



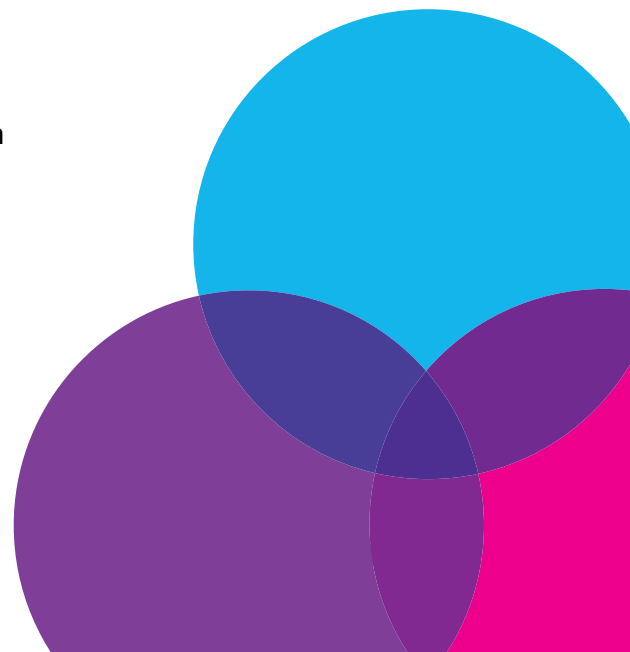
## Briefing

# 11. Advocacy – a stepping stone to recovery

**Karen Machin and Karen Newbigging**

## INTRODUCTION

This briefing paper examines the role of advocacy in empowering people to express their views and preferences and also their understanding of the meaning of mental distress. It provides an overview of the different types of advocacy, and the situations in which advocacy might be particularly important. It also addresses some of the misunderstandings surrounding the concept of advocacy. Finally, it outlines the contribution that advocacy can make to supporting and facilitating peoples' recovery and discusses the role of advocates compared with peer workers. The paper ends with a discussion of the ways in which mental health services and commissioners can better support the development of advocacy. It is aimed at people with lived experience, carers, advocates, mental health professionals, commissioners and all those with a stake in recovery-oriented mental health.



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## WHAT IS ADVOCACY?

The term advocacy can be confusing, because it is used differently in diverse contexts. For example, it is perhaps most commonly used in a legal context to refer to the representation and defence of an individual's case. In this paper, we are most

concerned with how the individual's voice can best be supported to influence decisions about their personal care and treatment in the context of mental health services. Some of the most frequently asked questions regarding advocacy are summarised in Box 1.

### Box 1: Advocacy: frequently asked questions

**Who can be an advocate?** In general, anyone can be an advocate as long as they have no conflict of interest with the person they are advocating for (the advocacy partner). Peers, friends and family can take on an advocacy role if asked to. Some advocates have recognised qualifications and a particular role and commissioners have a duty to provide these services. These include Independent Mental Health Advocates (IMHAs), Independent Mental Capacity Advocates (IMCAs) and Care Act Advocates.

**When might I need an advocate?** When you find yourself unable to speak up for yourself and let services know what you think is best for you and what you want. There may be times when you feel unable to do this for a whole variety of reasons or in particular circumstances. You may be unwell, detained under the Mental Health Act or lack confidence and knowledge about particular services.

**Is advocacy just for people who lack capacity to speak up for themselves and make decisions?** No. We can all value the support of an advocate to speak up for us in our relationship with services, which can appear very powerful. One of the common confusions is that advocacy is only for people detained under the Mental Health Act who lack capacity. This is wrong. Anybody who is detained under the Mental Health Act is entitled to an IMHA, and there may be other local services providing more general advocacy.

**How long will I need an advocate for?** That depends on you but the advocate should be empowering, supporting you to speak for yourself. With their support, you should find that you become more able to speak out for yourself so that you no longer need them. You may find that advocacy services limit the amount of time they are able to give you or only agree to advocate on specific issues.

**Is advocacy the same as information and advice services?** No. Giving information, particularly about rights or services, is an important strand of empowering you to speak out for yourself. But advocates should never give advice. Their role is to support you in your decisions, not advise you on what to do. They can direct you to other services that provide advice.

**How do I find out what advocacy services are available?** Mental health professionals should be able to signpost you to a local advocacy service. The Local Authority is mainly responsible for commissioning advocacy services where you live and should also be able to provide information, but this is likely to be about paid advocates. Local advocacy services may also have a website or you could ask local service user or carer groups.

**Who pays for advocacy?** Advocacy is free. It is most widely provided by voluntary organisations operating on a not-for-profit basis. They receive grants or have a contract with the Local Authority to provide specific types of advocacy. Many voluntary organisations, including service user groups and community organisations also recruit and train volunteers to provide advocacy. There are some advocates who are self-employed or organisations that operate on a for-profit basis and which may also receive funding to provide an advocacy service.



Advocacy has its foundations in the mental health survivor/service user movement, which has long promoted advocacy as enabling self-determination. Mind<sup>1</sup> defines individual advocacy as ‘a process of supporting and enabling people to:

- express their views and concerns
- access information and services
- defend and promote their rights and responsibilities
- explore choices and options.

Mind goes on to promote advocacy as a way of:

*“challenging the discrimination faced by users and survivors of the mental health system [so that] advocacy in all its forms seeks to ensure that people are able to speak out, to express their views and defend their rights.”*

The role of an advocate is therefore to listen, to understand the person’s wishes and views, and to support them to speak for themselves or to speak on their behalf. This may be done on an individual basis or on behalf of a group with similar issues. The ideal form of advocacy is self-advocacy, i.e. the person speaking up for themselves. This must always be the ultimate goal.

In this paper we will also focus on ‘independent advocacy’. The term ‘independent’ is used because one of the key principles is that the advocate should be as independent as possible of the health and social care system. ‘Independent advocacy’ cannot, therefore, be delivered by a care coordinator or other member of staff employed by the services themselves. By providing independent advocacy this enables the person to question or challenge the professionals’ views, while retaining confidentiality if they need to (VoiceAbility, 2015).

But advocacy is not merely about enabling a person to express their views and choices. Important as that is, it goes deeper, to be concerned with enabling the person to convey the meaning of their experience and what matters to them. This may be at odds with professional understandings and this can lead to differences of opinion between advocates

and mental health professionals. This is actually to be welcomed as it is through these discussions that both perspectives can be clarified and, hopefully, mutual respect facilitated to enable the process of recovery to be supported. Advocacy is, therefore, particularly vital for people whose views might be most readily discounted, such as people with learning disabilities or older people (O’Brien, 1987).

If issues are being raised by or on behalf of a group of service users, this is often referred to as ‘collective advocacy’. This is important where membership of a particular group is subject to stigma (negative stereotypes) and discrimination, which leads to the person’s views being perceived as irrational or unrealistic. Collective advocacy also has the potential to address the discrimination encountered in mental health services by certain communities, for example, people from African or African-Caribbean communities, refugees and asylum-seekers (Keating et al. 2002; Newbigging et al. 2007). In this way it can promote social inclusion, equality and social justice (Macadam, Watts and Greig, 2013) and address some of the exclusion and marginalisation of people from communities who may have little trust in mainstream provision (Rai-Atkins et al. 2002; Newbigging et al. 2007). Local commissioners need to understand this and to commission advocacy services that are able to meet the diverse needs of local populations. An example of working with an asylum seeker from an advocate, whose service has developed for people from Black and Asian minority ethnic (BAME) communities is given in Box 2.

## Box 2: Working with an asylum seeker: an advocate's story

I had been supporting an asylum seeker who was struggling with depression and anxiety as well as post-traumatic stress disorder. She had been through an arduous process to get appropriate services. Once her asylum application had been successful, she was then threatened with the ending of her Section 117 after care. At the same time, she also needed support with her benefits, housing and utilities as she tried to rebuild her life. As her advocate, I brought all services together to ensure that she would continue to be supported. She had struggled to do this by herself so we looked at ways to build her own sense of empowerment. She came on a local Peer Advocacy training programme which supports people to understand their rights and responsibilities. From this training, she has gained more confidence and is now hoping to set up her own service to support people in similar situations. I was not only able to make sure that her views on her support were heard, but was also in a position to encourage her to take up opportunities which could develop her own empowerment. She went from feeling hopeless about her future following the threat of removal of support, through to choosing to take up opportunities around self-advocacy: echoing the hope, control and opportunities that are essential to recovery.

There are different types of advocacy, which are summarised in Box 3. They are all underpinned by four principles – empowerment, autonomy, social inclusion and citizenship (Atkinson, 1999).

Advocacy can also be thought of as a 'reasonable adjustment' under equality legislation, to enable people whose ability to communicate is affected by their mental health or by a learning disability (National Development Team for Inclusion, 2012). It does not preclude the use of other forms of support to enable the person to communicate effectively, for example interpreters and signers. Local Authorities are under a duty to provide access to paid statutory advocacy, but there are now concerns that access to generic advocacy is becoming more limited as they face increasing threats to their budgets.

**Box 3: Different types of advocacy (adapted from Newbigging et al. 2015)**

Type of advocacy	Description	In relation to services
Self-advocacy	People asserting their own rights, speaking for themselves, expressing their needs and wishes.	The ideal with services able to hear and respond effectively.
Collective (or group or community) advocacy	People speaking up collectively about concerns that affect them. Community advocacy is more commonly used for collective advocacy of the interests of a particular community, for example people from Black, Asian and minority ethnic communities.	To speak out on collective concerns, to highlight issues and seek redress to promote better, more equitable and responsive services.
Citizen advocacy	Usually a long-term advocacy partnership when an (unpaid) volunteer or community member takes on an advocacy role.	Developed primarily by supporters of normalisation to ensure there are people in the lives of people who care about what happens to them and are not paid to be with them.
Peer advocacy	Provided by people who have 'insider' knowledge by virtue of shared characteristics or experience, e.g. age, ethnicity, disability and/or use of services.	Peers are an important strand of recovery-based approaches but may provide a range of support other than advocacy, for example mentoring.
Professional (or paid) advocacy	Provided by trained and paid independent advocates, including generic advocacy and statutory advocacy (IMHAs, IMCAs and Care Act advocates). May be short- or long-term.	IMHAs, IMCAs were introduced in England and Wales and Care Act Advocacy under legislation. Any eligible person, as defined by these Acts, has a right to access such statutory forms of advocacy and services have responsibilities to support the exercise of this right.
Non-instructed advocacy	When individuals are unable to personally instruct their advocate, because they lack capacity, but still need an advocate to ensure their rights are upheld. An advocate will spend time observing and will look for ways for the partner to communicate their wishes and, if relevant, gather information from other people.	Various forms of advocacy can be non-instructed, e.g. citizen advocacy. IMCA is the most widespread form of non-instructed advocacy, since its introduction in 2005.



## WHAT ADVOCACY IS NOT

A common confusion is that providing information or advice is the same as advocacy. Providing information may be necessary to enable a person to understand their situation and to exercise greater choice and control, but an advocate will not provide advice, although they may support someone to access this if needed.

Many mental health professionals, especially nursing staff and social workers, see themselves as having an advocacy role. This aspect of their professional role is usually encouraged during their initial training and reinforced by professional codes of conduct. Being a key worker or care coordinator involves getting to know the person well, spending time with them and taking a holistic view of their needs. This can be thought of as a form of ‘pseudo-advocacy’ (Beaupert, 2009) since mental health professionals will have a conflict of interest if the person’s views conflict with their professional duty of care. The mental health professional’s conception of advocacy is often a ‘best interest’ one, balancing the person’s wishes with their

protection. Mental health professionals can, and should, advocate for an individual’s interests and this should be based on a good understanding and knowledge of the person concerned. However, it does not negate the need for independent advocacy. An independent advocate’s focus is the wishes of the person, which may involve challenging decisions.

Family and friends may also be motivated to act in what they perceive to be the ‘best interests’ of the person concerned. They may be able to act as advocates on some aspects of a person’s care, such as securing accommodation or offering a history, but they may disagree about the need to be in hospital, or take medication. Such situations are challenging and a test of the commitment to self-determination.

Finally, advocates are not legally trained and although they may provide support and enable the person to have a voice in legal proceedings, a person may also need a solicitor to represent them and ensure that the process of the law is being properly followed.

## WHY IS ADVOCACY NEEDED?

Many people who use mental health services can speak up for themselves most of the time (self-advocacy); many others will have family, friends or peers who are able to take on this role temporarily, when needed. However, there may still be times or situations when the person may require someone independent to speak on their behalf, to safeguard their rights, and to enable them to access the care and support they need to facilitate their recovery. Advocacy is built on an understanding that self-determination and personal agency are important for everyone, but that the power of professionals and services can sometimes serve to compromise peoples’ rights and limit their choices. Here are three examples of where this has been recognised in law, thus giving people in these circumstances

the statutory right to advocacy: (a) treatment under the Mental Health Act; (b) where there are considerations arising from the person’s mental capacity and (c) under the Care Act 2014.

### Advocacy and compulsory treatment

Advocacy can be vital for people whose rights and choices are limited through compulsory treatment under the Mental Health Act. The numbers of people detained under the Act has been steadily rising over the last 20 years and, although only recently introduced, far from reducing the number of compulsory treatments, increasing use of Community Treatment Orders (CTO) has contributed



to steadily increasing numbers of people being treated against their will (Care Quality Commission, 2015). During its inspection of the use of the Act, the CQC has also identified services where control is more evident than care (Care Quality Commission, 2012) and where people’s rights have been disregarded (Care Quality Commission, 2015).

Disproportionate rates of detention, negative experiences, dissatisfaction and poorer outcomes for people from BAME communities have been consistently highlighted (Care Quality Commission, 2011).

‘Hope’, ‘control’ and ‘opportunity’ are essential themes for recovery-focused services, but these can feel very distant for people who are detained under the Mental Health Act: they are specifically *disempowered*. Indeed, it can be argued that the very existence of compulsory treatment runs counter to the principles of recovery (Repper and Perkins, 2014). If people are being forced into a service, they are unlikely to trust it and are likely to value independent support even more. People who are in crisis, or recently admitted, may be confused and unsure who to trust. Others who have been recently discharged on a CTO may feel that they have to agree with services to avoid another admission.

*“You are without any power to make contributions to major decisions that affect your life chances. I had been in positions of power at work but then my world imploded. When I was sectioned there was nothing and no one available to help me to make any sense of what was happening. I was on a ward with no understanding of the processes that were happening around me, or to me. I felt helpless and hopeless. Someone tells you your rights and you don’t understand what they are saying. Their lips are moving, but you can’t hear what they are saying. We need someone with us as an advocate to see us through an appalling situation. Getting advocacy support from someone who understands us can help us grow what I call “the seeds of empowerment” (Sadd, 2015, p.7).*

For this reason, Independent Mental Health Advocacy (IMHA) was introduced as a

safeguard within the Mental Health Act (2007). People of all ages who are detained under the Mental Health Act, including those subject to guardianship or a CTO, have the right to access an IMHA, and mental health staff are under a duty to facilitate their access to an IMHA. IMHA can help detained patients to exercise their rights by participating in decision-making, and this can include representing them and speaking on their behalf. IMHA is only intended to support the group of people as defined in Box 4. However, several national organisations (House of Commons Health Committee, 2013; National Institute of Health and Care Excellence, 2011; Welsh Government, 2011) have promoted extending this support to all inpatients (as is the case in Wales). Many IMHAs also work as generic advocates, seeing the IMHA role as part of a wider advocacy role, which can include Independent Mental Capacity Advocacy (see below).

#### Box 4: Patients detained under the Mental Health Act eligible to use IMHA services (adapted from the Code of Practice, Department of Health, 2015)

- patients detained under the 1983 Mental Health Act (even if on leave of absence from the hospital)
- conditionally discharged restricted patients
- patients subject to guardianship
- supervised community treatment patients

Informal patients are eligible for IMHA services if they are:

- being considered for a treatment to which Section 57 applies (i.e. treatments requiring consent and a second opinion)
- under 18 and being considered for ECT or any other treatment to which Section 58A applies (i.e. treatments requiring consent or a second opinion).





The remit of IMHA services is specifically around protecting people’s rights and they help patients obtain information about the Mental Health Act, to understand their rights and the particular parts of the Act that apply to them (e.g. the basis upon which they are detained) and which therefore make them eligible for advocacy. They should include any conditions or restrictions to which they are subject (e.g. regarding leave of absence from

the hospital) and reasons for any medical treatment they are receiving or might be given, together with the legal authority for providing that treatment and the requirements of the Act that apply to that treatment (e.g. relevant safeguards). This is only possible if the independent advocate builds a positive alliance with the person who has been detained under the Mental Health Act, as illustrated in Box 5.

### Box 5: Experience of Interdependent Mental Health Advocacy: Kris’ story (from Chastey, 2015)

I had no idea what an advocate was, let alone how much they could help me. Upon meeting the advocate it became very clear, very quickly, this wasn’t just another member of staff. This person listened to me: this person LISTENED. I became a name, a human being again, not just a section. We spoke at length about my situation and how we could go about improving it. The advocate spoke to me like a person, open and honest, nothing was guarded or sugar coated. I asked a question, I got a straight answer, good or bad, it was the information I was craving. From then on, every ward round or meeting with the doctor, I’d take the advocate. The advocate asked a question on my behalf, usually getting a positive result or feedback. Me asking that same question, I’d get a “we’ll discuss it as a team and get back to you”; the advocate asked and it’s done. A good advocate becomes your mouthpiece, asking the questions you need answering, getting you the results you need. Working together with my advocate sped up the process of everything I needed, reducing medication, increasing leave, and eventually getting discharged. On many occasions the advocate was unhappy with my situation and wanted answers: answers they got. If I asked those same questions as a patient, you’re not taken seriously at best, a sign of becoming unwell at worst.

My situation improved the moment I took the chance to get the advocate involved. I found an ally, a voice of reason, a person who could help me at every step with my journey through hospital. The last step of which was my Tribunal; my advocate sat right next to me, after talking me through the whole process and helping me through it. I found using the advocate was the change that started helping me the most. I saw from my own experience the patients who used the advocate, went through the whole hospital process much quicker and seemed much more content with the way things were going.

The patients who avoided all contact with the advocate (the majority) struggled through, with all the same problems, unhappy with medication, their leave, their situation, it didn’t seem to improve because as a patient on your own, you’re not taken seriously or put to the back of the queue. When I took the advocate to ward rounds, the whole weekly meeting became very different. The doctor, the staff, became much more efficient, as if just by having the advocate there it kept them on their toes. The dynamic of ward rounds changed, we got answers, clear ideas and a structure on how my care would go. Every question and request was answered and explained there and then. No more “we’ll discuss as a team and get back to you” - we got a “yes” or a complete and clear reason for not agreeing. My whole situation was improved by my advocate.

## Advocacy and mental capacity

The Mental Capacity Act (2005) introduced Independent Mental Capacity Advocacy (IMCA) for anyone over the age of 16 who lacks capacity to make certain decisions relating to either: (a) a serious medical conditions, other than mental health; or (b) long-term moves (more than 28 days in hospital or 8 weeks) in a care home. The Mental Capacity Act established an important principle that capacity should be assumed unless proven otherwise and is specific to the decision being made. This means that care has to be taken in assessing whether people have the capacity to make a relevant decision and cannot be assumed on the basis of a diagnosis (for example, dementia, schizophrenia, or other cognitive disability). However, people can be detained under the Mental Health Act, whether or not they have capacity to consent and, in general, the Mental Health Act ‘trumps’ the Mental Capacity Act (Herlihy & Holloway 2009, p.479).

People can lack the capacity to instruct an advocate, including when they are detained under the Mental Health Act, and in such situations advocacy can be provided by an IMHA. This is usually referred to as non-instructed advocacy, with the advocate representing the person’s wishes (as much as they are known) and ensuring that his or her rights are respected. Advocates working in a non-instructed way are usually keen to invest as much time as possible to establish capacity and to ensure that involving an advocate is what the person wanted (Newbigging et al. 2012; 2014).

## Advocacy and the Care Act

The Care Act (NHS, 2014) also sets out a range of measures to enable adults to be in control of their care and introduced the role of ‘Care Act advocacy’. This places an obligation on Local Authorities to provide access to independent advocacy in order to strengthen the involvement of people in decisions made about their care and support (Section 67) and safeguarding reviews (Section 68). It is targeted at adults, including carers, who would otherwise have difficulty with this.

Care Act advocacy is for people who have substantial difficulty in engaging with care planning, reflecting reduced capacity for decision-making, and do not have anyone appropriate to help. As with other forms of statutory advocacy, the role of the Care Act advocate is to support the person to communicate their views and wishes, strengthen their involvement in decisions about their life, and understand and protect their rights. The advocate can also challenge decisions made by the Local Authority on behalf of the person concerned.

This new form of advocacy only came into force in April 2015 and it may be some time before it is fully in place. Care Act advocacy can help ensure that the care and support from adult social care is truly personalised by ensuring that the person has a strong voice in determining how their needs can be met. Care Act advocacy can also support people to access personal budgets and direct payments which are often integral to recovery (Alakeson & Perkins, 2012) grounded in a need to understand “whole people in the context of their lives” (Brewis & Fitzgerald, 2010).

So, what is the relationship between advocacy and recovery?



## ADVOCACY AND RECOVERY

*“If personal recovery is about anything, it is about empowerment.”* (Slade, 2009, p73)

As we have seen, advocacy promotes self-determination and aims to empower people to have greater control and choices in their relationships with a range of services and opportunities. Advocates value the knowledge and experience of people and provide a range of support that enables them to have their voice heard on issues that are important to them. This process can offer hope, help them to explore their choices and options and facilitate shared decision-making. Thus, advocacy is very much related to supporting recovery; and defines a set of principles (empowerment, autonomy, social inclusion and citizenship), without which pursuing personal recovery is simply not possible.

For both advocacy and recovery, empowerment is a central idea. Empowerment, and therefore recovery, is not possible without the individual having a voice: expressing what is important to them, exploring their options and choices, and being actively involved in decisions about their life. The focus on empowerment has strong roots in the consumer/survivor movement and in self-help alternatives to traditional services (Chamberlin 1988; 1998; Deegan, 1988; Wallcraft, 2003). Empowerment is framed by Jacobson and Greenley (2001, p. 483) as ‘a corrective to the lack of control, sense of helplessness and dependency that many consumers develop after long-term interaction with the mental health system’. As such, it is central to recovery with its focus on hope, control and opportunity (Repper & Perkins, 2003; Shepherd, Boardman and Slade, 2008). So advocacy can support recovery by ensuring that an individual:

- always has a voice in decisions about their life
- has information about the options available to them

- is empowered to exercise their rights
- can challenge health and social care professionals.

In practical terms this could mean that the advocate will enable:

- self-advocacy
- an individual to express their views and preferences in key meetings with health and social care professionals
- an individual to be an active player in developing a wellness or recovery plan, or advance statement
- services to have a good understanding of the person’s strengths and talents
- a shift to shared decision-making and co-production leading to increased personalisation, and greater choices and control
- access to a broader range of options in terms of therapy, care and support and more widely in relation to accommodation, employment and friendships
- an individual’s rights to be protected, such as the right to the least restrictive option if detained under the Mental Health Act.

### Advocacy and peer support

ImROC has argued in previous papers that peer support is one of the key service developments to support personal recovery (Repper, 2013a; 2013b). While peer support has some similarities with advocacy, there are key differences between the two roles. These are summarised in Box 6 (overleaf).



### Box 6: Comparison of peer support worker and advocate roles

	Peer support worker	Advocate
Purpose	Supporting personal recovery.	Ensuring voice is heard.
Support offered	Support might include social support, wellbeing plans, sharing coping skills, navigation around services.	Helps you to say what you want, get heard, represent your interests, get the services you need and know your rights.
Experience	Lived experience essential to the role.	Not necessarily having lived experience.
Qualification	Varies with organisation: qualifications mandatory in some organisations.	Varies with mandatory training for statutory advocacy roles, leading to accredited City and Guilds certificate in independent advocacy.
Training	Recovery including active listening, solution focused problem solving and a strengths based approach.	Certificate in Independent Advocacy covers the purpose and principles of independent advocacy and importance of understanding the social context. Specialist modules can be added for statutory advocacy, including providing IMCA, IMHA and Deprivation of Liberty Safeguards.
Range of support	Range of peer support including paid workers, volunteers, self-help groups.	Range of advocacy roles include generic advocacy, citizen advocacy, statutory advocacy.
Access	Locally offered services may vary.	Advocacy services may vary, but all areas must provide statutory advocacy (IMHA, IMCA and Care Act advocacy).

Advocacy does not necessarily have to be provided by people with lived experience. Where this is an essential part of the advocacy role, the term ‘peer advocacy’ is often used to distinguish it from other forms of advocacy. Both peer supporters and peer advocates are able to disclose their own lived experience, sharing their coping skills and recovery journey in order to support someone

else who is struggling. The authenticity from having been there generates a unique relationship based on trust.

While peer advocates and peer supporters may both offer support for recovery, and both come from a position of lived experience, the differences between the two highlight the breadth of support on offer. Peer advocates



have a narrower role in supporting someone to get their opinions heard. While this may be part of a peer support role, the peer supporter may also provide social support, encouraging a person to make the most of opportunities and enabling them to combat anxieties about moving forward. Peer supporters may also provide a listening ear and mentoring about recovery, supporting the person through transitions between and out of services.

One of the concerns about advocacy is that because advocates do not necessarily have to have lived experience, some people feel that the advocacy role is becoming ‘professionalised’ and advocates may not be as grounded in lived experience and grassroots concerns as they should be. The counter view to this is that the formal recognition of the advocate role (in the Mental Health Act, Mental Capacity Act and Care Act) gives advocates more power to support and represent people using services and may therefore be more effective in ensuring that services listen.

## The impact of advocacy

There are many accounts of the positive impact that advocacy has had on people’s lives, improving their situation and supporting their personal journey of recovery, as with the two examples given earlier. Studies of advocacy have distinguished between the process and the changes observed in both the short and long-term. These are illustrated in Box 7. The reasons why particular outcomes may not be achieved are complex. Someone may feel valued and listened to as a person (process), but the advocacy may not have achieved the outcome they wanted, for example getting off a section, having a direct payment or getting a job. There is a risk that advocacy can serve to maintain the status quo, enabling services to think that they are listening to people when in reality they are not being heard (McKeown et al, 2014; Newbigging et al, 2015). Although it is important to recognise this, advocacy has an important contribution towards enabling people with mental health problems to take back control and work towards their goals, and is widely appreciated.

### Box 7: Process and changes for short and long-term advocacy outcomes (from Newbigging et al., 2015)

	Short-term outcomes	Long-term outcomes
Process	<p>Improved awareness of rights and understanding of the mental health system.</p> <p>Exercising rights and having a say in decision making.</p> <p>Service users are able to direct their own care meetings.</p>	<p>Ability to plan for self, keep well and live independently.</p> <p>Changes in service culture, enabling person-centred approaches and improvements in how service users are listened to by mental health professionals.</p> <p>Increased accountability of mental health professionals.</p>
Change	<p>Increased self-confidence and self-esteem.</p> <p>Better able to self-advocate and negotiate care and treatment.</p> <p>Addressing issues affecting mental health.</p>	<p>Being able to sort out or access support to help with any issues that could affect independent living or mental health.</p> <p>Avoidance of compulsory admission or rehospitalisation.</p>



## HOW CAN MENTAL HEALTH SERVICES BEST SUPPORT THE WORK OF ADVOCATES?

The fundamental values of advocacy support a person-centred approach and shared decision-making, which should be the standard of all recovery-focused services

Mental health services can support the role of advocates in several different ways. In the first place, everyone in the service should be committed to self-advocacy. Here are some suggestions about the steps that people can take to self-advocate and which staff can support.<sup>2</sup>

1. **Be actively organised:** Keep records and notes of important meetings, organised and in date order so that you can track what is happening. Keep a calendar of important dates so that you can be prepared.
2. **Develop a plan for action (e.g. Wellbeing and Recovery Plan):** Identify the issue, what is most important to you and what needs to happen. Write down the possible solutions to the issue and choose the option that works the best for you to get you the results you need.
3. **Take action:**
  - Be prepared to take action by identifying, and using, any resources you may have to overcome any barriers to achieving your goal.
  - Be calm and able to listen so you don't let your emotions get in the way of getting what you need
  - Be persistent: don't give up. Find other ways of convincing people of what you want to achieve.

### 4. **Don't be afraid to ask for help:**

Problems affect people in all sorts of ways and there can be people in your support network who may be able to help – family, friends, peers, faith organisations, community groups and others, including advocates if needed.

In addition to supporting self-advocacy, mental health professionals shape the culture in which advocates work and their attitudes can facilitate or hinder the advocates' role. Recovery-focused services understand that feelings of being 'in control' and having the opportunity to pursue personal life goals are essential to recovery. Some of the ways in which mental health professionals can help or hinder advocacy (and hence recovery) are summarised in Box 8.



## Box 8: The role of mental health professionals in helping or hindering advocacy

Facilitating the advocacy role	Impeding the advocacy role
<p>Recovery-oriented practice.</p> <p>Appreciation and understanding the advocacy role in safeguarding rights and promoting empowerment.</p> <p>Ensuring that people have the means to contact the advocacy service independently of staff.</p> <p>Providing information and facilitating access to an advocacy service.</p> <p>Ensuring that advocates have a private place to meet with advocacy partners.</p> <p>Taking care when scheduling key meetings that the advocate can be present, if needed.</p> <p>Eliciting feedback from advocates on collective issues and ensuring that these are addressed.</p>	<p>Communicating a hostile attitude about advocacy and seeing it as an unnecessary interference.</p> <p>Asserting that professionals are the ‘true’ advocates for promoting service users’ interests.</p> <p>Seeing advocacy as working against service users best interests and that promoting service users’ views is irrational or unreasonable.</p> <p>Avoidance of advocacy and referral as a tick box exercise.</p> <p>Scheduling meetings without checking whether the advocate will be available.</p>

Both advocates and mental health professionals need to respect their unique contributions. If advocates are doing their job well, they will be alert to ways in which individual rights are being compromised and may challenge staff views or raise such issues on behalf of an individual or on behalf of a group of service users. Difficulties may arise when the advocacy service is located in the same building as the mental health professionals. They may get to know each other well and this can lead to the advocate avoiding (or being pressured to avoid) raising difficult issues with certain staff members. This requires skill, on the part of both the advocate and mental health professionals, to navigate successfully.

Above all, the organisational and service culture will influence the attitude of mental health professionals to advocacy, alongside their personal and professional values. Organisations that are working towards recovery-oriented services and practices, investing in peer support, and having service users extensively involved in their governance should welcome advocacy as another tool to promote self-determination and recovery (see Box 9, overleaf).



### Box 9: A ward manager's story (adapted from unpublished data, Newbigging et al., 2012)

The really positive thing is that it's given me an opportunity to think about some of the stuff (advocacy) and how it fits in. We are at a point in our evolution where we can really start to use the kind of advocacy that she's offering. She does the IMHA stuff and she'll go into ward rounds. I also have invited her along to some of my ward meetings where we talk about our ward service development (which includes adopting a recovery-oriented approach]. There's the potential for me to get views that patients might not want to tell other people and so she's collating this so we can get a more comprehensive picture. So she's quite integral to what we're doing but her independence is so important.

What she made clear to me is her role is advocating what the patient is asking for even when it might appear not actually be to their benefit, i.e. she is simply articulating what they have asked. Now it might be that she tries to help them with that and to work it out better, but I don't think it had hit me as strongly before that this was at the heart of the work that she does. We have had a number of conversations about this and what we tend to do now is that if this situation arises, we'll sit down all three of us together and try to resolve things properly, so it's really direct. No matter what I do, the patients are always going to see me as a Ward Manager, some will like me, some won't, but I'm a nurse and you can't take that away. So, I think having an Advocate that's able and committed gives you immense possibilities for progressing things that you might have otherwise struggled with. Anyway, that's what I've found.

## CONCLUSIONS

It is self-evident that having a voice is fundamental to recovery for people with mental health problems. Therefore, building capacity to self-advocate should be a focus for peer support and recovery-oriented mental health services. Families and carers also have a key role to play in promoting the role of advocacy and self-advocacy as do mental health professionals and commissioners (health and local authority). In order to ensure that everyone who needs an advocate is able to access one, advocacy organisations need to work effectively with a variety of local stakeholders.

To summarise:

1. Local Authority commissioners have a key role in ensuring an appropriate level of investment so that the provision of advocacy services is not a superficial exercise. This will involve an adequate needs assessment to understand the diverse range of advocacy needs across their locality.
2. Clinical Commissioning Groups can also take steps to ensure that the mental health services they commission fully understand the contribution that advocacy can make to supporting the development of more recovery-oriented services.
3. Mental health professionals need to be grounded in an understanding of the different types of advocacy and their duties in relation to statutory advocacy. Appropriate training and development should be available, drawing on service user and survivor input.





4. Advocacy services are required to fully understand the diverse needs of people who require an advocate. This means working in effective partnerships with other community organisations and upskilling them to provide advocacy, as appropriate.
5. Service user and carer groups need to be aware of the range of advocacy services available locally and their relationship to national developments. They can keep a watchful eye to ensure that these advocacy services properly meet local needs, as well as in helping promoting them. Carers also have a role to play in ensuring that the people they support are made aware of local provisions.
6. Finally, the emphasis on advocacy and self-advocacy will be greatly helped if it underpinned by a robust infrastructure to facilitate collective advocacy and co-production in the commissioning, design and delivery of mental health services across the system.

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## Advocacy – a stepping stone to recovery

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For more information on the current work of ImROC, please visit [www.imroc.org](http://www.imroc.org).

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