National Institute for Health and Care Excellence

Final

Advocacy services for adults with health and social care needs

[I] Training, skills and support for advocates

NICE guideline NG227

Evidence reviews underpinning recommendations 1.9.1 to 1.9.4, 1.9.6, 1.9.7 and 1.8.7 in the NICE guideline

November 2022

Final

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Key theme

- Training, skills and support for advocates

Introduction

The aim of this review is to identify the training, skills and support needed for advocates.

Recommendations about advocacy have been made in a number of existing NICE guidelines. However, these have identified a lack of evidence relating to advocacy that would meet inclusion criteria for standard evidence reviews. Therefore, it was agreed that recommendations for this guideline would be developed by adopting and adapting advocacy-related recommendations from existing NICE guidelines, using a formal consensus based on statements generated from a call for evidence, and documents identified by the guideline committee, and informal consensus methods to address any areas of the guideline scope that are not covered by the existing NICE guidelines or the formal consensus process.

Summary of the inclusion criteria

Please see Table 1 for a summary of the inclusion criteria applied to evidence received in response to the call for evidence and identified by the guideline committee.

Table 1: Summary of the inclusion criteria

Country	UK
Geographical level	National* *For policy or guidance documents, this means, the policies and recommendations apply nationally. For original research, this means the studies have been conducted in the national policy and practice context of our scope, i.e., the English health and social care system
Publication date	2011 onwards
Study design	Primary qualitative or quantitative studies (including unpublished research), excluding case-studies Systematic reviews or quantitative studies, excluding case studies Guidelines or policy documents that are based on qualitative or quantitative evidence, excluding case-studies
Topic areas	Training, skills and support for advocates

Methods and process

The process for identifying, adopting and adapting recommendations from existing NICE guidelines, the call for evidence and formal consensus methods are described in supplementary material 1.

Declarations of interest were recorded according to NICE's 2019 conflicts of interest policy (see Register of Interests).

Effectiveness evidence

Included studies

Existing NICE guidelines

Existing recommendations relevant to training, skills and support for advocates were identified from 3 NICE guidelines ([PH50] Domestic violence and abuse: multi-agency working, [NG108] Decision-making and mental capacity, [NG93] Learning disabilities and behaviour that challenges: service design and delivery). The audiences for these guidelines included: people with the condition or users of services and their families, friends and carers; health and social care professionals, practitioners and providers; service managers; commissioners and local authorities; and other staff who come into contact with people using services (for example, specialist domestic violence and abuse services, education, housing, voluntary and community services, employment, police, criminal justice and detention centre staff). Only NG108 specifically listed independent advocates (with statutory and non-statutory roles) among its target audience.

Formal consensus

A single call for evidence was undertaken for all topics included in the scope of this guideline. Additional documents were identified by the guideline committee. See the study selection flow chart in appendix A.

Four documents were identified for this review (Lawson 2017, Mercer 2020, Newbigging 2011, Newbigging 2012).

One document each focused on independent advocacy services (Mercer 2020), those who have duties to commission and arrange advocacy services (Lawson 2017), African and Caribbean men using mental health services and providers of mental health advocacy services (Newbigging 2011), and patients detained under the amended Mental Health Act 1983 (Newbigging 2012).

Excluded studies

Formal consensus

Documents not included in this review are listed, and reasons for their exclusions are provided in appendix D.

Summary of included studies

Summaries of the documents included in the formal consensus process for this review are presented in Table 2.

Table 2: Summary of documents included in the formal consensus process

Document	Population	Evidence base
Lawson 2017 Report National	Those who have duties to commission and arrange advocacy services for safeguarding adults	Briefing including qualitative discussions with advocates from across England to determine the enablers and barriers to involvement of advocacy in safeguarding adults
Mercer 2020 Scoping review	Independent advocacy services commissioned to provide advocacy to people accessing support/service through:	A scoping exercise to establish current arrangements for delivery of independent advocacy across England, establish the training needs of advocates and how

Document	Population	Evidence base
National	i) s117 aftercare (under the Mental Health Act); ii) NHS Continuing Healthcare (adults) (NHS CHC); iii) Children and Young People's Continuing Care (CC); iv) Personal Health Budgets; v) Personal Wheelchair Budgets.	advocacy within these processes and systems interact with other types of advocacy.
Newbigging 2011 Systematic Review National (England, Wales, and Northern Ireland)	African and Caribbean men using mental health services; providers of mental health advocacy services for adults that either targeted African and ⁄or African and Caribbean men, BME communities or provided a service for the whole population in a locality.	Systematic literature review, a national survey on the provision of advocacy (n=391 providers of mental health advocacy services), focus groups with African and Caribbean men (n=25), and case studies (22 people including 7 service users, 6 commissioners, 4 mental health service providers and 5 experts in the field).
Newbigging 2012 Mixed methods: literature review, qualitative research (focus groups and interviews), case studies England	Patients detained under the amended Mental Health Act 1983, who are eligible for support from IMHA services (including people with and without capacity and children under the age of 16 years)	Multiple methods (including literature review, 11 focus groups, shadow visits with IMHAs, expert panel review) to obtain information on IMHA services to develop draft quality indicators for IMHA services. Data from 8 case studies (NHS Trust areas) to understand experiences of qualifying service users and the commissioning and delivery of IMHA services and their relationship with mental health services

BME: Black and Minority Ethnic; IMHA: Independent Mental Health Advocate; NDTi: National Development Team for Inclusion; NHS: National Health Service.

See the full evidence tables for documents included in the formal consensus process in appendix B and a summary of the quality assessment of these documents in appendix C..

Summary of the evidence

Existing NICE guidelines

A total of 3 existing recommendations related to training, skills and support for advocates were identified from the 3 NICE guidelines. The committee agreed 2 recommendations should be adapted and 1 recommendation should not be used in this guideline.

See Appendix F for a list of the existing recommendations, a summary of the supporting evidence behind these recommendations, and the decisions made based on the committee’s discussion of these recommendations.

The quality of existing NICE guidelines was assessed using the Appraisal of Guidelines for Research & Evaluation Instrument (AGREE II). See the results of the quality assessment in appendix C.

Formal consensus round 1

One document (Lawson, 2017) was assessed using the AGREE II tool, 1 document (Newbigging, 2011) was assessed using both the Risk of Bias in Systematic reviews (ROBIS) checklist and the Critical Appraisal Skills Programme (CASP) tool for qualitative research as it included both a systematic literature review and a survey with qualitative components, 1 document (Mercer, 2020) was assessed using the Risk of Bias in Systematic reviews (ROBIS) checklist, and 1 included document (Newbigging, 2012) was assessed using the CASP tool for qualitative research. See the results of the quality assessment in the evidence tables in appendix B and quality assessment tables in appendix C.

The committee were presented with 24 statements in round 1 of the formal consensus exercise; responses were received from 12 of 13 committee members. Twenty-two of these statements reached ≥80% agreement in round 1 and were included for the discussion with the committee. Two statements had between 60% and 80% agreement and were redrafted for round 2. No statements had <60% agreement.

See appendix G for the statements that were rated by the committee and results of round 1, which are provided in Table 10.

Formal consensus round 2

The committee were presented with 2 statements in round 2 of the formal consensus exercise; responses were received from 12 of 13 committee members. One statement reached ≥80% agreement and was carried forward to the committee discussion. The other statement had between 60% and 80% agreement and was discarded.

See appendix G for the statements which were rated by the committee and results of round 2, which are provided in Table 11.

Economic evidence

Economic considerations will be taken into account together with resource impact. To further aid economic considerations in this area an economic analysis of providing increased training was undertaken. This is reported in Appendix H.

The committee’s discussion and interpretation of the evidence

The outcomes that matter most

In the methods used for this guideline (adopting and adapting existing recommendations and formal consensus) no outcomes were considered formally by the committee; therefore, the committee were not required to determine which outcomes were critical or important.

The quality of the evidence

Existing NICE guidelines

The quality of the existing NICE guidelines was assessed using AGREE II. Overall, the guidelines are of a very high quality (2 or more domains scored ≥90%) and are recommended for use. One guideline scored lower in stakeholder involvement because there were fewer experts by experience included in the committee group compared to other guidelines. In addition, the committee considered whether the recommendations could be generalised to a new context when making a decision about adopting or adapting the recommendations, which is documented in the benefits and harms section and appendix F.

Formal consensus

The quality of some of the documents identified by the committee and through the call for evidence was assessed using ROBIS and the AGREE II tool, which is explained in detail in the methods supplement for this guideline. ROBIS is intended for use in assessing the quality of systematic reviews but was also used for the purpose of this guideline to assess a number of reviews that were not intended by the authors to be systematic as it was the best available tool. The AGREE II instrument is intended for use assessing the quality of systematically developed clinical practice guidelines, including assessments of methodological rigour and transparency. Therefore, some domains of ROBIS and the AGREE II tool may be less relevant for these documents and they would not have followed reporting guidelines for systematic reviews. All supporting material published with documents was reviewed to inform quality assessment, however it was not feasible to contact the authors of each document. Therefore it is plausible that the documents may have scored lower on quality assessments than the underlying methodology would warrant had authors made their full methodology available or if more appropriate tools were available. The committee were aware of this in their discussions of the existing recommendations and statements extracted from documents identified from the call for evidence. Where shortcomings in the quality of documents impacted the committee's opinions about using the statements, this is described in the benefits and harms section below. On the whole however, where there was full committee support for a statement extracted from a lower quality document, the committee made the recommendation because their experiential knowledge corroborated the statement and strengthened the argument to use it as the basis for a recommendation.

The quality of one document (Lawson, 2017) was assessed using the AGREE II tool. High quality documents were defined as those where any two domains scored ≥ 70%. The document scored an overall rating of 29% and was therefore not deemed to be high quality. Methodological limitations included a lack of rigour of development, applicability, or editorial independence. Other concerns related to insufficient information regarding stakeholder involvement, and a lack of clarity of presentation.

The quality of 1 document (Newbigging, 2011) was assessed using both the ROBIS checklist for systematic reviews and the CASP checklist for qualitative research as it included both a systematic literature review and a survey with qualitative components. This document was judged to have unclear risk of bias according to the ROBIS checklist for systematic reviews because insufficient details were provided to enable a judgement to be made. The document had no or very minor methodological limitations according to the CASP tool for qualitative research.

The quality of 1 document (Mercer, 2020) was assessed using the ROBIS checklist for systematic reviews and judged to be at high risk of bias. Methodological limitations included an absence of reporting about eligibility criteria, insufficient information on study selection, lack of critical appraisal of included papers, and an absence of testing the robustness of the review findings.

The quality of 1 document (Newbigging, 2012) was assessed using the CASP checklist for qualitative research and was judged to have minor methodological limitations, including lack of discussion of data saturation.

Benefits and harms

In the committee's view advocacy is still establishing itself in the consciousness of both the people who can use it and the professionals who can make referrals to it. If it is to be effective, it is crucial that it advocacy is recognised and valued. Advocates need to be able to support people from a variety of backgrounds and with different needs and so they need to develop the appropriate skills, knowledge and behaviours to do this effectively. In the committee's experience, comprehensive and consistent training is the most effective way to achieve this. However, there is variation in the current content and availability of training and so the committee made recommendations in these areas.

Training advocates to be able to support people from a variety of backgrounds

The committee agreed that the existing recommendation from the 2018 NICE guideline on decision-making and mental capacity [NG108] about commissioners and providers working to increase investment in training for advocates, should be adapted for this guideline. Further details about the committee's decisions to adopt or adapt existing NICE recommendations in the area of training advocates are given in appendix F. They agreed to remove the specific groups and instead focus on the broadly applicable message of increasing investment in training so that advocates are trained and competent to support people with a wide range of needs and from a variety of backgrounds. The committee agreed that listing specific groups of people that advocates should be able to support would risk excluding some populations who benefit from advocacy support and, in their experience, certain stereotypes of working with specific populations might be reinforced, which could reduce advocacy support being tailored to the individual. Furthermore, the committee agreed to incorporate the existing recommendation from the 2018 NICE guideline on learning disabilities and behaviour that challenges [NG93], and statements 14, 18, and 19 into this recommendation as they all address the need for IMHAs to be knowledgeable about mental health difficulties and to have training on mental health problems in order to provide advocacy more effectively. In the committee's experience, comprehensive and consistent training is the best way to develop the skills, knowledge and behaviours needed to provide advocacy effectively. However, there is a wide variation in the availability of training, and advocates may find it difficult to access training. The committee therefore agreed it was important to make this recommendation, to ensure sufficient training for advocates is provided.

Areas training for advocates should cover

Statements 2, 3, 4, 5, 13 and 15 identified different areas in which advocates should be trained. The committee acknowledged that some of these statements (2, 3, 4, and 5) had been extracted from a document judged to be of lower quality. However they were in full agreement with these statements and because their own knowledge and experience chimed with the point being made they concluded it would be important to make a recommendation on that basis and that the benefits of doing so outweighed any risks of excluding the statements altogether. The committee agreed that these statements should be combined into a single recommendation for clarity and ease of reference. The committee agreed that the areas covered by these statements relate to a range of health processes, social care processes, and justice and legal processes and because they know from experience that knowledge in these areas is lacking or inconsistent, but necessary to undertake the advocate role effectively, they recommended that advocates are trained and have sufficient knowledge in the processes that are specifically relevant to their role. They also agreed to include some examples of particular processes to help advocacy providers with implementation of this recommendation. However the list wasn't designed to be exhaustive with the committee acknowledging that there may be many other relevant processes in which advocates would benefit from training and they did not want to exclude these.

Training to develop skills and qualities

Statements 7, 8, 9, 10, 11, and 12 covered essential personal qualities for Independent Mental Health Advocates (IMHAs). It is not within the remit of NICE guidelines to make recommendations about the personal qualities of practitioners. Therefore, the committee agreed to make a recommendation based on the above statements and their own knowledge and experience about training for advocates that might help to develop these skills and qualities. However, the committee could not identify any specific training that would ensure advocates are dependable, attend appointments as expected and do what they say they will, so statement 12 was discarded. In the committee's experience, there are inconsistencies in the training advocates currently receive. Therefore, they agreed it was important that advocates received training in these areas to enable them to carry out their roles effectively. Statement 16, which covered advocates participating in induction and other training programmes on topics such as equal opportunities and diversity, was also used to inform this recommendation.

Completing the National Qualification in Independent Advocacy

Statement 23 highlighted that IMHAs should complete the IMHA modules of the National Advocacy qualification. Statutory Guidance to the Care Act (7.43) states that "Once appointed, all independent advocates should be expected to work towards the National Qualification in Independent Advocacy within a year of being appointed, and to achieve it in a reasonable amount of time." Therefore, the committee agreed that the recommendation should apply to all advocates, not just IMHAs. The committee noted that the Statutory Guidance is vague about the time frame for achieving this qualification and in their experience, “a reasonable amount of time” is interpreted very differently. The committee agreed that the quality of advocacy services would improve if all advocates achieved this qualification and so highlighted the need to complete it, although they could not recommend a specific timeframe as the Statutory Guidance does not stipulate this.

Sufficient time for training

Statement 24 covered contracts for advocates and adequate time for training. The committee agreed that it was the responsibility of commissioners to ensure contracts and service specifications for advocates incorporate protected time for training. In the committee’s experience, if time for training is not protected it will be very difficult for advocates to be able to complete the training required for them to carry out their roles effectively.

Training on when and how to use non-instructed advocacy

The committee also discussed statement 17, which said that advocates should participate in induction and other training programmes on topics such as non-instructed advocacy. There was agreement with the statement but they reworded it to make a recommendation about training for advocacy staff including when and how to use non-instructed advocacy. In the committee’s experience, people who are unable to instruct an advocate are less likely to have an advocate. Providing non-instructed advocacy helps to ensure that people’s rights to advocacy are protected and is a key way to provide effective advocacy, regardless of a person’s ability to request that support. Furthermore, the Care Act (2014) states that advocates must have appropriate training and this would include non-instructed advocacy. The committee agreed that making this recommendation would help to address the wide variation among advocates in terms of their confidence and skills using approaches to deliver non-instructed advocacy. Although support and supervision have been recommended for all advocates (see evidence review K), and training and support for volunteer advocates is also covered by recommendations in training practitioners (see evidence review J), the committee made an additional recommendation to highlight that increased support and supervision may be needed for advocates delivering non-instructed advocacy due to the recognised lack of confidence among advocates in delivering non-instructed advocacy. Further, as discussed in evidence review E, additional steps may be required in order to determine the person’s likely wishes, feelings and desired outcomes in the absence of instruction from the individual. It is important that advocates are supported to do this in order to ensure that advocacy remains focused on the person and that independence is not compromised.

Statements that were not used in this review

Statement 1 was not used to inform a recommendation as the concept is already covered by recommendations 1.9.2 and 1.9.3 in this review, which describe what the training for advocates should cover. Statements 20, 21 and 22 were carried forward to committee discussions but not used to inform recommendations because they did not provide enough detail to inform what action should be taken.

Existing recommendations not used in this guideline

One existing NICE recommendations that the committee was neither adopted nor adapted for the section on training advocates. The reasons behind their decision making are given in appendix F.

Cost effectiveness and resource use

There are currently variations in the training given to advocates on health and social care, justice, and legal processes, as well as in areas needed to provide effective advocacy. The committee considered costs of providing training opportunities which were estimated in a bespoke costing analysis. While the range of costs estimated would lead to a resource impact in the short term the committee highlighted a number of ways in which improvements would be made to the service. These included professionalisation of the service, standardisation of skills and processes and more effective advocacy especially in the areas of communication and legal literacy. The committee also highlighted that there were likely to be cost savings longer term from more effective advocacy especially around avoiding complaints requiring mediation, repetition of meetings and work, more efficient knowledge of how to obtain information and the ability to identify needs earlier before they escalate. The committee particularly highlighted this last point as it could prevent expensive unplanned hospitalisations and hospital stays and the need for residential care both of which are associated with large costs and adverse outcomes for people using advocacy services. More professional advocacy with better communication and preventing escalations of need will also lead to improvements in the quality of life of people using advocacy services.

The committee also highlighted that the estimates from the economic analysis were likely to be high. The analysis assumed that all learning time would be protected and paid and used a national qualification, which is relatively intensive as an example. In reality such training may not be paid (or not all paid) and training to such a level may not be required. The National Advocacy Qualification is now a prerequisite for many advocacy roles and thus such a level of training would not need to be undertaken.

Being trained in non-instructed advocacy is in line with the requirement in the Care Act (2014) for advocates to have appropriate training and so should not have additional resource requirements. Providing increased support, supervision and reflective practice for those undertaking non-instructed advocacy is likely to require an increase in time of senior advocacy staff in a large number of areas where this is not already happening or is not happening to a high level. Again this is likely to lead to higher level of service from advocates leading to similar benefits to those discussed above.

Not all contracts and specifications for advocacy include time allowances for training and continuing professional development so some change in practice may result from the recommendations. However, having advocates who are suitably trained and competent to do this role should result in less complaints, improved services and the ability to identify needs earlier before they escalate.

Recommendations supported by this evidence review

This evidence review supports recommendations 1.9.1 to 1.9.4, 1.9.6 to 1.9.7 and 1.8.7.

References – included studies

Existing NICE guidelines

National Institute for Health and Care Excellence 2014

National Institute for Health and Care Excellence (2014). Domestic violence and abuse: multi-agency working [PH50]. Available at: https://www.nice.org.uk/guidance/ph50/resources/domestic-violence-and-abuse-multiagency-working-pdf-1996411687621

National Institute for Health and Care Excellence 2018

National Institute for Health and Care Excellence (2018). Learning disabilities and behaviour that challenges: service design and delivery [NG93]. Available at: https://www.nice.org.uk/guidance/ng93/resources/learning-disabilities-and-behaviour-that-challenges-service-design-and-delivery-pdf-1837753480645

National Institute for Health and Care Excellence 2018

National Institute for Health and Care Excellence (2018). Decision-making and mental capacity (NICE Guideline 108). Available at: https://www.nice.org.uk/guidance/ng108/evidence/full-guideline-pdf-6542486605

Formal consensus

Lawson 2017

Lawson, J. (2017). Making Safeguarding Personal. What might ‘good’ look like for advocacy? Local Government Association. Available at: https://www.local.gov.uk/sites/default/files/documents/25.30%20-%20Chip_MSP%20Advocacy_WEB_2.pdf [Accessed 07/04/2021]

Mercer 2020

Mercer, K., Petty, G. (2020). Scoping Exercise Report – An overview of advocacy delivery in relation to Personal Health Budgets and other Health Funded support. Available at: https://www.ndti.org.uk/assets/files/Advocacy-Health-Funded-Support-Report-pdf.pdf [Accessed 07/05/2021]

Newbigging 2011

Newbigging, K., KcKeown, M., French, B. Mental health advocacy and African and Caribbean men: good practice principles and organisational models for delivery. Health Expectations an International Journal of Public Participation in Health Care and Health Policy, 16(1), 2011.

Newbigging 2012

Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D., Able, L., et al. (2012). The Right to Be Heard: Review of the Quality of Independent mental Health Advocate (IMHA) Services in England, University of Central Lancashire. Available at: https://www.firah.org/upload/notices3/2012/uclan.pdf [Accessed 13/05/2021]

Economics

Bauer 2015

Bauer, A., Wistow, G., Dixon, J., & Knapp, M. (2015). Investing in advocacy for parents with learning disabilities: what is the economic argument?. British Journal of Learning Disabilities, 43(1), 66-74.

Jones 2021

Jones, K. & Burns, A. (2021) Unit Costs of Health and Social Care 2021, Personal Social Services Research Unit, University of Kent, Canterbury.

Other

Department for Constitutional Affairs 2005

Department for Constitutional Affairs. Mental Capacity Act Code of Practice. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/921428/Mental-capacity-act-code-of-practice.pdf.

Mental Capacity Act 2005

Mental Capacity Act, 2005 (c.9). Available at: http://www.legislation.gov.uk/ukpga/2005/9/contents [Accessed 23/02/2021]

Care Act 2014

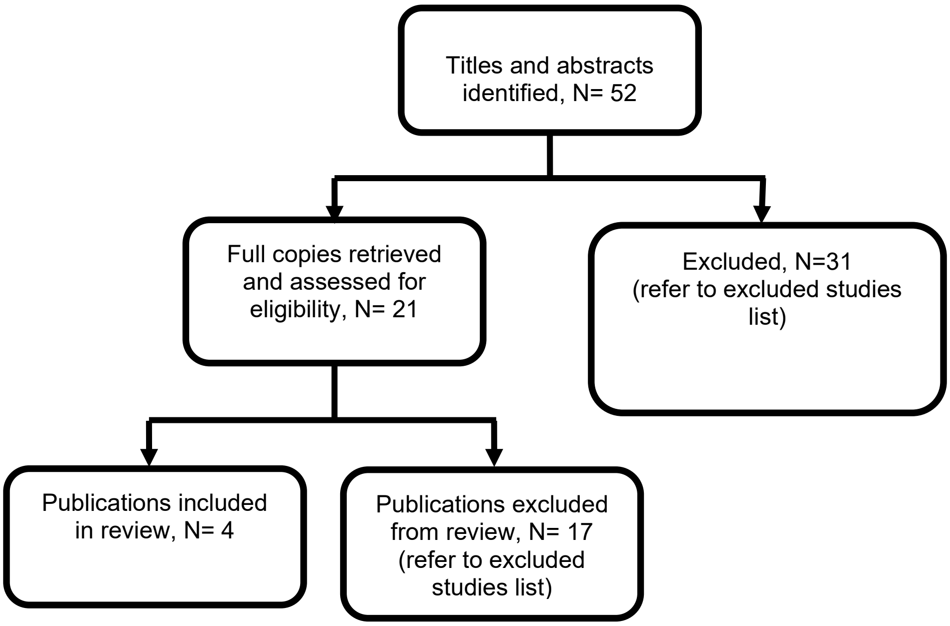
Care Act 2014, c. 23. Available at: https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted [Accessed 21/09/2021]

Appendices

Appendix A Study selection

Study selection for scope area: Training, skills and support for advocates

Figure 1: Study selection flow chart



Appendix B Evidence tables

Evidence tables for scope area: Training, skills and support for advocates

Table 3: Evidence tables

Study details	Population	Recommendations/key findings	Quality assessment
Full citation Lawson, J. (2017). Making Safeguarding Personal. What might 'good' look like for advocacy? Local Government Association. **Country/ies where the study was carried out** England **Study type** Report/Review **Study dates** 2017 **Source of funding** No sources of funding reported.	Those who have duties to commission and arrange advocacy services	**Key findings in relation to training, skills, and support for advocates (Delivering Advocacy)** • Advocacy providers and commissioners can establish Making Safeguarding Personal as integral to safeguarding components of advocacy training • Commissioners must ensure that service specifications cover issues of competency and training for advocates and should cover the funding implications of this • Care and Support Statutory Guidance on workforce development/support: • Regular face to face supervision to enable staff to work confidently and competently; guidance and support staff; skilled knowledgeable supervision focused on outcomes	**Quality assessment using AGREE II** 1) **Scope and Purpose** 61% Overall objective and population are described. Health question is not specifically described but alluded to 2) **Stakeholder involvement** 22% Target users are defined but not information on guideline development group and views and preferences from population has been included. 3) **Rigour of development** 8% Health benefits when describing recommendations have been considered. No information on systematic methods, criteria selection, strengths and limitations, and methods for formulating recommendations have been provided. Link between recommendations and supporting evidence not clear. No information on external reviewing, and procedure for updating have been provided. 4) **Clarity of presentation** 22% Recommendations are not always specific and easily identifiable. No mentioning of different options for management. 5) **Applicability** 4% Some mentioning of potential tools provided. No further information on facilitators/barriers, potential resource implications, and auditing criteria provided. 6) **Editorial independence**

Study details	Population	Recommendations/key findings	Quality assessment
			0.0% No funding body and competing interest have been identified. **Overall rating** 29%
Full citation Mercer, K., Petty, G. (2020). Scoping Exercise Report – An overview of advocacy delivery in relation to Personal Health Budgets and other health funded support. **Country where the study was carried out** England **Study type** Report of a scoping exercise (including freedom of information requests, advocate survey, semi-structured telephone interviews and desktop review of legislation and guidance) **Study dates** January to March 2020 **Source of funding** Commissioned by NHS England and NHS Improvement	Independent advocacy services commissioned to provide advocacy to people accessing support/service through: i) s117 aftercare (under the Mental Health Act). ii) NHS Continuing Healthcare (adults) (NHS CHC). iii) Children and Young People's Continuing Care (CC). iv) Personal Health Budgets. v) Personal Wheelchair Budgets.	**Key findings in relation to training, skills and support for advocates (Delivering Advocacy)** - It was agreed that there was a gap in training and there was universal support for specialist training to be available to advocates. **Recommendations in relation to training, skills and support for advocates (Delivering Advocacy)** - Design and implement specialist training for independent advocates in relation to NHS CHC, CC, PHBs and other health funded support processes.	**Quality assessment using ROBIS** ***Phase two*** **1.1 Did the review adhere to pre-defined objectives and eligibility criteria?** Probably no – There was no evidence of eligibility criteria but pre-specification of objectives the scoping exercise are provided. **1.2 Were the eligibility criteria appropriate for the review question?** No information – Eligibility criteria were not provided. The scoping exercise included a freedom of information request, advocate survey, semi-structured telephone interviews and desktop review of legislation and guidance which appear to be conducted by the authors themselves. **1.3 Were eligibility criteria unambiguous?** No – Specific queries remain about the eligibility criteria including ambiguities about the types of study, population, interventions, comparators and outcomes. **1.4 Were all restrictions in eligibility criteria based on study characteristics appropriate?** No information – Restrictions around the studies characteristics are not provided. **1.5 Were any restrictions in eligibility criteria based on sources of information appropriate?** No information – Restrictions applied on the basis of sources of information were not clearly described. ***Concerns regarding specification of study eligibility criteria***

Study details	Population	Recommendations/key findings	Quality assessment
			High concern – There were insufficient details regarding study eligibility criteria to judge whether the appropriate studies were included in the scoping exercise. **2.1 Did the search include an appropriate range of databases/ electronic sources for published and unpublished reports?** No information – Searches appear not to have been conducted **2.2 Were methods additional to database searching used to identify relevant reports?** No information – Additional database searching appears not to have been conducted **2.3 Were the terms and structure of the search strategy likely to retrieve as many eligible studies as possible?** No information **2.4 Were restrictions based on date, publication format, or language appropriate?** No information **2.5 Were efforts made to minimise errors in selection of studies?** No information ***Concerns regarding methods used to identify and/or select studies*** High risk - There is insufficient information reported however it appears as though some eligible studies are likely to be missing from the scoping exercise. **3.1 Were efforts made to minimise error in data collection?** No information **3.2 Were sufficient study characteristics available for both review authors and readers to be able to interpret the results?** No **3.3 Were all relevant study results collected for use in the synthesis?**

Study details	Population	Recommendations/key findings	Quality assessment
			Probably no – Unclear whether all relevant study results were included **3.4 Was risk of bias (or methodological quality) formally assessed using appropriate criteria?** No – Study quality was not formally assessed **3.5 Were efforts made to minimise error in risk of bias assessment?** No ***Concerns regarding methods used to collect data and appraise studies*** High concern – Some bias may have been introduced through the data collection and no risk of bias assessment completed **4.1 Did the synthesis include all studies that it should?** No information **4.2 Were all predefined analyses followed or departures explained?** No information **4.3 Was the synthesis appropriate given the nature and similarity in the research questions, study designs and outcomes across included studies?** No information **4.4 Was between-studies variation (heterogeneity) minimal or addressed in the synthesis?** No information **4.5 Was robustness of the finding(s) assessed e.g. through funnel plot or sensitivity analyses?** No information **4.6 Were biases in primary studies minimal or addressed in the synthesis?** No – The studies were not explicitly evaluated for quality or risk of bias ***Concerns regarding the synthesis and findings***

Study details	Population	Recommendations/key findings	Quality assessment
			Unclear concern – There is insufficient information reported to make a judgement on risk of bias ***Phase three*** **A. Did the interpretation of findings address all of the concerns identified the Phase 2 assessment?** No **B. Was the relevance of identified studies to the review's research question appropriately considered?** No **C. Did the reviewers avoid emphasizing results on the basis of their statistical significance?** Yes **Risk of bias** – High risk of bias
Full citation Newbigging, K., McKeown, M., French B. (2011). Mental health advocacy and African and Caribbean men: Good practice principles and organizational models for delivery. Health Expectations, 16(1), 80-104. **Country where the study was carried out** UK (England, Wales, and Northern Ireland) **Study type** Systematic literature review and national survey **Study dates** 2011	African and Caribbean men using mental health services; providers of mental health advocacy services for adults that either targeted African and/or African and Caribbean men, BME communities or provided a service for the whole population in a locality.	**Key findings in relation to training, skills and support for advocates (Delivering Advocacy)** • BME organisations expressed concerns about capacity and in particular concerns about access to training and supervision and the demands made on the organisations to represent BME communities.	**Quality assessment using ROBIS** ***Phase two*** **1.1 Did the review adhere to pre-defined objectives and eligibility criteria?** Yes – There were a clear protocol and pre-specification of objectives the review are provided. **1.2 Were the eligibility criteria appropriate for the review question?** Yes – Eligibility criteria seem appropriate for review question **1.3 Were eligibility criteria unambiguous?** Yes – Eligibility criteria were clearly defined **1.4 Were all restrictions in eligibility criteria based on study characteristics appropriate?** Yes – Restrictions seemed appropriate **1.5 Were any restrictions in eligibility criteria based on sources of information appropriate?**

Study details	Population	Recommendations/key findings	Quality assessment
Source of funding Social Care Institute of Excellence (SCIE)			Yes – Restrictions applied on the basis of sources of information were clearly described. **Concerns regarding specification of study eligibility criteria** Low Concern – Considerable effort has been made to clearly specify the review question and objectives, and to pre-specify and justify appropriate and detailed eligibility criteria that have been adhered to during the review **2.1 Did the search include an appropriate range of databases/ electronic sources for published and unpublished reports?** Yes – Direct databases are all clearly identified. **2.2 Were methods additional to database searching used to identify relevant reports?** Yes – secondary reference search was undertaken. **2.3 Were the terms and structure of the search strategy likely to retrieve as many eligible studies as possible?** No information **2.4 Were restrictions based on date, publication format, or language appropriate?** No – Search was restricted to English language publications. **2.5 Were efforts made to minimise errors in selection of studies?** Yes – Two authors independently screened and searched data. **Concerns regarding methods used to identify and/or select studies** Unclear concern – Some information regarding search strategy is missing

Study details	Population	Recommendations/key findings	Quality assessment
			3.1 Were efforts made to minimise error in data collection? Yes – 2 authors independently data extracted. **3.2 Were sufficient study characteristics available for both review authors and readers to be able to interpret the results?** Probably yes – Link to full study characteristics provided; however cannot access these. **3.3 Were all relevant study results collected for use in the synthesis?** Probably yes – Unclear whether all relevant study results were included **3.4 Was risk of bias (or methodological quality) formally assessed using appropriate criteria?** Yes – TAPUPAS standard was used to critically assess included studies. **3.5 Were efforts made to minimise error in risk of bias assessment?** Yes – Two reviewers independently critically assessed included papers and a third reviewer was used where there were discrepancies. **Concerns regarding methods used to collect data and appraise studies** Low concern – Insufficient information about study characteristics but risk of bias as assessed accordingly. **4.1 Did the synthesis include all studies that it should?** No information **4.2 Were all predefined analyses followed or departures explained?** No information

Study details	Population	Recommendations/key findings	Quality assessment
			4.3 Was the synthesis appropriate given the nature and similarity in the research questions, study designs and outcomes across included studies? No information **4.4 Was between-studies variation (heterogeneity) minimal or addressed in the synthesis?** No information **4.5 Was robustness of the finding(s) assessed e.g. through funnel plot or sensitivity analyses?** No information **4.6 Were biases in primary studies minimal or addressed in the synthesis?** No – The studies were evaluated for risk of bias but results were not incorporated into findings/conclusion **Concerns regarding the synthesis and findings** Unclear concern – There is insufficient information reported to make a judgement on risk of bias ***Phase three*** **A. Did the interpretation of findings address all of the concerns identified the Phase 2 assessment?** Yes **B. Was the relevance of identified studies to the review's research question appropriately considered?** Yes **C. Did the reviewers avoid emphasizing results on the basis of their statistical significance?** Yes **Risk of bias** – Unclear risk of bias

Study details	Population	Recommendations/key findings	Quality assessment
			Quality assessment using CASP qualitative studies checklist **1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes – Aims very clearly defined **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes **4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – Recruitment strategy clearly defined and deemed appropriate. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes – Focus groups and national surveys were used. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Can't tell – No information provided **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes – Ethical issues were considered **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes – Thematic analysis was used and clearly defined.

Study details	Population	Recommendations/key findings	Quality assessment
			9. Is there a clear statement of findings? (Yes/Can't tell/No) Yes – to some extent. The findings are clearly stated, but the researchers did not discuss the credibility of their findings **10. How valuable is the research?** Valuable – Researchers also highlight that there is further need for research on the impact of advocacy on the use of mental health services, satisfaction with care, and mental health and broader social outcomes for African and Caribbean men and the relationship between different organizational models for provision and this range of outcomes. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** No limitations
Full citation Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D., Able, L., et al. (2012). The Right to Be Heard: Review of the Quality of Independent mental Health Advocate (IMHA) Services in England, University of Central Lancashire. **Country/ies where the study was carried out** England **Study type** Mixed methods: literature review, qualitative research (focus groups and interviews), case studies	Patients detained under the amended Mental Health Act 1983, who are eligible for support from IMHA services (including people with and without capacity and children under the age of 16 years)	**Key findings in relation to training, skills and support for advocates (delivering advocacy)** • Overall, IMHAs were considered to be highly skilled, experienced advocates. A minority believed they should be more knowledgeable in relation to diagnostic labels and treatment. • A number of key personal qualities, as well as skills and training were expected of IMHAs, and professionals with direct experience of IMHAs (that is, IMHA partners) indicated that the quality of IMHA staff varied, even	**Quality assessment using CASP qualitative studies checklist** **1. Was there a clear statement of the aims of the research? (Yes/Can't tell/No)** Yes – to review the extent to which IMHA services in England are providing accessible, effective and appropriate advocacy support to people who qualify for these services under the MHA 1983. To identify the factors that affect the quality of IMHA services. **2. Is a qualitative methodology appropriate? (Yes/Can't tell/No)** Yes. **3. Was the research design appropriate to address the aims of the research? (Yes/Can't tell/No)** Yes.

Study details	Population	Recommendations/key findings	Quality assessment
Study dates 2010 to 2012 **Source of funding** Department of Health		between IMHAs in the same service. - Across stakeholders, the following personal qualities of IMHAs were identified as essential: o Personable, friendly, and approachable personality. o An ability to relate well to a broad range of qualifying patients and to understand their perspectives. o Perseverance and following through. o Non-judgmental approach. o Clear and honest in communication. o Dependable, turning up as expected and doing what they say they will. - Stakeholders expected IMHAs to be knowledgeable about mental health law and the Code of Practice; mental health difficulties; how the mental health services system works and how to navigate through this. - Approximately 3 of 4 IMHAs had completed the IMHA module of the National Advocacy qualification. Although in one service only a third of IMHAs were trained and in another service just a quarter were trained.	**4. Was the recruitment strategy appropriate to the aims of the research? (Yes/Can't tell/No)** Yes – how IMHA services and service users were identified is explained, in addition to identification of carers and family members, mental health staff and commissioners. **5. Was the data collected in a way that addressed the research issue? (Yes/Can't tell/No)** Yes – the methods used were explicitly described and justifications for their use were provided, although saturation of data was not discussed. **6. Has the relationship between researcher and participants been adequately considered? (Yes/Can't tell/No)** Yes – the authors acknowledged the potential for the quality of the data collection and analysis to be influenced by the researchers. **7. Have ethical issues been taken into consideration? (Yes/Can't tell/No)** Yes – ethical approval was received from the Cambridgeshire Research Ethics Committee and the International School for Communities, Rights and Inclusion Ethics Committee at the University of Central Lancashire. **8. Was the data analysis sufficiently rigorous? (Yes/Can't tell/No)** Yes – the authors describe the analysis process and sufficient data are presented to support the findings. **9. Is there a clear statement of findings? (Yes/Can't tell/No)** Yes. **10. How valuable is the research?**

Study details	Population	Recommendations/key findings	Quality assessment
		• Advocates had participated in induction and other training programmes run by the advocacy services as well as NHS Trusts on topics such as equal opportunities and diversity; non-instructed advocacy; and personality disorder. Some received training on tribunal procedures from solicitors. • The professional training was reported to better equip some advocates to do IMHA as it was more in-depth. For example, “Id did the module because I had to, and I certainly didn’t find it difficult. I think the social work training enables me to do a better job as an IMHA”. [IMHA] (p.123) • Some health professionals were of the opinion that IMHAs needed more training on mental health problems/distress as this could also impact on the appropriateness of interventions provided. **Recommendations in relation to training, skills and support for advocates (delivering advocacy)** • Training and preparation of the future generation of IMHAs is needed and consideration of	Valuable – the authors highlight gaps in the evidence, how the evidence relates to previous research, and implications for practice and policy and future research. **Overall methodological limitations (No or minor/Minor/Moderate/Serious)** Minor limitations.

Study details	Population	Recommendations/key findings	Quality assessment
		opportunities for career progression in order to retain and develop high calibre staff. • Pre-registration training should explicitly address the meaning of advocacy in the context of the professional role for health and social care professionals. There is a need for the development of an academic focus for advocacy which would develop the theory and practice of advocacy and build capacity of advocates to lead their own research agenda.	

AGREE: Appraisal of Guidelines for Research & Evaluation Instrument; BME: Black and Minority Ethnic; CASP: Critical Appraisal Skills Programme; CC: Continuing Care; IMHA: Independent Mental Health Advocate; MHA: Mental Health Act; NHS: National Health Service; NHS CHC: NHS Continuing Healthcare; PHB: Personal Health Budget; ROBIS: Risk of Bias Assessment Tool for Systematic Reviews; TAPUPAS: transferability, accessibility, propriety, utility, purposivity, accuracy and specificity; UCLAN: University of Central Lancashir

Appendix C Quality Assessment

Quality assessment tables for scope area: Training, skills and support for advocates

Existing NICE guidelines

Table 4: AGREE II quality assessment of NICE guidelines

		Domains						
Guideline	**Year**	**Scope and Purpose**	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**	**Overall rating**
Domestic violence and abuse: multi-agency working [PH50]	2014	100 The overall objective of the guideline, the health question covered by the guideline, and the population to whom the guideline applies are specifically described.	72 The guideline development group included a range of individuals from relevant professional groups, and information about their profession and discipline is reported in detail. There is no report that the target audience (for example, people affected by domestic violence and abuse and their families and carers, or	96 Systematic methods were used to search for evidence and have been reported transparently. The criteria for selecting the evidence are clearly described in the review protocol. The risk of bias for the body of evidence has been conducted and reported clearly. There is clear and adequate information of	100 The recommendations are specific and unambiguous, and the different options for management of the condition or health issue are clearly presented. Key recommendations are easily identifiable and specific recommendations are grouped together in one section. The description of recommendati	92 There is some description of the facilitators and barriers and how these influenced the formation of the recommendations. Feedback from key stakeholders were obtained. There is a clear description of how the recommendations can be put into practice and there is an implementation section in the guideline.	100 The funding body has been stated and there is an explicit statement reporting the funding body has not influenced the content of the guideline. Competing interests of guideline development group members have been recorded and addressed explicitly.	93

Domains								
Guideline	**Year**	**Scope and Purpose**	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**	**Overall rating**
			members of the public) were included in guideline development. The target users of the guideline are clearly defined.	the recommendation development process. There are supporting data and discussions of the benefits and harms of the evidence and it is clear that this has been considered when making recommendations. The guideline describes how the guideline development group linked and used the evidence to inform recommendations, and each recommendation is linked to a key evidence description. The guideline has been externally review by	ons are summarised as flow charts.	There are references to tools and resources to facilitate application and there are directions on how users can access these. There are details given on the potential resource implications of applying the recommendations. There are identification criteria to assess guideline implementation and monitoring or auditing criteria.		

Domains								
Guideline	**Year**	**Scope and Purpose**	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**	**Overall rating**
				experts in a consultation phase prior to its publication, and details of this process are available. A statement that the guideline will be updated is provided though the methodology for this procedure is unavailable.				
Learning disabilities and behaviour that challenges: service design and delivery [NG93]	2018	100 The overall objective of the guideline, the health question covered by the guideline, and the population to whom the guideline applies are specifically described.	100 The guideline development group included a range of individuals from relevant professional groups, and information about their profession and discipline is reported in detail. The views from the target audience were included in	96 Systematic methods were used to search for evidence and have been reported transparently. The criteria for selecting the evidence are clearly described in the review protocol. The risk of bias for the body of evidence has been	100 The recommendations are specific and unambiguous, and the different options for management of the condition or health issue are clearly presented. Key recommendations are easily identifiable and specific recommendati	96 There is description of the facilitators and barriers and how these influenced the formation of the recommendations. Feedback from key stakeholders were obtained. There is a clear description of how the recommendati	100 The funding body has been stated and there is an explicit statement reporting the funding body has not influenced the content of the guideline. Competing interests of guideline development group members have	99

Domains								
Guideline	**Year**	**Scope and Purpose**	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**	**Overall rating**
			guideline development. The target users of the guideline are clearly defined.	conducted and reported clearly. There is clear and adequate information of the recommendation development process. There are supporting data and discussions of the benefits and harms of the evidence and it is clear that this has been considered when making recommendations. The guideline describes how the guideline development group linked and used the evidence to inform recommendations, and each recommendation is linked to	ons are grouped together in one section. The description of recommendations are summarised as flow charts.	ons can be put into practice and there is an implementation section in the guideline. There are references to tools and resources to facilitate application and there are directions on how users can access these. There are details given on the potential resource implications of applying the recommendations. There are identification criteria to assess guideline implementation and monitoring or auditing criteria.	been recorded and addressed explicitly.	

Domains								
Guideline	**Year**	**Scope and Purpose**	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**	**Overall rating**
				a key evidence description. The guideline has been externally review by experts in a consultation phase prior to its publication, and details of this process are available. A statement that the guideline will be updated is provided though the methodology for this procedure is unavailable.				
Decision-making and mental capacity (NICE Guideline 108)	2018	100 The overall objective of the guideline, the health question covered by the guideline, and the population to whom the guideline applies are	100 The guideline development group included a range of individuals from relevant professional groups, and information about their profession and discipline is	96 Systematic methods were used to search for evidence and have been reported transparently. The criteria for selecting the evidence are clearly described in	100 The recommendations are specific and unambiguous, and the different options for management of the condition or health issue are clearly	96 There is a description of the facilitators and barriers and how these influenced the formation of the recommendations. Feedback from key stakeholders	100 The funding body has been stated and there is an explicit statement reporting the funding body has not influenced the content of the guideline.	99

Domains								
Guideline	**Year**	**Scope and Purpose**	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**	**Overall rating**
		specifically described.	reported in detail. The views of the target audiences were included in guideline development. The target users of the guideline are clearly defined.	the review protocol. The risk of bias for the body of evidence has been conducted and reported clearly. There is clear and adequate information of the recommendation development process. There are supporting data and discussions of the benefits and harms of the evidence and it is clear that this has been considered when making recommendations. The guideline describes how the guideline development group linked and used the	presented. Key recommendations are easily identifiable and specific recommendations are grouped together in one section. The description of recommendations are summarised as flow charts.	were obtained. There is a clear description of how the recommendations can be put into practice and there is an implementation section in the guideline. There are references to tools and resources to facilitate application and there are directions on how users can access these. There are details given on the potential resource implications of applying the recommendations. There are identification criteria to assess guideline implementation and monitoring	Competing interests of guideline development group members have been recorded and addressed explicitly.	

Domains								
Guideline	**Year**	**Scope and Purpose**	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**	**Overall rating**
				evidence to inform recommendations, and each recommendation is linked to a key evidence description. The guideline has been externally review by experts in a consultation phase prior to its publication, and details of this process are available. A statement that the guideline will be updated is provided though the methodology for this procedure is unavailable.		or auditing criteria.		

AGREE: Appraisal of Guidelines for Research & Evaluation Instrument; NICE: National Institute for Health and Care Excellence

Formal consensus

Table 5: AGREE II quality assessment of included guidelines

Ratings								
Guideline	**Year**	**Scope and Purpose**	**Stakeholder involvement**	**Rigour of development**	**Clarity of presentation**	**Applicability**	**Editorial independence**	**Overall rating**
Lawson 2017	2017	61%	22%	8%	22%	4%	0%	29%

AGREE: Appraisal of Guidelines for Research & Evaluation Instrument

Table 6: ROBIS quality assessment of included systematic reviews

Domains (Low concern/High concern/Unclear concern)						
Systematic review reference	**Year**	**Study eligibility criteria**	**Identification and selection of studies**	**Data collection and study appraisal**	**Synthesis and findings**	**Overall risk of bias**
Mercer 2020	2020	High concern	High concern	High concern	Unclear concern	High concern
Newbigging 2011	2011	Low concern	Unclear concern	Low concern	Unclear concern	Unclear concern

ROBIS: Risk of Bias Assessment Tool for Systematic Reviews

Table 7: CASP quality assessment of included qualitative studies

Screening questions (Yes/No/Can't tell)											
Qualitative study reference	**Year**	**Clear statement of aims of research**	**Appropriate methodology**	**Research design appropriate to address aims**	**Appropriate recruitment strategy**	**Appropriate data collection methods**	**Relationship between researcher and participants adequately considered**	**Ethical issues taken into consideration**	**Data analysis sufficiently rigorous**	**Clear statement of findings**	**How valuable is the research**
Newbigging 2011	2011	Yes	Yes	Yes	Yes	Yes	Can't tell	Yes	Yes	Yes	Valuable
Newbigging 2012	2012	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable

CASP: Critical Appraisal Skills Programme

Appendix D Excluded studies

Excluded studies for scope area: Training, skills and support for advocates

Formal consensus (documents identified by the call for evidence and the guideline committee)

Table 8: Excluded studies and reasons for their exclusion

Study	Reason for Exclusion
Bauer, B., Wistow, G., Dixon, J., Knapp, M. (2013). Investing in Advocacy Interventions for Parents with Learning Disabilities: What is the Economic Argument? Personal Social Services Research Unit. Available at: http://eprints.lse.ac.uk/51114/1/Investing%20in%20advocay.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Chatfield, D., Lee, S., Cowley, J., Kitzinger, C., Kitzinger, J., Menon, D. (2018). Is there a broader role for independent mental capacity advocates in critical care? An exploratory study. Nursing in Critical Care, 23(2), 82-87.	No key findings or recommendations relevant to Training, skills and support for advocates
Davies, L., Townsley, R., Ward, L., Marriott A. (2009). A framework for research on costs and benefits of independent advocacy, Office for Disability Issues. Available at https://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/odiframework.pdf [Accessed 16/02/2022]	Publication has no evidence base
EY (2017). Society's return on investment (SROI) in older people's cancer advocacy services. Available at: https://opaal.org.uk/?s=Society%27s+return+on+investment+%28SROI%29+in+older+people%E2%80%99s+cancer+advocacy+services [Accessed 16/02/2022]	Publication is based on case-studies
Feeney, M., Evers, C., Agpalo, D., Cone, L., Fleisher, J., Schroeder, K. (2020). Utilizing patient advocates in Parkinson's disease: A proposed framework for patient engagement and the modern metrics that can determine its success. Health Expectations, 23, 722-730.	Non-UK based (International)
Healthwatch (2015). Independent Complaints Advocacy: Standards to support the commissioning, delivery and monitoring of the service. Available at: https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/healthwatch_advocacy_standards_10022015.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Kilinç, S. Erdem, H., Healer, R., Cole, J. (2020). Finding meaning and purpose: a framework for the self-management of neurological conditions. Disability and Rehabilitation, 44(2), 219-230.	Publication is based on case-studies
Lawson, J., Petty, G. (2020). Strengthening the role of advocacy in Making Safeguarding Personal, Local Government Association.	No key findings or recommendations relevant to Training, skills and support for advocates

Study	Reason for Exclusion
Available at: https://www.local.gov.uk/sites/default/files/documents/25.167%20Strengthening%20the%20role%20of%20advocacy%20in%20MSP_04.pdf [Accessed 07/04/2021]	
Macadam, A., Watts, R., Greig, R. (2013). The Impact of Advocacy for People who Use Social Care Services, NIHR School for Social Care Research Scoping Review. Available at: https://www.ndti.org.uk/assets/files/SSCR-scoping-review_SR007.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
National Development Team for Inclusion (2014b). Office for Disabilities Issues Access to Advocacy Project: Summary Findings Minister's Briefing Note. Unpublished	No key findings or recommendations relevant to Training, skills and support for advocates
National Development Team for Inclusion (2014c). Office for Disabilities Issues Access to Advocacy Project: Executive Summary. Unpublished	No key findings or recommendations relevant to Training, skills and support for advocates
National Development Team for Inclusion (2012). Reasonably Adjusted? Mental Health Services and Support for People with Autism and People with Learning Disabilities. Available at: https://www.ndti.org.uk/assets/files/Reasonably-adjusted_2020-12-30-150637.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
National Development Team for Inclusion (2014). The impact of advocacy for people who use social care services: a review of the evidence, NDTi Insights. Available at: https://www.ndti.org.uk/assets/files/Insights_19_Impact_of_Advocacy_FINAL.pdf [Accessed 11/02/2022]	No key findings or recommendations relevant to any scope area
Harflett, N., Turner, S., Bown, H., National Development Team for Inclusion (2015). The impact of personalisation on the lives of the most isolated people with learning disabilities. A review of the evidence. Available at: https://www.ndti.org.uk/assets/files/Isolation_and_personalisation_evidence_review_final_02_06_15.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
National Development Team for Inclusion (2016a). Advocacy Outcomes Framework: Measuring the impact of independent advocacy. Available at: https://www.ndti.org.uk/assets/files/Advocacy_framework.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
National Development Team for Inclusion (2016b). Advocacy Outcomes Toolkit: An accompanying guide to the advocacy outcomes framework. Available at: https://www.ndti.org.uk/assets/files/Advocacy_Outcomes_Toolkit.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
National Development Team for Inclusion (2020). Valuing voices: Protecting rights through	No key findings or recommendations relevant to Training, skills and support for advocates

Study	Reason for Exclusion
the pandemic and beyond. Available at: https://www.ndti.org.uk/assets/files/Valuing_voices_-_Protection_rights_through_the_pandemic_and_beyond_Oct_2020.pdf [Accessed 07/04/2021]	
National Development Team for Inclusion (2020). Valuing voices in Wales: Protecting rights through the pandemic and beyond. Available at: https://www.dewiscil.org.uk/news/valuing-voices-in-wales-report [Accessed 07/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
National Development Team for Inclusion. (2018). The Advocacy Charter (Poster). Available at: https://www.ndti.org.uk/assets/files/Advocacy-Charter-A3.pdf [Accessed 16/02/2022]	Publication has no evidence base
National Development Team for Inclusion. (2018). The Easy Read Advocacy Charter (Poster). Available at: https://www.ndti.org.uk/assets/files/The-Advocacy-Charter-Easy-Read.pdf [Accessed 16/02/2022]	Publication has no evidence base
National Development Team for Inclusion. (2018). Advocacy QPM: Assessment Workbook. Available at: https://qualityadvocacy.org.uk/wp-content/uploads/2021/12/QPM-Assessment-Workbook_V4_V1.3_Dec-2021.pdf [Accessed 16/02/2022]	Publication has no evidence base
National Development Team for Inclusion and Empowerment Matters CIC. (2014) Advocacy Quality Performance Mark (QPM). Recognising Quality in independent advocacy. Code of Practice 2014	Publication has no evidence base
Newbigging, K., Ridley, J., McKeown, M., Machin, K., Poursanidou, D., Able, L., et al. (2012). The Right to Be Heard: Review of the Quality of Independent mental Health Advocate (IMHA) Services in England, University of Central Lancashire. Available at: https://www.firah.org/upload/notices3/2012/uclan.pdf [Accessed 13/05/2021]	Summary of Newbigging 2012: No additional information reported
Newbigging, K., Ridley, J., McKeown, M., Machin, K., Sadd, J., Machin, K., et al. (2015). Independent Mental Health Advocacy – The Right to Be Heard: Context, Values and Good Practice. Jessica Kingsley Publishers: London, UK.	Publication is a book/book chapter.
Older People’s Advocacy Alliance (2014). Every Step of the Way. 13 stories illustrating the difference independent advocacy support makes to older people affected by cancer. available at: https://opaal.org.uk/app/uploads/2015/09/Advocacy-Stories.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Older People’s Advocacy Alliance (2014). Every Step of the Way. 13 stories illustrating the difference independent advocacy support	Publication is based on case-studies

Study	Reason for Exclusion
makes to older people affected by cancer. available at: https://opaal.org.uk/app/uploads/2015/09/Advocacy-Stories.pdf [Accessed 16/02/2022]	
Older People's Advocacy Alliance (2017). Time: Our Gift to You – why cancer advocacy volunteers support their peers. Available at: https://opaal.org.uk/app/uploads/2017/02/Time-our-gift-to-you.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Ridley, J., Newbigging, K., Street, C. (2018). Mental health advocacy outcomes from service user perspectives, Mental Health Review Journal, Vol. 23(4), 280-292.	No key findings or recommendations relevant to Training, skills and support for advocates
Roberts, H., Turner, S., Baines, S., Hatton, C. (2012). Advocacy by and for adults with learning disabilities in England, Improving Health and Lives: Learning Disabilities Observatory. Available at: https://www.ndti.org.uk/assets/files/IHAL_2012-03_Advocacy.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
SERIO (2021). The Veterans' Advocacy People: Final Evaluation Report and Social Return on Investment Analysis, The Advocacy People. Available at: https://www.vfrhub.com/wp-content/uploads/2021/01/898ed6_d72d832632234777aa1b5b68e8c314e6.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
Social Care Institute for Excellence, University of Central Lancashire (2015). At a glance 68: Understanding Independent Mental Health Advocacy (IMHA) for people who use services. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-users/understanding/ [Accessed 16/02/2022]	Publication is based on case-studies
Social Care Institute for Excellence, University of Central Lancashire (2015). At a glance 68: Understanding Independent Mental Health Advocacy (IMHA) for people who use services, easy read version. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-users/understanding/easy-read/ [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2014). At a glance 67: Understanding Independent Mental Health Advocacy (IMHA) for mental health staff. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/understanding/ [Accessed 16/02/2022]	Publication is based on case-studies
Social Care Institute for Excellence and University of Central Lancashire (2015). Flowchart for Open Access IMHA. Available at: https://www.scie.org.uk/independent-mental-	Publication has no evidence base

Study	Reason for Exclusion
health-advocacy/resources-for-staff/improving-access/ [Accessed 16/02/2022]	
Social Care Institute for Excellence, University of Central Lancashire (2015). Improving access to Independent Mental Health Advocacy for providers of mental health services. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/improving-access/ [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2015). Improving equality of access to Independent Mental Health Advocacy (IMHA): a briefing for providers. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/improving-equality-of-access/briefing/ [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence and University of Central Lancashire (2015). Improving equality of access to Independent Mental Health Advocacy (IMHA): a report for providers. Available at: https://www.scie.org.uk/independent-mental-health-advocacy/improving-equality-of-access/report/ [Accessed 16/02/2022]	Publication is based on case-studies
Social Care Institute for Excellence, University of Central Lancashire (2015). Commissioning Independent Mental Health Advocacy (IMHA) services in England: 10 top tips for commissioners. https://www.scie.org.uk/independent-mental-health-advocacy/measuring-effectiveness-and-commissioning/10-top-tips.asp [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2015). What does a good IMHA service look like? (Self-assessment tool) Available at: https://www.scie.org.uk/independent-mental-health-advocacy/measuring-effectiveness-and-commissioning/what-good-imha-service-looks-like/ [Accessed 16/02/2022]	Publication has no evidence base
Social Care Institute for Excellence, University of Central Lancashire (2015). Making a difference: measuring the impact of Independent Mental Health Advocacy (IMHA). Available at: https://www.scie.org.uk/independent-mental-health-advocacy/measuring-effectiveness-and-commissioning/impact/ [Accessed 16/02/2022]	Publication is based on case-studies
Strong, S. (2012). User-led organisation leadership of support planning and brokerage. The International Journal of Leadership in Public Services, 8(2), 83-89.	Publication is based on case-studies
Taylor & Francis Production Disability and Rehabilitation (IDRE). My Life Tool (self-management tool): www.mylifetool.co.uk	Publication has no evidence base

Study	Reason for Exclusion
Teeside University (2015/2016). UTREG Online Module Specification: Advocacy - Evolution, Equality and Equity. Unpublished.	Publication has no evidence base
Townsley, R., Marriott, A., Ward, L. (2009). Access to independent advocacy: an evidence review, Office for Disability Issues. Available at: http://www.bristol.ac.uk/media-library/sites/sps/migrated/documents/iar-exec-summary-standard.pdf [Accessed 16/02/2022]	Not published in the last 10 years
Turner, S., Giraud-Saunders, A. (2014). Personal health budgets: Including people with learning disabilities, Think Local act Personal. Available at: https://www.thinklocalactpersonal.org.uk/_assets/Reports/TLAPIncludingLD.pdf [Accessed 16/02/2022]	Publication is based on case-studies
Turner, S. (2012). Advocacy by and for adults with learning disabilities in England: Evidence into practice report no.5, Improving Health and Lives: Learning Disabilities Observatory. Available at: https://www.ndti.org.uk/assets/files/IHAL-ev-_2012-01.pdf [Accessed 06/04/2021]	No key findings or recommendations relevant to Training, skills and support for advocates
VoiceAbility (2021). Preventing over-medication: STOMP top tips for advocates: How you can help to stop the over-medication of people with a learning disability, autism or both. Available at: https://www.voiceability.org/assets/download/STOMP-2021B.pdf [Accessed 16/02/2022]	Publication has no evidence base
VoiceAbility (2021). STOMP and STAMP: Stopping the over medication of children, young people and adults with a learning disability, autism or both.	Publication has no evidence base

Excluded economic studies

No economic evidence was considered for this scope area.

Appendix E Research recommendations – full details

Research recommendations for review question: Training, skills and support for advocates

No research recommendations were made for this scope area.

Appendix F Existing NICE recommendations

Table 9: Existing NICE recommendations for scope area: Training, skills and support for advocates

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
Level 4 Staff should be trained to give expert advice and support to people experiencing domestic violence and abuse. This is for specialists in domestic violence and abuse. For example, domestic violence advocates or support workers, independent domestic violence advisers or independent sexual violence advisers, refuge staff, domestic violence and abuse and sexual violence counsellors and therapists, and children's workers.	**Domestic violence and abuse: multi-agency working [PH50] – 1.15.2** Impact statement: Topic experts have suggested the need for health and social care professionals' training on domestic violence to include current legislation and risk in vulnerable groups. The current recommendations advise on multiple levels of training with more intensive training for those staff working directly with people experiencing domestic violence and abuse. The recommendation references the content suggested by topic experts, such as risk identification and assessment and awareness of legal duties.	**Recommendation not used in this guideline** This recommendation was not included in this guideline as the committee agreed that the remit of independent domestic violence advisers/advocates is broader than the definition of advocacy used for this guideline.	Not applicable
Relevant commissioners and providers should work with public bodies and providers to increase investment in training for statutory independent mental capacity and other statutory advocates in key areas, in order to ensure they are able to support: • people who have communication difficulties and • Independent Mental Capacity Advocates to have expertise in specific	**Decision-making and mental capacity [NG108] – 1.1.11** Other considerations: Recommendations 1.1.10 and 1.1.11 were drafted on the basis of lengthy committee discussions, drawing on members' expertise and knowledge of similar findings in a number of reports by the Department of Health, the Care Quality Commission and the House of Lords. The consistent message from	**Adapted** This recommendation was adapted to remove specific groups so that populations who would benefit from advocacy support would not be excluded and to not reinforce certain stereotypes of working with specific populations. Further, it was amended to focus on improving the availability of training and ensuring this enables advocates to support people with a	Commissioners and advocacy providers should work with public bodies and providers to increase investment in training for advocates so that they are trained and competent to support people from a variety of backgrounds and with a variety of needs.

Original recommendation	Underpinning evidence (from original NICE guideline)	Action taken	Final recommendation
areas that require additional skills and knowledge – for example working with people with impaired executive function arising from acquired brain injury, mental illness, dementia or other illness.	this body of work, as it was interpreted by the committee, was that practitioners and people using services lack understanding of the critical role that Independent Advocacy can play in upholding rights. The committee recognised and discussed the potential resource implications linked with recommendation 1.1.11, especially in areas where it is not currently routine practice. However given that it represents good practice, they determined that the recommendation represents value for money.	wide range of needs. Recommendation 1.2.9 below from NG93 and statements 14, 18 and 19 also informed this recommendation. See the Benefits and harms section of The committee's discussion and interpretation of the evidence in this review for more information.	
Ensure that independent advocates working with children, young people and adults with a learning disability and behaviour that challenges have skills and experience in working with these groups, and in working with specialist learning disability services.	**Learning disabilities and behaviour that challenges: service design and delivery [NG93] – 1.2.9** Other considerations: Recommendations 1.2.8 and 1.2.9 were consensus recommendations following on from discussions about the importance of the availability of advocacy to enable involvement in one's own care and decision making, but also that to be effective, advocates had to have specialist knowledge of navigating services for learning disabilities and behaviour that challenges. The view of the committee was that this could only happen if the commissioner made sure that independent advocates could demonstrate they had this specialist knowledge and skills in this area.	**Adapted** This recommendation was combined with recommendation 1.1.11 above from NG108. See the Benefits and harms section of The committee's discussion and interpretation of the evidence in this review for more information.	Commissioners and advocacy providers should work with public bodies and providers to increase investment in training for advocates so that they are trained and competent to support people from a variety of backgrounds and with a variety of needs.

Appendix G Formal consensus

Additional information related to scope area: Training, skills and support for advocates

Table 10: Formal consensus round 1 statements and results for scope area: Training, skills and support for advocates

Statement no.	Statement	Percentage agreement	Reference	Action taken
1	There is a gap in training and specialist training should be available to advocates.	75.00%	Mercer, 2020	Re-drafted for round 2
2	Independent advocates should receive specialist training in relation to NHS Continuing Healthcare.	100.00%	Mercer, 2020	Carried forward to committee discussion
3	Independent advocates should receive specialist training in relation to Children and Young People's continuing care.	88.89%	Mercer, 2020	Carried forward to committee discussion
4	Independent advocates should receive specialist training in relation to personal health budgets.	100.00%	Mercer, 2020	Carried forward to committee discussion
5	Independent advocates should receive specialist training in relation to health funded support processes.	100.00%	Mercer, 2020	Carried forward to committee discussion
6	IMHAs should be more knowledgeable in relation to diagnostic labels and treatment.	63.64%	Newbigging, 2012	Re-drafted for round 2
7	Essential personal qualities of IMHAs include having a personable, friendly, and approachable personality.	100.00%	Newbigging, 2012	Carried forward to committee discussion
8	Essential personal qualities of IMHAs include an ability to relate well to a broad range of qualifying patients and to understand their perspectives.	100.00%	Newbigging, 2012	Carried forward to committee discussion
9	Essential personal qualities of IMHAs include perseverance and following through on actions.	100.00%	Newbigging, 2012	Carried forward to committee discussion
10	Essential personal qualities of IMHAs include taking a non-judgmental approach.	100.00%	Newbigging, 2012	Carried forward to committee discussion
11	Essential personal qualities of IMHAs include being clear and honest in communication.	100.00%	Newbigging, 2012	Carried forward to committee discussion
12	Essential personal qualities of IMHAs include being dependable, turning up as expected and doing what they say they will.	100.00%	Newbigging, 2012	Carried forward to committee discussion

Statement no.	Statement	Percentage agreement	Reference	Action taken
13	IMHAs should be knowledgeable about mental health law and the Code of Practice.	90.91%	Newbigging, 2012	Carried forward to committee discussion
14	IMHAs should be knowledgeable about mental health difficulties.	100.00%	Newbigging, 2012	Carried forward to committee discussion
15	IMHAs should be knowledgeable about how the mental health services system works and how to navigate through this.	100.00%	Newbigging, 2012	Carried forward to committee discussion
16	Advocates should participate in induction and other training programmes on topics such as equal opportunities and diversity.	91.67%	Newbigging, 2012	Carried forward to committee discussion
17	Advocates should participate in induction and other training programmes on topics such as non-instructed advocacy.	83.33%	Newbigging, 2012	Carried forward to committee discussion
18	Advocates should participate in induction and other training programmes on topics such as personality disorder.	91.67%	Newbigging, 2012	Carried forward to committee discussion
19	IMHAs may need more training on mental health problems/distress.	81.82%	Newbigging, 2012	Carried forward to committee discussion
20	Training and preparation of the future generation of IMHAs is needed in order to retain and develop high calibre staff.	91.67%	Newbigging, 2012	Carried forward to committee discussion
21	Pre-registration training should explicitly address the meaning of advocacy in the context of the professional role for health and social care professionals.	91.67%	Newbigging, 2012	Carried forward to committee discussion
22	There is a need for the development of an academic focus for advocacy which would develop the theory and practice of advocacy and build capacity of advocates to lead their own research agenda.	100.00%	Newbigging, 2012	Carried forward to committee discussion
23	IMHAs should complete the IMHA module of the National Advocacy qualification.	100.00%	Newbigging, 2012	Carried forward to committee discussion
24	Contracts for advocates do not always allow for adequate time for training.	85.71%	Lawson, 2020	Carried forward to committee discussion

IMHA: Independent Mental Health Advocate; NHS: National Health Service.

Table 11: Formal consensus round 2 statements and results for scope area: Enabling and supporting effective advocacy

Statement no.	Statement	Percentage agreement	Action taken
1	There is a lack of standardised training for advocates in terms of the role of advocacy in health processes/system, and further specialist training opportunities should be made available to advocates.	87.50%	Carried forward to committee discussion
6	Service providers should work with and support IMHAs to ensure they have sufficient knowledge of mental health diagnoses and treatment to be able to tailor their support to individuals.	58.33%	Discarded

IMHA: Independent Mental Health Advocate

Appendix H Economic Analysis

Introduction

Given the potential for a number of recommendations around the provision of training for advocates, which will lead to at least a short term increase in costs, and the paucity of economic evidence for the topic identified in the call for evidence a costing analysis and discussion of potential outcomes from increased training provision was undertaken. The analysis was intended to help inform decisions in this area and aid the committee to consider issues around both effectiveness and cost effectiveness and whether recommendations were likely to be an efficient use of limited funds for health and social care. The scope of any costings were limited to those to the NHS and Personal Social Services (PSS) and third sector organisations providing advocacy such as not-for-profits and charities as these provided a substantial proportion of all advocacy services. The scope of the analysis was also extended beyond just the cost of providing training to also allowing protected time to attend any structured learning sessions or to allow protected time for unstructured learning for advocates. Protected time is time during an advocate's working hours which is solely for the purpose of undertaking training. This time should be ringfenced so as not to be shared or interrupted by other responsibilities. It was also the aim that any costs or outcomes here could be used by other potential recommendations in the guideline where economic considerations would be especially beneficial and training or protected time was needed to implement them.

Methods

Two key components for of training costs for advocates were identified. The first was costs of advocates having protected time for learning and building such time into contracts when advocacy services are commissioned. The second cost are those of providing the training through appropriate professionals and qualification fees where formal qualifications are obtained.

Estimation of hourly cost of advocate time

The call for evidence for the guideline did not identify any evidence in relation to training for advocates or allowing protected time for other objectives. There was also no relevant evidence identified by the committee to inform costs and resource use in this area. To try and estimate the cost of advocates' time publicly available sources of costs and resource use, especially those explicitly stated in the NICE Guidelines Manual, were searched to identify evidence to inform this part of the economic analysis. Such sources were likely to be of high quality to inform estimates and relevant to the UK setting. The most relevant source of evidence identified from the suggested sources Personal Social Services -Research Unit (PSSRU) report on unit costs of health and social care (Jones 2021). This is an annual source of unit costs of health and social care with the latest year available for this publication being 2021.

The PSSRU report provided unit costs for advocacy support for parents requiring learning disability support with children at risk of being taken into care. The PSSRU report also estimated unit costs for providing advocacy for children with additional/ complex needs. Although advocacy for children was outside the scope of this guideline it was considered, in light of the lack of other identified evidence, that this could be used to inform estimates. How these unit costs were estimated, used and interpreted are discussed in detail below.

The PSSRU estimated the unit cost for hour worked and per case based on Bauer 2014 which was an economic evaluation of advocacy services for parents with learning disabilities who have children at risk of being taken into care. Whilst the economic evaluation was used to consider the costs and outcomes of providing an advocacy service, rather than of providing training, it was used by the PSSRU to estimate a cost for advocates' time. In line with the guideline methods and processes (see Supplement 1) this economic evaluation was not formally appraised although being a recent study from the UK it would have been highly applicable to the decision problem if the guideline had considered interventions for the specific populations covered in the analysis. The economic evaluation used 2 workshops and a survey to collect activity and outcomes at both a case and service level. UK National unit costs and a simple decision model were then applied to get an estimate of costs. There were a number of limitations with the study including the small number of before and after studies used with the study only covering 4 different advocacy services. The committee highlighted this as a particularly large limitation given large variation in how services are commissioned and run across different geographical areas. Services are also likely to employ staff on different and potentially much higher salaries especially if using more experienced or agency workers. This again is a large limitation given that salaries are over 70% of total costs. These issues are discussed in more detail below.

Another limitation is that not all cost savings are likely to be captured in the study especially those from any longer term need to provide sustained support over future years which would likely be a significant proportion of costs. There was also limited exploration of uncertainty in costs. Under usual NICE methodology for appraising economic evaluations the economic methodology would be deemed to have potentially serious limitations for this analysis.

Of the 4 different advocacy services covered 2 are used to inform the PSSRU estimates. One service which covers both urban and rural areas where the majority of advocacy users live in areas of deprivation and another service which is almost exclusively urban covering large areas with high levels of child protection issues and poverty. Nationally available unit costs are used to supplement the estimates from Bauer 2014. Where pay scales have been used the midpoint from the said pay scale has been taken for estimates. The following broad area of costs were included in the estimates: wages and salaries, wage on-costs such as national insurance and pension contributions and overhead costs. Overhead costs include costs of management and supervision from other team members, direct over heads such as office and utilities, indirect overheads such as providing services such as human resources and more general management and finances. Capital overheads pertain to building accommodation such as offices. The estimates also take account of statutory leave, study leave and sickness leave. Full details about assumptions used to estimate these are presented in the PSSRU unit costs document.

Three broad areas of costs were not included in the estimates; qualification, travel and training costs. Qualification costs are included in PSSRU estimates of costs where available. These costs are to assign a monetary value to training advocates and other roles based on the investment needed to achieve qualified status and the amount of years an individual will work in the field. These are included so that longer term marginal costs, such as the substantial costs of education, training and formal qualifications to allow people to perform in their role, prior to employment, are captured. Excluding such costs may underestimate the true cost of any recommendations especially where additional staff resources require an investment in getting a greater number of people to a qualified level. However, qualification costs are usually excluded from the base-case analysis in NICE economic evaluations as whilst they represent a real cost they are not often incurred by the NHS, PSS or other third sector organisations that are typically in the scope of analyses. Given these costs are not usually considered, that they would be difficult to estimate and that there is likely to be large variation in qualification levels between advocates in different services there was no attempt made for this analysis to calculate these costs. Travel costs were not estimated by PSSRU. The 2 services used in the examples covered a range of geographical areas with different population densities. There will also be large variation around this for advocacy services outside of those used for the estimates. It was therefore not possible to estimate a cost for travel that would be generalisable to all services which sparsely populated geographical areas requiring further and longer travel incurring greater costs. Given this variation in travel costs between advocacy services in different geographical areas it would be unlikely that these would be representative of any one service within England and that any estimates from this analysis should be interpreted with services own travel costs and times in mind. Again no attempt by this analysis was made to estimate these.

Training costs were also not included. Whilst this is a real cost to advocacy services, and would lead to a more accurate estimate, exclusion of such costs is beneficial to this analysis. As we are trying to estimate training costs partly based on PSSRU estimates of the cost of social worker time, the absence of this cost from PSSRU estimates reduces any double counting which may occur in estimates from this analysis.

The PSSRU estimated costs are based on 2 part-time advocates (salary range £20,000-£25,000), 3.5 hours per week advocate (salary range £26,401-£28,031) and 80 percent full time of a service manager (salary range £29,604-£31,766) across the 2 advocacy projects considered. The salary range of the part-time and 3.5 hour week advocate differ as a result of different employers, responsibilities and seniority. Despite both having the job title of advocate there were significant differences between the 2 roles. 2020/21 unit costs have been used where available. If the most recent unit costs are for previous years these have been inflated using the Personal Social Services (PSS) Pay & Prices inflation index (PSSRU) to 2020/21 prices. A full breakdown of costs are presented in Table 12.

Table 12: Estimated annual cost of providing advocacy services for adults with learning disabilities with children at risk of being taken into care

	Total cost[†]
Wages	£39,681
Salary on-costs	£10,179
Management and supervision	£ 7,197
Direct overheads	£3,453
Indirect overheads	£7,977
Capital overheads	£3,191
Total cost (wage plus salary)	£49,860
Total cost (All)	£71,678

[†] Total cost across the 2 projects considered by the PSSRU estimates and discussed in the section ‘Estimation of hourly cost of advocate time’

Based on the total costs for providing the 2 advocacy services we estimated a cost per hour for advocacy workers. This was done under a number of assumptions to estimate a range of costs to reflect differing circumstances between advocacy services and provide a range of potential and plausible costs. To do so a total number of worked hours were estimated taking into account annual leave, sickness absence and training. The potential for double counting with including training is discussed later. It was also assumed that not all hours an advocate works would be direct contact with people using advocacy services. Based on observations from Bauer 2014 for the 2 projects used in the calculations for every 1 hour of direct contact time, 8 minutes were spent on indirect work such as administration and preparation. It is acknowledged from the committee that this is likely to differ widely between different types of advocacy with the indirect work requirement likely to be greater for more complex cases which require more planning and coordination between other professionals. The estimated working hours are presented in Table 13.

Table 13: Estimated annual working hours for providing advocacy services for adults with learning disabilities with children at risk of being taken into care

Component	Amount
All working hours	1,516
Ratio direct to indirect work	1 hour direct for every 8 minutes indirect
Direct working hours	1,344

Four different hourly rates were calculated under different assumptions. It is assumed that these hourly rate are the cost to cover any core work missed as a result of an advocate being unavailable through attending or undertaking training. Where advocates attending training's core work is not covered by other advocates these values estimate an opportunity cost of advocacy work that could have been carried out during that time. These assumptions differ to those estimated by the PSSRU to make them more consistent with methodology used in the production of NICE guidelines and therefore the results may differ from the hourly rates reported in that document. The four estimated assumptions are:

Hourly wage rate accounting for all working hours and including only salary and salary on-costs (wage rate A): This was considered the most reflective of the true opportunity cost of providing time for training. It was assumed that any cover for advocates unavailable due to participating in training would be done at the current wage rate and that additional overhead costs either direct, indirect or capital would not be incurred again. It also, somewhat counterintuitively, assumes that only missed direct time needs to be covered to allow the core functions of advocacy to continue unhindered.

Hourly wage rate accounting for only direct working hours and including only salary and salary on-costs (wage rate B): This is as for wage rate A but assumes that both direct and indirect work would need to be covered by any advocate taking on core duties.

Hourly wage rate accounting for all working hours and including all costs (wage rate C): As for wage rate A but all overheads will be incurred again by the person covering.

Hourly wage rate accounting for only direct working hours and including all costs (wage rate D): As for wage rate B but all overheads will be incurred again by the person covering.

The same methodology was used as above for advocacy services for children with additional or complex needs with estimates from 1 service reported in the PSSRU. The example service is for children and young people aged between 10 and 21 with additional, multiple or complex needs who require either immediate care, are looked after or are a care leaver. This was considered a ‘typical’ service for this group. Such services are outside of the scope of this guideline. Complexity, costs and resource use for children and young persons' services will on average be greater than that of advocacy services for adult. In light of paucity of other evidence the committee thought that it was an adequate proxy for advocacy in more complex cases involving adults where co-ordination is needed between many professionals and additional time needed both for preparation and undertaking of any direct meetings with people using the services. It would likely represent an upper estimate of the cost per hour of adult advocacy services. The same methodology was used as for adult services above. The service comprises of 2 senior advocates (30 hours per week), an advocate (21 hours per week), a trainee advocate (30 hours per week) and a sessional advocate who works 12 additional hours per week. Whilst PSSRU included travel and training costs for estimates based on this service these were excluded from this analysis so as to be consistent with the main analysis and to avoid double counting in the results. Given the greater complexity of advocacy work with children there is a greater amount of indirect work relative to direct work. This would also be true for complex cases in adult advocacy. For every hour of direct work there is 56 minutes of indirect work. Total costs are presented in Table 14 with the hours and the number of hours worked provided in Table 15.

Table 14: Estimated annual cost of providing advocacy services for children with additional or multiple needs

	Total cost[†]
Wages	£106,220
Salary on-costs	£20,089
Management and supervision	£41,811
Direct overheads	£4,114
Indirect overheads	£19,585
Capital overheads	£21,161
Total cost (wage plus salary)	£106,220
Total cost (All)	£212,980

[†] Total cost across the 2 projects considered by the PSSRU estimates and discussed in the section ‘Estimation of hourly cost of advocate time’

Table 15: Estimated annual working hours for providing advocacy services for children with additional or multiple needs

Component	Amount
All working hours	5,043
Ratio direct to indirect work	1 hour direct for every 56 minutes indirect
Direct working hours	2,600

The total cost of any training in advocacy will be dependent on the amount of time needed to be allocated for advocates to be able to undertake it. Some training may be able to be completed in short sessions taking less than a day whilst others may require over a week. Only one specific training programme was considered by the analysis, the National Advocacy Qualification although a range of timings and teaching costs have been presented so that the analysis can be more generalizable to other lengths and types of training.

Estimation of time needed to undertake training

The National Advocacy Qualification is a Department of Health supported qualification aimed at people who wish to work as independent advocates. The qualification is made up of multiple levels with level 3 most popular with those who wish to work as independent advocates with lower levels aimed at those who only require an understanding of such roles. On top of this individuals are able to undertake the level 3 qualification to certificate or diploma level.

To estimate the cost of these training courses we took the stated needed hours from the qualification provider’s website. These separated out the hours needed for each qualification into guided and non-guided learning time. Guided learning time is that delivered by another professional or tutor and can be done face-to-face or remotely. It is also possible to deliver these via pre-recorded teaching or by interactive digital teaching modules where a person will not be required to dedicate time to deliver it. Non-guided time is the time required through independent study and will either be undertaken by the advocate at their home or in their office accommodation. For the level 3 qualifications the required hours to achieve the qualification were identical for Independent Advocacy Management, Independent Advocacy with Adults, Independent Advocacy with Children and Young People, Independent Mental Capacity Advocacy and Independent Mental Health Advocacy. The required hours and qualification cost are presented in Table 16. The qualification cost covers the fees of the organisation checking attainment and providing accreditation for the qualification.

Table 16: Hours needed and qualification fee needed to achieve each level of the National Advocacy Qualification

	Level 2	Level 3 certificate	Level 3 Diploma
Guided Learning (Hours)	25	150	166
Non-guided learning (Hours)	15	170	214
Total Hours	40	320	380
Qualification Fee	£42		

To estimate the cost to advocacy services of providing this two assumptions were made:

Assumption 1: The first assumption was that all guided hours of learning would be undertaken during working hours and therefore advocates would be reimbursed through their wages for this time but that non-guided learning would be expected to be undertaken in the advocates own time.

Assumption 2: Both guided and non-guided hours of learning would be reimbursed through the advocate's wages. It is unlikely that many centres would reimburse non-contact teaching hours but this should provide an upper estimate of the total time required and an estimate of upper cost.

Both assumptions will include the qualification cost. The cost of providing a tutor or other professional were not included in the estimate of costs. This is likely to vary widely across areas and will depend on whether a person or interactive digital module is used. Some areas may also be able to provide guided learning for a larger number of people using the same number of people to deliver it. Therefore, the cost per advocate undertaking the qualification will be smaller. No other costs such as providing refreshments or dedicated space for teaching were included as these would vary both in price and whether they were incurred at all across all areas.

All costs in the analysis were estimated per advocate. No attempt was made to estimate an overall cost of implementing training given the variability in what is already being done, to what level and in which areas advocates are already trained and how training can be delivered.

Results

Hourly cost of advocate time

The 4 estimated wage rates for the base-case scenario are presented in Table 17. Unsurprisingly, wage rates were highest when additional costs such as overheads were included with these making up just over 30% of the total wage costs for wage rate C and wage rate D.

Table 17: Estimated hourly wage rates base-case analysis

Wage Rate	Cost per Hour
A	£33
B	£37
C	£47
D	£53

For the additional analysis for services for children and young adults costs are presented in Table 18. The wage rate was lower under the assumptions for the first 3 wage rates but significantly higher for wage rate D when compared to the base-case scenario. This was counterintuitive but was as a result of some staffing costs, such as the service manager, being included as overhead costs rather than salary or salary on-costs. It would have been beneficial for this analysis for service manager costs to be included in wage rates rather than overheads as training for such roles is within the scope of the guideline and this analysis and would have allowed consistency in methodology with our base-case estimates. It was however not possible to include this service manager cost in this way given what was reported in the PSSRU calculations. As these estimates were only intended as an upper estimate for the most intensive of services only wage rate D was carried forward for further analysis. This estimate would have been identical under either method of including this cost. It was considered by the committee unlikely that there would be hourly wage rates greater than this within advocacy services.

Table 18: Estimated hourly wage rates- children's' and young adult services alternative analysis

Wage Rate	Cost per Hour
A	£25
B	£49
C	£40
D	£78

Total cost per person of providing training

The estimated costs of achieving the national advocacy qualification are presented in Table 19. The costs of achieving a qualification range from £864 to £24,844. For a level 3 diploma the range is £12,540 to £29,494.

Table 19: Estimated costs of achieving National Advocacy Qualification

	Level 2		Level 3 Certificate		Level 3 Diploma	
	Guided Learning	All Learning	Guided Learning	All Learning	Guided Learning	All Learning
Wage Rate A	£864	£1,358	£4,975	£10,567	£5,502	£12,540
Wage Rate B	£969	£1,526	£5,607	£11,913	£6,200	£14,139
Wage Rate C	£1,224	£1,933	£7,134	£15,172	£7,891	£18,009
Wage Rate D (Base-case)	£1,375	£2,175	£8,042	£17,108	£8,895	£20,308

	Level 2		Level 3 Certificate		Level 3 Diploma	
Wage Rate D (Childrens and young adult services)	£1,980	£3,142	£11,668	£24,844	£12,908	£29,494

Outcomes

No formal attempt to estimate outcomes from increasing the training of advocates was undertaken and no previous evidence on the topic was identified. Of the 3 recommendations identified for this review, 2 were adapted into this guideline. Neither recommendation was based on formal economic analysis.

The 2 were from the ‘Decision-making and mental capacity’ guideline [NG108] and ‘Learning disabilities and behaviour that challenges’ guideline [NG93]. The populations for these 2 guidelines are likely to overlap with a large proportion of the population covered by this guideline. For the ‘Decision-making and mental capacity guideline’ the committee recommended an increase in investment in regards to training. Limited evidence, for both effectiveness and cost effectiveness were identified for this and the recommendation was made after lengthy committee discussion and similar recommendations in reports by the Department of Health, the Care Quality Commission and the House of Lords. The committee highlighted there would be a resource impact from this recommendation but that it represented good value for money although did not provide further discussion beyond it being considered good practice.

The ‘Learning disabilities and behaviour that challenges’ guideline recommended that independent advocates working with children, young people and adults possessed the required skills, training and experience. The committee again highlighted there was limited effectiveness or cost effectiveness evidence and that the recommendation would represent an investment. The committee provided the rationale that if advocacy is effective in representing people's needs and helps people navigate a complex service system, this has the potential to lead to the provision of the right services at the right time which match individuals’ needs, which can lead to better outcomes and more efficient use of resources.

The committee agreed with these rationales although acknowledged they were limited. The committee listed a number of positive outcomes they considered likely to be achieved by improving and allowing time for training advocates.

Professionalisation of advocacy was highlighted as the main advantage of improved training of advocates. This was likely to lead to the other improvements discussed below. Better trained advocates are likely to need less supervision and would reduce the amount of contact time they need with other advocates or organisations to ask for advice when they are unsure of processes or the best course of action. This will also reduce time needed to access information as advocates will be aware of procedures to acquire it reducing costs and speeding up advocacy and access to services. Better trained advocates were also likely to better meet the needs of people leading to better care and less inappropriate referrals. In the most extreme cases it may also prevent unnecessary escalation in need avoiding large hospitalisation and other health care costs and large reductions in quality of life. It would also reduce the number of complaints, repeated sessions and in the most extreme circumstances inquests which require time and costs to deal with.

There are particular skills that the committee highlighted which could be taught and are particularly covered by the National Advocacy Qualification. Communication skills allowing for better and potentially quicker advocacy meetings reducing the time needed per meeting. There may also be cost savings, in some circumstances, from reducing the need for speech and language services to be involved if advocates are better trained in areas such as non-verbal communication and wishes can be expressed by a person without the need for a speech and language therapist. Advocates should be careful that if speech and language services are excluded that the absence of these specialists does not reduce the person's ability to communicate and take a full part in the meeting and any decision making.

Better knowledge of the law and legal literacy about advocates' actions may reduce complaints and need for independent legal advice. Better compliance with statutory requirements will reduce complaints against services.

Training, especially through a national qualification, may lead to efficiencies through more standardised practice. This will reduce variation in how roles are performed and should allow greater flexibility of workforce if advocates can be easily moved to different roles or organisations. This should reduce the time needed for inductions.

Training should also lead to a higher quality workforce again reducing complaints the need for mediation. It should also allow advocates to spot issues earlier (such as bed wetting and psychosis) and feel knowledgeable and empowered to be able to raise these before an escalation of need occur, again improving quality of life and preventing expensive interventions. Earlier identification in people using advocacy services may also increase life expectancy reducing the gap between that of the general population.

Discussion

Our analysis estimates a range of costs for advocacy time to estimate an hourly wage rate if advocates were taken away from core duties. The estimates are made using examples from UK practice and include additional overhead costs that wage rates alone would not capture. We used 3 different services but acknowledge there is great variability across services in the UK with the overhead costs and type and number of advocates and other support staff used depending on the intensity and difficulty of the intervention needed and type and level of advocates employed. It would not be practical to provide estimates for every possible type of service but the range should cover all plausible hourly rates. We focussed on a single qualification but the estimates could be used to estimate a cost for any type of training or refresher course.

A number of costs were missing from our estimates most importantly travel. It is not thought likely though that this cost would be repeated if the core duty had to be replaced so this may not have biased the estimates.

There were a number of reasons why costs may have been overestimated. The costings already allow for indirect work time for training purposes. The base-case analysis already allows for 10 days for advocates to undertake training. There will be some double counting from this although this is expected to be small.

The largest potential source of overestimation of costs is that we assumed that advocates would take time away from their core duties to undertake training. Many organisations would expect some or all training, especially that which did not require attendance at a physical training session to be undertaken in the individual's non-working time. There may also be some people who would be willing to take on unpaid training or training in their own time to improve their own skills and marketability when looking for employment opportunities. These recommendations also cover volunteer advocates for which these wage rates would not apply. As the vast majority of the estimated cost are wages or other on-costs incurred by the organisation related to employment, costs for these groups would be significantly lower.

Our estimates also assume that any training will be done in dedicated sessions or during time away from core duties. Whilst this analysis has focussed on a particular qualification much training can be done 'on-job' or during time with line managers or supervisors. In these cases time will not need to be taken away from core duties and costs significantly reduced.

There will be a significant increase in resource use from providing training at least in the short term. The estimates from this analysis are high and could be costly if run for all advocates although current training, training needs and method of delivering it will vary across centres. These should therefore be considered as upper estimates. There will however be huge improvements from a more professional service which should be more efficient and effective. This should recapture some or all costs over the medium or longer term.