



Department of  
**Health, Social Services  
and Public Safety**

[www.dhsspsni.gov.uk](http://www.dhsspsni.gov.uk)

# **A DRAFT POLICY FOR DEVELOPING ADVOCACY SERVICES**

## **A Guide for Commissioners**

**Mental Capacity  
Legislation Unit  
DHSSPS  
27 June 2011**

## Contents

### Ministerial Foreword

### Executive summary

1. Introduction
2. Aim and objectives
3. Context
4. Scope
5. Understanding what advocacy is and what it is not
6. Understanding where advocacy fits in
7. Commissioning advocacy services
8. Supporting advocacy services
9. Monitoring and evaluation of advocacy services
10. Implementation/Next steps

Appendix 1: Models of advocacy

Appendix 2: Glossary of Terms/Abbreviations

## Ministerial Foreword

The publication of this document - *A Draft Policy for Developing Advocacy Services – A Guide for Commissioners* - is a significant development which reflects the growing recognition of the value of advocacy services both in terms of protecting the human rights of the most vulnerable in our society and tackling inequalities in health and social care.

Drawing on best practice here and elsewhere, the draft policy aims to develop advocacy services by clarifying what advocacy is and its role in the health and social care context, recognising that it can have significant benefits for commissioners as well as people who use these services. It also sets out a number of principles and standards that are commonplace elsewhere and, together with the proposed regional LCG Advocacy Network, should go a long way to achieving greater parity and consistency in relation to the commissioning and delivery of advocacy services here.

The views of many interested groups and individuals have influenced the content of this draft policy. Workshops held both prior to its development in the autumn last year and subsequently in May this year were invaluable in terms of shaping the final draft which we are now consulting on. Our hope is that, given this level of engagement, most of the content of this draft policy should be fairly familiar to you and I would like to take this opportunity to thank everyone who has contributed so far.

A draft action plan is included at the end of this document which is designed to ensure that the policy when finalised is implemented as soon as possible given that it also aims to pave the way for the proposed new statutory right to an independent advocate in the Mental Capacity (Health, Welfare and Finance) Bill which the Department is currently preparing on behalf of the Executive. It is essential that commissioners start now to build on existing effective advocacy provision in preparation for the introduction of this new right.

I would encourage everyone with an interest in advocacy to respond to this consultation exercise and I look forward to hearing what you have to say about the work we have done so far.

**Edwin Poots MLA**  
**Minister of Health, Social Services & Public Safety**

## Executive summary

In light of the recommendations in the Bamford Review report on Human Rights and Equality of Opportunity and following a workshop held in January 2010 by the Advocacy Network NI, the Department established a working group to help develop a policy on advocacy services in a health and social care setting.

To inform this work, the Department carried out a scoping study of advocacy services commissioned or provided by the five HSC Trusts as well as research into advocacy provision in the rest of the UK, the Republic of Ireland and internationally (New Zealand and South Australia mainly). These, along with the outcomes of three workshops held in September and October 2010, helped inform the content of this draft policy.

The purpose of the workshops was to engage, at an early stage, with interested groups (including statutory and voluntary sector organisations and service users and carers) to inform policy development. A further three workshops were held in May 2011 to test the key elements of the draft policy prior consultation. The Department also further engaged directly with advocates at events held in March and April this year.

The draft policy aims to develop advocacy services by improving understanding of what advocacy is and providing practical guidance on the commissioning of advocacy services in a health and social care setting. It sets out key principles and standards for the future commissioning and delivery of advocacy services and addresses the issue of independence. It also provides guidance on how advocacy services can be supported and monitored and evaluated.

A key driver for this work is the proposed introduction of a new statutory right to an independent advocate in the Mental Capacity (Health, Welfare and Finance) Bill which the Department is currently preparing. This proposed new statutory right reflects the growing recognition of the value of advocacy services in protecting the human rights of the most vulnerable in our society as acknowledged in the Bamford Review report on Human Rights and Equality of Opportunity.

While further guidance will be prepared for commissioners on the proposed new statutory right once the detail has been developed, this draft policy also aims to pave the way for its

introduction by encouraging commissioners to begin now the process of building on existing effective advocacy provision.

## **Overview**

### **Section 1 – Introduction**

### **Section 2 – Aims and Objectives**

### **Section 3 – Context**

### **Section 4 – Scope**

This section sets out the scope of the draft policy which has been developed to inform the commissioning and provision of advocacy services in a health and social care setting for persons aged 16 and over who, for whatever reason, require support in relation to a decision about their health or well-being. This is in line with the proposed age threshold for the Mental Capacity (Health, Welfare and Finance) Bill. Recognising the important support provided by carers, the draft policy should also inform the commissioning and provision of advocacy services for carers. Furthermore, it is the Department's view that the draft policy may also be of use to those commissioning and providing advocacy services for other groups including children and young people.

### **Section 5 – Understanding what advocacy is and what it is not**

This section is intended to help clarify what advocacy is by recognising that advocacy can be delivered in a variety of different ways depending on the needs of the individual. It contains descriptions of the four main models of advocacy (group, peer, citizen and individual), addresses the issue of independence, explains why independent advocacy services are needed in health and social care and the benefits of investing in independent advocacy services. It also sets out what the proposed new statutory right to an independent advocate in the Mental Capacity Bill is likely to entail.

### **Section 6 – Understanding where advocacy fits in**

This section explains how effective advocacy services have the potential to contribute to a number of strategic goals for health

and social care that ultimately promote wider equality and human right objectives. These include:

- Social Inclusion and justice;
- Health improvement and well-being;
- Reducing inequalities in health and well-being;
- Personal and public involvement;
- Safeguarding adults; and
- Bamford Review/Modernising Mental Health and Learning Disability Services (including proposed Mental Capacity legislation).

## **Section 7 – Commissioning Advocacy Services**

This section looks at the current commissioning arrangements and how they might be enhanced in relation to advocacy services to achieve greater parity and consistency of approach across the five HSC Trust areas. It proposes the setting up of a new Regional LCG Advocacy Network to consider and identify opportunities for more collaborative working. It also sets out principles for the commissioning of advocacy services that would be in addition to the standard commissioning principles that apply to all health and social care services and provides some guidance on how to achieve personal and public involvement in the commissioning of advocacy services.

## **Section 8 – Supporting Advocacy Services**

This section sets out some practical ways in which commissioners can support advocacy service providers and includes guidance on:

- The development of a model contractual agreement for advocacy services;
- Funding for advocacy service providers;
- Best Practice Fora for advocates;
- Raising Awareness of advocacy services;
- Training/Awareness raising for Health and Social Care staff; and
- Training for advocates.

## **Section 9 – Monitoring and Evaluation of advocacy service**

This section sets out core service delivery principles and standards for advocacy services which can be applied to all models of advocacy and provides guidance to commissioners on how advocacy services can be monitored and evaluated, recognising the need to focus on processes as well as outcomes.

## **Section 10 – Implementation/Next Steps**

This section contains a detailed Action Plan to assist the implementation of this draft policy.

## 1. INTRODUCTION

- 1.1 This draft policy has been developed by a working group established by the Department in June 2010 and chaired by the Chief Executive of the PCC. The group was set up in light of the recommendations in the Bamford Review report on Human Rights and Equality of Opportunity in relation to advocacy<sup>1</sup> and following a workshop held by the Advocacy Network NI in January 2010 which focused on the future development of advocacy services in Northern Ireland.
- 1.2 The draft policy has been informed by the outcomes of a scoping study carried out in May 2010 which gathered information on advocacy services commissioned or provided by the HSC Board and Trusts in Northern Ireland for people aged 16 and over with mental health conditions, learning disabilities, physical and sensory disabilities and older people (focusing on those with dementia).
- 1.3 In addition, evidence was gathered on advocacy services in the rest of the United Kingdom, the Republic of Ireland and internationally. Three workshops were also held during September and October 2010. The purpose of these workshops was to gather the views of key statutory and voluntary sector organisations as well as service users and carers on the key issues relating to the development of advocacy services in Northern Ireland. A further series of workshops were held in May 2011 to test the draft policy with key stakeholders prior to consultation.<sup>2</sup>

## 2. AIMS AND OBJECTIVES

- 2.1 This draft policy is primarily targeted at the commissioners of health and social care services in Northern Ireland i.e. the HSC Board, the PHA, LCGs and the five HSC Trusts. LCGs are constituent parts/committees of the HSC Board but have a distinct role and membership.

---

<sup>1</sup> [www.dhsspsni.gov.uk/human\\_rights\\_and\\_equality\\_report.pdf](http://www.dhsspsni.gov.uk/human_rights_and_equality_report.pdf)

<sup>2</sup> Scoping study, research and workshop summary papers can be viewed on [http://www.dhsspsni.gov.uk/show\\_publications?txtid=47432](http://www.dhsspsni.gov.uk/show_publications?txtid=47432)

- 2.2 The draft policy aims to clarify and help improve understanding of what advocacy is and its role in the health and social care context (sections 5 and 6). It also aims to provide some practical guidance on the commissioning of advocacy services, including the setting of principles and standards to underpin this (section 7). In addition, guidance is provided on how advocacy services can be supported and monitored (sections 8 and 9), two key factors in ensuring the provision of high quality, effective advocacy services in the future.
- 2.3 This draft policy also aims to help pave the way for the introduction of a new statutory right to an independent advocate under the proposed Mental Capacity (Health, Welfare and Finance) Bill. This Bill is currently being prepared by the Department on behalf of the Northern Ireland Executive.
- 2.4 While further guidance will be required once the detail of the new statutory right has been developed, underpinning this draft policy is the need for commissioners to as much as possible start to build the capacity of, and support, existing effective advocacy provision in planning for the introduction of this new statutory right.
- 2.5 This draft policy will therefore be of interest not only to commissioners but also to existing advocacy service providers, users and their carers as well as advocates themselves, all of whom have a clear interest in how advocacy services in a health and social care setting are commissioned in the future.

### 3. CONTEXT

- 3.1 Currently, there is a vast array of advocacy services being provided by a range of mainly community and voluntary organisations and groups across Northern Ireland which receive funding from a variety of sources, including the statutory sector. As a result, a wealth of experience and skills has already been built up in relation to advocacy services. However, in terms of what is commissioned by the statutory sector, existing provision is patchy with some HSC Trusts having more established arrangements in place than others. There is also evidence of some regional commissioning of advocacy services by the Department and the HSC Board.
- 3.2 Future arrangements for the commissioning of advocacy services will need to take into account the new commissioning arrangements for all health and social care services introduced in 2009 through the reform and modernisation agenda. The assessment and prioritisation of need are important features of these new arrangements and will be central to ensuring that informed decisions are taken in relation to all service provision, including advocacy. These decisions will also be influenced by the challenges and pressures resulting from the current difficult fiscal environment.
- 3.3 In light of this, it is essential that commissioners understand the important role that advocacy services can play in protecting the human rights of the most vulnerable people in our society and in tackling inequalities in health and social care service provision, two key ministerial priorities. The Bamford Review highlighted this in several of its reports, and the proposed new statutory right to an independent advocate, in particular, is a significant development for those who have sought to highlight the vital role that advocacy can play in a health and social care context.
- 3.4 The introduction of this new statutory right will necessarily add a new dimension to the commissioning of advocacy services. Managing the interface between this new right and existing effective provision will be one of the key challenges for commissioners going forward, particularly given the financial context.

## 4. SCOPE

- 4.1 This draft policy has primarily been developed to inform the commissioning and provision of advocacy services in a health and social care setting for people aged 16 and over who, for whatever reason, require support in relation to decisions about their health and well-being. This aligns with the proposed age threshold for the Mental Capacity (Health, Welfare and Finance) Bill and is likely to include some people who are living with disabilities – physical, sensory, mental, learning or communication related.
- 4.2 Recognising the important support provided by carers, this draft policy should also inform the commissioning and provision of advocacy services for carers. Furthermore, the Department's view is that the broad content of this draft policy may also be of use to those commissioning and providing advocacy services for other groups, including children and young people.

## 5. UNDERSTANDING WHAT ADVOCACY IS AND WHAT IT IS NOT

### What is advocacy?

- 5.1 Advocacy means different things to different people. However, a core theme running through most of the definitions is that advocacy is about supporting people who are not being heard to say what they want and have their views heard. An advocate will therefore listen to the person who, for whatever reason, is experiencing difficulty in having their views heard in order to understand their position, inform them about their choices or options and then help them to take action to have their voice heard.
- 5.2 Particular challenges arise, however, where a person, for whatever reason, is unable to clearly articulate or express their views. These cases highlight the vital role that advocacy can also play in securing a person's rights, representing their interests and ensuring that decisions are taken with due regard to a person's preferences or perspectives.<sup>3</sup>

---

<sup>3</sup> This type of advocacy is often referred to as non-instructed advocacy and is discussed further at paragraphs 5.9-5.10.

- 5.3 Advocacy does not, however, in any way involve taking decisions on behalf of the person being supported. Nor is it a mediation, counselling, befriending, lobbying or complaints service, although some of these may be useful skills for an advocate to have and an advocate may be involved in supporting someone through a complaints process. It is also not an advice service in the sense that it is not an advocate's role to tell someone what they should or should not do.
- 5.4 What is fundamental is that the advocate always acts for the person being advocated for. This may, at times, involve challenging others, not in a way that seeks confrontation but, where possible, working in partnership and maintaining good relations with all involved in the person's life while remaining ultimately loyal and accountable to that person.
- 5.5 The term "advocacy" has been used to cover a raft of services, such as those mentioned in paragraph 5.3, which would not be captured by the description of advocacy above. This does not mean, however, that those services are any less valuable or necessary. Rather, they are part of what can be described as a "continuum" of services which supports people who require help with overcoming obstacles in, for example, accessing services and playing an active role in society.
- 5.6 It is important that it is made clear that the purpose of highlighting this is not to devalue the other elements of that continuum but rather to clarify what advocacy means. This is important in the health and social context so that commissioners, service providers, advocates, service users and carers can understand the boundaries and limitations of advocacy and when, for example, it might be appropriate to refer to another service or organisation.

### What are the different types of advocacy?

- 5.7 It is widely accepted that advocacy services can be delivered in a variety of ways depending on the needs of the person requiring support. The most common types or "models" of advocacy are as follows:
- **Citizen advocacy;**

- **Group or collective advocacy;**
- **Peer advocacy; and**
- **Individual advocacy.**

5.8 The SIIA has, in various publications, described what each of these models entail. These descriptions are attached at Appendix 1.

5.9 Individual advocacy can also be referred to as “professional advocacy”. However, to reflect the strong view expressed at the workshops that professionalism should straddle all the models of advocacy and to avoid the potential confusion around any links with health and social care professionals such as doctors, social workers etc, the term “individual advocacy” is preferred for the purposes of this draft policy.

5.10 It is also worth mentioning that organisations providing advocacy services can and do offer more than one of these models of advocacy to their clients. So, although it is helpful to identify and describe the various models, they should not be viewed in isolation as a person could benefit from more than one of the models at any given time, or at different times, in their life.

5.11 Ultimately, **self advocacy** is what all the models of advocacy described in Appendix 1 aim to achieve or lead to. These models are a means of building a person’s confidence and knowledge to enable them to speak up for themselves and have their voice heard. However, this may not always be possible, for example when a person lacking capacity is involved. In these cases, the role of advocacy is considered to be particularly important and is often referred to as **non-instructed advocacy**.

5.12 Non-instructed advocacy could take the form of any of the models described above and will be central to the outworking of the new statutory right to an independent advocate in the proposed Mental Capacity (Health, Welfare and Finance) Bill.

## What does independence mean?

5.13 Three different types of independence can be applied to advocacy services. They are:

- Structural independence;
- Financial independence; and
- Psychological independence.

5.14 In Scotland, an independent advocacy organisation is described as being structurally, financially and psychologically separate from service providers and other services i.e. it is a separate organisation in its own right, has its own source of funding and is true to the principles of independent advocacy.<sup>4</sup>

5.15 A less stringent approach is adopted, however, in England and Wales. An independent advocacy scheme there is considered to be one which is structurally independent from statutory organisations and *preferably* from all service provider agencies. It also must be as free from conflict of interest as possible both in design and operation, and actively seeking to reduce any conflicting interests.<sup>5</sup>

5.16 In practice, the England and Wales model requires the advocacy arm of an organisation which also provides other services (such as day care or residential care services) to be as operationally independent of the rest of the organisation as possible. It would not, however, envisage an advocate employed by an organisation being assigned to a case involving an issue relating to another service provided by the same organisation. That said, there are some services which would be regarded as being complementary to advocacy, such as counselling, mediation or befriending, and therefore would not be seen as compromising the independence of the advocacy service if provided by the same organisation.

5.17 For the purposes of this draft policy, it is considered that independent advocacy should always be the preferred option for commissioners of advocacy services in a health and social care setting in Northern Ireland. This was

---

<sup>4</sup> SIAA: Principles and Standards for Independent Advocacy

<sup>5</sup> The Advocacy Charter - Action for Advocacy

strongly supported at the workshops and, in particular, by service users and carers. However, it was also widely accepted at the workshops that, if adopted here, the Scottish model of independence could present significant difficulties for many of the existing providers of advocacy services. As a result, it could potentially have a negative effect on the expertise that has already been developed as well as the availability of advocacy services to those who need them.

5.18 Therefore, while acknowledging that structural independence from service providers as well as all statutory organisations should be the ultimate goal as is currently the case in Scotland, it is considered that the model described above that is applied in England and Wales is the more pragmatic one to adopt in Northern Ireland at this stage. It is important to emphasise, however, that if advocacy is commissioned from an organisation that also provides other services, every step should be taken to minimise potential conflicts of interest and to actively encourage psychological independence which, arguably, is the most important of the three types of independence described above.

5.19 It is envisaged that this approach will be reflected in the definition of independence for the purposes of the new statutory right in the proposed Mental Capacity (Health, Welfare and Finance) Bill. Furthermore, as this draft policy is intended to pave the way for this new statutory right, it is also reflected in the principles and standards for the commissioning and delivery of advocacy services set out in sections 7 and 9 of this document.

### Why do we need independent advocacy services in health and social care?

5.20 It is widely accepted that advocacy is something which is part of everyday life. Many people turn to someone whom they trust for help or support to express their views, have their views heard or respond to difficult questions being asked of them. That person could be a family member, a peer, a carer or a health and social care professional, many of whom provide a vital informal advocacy service on a daily basis which should not be undervalued.

- 5.21 However, the need for independent advocacy services becomes important where a person or a group of people, for whatever reason, is at risk of being discriminated against or excluded from major decisions affecting their lives, either because of other people's prejudice or their own vulnerability, or both. In the health and social care context, this includes decisions about their care, treatment and support.
- 5.22 The types of things that might put someone at risk are many and varied, for example; age, disability (physical, sensory, learning, mental, communication related), gender, ethnic origin, sexual orientation, social exclusion, reputation, abuse, family breakdown. People who lack capacity can be particularly vulnerable not least because of the extent of their reliance on others for help with many aspects of their care, treatment and support and the fact that they are least likely independently to exercise their right to make a complaint.
- 5.23 It may also be the case that the person who is at risk does not have any well-motivated or capable family members or friends to call upon or it may even be that family and friends have different views or wishes to that of the person needing support. In these circumstances, it is not difficult to see the potential for that person not having their views or wishes taken into account properly which is their right.
- 5.24 Difficulties also may arise where professional health and social care staff involved in a person's care, treatment or support may be of the opinion that what the person wants is not in their best interests. While nurses, doctors, social workers and other professionals may look out for and speak up for their patients or clients on a daily basis as acknowledged above, they cannot be as free from potential conflicts of interest as an independent advocate. They may, for example, be influenced by legal obligations or duties they have to fulfil or by loyalty to their employer, whereas an independent advocate's loyalty and accountability must always be to the person requiring support. Their job is to see things from the person's point of view not the service provider or government.

## What are the benefits of investing in independent advocacy services?

- 5.25 Investing in independent advocacy services means that people who may be at risk of exclusion or being discriminated against have a vehicle through which they can, where possible, express their views or wishes, access information to help them make informed choices about their health and well-being and take control over their own lives. Advocacy empowers people to have their voice heard and helps to safeguard those who, for whatever reason, are unable to express their own views.
- 5.26 However, investing in advocacy services not only benefits the person needing support. It can also benefit commissioners and providers of health and social care services. For example, advocacy can help prevent crises arising in a person's life which otherwise may result in an intervention that has much greater resource implications. It can also enhance capacity building at a community and individual level which can ultimately serve to reduce dependency on other health and social care services.
- 5.27 By giving those most at risk a vehicle through which they can have their voice heard, advocacy services can also help commissioners and service providers gain a better understanding of the needs of this important group. They can act as a valuable channel for seeking ideas and views on how current health and social care services can be improved to better meet those needs and to inform planning for future needs and service re-design.

## Who will the new statutory right to an independent apply to and what exactly will it involve?

- 5.28 The decision to introduce a new statutory right to an independent advocate in the proposed Mental Capacity (Health, Welfare and Finance) Bill reflects an increasing recognition of the importance of independent advocacy in a health and social care context. While the detail is still being developed and further guidance for commissioners will be required in advance of its introduction, some decisions have been taken in relation to who the new right will apply to and what the role of the advocate might be in the context of the Bill.

5.29 For example, it is envisaged that the right to an independent advocate under the Bill will arise in the following circumstances:

- Where an intervention is being proposed which amounts to a deprivation of liberty in respect of a person lacking capacity (Deprivation of Liberty (DOLs) cases);
- where a serious health (physical or mental) or welfare intervention is being proposed in respect of a person lacking capacity who is non-compliant or resisting the intervention or whose nominated person (replacement for nearest relative) is objecting to the intervention; and
- where a serious health (physical or mental) or welfare intervention is being proposed in respect of a person lacking capacity who is compliant but is “unbefriended” i.e. they choose not to have a nominated person.

5.30 In these circumstances, it is intended that there will be a legal duty on commissioners to make arrangements for an independent advocate to be available to the person lacking capacity and to ensure that those entitled to an independent advocate under the Bill have the opportunity of making use of this service. The Bill will also recognise the right of a person to refuse an independent advocate if they are assessed as having the capacity to make that refusal.

5.31 The precise role of the advocate in these circumstances will be set out in subordinate legislation and is likely to include supporting and representing the person lacking capacity, obtaining and evaluating relevant information, ascertaining as far as possible the person’s wishes and feelings and communicating these to the decision maker. The advocate will also be able to challenge the decision-maker if they feel the action proposed is not in the person’s best interests (but not ultimately to decide whether the intervention should take place or not).

5.32 It is also intended that the appointment of independent advocates for the purposes of the Bill will be governed by subordinate legislation. This legislation will, among other

things, set out the minimum standards that will need to be met by organisations providing this service. It is important to recognise that additional standards to those set out in section 9 of this draft policy may be required for this purpose given the decision specific and time constrained nature of the advocate's role under the proposed legislation and also the fact that the type of advocacy will primarily be non-instructed.

## 6. UNDERSTANDING WHERE ADVOCACY FITS IN

- 6.1 By empowering and helping to safeguard people who are at risk of exclusion or being discriminated against, advocacy has a significant role to play in promoting human rights and tackling inequalities in health and social care.
- 6.2 In particular, effective advocacy services have the potential to contribute to a number of strategic goals for health and social care that ultimately promote wider equality and human right objectives. These include:
- Social inclusion and justice;
  - Health improvement and well-being;
  - Reducing inequalities in health and well-being;
  - Personal and public involvement;
  - Safeguarding adults; and
  - Bamford Review/Modernising Mental Health and Learning Disability Services.

### Social inclusion and justice

- 6.3 The support that advocates provide can help people avail of opportunities and exercise rights to which they are entitled. This not only has the potential to enhance their daily lives but also to build up their confidence and capacity to play an active role in society and secure greater equality in service provision generally.

### Health improvement and well-being

- 6.4 The Department, HSC Board, PHA, LCGs and Trusts all have duties in relation to improving the health and well-being of the people of Northern Ireland. These duties have been translated into a number of goals and objectives. Advocacy can play a vital role in achieving

these by empowering people to take control of their lives and helping them (or where appropriate) others make better informed decisions about issues affecting their health and well-being. At a practical level, the support of an advocate can also help improve the effectiveness of treatment and, in some cases, help prevent the need for treatment.

## Reducing inequalities in health and well-being

- 6.5 In many ways, improving health and well-being for all is dependent on tackling inequalities in health provision and again various strategies have been developed with this aim. Advocacy can be an effective way of highlighting inequalities and can also help to address these by increasing awareness of services among those who need them most and bringing forward ideas as to how they might be improved to meet their needs.

## Personal and Public Involvement (PPI)

- 6.6 Investing in advocacy is also one of several ways in which commissioners and others can deliver their goals in relation to Personal and Public Involvement (PPI) which is about giving people the opportunity to influence the design, delivery and evaluation of health and social care services.
- 6.7 Advocacy services can offer support to those who may otherwise find it difficult to contribute to this process and can also act as a valuable channel or source of information and advice for commissioners and service providers seeking to find effective ways of engaging with vulnerable groups of people.

## Safeguarding adults

- 6.8 As well as supporting people to speak up for themselves, advocacy can also have a role to play in helping to safeguard those in our society who, for whatever reason, are vulnerable or are at risk of being discriminated against. This may include someone who is at risk of harm or in need of protection. Advocacy can help to empower people in these circumstances and working alongside other services, it can also help to identify when harm is occurring and ensure that appropriate action is taken.

## Bamford Review/Modernising Mental Health and Learning Disability Services

- 6.9 The Bamford Review set the agenda for the modernisation of mental health and learning disability services in Northern Ireland through the making of a wide range of recommendations many of which have been implemented or are in the process of being implemented.
- 6.10 The proposed Mental Capacity (Health, Welfare and Finance) Bill will advance that agenda significantly by providing a comprehensive legislative framework for mental capacity and mental health law in Northern Ireland. This will include a number of safeguards for people lacking capacity, one of which will be the new statutory right to an independent advocate in certain circumstances. The Bamford Review recognised the need for this, specifically highlighting the importance of independent advocacy in ensuring that the human rights of people with a mental illness or learning disability are respected and the promotion of equality of opportunity.

## 7. COMMISSIONING ADVOCACY SERVICES

- 7.1 The need for greater parity and consistency of approach in the commissioning of advocacy services was a key concern raised at the workshops and supported by evidence gathered during the scoping study. Taking this into account and building on existing commissioning arrangements, this section sets out some practical ways in which the commissioning of advocacy services in a health and social care setting might be enhanced. It is informed and underpinned by preceding sections of this draft policy, in particular the recognition of the different models of advocacy and the definition of independence in section 5.

### Current commissioning arrangements

- 7.2 The Health and Social Care (Reform) Act (NI) 2009 introduced new commissioning arrangements through the reform of the health and social care structures along with a requirement on the HSC Board and the PHA to develop a joint commissioning plan describing how the allocated health and social care budget will be invested to meet

Ministerial priorities and ultimately improve the health and social well-being of the people of Northern Ireland.

- 7.3 *A Commissioning Framework for Health and Social Care*<sup>6</sup> was developed to prepare the way for these new arrangements and provides detailed guidance on the commissioning process.
- 7.4 Under the new arrangements, the HSC Board is required, where appropriate, to devolve commissioning to Local Commissioning Groups (LCGs), who must produce an annual commissioning plan for the population in the geographical area they cover. These LCGs are coterminous with the boundaries of the five HSC Trusts.

### Regional LCG Advocacy Network

- 7.5 As part of the annual commissioning cycle, LCGs should recognise the importance of the “continuum” of services referred to at paragraph 5.5, of which advocacy is a component part, that provides vital support to people who require help overcoming obstacles in their lives and, where appropriate, LCGs should assess and prioritise the needs of their local population in relation to advocacy services, taking into account available resources. Evidence of this should be identified in, and inform the preparation of, LCG annual commissioning plans.
- 7.6 To achieve this, each LCG should where possible have a named person to lead on the commissioning of advocacy services and the preparation of the relevant input to commissioning plans.
- 7.7 In addition, a regional LCG Advocacy Network, comprising the LCG advocacy leads, should be established to consider and identify opportunities for collaborative working across the five HSC Trusts in relation to the commissioning of advocacy services.
- 7.8 This new LCG Advocacy Network should also specifically consider the potential need for the regional commissioning of advocacy services required to support the proposed new statutory right to an independent advocate under the Mental Capacity (Health, Welfare and

---

<sup>6</sup> [www.dhsspsni.gov.uk/mipb\\_-\\_09-09.pdf](http://www.dhsspsni.gov.uk/mipb_-_09-09.pdf)

Finance) Bill. As a matter of good practice, this should include consideration of how existing effective advocacy provision can be built upon and complemented in preparation for this new statutory right. This will be a key feature of the further detailed guidance for commissioners that will be required prior to the introduction of this new right.

- 7.9 A senior named person at HSC Board/PHA level should be identified to coordinate this network and any future regional commissioning of advocacy services.

### Principles for commissioning of advocacy services

- 7.10 The *Commissioning Framework for Health and Social Care* sets out a number of principles governing the contractual relationship between commissioners and service providers. In addition to these, the following principles have been developed and should be adhered to when commissioning advocacy services in a health and social care setting:

#### Advocacy Commissioning Principles

Recognising the different models of advocacy described in section 5:

##### Principle 1 – Accountability

Advocacy services are commissioned which can clearly demonstrate that they are accountable to the people who use them.

##### Principle 2 – Independence

Advocacy services are commissioned in a way which ensures that they are structurally independent from all statutory organisations and *preferably* from all service providers.

##### Principle 3- Empowerment and Enablement

Advocacy services are commissioned which are effective in empowering and enabling people who use them to have a voice and to be involved as fully as possible in decisions about their care, treatment or support.

##### Principle 4 - Evidence based approach

Commissioners should continually monitor and evaluate the advocacy services they commission with a view to achieving measurably better outcomes for users.

#### Principle 5- Shared learning

Commissioners should make explicit in their commissioning arrangements their openness to learning from the experience of advocates and advocacy service providers.

### Monitoring adherence to commissioning principles for advocacy services

7.11 As part of its role in assuring the quality and safety of commissioned health and social care services, the RQIA should be responsible for monitoring adherence to the principles outlined above to underpin the commissioning of advocacy services.

### Personal and Public Involvement in commissioning advocacy services

7.12 The Health and Social Care (Reform) Act (Northern Ireland) 2009 also places a legislative requirement on health and social care organisations to deliver meaningful involvement of service users in the planning of health and social care services through a programme of PPI. Therefore, the HSC Board, PHA, LCGs and Trusts should ensure that those with an interest in advocacy services are involved in the key stages of the commissioning cycle. This was strongly supported at the workshops, particularly by service users and carers.

7.13 Existing processes, structures, networks, fora and databases that have been established to facilitate stakeholder involvement in the commissioning process to date should therefore be reviewed to ensure that they take account of the need to include appropriate and adequate representation from the wide range of individuals and organisations that have an interest in advocacy service provision.

7.14 This will require consideration of the following :

- Who are the key stakeholders in relation to advocacy services?
- What is the purpose of involving them in the commissioning cycle?
- How should they be involved?
- When should they be involved?
- Do they have the time, commitment, energy and support to take part?

7.15 It will be important to make sure there is a range of ways that those interested in advocacy services can be involved and that the approach adopted reflects the diversity of the population who may need advocacy services and is as inclusive as possible. Whatever approach is decided upon, careful consideration needs to be given to practical issues such as venue, transport, provision of translation and interpreting services, etc.

7.16 It is also essential that there is access to accurate, fit for purpose information that provides stakeholders with a meaningful overview of the issues relating to advocacy in order that they can agree what actions need to be taken and identify individual stakeholder roles and responsibilities in bringing about improvements in advocacy provision.

## 8. SUPPORTING ADVOCACY SERVICES

8.1 As well as planning, negotiating and paying for services, it is important to recognise the role that commissioners also have in enabling and facilitating the work of service providers. This section sets out some practical ways in which commissioners can support advocacy service providers in line with the commissioning principles set out in section 7.

### Contractual agreements between commissioners and non-statutory advocacy service providers

8.2 Commissioners should ensure that contractual agreements are developed in partnership with advocacy service providers and are in place at the start of the

financial year so that both parties are clear from the beginning about what is expected of them.

8.3 Building on existing templates for contractual agreements between HSC commissioners and non-statutory organisations, it is recommended that contractual agreements with advocacy service providers should as a matter of good practice specify the following:

- Aim and purpose of the agreement;
- Type(s) of advocacy service to be provided (using the descriptions set out in Appendix 1);
- Location of the advocacy service provider;
- Statement explaining why the advocacy service(s) is needed;
- Statement that the advocacy service provider will work within an agreed set of principles and standards (see section 9);
- Statement of the commissioner's responsibilities in relation to the contractual agreement;
- Objectives and targets for the advocacy service(s) i.e. service specification;
- Referral and access criteria for the advocacy service;
- Duration of the contractual agreement;
- Funding and payment arrangements including financial controls;
- Monitoring and performance evaluation arrangements (see section 9);
- Management and staffing issues including:
  - adherence to relevant policies, documents and legislative requirements;
  - training and sharing of best practice requirements;
- Complaints procedures;
- Contract Variation;
- Termination of contract; and
- Arbitration

8.4 Based on the outline provided above, a model contractual agreement for advocacy services should be developed that is capable of being adapted depending on the type of advocacy being commissioned and should be made available to all HSC commissioners of advocacy services. This model will need to be reviewed to reflect any additional requirements that might apply to providers of

the independent advocacy service envisaged under the proposed Mental Capacity (Health, Welfare and Finance) Bill.

### Funding for advocacy service providers

- 8.5 It should always be clear how much funding the service provider is receiving in return for the provision of advocacy services. This means that where a service provider is being funded for a range of services, one of which is advocacy, the proportion of the funding for advocacy should be clearly specified. This is essential to ensure the effective monitoring and evaluation of those services.
- 8.6 Best practice would suggest that, ideally, the contractual agreement should aim to outline funding for up to three to five years subject to evaluation on a yearly basis. It is recognised, however, that this will be difficult to achieve in the current financial context.

### Best Practice Fora for Advocates

- 8.7 Advocates benefit from exchanging ideas and information. Consideration should therefore be given to how existing local advocacy networks and fora can be supported and facilitated. For example, capacity for advocates to participate in these fora could be recognised and facilitated in the contractual agreement between the commissioner and the advocacy service provider.
- 8.8 As far as practicable, these fora should be self-supporting and it is considered important that, given the importance of independence, the facilitation role is undertaken by a body or organisation which is acceptable to those people/organisations involved in the forum. It is also considered important that the focus of the fora should primarily be on the sharing of best practice. The use of on-line networks, possibly linked to the regional LCG Advocacy Network, referred to in paragraph 7.7, could also be examined.

### Raising Awareness of advocacy services

- 8.9 A key message from the workshops was the need for greater accessibility to, and information on, advocacy

services in Northern Ireland. To achieve this, commissioners should give consideration to how advocacy services can be advertised more widely via posters, leaflets, radio and media advertising and also through outreach activity recognising that face to face communication can sometimes be more effective in getting messages across and raising awareness more generally.

- 8.10 The setting up of an advocacy website and a central directory for advocacy services in the form of an electronic database could also be considered. A list of advocacy services at all GP surgeries and all health and social care facilities would also help to raise awareness. Other ideas put forward at the workshops included an advocacy awareness week, an advocacy blog and the use of theatre/arts to promote awareness.

### Training/Awareness raising for Health and Social Care Staff

- 8.11 Taking into account current levels of awareness and training, arrangements should be put in place to ensure that all health and social care staff who may come into contact with an advocate or people who may require an advocate receive an appropriate level of training or awareness raising in the role and benefits of advocacy, the availability of such services and, in particular, the importance of independence.
- 8.12 Consideration should also be given to providing initial and ongoing training for senior planners and directors in health and social care organisations to highlight where advocacy fits in and the wider benefits that advocacy can bring.
- 8.13 Decisions around the targeting of this training/awareness raising should be made in consultation with the HSC Trusts and advocacy service providers as well as service users and carers and should take into account that further training may also be required on foot of further guidance on the new statutory right to independent advocacy proposed under the Mental Capacity (Health, Welfare and Finance) Bill.

## Training for Advocates

- 8.14 Contractual agreements with advocacy service providers should specify the need for all advocates, including volunteers, to receive core induction training which sets out the role of an advocate, the different models of advocacy, the principles and standards that advocates are expected to adhere to (see section 9) and the importance of independence (section 5). This should be provided either in-house by the advocacy service provider or via an external provider. Either way, resources for this should be clearly identified in the contractual agreement. A core induction pack for advocates should be developed to inform this training.
- 8.15 Advocacy service providers should also ensure that advocates have the opportunity to complete further training as necessary. Ongoing training requirements should be assessed by the advocacy service provider to ensure, where possible, that adequate resources are identified and set aside for this purpose during the development of the contractual agreement. This training should be competency based and subject to ongoing assessment.
- 8.16 To support this, a substantial piece of work is required to map current advocacy training in Northern Ireland against potential future need to identify gaps in training provision and inform decisions on future funding requirements. This should include consideration of, and make recommendations on, the level of training and/or experience that advocates appointed for the purposes of the proposed Mental Capacity (Health, Welfare and Finance) Bill may be required to meet and, in particular, whether there is a need for a recognised formal qualification such as a certificate or diploma in independency advocacy along the lines of that currently available in England and Wales.

## 9. MONITORING AND EVALUATION OF ADVOCACY SERVICES

- 9.1 Everyone involved in the commissioning and provision of advocacy services has an interest in knowing that advocacy is effective. While commissioners have a duty to ensure that public money is being used well, those providing the service should also recognise that they are accountable to the public for how they use this money.
- 9.2 It is therefore important that appropriate mechanisms are put in place to monitor and review the impact any investments being made in advocacy services are having on the quality of service experienced by service users. These should be agreed between commissioners and advocacy service providers during the development of the contractual agreement as reflected in section 8.

### Principles and Standards for the delivery of advocacy services

- 9.3 The model contractual agreement described in section 8 should contain a statement that the advocacy service provider will work within an agreed set of principles and standards. While commissioners will be entering into agreements with service providers for different types of advocacy, it is widely accepted that the same core principles and standards can apply to all types/models of advocacy. How adherence to these principles and standards is demonstrated will however differ and will require the development of separate performance indicators for each type/model of advocacy.
- 9.4 Based on the evidence gathered to inform this draft policy from the workshops and research into experience elsewhere, the following set of core principles and standards have been developed:

#### Advocacy Service Delivery Principles

##### Principle 1- Clarity of purpose

Standard 1.1 - The advocacy service has clearly stated aims and objectives that communicate to users and other relevant stakeholders the scope and limitations of the service.

## Principle 2 – Independence

Standard 2.1 - The advocacy service provider is structurally independent from statutory organisations and preferably from all other service providers.

Standard 2.2 - The advocacy service is as free from conflict of interest as possible both in design and operation, and actively seeks to reduce conflicting interests.

Standard 2.3 - Advocates always act for the individual while working in partnership, and maintaining good relations, with others involved in the individual's care, treatment or support.

## Principle 3 – Putting People First

Standard 3.1 - The advocacy service is directed by the needs, interests, views and wishes of the people who use it to enable them to have control over their lives and to be fully involved in decisions which affect them.

Standard 3.2 - The advocacy service values the people who use it and always treats people with dignity and respect.

Standard 3.3 - Advocates ensure that any information they receive concerning the people they advocate for is shared with them.

Standard 3.4 - Advocates represent the views of the individual whether they agree with them or not.

## Principle 4 – Empowerment and Enablement

Standard 4.1 - The advocacy service supports self-advocacy and empowerment through its work.

Standard 4.2 – Where an individual is unable to communicate their views, ethical guidelines are used to inform decisions about advocacy activities.

Standard 4.3 - The advocacy service ensures that people who want to can influence and be involved in the running and management of the service.

## Principle 5 – Accessibility

Standard 5.1 – The advocacy service reaches out to the widest possible range of people who may require the services of an advocate, regardless of ability or life circumstances and actively seeks out those that are most vulnerable or at risk of being excluded.

Standard 5.2 - The advocacy service aims to ensure that its premises, policies, procedures and publicity materials promote access for the whole community.

### Principle 6 – Supporting advocates

Standard 6.1 – The advocacy service provider ensures that advocates, paid and volunteers, are prepared, trained and supported in their role and provided with opportunities to develop their skills and experience linked to the aims and objectives of the service.

### Principle 7 – Accountability

Standard 7.1 - The advocacy service is accountable to the people who use it and operates within the law.

Standard 7.2 - The advocacy service is effectively managed and has in place systems for the effective monitoring and evaluation of its work.

### Principle 8 - Confidentiality

Standard 8.1- The advocacy service has a written policy on confidentiality which states that information known about a person using the service is confidential and any circumstances under which confidentiality might be breached.

Standard 8.2 – All client records are stored securely and in accordance with relevant data protection laws.

## Monitoring of advocacy services

**9.5** Monitoring is the process of checking continuously how things are going. From the outset, advocacy service providers should set up systems for gathering the routine information they need so that they know how they are doing against agreed aims and objectives in the same way as any other service provider would do. This may however be somewhat more challenging for an advocacy service provider given the need to ensure that these systems do not compromise any of the principles outlined in paragraph 9.4 above.

**9.6** In light of this, the assistance that commissioners can provide in supporting and advising advocacy service providers when developing or improving existing monitoring systems and deciding what information to collect should not be under-estimated.

- 9.7 Advocacy service providers should see monitoring as primarily something which benefits them, not as a chore to please commissioners. It is therefore important that the process is not too burdensome and that the amount of information that needs to be collected is proportionate with the aims of the exercise.

## Evaluation

- 9.8 Evaluation involves a planned process of gathering information, reaching conclusions and making recommendations. Any evaluation of an advocacy service should as a matter of good practice seek to take into account the perspectives of all stakeholders: people who need advocacy, paid and volunteer advocates, management and staff of the organisation providing the advocacy service, commissioners, referrers where appropriate.
- 9.9 Evaluation also involves making a judgement of how good something is, not just whether or not it has complied with the funding specification. It should focus on outcomes as well as activities, relevance as well as numbers, what could have been done as well as what was done.
- 9.10 However, evaluating any service is not a particularly easy exercise and, in relation to advocacy services, there is scope for it to be even more complicated. This should be borne in mind by commissioners during any evaluation process. It is likely for example that different views will be expressed depending on who is consulted so it is important to seek the views of as wide a group as possible. Also, those affected most by the service may often not be able to articulate their experiences as well as others and this should be taken into account when reaching conclusions and drawing up recommendations.
- 9.11 Some of the real achievements or successes of an advocacy service may also be difficult to identify because they are often around avoiding things happening or preventing the worst from happening. Therefore, looking at the history or steps leading up to an outcome can often be as important in the context of evaluating advocacy services as the outcome itself.

9.12 Finally, consideration should be given to the development of an evaluation framework for advocacy service providers that would include advice on processes and tools for gathering and analysing information on outcomes and for measuring this against the principles and standards set out above. This framework could be used for self-assessment and external evaluation purposes if deemed appropriate.

## **10. IMPLEMENTATION/NEXT STEPS**

10.1 The action plan set out below has been developed to assist with the implementation of this draft policy when it has been finalised. As lead responsibility for the majority of the actions falls to the HSC Board, the plan will be taken forward by a project manager within the HSC Board.

10.2 Given that this draft policy is intended to pave the way for the introduction of the new statutory right to an independent advocate under the proposed Mental Capacity (Health, Welfare and Finance) Bill in 2013, it is essential that it is finalised and implemented as soon as possible.

**DHSSPS**  
**June 2011**

## Policy for Developing Advocacy Services: Action Plan

### Commissioning of advocacy services

ACTION	LEAD RESPONSIBILITY	TARGET COMPLETION DATE *
1. Identify HSC Board/PHA and LCG advocacy leads and establish regional LCG Advocacy Network.	<b>HSCB and PHA in collaboration with LCGs</b>	<b>February 2012</b>
2. Develop terms of reference for the regional LCG Advocacy Network.	<b>HSCB and PHA in collaboration with LCGs</b>	<b>February 2012</b>
3. Endorse and implement principles for commissioning of advocacy services, including the proposed approach to independence.	<b>HSCB and PHA in collaboration with LCGs and HSC Trusts</b>	<b>April 2012</b>
4. Agree and put in place appropriate mechanisms to monitor adherence to principles for commissioning of advocacy services.	<b>HSCB and PHA in collaboration with LCGs, HSC Trusts and RQIA</b>	<b>April 2012</b>
5. Review of existing processes, structures, networks, fora and databases established to facilitate stakeholder involvement in the commissioning process to ensure adequate and appropriate representation from individuals and organisations with an interest in advocacy.	<b>HSCB and PHA in collaboration with LCGs and HSC Trusts.</b>	<b>April 2012</b>
6. Develop further guidance on commissioning of advocacy services for proposed Mental Capacity (Health, Welfare and Finance) Bill and associated costs.	<b>DHSSPS in collaboration with HSCB, PHA, HSC Trusts and others</b>	<b>October 2012</b>

## Supporting advocacy services

ACTION	LEAD RESPONSIBILITY	TARGET COMPLETION DATE
7. Develop and implement a model contractual agreement between HSC organisations and non-statutory advocacy providers for the provision of advocacy services.	HSCB and PHA in collaboration with HSC Trusts	April 2012
8. Identify existing advocacy fora within each Trust area focusing on the sharing of best practice and consider how they can be supported and facilitated.	HSC Trusts	October 2012
9. Develop and implement a training/awareness raising plan for all relevant health and social care staff, including senior planners and directors, on the role and benefits of advocacy.	HSCB and PHA in collaboration with HSC Trusts and training providers	October 2012
10. Develop and implement plan for raising public awareness of advocacy services to include for example information packs for GP surgeries, an advocacy website, outreach and an electronic database of existing services.	PHA	April 2012
11. Develop core induction pack for all advocates.	HSCB, PHA and HSC Trusts	October 2012
12. Undertake mapping exercise of current advocacy training to identify gaps and inform future decisions on funding and the level of training and/or experience that advocates appointed under the proposed Mental Capacity (Health, Welfare and Finance) Bill should be required to meet and associated costs.	HSCB and PHA in collaboration with HSC Trusts	April 2012

## Monitoring and Evaluation advocacy services

ACTION	LEAD RESPONSIBILITY	TARGET COMPLETION DATE
13. Endorse and implement principles and standards for the delivery of advocacy services.	<b>HSCB and PHA in collaboration with LCGs, HSC Trusts and advocacy providers</b>	<b>April 2012</b>
14. Develop key performance indicators to illustrate how adherence to the principles and standards for the delivery of advocacy services can be demonstrated by advocacy providers for each of the different models of advocacy described in section 5.	<b>HSCB and PHA in collaboration with LCGs, HSC Trusts and RQIA.</b>	<b>October 2012</b>
15. Develop an evaluation framework for advocacy services to include processes and tools for gathering and analysing information on outcomes, measuring their work against the principles and standards and facilitating an external evaluation if appropriate.	<b>HSCB and PHA in collaboration with LCGs, HSC Trusts and RQIA.</b>	<b>April 2013</b>

\* All dates assume finalisation of the policy by the end of 2011.

## **Appendix 1: Models of Advocacy – SIAA Independent Advocacy: A Guide for Commissioners**

### **Citizen Advocacy**

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 organisation providing the advocacy service. The advocate supports their partner using their natural skills and talents rather than being trained in the role.

### **Group or Collective advocacy**

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**

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 use their own experiences to understand and empathise with their advocacy partner. Peer advocacy works to increase self awareness, confidence and assertiveness so that the individual can speak out for themselves, lessening the imbalance of power between the advocate and their advocacy partner.

## **Professional (Individual) advocacy**

Professional advocacy is also known as one-to-one, individual or issue based advocacy<sup>7</sup>. 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.

---

<sup>7</sup> To be known as Individual advocacy for the purposes of this draft policy – see paragraph 5.9.

## **Appendix 2: Glossary of Terms/Abbreviations**

<b>Bamford Review</b>	The Bamford Review of Mental Health and Learning Disability Services in Northern Ireland
<b>Department</b>	Department of Health, Social Services and Public Safety (DHSSPS)
<b>DOL</b>	Deprivation of Liberty
<b>HSC</b>	Health and Social Care
<b>LCG</b>	Local Commissioning Group
<b>PCC</b>	Patient Client Council
<b>PHA</b>	Public Health Agency
<b>PPI</b>	Personal and Public Involvement
<b>RQIA</b>	Regulation and Quality Improvement Authority
<b>SIAA</b>	Scottish Independent Advocacy Alliance