

Structured abstract

Purpose: This paper considers independent advocates' perspectives on their roles in Scottish Adult Support and Protection (ASP) work, and the facilitators and barriers impacting on these roles in practice.

Design/methodology/approach: Semi-structured interviews were conducted with twenty managers and staff from six independent advocacy agencies operating across nine local authority areas.

Findings : Participants described key roles in supporting individuals to understand their rights and to negotiate ASP processes. They conceptualised their independence to be the key distinguishing feature of their role.

Participants noted lower than expected rates of referral of ASP concerns to advocacy and variable experiences of communication with the statutory services. Particular emphasis was placed on the late stage at which many referrals are received. Awareness, understanding and acceptance of advocacy amongst the statutory services was felt to vary at both practice and strategic levels.

Research limitations/implications: The sample is not a representative one. However, some commonalities are worthy of note: particularly the participants' commitment to ASP work and the perceived impact of statutory agencies on their involvement in it. The issue of late referrals merits some consideration at a national level. Issues of awareness and understanding amongst the statutory services, and their links with referral rates, are for further local-level exploration. The independent advocacy community might wish to discuss further the impacts on them of incorporation into statutory frameworks.

Originality/value: Advocacy perspectives have been little drawn on in pre-existing ASP research.

Keywords: Adult support and protection; safeguarding; independent advocacy; voluntary organisations; inter-agency working

Article classification: Research paper

Introduction

This paper reports some of the findings of a research project that investigated independent advocacy perspectives on work to keep adults safe from mistreatment in Scotland. The project investigated the interface between advocacy work to safeguard people's rights and statutory-led Adult Support and Protection (ASP) interventions from a number of angles (Sherwood-Johnson

2015). Independent advocates' views about their own roles in formal ASP processes, and the facilitators and barriers impacting on fulfilment of these roles in practice, are reported here. The paper is intended to be of particular interest to local authority personnel and others working alongside independent advocates in Scottish ASP work. It will also be of interest in other countries with comparable social services systems, on account of: a) some shared messages for adult protection or safeguarding practice; and b) some insights into the evolving nature of independent advocacy services and their differences across policy and legislative contexts.

Background

The Scottish independent advocacy movement developed in the 1970s and 1980s out of the campaigning work of people using and providing health and social care services, particularly patients in mental health hospitals who campaigned for more equitable treatment (Scottish Independent Advocacy Alliance 2013b). It was also informed by the citizen advocacy movement that developed in North America from the 1960s (O'Brien & Wolfensberger, 1979). The Scottish movement evolved to encompass more settings and models of working in parallel with major developments in the health and social care sector itself. In particular, independent advocacy organisations worked to give people a voice and strengthen social networks in the context of the 1990 community care reforms and the closure of many long-stay hospitals. More recently the movement has been influenced by legislation passed by the devolved Scottish parliament, especially the Mental Health (Care and Treatment) (Scotland) Act 2003 (the MHCTSA), which granted anyone with a "mental disorder" a right to independent advocacy. "Mental disorder" in this context encompasses personality disorder and learning disability (MHCTSA ss.259(1); 328(1)). A particular focus of implementation of this right has been the provision of advocacy to people subject to compulsory intervention under the MHCTSA. A higher profile and increased funding of advocacy has followed, though some argue that alternative models of working, particularly longer-term and collective models, have suffered in comparison with crisis casework linked directly to formal MHCTSA powers (Scottish Independent Advocacy Alliance 2013b).

The Adult Support and Protection (Scotland) Act 2007 (the ASPSA) is widely conceptualised as having completed a 'trio' of Scottish legislation concerned with the welfare of adults requiring support in the face of particular risks and/or vulnerabilities. It sits alongside the MHCTSA and the earlier Adults with Incapacity (Scotland) Act 2000 to provide a suite of powers and duties intended to complement each other and to be drawn upon in tandem (Mackay 2008). The ASPSA is specifically concerned with 'harm' to an 'adult at risk'. It requires councils to inquire into suspected instances of 'harm', and a range of public bodies to co-operate to support investigations and protective interventions. A significantly broader range of stakeholders than public bodies alone are also envisaged as partners in these safeguarding activities. In particular, practitioners operating under the ASPSA are required to "have regard to the importance of the provision of" independent advocacy services (ASPSA s.6(2)). The ASPSA has accordingly led to further increases in demand from statutory agencies and some changes to the Service-Level Agreements between independent advocacy organisations and local authorities (Scottish Independent Advocacy Alliance 2013a).

Definitions of independent advocacy in Scottish legislation mirror the ways that independent advocacy organisations define themselves, to the extent that they focus on support and/or representation which is as free as possible of conflicts of interest, with the aim of empowering people to have control over their lives (MHCTSA s.259(4)&(5); ASPSA s.6(3)). There is no equivalent in Scotland of the Independent Mental Health Advocates (IMHAs) and Independent Mental Capacity Advocates (IMCAs), the functions of whom are more fully detailed in English and Welsh statute (Redley et al, 2011, Newbigging et al, 2015).

Early research into work under the ASPSA has accessed some practitioner perspectives, particularly those of social workers (e.g. Mackay et al, 2011), and some service user perspectives (e.g. Altrum Risk Research Team 2011, Scottish Government 2014), albeit that there is significantly more work to be done in this respect. There has also been service user and carer involvement in some local authority-level evaluation exercises (e.g. East and Midlothian Adult Protection Committee 2010), some facilitated by advocacy agencies. Independent advocacy views have not been drawn upon substantially in their own right, however, despite the particular vantage point that advocates contribute to this field. The following section describes how the present study set out to address this gap.

Method

The study used semi-structured interviews to begin to map some independent advocacy perspectives on:

- The processes and outcomes of statutory ASP work;
- The impact of evolving ASP policies and practices on independent advocacy organisations and their work to protect adults from mistreatment and safeguard their rights.

This paper is concerned specifically with the contributions of independent advocacy to formal ASP processes, and the facilitators and barriers impacting on these contributions.

Twenty workers from six independent advocacy organisations participated in the study. Organisations were approached with a view to securing a diverse sample in terms of rural/urban location, populations served and models of advocacy employed. All those who responded within the time-frame of the study were included in the sample. Some of the participating organisations offered advocacy services within a single local authority area, whilst others offered services spanning more than one area. Between them, participants were working across nine local authority areas. Some participants were managers; others were workers with a range of specialisms including mental health, learning disability, work with carers and ASP work specifically. Participants opted to be interviewed individually or in groups with colleagues from their agency.

The study was approved by the Ethics Committee of the School of Applied Social Sciences, University of Stirling. Participants discussed their ASP work without sharing individuals' names or personal details. They took part on the understanding that neither they, their agencies nor users of their services would be identified in reports of the study. Accordingly, the following sections identify participants by interview number only, and by a participant code where more than one participant was interviewed together. No identifying details of service users or carers are included.

Findings

The findings are presented here in two main sections. The first section sets out how participants characterised the role of independent advocacy in statutory ASP work. The second section considers aspects of the practice of statutory agencies that were thought to help or hinder fulfilment of this role.

The independent advocacy role in ASP

Participants described a range of roles that they might undertake within ASP situations. First, advocates might play a role in helping individuals to understand their rights in the context of the harm itself:

"He's able to tell you, he's able to point to parts of his body, and pinch, and say the word 'nip'. And sign who's done it. ...and for me as an advocate to say to him it's his right, he has a right to be free from abuse and that shouldn't happen." [Interview 5; Participant D]

They might also assist with understanding ASP procedures and interventions and the individual's rights in relation to these:

"...And trying to make them see that any interventions are potentially positive. But make sure they still have that informed choice, underlying it. And you know, they don't have to stay if they're removed to a place of safety. But you give them the consequences as well, if they don't." [Interview 9]

One participant characterised statutory ASP processes as having a key role in safeguarding people's rights to life, and to live well, and independent advocacy as having a key role in "safeguarding people's other rights" [Interview 10]. From the ways all participants described their work, the rights to make choices and to participate in decision-making processes can be inferred to be key amongst these "other rights".

Participants placed a great deal of emphasis on the support they can provide to individuals to participate in ASP meetings and case conferences. They described discussions with the individual beforehand to help them to consider their options and to plan what they would like to

communicate. They described attending meetings together with their partner¹, or on their behalf, depending on the partner's own preference. There is a moral support element to preparing and attending together that one participant characterised as "metaphorically holding their hand" [Interview 9]. In terms of practical assistance, helping to ensure that a partner's communication needs are adhered to, requesting breaks in meetings where required by the partner, for instance because they are upset or for further explanations of content, and acting as the partner's "memory" [Interview 2; Participant A] by keeping a note of proceedings for their purposes, were all reported to be part of an advocate's role. Participants described representing the pre-agreed perspectives and choices of their partner at meetings, where they had been requested to do so, or sitting silently where the partner themselves preferred to speak. They also described helping to set up alternative arrangements, such as smaller pre-meetings, for individuals to communicate their views if this would be their preference. Going over what happened with their partner after a meeting, whether or not the partner attended, and answering any questions, were also characterised as key parts of the advocacy role. Where an individual is unable to communicate their views, participants also described the means that they employ to investigate preferences, needs and/or past views in order to represent these, for instance by spending time with the person, using a range of communication aids, and having discussions with relatives and other key people in the person's life.

All participants characterised their role as one element in a broader process. They acknowledged that "it doesn't work for everybody" [Interview 7], and some mentioned partial overlaps with other people's roles: for instance, social workers should also be providing information about ASP processes. However, the distinctiveness of independent advocacy's contribution was identified to lie in the type of relationship an advocate can establish with an advocacy partner. Most importantly, the advocate is independent of conflicts of interest, including the conflict of interest inherent in the roles of professionals who have a duty of care. Specifically, the advocate is not concerned to advise partners in relation to their best interests nor, where their partner is able to instruct them, to make or express best interest judgements themselves. Aside from their role in helping the partner to understand the options and their consequences, the advocate is also not influenced in their activities by the interests of anybody else:

"We aren't sitting there as the care provider, saying: I want to keep this person here in this service: I need that funding. I'm not the social worker saying: Oh, I just want this to get sorted out." [Interview 8; Participant D]

This sets up a particular dynamic that was widely portrayed as a vital additional safeguard, not least for people who are particularly susceptible to persuasion and least practised in asserting themselves, in the context of a process with potentially major implications for their life.

The role of advocacy in helping to press for further action where the outcomes of ASP processes are *not* satisfactory to an individual and/or appear to be in breach of their rights is one example of this distinctive type of relationship and safeguard in practice. Conversely, some participants spoke about

¹ People supported by advocacy are referred to as "advocacy partners" or "partners" throughout this paper.

the use of their relationship with an advocacy partner to facilitate the work of other professionals, where this best helps to safeguard an individual at risk:

“...it was only when advocacy came in that, all the professionals around him, that he was able to trust those professionals. And it was the advocacy worker who then supported him to look at the different options, places of safety, and it was the relationship between the advocacy worker and the advocacy partner that allowed all the other professionals to really be involved in a proactive way.” [Interview 2; Participant A]

Incorporating both a degree of “positive challenge” [Interview 2; Participant B] alongside a commitment to partnership-working, then, independent advocacy was unanimously characterised as taking its direction in any given situation from the informed choices of a partner able to instruct the advocate, or from the basic rights of a partner unable to express a view.

Facilitators and barriers

Having summarised participants’ descriptions of the contributions that independent advocacy can offer to formal ASP processes, the following subsections consider the most commonly mentioned factors impacting on advocates’ abilities to fulfil these roles in practice. These factors are: rates of referral to advocacy; awareness, understanding and attitudes towards advocacy; timing and quality of communication; and facilitators and barriers at strategic level.

Rates of referral to independent advocacy

In the first instance, self-evidently, advocacy organisations need to be informed about a situation before they can begin to make a contribution to it. However, one or more participants in all of the six agencies expressed some concerns about the numbers of ASP referrals to independent advocacy received from the statutory services. Generally referrals were consistently lower, and sometimes had fluctuated more, than might have been predicted from the volume of ASP work undertaken in each local authority area overall. The reasons for low referral rates were generally felt to require more exploration. There was a widely-shared sense that having “considered” advocacy might mean one of several things, and that explanations and offers of advocacy might be made in more or less helpful ways.

“sometimes we’re not sure what people are actually sharing about what it is we’re doing. Or whether the staff are informed enough about our role.” [Interview 7]

“Because advocacy’s not required for ASP. It’s required to consider it. ...And that’s problematic. ‘So we’ve considered it: No.’ So I mean that might be obtuse. But you know, that is all that is required.” [Interview 2; Participant C]

Three participants described sections that had been introduced into their local authority’s initial recording form, in which council officers were required to indicate if advocacy had been considered and/or offered, and to account for any decision *not* to offer advocacy. This was felt to be a positive

development, notwithstanding the points raised above and some specific teething problems with these systems in practice.

Awareness, understanding and attitudes towards advocacy

For many participants, the wider issue linked to their concerns about referral rates was the understanding of independent advocacy, and feelings towards the involvement of independent advocacy, on behalf of some of their statutory colleagues. Although development activities associated with the implementation of the ASPSA were considered by some to have raised the profile of independent advocacy overall, two participants reported spikes in referral rates following their involvement in training or awareness-raising sessions, and substantial drops in referral rates during periods when such involvement had not been possible for a variety of reasons. Awareness and willingness to offer advocacy can quickly dip, therefore, without ongoing reminders.

Some participants were also aware of specific pockets of misunderstanding that they considered to be linked to some decisions not to offer advocacy:

"We have heard that, occasionally, if a person doesn't have capacity, they don't think that advocacy would be suitable. So I've had to kind of have a conversation, that even if somebody's deemed not to have capacity, they still have a view, and it's still really, really important to find out ...what their view is, and have somebody support them to voice that. And even if they can't do that, having somebody independent there to safeguard them through the process is equally just as important." [Interview 7]

"it's not just these little meek, you know, people who just look at their toes and they never speak up in meetings, that's not the only type of people that we support. ...because they maybe shout quite loud, that doesn't mean that they are assertive when they need to be in difficult situations. It doesn't mean that they feel comfortable in formal surroundings." [Interview 3; Participant B]

Participants in three interviews, in particular, argued that the individual themselves should always have the opportunity to accept or decline an independent advocate, rather than a judgement about need and/or suitability being made by professionals on the individual's behalf.

Alongside some misperceptions about the usefulness of advocacy to some "types" of people, participants were aware of a level of misunderstanding amongst some other professionals about their role and its usefulness in the context of the multi-disciplinary team. Some confusion was reported to arise where professionals could not appreciate that the view being represented by an advocate was not necessarily the advocate's own. Most frequently mentioned, however, was the resistance, even hostility, that can follow from a perception that advocates set out to be "challenging" or "adversarial", and/or that they make the work of the statutory services more difficult:

"we're quite often seen as just a nuisance because it prevents things from happening in a certain way, because we're giving the client their options to make an informed choice."
[Interview 5; Participant C]

Conversely, one participant had experienced some misperceptions about the ways in which advocacy might be expected to be *helpful*. Specifically, she felt that advocacy can sometimes be brought in once a relationship between an individual and a statutory worker has become difficult, on the assumption that the advocate might be better able to persuade the individual to do what the worker wants. Where individuals are more "malleable", on the other hand, this participant felt that advocacy might not be considered to be as valuable by the professionals involved. Unsurprisingly, both positions were held up by this participant as misrepresentations of the proper role of independent advocacy.

A number of examples of clear understandings and positive attitudes towards independent advocacy were also raised across the interviews:

"we work for quite a good local authority here. The staff are quite well aware of what our role is, and they believe that the individual has the right to have their voice heard through that process." [Interview 7]

"But there's other sea-changes, in the hospital and that, where people saying: Oh it's the advocate; and they accept us, and we get on with it." [Interview 4]

Like the more negative experiences, these positive examples also underline participants' perceptions that the ability of advocacy to offer a service in ASP situations hinges on the attitudes and beliefs of third parties in important ways. These attitudes and beliefs, moreover, were perceived to vary from worker to worker, from team to team, and from local authority to local authority.

Timing and quality of communication

In situations where independent advocacy is made aware of an ASP situation, the single most frequently mentioned barrier to providing a full service concerned the stage in the process at which this referral is received. The majority of participants cited common experiences of referrals received days or even hours before an ASP case conference. Because so much of the work of an advocate is preparation for meetings and "behind the scenes" support [Interview 8; Participant E], which depends for its effectiveness on establishing communication and trust, late referrals were repeatedly described as a barrier to accomplishing this work:

"we can't just turn up on the day and sit next to the person. Our role is to help them say what they want to say, or to help them understand what this is all about. And we can't do that if we haven't had the opportunity to see them beforehand." [Interview 3; Participant B]

"They can have had the initial case conference, and it's at that point they'll say: Oh, maybe we should see if an advocate would be useful here. So, you know, a protection plan's

already been maybe discussed and put in place, without the person really being engaged in that, you know? Because they maybe didn't have an advocate." [Interview 1]

Conversely, those participants whose other roles had enabled them to establish pre-existing relationships with certain individuals stressed how beneficial this can be when ASP processes then require swift advocacy input. These pre-existing relationships might have been established through support with other issues, for example, or through the individual's involvement in collective advocacy groups.

Several participants described the elements of an advocacy service they were able to provide to individuals they had not had the opportunity to get to know beforehand. For instance, information can still be gathered, processes explained and rights to participation promoted at the initial meeting attended by the advocate. Participants also appreciated that workloads are heavy and timescales tight for statutory workers responding to ASP concerns. They emphasised the need for referrals as early as possible, however. In addition, one participant questioned whether timescales always need to be so tight, where the result is a diminished opportunity to understand and participate in ASP on the part of the adult at risk.

Participants also reported mixed experiences of the quality of communication from statutory services on an ongoing basis, to enable them to keep track of ASP processes in a given case. This was portrayed as a tricky area to negotiate in some respects, because the advocate's entitlement to information is clearly linked to the mandate received from their partner:

"I just find it sometimes difficult ...when the emails are flying back and forth, and everybody is cc-ed into the email. And sometimes – I shouldn't know more than my client. And it puts me in a difficult situation." [Interview 8; Participant B]

Nevertheless, in the examples reported of greatest dissatisfaction with the quality of ongoing communication, participants drew links between their own exclusion and the ability of their partner to be included, where that partner had opted for advocacy support.

In circumstances where they struggled to access information, some participants linked this back to negative attitudes towards advocacy amongst some statutory colleagues:

"And you can't help but feel with some of the referrals, they really are tick-box referrals. As is evidenced by the extreme lack of desire to keep you in any part of the loop thereafter." [Interview 5; Participant B]

Elsewhere, links were drawn between the quality of information-sharing and the commitment and support of individuals in key strategic roles:

B: I'm just trying to think if it was at that time, when there was someone consistent in post.

- A: *And that's the lead officer role isn't it? Because at that point, the lead officer was really involved.*
- B: *And things, communication was good, and the social worker really had a really good understanding of advocacy. And wanted that support. And the person wanted the support ...there was lots of good communication going on. And you always knew when meetings were, and you weren't the last to know and... if there's someone that's, there's a strong representative at the top then it all works out. [Interview 2]*

Just as the positive attitudes and facilitative practice of front-line workers was seen to support the role of advocacy in ASP situations, then, so the active support of individual members of more senior staff was frequently cited as a key facilitative factor. This point is taken up again below.

Facilitators and barriers at strategic level

The benefits to independent advocacy of strategic activities such as engagement with local area forums and Adult Protection Committees were emphasised by several participants, particularly those who were managers of their respective agencies. Strategic engagement was reported to have helped maintain the profile of independent advocacy amongst senior stakeholders, facilitated discussions about referral protocols and other information-sharing issues, and allowed some of the agencies to contribute to multi-agency ASP training. As noted above, these facilitative relationships and levels of strategic representation were frequently associated by participants with the commitment of particular individuals within their local councils:

"I think one of the things that has been fought for for quite a long time by the ASP co-ordinator in [place] is to have independent advocacy represented on the committees and that. And that's only really happened in the last year. ...And it was through her kind of continually saying: We should have independent advocacy on here. Because she's very pro-independent advocacy ...she really believes in the process, in people's choice and that." [Interview 3; Participant A]

"And the training officer is also very advocacy-friendly. Hence the fact we have a slot in the training. So we've always, we've deliberately fostered that relationship, but we didn't really need to bang on doors to get in there." [Interview 9]

Problems were reported, conversely, where supportive individuals moved on or these posts remained unfilled. One participant also noted the resource issues that act as barriers to the involvement of smaller voluntary organisations in forums where strategic relationships can be cultivated.

In participants' consideration of the barriers and facilitators of advocacy input into ASP situations, a number of further references were made to funding, capacity and related issues. First, some specific pieces of work were noted to be constrained by a shortage of time or other resources. For example, Interviewee 4 felt that a more sustained relationship with one of her partners would enable a fuller insight to emerge into the suspected undue pressure being exerted by a harmer, to the benefit of

the partner and the ASP process. However, alongside some other complicating factors, constraints on this participant's time rendered it difficult to build such a relationship:

"And because we're issue-based, it's always, what is the issue? Well the issue is: this is what's happening, this is what they want to do – what do you want to happen? How do you feel about it? So it's not, there's not been that – although I've been supporting her on and off for years, there's not been that longevity of, let's build up this relationship and really, you know, work out what it is. ...I don't know if I would have the time." [Interview 4]

Another participant reported difficulties establishing the level of communication and trust required to advocate effectively, where a client requires an interpreter. Again, further difficulties are involved here, not least the complications of building a relationship via a third party. However, the absence of interpreters for any more casual contacts outside of formal meetings was reported to be a significant barrier given, again, the background work intrinsic to the advocacy role.

The complexity and time-consuming nature of many pieces of ASP work, in general, was mentioned by several participants.

"because it's ASP ...that is a higher, a higher factor of being involved with somebody. ...I have to push something to one side to fit that in." [Interview 6]

Three of the agencies had received some additional funding to assist with increases in workload associated with the ASPSA, though agencies covering more than one local authority area had not necessarily received funding from each area in which they work. Where no additional funding had been forthcoming, this was reported to have had a range of impacts. For instance, there were short-term capacity implications in one agency when ASP referrals started coming through; however, these have lessened as referrals have steadied out, as experience has built up and as volunteers have increasingly been brought on board to undertake some of this work. Two further participants in different locations reported being able to manage their levels of ASP work currently, but had some concerns about future capacity, given how many more referrals they felt that they *should* be receiving, as noted above.

Three of the agencies were situated in areas where a contract to undertake certain kinds of advocacy work, including ASP work, had been put out to tender. In some areas this had resulted in particular local advocacy agencies receiving ongoing funding and others experiencing a drastic reduction of funds or being forced to close. Participants in one area in particular were deeply concerned about the specifications for ASP work that had been set out in the tender issued locally. This had specified a maximum of three "contacts" with the individual in any given ASP situation, over a maximum period of three months. This "time-limited crisis management" model [Interview 2; Participant A], was thought potentially to be appropriate to some kinds of work under mental health legislation, but to be inappropriate to many kinds of ASP situation. Its in-built time restrictions, together with the absence from the contract of any independent advocacy support unless the work was "statutory", was felt to reflect the priorities of procurement officers who neither understood advocacy nor had consulted adequately with users of advocacy services:

"It felt like they'd already decided what was going to be within the tender. And it was going to be legislative-based." [Interview 2; Participant B]

As a result of these "horrendous", "box-ticking" consultation exercises [Interview 2; Participant C] and a conception of independent advocacy as only actually *required* within certain narrowly-defined types of "legislative" process, these participants felt that the movement's grass-roots principles had been under-acknowledged. Furthermore, where agencies had been successful in sourcing funding for alternative models of practice from elsewhere, there was a fear about the emergence of "tiered advocacy provision" [Interview 2; Participant A]:

"...so if you fit within one of our projects, we'll work with you for as long as it takes. And hopefully you'll end up at the end of the process, if not more empowered, ...at least you'll have been involved in the process. And so that's one level. And then another level we have the contract. You'll have had three visits, you know, bish bash bosh, it's out. And for me... it should be the deluxe model. If you're going through these processes, that are already so complex, and have such a huge impact on your life... should it not be the other way round?" [Interview 2; Participant A]

Instead, however, those with a contract to deliver ASP support were thought to be left "working around" specifications that did not truly represent best practice, in this locality at least. Meanwhile, the broader scope of independent advocacy to prevent harm and safeguard people in a more holistic sense was being overlooked and underfunded.

Discussion and conclusions

This study sought the views of twenty managers and staff from six independent advocacy organisations across Scotland. Its findings cannot be treated as representative of all Scottish independent advocacy workers. Nevertheless, there were some notable commonalities, and some equally notable variations in experiences and views, on which further discussions might usefully be based.

One key commonality was the participants' perceptions that independent advocacy can complement the work of statutory ASP staff. The participants supported the principles of the ASPSA and wanted to work in partnership with statutory colleagues to deliver these, within the proper boundaries of their specific roles. It was also very commonly noted that statutory staff at every level have important roles to play in ensuring that advocates are able to contribute to ASP work as fully as possible: that is, as fully as people who use services would wish and find helpful.

Where barriers exist to full advocacy involvement, some require examination and action to address at a local level. In particular, participants reported variations in understanding and acceptance of advocacy between local authorities, between teams, and from one individual statutory worker to another. This suggests that Adult Protection Committees (APCs) should seek feedback from their

local advocacy agencies about understanding and acceptance at these levels in their areas, and work together with them to develop awareness-raising and training strategies as required. Further research initiated by these collaborative partnerships might specifically examine how and in what circumstances independent advocacy is being offered to individuals subject to ASP. Where resistance to advocacy is identified through these exercises, APCs and key strategic leads in the statutory services might also wish to consider potential reasons for this beyond the need for further training: for instance, whether statutory staff are working to timescales that struggle to accommodate independent advocacy, or are impacted by other contextual factors that make them feel threatened or defensive about the boundaries of their roles (Hardwick 2014).

The concern about the late stage in the ASP process at which many referrals to advocacy are made was common enough to merit some consideration at a national level. Clearly, some ASP situations require emergency action and all should be responded to in a timely fashion. However, the findings with respect to late referrals raise the question of whether an appropriate balance is being struck between procedures to ensure timeliness, on the one hand, and flexibility to foster person-centred practice including the involvement of advocacy, on the other. The experience of those in England and Wales working to reconcile safeguarding with personalisation could usefully inform further discussions about the achievement of such a balance in the Scottish context (Lawson et al., 2014).

Alongside the Scotland-specific implications, there are findings reported here that would benefit from discussion and comparative analysis within a broader context. The barriers created by limited resources and variable understanding and acceptance of advocacy amongst other professionals, for instance, have resonance with other UK empirical research (Newbigging et al., 2015; Forbat & Atkinson, 2005; Carver & Morrison, 2005; Older People's Advocacy Alliance UK, 2009). Questions about the evolution of advocacy as it becomes increasingly closely allied with statutory processes are also echoed in this literature (Newbigging et al., 2015; Redley et al., 2011). Whilst the IMHA and IMCA services introduce differently nuanced considerations in the English and Welsh contexts (Newbigging et al, 2015; Redley et al., 2011; Townsley & Laing, 2011), some drawing together of cross-cutting themes might extend this discussion in ways of interest to the independent advocacy and broader voluntary and community sectors across the UK and elsewhere.

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