

Discuss whether Advocacy can be truly independent when a service is commissioned by a statutory body.

Advocacy work is intricately influenced by the legislative rules, professional standards, and ethical values that govern interactions and behaviours within the field (Advocacy Quality Performance Mark (2014). This introduction emphasises the importance of upholding professional ideals while critically examining how these foundational elements impact advocacy behaviour on a personal level (Health Education England, 2017). It explores the effect of legislation on maintaining professional boundaries, delivering efficient advocacy services, and addressing potential conflict within care models (National Institutes of Health and Care Excellence (NICE), (2022). By highlighting the significance of adhering to standards and ethical principles, this essay aims to demonstrate the integrity and efficacy of advocacy work across diverse interest groups and care settings (Devaney, 2016).

This essay will draw on materials containing theory, policy, and practice, as well as academic journals, databases, publications, online resources, and educational institutions that may be relevant, to conduct a comprehensive examination of advocacy practices. The objective is to investigate, interpret, and assess the title of this essay through a multidimensional exploration of the topic.

A critical study is essential in analysing the various forms of advocacy and evaluating their effectiveness in different service settings and with diverse clientele groups (National Institutes of Health and Care Excellence (NICE), (2022). This examination will also involve a thoughtful assessment of the advocate's responsibilities in supporting those in need, acknowledging the complexities encountered by individuals seeking advocacy (Chapman, 2001). Furthermore, advancing diversity, empowerment, and inclusion in social care settings hinges upon understanding the role of person-centred approaches in fostering inclusive practices (Coulter and Oldham, 2016). By critically analysing these interconnected components, this essay aims to

illuminate the complexities of advocacy, the importance of person-centred care, and the transformative potential of inclusive practices in social welfare (Byrne, Baldwin, and Harvey, 2020).

In the UK, advocacy has been practised for over 30 years, leading to the development of diverse methods and programs tailored to different populations in need (Stewart and MacIntyre, 2013). Advocates are crucial in ensuring that individuals facing challenges such as social attitudes, financial difficulties, or health issues have their needs and opinions acknowledged (Action for Advocacy, 2006; Advocacy Quality Performance Mark (QPM), (2014). Advocacy aims to support individuals by addressing their views and concerns, helping them explore their options and rights without pressure, and facilitating connections with relevant individuals or making decisions on their behalf (Advocacy QPM, 2014). Maintaining each service user's autonomy and self-determination is paramount, as highlighted by Dalton and Carlin (2022). By collaborating with those who use the service, advocacy promotes social inclusion, equality, and justice (National Development Team for Inclusion (NDTi), 2016). To create an empowering relationship, advocates place a high value on listening to the person's instructions and, whenever possible, giving them the freedom to speak for themselves (NDTi, 2016; Henderson, Pochin, 2001). Advocates uphold transparency by disclosing all pertinent facts, continuously assisting the individual, and honouring their permission in actions and communication (Henderson, Pochin, 2001).

Additionally, advocates offer support and companionship during meetings and appointments (Mind, 2018b; Advocacy Quality Performance Mark (QPM), 2014). It is crucial to differentiate advocacy from other forms of support, such as counselling, befriending, mediation, and advice-giving (Stewart and MacIntyre, 2013). As emphasised by Dalton and Carlin (2022), advocates refrain from passing judgment on a service user's speech or opinion.

In certain instances, individuals may experience limitations in their freedom of choice or ability to articulate their needs (Advocacy QPM, 2014). In such circumstances, independent advocates step in to protect individual rights and acknowledge their needs, desires, and opinions.

The Advocacy Quality Performance Mark (QPM) (2014), offered by the National Development Team for Inclusion (NDTi) (n.d), is recognised as the sole Quality Mark approved for companies providing independent advocacy services (NDTi, n.d). This quality assurance evaluation targets

independent advocacy providers in England, Wales, and Northern Ireland, enabling them to highlight compliance with various standards based on the values outlined in the Advocacy Code of Practice and Advocacy Charter (NDTi, n.d). Although the QPM is accessible to statutory and non-statutory independent advocacy providers in England, Wales, and Northern Ireland, it does not extend to Scotland. This distinction emphasises the regional focus on the QPM evaluation (NDTi, n.d). The principles of the Advocacy Charter and the Code of Practice were updated in 2014 to consider modifications to the law and advancements in the field of advocacy (Advocacy QPM, 2014). The Code of Practice provides direction to carers of persons who might not be able to make certain decisions for themselves (Department for Constitutional Affairs, 2007). It describes what is expected of those making decisions for those who cannot do it for themselves. The Code emphasises and specifies the responsibilities of those who have a responsibility of care to those incapable of giving permission (Advocacy QPM, 2014). One of the Code's terms is a person who lacks capacity, which means an individual incapable of deciding or acting on their behalf when necessary (Department for Constitutional Affairs, 2007). Advocacy is beneficial in situations where people do not have a network of friends or contacts they can turn to in times of need, Forbat and Atkinson (2005) state. The National Development Team for Inclusion (2016), in their framework '*Measuring the impact of independent Advocacy*' explains the framework's goal of quantifying and illustrating the effects of independent advocacy on people, the health and social care industry, the public, and the advocacy industry itself (NDTi, 2016). It draws attention to the framework's goal of offering a uniform framework for evaluating the impact areas and related results to gain a deeper understanding of the influence and efficacy of independent advocacy services on a local and national scale (NDTi, 2016).

Furthermore, the tool is intended to be used by commissioners and advocacy services to assess the effectiveness and impact of their offerings. It outlines the four effect regions: the lives of those who use them are affected, the way health and social care are provided is changed, the community's support for inclusion and participation is strengthened, and the advocacy services themselves are encouraged to grow and develop NDTi (National Development Team for Inclusion, 2016). However, as Dalton and Carlin (2002) argue for advocates to express their clients' opinions accurately, their independence is essential. Professionals in mental health can advocate, but there are restrictions since they might have conflicts of interest as treatment providers (Henderson, Pochin, 2001). Advocates must stay impartial and devoted only to the

person they are standing in for (Townesley, Marriott and Ward, 2009). Funding and administrative concerns must be addressed to guarantee advocates can fully carry out their duties without sacrificing their independence, as Dalton and Carlin (2002) state. Potential conflicts of interest may prevent advocates from effectively fighting for their customers if advocacy services are under the authority of service providers (Dalton, Carlin, 2002).

Moreover, as Henderson and Pochin (2001) argue, in care institutions, mental hospitals, and children's homes, among other service settings, vulnerable people frequently endure several types of abuse (Henderson and Pochin, 2001). Advocacy programmes must be impartial towards users, free from conflicts of interest, and able to accurately question authority to represent these people (Advocacy QPM, 2014). Programme design and execution, including ownership, selection and support of advocates, organisational structure, and advocate selection, are impacted by advocacy programmes' independence (Henderson and Pochin, 2001). Companies or recognised organisations with elected committees run numerous advocacy programmes independently. This paradigm protects the schemes' guiding principles from outside interference and corruption while fostering autonomy (Henderson and Pochin, 2001).

There are many forms of advocacy, such as professional advocacy and self-advocacy, in which people acquire training to voice their opinions (Mind, 2018a). Certain independent advocates have received training in helping people with mental health conditions and dementia (Mind, 2018a). Advocacy services should run separately from the NHS or social services to preserve their independence and may enlist volunteers (Independent Age, n.d). Moreover, as Forbat and Atkinson (2005) state, advocates might need to help maintain complete independence in larger voluntary organisations since they may have to confront their bosses or handle difficulties inside their industry (Forbat and Atkinson, 2005). Since advocates' efficacy depends on their capacity to act independently on behalf of the people they represent, the literature also stresses the significance of advocates being independent individuals (Forbat and Atkinson, 2005). Organisations can take part in actions that impact and add to the discourse surrounding the creation of public policy (Mind, 2018c). A person's circumstances and the support they seek will determine which advocacy services can be helpful (Mind, 2018b). The Charity Commission commissioned research emphasising the charity sector's contributions to people and society (Charity Commission for England and Wales, 2019). The sector's impact and success in serving the community are influenced by its capacity to create local relationships, advocate for the most

vulnerable, provide knowledge, and foster a culture of trust (Charity Commission for England and Wales, 2019).

As Peachey (2019) states, not-for-profit organisations engage in advocacy. They accomplish various functions vital to a country's economy and are established to bring about constructive changes in the community (Peachey, 2019).

The exclusive goals of an independent advocacy organisation are to provide, advance, uphold, and promote independent advocacy (Townesley, Marriott and Ward, 2009). It maintains its structural, monetary, and psychological independence from other things and pursuits (Scottish Independent Advocacy Alliance, n.d). Advocacy workers, or independent advocates, help people make decisions based on their knowledge, communicate their preferences to others, and speak up for those unable to speak for themselves (Scottish Independent Advocacy Alliance, n.d).

Not-for-profit organisations can participate in activities that affect and add to public policy formulation as part of a social change agenda (Peachey, 2019). However, as Ward *et al.* (2022) argue, over the past 20 years, nonprofit advocacy studies have changed dramatically. However, there still needs to be more knowledge of the procedures and functions of nonprofit organisations in creating and modifying public policy (Ward *et al.*, 2022). Moreover, Casey (2014) declares that efforts to influence public policy and decisions are included in advocacy, whether through direct interaction with decision-makers or indirect manipulation of public opinion. Nonprofits that want to participate in policymaking must know their strategic alternatives and potential obstacles (Casey, 2014).

People have a legal right to an advocate appointed by their local government in specific circumstances (Independent Age, n.d), which is statutory advocacy.

When an individual lacks the capacity to express their needs and wishes due to circumstances like temporary unconsciousness, brain injury, dementia, etc., an advocate will employ strategies like observation and interviews with close friends and family members to create a profile of the individual's needs and preferences (POhWER, n.d). This profile will be used to ensure the individual's best interests are represented (POhWER, n.d).

Furthermore, mental capacity is when a significant person faces vulnerabilities in their decision-making, as their choices might be influenced by what others may say (National Health Service, 2019). *The Mental Capacity Act* (2005) showcases a framework for safeguarding and protecting vulnerable people. The individual must be correctly assessed before diagnosis

(National Health Service, 2019). There are also challenges when it comes to respecting the individuals' beliefs and values, which is essential to enhancing the efficacy and results of decision-making processes and capability evaluations (Munson, 2022). There are also two stages of assessing who has the capacity; the first thing would be to collect background information on the individual to help with the decision-making, interview with a psychiatrist or medical professional or a visit from a social worker to conclude the pieces of information. As stated by the Mental Capacity Act Code of Practice, to decide on behalf of someone else, their best interest and maximum freedom must be considered first (Munson, 2022). In addition, statutory advocacy is the term for the service, which is always offered without charge and based on primary legislation, guaranteeing that specific organisations are legally entitled to free advocacy services (Mercer Training, 2018). Although this ensures that qualified persons will receive advocacy support, the drawback is that only some people belong to these specific groups, which restricts access to advocacy services for everybody (Mercer Training, 2018).

Moreover, The *Mental Capacity Act* (2005), which applies to both England and Wales, offers a legal framework for individuals who cannot make decisions for themselves or are capable but wish to plan in case they lose their capacity in the future (Davaney, 2016). It outlines who has decision-making authority, when they should exercise that authority, and how to do so. No one can label another person incapable, and each decision made should be considered individually (Davaney, 2016).

The *Mental Capacity Act* (2005) (MCA) requires that in England, the NHS, or the authorities to commission *Independent Mental Capacity Act* (2005) (IMCA) services to people who may need them, while in Wales, it is the Local Health Board that provides these services for people. IMCA's primary services are provided in England and Wales, and existing advocacy organisations are used to offer their services (Department for Constitutional Affairs, 2007). The duty of IMCA is to make decisions for the person lacking capacity and to ensure their beliefs and values are the main focus. IMCA can also make a decision and request a medical opinion, and, if there are serious concerns, seek permission to contact and refer to the Court of Protection; because of that, IMCA has permission to obtain any medical or care records (Department for Constitutional Affairs, 2007). IMCA remains a relatively accurate description of advocacy in the UK (Armstrong, 2002). The hallmark of effective advocacy is detachment from the decision-maker (Gostin, 1981). The original idea behind advocacy was to give voice to those

who might be at risk of having their autonomy and wants ignored when faced with the authority of social services (Henderson and Pochin, 2001). If IMCA and staff cannot come to an agreement, it can be settled through negotiation and discussing other options; if that cannot be resolved, the staff then needs to follow appropriate formal procedures to settle the dispute, the person's religion and beliefs also have to be the main focus when trying to resolve an issue (Redley *et al.*, 2009). White and Baldwin (2006) have criticised the IMCA and MCA for being too lengthy, for not changing the law too much, and for giving more power to the government (White and Baldwin, 2006). There is not much commentary on the topic of why the Acts grant social workers and healthcare providers more authority than they do for disabled persons and their families (Oliver *et al.*, 2012). Several medical professionals have complained about the Act, stating that it does not give them enough power and have demanded that the designated decision-makers for the individual be reduced or changed from advisors to specialists (Wrigley, 2007). Some medical professionals even stated that the individual's capacity standard is not scientific or subjective (Veitch, 2006).

Furthermore, according to the IMCA regulations, the service that is being provided for adult safeguarding, the local authority can give or provide an advocate to an individual if they believe that person will benefit from that representative (Victoria, 2013). IMCA has been providing generic advocacy for many years, and the training given to the advocates for MCA usually takes only four days (SCIE, n.d). In contrast to other personnel engaged in adult protective procedures, more is needed to know about the educational backgrounds and professional paths of IMCAs, as formal qualifications can increase while working with the adult safeguarding team (Victoria, 2013).

Additionally, the *Mental Capacity Act* (2005) (MCA) and *Mental Health Act* (2007) (MHA) work in similar ways with the exception of if someone is being detained under the MHA in most cases, decision-makers cannot depend on the MCA to provide mental health treatment or to decide on that patient's behalf (Department for Constitutional Affairs, 2007). MHA provides help and treatment to those who have mental health issues or disorders that can put others or themselves in danger. MHA also does not see the differences between the people who lack capacity and those who do not. Still, most of the people covered by the MHA can make decisions for themselves (Department for Constitutional Affairs, 2007). In certain circumstances, decision-makers must choose between using the MHA, MCA, or both to talk about the needs of

whoever is dealing with mental health issues who is incapable of making decisions about their personal care (Department for Constitutional Affairs, 2007). In a lot of countries, there are laws in order to give the state people the power to be able to detain someone with mental health problems to bring them to a hospital without their consent. In the UK, especially in England, that is done through the *Mental Health Act* (1983), known as sectioning. This Act is used to refer the person to treatment or detention under the Act (Hamilton, 1986).

Mental Health Act (2007) also requires people to comply with the orders of the treatment they are being given. The MHA in England is significantly rising in number of people, but the reasons have not been stated or understood (House of Commons Select Committee 2013, Atkinson, 2017). MHA revisions are accused of upholding state-sanctioned coercion and have been criticised for being an unsatisfactory blend of safeguards and formality (Pilgrim, 2012).

Ethnic communities of colour that are black have higher rates of incarceration overall (Newbigging *et al.*, 2014), unfavourable treatment experiences, and worse results (Morgan 2012). While others saw the establishment of IMHA services as a reaction to sustained resistance throughout the MH Act change process, others applauded the installation as a positive development for the rights of service users (Mental Health Alliance 2008).

To conclude this essay, as Forbat and Atkinson (2005) state, support services need to recognise the difficult job of advocates outside the traditional health and social care systems. Within these institutions, advocates fight for the rights of marginalised people, emphasising how crucial it is for practitioners to distinguish between autonomous and professional-based lobbying (Forbat and Atkinson, 2005). Practitioners—social workers, in particular—should understand the objectives of independent advocates and the difficulties involved in challenging existing systems from the outside (Forbat and Atkinson, 2005). Prioritising these elements in advocacy and health/social care services it may dispel the myth that advocacy is directive rather than user-driven and promote a more moral and user-centred approach (Forbat and Atkinson, 2005).

To guarantee that advocates feel supported rather than threatened or undermined, professionals require assistance understanding the function of independent advocacy (Stewart and MacIntyre, 2013). This calls for a thorough comprehension of the function of advocacy, including its capacity to promote anti-oppressive activities like fighting for the rights of the individual, such as children. Advocates must exercise imperative that advocates exercise caution while

participating in formal processes such as adult safeguarding or child protection to prevent unnecessarily entering the investigative process (Stewart and MacIntyre, 2013). Advocacy services must set up efficient systems for identifying and recording individual outcomes, considering the possibility of differences in these outcomes between service providers and persons in need of support (Stewart and MacIntyre, 2013).

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