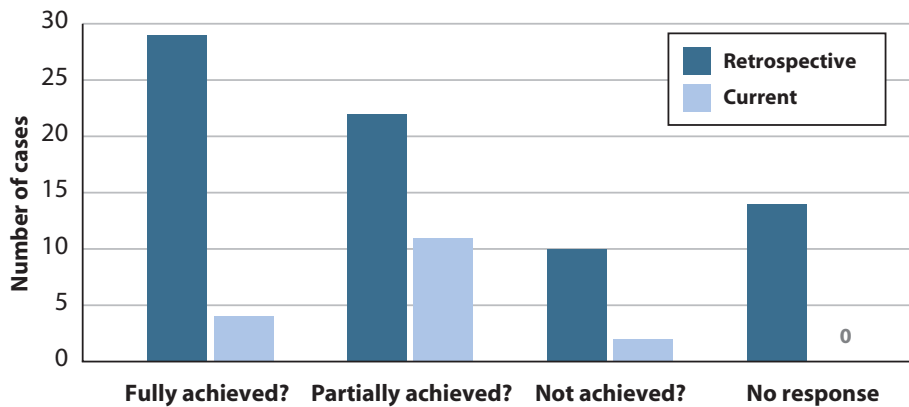
- Whether and to what extent the goals identified by the advocacy partner had been achieved
- Whether and to what extent the goals identified by the advocate had been achieved
- Whether the abuse had ended
- The level of satisfaction the advocacy partner felt about the advocacy support received
- The level of empowerment the advocacy partner considered they had reached

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When asked whether – and to what extent – the goals identified by the older person had been achieved, the responses in the retrospective data indicated that they had been fully achieved in 29 cases; partially achieved in 22 cases; but not achieved in 10 cases. There were no responses for 14 cases. In the current data the goals identified by the older person themselves had been fully achieved in 4 cases; partially achieved in 11 cases; but not achieved in 2 cases. (Figure 7)

Figure 7. Achievement of goals identified by the older person

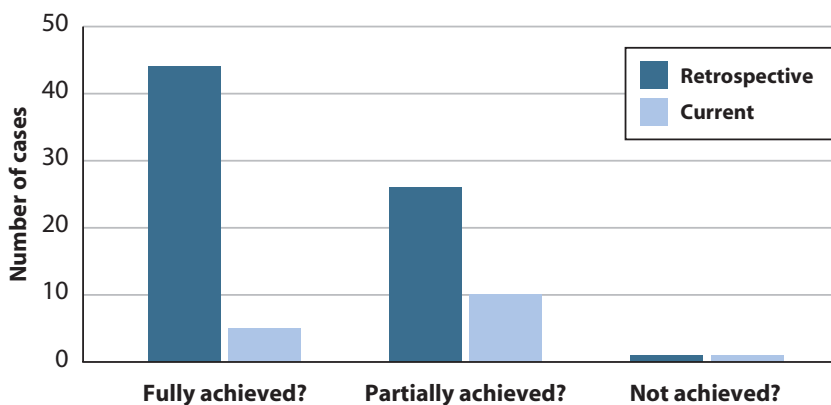
THE GOALS IDENTIFIED BY THE OLDER PERSON WERE...



Looking at the achievement of advocacy goals identified by the advocate, the retrospective data showed that they had been fully achieved in 44 cases; partially achieved in 26 cases, and not achieved in 1 case. The current data showed that the goals identified by the advocate had been fully achieved in 5 cases; partially achieved in 10 cases, and not achieved in 1 case. (Figure 8)

Figure 8. Achievement of goals identified by the advocate

THE GOALS IDENTIFIED BY THE ADVOCATE HAVE BEEN...



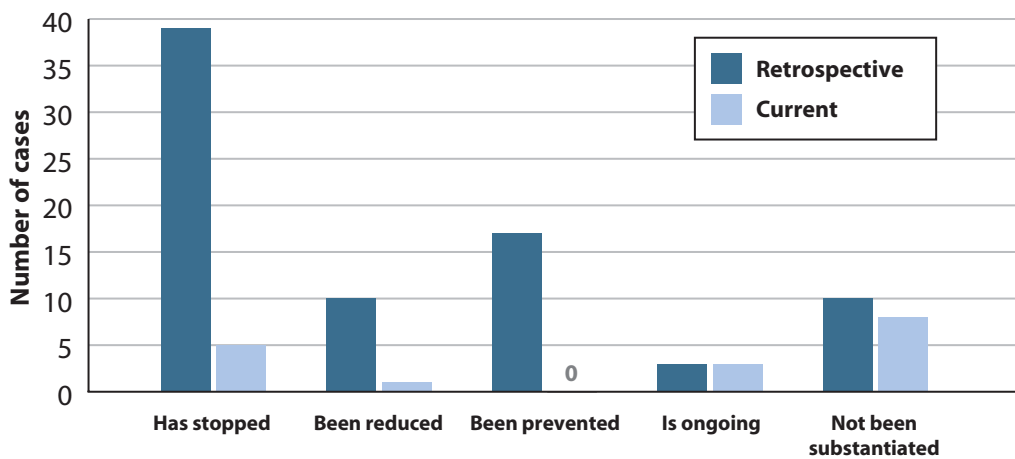
Therefore, approximately 85% of the goals identified by the older person were said to some extent have been achieved in the retrospective data responses received, and nearer 90% in the current cases. The achievement of the goals identified by the advocates was reported to have reached almost 100%. However, closer analysis yields some qualifications and suggests the need for some further consideration of these impressive percentages.

Given that the goals identified by the advocate generally tended to be a little more instrumental than those of the partner, they were perhaps more clearly translated into being achieved or not, for example the partner’s complaint made and upheld with the support of the advocate. The partial achievement category was perhaps too crude and did not pick up the relative significance of the identified goals and areas that had remained elusive and unmet.

Turning now to an exploration of outcomes with regard to ending abuse, in the retrospective data advocacy schemes reported that in their judgement the abuse had been stopped in 39 cases; reduced in 10 cases; been prevented in 17 cases; was ongoing in 3 cases, and remained unsubstantiated in 10 cases. In the current data the advocacy schemes reported that abuse had stopped in 5 cases; reduced in 1 case; but was ongoing in 3 cases, and was not substantiated in 8 cases. (Figure 9)

Figure 9. Advocacy schemes: judgments about ongoing abuse

IN YOUR JUDGMENT THE ABUSE HAS...



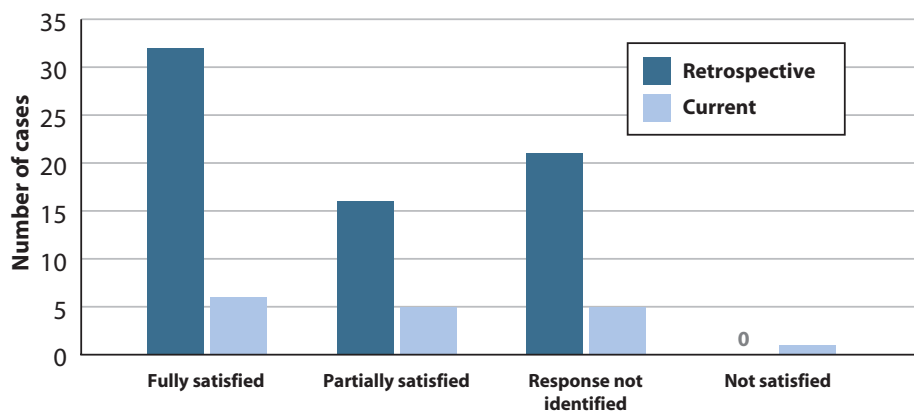
Of course, the advocacy schemes themselves were not the sole agency involved in these cases. However, given the advocacy goals and interventions highlighted above, they can be seen to have had a more or less significant part to play in the eventual outcomes – predominantly the prevention, reduction or eradication of abuse.

4

The reported level of satisfaction with advocacy support was also surveyed. The reported feelings of the older person regarding the advocacy support they had received in the retrospective data were those of being fully satisfied in 32 cases and partially satisfied in 16 cases. No response was identified in 21 cases. There were no reports of the older person not being satisfied. Within the current data, the older person was fully satisfied in 6 cases and partially satisfied in 5 cases. In 1 case an older person felt that they were not satisfied by the advocacy support they received. No response was identified in 5 of the current cases. (Figure 10)

Figure 10. Reported satisfaction levels among advocacy partners

WHAT DOES THE OLDER PERSON REPORT FEELING ABOUT THE ADVOCACY SUPPORT RECEIVED?

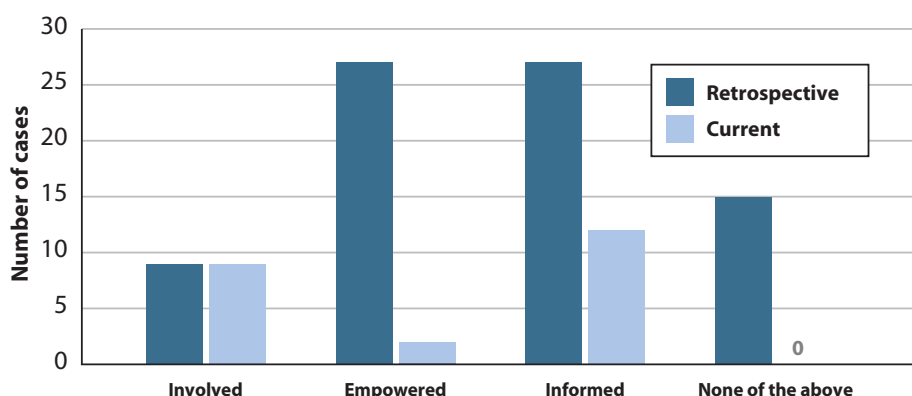


The above table suggests a very positive outcome for advocacy partners and advocacy schemes alike. However, the question did not signify a thorough or sophisticated investigation of satisfaction, it just provides a sense of how people feel about the advocacy support received. Some advocacy partners with whom there are challenges regarding capacity or communication might not have been able to respond to this question when asked directly, and other techniques might be required. Some benchmarkers were also uncomfortable with the use of what they felt to be consumerist language around 'customer care' and felt that it diminished the nature of the advocacy relationship.

Form 1A also asked about the level of empowerment that the advocacy partner felt they had reached. In the retrospective data gathered, the older person considered that they had been empowered in 27 cases; informed in 27 cases, and involved in 9 cases. They were reported not to have been empowered, involved or informed in 15 cases. There were 11 non-responses. Amongst the current cases, 12 older people considered that they were informed; 9 were involved, and 2 were empowered. (Figure 11)

Figure 11. Reported outcomes for advocacy partners

DOES THE OLDER PERSON CONSIDER THEY HAVE BEEN...



Once more, this question suggests a positive outcome for advocacy partners and indeed the advocates themselves. It provides a result which highlights empowerment as well as protection as being an outcome of advocacy. However, it is again an area in need of further work in forming a more in depth investigation of how advocacy partners conceptualise empowerment and how it can be effectively measured and attributed to the advocacy process.

The above findings and brief discussion of results regarding the outcomes of advocacy intervention requires some further comment on the nature of wider debates and developments. The benchmarkers complied but were generally concerned about the imposition of inappropriate outcome measures and movement towards ‘commissioning by results’ locally and nationally. A linear contract-process-outcomes model might be too mechanistic and miss the more expressive elements of the advocacy relationship – as well as underestimating the time that might be taken to produce a ‘result’. Other methods, such as the use of advocacy stories, might contribute to the validation of outcomes as well as enabling reflection and assisting the attempt to focus on what advocates actually do.

“There is a tendency to push us towards attacking the problem, solve it, quick outcome and move on – but maybe we need to uncover more to be really effective. In some of our advocacy partnerships the outcome was completely different to what was expected or hoped for at the start. But it was great! It was the process that changed things and brought out the things that really mattered to the person. Can you capture that?” (Advocacy Scheme C)

5

Conclusions and recommendations

The Benchmarking Advocacy and Abuse project has been an exploratory piece of work involving national partners and contributors as well as a small but diverse group of local advocacy schemes themselves. The project was shaped by three broad objectives: wishing to learn about the impact of advocacy, document the evidence and develop the evidence-base, and improve practice through joint-working. This report has sought to provide a discussion about the context, methods and findings of the project. This conclusion is presented in relation to the original main aims of the project and also proposes some areas for future work beyond the pilot phase.

Conclusions

The abuse of older people is a significant social problem, the nature and extent of which is still unfolding. Advocacy can play a crucial role in prevention and protection from abuse by supporting the older person to secure or exercise their rights, choices and interests – as clearly demonstrated in the work of the advocacy schemes engaged in this project. Yet, despite the positive acknowledgement of advocacy in a plethora of official policy documents, the legislative framework (and thus the status of advocacy itself) is limited and fragmentary.

Provision on the ground has grown over the past decade or so, but remains patchy, fragile and under-resourced. The advocacy movement has initiated and worked in partnership with government and other statutory bodies to further develop policy and practice. The advent of a new government agenda to transform public services and promote personalised care, along with the review of the *No Secrets* (Department of Health 2000) guidance brings new opportunities and challenges for independent advocacy in safeguarding older people.

Understanding of the impact of advocacy when working with victims of elder abuse

Advocacy schemes can be seen to work with a diversity of older people in a range of settings. Work with older people from black and minority ethnic groups may be seen to require further attention. The advocacy schemes work with older people experiencing all types of abuse – physical, psychological, financial, sexual and neglect – but predominantly financial and psychological abuse. Referrals are received from a number of sources, but mainly from local social services. The volume, source and quality of referral depend upon public and professional awareness of the role of advocacy as well as the relationships and credibility built up by the scheme itself.

Advocacy goals are generally shared between the advocate and their advocacy partner, but may vary in the balance between instrumental and expressive roles, or in differing perceptions of the central problem to be confronted. Advocates employ directed and non-directed approaches and undertake a range of instrumental and expressive roles to meet the goals in practice, including providing the person with

information about rights and choices, representing the person at multi-agency meetings and maintaining a 'watching brief'.

Advocacy schemes report a high rate of success in terms of meeting the goals identified by advocacy partners and their advocates and in helping to prevent, reduce or stop abuse taking place. Advocacy partners are also reported to have high levels of satisfaction and of empowerment.

However, the schemes raised concerns about the development of 'commissioning by results' and it was recognised that more work is required in this area to develop appropriate measures of performance. The significance of process as well as outcome was emphasised. The use of advocacy stories was seen to be a useful advocacy tradition that could be incorporated into such work and added to the advocacy evidence base.

Learning about relationships between advocacy schemes and the Safeguarding Adults teams and processes

There was evidence of a relationship between advocacy schemes and Safeguarding Adults teams and processes throughout each stage of the casework described in this report. However, this relationship was by no means clear, consistent or comprehensive across all schemes or within each scheme. Knowledge held by Safeguarding teams with regard to the nature of advocacy and the work of advocacy schemes was reportedly variable. The need for awareness raising, trust building and professional development was highlighted.

Advocacy schemes had considered their position in relation to the Safeguarding structure, and generally favoured being one step removed rather than 'part of the team' in order to be able to maintain their independence in representing the advocacy partner. Data on referrals showed that Safeguarding teams did refer to advocacy schemes directly or were aware of referrals being made by social workers.

There were a number of cases of advocates making the Safeguarding alert, supporting partners through the Safeguarding process, and representing the partner during the multi-agency Safeguarding Adults procedure. Some advocacy schemes raised concerns about the lengthy Safeguarding processes and the damage and distress this had caused the advocacy partner. Others cited problems in obtaining feedback or notification of decisions made within the Safeguarding system. Overall, there was a sense of some progress being made.

However, for the most part, relationships were not yet as close as they should be in order to best meet the needs of older people themselves.

5

Exploring the potential for advocacy schemes to benchmark best practice in this area

Despite the limits of the pilot project itself, as outlined in Section Three of this report, the benchmarking approach showed some potential – albeit partial in its application. The participating advocacy schemes took the opportunity to meet and openly shared their practice, experiences and concerns. The reflective practice element of the project was particularly highly valued, individually and organisationally. This led to the creation of advocacy stories from the perspective of the advocates and to the discussion of thorny issues and professional and personal dilemmas in a safe environment. This also brought a re-affirmation or revision of policy and practice when participants returned to their schemes.

Despite its title, the project did not generate a set of benchmarks – this was not intended in its aims and was unrealistic given the size of the sample and the diversity of organisations represented. The tensions between managerialist and more person centred approaches to the debate were palpable throughout the project, not least in the exploration of outcomes. But the project has identified some areas in which benchmarks might be feasible and helpful regarding the advocacy response to the abuse of older people, including: referral procedures; engagement with black and minority ethnic groups; protocols with Safeguarding; confidentiality; decision making, and supervision.

There is a need to have cognisance of, and to complement, current initiatives in the field (such as the Lost in Translation project on advocacy outcomes being undertaken by Action for Advocacy). OPAAL could also look towards some of its own parallel projects (such as its user engagement initiative) to explore reflections, stories and approaches to benchmarking which incorporate the views of advocates and older people.

Recommended next steps

Having concluded the findings and discussion of the Benchmarking Advocacy and Abuse project 2008-2009, the following next steps are recommended:

Practice developments

- 1 A substantive project to benchmark specific areas of the work of advocacy schemes identified in this exploratory project.** These areas might include the engagement of black and minority ethnic groups, confidentiality and decision making. A new project of this nature should ensure that there are clear terms of engagement between all national and local partners, sufficient resources, and connections with user groups.
- 2 A further discrete initiative on the development of best practice and protocols between Safeguarding systems and advocacy schemes.** This project would involve joint working between a group of local statutory Safeguarding agencies and advocacy schemes. The project would produce guidance and examples of best practice in this area for wider dissemination to policy makers and practitioners.
- 3 A project to develop an advocacy-friendly toolkit or resource pack on reflective practice.** The materials would be suitable for use by advocates, advocacy managers and supervisors on an individual, one-to-one and group basis, with references to working with abuse and other key areas of practice. An author with appropriate expertise and experience could be commissioned to undertake this task.

'Advocating for advocacy'

- 4 There is also an evident and pressing need to continue to 'advocate for advocacy' in the field of elder abuse – and indeed more widely.** At a policy level, OPAAL and national and local partners must promote the critical role of independent advocacy as a means of empowering and safeguarding citizens in the post *No Secrets*, personalised services era.

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“The woman had Alzheimer’s. The social workers seemed in denial or lacked knowledge that the financial abuse was happening. They seemed to have no idea of how to respond to it or if they or anybody else should get involved with the family. So we did it. We engaged the lady, assessed the situation and made the alert. We got everybody around there who needed to be there. We also made sure that she was represented through the process.”

(Casework from an advocacy scheme which contributed to the Benchmarking Advocacy and Abuse project)

Speaking up to Safeguard is the report of the Benchmarking Advocacy and Abuse project, which set out to learn about the impact of advocacy on elder abuse and to explore the potential for advocacy schemes to benchmark best practice in this crucial area of work.

Combining data and reflections from seven advocacy schemes, examples of casework, and recommendations for research and practice, this report from OPAAL UK provides a timely contribution to the evidence base for the role and value of independent advocacy in safeguarding older people from abuse.

Speaking up to Safeguard will be of interest to politicians and policy makers, academics, commissioners, Safeguarding Adults teams, health and social care and related practitioners, voluntary organisations, and older people’s groups and advocacy schemes.


Older People’s Advocacy Alliance (OPAAL) UK

Parkfield House, 64 Princes Road, Hartshill, Stoke-on-Trent ST4 7JL

Tel: 01782 844 036 Email: kathryn.parson@btinternet.com

www.opaal.org.uk

Registered charity number 1090182

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