

Advocate Provocateur

A challenge and a call
to advocates in 2017



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Advocate Provocateur - A and a call to advocates

The right to receive advocacy support has never been stronger: statutory advocacy now includes Independent Mental Health Advocacy (IMHA) for people subject to the compulsory powers of the Mental Health Act, Independent Mental Capacity Advocacy (IMCA) for people who lack capacity to make certain decisions; advocacy for people accessing NHS complaints processes; advocacy for children and young people receiving services under the Children Act and now the Care Act introduces the right of advocacy for people who face difficulty in being involved in assessment, planning, review and safeguarding decisions and have no-one else to support their involvement.

Given the smorgasbord of advocacy on offer, you would be forgiven for thinking things had never been better within the sector. Yet the reality is somewhat different. Here, we look at three areas where we believe advocacy is failing: the lack of referrals, lack of supported decision making and the lack of challenging decisions. We implore the sector to look for ways to improve.

Lack of referrals

Here are some sobering statistics:

- Around 50% of people entitled to receive IMHA support actually do so¹
- Fewer than 1 in 10 people accessing NHS complaints procedures were provided with advocacy support²

- A freedom of information request made by Community Care, found that³ independent advocates were provided to just 2.1% of 253,000 people assessed under the Care Act between April and September 2015. The government's impact assessment estimated 7% would qualify for, and accept, support.

Whilst not every person eligible to receive advocacy support will choose to make use of this right, there are serious concerns that people are simply not supported to access independent advocacy. Commonly, missed opportunities to promote advocacy include:

- Local Authorities [not] including information about their advocacy offer on their websites (despite it being a legal duty). If you want to test this out call your local authority and ask who provides Care Act Advocacy
- [Not] training health and care workers in understanding the different types of advocacy available so they clearly understand when they must refer and when they must offer advocacy
- [Failing to] embed the offer of an advocate within clear decision making processes
- [No] monitoring of the offer and take up of advocacy within local areas (with a specific focus on people from seldom heard groups who are less likely to access statutory advocacy).

A challenge in 2017.

Upon first glance, it is easy to see these activities as being the responsibility of the Local Authority, it is after all their legal duty to provide advocacy. However, commissioned advocacy services have a powerful opportunity to influence these activities and must not shy away from taking strong action to ensure advocacy is promoted within its area. Without this strong action, the sector risks colluding in the gatekeeping of advocacy to a select few.

But how do you influence stakeholders with limited resources and budget? An incredibly effective way to encourage specific behaviour is to use Nudge theory.

Nudge theory received popular acclaim via a toilet in Schiphol airport when a fly was painted onto urinals to 'nudge' men to pee in the right place. It would appear that given something to aim at, the majority of men love a target, and were consequently 'nudged' into peeing into the urinal (rather than the floor which was becoming a problem). Advocacy services can use nudge theory to plan its communications with local authorities to nudge them towards a shared commitment to making advocacy a practical right for people. For example:

- Showcase where it is working. Advocacy services can use data from neighbouring councils where referrals are high (or higher) to easily show how colleagues from across the country are making advocacy accessible. This could 'shame' the council into taking this seriously or provide hope that increasing referrals is achievable.
- Get current and up-to-date information so you have accurate information on the current state of play. One easy approach is to work with your Local Authority to make Freedom of Information requests on:
 1. How many times advocacy was offered to eligible people
 2. How many times advocacy was taken up
 3. How many times advocacy was not taken up (and the reason why)
 4. How many times an 'ineligible' person challenged the decision they were not entitled to receive advocacy support?
- Request the local authority to embed the decision to refer to advocacy within existing processes. Ensure the question 'is the person entitled to an independent advocate?' is a mandatory field within assessment questionnaires, so social workers will not have to remember to offer, they will be automatically asked to.
- Adopt an opt-out not opt-in referral scheme⁴.

And if 'nudging' fails to achieve the change, advocacy services must adopt the rhino archetype: thick skin and the strength to push through change. Remember you are powerful organisations who can ably move to a more formal challenging process, the law is on your side: make full use of complaints procedures

and judicial review when they are needed.

The lack of Supported Decision Making

A huge part of the advocacy role is to help people make decisions. This is generally undertaken by:

- A. Helping a person to access information
- B. Supporting a person to understand it
- C. Exploring with a person what they think about the information and their options; and then finally
- D. To make a decision and to communicate it.

Most of us, at varying times in our lives, need help to make decisions. This could be a non-judgemental face across the table listening to our aspirations or concerns, or it could be much more involved – particularly if we are facing challenging times or have a condition or impairment that means we face difficulty or lack the capacity to make certain decisions.

And it is here where advocacy, perhaps, can fall down.

Substituted Decision Making

The Mental Capacity Act (MCA), provides the best guidance a person needs to follow when they are going to make a decision on behalf of an incapacitated person. The process of making this decision is called Substituted Decision Making, and the MCA requires the State to follow 5 principles when making (or substituting) a

decision on behalf of the person. A quick recap of the principles tells us that the decision maker substituting the decision on behalf of the person must:

1. 'Assume that the person has capacity unless it is established that he lacks capacity.' (section1(2))
2. 'Not treat the person as unable to make a decision unless all practicable steps to help him to do so have been taken without success.' (section1(3))
3. 'Not treat the person as unable to make a decision merely because he makes an unwise decision.' (section 1(4)).

Only once these three things have been completed, not before, can the person's capacity be assessed AND then only once a lack of capacity has actually been established can the decision maker substitute their decision:

4. By acting in their best interests (section 1(5))
5. And after having regard to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

The process of making best interest decisions, requires the decision maker to have regard to the person's wishes and feelings – and the role

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of the independent advocate then becomes finding out likely wishes and views and representing these.

The problem with this focus and emphasis on representation, is that advocates (including IMCAs, IMHAs and Care Act Advocates) can all too readily become part of the substituted decision making model without protecting the supported decision model. IMCAs up and down the country are instructed by the decision maker, adopt a Non Instructed Advocacy model and go about gathering information that is presented to the decision maker about the person with the goal of helping the decision maker make the substituted decision.

How would people's lives look if the IMCA (or Care Act Advocate) had the goal of supporting the person to make their own decision. Instead of finding out from people around the person, what they may or may not think about a move to a new care home, perhaps the advocate should spend more time helping the person visit the new care home and experience what the decision really means.

There are of course, two well-known problems to this: firstly is the lack of time available to advocates and secondly is the obvious acknowledgment that no matter what support is offered, the person's impairment is so severe they will be unable to make a decision.

In response to these problems, advocates need to be careful that they are not colluding

with the problem rather than solving it. It is time to take responsibility for how you use your time. Time is the only equaliser in life – no one person has any more time than anyone else, so we must be clear about how this time is spent. If the advocate chooses to spend this time pursuing the substituted decision making then take responsibility for this. But consider for a moment the difference advocacy could make if this time was spent firmly on exploring the supporting decision-making model.

In response to the second issue that not everyone will be able to make a decision due to their condition or impairment, this is agreed. However, people with disabilities are routinely denied daily opportunities to make decisions (whether this is what to wear, what to eat, who to see, where to go). If we take a step back, this is clearly unacceptable on a day-to-day basis, advocates MUST stand up and start pushing for more supported decision making opportunities rather than be complicit in systems that deny people opportunity to take decisions.

Lack of Challenging Decisions

The last area to shine a light upon is that fundamental aspect of advocacy: challenging decisions and processes. This will mostly involve offering support to a person who wants to challenge the decision (regardless of whether the advocate agrees the decision is wrong) but will on occasion, involve the advocate making a decision on whether to challenge a decision or appeal on behalf of a person when they are unable to do so.

In 2017, we are working with advocates who tell us about decision-making processes that routinely:

- Exclude people (by not undertaking correct capacity assessments e.g. a decision-maker uses an old assessment as evidence the person lacks capacity)
- Deny people opportunity to put forward their views (by excluding them from decision-making processes e.g. a mental health hospital has a policy of not inviting patients to their ward rounds)
- Ignore people's views and wishes (e.g. not including within a care plan what the person's aspirations are, even though these were well known)
- Fail to implement legal requirements (e.g. not completing an assessment of a person's care and support needs for 7 months despite one being requested)
- Fail to offer people representation (e.g. people who are entitled to receive IMCA, IMHA and Care Act Advocacy support are routinely not offered it).

So surely this means that advocates must be inundated making complaints to the Ombudsman and pursuing legal challenges?

No. Instead we see sections of the sector who find it difficult to routinely challenge these decisions.

Why? We believe there are 3 reasons why advocates are not pursuing things to the fullest:

1. Low expectations. In other words advocates have such poor expectations they have become resigned to expect decisions not to reflect their partners goals or aspirations. They have been told "NO" so many times, they have stopped asking. "There is no money, what is the point" is a comment we have heard from advocates more than once this year.
2. No resources. Advocates are starting to support so many people at once, that it is impossible to effectively offer 100% commitment to each person. This leaves the service doing the best they can with the resources they have – a recipe that is unlikely to result in world class advocacy.
3. Culture. Some advocacy services have replaced a culture of questioning and challenging, with one of compliance and conformity.

Ask yourself, when was the last time you challenged a decision that resulted in change? Then ask yourself when was the last time your service challenged the local authority and something changed? How many times has this happened in the last month? Last 3 months? Last year? Last 5 years?

Hypernormalisation

Adam Curtis, a BBC documentary maker, uses

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the term hypernormalisation to describe a post truth world that everyone knows is untrue yet accepts it real. He describes how 'everyone knows the system was failing, but nobody can put forward an alternative so we accept the status quo, we maintain the pretence of a functioning society'.

The way the world actually works is very complex so we buy into simpler models that smooth our everyday experiences but are incorrect. We know deep down they are incorrect but as a society we are all complicit and buy into the story.

I don't think it is unfair to suggest that perhaps there are sections of the advocacy sector where advocates may have bought into this post truth world where there is a belief there is little point in challenging systems or decisions, because things are so broken it would be impossible to fix. There is no point in asking for things as austerity has removed financial resources. The advocacy service therefore concentrates on those areas where it believes the greatest impact can be had, perpetuating the status quo and smoothing the day-to-day rather than focusing on where the impact is truly needed. Concentrating on the quantity of advocacy referrals you can be seen to cope with, rather than the quality of support on offer.

Is there a Brighter Future?

Of course there is. And the great thing is that all advocates need to do, is remember that they

are powerful beyond imagination and capable of making great change.

And as an end note, I would ask your forgiveness if this has come across as critical of our sector – it is not my intention to criticise unfairly the world I love. Instead, I ask you to see things as they truly are, not worse than they are or better than they are...

And remember you are a magnificent rhino.



1 See UCLAn 'A Right To Be Heard'

2 Healthwatch England 2014, Suffering in Silence

3 <http://www.communitycare.co.uk/2016/01/13/social-workers-urged-review-practice-given-low-care-act-advocacy-case-numbers/>

4 See <http://www.scie.org.uk/independent-mental-health-advocacy/resources-for-staff/improving-access/> for further guidance

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