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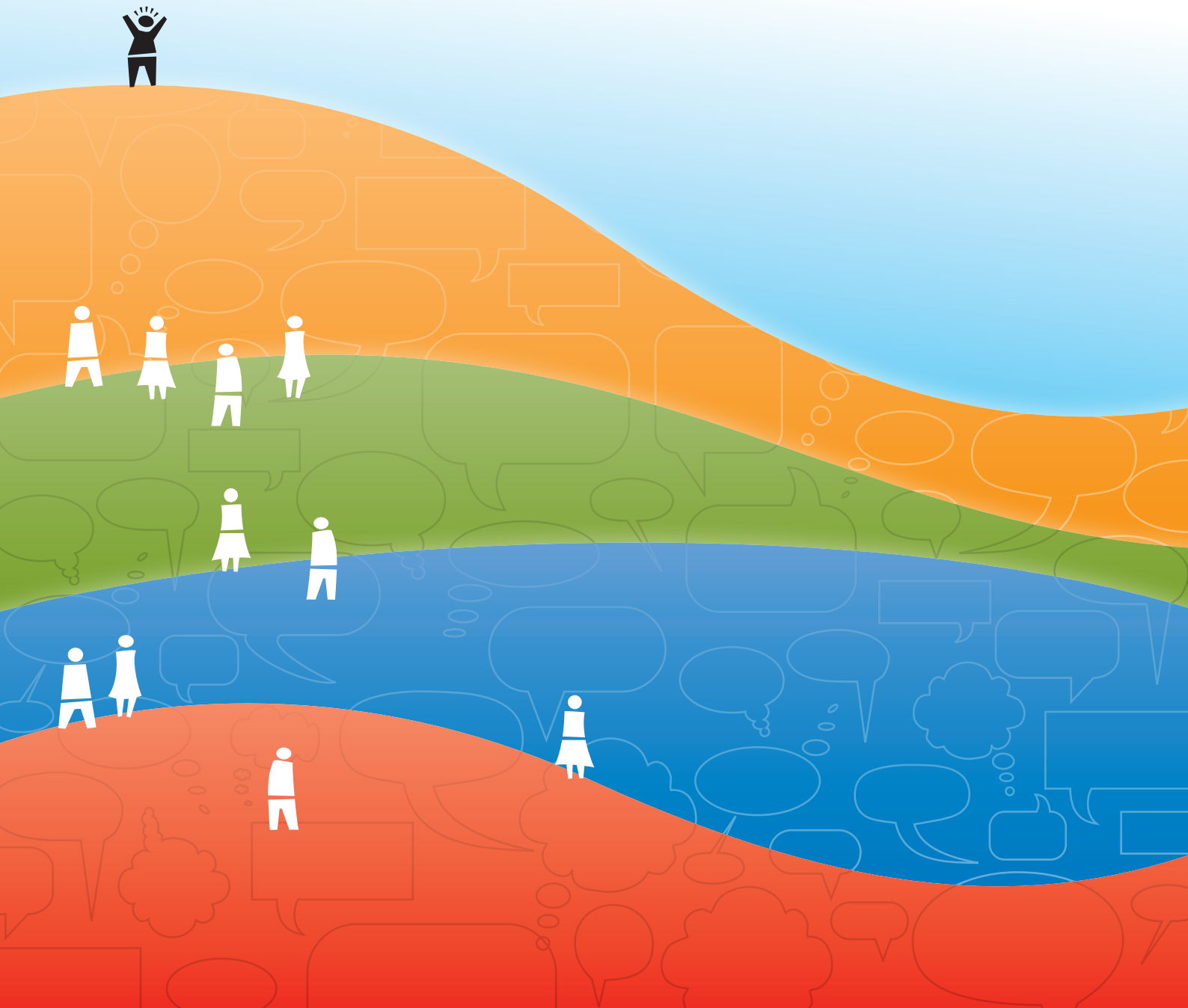
A report on independent advocacy for individuals with problem drug use in Scotland



Foreword by the Minister

Whilst developing *The Road to Recovery* strategy in 2008, we quickly identified the important role that Independent Advocacy could play in supporting recovery within Scotland.

This report pulls the threads of best practice and learning together in relation to Independent Advocacy. This in turn provides us with a clear picture and some potential ways to support the capacity building of Independent Advocacy Services in Scotland.

Problem drug use has a devastating impact on individuals, families and communities. Anything that can make a difference to this should be considered along with other resources to support recovery from problem drug use.

Therefore, the message remains overwhelmingly straight forward, with the correct support, individuals, families and communities can recover and flourish from the impact of problem drug use in Scotland.

Thank you to the services and individuals who were involved in the compiling of this report.

Fergus Ewing,
Minister for Community Safety

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1 Introduction

The Scottish Government strategy on tackling problem drug use in Scotland is detailed in the report *The Road to Recovery* **Scottish Government May 2008**. The move to a recovery based approach *'will mean a significant change in both the pattern of services that are commissioned and in the way that practitioners engage with individuals.'* The report states that *'The Government will set in train a number of actions to achieve a shared understanding of how to promote and support recovery, including the following:…**build the capacity of advocacy services**…'*

Following the publication of this report, in July 2008, the Scottish Government Drug Policy Unit and the Scottish Independent Advocacy Alliance agreed a project to support this action point.

The aims of the project were

- To identify what advocacy work is already happening with individuals with problem drug use.
- To raise awareness amongst those with problem drug use and relevant agencies enhancing their understanding of advocacy and the need for advocacy for this group.
- To raise awareness amongst Health Boards and Local Authorities of the importance of funding advocacy services for individuals with problem drug use.

This document reports on the findings of the project, details key learning points and outlines recommendations for development of independent advocacy for individuals with problem drug use.

Background

In 2004 the Scottish Executive Effective Interventions Unit published *Advocacy for Drug Users: A Guide*. The Guide posed the question 'Could advocacy be useful for drug users?' In response to this the report states

'Evidence shows that people who have drug misuse problems will, in many cases, have a range of other difficulties in their lives. These difficulties include problems with housing, family relationships, employment, offending behaviour and debt…The evidence from the EIU advocacy survey, consultation seminar and focus groups suggest that service users and providers consider advocacy to be an important component of effective treatment and care provision.'

It also reported that the relatives and carers of those with problem drug use may benefit from advocacy.

Many individuals, including those with problem drug use, can find it difficult, at times, getting their voice heard.

Independent advocacy can support and enable individuals to:

- Express their views and concerns
- Access information and services
- Defend and promote their rights
- Explore choices and options

There are several different models of independent advocacy delivered in Scotland.

Citizen Advocacy happens when ordinary citizens are encouraged to become involved with a person who might need support in their communities. The citizen advocate is not paid and not motivated by personal gain. The relationship between the citizen advocate and their advocacy partner is on a one-to-one, long term basis. It is based on trust between the partner and the advocate and is supported but not influenced by the advocacy organisation. This model of advocacy is most often used with people with learning disabilities.

Group or Collective Advocacy happens where a group of people who are all facing a common problem get together on a formal basis to support each other over specific issues. Individual members of the group may also support each other over specific issues. The group as a whole may campaign on an issue that affects them all. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore. Being part of a collective advocacy group can help to reduce an individual's sense of isolation when raising a difficult issue.

Peer Advocacy happens when individuals share significant life experiences. The peer advocate and their advocacy partner may share age, gender, ethnicity, diagnosis or issues. Peer advocates can use their own experiences to understand and empathise with their advocacy partner.

Professional Advocacy is also known as one to one, individual or issue based advocacy. It is provided by both paid and unpaid advocates. An advocate supports an individual to represent their own interests or represents the views of an individual if the person is unable to do this themselves. They provide support on specific issues and provide information but not advice. This support can be short or long term.

One major impact of illness, disability or addiction problems, or indeed any type of disadvantage such as poverty, poor housing or social exclusion can be an imbalance of power. In Advocacy in Healthcare, Kevin Teasdale states that

'power imbalance which determines the need for advocacy arises from all aspects of the experience of illness or trauma, both of which may be regarded as a form of loss of control.'

Independent advocacy seeks to redress such a power imbalance and to empower vulnerable individuals.

The importance of independent advocacy for vulnerable individuals has been recognised for many years.

'Independent advocacy is a crucial element in achieving social justice. It is a way to ensure that everyone matters and everyone is heard—including people who are at risk of exclusion and people who have particular difficulties in making their views known.'

Independent Advocacy—A Guide for Commissioners,
Scottish Executive 2001

'…advocacy is generally acknowledged to play an important, perhaps a crucial role in the implementation of community care.'

A Right Result—Advocacy, justice and empowerment,
Rick Henderson and Mike Pochin

This recognition in Scotland has led, in recent years, to the inclusion of independent advocacy in legislation. The Mental Health (Care and Treatment) (Scotland) Act 2003 places a duty on health boards and local authorities to ensure access to independent advocacy for those with a mental disorder. The Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007 place a duty on statutory bodies to consider independent advocacy. The Adult Support and Protection Act states that if a council decides, after making inquiries under the Act, that intervention is required, it…

'…must have regard to the importance of the provision of appropriate services (including, in particular, independent advocacy services) to the adult concerned'

To ensure the delivery of high quality advocacy, organisations work within the *Principles and Standards for Independent Advocacy,* Scottish Independent Advocacy Alliance 2008. Advocates and advocacy organisations use this document to assist them to operate in a clear and responsible way. Good practice in the commissioning of any independent advocacy is detailed in *Independent Advocacy: A Guide for Commissioners,* Scottish Independent Advocacy Alliance 2010.

The majority of independent advocacy organisations in Scotland today provide advocacy for people with mental health problems and those with learning disabilities. There are some organisations with a wider scope, some advocate for older people, some for carers and some for adults with a community care issue. A number of organisations do state that they work with people with problem drug use however these clients would access the organisation through other criteria such as mental health problems, learning disabilities etc.

There are currently no independent advocacy organisations in Scotland that state they have specific funding to work with individuals with problem drug use.

Without such a specific remit independent advocacy organisations are unable to develop links with statutory and voluntary agencies working with this client group. This contributes to a continued limited awareness and understanding of the role independent advocacy can play in promoting and supporting recovery for these individuals.

2 Advocacy in England

There are different models of advocacy available for individuals with problem drug use in different parts of England, however access is patchy. Much of the advocacy provision has been developed as part of user led support organisations in response to requests for support and information around treatment issues. There is recognition of the need for and value of advocacy for this client group, their family and friends.

For many advocacy services for this client group in England and Wales the preferred model is peer advocacy. In discussion with these advocacy projects it is apparent that there are pros and cons to this model. Peer advocacy can help potential advocacy service users overcome anxiety or reluctance to contact the service, they may feel that the peer advocate is more likely to understand their situation and will be less likely to 'judge' them. Working with a peer advocate can also help improve an individual's confidence, giving a practical demonstration of a person who has had similar experiences and has overcome difficulties. In addition it can give added value in supporting the peer advocate towards increased confidence and improved self-esteem. It can also provide the opportunity for individuals to 'give something back', an often expressed wish of individuals in recovery.

The following are examples of organisations delivering peer advocacy.

- Members of a user led organisation, the Oxfordshire User Team (OUT), are supported by Allied Advocacy and the Alliance, a national organisation, as peer advocates to represent users experiencing difficulties with drug and alcohol related services.
- The (Methadone) Alliance is a national user led organisation which provides advocacy, training and helpline services to those currently in drug treatment, those who have accessed drug treatment in the past and those who may access drug treatment in the future.
- **M**utually **o**rganised **r**ehabilitation & **p**ractical **h**elp (m.o.r.p.h) is a user activist group, based in Southampton, formed by ex and ongoing drug users. They provide peer advocacy for anyone affected by drugs in any way.

These are all related in one way or another to user led organisations delivering a range of supports and services and all provide advocacy solely in relation to drug treatment issues.

Although the main focus is on peer advocacy there are other advocacy models used in some parts of England.

The Care Forum is an independent voluntary and community sector infrastructure organisation working primarily across Bath and North East Somerset, Bristol, North Somerset and South Gloucestershire. They provide a drugs advocacy service for people who use, or wish to use Bristol's drug services offering assistance on issues such as getting treatment that suits the individual, complaints about services and many other drug treatment related problems. They offer different levels of support from advice around self advocacy through to trained volunteer advocates and professional advocacy.

This advocacy service was commissioned by the local authority and, initially, was set up as a peer advocacy service in response to the views of the local user forum. The model was changed because the organisation found that there were insufficient resources to deliver quality advocacy and to provide adequate support to volunteer peer advocates. If advocates are still experiencing drug dependency problems themselves this can create issues with the reliability of the service unless there are enough staff always available to step in at short notice. Given the limitations of the resources available the model of advocacy was changed.

Most of the specific drug related advocacy available in England and Wales is very much focused around treatment issues with no mention of issues around housing, employment, criminal justice, child protection etc.

There is a clear recognition in Scotland of the need for independent advocacy in relation to many issues. Information gathered from service users in the process of producing this report further evidences the findings detailed in the publication *Advocacy for Drug Users: A Guide*:

'...difficulties include problems with housing, family relationships, employment, offending behaviour and debt.'

The projects delivering advocacy tend to be a part of a larger organisation delivering a range of supports and services and are therefore not independent advocacy organisations. In Scotland the importance of independence in advocacy has been recognized for many years.

While there are organisations that would argue that their workers advocate on behalf of their clients or patients, it would be difficult for them to advocate freely in a situation where a conflict of interest arose. This is detailed in the *Principles and Standards for Independent Advocacy,* Scottish Independent Advocacy Alliance 2008.

'Paid carers may have a duty to defend the actions of the organisation that they work for. This means that they have a "conflict of interest". Independent advocacy is as free as possible from conflicts of interest like these, is completely separate from service providers and funders and does not provide services other than advocacy.'

Key Points

- It is clear that the peer advocacy model is valued by many and can bring added value in providing opportunities for people in recovery. If considering development of such a model sufficient resources must be put in place to ensure that peer advocates are adequately supported in their role and to ensure the delivery of quality advocacy for service users.
- It is important, in developing wider access to independent advocacy for those with problem drug use, that such advocacy is available for the range of problems that may be encountered by members of this group.
- Given the recognition, in Scotland, of the importance of independence and given the right of access, included in the Mental Health (Care & Treatment) (Scotland) Act 2003, to independent advocacy, it is important that capacity is built within independent advocacy organisations to provide advocacy to people with problem drug use.

3 The current situation in Scotland

3.1 Advocacy Survey

The Scottish Independent Advocacy Alliance conducted a survey of Scottish advocacy organisations to identify existing advocacy provision and any barriers to accessing advocacy for people with problem drug use.

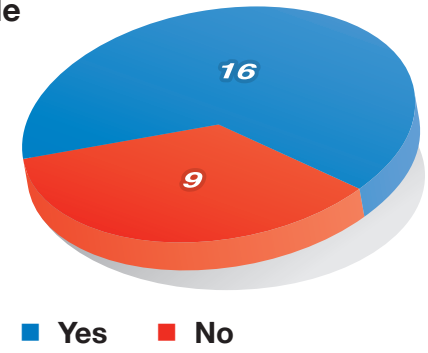
Methodology
A letter and questionnaire were sent out in early July 2009 to 85 advocacy projects throughout Scotland. Organisations were invited to complete and return the questionnaire by the end of July 2009. Information on the survey was included in the SIAA weekly ebulletin informing advocacy organisations about the survey and encouraging any organisations not yet in receipt of the questionnaire to contact the SIAA.

In conducting surveys with advocacy organisations previous experience has shown that it can be difficult getting many responses, often due to the limited resources and time of these organisations. The response to this survey was 30% with 23 completed or partially completed questionnaires returned and email messages from a further 2 organisations to say that they did not work with individuals with problem drug use and that they were therefore not returning the questionnaire. There were no responses received from 60 organisations. Of these 7 are collective advocacy organisations working with people with mental health problems or with learning disabilities, 5 work solely with carers, 3 only with older people, 5 with children and young people and 7 only with people with learning disabilities, the last figure includes 6 citizen advocacy organisations. The referral criteria for these organisations are quite specific and they would therefore either not work with individuals with problem drug use or would not capture data on such issues.

Questionnaire results
Results from the questionnaire are as follows.

Q1: Does your organisation work with people who have problem drug use?

Of the organisations that completed questionnaires more than two thirds (**16**) said they did work with individuals with problem drug use. Of the total responses to this question (**25**) around one third (**9**) organisations did not work with individuals with problem drug use.



Those organisations not working with this client group were asked to complete question 2.

Q2: If No, please tick possible reason

There were three options:

a) No funding for such work
b) Do not gather such information from advocacy partners
c) Other (Please state)

3 organisations stated that they did not have funding for this work, 2 that they did not gather this information from advocacy partners, and the reasons for other responses were as follows:

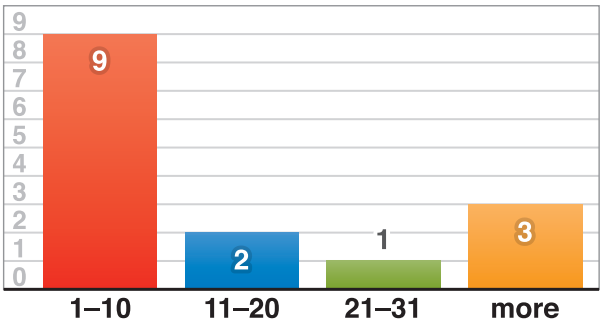
- 'No demand to date—children's advocacy.'
- 'We are mainly a mental health organisation—some of our clients do have drug issues but we would not deal with these as such—we do not have training.'
- 'No referrals received in relation to drug problems.'

It appears from these responses that some of these organisations do work with individuals with problem drug use but that they record referral criteria to meet their funding criteria.

Organisations working with the client group were asked to complete the rest of the questionnaire. Answers are as follows.

Q3: If Yes, how many people with problem drug use have contacted your organisation between January and June 2009?

Options were: **a)** 1–10
b) 11–20
c) 21–30
d) More

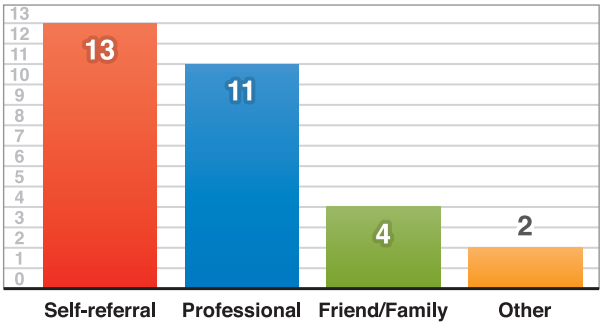


In the time period, nine organisations had worked with between 1 and 10 individuals with problem drug use, two with between 11 and 20 and two with between 21 and 30. One organisation working with between 21 and 30 clients stated that this number may be higher but that the referral criteria would have been mental health or learning disability. Three organisations stated that they did not know how many, of those one stated that they do not gather such information, that they are aware that some clients have problem drug use but that would not be the referral criteria.

It would appear from these responses that there is already a significant amount of work being done with this client group but that the problem drug use would not be the issue to give access to advocacy.

Q4: How did they contact you?

Options were Referral by:
a) Self
b) Professional
c) Friend/Family
d) Other
(please state)



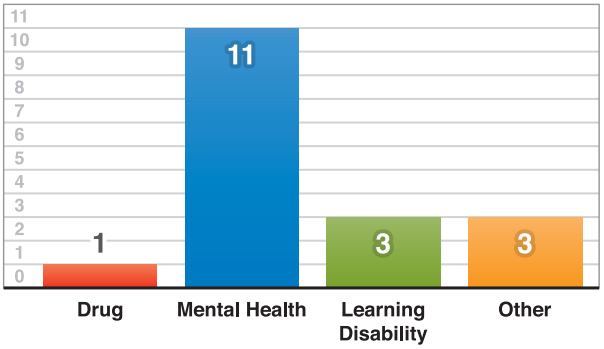
One or more of these options could be ticked. Responses were as follows.

The ‘other’ referral routes were through other advocacy organisations. Two organisations did not know referral routes as they do not routinely capture this information.

Q5: What was the primary issue for referral?

Options were:

a) Problem Drug Use
b) Mental Health
c) Learning disability
d) Other (please state)



Once more, one or more of these options could be ticked. Responses were as follows.

Other issues included Accommodated children and parents of children with a disability.

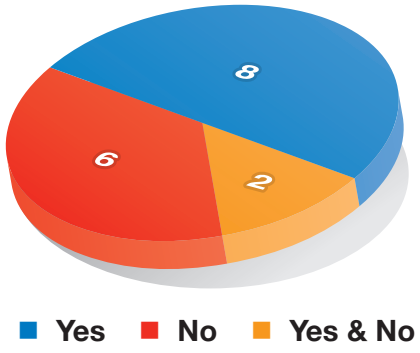
Given responses to the other questions it would seem likely that the primary presenting issue recorded was affected by the funding criteria of the organisation.

Q6: Were their advocacy issues related to drug issues?

Responses were as follows:

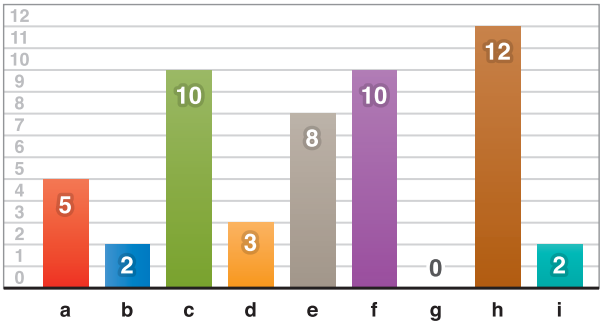
Yes:	8
No:	6
Yes and No:	2

Those organisations that ticked both Yes and No then went on to indicate a wide range of advocacy issues raised in the next question.



Q7: Please indicate any advocacy issues raised.

Options were:
- **a)** Accessing drug treatment programmes
- **b)** Physical health issues
- **c)** Housing
- **d)** Employment
- **e)** Criminal justice Service
- **f)** Child protection
- **g)** Education
- **h)** Mental Health
- **i)** Other (please state)



The majority of issues related to mental health, housing, child protection and criminal justice. The next highest was the issue of access to drug treatment programmes. Of the two organisations that ticked 'other' issues one related to healthcare and support funding for children the other gave issues as debt, family issues and abuse.

This data supports the statement in the 2004 Guide

'people who have drug misuse problems will, in many cases, have a range of other difficulties in their lives.'

Q8: If you believe there are barriers for people with problem drug use accessing your service please give details.

Options were:
- **a)** We are not funded to work with this group
- **b)** We do not have the specialist expertise
- **c)** Never had any referrals
- **d)** Other (please state)

None of the organisations currently receive specific funding to work with this client group. Nine organisations said one barrier to access was that they were not funded to work with this group. One organisation had previously had a three year grant from the Big Lottery to provide advocacy for this group

however it had not been possible to get additional funding when the grant ended. They still do the work if the individuals also present with mental health problems and/or learning disabilities however they stated that it made a big difference to the service when they had dedicated funding and were able to offer the service to people who did not have a dual diagnosis. *Details of the benefits of this dedicated funding and the impact on the end of this funding are included in the Summary.*

Five organisations felt that their lack of specialist knowledge/expertise presented a barrier; one felt that lack of awareness of advocacy was also a barrier. The organisation working with parents of children with a disability believes that the possibility of associated stigma and fears around child protection issues created barriers to accessing advocacy.

Q9: Do you have links with any drug agencies in your area? If so what sort of links.

Six organisations had no links with any local drug agencies. The other organisations had a range of links, some formal, some informal, with local DATs and local voluntary sector organisations.

Summary of findings

It is clear that several advocacy organisations throughout Scotland are already working with individuals with problem drug use. While no organisations are currently funded to work directly with this client group access to advocacy has been made available through other referral criteria such as mental health. One organisation (AIMS Advocacy) did have a three year grant from the Big Lottery Fund, now expired, to work with individuals with problem drug use. Following the expiry of the Big Lottery grant they continued to fund this service using their reserve funds. The manager of AIMS stated that this was because *"we felt these people had a real need to access advocacy"*.

The records of advocacy issues raised showed a wide range of issues with a few relating to drug treatment issues. Some organisations answered both Yes and No to the query about whether advocacy issues were related to problem drug use. This related to the difficulties that individuals with problem drug use can experience in their lives as a direct result of the drug use, the chaotic lifestyles that can be a feature and of the associated stigma.

While many of the advocacy referrals came from other professionals, Social Work, DATs etc, the majority of were self-referrals. Many had found out about advocacy organisations through word of mouth, some having been aware of friends or relatives accessing advocacy. Responses from most organisations showed that no advocacy awareness raising had been done specifically for this client group. The exception to this was the work done by AIMS during the life of the grant.

The biggest barrier, reported by advocacy organisations, to providing advocacy for this client group was lack of resources. In most cases funding for advocacy organisations will be for specific groups—mental health or learning disability service users, older people, carers etc. In order to access advocacy individuals with problem drug use, in most cases, currently need to be referred through some other criteria. Some organisations also cited lack of specialist knowledge/expertise as a barrier although this was usually in relation to treatment issues; organisations that did cite lack of knowledge/expertise were comfortable with providing advocacy support for all other issues.

case study

An illustration of the need for flexibility and the positive benefits of access to independent advocacy is demonstrated in this story of one Ayrshire resident. This client, who had previously been referred to AIMS, called early one morning having been put out of the family home when his family felt they could no longer cope with his problem drug use. He did not know what to do or where to go. The advocacy worker spent the whole day providing intensive support enabling the client to present as homeless to social services. From this he got access to temporary accommodation and appropriate support services. The client kept in touch with AIMS over the following two years requesting advocacy support now and again for a range of difficulties and issues. He is now in recovery, has his own flat, is in regular touch with his family and has started a dog walking business.

AIMS reported a number of benefits as a result of the 3 year grant funding this specialised advocacy provision.

The organisation employed two advocacy workers for this project; this offered the opportunity for the workers to build relevant specialist knowledge, develop links and relationships with local statutory and voluntary agencies and provided consistency for clients accessing the advocacy organisation. The workers had smaller caseloads than those working with other client groups such as mental health or learning disability. This reflected the needs of clients with problem drug use, recognition of the sometimes chaotic nature of a client's life and flexibility to be with a client for long periods in case of crisis.

The specialist advocacy workers built links with local community based services for people with addictions. They were invited along to group activities to talk about independent advocacy and were invited to join the North Ayrshire providers' network. The workers were able to do a great deal of very effective outreach, going to the places that people with problem drug use go, building relationships and building trust. All of this work led to steadily increasing demand for advocacy from this client group in North Ayrshire.

There have been negative impacts on the service since the Big Lottery grant expired.

Although AIMS have continued to do some of this work it has been greatly reduced with very limited resources. The relationships built over the period of the grant have continued but it has not been possible to maintain the level of outreach. It is not easy to maintain the level of flexibility that was such an important feature of the project. The manager of AIMS has also reported a level of frustration about the apparent lack of interest from commissioners on the data and personal stories gathered during the life of the project.

Key Points

- There is a need for the inclusion of problem drug use in the access or referral criteria agreed for independent advocacy Service Level Agreements. This will ensure ease of access for those with problem drug use.
- Advocacy organisations should be given resources to enable the building of links with relevant statutory and voluntary agencies. This will lead to increased awareness of independent advocacy and the potential for benefits to their service users and will ensure that staff from these agencies considers referral to independent advocacy organisations. There is also a need for assertive outreach to ensure awareness and uptake of independent advocacy amongst individuals with problem drug use.
- Creating opportunities for the development of specialist knowledge in this area for independent advocacy organisations will help improve access to advocacy for individuals with problem drug use.

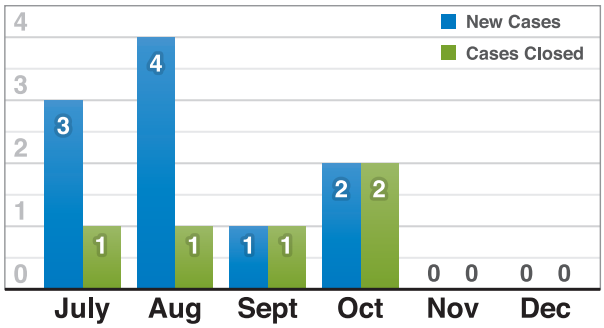
3.2 Data Gathering

Organisations were asked to indicate if they would be willing to take part in a six month survey to gather data on access to and use of advocacy for individuals with problem drug use. 8 organisations indicated that they would be willing to take part. They were sent a monthly data sheet to complete and asked to record this data from July to December 2009.

Since the initial contact 4 organisations withdrew from the data collection because of time and resource issues. The four organisations collecting the data provided a good spread in relation to contrasts between rural and urban areas, population size and percentage share of areas of multiple deprivation.

At the beginning of the period on 1st July 2009 the participating organisations reported a total of 25 individuals in receipt of advocacy.

Numbers of new cases and cases closed July to December 2009.



By 31st December 2009 the participating organisations reported 30 individuals in receipt of advocacy. Over the 6 months there had been 10 new referrals and 5 cases closed. Of those 10 new referrals all were male and all lived in urban areas. Age ranges of new referrals showed one in the 18–29 age range, four in the 30–39 range and five in the 40–49 range. As only one of the participating organisations are funded to work with children and young people we would not necessarily expect the data to show any new referrals under 18.

Organisations were asked what the referral criteria were for all new referrals in this period, reports showed 8 with mental health problems and 2 with acquired brain injury. They were also asked what the routes of referral were, 6 came via social services, 2 via health services and 2 were self referrals. It is worth noting that the two referrals for those with acquired brain injury came in the same month to the same organisation, one was referred by social services and the other was a self referral.

There were a range of issues that people sought advocacy support to deal with. These included housing, health, assessment for services, contact with Criminal Justice Services and issues around the Mental Health Act.

Despite the lack of funding for advocacy for individuals with problem drug use and the fact that organisations do not routinely offer information on advocacy to this client group nevertheless these figures demonstrate a steady increase in requests for advocacy.

3.3 Awareness Raising/Information Sessions

The questionnaire asked if organisations would be willing to arrange events, training or meetings to raise awareness on advocacy to agencies working with individuals with problem drug use in their area and to individuals with problem drug use. 10 organisations said they would be willing, 5 said that they did not have the resources to meet any possible increase in demand.

A follow up letter was sent to the 10 organisations asking that, if they were still willing to take part in any awareness raising, they send details of these plans. Four organisations agreed to organise events, one other expressed interest but withdrew because of time and resource pressures.

As with the data collection the organisations that agreed to undertake this work provided a good spread in relation to contrasts between rural and urban areas, population size and percentage share of areas of multiple deprivation.

Ceartas
Suites 5–7 McGregor House
10 Donaldson Crescent
Kirkintilloch
G66 1XF

Ceartas had good links with the local community addiction team and ran a series of evening groups for people with problem drug use. At the time of response to the questionnaires their funding for these groups had been cut so, while they were reluctant to offer to do too much at that stage they welcomed the opportunity to discuss how they could enhance their work in this field.

The organisation consulted with local addiction services and interested stakeholders in East Dunbartonshire with a view to considering how advocacy services for individuals with problem drug use can be developed locally. The consultation included local existing groups e.g. addiction recovery centre, ED service user network, and a Youth initiative in Lennoxtown.

They also delivered training to advocacy staff and volunteers to assist in their work with people affected by problem drug use and include issues such as addressing stigma etc.

Ceartas plans to present a report on this consultation to stakeholders at a seminar allowing further discussion and an action plan to be drawn up which will then be submitted to East Dunbartonshire Council Prevention, Education and Control Group.

This event has yet to take place however there has been some discussion with East Dunbartonshire Social Work Dept. on the issue. The Social Work Dept have acknowledged the need for independent advocacy for individuals with problem drug use and the fact that services are being provided under the banner of mental health without proper recognition of the skills required. Since these discussions Ceartas have been in contact with the newly formed East Dunbartonshire Alcohol and Drug Partnership. The ADP have agreed to fund a project that Ceartas will manage, involving a member of staff supporting volunteers to engage with service users of addiction services on a number of local initiatives and report back to the ADP. This will provide a collective advocacy opportunity for individuals with problem drug use providing the opportunity to inform the shape of future services.

Mental Health Advocacy Project
Unit J, Kirkton Business Centre
1 Kirk Lane, Livingston Village
West Lothian
EH54 7AY

The Mental Health Advocacy Project has existing links with local drug agencies.

The organisation provided a series of seminars to workers in key services in West Lothian delivering advocacy awareness training and providing opportunity for discussion and networking. They plan to hold at least one awareness raising event for a service user group.

AIMS Advocacy
31 Hamilton Street
Saltcoats
KA21 5DT

Aims had a 3 year grant from the Big Lottery Fund to provide advocacy for individuals with problem drug use. The grant has now ended however they do continue this work, funding this with organisational reserve funds, providing advocacy for those clients who also have mental health problems or a learning disability.

The worker who delivered the advocacy for this group has good links with local agencies and with individuals with problem drug use developed over the life of the project. He met with the lead clinician for the local DAT, Social Services Addiction Services Manager and local voluntary sector agencies. In addition he conducted 12 interviews with individuals with problem drug use. He asked what the reasons for referral were, what helped encourage referrals, what made for easy access to advocacy, what people get from advocacy and what doesn't work.

Advocacy Western Isles
Lamont Lane
Bayhead
Stornoway
HS1 2EB

This organisation arranged a display stand with general information about independent advocacy and what it can do, especially in relation to those with problem drug use and the issues they might have. This board was displayed in the Crossreach Lifestyle Centre in Stornoway, a drop-in centre for those with problem drug use. Staff from the organisation attended various drop-in sessions, giving informal talks to service users about independent advocacy and gathered feedback from this group and from current advocacy clients with problem drug use.

As part of the ongoing work of the organisation they met with relevant professionals in Health and Social Services as well as voluntary sector staff with a view to raising awareness of independent advocacy and to obtaining feedback on understanding of advocacy, potential use of advocacy and possible barriers to access.

3.4 Feedback

From staff

In the discussions held with relevant statutory and voluntary agencies workers recognised the importance for their clients of access to independent advocacy. There was a general perception that advocacy could help ensure that individual rights were upheld and communication between service users and services enhanced. Staff of a local Addiction Team felt that advocacy support could help clients with many issues including those falling under the following categories:

- Housing/homelessness
- Family issues
- Medical treatment
- Meetings with professionals
- Finance/debt
- Employment problems
- Access to legal services/criminal matters—including service user as a victim of crime

In one of the areas included in the survey it was highlighted that the team work with people experiencing alcohol as well as drug dependency. The team felt strongly that these issues should not be separated as the problems experienced by their clients are generally very similar.

There was also discussion around the help that collective advocacy can provide to this client group. Collective advocacy can offer mutual support to a group of people who are all facing similar difficulties and issues. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore. Being part of a collective advocacy group can help to reduce an individual's sense of isolation by helping them realize that they may not be the only person facing a specific difficulty and by providing support when raising a difficult issue.

One advocacy organisation had supported the development of a user network, supporting a former service user in a volunteer role assisting in the facilitation of the network. In another area a forum has been developed for people with drug and alcohol dependency problems however this is facilitated by a worker from the local DAT and is therefore not independent. All members of that team felt that it would be better if this forum was independent as it was identified that conflicts of interest can arise for the worker.

Overall feedback from workers suggests that access to independent advocacy dedicated to service users with problem drug use would be extremely helpful in terms of combating both stigma and poverty so often experienced by people with addictions and in helping to improve the quality of life of their service users.

From service users

There were four themes discussed with individuals with problem drug use.

What do people get out of independent advocacy?

Service users reported that, with independent advocacy, they were listened to, that they were involved in decision making about themselves and their lives and that they were consulted every step of the way. They reported increased self-esteem which they attributed to feeling supported to take back some control and tackle issues. Individuals reported that, working alongside an organisation that was taking instruction directly from them and not from other agencies, led to a feeling of getting back some form of independence. There was an increased sense of inclusion when dealing with external agencies. People who had used independent advocacy for some time said that they now felt able to challenge decisions and to make requests when they would previously have felt unable to do so.

There was also a realization, for some, that sometimes advocacy workers had started out as volunteers, that they were just ordinary people from various backgrounds with many different life experiences. In some cases this has led to service users exploring the option of volunteering as a first step in moving forward.

What would put people off using advocacy?

There were statements around general access difficulties including accessibility of premises, and to public transport, there were also potential issues around opening times and it was stated in some cases that more outreach should be available.

In addition to practical issues many stressed the need for any advocacy to be independent. People reported previous bad experiences of using services run by health boards and/or local authorities and felt that, were an advocacy organisation to be a part of another organisation, they might be reluctant to use it.

Some reported that, while initially they had felt that advocates should have specialist knowledge of problem drug use, their experience of using independent advocacy had led to this being less of an issue. There was a view expressed that advocacy issues could be the same for anyone and need not necessarily relate specifically to problem drug use.

What makes an advocacy service easier to access?

There were a number of factors identified by service users that would contribute to ease of access. All these factors related to the approach of advocacy staff and the culture and ethos of the organisation. Some people reported that the attitude of the staff and the general atmosphere prevailing in the office can have an impact on how easy they found access to advocacy. Most said that, being made to feel welcome encouraged them to use the service and to return.

Service users reported that they appreciated staff being 'up front and honest' and that this reassured those experiencing advocacy for the first time that there were no hidden agendas and that they were in control of the process. They felt that the boundaries of the advocacy relationship were made very clear from the outset and that all parties involved understood the role of advocacy. People felt reassured that there was no pressure put on them to make immediate decisions and that, even if any decision they made did not work out, the advocate would support them to reexamine the situation and start the process again. Individuals using advocacy services understood that the role of the advocate does not include giving advice. Many service users felt that, in the past, they had sometimes been given advice, by workers, that was not always good or even accurate, they felt that being supported by an advocate to explore options could be more productive than enforced decision making based on inaccurate advice.

An important factor stressed by service users was reported as 'not being judged'. This was an issue for individuals with problem drug use. A number reported having had negative experiences from service providers where

they felt they were being judged on their addiction/s and chaotic lifestyle. In contrast they felt advocacy staff supported them in dealing with the present issues and did not judge them on their past. Some service users also believed that they had previously had a negative reputation with some service providers and that having the support of an independent advocate when engaging with services contributed to them being seen in a more positive light.

What could be barriers to accessing advocacy?

In general people felt there was not enough advocacy available. They also felt that workers from other agencies did not always inform people about advocacy or promote advocacy enough to users of their services.

Some respondents felt that advocacy should be available for all. There was a feeling that there should not be the need to fulfill specific criteria such as mental ill health, learning disability or any other as this could be discriminatory. It was felt that there were many people who might not fit into a specific category but could, nevertheless, be vulnerable and in need of support at times.

One factor raised as a potential barrier to accessing advocacy was the attitude of workers from other services towards advocacy. It was felt that there was a lack of awareness of independent advocacy and, in some cases, a negative attitude towards advocacy. This leads to a lack of promotion of advocacy to service users. There was also the belief that advocacy should be promoted by services from the outset and not as a 'last chance option'.

A further aspect of this negative attitude towards advocacy was that advocacy was not always acknowledged as putting forward the views of the service user. Some reported that they felt that some agencies used the inclusion of advocacy as a 'box-ticking exercise'.

case study

One organisation related the story of a person they had worked with over a 4 month period in 2009. This person had been in touch with mental health services for some time and was experiencing problem drug use. She lives in a small rural community and had a range of difficulties when she first contacted the advocacy organisation. The organisation provided advocacy support for many of these issues including housing issues, care planning and fuel poverty. When asked what, if any, difference she felt advocacy had made to her life she said that the support and the strength she had drawn from that had made a real difference in her life. She felt her own confidence growing and felt increasingly able to speak up on her own behalf at meetings when the advocate was with her. She felt people really listened to her when the advocate was there. When she had first contacted the advocacy organisation she had felt angry, helpless and hopeless. She can now see a way forward. She is looking into college courses and work opportunities and feels that she now has ambitions and hopes for the future. Previously, when in contact with services, she had felt that people were judging her and that they had a low opinion of her. She now feels that others' perceptions have changed and that other people have a more positive view of her.

Key Points

- Advocacy can help in combating both stigma and poverty that is so often experienced by people with addictions.
- Collective advocacy can offer mutual support to individuals with problem drug use who may be facing similar difficulties and issues. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore.
- Advocacy support can lead to an increased sense of inclusion when dealing with external agencies. Individuals felt able to challenge decisions and to make requests when they would previously have felt unable to do so.
- People with problem drug use felt that independence was important for advocacy.
- People felt that advocacy issues could be the same for anyone and need not necessarily relate specifically to a drug dependency problem.
- People felt reassured by the support provided by advocacy organisations to consider options and make informed choices. They felt that there was no pressure put on them to make immediate decisions and that, even if any decision they made did not work out, the advocate would support them to reexamine the situation and start the process again.
- Independent advocacy should be more widely available for people with problem drug use.
- Staff from health and support agencies should be given training to increase awareness of independent advocacy. They should inform service users about independent advocacy and promote access to it.

4 Conclusion and recommendations

It is clear that independent advocacy can be important for individuals with problem drug use. There is much anecdotal evidence of the value that those with problem drug use place on independent advocacy and of the difference it can make to their lives. There is also evidence of a recognition amongst staff from voluntary and statutory sector agencies of the role advocacy plays in the lives of their clients and the positive impact it has had. It was highlighted by some workers that this is also true for those with alcohol dependency problems.

In England much of the advocacy available for this client group is in direct relation to problems with treatments relating to dependency without any advocacy available providing support with other issues. Feedback received from Scottish advocacy organisations suggests that people with problem drug use may experience a range of difficulties, including those relating to housing, education, employment, physical and mental health problems, child protection issues and contact with the Criminal Justice service. Independent advocacy support has been sought by those with problem drug use for all of these issues as well as for treatment issues. Problems experienced by these individuals can sometimes be as a direct result of the associated stigma, advocacy can help combat such stigma.

Recommendation
Independent advocacy should be made available across Scotland for individuals with problem drug use. This advocacy should be available for support in dealing with a range of problems. Both individual and collective advocacy should be developed.

While many people with dependency problems do access advocacy it is often because they meet other referral criteria. Access to advocacy varies across Scotland and across client groups. Currently, throughout Scotland, access to independent advocacy for individuals with problem drug use is patchy. This can mean that some individuals cannot access independent advocacy.

Recommendation
There is a need for resources to be made available to ensure access to independent advocacy for individuals with problem drug use. When drawing up a Service Level Agreement commissioners and advocacy organisations should ensure that problem drug use is included as an access or referral criteria.

There is a clear recognition of the importance of independence of advocacy organisations amongst staff from statutory and voluntary services as well as amongst service users. The importance of independence for advocacy organisations is acknowledged in legislation. There is also a need to ensure the advocacy delivered is of the highest quality.

Recommendation
Advocacy organisations working with individuals with problem drug use should work within the Principles and Standards for Independent Advocacy.

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

There were a number of barriers to accessing independent advocacy identified. Many of these were in relation to availability of advocacy for this client group. One identified barrier was in relation to spread of information on advocacy, what it is and what it can do. A further barrier, identified mainly by advocacy organisations was in relation to lack of specialist knowledge of problem drug use and potential related issues.

Recommendation
Resources should be available for independent advocacy organisations to enable the building of links with relevant statutory and voluntary agencies and for assertive outreach to ensure awareness and uptake of independent advocacy amongst individuals with problem drug use.

Creating opportunities for the development of specialist knowledge in this area for independent advocacy organisations will help improve access to advocacy for individuals with problem drug use.

There are a number of different models of advocacy in use in Scotland today.

All models are recognized as being valuable for individuals with problem drug use. All can achieve the aims of independent advocacy to stand alongside those who are in danger of being pushed to the margins of society, to help people to secure their human, civil and social rights, to make sure that people have a voice and are listened to and to help build confidence and self-esteem.

Recommendation
Consideration should be given to developing collective advocacy as well as one-to-one advocacy. Collective advocacy can offer mutual support to individuals with problem drug use who may be facing similar difficulties and issues. A collective voice can be stronger than that of an individual, as groups are more difficult to ignore.

Working with a peer advocate can help improve an individual's confidence, giving a practical demonstration of a person who has had similar experiences and has overcome difficulties. It can also give added value in supporting the peer advocate towards increased confidence and improved self-esteem.

Recommendation
If considering development of a peer advocacy model, sufficient resources must be put in place to ensure that peer advocates are adequately supported in their role and to ensure the delivery of quality advocacy for service users.

Guidance for the commissioning of independent advocacy can be found in *Independent Advocacy: A Guide for Commissioners,* Scottish Independent Advocacy Alliance 2010. The Guide states that service users should be involved throughout the process.

Recommendation
Individuals who are experiencing or have experienced problem drug use should be consulted and involved in the planning and development of independent advocacy for that group.

References

Advocacy 2000 (2000) *Key ideas on independent advocacy* Edinburgh: Advocacy 2000

Henderson R and Pochin M (2001) *A Right Result? Advocacy justice and empowerment* Bristol: Policy Press

Scottish Executive (2000) *Independent Advocacy: A Guide for Commissioners* The Stationery Office

Scottish Government (2008) *The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem* www.scotland.gov.uk/Publications

Scottish Government (2004) *Effective Interventions Unit: Advocacy for Drug Users—A Guide* www.scotland.gov.uk/Publications

Scottish Health Advisory Service (1997) *Advocacy—A Guide to Good Practice The Stationery Office*

Scottish Independent Advocacy Alliance (2008) *Principles and Standards for Independent Advocacy* Edinburgh: SIAA

Scottish Independent Advocacy Alliance (2008) *Code of Practice for Independent Advocacy* Edinburgh: SIAA

Scottish Independent Advocacy Alliance (2010) *Independent Advocacy: A Guide for Commissioners* Edinburgh: SIAA

Teasdale K (1998) *Advocacy in Health* Care Oxford: Blackwell Science Ltd

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