In-between the person and the process: the liminal role of independent advocates under England’s Care Act 2014

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Abstract

The Care Act 2014 extended rights to independent advocacy for some users of adult social care in England. The Care Act Advocate (CAA) role supports and represents people regarding involvement in processes conducted by the local authority, including needs assessment, care and support planning, and safeguarding. CAAs' responsibilities include making necessary challenges to the local authority, with or on behalf of the person.

This thesis addresses knowledge gaps about the nature and operation of the CAA role. Key questions concern how legal and policy requirements for CAA services are being implemented, how effective CAAs are in fulfilling their defined role, and what factors influence effectiveness. The CAA role's identity is explored, including its relationship to other types of advocacy. Links between advocacy's form and its effectiveness in achieving various outcomes are examined.

The analysis is novel in viewing independent advocacy through the conceptual lens of liminality, doing so across two dimensions. *Acting in-between* describes CAAs' interactions with service users and local authority practitioners, as they seek to bridge gaps in involvement. *Being in-between* refers to the CAA role's indeterminate qualities. Significant technical knowledge is required of CAAs, given they must uphold rights within complex legal and procedural contexts. This creates professionalising impetus, which is shown to be in tension with other aspects of advocate identity that are linked to pursuing egalitarian partnerships with service users.

Case studies of CAA services in two local authorities were conducted, via interviews with CAAs, CAA managers, service users, social workers and a local authority commissioner. Four individuals with national-level expertise were also interviewed. Braun and Clarke's method of reflexive thematic analysis of data was applied. Five main themes were discerned: 'barriers to access'; 'defining advocacy relationships', concerning person-centred advocacy practices and limits to these; 'partnership, negotiation and challenge', about CAAs' interactions with practitioners; ‘constructing occupational identity’; and ‘developing organisational effectiveness’, regarding service structure and funding.

A critical realist approach was taken, involving exploration of the underlying causal mechanisms that help shape people’s experiences of CAA services. Blom and Morén’s CAIMeR model, which applies critical realism to social care studies in order to understand causation within complex systems, influenced the analysis. Recommendations for policy, practice and future research are presented.

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Abbreviations used

ADASS	Association of Directors of Adult Social Services
AMHP	Approved Mental Health Professional
AQPM	Advocacy Quality Performance Mark
BIA	Best Interest Assessor
BASW	British Association of Social Workers
CA2014	Care Act 2014
CAA	Care Act Advocate
CAIMeR	Context, Actors, Interventions, Mechanisms and Results (methodological model developed by Blom and Morén)
CHW	Community Health Worker (a US-based role)
CQC	Care Quality Commission
DCA	Department of Constitutional Affairs
DH	Department of Health
DHSC	Department of Health and Social Care
DoLS	Deprivation of Liberty Safeguards
DPO	Disabled People's Organisation
IFSW	International Federation of Social Workers
IMCA	Independent Mental Capacity Advocacy/ Advocate
IMHA	Independent Mental Health Advocacy/ Advocate
LGSCO	Local Government and Social Care Ombudsman
JCDMHB	Joint Committee on the Draft Mental Health Bill 2022
MCA2005	Mental Capacity Act 2005
MDT	Multi-disciplinary Team
MHA1983	Mental Health Act 1983
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
NDTi	National Development Team for Inclusion
RPR	Relevant Person's Representative

UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
SAR	Safeguarding Adults Review
SCIE	Social Care Institute for Excellence
SWE	Social Work England

Introduction

1.1. Thesis overview

England's Care Act 2014 (CA2014) introduced new rights to independent advocacy for some users of adult social care. Care Act Advocate (CAA) services are designed to aid people's involvement in care and support functions that are conducted by the local authority under the CA2014. CAAs should support the person to engage with these processes and represent them as necessary (Department of Health and Social Care (DHSC), 2024:ch.7). A person qualifies for a CAA if two criteria are met: first, they would otherwise have 'substantial difficulty' being involved in care and support processes; second, suitable informal support with involvement, from a relative or friend, is unavailable (CA2014, ss.67,68). CAA services are provided by organisations that are independent from local authorities. They are tasked with ensuring a person's 'wishes, feelings and needs' are central to assessment, care planning, review, and safeguarding processes (DHSC, 2024:7.5). CAAs should scrutinise the conduct of local authority practitioners and managers, and—when necessary—challenge them on the person's behalf, to ensure their rights are upheld and their wellbeing promoted. The CAA role is thus intended to advance promote person-centredness within the conduct of care and support processes and reflect advocacy's function as a 'social safeguard' (Morgan, 2017:2).

In this thesis, I explore CAA services via two local authority-based case studies and interviews with individuals possessing national-level expertise. My analysis is novel in its application of the concept of liminality to CAAs and their work, where this refers to a state of ambiguity arising from being in-between social groups and processes (Beech, 2011). CAAs are located in-between service users and local authority practitioners regarding conduct of care and support processes, being required to perform a 'bridging' function that facilitates participation and enhances person-centredness (Lonbay and, 2017:78). I also discuss the relationship between CAAs' abilities to connect individuals and processes and their ambiguous occupational standing (Golden and Bencherki, 2023), which involves contested notions of burgeoning professional status (Morgan, 2017). Opportunities and challenges arising from CAAs' liminal positioning are identified throughout the research, as I consider how they work 'in-between the person and the process'.

In this opening chapter, I present the rationale for my research and preview content from the thesis. First, I set out my research aims and the questions I address. I then elaborate upon this research agenda by overviewing the nature of the CAA role and its place within the care and support system that is underpinned by the CA2014. I also consider recent policy discussion that is pertinent to my research aims, personal motivations for undertaking the research, and terminological choices made. Finally, I introduce the thesis's chapter structure.

1.2. Research aims

Despite its importance, the CAA role is under-explored within scholarship. My first research aim is to address gaps in knowledge about how legal and policy requirements for CAA services are being implemented, and how effective CAAs are in fulfilling their defined purpose. I therefore contribute to addressing longstanding questions about how advocacy works and what outcomes it achieves (Henderson and Pochin, 2001). Advocacy is inherently difficult to evaluate, as advocates work within complex systems of practice; they seek to influence professionals' decision-making while lacking direct control over this (Hussein et al., 2006). It is therefore necessary to understand how CAAs interact with both service users and local authority practitioners. Moreover, evaluations must consider the direct benefits that advocacy brings alongside its effects on the conduct of statutory processes and the outcomes these engender (Townsley et al., 2009; Ridley et al., 2018; Gratsias, 2021). Key concerns are how well people feel they are supported by CAAs as they engage with care and support processes, and whether a CAA's input can influence access to sought-after care and support provision, such as through challenging the local authority if the conduct of processes has fallen short. Therefore, my research agenda also involves seeking more general insight into the nature of the English adult social care system, including opportunities for redress regarding official decision-making. Moreover, given previous evidence of gaps in access to advocacy (e.g. Lonbay and Brandon, 2017; Dixon et al., 2020;

Newbigging et al., 2015, 2021), a crucial step before considering potential benefits from CAA involvement is whether eligible people can access this service to begin with.

My second research aim is to critically assess CAA provision in its wider context, locating it within a diverse advocacy landscape and exploring its character as an occupational role. The two research aims are intertwined: longstanding questions exist about the relationship between the form advocacy services take and their effectiveness (Henderson and Pochin, 2001; Rapaport et al., 2006). The introduction of statutory roles, of which CAA is the latest, has sharpened contention about the merits of advocacy assuming a more professionalised character. While professionalism arguably aligns with discharging the quasi-legal function that independent advocates are accorded by statutory roles, it may compromise maintaining a more informal, grassroots identity that prioritises community engagement and longer-term relationship building with service users (Morgan, 2017). Questions about service design have profound real-world consequences: for advocacy services and people using them; for practitioners making referrals and working alongside advocates; and for those making policy and funding decisions (Forbat and Atkinson, 2005; Rapaport et al., 2006; Macadam et al., 2014; Lonbay and Brandon, 2017). This work seeks to generate knowledge that will be useful in the context of recent policy discussion about the quality and effectiveness of independent advocacy roles, and how they should be developed (DHSC, 2021a; National Institute for Health and Care Excellence (NICE)(2022); Equalities and Human Rights Commission (EHRC), 2023).

1.3. Research questions

From my research aims, I have developed the following questions to guide my enquiry:

1. How have requirements for independent advocacy under the CA2014 been translated into practice?
2. What factors influence CAAs' effectiveness, and how?
3. What is the nature and identity of the occupational role undertaken by CAAs?
4. How do CAA services relate to other types of advocacy?

I now lay some groundwork for addressing these questions, detailing key requirements for CAA services that arise from law and policy.

1.4. The CA2014 and new advocacy rights

1.4.1. Overview of the CA2014

The CA2014, introduced by the Conservative–Liberal Democrat Coalition government, was hailed by the responsible minister as ‘the most significant reform of care and support in more than 60 years’ (Lamb, 2014:online). It is a law with consolidating and reforming aspects (Burn et al., 2024). Replacing a raft of previous legislation, the CA2014 established a codified legal framework for local authorities’ conduct of care and support functions, ranging from work with individuals to strategic planning (Brammer, 2020). Its statutory guiding principles include a ‘general duty’ on local authorities to act concertedly to promote individual wellbeing (CA2014, s.1), which had been lacking from previous legislation (Barnes et al., 2017). More specifically, the CA2014 governs such responsibilities as how local authorities should make initial contacts with individuals, how they should assess their needs, and how they should arrange and charge for services (DHSC, 2024). It introduced national eligibility criteria for care and support; made local authorities legally responsible for conducting safeguarding enquiries into suspected abuse or neglect; and granted new rights to informal carers (Brammer, 2020; Fernández et al., 2020). The CA2014 also mandated personal budgets within care and support planning, a policy associated with the ‘personalisation’ agenda (Tarrant, 2020). Local authorities’ role as service commissioners was further embedded, with the legislation giving them responsibilities to ‘shape’ local care markets and ensure preventative services are available (Burn et al., 2024). Local authorities also became required to promote integration and co-operation between social care and other local services, including healthcare (DHSC, 2024, ch.15).

1.4.2. CAA: expanding the reach of statutory advocacy

Another innovation of the CA2014 was establishing the CAA role, which became operational when the law was implemented from April 2015. CAAs’ work is legally underpinned by the

CA2014 (ss.67,68) and accompanying Care and Support (Independent Advocacy Support) Regulations (No.2) 2014. The *Care and support statutory guidance* (DHSC, 2024) explains how the CA2014 should be interpreted in practice, with chapter seven focusing on independent advocacy. Local authorities must follow this guidance, unless they identify 'legally sound reasons' otherwise (DH, 2014b:3). Much of the following overview is based upon the statutory guidance, which Tarrant (2020:11) suggests 'exists somewhere between law and policy'.

The CA2014 markedly expanded statutory advocacy rights beyond those established by the Mental Capacity Act 2005 (MCA2005) and Mental Health Act 1983 (as amended 2007) (MHA1983). These laws created the roles of Independent Mental Capacity Advocate (IMCA) and Independent Mental Health Advocate (IMHA) respectively. IMCAs and IMHAs offer advocacy protections regarding specific legal interventions that can involve profound intrusion upon individual autonomy and liberty (Newbigging and Ridley, 2018). The CA2014 added independent advocacy rights over involvement in all care and support functions conducted by local authorities. However, rights of access to a CAA remain restricted by legal eligibility criteria, regarding 'substantial difficulty' and absence of 'appropriate' informal support (Dixon et al., 2020). The Government's impact assessment for the CA2014 estimated only 10% of people having an assessment or review would not have friends or relatives who could support their involvement, with around 70% of eligible individuals then expected to accept an offer of independent advocacy (Department of Health (DH), 2014a:55).

Eligibility for engaging a CAA is the same regardless of which CA2014 process support is needed with (DHSC, 2024:7.19). For adult service users, these processes are assessment of needs; planning care and support to meet needs; reviews of plans; and safeguarding enquiries and safeguarding plan reviews. For example, an older person who experiences memory and mobility problems, and who requires assistance with personal care and meal preparation, might be supported by a CAA to be involved in their needs assessment and subsequently in arranging a care and support plan that includes domiciliary care calls. Unpaid carers may be eligible for a CAA, regarding assessment of their support needs as carers, support planning, and support plan reviews. Some young people aged under 18 also qualify for a CAA, either as service users or carers. This arises when CA2014 processes are activated while planning their transition from children’s to adult social care (DHSC, 2024:ch.16). In this thesis, I use the term ‘service user’ predominantly in the sense of a person accessing CAA services, meaning their use of advocacy could relate to their informal caring role. However, I focus mainly on CAAs’ involvement with adults with care and support needs, reflecting the main balance of CAA service use in the case studies. I return later to reflecting on terminological choices made.

Requirements for independent advocacy are tied to the general duty the CA2014 imposes on local authorities to involve people in decisions about their care and support (DHSC, 2024:7.6-69). Such involvement can be empowering, enabling people to exercise personal agency over important matters in their lives (Lonbay, 2015), with the term ‘empowerment’ signifying a redistribution of power to individuals and groups experiencing oppression (Payne, 2014). Commitment to empowerment is enshrined in the *Advocacy Charter*, a statement of principles for advocacy providers (National Development Team for Inclusion (NDTi), 2018). This charter was originally produced in 2002 by Action for Advocacy and subsequently revised under the lead of NDTi, an organisation that supports the advocacy sector (Advocacy Quality Performance Mark (AQPM), 2014a; NDTi, no date).

Statutory guidance states that people should be ‘active partners’ within care and support processes (DHSC, 2024:7.6), with the local authority considering their potential to contribute to, participate in, and direct these processes. Potential for different levels of involvement is thus acknowledged (Lonbay, 2015). Even when the person cannot provide direction, due to a cognitive impairment or other factors, local authorities are required to ensure that processes and outcomes are ‘person-centred and person-led’ (DHSC, 2024:10.5). The statutory guidance states:

> No matter how complex a person’s needs, local authorities are required to involve people, to help them express their wishes and feelings, to support them to weigh up options, and to make their own decisions (DHSC, 2024:7.6).

CAAs therefore share responsibility with local authority practitioners to act as agents of service user involvement (Lonbay and Brandon, 2017). CAAs are expected to facilitate supported decision-making, which rejects paternalism in favour of enabling disabled people to overcome barriers to exercising choice and control in their lives (Newbigging et al., 2021; Dixon et al., 2020).

1.4.3. Advocacy, wellbeing and involvement

Local authorities' responsibility to promote involvement is strongly linked to their paramount duty, under s.1 of the CA2014, to advance individual wellbeing. By facilitating involvement, independent advocacy therefore contributes to fulfilling the wellbeing duty, and while the link between advocacy and wellbeing is not addressed in depth within the statutory guidance, some key connections are made. The guidance acknowledges wellbeing to be a 'broad concept' (DHSC, 2024:1.5), although s.1(2) of the CA2014 lists nine overarching areas that wellbeing must be considered in relation to, including personal dignity; and physical and mental health and emotional wellbeing (see full list in appendix A). It is therefore stated in the CA2014, s.1(3) that wellbeing must be determined on an individual basis: according to the person's circumstances; their own 'views, wishes, feelings and beliefs' (s.1(3)(b)); and their participation in processes to the fullest extent possible. Also given statutory weight is the assumption that the person is 'best placed to judge' their own wellbeing (s.1(3)(a)). CAAs are tasked with helping to ensure all these criteria are satisfied, with the statutory guidance confirming they must always have regard to the wellbeing and interests of the person they are advocating with (7.46). The CAA's role in supporting a person undergoing safeguarding processes (see 7.49) is clearly linked, for example, to aspects of wellbeing involving 'protection from abuse and neglect' (CA2014, s.1(2)(c)). Moreover, as will be discussed below in section 1.7, a CAA acting as the person's representative must challenge the local authority if they believe it is not complying with its wellbeing duties (7.51).

Critique of how these aspirations regarding wellbeing are being implemented is highly pertinent to understanding CAAs' function and the contexts they operate within. Tarrant

(2024:472) argues that the wellbeing principle is central to the CA2014's 'progressive potential', whereby judicial rulings have underscored its importance regarding upholding principles of personal agency, autonomy and expression of unique personhood. These principles interface with rights to independent and autonomous living, as established by the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which the UK became signatory to in 2009, and which is discussed further in the next chapter. However, sufficient resources must be available to actualise the wellbeing principle, which have been lacking to date (Tarrant, 2019). Slasberg and Beresford (2014) highlight similar concerns about translating the CA2014's wellbeing aspirations into reality, as local authorities retained ultimate powers to determine assessed needs, and the statutory guidance does not stipulate how they should balance requirements to meet eligible needs with requirements to adhere to budgetary constraints. Tarrant (2019) and Slasberg and Beresford (2014) each discern gaps between the limited rights that exist under the CA2014 and the more expansive ones regarding citizenship and independent living proclaimed under the UNCRPD. How CAAs address such gaps between promise and reality is a key concern of this thesis. This is especially important as wellbeing has, as Stanley (2016) argues, both human rights and asset-based aspects. The latter concerns the material and emotional resources available to individuals, and the relational and psychosocial aspects of wellbeing (Stanley, 2016). This thesis therefore considers how CAAs advance wellbeing by promoting access to community engagement, alongside exercise of advocacy's broader function as an agent for social inclusion in its own right.

1.5. Access to CAA

Local authority practitioners are tasked with determining whether a person requires CAA support, applying legal eligibility criteria that are expounded upon in statutory guidance (DHSC, 2024:7.29, 7.4-7.42). It is therefore crucial to understand how well practitioners enable CAA access for qualifying individuals (Lonbay and Brandon, 2017; Dixon et al., 2020; Lawson and Petty, 2020). This also raises issues of power regarding access to CAAs, making this subject to professional judgement and inviting questions about the ability of disabled people to seek out advocacy support.

Judgements about ‘substantial difficulty’ concern the person’s functional ability to be involved in care and support processes (CA2014, s.67(4); DHSC, 2024:7.10-16). A determination of substantial difficulty does not require formal diagnosis with a condition causing cognitive impairment, such as dementia, however the local authority must ‘have regard to’ relevant diagnoses, and whether the person is at safeguarding risk ((Independent Advocacy Support) Regulations, s.3). ‘Substantial difficulty’ is effectively a lower threshold for receiving advocacy input than that of lacking capacity to make a decision under the MCA2005, which applies to accessing an IMCA (DHSC, 2024:7.64). This highlights another way in which the CA2014 extended advocacy rights.

According to the CA2014, s.67(5), there is no requirement to provide CAA to someone who already has an ‘appropriate person’ to provide support and representation to facilitate their involvement in processes (statutory guidance uses this term interchangeably with ‘appropriate individual’, as I will now use for clarity). An appropriate individual cannot be providing care or treatment to the person on a paid basis. The law further states that the person must consent to the appropriate individual’s input; or, if the person lacks capacity or is otherwise unable to give consent, the local authority practitioner must determine that the appropriate individual’s support is in the person’s best interests (s.67(6)). The statutory guidance provides further grounds for determining the appropriateness of a friend or relative to act in place of an independent advocate (DHSC, 2024:7.33-7.40, subsequent section number references are from this statutory guidance). There may also be ‘appropriate persons’/individuals if more than one friend or relative meets these criteria (e.g. 7.39). An appropriate individual must be able to facilitate the person’s involvement in local authority processes, such as by explaining to them why a practitioner is assessing their needs. The appropriate individual must have a sufficient level of contact with the person and be able themselves to understand CA2014 processes. They must also be free of conflicts of interest and not present a safeguarding concern. Limited circumstances also exist where a person can qualify for a CAA even if an appropriate individual is available. Among these are disputes between the local authority and appropriate individual, when both agree involving a CAA would benefit the person (7.42)

Early in the CA2014's implementation, *R (SG) v London Borough of Haringey [2015]* provided case law underscoring the importance of ensuring appropriate access to CAAs. Haringey's assessment of the social care needs of SG, a woman seeking asylum, was quashed because of a lack of independent advocacy support (Dixon et al., 2020). The judge described this a 'paradigm case' of a CAA being needed, 'as in the absence of one the claimant was in no position to influence matters' (Schraer, 2015:online).

The importance of ensuring rightful access to a CAA was also tragically highlighted by the findings of a statutory safeguarding review concerning 'Jo-Jo', a woman with Down's Syndrome who died in circumstances of severe neglect (Winter, 2019). Professionals had not involved a CAA to help Jo-Jo's 'voice' be heard and had instead looked to Jo-Jo's mother to advocate for her, despite her mother being unable to do this 'fully' (Winter, 2019:36). These findings resonate with stipulations that functional ability to facilitate involvement is essential for appropriate individual status, and 'It is not sufficient to know the person well or to love them deeply' (DHSC, 2024:7.5).

1.6. CAAs and the advocacy landscape

Local authorities commission CAA services from advocacy organisations located in the third, or non-profitmaking sector (Newbigging et al., 2021). Organisational separation from the local authority is intended to permit CAAs to work unequivocally to promote service users' wishes and interests (DHSC, 2024:7.43-5). CAA, IMCA and IMHA roles all interface in various ways, whereby a person's entitlement to advocacy can shift between statutory remits according to their needs and circumstances (Dixon et al., 2020). Connections between CAA and IMCA roles are especially strong, as the latter support with making decisions about accommodation moves for people lacking relevant mental capacity, with such moves often involving CA2014 processes (DHSC, 2024:7.63-66). The statutory guidance therefore encourages 'seamless advocacy', where a single advocate can act as both CAA and IMCA to a person (7.9).

The statutory guidance also draws attention to links between CAA services and a broader advocacy conception that transcends legal requirements. Local authorities are expected to build upon existing advocacy resources in their area when commissioning CAA services (DHSC, 2024:7.62). The statutory guidance also quotes from the influential definition of advocacy contained in the *Advocacy charter* (DHSC, 2024:3.9)[1]. This states:

> Advocacy is taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice. (NDTi, 2018:online)

Advocacy is thus an expansive concept, manifested in heterogenous forms of practice (Hardwick, 2018; Dixon et al., 2020). Varied types of non-statutory advocacy exist, often with a grassroots focus, which are sometimes collectively referred to as 'community advocacy' (Joint Committee on the Draft Mental Health Bill, 2023:90). One type is citizen advocacy, where volunteers form enduring advocacy partnerships with people (Hardwick, 2018). Some approaches have roots in self-advocacy movements among disabled people (Newbigging et al., 2021).

In this thesis, I examine how CAAs seek to translate core advocacy principles, such as those enshrined in the *Advocacy charter*, into practice and I explore how their role relates to other forms of advocacy, statutory and non-statutory. I thus consider what crossover points exist between CAA and IMCA and IMHA roles, and what the occupational and organisational implications of these are. I also consider the strength of links between CAA services and community advocacy, which generally seeks to counter social marginalisation (Hardwick, 2018). In doing so, I explore contested notions of formalisation and professionalisation within advocacy services (Morgan, 2017; Hardwick, 2018). Statutory guidance declares CAA to be a 'responsible position' (DHSC, 2024:7.48), and alongside other statutory advocacy roles it has a developing occupational infrastructure. CAAs are required to be competent, appropriately experienced, and supported by training and supervision; they are also

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[1] The statutory guidance's quotation from the definition in the *Advocacy Charter* is partial and unattributed (DHSC, 2024:3.9; NDTi, 2018).

expected to pursue the vocational National Qualification in Independent Advocacy (7.43). I address questions about compliance in these areas.

In exploring CAA services, I start from the premise that advocacy encompasses a cluster of liberatory practices that strive to advance the rights and interests of individuals or groups experiencing oppression, especially the right to be heard (Payne, 2014; Newbigging and Ridley, 2018). Integral is the notion of individual and community voice, also the breaking down barriers not only to expression but to comprehension and acceptance, such as around a person's needs and wishes in a social care context. Statutory guidance states that 'high quality advocacy services' are 'essential for people to have their voices heard' (DHSC, 2024:7.44). Here 'voice' may be metaphorical, given that many users of advocacy services do not communicate verbally. This is significant given the attention in this thesis to 'non-instructed' forms of advocacy, where the advocate uses various methods to learn about the person being advocated for so they can represent them effectively, as the person cannot directly 'tell' their advocate or decision-makers what they want (Lee-Foster, 2010; Series, 2013). It is also important to take a nuanced view of what 'voice' entails. Following Newbigging and Ridley (2018), I discuss how voice relates to the ethics of knowing, via Fricker's (2007) theory of epistemic injustice. There are two dimensions of such injustice: first, where the person's communication is disregarded; and second, where the person is deprived of the discursive resources to make sense of their situation and express it to others (Fricker, 2007). Addressing these differing forms of epistemic injustice is potentially cross-cutting with whether advocacy is channelled into working with individuals in a case-oriented, 'transactional' way that seeks advancement within existing service and societal structures; or whether it has potentially more 'transformative' goals (Ridley et al., 2018), such as when undertaken at collective level for mutual empowerment or in service of a 'cause' (Payne, 2014). The emphasis of this thesis is on individualised case advocacy, as CAA is configured in this format (Dixon et al., 2020). However, this should not be seen as overlooking the importance of other forms of advocacy, and I discuss the boundaries between case-oriented CAA practice and other expressions of advocacy, as in discussions about the development of alliances between mainstream advocacy services and culturally-focused organisations. In the next chapter, I discuss some different models of advocacy in more depth, further relating them to this conceptual base.

According to Ybema et al. (2009), identity concerns how individuals construct a sense of self as they navigate their place in the world; it encompasses how they are perceived by others and how this feeds back into self-conception and presentation. Identities are thus dynamic and constructed relationally. I explore CAAs' identity within the context of the care and support system and the wider advocacy landscape. This emphasises the importance of understanding how the boundaries of CAA identities are set in relation to adjacent roles (see Heiss et al., 2018), and the implications of this for work with service users.

1.7. Support, representation and challenge

CAAs have a wide-ranging role that demands flexibility (DHSC, 2024:7.46-66). They may have to spend significant time with a person and be creative in how they engage with them. Their work also requires sensitivity, as when supporting potentially distressed people through safeguarding processes (7.28). CAAs are expected to help people understand processes and their rights relating to these, assist them to articulate their wishes and perspectives, and support them in making decisions. Practitioners must take 'reasonable steps' to assist CAAs, such as by informing them of meetings and ensuring their access to appropriate information (7.56). Whether professionals permit such co-ordination in practice has been a key question for advocacy research more generally (Lonbay and Brandon, 2017; Sherwood-Johnson, 2016).

Statutory guidance draws a partial distinction between the supportive and representative aspects of the CAA role (DHSC, 2024:7.50-52). The representative component comes to the fore when a person, even with assistance, is unable to make decisions about their care and support, or to communicate their wishes to decision-makers. The CAA must then ''advocate' on their behalf' (7.52). This demonstrates how CAAs work at a key point of intersection between the CA2014 and MCA2005. When a person lacks mental capacity regarding a care and support decision, the CAA should feed into the process whereby a practitioner makes a decision on the person's behalf, in their best interests, under the MCA2005, s.4. The CAA is also tasked with scrutinising the practitioner's decision-making conduct to ensure the person's rights are upheld, including ensuring the 'least restrictive' option for delivering a care and support intervention is always considered (DHSC, 2024:10.49-10.54,10.59-10.72). This reflects advocacy's basis in human rights (Dixon et al., 2020; Newbigging et al., 2021).

CAAs should contribute to ensuring a bespoke care and support plan is crafted for the person, helping them understand their options for this (DHSC, 2024:7.48). The CAA role thus relates to wider aspirations under the CA2014 to bolster people's exercise of choice and control, including by developing more personalised provision (4.46). Mandatory personal budgets are intended as one mechanism for achieving this, increasing transparency by quantifying the theoretical cost to the local authority of meeting eligible needs (Needham et al., 2018). CAA is also aligned with the 'making safeguarding personal' agenda (DHSC, 2024:14.15; Lawson and Petty, 2020). This opposes rigid and paternalistic approaches to adult protection that had previously been common, instead emphasising the need to follow the person's own wishes regarding their safeguarding wherever possible (Manthorpe et al., 2014).

CAAs are expected to challenge local authorities when needed, although how this should happen depends on the person's ability to direct proceedings (DHSC, 2024:7.50-52). CAAs must support a person who wishes to challenge the local authority regarding the conduct or outcome of CA2014 processes. A CAA working as the person's representative must also challenge any local authority decision which they believe contravenes the statutory responsibility to advance wellbeing. In the next chapter I discuss further why this challenge function is needed and how it is enacted.

CAAs' interactions with local authority practitioners are thus profoundly important. Practitioners include social workers, who have particular professional responsibilities regarding conducting CA2014 processes, especially those of heightened sensitivity and complexity such as safeguarding (Whittington, 2016). Advocacy is also part of social workers' own skillset and identity (Wilks, 2012; Social Work England, 2020; International Federation of Social Workers (IFSW), 2014). I will show that CAAs' and social workers' dual claims to legitimacy in advocating for people adds another layer of complexity to their interactions.

1.8. Current policy and practice developments

1.8.1. Focus on advocacy quality

The significance of my research aims is underscored by recent policy literature concerning advocacy services, which raises questions about their quality and effectiveness. Wide-ranging guidelines for independent advocacy, produced by the National Institute for Health and Care Excellence (NICE), acknowledge 'a need to standardise good practice' (NICE, 2022:82). The guidelines establish recommendations for different stakeholder groups, principally leaders of advocacy services, individual advocates, service commissioners, and health and social care practitioners.

An inquiry report by the Equalities and Human Rights Commission (EHRC) raises questions about the effectiveness of independent advocacy services in mounting necessary challenges to care and support decisions made by local authorities in England and Wales (EHRC, 2023). It identifies concerns about access to advocacy and whether advocacy providers always assert sufficient independence from local authorities. The latter involves a potential conflict of interest, where advocacy organisations must scrutinise and hold local authorities to account, while also relying on them for funding (EHRC, 2023).

Advocacy effectiveness was also addressed in the government's white paper on *Reforming the Mental Health Act* (DHSC, 2021a). This specifically addresses advocacy in the context of mental health services, yet it mentions linkages with CAA services (DHSC, 2021a:130) and poses questions for the wider advocacy sector. The white paper refers to 'conflicting views' among stakeholders about the quality of advocacy services (54), highlighting particular areas of concern including whether sufficiently specialised provision for people with learning disabilities and autistic people is available. It also identifies needs for 'culturally appropriate advocacy' (92), whereby existing advocacy services are often insufficiently attuned to the needs and perspectives of ethnically minoritised people. Culturally appropriate advocacy is linked to a wider agenda for redressing systemic racial inequity within mental health provision, as reflected in the severely disproportionate level at which people of Black African and Caribbean descent are detained under the MHA1983 (DHSC, 2021a).

Reforming the Mental Health Act also links questions about advocacy quality to those concerning role formation, identifying potential trade-offs over occupational development (DHSC, 2021a:54-55). The government asks whether further formalising advocacy roles might enhance their effectiveness. Increased regulatory oversight of advocacy services and steps to 'professionalise' roles via enhanced accreditation, such as by introducing a registration requirement, are mooted as possible steps. Yet risks are acknowledged that such initiatives might undercut the value that advocacy derives from more informal status. This includes being relatable to people and allowing for smaller, more tailored advocacy services, such as those that might specialise with cultural communities (DHSC, 2021a). These discussions accentuate the unique character and position of advocacy services within the adult social care ecosystem. For example, advocacy organisations are not regulated by the Care Quality Commission (CQC), as providers of care and support services are (CQC, 2022).

Reforming the Mental Health Act was followed by the Draft Mental Health Bill 2022, although the Conservative government subsequently dropped this prospective legislation from its parliamentary programme (Samuel, 2023a). However, the Labour government elected in July 2024 has pledged to legislate in this area (Labour Party, 2024), underscoring the importance of examining issues around potential reforms to independent advocate roles and service configurations.

1.8.2. Systemic pressures in adult social care

Questions about the quality and effectiveness of independent advocacy come into even sharper relief via the surrounding context of acute stress on the English adult social care system. The CA2014 was introduced against a backdrop of public sector austerity pursued by the Coalition and subsequent Conservative governments (Jones, 2020). Adult social care spending fell in real-terms between 2009 and 2016, despite rises in overall needs and the implementation costs of the new law (Burn and Needham, 2021). These cuts came amid enduring political indecision over securing a long-term funding settlement for adult social care, necessary to address persistent resourcing shortfalls (Burn et al., 2024).

Multiple systemic issues were intensified by the Covid-19 pandemic, including unmet care and support needs; deficiencies in service quality; unwarranted variations between localities; poor co-ordination with health services; and problems recruiting and retaining an adequate workforce (Bottery, 2020). The Association of Directors of Adult Social Services (ADASS) has since reported continued large backlogs affecting assessments and service provision, with many unpaid carers experiencing crisis (ADASS, 2023). A review of complaints against local authorities by the then Social Care Ombudsman discerned that 'a common theme is councils failing to provide care, or limiting it, and justifying this because of the cost' (Local Government and Social Care Ombudsman (LGSCO), 2022:online). It is therefore vital to consider how well CAAs can stand up for people's interests against resource-driven pressures undermining wellbeing (Whittington, 2016). It is also necessary to examine the effects of local authority resource shortages on CAA services themselves, given their reliance on this funding source (Newbigging et al., 2021).

1.9. Methodological approach

This thesis is underpinned by a critical realist philosophical approach, which looks to identify causal mechanisms that shape events and phenomena in the social world (Porpora, 2015). I also draw on realist evaluation, a related methodology for studying the implementation of social interventions in real-world circumstances, which emphasises the contingent nature of individual outcomes (Pawson, 2013). This thesis thus takes up a challenge posed by Ridley at al. (2018:290), of using realist approaches to study mechanisms that produce 'multi-layered and complex' advocacy outcomes. My approach is especially indebted to realist methodological work by Blom and Morén (2010, 2011), whose CAIMeR model has specific application to social care studies. This directs attention towards the interactions of practitioners, service users and other key actors within micro-systems of practice. These are surrounded and influenced by intermediate-level structures such as institutional arrangements; all are nested within and shaped by overarching societal structures.

I consider causal mechanisms operating across two analytical dimensions, which relate to CAAs' liminal positionality: *acting in-between* and *being in-between*. The former refers to CAAs' bridging function within practice systems, the latter to indeterminacy in their role construction. Taking a theoretical lead from Golden and Bencherki (2023), I draw connections between these two liminal domains. Acting in-between thus entails fusing technical knowledge about the adult social care system with relational skill in engaging with service users (see Rennstam and Ashcraft, 2014). Such blending of knowledge practices can lead to unsettled occupational status (Golden and Bencherki, 2023), as evidenced by tensions over professionalised versus grassroots conceptions of advocate identity (Morgan, 2017; DHSC, 2021a).

I conducted case studies of CAA services in two local authorities, comprising interviews with individuals from various stakeholder cohorts: CAAs and their managers; social workers; people with lived experience of using advocacy services; and a local authority commissioning manager. I also obtained a broader perspective by interviewing four individuals with national-level expertise relating to CAAs' role. Five overarching themes were identified via thematic analysis of the data (Braun and Clarke, 2022), with these used to structure the reporting and discussion of findings.

1.10. Impact of Covid-19

This study was conceived before the Covid-19 pandemic, but it has been significantly affected by it. The pandemic had a profound impact upon advocacy (NDTi, 2020; ADASS, 2020). There was evidence of suppressed levels of referral to statutory advocacy during the first national lockdown from March 2020, despite legal entitlements to advocacy being maintained throughout the pandemic (NDTi, 2020). Moreover, many people's advocacy needs increased during this time, due to diminished access to informal support and heightened restrictions upon their liberty, especially in settings such as residential care. Public health measures sometimes posed barriers to advocates making in-person contact with service users; there were also concerns some service providers were unduly impeding access (NDTi, 2020; ADASS, 2020). The pandemic period also saw heightened awareness of forms of structural oppression, demonstrated by the Black Lives Matter movement for racial justice. This highlighted the importance of embedding anti-discrimination within advocacy services (ADASS, 2020).

I collected data between October 2021 and August 2022, after national lockdowns ended, yet while Covid-19 continued to disrupt adult social care and beyond. The pandemic led to delays in data collection and contributed to difficulties in recruiting participants. My study is based on a relatively brief timeframe that saw changes to public health policy. This was reflected in the UK government's publication of its plan for 'living with Covid-19' in February 2022 (UK Government, 2022:online). The data collected indicated the pandemic's most acute effects on CAA services were receding, while some responses persisted, including CAAs regularly working from home and wearing face coverings when meeting service users. I consider such impacts at various points in my analysis. However, my study lacks the temporal lens necessary for a full assessment of the pandemic's effects on CAA services, including how lasting some changes will prove.

1.11. Inspirations for the research

My interest in this area was generated by my experiences as a social work practitioner. Overall, I had positive interactions with CAAs and observed them making important contributions to involving the person in care and support processes. One such instance involved creating a safeguarding plan with an older woman regarding protecting her from financial abuse; the CAA helped ensure detailed arrangements were agreed with the woman, via conducting a series of meetings to go through her options (see DHSC, 2024:7.49). However, as a local authority practitioner, I also found some aspects of CAA more problematic, especially regarding my responsibility to determine people's eligibility for it. Difficulties could be pronounced when considering the 'appropriateness' of a person's family member to advocate for them informally. Sometimes it was the person's first contact with the adult social care department, meaning a family member's appropriateness had to be judged with minimal background information. Moreover, pressure to form judgements about close relationships was accompanied by competing imperatives—including to build rapport with the person needing support and with those same members of their immediate network—all while addressing the pressing wellbeing issues that had prompted social work involvement.

I was aware of complexity in relationships between social workers and CAAs. I was accustomed to inter-professional tensions arising from differing disciplinary perspectives and organisational agendas, as when working with healthcare colleagues. However, these relationships were mediated via mutual recognition of professional status, signifying degrees of expertise within our respective fields of practice. Interactions with CAAs entailed a different dynamic, as advocates are not expected to advance their own views, only those of the person, and they must be prepared to challenge practitioners on the person's behalf (Hardwick, 2014). I was cognisant of some social work colleagues having conflictual interactions with CAAs. Conversations suggested that some colleagues experienced dissonance between their identity as social worker advocates and experiences of being challenges by CAAs.

These practice observations found echo in some literature reviewed and data collected for this thesis, allowing me to explore the issues in depth. A key aim for the work has been to generate valuable knowledge for stakeholders, including those in positions across the independent advocacy sector, local authority practitioners, service commissioners, self-advocates and policymakers. I conclude the thesis by presenting recommendations for policy, practice and further research.

1.12. Terminology

I now explain some choices of terminology used in this thesis.

1.12.1. Care Act Advocate

Use of 'Care Act Advocate' (CAA) is not straightforward, as it does not feature in the CA2014 or statutory guidance (DHSC, 2024), which refer only to 'independent advocacy' and the role of 'independent advocate'. Conversely, the positions of IMCA and IMHA are explicitly named in legislation, albeit non-abbreviated (MCA2005, s.35; MHA2007, s.30). Naming issues over CAAs are mentioned in a working paper by Newbigging et al. (2017) about the early phases of commissioning independent advocacy under the CA2014. This shows differing interpretations of legal and policy requirements were evident at an early stage, as with other aspects of implementing the CA2014 (Burn and Needham, 2021). Newbigging et al. (2017:6) found some local authority commissioners referring to 'Independent Care Act Advocacy' (ICAA), casting this as a distinct statutory service akin to those provided by IMCAs and IMHAs. Yet this terminology was absent in other local authorities, where commissioners saw scope to fulfil the new independent advocacy duties via pre-existing services, with a specific 'Care Act' advocacy service yet to be commissioned (Newbigging et al., 2017). The non-specific reference to 'independent advocacy' in the CA2014 also seems consistent with the government's response to a report from the Law Commission (2011) that preceded the legislation. Regarding introducing new advocacy requirements, the government stated: 'it is not our intention to require local authorities to provide a specific service, but rather to focus on meeting the needs of individuals' (DH, 2012:55). These terminological considerations thus point to bigger questions about the nature of the CAA role and its relationship with other types of advocacy, which I explore throughout this thesis.

In referring to those providing independent advocacy under the CA2014 as Care Act Advocates, I reflect this label's widespread adoption in practice (e.g., Voiceability, no date; Embrace Wigan & Leigh, 2022), including its use by participants in my research. Some services do however employ 'Independent Care Act Advocacy' as an alternative (e.g. Advocacy Focus, 2023). 'Care Act Advocacy' is also used in some scholarship (e.g. Lonbay and Brandon, 2017; Newbigging et al., 2021; Gratsias, 2021). The term aids differentiation from other forms of independent advocacy. My use of it also reflects how, in the case study sites at least, CAA provision was configured as a targeted statutory service.

A single advocate will often be employed to work as a CAA *and* as an IMCA or IMHA, or in all three roles (see DHSC, 2023:7.9). This potentially makes CAAs' role part of a broader independent advocate occupation and identity. However, there are inconsistencies in arrangements for combining statutory advocacy duties, as I will discuss. Therefore, I refer to CAA as a singular role, unless I am specifically addressing independent advocates working in this combined way.

1.12.2. People being advocated for/with

I take a somewhat flexible approach to referring to recipients of CAA services. I mostly refer to the 'person' or the 'individual', following the statutory guidance (DHSC, 2024). However, I sometimes use the term 'service user', mainly where context suggests a need for more precision. Here, I am following widespread usage of this term in adult social care (McLaughlin, 2009), and it features in some scholarship about statutory advocacy (Dixon et al., 2020; Newbigging et al., 2021). Nevertheless, like all terminology, there are problems associated with 'service user' (McLaughlin, 2009). Banks (2021) notes its reductive nature, as it defines people via their service use, with this being additionally problematic when a person does not receive a service to which they are entitled. This issue is highly relevant to CAA services, as I will show.

Some advocacy scholarship refers to the person being advocated with as a ‘partner’ (e.g., Sherwood-Johnson, 2016; Forbat and Atkinson, 2005; Hardwick, 2018). This term is especially associated with citizen advocacy (Henderson and Pochin, 2001). ‘Partner’ was not used by the CAAs interviewed for this study, among whom the terms ‘service user’, ‘citizen’ and ‘client’ were variously favoured. ‘Citizen’, which infers rights-based notions of social citizenship (Rummery, 2023), was commonly used in a case study site. ‘Clients’ features in the *Advocacy code of practice* (AQPM, 2014) and was once common currency among UK social workers, although its use has latterly been criticised for implying a hierarchical relationship that valorises the service-giver’s expertise (McLaughlin, 2009). These language variations therefore suggest differences in advocates’ role conception, along with broader terminological shifts in adult social care.

1.12.3. Other terminology

I mainly refer to workers conducting processes on behalf of local authorities as ‘practitioners’. Social workers are the principal professional group fulfilling care and support functions under the CA2014 (Whittington, 2016), although many processes are also conducted by staff without a professional designation (Symonds et al., 2018). I refer to social workers specifically at various points: this variously reflects participants’ language, the coverage of scholarship cited, and instances of direct comparison and contrast between CAAs’ and social workers’ roles and identities.

I refer to ‘friends and relatives’, or variations on this, as an encompassing term for members of a person’s social network, including intimate partners. Often members of a person’s network may act as informal carers, providing emotional or practical support to them (see CA2014, s.10(11)), but this is not necessarily the case. In referring to ‘friends and relatives’ in this inclusive way, I am not making inferences about the character of relationships, including emotional closeness and frequency of contact. I will discuss how these relationship factors become acute when determinations are being made over whether an ‘appropriate individual’ is available. I considered alternative, briefer terms to refer to important members of the person’s social network, including ‘close ones’ and ‘significant others’, but these imply a proximity of relationship that may not apply.

I take a broadly intersectional perspective. This involves recognising that an individual’s social location is determined by multiple, cross-cutting aspects of identity, and that combinations of social factors can shape experiences of power and oppression (Martinez Dy et al., 2014; Hankivsky and Jordan-Zachery (2014). Within this context I sometimes refer to ‘groups’ of service users. Such categorisation mainly reflects service use, such as related to experience of a particular condition, form of impairment, or stage of the life-course—what Carey (2019:42) terms ‘impairment groups’. I therefore use ‘groups’ in an analytical sense, such as to help answer questions about whether specialist advocacy services are needed, including for people with dementia (Dixon et al., 2020) and people with learning disabilities and autistic people living in highly restrictive settings (Mercer and Petty, 2020). As Wilks (2012) notes, caution is needed as such language may seem at odds with person-centredness: there is great diversity within groups, membership of different impairments groups can intersect, and these designations combine with other social identities. Yet terminology about groups retains analytic value (Wilks, 2012).

Some of the language used to refer to service users is contested. A key distinction is between ‘person-first’ and ‘identity-first’ language, where language preferences can vary between people affected by different forms of condition or impairment, and between individuals within these groups (Grech et al., 2023). I take a mixed approach, and my choice of particular terms is not a rejection of the validity of alternatives. My use of ‘disabled people’ aligns with a social model approach, which is discussed in the next chapter (Shakespeare, 2013). However, my use of ‘person/people with learning disabilities’ reflects common usage in the UK, although ‘person/people with intellectual disabilities’ is favoured in some other countries (Jarrett and Tilley, 2022). There is no consensus about how to discuss autism. I refer to ‘autistic person/autistic people’, which is terminology favoured by some activists within the autism community, where autism is seen as an aspect of the person’s identity rather than a negative condition that is separate from them (Keating et al., 2022). The resulting terminology of ‘people with learning disabilities and autistic people’ also features in recent government outputs (e.g. DHSC, 2021a:165).

1.13. Chapter structure

The thesis is ordered as follows:

1. Introduction

2. Advocacy in the UK: A chapter providing conceptual and empirical grounding for the study. I explore various advocacy models and the development of statutory advocacy. Other key concepts, including professionalism and liminality, are examined.

3. Literature review: A narrative review of scholarship and grey literature concerning how advocacy works in different contexts and how effective it is. This encompasses topic areas including access to advocacy, the impact of commissioning practices, and advocate–practitioner relationships.

4. Methodology: I introduce the study’s critical realist philosophical basis, and its application of realist evaluation and insights from CAIMeR theory. I explicate the research design and how the study was conducted.

5. Theme one: Barriers to access. In the first of five findings and analysis chapters, I explore gaps in access to CAAs for qualifying individuals. Practitioners’ gatekeeping function, linked to their powers of referral, is examined, with particular focus on the challenges they encounter when determining eligibility for CAA services.

6. Theme two: Defining advocacy relationships. Here I concentrate on the relational character of CAAs’ practice, concerning how they build rapport with people and support their involvement in CA2014 processes. I also consider limitations to CAAs’ conduct of person-centred advocacy, via constraints arising from their statutory remit, and how they respond to ensuing tensions.

7. Theme three: Partnership, negotiation and challenge. Focus now shifts to interactions between CAAs and practitioners, with dynamics of partnership working explored. I also examine the various avenues by which CAAs might pursue challenges, possibly entailing negotiations with local authority personnel alongside more procedurally and legally escalatory approaches.

8. Theme four: Constructing occupational identity. This theme concerns the nature and identity of the CAA role, with particular reference to professionalism. Aspects of workforce organisation and development are discussed. So too are comparisons between CAAs and social workers, along with the possibility of a dual CAA–social worker identity being held by some workers.

9. Theme five: Developing organisational effectiveness. Various organisational aspects of CAA services are covered, including local authority commissioning practices, relationships with other types of advocacy services, and whether scope exists for forms of specialism within CAA services. Application of the tenets of culturally appropriate advocacy within CAA services is also explored.

10. Conclusion: I combine analysis from each thematic chapter, via discussion of acting in-between and being in-between. I present a summary of causal factors identified across the themes, relating this to what the CAIMeR model identifies as the interaction of Context, Actors and Interventions, which activates Mechanisms and achieves ensuing Results (Blom and Morén, 2010). This includes consideration of underlying mechanisms that shape CAAs' position and functioning within the care and support system, via reference to economic, social, political and legal structures. Finally, recommendations are presented.

2. Advocacy in the UK

2.1. Introduction

I now turn to laying further empirical and conceptual foundations for my study. I begin by delineating various advocacy types and exploring tensions between these. I trace how the arrival of statutory advocacy consolidated case-oriented and professionalising tendencies in the sector, related to advocates providing a quasi-legal safeguard within decision-making structures (Redley et al., 2010; Morgan, 2017; Series, 2022). The introduction of the CAA role is linked to these developments, especially regarding its potential to facilitate supported decision-making and enact challenges to local authorities. I also consider why these functions are necessitated by constraints on social work advocacy. In later sections, I consider theory about professionalism and liminality, including how these concepts have so far been applied to advocacy roles, or to roles adjacent or analogous to advocacy.

2.2. Defining advocacy

Advocacy is a wide-ranging and contested concept, manifested in diverse practices that can be complementary or in tension (Payne, 2014; Ridley et al., 2018; Macadam et al., 2014). The first recorded use of the word 'advocate' dates from the fourteenth century (Oxford English Dictionary Online (OEDO), 2024). The Latin roots *vocare* ('to call') and *advocatus* ('one who is summoned to give evidence') refer to pleading on a client's behalf before a court. Advocacy remains prominent within contemporary legal terminology (Jugessur and Iles, 2009:188), which is notable given the quasi-legal function of statutory advocacy roles (Morgan, 2017; Series, 2022).

In everyday English, advocacy means to 'support, recommend, or speak in favour' of a person or thing (OEDO, 2024: online). In this sense, anyone can advocate, which problematises setting boundaries around dedicated advocacy roles. Such roles are often termed 'independent advocacy': advocacy is their sole function, distinct from how health and social care professionals undertake some advocacy within their wider practice (Ridley et al., 2018). Independent advocacy is also distinct from familial advocacy, which is invaluable for many service users, although in some instances family members may act against a person's interests or be paternalistic (Walmsley et al., 2017; Series, 2022). Laws regarding eligibility for CAA and IMCA support implicitly validate the importance of friends and relatives' advocacy, as they frame statutory advocacy as being only required when informal support is absent or deemed unsuitable (Dixon et al., 2020).

Crucially, there is self-advocacy, which involves service users 'speaking up' for themselves (Forbat and Atkinson, 2005:323). The *Advocacy Charter* states all advocacy practice must seek to optimise self-advocacy potential (NDTi, 2018). Peer advocacy adds a collective dimension to self-advocacy: speaking up is on reciprocal and mutual bases, such as among individuals with shared experience of a form of oppression (Wilks, 2012; Rapaport et al., 2006).

Advocacy is an internationally recognised concept (Dalrymple and Boylan, 2013). Pioneering formal advocacy programmes operated in US hospitals from the 1970s and in the Dutch and Austrian mental health systems from 1980 (Morgan, 2017). In this chapter, I focus mainly on advocacy in UK adult social care, due to CAAs' specific legal remit. Later in the chapter, I open the discussion to include some adjacent roles, including insights from a study of peer parental advocacy within English child protection (Diaz et al., 2023).

2.3. Advocacy, empowerment, and epistemic injustice

Advocacy models differ across various dimensions. A key distinction is between notions of advocacy as a formalised 'service', often accompanied by notions of professionalism, versus as a grassroots 'movement' that encompasses self-help, mutual aid, voluntary action, and community-oriented approaches (Henderson and Pochin, 2001; Hardwick, 2018). Payne (2014) distinguishes more precisely between 'case' and 'cause' advocacy. The former focuses on advancing the interests of individuals, such as regarding access to particular services. The latter seeks improvements for oppressed social groups, often linked to collective organisation and campaigning. CAA and other statutory advocacy roles are representative of case advocacy (Dixon et al., 2020). Among individualised advocacy approaches, a key difference is whether involvement is limited to addressing specific issues or if it allows for longer-term advocacy partnerships (Forbat and Atkinson, 2005). Cause advocacy also takes various forms and is practised at different scales, including by large charitable organisations (Rapaport et al., 2005).

These points of difference shape advocacy's political complexion and relationship to empowerment. Case advocacy has been linked to a 'social democratic' (Payne, 2014:295) or 'transactional' (Newbigging and Ridley, 2018:282) orientation that prioritises individual advancement within existing bureaucratic and service configurations. Conversely, a 'transformational' advocacy paradigm aligns with political projects aimed at challenging oppressive structures, in their material and ideological forms (Newbigging and Ridley, 2018:282).

This transactional/transformational distinction can be further conceptualised in terms of addressing epistemic injustice (Ridley et al., 2018; Newbigging and Ridley, 2018). Epistemic injustice arises when someone is 'wronged specifically in her capacity as a knower' (Fricker, 2007:*x*). Fricker (2007), who developed the concept, delineates two main types of epistemic injustice. 'Testimonial injustice' is when a person's self-expression is ignored or undermined, such as when their account is not believed. 'Hermeneutical injustice' is when discursive systems limit a person's ability to engage in self-expression, as when they are denied the lexical or conceptual means to have their knowledge validated by others. Both forms of epistemic injustice are rooted in prejudice, where even well-meaning people can help perpetuate oppressive stereotypes (Fricker, 2007). Newbigging and Ridley (2018) argue, via focus on IMHAs, that statutory case advocacy is more attuned to countering testimonial injustice, as it helps people's voices be heard by practitioners. Pursuing hermeneutical justice requires more collectivist expressions of advocacy, raising consciousness of structural oppression and helping people adopt liberatory perspectives upon their circumstances (Newbigging and Ridley, 2018; Harper and Vakili, 2021). This aligns with Fricker's view that countering marginalisation due to hermeneutical injustice demands ‘group political action for social change’ (Fricker, 2007:174).

2.4. Advocacy models

Having outlined these key areas of difference affecting advocacy, I now consider some practice models in more depth.

2.4.1. Case advocacy

During the twentieth century, case advocacy’s development was linked to that of the welfare state. This was reflected in social work’s evolution: originating in voluntary action, it became a distinctive vocational role and later assumed professional status within expanding state structures (Dalrymple and Boylan, 2013; Payne, 2014; Morgan, 2017). Demonstrating this link between advocacy and social work, Eileen Younghusband, a pioneering social work educator, helped establish the first Citizens Advice Bureaux in London during the Second World War (Wilks, 2012). The successor organisation remains a major provider of advice about benefits and housing (Citizens Advice, no date). Such ‘welfare rights’ advocacy was once an important social work function but from the 1960s it was hived off into specialist roles (Levy and Payne, 2005). This reflected a narrowing of social work’s remit to focus on fulfilling designated statutory duties (James, 2004). The Seebohm Reforms of 1968 consolidated social work’s status as a case-based role practised within local authority structures, with advocacy incorporated into work with adults and children (Payne, 2014).

Case advocates assist people by utilising knowledge about laws, policies, and processes (Bateman, 2000). The advocacy relationship can itself be a mechanism of positive change, as when the person derives feelings of validation and increased self-confidence from the help they are receiving (Rapaport et al., 2006; Morgan, 2017). The need for highly knowledgeable case advocates creates pressure for these to be paid staff rather than volunteers. This tendency towards professionalisation is a longstanding topic of contention in the advocacy sector (Henderson and Pochin, 2001).

2.4.2. Self-advocacy movements

Self-advocacy movements stand in significant contrast to case advocacy, being aligned with wider disabled people's activism that challenges societal oppression (Wilks, 2012; Morgan, 2017; Henderson and Pochin, 2001). These movements are therefore oriented towards opposing epistemic injustice (Newbigging and Ridley, 2018). Modern self-advocacy movements emerged during the 1960s, alongside other internationalised struggles for civil rights, justice, and equality, including anti-racist and feminist activism (Payne, 2014). Self-advocates organised themselves amid the closure of large institutions, where many disabled people had lived in oppressive conditions (Walmsley, 2014). To a significant degree, self-advocacy movements developed separately and inconsistently between service user groups (Series, 2022), with relatively weak user movements among older people, for example (Thompson, 2002). There was accompanying intellectual ferment, with activists with physical impairments being instrumental in developing the social model of disability. This sees disability as caused by social structures that exclude people with impairments, as opposed to a medical model that frames impairment as personal deficit (Shakespeare, 2013).

Self-advocacy has been undertaken prominently by users of mental health services, often identifying as 'survivors' (Beresford, 2002). By the 1980s, strong user-led groups, such as Survivors Speak Out, provided a radical critique of the psychiatric system, with some having links to MIND, a UK mental health charity (Wilks, 2012; McKeown et al., 2014). The Hearing Voices Network has been another locus of activism, since it originated in the Netherlands in the 1980s. It seeks to engender a changed understanding of voice-hearing, away from a dominant biomedical discourse about 'auditory hallucination' as a symptom of psychosis, and towards acceptance of this as a common human experience (Styron et al., 2017; Harris et al., 2022). This is an example of self-advocacy as a resource for opposing hermeneutical injustice, by advancing alternative perspectives on mental distress that allow individuals to re-frame their experiences in empowering ways (Newbigging and Ridley, 2018; Harris et al., 2022).

People First was a pioneering self-advocacy organisation established by people with learning disabilities in 1980, yet it was not until the 1990s that such activism became widely acknowledged as part of the disabled people's movement (Series, 2022). Self-advocacy among people with learning disabilities also draws upon the social model of disability (McNally, 2005). It can involve seeking empowerment away from professional input that risks 'reinforcing the victim status of people with learning difficulties' (Goodley, 2005:334). An adjacent strand of activism has been collective advocacy by parents of people with learning disabilities (Walmsley et al., 2017).

2.4.3. Citizen advocacy

Citizen advocacy is individual-focused but, as originally conceived, strongly distinct from issue-based case advocacy (Forbat and Atkinson, 2005). Citizen advocacy involves a long-term partnership between a volunteer advocate and a person needing support. The advocacy relationship assumes emotional and political resonance, being an act of solidarity (Henderson and Pochin, 2001) while having qualities akin to friendship or familial ties (Hardwick, 2018). Citizen advocacy has mainly been implemented with people with learning disabilities, but it has broader applicability (Payne, 2014). As with self-advocacy movements, de-institutionalisation formed a backdrop to citizen advocacy's development. Citizen advocacy was founded in the USA by Wolf Wolfensberger, a disabilities scholar, who recognised that people departing institutions needed access to community-based support and social connections (Williams, 2011). Citizen advocacy schemes proliferated in the UK during a period of accelerated deinstitutionalisation under the 'care in the community' reforms that commenced in the 1980s (Hardwick, 2018; Rapaport et al., 2005; Henderson and Pochin, 2001).

Citizen advocacy's development was conceptually linked to Wolfensberger's theory of 'social role valorisation' (Wolfensberger, 1983). Advocacy partnerships were seen to exist between disabled people and those already in relatively valorised social positions, thus acting against the societal devaluation of disabled people (Hardwick, 2018; Williams, 2011). Citizen advocacy has 'instrumental' and 'expressive' dimensions: the former encompasses helping the advocacy partner with daily living tasks and interactions with professionals, while the latter comprises emotional and social support (Wolfensberger, 1977:3; Williams, 2011).

Citizen advocacy has been criticised. Its focus on enduring advocacy partnerships arguably risks reinforcing a paternalistic view of disabled people as being necessarily dependent, stifling self-advocacy (Morgan, 2017). Wolfensberger (1977) argued citizen advocates might act as protector of their partner, potentially by utilising guardianship powers. Moreover, notions of loyalty within advocacy relationships are problematic if they prevent the person exercising choice over who supports and represents them (Henderson and Pochin, 2001).

2.5. Introducing statutory advocacy

2.5.1. Moving towards statutory advocacy

By the early 2000s, a diverse advocacy sector had developed. Yet there were pressures to channel advocacy into more formalised, service-oriented approaches that could be at odds with grassroots and volunteerist conceptions (Rapaport et al., 2006; Hardwick, 2018; Henderson and Pochin, 2001). In 2001, a government white paper, *Valuing people: a new strategy for learning disability for the 21st Century*, promoted self-advocacy and citizen advocacy and stated people with learning disabilities should have different advocacy options available locally (DH, 2001). A significant increase in resources for advocacy followed (Hussein et al., 2006). However, geographic unevenness persisted in the development of advocacy for people with learning disabilities, producing a ‘postcode lottery’ (Rapaport et al., 2006:204). Some also had concerns that configuring advocacy as a public service could detract from self-organisation among people with learning disabilities (Goodley, 2005).

There were other manifestations of tension within the advocacy sector. Some self-declared citizen advocacy schemes came to resemble general case advocacy undertaken by volunteer advocates (Henderson and Pochin, 2001), possibly overseen by a paid co-ordinator (Rapaport et al., 2005; Forbat and Atkinson, 2005). Here, service demands strained citizen advocacy’s relationship-based model: advocates found they needed to prioritise helping individuals with presenting issues, while reliance on volunteers posed recruitment and retention challenges (Hardwick, 2018). Furthermore, professionals could be critical of volunteer advocates, arguing they lacked necessary legal knowledge (Hunter and Tyne, 2001).

Pressure to formalise advocacy aligned with legislative developments that created the first statutory advocacy roles in English and Welsh adult social care (Rapaport et al., 2006). IMCA and IMHA roles were introduced to safeguard the rights of people who are subject to legal frameworks that can permit profound infringement of personal autonomy (Department of Constitutional Affairs (DCA), 2007; DHSC, 2017:54; Series, 2022; Morgan, 2017). I now consider these roles in more depth.

2.5.2. The Independent Mental Capacity Advocate (IMCA) role

The introduction of the IMCA service from April 2007 followed the enactment of the MCA2005, which established a codified legal framework for mental capacity (Morgan, 2017). The new law set clear criteria for determining a person's capacity to make a decision, alongside rules governing how a best-interest decision should be taken on behalf of a person lacking capacity (Brammer, 2020). The MCA2005 requires that, for best-interest decisions about long-term accommodation change or serious medical treatment, an IMCA be engaged when there is no relative or friend of the person deemed 'appropriate to consult', such as because their relationship is insufficiently close (DCA, 2007:178). Decision-makers can also involve IMCAs regarding care reviews and safeguarding interventions where the person lacks relevant capacity, although this is not mandatory (DCA, 2007). Initial proposals for IMCAs to cover a wider range of decisions were rejected on cost and feasibility grounds (Redley et al., 2010).

The IMCA role's core purpose is to aid the making of the best-interest decision; the IMCA gathers information about the person and makes representations on their behalf to the decision-maker (Series, 2013; DCA, 2007). Furthermore, the IMCA must ensure principles established by the MCA2005, s.1 are upheld, including that the person's involvement in decision-making processes is maximised and the 'least restrictive' option for delivering a care and support intervention is always considered. IMCAs should question or challenge decisions which do not appear to be in the person's best interests (DCA, 2007:189-191). Redley et al. (2010) contend that the introduction of IMCA responsibilities marked a major shift for advocacy, which for the first time became a service operating *within* formal decision-making structures, rather than supporting people at one step's remove.

While the MCA2005 is key domestic legislation regarding supported and substituted decision-making, the United Nations' Convention on the Rights of Persons with Disabilities (UNCRPD), which the UK signed up to in 2009, has also prompted socio-legal discussion in this area (Dixon et al., 2021). Article 12.3 of the UNCRPD stipulates that 'States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity' (United Nations General Assembly, 2006). Such supported decision-making implies a social model approach to overcoming barriers to people exercising self-determination. Independent advocates potentially enable this, although supported decision-making remains a developing concept (Newbigging et al., 2020; Dixon et al., 2020).

The extent to which the MCA2005 complies with the UNCRPD is contentious. The MCA2005 allows substituted decision-making on behalf of a person lacking capacity, while the UNCRPD, Art.12, seems to disassociate from this approach (Dixon et al., 2020). This has led to the UNCRPD being criticised for reflecting an unrealistically purist stance on supported versus substitute decision-making, which would withdraw safeguards from the most vulnerable individuals who remain unable to make an autonomous decision, even when full support is provided (Gooding, 2015). Browning et al. (2014) oppose a dichotomous view of supported and substituted decision-making, suggesting these might exist on a continuum if legal and practice mechanisms permit. They argue this would entail relational forms of decision-making that stress interdependence. Here advocacy is important: Dixon et al. (2020) contend that advocates can provide a bridging function between supported and substituted decision-making. IMCAs seek to include the person as much as possible in decision-making, while providing ‘an expert interpretation on what an individual’s wishes would be’, so these can be considered by the substitute decision-maker (Dixon et al., 2020:225).

The IMCA role’s purpose can also be conceptualised as helping to pursue ‘authentic autonomy’, whereby attempts are made to identify the choices and behaviour of a person that are ‘authentic’, as in ‘deeply in character’ for them as an individual (Leece and Peace, 2009:1851). This theory of autonomy is disruptive of notions of individuals acting as entirely independent agents. Therefore, when a person is unable to take a decision independently, IMCA involvement can contribute to actualising ‘delegated autonomy’. This is where others are taking decisions on the person’s behalf but doing so in accordance with the determination of authenticity, with associated attentiveness to upholding rights and maximising freedom (Leece and Peace, 2009).

2.5.3. IMCAs and ‘care professional legalism’

The MHA2007, s.50 amended the MCA2005 (s.65(4)), leading to the Deprivation of Liberty Safeguards (DoLS) being introduced. This responded to need for a human rights-compliant regime for authorising and overseeing the accommodation of people in hospitals and care homes, where they lack capacity to agree to highly restrictive arrangements that amount to being deprived of their liberty (Brammer, 2020; Series, 2022). IMCAs were accorded additional powers under DoLS. Advocates could also act in a new role tasked with safeguarding the person’s interests, that of Relevant Person’s Representative (RPR), when friends or relatives do not assume these responsibilities (SCIE, 2017). Series (2022:218) identifies IMCA as one of various roles that demonstrate ‘care professional legalism’ within a system of ‘social care detention’, which is underpinned by DoLS and allied arrangements for authorising deprivations of liberty in domestic settings. Legalism is a broad concept that emphasises legal adherence and a rules-based order, limiting scope for discretionary action by political and professional actors (Lapuente and Suzuki, 2020). Care professional legalism therefore involves expertise in using legal frameworks to uphold rights, promote liberty and dignity, and provide counterweight to paternalistic tendencies in professional decision-making (Series, 2022).

The DoLS regime introduced mechanisms for advocates and others to exert legalist pressures, such as challenging a deprivation of liberty under the MCA2005, s.21a, which brings it before the Court of Protection for review (Series, 2022). The 2011 case of *London Borough of Hillingdon v Neary* illustrates the legalist potential of IMCA practice under DoLS, and how statutory advocacy can complement familial advocacy (Series, 2022; Morgan, 2017; Dixon et al., 2020). The case concerned a young autistic man with learning disabilities, Steven Neary, whom the local authority accommodated in a 'positive behaviour unit' under a DoLS authorisation, against his father's wishes for him to return home. Only after an IMCA raised concerns was the detention reviewed, including under the MCA005, s.21a, and subsequently overturned (Series, 2022). A judge praised the quality of the IMCA's report that analysed the best interest decision about Mr Neary's placement (Dixon et al., 2020).

Series (2013) contrasts the legalist avenues existing under DoLS with the more limited powers of challenge afforded to IMCAs when they are supporting best interest decision-making under the MCA2005's original provisions. These entail no formal requirement to 'monitor or challenge mental capacity assessments or best interests decisions' (Series, 2013:164). The *Code of practice* to the MCA2005 states the IMCA 'may' need to challenge a decision they have concerns about (DCA, 2007:189). However, they do not have enhanced powers to enact challenges, beyond those of 'any other person caring for the person or interested in his [sic] welfare' (DCA, 2007:189). The *Code of practice* states that challenges can be pursued via the local authority's complaints procedures, while there are some avenues for pursuing legal redress in particularly serious or urgent circumstances (DCA, 2007:189-191).

2.5.4. The Independent Mental Health Advocate (IMHA) role

In an update to the MHA1983 in 2007, one of the legislative amendments introduced the IMHA role, an advocacy safeguard around the use of compulsion with people experiencing mental health problems (McKeown et al., 2014). An individual qualifies for IMHA support if they are subject to one of certain provisions of the MHA1983 (Brammer, 2020). These include detention in hospital for assessment (under s.2) or treatment (s.3), and some community provisions such as being subject to a Community Treatment Order. 'Informal' hospital patients are also eligible for an IMHA if they are being considered for certain forms of mental health treatment (Brammer, 2020). IMHAs are tasked with helping a person understand and exercise their rights, including to participate in decisions about their care and treatment and appeal against their detention to the Mental Health Tribunal (Newbigging et al., 2012). Access to an IMHA is unaffected by any involvement of friends or relatives, unlike with eligibility for a CAA or IMCA. A professional responsible for the qualifying person's care must inform them of their right to an IMHA (DHSC, 2017).

2.6. Introducing the CAA role: extending supported decision-making

The policymaking process leading to the CA2014 saw further impetus to extend the reach of advocacy as a legal protection, via a rights-based framing (Morgan, 2017; Series, 2022; Newbigging et al., 2015). However, as when preparing the MCA2005, there was contention about what the scope of new statutory rights to advocacy should be (Redley et al., 2010; Dixon et al., 2020). A review of adult social care law by the Law Commission (2011) highlighted how much advocacy provision was non-statutory in nature. Its availability was thus contingent on factors such as discretionary local authority funding, with the risk of financial support being withdrawn from advocacy organisations deemed overly critical of their funders. The Law Commission reported stakeholders' views that advocacy is 'a vital component of achieving independent living and full citizenship for disabled people' (Law Commission, 2011:185). It stated that a right to advocacy derived in some circumstances from the European Convention on Human Rights (Art. 8) and 'arguably' was implied by the UNCRPD (Law Commission, 2011:186). The Law Commission (2011) recommended that generalised rights to advocacy contained within the Disabled Person's (Services, Consultation and Representation) Act 1986, which were never implemented, should be retained in law, and the Government should assume powers to effectuate them in updated form. The Government rejected this proposal (DH, 2012), instead opting for a more limited right to advocacy based on 'substantial difficulty' (Dixon et al., 2020).

Despite the absence of a universal advocacy entitlement in the CA2014, requirements for CAAs represented a significant extension of rights to supported decision-making (Dixon et al., 2020; Newbigging et al., 2021). There was marked increase in coverage relative to IMCAs' remit. 'Substantial difficulty' is essentially a lower threshold for support than that of lacking capacity to make a decision, although the two are assessed with reference to similar criteria regarding the person's ability to understand relevant information, retain it, weigh it up and communicate wishes (MCA, s.3; DHSC, 2024:7.15, 7.64; further section numbers in parentheses are from this guidance). Where a person lacks capacity about a decision, CAAs extend advocacy scrutiny and support to best-interest decision-making conducted across all care and support processes (10.49-10.54; 10.59-10.72). This means the CAA and IMCA roles can interlock: a person being supported by an IMCA regarding an accommodation change will generally also qualify for CAA input regarding the CA2014 processes that surround this decision (7.65-66). Statutory guidance therefore recommends commissioning arrangements that facilitate a single, appropriately trained advocate to perform both CAA and IMCA functions with a person (7.65-66).

The relatively broad applicability of 'substantial difficulty' means CAA work encompasses both instructed and non-instructed advocacy. This important distinction, referred to in the Advocacy *Code of Practice* that accompanies the *Advocacy Charter*, concerns whether a service user is able to personally direct their advocate regarding their views and wishes—that is, to 'instruct' them (Advocacy Quality Performance Mark (AQPM), 2014). The statutory guidance makes only passing reference to this terminology (DHSC, 2024:7.43). However, instructed and non-instructed approaches map partially onto the respective 'support' and 'representation' components of CAA practice that it describes (see especially 7.52). This is especially apparent from the depiction of a CAA acting to 'represent' a person who is unable to make decisions about their care or support or communicate their wishes to decision-makers (7.52). The CAA role then correlates with a non-instructed approach, focused on working pro-actively to ascertain and convey the person's wishes, as well as possible, and uphold their rights. This necessitates a questioning approach, so professionals' proposals for the person are rigorously examined (DHSC, 2024:10.49-10.72; AQPM, 2014; Stewart and MacIntyre, 2013; Lee-Collins, 2010).

Attempts have been made to systematise non-instructed advocacy practices. These include the 'witness observer' approach that emphasises embodied attentiveness to the person, in order to learn about them and identify any concerns, such as about services they are receiving (Advocacy Support Cymru, no date). Asist (no date) developed the 'Watching Brief' model, where information about eight domains of the person's life is gathered and used as a basis for scrutinising decision-makers' plans. Non-instructed approaches are often applicable when a person lacks capacity to make relevant decisions (Morgan, 2017; AQPM, 2014). Non-instructed advocacy techniques are therefore part of an interpretive skillset used for bridging supported and substituted decision-making (Dixon et al., 2020). Again this can also be conceptualised as enabling delegated autonomy for the person, with a model such as Watching Brief being an attempt to structure the process of determining of what is authentically aligned with their individual personhood (Peace and Leese, 2009; Asist, no date).

CAAs' role can be further distinguished from that of IMCAs by the presence of formal responsibilities to enact challenges in certain circumstances. How this works differs between supportive and representative modes of practice. The CAA must support a person wishing to challenge the local authority regarding the conduct or outcome of a CA2014 process (DHSC, 2024:7.48). When representing a person, the CAA must conduct a challenge if 'they believe the decision is inconsistent with the local authority's duty to promote the individual's wellbeing' (7.51). However, the statutory guidance provides scant detail about how challenges can be conducted. It does state that, in the context of 'representing' the person, the CAA must write a report about their concerns. The local authority should then meet with the CAA and provide a written response (7.50-52).

2.7. CAAs and social work advocacy: responding to gaps

Social workers' conduct of CA2014 processes raises important questions about contemporary social work advocacy. According to the *Professional standards* set by Social Work England (SWE), the statutory regulator, social workers must work in partnership with people, value their individuality, promote their rights and wellbeing, and demonstrate commitment to social justice (SWE, 2019). There is significant overlap with core principles of the *Advocacy Charter* (NDTi, 2018). Why then is independent advocacy necessitated, at least in the absence of appropriate support from friends or relatives?

The answer is that social workers' involvement in enacting state policies can complicate and constrain their ability to advocate via their practice, although advocacy remains an important social work skill (Wilks, 2012; Dalrymple and Boylan, 2013). *Guidance on the professional standards* issued by SWE (2020) recognises that social workers can act as advocates, such as by helping people articulate their wishes and access services. The guidance proceeds to note that arrangements for social work advocacy 'should be undertaken in line with the law and after careful consideration of any possible conflicts of interests', although this is not elaborated upon (SWE, 2020:online]. A relevant legal requirement is the need for social workers to act as substitute decision-makers when a person lacks capacity under the MCA2005. McDonald (2010) shows how, when seeking to weigh all 'relevant circumstances' as they prepare to act in a person's best interests under the MCA2005, s.4, social workers face significant tension as complex situations can be viewed through different conceptual lenses. These include rights-based approaches (linked to advocacy) and actuarial notions of weighing up risks to the person (McDonald, 2010).

Issues for social work advocacy go beyond substitute decision-making to encompass their place in the overarching care and support system. This is highlighted by scholarship showing that aspirations tied to the CA2014 remain at least partly unfulfilled. Whittington (2016) discusses how, within quarters of the social work profession, there were hopes the CA2014 would have a ‘liberating’ effect on practice; more creative, holistic, and relationship-based approaches would flourish, with social workers’ exercise of professional judgement reinforced. This was a hoped-for departure from the ‘care management’ model that had narrowed the focus of social work to relatively bureaucratic conceptions of assessing need and arranging services procured from the private sector. This had come to predominate under the NHS and Community Care Act 1990 and accompanying ‘new public management’ ideology, which favoured importing private business principles into the running of public services. Yet Whittington (2016) argues that much of this hope for the CA2014 was undermined by austerity, which stymied efforts to develop a more person-centred social care system that promotes individual wellbeing. Slasberg (2019) further shows how resource constraints can severely limit social workers’ abilities to practice in line with people’s wishes and wellbeing, straining their ethical and legal commitments. He argues that social workers’ exercise of professional judgement about people’s needs and what is necessary to meet them risks being undermined by managerialist pressures regarding allocation of resources. The contemporary situation can thus be seen as intensifying fundamental dilemmas facing workers in public sector bureaucracies. These are described by Lipsky (2010) in a classic work first published in 1980, where workers’ altruistic impulses to advocate for service users are confounded by procedural and resource constraints.

Other scholarship underscores the difficulties social workers and other practitioners face as they seek to conduct person-centred practice under the CA2014. Symonds et al. (2018, 2020), drawing on research conducted soon after the CA2014’s introduction, highlight the challenges of undertaking person-centred assessments. They found that practitioners sought to act in some ways akin to advocates, making the case within their organisations for meeting individuals’ needs. Yet their ability to take the person’s side was constrained by institutional pressures, including budgetary considerations and intense workload demands. Moreover, practitioners needed to extract certain information via assessments, such as to determine eligibility for care and support, which might involve distinguishing between the individual’s wants and needs—again limiting person-centredness (Symonds et al., 2018, 2020).

Southall et al. (2021) similarly found that tight timescales and workload pressures reduce scope for person-centred and relationship-based social work practice. They also note that resource limitations constrain best interest decision-making by narrowing the field of feasible options that can be chosen from on the person’s behalf. Southall et al. (2021) illuminate challenges that social workers face in seeking to actualise the empowering potential of personalisation policy, amid organisational and policy barriers. They highlight that ‘consumerist’ notions of service users acting autonomously to avail themselves of the opportunities of self-directed support mechanisms can be incongruent with practice realities. This is exemplified by use of direct payments, a monetary allocation to people for arranging their own care and support. Southall et al. (2021) cite research by Jepson et al. (2016) showing that people who lack capacity about relevant decisions are disadvantaged regarding benefitting from personalisation, with the availability of appropriate familial support becoming a key factor in whether these challenges can be overcome. Southall et al. (2021) argue that independent advocacy can play an important part in filling these gaps regarding person-centred practice, which social workers may struggle to do alone. Ensuring appropriate access to independent advocacy is also a professional requirement for social workers (SWE, 2019).

The CAA role must therefore be understood in the context of social work practice under the CA2014. That independent advocacy and social work are closely intertwined is further shown by Hardwick’s (2014) study of relational dynamics between these roles, based on research pre-dating the CA2014. This study of an advocacy hub in an English city illustrated how advocacy services can occupy space for relationship-based working with service users, which had partly been vacated by social work’s shift towards care management practice. It is therefore necessary to understand interactions between social work and independent advocacy, at micro, meso and macro levels, in the updated context of the CA2014.

2.8. Statutory advocacy and professionalisation

The introduction of statutory advocacy roles heightened contention about tendencies towards professionalisation (Morgan, 2017; Hardwick, 2018; Newbigging et al., 2021). This link was made clear by the *First annual report of the IMCA service*, which lauded this as ‘a new profession with a statutory role’ (DH, 2008:4). Theoretical elaboration of professionalism is therefore necessary, going beyond a simple sense of it involving paid rather than voluntary work. Yet there is no settled definition of a ‘profession’, or of ‘professionalism’ or ‘professionalisation’ (Heslop, 2011). I now discuss some scholarly perspectives on these terms, relating them to notions of knowledge, power, identity, and inter-occupational boundaries—all pertinent to analysing the CAA role.

Evetts (2003) describes an established ideology of professionalism, where the professional practises autonomously within a field in which they have gained exclusive claims to expertise, backed by professional self-regulation. Evetts (2003) also challenges this conceptualisation, which suggests a clear divide between professional and other occupations. She instead proposes a broad definition of professionalism, as comprising ‘the structural, occupational and institutional arrangements for dealing with work associated with the uncertainties of modern lives in risk societies’, with particular emphasis on occupations’ knowledge requirements (Evetts, 2003:397). Evetts (2003) also contends that established traits-based models of professionalism give insufficient insight into the power dynamics of professionalisation processes. A key question is whether professionalising impetus is generated internally or externally, the latter meaning professionalism is imposed on the occupation by more powerful societal actors. McClelland (1990 cited in Evetts, 2003:398) labels these trajectories as professionalisation ‘from within’ and ‘from above’.

Rennstam and Ashcraft (2014) delineate between technical and communicative knowledge practices within occupations. They argue that professional power has tended to reside with roles that emphasise the presence of more abstract, theoretical and technical knowledge, which is more readily codifiable into disciplinary fields. They contrast this with labour based on communicative knowledge, which is ‘situated and embodied knowledge about interaction that is also created and used in interaction' (Rennstam and Ashcraft, 2014:4 original italicised). Communicative knowledge, forged and exercised within interpersonal encounters, is foundational for practice in human services occupations (Rennstam and Ashcraft, 2014; Golden and Bencherki, 2023). However, despite its increased importance within modern economic formations, communicative knowledge has tended to be undervalued relative to technical knowledge. Rennstam and Ashcraft (2014) argue this knowledge hierarchy developed with gendered and classed characteristics. This has strong resonance for studies of adult social care occupations, where a large proportion of the workforce is female and there is sector-wide concern about pay and working conditions (Towers et al., 2022; Skills for Care, 2022; Local Government Association, 2023).

Heiss et al. (2018) consider how members of occupational groups exercise individual and collective agency as they seek to establish professional legitimacy, via processes of social construction that include linguistic framing of their roles. They argue that workers can be engaged in a continuous and unstable process of status negotiation and identity formation, undertaken in dialogue with surrounding social context. As such, 'professionalization discourses are dynamic social negotiations that shape and are shaped by culture, norms, politics, institutions, and history within and outside of a given profession' (Heiss et al., 2018:123). Occupational identity formation therefore involves workers interpreting their own place in society while staking this out in relational terms, meaning professionalisation partly rests on establishing boundaries with adjacent roles (Heiss et al., 2018). Abbott (1995) has been instrumental in identifying such boundary-setting as a key dynamic of professionalisation, involving contestation between adjacent roles for jurisdictional hegemony within a given field of practice. Abbot (1995) illustrates this historically via the development of the US social work profession.

2.9. Developing occupational infrastructure

My literature searching, discussed in the next chapter, has not identified any substantial application of these theoretical insights from occupational and organisational studies literature to the professionalisation of advocacy—a gap this thesis addresses. However, scholarship to date has included some empirical work about the identity of statutory advocates. Especially notable is Morgan's (2017) study of IMCAs, which discerns 'the emergence of statutory independent advocacy from occupation to profession' (Morgan, 2017:*x*). From interviews conducted with IMCAs soon after their role's introduction, Morgan (2017:112) discerned 'a sense of the practice developing a more professional ethos', although this was offset by some accompanying concerns about implications of advocacy becoming professionalised, which I return to below. Morgan (2017) found a burgeoning sense of identity among IMCAs, based upon their abilities to combine expertise in person-centred and relationship-based practice with technical knowledge of law and processes. Such values-based and relationally-exercised notions of expertise align with Series's (2022) designation of IMCAs as exhibitors of 'care professional legalism'. Morgan (2017) observes that IMCAs must be able to apply their knowledge and broad skillset in a flexible, adaptable way that is representative of the 'reflection in action' that Schön (1983) defined as typical of advanced professional practice.

The creation of accreditation systems to complement the introduction of the IMCA role, and later those of IMHA and CAA, reflects an intention to raise overall levels of competence among advocates (Morgan, 2017). CAAs are expected to work towards the National Qualification in Independent Advocacy (level 3) (DHSC, 2024:7.43). This qualification is largely vocational (City & Guilds, 2021). However, the existence of training and qualification requirements for statutory advocates is notable given exponents of some advocacy models, such as citizen advocacy, have tended to emphasise advocates possessing vaguer qualities such as 'common sense' (Morgan, 2017:103). Among some advocates, this view has even extended to wariness about training, due to concerns this will embed a 'service' conception (Henderson and Pochin, 2001; Hardwick, 2014, 2018). Statutory guidance to the CA2014 also mentions, but does not mandate, the Advocacy Quality Performance Mark (AQPM), a benchmarking award for advocacy organisations that is delivered by NDTi. The AQPM seeks to provide 'a robust national test of the quality of independent advocacy provision', in accordance with the *Advocacy charter* and *Advocacy code of practice* (AQPM, no date:online).

It is in this current context of occupational development that the *Reforming the Mental Health Act* white paper observes there are options for the 'professionalisation' of statutory advocacy, although these are contentious (DHSC, 2021a:54). Morgan (2017:117) describes the arrival of the IMCA service as eliciting a mixed response from advocates, reflective of 'an ambivalent turn-toward-professionalisation'. This included articulating anxiety that notions of professional expertise might dilute an advocate identity based on non-hierarchical forms of partnership with service users. Such worries are longstanding within the advocacy sector (Henderson and Pochin, 2001). Morgan (2017:108) quotes an IMCA identifying 'a danger that the essence of advocacy is lost, and by the essence I mean the advocate identifying very strongly with the service user and engaging with the service user on their own terms'. Another IMCA expressed concern about advocates losing their 'approachability' (Morgan, 2017:109).

Morgan (2017) draws upon traits-based notions of professionalism to question whether independent statutory advocacy should be considered a profession in its current form. He cites characteristics of these roles at variance with widely accepted markers of professionalism, specifically regarding the level of formal qualification required; questions about whether advocacy draws upon an identifiable, specialised body of knowledge; and the absence of professional registration of advocates (Morgan, 2017). There are contrasts here with social work, which has assumed more generally recognised professional status. Independent advocacy requires a level-three qualification (Morgan, 2017; DHSC, 2023:7.43)[2], of equivalent standing to an A-level in the UK qualifications framework (UK Government, no date). Conversely, entry to social work has been via degree-level qualification since 2004 (Higgs, 2022). Professional registration is an instrument of occupational regulation that is common across many social welfare disciplines in the UK (Christopher, 2015). It was introduced for social workers in 2003, with a key rationale being the protection of service users (McLaughlin, 2007; Byrne, 2016). Registration seeks to ensure

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[2] The *Care and support statutory guidance* states that CAAs should 'work towards the National Qualification in Independent Advocacy (level 3) within a year of being appointed, and to achieve it in a reasonable amount of time'. City & Guilds also provide a level 4 qualification in Independent Advocacy Practice (City & Guilds, 2024).

practitioners adhere to mandatory standards, via accountability mechanisms external to the employer–employee relationship, and it is commonly perceived as a marker of professional status (Evans, 2020). Research has shown registration can play an important part within contested processes of professional identity construction among entrants to qualified social work practice (Wiles, 2013).

However, using social work as a comparator regarding professionalism is rendered more complex if viewed through a lens of occupational power, as Evetts (2003) encourages. Practising within a neo-liberal policy framework—with attendant constraints of managerialism, reduced scope for relational work, and severe resource shortages—presents a challenge to social work professionalism (Rogowski, 2020; Trappenburg et al., 2020; Butler-Warke et al., 2021). I return to these different perspectives on professionalism, and occupational comparisons between independent advocacy and social work, at various points through the thesis.

2.10. Liminality and authenticity

Beech (2011) notes that the meaning of liminality differs somewhat between academic fields. In anthropology, liminality is understood as a temporary phase associated with social ritual (Beech, 2011). In a classic text, Turner (1967) identifies the 'liminar' as someone who has started but not yet completed a ritualised change process, placing them on the cusp of an alternative state. As such, they are 'threshold people' and 'are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial' (Turner, 1967:95). In organisational and occupational studies, however, liminality is 'a more longitudinal experience of ambiguity and in-between-ness', where different meanings get attached to a role that is subject to on-going change (Beech, 2011:288). A liminal role thus has an unresolved and insecure quality, as questions arise about whether an adjacent position could be substituted for it. It is this latter meaning of liminality that I apply to CAAs' work and identity. This directs us to consider how individuals can experience liminality as a sense of not-fitting-in, where they become aware of their role's contradictions, its precarity or perceived devaluation (Beech, 2011). More positively, a worker holding a liminal role may find this grants them significant latitude and potential to effect change, due to being situated at the threshold of different systems of practice (Croft et al., 2015). I explore these positive and negative aspects of liminality regarding CAA.

My explicit application of liminality to the study of statutory advocacy appears novel, yet previous scholarship has noted some in-between and ambiguous qualities associated with these roles. One concern is how they occupy borderlands around a clear outside/inside delineation, with statutory advocacy being at once independent from decision-makers yet prescribed within decision-making processes (Redley et al., 2010). McKeown et al. (2014) illustrate this via their study of IMHA–practitioner relationships, which shows practitioners can value IMHAs for their ability to play an intermediary role between themselves and service users. McKeown et al. (2014:402) observe that ‘For these staff, the advocate occupied a sort of hinterland: not one of the team, but very helpful for the team.’

This thesis is indebted to studies that have applied liminality to adjacent and analogous roles to that of CAAs. This is especially so for work highlighting linkages between a role’s in-between function and its liminal identity. Such a link is explicated by Golden and Bencherki (2023) in their analysis of how, in the USA, the Community Health Worker (CHW) role seeks to connect marginalised populations with health services. They show that, in doing so, CHWs integrate technical and communicative knowledge practices (Rennstam and Ashcraft, 2014). It is CHWs’ lived experience and personal links to the communities they serve that helps them dissolve interpersonal barriers to engagement with patients, in turn allowing them to act as a conduit for flows of technical healthcare information originating with clinical practitioners. The CHW role differs from advocacy in important ways, including by having a pronounced educative function. Yet there are similarities with how statutory advocates are expected to put technical knowledge about care and support processes at individuals’ service, via mechanisms of relational engagement. Golden and Bencherki (2023) proceed to relate CHWs’ integration of technical and communicative knowledge practices to their contested occupational status. One strain of opinion favours professionalisation, by introducing regulatory and registration requirements for CHWs. This is due to some powerful actors' lack of acceptance of CHWs' involvement, specifically among some established professional groups, including medics, and governmental agencies involved in healthcare administration (Golden and Bencherki, 2023).

Some challenges that CHWs experience have parallels with those facing peer parental advocates, as described by Diaz et al. (2023). Peer parental advocates support parents undergoing child protection procedures, drawing on their own experiences of this. Diaz et al. (2023) show that, as in adult social care, advocacy with children and families has come under pressure to become more standardised and professionalised. This includes a critique that peer advocates may lack sufficient technical knowledge to be effective across all advocacy functions. However, Diaz et al. (2023:32) highlight that professionalisation could prevent individuals with requisite 'lived experience' from fulfilling this important role—a similar argument to that made by Golden and Bencherki (2023:12) regarding CHWs. Both parental peer advocates and CHWs use their lived experience to help form effective connections with the people they support—thus enabling them to 'bridge the gap' with professionals (Diaz et al., 2023:8).

Lived experience is also a resource for peer support workers in mental health services, who similarly bridge gaps between service users and professionals (Gillard et al., 2015). As Simpson et al. (2018) show, peer support workers also face status conflicts arising from their liminal identity, because of a sense that they do not fit into either professional or service user categories. Their identity as people with experience of mental distress may thus be questioned due to their involvement in formalised practice systems that comprise rules and structures of authority (Simpson et al., 2018). This, and adjacent studies of service user representation in mental health services (El Enany et al., 2013:28), link to notions of 'authenticity' in role performance. 'Authenticity' incorporates discursive constructions about the level of perceived congruence between a social entity's outward expression and its 'true' self, defined via norms that are culturally, geographically, and temporally situated (see Lehman et al., 2019). Authenticity has been applied to cause advocacy (Mitchell, 2008; Brockington, 2014; Feldman et al., 2017). From research in Israel, Feldman et al. (2017)

identify that non-profitmaking organisations involved in 'social welfare advocacy' can be viewed as less authentic, and therefore less legitimate, if they are seen to have become overly enmeshed with state structures. I will apply this notion of authenticity, as expressed regarding both individual and organisational identity, in my discussions of the tensions besetting CAA.

As liminality is a discursive framing rather than a substantive theory it can be widely applied (Beech, 2011). Evans (2013) and Southall et al. (2021) identify social workers as operating in liminal spaces, in-between demands of law and policy and practical constraints upon their role. Leah (2018, 2019) relates the hybrid identity of Approved Mental Health Professionals (AMHPs), who undertake assessments regarding detention under the MHA1983, to their role's location at the nexus of different practice systems. AMHPs work in the gaps between these, requiring them to deploy a diverse skillset including mediatory and advocacy components (Leah, 2018, 2019). Therefore, liminality has already been used to elucidate the nuanced and precarious positionalities of various roles in adult social care and beyond. These variously show potential for connection and disconnection within practice eco-systems, and both vitalising and stymying aspects of indeterminate identity.

2.11. Conclusion

In this chapter, I have described advocacy's diverse nature. I have provided some rationale for why policymakers have sought, through statute, to channel advocacy activity within certain decision-making processes. The need for independent advocates to provide supported decision-making has been shown, including within contexts with ultimate constraints upon the exercise of individual autonomy. The need for CAAs' challenge function with the care and support system has also been discussed, including via reference to the limits of social work advocacy. Furthermore, the concept of professionalism has been explored and used to understand why the future development of statutory advocacy roles is contentious. Finally, liminality has been considered, where this can unite notions of CAAs *acting in-between* (working within the gaps in practice systems) and *being in-between* (their role has an indeterminate character). Having staked out this conceptual ground, I now consider what existing literature informs about how advocacy actually operates within real-world contexts.

3. Literature review

3.1. Introduction

I now present a narrative review of recent literature about advocacy in UK adult social care. My approach aligns with the general purpose of narrative literature reviews: to critically appraise the state of a field, identifying policy and practice issues, theoretical frameworks used, and areas of contention (Rumrill and Fitzgerald, 2001). The review builds on my previous discussion of different advocacy types and intended advocacy mechanisms, such as supported decision-making. I consider what existing literature tells us about how these mechanisms operate in practice, and how this relates to diverse outcomes experienced by users of advocacy services (Ridley et al., 2018).

3.2. Review methodology

Narrative literature reviews permit researcher subjectivity about inclusion of works and selection of themes for analysis (Rumrill and Fitzgerald, 2001). I have sought to partially offset this subjective approach via rigour within literature searching, employing both pre-defined and iterative processes (Aveyard, 2019). Three academic databases were searched: Applied Social Sciences Index and Abstracts (ASSIA); Scopus; and Social Care Online. Formal searches of these databases were conducted in August 2021 and May 2023. I provide further details about the searches in appendix B. Supplementary search techniques were also used, including backward citation searching via the reference lists of included articles.

Texts were considered if published since 2005 and significantly related to advocacy within UK adult social care. The choice of start date reflected the significance of the passage of the MCA2005, which created IMCA, the first statutory advocacy role in English and Welsh adult social care (Morgan, 2017). The end date for inclusion was extended to July 2023 to account for publication of a significant work providing conceptual elaboration of culturally appropriate advocacy (Salla et al., 2023). The breadth of my search criteria reflected the paucity of scholarship that focuses exclusively or even primarily on CAAs. Only one peer-reviewed paper based on original primary data collection about CAA services was located: a study by Newbigging et al. (2021) about the early phases of commissioning these. Inclusion of work about other forms of advocacy, statutory and non-statutory, also reflects the study's aim of understanding the CAA role in its wider context. Due to the significant volume of literature returned from searches, search terms were refined. My analysis also deals primarily with work about forms of independent case advocacy, which have most direct relevance for CAA, with less emphasis on exploring collective or cause-based advocacy in depth. Literature about non-UK advocacy was excluded, due to time and space constraints and the study's focus on the English statutory context. Among applicable scholarly works, only one paper (Sherwood-Johnson, 2016) concerned statutory advocacy from another UK nation.

For each scholarly work returned, I read its abstract and decided whether to include it based on its relevance to my research aims. Grey literature features prominently in the review and was especially valued for its potential to reflect recent developments (Pappas and Williams, 2011). However, inclusion of these items was approached with caution, as they lacked scholarly validation, such as via peer review (Bellefontaine and Lee, 2014; Pappas and Williams, 2011). A strongly purposive approach was taken to selecting grey literature, with items prioritised according to recency and relevance. Official outputs were also favoured, such as those from governmental bodies, reflecting the CAA role's basis in law and public policy. Appendix C presents a table listing all of the works about advocacy that are included in the review (*n*=72), identifying the type of literature, its methodology, and providing a brief critical appraisal. Literature types are designated as scholarly; grey; or official, i.e. produced by the Government or other public body discharging official functions, such as the CQC.

The review is structured around nine themes. These were identified via a combination of inductive analysis of the included content (Aveyard, 2019) and applying the aims of the narrative review, which in turn related to my overarching research aims. The themes are summarised in table 1. The chapter concludes with discussion about the specific knowledge gaps identified regarding CAAs' work.

Table 1 - Thematic summary of the literature review

Theme title	Topic coverage
Availability, eligibility and access	Evidence of gaps in access; availability of advocacy; practitioners acting as gatekeepers; steps to address access gaps.
Challenges of evaluation	Methodological considerations about evaluating advocacy. How desired outcomes differ between advocacy types.
Transactional advocacy mechanisms	How 'transactional', case-based advocacy operates (Ridley et al., 2018).
Commissioning: shaping organisations and practice	How commissioning of advocacy services relates to organisational form, and the scope and effectiveness of practice. Commissioning of CAA provision is a key consideration.
Constraints of statutory remit	Extends analysis of the previous theme, considering intrinsic limitations of statutory advocacy requirements. Explored via focus on supported decision-making and safeguarding.
Advocate–practitioner relationships	Factors affecting the quality of these interactions and implications for advocacy effectiveness.
Scope to conduct challenges	Ability of independent advocates to challenge professional decision-makers. Structural factors that shape this potential.
Specialism with service user groups	Issues about advocacy being organised according to the needs of different cohorts, defined with reference to impairment type/ service use.
Meeting diverse cultural needs	Ability of advocacy services to meet the needs of socially diverse populations. Emphasis on 'culturally appropriate advocacy'.

3.3. Availability, eligibility and access

3.3.1. Access gaps

Access to advocacy can be problematic. However, there is a lack of current, readily accessible data about advocacy provision across different areas, which hampers efforts to assess gaps in access (Mercer and Petty, 2021). For example, central government previously provided statistics about IMCA referrals, but reporting of these ceased after 2013/14 (DH, 2014c). ADASS (2020) calls for local authorities to converge on standardised collection and monitoring of data about advocacy.

There is nevertheless evidence of shortfalls in access to statutory advocacy. Regarding CAA, much of this relates to its early phases of implementation. Research based on Freedom of Information responses from 80 local authorities found CAA was provided to only 2.1% of people undergoing CA2014 assessments from April to September 2015 (McNicoll, 2016). Newbigging et al. (2021) report on data collected during 2016, which showed wide variation between local authorities in referral levels for CAAs. They attribute this at least partly to inconsistencies in how local authorities interpreted their new advocacy duties. Research has also highlighted local variations regarding access to other statutory advocacy types. Dixon et al. (2020) note that official monitoring of IMCA (DH, 2014c) and IMHA (CQC, 2015) shows disparities in referral levels between localities that cannot solely be ascribed to differing demographic characteristics.

The final official monitoring report on IMCA services (DH, 2014c) identified a national trend of increasing referrals, whilst the Covid-19 pandemic posed specific problems for advocacy access (ADASS, 2020). There is evidence that overall referral levels were depressed between March and May 2020, relative to the previous year, with CAA services among the worst affected advocacy types (NDTi, 2020).

3.3.2. Limited availability

Shortages in the availability of advocacy services can contribute to access gaps. Central government funding for advocacy is not ring-fenced (Dixon et al., 2020). Early problems with accessing CAA support arose partly from local authorities being insufficiently funded to meet their new advocacy responsibilities (Newbigging et al., 2021). This was evidenced by a survey of advocacy providers conducted for the Advocacy Action Alliance (AAA) in July 2015, which found that for 21 of the 24 local authority areas for which figures on anticipated advocacy spending by the local authority were reported, this was less than the amount projected as necessary, as per a tool developed via the Local Government Association (LGA). Moreover, average expenditure by these local authorities (as reported by the advocacy services surveyed) was the less than 50% of that projected by the LGA tool (AAA, 2015). A review by the Carers Trust of the first year of carers' support under the CA2014 noted apparent deficiencies in commissioning advocacy for informal carers (Bennett, 2016). Amid such resource shortages, the case law of *R (SG) v London Borough of Haringey [2015]* was clarifying (Schraer, 2015). This case concerned how Haringey's assessment of SG had taken insufficient account of her accommodation needs. The ruling established that, where eligibility for a CAA has been determined, such advocacy involvement must be provided from the commencement of CA2014 processes (Dixon et al., 2020). The judge quashed Haringey's assessment despite the local authority arguing SG had been on a waiting list for CAA (Dixon et al., 2020). Beyond CAA services, recent monitoring has identified continued evidence of inadequate IMHA provision in some locations, resulting in waiting lists (CQC, 2022:57).

There is evidence of depleted availability of non-statutory advocacy, as local authorities focus resources on what they must provide by law (NDTi, 2016; Morgan, 2017; Hardwick, 2018; Mercer and Petty, 2021; Newbigging et al., 2021). A survey of local authority commissioners found 20% reported reducing access to non-statutory advocacy or ceasing commissioning of it during 2015/16 (Newbigging et al., 2021). This compounded an evidence base, whereby an earlier survey had found slightly more than half of service provider respondents reporting that they or other advocacy organisations in their area had seen a reduction or ending of other advocacy contracts (although only a minority of respondents answered this question) (AAA, 2015). Guidelines by NICE (2022) note widely varying availability of non-statutory advocacy according to locality and service-type, despite such advocacy complementing statutory advocacy services in addition to helping meet the needs of people ineligible for those services. Non-statutory advocacy can thus improve quality of life and aid prevention, such as regarding need for hospital admissions (NICE, 2022). ADASS (2020) also argues local authorities should commission advocacy services beyond the legal minimum. As eligibility for CAA is related to involvement in processes, it is important to be cognisant of the national eligibility criteria which determine whether the local authority must arrange care and support to meet needs, as set out in appendix A.

Evidence of imbalance between advocacy needs and provision pre-dates the introduction of statutory advocacy requirements. Foley and Platzer (2007) discuss findings from a research project conducted in 2002, where mental health advocacy services were mapped across London, accounting for service type and spatial distribution. This enabled comparison with local demographic factors and the geographic dispersal of broader mental health services. The authors observed significant spatial variations in advocacy provision, with service providers and service users reporting funding inequalities that did not fully correlate with geographies of expressed need. They also noted misalignment between the types of services being commissioned and provided with the localised profile of user needs, with insufficient flexibility within service models. This included gaps in specialised provision for older people and people from minoritised communities. Regarding the latter, Foley and Platzer (2007) raise questions about where to locate the balance between developing capacity within mainstream advocacy provision versus bolstering grassroots, community-oriented services, with the latter often disadvantaged regarding fundraising capabilities. This research highlights longstanding questions about how best to ensure the availability of suitable advocacy provision for people from ethnically and racially minoritised communities, which remain highly pertinent given contemporary discussions, two decades on, about developing culturally appropriate advocacy (NICE, 2022). This is taken up below in section 3.11.

Some implications of a shortage of non-statutory advocacy are illustrated by Redley et al.'s (2010) analysis of an IMCA pilot programme. The average duration of IMCA involvement during the pilot was two months per case, which was relatively prolonged given IMCAs' decision-specific remit. For people changing accommodation, IMCAs could sometimes have withdrawn earlier if there were more community advocacy services available, to support the person through implementation of the decision (Redley et al., 2010).

3.3.3. Barriers to access

Some service user groups are at heightened risk of exclusion from advocacy. Sometimes this is due to the coverage of statutory advocacy requirements. Baxter et al. (2020) note a significant proportion of users of adult social care services are self-funders as they have finances above thresholds for state support, which can lead to them taking decisions about their care outside of involvement from the local authority (see appendix A). These authors challenge assumptions that self-funders are necessarily more capable of navigating the system and they recommend more advocacy for these individuals. There are also gaps in statutory advocacy rights for some people whose combined health and social care needs are met via NHS-funded provision. In particular, CAA eligibility does not extend to recipients of fully-funded NHS Continuing Healthcare (Mercer and Petty, 2021).

Among individuals with legal rights to advocacy, some groups face heightened barriers to access. Newbigging et al.'s (2015) review of IMHA services found this applied to: ethnically minoritised people, people with learning disabilities, older people with dementia, people with sensory disabilities, young people, and those whose mental health care is mandated via a Community Treatment Order. Newbigging et al. (2015) identify various potential explanatory factors, including levels of awareness of, and confidence in, advocacy services among these groups. They also highlight a dominant advocacy approach that stems from 'the largely white service user movement, grounded in instructed advocacy' (Newbigging et al., 2015:322)—this may undercut notions of assertive outreach to excluded individuals, who might not themselves proactively seek advocacy involvement. Such access difficulties are therefore emblematic of wider questions about the character of advocacy services and issues of power and societal marginalisation, which I return to in later sections of this review.

Newbigging et al. (2015:322) also highlight difficulties associated with professionals being positioned as ‘gatekeepers’ regarding access. Research has shown varying levels of awareness among practitioners regarding their responsibilities to ensure advocacy access, along with workload pressures increasing risks of missed referral opportunities (Lonbay and Brandon, 2017; Dixon et al., 2020; Lawson and Petty, 2020; Newbigging et al., 2021; CQC, 2022). Dixon et al. (2020) point to overlapping statutory advocacy remits causing confusion among practitioners, some of whom may also be wary of advocacy involvement given its mandate to hold them to account. Poor referral systems can also hamper access (Newbigging et al., 2021). Regarding access to IMHAs, a key consideration is how well practitioners promote IMHA services to qualifying individuals and process referral requests (CQC, 2015).

Research has highlighted further access issues concerning advocacy support with safeguarding. Lawson and Petty (2020) report advocates’ observations of a low level of advocacy referrals regarding safeguarding in some localities, along with concerns that some practitioners view advocacy as an obstacle to progressing interventions. Delayed access, such as due to late referrals, undermines advocacy’s effectiveness (Lonbay and Brandon, 2017). Personalised safeguarding practice requires the person’s desired outcomes be established at an early stage (Lawson and Petty, 2020). Similar issues concerning practitioners’ understanding of advocacy requirements regarding safeguarding have been identified in Scottish (Sherwood-Johnson, 2016) and Welsh statutory contexts (Older People’s Commissioner for Wales, 2018).

3.3.4. Addressing access gaps

A Safeguarding Adults Review (SAR) is required when an adult has died or suffered serious harm due to abuse or neglect, and concerns exist about the multi-agency response (DHSC, 2024:14.162-173). SARs can be a source of professional learning about advocacy access (Lawson and Petty, 2020), with ones authored by Kingston and Mortimer (2018) and Winter (2019) being examples of where a failure to appropriately engage advocacy input is noted. Winter's (2019) SAR regarding the death of 'Jo-Jo', mentioned in the introductory chapter, reflects the need to ensure any reliance on advocacy by family members is predicated on their capability and suitability to do this. This is especially important given findings by Southall et al. (2021) that some social workers can take an uncritical approach to familial advocacy, being too ready to see it as a proxy for the person's involvement.

Other routes to addressing access gaps have been identified. Training practitioners is a core requirement (Lonbay and Brandon, 2017; Lawson and Petty, 2020; NICE, 2022). Flags within electronic file systems can prompt about potential advocacy involvement, while student social worker placements with advocacy organisations help build practitioner awareness (Lawson and Petty, 2020). Moving to a presumption that CAA support will be provided to eligible individuals, unless they actively 'opt out' of this, was favoured by some advocates participating in Lawson and Petty's (2020:13) research. Levels of awareness of advocacy among service users and carers can be generally problematic (Dixon et al., 2020; Forbat and Atkinson, 2005). NICE (2022) recommends publicity to address this.

There have been advances in implementing opt-out approaches regarding IMHA support. The CQC (2022b) found some mental health services had followed its recommendation to arrange for all eligible individuals to meet an IMHA, although coverage was incomplete. Plans to put similar 'opt-out' arrangements for IMHA on a statutory footing were included in the Draft Mental Health Bill 2022. Legislative proposals included requirements for managers of hospitals or registered establishments to refer compulsorily detained individuals to the IMHA service, with the service then having to meet with the person to ascertain whether they wish to receive support (Joint Committee on the Draft Mental Health Bill, 2023). However, important differences remain between the nature of statutory eligibility for CAA and IMHA services, with a person automatically qualifying for IMHA support if they are subject to a particular provision of the MHA1983—whereas CAA eligibility hinges on ‘substantial difficulty’ and the absence of an ‘appropriate individual’ (Dixon et al., 2020).

3.4. Challenges of evaluation

3.4.1. Defining a basis for evaluation

Demonstrating advocacy’s effectiveness is important yet challenging. Establishing credibility and accountability increases the prospects of advocacy receiving policy recognition and adequate funding (Rapaport et al., 2005; Lonbay and Brandon, 2017; Macadam et al., 2014), and of practitioners making requisite referrals (NDTi, 2016). However, it is hard to devise common evaluation criteria for a heterogenous advocacy sector, while developing metrics relevant to relationship-based processes and empowerment-based outcomes is additionally challenging (Rapaport et al., 2006). Moreover, determining the specific effects of advocacy interventions is especially difficult given advocates are not decision-makers about care and support, and they operate within complex social contexts (Hussein et al., 2006). A scoping review of literature published between 1990 and 2013 found an ‘overwhelming lack of published, robust evidence’ for advocacy’s impact, although this was attributed more to a lack of high-quality evidence than to evidence of impact being absent (Macadam et al., 2014:33).

There is no widely adopted basis for conducting evaluations within the advocacy sector, (Newbigging and Ridley, 2018; Lawson and Petty, 2020; NICE, 2022). Guidelines by NICE (2022) call for evidence-based measurement of advocacy’s impact, including enhanced collection and analysis of standardised data. The guidelines also urge that evaluation mechanisms be designed to enshrine advocacy providers’ independence from commissioners. These issues chime with wider concerns about a lack of robust evidence for the effectiveness of social care interventions, including regarding social work with adults (Moriarty and Manthorpe, 2016).

Evaluating advocacy begs questions about *what* is being evaluated and *how* this should be done, although these are related considerations. Gratsias (2021) notes how various scholars (Macadam et al., 2014; Townsley et al., 2009; Stewart and MacIntryre, 2013; Newbigging et al., 2015) have used slightly different terminology to refer to two main types of positive effects from advocacy. Gratsias (2021) terms these 'process outcomes' and 'end-point outcomes': the former concerns the benefits that the person experiences from being supported through processes; the latter relates to tangible results from these processes, such as improved access to care and support. Townsley et al. (2009) cite respective examples of a person becoming more confident with decision-making ('process benefit') and experiencing improved community access ('outcome benefit'). Townsley et al.'s (2009) literature review discerned a stronger evidence base for the existence of process benefits than final-outcome benefits, alongside difficulties in establishing a causal link between these.

3.4.2. Evaluation methodologies

The choice of methodology for evaluating advocacy has important implications. The evaluation practices of service leaders and commissioners tend to prioritise measuring readily quantifiable 'outputs', such as numbers of referrals accepted, over 'outcomes and impacts', regarding the changes people wish to see in their lives (Lawson and Petty, 2020). Ridley et al. (2018) argue evaluations should seek to illuminate the workings of advocacy mechanisms through studying service users' experiences and perspectives. They suggest that co-production within service evaluations could highlight progress towards achieving outcomes, such as increased self-advocacy.

However, there are potential barriers to involving users of advocacy services in research. It can be difficult to directly garner the views of people with more profound cognitive or communication impairments (Macadam et al., 2014). Some important texts reviewed did not incorporate insights from service users (e.g. Redley et al., 2010; Lonbay and Brandon, 2017; Hardwick, 2018), while a paper on CAA (Newbigging et al., 2021) only included the voices of disabled people via their involvement in a roundtable meeting.

NICE has previously called for advocacy evaluations to include mixed-methods studies with a 'controlled effectiveness component (preferably randomised)' (NICE, 2018: online). The only work reviewed that had a significant quantitative component was survey-based research by Eades (2018), conducted with IMHA users in a forensic setting. This found evidence of an overall positive impact of IMHA support on mental wellbeing, including a high proportion of service users reporting increased confidence engaging with their care team. None of the works reviewed used experimental methodologies, such as randomised controlled trials, where participants are assigned between a group receiving an intervention and one that does not. While randomised controlled trials have high evidential status in healthcare evaluations, take-up regarding social care has been lower, due to epistemological and ethical concerns (Mezey et al., 2015). Webb (2001) argues such experimental methodologies cannot account for the complexity of human interactions that are involved within social care interventions. The CAIMeR theory of Blom and Morén (2010), which this thesis draws upon and I discuss in the next chapter, offers a response to these shortcomings of positivist methodologies.

There has also been a paucity of evaluations of whether advocacy represents value for money (Macadam et al., 2014). The Government's *Impact assessment* for the CA2014 indicated there is evidence that investing in advocacy can yield social returns, such as by aiding prevention and making services more responsive to people's needs (DH, 2014a; Voluntary Organisations Disability Group, 2012). However, the impact assessment acknowledges these insights cannot necessarily be applied directly to CAA services, because of the highly specific nature of their statutory remit (DH, 2014a).

3.4.3. Heterogenous advocacy outcomes

Advocacy's conceptual breadth necessitates a nuanced approach to evaluating its effectiveness. Advocacy types can differ widely: regarding the forms of empowerment they engender, their balance of process and outcome benefits, and their political implications. This is illustrated by a suite of outputs concerning mental health advocacy, comprising research reports (Newbigging et al., 2007, 2012) and secondary analysis and scholarly elaboration (McKeown et al., 2014; Newbigging et al., 2007, 2013, 2015; Newbigging and Ridley, 2018; Ridley et al., 2018). Ridley et al. (2018) use a qualitative meta-synthesis of data from three research projects to explore user-defined advocacy outcomes. Two of those studies are most pertinent to this review: one about experiences of individuals qualifying for an IMHA (Newbigging et al., 2012), the other concerning African and African-Caribbean men who had experiences of using mental health and community advocacy services (Newbigging et al., 2007). Ridley at al. (2018) found differences in how positive advocacy outcomes were viewed between these two sets of people. IMHA recipients tended to emphasise the benefits of being supported and represented through processes relating to their detention, care and treatment, leading to them 'having a voice' (Ridley et al., 2018:285). Among the African and African-Caribbean men, positive outcomes arose from self-advocacy and peer advocacy mechanisms, which bolstered a sense of self-reliance and departed from advocacy being viewed as a formal service. This collective advocacy approach could bring direct outcome benefits (see Townsley et al., 2009), including fostering a shared sense of cultural identity, based partly on common experiences of racism and other forms of marginalisation. Ridley et al. (2018) relate the experiences of IMHA users to 'transactional', case-based forms of advocacy that can advance testimonial justice; and that of the African and African-Caribbean men to notions of 'transformational' advocacy that advance hermeneutical justice (see Fricker, 2007). Ridley et al. (2018:289) argue that both advocacy paradigms are necessary and 'valued by service users'.

3.5. Transactional advocacy mechanisms

3.5.1. Elucidating transactional mechanisms

Literature has illuminated the transactional mechanisms by which case advocacy can bring primarily process-based benefits to people. Scholarly work about IMHA (Newbigging et al., 2012, 2015; Ridley et al., 2018; Newbigging and Ridley, 2018) foregrounds this role's in-between positionality and inter-personal aspects. Service users variously characterised IMHAs as acting as a 'bridge' between them and professionals, or as a lubricant that makes the mental health system work more smoothly; others described IMHAs' role in more directly instrumental terms, as a 'lever' or 'hammer' (Newbigging et al., 2015:321). Service users valued IMHAs negotiating on their behalf (Ridley et al., 2018) and acting as an 'ally' in formal meetings, exhibiting confidentiality and a non-judgemental approach (Newbigging and Ridley, 2018:41). This potentially included support with social issues affecting the person's wellbeing, such as regarding housing, benefits and personal relationships (Newbigging and Ridley, 2018). Service users might be satisfied with the input of their IMHA even if their desired outcomes from mental health processes were not achieved (Ridley et al., 2018). An audit of IMHA provision in two forensic settings also found service users benefitting from developing trusting relationships with IMHAs (Palmer et al., 2012). Environmental context was important, with IMHAs able to adopt a 'pro-active model of engagement' with service users, due to their physical proximity on the ward (Palmer et al., 2012).

Research has similarly shown IMCAs using their relational skills to activate bridging mechanisms, accompanied by scrutiny of professional practice in a way reflective of non-instructed advocacy (Morgan, 2017; Townsley and Laing, 2011; Series, 2013). IMCAs often negotiate on behalf of service users (Morgan, 2017). Studies of IMCA practice have shown their communication skills can enhance best interest-decision-making by helping maximise the person's involvement (Townsley and Laing, 2011), thus helping social care decision-makers understand the person's needs (Redley et al., 2010). Series (2013) points to evidence of some practitioners outsourcing aspects of relational engagement with service users to IMCAs. Moreover, IMCA support is sometimes so effective it can enable a person to make a capacitous decision (one they have legal capacity to make), despite this not being what the role is technically for (Series, 2013).

In a study based on data collection from two local authorities, pre-dating the CA2014, Lonbay and Brandon (2017) describe key mechanisms by which advocates promoted older people's involvement in safeguarding processes. 'Supporting the individual' was illustrated by explaining jargon used by social workers. 'Making challenges' was shown by advocates expressing concerns over the conduct of mental capacity assessments, or whether the 'least restrictive' principle for best-interest decision-making had been adhered to. 'Independent representation' could entail non-instructed advocacy; it came to the fore when family members were deemed unable to neutrally convey to practitioners what is important to the service user. Research is therefore needed to ascertain how such advocacy mechanisms work in the updated context of the CA2014, given innovations of the CAA role such as an explicit mandate to challenge local authority decisions that do not advance wellbeing (DHSC, 2024:7.52).

3.5.2. Limitations of transactional advocacy

Practical constraints and conceptual tensions exist over implementing the transactional advocacy models identified by Ridley et al. (2018). The power of statutory advocacy can be limited in the face of deficiencies in the professional and service systems it interfaces with. For example, IMHAs' impact can be stymied by general inadequacies within mental health services (Newbigging et al., 2015). During an IMCA pilot scheme, some practitioners had unrealistic expectations that IMCA involvement could help resolve delays in discharge of hospital inpatients, which related to a lack of suitable care 'placements' (Redley et al., 2010).

The literature reviewed featured no detailed discussion of how advocates' workload pressures are managed and how this might affect practical interpretation of their remit. This might be another area of disparity within provision: a study of IMHA services found the average caseload per IMHA varied from 8 to 55 between sites (Newbigging et al., 2015). Lonbay and Brandon (2017) identified a perception among advocates of their service being overstretched. Moreover, need to respond quickly to safeguarding concerns can limit scope for relational advocacy practice (Lonbay and Brandon, 2017; Sherwood-Johnson, 2016).

Non-instructed advocacy presents challenges in terms of practice and principle. Series (2013) notes non-instructed advocacy's contentious position within the advocacy sector, as it involves departing from established notions of fulfilling an advocacy mandate that emanates directly from the person. This tension with person-led principles is further manifested in the

IMCA role, where there is no legal provision for people to request or decline IMCA involvement or choose who should advocate for them in this regard (Series, 2013). As for IMHAs' practice, this—like that of CAAs—can straddle work with service users who have relevant capacity and those who do not (Newbigging et al., 2012). A study has shown some IMHAs expressing unease about non-instructed advocacy, describing its use as a last resort (Newbigging et al., 2012).

Lonbay and Brandon (2017) consider further potential difficulties in applying transactional advocacy models. They identify practical restrictions on the ability or willingness of some older people to participate at an advanced level in safeguarding processes, even with advocacy support. Lonbay and Brandon (2017) argue this shows the limits of advocacy models that are predicated upon individual empowerment—an emphasis they ascribe to a neo-liberal policy orientation. Stewart and MacIntyre (2013) note similar tensions: between an advocate seeking to represent a person's wishes in their most direct form, versus the advocate trying to 'empower' them to overcome forms of structural injustice.

Given these limits to transactional working, Lonbay and Brandon (2017) call for case advocacy to be complemented by collective-level advocacy. They identify scope for this via advocacy providers becoming involved in strategic safeguarding initiatives and dialogue, including participation in local multi-agency Safeguarding Adult Boards. The CA2014 placed these Boards on a statutory footing (DHSC, 2024:14.133-161). Another example of a more strategic approach is advocacy organisations working with people with learning disabilities to raise awareness of hate crime (Roberts et al., 2012). Moreover, ADASS encourages advocacy organisations to act as a 'critical friend' to local authorities, raising issues of concern that recur across advocacy cases and aiding co-production by facilitating user engagement in service design (ADASS, 2022:2). Advocacy organisations can also undertake policy advocacy: a report by NDTi features a pledge from contributing advocacy organisations to use their expertise to promote 'systemic change', making the case for reforms to the mental health and care and support systems (NDTi, 2020:22).

3.6. Commissioning: shaping organisations and practice

3.6.1. Commissioning CAA

The case-based nature of the CAA role aligns with notions of transactional advocacy (Ridley et al., 2018). It is therefore important to understand how the potential benefits and limitations of transactional advocacy translate into practice under the CA2014. Here, commissioning practices are a central concern, as Newbigging et al. (2021) show in their mixed-methods study of the early phases of implementing the CA2014's independent advocacy requirements, which drew on data including survey responses from commissioners in 46% of English local authorities. Their analysis highlights flux and diversity in commissioning practices during this initial period: local authorities took different approaches to meeting their statutory responsibilities, variously indicative of 'law-based' and 'valued-based' interpretations of advocacy (Newbigging et al., 2021:429). The former was reflected in the creation of dedicated CAA services, specifically for advocacy support with involvement in CA2014 processes. The latter was manifested in more holistic commissioning practices, with CAA provision being co-located with or even amalgamated within services meeting other advocacy needs. Advocacy hubs exemplified this value-based approach, by providing a single point of access to a diverse pool of advocacy services, including those specialising with particular user groups. However, Newbigging et al. (2021) found austerity pressures were influencing local authorities towards adopting more narrowly law-based interpretations of their responsibilities regarding advocacy, which meant the arrival of the CA2014 helped consolidate a retreat from providing much non-statutory advocacy. This evidence of fluidity and uncertainty around early commissioning of CAA adds to that provided by the survey report for AAA (2015), which found from its advocacy organisation respondents that almost two-thirds of contracts for independent advocacy were for a year or less. The report also cited anecdotal evidence that some advocacy services had to prompt local authorities regarding initiating a commissioning process for CAA (AAA, 2015).

Newbigging et al. (2021) identify various implications of this more restrictive approach. Advocacy risks becoming available only to people who meet the statutory eligibility criteria for adult social care. Moreover, individuals might only have intermittent access to advocacy, depending on whether statutory processes are active at that time; scope for advocacy to engender longer-term empowerment is therefore reduced. This reduces prospects for making supported decision-making available across the whole of disabled people's lives, as the UNCRPD envisions. Moreover, unfulfilled aspirations regarding decision-making were reflected in the under-utilisation of 'Disabled People's Organisations' (DPOs) as CAA providers, with these organisational types being more aligned with self-advocacy and peer advocacy models, and more likely to accept self-referrals. The research found only 12% of commissioned CAA providers were DPOs, which the authors ascribed to these fitting uneasily into a 'contract culture that favoured larger, better-resourced organisations' (Newbigging et al., 2021:435). Newbigging et al. (2021) relate these organisational trends to questions about the merits of professionalising advocacy, and they call for more co-design and co-production of advocacy services with disabled people—with a similar argument made in outputs by ADASS (2020) and NICE (2022). However, Newbigging et al. (2021) do not engage in depth with debates about how to define a DPO, including how DPO status relates to the composition of disabled people on the organisation's board and arrangements for their employment (Carey, 2019).

3.6.2. Commissioning practices and other advocacy models

Hardwick (2018)'s research into citizen advocacy reinforces how prevailing commissioning practices are leading to grassroots, community-oriented advocacy organisations being displaced by larger 'business-focused' ones (Hardwick, 2018:144). For Hardwick (2018), citizen advocacy is antithetical to neo-liberalism, as it prioritises human relationships and rejects the all-encompassing pursuit of economic rationality. Citizen advocacy organisations are therefore strongly disadvantaged by commissioning practices aligned with 'new public management', including emphasis on quantitative evaluation. Concerns that quality control regimes impact disproportionality on smaller advocacy organisations are longstanding (Rapaport et al., 2006) and feature in contemporary policy debate (DHSC, 2021a).

New public management practices further constrain the duration of statutory advocacy involvement with individuals (Hardwick, 2018; see also Newbigging et al., 2015, 2021).

Hardwick quotes an IMHA explaining that a pattern of intermittent engagement with service users partly reflected an organisational need to capture discrete advocacy outputs in statistics. Yet the IMHA acknowledged that for ‘clients who are incredibly vulnerable (…) you can’t just jump in and out of their lives like that’ (Hardwick, 2018:146). Against such tendencies, guidelines by NICE (2022) recommend that local authorities should not cap the number of hours of advocacy that will be funded per person. The guidelines also call for necessary long-term advocacy input to be facilitated, such as for individuals at ‘high risk’ of harm (NICE, 2022:82).

Advocacy can assume a markedly different character when not configured as a local authority-commissioned service. Cornes et al. (2018) show this via a study of a National Lottery-funded project, VOICES. This supported people experiencing multiple needs, comprising one or more of homelessness, substance misuse, mental health problems and reoffending. VOICES could take a more expansive approach to advocating with people and fuse this with providing practical support. Support from VOICES was therefore not confined to supporting individuals through active care and support processes, as it also covered the point of initial contact with adult social care. VOICES staff helped refer people to local authorities and were prepared to assertively challenge practitioners if requests for support under the CA2014, or even for an assessment itself, were declined due to a perception that people were making a ‘lifestyle choice’, such as due to substance use (Cornes et al, 2018:6).

3.7. Constraints of statutory remit

3.7.1. Supported decision-making

Limits on the ability of statutory advocates to implement supported decision-making are further explored by Dixon et al. (2020), via a critical review of legislation, policy and research regarding case advocacy for people with dementia in England and Wales. This dementia-specific focus directs attention to how advocacy mechanisms can work in particular ways with individuals affected by certain types of impairment, which I return to below. Dixon et al. (2020) argue the progressive nature of dementia shows the need for services to provide long-term advocacy partnerships. Such partnerships could span the divide between supported and substituted decision-making: if it becomes necessary for the advocate to represent someone who can no longer direct people regarding their choices and decisions, the advocate can be informed by the deep knowledge of the person that they have already accrued. Yet current service configurations, due to statutory limitations and resource-constrained commissioning, do not allow for these enduring partnerships (Dixon et al., 2020).

In response, Dixon et al. (2020) propose extending rights to independent advocacy, so they cover all people with ‘mental disabilities’[3] using health and social care services. They suggest this would bolster access and provide a legislative basis for continuous advocacy, with less potential for friction when a service user’s advocacy provision shifts between statutory remits (Dixon et al., 2020). There is some evidence this friction occurs: Mercer and Petty (2020) cite anecdotal evidence that larger advocacy providers tend to have more capacity to provide multiple forms of advocacy, easing transitions between these. Dixon et al. (2020) acknowledge that extending advocacy rights would have significant costs implications, where financial considerations have to date affected the government’s approach to setting statutory advocacy eligibility (see also Redley et al., 2010; DHSC, 2021a).

Introducing more inclusive rights to independent advocacy might have implications for the balance between this and family members’ informal advocacy (Dixon et al., 2020). This could in turn influence the effectiveness of the support some people receive, as some relatives may find it difficult to speak up against professionals, due to a sense of deference (Dixon et al., 2020). Series (2013) discusses how family members may find it difficult to challenge practice under the MCA2005, as many have less relevant technical knowledge than IMCAs do, and less ability to access channels of legal redress (Series, 2013). However, these

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[3] ‘Mental disabilities’ is an overarching term that Series (2022:*xiii*) notes can be used collectively in reference to ‘people with cognitive, psychosocial, developmental and similar disabilities’, although she acknowledges it is ‘far from ideal’. Following Dixon et al. (2020) I have applied the term in this context, where its definitional breadth is suitable, but as Series (2022) notes, more specific terminology should be used when possible.

concerns must be set against the principle that, wherever possible, people should choose who advocates for them (Series, 2013). Friends and relatives are sometimes best placed to provide support and representation; for example, it is common for people with dementia to value being assisted by familiar individuals (Dixon et al., 2020; 2021).

3.7.2. Safeguarding

The safeguarding potential of CAA services is affected by their statutory basis and associated commissioning practices. Lawson and Petty (2020) argue that more flexible funding arrangements would give advocates greater latitude to develop their presence within settings such as care homes and mental health wards. They could then engage and scrutinise on a wider and more proactive basis, helping to prevent or flag up concerns about abuse, neglect, or poor practice (Lawson and Petty, 2020) and thus contribute to fulfilling a preventative safeguarding agenda (DHSC, 2024:14.11). The necessity of advocacy's monitoring function has been recognised regarding in-patient provision for people with learning disabilities and autistic people, who may be accommodated far from their families and subject to segregation, seclusion or restraint (DHSC, 2021b). This includes mention in the Serious Case Review of institutional abuse at Winterbourne View Hospital (Flynn, 2012).

Funding shortfalls also stymy advocacy organisations' abilities to effectively promote safeguarding at a strategic level, such as by participating in Safeguarding Adults Boards and conducting outreach activities with safeguarding practitioners (Lawson and Petty, 2020). This undermines an agenda of advancing collective approaches to empowerment, which Lonbay and Brandon (2017) emphasise. Research by Sherwood-Johnson (2016) regarding adult safeguarding in Scotland has similarly shown that introducing statutory advocacy requirements increased overall funding for advocacy and raised its profile, while making it more individualised and short-term and thus less preventative. This was because the protective implications of more holistic and enduring advocacy relationships had been undermined. Relevant commissioning practices included imposing limits on the number of contacts that advocates could have with a person over a particular safeguarding episode (Sherwood-Johnson, 2016).

3.8. Advocate–practitioner relationships

The nature of advocates' relationships with practitioners can shape their ability to practice effectively. Pursuit of partnership must be balanced with recognition of advocates' challenge function (McKeown et al., 2014; Sherwood-Johnson, 2016). Advocates can help maintain service users' trust that they are on their side by staying visibly independent from practitioners, especially in circumstances such as detention under the MHA1983 where power imbalances with professionals are especially stark (McKeown et al., 2014). Yet it can be harder for advocates to maintain boundaries when they are involved in inter-professional collaborative working; Sherwood-Johnson (2016) cites situations where practitioners share information with advocates that the service user is not privy to, straining advocacy's person-led mandate.

Trust and mutual understanding of roles are necessary for effective advocate–practitioner relationships, yet some practitioners' understanding of their responsibilities to facilitate advocacy involvement is under-developed and their attitude towards it can be problematic (McKeown et al., 2014; Redley et al., 2011; Sherwood-Johnson, 2016; Lonbay and Brandon, 2017; Lawson and Petty, 2020). McKeown et al. (2014) report findings that suggest relationships between IMHAs and staff on mental health wards can have a personalised quality, with IMHAs describing inconsistencies regarding receiving information and being invited to meetings. Other potential problems are advocates receiving referrals lacking necessary information (Sherwood-Johnson, 2016) or not receiving feedback on their input (Redley et al., 2010; Lawson and Petty, 2020). Practitioners may also have unrealistic expectations of what advocacy input can achieve (Redley et al., 2010; Sherwood-Johnson, 2016). However, as when addressing access issues, advocacy organisations can respond to lapses in co-operative working: via training and outreach activities (Redley et al., 2011; Sherwood-Johnson, 2016; Mercer and Petty, 2020) or by advocacy managers taking up concerns about particular practitioners' conduct (McKeown et al., 2014).

Existing literature points to some underlying factors that can shape practitioners' attitudes. Advocates may be perceived as having a confrontational approach (Sherwood-Johnson,

2016) or being demanding of practitioners' time (McKeown et al., 2014). Some practitioners view advocates as possessing a less advanced knowledge base than their own (Dixon et al., 2020; Redley et al., 2011). McKeown et al. (2014:404) vividly illustrate this by quoting an Approved Mental Health Practitioner describing IMHAs as 'a bloody nuisance' and 'amateurs meddling'. Various studies suggest that professional knowledge hierarchies are pronounced regarding interactions between medical staff and IMCAs, especially over scrutiny of best-interest decisions about serious medical treatment (Redley et al., 2010; Chatfield et al., 2018; Luke et al., 2008). A perception of independent advocates encroaching on professional turf can also arise when advocacy forms part of practitioners' own identity. McKeown et al. (2014) identified this an issue among some nursing staff on mental health wards, with nurses allotted an advocacy role by the Code of the Nursing & Midwifery Council (2018).

Tense relationships with professionals can be stressful for advocates, who need appropriate support to maintain their wellbeing and effectiveness (Forbat and Atkinson, 2005). Such support mechanisms were under-explored in the literature reviewed.

3.9. Scope to conduct challenges

Discussions of advocates' challenge function highlight interactions between individual practice and structural parameters. A widely cited concern within the literature reviewed is that advocacy organisations might be wary of seeming overly critical of local authorities, in case they jeopardise their chances of being re-commissioned (e.g. Rapaport et al., 2006; Redley et al., 2011; Hardwick, 2018; Newbigging et al., 2021). This has led to the suggestion that centrally funding advocacy organisations could help preserve their independence (Manthorpe et al., 2006). Guidance from the Social Care Institute for Excellence (SCIE) (SCIE, 2022) calls for commissioning arrangements to have built-in safeguards for advocates' independence, including a system for dispute resolution and demarcated limits to local authority influence. Nevertheless, a recent EHRC inquiry report referenced on-going concerns (EHRC, 2023). It noted that some lawyers and 'civil society experts' who contributed evidence believed there were individual advocates who 'felt pressurised' not to pursue challenges, although prevalence was unclear (EHRC, 2023:23). Also reported were some service users’ experiences that advocates had not proactively helped them to make complaints. It called for oversight of advocacy services to ensure they are providing appropriate support with complaints. This feeds into debates about the merits of introducing enhanced regulation of services (DHSC, 2021a).

Series (2013) shows that legal remit, commissioning relationships, and resources are all factors can affect IMCAs’ abilities to undertake challenges. She points to a relatively low rate of formal challenges conducted by IMCAs, in terms of complaints to the local authority and Court of Protection applications. Series (2013) suggests this may arise from a combination of IMCAs seeking to avoid confrontation and, more positively, negotiatory mechanisms proving effective in resolving disputes. Other factors constraining challenges could be a lack of time to pursue these, and how the IMCA role is legally configured (Series, 2013). Individual IMCAs therefore exercise significant discretion over conducting challenges, which ‘injects an element of arbitrariness into the functioning of the IMCA service as a safeguard in itself’ (Series, 2013:164). Other empirical work lends support to these arguments. A study of an IMCA pilot programme found only 15% of decisions were challenged by IMCAs, with the conduct of the capacity assessment being the cause of dissent in a majority of these cases (Redley et al., 2010). A later study of IMCA involvement in safeguarding decisions also found IMCAs feeling constrained by a wish not to damage working relationships with safeguarding teams (Redley et al., 2011).

Constraints on enacting challenges are not confined to statutory advocacy work. Cornes et al. (2018) describe VOICES staff pursuing a ‘persistent advocacy’ approach, including readiness to use local authority complaints processes to challenge eligibility determinations (Cornes et al., 2018:6). However, this case study shows that even an organisation financially independent from the local authority, as VOICES was, still had to carefully calibrate its challenges. Staff held to notions that excessive conflict with statutory services might not only damage relationships but risk negative consequences for service users. It was observed that excessively ‘arguing the case’ might delay achieving some resolution to disputes, and hence to the person receiving some support (Cornes et al, 2018:7).

Statutory status can also enhance advocates' opportunities for holding decision-makers to account. Citizen advocates interviewed by Hardwick (2018) acknowledged that statutory advocates can benefit from improved rights of access to some service users, such as people living in 'dementia units', and to their records. Among participants there was also recognition that volunteers may find it harder to be assertive with health professionals. This is similar to observations that relatives may find challenging professional expertise difficult and daunting (Series, 2013; Dixon et al., 2020), highlighting the power differentials at play.

Issues about access to advocacy and ability to challenge decisions intersect. Some service users are excluded from assistance with challenging decisions as they do not meet statutory eligibility criteria. The EHRC (2023) supports compelling local authorities to commission independent advocacy support for making social care complaints. This would mirror arrangements for advocacy support with NHS complaints, which have existed in their current form since the passage of the Health and Social Care Act 2012, s.185 (EHRC, 2023).

3.10. Specialism with service user groups

An important organisational variable concerns whether advocacy services are configured to enable specialism with particular user groups. This helps determine the nature of advocacy processes and outcomes. Overall, there has been a broad shift towards 'generic' advocacy services, rather than those targeted according to type of service use (Roberts et al., 2012). Statutory advocacy duties exist on generic lines, so the availability of provision such as specialist 'dementia advocacy' varies according to local commissioning decisions (Dixon et al., 2020). All group-specific advocacy services that featured in the literature reviewed were non-statutory. A study by Brown et al. (2013) of dementia advocacy found a tailored approach; for example, when visiting people living in care homes, advocates combined social support for the person with opportunities to represent their interests to the home's manager. However, the viability of these dementia-specific services was being threatened by austerity cutbacks and competition with larger advocacy organisations vying for the same contracts (Brown et al., 2013). This shows a diminishing supply of group-specific advocacy services is reflective of broader structural trends affecting the sector.

Given the exclusionary impact of eligibility criteria for adult social care services (Newbigging et al., 2021), specialist advocacy services can help fill gaps in support. This is demonstrated by an evaluative study of Leeds Autism AIM (Advocacy, Information, and Mentoring), a hub for adults diagnosed with ‘high functioning autism spectrum disorder’ (Southby and Robinson, 2018). This study shows that the hub worked effectively to provide advocacy alongside social and practical support, although it was threatened by funding cuts. The presence of such a service aligns with government guidance recommending that wide-ranging advocacy support for autistic people be available, across areas including employment, health, and parenting (DH, 2015). Yet much of this support remains undelivered due to being non-statutory (Watts, 2017).

Advocacy organised on the basis of service user groups can engender collective forms of empowerment. Power et al. (2016) consider the workings of peer advocacy groups among people with learning disabilities, where the term peer advocacy is often used interchangeably with peer support or self-advocacy. These groups offer important opportunities to socialise, potentially offsetting some of the increased isolation that has arisen from enactment of personalisation policies (Power et al., 2016). Goodley (2005) views self-advocacy groups as an expression of collective agency and resilience among disabled people. However, other research about peer and self-advocacy organising among people with learning disabilities shows that some professional input may be necessary to help initiate and sustain these groups, which presents funding implications (Llewellyn and Northway, 2008; Power et al., 2016; Anderson and Bigby, 2020). This reinforces how the real-world application of advocacy models must be sensitive to the nature of people’s experiences of impairments, whether such advocacy is conducted on individual or collective bases (see Redley and Weinberg, 2007).

An area in which increased specialisation of statutory advocacy has been mooted is support for people with a learning disability and autistic people who are inpatients in highly restrictive settings. *Reforming the Mental Health Act* acknowledges a need for improvements in advocacy with these service user groups, including via development of the IMHA qualification (DHSC, 2021a:54)[4]. This aligns with a national plan to reduce the number of people with learning disabilities and autistic people who are accommodated in mental health inpatient services (DHSC, 2021a:80). Advocacy is also explicitly part of the 'named social worker' role that has been piloted as part of furthering this agenda, although this is advocacy by professionals rather than independent advocacy (James, 2021; King and Romeo, 2022).

A briefing by Voiceability and Kate Mercer Training (2020) calls for enhanced independent advocacy for all people with learning disabilities and autistic people who are in-patients or at risk of becoming such. This proposed service would span all statutory advocacy remits, support the person until they are in suitable community provision, and be undertaken by specially trained individuals, with requisite communication skills. The briefing suggests that such advocacy may need to be commissioned nationally to ensure its full independence from local authority commissioners, who are responsible for ensuring suitable community services are available as an alternative to inpatient provision. Avoiding confusion and duplication with locally commissioned advocacy would therefore be a priority (Voiceability and Kate Mercer Training, 2020). The need for the government to consider introducing a 'Central Advocacy Service' of this type has also been endorsed by parliamentarians scrutinising draft mental health reform legislation (Joint Committee on the Draft Mental Health Bill (JCDMHB), 2023:95). Therefore, questions of specialism interface with other key issues, including about the durability of statutory advocacy involvement, continuity across statutory remits, and independence from local authorities.

3.11. Meeting diverse cultural needs

Existing literature highlights that services must be able to meet advocacy needs among diverse populations (Newbigging et al., 2017; ADASS, 2020; NICE, 2022; EHRC, 2023).

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[4] The IMHA qualification is part of the broader City & Guilds Level 4 in Independent Advocacy practice (City & Guilds, 2024).

Culturally knowledgeable and attuned services are required, which display 'cultural sensitivity' (Newbigging et al., 2011:94) and 'cultural competence' (NICE, 2022:83). The latter concept refers to an on-going striving to develop understanding of diverse cultures, enabling work that transcends barriers and contributes to racial equity and social justice (Greene-Moton and Minkler, 2019). An instance of culturally sensitive advocacy might involve the person and their advocate communicating in a language other than English (El Ansari et al., 2009; Harrison and Davis, 2009; EHRC, 2010). Linguistic connections become especially important if there are gaps in interpretation services, as have been reported (NICE, 2022; Sherwood-Johnson, 2016).

Discussion of the need to foster culturally attentive services has been especially prominent regarding mental health advocacy. Newbigging et al. (2015) identify gaps in suitable IMHA provision for ethnically minoritised people, which they ascribe in part to the predominantly white ethnic composition of service user movements that fed into development of the contemporary advocacy sector. 'Culturally appropriate advocacy' has been proposed as a policy agenda and practice model in response to such gaps (DHSC, 2021a; NICE, 2022). *Reforming the Mental Health Act* established 'the development of culturally appropriate advocacy for people of all ethnic backgrounds and communities, in particular for people of black African and Caribbean descent' as a governmental objective (DHSC, 2021a:92). Two pilot programmes were subsequently implemented (DHSC, 2021a; JCDMHB, 2023).

The Draft Mental Health Bill 2022 did not include provisions to make culturally appropriate advocacy a legal requirement. Parliamentarians scrutinising the Bill were critical of this (JCDMHB, 2023). In their report, they identified various unresolved issues regarding culturally appropriate advocacy and noted the government's stated intention to roll out the initiative via policy measures, without statutory underpinning. Concerns were identified, based on consultations within the advocacy sector, about whether there is sufficient funding and sectoral capacity to implement culturally appropriate initiatives. In response, some consultees had suggested making greater use of peer advocates in delivering culturally appropriate advocacy, although the parliamentarians referenced corresponding questions about whether advocates with more informal status would be able to discharge the role effectively (JCDMHB, 2023). Deliberations about culturally appropriate advocacy thus raise recurring concerns about the relative merits of peer and professionalised approaches, underpinned by questions of power and resources. Yet despite contention about using non-statutory community advocacy as the primary delivery vehicle for culturally appropriate initiatives, the value of peer approaches in work with racially minoritised people has been emphasised within scholarship about mental health advocacy (Newbigging et al., 2013, 2015). It is also important not to present choices about optimal service configurations according to an either/or binary: NICE (2022) recommends developing partnerships between mainstream and culturally specialised advocacy services, for example.

Advocacy mechanisms arising from shared cultural identity have also been discussed in the context of more formalised services. NICE guidelines advise making the composition of advocacy staff teams more reflective of diversity within local populations (NICE, 2022:82). The guidelines also approvingly mention the possibility of giving service users a choice of advocate, such as based on ethnicity or gender, although they acknowledge smaller organisations may find it harder to do this (NICE, 2022). Newbigging et al. (2012, 2015) found the IMHA workforce they studied was three-quarters composed of white women, again suggesting possible barriers to offering choice.

A nuanced and intersectional view of how identity-sharing mechanisms work is also needed. Newbigging et al. (2012, 2015) found that most service users in their study attached greater importance to IMHAs' expertise and personality than to their gender, ethnicity and whether they were disabled. An EHRC report on *Advocacy in social care groups protected under equality legislation* (EHRC, 2010) also noted various possible dynamics. The report argued that shared cultural identity can help advocates build trust among people experiencing a high level of marginalisation, with an organisation advocating with people from the Gypsy and Traveller community cited in evidence. This was accompanied by observation of how, regarding some advocacy organisations working with women from minoritised ethnic communities, emphasis on shared gender was generally perceived to be most salient for building advocacy relationships (EHRC, 2010).

Such complexity is further evidenced by an evaluation of advocacy services for ethnically minoritised people in Glasgow (Bowes and Sim, 2006). This acknowledges the significance of cultural specificity, as with making linguistically appropriate advocacy available. It also found people tended to value more professionalised expressions of advocacy for its perceived ability to help them attain chosen outcomes from mainstream services. This suggests appreciation of a transactional mode of advocacy (Ridley et al., 2018). Bowes and Sim (2006) describe the mandate of advocacy organisations that serve ethnically minoritised populations in a way that underscores their in-between position. They must remain connected to the communities they serve, being attuned to their needs, while also looking outwards to mainstream services, so they can contest their constituency's marginalised status in respect of these. Bowes and Sim (2006:1223) conclude that 'advocacy is not therefore a substitute for responsive, ethnically sensitive and anti-discriminatory services, but a force that should promote them.'

As culturally appropriate advocacy continues to be developed in policy terms, Salla et al. (2023) focus on its application regarding mental health. They provide conceptual elaboration and recommendations to policymakers, commissioners, service providers and individual advocates, based on extant literature and the authors' scoping review and evaluation of pilots of culturally appropriate advocacy for the DHSC. They contend that the term culturally appropriate advocacy is 'enigmatic; it lacks robust definition' (Salla et al., 2023:3), in turn relating to how culture is a 'nebulous and intangible term'. They argue that having a profusion of similar and overlapping terms relating to cultural practice—cultural awareness, humility, adaptation, appropriateness, and others—can be obfuscatory. Recommendations advanced by Salla et al. (2023) are wide-ranging and they argue for the importance of the relationship between culture, as a social agent, and the social positioning of people from racialised communities. Yet they also argue against allowing culture to become conceptually overloaded to an extent that elides the specific operation of racial bias and the need to address racism is overlooked. Therefore, cultural sensitivity is important for all service users, regardless of ethnicity, yet a priority is for advocacy to address societal power differentials. The authors thus contend that alongside the confidence and ability to address all manifestations of racism, culturally appropriate advocates need to possess knowledge about the social drivers of mental ill health; have broad cultural knowledge that is constantly being built upon; and possess skills that include the ability to ascertain whether mental health professionals have properly accounted for the person's cultural background. In addition, Salla et al. (2023) call for more flexible commissioning, backed by appropriate resourcing, that can allow expansion beyond the individualised, transactional mode of IMHA practice to include group advocacy when appropriate, thus addressing hermeneutical injustice (Fricker, 2007). Their specific recommendations for advocacy organisations include ensuring that advocates are properly supported, such as around any racial trauma that may be triggered by their work.

3.12. Concluding discussion

This narrative literature review has considered the current state of knowledge about the nature and workings of diverse types of advocacy in UK adult social care. It has shown the need for contemporary understanding of how these various aspects of policy and practice relate specifically to the CAA role. The review has clarified that CAAs have so far received relatively little scholarly attention, especially relative to IMCAs and IMHAs. Yet even accounting for work about these other roles, a need for updated research concerning independent advocacy is strongly indicated. Some important studies about statutory roles are based on data collected during the first two years of their implementation. This applies to works on: IMCAs by Redley et al. (2010, 2011) and Morgan (2017); IMHAs by Newbigging et al. (2012, 2015); and CAAs by Newbigging et al. (2021). Evaluation at such early stages may not reflect a more settled situation that arises over time (Newbigging et al., 2021).

Each section of this review has highlighted policy and practice issues related to my research aims. There is a need to explore access to CAA support, which has multiple aspects: regarding service capacity; the gatekeeping role of practitioners; the nature of eligibility criteria; disproportionate disadvantage among some service user groups; and more. As the CAA role is configured in primarily transactional terms (Ridley et al., 2018; DHSC, 2024:ch.7), it is necessary to elucidate how these mechanisms work in practice and what their implications are for effectiveness, according to both process and outcome benefits (Townsley et al., 2009). Questions include: how is the difference between instructed and non-instructed modes of working manifested in CAA practice? And how does this relate to the facilitation of supported decision-making? Existing literature also shows a need to probe where the boundaries of CAA practice lie, such as regarding what areas of a person's life supported decision-making can cover, and over what timeframe. Other questions arise: does CAA work have preventative implications? And do provider organisations have capacity to operate strategically, as is suggested given the intrinsic limitations of transactional advocacy? Underpinning these concerns is a need to provide updated understanding of the commissioning of CAA services, building on Newbigging et al.'s (2021) work.

The review has indicated that advocates' working relationships with practitioners are integral to practice effectiveness and involve status considerations. There is a clear knowledge gap about how these relationships function in the specific context of practice under the CA2014. This also applies regarding CAAs' challenge function, with a need to understand whether negotiatory mechanism identified within IMCA practice (Series, 2013; Morgan, 2017) are similarly enacted by CAAs. How this relates to the availability of different procedural and legal avenues for challenge is another key question. Finally, the review has pointed to issues about capacity for specialism within advocacy services. This concerns work with different service user groups, alongside ensuring effective advocacy provision is available to meet the needs of socially diverse populations. A specific area of research and policy development has involved advocacy for ethnically minoritised people who use mental health services. There is therefore a need to develop understanding of the implications of culturally appropriate advocacy for CAA practice.

My study addresses these gaps in knowledge about CAAs' work. In the next chapter, I discuss how I went about undertaking research for this study.

4. Methodology

4.1. Introduction

Methodology concerns rationalising the approach taken to scholarly enquiry, linking underpinning philosophy to chosen methods of data collection and analysis (Crotty, 1998; Punch, 2014). In this chapter about my study's methodology, I first consider its metatheoretical basis in critical realism. I then outline what it draws from the related field of realist evaluation and the CAIMeR model of Blom and Morén (2010, 2011), which applies realist principles to social care studies. Next, I explain my research design, which combines localised case studies with national-level 'expert' interviews (Bogner et al., 2009). I discuss participant recruitment, data collection via semi-structured interviews, and reflexive thematic analysis of the data (Braun and Clarke, 2006, 2022). Difficulties encountered in undertaking the research are explored, especially regarding recruitment from some participant cohorts. I also engage with ethical and research integrity issues.

4.2. Critical realism

4.2.1. Defining principles

Critical realism is a philosophical movement that originated in the 1970s and is closely associated with the work of Roy Bhaskar (1989, 1998a, 1998b, 2008). It seeks to provide a sound metatheoretical basis for social scientific enquiry (Fletcher, 2017; Danermark et al., 2002). According to Porpora (2015), three tenets are foundational to critical realism: ontological realism, epistemological relativism, and judgemental rationalism. Ontological realism holds there are things in the world that exist objectively, independent of human perception. These are bound together by causal connections: some things cause other things to happen. Epistemological relativism involves the premise that people lack unmediated access to objective reality, because of limits to human comprehension. Therefore, everyone's perspectives on social phenomena are partial and subjective. Judgemental rationalism requires that, given these ontological and epistemological positions, scholars pursue the most accurate possible understanding of their object of study.

As there are objective social facts, some accounts must be closer to these than others. Yet the pursuit of knowledge is necessarily imperfect and value-laden: scholars make decisions about what to accept as truth, with ethical and political implications (Porpora, 2015). Critical realism, at least in its Bhaskarian form, thus rejects the possibility of researcher neutrality. It instead seeks to provide a philosophical basis for intellectual and political projects that strive towards better meeting people's fundamental needs, by advancing causes of freedom, justice, and equality (Bhaskar, 1989, 1998a, 1998b; Porpora, 2015). Yet critical realists argue this values-infused approach must not be confused with dogmatism (Sayer, 2011), and scholarship must be robust and reflect 'intellectual honesty' (Porpora, 2015:210).

Following Bhaskar (2008), critical realists propose a stratified model of social reality, with implications for research expounded by scholars including Fletcher (2017). The model proposes an analytical division of the social world into three levels, or 'domains': 'the empirical', 'the actual' and 'the real'. The empirical domain comprises all that people perceive and experience, including their thoughts and feelings. Qualitative data is drawn from this domain (Wiltshire and Ronkainen, 2021). Qualitative researchers therefore engage in a 'double hermeneutic': the practice of interpreting other people's interpretations (Danermark et al., 2002). Beneath the empirical is the actual domain, which contains the world's material contents and events, in their objective form—that is, how they truly exist, unmediated by human perception. The deepest level is the real domain, which comprises social structures that act as 'causal mechanisms' (Fletcher, 2017:183). These shape the contents of the actual and empirical domains, such as by influencing events and people's mental processes. Bhaskar (2008:3) termed these forces 'generative mechanisms'. Figure 1 illustrates this ontological stratification via an iceberg metaphor, which Fletcher (2017) deploys. The iceberg's visible tip is akin to the empirical domain. Yet just as there is a larger expanse of ice submerged from view, there are deeper parts to social reality. All three domains are connected, comparable to how the iceberg is ultimately one large mass (Fletcher, 2017).

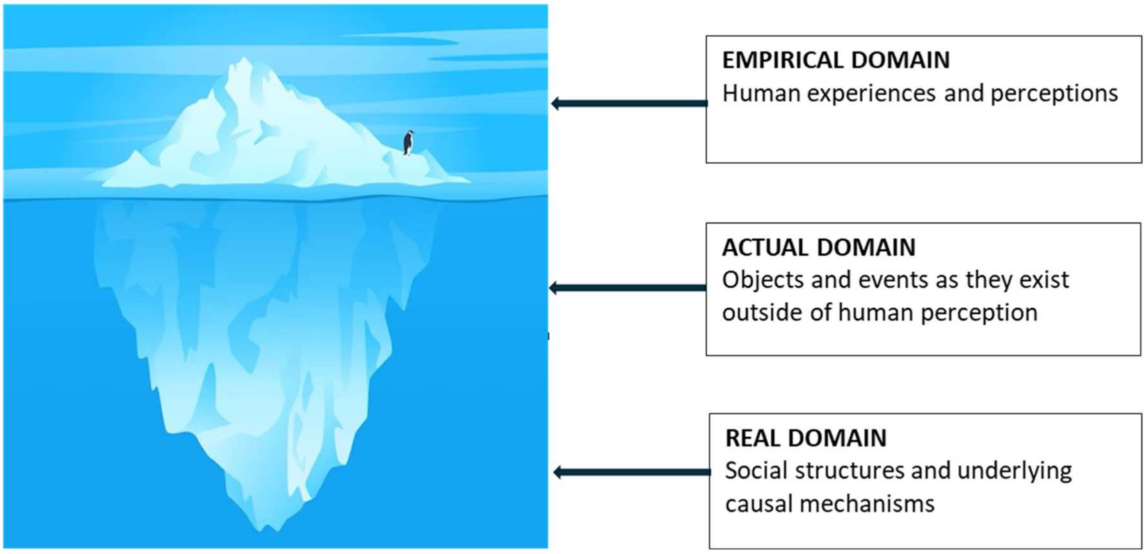

Figure 1 - Critical realism's stratified ontology

Diagram showing iceberg metaphor adapted from Fletcher (2017:183). Iceberg image designed by Freepik, used as per licence, www.freepik.com/

An example of how CAA practice relates to these ontological levels is as follows. A CAA reflects on their interactions with a service user, deliberating about where the limits of their remit lie *(empirical domain)*. There is a material basis to these interactions, which involve interpersonal contact, and to the CAA's attachment to an advocacy organisation, such as via an employment contract *(actual domain).* Underneath this interaction's physical form are multifarious causal processes, which may include the effects of 'new public management' ideology on public sector policy (Hardwick, 2018). This directs advocacy organisations to fulfil specific statutory tasks as contracted service providers and limits their activities in other areas, with organisations conveying these requirements to their staff *(real domain).*

Critical realist scholarship seeks to identify underlying causal factors that have bearing upon research data (Fletcher, 2017). Critical realists take a nuanced view of causation: generative mechanisms create tendencies towards a particular action occurring, but they do not determine this (Bhaskar, 2008). Human actions result from individuals exercising agency in response to their structural circumstances, which are the sum of multiple causal mechanism coinciding (Elder-Vass, 2010; Porpora, 2015; Fletcher, 2017).

4.2.2. Choosing critical realism

My use of critical realism reflects its value for applied research and broader social critique, given its commitment to identifying forces that shape the social world (Wiltshire, 2018). One way to assess validity in critical realist scholarship is considering how well explanations generated from data correspond to observations of how things work in real-world settings (Ronkainen and Wiltshire, 2021). Critical realism provides a basis for studying underlying causes of oppression, while acknowledging the complexity of causation via interaction of structure and agency (Porpora, 2015). Its emphasis on how multiple social forces operate together in a given situation shows compatibility with strands of intersectionality theory (Martinez Dy et al., 2014). Critical realism also encourages attentiveness to how people perceive and experience the world around them, given that human interpretations have their own causal significance for shaping future actions (Maxwell, 2012). Yet a critical orientation means all interpretations should be scrutinised, including those of research participants (Fletcher, 2017). Such features have led various scholars to see critical realism as well-suited to social care studies (Houston, 2001; Oliver, 2012; Craig and Bigby, 2015).

4.3. Structure and agency: the influence of normative social institutions

4.3.1. Norm circles and organisations as emergent social entities

This thesis considers stakeholders' personal experiences regarding independent advocacy, while seeking to relate these to deeper causal processes. In doing so, it draws upon the critical realist social ontology of Elder-Vass (2010, 2012), which provides a theoretical framework for understanding how particular types of social structures, namely normative social institutions, exert influence on people. Normativity concerns a sense of what is right or wrong, while institutions are groups of people, formally or informally constituted, who through their interactions exercise causal powers regarding creating and enforcing social expectations and obligations. Individuals experience these social mechanisms as pressure to conform in their thinking or behaviour, or both. Here 'emergence' is a key concept, being encapsulated in the maxim that 'the whole is more than the sum of its parts' (Bertalanffy, 1971 cited in Elder-Vass, 2010:22). Elder-Vass (2010) argues that social institutions have emergent properties, where the setting and upholding of norms is a product of the collective functioning of human networks and cannot be reduced to an aggregate of individualised acts.

Elder-Vass (2010) discusses two emergent social institutions: organisations and norm circles. While organisations are clearly manifested in the empirical domain and are thus generally recognised, often having legal form and physical manifestation such as occupancy of buildings, norm circles are an abstraction. Norm circles are collections of people who all subscribe, in some way, to a particular set of normative beliefs about how something should be. The norm circle has an emergent causal tendency to reinforce compliance with these beliefs among its members; as when a person in a particular cultural context holds beliefs about the appropriate way to act in a certain situation—or perhaps feels compelled to do so even if this does not reflect their sincere beliefs, such as due to their different cultural background or affiliations. Elder-Vass (2010) cites the example of queuing, where, via common adherence to behavioural conventions, the queue of people becomes a physical manifestation of a norm circle that is usually self-regulating. Beyond this prosaic example, norm circles theory can facilitate understanding of the internal and external tensions that people experience as they seek to live congruently with their beliefs and values. Elder-Vass (2010) argues that individuals belong to multiple, often overlapping norm circles, with such ‘normative intersectionality’ being a prominent feature of contemporary life because of the increasing complexity of social formations. For example, a person may find significantly different sets of norms applying in their work versus their family lives, or in local versus online communities. The person must then navigate these dissonances, exercising some degree of human agency. These competing normative pulls on the individual can elicit inter- and intra-personal conflict, which in turn drive personal change—and social change too via emergent processes.

While Elder-Vass’s (2010) elaboration of norm circles is largely theoretical in nature, his work has found diverse empirical application, including in scholarship about occupational roles, such as concerning gendered norms in entrepreneurship (Boddington, 2024); blue-collar temporary employees in Swedish manufacturing (Kjörling et al., 2024); and the position of left-wing academics within elite British universities (Cresswell et al., 2013). Each of these provide examples of people experiencing competing impulses in the workplace due to their membership of intersecting norm circles. This brings considerations of power to the fore, as one source of normative influence may be especially strong at a particular time or in a certain setting, making the exercise of agential action that opposes this especially difficult (Elder-Vass, 2010).

Within social care literature, empirical utilisation of Elder-Vass's (2010) theory of normative social institutions appears relatively scant to date. One exception is Hodgson et al. (2023), who use norm circles to theorise the contradictory structural imperatives that social workers are exposed to, as they seek to exercise professional judgement in concurrence with their value base, while also meeting expectations of them as local authority employees. Crucial here is the emergent power of organisations, which engender additional mechanisms regarding norm setting and enforcement, especially through assigning individuals to specific roles. Hodgson et al. (2023) discuss how local authorities establish the remit and procedures that constrain social workers' possible field of action, although such bureaucratic codes and routines cannot fully account for the intricacy of real-life practice scenarios that must be responded to. The resulting demand for professional discretion highlights limits to organisations' normative power and affirms the importance of norm circles as informal social entities that influence human behaviour.

4.3.2. Applying norm circles theory to CAA

Following Hodgson et al. (2023), I discuss the normative pressures that CAAs are exposed to in their work, which are often cross-cutting and in tension, and the ordering and enforcing role of organisations. Influential to my conceptualisation was the distinction that Elder-Vass (2010) draws between different types of norm circles, and Cresswell et al. (2013)'s application of these to understand the political implications of normative conflict within higher education environments. Hence there are *proximal* norm circles, involving direct embodied or technology-mediated contact between individuals, related to norm establishment and adherence; *actual* norm circles, which are the entire cohort of individuals involved in a particular political configuration that results in the upholding of the norm; and *imagined* norm circles, which relate to allegiance to a particular ideology or set of values. These are ‘imagined’ as the norm circle member looks outwards to a wider community of people adhering to the norm, but there is uncertainty over the boundaries of such membership (Cresswell et al., 2013; Elder-Vass, 2010).

In this thesis, two main norm circles regarding CAA are discussed. The first concerns adherence to beliefs about how individualised and issue-based advocacy services, working within tightly defined parameters, should function in order to meet the CA2014’s independent advocacy requirements. The proximal norm circle comprises managerial actors involved in commissioning and organising CAA services for a local authority, whose contact is oriented towards ensuring legal, policy and financial requirements are satisfied, and the CAA service meets set outputs and delivers stipulated outcomes. The actual norm circle operates on a larger geographical scale, as conversations between a local authority and their commissioned CAA provider do not happen in isolation from those elsewhere. Local authority managers, for example, share their own proximal norm circle with central government actors and counterparts in other local authorities, partly congruent with organisational forms such as the Local Government Association. The imagined norm circle regarding this law-based reading of CAA (Newbigging et al., 2021) pertains to a programme for organising advocacy services within an overarching neo-liberal governance framework, even if such ideological tenets are only uncertainly held or grudgingly accepted by those involved (Hardwick, 2018; Redley et al., 2010). Functioning of this norm circle therefore relates to advocacy being increasingly channelled into fulfilling state-defined purposes, with accompanying elevation of professionalism conceived in terms of technical proficiency and occupational standards. Frontline CAAs become part of this norm circle via accepting their role configuration to meet the targeted demands of commissioned service provision, even if adherence may again only be grudging and organisationally enforced, such as by employment contracts.

The second main norm circle identified in this thesis is an oppositional one regarding independent advocacy. However, evidence of this is less pronounced than for what Cresswell et al. (2013:33) term a 'norm circle of resistance' among left-wing academics against higher education managerialism. For independent advocates, this resistance is most apparent in terms of an imagined norm circle, defined by adherence to longstanding advocacy principles that pre-date the introduction of statutory requirements (Henderson and Pochin, 2001), including egalitarian notions of longstanding advocacy partnerships associated with citizen advocacy. Some of these values, including a strong social justice orientation, are codified in the *Advocacy Charter* (NDTi, 2018), demonstrating how this norm circle—in its actual and imaginary configurations—extends outside the local authority context.

The normative intersectionality discussed at length in this thesis is reflected in how demands to deliver tightly delineated, issue-based advocacy can clash with more expansive notions of longstanding advocacy partnerships, or more collectivised and community-oriented expressions of advocacy. Following Hodgson et al. (2023), I emphasise how the case study advocacy organisations are an institutional locus of these intersecting normative expectations, being potentially both disabled people's organisations and commissioned statutory advocacy providers (Newbigging et al., 2021). They are therefore sites of norm mediation and enforcement, where CAAs are subject to formal enforcement mechanisms regarding adherence to role parameters, as via conditions of employment, while also retaining an organisational ethos that reflects histories as voluntary sector organisations that pre-date the arrival of statutory advocacy.

How might CAAs respond to such normative intersectionality? Elder-Vass (2010) contends that people's responses to the structural force of normative pressures draw upon 'habitus' and 'reflexivity' to varying degrees. 'Habitus' refers to how socio-cultural environments become ingrained in individual lives, such as the lingering effects of social class that pattern individual modes of perception and thinking, which can lead to decision-making without conscious deliberation (Bourdieu, 1990b, cited in Elder-Vass, 2010). Reflexivity refers to how individuals deliberate on their structural context as they make decisions about social action, thus entailing a disaggregation of structure and agency, at least for analytical purposes (Archer, 2003). Elder-Vass (2010) argues that this aligns with modern understandings of neuroscience, where people can exercise a blend of conscious deliberation and more instinctual decision-making, with primacy shifting between these according to the demands of particular situations. Hence people are capable of both reflexive and non-reflexive action, which can feature in different parts of their lives, while experiences related to previous decision-making can over time inform the development of an individual's disposition. This thesis does not feature detailed analysis of decision-making in the context of individual biography, but I address in more general terms how CAAs respond to sometimes conflicting signals about how their role should be defined. This includes critical consideration of circumstances where the exercise of individual agency seems to have been paramount, as where discretion has been exercised about the form and duration of advocacy involvement with an individual service user.

4.3.3. Incorporating social constructionism

Elder-Vass (2012) has elaborated this emergentist social ontology to consider how language, culture and discourse are part of the operation of norm circles. As such, these act to regulate discourse, or the 'content' of communication (Elder-Vass, 2012), establishing parameters of accepted thought and expression. Elder-Vass (2012:6) favours 'moderate social constructionism', which draws attention to how people collectively create and enforce ideational structures for mediating understanding of an objectively existing social world. Language, culture, and discourse therefore all exert causal powers in their own right, in terms of how social meaning is created and shared among people. Yet these powers are not exercised independently from the broader social structures that norm circles are nested within (Elder-Vass, 2012).

This moderate social constructionism against a realist backdrop has important implications for my research approach, such as regarding CAAs' identity. It provides an ontological basis for considering how an ideology of professionalism affects occupational status—albeit yoked to overarching power structures and expressed dynamically according to factors such as whether occupational change is internally derived or externally imposed (Evetts, 2003). Elder-Vass's (2012) work complements critical realist scholarship about identity formation, which sees this arising from exertion of collective agency in dialogue with structural context (Marks and O'Mahoney, 2014). I pay particular attention to the role of language and discourse regarding discussions of whether CAA should be viewed as a 'profession', and if so, what this means in practice. The normative power of a concept such as professionalism is reflected, for example, in discussions about whether the elevation of a form of 'technical' knowledge (Rennstam and Ashcraft, 2014) would inevitably be exclusionary of a wider pool of skilled and committed individuals who might be less able to meet formal qualification requirements. The salience of moderate social constructionism for advocacy research has had some previous recognition. Lonbay (2015) draws on Elder-Vass (2012), such as when discussing the 'culture of involvement' in local authorities regarding older people's involvement in safeguarding (Lonbay, 2015:222). This describes normative practices, such as over consulting relatives when an older person is deemed to lack capacity regarding a safeguarding decision.

4.4. Realist studies of policy and practice

4.4.1. Realist evaluation

Critical realism has been critiqued, including by scholars who subscribe to some of its realist tenets. A key argument is that a value-infused approach can undermine empirical enquiry by allowing it to become politicised (Pawson, 2013; Hammersley, 2009). This helps explain the purpose of realist evaluation, as initially developed by Pawson and Tilley (1997). Realist evaluation applies aspects of critical realist philosophy to policy evaluation (Mukumbang et al., 2023). It therefore has a narrower focus, eschewing Bhaskarian critical realism's embrace of an explicitly emancipatory research agenda and concentrating on the requirements of 'evidence-based policy' (Pawson, 2013). Debate has ensued about the merits of realist evaluation versus critical realism (e.g. Pawson, 2016a,b; Porter, 2015a,b), although detailed discussion of this is outside the scope of this chapter. I utilise insights from critical realism and realist evaluation, especially as the CAIMeR approach draws on both sources (Blom and Morén, 2010, 2011).

According to Pawson and Tilley (1997), asking whether policies work outright is too simplistic. Realist evaluation considers how a policy, as a social intervention, is inserted into a specific environment, or 'context'. It is the interaction of intervention and context that determines how the policy works, and what outcomes result. Realist evaluators again use the language of 'mechanisms', this time to refer to the processes that are successful activated when interventions work as intended in their real-world context. This denotes successful policy implementation, as desired outcomes are achieved within highly contingent circumstances. Realist evaluations therefore consider 'how, why, for whom, to what extent, and in what context complex interventions work' (Wong et al., 2016:2).

Ridley et al. (2018) suggest using realist evaluation to explore how advocacy, in its various forms, can activate diverse empowerment mechanisms. Realist evaluation has also been used to examine the contextual factors that shape the scope for effectiveness of other roles with commonalities with CAA: namely peer parental advocacy in child protection (Diaz et al., 2023); Independent Domestic Violence Advocates (Rivas et al., 2020); mental health peer support workers (Watson, 2019); and the 'named social worker' role with people with learning disabilities (James et al., 2021).

4.4.2. The CAIMeR theory

In using realist methodology, this thesis draws especially upon the CAIMeR approach of Blom and Morén (2010, 2011), which is tailored to social care research. This extends realist evaluation's 'context–mechanism–outcomes' formula for studying causation, which has been criticised by some critical realists for omitting individual agency (Porter, 2015a). Identifying this omission aligns with broader critique of evidence-based policy approaches as failing to sufficiently account for the unpredictable nature of complex human interactions within fields such as social care practice (Craig and Bigby, 2015; Webb, 2001). CAIMeR stands for Context, Actors, Interventions, Mechanisms and Results. It makes explicit the role of actors and their interventions, while ‘outcomes’ are rebranded ‘results’.[5] CAIMeR also clarifies that the context of social care interventions is stratified across three levels: micro (practice); meso (institutions); and macro (societal structures) (Blom and Morén, 2010, 2011). This links practice, where mechanisms operate through intersubjective encounters, with the workings of larger causal structures. Such linkages are crucial for this thesis, which comprises evaluative analysis of how well CAA services work in their own terms alongside wider critique of the CAA role’s place within adult social care and the advocacy landscape.

In my concluding chapter, I frame overall discussion of my findings with reference to the CAIMeR framework, clarifying the existence of causal pathways that can be activated in certain circumstances, although the data collected did not permit undertaking of a full-fledged CAIMeR analysis. This summary can be usefully studied alongside the CAIMeR analysis that Lonbay (2015) presents of older people’s involvement in safeguarding practice. Yet while Lonbay (2015) maps an entire system of practice, my contribution focuses on its advocacy component.

4.5. Research design

4.5.1. Overview

Permission to undertake the research was granted by Manchester Metropolitan University’s Health, Psychology and Social Care Research Ethics and Governance Committee (reference 34011; see appendix D). I later deal in more depth with some particular ethical issues: regarding service user participation and the differing treatment of some participants’ contributions, especially regarding use of real names versus pseudonymisation.

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[5] A similar extension of CMO is proposed by Mukumbang et al., (2018), who describe ICAMO (Intervention, Context, Actors, Mechanisms and Outcomes).

4.5.2. Qualitative design

This is a qualitative study, reflecting how critical realists widely use qualitative approaches to explore how complex configurations of causal mechanisms operate in practice (Smith and Elger, 2014; Porpora, 2016; Price and Martin, 2018; Brönnimann, 2021). As Carminati (2018) contends, the validity of qualitative research rests on its analytical depth and ability to generate theoretical insights from data, where this theory may then be applied to help explain phenomena in related contexts. Such transferability of qualitative analyses is a nuanced process that takes account of the uniqueness of each context. It contrasts with the claims to generalisability that quantitative research often makes, where findings are directly extrapolated from the sample being studied to a population whole (Carminati, 2018).

4.5.3. Methodological hybridity

The study demonstrates some methodological hybridity. It augments case studies with insights from four participants whom I term 'national contributors'. They were included to provide a broader perspective on CAAs, rather than confining their observations to a particular local authority context. This hybrid approach was informed by the paucity of existing scholarship about CAA, meaning there was less prior knowledge available to anchor interpretation of the case study data. The value of using this wider lens was increased given the level of local devolution within the adult social care system: the case studies concern only two of the 153 English local authorities with adult social care responsibilities (House of Commons Committee of Public Accounts, 2024). Therefore, I have sought to partially offset this specificity with an element of my research that is explicitly oriented towards more general understanding of the CAA role. My choice of undertaking case studies alongside consulting national commentators reflects 'triangulation', where enquiries draw on multiple perspectives to gain more comprehensive understanding of a topic (Bogner and Menz, 2009).

4.5.4. Case studies

Case studies involve focused, in-depth exploration of a phenomenon within a singular context, with a case being a unit of analysis (Gilgun, 1994; Easton, 2009). This thesis partly draws upon the organisational case study approach, which is well-developed within critical realism. Organisations are thereby considered a locus of causal mechanisms, incorporating concerns such as institutional structure, dynamics, and culture (Vincent and Wapshott, 2014). There were two organisational participants in each case study: the local authority adult social care department and its commissioned provider of CAA services.

Use of a case study methodology adds focus to discussions about validity within qualitative and quantitative paradigms (Carminati, 2018). Case study approaches have been critiqued, such as where there are unclear criteria for case selection, and where generalisability is disputed according to the relationship of the selected case and others in a similar class (Carey, 2012; Bryman, 2014; Tight, 2017). Within critical realism, empirical findings from case studies provide a means of developing and testing substantive theory, with these theory-based outputs being potentially more widely applicable (Easton, 2009). Vincent and Wapshott (2014:20) argue that theory about institutional mechanisms that has been generated from an organisational case study can potentially be transferred to help elucidate other cases within the same ‘class’, although the specificity of local conditions should not be overlooked. Therefore, some of my case study findings might be illuminating for other local authority contexts, but such knowledge transfer cannot be approached uncritically.

A multiple-case study design was used. According to Yin (2018), this enables both exploration of cases as singular entities and cross-case comparisons, highlighting areas of similarity and difference. A replication design means substantially the same approach was taken for each case, with Yin (2018) further differentiating between ‘literal’ and ‘theoretical’ forms of replication. The former is when cases are purposefully selected with a view to generating results that are as predictably similar between cases as possible; the latter invites case selection that is expected to generate contrasting results, but for predictable reasons. During initial research design, I opted for theoretical replication, in order to aid comparative analysis.

4.5.5. Case selection

My initial research design only partly related to final case selection, as what began as an attempt at 'purposive sampling' to recruit local authorities with particular characteristics came to incorporate 'convenience sampling' based on participant availability (Punch, 2014). My initial approaches to local authorities proved unsuccessful. One local authority was then recruited via contacts established by one of my supervisors, and managers from that local authority assisted in recruiting another, in a limited form of snowball sampling. The recruited local authorities approached their respective CAA providers on my behalf, gaining their organisational assent to participate.

Planning meetings were held with the four organisational participants, to inform and consult them about the research, which they had an essential role in facilitating. The local authorities are pseudonymised as Fencross Council and Martborough Council and their CAA providers as Fencross Advocacy and Martborough Voices. Some information about the local authorities and advocacy organisations are summarised below, with details limited to preserve anonymity. The demographics of the areas served by the local authorities differed markedly, according to key factors of urban density, age profile, ethnic composition, and measures of socioeconomic deprivation (Office for National Statistics, no date).

There were important differences between the participating CAA providers, especially concerning whether they were the commissioned provider of IMCA services in their local area, and whether they undertook community advocacy alongside their statutory provision. Both had strong local identities and only provided CAA in a single local authority area, distinguishing them from larger, multi-area advocacy providers. Because of this similarity between the cases, I was only able to gather limited empirical evidence pertaining to the implications of organisational scale for character of advocacy delivery (Hardwick, 2018: Newbigging et al., 2021).

Summary information: case study sites

Case study one: Fencross Advocacy

Fencross Advocacy has a significant history as a local provider of voluntary and community services. It has been commissioned since 2015 to provide all statutory advocacy services in Fencross. It is not commissioned to provide any non-statutory advocacy services there. Fencross is an urban area with a high level of ethnic diversity among its population and significant levels of socio-economic deprivation.

Case study two: Martborough Voices

Martborough Voices has origins as a provider of community advocacy services in Martborough. It previously focused on working with people with learning disabilities. Since 2015 it has been commissioned to provide CAA and IMHA services in Martborough. IMCA services are provided by a different organisation, referred to using the pseudonym Citizens Empowered. Martborough Voices continues to provide various forms of community advocacy alongside its statutory provision, including citizen advocacy. Martborough is also an urban area, but its population is less ethnically diversity than that of Fencross.

4.5.6. Case studies: participant cohorts

I took a triangulated approach within the case studies, increasing evaluative potential by engaging a range of stakeholder perspectives (Bogner and Menz, 2009; Pawson and Tilley, 1997; Fox et al., 2017). Participants were drawn from among: CAAs, CAA managers, social workers, and service users. In one case study a local authority commissioning manager was also interviewed. All were recruited via participating organisations, which acted as gatekeepers, with both purposive and convenience sampling used. Full inclusion and exclusion criteria for all participants are provided in appendix E. Table 2 gives a breakdown of recruitment in each case study site.

Table 2 - Participant recruitment breakdown per case study site

Participant cohort	**Recruited in Fencross**	**Recruited in Martborough**	**Total recruited (both sites)**
CAA manager/ team leader	2	2	4
CAA	3	2	5
Commissioning manager	1	0	1
Social worker	2	2	4
Service user	1	1	2
TOTAL	9	7	16

4.5.7. Expert interviewing: national contributors

National contributors were included on the basis of having advanced and national-level knowledge relevant to the research questions. This included a participant whose expertise concerned CAAs' role in respect of the legal framework of the CA2014, and another whose focus was on non-statutory community advocacy. This element of the study was broadly representative of 'expert' interviewing (Bogner et al., 2009). Recruitment was based on purposive sampling, with prospective national contributors identified during project planning. Individuals were excluded from consideration if they were directly involved in providing a CAA service, as from these participants I sought some critical distance from frontline delivery of statutory advocacy. The recruitment target of four from the national contributor cohort was met. This target reflected judgement of what was a reasonable amount of time to allocate to this component, given its main purpose was to provide contextualisation and additional explanatory basis for the case studies.

4.6. Choice of data collection methods

4.6.1. Semi-structured interviews

One-to-one, semi-structured interviews were undertaken with all participants, except social workers who were interviewed jointly. As Brinkmann (2013) notes, semi-structured interviews allow for balancing elements of flexibility and rigour. Having a topic guide helps ensure sought-after data is obtained and there is some uniformity of approach across interviews. There is also scope for customisation: interviewer and interviewee can negotiate the depth in which topics are explored, via follow-up questions and the interviewee making additional contributions. This method is well-suited to critical realist research, which favours an interviewing approach that is guided by prior theory and research while still allowing participants to give rich accounts of their experiences (Smith and Elger, 2014).

The topic guides were informed by my research aims, research questions and literature review. Guides were tailored to each stakeholder cohort, according to their areas of expertise and experience regarding CAA. The guides were iteratively adjusted as data collection progressed, in response to what was working well or badly, and to address gaps in data collection. Appendix F supplies example topic guides.

All professional participants were sent the topic guide in advance and advised they could prepare for the interview at their own discretion. This was on the basis that preparation might increase the quality of participants' contributions, perhaps by prompting them to recall specific case examples to illustrate points they wished to make. I also considered that supplying the guides might help assuage potential anxiety about the interviews, especially if participants felt some form of pressure based on the perception they were acting as organisational representatives. Topic guides were not supplied to service user participants, as these were the least structured of all the interviews. This was because I lacked much prior information about these participants and their use of CAA services, and I wanted to be able to respond as sensitively as possible to their experiences and any additional needs they had as interviewees. However, in both cases I had a telephone conversation with the service user participant before meeting with them. In these I explained the nature of the interview and the main topics to be covered, which concerned their experiences of being supported by a CAA and what differences this had made for them. Both participants expressed that they were happy to proceed on this basis, although on reflection I acknowledge there was a potential power imbalance implied by my differential treatment of participants regarding preparation for the interview.

4.6.2. Joint interviews

Due to recruitment issues, the originally planned focus groups with social workers were replaced by joint interviews with members of this participant cohort. Only two participants were recruited for each intended focus group session. This lack of response to recruitment calls, which were made to social workers via their employers, might have been due to these sessions being held in January and February 2022, amid severe pressure on social care practitioners due to a wave of infection with the Omicron variant of Covid-19 (Preston, 2022). As two pairs of busy professionals had already committed to timeslots for the focus group sessions, I held these as arranged but instead conducted them as joint interviews. These transpired as having characteristics of dyadic interviews, with some interaction between participants (Morgan et al., 2015), although much less than for a focus group (Carey, 2012). I used the focus group topic guide as the basis for the joint interviews, which participants had received in advance.

4.7. Participant recruitment

Potential participants were given a participant information sheet, tailored according to stakeholder type (see appendix G), and had opportunities to ask questions before agreeing to be interviewed. In most cases, and certainly for service user participants, there was a gap of at least a few days between a person being provided with an information sheet and the interview being arranged, providing time for reflection upon their involvement (Temple, 2019).

4.7.1. Recruitment to the case studies

During the recruitment of organisations, their managers agreed to be interviewed, although the commissioning manager from Martborough Council was subsequently unable to participate. Managers also agreed to act as 'gatekeepers', using recruitment material I supplied (see appendix H). CAAs and social workers were recruited via circulation of this material within their organisations. Three CAAs were recruited from Fencross Advocacy (from eight staff undertaking some CAA work) and two from Martborough Voices (from three staff acting as CAAs). Some additional information was collected from professional participants before the interviews, including the ethnicity of CAAs (see appendix I).

The target for recruiting service user participants was flexible but based on an ideal of three per case study. In recruiting service user participants, the CAA providers agreed to select up to 10 people who had recently used their services (ideally within the previous three months) and were considered able to participate in a research interview. The provider then contacted those people in individually appropriate ways, either discussing the research with them verbally or supplying easy-read recruitment materials, or both. If the person was interested in participating, they contacted me directly or via the advocacy organisation, to further discuss involvement. A key inclusion criterion for service user participants was having mental capacity to give informed consent to participate in the research. The CAA providers agreed to ensure the people they approached would meet this criterion. I took ultimate responsibility for confirming participants had capacity to give informed consent at the time when this was recorded, drawing on my practice experience as a social worker.

Only two service user participants were recruited, one from each case study site. Reasons for this low level of participation were unclear. However, continued disruption and concern relating to the Covid-19 pandemic at the time of recruitment, in spring 2022, may have contributed. I discuss some ethical considerations regarding service user involvement in a later section. I also provide further details about their recruitment in appendix J, as changes were made to the original recruitment method that required amended ethical approval.

In sum, there was a shortfall in recruitment across three stakeholder categories: service users, social workers, and commissioning managers. This affected the overall balance of the study, making the contribution of CAAs and their managers especially prominent. This meant the study was relatively strong on capturing an ‘insider’ perspective on the nature and function of the CAA role, albeit with diminution of external, and possibly more critical perspectives.

4.7.2. Recruitment of national contributors

The national contributors were approached via email and invited to participate. From the outset of discussions, they were presented with the choice of participating on a real-named or pseudonymised basis and their choice was confirmed at the point when informed consent was taken. All four chose to be real-named and made this decision independently of each other, as I did not share the identity of any other national contributor with them. This contrasted with the case studies, where all participation was on a pseudonymised basis. I discuss the rationale for this disparity in a later section. Brief information about the national contributors is provided below, with their positions correct at the time of data collection.

National contributors

Kate Mercer (Director, Kate Mercer Training)

Kate Mercer works in the advocacy sector, in roles including trainer, consultant, and author.

Belinda Schwehr (Chief Executive Officer, CASCAIDr)

Belinda Schwehr is a lawyer, trainer and commentator with specialism in adult social care law. CASCAIDr (Centre for Adults' Social Care—Analysis, Information and Dispute Resolution) is a specialist advice charity.

Joe Monaghan (National Coalition of Advocacy Schemes/ Liverpool Citizen Advocacy)

Joe Monaghan is a Liverpool-based practitioner and organiser of community advocacy.

Gail Petty (Advocacy Lead, National Development Team for Inclusion (NDTi))

Gail Petty is Advocacy Lead and Manager of the Advocacy Quality Performance Mark (QPM) Programme for NDTi, a not-for-profit organisation that provides support to the advocacy sector.

4.8. How data was collected

4.8.1. Interview sequencing

Table 3 summarises key details about the interviews conducted. Three national contributors were interviewed during an early phase of data collection. This partly reflected the purpose of these interviews as a contextual anchor for the case studies. It was also because of delays in arranging the case study interviews due to the impact of the Omicron wave of Covid-19. Once underway, the case study interviews were sequenced according to progress with recruitment and participant availability. A total of 16 individual interviews and two joint interviews were conducted. These ranged from 17 to 77 minutes in duration and came to 17 hours and 2 minutes in total.

Three participants, two from Martborough Voices and one from Fencross Advocacy, are designated as managers for simplicity, as each had a specific job title and set of responsibilities. One difference between these management roles was whether, and to what extent, the holder undertook any frontline advocacy practice with service users. Fencross Advocacy had a team leader role, which combined supervisory and direct practice functions, and I have retained this designation.

Table 3 - Interview sequence and details

Interviewee	**Case study/ national contributor (NC)**	**Case study - participant cohort**	**Interview date**	**Interview duration (mins)**
Kate Mercer	NC	-	25/10/2021	73
Belinda Schwehr	NC	-	28/10/2021	51
Joe Monaghan	NC	-	25/11/2021	57
Clare/Joanne	Fencross	Social workers	20/01/2022	72
Catherine	Martborough	CAA manager	08/02/2022	53
Dawn/Emma	Martborough	Social workers	17/02/2022	63
Rosie	Fencross	CAA	25/02/2022	61
Isobel	Fencross	CAA	02/03/2022	65
Helen	Martborough	CAA	08/03/2022	59
John	Fencross	CAA	11/03/2022	77
Rachel	Martborough	CAA manager	15/03/2022	61
Gail Petty	NC	-	21/03/2022	55
Lisa	Martborough	CAA manager	11/04/2022	62
Stephen	Fencross	Commissioning manager	28/04/2022	63
Natalie	Martborough	CAA	11/05/2022	57
Arash	Fencross	Service user	19/05/2022	21
Amy	Fencross	CAA team leader	30/05/2022	55
Sophie	Martborough	Service user	15/08/2022	17

4.8.2. Conducting the interviews

All participants were offered a choice of online or in-person interview, except for the social workers who were interviewed online at their employers' request. Most interviews were conducted online. Although legal restrictions on in-person contact had been lifted by the time of data collection, I was aware of continued widespread concern about infection with Covid-19, especially among people with health conditions placing them at heightened risk, and those in contact with people at heightened risk. The interviews with professional participants were conducted online in all but one case, reflecting how these participants regularly conducted online meetings in their work. Both service user participants chose an in-person interview.

Each interview was recorded with the participant's permission. At the start of each interview, consent to participate was formally taken (see appendix K).

4.8.3. Transcription and respondent validation

I transcribed each interview verbatim, although non-lexical utterances ('ums' and 'erms') were omitted as I judged these superfluous. Such 'denaturalised' transcription leaves a 'cleaner' transcript, aiding focus on ascertaining meaning (Nascimento and Steinbruch, 2019).

Once a transcript was complete, I emailed it to the participant. They then had 14 days to make requests for revisions or redactions; during this period, participants could also withdraw their data in its entirety from the project. This process of 'respondent validation' (Lincoln and Guba, 1985 cited in Sim and Waterfield, 2019) was designed to ensure data quality and reassure participants, as they could correct something said in the interview if they later deemed it incorrect or unsuitable (Tilley and Woodthorpe, 2011; Huggins, 2014; Lancaster, 2017). Four participants made minor adjustments to transcripts. Respondent validation was disapplied for the joint interviews, as had been agreed for the planned focus groups. This is because one participant's alterations to the transcript may invalidate another's contribution (Sim and Waterfield, 2019).

4.9. Data analysis and reporting of findings

4.9.1. Reflexive thematic analysis

The data was analysed using reflexive thematic analysis, as developed by Braun and Clarke (2006, 2019, 2021). Thematic analysis involves identifying and exploring themes within qualitative data, where a theme 'captures something important about the data in relation to the research question, and represents some level of patterned response or meaning within the data set' (Braun and Clarke, 2019:82). Braun and Clarke have further honed their approach and labelled it reflexive thematic analysis, to differentiate it from other variants of thematic analysis (Braun and Clarke, 2022). Reflexive thematic analysis is potentially compatible with a range of qualitative approaches, provided these are attentive to participants' constructions of meaning. Given its flexibility, reflexivity should accompany its use, whereby scholars exhibit self-awareness and transparency about their methodology and its underlying philosophical assumptions. Reflexive thematic analysis is also compatible with critical realism, due to the latter's epistemologically relativist stance. A critical realist application of reflexive thematic analysis thus directs researchers to scrutinise participants' interpretations of phenomena, while recognising how these interpretations are structurally bounded (Braun and Clarke, 2022).

Braun and Clarke initially presented their thematic analysis method as a six-phase process (Braun and Clarke, 2006), which I broadly followed. Its first phase involves familiarisation with the dataset, comprising all interview transcripts. I undertook such familiarisation, aided by the transcribing process, but for time management reasons I started coding the data before completing all the interviews. Coding the data involves assigning fragments of data to particular groups, or codes. These represent facets of the dataset that are of interest given the research agenda. Examples of codes generated were: 'Covid: creating a backlog'; 'Access to external legal support'' and 'Lack of a career structure'. Coding was undertaken in NVivo, a qualitative analysis software package. Coding was ‘data-driven’ (Braun and Clarke, 2006:88), with codes derived from the data content, rather than using pre-ordained codes, such as those created from existing theory. This was because I wanted to be attentive to participants’ original insights, without seeking to fit these into a theoretical ‘script’ at an early stage. Appendix L provides two example extracts from coded transcripts.

I then undertook the phases of theme generation as an iterative process. This involves aggregating the codes into overarching themes, which reflect the identification of shared meaning in the data and provide the basis for analysis. Thus, while codes represent single facets, ‘themes are like multi-faceted crystals’ (Braun and Clarke, 2021:340). I undertook initial theme generation (phase three) within NVivo, clustering codes together using its functionality of layering codes according to a ‘parent and child’ hierarchy. Appendix M provides a code list exported from NVivo, which shows this initial ordering process underway. From there, I reviewed the themes (phase four), refining them and creating a multi-tiered structure, with sub-themes beneath the main themes. Much of this process took place away from NVivo, using pencil and paper. For evidence of the process of theme generation, see appendix N. This documents a reduction in themes from seven to six—later reduced to five—as I re-allocated codes between prospective themes, redefining theme boundaries and adding definitional clarity. Here, my practice did show some movement between the phases described by Braun and Clarke (2006), in that I only settled on the final theme definitions and names (phase five) after I had started drafting reports of them (phase six). The process of writing prompted me to critique what I had hitherto decided upon, and to make further analytic connections within the dataset. This flexible approach to analysis seems aligned with Braun and Clarke’s later reflections that their approach encourages researcher creativity and deep, recursive engagement with the data, rather than rigid following of ‘procedures’ (Braun and Clarke, 2019:594).

Data analysis and theme generation was generally a lone endeavour, reflecting the nature of the doctoral project and acceptance of researcher subjectivity within reflexive thematic analysis (Braun and Clarke, 2022). However, rigour was also sought, with a means of quality assurance being review by my supervisory team of the ‘candidate themes’ I developed (Terry et al., 2017). In reporting my findings I have illustrated the themes with extracts from the data and provided accompanying commentary.

4.9.2. Accounting for the hybrid research design

The process of coding and theme generation was based on the full dataset, comprising contributions from the two case study sites and from the national contributors. This was because all the data related to the same set of research questions; for example, the occupational status of CAAs was discussed with national contributors and most case study participants. Moreover, in presenting my analysis, I have in many instances interwoven the contributions relating to different components of the study. However, where relevant I have made it clear where an insight derives only from a single participant or participant cohort. To aid this, I exported my code list from NVivo with all data extracts attached, with a tag to identify the interviewee providing the extract. This made it clear if a particular code was based predominantly on contributions from a particular participant group or groups.

Therefore, while theme generation was based on data from all participants, there are nuances of presentation. I have primarily used the national contributors’ inputs as contextualisation for the case study research. This partly reflects a scoping function that is commonly fulfilled by expert interviews, especially within studies such as this that have a strong exploratory aspect due to previous scholarship being scant (Bogner and Menz, 2009). Moreover, my discussion of the case studies reflects how a multiple case design allows areas of similarity and difference to be identified (Yin, 2018). Across much theme reporting I discuss the contributions of participants from the two case studies in a unified way. For example, much of the time CAAs from Martborough and Fencross identified common, or at least congruent, observations about lines of enquiry—or, where contrasting views were expressed, these did not seem clearly related to having different employers. However, in some areas of reporting, the differences between the case studies were more pronounced, and I have drawn these out in the analysis. This was especially so regarding discussions of organisational matters.

In applying reflexive thematic analysis, I encountered some difficulties concerning my use of heterogenous data sources. All participants were valued for their different forms of expertise and lived experience regarding CAA. Therefore, in some parts of the analysis the sense of shared meaning was less pronounced, due to topics areas being spoken about by only a few participants, or a single one. The lack of participation from a commissioning manager from Martborough Council also created an imbalance between the two case studies, as discussion of organisational issues pertaining to Fencross Advocacy was enriched by the contributions of a commissioning manager from that local authority. However, that liminality was part of the central organising concept for each theme allowed for some seemingly disparate observations and viewpoints to be accommodated within these (see Braun and Clarke, 2021). An example is in theme four, which reports a national commentator offering suggestions about possible self-employment for CAAs, an issue that no other participant broached. Yet this related to an overarching sense of ambiguity about the occupational status of CAAs—a central organising concept of the theme—which reflects longstanding contention about how closely advocates' activity should be conditioned by ties to an organising or employing agency (Henderson and Pochin, 2001).

Caveats about singular participant contributions aside, there were signs of data 'saturation' across significant parts of the study. This meant that in the later stages of data analysis, substantially fewer new codes were generated from each additional interview considered. Therefore, diminishing levels of fresh insight could be expected from conducting further interviews (Hennink and Kaiser, 2022). This was especially so for topic areas such as CAAs' relationships with practitioners, their conduct of challenges to local authorities, and their occupational status.

Given participants' varying stakeholder identities, I have used in-text coding for clarification when referring directly to an individual or attributing quotations; see table 4. I sometimes refer to 'CAA participants', meaning CAAs and their managers, especially as most managerial participants did some CAA work.

Table 4 - In-text coding of participant identifiers

Code	**Designation**
FA	Fencross Advocacy
MV	Martborough Voices
FC	Fencross Council
MC	Martborough Council
CAA	Care Act Advocate
M	Care Act Advocacy manager
TL	Care Act Advocacy team leader
SW	Social worker
CM	Commissioning manager
PWLE	Person with lived experience (service user)
NC	National contributor
E.g. Dawn (SW, MC) is a social worker from Martborough Council	

4.9.3. Relating thematic analysis to CAIMeR

The composition of themes and sub-themes fed into my summary of causal factors, drawing on CAIMeR, which I discuss in the concluding chapter. Key components of my findings are assigned to the headings of Context, Actors, Interventions, Mechanisms and Results, according to the role they play in potential causal connections (Blom and Morén, 2010, 2011). This is tabulated in Appendix O. Wiltshire and Ronkainen (2021) note that themes in thematic analysis are potentially comparable to the critical realist concept of demi-regularities, which comprise ‘rough trends or broken patterns in empirical data’ (Fletcher, 2017:185). Demi-regularities therefore indicate a broad ‘direction of travel’ within the data, but they are not law-like statements that necessarily apply in all circumstances (Wiltshire and Ronkainen, 2021). For example, one of my sub-themes regarding access, ‘CAA input as a response to disputes’, covers how disagreements about care and support can lead to CAA involvement, where disputes may variously involve service users, family members and practitioners. This is representative of a demi-regularity as it is just one means by which CAA involvement can be activated. Whether this actually transpires depends upon a particular alignment of contextual circumstances, combined with the exercise of individual agency.

4.10. Research ethics and integrity

4.10.1. Service user participation

My research design responded to a clear rationale for involving service users in advocacy research, to improve understanding of their lived experiences and outcomes achieved (Ridley et al., 2018). It also reflects a general commitment to service user participation within social work research (Butler, 2002). Nevertheless, as Sobočan et al. (2019:810) starkly express, 'virtually all social research is exploitative and intrusive to some degree.' This is especially so when service users are considered 'vulnerable', or if there are pronounced power differentials between the researcher and participants (Sobočan et al., 2019). I therefore approached the inclusion of service user participants with caution and sensitivity, aware of the need to minimise any risks and ensure these are outweighed by the ethical benefits of service user involvement. Such ethical 'beneficence' (Ruch, 2014) of the research includes the prospect of improving understanding of advocacy and contributing to policy and practice development, bringing potential real-world benefits for service users.

An important consideration throughout was how CAA services are designed for individuals who have 'substantial difficulty' being involved in CA2014 processes, who therefore may have additional support needs regarding engaging in an interview related to this. I was aware from my own practice experience that a significant proportion of users of CAA services would not be able to participate in a research interview, because of the extent of their cognitive or communication impairments. This was reinforced to me via discussions with the participating advocacy managers. Therefore, a method for recruiting people with lived experience was co-designed with the participating organisations, based on them acting as gatekeepers and undertaking purposive sampling. However, this method was changed after initial approval from the research ethics committee and amended ethical approval was obtained, as detailed in appendix J. The amended method only differed in how CAA providers were given more latitude to directly identify and recruit service user participants.

‘Situational ethics’ came to the fore while conducting research with service users, involving the less procedural and more unpredictable aspects of research ethics (Morton, 2016). After making initial contact with each service user, I conducted telephone conversations with them to discuss their potential involvement. As part of arranging the interviews, I checked on their wishes regarding additional support with participation. One participant chose a support worker to be present. On the day of the interviews, we went through the easy-read participant information sheet together, which I had provided in advance, as part of ensuring the person was giving informed consent to participate. During the interviews, I made reflexive judgements about how to approach discussions about CAA involvement, as for both service users this was in the context of extremely stressful life-events. Plans were in place to respond to any distress encountered by participants, but these were not needed.

4.10.2. Confidentiality and anonymity

In the case studies, I followed standard research practice of maintaining participants’ confidentiality and anonymity as far as possible (McLaughlin, 2012). Case study participants are referred to via pseudonyms. However, there were potentially some limits to confidentiality and anonymity. Local authorities and CAA providers were asked to disseminate my recruitment material within their organisations, so potential participants could contact me directly. However, in some cases, managers in the participating organisations forwarded to me the names and contact details of staff who were interested in participating. This increased the likelihood that employers would be able to identify staff who participated. However, in all cases, participants would have known their employer was aware of their potential involvement. Respondent validation provided an additional safeguard, in case any participant said something in an interview that they later felt would be detrimental to their position as an employee.

I was aware of the risk to anonymity posed by ‘deductive disclosure’ (Kaiser, 2009), where a person with some prior knowledge can discern a participant’s identity by piecing together reported information. Participants were advised of these potential limits to confidentiality and anonymity. In places, I have reduced the amount of contextual detail reported. In a few instances, where more specifically personal information was divulged, I have not attributed comments to specific individuals.

4.10.3. Inclusion of national contributors

The inclusion of national contributors posed some issues, as concerns of power and epistemic privilege arise when sources of knowledge are designated as ‘expert’ (Bogner and Menz, 2009). All participants possess different forms of expertise (McLaughlin, 2009). The main rationale for according the perspectives of the national contributors expert status was found in their ‘action orientations’ (Bogner and Menz, 2009:54): all four operated in an influential way within networks either concerning or adjacent to advocacy policy and practice.

Issues about the differentiated status of participants are apparent from the different approaches taken to identification. Significant debate exists about anonymisation versus real-naming in academic social research (see Kelly, 2013). Anonymisation has predominated, yet this is open to challenge (Tilley and Woodthorpe, 2011; Moore, 2021). I approached this issue on the basis that participants sometimes want to be credited for their contributions and this should be supported where possible (Gordon, 2019), ‘subject to an overriding concern for protecting the vulnerable’ (Kelly, 2013:442).

The main reason for the different approaches between the national contributors and the case study participants is therefore that only the former could make an independent decision to be real-named, without identifying others. Another important factor was my judgement that it would be challenging to maintain the anonymity of the national contributors via pseudonymisation, due to them occupying distinctive roles within the advocacy or wider adult social care sectors (Tilley and Woodthorpe, 2011). ‘Deductive disclosure’ of their true identities would therefore be a significant risk (Kaiser, 2009), while omitting or altering contextual information might undermine the validity of their contributions (Saunders et al., 2015).

4.10.4. Researcher reflexivity

Reflexivity is important to critical realist scholarship, given its relativist epistemology (Price and Martin, 2018). The aspect of my own identity with most significance for conducting the research was my experience as a social work practitioner, and I presently remain a registered social worker (SW95387). I informed all participants of my professional background, rationalising that it may bolster my credibility in the eyes of some (Adu-Ampong and Adams, 2020). This related to notions about possessing some ‘harder-edged’ experiential knowledge about CAAs’ work, without appearing overly ‘academic’. My positionality as a researcher therefore comprised both ‘insider’ and ‘outsider’ elements (Hill and Dao, 2020), as my professional adult social care experience was not as a CAA but in a role that CAAs can find themselves in contention with. My positionality as a researcher aligned somewhat with Barnes’s (2021) conception of a ‘Liquid inbetweener’. Instead of a rigid insider/outsider binary, this describes how the researcher can shift closer to one or the other of these designations depending on the particular participant being interacted with or even the topic of conversation at a specific moment.

I found my ‘insider’ knowledge to be most valuable regarding discussions of social workers’ interactions with CAAs, in the interviews and in my subsequent analysis. Opportunities to bring my experiential knowledge to bear included discussions about challenges in applying the eligibility criteria for accessing a CAA, and about the possibility of a registered social worker choosing CAA work as their field of professional practice. However, even when interviewing social workers I did not occupy a fully insider position, as it was some years since I had been in frontline practice, and I had not worked for either of the case study local authorities. This was apparent when social workers from Martborough Council spoke of how their IT system gives prompts about potential need to refer for a CAA. I had experience of using a version of the same IT system, but the functionality of the system differs between local authorities and is frequently updated. This meant that, from the information provided by the interviewees, I was unable to form a clear understanding of how these prompts worked.

In some aspects of the research, my positionality was more notably that of an outsider. When discussing occupational status with CAAs, I was again cognisant of my professional background, given that various CAAs pointed to social workers being in a relatively privileged position in occupational terms. My social location as a white, male, non-disabled academic researcher was also pertinent to conduct of the research. For example, I was acutely aware of my privileged position as someone who has never been subjected to disablism or racism. Consequently, I lacked experiential knowledge that may have benefitted my engagement with these issues, in the way my professional background had benefitted comprehension of issues related to professionalism and social care processes. One way I sought to compensate for this when interviewing people with lived experience of receiving CAA services was to adopt a relatively open stance, as I sought to provide an empathetic and caring space for people to share their experiences (Sharma, 2024).

My identity as a social work researcher is also reflected in my explicit attempt to align my work with the profession's value base, including promotion of social justice and opposition to discrimination (Butler, 2002; Sobočan et al., 2019). These principles are embedded in SWE's Professional standards (SWE, 2019); in the *Professional capabilities framework* that informs professional development (British Association of Social Workers (BASW)(England), 2018a); and the Global Definition of Social Work (IFSW, 2014).

4.11. Limitations of the study

4.11.1 Positionality of the national contributors

While the featured national contributors each made valuable contributions to the study, some held particular positions that involved the provision of services within or related to the advocacy sector, potentially with a commercial component. Such positionality would likely have had a bearing on their contributions, as would be expected for any real-named interview participant with an identified organisational affiliation. For example, in her position at NDTi, Gail Petty held a managerial role regarding the Advocacy Quality Performance Mark (QPM). However, as the case studies will show, the QPM has not been taken up by all CAA providers and its position within the sector is contentious among some, at least as reflected in the experiences of Martborough Voices. Moreover, both Kate Mercer and Gail Petty have written publications regarding advocacy that are cited in my literature review (Belinda Schwehr has also written about advocacy for publication but such an article identified for inclusion in the review could latterly not be located online). This indicates a weakening of the distinction between the literature review and original primary data collection elements of the study, which sits alongside broader issues about the use of 'expert' contributors (see 4.9.2 and 4.10.3). This further explains my decision to use these contributions as a scoping element of the study, with the reporting and analysis of findings emphasising the case studies component.

There was an absence of input from national policy actors who are instrumental in creating the framework within which CAA services are delivered. Redressing this in future research might include interviewing representatives from ADASS, the Local Government Association, or DHSC.

4.11.2. Sampling strategy

The sampling strategy was strongly influenced by resource considerations, regarding what I considered feasible for a PhD study, especially one conducted during the pandemic period. Only two case study sites were chosen, in order to prioritise recruitment from four stakeholder groups within each. Regarding the size of interviewee cohorts, it was assessed that an adequate local authority commissioning perspective could be gained from participation of a single senior commissioning manager. The contribution of a commissioning manager from Fencross Council was highly insightful, with a significant limitation being the inability to recruit someone from a roughly equivalent position in Martborough Council. Accomplishing this would have enabled stronger comparisons between the two case study sites, especially as questions about commissioning and organisational format emerged as important areas of difference.

The social worker sampling strategy was aligned with plans to conduct focus groups. Recruitment was via convenience sampling, as although there was wide advertisement of the focus groups via local authority employers, recruitment was reliant upon self-selected volunteering of a relatively small sample of social workers from the two local authorities. As discussed in 4.6.2, recruitment regarding the intended focus groups was a significant area of disappointment. If repeating the study, I would look to undertake more purposive sampling of social workers for individual interview, which would include approaching social workers of varying experience levels and working in teams with different specialisms. However, the need to maintain anonymity would likely limit the level of reported information about a social work participant.

The approach to recruiting CAA managers and CAAs was largely purposive, as I sought recruitment of as many of these individuals as possible via organisational gatekeepers. This was largely successful, as all such workers were recruited from Fencross Advocacy and all but one from Millborough Voices.

4.11.3. Absence of multi-area advocacy organisations

Another limitation of my sampling strategy was that initial attempts at purposive sampling of case study sites, to heighten theoretical replication (Yin, 2018), were hampered by practical recruitment difficulties, as discussed in 4.5.5. The resultant convenience sampling, with an element of snowball sampling, resulted in the recruitment of two CAA provider organisations that only partially fulfilled the criteria for theoretical replication. The two CAA providers were significantly different in terms of the demographic characteristics of the areas that they served and range of services they offered, although both were alike in terms of being providers of statutory advocacy within a single local authority area. This point of similarity went against theoretical replication principles in the sense that one of the most important distinctions between statutory advocacy providers identified in extant literature is the difference between single-area providers, with roots as Voluntary and Community Sector (VCS) organisations in their locality, and larger advocacy organisations operating across multiple areas. As discussed in my literature review, such larger organisations possess potentially greater power in terms of bidding for statutory advocacy contracts and engaging in evaluation processes, given associated resource demands (Hardwick, 2018; Newbigging et al., 2021). I explore these points in my analysis; however this is largely from the perspective of further critique of these larger advocacy organisations by their smaller counterparts, without the empirical basis to test these claims or explore potential benefits of organisational scale. Here the contributions of the national contributors proved valuable: they discussed the potential under-representation of smaller advocacy providers in sectoral networking, but also how larger advocacy organisations can benefit from focused communication with national policymakers and enable identification of issues across multiple localities.

4.11.4. Limited service user participation

The limited extent of service user participation curtailed the ability to provide firm redress for the absence or paucity of such participation in much extant literature about statutory advocacy. This stymied the ability to properly fulfil the research objective of exploring advocacy outcomes from service users' perspectives (Ridley et al., 2018). This meant the study's evidence base was strongly weighted towards professional perspectives, with a relative lack of direct insight into how service users experience advocacy support. While seeking 'representativeness' of service user participants with a wider population would be misaligned with the qualitative paradigm (Carminati, 2018), greater service user participation would have opened up insights into how CAA works in a wider range of contexts, especially as both service user participants discussed CA2014 processes relating to their move to supported tenancies. Another limitation was restriction of the recruitment strategy to individuals who would be able to participate in interviews and have capacity to give informed consent to participate. The latter point was partly due to expected requirements to obtain ethical approval, where such requirements have previously stymied inclusion in advocacy research of service users identified as of heightened 'vulnerability' (e.g. Townsley and Laing, 2011; Lonbay, 2015). This is a significant omission given what will be shown as the importance of non-instructed advocacy within CAA practice. In chapter 10 I propose recommendations for future research that might help close this gap in future.

4.11.5. Absence of quantitative data

At points in the analysis there are strong indications that quantitative research would help elucidate the issues discussed. For example, participants conveyed broad concerns about gaps in access to CAA, without having the ability to confirm the scale or particular characteristics of any exclusion. This aligns with a previously noted deficit in the collection and collation of data about CAA provision, such as about what services are available and levels of usage (Mercer and Petty, 2021; ADASS, 2020). A mixed methods approach could have afforded complementarity between research components, as when qualitive enquiry provides explanatory depth regarding reasons for a quantitative finding; or quantitative analysis confirms the extent of a phenomenon initially observed anecdotally (Schoonenboom and Johnson, 2017; Creswell and Plano Clark, 2011).

I originally planned to incorporate a subsidiary quantitative element into the case studies, and I collected some data for this. I wrote to the four participating organisations (adult social care departments and CAA providers in each case study), to request data. From CAA providers, data was requested about: the volume of CAA referrals received during the latest full annual period, what type of care and support processes these related to, and the number of individuals receiving CAA support. From local authorities, data was requested about the volume of care and support process conducted during the same period, broken down by type. The intention was to compare referral volumes between the case study sites and see how this related to staffing resources. It was also intended to enable understanding of the proportion of total care and support processes in which the person has CAA input, comparing this to the Government's estimate of 7%, made prior to implementation (DH, 2014; Dixon et al., 2020). However, in conducting this quantitative element, I encountered issues such as inconsistencies between how organisations recorded output data, including the timeframes over which data had been captured. This made comparisons difficult, and I decided to focus exclusively on the study's qualitative aspect, especially due to the richness of qualitative data I was collecting. In chapter 10 I return to how a mixed methods paradigm could benefit future research about CAA.

4.12. Conclusion

I have now set out my study’s methodology. I have discussed its philosophical basis in critical realism, and how it additionally draws upon realist evaluation and CAIMeR theory. This allows CAA to be studied evaluatively, in its own terms, as well as from a more critical vantage point—interrogating its place in a wider practice system and comparing it with other advocacy types that may yield differing forms of empowerment. I have also explicated my research design, and described how the research was conducted, including amendments made in light of challenges encountered. A rationale has been presented for the study’s incorporation of methodological hybridity, involving triangulation of perspectives. I now turn to the first of my thematic chapters, in which I report and analyse my findings.

5. Theme one: Barriers to access

5.1. Introduction

In this first thematic chapter, I explore access to CAA services for qualifying individuals. I begin by considering evidence of access gaps, in the case study sites and beyond. Thereafter I analyse reasons for those gaps. I show that decision-making by practitioners is often crucial due to their gatekeeper role. This includes evidence that some practitioners are insufficiently aware of their responsibilities regarding enabling access to a CAA. I also discern difficulties that can arise when practitioners seek to apply eligibility requirements for CAA support to complex practice situations. These include challenges of evaluating friends and relatives' 'appropriateness' to advocate informally and sometimes related questions about service users' consent to receiving CAA input. I also discuss issues about delayed access and some service user groups being disproportionately disadvantaged regarding access. Finally, I consider progress in overcoming access barriers.

5.2. Identifying the access gap

Various participants perceived a shortfall in levels of access to CAA services among qualifying individuals. This affected the case study sites while also being a national concern. A lack of data about advocacy was reported to hinder assessment of this access gap—regarding its scale, extent of geographical variation, and underlying causes. Nevertheless, there was a sense that the problem was most immediately caused by practitioners failing to make necessary referrals in some instances. This was linked to practitioners having a gatekeeping status because of their powers of referral, linked to the local authority having ultimate responsibility for determining whether a person requires involvement from a CAA (DHSC, 2024:7.29). Potential reasons for why practitioners may not make referrals in line with legal requirements are explored below. From a national perspective, Gail Petty and Kate Mercer (NCs) each reported unevenness regarding whether practitioners appropriately enable CAA access. Mercer said this ranged across 'the good, the bad and the ugly'. Petty highlighted the Covid-19 pandemic as exacerbating previous inconsistencies:

> I think there's been some kind of change over the last two years (…), even prior to that, I think it's been really hit and miss in terms of practitioners appropriately both identifying and then making the referrals that people should be making. (Petty)

The case studies yielded further observations of access gaps. In both sites, practitioners had formal gatekeeping powers as only they could refer for a CAA. Managers from Fencross Advocacy and Martborough Voices reported receiving insufficient volumes of CAA referrals relative to estimated levels of need among local populations. Yet they were cautious in drawing conclusions, given they could not accurately quantify any shortfall:

> When we do our contract monitoring reports, we roughly have about 1,000 Care Act referrals a year. Now, given the population of Martborough and the fact that we are working with people aged 17 up to 100, maybe, I would suspect that they should be higher. (Lisa, M, MV)

A general trend of increasing CAA referral levels was reported for both case study sites. Stephen, a commissioner from Fencross Council, described 'steady growth' from relatively low levels in 2015, before a pandemic-induced 'slip back'. He acknowledged referral volumes remained insufficient, meaning the local authority needed to sustain efforts to ensure its practitioners enable necessary access:

> I'm not sure whether we've reached the optimum point (…) I couldn't put my hand on my heart and say that we are achieving necessarily the full statutory requirement. (Stephen, CM, FC)

Clearer insight into practitioners' performance regarding facilitating CAA input would require a 'deep dive' audit of case files, Stephen added. This was yet to happen.

5.3. Practitioners as gatekeepers

5.3.1. Practitioner-only referral routes

In the case study sites, practitioners' gatekeeping function was reflective of CAA services being of a targeted statutory type:

> It's got to be a professional referral because we're supporting through the assessment process. (Lisa, M, MV)
>
> We don't accept referrals just for, you know, generic advocacy; there has to be a process: so is there an assessment, is there support planning and is there a safeguarding? (Isobel, CAA, FA)

These access arrangements broadly reflect a 'law-based' approach to commissioning independent advocacy, where CAA involvement is closely aligned to statutory processes (Newbigging et al., 2021). Such boundary-setting has important implications for CAAs' practice and role formation, as I discuss across subsequent chapters.

Mercer and Petty contrasted practitioner-only referral protocols with the more open routes to CAA services existing in some local authorities, where self-referrals and referrals from others such as carers are permitted. Mercer also contrasted the restrictive access arrangements that are common for CAA with the more flexible ones for an IMHA, where IMHAs have a presence on mental health wards and 'qualifying patients' can request their involvement (DHSC, 2017:6.21):

> Care Act Advocacy doesn't seem to have been successful with that. It seems very dependent on a specific, formal referral into the service that the provider then responds to, and that doesn't make sense to me. (Mercer)

More flexible commissioning of CAA services might allow a pro-active approach, such as by allowing CAAs to develop an expanded presence within care homes (Lawson and Petty, 2020). This reflects how an advocacy presence in care and support environments can bolster uptake and subsequent engagement (Palmer et al., 2012). It may be harder to use mechanisms such as outreach from CAA providers to bolster access for community-dwelling individuals, not least due to the increased expenditure of personnel resources this would require from advocacy organisations.

Questions about access arrangements for CAA support relate to wider power imbalances between practitioners and service users. Petty described self-referral as ‘a much more empowering way for people to access advocacy services’. This aligns with Newbigging et al.’s (2021) argument that self-referral routes are more aligned with a ‘values-based’ conception of advocacy that evidences links to disability activism. Self-referral is therefore an expression of self-advocacy, where service users are facilitated to identify their own advocacy needs and assert their rights to have these met.

Discussions of self-referral possibilities suggest areas for further research. It was unclear from the data collected what proportion of local authorities have more open referral systems. Proper examination of the workings of access routes is needed to determine their effects on access outcomes and any implications for ensuing CAA involvement. The link that Newbigging et al. (2021) posit between self-referral opportunities and more holistic advocacy commissioning thus requires further empirical examination. Some participants mentioned advocacy organisations would need to check on the appropriateness of self-referrals. Therefore, while enabling self-referral might improve access for those meeting current eligibility criteria for statutory advocacy services, questions would persist about the breadth of advocacy needs that could be met under these arrangements.

5.3.2. Understanding and applying the eligibility criteria

Participants reported a widespread perception that some practitioners are insufficiently aware of when CAA input must be sought. Social workers agreed that, within their local authorities, some necessary CAA referrals were not being made:

> I don’t feel that advocates are used as much as they possibly could be. (Clare, SW, FA)
>
> I think sometimes there’s a bit of ignorance around it [CAA]. (Emma, SW, MV)

Another social worker acknowledged gaps in her own knowledge:

> I've not really had the experience of using Care Act advocates and I personally wouldn't even know what the process is, what the referral [pathway] is. (Joanne, SW, FC)

Joanne attributed this to being a newly qualified social worker during the pandemic period, when reduced contact with colleagues had diminished practice learning opportunities. This exemplifies how social workers were challenged by disruption to established support structures during this time (Kingstone, 2022). However, this cannot explain all awareness deficits among practitioners. One social worker recounted how, when she had worked as a manager, she had once addressed with an experienced social worker their failure to seek CAA input for a review with a person living in residential care.

Beyond awareness gaps, practitioners were seen to face potential difficulties applying the eligibility criteria for a CAA to complex casework scenarios, with workload pressures amplifying these challenges. This resonated with Dixon et al.'s (2020) argument that multiple, overlapping legal frameworks for independent advocacy can cause confusion. The interrelationship of the CAA and IMCA roles was one area of complication:

> They [social workers] still get mixed up now; we still get referrals that are inappropriate because they should go to IMCAs. (Helen, CAA, MV)

Another advocate observed that some practitioners miss opportunities to refer for a CAA as they confuse 'substantial difficulty' with the higher threshold of lacking decision-making capacity under the MCA2005.

Social worker participants acknowledged difficulties in applying both main eligibility criteria for CAA:

> I mean, the wording 'substantial difficulty': everyone can interpret it differently, can't they? (Emma, SW, MC)

> I feel that it’s very, very clear when a Mental Capacity Advocate is needed, when a Mental Health Advocate’s needed, but I think the Care Act Advocate…I don’t think it’s particularly clear for us as professionals to know what substantial difficulty is; is their neighbour the most appropriate person [to promote involvement]?’ (Clare, SW, MC)

These quotations refer to a sense that the eligibility criteria for CAA services are not clear cut, especially when compared to those for other statutory advocacy types. This makes it harder to apply technical knowledge about the CA2014 to each service user’s unique circumstances, as judgements must be formed about the effects of their impairment and the suitability of their informal support networks, often under great time pressures. Therefore, while independent advocacy is an important response to challenges in conducting person-centred social work practice, similar challenges can impede access to advocacy itself (Southall et al., 2021). I now explore these practice complexities in more depth.

5.4. Service users exercising agency regarding referrals

5.4.1. Capacity and consent considerations

Service users and their friends or relatives are sometimes able to exercise agency regarding access to a CAA, meaning access outcomes can result from complex relational processes. Some participants noted that practitioners should not assume service users’ consent to a CAA. Fencross Advocacy had encountered problems with receiving referrals that failed to register consent, which was addressed via an updated referral form and staff monitoring. Ascertaining consent could also raise mental capacity considerations:

> There’s been a couple of cases where, you are kind of thinking, do they need support through this assessment? But then they’ve actually declined it anyway, you know; and because it’s not an IMCA, it’s a Care Act advocate, I haven’t referred because I haven’t got consent. (Clare, SW, FC).

Here, rules regarding access to a CAA are distinguished from those for an IMCA. The observation that a person does not need to consent to IMCA involvement reflects that role’s overarching legal construction: the person lacks control over the IMCA’s involvement on their behalf, as this is to help make a decision about which they have already been assessed to lack capacity (Series, 2013).

However, there are nuances to the rules regarding access to a CAA that go unmentioned in the above quote, which infers the person has made a capacitous decision to reject a CAA. Issues about consent to receiving CAA support, including whether the person has capacity to give such consent, are not addressed explicitly in statutory guidance. The guidance does state the local authority 'must arrange an independent advocate' for someone who meets the eligibility criteria (DHSC, 2024:7.4). It also later advises 'it will be unlawful not to provide someone who qualifies with an advocate', although this is in the context of requirements on local authorities to ensure a sufficient supply of CAAs (7.59). Turning to primary legislation, the CA2014, s.67(2) states that, where the eligibility requirements are met, the local authority 'must (…) arrange for (…) an 'independent advocate' to be available to represent and support the individual'. By only requiring availability, this more clearly implies scope for refusal of CAA input. It nevertheless remains notable that the statutory guidance does not cover circumstances in which the person may be resistant to or reject CAA involvement, whether they have capacity to decide how they are supported through CA2014 processes or not. This contrasts with clear stipulations regarding support by an 'appropriate individual': the person must consent to this individual supporting them, or this must be in their best interests if they lack capacity (DHSC, 2024:7.34). Therefore, the statutory guidance stresses the importance of consent to dispense with CAA involvement, but it provides no equivalent direction regarding consent to receive it. Nor does it advise what should be done if consent is refused or withdrawn, even if no other suitable support is available. It can be inferred that, absent capacity, CAA involvement would be expected to be decided on the person's behalf, in their best interests, under the MCA2005, s.4.

Ultimately, the above discussion underscores the complexity of rules around access to independent advocacy (Dixon et al., 2020). By way of comparison, s.130B(6) of the MHA1983 clarifies that a service user can decline an IMHA's help (Mental Health Law Online, 2011). Any moves to assign advocates to people without their assent sits uneasily with notions of advocacy as a voluntary partnership (Sherwood-Johnson, 2016)—a tension that Series (2013) identifies as intrinsic to how the IMCA role has been established.

5.4.2. Service users' awareness of CAAs

Consent issues highlight the importance of considering levels of awareness and understanding of advocacy among potential service users. Participants identified deficits regarding this, with some mentioning that advocacy can be difficult to explain in simple terms. One social worker said she had experienced only an 'odd few cases' of people requesting a CAA:

> Sometimes advocacy is quite a difficult concept for people to grasp, especially people…if you've got a learning disability, a lot of people I've worked with wouldn't understand what an advocate is. (Emma, SW, MC)

This suggests scope for advocacy organisations to conduct further awareness-raising outreach. The case studies yielded some evidence of this, including a programme by Martborough Voices:

> We have what we call our community conversations, whereby we do engage with as diverse a range of stakeholders as is possible. (Catherine, M, MV)

However, it was noted that the impact of such outreach on access to CAAs was unclear; increased levels of community awareness would not necessarily translate directly into increased use of CAA services, as access remained channelled through practitioners' referrals.

Sophie (PLWE, MC) was an example of someone who pro-actively sought CAA input. She had prior knowledge of advocacy and had asked her social worker to refer her for a CAA. Sophie described wanting a CAA as an additional source of support as she navigated local authority processes regarding safeguarding and her move to a supported tenancy. Social worker participants also reported a person's relatives might seek CAA assistance with challenging a local authority decision, which I consider further below.

5.5. Consent and involvement of friends or relatives

Capacity and consent issues come to the fore when a person is expressing a preference to be supported by a friend or relative instead of a CAA. A social worker participant pointed to the possibility of a person wishing to be assisted by a relative whose 'appropriate individual' status is at least questionable, according to the criteria set out in law and guidance. The social worker referred specifically to the statutory guidance's stipulation that it would be difficult for a relative to fulfil the 'appropriate individual' role if they only have 'occasional contact' with the person (DHSC, 2024:7.35):

> There might be a family member that, according to the guidance, they aren't in contact very often. However, the person is saying 'no, I want you to speak to my son or my daughter.' So then, based on that person's wishes, we would use that person to advocate for them, unless you know, there was something glaringly obvious—they've only become involved since they realised that mum won the lottery for example [laughs]. (Clare, SW, FC)

This scenario highlights how important principles can conflict regarding CAA access: promoting a person's choice and control over how they are supported through CA2014 processes, versus ensuring that support is as suitable and effective as possible. These tensions might relate to practical considerations, such as the preference of many people with dementia to be supported by those they are familiar with (Sinclair et al., 2019; Dixon et al., 2021) and some family members being less capable than formal advocates of holding professionals to account (Series, 2013; Dixon et al., 2020). However, even the above quotation from Clare (SW, FC), which implies wide latitude regarding interpretation of the statutory guidance, acknowledges limits to service user choice regarding CAA access. Although perhaps couched in hyperbole and intended humorously, her comments imply there are circumstances such as suspected financial abuse that would preclude the relative being considered an appropriate individual (see DHSC, 2024:36). Nevertheless, the scope for tension is apparent. A possible route to resolution could be the person being supported jointly by a CAA and a friend or relative, which statutory guidance endorses in certain situations (DHSC, 2024:7.38). Yet it remains possible that the person or their friend or relative might reject the CAA element outright. Imposition of a CAA would again be problematic for the resulting advocacy relationship (see Sherwood-Johnson, 2016).

These choice and consent issues regarding access to CAA services therefore reflect a profound conceptual tension that affects advocacy practice itself: focusing solely on following the person's immediately expressed wishes can sometimes clash with working with them to pursue a deeper and longer-term empowerment agenda (Stewart and MacIntyre, 2013). Similar questions about constrained choice over support arrangements exist elsewhere in adult social care. For example, Pollock (2021) discusses access to interpreters for people with limited English-language proficiency, whereby statutory guidance to the CA2014 discourages the use of family members and carers as interpreters (DHSC, 2024:6.96), although there is no formal prohibition on this. Pollock (2021) contends that this, and other guidance weighing against using informal interpreters, conflicts with key statutory principles. These include the right under the MCA2005 for people with capacity to make unwise decisions, and the onus the CA2014 places on person-led practice.

There was also a suggestion that practitioners' exercise of discretion regarding familial advocacy could risk stymying rightful access to CAA support. Belinda Schwehr (NC) argued that some practitioners may undertake 'deliberate massaging of the way the facts look so that the individual doesn't get advocacy'. She pinpointed the possibility of the practitioner manipulating situations where the law requires consent—specifically that a service user, if capacitous, must agree to a friend or relative acting as their 'appropriate person' (CA2014, s.67(6)). How this manipulation might happen was described:

> So the most obvious fudging that is done is the requirement that a person with substantial difficulties consents to their informal supporter. Whereas in most real-life situations the local authority will say: 'isn't it great that your mum is prepared to speak for you.' And that will be a manoeuvring and the putting of a closed question to an individual designed to generate the answer—or just the grunt—'yep, that will be OK.' That person is not then consenting to giving up their right to advocacy because nobody told them that, actually, to be giving up their right to advocacy,

> they’ve got to positively consent to their relative doing it for them—not just acquiesce. (Schwehr)

This describes cynical and disempowering practice, where the person has been presented with an entirely superficial ‘choice’. They have not been properly informed of their rights to independent advocacy and there has been no attempt to create decision-making space where the possibility of CAA input can be considered independently of any familial influence. The risks of such an approach are apparent from statutory guidance, where a case study vignette depicts a woman with learning disabilities needing CAA support as a counterweight to her parents opposing her wish to live independently (DHSC, 2024:7.35). A practitioner’s avoidance of CAA input might also reflect a wish to avoid scrutiny and possible challenge. However, while Schwehr’s comments highlight risks associated with practitioners’ gatekeeper status, the rest of the data offered no insight into how prevalent such oppressive practice may be. Moreover, my own practice experience is that it can often be difficult to find opportunities for a frank conversation with service users about prospective advocacy involvement, away from friends or relatives’ presence and potential influence.

5.6. CAA input as a response to disputes

Participants observed that practitioners’ interactions with friends or relatives could variously create push and pull dynamics regarding activating CAA involvement. Friends or relatives might feel aggrieved at being held not to be ‘appropriate’ to provide support and representation:

> If there’s a family member who is not suitable and you need an advocate, you will get resistance from the family members, who say: ‘why would we need an advocate? Because we are advocates.’ (Dawn, SW, MC)

Friends or relatives may therefore perceive CAA as an encroachment on their own informal advocacy role, wherein they would likely be able to draw upon deep knowledge of the person. Furthermore, their ‘resistance’ to CAA input might impair their ongoing relationship with the practitioner. This could have significant implications for the person if the practitioner needs to consult with friends or relatives during CA2014 processes, especially regarding any caring role they fulfil (see Symonds et al., 2020). Friends or relatives' wariness about external advocacy, or resistance to this, can also significantly affect ensuing CAA involvement, as I discuss in the next theme.

Despite risks of alienating friends or relatives, some social worker participants referred to being assertive if CAA involvement is required but these third parties reject it. Reference was also made to a scenario not directly addressed in the statutory guidance: that of conflict among friends or relatives, such as between a service user's adult children:

> I've used them [CAAs] when there's been complex family dynamics and the citizen is in the middle (…). So we would get an advocate involved to make sure that citizen's voice is heard. (Clare, SW, FC)

Access to CAA could also be prompted by disputes between practitioners and friends or relatives over the person's care and support (DHSC, 2024:7.42). CAA input would then focus on ensuring the person's wishes and interests remain central to deliberations. However, there was suggestion that practice realities might differ from this ideal, and attempts could be made to instrumentalise CAA input:

> I think a lot of social workers see advocacy as a way to resolve disputes, or if they've got a 'difficult family'—which I know is a horrible phrase—then they will bring an advocate in. I think sometimes social workers and other professionals bring advocacy in to almost get them on side, so kind of there's evidence that the professionals are doing OK and they're doing the right thing. They're not really thinking about it from the person's perspective, which is what does this person need to be fully involved in this process? (Mercer, NC)

This quotation refers to a risk of CAA being co-opted as an instrument of defensive rather than person-centred social work practice, where the onus is on managing conflict with friends or relatives rather than ensuring the service user's rights are upheld. This represents unethical practice that is misaligned with social workers' *Professional standards*, where enabling access to independent advocacy accompanies more general responsibilities to promote the ‘views, wishes and feelings’ of people being worked with (SWE, 2019:1.2).

Other concerns existed about how CAA involvement may be sought in response to disputes. A CAA described a situation that can arise when a person wishes to complain about their assessment:

> (…) they [the local authority] refer into us, presumably thinking that we might be able to act as a mediator. And they’ll say, well, we’re having substantial difficulty assessing this person—as opposed to it being, does this person have substantial difficulty being a part of the process? (Isobel, CAA, FA)

Here the reported expectation of some practitioners is that, by acting as mediators, CAAs will take a neutral stance and work to resolve the dispute. This is instead of advocacy’s core purpose of siding resolutely with the person (NDTi, 2018), where the CAA would be compelled to support them in pursuing their complaint (DHSC, 2024:7.48). These comments further indicate misunderstanding among some practitioners of advocacy’s purpose. Such false or unrealistic expectations of CAAs’ input could then hamper their effectiveness, given the importance of CAA–practitioner relationships as I discuss in theme three.

Service users, or their friends or relatives, could themselves seek access to CAA involvement to aid their pursuit of certain care and support outcomes. Social worker participants saw this as the most common reason why a CAA may be requested:

> I have had cases where family have requested that advocacy are involved, but to support them, through funding processes and things like that. (Emma, SW, MC)

This refers to CAA input being sought out to assist with navigating processes, albeit these are specific to achieving desired outcomes regarding allocation of resources for care and support. This differs from a CAA being requested for more holistic and relational support, as suggested by the case of Sophie (PWLE, MC) discussed above. Assistance with funding processes alludes to technical components of CAA practice. The above quote also raises questions about having CAA involvement alongside that of friends or relatives, as the statutory guidance states a person is not normally eligible for a CAA if they already have an 'appropriate individual' to support their involvement (DHSC, 2024:7.42). I return to these points in later chapters.

5.7. Delayed access

5.7.1. Late referrals

Participants raised concerns that some people experience delayed access to CAA, limiting its effectiveness. This was largely attributed to practitioners making tardy referrals, again suggesting some may insufficiently appreciate advocacy's purpose. An advocacy manager said her service had a 'real problem' with practitioners only referring for a CAA once they were far progressed with their intervention:

> How do you think that that person's been supported through that process appropriately, when actually you've just gone ahead and you've done everything? (Lisa, M, MV).

Such practice contravenes how, once a need for CAA involvement has been established, it must be provided from the outset of CA2014 processes, as underscored by the case law of *R (SG) v London Borough of Haringey [2015]* (Dixon et al., 2020).

Advocacy managers from both case study sites also described frequently receiving urgent referrals for CAA input, placing unnecessary strain on the service if these could reasonably have been made earlier. This could reflect a lack of thought about the CAA's need to undertake preparatory work with the person, to better secure their participation. Such apparent oversights could significantly heighten tensions between occupational roles:

> (…) we are just a tick box exercise and that can be quite demoralising and frustrating for our staff. We will get a referral on the Friday morning: 'can you come Friday afternoon to a best interest meeting?' No, we bloody can't! (Catherine, M, MV)

This shows that the requirement that practitioners take ‘reasonable steps’ to support CAA involvement can go unmet, including regarding the pacing of CA2014 processes (DHSC, 2024:7.56).

Rachel (M, FA) described particular issues with the timeliness of referrals relating to hospital discharges. This involved cases where, at the time of admission, patient notes recorded a need for CAA involvement regarding arranging post-discharge care and support, yet the referral was only made shortly before the discharge date. A timely referral was more likely if the person’s case history showed they had previously received statutory advocacy, Rachel noted. This demonstrates how case recording systems act as a repository for knowledge forged interactionally with service users, which subsequent practice can draw upon to help determine eligibility for CAA services. This stored knowledge is especially valuable in situations such as hospital discharges, where the imperative to prevent ‘delayed transfers of care’ entails decision-making under severe time pressure (Gridley et al., 2022). Scope for embodied interactions with the person might be further diminished due to their ill health, absence from their home environment, and other circumstances. The identification of hospital discharges as a particular area of concern regarding timely access to a CAA might also reflect specific issues regarding clinical practitioners’ engagement with advocacy, as previous scholarship has indicated can affect IMCAs (Luke et al., 2008; Series, 2013; Chatfield et al., 2018). Further investigation into these issues is merited, especially given recent concern within the social work profession about the downgrading of social care assessments within hospitals, under the ‘discharge to assess’ model (Samuel, 2023b).

5.7.2. Delays in allocating a CAA

Another concern participants identified was under-resourced advocacy organisations being unable to swiftly allocate a CAA to a service user. Here the case studies presented a mixed picture. CAA and social worker participants from Martborough said they did not usually encounter post-referral delays in allocating CAAs. Staff at Fencross Advocacy described a more variable situation; this was stable at the time of data collection, but previously between 60 and 90 people had been awaiting allocation. This was attributed to overarching resource pressures, entailing under-staffing:

> There are not enough advocates. Not just within our service, but across the country [there] are very high caseloads—usually a backlog of cases that need allocating. I suppose different advocacy services manage that in different ways. (Amy, TL, FA)

This quotation refers to variations in CAA provision between local authorities; other participants also reported awareness of differing lengths of waiting lists between neighbouring local authorities. The presence of backlogs indicates some local authorities were failing in their obligation to ensure sufficient availability of CAAs (DHSC, 2024:7.59).

Social workers from both case study sites recounted how the onset of the Covid-19 pandemic had increased delays in allocating CAAs, although it was unclear how much this had persisted beyond the initial lockdown period. A social worker from Fencross recalled an experience of waiting weeks for allocation of a CAA. She argued these delays could deter practitioners from making further referrals, out of concern this might hinder essential progress with casework:

> Quite often they [CAAs] don't end up getting used because it's either a person left at risk without the support they need, or you just wait and wait and wait. (Clare, SW, FA)

These comments raise the prospect of practitioners rationalising a disregard for CAA involvement as a pragmatic and even ethical route to avoiding delays that could prolong a person's needs going unmet, potentially exposing them to harm. They describe a practice response to a situation that arose from an unprecedented public health crisis, its effects exacerbated by long-term under-funding of adult social care (see Pollock et al., 2020). Nevertheless, qualifying individuals retained a legal right to access statutory advocacy throughout the pandemic (NTDi, 2020). It was unclear how prevalent such non-observation of obligations to involve CAAs was, going unmentioned by other social worker participants. However, reasoning such as that described in the quotation above may have contributed to reduced referral rates for CAA during the early pandemic period, as reported in the case studies and nationally (NDTi, 2020). Such claims of deviation from legally required practice must be seen in the overall context of social workers' heightened exercise of discretion amid the upheaval generated by Covid-19, with attendant ethical dilemmas (Manthorpe et al., 2021).

5.8. Access disparities between service user groups

Some service user cohorts were reported to be particularly disadvantaged regarding access to CAAs. This largely derived from participants' anecdotal observations, reflecting a paucity of data about advocacy access, including with regards to protected characteristics under the Equality Act 2010 (NICE, 2022)[6]. Moreover, these issues were discussed in general terms that did not capture the nuanced and intersectional nature of individual social location (Hankivsky and Jordan-Zachery, 2014).

People accessing specialist mental health services were most often cited as experiencing heightened levels of exclusion from CAA support. Discussion returned to the challenge of upholding statutory advocacy responsibilities across various legal frameworks:

> I think it's been particularly hard with the Community Mental Health Teams, because they've been working under different legislation; they've always worked under the Mental Health Act and now they're having to get their heads around the Care Act and how that interlinks (…). (Lisa, M, MV)

Specific issues were also raised about access for people with substance misuse problems. One CAA observed that practitioners could mistakenly conflate the eligibility requirement of 'substantial difficulty' with the person having a diagnosed cognitive condition, such as dementia, or a specific form of impairment such as learning disabilities. For others without such diagnoses, insufficient account could be taken of their functional ability to be involved

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[6] The Equality Act 2010, s.4 designates the following as protected characteristics: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

in CA2014 processes, against which ‘substantial difficulty’ should be judged (DHSC, 2024:7.15). The advocacy needs of people with substance misuse problems can therefore be overlooked, the CAA argued. When referrals *were* received for people with substance misuse problems, the particularity of their experiences of substantial difficulty could be apparent:

> I find that actually we do get a few cases for people where there’s alcoholism, for example, or drug addiction, which means that they do have substantial difficulty being part of these conversations, because their lifestyles might mean that they’re not available all the time or they’re not remembering the information. Or I think sometimes, you know, they can feel maybe a bit harshly judged about sort of the decisions they’re making. (Isobel, CAA, FA)

This quote also highlights how perceived stigmatisation can be a barrier to involvement in care and support processes for some individuals.

References to the impact of stigmatisation were made in other discussions of the advocacy needs of people with substance misuse issues. A social worker referred to her practice with individuals experiencing both substance misuse and homelessness, intersecting forms of adversity referred to as ‘multiple-exclusion homelessness’ (England et al., 2024). Significant advocacy needs exist among this population, she noted, yet this tends to co-exist with a ‘massive mistrust of services’:

> Even though I feel like they could benefit sometimes from having an advocate, I think they would be really resistant and reluctant to do that. Because they already (…) are overwhelmed by the amount of people that provide them with support. (Joanne, SW, FC)

This underscores how experiences of marginalisation among this service user cohort create barriers to accessing CAAs, with some professionals’ dismissive attitudes a factor (see Cornes et al., 2018). Joanne argued that service users affected by these issues tend to look to staff in homelessness support services to advocate for them, because trusting relationships have already been established and looking beyond these networks may be ‘overwhelming’. Yet support staff are precluded from acting as an ‘appropriate individual’ if they are already paid to assist the person (DHSC, 2024:7.33). This distinguishes CAA practice from the more holistic type of involvement that organisations dedicated to working with multiple-excluded people might deliver (Cornes et al., 2018). Moreover, the mistrust that some service users have for professional practitioners is an important factor in the debate about the merits of professionalising advocacy, as I return to in future chapters.

Some participants referred to informal carers as another group facing disproportionate disadvantage in accessing CAA services. Mercer (NC) reported encountering knowledge gaps among senior local authority personnel about their responsibilities to commission CAA provision for carers. Fencross Advocacy's manager observed that awareness about carers' potential eligibility for CAA was especially low among practitioners:

> We don't get a lot of referrals from the local authority for carers. (Rachel, M, FA)

These concerns, although not explored in depth, align with previous research findings about informal carers having problems accessing advocacy (Hardwick, 2014; Bennett, 2016), alongside other evidence that the promise of the CA2014 regarding carers' support remains partially unfulfilled (Fernández et al., 2020).

Managers from Fencross Advocacy and Martborough Voices also reported that ethnically minoritised people seem under-represented among users of CAA services:

> I don't understand why we have such low levels of people being referred from different ethnic backgrounds; but they are low. (Lisa, M, MV)

These observations are especially notable given recent impetus towards developing pro-actively inclusive services (ADASS, 2020), including via culturally appropriate advocacy (DHSC, 2021a; NICE, 2022). Stephen (CM, FC) acknowledged that, to date, the 'onus' had been on practitioners to ensure appropriate access to CAAs for people from minoritised groups. The local authority had thus imposed limited expectations of Fencross Advocacy conducting 'outreach', beyond requirements such as staff training and provision of accessible literature. This raises further questions about whether departing from practitioner-only referral systems might help make access to CAAs more inclusive. I return to culturally appropriate advocacy in theme five.

5.9. Promoting access: opportunities and obstacles

Participants identified various mechanisms that positively contribute to expanded access to CAAs. These included a trend of gradually growing awareness among practitioners of the CAA role, mirroring earlier processes concerning IMCAs and IMHAs:

> I think that it takes time for legislation to embed in services. (Lisa, M, MV)

There was a strong communicative as well as technical component to this knowledge acquisition, as awareness was forged through practice interactions. A mutually reinforcing relationship could arise between improved access to CAAs and developing CAA–practitioner partnerships:

> (…) where practitioners have a good understanding of the role—and a good relationship with the advocates and the advocacy provider, then people's access to advocacy improves because the practitioner can see the benefit for the individual and for themselves. (Petty, NC)

This suggests potential for a positive feedback loop between demonstrations of CAAs' effectiveness and improved access to them. It highlights potential for collaborative CAA–practitioner working and aligns with previous research findings that practitioners generally seek to be person-centred, even if their own ability to conduct an advocacy function is constrained (Symonds et al., 2018).

The case studies showed how local authorities, advocacy organisations and individual CAAs can encourage these positive dynamics. One area of development concerned referral processes, which in some locations could be overly bureaucratic and discouraging to practitioners facing already intense workloads:

> Some services have, like, a 10-page referral form—who's going to fill that in? (Mercer)

In Fencross and Martborough, efforts to make referral pathways more streamlined and effective had helped raise the quantity and quality of referrals, in terms of appropriateness and completeness. The social worker participants spoke in a generally positive way about the ease of using these systems. Fencross Advocacy saw a marked increase in accepted referrals after introducing an online form with mandatory fields; previously, up to 95% of referrals received on a Microsoft Word document were 'incomplete or unsuitable' (Rachel, M, FA). Martborough Voices received referrals via a form integrated within the local authority's IT system. This evidenced the benefits of prompts to practitioners (Lawson and Petty, 2020), as a referral for a CAA could be initiated based on how certain fields on an assessment form are completed. However, social workers from Martborough also reported limitations to this partly automated system, including a lack of prompts on review documentation, as opposed to the more in-depth assessment documentation. A need for more detailed prompts was also suggested, such as to help practitioners judge the 'appropriateness' of friends or relatives to provide support:

> On Liquidlogic [IT system], there's a form with boxes you tick to say there's an [informal] advocate [i.e., friend/relative]. I think they should go further and say, is the advocate appropriate? You know, just to make people think more about it. (Dawn, SW, FC)

Fencross Advocacy and Martborough Voices delivered outreach sessions to practitioners to raise awareness of CAAs and give practical advice, such as about referral pathways. Practitioners new in post and members of teams with relatively low referral rates were prioritised for this. Stephen (CM, FC) partly attributed the increase in CAA referrals in Fencross to this 'battle for hearts and minds through education and training', echoing previous research findings about advocacy outreach (Sherwood-Johnson, 2016; Lawson and Petty, 2020). The sessions continued online during the pandemic, when increased turnover of practitioners made them especially valuable:

> Organisational knowledge has potentially taken a bit of a dip because of Covid and there's new staff to train. (Rachel, M, FA)

However, Rachel also reported that these outreach efforts were constrained by resources, further showing how funding rigidities can impede strategic action by advocacy organisations (Lawson and Petty, 2020).

The overlapping nature of statutory advocacy remits also provides opportunities for advocates to give prompts regarding CAA input. An advocate acting as IMCA or IMHA might encourage a practitioner to refer for a CAA, if it became apparent this was needed. The same advocate might then act as CAA. For example, participants referred to how IMHAs prompt CAA input when someone is to be discharged from detention under the MHA1983 and their aftercare arrangements involve CA2014 processes (see DHSC, 2024:7.23):

> I've got somebody and have let the mental health team know, asking (…) when are you going to start discharge planning? While you're doing discharge planning are you going to be doing a Care Act needs assessment? (Natalie, CAA, MV)

These reminders were observed to be especially valuable given issues about access to CAAs for users of mental health services. However, such cross-referral opportunities might be limited by commissioning arrangements that split statutory advocacy responsibilities between different providers. Rachel (M, FA) reported that in Fencross the needs of older people on mental health wards for CAA input were often only identified by her organisation's IMHAs. She therefore expressed concern that this service user cohort may be particularly disadvantaged in localities where different organisations provide CAA and IMHA services. I return to linkages between the CAA, IMCA and IMHA roles in theme five.

5.10. Conclusion

Several key issues regarding access to CAAs have been discerned. The findings suggest a significant number of people who are statutorily eligible for CAA support may not be receiving it, in the case study sites and beyond. Some service user groups are likely to be disproportionately affected by access gaps. Causal factors at macro, meso and micro levels help determine whether referral for a CAA is made in a particular case. Practitioners often act as gatekeepers and individual factors are therefore important, such as their level of awareness of the CAA role and requirements for it. One example of ‘contextual contingency’ (Blom and Morén, 2010) is the presence of friends or relatives: in some cases this can act as a spur to CAA involvement, in others it can inhibit this. The analysis has mostly focused on determinations about whether a referral for CAA should be made, but I have also given some consideration to service availability, regarding how waiting lists can delay access to CAAs.

Access issues are indicative of the CAA role having a still-emergent status, where despite its involvement being legally mandated in some instances it is yet to be accorded proper weight by all actors. This liminal position is also reflected in institutional-level knowledge gaps about CAAs, hence Mercer’s (NC) comment regarding variations in access to CAAs between local authorities: that ‘because nobody is monitoring it, arguably no one cares.’ The analysis has also indicated there can be some interpretative blurring of the statutory eligibility criteria as these are applied in practice. The findings are strongly suggestive that it can be sometimes difficult to determine eligibility for a CAA and act upon this, especially if the person is themself resistant to CAA input. Conceptual tension exists here: advocacy is person-led in its ethos (NDTi, 2018), yet establishing eligibility for CAA support rests upon external assessment of the person’s situation, with the link from this to consent being unclear within the statutory guidance (DHSC, 2024). A possible reason for this is that capacity to give such consent is another key variable that practitioners must consider.

The scope of this chapter has been limited to considering access to a CAA for people who are statutorily entitled to this. There are adjacent issues about access to advocacy for people who do not qualify for a CAA (NICE, 2022), which are addressed elsewhere in the study. This theme has itself served as an access point to the rest of the analysis. Some of the contextual factors and causal mechanisms mentioned find echo in forthcoming discussions. My analytical focus now shifts to CAAs and their direct work with service users.

6. Theme two: Defining advocacy relationships

6.1. Introduction

In this chapter I focus on interactions between CAAs and service users, considering the potential of these to be empowering. I explore how CAAs build knowledge and rapport with individuals, as a basis for promoting their involvement in CA2014 processes. I also examine complexities regarding the application of instructed and non-instructed advocacy models, especially over their interface with mental capacity considerations. CAAs' interactions with service users' friends and relatives and the Covid-19 pandemic's disruption of in-person working are also discussed. In later sections, I analyse how advocacy relationships are affected by ambiguity regarding the boundaries of CAAs' involvement. I consider how advocacy organisations and individual CAAs seek to navigate tensions, between embracing a holistic advocacy ethos on the one hand, and resource limitations that confine CAAs' support to within statutory parameters on the other.

6.2. Developing relational engagement

6.2.1. Communication and rapport-building

CAA participants' discussions of their practice highlighted the central role of relational processes. These comprised bespoke advocacy with each person, engaging with the richness and complexity of their lives, and taking account of cognitive or communication impairments. These advocacy interactions were described as requiring time and advanced interpersonal skills, as CAAs seek to build trusting relationships. This also necessitated overcoming relational barriers, some of which are the same factors that can stymy initial access to CAA services. For example, a person might be wary of a CAA's input due to a misconception that they work for statutory agencies:

> Because the referral comes from the local authority, then they kind of might be a little on their guard a bit, because they don't necessarily understand our role and why we're required (Helen, CAA, MV)

This suggests a further issue with practitioner-only referral protocols: they may obscure the independence of CAA services. This also underscores CAAs' liminal position, being in-between definitively insider and outsider positions relative to decision-making authority. CAAs provide independent support with participation in CA2014 processes, yet their arrival in the context of these processes can itself be a barrier to engagement.

CAAs described seeking to build knowledge about service users and their chosen outcomes, while also developing self-advocacy potential whenever possible. The fruits of both approaches could be brought forward to inform the conduct of CA2014 processes. Significant potential for effectiveness was reported:

> When they [service users] actually really know what advocacy [is], why we're there, what we can and can't do, I think they do warm, and they do open up if they can. (John, CAA, FA)
>
> (…) by working with people and spending that time with them, we're able to establish most of the time what they want and help them to voice their choices and what's important to them. (Rosie, CAA, FA)

These quotations show CAAs engaging in forms of 'embodied relational knowing' that are central to communicative knowledge practices (Rennstam and Lee Ashcraft, 2014:10). Yet possible limits to this knowing are suggested, regarding a person's ability to directly convey their wishes to their advocate. There was recognition that, in situations where people have more profound levels of impairment, the need for relational engagement is intensified rather than diminished:

> (…) we can go into somebody's life, who has absolutely no understanding of who we are, what our role is: you know, somebody with advanced dementia, complex learning disabilities; they haven't got a clue who we are or what we do on their behalf. And to build up that relationship takes time and effort and understanding. (Catherine, M, MV)

CAAs described taking flexible and imaginative approaches to communication, drawing on skillsets developed over time. Verbal communication could involve posing simply phrased, closed questions. Aids and adaptions, or even alternative communication systems, were sometimes employed. CAAs cited examples that included: ensuring documents are produced in large print or easy-read formats; using 'talking mats', a picture-based communication tool; and using Makaton, a sign-based language programme, albeit supported by a proficient third party.

6.2.2. Applying instructed and non-instructed models

CAAs discussed applying instructed and non-instructed models of advocacy, calibrating which model is used, or which predominates, in response to individual needs. Non-instructed advocacy was applied with a significant proportion of service users. Some accounts were indicative of a 'witness observer' approach in action (Advocacy Support Cymru, no date), with a dynamic clearly distinct from that of more discursive forms of advocacy interaction:

> When you're observing and non-instructed, it's looking at body language and how they interact, how the staff interact with them (…) to get a flavour of who they are. (Natalie, CAA, MV)

Accounts of non-instructed advocacy emphasised this to be a proactive mode of working, comprising a questioning and even investigatory approach (Lee-Foster, 2010). Information might be gleaned from written records and by consulting friends and relatives and care providers. A person-centred orientation meant CAAs sometimes gathered details that are important to individual selfhood and social identity, although less relevant to bureaucratic definitions of need: one CAA recounted a care home manager telling him what football team a service user supported.

CAAs also discussed the epistemic challenges that non-instructed advocacy presents. One observed there were limits to the knowing that could be derived from these approaches:

> It's kind of, trying to establish what you feel is (…) what that person wants. And (…) if I'm honest, sometimes we don't know. But then again, it's acting in that person's best interest and ensuring that their rights have been met, and the process has gone how it should. (Helen, CAA, MV)

This quotation foregrounds the interpretative elements of non-instructed advocacy, which exist within facilitated decision-making more generally (Series, 2013, 2022). Part of CAAs' communicative knowing is therefore demonstrating awareness of when knowledge cannot be elicited with any certainty. This shows statutory advocates' needs for reflexivity (Morgan, 2017). It also underscores a requirement for 'epistemic humility', which Skowron (2017:104) identifies as being of paramount importance in professional practice with individuals who lack capacity to make a relevant decision. In the above quotation, Helen emphasises how CAAs must respond to these challenges by monitoring the conduct of CA2014 processes and acting representationally, including by asserting the service user's rights under the MCA2005 (see DHSC, 2024:7.52;7.63,7.64). I explore mental capacity considerations in more depth below.

6.3. Making processes person-centred

6.3.1. Promoting involvement

CAAs described seeking to influence practitioners in their conduct of CA2014 processes, potentially acting as a corrective when these are not undertaken in person-centred ways:

> It shouldn't be, but it is a fight to make sure that the person is at the centre of that process. (Amy, TL, FA)
>
> Because we do pride ourselves very much on that person-centred approach and that gift of time—we're always saying to social workers, who are under such pressure to open and close [cases]: no we'll do it at the time that suits the individual, not the service; you might be service-led, but we are not. (Catherine, M, MV)

These quotations foreground tensions within social work practice between person-centred imperatives and opposing institutional pressures (Symonds et al., 2018, 2020; Southall et al., 2021)—although most practitioners would likely balk at this suggestion they are 'service-led'.

CAA is depicted as a corresponding force that can tip the scales towards person-centredness. Moreover, some other participants shared the view expressed in the second quotation, that CAAs generally have more time than practitioners for relational engagement with service users. This aligns with notions of independent advocacy being partly a response to social work's turn towards more bureaucratised practice (Hardwick, 2014). However, as I explore below, this contention can be problematised as CAAs themselves operate under significant institutional constraints.

By negotiating space for increased service user participation, CAAs can influence the format and pacing of processes. This reflects a social model approach that targets barriers to engagement, including those stemming from within professional practice (Newbigging et al., 2021). Participants emphasised a need to deliver flexible and creative advocacy, as per statutory guidance (DHSC, 2024:7.46):

> You've got to be a bit innovative sometimes, really. But we try our best to let the citizen participate as best they can. (Rosie, CAA, FA)

Mercer (NC) gave an example from her observations of practice, regarding a CAA advocating with an autistic person who reported feeling overwhelmed in lengthy, formal meetings. The CAA gained the person's agreement to intercede with their social worker, so their assessment would instead be spread over a series of shorter sessions.

Other practice examples were cited of CAAs and service users co-producing measures to enhance participation. A CAA described influencing the pacing of CA2014 processes to accommodate a person's preference to receive information in writing. The service user then responded in writing, although they could verbally communicate:

> If it's just because of the block in terms of (…) they want everything writing down, that doesn't mean they can't be in their reviews sitting with the social worker. It's just that bit might be a little bit more difficult than normal, or it might be just a bit more time-consuming. (Rosie, CAA, FA)

Supporting involvement might extend to establishing alternative means to conduct a process. A CAA recounted doing this with a service user who had been given insufficient opportunity to input into her own assessment, when this was originally completed by a social worker:

> The Care Act assessment had been done to her. (…) Well, we re-did it and it took us hours of going through each need, [taking account of] her points that she wished to put forward. (Natalie, CAA, MV)

As described, the initial version of the assessment had been imposed upon rather than produced in partnership with the person, denying them choice and control (DHSC, 2024:6.1). In response, the CAA seems to have assisted the person to complete a supported self-assessment, as the CA2014 allows for. The person thereby identifies and records their own needs, although the local authority must assure the self-assessment, regarding its accuracy and completeness (DHSC, 2024:6.44-48).

Supporting involvement could entail CAAs taking compensatory steps if practitioners lapsed into using inaccessible language:

> There is a lot of jargon. (…) Sometimes I feel like the mediator between the social worker and the person, to help them through the process. (Natalie, CAA, MV)

This reference to mediation is notable. As seen in the previous chapter, advocacy differs markedly from notions of mediation as a neutral force between parties in dispute, as advocates side unequivocally with the service user. However, another definition of mediation, which involves acting as an ‘intermediary agent’ or ‘medium of transmission’, accurately captures CAAs’ in-between position within practice micro-systems, acting as a conduit for communicative exchange (*OEDO*, 2024:online). This enables the person to better engage with CA2014 processes, facilitating supported decision-making. Simultaneously, their needs, choices and aspirations are conveyed back to practitioners, informing the on-going conduct of processes via a positive feedback loop. Such a link between a role’s mediatory quality and its liminal identity construction is also drawn by Leah (2018, 2021), who identifies how AMHPs enact advocacy, mediatory and other functions as they traverse disciplinary boundaries and organisational power structures while conducting MHA1983 assessments.

6.3.2. Advocacy principles and best interests

While CAAs and social workers are both expected to facilitate involvement in CA2014 processes, the roles' differing configurations come to the fore when the person lacks mental capacity regarding relevant decisions:

> I think that the biggest difference in terms of approach is that obviously advocates don't work from a best interest perspective. You know, often people advocate for their best interests, but they don't always; and social workers come at it from a point of best interests, whereas advocates—it's what someone wants, and you know, their wishes and their views. (Rachel, M, FA)

This quotation distinguishes a social worker's role via their responsibility to act as a substitute decision-maker under the MCA2005, when a person has been assessed as lacking capacity (Brammer, 2020). It also infers broader differences in the framing of CAA and social worker roles, where the latter's *Professional standards* include a generalised requirement to exercise authority in people's best interests (SWE, 2019:1.7). As such, judgements about risk feature consistently within social work decision-making (Moriarty et al., 2015), although social workers must always consider a service user's wishes and rights to self-determination, where possible (SWE, 2019:1.1-1.3, 1.7)). In contrast, CAAs described how their role focuses explicitly upon bringing forth the person's wishes, somewhat analytically separated from the mental capacity and risk considerations that social workers must weigh-up. This enables advocates to facilitate a supported decision-making component within processes under the MCA2005 that conclude with a substituted decision being made (Dixon et al., 2020; Series, 2022). The CAA's practice foregrounds determining whether choices would be authentic for the person, from which the exercise of delegated autonomy can proceed (Leece and Peace, 2009).

However, it is not necessarily straightforward to conceptualise the bridging of supported and substituted decision-making via reference to established advocacy models, as one participant made clear:

> So somebody may lack capacity, but they're still able to verbally instruct you. So you have to assess on an individual basis whether it's instructed or non-instructed advocacy that applies really. There's a lot of cases that are quite clear-cut. But there are some where you'll be going into a room full of professionals and saying: my client wants to move to France—and that's exactly what you'll ask. It might not be feasible, but the point is that is what your client wants. (Amy, TL, FA)

The ambiguity referred to in this quotation resonates with two arguments advanced by Series (2013): first, non-instructed advocacy remains a developing concept that has a complex relationship with mental capacity law; second, the character of non-instructed advocacy practice can vary markedly depending on whether the person communicates verbally. The quotation also highlights tensions within statutory advocacy: between a commitment to being person-led on the one hand, and requirements to support best interest decision-making when capacity is lacking, on the other. Series (2013) argues such tensions are pronounced in respect of IMCA practice, given its explicit remit to aid the making of a substituted decision. As for CAAs, there is evidence of some ambiguity within their role construction, given how statutory guidance directs them to consider various factors when acting representationally—including the person's 'eligible needs', wellbeing, and 'wishes and feelings' (DHSC, 2024:7.52). The statutory guidance does not proceed to suggest which factors the CAA should be prioritise in the event of contradictions between them. This was the case in the scenario described by Amy; her account emphasises the CAA privileging the directly person-led component.

There was also evidence it can be personally challenging for CAAs to take a determinedly person-led approach within scenarios that involve pronounced risks to service users. This could involve a service user expressing a wish to do something that might expose them to harm:

> It’s really difficult, isn’t it, because you’re asking for something that sometimes you know could be really risky for the client. But what you have to think to yourself is that I’m not the decision-maker. I’m there to uphold the person’s rights and to ensure that their views are considered and listened to. (Amy, TL, FA)

CAAs must therefore sometimes set aside their own views in order to uphold non-judgmentalism as a key advocacy principle (NDTi, 2018), although this can be a source of stress in interactions with practitioners (Forbat and Atkinson, 2005). The quotation suggests CAAs may seek to manage these strains by foregrounding the integrity of the advocacy role within a wider system of practice. It is then the substituted decision-maker who faces challenges as they apply legal knowledge and their professional and personal value-base to complex scenarios, potentially choosing whether to privilege more rights-based or risk-based considerations (McDonald, 2010; Williamson et al., 2012).

6.4. Interactions with friends and relatives

Participants’ accounts showed the presence of friends or relatives can be an important contingent factor affecting CAAs’ involvement. As with determining access to a CAA, such presence could variously yield positive or negative implications for advocacy input. The boundary between CAA practice and informal advocacy by members of the person’s social network can thus be zone of ambiguity and contestation. Participants reported that friends or relatives can provide important information about the person, aiding non-instructed advocacy particularly. Beyond this, Stephen (C, CM) noted advocacy tends to be seen as something undertaken by either family members or statutory advocates. This is despite references in statutory guidance to how CAAs might advocate with a person who is also being supported by a friend or relative, such as when a close relationship exists but all the ‘appropriate individual’ criteria are not met (DHSC, 2024:7.37,78).

Furthermore, Mercer argued there is often potential for CAAs to form stronger partnerships with families:

> I think that advocacy misses a trick—because advocates are singularly focused on the individual, an unintended consequence of that is that we fail to see the individual as part of their wider network. (…) There are loads of families who are loving and integral to that person's life and advocates don't always see that family as part of their advocacy function. (Mercer)

This highlights the risk of conceptualising person-centredness in a way that neglects the importance of relationships, in both emotional and practical terms (Series, 2022). Yet Mercer caveated her argument by noting potentially sound reasons why CAAs might avoid engaging with relatives, such as if this contravenes the service user's wishes or there are safeguarding concerns. She also suggested CAAs' reticence to co-operate with relatives may be particularly acute when the person is unable to give direction in this regard. According to statutory guidance, when a person lacks capacity to determine whether a CAA should consult their friends or relatives, the CAA must proceed according to what is in the person's best interests (DHSC, 2024:7.47). This requirement could be problematic given what previous discussions have indicated about CAAs' unease with working to a best-interest mandate.

That friends or relatives' presence can complicate or even impede CAAs' practice was evidenced by the accounts of case study participants. At worst, there could be open obstruction. An example was cited of family members from the same household as a person denying access to her, where the CAA was only able to meet with her after she was admitted to hospital. Less starkly problematic were occasions when friends or relatives misunderstood the purpose of the CAA role, requiring it to be asserted during interactions:

> (…) sometimes family members do get a little confused because they then believe that you're there to help them or to advocate on their behalf. And particularly where there may be a disagreement or a conflict, that then becomes quite difficult to manage and to manage their expectations really. So it's about being clear as well, that you are there actually to advocate for the individual—which, if they're the main carer, that becomes quite difficult for them to accept. (Helen, CAA, MV)

The above quotation shows how boundaries of CAA involvement can be contested by friends or relatives. It describes how some may have difficulty differentiating their own advocacy needs from those of the service user. They might then seek to instrumentalise advocacy for pursuing what is believed to be in their shared interests. Compounding this, if the friend or relative is an informal carer they may have a strong sense of the CAA being an external presence and a potential source of emotional challenge given the intense personal commitment that caring entails (Greenwood and Smith, 2019). This accentuates the importance of carers' advocacy being accessible, including CAA support for carers if there is an eligible need for this. Carers' advocacy must also be available separately from that for the service user, as some guidance states (e.g. London Borough of Enfield, 2021; Scottish Government, 2016). Statutory guidance clarifies that the same CAA can only support two individuals in the same household if there are no conflicting interests involved (DSHC, 2024:7.41).

The presence of friends or relatives can therefore increase the number of actors that CAAs occupy an in-between position relative to, potentially blurring their intermediary function in respect of the service user and CA2014 processes:

> Sometimes I feel like I'm piggy the middle, especially when there is family dynamics. Natalie (CAA, MV)

One CAA described how, to preserve focus on advocating with the service user, she might direct family members' enquiries to the social worker. This highlights a difference between the responsibilities of CAAs and practitioners, as the latter are explicitly required to seek to balance the service user's wellbeing with that of individuals caring for them (DHSC, 2024:1.14).

6.5. The impact of Covid-19

The Covid-19 pandemic had profound implications for CAAs' abilities to provide effective advocacy. Disruption to in-person contacts was highly detrimental given how embodied interactions are integral to CAAs' practices and identities as communicative knowledge workers—a position analogous to that of US Community Health Workers during the pandemic (Golden et al., 2023). CAAs described attempts to maintain in-person contact with service users whenever feasible and safe, reflecting guidance from ADASS (2020) and NDTi (2020). Some CAAs reported they had been generally quicker to resume regular in-person contact with service users than practitioners had.

CAAs recounted that barriers to in-person contact were especially problematic during the earliest phases of lockdown, due to public health policies and decisions by individual service providers, especially regarding access to care homes and supported tenancies. CAAs described weighing up various factors when deciding how and when to interact with service users. These included the service user's wishes, the feasibility of remote communication, and the case-specific balance of risks:

> It has been difficult with some people, particularly when care homes have been in lockdowns because they've had Covid outbreaks. And then it's a case of looking at [whether], actually, does this piece of work need doing now? What's going to benefit the individual most? (Helen, CAA, MV)

Manthorpe et al. (2021) describe how social workers with adults similarly exercised discretion regarding conducting visits during the pandemic. They relate this to social workers' assertion of professional autonomy over complex judgements about risk. This link between discretion, which CAAs also exercised, and professionalism is notable given the contested nature of CAAs' occupational status, as I explore in theme four.

Technology enabled some advocacy to be conducted remotely. Older technology was sometimes used, specifically telephone, text message and email. The use of online meeting platforms marked a particular departure from pre-pandemic practice. Some successful use of these with service users was reported, although CAAs generally emphasised the difficulties they encountered. This especially concerned accessibility issues for service users with cognitive or communication impairments:

> I can’t think of any clients that I’ve got that would be able to comfortably sit and have a good interaction over video. And I’ve tried it with a few different ones during Covid. (Isobel, CAA, FA)

Concerns about relying on communication technology for contacts with service users were widely shared within the advocacy sector (NDTi, 2020) and by social workers (Manthorpe et al., 2021). The accessibility issues described point to wider issues about disabled people’s experience of digital inequality and its intersection with other forms of marginalisation during the pandemic and beyond (Chadwick et al., 2022).

CAAs were more positive about their experience of conducting online meetings with practitioners. Here the pandemic provided a spur to positive practices that freed up time for other tasks. This could involve a hybrid approach: Lisa (M, MV) described how a CAA might follow ‘good practice’ by visiting a service user in-person, before participating with professionals in a best interest meeting conducted online.

At the time of data collection, CAAs continued to routinely wear face coverings during visits. This could have additional implications for embodied communication, especially with service users for whom observation of mouth movements and facial expressions was of particular importance:

> I’ve got to be honest, if you can in an area, I will pull it down, you know, because somebody’s showing frustration—they can’t understand what you’re saying at all. So yeah, the masks are still a barrier. (Natalie, CAA, MV)

Face coverings were only discussed in some interviews and there was a mixture of views; for example, the two service user participants expressed differing opinions about whether face coverings hindered communication with their CAA. Nevertheless, there is some resonance with work that has explored both the public health benefits of face coverings and their socially differentiated implications, especially for people with cognitive, communication, and some sensory impairments (Martin et al., 2020; Saunders et al., 2020).

6.6. Perceptions of effectiveness: processes and outcomes

6.6.1. CAA and local authority perspectives

All participants were to some extent positive about CAAs' potential to promote people's involvement in CA2014 processes. CAAs were generally confident about their ability to influence the conduct of these processes in a positive direction:

> I do sometimes fear that if Care Act advocates weren't around, then the individuals would be lost. (Amy, TL, FA)

There was some external validation of this. Social worker participants expressed generally favourable opinions about CAAs' effectiveness in promoting involvement. This was echoed by the participating commissioning manager:

> The local authority operates sometimes under great financial pressures and decisions are clearly impacted by resources, and they're certainly not always centred around people's wishes. They're centred around what is available and what is affordable. You know, that is a real issue within the system, but rigorous advocacy at least makes sure that people's voices are heard. The system doesn't necessarily like it. (Stephen, CM, FC)

Stephen's comments provide an 'insider' view of how resource scarcity is undermining aspirations for more person-centred adult social care practice (Whittington, 2016; Slasberg and Beresford, 2022)—with CAAs acting in individual cases to oppose deviations from the CA2014's principles due to structural pressures. Yet these comments invite scrutiny about the link between advocacy processes and outcomes regarding CAAs' practice (Townsley et al., 2009). CAAs can help ensure 'people's voices are heard' by local authority personnel but questions remain about whether this results in care and support arrangements that meet needs, satisfy preferences and advance wellbeing—especially as Stephen alludes to possible resistance from within 'the system'. This directs us to consider CAAs' abilities to bring effective challenges, as I consider in the next chapter. Nevertheless, there was widespread recognition among participants that support with processes alone can have value for service users. Mercer argued that evaluating 'good practice' does not just mean looking at outcomes:

> It's about making the process less stressful; dare I say pleasurable—but certainly helping people to retain some control over that. (Mercer)

One area in which social worker participants questioned the extent of CAAs' expertise was regarding specialist communication skills. A social worker expressed scepticism about whether CAAs' capabilities in this area distinguished their contribution from that of other practitioners. Another added:

> I don't think they [CAAs] have got enough training [regarding specialist communication techniques], especially when it comes to people with learning disabilities. (Dawn, SW, MC)

This highlights the importance of identifying when specialist professional input is needed regarding communication, such as that of speech and language therapists (DHSC, 2024:10.50).

6.6.2. Lived experience of CAA support

The accounts of the two participants with lived experience of using CAA services give valuable insight into the working of advocacy mechanisms. Their experiences show how a CAA's involvement can span a significant duration; it lasted at least several months for each, which enabled effective advocacy relationships to develop. Both Arash and Sophie, supported by Fencross Advocacy and Martborough Voices respectively, received CAA assistance with processes that resulted in them moving to new homes in supported tenancies. In each case, this involved a series of interlinking CA2014 processes: assessment, support planning and review. Sophie's CAA also supported her regarding a safeguarding process.

Arash's experience of statutory advocacy began with IMHA support while he was detained in hospital under the MHA1983, s.3. CAA involvement commenced regarding after-care planning, which led to his discharge into supported accommodation. Despite this move between statutory advocacy remits, Arash referred to a single advocacy experience, suggesting the aim of a smooth transition in this regard was met in his case. Such transitions are discussed further in theme five. The accounts of Arash and Sophie also showed they derived ‘process benefits’ from advocacy (Townsley et al., 2009). CAAs were valued as an empathetic and reassuring presence amid upheaval:

> If I had any worries or concerns, they were there. (Arash, PWLE, FC)
>
> The advocate was there if I needed that extra support. (…) She came round every week to see how I was doing. (Sophie, PWLE, MC)

Both service user participants agreed their CAA’s input had increased their involvement in CA2014 processes, such as by explaining complex issues and helping them articulate their opinions about care and support proposals. Each described conveying choices to their CAAs, indicating an instructed advocacy mandate applied. Arash said his independent advocate[7] had met with him to determine his wishes, before ‘going to the meetings and explaining about my situation’. This was suggestive of the independent advocate spanning supportive and representative functions. Sophie’s account indicated her CAA had emphasised facilitating self-advocacy; she said the CAA had ‘sat there, listened and helped to express what I needed’. Sophie said her CAA’s main contribution had been to provide reassurance about her exercise of personal autonomy:

> She just told me it was my choice at the end of the day. (Sophie, PWLE, MC)

This is evidence of empowering CAA practice that is calibrated to enable a person to exert self-determination. It shows how supported decision-making can arise out of relational engagement, providing a sense of validation for the disabled person and bolstering their confidence to articulate their wishes and make choices.

The accounts of Arash and Sophie showed that each accrued benefits from advocacy processes. Both also expressed satisfaction with a key outcome of these processes, regarding

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[7] Arash’s support from independent advocacy spanned IMHA and CAA remits and his description suggested that transition between these was relatively seamless. It was therefore difficult to tell if some of his descriptions of advocacy input referred to that under IMHA or CAA, or both.

their move to supported tenancies. However, it was not possible from the interview data to disentangle the specific contributions that their respective CAAs made to achieving these outcomes, reflecting why advocacy is difficult to evaluate (Hussein et al., 2006). This emphasises that CAAs are not working in isolation to facilitate involvement: Sophie in particular stressed her social worker had helped make it possible for her to exercise choice and control. She also mentioned that supported living staff would ‘fight on my behalf as well’, suggesting she perceived these as another source of advocacy. Although these staff cannot provide independent advocacy, their support for the person potentially adds additional dynamics to the practice micro-systems that CAAs work within.

Arash credited his independent advocate with facilitating his move to a supported tenancy, as part of his aftercare under the MHA1983, s.117. This s.117 status meant he was not liable for a financial contribution for services received (DHSC, 2024:8.14):

> I think one of the things that the advocate did was to find me the place and transfer me here, rather than being kept in the hospital. (Arash, PWLE, FC)

This suggests Arash valued independent advocacy at least in part because of how he perceived it had been instrumental in achieving a positive end-result, even though statutory health and social care agencies were ultimately responsible for arranging and authorising his move. Seen this way, process and outcome benefits become fused, and the contributions of advocates and practitioners are not perceived by the service user as clearly delineated. This also points to the possibility of positive outcomes from advocate–practitioner partnerships, as I discuss in the next chapter.

6.6.3. National contributors: potential limits to person-centred advocacy

Alongside the generally positive perspectives explored so far, Mercer and Petty (NCs) expressed nuanced views about the extent to which some CAAs are effective in promoting person-centredness. Their critiques focused on risks that arise from aligning advocacy input specifically to statutory processes, while also referencing the effects of system-wide underfunding of adult social care. Petty argued CAA practice can vary in quality; she described some as ‘fantastic’ and strongly person-led but also noted a danger of work becoming ‘very process-led’. This was represented by CAAs having needs-focused discussions with service users, rather than starting with identification of their desired outcomes:

> I see a lack of instruction and I see a lack of really stepping back out of adult social care, into John’s shoes [placeholder name] and thinking about ‘what’s this process going on? What do you understand?’ How can I help you understand it? How do you want to participate in it and what's important to you? (…)’ Some of those kinds of conversations I don’t think happen as much as they should. (Petty)

Petty attributed these concerns partly to systemic pressures, including CAAs receiving referrals at short-notice and facing large volumes of work, which could compromise the depth and quality of advocacy.

Mercer presented a related critique of some CAA practice being steeped in ‘issue-based advocacy’, aligned too rigidly with the contours of bureaucratic processes. She argued that CAAs perform the statutory advocacy role with most potential to be holistic and enduring, because of how CA2014 processes are wide-ranging and can run sequentially over an extended period. Yet Mercer pointed to how, within some local authority areas, there can be marked discontinuity between episodes of CAA involvement. She also argued that rigid enforcement of role boundaries can undermine CAAs’ person-centred potential:

> So that’s about funding. But it’s also about culture. (…) There are so many issues that sit around people: like finances, relationships, pets, going the football, things that you might not think of as adult social care needs, but things that matter. And advocates aren’t necessarily getting involved in that because they go, ‘Oh, that’s not me. I don’t do that; I don’t talk to Jeff [placeholder name] about getting tickets for the football. (…) That’s not an advocate’s job; that’s a support worker’s job.’ (Mercer)

These comments resonate with Newbigging et al.’s (2021) critique that implementation of the CA2014’s requirements have contributed to a narrowing of how advocacy is viewed, stymying potential to promote supported decision-making across broad domains of a person's life. It also speaks to enduring tensions over how to delineate between 'advocacy' and 'support' (Henderson and Pochin, 2001), especially given how these concepts are elided in models such as citizen advocacy (Williams, 2011). Mercer's comments depict the resource limitations of advocacy organisations acting to constrain CAAs' scope of practice, with CAAs becoming accustomed to working within these parameters in a way that further blunts their role's liberatory potential. This can be re-framed via a critical realist reading of culture, whereby material factors contribute to developing a set of normative expectations about what is feasible and therefore appropriate in a role; this forms part of the ideational structures that individuals respond to as they conduct that role on an everyday basis (see Elder-Vass, 2012). Therefore, availability of advocacy resources helps set the parameters of CAA involvement with individuals, while cultural and discursive mechanisms can further embed these role demarcations, reducing the possibility of them being challenged.

6.7. Setting limits to CAA involvement

6.7.1. Managing referral volumes

The case studies further demonstrated how CAAs' role boundaries can be ambiguous and contested, especially concerning the duration and scope of advocacy involvement. This again reflected how CAA services were configured in both case study sites as being of a targeted statutory nature, with involvement with a person expected to cease when there are no longer active CA2014 processes. This did not necessarily mean episodes of CAA involvement are brief, as Arash's and Sophie's experiences show. However, participants broadly recognised that expectations of CAAs following practitioners' patterns of engagement with service users meant that deeper advocacy needs might remain unmet at the point of withdrawal. This resulted in dilemmas for CAA services. CAAs expressed that if they continue working with a person beyond their expected remit, this could effectively divert finite advocacy resources away from meeting the needs of those newly referred into the service:

> I think there is a pressure to close cases, if you know that you've got loads of incoming cases (…). There's only a limited amount of advocates and (…) we have to

> use them to the best of our ability. (…) there's lots of occasions where you would like to work with people for longer—and you're not able to. (Isobel, CAA, FA)

> It's about ensuring that when we are working on cases, we're working on them to the best of our ability, giving each individual the time that is required under the circumstances for each case. But then you are weighing that up against other people who do qualify for advocacy who are coming into the service and sitting on, say, a waiting list. (Amy, TL, FA)

These quotations show that, given current resource levels, an argument can be presented for services retaining a relatively tight focus on CAAs' statutory remit. This ensures that CAA resources can be spread across those who have a legal entitlement to their support. It also suggests a focus on providing a high quality of support for involvement in CA2014 processes, instead of expending advocacy resources in a more diffuse manner.

Responses to these structural pressures were not uniform across individuals or organisations. Amy (M, FA) argued CAA providers might differ in how they approach the trade-offs that resourcing pressures necessitate. She also referred to individual CAAs differing in their personal approaches to managing role boundaries. These issues were negotiated amid what CAA participants from both case study sites referred to as significant workload pressures. These pressures were most prominently mentioned by participants from Fencross Advocacy, who informed of independent advocates being formally expected to work with around 30 individuals concurrently—although even this figure could be surpassed in practice:

> [Of workload] It's heavy. And they come in thick and fast, the referrals. (Rosie, CAA, FA)

CAAs described having to carefully manage their time, so they could respond if a need for intensive involvement with an individual arose. One characterised these as 'flurries of activity' (Helen, CAA, MV). Some mentioned that the tight timescales of safeguarding enquiries impose particular demands, possibly affecting how they can respond to other individual's needs.

6.7.2. Risks to relational and preventative advocacy

The CAA role's boundaried character was shown to impede the 'relationship continuity' that can be an important advocacy mechanism (Finlay and Sandall, 2009:1229). CAAs might have to manage service users' expectations about the duration of their input:

> It is a bit tricky, because that person can't overly get massively attached to you; because literally you're going to say to them: 'I'm probably coming to see you one more time and then I've finished for now.' (Rosie, CAA, FA)

This was compared with scope for longer-term relational work that had existed before the introduction of CAA services:

> You could hold a case for three years, they [service users] could ring you every minute, you know about anything and stuff like that, which was lovely. But for the work that we have to do now, within the Care Act, it wouldn't be feasible really. (Rosie, CAA, FA)

These comments hint at the workings of an alternative model of advocacy, albeit receding in its practice, which involves acting as an enduring source of emotional and practical support to individuals. In this mode of working, countering social isolation could be a primary rather than subsidiary advocacy outcome, with Rosie's comments indicative of a person drawing benefit from frequent contact with their advocate, even if not framed around any bureaucratic process.

Participants acknowledged that the configuration of CAA services impairs scope for more preventative advocacy. CAAs mentioned being able to undertake some preventative work, especially regarding safeguarding. However, a process-limited remit ultimately imposed constraints. A manager from Fencross Advocacy argued that increased resourcing would allow CAAs to assume a more 'proactive role', possibly enabling them to remain involved with a person in-between standard markers of practitioner input, such as periodic reviews of care and support plans (DHSC, 2024:ch.13). Advocacy involvement during these gaps in practitioner input might be less intensive but would still enable the CAA to 'check in on' the person and help re-activate statutory processes if wellbeing concerns arose. The CAA would then be well-placed to offer them support and representation once CA2014 processes resume, because of the relationship continuity that had been established. This might yield efficiencies alongside aiding prevention:

> I think reviews would take a lot less time. I think care and support planning would take a lot less time (…), you could potentially address need before it arises. (Rachel, M, FA)

That CAA providers lack the resources to operate in this way adds to evidence of shortcomings in fulfilling a preventative agenda under the CA2014. Insufficient up-front investment in services stymies their ability to reduce, delay or prevent needs that are more costly to address once they intensify (Tew et al., 2019).

6.8. Negotiating a contested remit

6.8.1. Exposure to competing pressures

Evidence from the case studies suggests there is some contestation over CAAs' boundaries of involvement with individuals, including the 'culture' of this that Mercer referred to. There was evidence of CAAs having to reflexively deliberate in the face of competing normative pulls: between resource-based pressures to ration involvement and an advocacy ethos that looks to more holistic engagement (see Elder-Vass, 2010). CAAs from both case study sites described being sometimes able to exercise degrees of discretion about their scope of input, albeit tightly constrained. Here the advocacy organisation could be a locus of intersecting cultural imperatives, due to being a commissioned service provider while having an ethos rooted in 'advocacy culture', rather than a 'service culture' (Henderson and Pochin, 2001:56). This was most apparent from the interviews with participants from Martborough Voices. They emphasised their organisation's origins in citizen advocacy and how this was challenging to reconcile with the process-based character of statutory advocacy:

> It's quite difficult sometimes to stop working and to pull away almost from things that aren't within our remit, that we would just have done years ago. (…) as a staff team we're all very good at wandering off task (…) we've all moved people, you know, literally physically—cardboard box into the boot of the car. (Catherine, M, MV).

Such limited transgression of role boundaries bears some resemblance to notions of 'street level bureaucracy' as developed by Lipsky (2010). Here, social welfare workers, broadly defined, exercise some discretion over their interpretation of rules, usually to the service user's benefit. This relates to the worker's impulse to fulfil an advocacy function and engage with the person in a holistic way rather than according to bureaucratic boundaries, the rigid enforcement of which is experienced by workers as anti-humanistic and alienating. However such advocacy exercised by street-level bureaucrats is fundamentally resource constrained. This exerts a zero-sum calculation, where additional worker time spent with one service user can be detrimental to the attention received by another (Lipsky, 2010).

Discussion of CAAs undertaking practical support tasks related this to concerns that no other individuals or services were available to assist the person. A highly boundaried approach to CAAs' remit is therefore problematised by a depleted infrastructure of non-statutory support services, due to austerity policies (Hernandez, 2021) and an attendant ideology of 'responsibilisation' (Trnka and Trundle, 2014). Narrowing of social workers' remit according to the 'care management' model is another important contextual factor (Hardwick, 2014).

Just as CAAs sometimes needed to curb their own impulses to extend involvement with individuals, they might also have to resist pressure from other actors to work more expansively. That some practitioners reportedly had unrealistic or inappropriate expectations of CAAs may have been related to what CAAs otherwise accepted were ambiguities concerning their role. Even participants from Martborough Voices acknowledged having to resist these currents, so they could focus on commissioned tasks:

> We can get asked to get involved with things that we say no to (…) they just think that we're going take people to doctor's appointments and things like that and act like glorified support workers (…) (Lisa, M, MV)

Catherine (M, MV) cited recent experience of a CAA attending a review, for a person who had recently received a large inheritance. The social worker and solicitor present had expected the CAA to provide practical assistance to the person regarding purchasing a property:

> In the past, we have done exactly that, you know, but now there are such pressures on us because of referrals coming in and other pressures. So we just don't have the time to do it. (Catherine, M, MV)

6.8.2. Relational contingencies

One way in which Fencross Advocacy and Martborough Voices sought to increase relationship continuity under the strictures of CAAs' remit was by re-allocating returning service users back to their previous advocate whenever possible, provided there were no sound reasons to the contrary. However, continuity in the CAA–service user relationship could be disrupted by the highly interpersonal nature of advocacy work:

> Sometimes you are burnt out with a certain case [laughs], and it is better to give it some fresh eyes and a bit more of enthusiasm from another advocate. (Rosie, CAA, FA)

This account does not reflect a failure of communicative knowing; rather it shows appropriate use of such knowledge, as the CAA reflexively recognises when there are issues within the relationship and a change of personnel may be beneficial. This also highlights how CAA work involves emotional management (Miller et al., 2007), in response to scenarios that can induce stress and emotional exhaustion (Hussein, 2018). I return to these issues in theme four.

Another aspect of communicative knowing was CAAs being attuned to individuals' needs and wishes regarding the duration of advocacy involvement. This required recognising that not everyone desired on-going advocacy relationships:

> (…) quite a lot of people are quite happy for us to come in and solve the issue and then just go away again until the next issue. It's having that different range of approaches and understanding of the individual and what the individual wants. (Catherine, M, MV)

Such cycles of engagement indicate that some people may value putting advocacy services on ‘standby mode’, where involvement can be easily reactivated if needed. Osgood (2017) has deployed a different metaphor to make a similar point[8]. These comments alert to how person-centredness means being able to choose from a range of advocacy designs, and then tailor this to bespoke support for the individual. I return to this need for diverse service provision in theme five.

6.9. Conclusion

In this chapter, I have explored CAAs’ interventions within micro-systems of practice, where from an in-between position they work transactionally to facilitate the person’s involvement in CA2014 processes. Key variables concerning the practice context and characteristics of other actors have been identified. These include the profile of service users—especially as framed by mental capacity considerations and related but distinct questions of their ability to ‘instruct’ their advocate. The experiences of the service user participants help illustrate the workings of advocacy mechanisms involving CAAs, with positive outcomes potentially arising from advocacy ‘processes’ (Townsley et al., 2009). Improved self-confidence and self-advocacy potential are two such outcomes. However, when the lens is widened, to take in critical consideration of how the CAA role is configured, boundary issues regarding the limits of statutory involvement are revealed. Important aspects of a service user’s life may be outside the coverage of statutory advocacy—blunting the person-centred and preventative potential of CAAs’ input. The meso-level context of these practice constraints has been explored, with resourcing considerations appearing paramount.

I build on this analysis in coming chapters. In the next, I examine CAAs’ relationships with practitioners, which are a key part of the context in which service users’ involvement is promoted. I also go from discussing involvement in processes to include questions about

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[8] In an academic commentary, Osgood (2017:197) presents a ‘final thought’: ‘Having an advocate must be a little like carting a boat on your back: at times the boat is not needed and feels a little heavy. But when a river needs to be crossed a boat is useful. The art of advocacy is to be easily inflatable and most times as light as air to carry.’

outcomes of these processes. This includes assessing the facility of CAAs to enact effective challenges when—although a service user may have been ‘heard’—their care and support provision contravenes their wishes or fails to meet their needs.

7. Theme three: Partnership, negotiation and challenge with practitioners

7.1. Introduction

I now consider more deeply CAAs' interactions with practitioners and practitioners' managers, exploring how partnership and challenge mechanisms operate within these relationships. Both types of mechanism can be activated within work within a single person, with the balance between them shifting over time. This can produce ambiguity within CAA–practitioner relationships, as the CAA navigates a liminal space in-between outright partnership or challenge modes of working. This often involves a negotiatory approach to dealings with the local authority.

I begin the chapter by exploring possibilities for co-operative CAA–social worker interactions, based upon joint commitment to promoting service users' participation. I then examine how CAAs can enact challenges, from informal discussions with practitioners through to seeking legal redress. I show how mapping and then traversing a pathway to challenge requires a mixture of communicative and technical knowledge practices (Rennstam and Ashcraft, 2014). CAAs must be able to advance legally literate arguments against local authorities' actions, while understanding the opportunities and drawbacks presented by different avenues of challenge. How challenges are actually pursued is determined via interactions with practitioners and with the service user. I also examine structural constraints to mounting challenges, such as regarding arrangements for making complaints to the local authority and seeking judicial review.

7.2. Partnership approaches

7.2.1. Benefits of partnerships

Participants emphasised the importance of CAAs and practitioners working in partnership to promote service users' involvement in processes. Partnership necessitates mutual understanding of roles, while each party's specific contributions to supporting involvement are negotiated through dynamic interaction. Case study participants reported witnessing such effective partnership working:

> I suppose there are probably examples where I'd say people have been very involved in that process, but I don't know that I could say that that's entirely down to advocacy support or whether that's about professionals working well together, so that there's an understanding of where the advocate fits in and where they support that person and (…) where the social worker then steps in and does their part of what they need to do well. (…) And I think where you work as a team, I think it can work really well. (Lisa M, MV)

This quotation shows collaboration can bring synergies, as when a person feels more confident engaging with their practitioner because their CAA has helped them prepare for the meeting. A social worker similarly observed efficiencies from co-ordinating inputs with CAAs:

> We're working well together, and we know each other's role and (…) it helps not to duplicate roles and it saves time—so we make plans together (…). Dawn (SW, MC)

There was recognition too of partnership being grounded in shared ethical commitments, as is generally motivational for interprofessional collaboration in health and social care (Hudson, 2002). A CAA reported participating in a 'multi-disciplinary team' (MDT), comprising inter-professional working to help safeguard a person. The MDT was led by a social worker and included police, housing officers and support workers, with the CAA reporting shared impetus to 'benefit that person we're working with' (John, CAA, FA).

7.2.2. Variables affecting partnerships

Participants identified various factors that can affect whether the potential benefits of CAA–practitioner partnerships are realised in practice. CAAs reported that practitioners vary in their levels of commitment to facilitating their input:

> They [practitioners] can tick that box, but then they often go off and do their own thing and not involve us as advocates. So we're not able to fulfil our role as best we

> can in those circumstances, whilst others really value your input and it’s much more a case of partnership working. (Helen, CAA, MV)

This superficial, or ‘tick box’, engagement is the same dispositional factor that can delay referring for a CAA. Attitudinal variations were also evident in the extent to which practitioners established an ‘open line of communication’ with CAAs (Isobel, CAA, FA), sharing appropriate information and notifying them of meetings. Another criticism was that some practitioners sought to confine advocacy input to a particular aspect of work with a person, co-opting it for a specific purpose while ignoring its wider implications.

Practitioners might also retreat from partnership amid complex and pressurised casework scenarios. A CAA suggested a lapse in communications could signal the practitioner was unsure of how to proceed with their intervention:

> I find that sometimes when things get tough, you get stonewalled. (Isobel, CAA, FA)

This illuminates how CAAs straddle insider and outsider positions within networks of professional collaboration, with the prospect of co-operation being withdrawn amid less favourable circumstances.

A singular relationship might develop between an individual CAA and practitioner, as they build familiarity over work with multiple service users. That the CAA teams in the case studies were small and had staff who were long in post had helped with fostering these ties:

> I’m working with some advocates that I shadowed when I was a student. So there’s a good relationship between the local authority and advocacy (Emma, SW, MC)

Organisational context can also influence CAA–practitioner relationships. In Martborough, both social worker participants favourably compared their experiences of working with staff from Martborough Voices with those from other advocacy organisations, particularly regarding ease of communication. These more negative experiences included those involving Citizens Empowered, the local provider of IMCA. As for CAAs, they might perceive differences between social work teams in their overall receptiveness to advocacy. Martborough Voices' chief executive reported her staff making such observations:

> For some of them, the relationship with the learning disability team is probably best—because they know us and the learning disability social workers understand advocacy, whereas a lot of the generic social workers don't really understand advocacy. (Catherine, M, MV)

Advocacy organisations' histories might therefore have a lasting impact on their relationships with statutory services, given Martborough Voices' origins in advocacy with people with learning disabilities. Thus co-operation had become more embedded with practitioners who themselves specialise with this service user group. Catherine's observation might also reflect a persistent legacy of advocacy's contrasting development across service user groups (Roberts et al., 2012). Advocacy for people with learning disabilities was a relatively prominent area of policy development pre-dating the CA2014, as evidenced by the *Valuing People* white paper (DH, 2001; Hussein et al., 2006).

7.2.3. Balancing partnership and independence

While CAA–practitioner partnerships were generally seen as positive, notes of caution were also sounded. Some CAAs articulated the need for a nuanced approach to collaboration, which prioritised retaining their independence. Without this, it would be harder to raise challenges and people might no longer see their advocate as siding with them unequivocally. However, there seemed no clear demarcation of when collaborative working with professionals risked breaching advocacy principles, indicating CAAs must exercise case-specific judgement. For example, a participant noted that when planning a visit, a CAA must decide whether it is more beneficial to see the person alone or accompanied by a practitioner—the visit's purpose and the person's wishes being key factors. Need for a discerning approach to involvement in formal structures of inter-professional collaboration was also highlighted:

> It's about including us where we need to be included, but also about excluding us in areas that we don't need to be involved in, because actually that compromises us in some ways, around our support for the person. Because you can get dragged into,

> and again this is this professionalised thing of: 'right, OK, let's all get together in a meeting; let's all have an MDT; let's all have a best interest meeting'—when the advocate has come along on behalf of the person and it's almost like the person's been forgotten in all of that (…). (Lisa, M, MV).

This shows CAAs must be wary of having practitioners designate them as a proxy for the person, perhaps unwittingly resulting in the person being excluded from discussions and decisions about them. The quotation also demonstrates that engaging in systems of inter-professional collaboration can have its own relational dynamic: expectations form around the CAA's attendance at certain meetings, grounded in notions of efficiency. An instructed advocacy mandate can therefore be strained via the CAA's participation in inter-professional forums (Sherwood-Johnson, 2016).

However, a need for caution about involvement in inter-professional arrangements was not expressed by all CAAs. One argued it is generally important to participate in meetings about the person:

> (…) I think to really support somebody throughout any Care Act process, you need to be included in those things to get a wider perspective of what's going on; to then be able to identify if something is missing, for example. (Isobel, CAA, FA)

Although not directly mentioned by participants, an important consideration could be whether the CAA is working to an instructed or non-instructed mandate, which might govern their readiness to act as the service user's representative within settings such as MDTs. The question is therefore not just whether CAAs attend such meetings but what role they perform within them. The approach described above by Isobel is suggestive of the CAA performing a watchperson function within non-instructed practice: monitoring professionals' conduct, questioning them and holding them to account (Lee-Foster, 2010).

CAA–practitioner partnership working can therefore have unintended consequences if improperly calibrated. This adds another element of complexity, beyond causes of friction that generally affect inter-professional collaboration. These include the presence of differing values bases and professional cultures; disputes about the boundaries of disciplinary expertise; and power imbalances related to professional standing (Hudson 2002; Lymberry, 2006). I consider these matters further in the next chapter, especially regarding CAAs' contested professional status.

7.3. The necessity of making challenges

CAAs stressed their commitment to robustly mounting necessary challenges, regardless of pursuing partnership in other contexts. The chief executive of Martborough Voices emphasised her organisation's embedded 'psychological independence':

> We'll challenge right up to (…) as far as it takes. (Catherine, M, MV)

Challenging practitioners rigorously gave rise to friction, albeit managed according to norms of interprofessional conduct:

> Sometimes advocacy is very uncomfortable, but what I do appreciate from our advocates is that they do strongly represent the wishes and feelings and expectations of service users. (Stephen, CM, FC)

Challenges could be in response to practitioners' conduct of processes or to outcomes arising from these, or both. Informal challenge to the conduct of CA2014 processes was mentioned in the previous chapter, as when a CAA supported an individual to self-assess because a practitioner's assessment was insufficiently person-centred. However, participants generally described explicit challenges as being in response to process outcomes, such as the level of care and support allocated to the person. CAA was thus positioned as a bulwark against oppressive tendencies within a severely strained system:

> I'm not talking bad of social workers, but their hands are tied. You know, they can only get so much through [funding] panel, through management, through their legal teams and without us challenging a lot of people would get lost or decisions would be made that weren't in line with the person's wishes. (Amy, TL, FA)

One CAA referred to her experiences of supporting people to challenge the local authority when, following a review under the CA2014, it had reduced their level of care and support.

Such practice by local authorities in response to austerity conditions has been a key area of contention, shown by legal contestation and Ombudsman rulings (Clements, no date; see also EHRC, 2023).

There was evidence that CAAs' preparedness to challenge could indirectly affect the conduct of CA2014 processes. This is via oversight mechanisms: the practitioner might act differently in response to the CAA's presence, to avoid triggering an overt challenge. Mercer (NC) described being struck by how often practitioners made comments akin to 'we'd better behave now, an advocate's here.' Although ostensibly jokes, Mercer conjectured these may reveal elements of truth:

> In terms of when there's cuts in budgets, I think the fact that there's an advocate there, I do think—rightly or wrongly, probably wrongly—it means that the local authority behaves better (…). (Mercer)

The uncertainty with which Mercer expressed her point shows the difficulty of establishing clear connections between CAA input and subsequent decision-making outcomes, especially for latent forms of challenge. Such epistemological factors are integral to why advocacy is difficult to evaluate (Hussein et al., 2006).

CAAs can also exercise monitoring and challenge functions regarding care and support services. Although the statutory guidance does not explicitly identify this as part of CAAs' role (DHSC, 2024:ch.7), it aligns with notions of advocacy as a broad-based safeguard for individuals as they engage with services (Flynn, 2012; Lawson and Petty, 2020). Mercer observed that CAAs' frequent visits to services make them well placed to contribute to 'broader safeguarding' and quality assurance agendas, yet she cautioned against viewing them as 'pseudo-inspectors'. Some case study participants made similar observations. References were made to directly challenging providers, such as regarding seemingly unwarranted restrictions on people's community access during the pandemic. A CAA also reported experience of reporting concerns to the local authority's quality monitoring team. Moreover, CAAs might collaborate with practitioners to uphold service quality:

> I’ve had a few meetings where, to be honest, it’s been me and the advocate battling against the provider, because the provider has not been doing something that they should be doing. And having the advocate there as an extra backing—so they don't just think it’s the social worker—has been really helpful. (Emma, SW, MC)

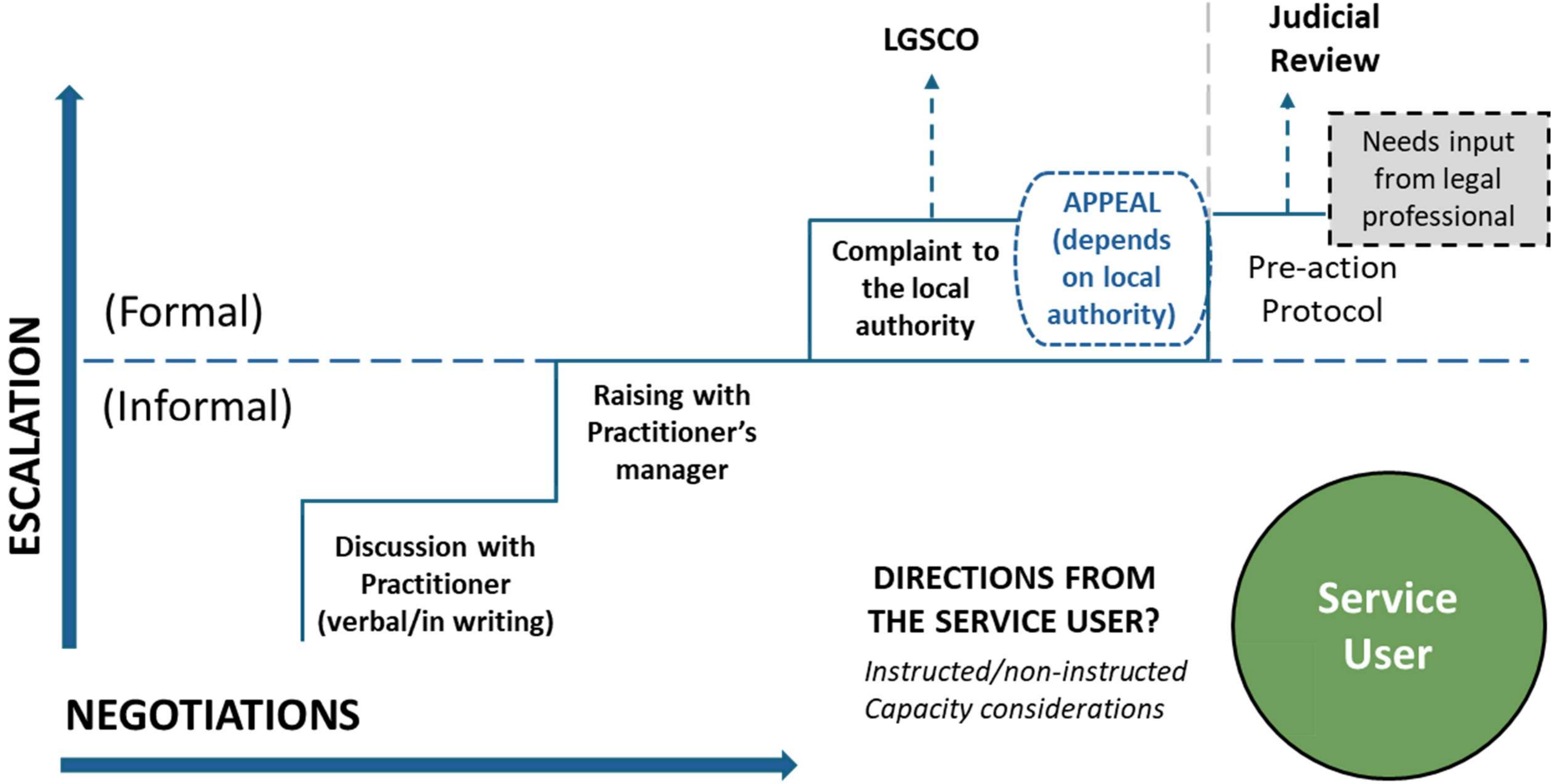
This represents a benefit of CAAs’ liminal position, where they can work flexibly across organisational boundaries, forming ad hoc alliances in support of people’s wellbeing (Croft et al., 2015). However, that CAAs’ involvement is largely coterminous with active CA2014 processes means their potential contribution to scrutinising services is limited, as quality and safety issues may arise outside these periods of engagement (Lawson and Petty, 2020).

7.4. Negotiation and escalation in challenges

CAAs described various potential avenues for challenging the local authority. This made possible an escalatory approach, characterised as ‘starting informally and then working up to formally if required’ (Natalie, CAA, MV). The most informal level was discussing concerns with a practitioner. From there, the CAA might proceed to addressing the issue with the practitioner’s manager. This could then be stepped up by lodging a formal complaint with the local authority, which if not satisfactorily resolved could progress to the Ombudsman (LGSCO, 2021). Legal challenges might also be pursued, although the route available would depend upon the type of decision being contested. The administrative court can judicially review how a local authority has made a decision about care and support under the CA2014 (Ashton et al., 2022). Alternatively, some matters CAAs are involved in come under the jurisdiction of the Court of Protection, which has broad powers under the MCA2005, s.15, to make best interest decisions for people who lack capacity (Series, 2022).

CAAs reported navigating complexity when making challenges. Technical knowledge is needed about the challenge pathways available, combined with the ability to apply this to determine the best way forward in the person’s circumstances. Challenges were also shown to be forged interactionally, via contacts with the practitioner or local authority managers, and with the person. Figure 2 presents a diagrammatic representation of different challenge pathways.

Figure 2 - Negotiatory and escalatory approaches to conducting challenges



Positive: Leveraging partnerships, minimising costs and delay to the service user

Negative: Limitations of formal routes to challenge. Possible influence of commissioning relationships. Possible limits to confidence, technical knowledge and availability of external legal expertise.

CAAs spoke of a general tendency to pursue more informal challenges, only escalating when other options are exhausted. This applied especially regarding formal complaints or legal challenges. A rationale for this approach was that it often achieves satisfactory redress for the person while avoiding them the delays, costs and stress that more formal procedures can entail:

> We've always found that we achieve far more on behalf of people by coming in peace (…) if we can find a way of working with the Council, and avoiding serious challenge, then we will. (Catherine, M, MV)

A tendency to raise issues informally meant the status of some challenges was ambiguous. A manager from Martborough Voices said her organisation probably issued formal challenges to the local authority less frequently than it had before becoming a provider of CAA services. However, she insisted this did not reflect any diminished commitment to upholding people's rights: 3

> You could flip it on its head and say, actually, maybe that's because we're able to negotiate more before we get to a challenge. (…) A negotiating stance is more the stance we take and [is used] before we've got to challenging really hard for people, because actually that takes a long time. (Lisa, M, MV)

The above quotation alludes to pull and push factors for keeping challenges informal. Pull factors concern how the CAA role's statutory status affords better-defined relationships with local authority personnel, with direct channels for raising concerns. Push factors are the difficulties associated with mounting formal challenges, especially the timeframe involved. These dynamics are akin to those cited by Series (2013) regarding IMCAs' tendency to pursue informal resolution to concerns about best interest decision-making. The above quotation from Lisa also depicts frequent negotiatory interactions with the local authority, echoing Morgan's (2017) emphasis on statutory advocates needing strong negotiation skills. CAAs described an approach akin to what Lens (2004) terms 'principled negotiation', which is often suited to advocacy as it is grounded in partnership with interlocuters, with a mutually satisfactory outcome sought. This contrasts with 'hard' negotiations involving outright confrontation, or weak and naïve forms of 'soft' negotiation (Lens, 2004). The prevalence of negotiation is also explicable given the scope for discretion within social services departments regarding application of organisational rules, including by managers (Evans, 2013).

CAAs gave further details of how they might raise concerns with practitioners. This was generally conducted in writing, albeit via regular email correspondence rather than by issuing a formal report:

> Care Act advocacy doesn't really have any reports (…). So there's contact in-person and over the phone, but in terms of any kind of issues, any challenges, it is usually always over email. (John, CAA, FA)

John recounted emailing a social worker to register concern about a mooted reduction in a person's day service attendance, with this proposal being subsequently withdrawn.

Some CAAs observed that escalating the matter within the local authority often brought resolution:

> We will go to the senior or the manager and it does normally get nipped in the bud. (Rosie, CAA, FA).

When approaching managers, CAAs might request a revision of CA2014 processes—such as a reassessment of needs—or that a different practitioner be assigned to the person's case. The descriptions CAAs gave of undertaking challenges were partly congruent with the process outlined in statutory guidance (DHSC, 2024:7.50), where a CAA presents their concerns in writing to the local authority, which must then respond. However, it was unclear whether meetings routinely took place between local authority personnel and the CAA to discuss the issue, as the statutory guidance also mentions, as none of the participants referred to this. The absence of dedicated CAA reports or meeting minutes potentially make it harder to establish an evidence base for CAAs' effectiveness in conducting challenges. This is important given the EHRC's (2023) recommendation for increased oversight of how advocacy organisations perform these functions.

Participants also elucidated push factors that disincentivise more overt challenges. One is long-winded complaints processes that are stressful for service users to undergo. Petty (NC) identified this as an issue across many local authorities:

> (…) lots of people's experiences of making a formal complaint to adult social care is that's going to take a year and a half, and in the interim life is suspended. And you may not be getting the package of care that you need in the interim; and you'll get a rubbish response anyway; and then you'll end up at the Ombudsman and it still won't go anywhere. (Petty)

Petty described widespread disappointment with the outcomes of complaints processes, even when the Ombudsman has made a final determination (LGSCO, 2021). This echoes some observations contained within grey literature. Complaints processes can take several months to conclude (Seaman et al., 2019) and local authorities are not statutorily required to provide care and support in the meantime (EHRC, 2023). The CA2014, s.72 empowered each local authority to establish a process for considering appeals against adult social care decisions, separate from complaints systems; however, it did not make this a duty. Seaman et al. (2019) argue that appeals processes offer a better route to challenging outcomes of CA2014 processes, compared with those for complaints, as they require timely review by senior local authority officers who were uninvolved in the original decision. The EHRC (2023) estimated only around a third of local authorities had voluntarily established such an appeal process. Mercer lamented the situation regarding appeals under the CA2014 as a 'lost opportunity', given initial expectations advocates would play a supportive role regarding these. In addition to these issues with complaints, participants discussed obstacles to formal redress via the courts, as I return to below.

CAAs therefore must exercise expertise about challenge pathways. Yet how they navigate these must also reflect their support for, and representation of, the person. CAA participants emphasised how, while weighing the merits of different approaches to raising concerns, they sought to be as person-led as possible. Some described experiences of instructed work regarding challenges. Supporting self-advocacy could involve assisting a person to lodge a complaint, or following their direction about consulting a solicitor:

> We would seek legal advice if that's what the client wanted. If they weren't happy with any resolution or amendments to the assessment, you know we would seek guidance. (Amy, TL, FA)

These comments reinforce how advocates must remain cognisant of their mandate from the person and the limits of principled negotiation, knowing when pursuit of more formal routes to redress becomes necessary (Lens, 2004).

7.5. The importance of legal literacy

Participants discussed how CAAs must mobilise knowledge of the adult social care system in order to advance challenges, whether informal or formal. This included having the ability to frame arguments on people's behalf via reference to statute, guidance and case law. Arguments could be articulated via a human rights-based discourse (see Brammer, 2020) and with reference to the CA2014's wellbeing principle, for example. Other laws CAAs mentioned drawing upon were the MCA2005, Human Rights Act 1998 and the Equality Act 2010. Schwehr (NC) also described how CAAs must utilise legal knowledge:

> It is public law principles that should be pouring out of advocates' mouths—not it says in section so and so, but the actual value-driven public law, administrative law principles that the Care Act guidance is written on, that the Care Act itself is based on, and the human rights that are supposed to be all pervasive. (Schwehr, NC)

This quotation highlights that CAAs must be confident advancing legally grounded arguments, but this is not the same level of technical expertise expected of a legal professional. This was also referred to as 'legal literacy' (Petty), a concept with strong currency in social work. Legal literacy concerns being able to apply legal understanding to practice, in a way congruent with professional values including emphasis on human rights (Preston-Shoot and McKimm, 2012). Yet practitioners work within institutional environments that can undermine legally literate and ethically aligned practice (Preston-Shoot, 2011). This makes CAAs' counterweight function additionally important. The public law principles to which Schwehr refers include a common law duty on public bodies to act fairly. This is relevant, for example, when addressing the adequacy of someone's Personal Budget (Ashton et al., 2022).

Discussions of CAAs' effectiveness in bringing challenges included contrasts with situations where people are reliant upon support from friends or relatives. This underscored the importance of CAAs' legal literacy and channels to the local authority, meaning they 'carry some clout', as one CAA put it. This CAA cited her experiences advocating with a young woman whose family had sought increased support for her from the local authority:

> The family had written some great letters, explaining everything about what their daughter needed (…) [It] didn't get anywhere. [She] needed some extra support, you know some extra hours—there was a lot going on, a really stressful time. I come along and one letter—it's all turned around. (Rosie, CAA, FA)

This example demonstrates the potential for CAAs to challenge testimonial injustice (Newbigging and Ridley, 2018). As described, the local authority had been given evidence of the woman's need for additional support, yet it was only after the CAA had validated this information and related it to the local authority's legal obligations that the increase was authorised. Such findings echo observations in extant literature that statutory advocates can have enhanced means of holding local authorities to account, relative to family members (Series, 2013; Dixon et al., 2020). This underscores the significance of practitioners appropriately determining eligibility for CAA, based on evaluating the abilities of friends or relatives to provide effective support and representation.

However, such views about CAAs' relative effectiveness in conducting challenges were contradicted by one participant. Clare (SW, FC) reported that complaints to Fencross Council tended to have outcomes favourable to the service user, regardless of whether a CAA was involved. Such variation in perception indicates a need for further research about challenging decision-making under the CA2014, to increase understanding of how local authorities respond to complaints. This is especially so given Clare's observation that complaints often achieved their desired ends.

The example cited above, regarding attempts to increase care and support provision for a young disabled woman, shows the possibility of a CAA becoming involved to support a challenge that has already been initiated by a family member. This may reflect a situation under the CA2014 where a service user can be supported by both a friend or relative and a CAA (DHSC, 2023:7.42). However, participants also referred to unmet advocacy needs among people who wish to challenge a local authority decision but are ineligible for a CAA, perhaps because they have familial support deemed to satisfy the ‘appropriate individual’ criterion. Fencross Advocacy’s CAA team leader reported having to decline ‘a lot’ of approaches from people because they were held to already have an ‘appropriate individual’, or not to have ‘substantial difficulty’:

> There is a huge gap in terms of challenging Care Act processes when people don’t meet the criteria for Care Act Advocacy. (Amy, TL, FA)

This underscores the lack of a statutory requirement to commission an advocacy service to assist with adult social care complaints, unlike with NHS complaints. The EHRC (2023) does, however, refer to social care complaints advocacy being available in many areas on a discretionary basis. How such arrangements operate would be a fruitful area for enquiry.

7.6. Managing the impact of challenges on relationships

7.6.1. Structural causes of friction

There are structural underpinnings to tensions in CAA–practitioner relationships, which must be individually managed. A discussion of hospital discharges illustrated this. Rachel (M, FA) reported that hospital-based practitioners may deem the person’s ‘best interests’ are served by facilitating their discharge at the earliest possible opportunity. The CAA might then challenge this, as when the person is unhappy with a proposed care ‘placement’. Rachel acknowledged that the intense pressures faced by local authority and NHS practitioners, grounded in staff and other resource shortages, can amplify a divergence of perspective. Another difference is that practitioners making discharges decisions often do not remain allocated to the person after they leave hospital, unlike the CAA:

> Perhaps they might view the advocate as delaying the discharge, when actually what the advocate is trying to do is ensure the person is put in a placement that works for them, so they're not re-admitted to hospital. (Rachel, M, FA)

This shows how CAAs can find their role set against that of practitioners such as hospital social workers. The latter face difficult decisions as they seek to promote individual wellbeing while experiencing a systemic imperative to avoid delayed transfers of care for people deemed 'medically fit' (Heenan and Birrell, 2019). Policy issues provide context for these oppositional interactions, including shortages of suitable service options that mean notions of 'patient choice' are heavily constrained or rendered illusory (Gridley et al., 2022).

Participants noted that conflictual interactions are generally managed within the norms of professional conduct and mutual recognition of roles. CAAs expressed empathy for practitioners, given they encounter institutional pressures that contradict person-centred aspirations:

> I think we have an understanding that they [social workers] are under a hell of a lot of pressure. So I would like to think that even when I do make challenges, it's never personal. I understand that often it's above the social worker's head (…). (Isobel, CAA, FA).

This comment is further suggestive of 'principled negotiation' (Lens, 2004), where attempts are made to understand the other party's position and not treat them as an adversary. Scope for partnership is thus retained, even amid challenges. CAA practice is therefore illustrative of 'soft' power to a significant degree, with attempts to persuade practitioners via argumentation that presumes shared good faith.

Practitioners were seen to respond to challenges in different ways, reflecting varying levels of understanding and appreciation of the CAA role. Some were accepting of CAAs' legally literate and values-based interventions, recognising this as a form of safeguard:

> I think some social workers find it little bit frustrating, but I think others find it beneficial because I think the social workers who are doing a very good job realize

> that we’re an aid—although we’re not supposed to be—but we make sure that they’re doing their job properly, essentially. (Amy, TL, FA)

These comments suggest strong alignment between independent advocacy and social work values, where social workers may accept CAAs as a corrective force, opposing institutional agendas that can militate against person-centredness. This also validates a need for critical reflection in social work practice, involving self-analysis and acceptance of external feedback (BASW, 2018a). Notions of CAAs acting as a prompt to practitioners about the ‘proper’ enactment of their role accentuates the distinctive character of CAA–practitioner interactions, where parties possess similar knowledge and value bases. This can lead to boundaries disputes (see Heiss et al., 2018), as I now consider.

7.6.2. Boundary issues in relationships with practitioners

There was some evidence that CAAs’ conduct of challenges could blur role distinctions between them and practitioners. However, the precise nature and extent of this was unclear; some notable contributions concerned only the experiences of a single participant, and it was not clear if these were more widely shared. This was especially so for a CAA who described a challenge that involved arranging alternative care and support for a person, working to their instructions. The person was in a temporary care placement after being discharged from hospital and wished to return to her home, which was opposed by the then-allocated social worker due to safety concerns. As described, the CAA’s response seemed to transcend promoting involvement in CA2014 processes being conducted by the social worker; it instead incorporated practical support with arranging alternative services:

> I enabled, you know, with some digging and peer support, or what’s available, we organised a short-term placement—well a short-term home trial. We organised privately a carer who would be going into her home. And this lady wanted to know whether she was able to go home or not and this would help her to make that decision. So anyway, after the six-day home trial, she went back to the care home, got reallocated a different social worker as well, and she got home. We managed to get her home. (Natalie, CAA, MV)

This brief account depicts a more expansive conception of the CAA role than was found elsewhere in the data: rather than merely presenting discursive arguments on the person's behalf, the CAA's challenge involved facilitating practical demonstration of the feasibility of arrangements that aligned with their wishes. The account also alludes to a possibility not mentioned by other participants: that options for practising in alignment with the person's wishes may differ if they have means to arrange services on a private basis. Further research is necessary to determine how reflective this scenario is of common issues and practices, which fits with a broader need to improve understanding of self-funders' experiences regarding arranging care and support (Baxter et al., 2020).

A social worker participant expressed unease at perceived transgressions of role boundaries by CAAs. Clare (SW, FC) reported that some CAAs exhibited 'the mindset of an us and them sort of relationship', which was oppositional by default. She described CAAs as being 'very quick to challenge decisions' and argued they may surpass their remit in doing so:

> (…) I feel that aside from promoting their [the service user's] engagement in the process, they [CAAs] have sometimes, I feel, overstepped their line of being an advocate and wanting to actually get involved in the support planning, and the decision-making from the social worker side of things, and actually influencing our decisions and our assessments. (Clare, SW, FC)

Clare added that CAAs sometimes fail to appreciate the structural constraints faced by social workers. This included a lack of recognition that social workers are expected to discount the possibility of using non-commissioned support, such as community resources, to meet a person's needs before they arrange formal services. This approach, associated with 'asset-based' practice models, has been widely mandated by local authorities amid austerity (Daly and Westwood, 2018). Clare argued that, by disregarding this, CAAs might unjustly raise a person's hopes of accessing a particular service.

Clare's remarks contradict claims by CAA participants of seeking to avoid an overly antagonistic approach; moreover, other social worker participants did not make similar observations. Nevertheless, her comments show tensions can arise from differing understandings of CAAs' assigned function. Her critique that CAAs should not become actively involved in support planning would mark a push-back against practice such as that described by Natalie (CAA, MV), where the CAA was pro-actively involved in developing alternative arrangements with the person, in opposition to the social worker's position. However, this critique would be more problematic if it extended to all instances of the CAA seeking to influence the practitioner. This would clash with the need for CAAs to sometimes act representationally, fulfilling a non-instructed mandate (DHSC, 2024:7.52). Such contestation of boundaries, and therefore of the terrain upon which a role can claim a monopoly of expertise (Heiss et al., 2018), has important implications for professional identity, as I consider in the next theme.

7.7. Questioning robustness

7.7.1. An insufficiently critical stance?

Participants identified potential constraints on CAAs' abilities to act as agents of challenge. Concerns that CAAs do not always hold local authorities to account as robustly as their role permits were foremost articulated by some national contributors. This may have reflected how their positions afforded them greater critical distance, relative to case study participants providing or managing CAA services. Mercer argued that, while CAAs may possess sound understanding of how CA2014 processes operate, there is a risk of them becoming inured to the oppressive consequences of austerity policies that have undercut much of the CA2014's promise:

> (…) I think local authorities are so strapped for cash [and] we're so far away from what should be happening that advocates kind of forget that and they get sucked into the reality rather than the idealism (…). The problem is that nobody sticks to the Care Act! It isn't being delivered properly. (Mercer)

As with discussion of a culture of 'issue-based advocacy' in the previous chapter, this critique can be viewed in critical realist terms (Elder-Vass, 2010, 2012). There are normative expectations about practice based on the CAA role's limited capacity to enact effective challenges in the face of oppressive macro-structural formations. These expectations in turn form part of the structural context that individual CAAs must reflexively respond to, making it harder to break out of established modes of practice and mount more assertive challenges to deviations from the CA2014's requirements.

Mercer's view of an overly accommodative approach among some CAAs contrasted with the self-perception of CAAs in the case studies, who emphasised their preparedness to challenge. Ultimately, these are generalised observations and the limits of a negotiatory approach would need to be probed in the context of individual cases. Mercer's observation does however suggest that risks identified in extant scholarship have been at least partly actualised: that by incorporating advocacy within statutory processes, some of its character as an independent and potentially oppositional force is blunted (Redley et al., 2010; Hardwick, 2018). There are also parallels with a process of de-politicisation within professional social work, which has occurred within a dominant neo-liberal policy paradigm (Butler-Warke et al., 2020).

7.7.2. Commissioning relationships: constraining independence?

A lack of consensus also existed among participants about the extent to which commissioning relationships may constrain challenges. Petty perceived this as a present concern:

> I hear it all the time: 'well we've been asked not to rock the boat too much' (…), 'we're mindful of not biting the hand that feeds us.' And so does that mean advocates don't stand up for what people want and need? No. Does it mean advocates are always as robust as they could be? Probably not (…). (Petty)

This cautious and nuanced perspective accentuates how difficult it is to disentangle CAAs' role within complex micro-systems and establish a clear motivational link between any shortfall in practice rigour and organisational relationships. This is especially so amid a general lack of evaluation of how CAAs are performing a challenge function (EHRC, 2023).

Managers from Fencross Advocacy and Martborough Voices also addressed the potentially subtle implications of commissioning relationships for pursuing challenges. Managers from Martborough Voices spoke of how their link to the local authority facilitated a negotiatory approach, but they rejected suggestions this could lead them to resile from standing up for the person:

> We're not that kind of organisation. (Lisa, M, MV)

Fencross Advocacy's manager addressed the potential conflict of interest differently, acknowledging that commissioning arrangements create an 'inherent tension':

> In terms of challenging the local authority, it's definitely one down to relationship management. (Rachel, M, FA)

How these inter-organisational mechanisms might affect individual CAAs' propensity to mount challenges was not fleshed out. Given such opacity, further research—including ethnography or analysis of individual case records—might elucidate how these mechanisms operate in practice, including where the balance lies regarding positive and negative outcomes from negotiation.

7.7.3. Limits to legalistic challenge

Some participants questioned the extent to which CAA practice is reflective of legalism. Schwehr pointed to how, while CAA is configured as a safeguard of legal rights, those performing it might lack some of the necessary technical expertise to maximise its potential:

> (…) if they don't have the knowledge base, it's like a surgeon going into an operating theatre without the necessary scalpels. You know, legal literacy is part of the job. (Schwehr)

Here CAA's technical knowledge requirements are emphasised, via a comparison with medicine—an archetype of a professional role grounded in technical expertise (Rennstam and Ashcraft, 2014). Schwehr argued that a shortfall in legal literacy could result in a CAA helping a person feel 'more involved' in CA2014 processes without necessarily making 'any valuable difference [to] decision-making'. This reflects the distinction between advocacy's process and outcome benefits (Townsley et al., 2009), where legalist challenge is important for achieving positive outcomes when the local authority has not fully discharged its responsibilities. To illustrate how this legalist mandate may go unfulfilled, Schwehr cited her experiences as chief executive of CASCAIDr, a legal charity:

> I get people referring themselves to the charity when they've had an advocate, but it still has allowed a legal wrong to just be sat there like the elephant in the room, and nobody has done anything about it. Maybe I only get the bad cases. (Schwehr)

Schwehr's arguments were indicative of a strongly legalist conception of CAA, as she emphasised advocates must be prepared to make robust interventions from an early stage of involvement. She advised CAAs to 'nail the issue in writing soon enough', such as by making representations to the local authority's funding panel about why a person's personal budget is insufficient to meet their eligible needs—a frequent issue amid austerity conditions (Tarrant, 2020). Although it was unclear to what extent practice in the case study sites deviated from this advice, there seemed at least a difference in emphasis from CAAs' descriptions of more informal approaches predominating, especially early in disputes.

Some case study participants also acknowledged legal literacy as an area for development. This was especially regarding challenges that might come before the courts:

> I think we could do with upskilling the team in terms of this, because I think that it's a developing area and I think it's also one of those where it sits slightly outside what you're trained to do in the City & Guilds qualification (…) (Rachel, M, FA)

The coverage of the National Qualification in Independent Advocacy is questioned here; this is taken up further in the next theme. The view that CAAs could vary in their ability to make robust challenges was corroborated by Emma (SW, MC), who said much depended on whether a CAA is 'skilled or confident enough'.

There was also some acknowledgement by case study participants of the risks of being overly informal regarding challenges, with an insufficiently escalatory approach to negotiations taken. One CAA recounted how, earlier in her advocacy career, she had sometimes taken ‘in good faith’ social workers’ assurances that positive outcomes would be achieved for people:

> I’m sad to say, but that doesn’t always happen, and then you feel that you’ve let the person down. So now I’m a bit more, I suppose quick to go down that route really—like the legal route and to escalate things. (Isobel, CAA, FA)

These comments are illustrative of a CAA reflexively adjusting their practice orientation in light of experience and recognising when ‘principled negotiation’ has run its course (Lens, 2004).

7.7.4. Barriers to judicial review

CAAs were seen to face significant obstacles in using judicial review to challenge local authority decisions. Case study participants made few references to this as an option. This is despite the possibility that issuing a pre-action protocol, which sets out disputed matters as a precursor to judicial review, can offer a swifter means of challenging adult social decisions than a formal complaint (ECHR, 2023). Participants’ discussions of judicial review referenced known issues with this avenue. These are principally the brief timeframe for making the application for judicial review (three months from the point of decision); that the process is often-protracted; and that legal aid for an application is means-tested, which can make its pursuit prohibitively expensive (Bondy et al., 2015; EHRC, 2023). Martborough Voices’ chief executive said her organisation had not been involved in a judicial review since before the CA2014 and she emphasised the obstacles involved:

> It takes years and years and years, and you have to have grim determination to see it through to the bitter end—if only to get bloody legal aid or whatever. (Catherine, M, MV)

In contrast, Petty recalled her previous experience in frontline advocacy practice, at a time when less restrictive rules on legal aid had enabled judicial review to be considered a more feasible ‘route to challenge’:

> I’m not suggesting that hurling judicial review around is a great approach, but it did sometimes get things moving when we needed things to get moving. (Petty)

This suggests that if a judicial review application is feasible, its prospect can be another source of leverage within negotiatory interactions. Petty also reported how, following legal aid changes, specialist advice regarding community care law is less readily available. Similar concerns are raised by Ashton et al. (2022) and the EHRC (2023).

In discussing opportunities for legalist challenge to decisions made under the CA2014, some participants drew unfavourable comparisons with possibilities afforded under mental capacity and mental health law. The situation regarding judicial review was contrasted with how independent advocates (acting as IMCA or Paid Representative) can be involved in challenging deprivations of liberty via the MCA2005, s.21a (SCIE, 2017)[9]. Importantly, non-means tested legal aid is available for people to be represented in these 's.21a reviews' before the Court of Protection (Series, 2022)[10]. Similarly, IMHAs can support service users regarding hearings of the Mental Health Tribunal, which is empowered to discharge people from detention under the MHA1983 (see Mental Health Law Online, 2011). Some participants argued that, because of these differences in legal infrastructure, independent advocates tend to display greater proficiency in making legalist challenges when they have experience of acting as IMCAs or IMHAs, compared to when they have only worked as CAAs:

> (…) those Care Act advocates that come from IMCA, if they've got IMCA experience, I think they're better at challenging decisions. I think they're more used to writing reports and they find it easier to access things like Court of Protection if the person lacks capacity. (Mercer)

These differing potentialities regarding legalism have implications for advocate identity and potentially for boundary issues between advocacy roles, as I address in coming chapters.

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[9] The Mental Capacity (Amendment) Act 2019 will replace the Deprivation of Liberty Safeguards (DoLS) framework with a new regime: the Liberty Protection Safeguards (LPS). However, the then-Conservative government subsequently announced implementation would be delayed, until at least after the general election that was then due (Samuel, 2023c). One element of the move to the LPS will be the diminution of some rights to access independent advocacy (Series, 2019).

[10] Series (2013:167fn) notes that the role of IMCAs in making challenges in DoLS cases is 'legally distinct' from that in non-DoLS cases. She emphasises the relative weakness of arrangements for IMCAs to initiate legal challenges to best interest decisions outside the DoLS framework.

7.8. Conclusion

In this chapter, I have explored CAA–practitioner interactions as a potential site of partnership and challenge mechanisms, which can be conjoined via negotiatory approaches. The picture that emerges is one of CAAs working within liminal spaces. CAAs are partly reliant upon practitioners' co-operation in enabling people's involvement in CA2014 processes, yet CAAs must preserve their role's independence and fulfil their responsibility to hold the local authority to account. This imparts a distinctive character to CAA–practitioner interactions, where there can be some sharing of ground regarding ethical values and expertise, potentially provoking boundary disputes. When a need to challenge the local authority is identified, CAAs' liminal positionality is again evident as they navigate a contested space that spans informal and formal routes, forging a path based on interactions with the practitioner and—especially when enacting instructed advocacy—with the person. Conduct of challenges shows how CAAs must be able to integrate technical and communicative knowledge practices (see Golden and Bencherki, 2023), with legal literacy a firm requirement. The macro context of law and policy determines what pathways to challenge are available. The meso context also exerts a key influence, such as regarding whether the local authority has an appeals system.

Analysis in this chapter has touched upon discourse about whether CAAs are 'professionals', including about how well-equipped they are to fulfil their role's legalist potential. I now turn to exploring the nature and identity of the CAA role in depth.

8. Theme four: Constructing occupational identity

8.1. Introduction

In this chapter I focus on the nature and identity of CAAs' occupational role, emphasising its liminal qualities. I begin by analysing participants' ambiguous discourse around viewing CAAs as professionals. A key element of this discourse is recognition of CAAs' need for technical knowledge, albeit sometimes alloyed with concern about how compatible professionalism is with key advocacy tenets. I also discuss relational aspects of identity construction, involving comparisons between CAAs and social workers. This has implications for applying the concept of professionalism, given the two roles make convergent claims to expertise within some areas of practice, despite sharply differing decision-making responsibilities. I then explore aspects of workforce development, including pay, recruitment and qualifications. Next, I consider some stressors that CAAs face and how these are managed. Finally, I return to the complex delineation of boundaries with social work, examining the potential for individuals to assume a dual identity: as CAA and professional social worker.

For clarity and consistency, I refer to CAAs throughout as having a singular occupational role. Some individuals act as CAAs in conjunction with being IMCAs or IMHAs, or both, potentially broadening their identity construction. Yet such role configurations vary between individuals and organisations, as I discuss in the next theme.

8.2. Contesting professionalism

8.2.1. Professionalism: recognition, rejection, and ambivalence

CAAs offered diverse opinions regarding applying the concepts of professionalism and professionalisation to their role. The interview data suggested a dominant view among CAAs that their occupation had assumed at least some professional traits, although there was no consensus about how embedded professionalism had become. Some participants seemed to favour further progress in this direction, while others expressed unease at this prospect.

Ambivalence was also present, with individuals tending to identify both opportunities and risks associated with professionalisation, rather than embracing or rejecting it wholesale. The following quotations illustrate this diversity of opinion:

> I feel like the job is so complex now and the knowledge level that you need to do it—it's at that level that it has to be professional, to be honest. (Lisa, M, MV)
>
> We don't see ourselves as professionals—we're there to be the person's voice. (Amy, TL, FA)
>
> [Of professionalisation] I'm on the fence, I'm afraid. (Natalie, CAA, MV)

Some argued it is the form that professionalising initiatives take which matters most:

> So I think it's about the way it's done [professionalisation]. But I think that for me, the consistency of service that we could achieve through this process could potentially override the negatives. (Rachel, M, FA)

This fractured discourse about professionalism seemed to stem partly from participants' differing understandings of what the concept entails, which is unsurprising given its contested nature in both vernacular and academic usage (Evetts, 2003; Evans and Hupe, 2020). However, there were also allusions to differences of viewpoint, or at least of emphasis, about substantive issues concerning development of CAAs' occupational role. These relate to questions of status and power and involve the balance between technical and communicative knowledge. How these concerns are manifested in specific areas such as qualifying course curricula and mooted registration requirements is key. These questions are also deeply relational in nature as they affect, and are affected by, the interplay with service users and practitioners that everyday advocacy practice comprises. I flesh out such issues throughout the chapter.

8.2.2. Embracing technical expertise

There was consensus among participants about the importance of CAAs possessing robust technical knowledge, involving expertise about the adult social care system. Participants' accounts also showed how technical knowledge must be fused with advanced interpersonal skills and commitment to advocacy values. Knowledge is thus not merely abstract but a resource for ‘knowing’ in practice situations (see Golden and Bencherki, 2023:2). The need for a firm understanding of legislation, guidance and case law was cited, as well as of local policies, procedures and services. CAAs could then draw on these to facilitate involvement, such as by explaining jargon, setting out care and support options, or assisting with challenges. CAAs discussed these ‘technical’ competencies in ways indicative of them being integral to their identity. Some used the term ‘technical’ directly:

> We work in a way that makes the person we’re working with feel comfortable, but ultimately statutory advocacy is about upholding people’s rights in quite a technical way. (Amy, TL, FA)

Participants who characterised CAA as a profession did so by emphasising these technical knowledge requirements. This reflects the dominance of this form of expertise within traditional constructions of professionalism (Rennstam and Ashcraft, 2014). CAAs spoke of the need to keep knowledge and skills updated so they can work effectively on service users’ behalf, as is reflective of ‘continuing professional development’ (Halton et al., 2015). CAAs also described a strong sense of being responsible and accountable, as they assisted people through processes with far-reaching implications and were entrusted to safeguard their rights:

> It’s not like we could just mess up on a case and it doesn’t matter—it does. (Isobel, CAA, FA)

Statutory guidance stipulates various requirements of CAAs, but it does not explicitly define theirs as a paid role (DHSC, 2024:7.43). Mercer (NC) said she understood the position of CAA to be generally a remunerated one, because of the demands it entails. There was also evidence that dominant approaches among commissioners to implementing the CA2014 had served to consolidate differences between paid and volunteer advocacy, embedding notions of professionalism via a burgeoning occupational infrastructure:

> The requirement that was (…) placed upon local authorities to provide services really sort of channelled all the energies into the professional advocacy model. Qualifications were defined; standards of service were defined; accreditations were

> defined; and it has now become a professionally delivered service. And most of the voluntary sector have been cut out or they themselves have backed away from perceiving themselves in the advocacy role. (Stephen, CM, FC)

This account from a commissioning manager correlates with analysis of organisational trends found in earlier studies, where there has been a downgrading of the ethos of volunteerism within parts of the advocacy sector (Hardwick, 2018; Newbigging et al., 2021).

Links between professionalisation and a narrowing conceptualisation of advocacy were viewed as especially problematic given the limits of CAAs' remit and a paucity of community advocacy provision:

> Having an equipped, knowledgeable, trained advocate there to represent you is a good thing, but it seems to be the only focus, you know. Grass roots advocacy is just dying out. (Amy, TL, FA)

I consider these organisational aspects further in the next chapter.

8.2.3. Relational identity construction: CAA and social work

CAAs frequently discussed their identity in relational terms, particularly via comparisons with social work. The roles' overlapping knowledge bases and concomitant boundary issues were widely commented upon. That CAAs must scrutinise and sometimes challenge social work practice led to arguments for recognising parity of expertise:

> A lot of the time we know the legislation a lot more than the social workers. (Amy, TL, FA)

> I think to be a really good, effective advocate, you've got the same knowledge as a social worker. (Isobel, CAA, FA)

Such expressions of equivalence may be insightful regarding occupational identity construction among CAAs. This is because technical knowledge requirements for CAA are being compared to those of a role that strongly asserts its professional identity (e.g. BASW, 2023), which is underpinned by statutory regulation (McLaughlin, 2007; Wiles, 2013).

Comparative processes of identity construction have practice implications. This concerns CAAs' 'social identity', or how they are perceived by others (Watson, 2009). Some participants observed that practitioners are more likely to be receptive to CAAs' input if they perceive them to have professional status:

> I think to be in the position where you are challenging things, it's good if people understand and respect your profession. (Isobel, CAA, FA)
>
> [Of professionalisation:] You're not the afterthought when something's going amiss and it's 'we need the advocate' (…) (Natalie, CAA, MV).

These quotations illustrate how professionalism ideology relates to the relative power of occupational groups (Evetts, 2003). In critical realist terms, interrelated notions of identity, culture and discourse all comprise mechanisms exerting causal pressure on actors. As such, normative expectations exist about how professionals should conduct themselves—including how they should respond to others with this status. These expectations are institutionally mediated and socially enforced, via informal and formal means (Marks and O'Mahoney, 2014; Elder-Vass, 2012). Understandings about whether CAAs are professionals might therefore form part of the pool of tacit knowledge that practitioners draw upon as they work amid complexity and under pressure (see Cheung, 2017). Possible implications include whether CAAs are invited to meetings and the amount of weight that is accorded to their representations.

8.3. Preserving partnerships with service users

8.3.1. Status and power

Power dynamics with service users were a focus of contention regarding professionalisation. Some participants expressed unease that notions of professional expertise could undermine advocacy relationships, elevating advocates' knowledge at the expense of the person's perspectives. Similar misgivings have long been present within the advocacy sector (Henderson and Pochin, 2001). These were related to concerns that professionalisation could render the advocacy role as less distinct from that of practitioners. Thereby people may feel less confident interacting with their CAA if they perceive them as a source of professional authority. A CAA discussed this with reference to debates about whether independent advocates should become professionally registered:

> People say to me all the time, 'oh Rosie, you know, it's great working with you, you're down to earth (…).' You know, they trust you a little bit more. (…) But if we were to come in saying 'oh we're a professional body, we're working for, you know'…they may feel less trusting of us. (Rosie, CAA, FA)

CAAs described maintaining a warm and approachable demeanour as they consciously sought to minimise any power imbalances with service users. This included dressing informally as a means of identity expression (Ybema et al., 2009), intended to de-emphasise power differentials with service users (Morgan, 2017; Scholar, 2013).

8.3.2. Institutional and personal history

References were made to individual and organisational factors that can influence CAAs' identity construction. The potential importance of institutional history was reflected in how managers of Martborough Voices expressed particularly keen awareness of tensions over professional status, which they related to their organisation's roots in citizen advocacy:

> We were very much of that political kind of ideology; that actually, you know, you walk alongside it with somebody and you're with that person on an equal footing. You've got a partnership with somebody—you're not the professional and they're not the service user—and all that kind of ideology that went with it is very much embedded in who we are and where we've come from as an organisation. (Lisa, M, MV)

Lisa acknowledged her views had evolved, despite ongoing ideological tensions arising from Martborough Voices becoming a statutory advocacy provider. She said that over a period of around five years she had come to accept the value of occupational infrastructure, such as the National Qualification, given statutory advocacy's technical requirements. Such shifts in outlook highlight a need for attentiveness to temporal aspects of identity construction (Ybema et al., 2009).

Suggestions were also made that a CAA's personal background could have bearing on their practice orientation. Amy (TL, FA) argued that CAAs who had only ever practised statutory advocacy tended to be more 'boundaried' in their approach, and less willing to transcend the parameters of their statutory remit. She typified such work as focusing upon promoting people's involvement in CA2014 processes and drawing on 'knowledge of local organisations who can support in (…) different areas where there is a gap'. CAAs in the case studies had varied occupational backgrounds: only some had been non-statutory advocates; some were qualified social workers; one had started as a volunteer advocate, inspired by experience of caring for a family member. The influence of these backgrounds was not explored in any depth in the interviews. Redressing this absence might be a productive avenue for future research, as personal biography can influence individual identity construction over the life course, as studies of other occupations have found (MacKenzie and Marks, 2019).

8.3.3. Professionalism and decision making

Another difficulty with applying professionalism to CAA concerned the concept's relationship with decision-making power. Some CAAs alluded to this tension: between notions of professional practitioners using their expertise to reach autonomous judgements (Evetts, 2003; Evans, 2020) and an ethos of advocates centring the person's own knowledge and perspectives (Hardwick, 2014). A CAA described the latter as foundational to how she and colleagues undertook their role, stressing the difference from an approach based on professional power and status:

> We can say we're independent, we work for a charity (…) I'm here solely for you to get your voice across. It's got a softer approach. (Rosie, CAA, FA)

A key demarcation from social work was drawn—while the roles may share some knowledge requirements, how that expertise is used remains distinct:

> (…) ultimately social workers make decisions and therefore I understand that that's why they are different in that respect. (Isobel, CAA, FA)

This is acknowledgement of how social workers must, according to guidance to their *Professional standards*, exercise power and 'make impartial decisions'—even while pursuing partnerships with service users wherever possible (SWE, 2020:online). Social work decision-making frequently involves judgements about risk (Moriarty et al., 2015), as seen in theme two regarding weighing of risk factors during best-interest decision-making. Conversely, advocates help enable supported decision-making, even when this is subsumed within a process of substituted decision-making that is conducted by the social worker, within the legal framework of the MCA2005 (Dixon et al., 2020).

Nevertheless, while CAAs do not make decisions on people's behalf, they must determine how to advocate for and with them. One CAA cited the need to apply 'professional judgement' when deciding whether instructed or non-instructed advocacy is more suited to a particular individual and their circumstances. Moreover, when acting representationally CAAs are required to formulate judgements about the person's wellbeing and act upon this, mounting a challenge if necessary (DHSC, 2024:7.51). A CAA mentioned experiences of exercising such agency to seek redress for problems with service quality:

> If I've got concerns and it's non-instructed, I have contacted the [local authority] quality team. (Natalie, CAA, MV)

This further accentuates the distinction between instructed and non-instructed modes of practice. The requirement to exercise independent judgement while working in a non-instructed way is more readily compatible with traits-based notions of professionalism, as it involves relatively autonomous exercise of judgement. However, such judgement continues to involve interpretation of what another person would want if they could express this directly, i.e. delegated autonomy resting on what is authentic to the person (Leece and Peace, 2010).

8.4. Developing the CAA workforce

8.4.1. Pay, career progression and recruitment

Discussion of workforce issues further highlighted ambiguity regarding the CAA role's nature and identity, with options for furthering professionalisation posing opportunities alongside risks. Key areas of opportunity were prospects for higher salaries and better-defined career structures. CAAs' pay was described as significantly lower than for established professional roles, particularly local authority social work. There was a strong sense of responsibilities and remuneration being misaligned:

> I don't think advocates get paid anywhere near as much money as they should do for what we're doing. (Rosie, CAA, FA)
>
> We're expecting advocates to have an in-depth knowledge of complex legislation (…) and we pay them not very much money. And so attracting the right people into the profession, I think is a challenge (…) (Petty, NC).

Petty drew an important link between pay and recruitment, given what NICE (2022:83) reported as 'a widely held view that there is a shortage of advocates'. She related this to generalised recruitment challenges across the adult social care sector, in which uncompetitive pay and relatively poor working conditions are key factors (Skills for Care, 2022; Local Government Association, 2023).

The case studies provided additional evidence of recruitment issues regarding CAAs. The chief executive of Martborough Voices gave vivid illustration:

> Lisa and I are always walking in fright that somebody will hand their notice in. (…) There's not people queuing up at the door to be advocates. It's something that is still an unknown quantity. (Catherine, M, MV)

This quote suggests part of the issue is widespread lack of awareness of CAA as a potential career, especially for those who might otherwise be interested in or suited to it.

In Fencross, issues with availability of advocates had tangibly affected service structures. Commissioners had intended to manage fluctuating levels of referrals for CAAs via a system of ad hoc, or 'spot' purchasing of additional CAA resource, augmenting a 'block' contract for pre-planned provision. Other local authorities have used such an arrangement (Newbigging et al., 2017). Yet in Fencross these hopes foundered on personnel shortages:

> The spot system relied on the ability to recruit sort of sessional, casual advocates—and they have just not been within the system. (Stephen, CM, FC)

Workforce planning can therefore involve distinguishing between staff employed on permanent and temporary bases. The possibility of sessional employment of CAAs also raises wider concerns about casualisation among social care personnel, including over workplace rights and levels of organisational belonging among temporary staff (Cunningham, 2015).

Staffing issues were shown to be linked to questions about entry routes to work as a CAA. Participants made suggestions such as having higher education institutions contribute more to training prospective advocates and publicising this as a career option. However, in the interviews I did not clarify which college or university courses might contribute to this, beyond social work programmes, which I address in detail in a later section. Petty (NC) pointed to developing initiatives within the advocacy sector for bolstering recruitment, including discussions about introducing advocacy apprenticeships. However, she observed that plans to expand entry are complicated by the lack of any pre-employment routes to qualifying as an independent advocate, such as via a BTEC[11]:

> There's a real dilemma with advocacy as well, I think, because the qualification [National Qualification in Independent Advocacy] is vocational. So you have to do the training once you're an advocate. (Petty)

Conversely, it is common in the UK for professional roles in human services disciplines to require pre-entry qualifications that are based at least partly on academic study—although there are exceptions to this such as policing, itself subject to contested notions of professionalism (Christopher, 2015).

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[11] A BTEC (Business and Technology Education Council) Diploma is a specialist work-related qualification, equivalent to an A-Level (Universities and Colleges Admissions Service, no date).

8.4.2. Advocacy as a vocation

Discussions of developing the CAA workforce were nuanced, accentuating both material and ideological sources of motivation to assume this occupational role. Some participants argued that certain individuals possess personal qualities and a value base that make them especially well-suited to being advocates, and workforce policy and individual recruitment must account for this. This viewpoint was linked to descriptions of CAA as a 'vocation'[12], i.e. an occupation someone has a particular 'calling' to undertake, at least partly to satisfy a sense of social obligation (Dik and Duffy, 2009; Kallio et al., 2022). A professional role can also be a vocation (Kallio et al., 2022), but the concepts are not necessarily aligned:

> My passion is advocacy—I think advocacy isn't a job, it's a vocation; you're an advocate or you're not. (Amy, TL, FA)

This quotation is particularly strong in its essentialised framing of advocate identity. However, its sentiment was echoed by some other participants. A sense of moral purpose suffused a CAA's description of her pathway to the role:

> I've always had an interest in social justice, upholding people's rights—that sort of thing. (…) I guess the remit of the jobs that I was looking for was anything within sort of social care, but I didn't really want to go down the being a support worker route; I wanted to really effect change. (Isobel, CAA, FA)

This quote strongly affirms CAA as a change-agent role, which can effectuate positive outcomes for people despite lacking direct decision-making power over their care and support. By being located outside structures of service provision, unlike support workers, CAAs are implied to have increased agential power to exercise with and on behalf of people. The role's ethical appeal is seen to derive not just from its independence but from its effectiveness in driving change from this outsider position.

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[12] Vocation' and 'advocacy' have similar etymologies. The root of the word 'vocation' is the Latin *vocare*, which means 'to call' (Dayringer, 2002); hence 'vocation' and 'calling' are often used interchangeably (Dik and Duffy, 2009). The word 'advocacy' similarly derives from *ad vocare* ('calling to') (Nash, 2010).

This stress on personal character and motivation has potential implications for conducting recruitment processes. Martborough Voices' chief executive spoke of being attuned to these considerations when assessing potential employees:

> It's not just about having the qualification of being an advocate, it's about whether they get *it*, whatever *it* is for advocacy. And one of the best advocates I ever worked with was the domestic cleaner in an institution, and he just got it. (Catherine, M, MV)

This quotation positions a CAA identity within a broader advocacy self-conception, comprising a strong ethos and essentialised qualities that are hard to define yet recognisable to other advocates. This is illustrated via an exemplary advocate whose cleaning job would not have required expertise about law or policy but would have involved embodied contact with people experiencing oppression due to those same laws and policies. Such adeptness within interpersonal encounters is demonstrative of communicative knowledge (Rennstam and Ashcraft, 2014), while Catherine implied the technical knowledge required by CAAs is not necessarily a prerequisite for appointment, as it can be accrued once in post. This discourse is also evocative of an 'authentic' advocate identity, where the worker's 'true self' is reflected in their personal qualities and motivational outlook (Lehman et al., 2019:1). This is strongly divergent from more disassociated forms of 'identity talk', where a worker may view their authentic self as at odds with their workplace identity (Ybema et al., 2009:305).

Concerns were expressed that tightening formal entry and qualification requirements for CAAs might exclude some individuals who would otherwise be effective advocates:

> Some of the drawbacks of professionalisation are, of course, it could be an access barrier to people as well. (….) Social workers have to have a degree—I don't necessarily think you need a degree to be a really good advocate. (Rachel, M, FA)

Mercer similarly referred to how professionalisation could contradict other sectoral priorities, including 'valuing peer advocacy' and bringing more people with lived experience of service use into paid advocacy roles.

8.5. Developing occupational infrastructure

8.5.1. The National Qualification

Participants' discussions of the National Qualification in Independent Advocacy further indicated ambiguity within role development. There was broad agreement that CAAs must be trained to a high standard, with effective mechanisms for validating their knowledge and skills required. However, talk about the National Qualification specifically suggested its place within collective occupational identity construction is uncertain. Mercer, who was involved in developing the National Qualification, informed that advocacy providers vary in whether they support staff to complete all its stages. She argued it should be mandatory for all CAAs. Yet Mercer also reflected on how the National Qualification had strengthened impetus to embed an 'issue-based' and process-oriented advocacy paradigm within occupational infrastructure. This increased focus on advocacy conducted within bureaucratically defined parameters, which is often less person-centred and more fragmented:

> I've got to hold my hand up with the qualification, you know we've added to that in the quest to make it professional. An unintended consequence has definitely been this over-reliance on issue-based, seeing people as single issues to fix—short term, in and out, and 'right, close the assessment—we'll reopen when we get to the plan'. (Mercer)

These concerns have some resonance with further-reaching critiques of occupational frameworks from within citizen advocacy circles, whereby systems of training and accreditation are seen to further entrench a 'service' mindset that departs from more strongly relational advocacy orientations (Hardwick, 2018).

Case study participants expressed contrasting opinions about the National Qualification. Some viewed it positively, as part of a burgeoning CAA identity that valorises technical knowledge:

> It [the National Qualification] provides people with a really good framework to be able to understand all the different legislative elements. (Rachel, M, FA)

Among those more critical, a CAA highlighted what she saw as the limited depth of coverage of each statutory advocacy type within the National Qualification's syllabus:

> I just think, how can you cover Care Act in, you know, one or two days? (Isobel, CAA, FA)

Isobel drew a link between this perception of relative superficiality and that of CAA being a lower status role than social work. However, this observation must also be seen in the context of concerns about the exclusionary implications of tightening entry requirements, suggesting fundamental tensions about occupational development remain unresolved.

8.5.2. Professional registration

Mercer and Petty (NCs) each referred to questions about introducing professional registration being contentious within the advocacy sector. The lines of debate about registration broadly followed those about professionalisation more generally, with case study participants offering a range of opinions:

> If you are professionalising advocates, then I don't see why registration should be an issue. I think it ensures that advocates are working at particular standards (…) (Helen, CAA, MV)

> [Of registration:] I think that's probably a step too far for me. (Lisa, M, MV)

Among those in favour, registration was seen as a means for ensuring CAAs are competent and accountable, helping instil confidence among those they work with and alongside. Opposing this were concerns about reinforcing notions of professional authority and compromising principles of advocates being independent from all state structures. Scepticism was also expressed about willingness among CAAs to accept payment of registration fees, reflecting a broader issue about professionalisation's significant costs being imposed upon relatively low-paid human services workers (Emslie, 2012). Moreover, some CAAs queried the evidence base for claims that registration would make CAAs more respected and ensure they maintain high standards.

8.5.3. Departing from advocacy organisations?

Despite areas of contention regarding developing the CAA role, participants largely discussed it in terms of remaining based in employment by advocacy organisations. Some pointed to benefits from building an enhanced career structure within this organisational framework. The possibility of an alternative approach was, however, also proposed. Schwehr (NC) questioned the feasibility of developing career pathways for CAAs, arguing this seems difficult to reconcile with the role's core purpose of scrutinising and challenging public bodies on people's behalf:

> I think it's a maverick thing to do, and as such there will never be a career structure. (Schwer)

Schwehr suggested another option might be for local authorities to commission an agency to provide supervision to self-employed CAAs, where supervision of CAAs is a statutory requirement (Care and Support (Independent Advocacy Support) Regulations 2014, s.2(1)(e)). Schwehr said these alternative arrangements might enhance focus on ensuring CAAs are legally literate. She also likened them to how some Best Interest Assessors (BIAs) conduct assessments for local authorities on a self-employed basis. The BIA role, which is predominantly undertaken by social workers (Hubbard, 2018), is identified by Series (2022) as representative of 'care professional legalism'. BIAs must act independently to determine the best interests of a person deprived of their liberty, with a focus on upholding their rights and ensuring interventions are as least restrictive as possible (Hubbard, 2018; Buckton, 2023). This choice of comparator role further underscores the para-legal aspects of CAA.

Such a proposal for shifting CAAs' occupational basis raises important considerations, especially about the relationship between individual advocates and advocacy organisations, and where the balance of power between them lies. Approaches to this vary between advocacy models. For example, proponents of citizen advocacy have tended to emphasise advocates' autonomy from their agency, given the onus on individualised advocacy partnerships (Henderson and Pochin, 2001). Moreover, self-employed status could arguably buttress advocates' independence, by placing them at one step's remove from commissioning relationships with local authorities. However, such loosening of ties to established advocacy organisations would be less congruent with views that emphasise the latter’s potential as vehicles for empowerment. In this framing, advocacy organisations can link statutory advocacy to a wider pool of advocacy activities. They can also help anchor practice within the ethos of the disabled people’s movement, such as by ensuring user-involvement in service design (Carey, 2019; Newbigging et al., 2021). I return to these organisational aspects in the next chapter.

8.6. Supporting the CAA workforce

8.6.1. Stress and other emotional demands

The CAA role’s psychological demands were shown to affect occupational identity construction. In discussions of this, the character of CAAs’ interpersonal encounters came to the fore, with less emphasis on their technical knowledge. CAAs described bringing empathy and compassion to their role, while supporting people experiencing vulnerability and distress could be emotionally challenging. CAA is thus reflective of ‘emotional work’ within human services roles, where the management of genuinely evoked emotion is a key occupational demand (Miller et al., 2007):

> If somebody’s got nobody, they are totally un-befriended—I’ve had a few when they’re in care homes, then you just feel, you know, compassion (…). It’s so sad. (Natalie, CAA, MV)
>
> It’s challenging to work in the health and social charity sector, but our advocates are fantastic, and they really do care. (Rachel, M, FA)

CAAs described experiencing other stressors. Some mentioned facing intense workload pressures, as they sought to keep pace with the conduct of statutory processes while dividing their time between work with numerous individuals:

> You’ve got this to do in this timescale; if you don’t do this, you might be getting reprimanded. (Rosie, CAA, FA)

This reference to possible disciplinary repercussions underscores how CAAs are subject to accountability mechanisms via their employing organisations. However, the data collected imposes provides limited scope for analysis about occupational stress, as I did not directly ask participants about experiences of this. Nevertheless, CAAs' accounts indicated a conjunction of emotionally charged work with institutional pressures around workload demands, which is notable given the cumulative effect of these factors is central to understanding stress and burnout among social workers (Moriarty et al., 2015).

Participants also mentioned difficult experiences more specific to CAA, especially the interpersonal conflict that can accompany scrutinising and challenging practitioners. CAAs' liminal position was manifested in requirements to participate in multi-professional forums while staying independent from other participants and potentially opposing their plans:

> You can feel a real sense of responsibility sometimes if you're the only person in the room that's advocating for something differently to other people. It can be quite stressful—and quite a lonely sort of position to be in. (Isobel, CAA, FA)

Demands on advocates due to conflictual interactions pre-date the introduction of statutory roles (Forbat and Atkinson, 2005). However, these pressures will likely have intensified given increased expectations that statutory advocates act as legally literate protectors of people's rights (see Morgan, 2017).

8.6.2. Supporting resilience

There was evidence of an in-group culture developing among CAAs in response to demands upon them. This entailed resolve in the face of contentious practice scenarios:

> I think overall we annoy people, but we don't really take it to heart. (…) there's an advocacy saying (…): 'if you've not had a complaint as an advocate, you're not doing a good job [laughs].' (Amy, TL, FA)

This quotation suggests a commitment to rigorous challenge is an important part of CAAs' self-conception and a binding aspect of collective identity. There is strong assertion of resilience and defiance in the face of conflict, which might be intense enough to prompt a practitioner to complain about a CAA's conduct to the advocacy organisation that employs them. Moreover, based on Amy's account, such backlash is not only to be accepted by CAAs but viewed with pride, as evidence of effectiveness in their role. Such commentary seems indicative of how shared experiences of in-work hardship can foster a sense of solidarity among holders of an occupational role, which is a protective factor for wellbeing (MacKenzie and Marks, 2019). It also accentuates how CAA identity is partly defined in opposition to the role of practitioners such as social workers. This oppositional dynamic is similar to that observed in Hardwick's (2014) study of an advocacy hub—even if CAAs' oppositional practice makes greater use of technical knowledge than that of the non-statutory advocates in this earlier study. Finally, Amy's reference to CAAs not 'taking to heart' practitioners' annoyance alludes to mechanisms of disassociation. Hochschild (1983) describes disassociation as an emotion management technique used within contentious workplace environments, where a sense of high stakes can amplify interpersonal tensions. Ybema et al. (2011:301) also note that 'emotional distancing' can be part of occupational identity construction. However, any notion of CAAs employing emotional distancing seems more applicable to their interactions with practitioners than with service users, given descriptions of a caring approach taken with the latter.

Participants mentioned CAAs benefitting from other supportive mechanisms. These work cumulatively to promote resilience, which is a 'psychosocial process' for avoiding negative consequences to wellbeing from stressful situations, engaging resources internal and external to the individual (Kapoulitsas and Corcoran, 2015:88). Strong support structures are crucial for enabling resilience among social care practitioners, with supervision a core component (Kapoulitsas and Corcoran, 2015). In both case study sites, CAAs described having supervision according to regular timescales, with it also available on an ad hoc basis if they faced challenging situations.

> So we do have formal supervisions and we do try and like, you know, if somebody is going through something, that you would have them more regularly. (Isobel, CAA, FA)
>
> I have a good team lead; I've just rung her today and spoke to her and, you know, you don't have to wait for supervision. (Rosie, CAA, FA)

CAAs also reported valuing peer support. This operated via similar mechanisms to social work peer support (Collins, 2008), as CAAs benefited from both casework-specific advice and emotional support from colleagues with shared experience of the role's demands:

> If I'm struggling with something, I know there's always a colleague that I can refer to. (Helen, CAA, MV)

CAAs from Martborough Voices also mentioned how group peer supervision sessions in team meetings provide space for collective reflection and exchanges of advice. This highlights advocacy organisations' responsibilities to support individual advocates. The *Advocacy Charter* enshrines this, via requirements for the advocacy provider to provide training and supervision and aid access to legal advice, alongside creating a generally 'supportive culture' in which advocates can discharge their own responsibilities under the *Charter* (NDTi, 2018:online). These observations of the importance of the advocacy organisation's supportive function are additionally significant given previous discussion about possible alternative paths to developing the CAA role, including via introduction of self-employed status.

8.6.3. Covid-19: disrupted support networks

The Covid-19 pandemic severely hampered the workings of CAAs' interpersonal support networks. In the case study sites, the imposition of a national lockdown in March 2020 caused a dramatic shift in CAAs' working arrangements, from office-based to home-based as the norm. At the time of data collection, Fencross Advocacy and Martborough Voices had each introduced hybrid arrangements, with CAAs splitting their time between home and office bases, albeit spending much of their working hours out visiting service users. Participants variously identified positive and negative aspects of the shift to home-working, although this had been partially reversed. Benefits included less time being consumed by travel, mirroring findings from a survey among advocates conducted early in the pandemic (NTDi, 2020). Drawbacks included psychological pressures linked to a blurring of boundaries between work and home life, and increased stress from diminished in-person contact with service users and colleagues. These depictions of heightened stress are similar to those that Golden et al. (2023) identify as having faced Community Health Workers in the USA, arising from disruptions to communicative knowledge practices based on embodied interactions. These favoured patterns of working were related to CAAs' perceived personal attributes:

> Our advocates are 'people' people (…) they do this job because they want to work and interact and be with others. (Rachel, M, FA)

Some CAAs described feeling the diminution of in-person support especially keenly. This comprised access to assistance from peers and supervisors:

> I think before Covid, the office environment was so important (…). It could be a 10-minute conversation with somebody just to offload and then that would be nipped in the bud, you feel much better and on you go. (Isobel, CAA, FA)

A participant mentioned efforts within Fencross Advocacy to mitigate these difficulties, including via 'online wellbeing meetings', although it remained the case that home working 'can leave some staff members quite isolated'. These discussions link to broader societal concerns about the merits of remote versus in-person working, especially regarding workers' wellbeing and effectiveness (Becker et al., 2022). They also relate more specifically to questions about how to support the wellbeing of frontline health and social care personnel who started working at least partly remotely from the pandemic's onset. Problems accessing informal support structures have had similarly negative implications for mental health nurses (Liberati et al., 2021) and social workers (Kingstone et al., 2022).

8.7. CAA and social worker: intersecting identities?

8.7.1. Locating crossover points

Further insight into CAAs' occupational status was provided by discussions of potential intersection between the CAA and professional social worker roles. These discussions concerned individuals moving between these roles and the possibility of a joint CAA–social worker identity being held. Both short and long-term forms of crossover were mentioned. The former comprised student social workers undertaking advocacy roles while on practice placements with providers of CAA services. Martborough Voices and Fencross Advocacy each provided such placements. Longer-term movement involved qualified social workers becoming employed as CAAs. This was also evidenced in the case studies: of the nine participants who worked for advocacy organisations, three were qualified social workers and one was also a practice educator, supervising social work students on placement (Madden, 2022). However, there were signs that navigating such a dual or even hybrid identity is a complex undertaking (see Leah, 2018, 2020; Croft et al., 2015), with participants offering differing opinions about the ultimate compatibility of the two elements.

8.7.2. Student placements

Participants described advocacy placements for student social workers in strongly positive terms. These were seen to help build mutual understanding and respect between CAAs and social workers, informing the latter's post-qualification practice:

> We're sort of bridging the gap and they're able to take that knowledge about advocacy back into stat [statutory] services, which has been pretty successful (Rachel, M, FA)

Here 'bridging the gap' refers to addressing an aspect of CAAs' liminal position, being in-between legal and policy requirements for their involvement and the reality of sub-optimal utilisation, where CAA input is too often viewed in discretionary rather than essential terms. Practice placements were also seen to bring benefits that ripple beyond the individual student participant, as when students discussed their placement experiences with their peers. Participants' observations therefore supplement previous research findings about the value of student placements with advocacy organisations (Lawson and Petty, 2020). They also add to evidence of the merits of 'non-traditional' social work placements that are based outside local authorities, which help give students a broader perspective on the profession and adjacent practice arenas (McLaughlin et al., 2015).

An advocacy placement could also inspire a student social worker to pursue subsequent employment as a CAA, rather than as a local authority social worker. Both Fencross Advocacy and Martborough Voices had employed some former placement students, including one of the study participants. Catherine (M, MV) described this as her organisation's 'most successful means of recruitment'. Another participant recognised this crossover as marking a common career trajectory:

> A lot of people I know haven't even gone into social work because of how much they've fallen in love with their placement as a statutory advocate. (Amy, TL, FA)

8.7.3. From social work to advocacy

Movements between the occupational designations of CAA and social worker were seen to provide opportunities for cross-pollenating knowledge and practice wisdom (see Cheung, 2017). A CAA participant said they had drawn extensively on their social work training within their current role. This was especially regarding the onus such training placed on instilling an anti-oppressive and anti-discriminatory value base and a reflective approach to practice, as required by social work's *Professional Capabilities Framework* (BASW, 2018a):

> [Of social work training:] I think it's definitely helped, in terms of recognising your own values and how you work with people and the way you present. (CAA/ qualified SW participant)

Discussions of what motivates some qualified social workers to become CAAs gave further insight into the relationship between the roles. Both push and pull factors for such career changes were identified. Regarding the former, Amy's (TL, FA) reference to placement students 'falling in love' with advocacy aligns with notions of advocacy as a vocation, where someone can authentically express their personal values through their work (Kallio et al., 2022). Two CAA participants with social work qualifications described being attracted to CAA in this way, contrasting this with feelings of moral unease about statutory social work practice. Disenchantment with statutory social work arose especially from a sense of there being strong structural barriers to practicing in alignment with the profession's anti-oppressive value base:

> On graduating I realised that actually I didn't want to be a social worker. Things I'd seen on [statutory social work] placement etc. had kind of put me off. It's not what I

> went into the profession for—having to fight for resources and funding etc. (CAA/ qualified SW)

This quotation refers to the ethical tensions that arise from social work practice amid severe resource constraints, mediated by managerialist pressures (Slasberg, 2019; Butler-Warke et al., 2020). The participant proceeded to depict a CAA role as an opportunity to practice in the same field, while being able to side unequivocally with the person. Schwehr similarly alluded to such motivations when she described CAA as a 'maverick occupation', which some pursued because they 'couldn't bear to work in the system'. However, another perspective can be taken on social workers' conflicted position: it is because of their conduct of care and support processes and proximity to managerial authority that their responsibility to advocate for service users within local authorities is so acute, despite being often personally difficult. For example, social workers' assessments should accurately capture people's needs, regardless of what local authorities' resources permit in terms of meeting these. Identification of unmet needs would facilitate representations over shortfalls in care and support plans (BASW (England), 2022; Slasberg, 2019). This would also align with professional commitments to advance social justice (SWE, 2019:1.6), including by raising concerns about systems and working environments that stymy the discharge of other professional responsibilities (6.2). By recognising that practitioners must 'fight for resources' within local authorities, the above quotation actually captures an essential part of social work advocacy (Wilks, 2012).

8.7.4. CAA as a field of social work practice?

The case studies presented a mixed picture regarding development of a dual CAA–social worker identity. Potential for a qualified and registered social worker to pursue independent advocacy as their field of professional practice was evidenced by the participant who had followed this pathway and, as a practice educator, was helping train future social workers. However, some other participants raised issues likely to affect whether this career pathway is more widely followed. Salary and perceived status differentials with statutory social work were highlighted; Amy (TL, FA) said CAA is hampered by 'a misconception that it's a step-down job'.

Questions were also asked about how readily CAA practice would allow progress with professional development as a registered social worker. Of the two other CAA participants with social work qualifications, one had relinquished their registration after deciding their career lay with independent advocacy, while the other was newly qualified and in the process of registering. The latter's experiences and perspective are illuminating. They stated their longer-term career aim was to move from their CAA role to practising social work with a local authority. They described CAA work as a 'brilliant job' that was helping them build confidence and technical knowledge that would benefit their future career. They also said they were experiencing less 'pressure' than if they had entered local authority practice straight after qualifying. However, the participant questioned the core compatibility of CAA and social worker designations, citing the importance of decision-making within social work practice:

> The drawback of advocacy with social workers—although there are massive, massive benefits (…)—you're on the other side in terms of doing assessments; doing safeguarding; being the decisionmaker. (CAA/ newly qualified SW)

This participant added that they expected it would be difficult to complete the Assessed and Support Year in Employment, a milestone for newly qualified social workers (Skills for Care, no date), while employed as a CAA. The *Professional capabilities framework* for social workers at this career stage includes requirements to demonstrate 'professional judgement' over social work interventions, which must be targeted to engender positive outcomes for service users (BASW, 2018a:10). These requirements are again couched in terms of practitioner expertise and agency, although promoting the person's self-determination is stated as a desired outcome. This shows a need for careful consideration about how CAA practice can be formulated in these terms, given the role's strongly user-led remit and the limitations this can impose upon autonomous practice.

It must be stressed that this discussion of compatibility between CAA and social worker identities rests on the small evidence base provided by the case studies, where this topic was only raised with a few participants and was not probed in depth. However, there is a seeming lack of readily available textual sources that can explain these matters further. None were encountered during structured searching for my literature review, nor through online searches I conducted, using Google, while trying to gather additional information after conducting the thematic analysis. No reference is made to independent advocacy within a literature review of roles and issues within the social work profession in England (Moriarty et al., 2015), nor within the 'careers' section of BASW's website (BASW, 2023).

8.8. Conclusion

In this chapter I have explored the liminal qualities of the CAA role and its associated identity. The evidence encountered suggests CAA identity is located in-between increased professional recognition on the one hand, and on the other notions of advocacy being a unique form of work—paid and voluntary—that fits uneasily within the terms by which professionalism is generally understood. While these tensions are widely acknowledged, CAAs can differ in the emphases they place on various aspects of occupational identity and how they frame these discursively. From a realist perspective, ideation about occupational identity acts as a causal mechanism, being part of the structural context that individuals respond to according to their personal disposition and reflexive exercise of agency (Elder-Vass, 2012; Marks and O'Mahoney, 2014). CAAs' identity can therefore influence how practitioners react to their interventions, as practitioners may pay closer attention to contributions they deem are from a 'professional' source. Furthermore, a CAA's self-identity might play a role in how they rationalise a conflictual encounter with a practitioner, helping them minimise its emotional implications.

The analysis has also underscored how identity constructions are structurally constrained (Marks and O'Mahoney, 2014). This is strongly evidenced by how pay and status differentials reinforce occupational boundaries with professional social work, even when these roles converge over some areas of technical and relational expertise. The causal powers of institutions (Elder-Vass, 2010) also affect individual processes of identity construction. The influence of Martborough Voices' roots in citizen advocacy shows this, as do questions about the implications of moving to a self-employment model for CAAs—how advocacy organisations, which embed an ethos that transcends any particular form of statutory practice, provide a shaping and supportive context for individual advocates to work within is a core concern. In the next and final thematic chapter, I delve further into organisational issues around CAA services.

9. Theme five: Developing organisational effectiveness

9.1. Introduction

I now turn to focus on organisational aspects of CAA services, and how they influence effectiveness. I first consider local authorities' commissioning of such services, including funding levels, debates about local versus national commissioning, and challenges around service evaluation. Then, I explore elements of boundary-setting, examining the CAA role's relationship with other advocacy types, non-statutory and statutory. I also discuss scope for specialisation within the CAA role, regarding work with particular service user groups. Thereafter, I consider 'culturally appropriate advocacy' (NICE, 2022), showing how application of this concept to CAA remains at formative stages. Finally, I discuss ways in which 'advocating for advocacy' (Osgood, 2017) is happening at national and local levels. This includes prospects for encouraging dialogue and collective representation within the advocacy sector, and the possibility for reform of CAA services as mooted in a case study site. A key concern for the chapter is how advocacy organisations are liminally situated, as they experience resource scarcity, precarity, unresolved boundary issues, and operate in a fragmented system that can suppress unified expressions of cause advocacy. All these factors contribute to an in-between status, whereby ethos and expectations become misaligned with service conditions.

9.2. Commissioning CAA

9.2.1. An interrupted commissioning cycle

Fencross Advocacy and Martborough Voices had each been commissioned CAA providers since 2015. Stephen, commissioning manager at Fencross Council, noted the local authority had twice extended its original three-year contract for statutory advocacy services. This was attributed to pandemic disruptions and the wait for details about the Liberty Protection Safeguards (LPS), a replacement framework for DoLS. The Mental Capacity (Amendment) Act 2019 legislated for the LPS (Series, 2019), yet implementation has been subject to repeated deferrals (Samuel, 2023c). Delays in recommissioning statutory advocacy in Fencross meant there had been limited scope to enact structural changes to local CAA services:

> We're up to coming up to the end of its seventh year—that is an excessive period for a contract to be in place in local authority terms. (Stephen, CM, FC)

Recommissioning in Fencross was set for 2023 and the consultative process had begun. This was to feature discussions with stakeholders, including local service user groups and a proposed 'citizens' co-production panel'. Stephen acknowledged that ideas of applying user-involvement principles via the co-production of advocacy services (SCIE, 2022) needed practical elaboration:

> It's a bit of a moving target is co-production; it's constantly developing. And we're endeavouring to get better at it. (Stephen, CM, FC)

9.2.2. Funding pressures

Participants widely identified that CAA services are significantly underfunded relative to local needs. This was perceived to be a problem in the case study sites and nationally, albeit with some geographical variation. Fencross Advocacy's manager commented as such, based on her sectoral contacts:

> There are huge variations across the country in terms of the number of, the amount of advocates per area. What I would say is there are very few that are adequately resourced to meet the demand. (Rachel, M, FA)

Participants related these funding shortfalls to a bigger picture of severe funding constraints on local authorities, with Stephen (CM, FC) highlighting the challenge of introducing CAA services amid austerity cutbacks. In 2020 Fencross Council had arranged an external review of its commissioning of advocacy, which Stephen acknowledged had shown 'probably our underfunding of the service, to a certain degree.' CAA participants widely linked the impact of underfunding to challenges discussed across preceding chapters, including limits on the scope and duration of CAAs' involvement with people that restrict preventative working. 'Downwards pressure' on CAA salary levels was also noted (Rachel, M, FA).

A stark illustration of funding pressures came with Martborough Voices' chief executive reporting that it subsidised its statutory advocacy services with around £30,000 per year from organisational reserves. She attributed this to local authority funding being insufficient to enable staff to work to the 'standard' they seek:

> (…) If we were to actually charge the local authority on an individual, bespoke, per head contract [i.e., for the amount of work undertaken with each service user] they couldn't afford us. (Catherine, M, MV)

This situation indicates interlocking power imbalances: between local authority commissioners and advocacy organisations; and between central and local government. In each case, financial allocations are insufficient to meet legal obligations and service expectations (Bottery, 2020; Burn et al., 2024)—yet final responsibility for service delivery lies with the advocacy provider. In a situation such as that of Martborough Voices, staff commitment to maintaining service quality is further indicative of ethically imbued notions of advocacy as a vocation. Resistance to erosion of quality is enacted at organisational expense. Yet, as Hardwick (2018:148) argues, such 'stealth volunteering' can be 'a counterproductive strategy in the long term as it depletes organisational resources and leaves commissioners unaccountable for gaps in service provision'. Given the scale of financial loss, it was unclear how sustainable Martborough Voices' approach was.

9.2.3. Local versus central commissioning

Participants provided a nuanced discussion of the advantages and disadvantages of local commissioning of statutory advocacy. This variously incorporated critiques of fragmentation within adult social care (Carey, 2015) and recognition of the merits of local control. Petty (NC) identified 'problematic' aspects of local commissioning, including a lack of ringfenced funding for advocacy increasing geographic variations and concerns CAA providers may be wary about challenging their funders. Mercer (NC) cited previous experiences of central commissioning of NHS complaints advocacy. Central government originally procured this from three providers, operating regionally (DH, 2008), before commissioning responsibilities were transferred to local authorities by the Health and Social Care Act 2012, s.185:

> It was so joined-up; it was very effective. They had loads of money chucked at it. (…) And I think the learning from that is there was so much power in those three providers having the ear of government because they could look at the themes; they could look at the trends. (Mercer)

This quotation refers to the original providers of NHS complaints advocacy deriving power and influence from their organisational scale, which facilitated direct communication with national government. This is shown to contrast markedly with the more fragmented system where providers are commissioned individually by 153 local authorities. Mercer also refers to how central commissioning meant advocacy providers covering larger areas and populations could better collate intelligence about issues being encountered in practice and bring these to policymakers' attention. This suggests opportunities for cause advocacy by advocacy providers, where they identify systemic challenges rather than just how they manifestation in individual circumstances—an issue I return to below. This identification of potential benefits of larger-scale advocacy operations is a useful counterpoint to perspectives that have emphasised the merits of more localised advocacy formations, via strong links to communities and grassroots disability activism (Hardwick, 2018; Newbigging et al., 2021).

Arguments were also presented in favour of the current system of locally devolved commissioning:

> I certainly think by doing it locally we can be more sensitive to local requirements, and we can make sure it's joined-up better with local services. (…) I suspect it's cheaper and more effective. (Stephen, CM, FC)

As with Mercer's comments about centrally commissioned advocacy, reference is made to the quality of being 'joined-up'; yet here this concerns better aligning advocacy with other locally organised services. The rationale presented by Stephen (CM, FC) is broadly congruent with arguments by Hudson (2019:414) for commissioning 'small and local' social care services, which better reflect what local populations want, rather than appearing distant and depersonalised. There is also resonance with arguments that community-based services benefit from people's attachment to a sense of place and better enable local 'assets', such as voluntary initiatives, to be utilised (Wildman et al., 2019). Local commissioning also more readily permits service user involvement in co-producing services (SCIE, 2022), as recommissioning plans in Fencross show. Fencross Advocacy and Martborough Voices represented examples of local commissioning arrangements leading to smaller, community-rooted organisations being contracted to deliver statutory advocacy services. Nevertheless, the complexity of questions about optimal commissioning structures was reflected in Stephen's (CM, FC) acknowledgement that, despite localism's advantages, centralised arrangements 'might just attract more funding' for CAA provision.

9.3. Organisational form and performance

9.3.1. Organisational scale

While devolved commissioning allows some locally rooted advocacy organisations to win CAA contracts, factors weighing against this were also identified. Monaghan (NC), an organiser of community advocacy, described a tendency towards larger organisations providing statutory advocacy across multiple areas. He contrasted this with smaller organisations being often disadvantaged in terms of resources and professionalised status, echoing Hardwick's (2018) critique of exclusionary commissioning practices within a new public management framework. In this context, Monaghan identified key contingencies regarding whether grassroots organisations can remain resilient, regarding the skills of their managers and the outlook and knowledge of local commissioners:

> You've got some groups that have managed to survive it and managed to keep a level of informal advocacy within a much broader church of what they do. But they've been very adept and invariably it's because they've got commissioners who understand the city that they're commissioning for. (Monaghan)

The current study does not, however, provide direct evidence of a link between organisational scale and quality of CAA services, especially as a larger advocacy organisation was not included as a comparator case.

Experiences at Martborough Voices were illustrative of resilience among grassroots advocacy organisations. Catherine (M, MV) said her organisation's desire to continue asserting a community-oriented approach had motivated its tender for the statutory advocacy contract. She described this as a desire to 'keep the big boys out', suggesting vernacular phraseology for what Hardwick (2018:144) terms 'large, business-focused advocacy organisations':

> We were aware of the fact that, had one of the corporate advocacy organisations got a foothold in Martborough, that we would have been swallowed up to some extent. (Catherine, M, MV)

This indicates that, for Martborough Voices, assuming statutory advocacy responsibilities was a strategy for maintaining organisational health, or even survival, given diminished funding for community advocacy. This sense of organisational precarity was similarly implied by a participating advocacy manager observing that their organisation may lose its statutory advocacy functions after the next commissioning round. If this threat was more pronounced for smaller advocacy organisations it would suggests that these experience liminality in an especially acute way. However, further research is needed to investigate whether and how larger advocacy organisations undergo stress and a potential draining of resources relating to the uncertain pursuit of contract renewal.

9.3.2. Systems of evaluation

Commissioners and advocacy leaders face difficulties in evaluating the effectiveness of CAA services. Participants noted the absence of a sector-wide evaluation framework; Petty reported 'there is little information out there as to the effectiveness of advocacy, full stop'. The participating commissioner lamented the lack of established metrics to underpin a 'dive into the rigour of the service':

> We may well be falling short, and it would be good to have national benchmarks and national monitoring. (Stephen, CM, FC)

This aligns with arguments favouring more overarching scrutiny of the advocacy sector, linked to standardised measurements of service performance. The inference is this would help local authorities discharge their responsibilities under the CA2014 to commission appropriate, high quality and cost-effective services (DHSC, 2024:ch.4).

The absence of overarching scrutiny led to emphasis on localised evaluation mechanisms in the case study sites. Managers from Fencross Advocacy and Martborough Voices described conducting internal performance monitoring and evaluation, which they reported to commissioners. They discussed this in ways resonant with the distinction that Lawson and Petty (2020) draw between outputs and outcomes. The participating managers noted that outcomes were less readily quantifiable and harder to capture, echoing previous research findings (Rapaport et al., 2006; Hardwick, 2018; Newbigging and Ridley, 2018). Efforts were underway to improve outcome monitoring; for example, Fencross Advocacy's staff used 'easy read' materials within evaluative discussions with service users. However, the volume of incoming work posed difficulties:

> Even being able to contact someone that you've been working with—bearing in mind they might have communication needs—to gather that feedback…it's just additional time when we're very busy. (Rachel, M, FA)

This illustrates how funding constraints can deter organisations from undertaking valuable work beyond immediate provision of statutory advocacy (Lawson and Petty, 2020), as previously seen regarding practice that seeks to embed prevention via longer-term engagement with people.

Martborough Voices' reports to commissioners combined statistical analysis of outputs with narrative case studies about advocacy's positive effects—a hybrid approach promoted in subsequently issued NICE (2022) guidance. Martborough Voices' chief executive also described pursuing innovation within outcome evaluation, via a project with an external consultant to develop a bespoke 'model for measuring social impact'. This was to provide evidence for the benefits of community-oriented advocacy, such as the fostering of local connections that help address the social isolation experienced by many service users. It was hoped these efforts would benefit any future re-tendering bid to provide statutory advocacy:

> What we can capture locally will hopefully be our unique selling point, over and above the big boys. (Catherine, M, MV).

9.3.3. The Advocacy Quality Performance Mark

A lack of consensus about evaluation pathways was further evident from the contrast between the case study sites about uptake of the Advocacy Quality Performance Mark (AQPM), an accreditation scheme that is mentioned, but not mandated, in statutory guidance (DHSC, 2024:7.44). Fencross Advocacy had the AQPM and was in the process of renewing it; Martborough Voices had not applied for it. This difference seemed partly related to the stances of respective commissioners. Within Fencross Council, the AQPM was valued as a means of independent quality assurance. Need for this related to the conflict of interest that was implied by commissioners' directly scrutiny of a service that should itself hold the local authority to account:

> We didn't feel totally comfortable about going in and doing our own sort of quality audit of the service; so we thought it was best to build in a QPM requirement and oblige them to maintain it. (Stephen, CM, FC)

Conversely, Martborough's commissioners had not made the AQPM obligatory, leading to deliberation within Martborough Voices about whether to pursue it. Its managers discussed the AQPM in terms of an overall trajectory towards standardising and professionalising advocacy, of which there was wariness within their organisation. Catherine (M, MV) expressed a nuanced view, acknowledging the AQPM has value while contrasting the limits of external scrutiny with the promise of the locally focused evaluation measures her organisation was developing:

> We kind of have our own standards that we aspire to, and there are organisational values, and this will all come out in the impact report work that we're doing. Anybody can walk into our organisation, and I can show them any policy. I can show them any mission statement, any of that stuff and they can say that would be £3,000 please—tick, tick, tick; here's your certificate. But it's not good enough. We have to be able to prove that we actually practice what we preach and that's coming out through the social impact work. (Catherine, M, MV)

This quotation reflects broader tensions over how to evaluate advocacy, given its complex and heterogenous nature. Questions about the AQPM, an initiative originating within the advocacy sector (AQPM, 2021a) are distinct from those about introducing external regulation of advocacy organisations (see DHSC, 2021a). Nevertheless, evidence from Martborough Voices suggests scepticism from at least some in the advocacy sector about the prospect of introducing more standardised evaluation measures, which may be perceived as favouring tokenism and being misaligned with innovations in local impact measurement. Yet, given attempts to define and measure the 'social impact work' undertaken by Martborough Voices were on-going at the time of data collection, further research is needed to explore the implementation of such initiatives and how they differ substantively from the AQPM.

While acknowledging a lack of consensus within the advocacy sector about evaluation, Petty referred to a 'strong sense' that imposing existing regulatory regimes for adult social care, such as via the CQC, would contradict the distinctive role that advocacy plays in holding other parts of the system to account:

> My sense is that we want and need the independent advocacy sector to remain independent, and that if we start to regulate that via existing statutory bodies, that we start to risk losing some of the essence of independent advocacy. (Petty)

Therefore, questions about oversight, evaluation and regulation join those about qualifications and professional registration in highlighting the liminal position of the CAA role and services. There is pressure to expose these to the same accountability requirements that workers and services providing direct care and support are subject to, while simultaneously concerns exist about preserving advocacy's special, independent character. How standards should account for the application of advocacy principles to real-world complexity, avoiding 'tick box' superficiality, is another area of contention.

9.4. CAA and community advocacy

9.4.1. Retreating from non-statutory advocacy

Participants widely reported observing an overall reduction in the availability of non-statutory advocacy since the CA2014 was introduced, albeit with geographical variations. This was generally ascribed to commissioners prioritising spending on statutory advocacy amid austerity. Stephen (CM, FC) acknowledged Fencross Council had responded to the CA2014 by taking 'probably a very finance-led decision' to focus resources on a statutory advocacy hub, withdrawing funding from various 'small-scale informal advocacy services'—including those focused on welfare rights and support for people with learning disabilities. This reflects a commissioning approach that concentrates overwhelmingly on statutory compliance, possibly at the expense of a more holistic conception of meeting advocacy needs (Newbigging et al., 2021).

Participants described a retreat from non-statutory advocacy provision that created gaps in services. People ineligible for care and support under the CA2014 and those who do not meet the 'substantial difficulty' criterion were among those observed to potentially miss out. Fencross Advocacy received frequent requests for more general-purpose advocacy:

> (…) we do try and see if we can fit people in where there's a need; but it is challenging, obviously, alongside juggling work inside the statutory advocacy provision. (Rachel, M, FA)

Participants highlighted high levels of unmet need for certain advocacy types, including welfare rights assistance, non-statutory mental health advocacy, and specialist support for parents with learning disabilities who are involved in child protection processes. However, CAAs did refer to connecting people with other services and support networks, where these existed. A CAA from Fencross Advocacy mentioned signposting people to a local service that offers practical support to people with learning disabilities, such as regarding shopping, correspondence and medical appointments.

9.4.2. Plurality of advocacy provision

Geographical unevenness within advocacy provision was reflected in differences between the case studies, where Martborough Voices continued to deliver some non-statutory advocacy services while Fencross Advocacy did not. The former's additional services comprised a longstanding citizen advocacy scheme, with up to 12 active volunteers; an advocacy group for people with learning disabilities, based on peer and self-advocacy models; a carers' support group; and a social group for autistic people. Retaining this span of provision, with a firm community grounding, was important to Martborough Voices' assertion of resilient organisational identity amid neo-liberalising structural change (Hardwick, 2018):

> We try to cling on to those roots and we still have citizen advocates. (…) we try to cling on to that I suppose in a world where (…) it feels like maybe it gets diluted (…). (Lisa, M, MV)

This description evokes a sense of valued authenticity within services (Lehman et al., 2019), with 'roots' denoting connectedness to community and continuity with institutional origins.

Martborough Voices' resilient organisational configuration presented opportunities to offer a more flexible advocacy framework, better suited to the complexity of people's lives. This could enable a more seamless shift to community advocacy for a person once their statutory involvement has ceased, via a 'step down' approach to longer-term but less intensive support:

> That volunteer citizen advocate will nip any advocacy issues in the bud before it escalates and gets back out of hand, where we're having to try and find a social worker to reopen [the person's case]. (Catherine, M, MV)

This positions citizen advocacy as having a preventative function, with the citizen advocate supporting their partner outside of social care processes, but able to assist in reactivating these if necessary and approved by their partner. However, Martborough Voices' citizen advocacy offer was limited by its reliance on volunteers, as often affects such schemes (Hardwick, 2018). Martborough Voices was therefore seeking public funding for some of its ‘step down’ work, which links back to core concerns about scarce resources for non-statutory services.

Martborough Voices’ multi-service offer aligned somewhat with ‘Advocacy Plus’, a strategy that Monaghan (NC) was involved in developing through Liverpool-based organisations in the 2000s. He described ‘Advocacy Plus’ being as based on recognition that ‘advocacy ranges from the support and encouragement of a friend up to legal advocacy’ and is part of a ‘social inclusion movement’. It necessitated local arrangements to direct people to the most appropriate form of advocacy for their needs at that time:

> It was basically to say that advocacy covers the whole area of people’s lives and not simply the health and social care area. So that’s really where the difference is in terms of statutory advocacy. Statutory advocacy is just one piece of the jigsaw. It may be a vital piece of the jigsaw to some people; but it’s not the only piece of the jigsaw. (Monaghan)

The person-centred ethos of Advocacy Plus thus correlates with the values-based approach to advocacy discerned by Newbigging et al. (2021), which takes an expansive view of supporting decision-making according to individual needs, rather than rigid process and service boundaries.

9.4.3. Displacing community advocacy

Boundary issues between statutory and community advocacy can arise over questions about which advocates have legitimacy to support people through statutory processes. Stephen (CM, FC) acknowledged it is generally ‘a family member or (…) a professional advocate’ who supports involvement in CA2014 processes. He attributed this partly to practitioner wariness, given many non-statutory advocates ‘don’t fall within that professional advocacy service definition’. Monaghan raised the possibility that a volunteer community advocate could, once statutory processes are activated, be excluded from assisting someone with whom they already have an advocacy relationship. He cited his own experiences:

> You try to advocate, and someone says, ‘you’re not a professional advocate: where’s your certificate, where’s your qualification?’ That is the big danger (…) I’m not knocking the models of advocacy; I’m simply saying that by sort of professionalising and having them defined effectively by the state (…) you are watching the demise of informal involvement of people (…). (Monaghan)

Here risks of professionalising advocacy are cited, as professionalism generally entails monopolising claims over the right to practice in a given field (Evetts, 2003). This presents a consequent threat to the vitality of a volunteerist ethos (Hardwick, 2018). Monaghan’s comments also relate to a wider debate that transcends national boundaries: about how welfare state activity relates to social capital, as manifested in forms of civic engagement such as volunteering (Gundelach et al., 2010).

9.5. Integrating statutory advocacy

9.5.1. Joined-up commissioning?

The nature of the organisational relationship between different statutory advocacy types has implications for effectiveness, role definition and identity. Questions of preserving specialism versus advancing integration can entail status considerations, alongside practical concerns about how to optimally configure working practices. Mercer and Petty reported a general trend towards more joined-up commissioning of statutory advocacy by local authorities. Participants broadly endorsed this approach, which enables more seamless advocacy support as someone’s needs cross between legal remits, with a single advocate ideally remaining involved with the person throughout. Statutory guidance states this rationale for encouraging joined-up commissioning of CAA and IMCA services (DHSC, 2024:7.65). Participants saw this advocate continuity as bringing efficiency gains for services while facilitating more person-centred and relationship-based support:

> There are some real benefits for the person in having an advocate who knows them more holistically as a human being, I think, than just for those kind of episodic interactions that statute brings about. (Petty)

Stephen (CM, FC) similarly cited these advantages when explaining why Fencross Council contracted with a single provider for all statutory advocacy services.

Martborough was a contrasting case in this regard: Martborough Voices provided CAA and IMHA services while Citizens Empowered provided IMCA services. This was explained as arising from legacy commissioning arrangements, following the introduction of statutory advocacy requirements in different legislative instalments (Dixon et al., 2020). Participants from Martborough Voices acknowledged this service structure presented problems; some people became confused over why they had another advocate, when their circumstances had led to a different legal mandate being activated. Lisa (M, MV) criticised the 'rigidity' of arrangements that meant a CAA who was already advocating with a person had to defer to separate IMCA input once the latter's remit was engaged, most often regarding a proposed change of accommodation. Helen (CAA, MV) described how, having built a strong relationship with a person over several episodes as his CAA, she was unable to advocate for him regarding a best interest decision about where he should live after being discharged from hospital. The result is a service-led rather than service-user led approach, with advocacy delivery segmented according to bureaucratic requirements rather than what is needed to promote wellbeing:

> I don't see the benefit for people to have lots of unnecessary people involved. Because advocacy, whatever legislation it fits within, the role of the advocate stays the same. (Lisa, M, MV)

How service configurations can ensure person-centred advocacy is paramount, as discussions about 'Advocacy Plus' have shown. However, the nature of the relationship between CAA, IMCA and IMHA services more narrowly concerns continuity of working across statutory remits, rather than conceptualising an alliance between advocacy forms that reflect significantly different practice models. I discuss more radical conceptions of this type below.

9.5.2. Legalism and status tensions

Organisational boundaries can foster status-based tensions between practitioners of different statutory advocacy disciplines. A manager from Martborough Voices suggested this affects relationships between her organisation's staff and those from Citizens Empowered:

> There's a bit of a hierarchy in advocacy as well, where it is like the IMCA role is that little bit, you know, more important (…). There's a little bit of elitism going on with the old IMCA role [laughs]. (Lisa, M, MV)

While no other participant explicitly raised this issue, others observed distinctions between the character of IMCA and CAA roles, which might engender status differences when these are separately held. Some key differences were mentioned in theme three, regarding a sense that IMCAs have greater potential for mounting legalistic challenge on the person's behalf, including via routes afforded by the DoLS framework. The significance of this perceived difference, regarding statutory advocacy's quasi-legal function, may in turn relate to the privileging of technical knowledge within established notions of professionalism (Rennstam and Ashcraft, 2014). Underscoring these distinctions were references to differences regarding report-writing. IMCAs must present reports to decision-makers, which set out their contacts with the person, enquiries on their behalf, and more (DCA, 2007:185). Participants noted the production of formal reports was not standard CAA practice. They attributed this to CAAs' involvement tending to be wider-ranging and more fluid than that of IMCAs, which is oriented towards informing a specific best interest decision. Bifurcation of roles along organisational lines can thus stymy the development of a cohesive independent advocacy identity and encourage jurisdictional tensions over the 'turf' of legalistic advocacy. This shows how boundary issues can shape role formation (Abbott, 1995).

9.5.3. Integration within organisations: CAA and IMHA

The level of practical integration between statutory advocacy types can also vary according to institutional initiative. At the time of data collection, Fencross Advocacy was reconfiguring its staff teams to create a 'multi-specialist' independent advocate role, involving practice across all statutory remits. While the organisation's advocates already tended to combine CAA and IMCA functions, creation of a fully integrated role was seen to offer further opportunities, including for more synergistic working across CAA and IMHA remits. This aligned with Mercer's observation that, across the advocacy sector, there exists widespread untapped potential in this regard:

> There's very little alignment with IMHA and Care Act [Advocacy], and I think that's a problem. (Mercer)

The relative under-emphasis of CAA–IMHA connectivity is reflected in statutory guidance, which does not explicitly state the benefits of a single advocate performing both CAA and IMHA roles (DHSC, 2024:7.23), as it does for CAA and IMCA (7.65). Moreover, the *Reforming the Mental Health Act* white paper calls for local authority commissioners to issue guidelines clarifying that 'IMHAs are best placed to provide support in cases where there is an overlap with Care Act / MCA advocacy' (DHSC, 2021a:130). This seems indicative of continued emphasis on specialisation of IMHAs, reinforcing current boundary delineations and showing arguments around generalised integration of statutory advocacy are not clear-cut.

Potential for a cohesive approach involving CAA and IMHA roles was, however, evidenced by the accounts of participants from Martborough Voices. The CAAs interviewed from this organisation also undertook IMHA work, and they described positive experiences in this regard. This service alignment might have partly been a compensatory response to the organisational disconnect with IMCA. An individual advocate's joint CAA–IMHA designation allowed them to provide relatively continuous advocacy to some people, spanning periods of community-dwelling and detention under the MHA1983:

> Currently, I'm working with somebody—I'm meant to meet him at his home, he's under the Mental Health Team, for a Care Act assessment. However, he subsequently, due to his presentation, he got detained onto the ward, which I cover. So I went to see him on the ward; so I've been supporting him there. And now he's gone to a short-term placement, so I'll be going this week to see him there and going back to being the Care Act [advocate]. So yeah, it links in really well. (Natalie, CAA, MV)

Co-location of CAA and IMHA services is also valuable for addressing the shortfall in CAA referrals for individuals whose service use primarily concerns their mental health, as discussed in theme one.

Combining statutory advocacy roles can be demanding. In Fencross Advocacy, the transition to an integrated role was gradual, as staff needed training across all remits. Increased needs for workplace support were also expected:

> (...) trying to have one worker who can morph into all those specialisms, I think, will be challenging indeed. (Rosie, CAA, FA).

Integration also posed practical issues concerning diary and workload management, given that, for example, much IMHA work is based on hospital wards while CAA and IMCA practice requires regular community visits.

9.6. Advocacy across service user groups: specialism versus genericism

Various participants noted a tendency for local authorities to commission a single organisation to provide all CAA services, as in the case studies. This partly reflected how the CA2014's independent advocacy requirements are defined functionally and apply across service user groups (Dixon et al., 2020). Martborough Voices demonstrated the organisational impact of this approach, providing a CAA service to all eligible individuals despite having previously focused on community advocacy with people with learning disabilities. Moreover, in both case study sites, individual CAAs worked with people from all service user groups, making their practice mainly 'generic' rather than 'specialist', using Challis et al.'s (2007) terminology. This was tempered by some informal specialisation within both organisations, when circumstances permitted:

> We try to, I suppose, work to people's skill sets and areas that they like working in and that they're comfortable working in, really, and make sure that we allocate accordingly. (Lisa, (M, MV)

There was some ambivalence among participants about the merits of genericism versus specialism, with trade-offs acknowledged. The universalism of advocacy principles and the transferability of interpersonal skills were recognised; yet expertise specific to work with people from particular service user groups was also valued, including knowledge of specialist local services. Overall, discussions emphasised organisational realities, where the small size of CAA teams favoured genericism, even if this required compromise in other areas:

> We don't have enough advocates to have specialisms. I suppose it would be great really, because you do build up that knowledge base, but while we have the amount of advocates that we have, then you have to have a broad knowledge of everything. (Isobel, CAA, FA)

Participants most often mentioned the need for group-specific knowledge when discussing advocacy with people with learning disabilities and autistic people. Petty drew on her experience of evaluating such advocacy, especially for people in restrictive in-patient settings:

> Personally, I've been shocked at some of the lack of knowledge and awareness of how to support someone with a learning disability. As well as seeing some amazing practice (…). (Petty)

Some social worker participants also identified a need for greater expertise among CAAs in working with these service user groups:

> I don't think they've got enough training, especially when it comes to people with learning disabilities. (Dawn, SW, MC)

These contributions relate to broader discussions about the need for more specialised advocacy for people with learning disabilities and autistic people, especially around service users detained in hospitals (Voiceability and Kate Mercer Training, 2020; JCDMHB, 2023). These policy discussions also refer to benefits of introducing central commissioning of specialist advocacy, adding another dimension to contention about the merits of local versus centralised approaches. However, none of the case study participants referred specifically to advocating with people with learning disabilities and autistic people who are long-term inpatients, meaning there was a gap in coverage of this important topic.

While a generic practice orientation was largely viewed as an operational necessity, there was also recognition it could bring micro-level benefits. CAAs would over time accrue expertise in working with different service user groups, and diversity of practice could be personally satisfying:

> I think on the whole everybody quite likes that you've got no idea what the referral is going to be; it's like opening up a Pandora's box, isn't it? (Catherine, M, MV).

There were also opportunities to adapt and transfer advocacy approaches across different service user groups. Staff at Martborough Voices found that techniques familiar from advocacy with people with learning disabilities were sometimes applicable in work with people with dementia or an acquired brain injury. Use of communication aids such as 'talking mats' exemplified this.

9.7. Developing culturally appropriate advocacy

9.7.1. Culturally appropriate CAA services: an emerging concept

Participants widely acknowledged a need for CAA services to become more culturally appropriate and generally responsive to societal diversity. Discussions in this area also drew in concerns about how CAA practice is configured relative to other forms of advocacy. Mercer argued a tendency towards 'issue-based advocacy' might constrain CAAs' attempts to tailor work with people according to their specific social location, as defined via the 'protected characteristics' enshrined in the Equality Act 2010, s.4.:

> I think that because we're getting fixated on issues, we're not always appreciative of those characteristics in that context. (Mercer)

In the case studies, culturally appropriate advocacy was shown to be an emerging concept, with its implications for CAA services yet to be clearly defined. This seemed to reflect policy emphasis on developing culturally appropriate advocacy regarding mental health practice (DHSC, 2021a; JCDMHB, 2023). Nevertheless, participants pointed to efforts to enhance cultural appropriateness via the practices of CAA providers and individual CAAs. Training was seen as important to accruing cultural competence (Kolapo, 2022), preparing staff to work effectively with people from diverse backgrounds. Fencross Advocacy was due to extend such training, following acknowledgement this had been insufficient to date:

> (…) I feel that I haven't had much training that's sort of like culturally specific, so that's very specific to how you deliver advocacy in a culturally appropriate way. (Isobel, CAA, FA)

Access to interpretation and translation services was seen as crucial, with this being arranged via the local authority. Comments indicated this generally worked well, although a CAA from Martborough Voices mentioned sometimes encountering issues with interpreter availability, if the language was less widely spoken locally.

9.7.2. Developing culturally appropriate practice

CAAs reported striving to make their own practice more culturally appropriate. Their discussions highlighted the interrelationship of cultural competence and 'cultural humility', which emphasises how building awareness of diverse cultures is a permanently on-going process that demands reflexive self-awareness. This entails recognising gaps in personal knowledge and aspects of the self that might negatively affect interactions with someone from another cultural background (Greene-Moton and Minkler, 2019). The combination of these cultural imperatives with heavy workloads meant CAAs needed an open and adaptive approach:

> That person's got a learning disability, happens to be from a Polish background—well, how are we going to do that? We'll have to think on our feet. You know, obviously, if we can get support and there's another service out there that does some work, then we can work alongside them as well. (Rosie, CAA, FA)

Here Rosie acknowledged responsibility for ensuring the person receives culturally appropriate support, while raising the possibility of gaining assistance via collaboration with an external partner, if one exists. Her use of 'thinking on your feet' is notable; Schön (1983:54) cites this as a 'common sense' formulation of his concept of 'reflection in action', where a professional practitioner improvises their response to an unfolding situation, flexibly applying their skills and knowledge. This correlates with Morgan's (2017:40) identification of reflexivity as one component of a burgeoning professional identity among independent advocates.

John (CAA, FA) similarly described a responsive approach to cultural learning, where he had undertaken ad hoc 'research' to inform his advocacy with people from different faiths. For example, in preparing to work with a Jewish person, he would ask what branch of Judaism the person identified with and consider how different aspects of custom and religious practice may influence his involvement. John also learnt from retrospective deliberation on his practice, which Schön (1983) terms 'reflection on action'. He recalled observing a care home manager check whether a Muslim man had access to the Qur'an, with his internal response being 'I should have thought of that'. He also resolved to apply this learning within future practice. CAAs also mentioned the importance of attentiveness to cultural factors when undertaking non-instructed advocacy, such as when a person is unable to direct carers over their dietary requirements. Cultural appropriateness is therefore intertwined with person-centred and anti-discriminatory practice approaches (Thompson, 2020).

9.7.3. Workforce diversity

The composition of the CAA workforce has implications for delivering culturally appropriate advocacy. Some benefits of workforce diversity were discussed:

> (…) just because there's a Black person being referred into the service needing support, they don't need to be matched up with a Black worker. But it would be good generally if they know that there's Black workers within the organisation that they're approaching (…). I think it just makes it feel a little bit more (…) comfortable, accessible, familiar. (Rosie, ICAA, FA)

Of the case study participants employed by advocacy organisations, all but one were of White British ethnicity.

Participants perceived that the small size of CAA teams potentially limited their ability to reflect local demographic diversity. There were similarities with discussions about whether scope existed to provide specialist advocacy according to type of service use. In considering the ethnic composition of CAA staff teams, some participants also cautioned against inadvertently projecting a homogenising view of the identities of non-White British people:

> Well, that doesn't mean that, you know, because you've got a member of staff that might be from an African cultural background that then they can go out and deliver culturally appropriate advocacy for somebody that's from a Jamaican background, or an Asian… (…) How far do you have to go before you are being culturally appropriate? (Lisa, M, MV)

This refers to important issues about how specifically targeted culturally appropriate advocacy can be. *Reforming the Mental Health Act* suggests different levels of focus in policy development regarding culturally appropriate mental health advocacy (DHSC, 2021a). It foregrounds discussion of advocacy for people of Black African and Caribbean descent. Beyond this, it identifies a broader need to prioritise establishing culturally appropriate advocacy provision for people from 'black, Asian and minority ethnic backgrounds', with an overarching goal of having advocacy 'that can effectively meet the diverse needs of all service users' also stated (DHSC, 2021a:55). Participants extended this nuanced perspective, mentioning needs for advocacy to account for other aspects of social location, including migration status, social class, sexuality, and gender diversity. Time constraints meant these factors were not further explored in the interviews.

9.8. Partnership approaches to culturally appropriate advocacy

9.8.1. Building alliances with cultural organisations

Given apparent limitations on developing culturally appropriate advocacy within existing CAA service configurations, participants discussed prospects for drawing more on external resources. A social worker participant suggested that personnel from organisations serving particular ethnic and cultural communities could be trained to act as CAAs. However, participants more widely endorsed a partnership model akin to that mentioned in NICE guidelines (NICE, 2022), where established statutory advocacy providers keep overall responsibility for delivering CAA, yet work in closer alliance with community groups:

> I would see that as the most effective way of doing it, because I think you're going to get then some focused interchange of skills, between what are your mainstream advocacy organizations and some developing advocacy organizations within those ethnic minority communities. I think it's better than a scattergun approach. (Stephen, CM, FC)

Some participants compared this collaborative model to that being implemented in the culturally appropriate mental health advocacy pilots that were then underway. Notions of organisational reciprocity suggest CAA providers can impart some technical knowledge about statutory processes to culturally focused organisations. The latter meanwhile bring authenticity to interactions with people from diverse backgrounds: they provide 'a new channel [for] developing a more credible approach', as they are 'rooted in those communities' (Stephen, CM, FC). This promises the benefits of professionalised practice alongside compensation for some of its shortcomings. The use of 'rootedness' as a discursive trope is like that seen in discussions of Martborough Voices' citizen advocacy services, describing advocacy responses growing out of communities rather than reaching into them from outside. The model described also positions the CAA provider as a central hub and culturally oriented community organisations as spokes, as illustrated in figure 3. This shows how connections between the commissioned statutory advocacy provider and local culturally focused organisations can be forged at a strategic level, so these advocacy alliances can then be activated as appropriate in individual circumstances. The figure reflects that, at least in theory, multiple culturally focused or otherwise identity group-oriented organisations might be engaged during work with a single person, reflecting intersectional aspects of social location.

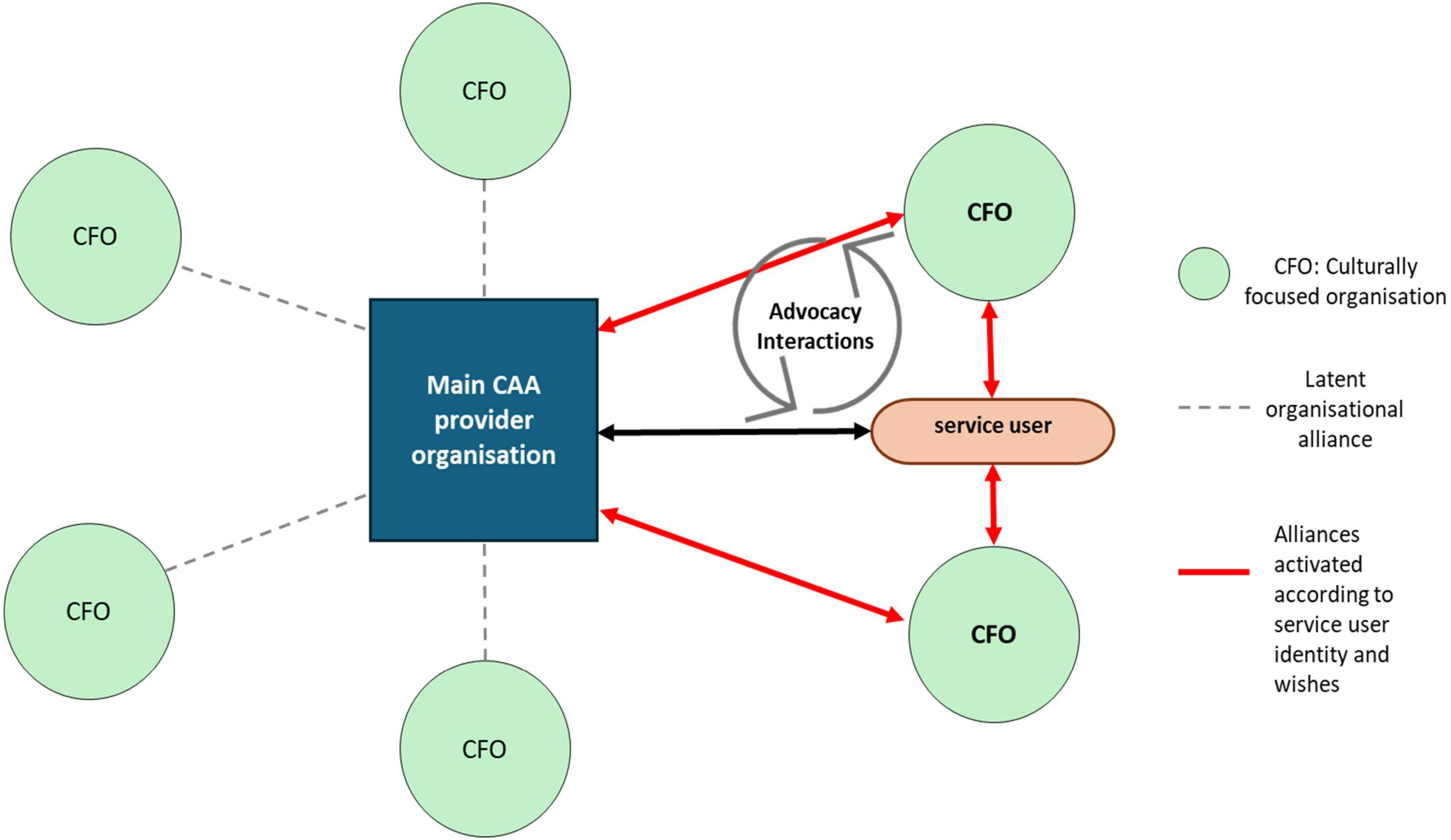


Figure 3 - Hub and spokes model of alliances between commissioned CAA providers and local culturally focused organisations

Some potential challenges for developing a partnership model of culturally appropriate advocacy were identified. As previous discussions of strategic work have highlighted, CAA providers would need funding to support development of organisational ties, as much of their resources are consumed by frontline advocacy delivery. Diminished capacity among smaller voluntary and community sector organisations, due to austerity, was also noted. Barriers to implementing a partnership model might also exist at the micro level. An example of this was perceived risks to confidentiality if the advocate and service user share membership of social networks related to a particular cultural community, especially one with a relatively small local presence. Similar unease in this regard has been reported among some users of interpretation services (Pollock, 2023). Regarding CAA, these concerns were raised by a social worker participant, who described an experience from her practice where a person became wary when allocated an advocate who shared their heritage in a certain African country. The social worker said her own background as a migrant from that country increased her sensitivity to this issue:

> So they [service users] actually respond well with someone from a different background (…). Because they will be thinking this is sensitive information; this is something to do with your family which you want kept within the family and you don't know what that person is going to do with this information outside work. (SW participant)

Confidentiality is a core principle enshrined in the *Advocacy Charter* (NDTi, 2018), although these comments suggest that existing safeguards are not always trusted.

9.8.2. Questions of power

For organisational partnerships regarding culturally appropriate advocacy, the specific form these take is especially important given the power dynamics that statutory processes entail (JCDMHB, 2023). The identity and status of the advocate who takes a primary role in supporting a person through these processes is potentially an important consideration. This was illustrated in a case example provided by Catherine (M, MV), of advocating for a young disabled woman of Asian British ethnicity, who was experiencing unwanted pressure from some family members to have an arranged marriage:

> In the end, I said to [her] mum [who also opposed the marriage]: ‘I’m not sure that I’m the right person to be advocating for you all, because I’m from a very different mindset, and a very different culture. Do you want me to see if I can find a volunteer advocate from your cultural background?’ And she said, ‘why on Earth would I want that, Catherine?’ And I said, ‘well, because I don’t really know what I’m talking about!’ And she said: ‘no (…) I want a white middle-class woman in a suit to go into those meetings, because you’ll be taken notice of, and I won’t.’ (Catherine, M, MV)

Catherine acknowledged this interaction, from a case predating the CA2014, was a ‘sad reflection’ of entrenched racial inequality. It shows how structural racism can create testimonial injustice, as social marginalisation is partly experienced as a sense of being unheard (Della Croce et al., 2021). Catherine demonstrated cultural humility via a socially aware form of listening, akin to that Fricker (2007:171-2) designates as shown by a ‘virtuous hearer’. However, it was the power associated with a professionalised and ‘transactional’ conception of advocacy that the young woman’s mother prioritised for rebalancing the situation in favour of epistemic justice (Ridley et al., 2018). This was grounded in the perception of Catherine occupying a relatively privileged social location based on intersections of race and class. Catherine’s attire was perceived as a marker of professionalism and gravitas, and thus likely to help generate a positive outcome. This differs from previously discussed observations of advocates tending to dress casually, suggesting even this relatively commonplace aspect of CAA identity can have differing meanings ascribed to it.

The above is only a single case example, and not an especially recent one, yet it nevertheless complements findings of Newbigging et al. (2012) regarding IMHA: that at least some people may prioritise their advocate having perceived expertise over sharing cultural identity with them. Any attempt to further embed complementary working between CAAs and culturally focused community organisations would need to be sensitive to power differentials—how these are manifested between different types of advocates and advocacy organisations, and how this relates to potential to achieve the person’s desired outcomes.

9.9. Advocating for advocacy

Some participants discussed impetus for development and reform of CAA services, via initiatives at national and local levels.

9.9.1. National level: sectoral 'voice'

Regarding statutory advocacy, the only form of inter-organisational initiative discussed by participants was the Leaders in Advocacy Network. This was established during the first Covid-19 lockdown, with the aim of promoting dialogue across the sector and with policymakers (NDTi, 2020; AQPM, 2021b). The Network is co-ordinated by NDTi, the organisation for which Petty is the Advocacy Lead. She described the Network as manifesting a level of sectoral collaboration that had been absent for some time, and reported it was beginning to develop influence with the Local Government Association, DHSC and other policy actors. Petty also proposed the Network as a potential forum for addressing the 'ongoing lack of clarity around the role and remit of a Care Act Advocate':

> (…) it's still a relatively young role compared to IMCA for instance, isn't it? But what I don't see is organisations or the sector owning that and leading the development of that role in the same way that we did with IMCA. (Petty)

Petty observed a need for greater involvement of smaller advocacy organisations in the Network, especially as these organisations have less internal capacity for engaging with national policymakers. Efforts to bolster sectoral 'voice' must therefore be inclusive of the broad scope of advocacy providers, so existing power imbalances (Hardwick, 2018) are not inadvertently amplified.

9.9.2. Local level: reconfiguring advocacy services?

In the case study sites, commissioners and CAA providers held discussions about how to develop services and address concerns. In Fencross, consultations were underway with social workers in preparation for the forthcoming recommissioning process. These provided suggestions for reform:

> They [social workers] would like more informal advocacy and they'd like to be able to use the service more flexibly, so that advocacy isn't just part of the assessment process and part of designing the support plan but may also actually be a part of the support plan itself. People may need—particularly someone with learning disabilities—(…) advocacy to help themselves be better understood within their own family or within their own community, or with the agencies that they're having to deal with on a daily basis, so that their health and wellbeing needs are met. (Stephen, CM, FC)

Such reconfiguration of independent advocacy would, in one sense, extend opportunities for supported decision-making across different areas of the person's life (Newbigging et al., 2021). Rather than advocacy input being confined to the point of arranging care and support, it might continue once these services are in place—enhancing its preventative and safeguarding potential (Lawson and Petty, 2020). Stephen (CM, FC) also suggested a peer advocacy option might be built into more flexibly delivered independent advocacy services. Activating relational mechanisms through independent advocacy could also help fill terrain that has been partially vacated by social work practice's more bureaucratic turn, which has increased reliance on commissioned services to ensure people's voices are heard and understood (Hardwick, 2014).

However, Stephen acknowledged any such extension of independent advocacy services would depend on funding decisions. Moreover, any initiative that risked blurring boundaries between independent advocacy and care and support provision would necessitate scrutiny. For example, Stephen mentioned receiving suggestions that independent advocacy might sometimes be funded from a person's personal budget, as a support service to help meet eligible needs under the CA2014. This would raise profound questions about whether independent advocacy could retain a distinct identity and operational separation from both the local authority and care and support services. It would also prompt queries as to whether users of advocacy services functioning in this way might be liable for a financial contribution under the CA2014, s.14, which would breach the principle of advocacy being free at the point of use (NDTi, 2018; see DHSC, 2023:ch.8, especially 8.14).

9.10. Conclusion

In this chapter I have discussed aspects of CAA services related to organisational form and function. I have identified flux, contention and geographical variance throughout, reflecting CAAs' liminal status within an English adult social care system that itself faces acute structural challenges (Pollock et al., 2020; Burn et al., 2024). Resourcing issues have been recurrent through much of the analysis. I have also discussed impetus for reform, where the commissioning cycle provides opportunities for reviewing and reconfiguring services (Burch and Dhillon, 2014). This even affords potential to change providers, although this heightens precarity for advocacy organisations. However, at the core of much discussion of the character and reach of CAA services are concerns about what independent advocacy provision is mandated by law, and about the macro-level resourcing context that local authorities operate within. Since data collection was undertaken, this link between statutory requirement and fulfilment of policy aspirations has been underscored by disappointment among stakeholders that the Draft Mental Health Bill 2022 failed to put culturally appropriate advocacy on a statutory footing (JCDMB, 2023). There are therefore strong indicators that embedding more holistic supported decision-making within adult social care requires legislative change (Dixon et al., 2020).

10. Discussion

10.1. Introduction

In this final chapter, I integrate analyses from all five themes to show how I have addressed my research questions, which are:

1. How have requirements for independent advocacy under the CA2014 been translated into practice?
2. What factors influence CAAs' effectiveness, and how?
3. What is the nature and identity of the occupational role undertaken by CAAs?
4. How do CAA services relate to other types of advocacy?

I begin by focusing on the first two questions, which concern *acting in-between*: how CAAs work as an intermediate force between service users and practitioners, supporting the former's involvement in CA2014 processes and taking their side. I present a summary of key aspects of causation, referencing the CAIMeR model that acknowledges Context, Actors, Interventions, Mechanisms and Results (Blom and Morén, 2010, 2011). In accompanying commentary, I apply liminality as a lens for understanding how CAAs—and practitioners acting as gatekeepers—navigate complex practice scenarios with myriad, overlapping contextual aspects. I then turn to discussing my findings regarding research questions three and four, which concern *being in-between*. Here the liminal nature of the CAA role is reflected in its occupational character and identity construction, as with ambiguous discourse regarding professionalism. I relate this to macro-level contextual forces, including those affecting adult social care more generally. To close the chapter and the thesis, I discuss the study's limitations and present recommendations for policy, practice and future research.

10.2. Acting in-between: a CAIMeR-influenced analysis

10.2.1. Mapping causal factors identified in the analysis

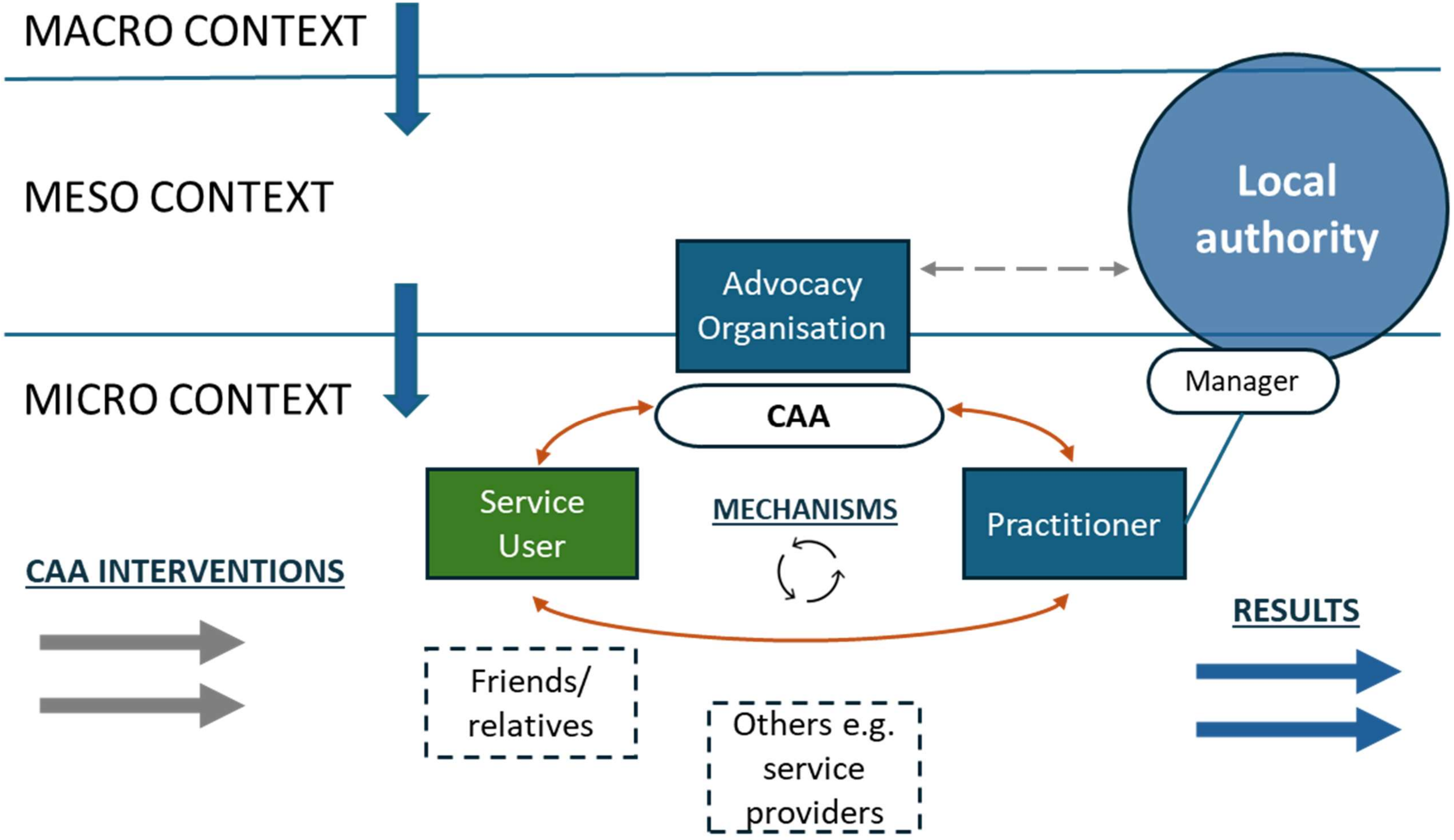
CAAs work to bridge gaps in people's involvement in CA2014 processes (Lonbay and Brandon, 2017). They do so by integrating technical and communicative knowledge practices, in a way analogous to that discerned by Golden and Bencherki (2023) regarding Community Health Workers in the USA—another liminal role that intervenes within complex systems, aiding people's access to wellbeing-enhancing services. CAAs draw on a body of technical knowledge about adult social care, employing this via communicative knowing which involves embodied interactions with service users and practitioners (Rennstam and Ashcraft, 2014). Through communicative knowledge practices, CAAs extend the reach of technical knowledge. They make it accessible to service users and mobilise it for person-centred purposes, such as challenging oppressive outcomes from CA2014 processes (Golden and Bencherki, 2023). My findings support the notion that CAAs' ability to present their role in relatively informal terms to service users—compared to other professional actors—helps reinforce their independence and ability to form interpersonal connections. This has important implications for policy debate about development of the CAA role (DHSC, 2021a), as I address in depth below.

Challenges accompany these opportunities. CAAs must navigate spaces of disconnection, such as between a person-centred advocacy ethos and statute and resource-defined parameters to engagement with people. There can also be a prominent gap between commitment to robust challenge and the availability of strong legal and procedural routes to pursuing this. The borders around CAA, which delineate it from other roles and help shape occupational identity (Heiss et al., 2018), can be fluid and contested.

Realist social theory aids understanding of how CAA works amid this context. In a series of tables presented in appendix O, I map key elements of analysis from my thematic chapters to the CAIMeR framework. This highlights linkages between the various themes and sub-themes of my analysis. In figure 4, I present a diagrammatic overview, which shows CAAs' location within practice micro-systems with many moving parts: they are in-between the service user and practitioner, while others may also be involved, such as friends or relatives

Figure 4 - CAA support for a person within a micro-system of practice: CAIMeR-influenced analysis

Based on CAIMeR theory for realist analysis of social work practice (Blom and Morén, 2010, 2011)



and service providers. My analysis focuses on CAAs as principal intervention actors in these systems. The exception is regarding access, where the practitioner has this designation, as the CAA is yet to become involved. Following Blom and Morén's (2010, 2011) theoretical framing, this micro-system is nested within meso (institutional) and macro (societal, economic, political, and legal system) contexts. Moreover, some mechanisms, such as interactions between CAAs and practitioners, form part of the micro-context of CAA interventions. Given the overwhelming complexity of causation in each real-life situation (Porpora, 2015), my tabulation of factors in appendix O is general in nature. It is not exhaustive of all relevant factors, and nor will all factors listed apply in each situation.

My findings have shown the importance of reflexivity within CAA practice, aligning with CAIMeR theory's attentiveness to agential action (Blom and Morén, 2010, 2011). This builds upon Morgan's (2017) discussion of IMCAs' exercise of reflexivity. CAAs' liminal position can be related to 'normative intersectionality', where actors are subject to competing normative pulls, which they negotiate according to individual disposition and conscious reflexivity (Elder-Vass, 2010, 2012; Nichol et al., 2021). CAAs must therefore formulate a response to sometimes clashing normative expectations regarding their role. This occurs within the meso context of agency expectations, as well as inside macro-structural parameters, such as regarding legal infrastructure and politically determined resourcing allocations (Elder-Vass, 2010, 2012).

Each practice scenario involves different configurations of causal powers, while interactions are dynamic and feed back into each other via 'dialectical interplay' (Morén and Blom, 2003:55). For example, the CAA responds to the practitioner's interventions with the person, seeking to influence their conduct. This can be according to the person's direct instruction or via working representationally, whereby the CAA must also engage in an interpretative way of working with the person. The interaction of causal powers gives practice micro-systems an emergent quality: they are more than the sum of their parts (Elder-Vass, 2010). Within realist evaluations, designating something as 'context', 'mechanism' or 'outcome' depends on the frame of analysis: what is a mechanism from one perspective can viewed as context or an outcome from other vantage points (Pawson, 2013). This can be seen from a comparison of my CAIMeR-influenced analysis with that of Lonbay (2015) regarding older people's involvement in safeguarding practice. Lonbay identifies social workers' attitudes to involvement as a key mechanism, whereas I designate this as part of the context that CAAs work within. Access considerations further illustrate how an outcome—referral for a CAA service—forms part of the context by which another actor—a CAA—initiates their own intervention. A final example is that if an outcome of CAA involvement is a person feeling more confident self-advocating, this forms part of the context of the practitioner's ongoing intervention.

10.2.2. Limitations of applying CAIMeR in my analysis

My use of CAIMeR theory (Blom and Morén, 2010, 2011) was ultimately as a 'loose framework' for analysing and synthesising findings, akin to that of Viitasalo et al. (2024:507) in their systematic review about promoting financial capability in child and family social work. At this doctoral project's outset, I aspired to discern specific CAIMeR configurations within CAA practice, i.e., how an Actor's Interventions lead to their interactions with other Actors, conducted within micro, meso and macro-Contexts; these activate Mechanisms, which engender particular Results. However, in the course of the research this became a more exploratory mapping exercise, where findings from the thematic analysis were assigned to headings of the CAIMeR heuristic in a general way, and patterns of causation were not necessarily discerned. The array of components categorised according to their CAIMeR designation in Appendix O can therefore be thought of as building blocks that might be assembled into a multiplicity of causal configurations, potentially of significant complexity. Many of these configurations exist as latent possibilities until a particular set of actions and circumstances align. Yet, despite its considerable length, the list in Appendix O has been constructed from only significant findings of this exploratory study. The actual arrangement of causal factors in any real-world situation comprises a level of complexity beyond human comprehension, and any attempt to exercise judgemental rationalism regarding what is ontologically true about the world requires simplification (Porpora, 2015). The research ultimately afforded limited opportunities to trace these causal dynamics through accounts about actual CAA practice with service users, due to the generalised way in which CAA work was discussed in much of the interview data. This is one reason why the recommendations for future research, presented in section 10.12, note the promise of ethnographic and individual case study enquiry, so we might better observe sequences of causal factors playing out in the specifics of advocacy interactions.

To illustrate, a simplistic set of CAIMeR configurations regarding a case might be as follows. A situation where a service user is being discharged from hospital **(micro-context)** also has a particular organisational **(meso)** and political **(macro) context**, including acute pressure on hospital staff to prevent 'delayed transfers of care', as under-funded services are overstretched (Gridley et al., 2022). The CAA **(intervention actor)** interacts with other **key actors**: the service user, their family members, and health and social care practitioners. An example of **micro-contextual mechanisms** is the existence (or otherwise) of partnership working between the CAA and practitioners. Critical **actor characteristics** might include: the nature and extent of the service user's impairment, including their ability to instruct their CAA; the CAA's relational and communication skills and their procedural knowledge; and the attitudes of family members towards advocacy input and their own inter-familial dynamics (which comprise a set of mechanisms in their own right). The CAA's **intervention** would involve spending time with the service user, getting to know them and what is important to them, aided by input from family members. It would also involve interacting with practitioners, so that information can be fed into the conduct of CA2014 processes for arranging post-discharge care and support, while the CAA also monitors these processes. Through this conjunction of structure and the actions of agential actors, particular **mechanisms** are fired, including interpretation of the service user's unique personhood in line with notions of 'authentic autonomy' (Leece and Peace, 2009), and non-instructed and representational advocacy mechanisms. The ensuing **results** may be most apparent when the person obtains care and support that meets their needs and is as person-centred as possible, while ensuring their rights (such as a 'least restrictive' approach to meeting needs) and dignity are upheld, and their wellbeing is promoted.

Another difficulty in being able to show more concretely the alignment of causal processes regarding CAA practice was the fact that, given the transactional nature of care and support processes under the CA2014, it is local authority practitioners that are positioned as primary intervention actors. This makes it harder to identify CAA support acting as an independent variable in care and support decision-making, from which specific results arise. In contrast, an example of CAIMeR being fruitfully employed in an evaluation study of direct practitioner interventions is a study by van Genk et al. (2024) of an intensive outreach support service for people living in a Dutch community with severe mental illness. Causal configurations are mapped using CAIMeR, via an analysis confined to issues within the purview of the support service, with most key interactions being dyadic between the support worker and service user. This differs from the (at least) tripartite interactions that CAAs participate in, comprising the service user and practitioner also.

It is hoped that future work about CAA will be able to build upon this tentative elucidation of a CAIMeR framework, progressing towards fulfilling the model's potential to be 'comprehensive and schematically sophisticated' (Houston and Montgomery, 2018:59).

10.3. Acting in-between: commentary

10.3.1. Access

Practitioners' deliberations about access involve various causal factors. Among these are: the macro and meso structures of law, policy, and institutional requirements; the effects of a person's impairment and the character of their social environment; and the potentially instrumental exercise of agential action by people and their friends or relatives. Similar contingencies then have a bearing on any ensuing CAA involvement.

Practitioners must apply technical knowledge about the eligibility criteria for CAA support, doing so interactionally via communicative knowledge practices (Rennstam and Lee Ashcraft, 2014). My findings complement existing literature by showing that shortfalls in some practitioners' awareness of statutory advocacy requirements remains problematic, and that some practitioners may seek to avoid a source of potential challenge or perceived obstruction to their work (Lonbay and Brandon, 2017; Lawson and Petty, 2020; Dixon et al., 2020). There is also alignment with previous research findings that under-utilisation of independent advocacy may partly arise from practitioners tending to see familial advocacy as a default (Lonbay and Brandon, 2017; Southall et al., 2021). This is despite limitations on the suitability and effectiveness of such familial advocacy in some cases (Dixon et al., 2020). People may also express a preference for the familiar support of friends or relatives over accepting external assistance. As such, I have highlighted potential difficulties in applying the eligibility criteria for CAA, as stipulated in law and statutory guidance, to some practice contexts. That statutory guidance (DHSC, 2024:ch.7) does not directly address some possibly significant capacity and consent issues regarding CAA access highlights how practitioners may have to make judgements amid significant ambiguity.

Local commissioning permits significant variation between institutional contexts. Practitioner-only referral systems in the case study sites were reflective of CAA provision being configured there as a discrete statutory service. That national contributors also mainly spoke of CAA services in these terms suggests a tendency towards law-based commissioning of CAA—identified by Newbigging et al. (2021) during its early phases of implementation—has since become more entrenched.

10.3.2. Gap-bridging to facilitate involvement

My findings show the potential for CAAs to fulfil an effective bridging function between service users and practitioners, providing a transactional form of advocacy that improves the working of statutory processes (Ridley et al., 2018). CAAs can therefore enable supported decision-making within the context of these processes, making them more person-centred (Dixon et al., 2020; Newbigging et al., 2021). Such gap-bridging is analogous to that undertaken in other advocacy roles (Newbigging et al., 2015; Lonbay and Brandon, 2017; Diaz et al., 2023). CAAs act variously as an aid and a corrective to professional practice. This can be crucial given that social workers themselves operate within liminal spaces, navigating between often competing pressures, such as between institutional drivers and professional principles (Southall et al., 2021; Slasberg, 2019). CAA practice can be facilitative: easing communicative flows, influencing the pacing of processes, and more. Through gap-bridging, CAAs help counter testimonial injustice, breaking down barriers to the service user's 'voice' being heard by practitioners (Fricker, 2007; Newbigging and Ridley, 2018; DHSC, 2024:7.44).

My findings therefore add to the evidence base showing that advocacy can work. Yet they also underscore the difficulty of developing evaluation systems for advocacy, given CAAs' place within complex systems of practice (Rapaport et al., 2005; Hussein et al., 2006; Lawson and Petty, 2020). Disentangling the 'process benefits' and 'outcome benefits' (Townsley et al., 2009) of CAA inputs is especially difficult, as much of what arises from these is relayed back into the local authority, which determines care and support allocations. Evaluations must therefore engage service users' perspectives (Ridley et al., 2018). My literature review has indicated this study is novel as a scholarly work, in its exploration of some service users' direct experiences of CAA input. This has enabled some process-based benefits of CAA practice to be captured, such as the increased confidence to self-advocate that Sophie, a service user participant reported.

In calibrating their input with each service user, CAAs must choose between a predominantly instructed or non-instructed approach. My findings complement previous scholarship showing potential incongruence between non-instructed work and notions of advocacy as a directly person-led process, and how to understand and implement non-instructed advocacy therefore remains under development (Series, 2013; Newbigging and Ridley, 2015). Linked to this, CAAs must ensure support with decision-making is responsive to the nature and effects of the person's impairment (Dixon et al., 2020). Such onus aligns with critical realist approaches within disability studies, which critique overly simplistic reductions to medical versus social models, instead viewing the causes of disability as multifactorial. This allows nuanced understanding of the interaction of individual characteristics and disabling social structures, which themselves have material and cultural aspects (Bhaskar and Danermark, 2006; Shakespeare, 2014; Bigby, 2019).

10.3.3. Partnership mechanisms: with practitioners and friends or relatives

My findings complement existing scholarship that highlights the need for partnership working between advocates and practitioners (Sherwood-Johnson, 2016; Lonbay and Brandon, 2017). Yet CAAs must exercise reflexivity regarding these interactions, as while partnership mechanisms generally bring positive outcomes, there is a risk of them 'backfiring'. This happens if pursuit of partnership is perceived to stop other mechanisms functioning properly—specifically relational mechanisms, if trust in the CAA's independence is eroded; self-advocacy mechanisms, if the person is excluded from professional decision-making forums; or challenge mechanisms, if overly 'soft' forms of negotiation predominate (see Lens, 2004).

Contact with friends or relatives, where this exists, is another contingent aspect of CAA practice, potentially adding another layer of complexity to relational interactions. Friends or relatives' input can positively inform CAA practice, and there can be synergy between CAA input and the informal advocacy of friends or relatives. However, sometimes the involvement of members of the person's informal social network is more problematic, as when they contest a CAA's legitimacy to act as the person's representative. This engagement between formal advocates and the person's friends and relatives has received little close attention in scholarship to date. It is also a key connecting thread between issues affecting access to CAAs and the practice complexities the CAA may encounter, if one becomes involved.

10.3.4. Conducting challenges

When CAAs conduct challenges, legalist, procedural and negotiatory mechanisms may be activated to varying degrees. Tension and ambiguity in how their role is constructed, combined with macro and meso structures shaping opportunities for making challenges, can push CAAs towards pursuing more informal ways to resolve concerns. Overall, my findings suggest similarities with the dynamic described by Cornes et al. (2018): of advocates seeking to act robustly on the person's behalf, while drawing on partnership resources wherever possible and remaining wary of possible unintended consequences from pursuing formal challenges. My findings also complement those of Series (2013), regarding how individual IMCAs can exercise significant discretion in their responses to professional decision-making. However, for CAAs, such discretion may be more limited, as CAA participants described being guided by the person's wishes wherever possible. The distinction between instructed and non-instructed advocacy is again significant.

The 'outcome benefits' of CAA involvement (Townsley et al., 2009) were most clearly evident in respect of challenges. Participants cited occasions when they felt a CAA's interventions had been instrumental in achieving more favourable results regarding a person's care and support plan. This is notable given the distinction that Newbigging et al. (2021) draw between law-based and value-based approaches to commissioning advocacy, as CAAs' use of the law emerges as a key means of practising in alignment with advocacy values. This was encapsulated in a participant's reference to CAAs 'upholding people's rights in quite a technical way' (Amy, TL, FA).

10.3.5. Reflexivity: responding to structural constraints

CAAs can find themselves negotiating spaces in-between their role boundaries and the complex reality of people's lives. Needs for supported decision-making often transcend the parameters of CA2014 processes (Dixon et al., 2020; Newbigging et al., 2021). As such, participants referred to some people having unmet advocacy needs in life domains such as managing close personal relationships. In response, CAAs undertook reflexive deliberation over whether to extend involvement with a person beyond support with CA2014 processes. Elder-Vass (2010, 2012) conceptualises reflexivity as exercised by individuals who have a pre-existing disposition, shaped by personal biography. For CAAs this includes their past experiences of working in the advocacy sector. Reflexivity also means responding to the normative pulls of institutional context, itself a site of tensions: as in an organisational history of citizen advocacy being set against contemporary status as a statutory advocacy provider. Moreover, some micro-contextual factors such as safeguarding protocols produce imperatives regarding workload prioritisation. One way in which CAAs may respond to these remit-based tensions is by referring or signposting the person to other forms of advocacy and support—but this depends on such services being available.

10.3.6. Macro context

Evidence of constraints on CAAs conducting longer-term advocacy supports contention that its preventative safeguarding (Lawson and Petty, 2020) and supported decision-making (Dixon et al., 2020) potential is diminished. My findings complement other evidence of promising innovations of the CA2014 being undermined by their implementation amid austerity (Whittington, 2016). This includes studies of the wider preventative agenda (Tew et al., 2019); support for informal carers (Fernández et al., 2020); and market-shaping and personalisation (Needham et al, 2020). Burn et al. (2024:58) note ongoing uncertainty over how key principles of the CA2014, such as commitment to advance wellbeing, will be met given immense structural pressures on adult social care. The absence of an equitable and durable funding settlement is key (Burn et al., 2024; Bottery, 2020; Pollock et al., 2020). Some problems affecting CAA services are a sub-set of those undermining the wider potential of the CA2014's reforms, as when access to CAAs is inhibited by intense workloads for practitioners and high turnover levels among them (Burn et al., 2024). Resource constraints have also curbed local authorities' scope to be flexible and innovative in meeting their statutory obligations (Burn et al., 2024). The participating manager from Fencross Council acknowledged this had bearing on how CAA had been commissioned in his area. Comments by a CAA manager further reflected a sense of disappointment at lost opportunities from putting independent advocacy on a statutory footing:

> The times that we used to say: 'if only this could be upheld by legislation.' And now that it is, it's not necessarily the best outcome, because it is so under-resourced. It's all about the resources, isn't it? (Lisa, M, MV)

This aligns with critique of an overarching neo-liberal policy orientation shaping adult social care. Failings regarding embedding person-centredness and meeting needs are emblematic of wider social welfare retrenchment, increased onus on personal responsibility, and the undermining of collective and community-oriented provision (Hardwick, 2018; Butler-Warke et al., 2020; Simmonds, 2021).

I now provide further commentary on the liminal nature and identity of the CAA role, again relating this to macro-structural context. Some of the causal mechanisms I discuss are ideational, including the influence of an orthodox ideology about professionalism and its potential to conflict with an advocacy ethos. I also consider CAA as a response to managerialism's effects on social work practice, as a manifestation of systemic pressures under neo-liberalism (Butler-Warke et al., 2020). Working in a quasi-legal capacity is an important part of CAAs' emerging occupational identity. Yet there are structural constraints upon legalism within CAA practice, related to limitations of how rights are framed under the CA2014 (Collingbourne, 2014; Dixon et al., 2020).

10.4. Culturally appropriate advocacy

10.4.1. Implementation of culturally appropriate advocacy in the case studies

In the case studies, the process of translating the concept of culturally appropriate advocacy into CAA practice remained at relatively formative stages. This partly reflected how mental health advocacy was the main locus of policy development in this area (DHSC, 2021a; JCDMHB, 2023). The research highlighted the importance of CAAs exhibiting reflexivity around cultural competence and cultural humility (Greene-Moton and Minkler, 2019). The need for an intersectional perspective was also strongly indicated, with participants acknowledging that any attempts to organise advocacy around markers of collective identity must account for nuances of individual social location (Hankivsky and Jordan-Zachery, 2014).

Discussions of culturally appropriate advocacy also highlighted possible contingencies around people's responses to sharing aspects of identity with their advocates, building on previous observation of these dynamics (Newbigging et al., 2015; EHRC, 2010). There was broad recognition of the value of aspects of identity-sharing between CAA and service user, or of the CAA being able to draw upon culturally-specific forms of external support—such as the Polish community group cited by one participant. However, it was also noted that some people might have confidentiality concerns if they view their advocate as too socially proximate to them. This observation contrasts with Newbigging and Ridley (2018)'s analysis of IMHA, which found that some racially minoritised people prefer peer support to formal advocacy services, partly because they view their peers as more likely to protect their confidential information. This indicates these issues need exploring further, with strong awareness of limits to the transferability of learning between different advocacy forms and contexts.

Meso-context helps define the space for culturally appropriate advocacy practice. For example, the case studies bear out the recognition in NICE guidelines that the scale of advocacy organisations can affect their ability to offer choices to people about their advocate's identity, as some smaller organisations will have few personnel (NICE, 2022).

The dominant approach to developing culturally appropriate advocacy in the case studies, such as could be discerned, involved expanding cultural competence (Kolapo, 2022) within mainstream advocacy services. This was augmented by formative alliance-building with culturally-focused organisations and expressed wishes to extend and formalise these ties via the hub-and-spokes model sketched in figure 3, with the commissioned statutory advocacy provider remaining at the centre. Such a twin-track approach to developing cultural appropriateness—via internal reform and external partnership—has been alluded to in guidelines from NICE (2022). Alliance-building with culturally specific organisations, which can forge connections with service users predicated on shared identity, has long been promoted for the advocacy sector (e.g. Rai-Atkins et al., 2002). However, my findings highlight organisational capacity as a potential barrier to realising this potential, as funding models may leave advocacy providers unable to devote necessary resources to such strategic initiatives. This could combine with potential lack of clarity about division of tasks and balance of power between different organisations becoming involved in statutory advocacy provision.

My findings support the argument of Salla et al. (2023) that cultural appropriateness partly involves extending advocates' relevant skills and knowledge base, while retaining humility about limits to attaining full cultural competence. There was evidence of CAAs' commitment to accruing knowledge of individual service users and their cultures, helping address shortfalls in professional and service practice by providing insight into cultural needs and desired outcomes (Salla et al., 2023). An important example is a CAA reporting attentiveness to ensuring appropriate dietary provision for a service user within an institutional setting, reflecting the profound cultural significance of food. Possession of cultural knowledge, or ability to acquire this on a more ad hoc basis, is especially important when undertaking non-instructed advocacy, as the person cannot directly convey how their cultural needs should be met.

The analysis becomes more challenging if we follow the critique of Salla et al. (2023:3) that culture, although a key consideration, can become conceptually overloaded and we must look to how advocates challenge racism. My findings yielded little overt evidence of manifestly anti-racist advocacy practice, although this likely reflected limitations in data collection, rather than absence of such practice or need for it. It is also necessary to consider structural racism, i.e. how society is ordered to favour sustaining and compounding economic, social and political disadvantages based upon racialised status, which are systemically embedded rather than solely the product of racist acts by individual institutions or persons (Porter, 1993; Miller, 2021). This reflects the emergent nature of social structures (Elder-Vass, 2010). Critical realism's ontological depth makes it a suitable metatheoretical basis for studying structural racism (Porter, 1993). In this context, CAAs' abilities to address power differentials related to racial bias are key. This alerts to contemporary deliberation about developing culturally appropriate advocacy in the context of reforms to the MHA1983, regarding where the balance should lie between professional and peer-based approaches, given the power invested in statutory processes that can hugely affect a person's life (Joint Committee on the Draft Mental Health Bill, 2023). The stakes attached to such transactional advocacy practice were apparent in the case that Catherine (M, MV) recounted regarding advocating with a young British Asian woman experiencing intra-familial tension relating to arranged marriage practices; supportive relatives looked to professionalised advocacy as being efficacious in helping make the woman’s case in interactions with professional practitioners, in a way they themselves felt excluded from due to their intersectional class and ethnic identity.

10.4.2. Elaborating cultural appropriateness in the specific context of CAA practice

My findings suggest a need for theoretical development concerning culturally appropriate advocacy, reflecting its place within the wider advocacy policy agenda (NICE, 2022), beyond its specific application within the mental health field. Salla et al. (2023) provide valuable conceptual elaboration of culturally appropriate advocacy with a focus on IMHA, and much in this is potentially transferable to CAA practice. But there should also be recognition of where nuanced adaptation may be necessary. Discussion of Government policy regarding culturally appropriate mental health advocacy is framed around responding to evidence of racial inequity in mental health care, especially profound ethnic disparities in rates of detention under the MHA1983, affecting Black people most starkly (DHSC, 2021a). Further empirical work is needed to elucidate how structural racism operates in the context of adult social care arranged under the CA2014 and how differing advocacy needs consequently arise. Such a research agenda has some pedigree regarding mental health, as shown by a 2002 report about needs for advocacy services among Black and minority ethnic users of mental health services in Trent and Yorkshire areas. This concluded:

> Mental health advocacy best meets the needs of black service users and their carers if it acknowledges their specific experiences of disadvantage, often resulting from very different causes than for white users. (Rai-Atkins et al., 2002:4)

Some of this evidence base regarding needs for culturally appropriate adult social care advocacy is accruing, albeit with emphasis on healthcare services accessed by people with care and support needs under the CA2014, rather than social care services specifically. Ahmed et al. (2024) review evidence that Black and minoritised people are generally under-represented in use of dementia services, or they tend to access these with comparative delay. These authors discern multiple potential causal factors, including professional stereotyping regarding familial caring practices; experiences of racism within services; and a lack of culturally appropriate provision. Quantitative work by Frost et al. (2024) highlights a significant absence of targeted dementia health services for minoritised people, although again there is a need to look beyond healthcare to consider social care provision specifically. Stereotypes about family caring practices do coexist with increased likelihood of people from minoritised communities looking to non-state provided support, via family and community networks, including those centred on religious institutions (Njoki, 2022). Moreover, understandings of dementia, and the language with which this is expressed, differs between cultural communities, with implications such as for the presence of stigma (Njoki, 2022). This aligns with Salla et al.'s (2023) reminder that it is important not to take a homogenising view of racialised identity or see this as fixed. A systematic review of the healthcare experiences of people with learning disabilities from minoritised backgrounds has also noted barriers regarding a lack of cultural responsiveness within services (Roberts et al., 2024).

Evidence therefore exists indicating need for cause and case advocacy regarding culturally appropriate adult social care: the former directed at policymakers and commissioners to redress service gaps; the latter bridging such gaps on an individual basis, so services and professional practice can recognise and meet the person's cultural needs, including by engaging specialised support if necessary. The *Care and support statutory guidance* (DHSC, 2024) lays down some basic directions regarding cultural appropriateness, which cause and case advocates might point to in furthering their objectives. Guidance compels local authority commissioners to consider the suitability of services for people from different communities and cultures, with shared aspects of lived experience between service provider and user fostering 'cultural sensitivity' (DHSC, 2024: 4.38). For their part, practitioners must consider how 'a person's cultural and spiritual networks can support them in meeting needs and building strengths, and explore this with the person' (6.64). Yet the statutory guidance makes few other references to culture. While the loose framework definition of wellbeing it offers does not specifically mention culture, it is nevertheless broad enough to accommodate notions of cultural fulfilment and connectedness. This underscores the need for conceptual development regarding cultural appropriateness that is specific to CAA practice.

CAA services might need to account for additional factors when considering translation of good practice in culturally appropriate mental health advocacy. A culturally appropriate mental health advocacy pilot, commissioned by the DHSC, included groupwork in inpatient and community settings, and was restricted to people currently or previously detained under the MHA1983 (Gaddum, no date). The hospital environment provides a well-defined physical context for groupwork that may be facilitative of collective advocacy mechanisms, while also presenting potential issues. There is resonance here with Palmer et al.'s (2012) observation of how proximity between IMHAs and service users on a forensic ward promoted advocacy engagement. Culturally centred groupwork in a community setting would necessitate heightened attentiveness to access issues, especially where individuals' physical and cognitive impairments might inhibit participation without necessary support.

The lacunae in developing culturally appropriate advocacy regarding CAA, relative to regarding IMHA, also has a theoretical dimension. This concerns ideas about countering hermeneutical injustice (Fricker, 2007) regarding experiences of physical and mental disability for minoritised people. This is additional to cognisance of the racialised ways in which mental distress is conceptualised and interpreted, such as framing risk from the cultural and theoretical vantage points of the 'psy' disciplines (Fernando, 2017). Frederick and Shifrer (2019:201) contend that, regarding sociology generally, 'the discipline has not offered much in the way of expansive intersectional analyses of race and disability beyond social determinants of health (Frederick and Shifrer, 2019:201). One area of push-back is arguments for decolonising disability studies, challenging the hegemony of Global North understandings of impairment and societal responses (Meekosha, 2011).

This thesis has favoured comparative analysis of CAA and social work, identifying where the roles overlap as well as being in tension. The argument that culturally appropriate advocacy should be explicitly formulated to counter racism (Salla et al., 2023) suggests potential synergies with impetus towards anti-racist social work (Reid, 2020). Anka's (2024) research about efforts to decolonise the social work curriculum at an English university cites epistemic injustice and cultural humility as being foundational for moves to ‘embrace other ways of knowing, being and doing that reflect diverse communities’ (Anka, 2020:2891). This includes understanding of how historical colonialist practices have undergirded racism in the UK while causing deep and lasting harms for the lands that were colonised. Moving to practice implications, Pollock’s (2021) work that questions established procedures favouring use of professional translators over family ones for people with limited English proficiency aligns with the approach mentioned above of mobilising the CA2014’s principles—in this case relating to choice and self-determination—to challenge practices that may be culturally exclusionary. There are commonalities with Njoki’s (2022) recommendations for relaxing Direct Payments regulations to enable family members to be employed as Personal Assistants for people with dementia from minoritised communities, given such groups experiencing heightened barriers to utilising this support. Both these examples suggest scenarios where CAAs might partner with social workers and carers in advocating for cultural appropriateness regarding care and support processes and their outcomes, although given both are predicated on the involvement of family members there is also a need to look to circumstances where this may not be the case.

10.5. Being in-between: role status and identity

10.5.1. Boundaries with other advocacy roles

An occupational role is partly defined by the boundaries that separate it from adjacent ones (Abbott, 1995). As the CAA role is liminal, some of its boundaries are unclear and contested. In the case studies, CAA functions seemed generally more joined-up with other types of statutory advocacy than with forms of non-statutory, community advocacy. Nevertheless, commissioning arrangements and intra-organisational factors can hamper the integration of CAA functions into a unified statutory independent advocate role. The borders between statutory advocacy disciplines can be sites of tension over jurisdictional claims to practice, such as regarding who is best placed to provide support for a best interest decision about a change of accommodation. Questions about status and prestige can arise from differential claims to expertise (Heiss et al., 2018), as reportedly manifested in CAA–IMCA relationships in Martborough. This was reinforced by comments suggesting the IMCA role is imbued with greater legalist potential, given its report-writing can be a means of scrutinising professional decision-making (Dixon et al., 2020) and its explicit powers of initiating challenges to social care detention (Series, 2022).

As Fencross Council's commissioning manager explained, CAA services might evolve via enhanced partnerships with other sources of advocacy. Forging improved links with community resources, such as peer advocacy, is a key proposal regarding embedding cultural appropriateness. Here local discussions reflected debates around policy development on a national basis (JCDMHB, 2023; NICE, 2022). There were also suggestions of CAA provision forming part of a suite of options that allow for more holistic and longer-term advocacy engagement. Such proposals, if implemented, might lead to greater emphasis on support that seeks more transformational outcomes, including via collective empowerment mechanisms (Ridley et al., 2018; Newbigging and Ridley, 2018). Commissioners would need sound understanding of local communities and resources within these, and the case for contracting with smaller, locally focused advocacy providers might be strengthened.

However, challenges exist alongside the opportunities suggested by these proposals. There are questions about how inter-advocacy alliances would be nurtured. These concern practicalities, such as funding requirements, alongside fundamental questions about power relationships, as with the pressures that grassroots organisations are exposed to when brought within formal service structures (Hardwick, 2018). Writing of self-advocacy groups for people with learning disabilities, Goodley (2005:342) has previously advised caution about policy 'foraging in the self-advocacy movement'.

My findings suggest that attempts to bring different forms of advocacy together must ensure confidentiality safeguards and clarify different advocates' expected contributions, lest there be further blurring of the CAA role's boundaries. Moreover, increasing the number of advocates working with a person risks confusion or even their wariness, with knowledge and relationship-building potentially disrupted by handovers between advocates. Policy development must also be attentive to power differentials between advocacy organisations, recognising where the status of statutory advocates accords them greater capacity to influence professional actors (Hardwick, 2018). This imposes a potential limit on the effectiveness of culturally appropriate advocacy that is reliant on peer support, as so many of the outcomes that matter to people lie within the purview of professional decision-making (JCDMHB, 2023).

10.5.2. Professionalism and CAA

My findings highlight how identity construction among CAAs reflects longstanding tensions over professionalising advocacy (Henderson and Pochin, 2001; Morgan, 2017). Yet there is also evidence that CAAs' thinking about their role can evolve, suggestive of how an ideology of professionalism can be a mechanism of occupational change (Evetts, 2003). For CAAs making claims to professional status, this is based on their expertise regarding the legal and procedural basis of adult social care, which they must transpose into practice in value-led ways. This process broadly equates to 'legal literacy' (Preston-Shoot and McKimm, 2012) and is akin to what Series (2022) theorises as 'care professional legalism' regarding social care detention. CAA practice exists partly outside the legal framework of social care detention, as shown by disparities in routes to legal challenge. Yet CAAs do provide a counterweight to professional power, using their legal knowledge to assert rights. Ashton et al. (2022) highlight the role's legalist potential by suggesting that trainee solicitors undertake placements with advocacy organisations, thus strengthening the practice of community care law. That some student social workers currently benefit from placements in these settings shows independent advocacy is a site where different professional knowledge bases and fields of practice intersect.

However, there are limits to the applicability of professionalism to CAA work, at least as the concept is traditionally conceived. Professional status implies claims to monopolisation of relevant expertise within a given field of practice (Evetts, 2003; Heiss et al., 2018). Yet CAA input is only required in the absence of what is deemed suitable support from friends or relatives, profoundly affecting access (Dixon et al., 2020). This implies CAA exists in a state of ‘substitutability’, which Beech (2011:288) describes as characteristic of liminality. My findings demonstrate boundary issues regarding CAAs’ relationship with social worker and other practitioner roles. There is some convergence between CAA and social worker roles, regarding detailed knowledge of care and support processes and responsibilities to facilitate people’s involvement (DHSC, 2024; Symonds et al., 2018, 2020; Sherwood-Johnson, 2016). CAAs’ responsibilities to challenge add potential friction to this overlap and can provoke backlash from practitioners, who may perceive encroachment on their professional turf.

The idea of an occupational group accruing benefits from professionalising (Evetts, 2003), including enjoying elevated status (Heiss et al., 2018), fits uneasily with an advocacy ethos dedicated to advancing the person’s perspectives and interests. There are echoes of debates about the professionalisation of social work. This was also once widely contested, especially during the 1970s when radical social workers deemed the notion elitist and motivated by gaining greater power and prestige (Rogowski, 2020). Participants’ diverse views about a mooted registration requirement is evidence of how a ‘professionalisation discourse’ (Heiss et al., 2018:123) regarding CAA is yet to cohere. Yet there is also a strand within professionalisation theory that sees the interests of the occupational group and wider society as possibly coalescing (Evetts, 2003), which may be reflected in a drive to develop the CAA role, including by enhancing definitional clarity. Organisational initiatives such as the Advocacy Leaders Network may promote occupational self-confidence (Heiss et al., 2018), in turn benefitting service users by encouraging more effective advocacy provision. Increasing pay would also aid workforce development, as current salary levels help shape common perceptions of responsibility levels and knowledge requirements for CAAs. This illustrates how material factors impose constraints on the ideational and discursively enacted aspects of identity construction—i.e. how a role is thought and talked about (Sims-Schouten et al., 2007; Marks and O’Mahoney, 2014).

10.5.3. Positive liminality

This study has discussed two linked facets of CAA as a liminal role: CAAs perform an in-between function, and in doing so they blend technical and communicative knowing in a way that gives their role an indeterminate, or ‘hard to place’ identity (see Golden and Bencherki, 2023). This study has shown the positive potential of this liminal positionality (Croft et al., 2015), wherein advocacy’s ethos, relational practice, and elements of legalism can coalesce, enabling CAAs to operate effectively across multiple domains. CAAs foreground different elements of their occupational makeup according to the demands of particular practice situations, as do other liminally situated practitioners. As such, Watson (2019:686) argues the ‘skill’ of mental health peer support workers ‘is to occupy a liminal space, between friend and worker, and between service user and service provider’. Similarities also exist with roles, albeit more generally accepted as professional, that exhibit ‘boundary-spanning’, where practice cuts across different domains and knowledge bases (Nissen, 2010; Needham et al., 2017). For example, Leah (2019) identifies AMHP work as characterised by professional hybridity, due to the complexities of conducting MHA1983 assessments. It comprises ‘legal roles’, including ‘quasi-judge’; and ‘advisory roles’, including ‘advocate’, ‘mediator’ and ‘therapist’. Similarly, Buckton (2023:310) describes BIAs’ ‘fluid sense of professional self’ as they work amid organisational fragmentation and inadequate service provision, while exercising a para-legal function focused upon upholding human rights. BIAs can become involved in ‘unpicking’ the work of decision-makers such as social workers, regarding restrictions placed on people as part of their residence and care arrangements (Buckton, 2023:306). CAAs are also expected to exercise some oversight functions and, if necessary, contribute to unpicking decisions.

However, it is important not lose sight of the significant differences between CAA and roles such as AMHP and BIA, which involve exercising formal decision-making powers (Leah, 2019; Hubbard, 2018). Hence BIAs must ensure that deprivations of liberty are in a person’s best interests and suggest conditions regarding that deprivation (Buckton, 2023). Moreover, AMHP and BIA roles have clear professional status, being open only to registered professionals from a range of disciplines (DHSC, 2017; Ministry of Justice, 2008), albeit they are undertaken predominantly by social workers (Leah, 2019; Buckton, 2023). Therefore, it is necessary to recognise the power and status accorded to a role when considering its ability to work across occupational and organisational boundaries. Croft et al. (2015) note that relatively powerful groups, such as senior clinicians, find it easier to traverse professional domains. Moreover, my findings have highlighted how CAAs face a particular challenge: to retain an authentic identity involving minimal power differentials with service users, while simultaneously exercising influence within bureaucratised systems that privilege formalised expertise and authority. CAAs must therefore strike a similar balancing act to that of mental health peer support workers (Gillard et al., 2014; Simpson et al., 2018), whose liminal position presents risks of rejection by service users and professionals alike (Watson, 2019).

10.6. Challenging managerialism

CAAs' positioning relative to statutory social workers illustrates relational aspects of identity construction (Heiss et al., 2018). My findings complement Hardwick's (2014) work, pre-dating the CA2014's implementation, that depicts independent advocacy as a response to perceived shortcomings in statutory social work practice. For Hardwick (2014), this particularly concerned relational retrenchment within a care management paradigm. CAA involvement can be seen as mitigating continuing deficits in relationship-based social work practice under the CA2014. However, CAA services are distinct from the advocacy models described by Hardwick (2014), given their convergence with social work around the importance of legal literacy, which facilitates CAAs' process-based challenges (Preston-Shoot and McKimm, 2012).

The importance of CAAs' challenge function relates to the rise of managerialism, which has affected social work practice throughout the neoliberal period, especially since the 1980s (Butler-Warke et al., 2020; Rogowski, 2020). As Hjörne et al. (2010) argue, managerialism has undermined social workers' linchpin role, where they operate in-between the service user and the social services organisation, exercising discretion as a 'street level bureaucrat' (Lipsky, 2010). Managerialist pressures to control service costs, accompanied by legal changes, have narrowed the scope of social work practice. Care management has demanded higher levels of legal and procedural competency from practitioners, while psychologically-informed and relationship-based working have been de-prioritised (James, 2004). Therefore changes within the social work occupation that reflect traits-based professionalisation, regarding increased formalisation and standardisation of work, have accompanied heightened managerial control that actually undermines worker autonomy (James, 2004). This paradoxical tendency has been observed more widely across developing human services roles (Evans, 2020), as with police reform (Heslop, 2011). It highlights the power issues at play regarding professionalism, where an ideological fixation on the presence of classical professional traits can constitute a 'myth', divorced from contemporary realities (Evetts, 2003:406). This found illustration in the current study, via observations that social workers' 'hands are tied' (Amy, TL, FA), with some local authority practice not person-centred but 'centred around what is available and what is affordable' (Stephen, CM, FC).

However, CAA services are exposed to some structural pressures akin to those they seek to offset. My findings resonate with Hardwick's (2018) argument that dominant commissioning practices expose advocacy organisations to the strictures of 'new public management', whereby output-based accountability mechanisms constrain their field of action. However, creative steps were underway to challenge this via developing internal evaluation mechanisms that are outcome-oriented and sensitive to community context. Moreover, some participants expressed concern that pressure to further formalise and standardise CAA practice could imperil its independence, whether this pressure is applied at the individual level through professional registration or organisationally via statutory regulation by the CQC. This would reflect professionalisation 'from above' (Evetts, 2003:410), where professionalisation discourse accompanies the imposition of occupational change, in ways workers may disagree with. For CAAs, this professionalisation paradox runs parallel to concerns about legalism, where statutory advocacy's focus on upholding rights through legal mechanisms is accompanied by further restriction of its remit to that established in legislation. This in turn risks compounding division between statutory and non-statutory advocacy, further undercutting services' links to the disabled people's movement (Lonbay and Brandon, 2017; Newbigging et al., 2021). Questions about the scope of CAA practice therefore partly mirrors contention between 'wide' and 'narrow' visions for social work (Higgins, 2015): the former foregrounds working in partnership with people to engender emancipatory change, as per the *Global definition of social work* (IFSW, 2014); the latter refers to the more bureaucratically bounded nature of much statutory social work. However, this should not be taken as an uncritical defence of worker discretion, as rules-based practice permits some transparency regarding decision-making (Evans, 2013), which CAAs can utilise in their quest to uphold rights.

10.7. The limits of legalism

Rights, by definition, must be enforceable (Series, 2022). The legal and procedural environment that CAAs work within thus restricts their potential effectiveness, by presenting barriers to pursuing more formal redress for service users. The political context to this, moreover, shows how legalism's scope can be limited by oppressive socio-economic forces (Pilgrim, 2012). The CA2014, which is framed mainly in terms of welfare, failed to transpose socio-economic rights regarding independent living for disabled people, codified under Article 19 of the UNCRPD, into domestic law. This equates to a lack of a legal backstop for a person's rights to have their wellbeing maximised by receiving the best possible support within resource constraints (Collingbourne, 2014). Crucially, this differs from the situation regarding the predominantly 'negative' rights enshrined in the European Convention on Human Rights, which was transposed into UK law via the Human Rights Act 1998. Many of these provisions are safeguards against the arbitrary power of the state to restrict liberties (Dixon et al., 2020). This mismatch between positive and negative rights was reflected in the contrast that various participants drew between legalist opportunities for challenging decision-making regarding social care detention (Series, 2022), and the weaker instruments available for CAAs to contest allocations of care and support. Therefore, while Newbigging et al. (2021) argue that CAA providers in their study placed insufficient emphasis on rights when framing their organisational purpose, this must be seen in its macro-context, where some of those rights are insufficiently legally embedded. Herrero and Nicholls (2017:83) similarly call for social workers to embrace a 'broader and richer' view of rights, comprising those both positively and negatively defined. However, this distinction only holds so far, as positive and negative rights are intimately connected (Browning et al., 2014; Series, 2022). The agenda for avoiding use of long-stay, highly restrictive inpatient placements for people with learning disabilities and autistic people exemplifies this (DHSC, 2021a,b; James, 2021). Here increased liberty can only be achieved by ensuring suitable community provision is available as an alternative to these inpatient services (Ince et al., 2022).

10.8. CAAs’ experiences of normative tensions

10.8.1. Professionalism and norm circles

This research has given insight into the operation of norm circles regarding CAA services, with emphasis on the normative intersectionality experienced by CAAs. Normative intersectionality provides a realist ontological basis for understanding the liminal position that CAAs occupy, where their status is contested, and they are exposed to competing normative impulses. This is pronounced regarding occupational identity formation. Professionalism can be seen as highly normative, with characteristics such as continuing commitment to occupational excellence, as Swick (2000) identifies for medical professionalism.

Norm circles have a discursive component, where the norms being adhered to by members entail commonly accepted parameters of expression (Elder-Vass, 2012). This aligns with notions of professionalism as an ideology and related discourse (Evetts, 2001, 2013). Such discourse acts as a social conditioning mechanism in the real domain (Elder-Vass, 2012) and is thus bound up with exertions of power. Evetts (2013:788) argues that normative discourse around professionalism is a ‘mechanism to facilitate and promote occupational change’, prompting questions about whether professionalisation develops more via internal occupational impetus or external imposition.

My findings point to CAAs in the case studies belonging to two overlapping norm circles. The first relates to the belief in, or at least compliance with, the notion of CAAs having an emerging professional role within a commissioned service context. This emphasises the acquisition of technical competence, placing this at service user’s benefit but in a highly boundaried way, where extending CAA input with one service user is acknowledged to effectively delay or divert it from another with pressing and eligible statutory advocacy needs. As discussed in section 4.3.2, the operation of this norm circle, especially in its ‘imagined’ form whereby membership transcends particular localised interpersonal interactions and looks instead to a broad community of interest, is a structural entity related to larger political configurations regarding how advocacy services are commissioned. This occurs within an overarching neo-liberal governance framework, where advocacy has increasingly been channelled into state-defined purposes, with accompanying elevation of professionalism conceived in terms of technical proficiency and occupational standards, and oversight and governance according to New Public Management principles (Hardwick, 2018; Redley et al., 2010; Morgan, 2017).

The other norm circle identified, partly oppositional to the first, has membership predicated on attachment to notions of partnership with service users, in which amplifying their voice is prioritised without restriction by service, process or issue-based boundaries. Democratic and egalitarian principles underpin a sense of partnership, without elevation of 'professional' knowledge. The imagined version of this norm circle again extends beyond local authority borders, where members look to fellow adherents who may operate in other fields of advocacy practice. They share essentialised notions of an 'advocate' having a particular value base and personal characteristics, at least partly separate from what occupational infrastructure such as qualifications can guarantee. My findings show that such normative intersectionality can create a sense of bind for CAAs about how best to undertake their role with a particular service user, additional to a dislocated identity that is in-between partnership and professional designations.

Regarding the other type of normative social entity discussed by Elder-Vass (2010), my analysis emphasises how advocacy organisations are an institutional locus of these intersecting normative expectations. CAAs' employing agencies can be both commissioned providers of statutory services and established members of the Voluntary and Community (VCS) sector, with strong bases in grassroots action and potentially an identity as a disabled people's organisations (Newbigging et al., 2021). They are therefore sites of norm mediation and enforcement, including via such mechanisms as conditions of CAAs' employment, while having an historic organisational ethos that may not be wholly aligned with some of the restrictions of delivering statutory advocacy. This sense of dissonance was most apparent in the insights shared by managers from Martborough Voices.

Advances towards more formal professionalisation of the CAA role would likely entrench the influence of the formerly discussed norm circle and strengthen the organisational entities related to it. It would bolster normative adherence that transcends local authority boundaries, for example around study for the National Qualification, meeting the requirements of the Advocacy QPM, and involvement in sectoral initiatives such as the Leaders in Advocacy Network. Any future introduction of a registration requirement would accelerate these processes, such as via laying down normative requirements in a professional code. Research about social work's registration requirements has shown the possibility of motivational and disciplinarian causal forces arising. Registration can be an ingredient in the assumption of social work professional identity by new entrants to the role, indicating positive embrace of normative adherence (Wiles, 2013). Meanwhile, a professional regulator, as a new organisation, would bring about compliance mechanisms such as fitness to practice processes (McLaughlin, 2007). Mandating registration would therefore have strong implications for power relationships between norm circles and with other normative institutions.

Manifestations of this normative intersectionality were widely evident in the accounts of participating CAAs. However, individuals differ in their positions within intersecting norm circles, and they provide agential responses to the structural conditions that norm circle membership represents (Elder-Vass, 2010). Therefore, the precise nature of norm circle membership is individualised and the social positioning of CAAs should not be homogenised. Moreover, this study has given attention to how CAAs respond to sometimes conflicting signals, including evidence of the exercise of individual discretion when determining the extent of advocacy involvement with an individual service user. Elder-Vass's (2010) work suggests scope for both conscious reflexivity and unconscious disposition in these personal responses to social structures. While the study has not probed the psychological impetus for CAAs' decision-making or related identity formation on an individual level it has, for example, noted a participant's observation that a CAA's employment history, including whether all their advocacy experience has been gained in a statutory context, could affect their willingness to accept working in a boundaried way that restricts the scope of their remit to supporting involvement in CA2014 processes.

10.8.2. Liminality and the Voluntary and Community Sector

It was seen in section 2.10 that liminality has been used as a conceptual lens to study tensions in roles adjacent to that of CAAs, as where mental health peer support workers experience being in-between professional and service user identities (Simpson et al., 2018). Findings from the present study also resonate with analyses of power affecting other organisations in the Voluntary and Community Sector (VCS), otherwise known as the 'third sector' (Alcock and Gregory, 2022), via their engagement with the state. This again relates to contestation arising from employees or volunteers being subject to overlapping yet partially contradictory normative standards, and the structuring and enforcing presence of their organisations. Indeed, the contested and arguably liminal positioning of VCS organisations relates to what Alcock and Gregory (2022) identify as their ambiguous constitution: as private entities in the sense of standing apart from the state provision of services, but 'not part of the private market or commercial provision of welfare, primarily because they do not operate exclusively with a concern for profit and loss' (Alcock and Gregory, 2022:46). Co-option and a degree of control by the state, via measures labelled New Public Management, is key, especially against a backdrop of austerity (Hardwick, 2018). Grounds for state control follow from independent advocacy stepping in as a replacement for various social care functions that were previously in the state's direct ambit, especially certain relational functions that professional social work retrenched from under a care management model (Hardwick, 2014).

Some of my findings thus align with other scholarship about VCS organisations engaging in service delivery against a backdrop of hollowed-out state provision, with ensuing tensions for volunteer workers. Fisher et al. (2019:252) discuss the work of Home-Start, a family support organisation that had been 'co-opted to deliver on local authority agendas', as these local authorities stripped back direct provision of preventative services to families and thresholds for social work intervention were raised. This had diverted Home-Start from pursuing an innovative and even broader-based agenda of community engagement to amass 'social capital' (Fisher et al., 2019:252). There are commonalities here with the necessitated shift in focus away from grassroots advocacy organising in the community, with Home-Start also being increasingly subject to the strictures of evidence-based commissioning. Against this backdrop of increasing work with families experiencing difficulties, Fisher et al. (2019:260) discuss Home-Start volunteers' experience of normative tension while occupying 'a liminal space 'betwixt and between' a professional and a friend' in their relationship with families. This entailed a sense of uncertainty about where appropriate boundaries lie regarding engaging in particular support tasks, also about how to end support relationships, which are meant to be time-limited so volunteer resources can be redirected towards other families. There are similarities here with the push/pull that CAAs can experience regarding extending their involvement with service users beyond their established remit, as when supporting people practically around accommodation moves or with financial management—with potential for moral distress most acute when no other suitable individuals or services seem available to help. Another example of a liminally situated VCS role is provided by a study of Community First Responders (CFRs) to medical emergencies in rural Scotland (Roberts et al., 2014), where CFRs were found to experience a sense of having an identity in-between that of citizen and health practitioner. Again, this was set against concerns that the rural CFR role had been introduced to fill gaps arising from diminished access to state-run services; and CFRs reported unease about their role parameters and a sense that they might be able to do more to help people.

However, it is important not to overstate these parallels with other VCS roles and lose sight of independent advocacy's distinctive character. Independent advocates work not only in partnership with public sector professionals, and themselves perform some functions that were once the preserve of the state, but they must also act as a source of potential challenge to state bodies, with this enshrined as a statutory function. Hence CAA is operationalised as a remunerated occupational role and is making claims to professionalism, but from a base within the VCS. Indeed, any blurring of the separation between state and VCS functions concerning independent advocacy produces particular risks, given the external scrutiny function that Mercer characterised as 'a safety critical feature of adult social care'. A

Safeguarding Adults Review of staff abuse of service users at Whorlton Hall, an independent, 'specialist' mental health hospital accommodating people with learning disabilities and autistic people, underscores the implications of having an 'illusion of advocacy' when such high quality, effective and independent advocacy provision is not in fact available (Fish et al., 2023:16).

Another feature of liminality that CAA providers share with other VCS organisations is that of being responsible for service delivery on behalf of the state while having significantly less security of tenure than state actors. While scholarship has identified the precarity of liminal occupational roles (Ibarra and Obodaru, 2016), my findings about CAA services hint at such precarity on an organisational scale. A condition of 'substitutability' is intrinsic to liminal states (Beech, 2011:288) and there was evident awareness among the CAA managers interviewed that organisational continuity depends on the outcomes of local authority commissioning processes. Managers from Martborough Voices were most forthcoming in referring to a sense of having contingent organisational future. They referred to the demands of dedicating time and financial resources to building an evidence base of their service's impact, with a view to bolstering opportunities for being recommissioned given expected challenges from better-resourced, multi-area advocacy organisations (see Hardwick, 2018). Implications of this were not explored in depth, but it can be speculated that this would have entailed some diversion of focus and means away from frontline advocacy provision.

10.9. Connective professionalism

Scholarly efforts to reconceptualise professionalism allow the CAA role to be viewed from fresh theoretical vantage points. Noordegraaf (2020) argues traditional notions of professionalism are breaking down amid various contemporary socio-cultural and economic currents, including technological shifts and heightened managerial control. These have weakened the boundaries around professions and called into question the exercise of professional authority within hierarchical structures. Noordegraaf (2020) proposes ‘connective professionalism’ as a theorisation of this new reality. This views professionalism as being essentially relational, rather than something bestowed upon an occupational group possessing particular traits. Connective professionalism ‘occurs in-between professionals, clients/cases, and stakeholders, in wider social domains’ (Noordegraaf, 2020:220).

My findings suggest connective professionalism can be located within triadic micro-systems involving CAAs, practitioners and service users. Thus, CAAs contribute to connective professionalism even if their role, taken in isolation, lacks some established professional traits, such as decisional autonomy within an exclusive arena of expertise. By facilitating service user participation, CAAs also help fulfil connective professionalism’s function of decentralising executive authority, allowing ‘clients and stakeholders’ to be conceived of as ‘co-deciders and even co-producers’ (Noordegraaf, 2020:210). That Noordegraaf (2020:220) depicts connective professionalism as located ‘in-between’ individual participants in practice systems resonates with my description of the liminal positioning of CAA—and with descriptions of the liminal status of social workers also (Evans, 2013; Southall et al., 2021).

Notions of an interconnected professional system aid understanding of how CAAs and practitioners can co-construct person-centred practice, even amid discordant relationships arising from how their roles are constituted. This is similar to Cornes et al.’s (2018) observation that constructive networked interaction between practitioners and advocates helps to shape conduct of personalisation policy under the CA2014. These authors argue this is especially important given the ‘high ambiguity’ governance context in which such policies are enacted, which grants space for ‘bottom-up’ actors to interactionally forge the specifics of implementation (Matland, 1995). My findings illustrate such connectivity regarding best interest decision-making under the MCA2005, where CAAs bolster a supported decision-making component within overarching substitute decision-making processes (Dixon et al., 2020; Series, 2022) and therefore help actualise delegated autonomy (Leece and Peace, 2009).

A connective professionalism perspective also alerts to potential synergies between CAA and social work advocacy. CAAs can help social workers fulfil their professional and ethical duty to assert their judgements about what provision is needed to meet a person's assessed needs, highlighting where the local authority's offer is inadequate (BASW (England), 2021; Banks, 2021). Regarding mental capacity practice, there are also prospects for independent advocacy and social work advocacy to act in tandem, as when emphasising the right of people with capacity to make unwise decisions (McDonald, 2010). Such alliances were hinted at via Amy's (TL, FA) reference to CAAs acting as a potential 'aid' to anti-oppressive social work practice.

With technological change a key driver of connective professionalism (Noordegraaf, 2020), questions arise about how further innovations could affect CAA, and adult social care more generally. Future widespread adoption of generative artificial intelligence could have profound implications for notions of expertise within adult social care, and thus for the demarcation of professional roles (Meilvang, 2023). This would be reflective of this technology's potential to recalibrate the relative esteem in which technical and relational skills are held across diverse spheres of economic activity (Jaharri et al., 2023).

10.10. Limitations of the study

10.10.1. Limitations of research design, recruitment and topic inclusion

This thesis has mainly involved case studies in two local authorities, although a small number of national contributors broadened the geographical perspective. This specificity must be borne in mind when considering the potential transferability of my analysis to CAA services elsewhere (Vincent and Wapshott, 2014). The study has highlighted important variations regarding CAA provision between local authorities: regarding referral processes; funding levels; and the character and scale of advocacy organisations and the spread of advocacy services they provide. CAA services in other locations may therefore work in substantially different ways to those in Fencross and Martborough.

The study's exploratory character has reflected the paucity of previous scholarship about the CAA role. I have mostly focused on identifying potential causal processes affecting CAA practice and services, such as the possibility of infusing challenges with legalism, rather than attempting judgements about how often these processes are activated and how they translate into specific outcomes. This prioritisation of analytical depth over enquiry that may yield more predictive potential is a clear consequence of the qualitative methodology adopted (Carminati, 2018).

CAAs and their managers were the largest cohort of participants by a significant margin. This meant their perceptions predominated and they were generally positive about the work they were undertaking. The recruitment of more social workers would have facilitated greater critical analysis of CAA practice. The level of service user participation was also a weak point, given the importance of determining what outcomes service users experience from advocacy interventions (Ridley et al., 2018). Moreover, having participation of a commissioning manager from only one case study site stymied comparative analysis, especially regarding meso-level factors shaping CAA services.

The topic coverage of the interviews was broad, and some important issues were not addressed in any depth. Among these were CAA support for carers and for young people 'transitioning' into adult social care. In theme three I discussed a case example involving privately funded care, yet advocacy for self-funders was otherwise unexplored (see Baxter et al., 2020)[13]. That participants did not explicitly raise issues regarding advocacy for people self-funding some or all of their support suggests this was not a prominent area of CAA practice in the case studies sites, but this would need further exploration, and the situation might differ elsewhere.

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[13] This issue had been expected to become more pertinent due to planned implementation of the government's Fair Cost of Care Reforms. These were set to include full implementation of s.18(3) of the CA2014, allowing self-funders to ask their local authority to arrange a care home placement for them, so they can receive this at a reduced rate (Foster, 2022). This might have brought more self-funders within the ambit of CAA involvement. However, in July 2024 these social care funding reforms were cancelled by the newly elected Labour government (Samuel, 2024).

Another limitation of the study is that it gave minimal attention to individualised aspects of identity construction, such as how CAAs' personal backgrounds may affect their approach to their role. This could include whether any CAAs identified as being a disabled person or had lived experience of service use or being an informal carer. This is salient given previous research, albeit about non-statutory mental health advocacy, suggesting shared experience of service use might be beneficial to relationship formation between the advocate and the person they are advocating with (Carver and Morrison, 2005). Moreover, questions about whether the case study CAA providers could be considered Disabled People's Organisations, along with any practical implications of this, were neglected (Carey, 2019; Newbigging et al., 2021). While Martborough Voices' roots in the citizen advocacy movement were discussed extensively, CAA providers' governance structures were not explored, for example. There was also a lack of detailed consideration of the extent to which service users are meaningfully involved in co-producing CAA services. This may have reflected the acknowledged situation in Fencross, where co-production was deemed an evolving concept that required effort to improve its practical application, despite its importance being acknowledged in theory (SCIE, 2022). This relative inattention to co-production affected the design of the study itself.

10.10.2. Focus on individual case advocacy and transactional processes

The study has focused overwhelmingly on individualised case, transactional advocacy, which is only one form of advocacy practice. This focus has reflected the case-based remit of CAA services (Dixon et al., 2020), based on supporting involvement in care and support processes (DHSC, 2024). Accordingly, interviews with stakeholders were directed mainly towards elucidating process-oriented advocacy mechanisms, with less attention to considering how CAA involvement might contribute to longer-term and more holistic change for service users, including when relationally or collectively oriented. It was also clear that current service configurations limit such possibilities. Nevertheless, commitment to advancing social justice is enshrined in the *Advocacy Charter* (NDTi, 2018) and can be manifested in activities such as advocating to improve the quality of services (Ridley et al., 2018). Exploring these possibilities is another area where greater service user participation would have benefitted the research, by helping gauge how CAA involvement related to the achievement, or otherwise, of user-defined outcomes. In the two interviews conducted with people with lived experience, reference to these broader potential benefits of CAA input were most apparent when Sophie (MC) spoke positively about how her CAA's support had focused on providing reassurance and galvanising her confidence and ability to self-advocate. More longitudinal research is necessary to consider whether such outcomes are sustained and progressed over time. This might also improve understanding of how independent advocacy acts as an independent variable in the empowerment process, although critical realist metatheory (Porpora, 2015) and work on the emergent properties of social entities (Elder-Vass, 2010), suggests that advocacy's influence on individual action can never be fully disaggregated from the influence of other actors and social forces.

Another limitation was a lack of detailed consideration of activities that the CAA provider organisations undertook at a strategic level. This omission is important given previous work highlighting the potential for advocate participation in local multi-agency Safeguarding Adults Boards (SABs) (Lonbay and Brandon, 2017); or performing a 'critical friend' function to local authorities, such as through feedback about issues recurring across cases (ADASS, 2022). Managers from Fencross Advocacy and Martborough Voices referred to having constructive dialogue with their respective commissioners, but details of these conversations were not elicited. Online searching did not yield evidence of a CAA provider presence on the SABs in Fencross and Martborough. Discussion of the involvement of managers from Fenlock Advocacy in the Advocacy Leaders' Network was a rare example of discussion of strategic work beyond the local authority arena. However, given that CAA managers at both case study sites emphasised the constraints of receiving targeted funding to deliver commissioned tasks, this would likely limit scope to undertake more strategic functions, as Lawson and Petty (2020) have suggested. Further research might confirm this.

Within the data collected there was some evidence of desire to see the commissioning of independent advocacy services expanded to include more potentially transformational work.

An example was the suggestion of social workers at Martborough Council, made as part of the recommissioning process, for longer-term advocacy to be available to help individuals navigate relationships with family members or others in the community, potentially via peer advocacy. However, insufficient data was collected in order to clearly ascertain how advanced these plans may be and how feasible their implementation. There was indication, however, that achieving this would be reliant upon significantly increased advocacy funding—as with Catherine's (M, MV) wish to bolster her organisation's 'step down' advocacy offer that was based on citizen advocacy. Future evaluation regarding this policy agenda should consider it alongside attempts to develop cultural appropriateness that are based on meaningful alliances between mainstream advocacy organisations, with their process-oriented expertise, and the more transformational possibilities afforded by grassroots initiatives.

10.11. Conclusions

I now present some recommendations: first for policy and practice, then for future research.

10.11.1. Legal reform

My analysis supports the contention that further legislative reform regarding advocacy would bring benefits. Multiple findings lend weight to Dixon et al.'s (2020) argument for a right to independent advocacy for all people with a mental disability who use health and social care services. This would aid access by markedly simplifying eligibility determinations and facilitating a more joined-up approach to advocacy, potentially enabling greater synergy between informal (familial) and formal (e.g. CAA) advocacy types. Determinations about the appropriateness of friends or relatives' support would carry less importance, and practitioner judgements in this regard would therefore be less likely to stymy advocacy access. By no longer tying advocacy explicitly to the conduct of specific statutory processes it would also allow advocates to forge longer-term, more holistic advocacy relationships that enable supported decision-making to be more fully realised. Such reforms would have significant cost implications (Dixon et al., 2020) but may produce savings in some areas due to their preventative implications. Any extension of advocacy rights would likely need to be part of wider-ranging legal reform within adult social care, necessary to bring about a sustainably-funded system that can properly meet needs (Allen et al., 2024). Such change should further embed the principles of the UNCRPD into domestic law, including rights to independent living and supported decision-making that advocacy helps to uphold (Collingbourne, 2014; Newbigging et al., 2021).

10.11.2. Data availability and monitoring

More immediately, better availability and monitoring of data about advocacy is needed (NDTi, 2020). This should include data about what advocacy is commissioned in each area and who is accessing it, including consideration of protected characteristics under the Equality Act 2010. This would ease identification of unmet advocacy needs and help in holding local authorities to account for what they commission. This in turn would increase pressure on central government to ensure sufficient funding to local authorities for advocacy, possibly including some ringfenced monies.

10.11.3. Access

Access to CAA support could benefit from allowing self-referral, with guidelines by NICE (2022:82) promoting this route to receiving advocacy services more generally. However, the CAA role's statutory purpose would necessitate some checking of referrals to ensure suitability, as some participants indicated. Where self-referral for CAA services exists, this should be evaluated so any learning can be transferred. Referral systems should be streamlined, with practitioners' IT systems providing prompts about potential need for advocacy input (Lawson and Petty, 2020). The statutory guidance (DHSC, 2024) could be usefully updated to clarify issues about consent to accessing CAA support.

10.11.4. Practitioner awareness and engagement

Practitioners should be aware of their responsibilities, regarding enabling access to CAAs and then properly facilitating their input. This includes emphasising the importance of conducting appropriate assessments of the ‘appropriateness’ of friends or relatives to advocate informally, as per law and statutory guidance (CA2014, s.67(5-6); DHSC, 2024:7.32-42). Awareness-raising should be framed positively, showing how CAA involvement can aid anti-oppressive practice and practitioner advocacy. For example, Symonds et al. (2021) suggest one way to make CA2014 assessments more person-centred would be to enable the person or their ‘representative’, which could be an CAA, to set the agenda and/or chair the assessment meeting. Training about advocacy must be provided to practitioners at all levels. Local authorities must also ensure staff are fulfilling their responsibilities regarding CAA. The introduction of CQC inspections of local authority adult social care departments, following the Health and Care Act 2022, offers a potential oversight mechanism, as inspectors will examine levels of compliance with the CA2014 (CQC, 2023).

10.11.5. Challenge

My findings add weight to the EHRC’s (2023) recommendations for all individuals to be eligible for advocacy support with social care complaints, given evidence of gaps in such provision. There is also evidential support for the need for reform of local authority complaints procedures (EHRC, 2023). CAAs should have appropriate knowledge about all relevant legal and procedural avenues for pursuing redress for people, covered via training and qualifying course content. They should also be able to call on specialist legal support when necessary, an area of development bound up with the need for review of legal aid rules and strengthening capacity within community care legal practice (EHRC, 2023; Ashton et al., 2022). When updating statutory guidance, attention should be given to elaborating on how challenges should be conducted via direct contacts between CAAs and local authorities, given a lack of evidence from the case studies about CAAs writing reports and then being invited to meetings to formally address issues (DHSC, 2024:7.50-52). Practice development in this regard could be embedded via training and qualification requirements.

10.11.6. Role and workforce development

Ongoing attention is needed to developing CAA as an occupational role, including as part of a broader independent advocate designation. Changes should be designed in partnership with CAAs rather than imposed upon them. Initiatives to enable dialogue within the advocacy sector and emergence of a more cohesive sectoral voice should be encouraged, but they must be inclusive of a broad range of advocacy organisations.

Developing a strong advocacy workforce remains a priority. While writing this thesis, a need for significant workforce expansion seemed apparent given plans to implement a cap on care costs (Burn et al., 2024). This was expected to significantly increase the volume of CA2014 processes that local authorities must conduct (DHSC, 2024), with an accompanying rise in referrals for CAAs to be reasonably expected. However, these plans were cancelled by the newly elected Labour government in July 2024 (Samuel, 2024). Nevertheless, as Petty argued, work to further define the CAA role is needed. Various areas require attention: entry routes to the occupation; training and qualification regimes; and improving pay. Training must be available to ensure CAAs can acquire any necessary specialist skills, as regarding work with particular service user groups. Student social work placements with advocacy organisations should be extended to any localities where these are not offered, although availability of practice educators may be a constraining factor. There is need to consider expanding recognition of independent advocacy as a field of professional social work practice, recognising opportunities and challenges. This would involve more thorough exploration of how the CAA role evidences the requirements of social work practice and professional registration (SWE, 2019), including progress through the milestones of professional development as per the Professional Capabilities Framework (BASW, 2018).

This thesis has identified that the CAA role's liminal position can be a source of strength. From the evidence examined, professionalising tendencies seem positive to the extent they underpin CAAs' effectiveness within their statutorily defined remit, including the ability to enact effective challenges. However, it is vital CAA remains connected to a broader advocacy conception.

10.11.7. Joined-up statutory advocacy

A cohesive approach to commissioning different forms of statutory advocacy is needed. While the need for integrated working across IMCA and CAA activities is especially apparent, there may be untapped potential for enhancing connectivity between CAA and IMHA duties.

10.11.8. Evaluation

My findings show a need for a common evaluation framework for independent advocacy, at least in its statutory form, that will be acceptable to advocacy organisations and commissioners alike. Development of this framework must be sensitive to independent advocacy's unique character, while ensuring advocacy organisations are accountable. This should include monitoring whether they are acting as a source of robust challenge to local authorities, as the EHRC (2023) has argued for.

10.11.9. Funding diverse advocacy provision

Increased funding for CAA services is necessary, to minimise waiting lists and ensure delivery of a high standard of advocacy, without having to divert resources from other activities. Non-statutory advocacy must also be adequately resourced. This would enable advocacy needs that fall outside statutory parameters to be met, in turn aiding the proper functioning of statutory advocacy (NICE, 2022). Any further professionalisation of the CAA role should take place alongside ensuring a wide range of advocacy services are available to meet the diverse advocacy needs of local populations. This would reflect the 'Advocacy Plus' approach that Monaghan (NC) espoused, where a person can access the type of advocacy that is most appropriate for them at that time, and advocacy forms part of an overarching 'social inclusion movement'.

10.11.10. Culturally appropriate advocacy

There is a need for further conceptual and practical development of culturally appropriate advocacy in respect of CAA. This will include transferring appropriate learning from the pilots regarding mental health, while being sensitive to contextual differences. Delivering culturally appropriate CAA services will require increased internal focus on building cultural capacity, such as via staff training. This should also constitute part of a broader agenda of ensuring statutory advocacy services have strong alliances with community organisations and overall focus on promoting social inclusion. Services must also be attentive to other aspects of people's social location, with advocacy needs regarding sexuality and gender diversity being areas identified (see Westwood, 2022).

10.11.11. Cause advocacy

CAA providers should also engage in cause advocacy, directed especially at local and central government and other policy actors. Here, advocacy organisations can draw on experiences of working with many people, collating learning of how structural issues impinge upon individual lives. Working within the law must be accompanied by campaigning for necessary legal changes. Prospects for such campaigning were not explored in any depth in the research, although developing inter-organisational dialogue within the advocacy sector may present possibilities in this regard. Developing collective channels of expression would allow advocates to become more involved alongside social workers, service users and others in calling for political-level change, especially around ensuring resources are available to meet people's needs (see Slasberg and Beresford, 2022). This is underscored by Slasberg's (2019) critique that, given overarching constraints on local authorities' finances, effective advocacy for one person could be to the detriment of another who is less able to make the case for receiving a necessary service.

10.12. Recommendations for future research

These discussions of the study's limitations and recommendations arising suggest areas for further research about advocacy generally and CAA specifically. There is a need to examine CAA in more local authorities, accounting for differences such as the presence of larger, multi-area advocacy providers in some. There should be attempts to explore how these contextual variables affect CAA practice and outcomes. This is the case, for example, regarding understanding how CAA services can be delivered in culturally appropriate ways, given the overwhelming majority of CAA participants in this study were of White British ethnicity.

Different methodological approaches would also be beneficial. There is need for quantitative enquiry regarding CAA provision (NICE, 2018), which would enable research across a larger spread of local authorities, as with that conducted by Newbigging et al. (2021) during early implementation of the CA2014. Evaluations regarding access would benefit from comparing data about volumes of CAA referrals with corresponding volumes of CA2014 processes conducted, considering how this varies between localities and over time. There remains a need to establish a practical and robust basis for evaluating advocacy services (Newbigging and Ridley, 2018; Lawson and Petty, 2020; NICE, 2022), including a quantitative component.

Ethnographic research would enable direct analysis of advocacy processes in action, serving a critical realist agenda of understanding how causal mechanisms operate in particular circumstances to produce empirically observable outcomes (Porter, 1993; Decoteau, 2017). Ethnographic methods could therefore help illuminate how advocacy processes relate to outcomes (Townsley et al., 2009), such as regarding supported decision-making (Dixon et al., 2021). As improving understanding of non-instructed advocacy is a priority (Newbigging et al., 2015; Series, 2022), there is need to look beyond interview-based data collection, which effectively excludes participation by a significant proportion of users of CAA services. Here, methodological approaches that are attuned to the sensory experiences of people with profound and multiple learning disabilities (Gjermestad et al., 2023) are potentially instructive. So too are guidelines on *Conducting research with people not having the capacity to consent to their participation,* which cover circumstances where this is legally and ethically justifiable (British Psychological Society, 2020). Where interviews are undertaken with both professional and service user participants, attention should be given to the power differentials implied by differential approaches taken between cohorts, and the extent to which these can be justified on research integrity and ethical grounds.

I can also suggest two areas for fruitful enquiry using interview methods. The first involves gaining better understanding of how CAA practice interfaces with decision-making processes within local authorities, especially when there is dispute about care and support provision. Here, key questions concern how practitioners and managers experience and respond to CAAs' challenges. The second research agenda, located closer to the occupational and organisational studies discipline, is for deeper investigation of identity formation (Ybema et al., 2009) among CAAs. This would entail greater focus on individual biography, exploring CAAs' motivations and internal dialogue about their role in a way that shows reflexive responses to social structures.

10.13. Final thoughts

This thesis has contributed to knowledge about the CAA role, which had been under-researched. It has also added to understanding of advocacy more broadly: regarding how it works in different contexts, and what the implications may be of different options for developing advocacy roles. I have identified CAA as a liminal role, where an ambiguous occupational status relates to being in-between the person and the practitioner's conduct of CA2014 processes, seeking to bridge gaps in involvement. Both opportunities and challenges associated with this liminal position have been discussed. I have argued that, as with other statutory advocacy roles, technical knowledge requirements have been foregrounded for CAAs, especially relative to many longer-established forms of community advocacy. In the context of the contemporary care and support system, CAAs' abilities to fuse technical and communicative knowledge practices is integral to their role's value (Golden and Bencherki, 2023). Yet other aspects of the role remain incongruent with orthodox conceptions of professionalism. These particularly relate to advocacy's special character, comprising absolute focus on amplifying the person's 'voice' (Forbat and Atkinson, 2005; NDTi, 2018). Future development of CAA services will need to ensure these essential components of the role—the technical, the communicative skills, and a core advocacy ethos—remain in balance, so synergies can exist alongside inevitable tensions. By way of theoretical contribution to addressing this challenge, I have proposed the applicability of 'connective professionalism' to the CAA role (Noordegraaf, 2020). This suggests that, instead of analysing

CAAs’ occupational configuration in isolation, we should consider it relationally, given its place within a broader practice system.

This thesis has been significantly exploratory in nature, and I hope it provides a basis for future scholarship about CAAs to build upon, to further improve understanding of this valuable role.

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Appendix A: Eligibility criteria for care and support

This thesis has discussed issues about Care Act Advocacy being focused on facilitating involvement in care and support processes conducted by the local authority under the Care Act 2014. Below, I clarify eligibility criteria for local authority-arranged care and support under this legislation. I also set out grounds by which local authorities must undertake safeguarding enquiries. Finally, I refer to charging for services, specifically regarding implications for people who become self-funders.

Eligibility of an adult for care and support

National eligibility criteria were established by the CA2014, s.13 and the Care and Support (Eligibility Criteria) Regulations 2015 (SI 313). Separate but related eligibility criteria exist for carers support. A determination of eligibility is made following assessment of the person's needs. Local authorities have a duty to meet eligible needs; however, see notes below regarding self-funders.

There is a three-stage process for determining whether eligibility criteria for an adult are met. Questions posed in the three stages below must all be answered in the affirmative. The question-based format draws from that presented within an online resource produced by the Social Care Institute for Excellence (SCIE) (SCIE, no date), with further material from the *Care and support statutory guidance* included (Department of Health and Social Care (DHSC), 2024:6.102-6.111). Additional points of consideration when answering these questions are contained in the law, regulations and guidance:

1) Do the adult's needs arise from, or are related to, a physical or mental impairment or illness?

2) Do these needs mean that the adult is unable to achieve two or more of the following outcomes?

These outcomes are: (a) managing and maintaining nutrition;
(b) maintaining personal hygiene;
(c) managing toilet needs;
(d) being appropriately clothed;
(e) being able to make use of the adult’s home safely;
(f) maintaining a habitable home environment;
(g) developing and maintaining family or other personal relationships;
(h) accessing and engaging in work, training, education or volunteering;
(i) making use of necessary facilities or services in the local community including public transport, and recreational facilities or services; and
(j) carrying out any caring responsibilities the adult has for a child.

3) Is there consequently a significant impact on the adult’s wellbeing?

The CA2014, s.1(2) requires consideration of the following aspects of wellbeing:

(a) personal dignity (including treatment of the individual with respect);
(b) physical and mental health and emotional well-being;
(c) protection from abuse and neglect;
(d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
(e) participation in work, education, training or recreation;
(f) social and economic well-being;
(g) domestic, family and personal relationships;
(h) suitability of living accommodation;
(i) the individual’s contribution to society.

Sources: DHSC (2024, 6.111); SCIE (no date:online)

As guidance from SCIE (no date) explains, significant impact can arise in various ways. First, inability to meet two or more outcomes can have significant impact regarding a single aspect of wellbeing. Second, significant impact can arise cumulatively from lower-level effects across a range of aspects of the person's life. Third, there can be a consequential effect, where it is expected that impact on one wellbeing area will have ensuing effects across other areas, leading to significant impact on wellbeing.

Safeguarding

Different grounds give rise to duties to initiate safeguarding procedures. Under the Care Act 2014, s.42, the local authority must make enquiries, or cause others to do so, if they reasonably suspect the following criteria are met:

> (a) An adult in their area has needs for care and support (whether or not the authority is meeting needs)
>
> (b) The adult is experiencing, or is at risk of, abuse or neglect, and
>
> (c) As a result of those needs the adult is unable to protect themselves against the abuse or neglect or the risk of it.

See also: DHSC, 2024:14.2.

Charging for services

Rules about charging for services are separate to those regarding determining eligibility. Charging rules involve the local authority taking account of a person's capital. These rules are contained in Sections 14, 17 and 69-70 of the Care Act 2014; the Care and Support (Charging and Assessment of Resources) Regulations 2014; the Care and Support and Aftercare (Choice of Accommodation) Regulations 2014. Chapter eight of *The Care and support statutory guidance* addresses financial assessments and charging for services.

There is an upper capital threshold, meaning that when the person has capital above this the local authority is not required to financially support the cost of the person's care. The local authority must, however, meet the person's eligible needs by arranging care and support, if asked to do so, although the person may be liable for the full cost. The exception is when the person's needs are to be met within a care home. Then the local authority has discretion to arrange that care in order to meet needs, but it is not under a duty to do so (DHSC, 2024:8.13).

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Appendix B: Literature search methods

In presenting the narrative literature review in chapter three, I sought to explore key aspects of the scholarly and grey literature regarding my field of research (Rumrill and Fitzgerald, 2001). The review was not conducted according to the clearly defined parameters of a systematic review (Campbell Collaboration, 2021; Aveyard, 2019). Some rigour in literature searching was sought, although this could not be fully comprehensive. This was especially because of advocacy's conceptual breadth, even when considered only in the context of UK adult social care. I approached literature searching as follows:

Initial scoping

I identified and read some texts that were of most immediate relevance to my topic area, to improve my understanding of the scale and coverage of pertinent literature. From this, I developed a search strategy.

Search terms

Date coverage: Items were potentially included if published since January 2005. This year was selected because of the passage into law of the Mental Capacity Act 2005, which created Independent Mental Capacity Advocacy (IMCA)—the first statutory independent advocacy role in England and Wales. Formal searches of online databases were conducted in August 2021 and May 2023, meaning that articles indexed by these dates were potentially included.

Geographical coverage: Searching was restricted to items about adult social care advocacy in the UK nations. International coverage was deemed too broad given the review's time and space constraints.

Literature type: Items of both scholarly and grey literature were potentially included. Grey literature refers to literature that has not been subject to scholarly processes such as peer review (Bellefontaine and Lee, 2014; Pappas and Williams, 2011). However, a cautious approach to the inclusion of grey literature was taken, as discussed below.

Databases searched: Core searching was conducted in the following databases: Applied Social Sciences Index and Abstracts (ASSIA); Scopus; and Social Care Online. Social Care Online was discontinued in March 2024.

Search terms: These were set to try and ensure strong coverage of literature about different forms of advocacy, while ensuring the volume of search results was manageable. Boolean operators were used to combine search terms. The following string of terms formed the core of the searches conducted in the title, abstract and keyword fields of the academic databases:

> Advoca* AND (“social care” OR “social work*” OR “Care Act” OR “mental health” OR “learning disab*” OR “intellectual disab*” OR “dementia” OR “older pe*” OR “citizen advoca*” OR “self-advoca*” OR “community advoca*” OR “independent advoca*” OR “peer advoca*” OR “mental capacity” OR “cognitive impair*” OR “acquired brain” OR “supported decision*” OR “safeguard*” OR “deprivation of liberty” OR “autism”)

** designates a wildcard*

Database-specific filters were then used to narrow the results, including to those pertaining to UK contexts. Moreover, significant numbers of results relating to children’s social care were returned from the above searches. These were removed via exclusion of results tagged with relevant keywords, such ‘child’.

Once a manageable number of results had been generated via application of the filters, these were exported along with key bibliographic information and accompanying abstracts into Excel spreadsheets. I then read through this information about each item and took a decision about whether to include it in the review. This was ultimately based on the item's relevance to the thesis's research aims. All scholarly articles addressing CAA in a significant way were included. Articles relating to other case-based forms of independent advocacy, such as IMHA and IMCA, were also prioritised for inclusion, as these have most similarity and overlap with CAA.

An example of this search strategy is as follows. Searching via the above terms in Scopus initially yielded 1,419 document results. This included many irrelevant entries, which were reduced significantly by using keyword exclusions to filter out articles with keywords such as 'medical education', 'children' and 'Africa'. The 'source title' field was also used to exclude items published in journals that are clearly unrelated to my field, such as *Education Science* and *Pastoral Medicine*. From there, the results and abstracts were exported to Excel and I undertook further screening. First, I excluded clearly irrelevant articles on the basis of title alone, before reading the abstracts and taking a decision about inclusion.

Grey literature was prioritised for inclusion according to relevance and recency. This meant that included items of grey literature addressed some policy and practice issues within the advocacy sector that were not addressed in any depth within the scholarly literature encountered. Examples of this are works by Lawson and Petty (2020), Voiceability and Kate Mercer Training (2020), and National Development Team for Inclusion (NDTi) (NDTi, 2020). Otherwise, grey literature published by government departments was favoured for inclusion, or that produced by public bodies with official status. Examples of the latter are reports by the Equality and Human Rights Commission (EHRC) (EHRC, 2023), National Institute for Health and Care Excellence (NICE) (NICE, 2022) and Care Quality Commission (CQC) (CQC, 2022). Moreover, some PhD theses were included, where these had strong relevance, such as those by Series (2013) and Lonbay (2015).

Supplementary searches: Additional searches were undertaken using Google Scholar and the Manchester Metropolitan University Library catalogue. These employed a range of the search terms listed above. Backward citation searching was also conducted using the reference lists of included articles.

Designation of themes in the literature review

Reporting of the review was structured via nine topical themes. As I took notes from each item of literature, I summarised its coverage and main arguments. I then compiled and re-read these notes, with predominating concepts identified and used as the basis for organising the themes. This approach broadly followed that discussed by Aveyard (2019). Many of the themes were generated deductively based on areas that I wanted to investigate according to my research aims, such as regarding access to advocacy, measurement of its effectiveness, how advocates conduct challenges, and the nature of advocate–practitioner relationships. Other themes were generated more inductively. This included recognition of the strong emphasis in much of the literature about case advocacy regarding how advocacy is conducted through transactional mechanisms (see Ridley et al., 2018).

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Appendix C: Summary and critical appraisal of literature reviewed

Reference	Type	Coverage	Methodology	Commentary
Advocacy Action Alliance (2015)	Grey	Report produced by the Mental Health Foundation for the Advocacy Action Alliance, a coalition of English and Welsh advocacy groups. Based on a survey of advocacy providers, regarding observations of early commissioning initiatives by local authorities, to meet their new responsibilities regarding independent advocacy under the CA2014.	Online survey of advocacy providers was undertaken in summer 2015; 10 questions were posed, asking providers to provide information about how the local authorities they worked within were going about commissioning independent advocacy.	Provides important insight into early trends within commissioning CAA, which complements work by Newbigging et al. (2021). However this study has various limitations. There were 101 responses to the survey and these covered 72 local authority areas. This was a response rate of slightly less than half of the then-152 English local authorities commissioning adult social care and not all responses were complete. There were relatively low responses to questions requesting financial information and the authors acknowledge that the person completing the survey may not have had access to this information. Moreover, the survey was disseminated in July, approximately three months after implementation of the CA2014 began, making this a snapshot of this very early phase, with significant upheaval. It can be expected that commissioning arrangements would have significantly settled since.

Anderson and Bigby (2020)	Scholarly	Paper focuses on the role of support workers in independent self - advocacy groups in Australia and the UK and is part of a larger research project about such groups.	Constructivist grounded theory, encompassing semi-structured interviews with 25 self-advocates from 6 different groups (2 Australian, 4 in the UK) and 10 supporters drawn from across these groups. Sampling strategy for groups was a mixture of purposive and convenience, encompassing key aspects of difference such as group size and urban vs rural locations. Findings from UK and Australian groups are analysed together.	This paper points to potential for considering advocacy's international dimensions, especially as it concerned two countries (UK and Australia) that bear some similarities regarding their respective formats for statutory advocacy (see Maylea et al., 2020). However, working across national contexts for a study of statutory advocacy would need to take greater account of contextual differences regarding the social care system in each nation, e.g. this paper refers to the Australian groups receiving funding from State Governments, which are a different unit of governance to English local authorities.
Association of Directors of Adult Social Services (ADASS) (2020)	Grey	Short briefing paper setting out 'actions for local authority leaders, commissioners, and managers' regarding advocacy, following onset of the Covid-19 pandemic.	States the briefing was prepared after consultations with individual sectoral figures and a 25-person strong 'structured discussion group'.	Provides insight into sectoral concerns and proposed ways forward at this time of acute challenge. Its evidential basis is limited, with acknowledged methodological limitations due to being undertaken to tight timescales. There is no information to evaluate how representative consultees may have been of the wider sector, including no details given about how consultee selection took place.
Baxter et al. (2020)	Scholarly	Qualitative study of self-funders' experiences of	Comprised interviews with a robust sample (40 interviews	The study's specific relevance to CAA is limited as it relates to broader statutory

		accessing advice and support regarding navigating the care system.	with self-funders or their relatives; 19 with professionals) that was purposively recruited to ensure different characteristics were encountered, including according to age, location and level of support needs.	duties to ensure the provision of advice and information to self-funders, rather than the more targeted nature of independent advocacy support for people with ‘substantial difficulty’. The article also does not engage with whether self-funders are able to access services such as CAA, even on a discretionary basis. The evidence base is also from the first year of the CA2014’s implementation, again raising questions about how representative this is of more contemporary practice.
Bennett (2016)	Scholarly	Report based on a review of the CA2014 after one year of implementation, undertaken by the Carers Trust and based on the work of a Review Commission.	Comprises findings from a survey of carers, quotations from carers, and evidence reports by representatives from bodies including local authorities, the Local Government Association and NHS England.	Evaluation of the methodology utilised is not possible as details are not included in the report but via a link to the Carers Trust website, which is broken. Only brief reference is made to advocacy, and this relates to an absence of specific evidence of carers’ advocacy being available to the review, rather than actual evidence of absence.
Bowes and Sim (2006)	Scholarly	Journal article based on a report commissioned by local statutory services in Glasgow regarding understanding and expectations of advocacy services for people from	Interviews with representatives of 18 community-based groups and 60 potential service users from minoritised communities, including refugees and asylum seekers.	Methodology enables triangulation of service provider and potential service user perspectives. The work has a novel element in that it seeks the views of potential rather than actual advocacy service users, about what they want from services and not their experiences of them. Deployed snowball

		Black and minority ethnic backgrounds.		sampling, while the use of sampling quotas ensured there was some reflection of the diversity of the local population. Based on a research report published in 2002, so now significantly dated.
Brown et al. (2013)	Scholarly	Qualitative study of ‘dementia advocacy’, using a mixture of qualitative methods	Covers services in five localities, with interview data augmented by an ethnographic component, with observations conducted in three localities.	Sites studied included a mixture of urban and rural locations; thus increasing variation in the sample size and enriching understanding with insights from different contexts. There was also variation of advocate perspective, as participants comprised different types of advocates—including volunteer and statutory advocates. There was further triangulation of perspective via interviews with other stakeholders, including a social worker, and inclusion of an ethnographic component. However there is a lack of service user input and the study pre-dates the CA2014. This law had important implications for ‘dementia advocacy’ given it framed statutory advocacy requirements in functional rather than condition-specific terms, meaning whether specialist ‘dementia advocacy’ was provided came to be at commissioners’ discretion.
Carey (2019)	Scholarly	PhD study about Disabled People's User Led Organisations (DPULOs),	Sequential mixed methods. Semi-structured interviews with 12 CEOs of DPULOs,	The initial 12 CEOs were recruited via purposive sampling, to ensure a mixture of DPULOs of different organisational ages and

		regarding their development, challenges faced and how their future security can be ensured.	which then informed creation of a survey of a larger cohort of 340 CEOs (133 responses were received).	from different UK nations. This thesis addresses advocacy but does so as part of broader understanding of role of DPULOs, which may engage significantly in non-advocacy activities, including commercial services such as transcription enterprises. It therefore helps explore the fluid and contested boundary between advocacy and non-advocacy activities.
Chatfield et al. (2018)	Scholarly	Small scale study about use of the IMCA service within critical care settings, and whether this could be expanded to support family and friends of patients in such settings.	Interviews conducted across 2 hospital trusts, with critical care clinicians (*n*=6), relatives of patients (*n*=5) and IMCAs (*n*=4). Study design used mixed methods, and questionnaires were sent to all 50 IMCA services across England and Wales.	There was a low response level to the questionnaires (15 out of 50) and so no quantitative data was included, and only a small amount of qualitative data from the questionnaires was specifically cited. In the thematic analysis it is sometimes unclear whether the analysis refers exclusively to data gathered from the two hospital trusts or whether some data from the questionnaire responses has been incorporated. The confinement of the main part of the study to only two hospital trusts could strongly limit generalisability of findings, especially as aspects such as the availability of training in the MCA2005 could vary between trusts.
Care Quality Commission (2015)	Official	Official monitoring report concerning implementation of the MHA1983 by the statutory regulator, including	Draws on a large qualitative and quantitative dataset, including reports from service and MHA visits, by inspectors and Second	Provides a strong evidence base, including a survey undertaken during MHA visits during early 2015 about compliance with IMHA requirements that were then to be included in the new Code of Practice to the MHA1983.

		responsibilities regarding IMHA.	Opinion Appointed Doctors; death notifications; and complaints. Includes analysis of a sample of visit reports and consultations with inspectors.	
Care Quality Commission (2020)	Official	Official monitoring report as per entry for CQC (2015).	Large qualitative and quantitative evidence base drawn from regulatory activities, as per above entry. This edition of the report highlights consultation with service users: 2,667 patients and 726 carers. Advocates were also spoken to, along with staff. Analysis is quantitative and qualitative. Expands on the evidence base of the 2015 edition by including Independent Education and Treatment Reviews for people who are autistic or who have learning disabilities.	Input from advocates is well represented in the qualitative data presented throughout the report. However the main section of the report that specifically addresses advocacy (pp.57-8) is relatively brief and lacks overarching quantitative data regarding access to advocacy, with broader statements that are less precise regarding the proportion of services affected, e.g. 'We have found that some IMHA services are overstretched or limited by their contractual obligations' (p.57).
Cornes et al. (2018)	Scholarly	Case study of a 'Fulfilling Lives' partnership project, based in an English city. This works with people experiencing 'multiple	Paper is not grounded in empirical case study research but is instead the product of study group meetings, comprising representatives	This service was funded by the 'Big Lottery'. Therefore, while it undertook advocacy functions, it must be differentiated from a CAA service, which are funded by the local authority. For example, access to the project

		needs', potentially including homelessness, with an emphasis on empowering personal change and promoting access to services.	of the service in question, along with others including academics and social workers.	being studied is not via local authority referral; to the contrary, the project seeks to promote access to local authority processes by advocating for service users to have their needs assessed under the terms of the CA2014. This therefore represents, to a significant degree, a contrasting case relative to CAA services. However, generalisability is limited by this being a study of a single case. The paper includes acknowledgement of a lack of independence from the project being studied, with the authorship team including project representatives. This may introduce positivity bias in discussing the project, although the authors stated an attempt to curtail this via 'critical reflexivity' (p.3).
Department of Health (DH) (2014c)	Official	Official monitoring report about the IMCA service.	Based primarily on data extracted from a national database, where IMCA providers inputted data about each referral. From this, quantitative data was extracted and presented in chart and graph form, e.g. about referral volumes and their demographic composition. Commentary on these statistics was informed by consultations	Consultations were undertaken with IMCAs and 'the heads of some of the biggest IMCA providers' (p.9). These evidenced the relatively privileged role of larger, multi-area service providers in influencing advocacy policy, whereby their views and interests may be not representative of the wider advocacy sector. The report highlights the value of having national monitoring of statutory advocacy referrals, which was thereafter discontinued. It states that reporting requirements for IMCA referrals were being reviewed due to concerns about

			undertaken within the IMCA sector.	compliance and that they may be onerous for providers.
Dixon et al. (2020)	Scholarly	Considers case-based advocacy for people with dementia in England and Wales as a case study for how well such practice can act to promote and safeguard human rights. Article is not based on original primary research but instead builds on synthesises of extant literature and case law.	Socio-legal analysis and discussion of extant literature (official, grey and scholarly).	Much of the literature covered is featured in the literature review for this thesis. A strong socio-legal perspective encompasses discussion of domestic and international law, e.g. the UN Convention on the Rights Persons with Disabilities. Despite the focus on dementia, there is relevance to case advocacy for other service user groups. Yet the article also foregrounds the importance of considering the specific nature of individual need as this may relate to condition, diagnosis or impairment. As such, the progressive nature of dementia as an illness has implications for appropriate service design, based on enabling continuous and responsive support that can adjust to evolving needs over time.
Eades (2018)	Scholarly	Evaluative study of an IMHA service in a high-secure forensic hospital (Broadmoor), concerning the impact of the service on patients' levels of self-determination.	Questionnaire with qualitative and quantitative questions, the latter aligned with measurements based on Deci and Ryan's self-determination theory. The questionnaire was co-produced with patients and distributed to nearly all	This study lacks independence as it is an evaluation of a service by the service provider, with the author being the Service Manager. The highly specialised nature of the service may account for this; it is likely identified by name as it is one of only three such in England. The positive research findings may have been skewed by the response rate, with those more favourable to

			resident patients (197 of 210), drawing 115 responses (58%).	the service being possibly more likely to participate. The author acknowledges that, in order to create more generalisable findings about the impact of IMHA services on self-determination, there would need to be equivalent research in more services and with larger sample sizes, possibly accompanied by a longitudinal aspect. Considerations of generalisability must also account for the highly specialist nature of the service at Broadmoor Hospital.
Equalities and Human Rights Commission (EHRC) (2010)	Official	Research about the provision of social care advocacy for people from groups protected by equality legislation.	Telephone survey with 403 advocacy providers and 200 commissioners of social care and health services. Augmented by 13 case studies highlighting good practice.	The research aimed to assess the availability of advocacy for people from different backgrounds, but the methodology chosen poses issues for the robustness of conclusions. Participation was not based on random sampling but solely on identifiability and willingness to participate. All 1500 advocacy providers on 3 national databases were contacted (the databases may not have been incomplete); 403 providers participated. Commissioners were approached according to factors such as availability of contact information, while snowball sampling also contributed to recruitment in this area. The findings may therefore reflect a positivity bias, with organisations feeling they have a good story to tell being more likely to participate. That

				the case studies—the only component with service user input—were confined to examples of good practice reinforces this suggestion of positivity bias. The research covers all three nations of Great Britain, with Scotland and Wales over-represented in commissioner contributions relative to population. This research predates the Care Act 2014, which created pressures towards more generically organised advocacy provision, at least concerning support with statutory processes.
EHRC (2023)	Official	Inquiry report about challenging decision making in adult social care, including findings of research commissioned by the EHRC.	Mixed methods, with two major components being in-depth semi-structured interviews with 41 individuals with experience of challenging decision-making in adult social care and a survey of all 174 local authorities in England providing adult social care.	The survey received an 88% response rate, indicating a relatively strong evidential basis regarding subjects of enquiry, such as the proportion of local authorities with established appeals procedures regarding adult social care decisions. The methodology for the in-depth interviews and survey of local authorities is detailed in accompanying documents, although the method of qualitative analysis is not discussed. The inquiry report also mentions evidence gathered from other stakeholders, including interested and informed parties such as lawyers and academics, although methodological concerns regarding the inclusion of such insights is less clearly addressed in the report and accompanying

				documentation. This inquiry report is highly pertinent to the current thesis due to its focus on adult social care decision-making under the CA2014 (and equivalent legislation in Wales), including the role of independent advocacy in enabling challenges.
El Ansari et al. (2009)	Scholarly	Analysis of the development of a multi-lingual advocacy service in a Hospital Trust in East London, an area of high social diversity.	Delphi-like collective expert analysis involving the four co-authors, based on their experiences of the service. This involves iterative discussion to seek consensus (although full implementation of the Delphi-method would have been conducted between anonymous participants). The authors settled on a list of challenges and possible ways forward. Approach was augmented via analysis of secondary data supplied by the service, including policy documentation and evaluation summaries.	Focuses on a single service, which may not be representative of other service provision that fuses advocacy and interpretation. Based on external experts' perceptions, it lacks validation from those providing or using the service. Follow-up work is needed to assess whether attempts were made to implement the recommendations and determine results. The paper does not address how multi-lingual advocacy services might be affected by the introduction of statutory advocacy roles that were then relatively new (Health Complaints Advocacy, IMCA, IMHA). The paper also predates developments such as the introduction of more rigorous independent advocacy qualifications.
Flynn (2012)	Official	Serious Case Review (SCR) report into institutional abuse at Winterbourne	Builds on management reviews from the service provider, CQC,	Provides granular detail of appalling abuse and failure of agencies to appropriately respond, with granular detail. Failings

		View, an independent hospital for people with learning disabilities and autism, uncovered in 2011 by a BBC investigation.	Commissioning NHS Trust, local authority, and police service. Another source was the BBC Panorama programme that exposed the abuse.	concerning gaps in independent advocacy provision are mentioned, but these are only part of broader systemic failure. The CAA role was yet to be introduced at the time of the SCR, so it does not provide evidence regarding the effectiveness of CAA services specifically in acting as a proactive safeguard or response to institutional abuse.
Foley and Platzer (2007)	Scholarly	Paper discussing a research project that mapped Mental Health Advocacy Services in London in 2002. Project considered types of service provision and their spatial arrangement and compared this to the geographic and demographic characteristics of mental health service use in the city more generally.	Mixed methods. Quantitative element consisted of cartographic and statistical analysis of topographic, demographic and service location data, using computerised Geographic Information System resources. Qualitative element comprised interviews and focus groups with service providers, commissioners and service users.	Provides strong evidence for a ‘postcode lottery’ in service provision, with availability of advocacy services sub-optimally correlated with locations of need, albeit the research was confined to the UK’s capital city and may not be more widely applicable. The paper also raises issues about the type of advocacy services available and the extent to which these appropriately serve people from different groups, including ethnically minoritised communities. It explores issues that have increased in policy salience in the two decades since its data was collected, regarding how ‘culturally appropriate advocacy’ should be delivered and where responsibilities for this should be allocated between mainstream and more grassroots/specialised services. The research pre-dates the introduction of statutory advocacy responsibilities so the paper cannot account for how these might impact upon

				the landscape of advocacy provision, although the commentary does refer to IMHA's introduction bolstering pre-existing professionalising tendencies in the sector.
Forbat and Atkinson (2005)	Scholarly	Review of theory and practice regarding advocacy, drawing on the authors' evaluation of advocacy services in Nottinghamshire.	Mixed methods: qualitative interviews with advocates and service users; and a survey that had 132 responses, again including service users. This was combined with document review and observational review, including speaking to people in healthcare locations to gauge levels of advocacy awareness.	The evaluation reported on is methodologically robust and the paper provides important insights, e.g. regarding the relationship between advocacy and professional social work. The main limitation of this paper in the context of the current thesis concerns recency, with the evaluation conducted in 2003. Thus the context for the paper's empirical work is significantly different than that under the CA2014, as reflected in the advocacy provision being evaluated being split between five providers grouped according to type of service use (e.g. working with older people; people with learning disabilities). Moreover, the study emphasises advocates' role in challenging professionals, and mentions advocates speaking out at meetings, but other key mechanisms by which challenges may be pursued (e.g. use of complaints procedures) are not detailed.
Goodley (2005)	Scholarly	Paper critiquing then-government policy towards support for people with learning	Critique is based on policy analysis, literature review and incorporates reports and ethnographic data	The case study content is presented as illustrative of the argument presented throughout the paper and the methodological basis for inclusion is not

		disabilities, following the *Valuing People* White Paper, from the perspective of relationship to the self-advocacy movement.	concerning the author's engagement with two self-advocacy groups.	addressed explicitly. While helping elucidate how self-advocacy mechanisms can function in practice this paper does not adequately address whether scope may exist for synergies between such collective advocacy and case advocacy that encompasses support for an individual's engagement with statutory processes.
Gratsias (2021)	Scholarly	PhD study considering advocacy's impact and outcomes from service users' perspectives. The author was working as an independent advocate and facilitated self-advocacy groups.	Study is grounded in participatory research principles, including via a steering group of self-advocates. Data collection comprised 13 semi-structured interviews with people who have used advocacy services, case vignettes and a focus group.	The conduct of research by practising advocates is an area for occupational development (Newbigging et al., 2015), with this being one of the few such works encountered (see also Morgan, 2017). This study is based on a single advocacy organisation where the author worked and generalisability may thus be limited. It spans different advocacy types—professional, case, citizen, peer and self—which is useful for comparative analysis of how different advocacy mechanisms produce different outcomes. However, the study does not consider in detail how these mechanisms interface with specific aspects of the care and support system under the Care Act 2014, e.g. how advocacy support with letter-writing may then initiate mechanisms within the local authority regarding review of decision-making about care and support.

				Participation was also limited to recipients of instructed advocacy.
Hardwick (2018)	Scholarly	Article based on an unpublished study commissioned by the National Coalition of Advocacy Schemes to discern levels of need for citizen/informal advocacy, and scale of provision.	Interviews with representatives from NCAS affiliated organisations (*n*=17) and one local authority commissioner.	Participating advocacy organisations are a mixture of those that have retained focus on informal advocacy and those that have moved, in whole or part, to statutory advocacy provision. They were drawn from different parts of England. The paper acknowledges a paucity of perspectives from outside the advocacy sector; only one commissioner was interviewed and their views may not have been representative of those of their peers. The article is strongly critical of 'large, business-focused advocacy organisations' (p.144), which would align with the positionality of the smaller, locally-focused organisations interviewed, but there is no input from representatives of such larger, multi-area organisations nor exploration of the possibility that commissioning from larger organisations may have advantages in some respects.
Harrison and Davis (2009)	Professional journal	Article in a journal with a readership of practising clinicians. Provides an overview of independent advocacy, especially relating to work with people with mental health	Not based on original research - discusses literature and draws on the authors' own experiences as a consultant psychiatrist and as a manager of advocacy services. Also draws on	Overview article that acts as a broad introduction for a professional audience, regarding key points about advocacy necessary for practice. States that literature searches were undertaken and critiques extant literature as 'largely illustrative and/or

		problems and learning disabilities.	knowledge from the Royal College of Psychiatrists' Working Party on Advocacy.	polemical' (p.57) but details of the literature search are not provided.
Hussein et al. (2006)	Scholarly	Mixed-methods research regarding the nature of advocacy services for people with learning disabilities, following significant increase in funding declared in the *Valuing People* white paper (DH, 2001). Emerging trends in advocacy evaluation are emphasised.	Survey of local authorities, conducted in 2004-5, and a seminar with key stakeholders, including people with lived experience.	The survey received a response from only a minority of local authorities, although this represented a significant sample of local authorities (*n*=54) and concerned a significant number of advocacy schemes (*n*=97). The seminar critically discussed emerging trends in evaluation, including use of service-level agreements. It highlighted issues about how service users can feed into evaluations and distinguished between process and outcome-oriented evaluation. While this article raises important conceptual issues its evidential value for the current thesis is reduced due to the time that has passed since data collection and its focus on various advocacy types that differ significantly from the statutory advocacy services studied in this thesis: namely group-specific, self, peer, and citizen advocacy.
James (2021)	Scholarly	An attempt to 'review and synthesise the genealogy of the named social worker pilot' (p.7), which involved long-term allocation of a social worker to adults with	Literature-based review, synthesis and scholarly critique.	This could usefully be read alongside evaluation of the named social worker pilot by SCIE (2018). The pilot has strong relevance for exploring the social work advocacy function. The relationship between social work advocacy and independent advocacy

		learning disabilities whose behaviour challenges services. It considers the nature of the policy, its historical development and there is philosophical critique via reference to concepts such as theories of recognition and justice (including work by Honneth).		needs to be explored further in light of this explicit policy endorsement of the former.
Joint Committee on the Draft Mental Health Bill (JCDMHB) (2023)	Official	Pre-legislative scrutiny report by a committee of parliamentarians from both Houses of Parliament, regarding the Mental Health Bill 2022 (which did not become law but was the basis for legislation proposed by the Starmer Labour Government).	Based on an inquiry undertaken by the committee, which included: 12 public evidence meetings, with more than 50 witnesses; a hospital visit and a virtual roundtable event with service users; 114 written submissions; and an online survey, including in ‘easy read’ format, with 100+ responses.	The report contains a chapter on independent advocacy that addresses key topics: access, including on an opt-out basis; funding; need for specialist advocacy services; and culturally appropriate advocacy. Report provides links to evidence sessions that include participants from advocacy organisations and academics, with other organisations such as the British Association of Social Workers making written submissions. It is unclear from the report and associated evidence documentation how those giving evidence were selected, however it is understood there would have been a publicised call for evidence from interested and knowledgeable parties. Of advocacy providers submitting evidence, there was identifiably a representative of a

				large multi-area advocacy provider, a smaller organisation providing statutory services in a single city region, and a specialist provider of culturally appropriate advocacy services. However, questions remain about how representative this range of contributors are of the advocacy sector generally. The report does make clear the existence of differences of opinion, or at least of emphasis, within the sector regarding how best to develop culturally appropriate advocacy services.
King and Romeo (2022)	Official	Blog on the Government's website, published under the auspices of the DHSC, and authored by Ewan King of SCIE and introduced by Lyn Romeo, then chief social worker for adults. This post draws on the pilot of the Named Social Worker role, which sought to assign a consistent caseworker to people with learning disabilities, autism or mental health needs, to support them through complex decisions about their care and support. It	This is a relatively brief blogpost and does not refer in depth to its evidential basis, although it does cite SCIE's evaluation of the Named Social Worker pilot (SCIE, 2018).	This source provides context about a specific social work role that is strongly predicated on the notion of professional advocacy, although this is not explicitly mentioned in this blogpost (see James, 2021).

		makes the case for this model to be more widely applied.		
Kingston and Mortimer (2018)	Official	Safeguarding Adults Review (SAR) about the death of a man, ‘Paul’, in circumstances of self-neglect, where there was concern about statutory agencies’ response to his situation.	Analysis of the following: agencies’ chronologies of events; agencies’ management reviews; discussions at multi-agency review panel meetings; information from CQC.	The SAR notes that the statutory requirement to provide Paul with an independent advocate to support him regarding CA2014 processes was not met, although he was provided with an advocate regarding benefits advice. Implications for practice and policy regarding advocacy are not addressed explicitly, possibly reducing potential learning opportunities in this area. This might have included consideration of whether there was any confusion among professionals about these different forms of advocacy.
Lawson and Petty (2020)	Grey	Briefing for the LGA and ADASS, funded by the DHSC, regarding strengthening advocacy’s role in Making Safeguarding Personal. This was part of a sector-led improvement programme.	Conversations with advocates, via semi-structured focus group sessions, conducted over teleconference. 28 advocates participated, from 18 different providers and covering 33 different local authority areas. Findings are structured thematically and	Limited methodological detail given, e.g. about how participants were recruited (although a full list of all participating advocacy organisations is supplied) or how the focus group sessions were conducted. Although participating organisations were from different English regions, there was not full national coverage - e.g. there were none from the North West region. There is no discussion of how the sample was selected in

			relate to 15 ‘core messages’, alongside other issues for consideration.	terms of organisational size, range of advocacy functions etc.
Llewellyn and Northway (2008)	Scholarly	Paper detailing a grounded-theory study that explores how people with intellectual disabilities define advocacy and identify their advocacy needs. Includes consideration of whether professionals can be advocates, with a focus on the role of learning disability nurses.	Grounded theory study formulated using inclusive research principles. Focus groups were undertaken with: 1) individuals in a long-stay hospital for people with learning disabilities; 2) at a day centre; 3) attendees at a self-advocacy group. Total of 23 participants. Results analysed using situational analysis and mapping, graphically representing key themes and relationships.	Findings demonstrate the diversity of advocacy, suggesting that service users’ understanding of what it comprises is shaped by what is available. All participants were labelled as having mild/moderate learning difficulties, thus the experiences of advocacy discussed may not capture instances where more representational forms of advocacy are appropriate. Data regarding views on the advocacy role of professionals is useful, but opinions relating to social workers (rather than learning disability nurses) may have been more relevant for the current thesis.
Lonbay and Brandon (2017)	Scholarly	Scholarly study, based on doctoral research, about how independent advocates promote older people’s involvement in safeguarding processes.	Based on case studies about older people’s safeguarding in two local authorities. Semi-structured interviews with a total of six advocates (mixture of IMCAs, IMHAs, and general case advocates). Analysed via thematic analysis, with the study	Emphasis on individualised, transactional processes and the potential benefits and limitations of this. The ability and willingness of older people to become involved in such processes were shown to be key variables, although not fully independent of support provision. Participants included advocates and social workers, enabling some triangulation of perspectives. However, as in

			grounded in critical realist metatheory.	the current thesis the evidence base is limited to only two local authorities, potentially limiting transferability. The article acknowledges the lack of service user participation to be an issue. Relevance to the study of CAA is also reduced as the empirical work pre-dated implementation of the CA2014.
Luke et al. (2008)	Scholarly	Journal article based on an evaluative study of seven advocacy organisations piloting IMCA services (see also Redley et al. (2010), another output from this evaluation).	Semi-structured interviews with doctors and senior nurses across 4 hospitals (40 interviews in total), followed by participant validation.	Paper allows comparative analysis between non-instructed advocacy in respect of healthcare (serious medical treatment) and social care (discharge destination) decisions, with participants having expertise in different clinical areas. However, the study was only undertaken during piloting of the IMCA role, and a significant proportion of participants were yet to have experience of engaging with IMCAs. Therefore, this paper may not be reflective of attitudes and practices that developed during more mature implementation of the IMCA role.

Macadam et al. (2014)	Grey	Scoping review of evidence about the impact of advocacy, conducted by staff from NDTi, under commission from the NIHR School for Social Care Research.	This is acknowledged not to be a full Cochrane-type systematic review. It is however described as seeking rigour, with full search criteria cited and a method for analysis described that uses a thematic content analysis grid. The review is predominantly based on published sources (scholarly and grey), but also includes unpublished sources, including localised evaluations of advocacy schemes. The review also includes generalised comments about evidence quality regarding advocacy research. It is wide-ranging, encompassing literature from the UK and Ireland published since 1990, including that about advocacy in children's and adult social care.	As Newbigging et al. (2015) have noted, this type of review is potentially insufficiently attentive to the very different contexts in which advocacy operates, and outcomes sought. This is reflected in the inclusion of literature regarding advocacy in children's social care. The relevance of this review to the current study is also diminished as it pre-dates the CA2014 and includes literature that is now very dated and may not be relevant to the contemporary context.

Manthorpe et al. (2005)	Scholarly	Literature review and research with stakeholders regarding models for evaluating advocacy for people with learning disabilities. Commissioned by the Department of Health as part of significant public funding increase for advocacy schemes.	See Rapaport et al. (2005, 2006) and Hussein et al. (2006), which report study findings in scholarly journals.	See Rapaport et al. (2005, 2006) and Hussein et al. (2006).
McKeown et al. (2014)	Scholarly	Paper reporting findings from the national evaluation of IMHA services (Newbigging et al., 2012), focusing on relationships between IMHAs and mental health nursing practitioners, and the implications of these for conduct of their respective roles.	See entry for Newbigging et al. (2012)	Features important analysis of the interaction, and limitations, of practitioner/ professional and independent advocacy mechanisms, within the specific context of IMHA. See discussion of the methodology of Newbigging et al. (2012), including the uncertain representativeness of the case study approach and the conduct of the research relatively early in IMHA's implementation.
McNicoll (2016)	Grey	Journalistic article in *Community Care*, a prominent professional media channel (online only) regarding issues with the implementation of	Evidence is based on a Freedom of Information request, which a large sample of local authorities with adult social care responsibilities responded to	Strong evidence of under-utilisation, especially when compared to the Government’s planning estimate of 7% utilisation. However, findings related to assessments only, with other care and support processes not covered. Moreover,

		access requirements for CAA services.	(80 out of c.150). This showed only 2.1% of people assessed between April and September 2015 had CAA support.	findings referred to only the first six months of implementation of the CA2014, with the article noting that arrangements regarding implementing CAA responsibilities had yet to be settled in many local authorities (e.g. regarding the contracting of services), and so results will likely not be reflective of the current situation. The article quotes various national commentators, some of whom also contributed to this thesis, regarding their views of the reasons for access issues.
Mercer and Petty (2021)	Grey	Scoping exercise commissioned by NHS England and NHS Improvement regarding the state of independent advocacy provision concerning health-funded care and support, including s.117 aftercare under the Mental Health Act 1983; NHS Continuing Health Care; and Personal Health Budgets. Commissioned with a view to fostering improvements, e.g. by identifying training needs among advocates.	Mixed methods: information gathering via Freedom of Information (FoI) requests to all local authorities and Clinical Commissioning Groups regarding what they commission; a survey of advocacy organisations about what they provide; semi-structured interviews with representatives of advocacy providers and individual advocates, to gain more detailed insights, e.g. about gaps in provision; a desk-based review of law and policy.	Addresses an important topic not covered by other literature identified. Provides limited information about some aspects of the methodology used. It is unclear whether all statutory agencies successfully responded to FoI requests, although it can be inferred from the text that there was a high response rate. Recruitment for the survey was via channels including NDTI’s Advocacy and Advocacy Quality Performance Mark (QPM) mailing lists, although not all advocacy organisations are accredited via the QPM. There were only 24 survey completions, which the authors acknowledge may have been due to Covid-19 disruption. From the survey responses, seven organisational representatives self-selected for follow-up interview by expressing willingness regarding this. Such self-selection

				again makes representativeness less likely, relative to random sampling. Limited information is given about methods of interviewing or resulting analysis.
Morgan (2017)	Scholarly	Book about independent advocacy, focusing predominantly on IMCA services, considering growing professionalisation and spiritual aspects of the role.	Semi-structured interviews (total of 40) with advocates, hospital chaplains and service users. Advocates were drawn from services the author used to work within.	Provides a robust exploration of independent advocacy as an occupational role, with attentiveness to professionalisation. The book is novel in its application of perspectives from Practical Theology and consideration of the spiritual dimensions of advocacy. This reflects the author's own background as an ordained clergyman, having worked as an IMCA and later as a hospital chaplain. It is also one of the few works identified written by someone with experience of working as an advocate (see also Gratsias, 2021). Interviews were nearly all completed during the first two years of the introduction of IMCA services (2007/8) and so this service may have remained at a relatively formative stage. The book also utilises a case study approach, regarding services the author used to work in, so generalisability may be limited. There is also limited methodological reflection about how the author’s insider status may have affected the conduct of the interviews.

Newbigging et al. (2007)	Scholarly	Book-length knowledge review regarding the mental health advocacy needs of African and Caribbean men, covering various aspects including: the nature of provision; what models of organisation and funding exist; what impact and outcomes services result in.	Multi-method: i) research review with rigorous selection criteria for literature that was included, with this review published in full separately; ii) three practice surveys. The first was an email and telephone survey to establish the range of mental health advocacy that can be accessed by African and Caribbean men. It led to development of a database of nearly 400 projects, from which an email/ telephone survey was conducted with a sample of 52 organisations. The second practice survey involved four focus groups and a small number of individual interviews, involving a total of 30 men. Practice survey three comprised two case studies and additional interviews with stakeholders commissioning and providing advocacy with African and Caribbean men.	Addresses key questions about the availability of suitable provision, its organisation, formalisation, and difficulties in evaluating the impact of advocacy. Raises other key questions about culturally appropriate advocacy provision that prefigure current discussions about how to implement this concept in practice, as part of a programme of legal and practice reform relating to the Mental Health Act (see JCDMHB, 2022). This includes debate about whether specialist or mainstream services should be the main locus of development for cultural appropriateness. Qualitative data was analysed using systematic thematic content analysis but there are no details about how this was done. The authors acknowledge difficulties in identifying African and Caribbean men who had experience of advocacy, and therefore individuals with this experience comprised a minority of interviewees/ focus group participants. There was also a relatively low response rate to the national survey. This work pre-dates implementation of the IMHA role and therefore cannot elucidate how the the targeted advocacy provision for African and Caribbean men that is the subject of this report might relate to IMHA services.

Newbigging et al. (2012)	Report	Book-length research report providing a national evaluation of IMHA services. Research aims to: determine how IMHA services are being implemented; what good should look like for services; and what factors influence quality.	Large, mixed methods study. First stage included 11 focus groups conducted across England with various stakeholders, and visits to mental health services. The emphasis here was on determining quality indicators. The second stage was undertaken at eight case study sites to determine implementation against these quality indicators. Methods included: questionnaires to IMHA providers; documentary analysis; and interviews with stakeholders. This stage comprised 214 interviews exploring experiences of IMHA, with 90 of these with 'qualifying patients' eligible for IMHA, 61 of whom had actually received a service. Analysis included descriptive statistics, including regarding access to IMHA. Selection of study sites was indicative of 'theoretical replication' (Yin, 2018) as they were chosen to	Large evaluative study that covers a wide range of topics, many of which were selected for attention within my own study of Care Act Advocacy. These specifically included: access to IMHA; the landscape of IMHA services and their relationship to generic advocacy provision; the nature of the IMHA workforce; commissioning. Sub-topics with strong relevance to this thesis about CAAA included: IMHAs who have social work qualifications; whether culturally focused organisations could be 'upskilled' to provide IMHA; the merits of specialisation according to service user group; and IMHA-practitioner relationships. The research was undertaken during the first three years of IMHA implementation and so may not reflect the contemporary situation. For example, data collection pre-dated local authorities assuming responsibilities for commissioning IMHA from Primary Care Trusts in 2013 (exact dates of data collection not stated in this report but are given in Newbigging et al. (2015)). There was strong evidence of participatory research principles, enacted by a 13-strong research team included co-researchers with experience of service use and varying ethnic backgrounds.

			reflect variations in local demographics and service configurations.	However, there were limitations to the methodological approach used. The researchers acknowledged recruitment issues, related partly to data availability, which also affected the ability to make comparisons between sites. The recruitment of older people service users was also disproportionately low. Participants needed to have capacity to give informed consent and so some service user groups, e.g. people with more profound cognitive impairment related to advanced dementia, may have been more likely to be excluded. The authors also acknowledged that the representativeness of the eight case studies cannot be determined, especially as no national survey of IMHA provision was undertaken.
Newbigging et al. (2013)	Scholarly	Paper reporting findings from the SCIE-commissioned knowledge review into advocacy provision for African and Caribbean men (see Newbigging et al., 2007)	Methodology as per that detailed for Newbigging et al. (2007).	Distils findings reported in Newbigging et al. (2007), including through a tabular format. Methodological limitations are as reported for Newbigging et al. (2007). The conclusion links key issues posed by the knowledge review to the developing IMHA role, with implementation of the IMHA service commencing since the original research was undertaken.

Newbigging et al. (2015)	Scholarly	Paper reporting findings from the national evaluation of IMHA services (Newbigging et al., 2012).	See entry for Newbigging et al. (2012)	Paper extracts some key findings for an academic audience and also further elucidates some methodological and ethical points.
Newbigging and Ridley (2018)	Scholarly	Paper reporting findings from the national evaluation of IMHA services (Newbigging et al., 2012). It applies Fricker's (2007) concept of epistemic injustice as its analytical framing.	See entry for Newbigging et al. (2012). However, this paper further elaborates on some methodological aspects, including regarding use of thematic analysis and how a coding framework was developed.	Application of epistemic injustice helps theorise crucial notions of 'voice', which recurred within the findings. The distinction between hermeneutical and testimonial forms of epistemic injustice is linked to other ways in which differences between advocacy mechanisms have been framed. The authors acknowledge that other data collection methods may have yielded greater insight into how epistemic in/justice mechanisms actually operate, and they propose direct observation and conversation analysis as having potential in this regard.
Newbigging et al. (2021)	Scholarly	Paper discussing findings from a research report (Newbigging et al., 2017) about developing models of commissioning independent advocacy under the Care Act 2014, considering how these can be strengthened.	Mixed methods: online surveys of commissioners and advocacy providers and follow on interviews within these cohorts. Documentary analysis of local evaluations.	This is the only scholarly work based on primary research about Care Act Advocacy that was published during the literature search period. However, some potential limitations are noted by the authors. First, the research was conducted early during the implementation period, when commissioning arrangements underwent upheaval and had not settled. Second, survey responses covered 46% of local authorities and those participating may have felt they had a

				positive story to tell, meaning the survey did not capture the local authority population as a whole. Third, the participation of disabled people was limited to roundtable events. The paper also discusses issues around the organisational composition of CAA providers but it does not engage with contention about what the term Disabled People's Organisations specifically entails (see Carey, 2019).
National Development Team for Inclusion (NDTi) (2016)	Grey	Framework aimed at providers and commissioners, setting out ways to measure and evidence the impact of independent advocacy.	The evaluation toolkit was co-produced with advocacy services, commissioners and service users; literature about advocacy outcomes was also consulted.	The observation that funding for advocacy services was increasingly being concentrated on statutory provision, cited in my literature review, is an observation contained in the document's foreword by NTDi's chief executive. Given NDTi's leading role in supporting the advocacy sector, this is useful given the paucity of formal tracking of the amount and location of advocacy provision. However, as a brief anecdotal statement in a document foreword, it is of relatively limited evidence quality.
National Development Team for Inclusion (NDTi) (2020)	Grey	Report regarding implications of the Covid-19 pandemic for advocacy and advocacy responses to it.	Survey of 435 advocates in England and Wales, conducted in June 2020.	Limited methodological detail given regarding conduct of the survey. The report identifies the advocacy organisations that partnered in producing the report, although it is unclear whether advocate recruitment was restricted to representatives from those

				organisations. The weighting of the sample does not seem geographically representative—e.g. there were 86 respondents from North West England, yet only 52 from South East England, which has a larger population. This is reflective of the work being a rapid response to the situation created by the Covid-19 pandemic.
National Institute for Health and Care Excellence (NICE) (2022)	Official	Official guidelines regarding advocacy for people using health and social care services in all adult settings, concerning commissioning and delivery of such advocacy services.	Guidelines produced by committee, via evidence review that is documented in depth in separate documents linked to each section, and rationale and impact sections in which the reasons for making the recommendations are explained. Evidence effectiveness reviews used instruments of evidence evaluation adopted within NICE. The published evidence that was reviewed comprised grey and scholarly sources but there were limits to inclusion, e.g. works based on individual case studies were rejected.	Guidelines are based on a form of literature review. The scope of the guidelines is wide, covering advocacy in many different contexts. The evidence base reviewed included work about advocacy in the field of domestic abuse, for example. This means many of the recommendations are expressed in broad terms and would need to be implemented in a context-dependent way.

Older People's Commissioner for Wales (2018)	Official	Report of the Older People's Commissioner for Wales regarding independent advocacy provision in the country.	Report draws on various sources, including legislation and policy, official reports, casework undertaken by the Commissioner's own casework team, and consultations undertaken within the advocacy sector.	Methodology for gathering information for the report is not clearly stated, e.g. there is no firm indication of how many advocacy providers were consulted and how these were selected. Moreover, awareness of the difference between the English and Welsh statutory contexts is needed. The Social Services and Wellbeing (Wales) Act 2014 contains what seems to be many similar independent advocacy requirements to the Care Act 2014; however, it also stipulates that independent advocacy must be considered regarding a wider range of local authority processes.
Palmer et al. (2012)	Scholarly	Small-scale study comprising an audit evaluation by a service provider of one of its own services, where IMHA is provided in a forensic mental health setting.	Paper is based on interviews with service users, thus providing valuable insight into engagement and involvement mechanisms from these perspectives.	Authors acknowledge the relatively small sample size (10 service users) and that no claims to generalisability are made based on the single service nature of the study. Engagement mechanisms are described, including advocates building rapport with service users based on environmental proximity within a secure service. This might not translate to many instances of CAA practice, especially that conducted in the community. Methodologically, the conduct of the audit by advocates providing the service poses significant limitations; the paper acknowledges that service users may be more likely to report enhanced wellbeing,

				self-efficacy and empowerment outcomes based on a perception of this being the sought-after response.
Power et al. (2016)	Scholarly	Qualitative study of self-advocacy groups of people with learning disabilities. The research team included two self-advocates as co-researchers.	Comprised 12 interviews and observations of four groups in operation.	The paper lacks detail about how the composition of the 12 interviews relates to membership of the four groups observed. The paper acknowledges the limitations of the discursive interview format and that other methods such as photo-voice could have been used; also that the self-selected sample of participants limits scope for generalisability. The research was also conducted in 2015, and while it discusses the austerity context and the susceptibility of these groups to cutbacks, it would be useful to have more current information about the levels of self-advocacy provision that exist.
Rapaport et al. (2005)	Scholarly	Literature review conducted as part of trio of outputs about how commissioners evaluate outcomes of advocacy for people with learning disabilities and their carers (see also Rapaport et al., 2006 and Hussein et al. (2006).	Review to establish a 'knowledge base', conducted July to December 2004, via searches of academic, grey and official literature.	Limited information about the search strategy, including omission of the date period searched and the exact terms used. This review is of texts pre-dating the arrival of statutory advocacy, so currency is limited. However, it provides valuable background information about longstanding tensions concerning evaluation, while giving insight into how this was feeding into development of the IMCA role, for which legislation was being prepared at the time.

Rapaport et al. (2006)	Scholarly	Part of a trio of outputs (with Rapaport et al. (2005) and Hussein et al. (2006)) regarding the development of advocacy services for people with learning disabilities in the UK. This paper focuses on perceptions of advocacy among stakeholders.	Semi-structured interviews with 27 representatives from statutory and voluntary agencies, selected via purposive sampling. Agencies included government departments, commissioners, policy makers, advocacy providers and advocates, including people with learning disabilities who act as self-advocates. The data was thematically analysed. An event was held with participants to discuss the findings and enable participant validation.	The authors acknowledge that participants may not be representative of wider stakeholder opinion. Limited details are given about participants' roles, which may have been to preserve anonymity. The research was conducted during 2004-5 and captures data about emerging debates relating to the introduction of statutory advocacy roles. However, given these roles were yet to be implemented in England and Wales, some of this data is now of more historical interest regarding policy formulation rather offering contemporaneous insight.
Redley and Weinberg (2007)	Scholarly	Study of the Parliament for People with Learning Disabilities (PPLD), a self-advocacy group that modelled itself in part on the Westminster system.	Ethnographic analysis of meetings of the group, drawing on a conversation analytic approach (a form of discourse analysis).	Uses analysis of the PPLD as the basis of a cautious critique of the application of liberal notions of citizenship to forms of self-organisation among people with learning disabilities, given the reality of intellectual impairment experienced by participants. However this is based on analysis of only a single self-advocacy group, albeit a notable and distinctive one, and these conclusions would need to be compared and contrasted with a wider set of empirical evidence.

Redley et al. (2010)	Scholarly	Evaluation of pilot IMCA services being provided by seven different organisations in the 15 months before implementation of the IMCA service nationally, which happened from April 2007.	Mixed methods study of pilot services provided by seven different organisations. Quantitative analysis included breaking down the types of referrals received and the duration of work with service users. The qualitative (interview) element encompassed both IMCA and local authority practitioner perspectives.	There was no participation by service users (possibly due to the limits of ethical approval). The main limitation of this study is that it analysed services provided on a pilot basis, which are likely not fully reflective of the more mature implementation of services.
Redley et al. (2011)	Scholarly	Mixed-methods study about the extension of the remit of the IMCA role into safeguarding (on a discretionary basis).	This utilised a relative wealth of primary data about statutory advocacy, as the researchers had access to a national database regarding all IMCA referrals, which has since ceased to operate. This was complemented by qualitative data from 10 IMCA providers, allowing study of the IMCA services provided to 204 adults experiencing safeguarding processes.	Limitations included those frequently identified for other works reviewed: lacking service user input and being about the early phases of implementing a statutory role. This study covered the first year of the national IMCA service (April 2007—March 2008). The basis for statutory advocacy involvement regarding safeguarding, via the IMCA role, has also been superseded to some extent by the introduction of CAA, which significantly expanded statutory advocacy coverage and made it a duty and not just a power to provide advocacy to qualifying individuals undergoing safeguarding processes.
Ridley et al. (2018)	Scholarly	Qualitative meta-analysis of three papers written by	Meta thematic analysis of papers about i) mental health	Provides a focus on advocacy outcomes from service user perspectives, which had been

		the authors regarding different types of mental health advocacy, focusing on variations in types of advocacy outcomes.	advocacy for African and African-Caribbean men (Newbigging et al., 2007); ii) IMHA for 'qualifying patients' under the Mental Health Act 1983 (Newbigging et al. (2012); iii) advocacy for children and young people. Discerned four main categories as the basis for reporting.	missing from much advocacy scholarship. Discerns a distinction between transactional/ transformational advocacy outcomes, which partially overlaps with distinctions drawn in other works, e.g. between process and outcomes (Townsley et al., 2009) and testimonial and hermeneutical justice (Newbigging and Ridley, 2018). This paper is subject to the potential methodological limitations of the individual studies that comprise the meta-analysis. Also, the meta-analysis includes scholarship that pre-dates the implementation of statutory advocacy, and it is important to be aware of how provision may have changed in the intervening period.
Roberts et al. (2012)	Grey	Research report issued by the Improving Health and Lives Learning Disabilities Observatory, supported by the Department of Health. The report authors have sought to undertake a wide-ranging mapping of the contours of advocacy by and for adults with learning disabilities in England, as it then existed.	Surveys of advocacy organisations (88 respondents) and commissioners from local authorities (78 respondents); augmented by case studies of three self-advocacy organisations.	Grounded in participatory principles, as initiative for the research came from an advisory group of people with learning disabilities. Survey responses provided a wealth of information, including about crucial areas: specialisation of advocacy for people with learning disabilities, funding, and evaluation methods. However, the report lacks information about how the advocacy organisations surveyed were selected for inclusion, and regarding the choice of case studies. Furthermore, the research pre-dates the CA2014, which created trajectory

				towards more generically organised advocacy services (e.g. not focused on working with people with learning disabilities) to meet the requirements of statutory eligibility for independent advocacy.
Salla et al. (2023)	Scholarly	Paper dedicated to developing a conceptual framework for culturally appropriate advocacy, related mainly to IMHA policy and practice.	Wide-ranging discussion paper that draws upon extant literature and the authors' experience of scoping and undertaking evaluation of pilots regarding culturally appropriate advocacy.	Paper offers in-depth critical analysis of a concept that has assumed significant importance within advocacy policy but is under-developed. It focuses exclusively on mental health advocacy and therefore, while it has relevance for considering cultural appropriateness regarding other forms of advocacy practice, caution must be exercised as contextual differences may limit scope for transferability, e.g. from IMHA to IMCA or Care Act Advocacy practice. There is no discussion of how the literature cited was identified.
Social Care Institute for Excellence (SCIE) (2022)	Grey	Guidance to local authority commissioners regarding commissioning CAA.	How the evidence base was assembled is unclear. However it evidently draws on statutory guidance; it includes quotes from participants in co-production workshops; and features 3 local authority case studies.	It is unclear how quotes were selected for inclusion, from co-production workshop participants and stakeholders in the case studies. Case study selection is also unclear and the tone of reporting of the case studies suggests an intention to emphasise the positive, as case examples of good practice.

Series (2013)	Scholarly	PhD thesis providing socio-legal analysis of institutional care for adults with learning disabilities, under the MCA2005.	Based primarily on methods of legal analysis, including doctrinal analysis (analysis of the law itself and associated written material). Freedom of Information requests were used. The study also drew on interviews—initial scoping interviews that included three non-statutory advocates, and then three advocates included in more focused interviewing.	Located in the socio-legal field, this study uses a methodological basis of doctrinal analysis that differs from much social care research. The interviews are partly used to orient the discussion, and the author acknowledges the difficulties of generalising from such a small sample of interviewees. Recruitment methods for the IMCAs are not detailed and approximate dates when the interviews were undertaken are not supplied, so it cannot be ascertained precisely how long the IMCA service had been operating for at the time that interviews about it were conducted.
Sherwood-Johnson (2016)	Scholarly	Scholarly study about advocacy support for adult safeguarding practice in Scotland.	Semi-structured interviews with 20 staff (including managers) from six independent advocacy providers, working across nine Scottish local authority areas.	This work yields significant commonalities of findings with studies about equivalent practice in the English context, including regarding the following topics: apparent under-referral and late referrals; a shift towards more ‘issue-based’ advocacy that is less predicated on long-term relationships, resulting from commissioning practices; and how advocacy practice can complement the input of statutory practitioners, such as social workers. These similarities are indicative of some common causal factors being present across these different legal jurisdictions. However, the difference of legal context does pose issues for direct

				comparison, given that the Scottish legal framework described in the article has a more limited basis for mandating independent advocacy input than under the CA2014, with potentially greater levels of practitioner discretion about making referrals. The research yields potentially significant levels of generalisability of insight within the Scottish context as advocate participants were from six different advocacy organisations spanning nine local authority areas. The methodology for the thematic analysis of the interview data is not stated and there was no service user participation.
Southby and Robinson (2018)	Scholarly	An evaluative study of a hub for adults diagnosed with 'high functioning autism spectrum disorder' in Leeds.	Interviews with service users (*n*=14), relatives (*n*=3); volunteer mentors (*n*=2); professionals from the service and the local authority (*n*=11). Thematic analysis of the data.	Case study of a single service, findings from which may not be generalisable. Authors acknowledge the sample of participants could have been more varied, to ascertain nuances regarding levels of effectiveness for different sub-groups within the overall service user cohort—e.g. people from ethnic minorities. Use of mixed methods had been planned but there were issues with the quantitative aspect, especially levels of survey completion. The service being evaluated was broad-based, which raises questions about where conceptual boundaries lie between advocacy and other

				aspects of support, such as befriending and practical assistance.
Southall et al. (2021)	Scholarly	Meta-analysis of findings from two PhD studies, regarding how social workers seek to apply personalisation policy in the context of work with service users who have cognitive impairments.	Of the featured PhD theses: i) Southall (2017) involved interviews with 20 social workers regarding mental capacity assessments and best interest decisions; ii) Lonbay (2015) concerned older people's involvement in adult safeguarding, with the meta-analysis drawing on interviews conducted with eight social workers.	One of the two doctoral studies featured in the meta-analysis (Lonbay, 2015) is also the basis for Lonbay and Brandon (2017). The meta-analysis is based on research that pre-dates implementation of the Care Act; while the methodology section of Southall et al. (2021) does not state when data for the other featured PhD study (Southall, 2017) was collected. Therefore, there are questions about the extent to which these findings may still apply to the situation regarding personalisation under the CA2014. Moreover, this paper also does not focus primarily on independent advocacy, but it does demonstrate the importance of social workers ensuring rightful access to independent advocacy.
Stewart and MacIntyre (2013)	Grey	Evidence review regarding advocacy models and their effectiveness, published by a charity that supports social work and social care in Scotland.	Literature review featuring grey and scholarly literature.	The review was authored by academics and states it has been subject to some peer review, however the nature and extent of this is unclear. There is no discussion of how evidence was selected or evaluated, with advocacy in work with both adult social care and children and families blended together without discussion of the contextual differences. Moreover, the discussion is not particularly in-depth. The review seems

				oriented towards a practitioner readership based in Scotland, although UK-wide evidence is considered. The evidential value of this paper is also limited by its age, with some of the papers reviewed by the authors dating back to 2004.
Townsley et al. (2009)	Official	Evidence review for the Government's Office for Disability Issues (latterly Disability Unit). Focus is on: the existence of need for independent advocacy; and advocacy's benefits and costs, regarding four types of situation specified by the Government's Independent Living Strategy—namely transition of disabled young people to adulthood; disabled parents whose children are subject to safeguarding procedures; when entry to residential care for a disabled person is a possibility; and when a disabled person is a victim or perpetrator of anti-social behaviour.	Systematic literature review (grey and scholarly), with inclusion of texts published from 1997 to 2008.	This report makes an important distinction between process and outcome benefits from advocacy. This distinction has been cited in subsequent scholarship, and it partially overlaps with other ways in which scholars have sought to differentiate regarding effects of advocacy, e.g. between transactional and transformational outcomes (Ridley et al., 2017). However, there are issues regarding the recency of the evidence base as much of the work that the authors cite is non-recent, going back to 1997. The authors also pay significant attention to trying to discern an evidence base regarding monetary cost/benefits associated with advocacy, possibly related to this being a report to Government. However, viewing advocacy in these terms is perhaps not compatible with a realist philosophical perspective, which emphasises how advocacy operates in complex contextual circumstances; therefore attempts to determine a quantitative value for advocacy may not account for the

				complexity of social interactions that its workings entail.
Townsley and Laing (2011)	Grey	Report about the impact of IMCA casework, commissioned and funded by SCIE and undertaken by academics.	Mixed methods. Stage one was an online survey of IMCAs from 11 provider organisations. There were 23 respondents (from 46 invited to participate) and these referred to 151 of their cases, which enabled quantitative and qualitative analyses of the survey results. Stage two was detailed semi-structured interviews with nine IMCAs, who discussed 17 of their cases in depth.	Authors acknowledge encountering significant methodological issues. They originally intended to involve decision-makers under the MCA2005 (e.g. social workers) and spend time with service users to gather data, but these elements were abandoned due to problems with gaining ethical approval, related to participants' capacity to given informed consent. Moreover, the survey response level was less than anticipated. Efforts were made to optimise the representativeness of IMCA participants: of 17 IMCA providers initially approached, there were attempts to match key characteristics against a national database of providers, e.g. reflecting the urban density and general demographic character of areas. Data collection for this report was undertaken during the third year of IMCA services being implemented and therefore studies such services at a more mature stage of operation than work by Redley et al. (2010,11). However, this report remains based on research conducted relatively early in the implementation of the IMCA service; individual and organisational practices may have developed significantly in the time since.

Voluntary Organisations Disability Group (VODG) (2012)	Grey	A case study report by the VODG, an umbrella group of voluntary sector providers of social care services for adults with disabilities. It seeks to highlight what advocacy is and what positive outcomes it can help achieve.	Five case studies of the work of different organisations involved in providing advocacy.	The report provides a useful illustrative ‘showcasing’ of advocacy in action, but it is not a rigorous, independent evaluation of these services; instead it has a promotional aspect, being a presentation by the organisations themselves of what their work involves, so they can highlight its value.
Voiceability and Kate Mercer Training (2020)	Grey	Briefing paper about ‘Advocacy with people with learning disabilities and autistic people, who are subject to seclusion, segregation or restraint’. The paper makes policy and practice recommendations.	The evidence base for the briefing is not stated.	This briefing seems to draw on experiential insights derived from the authoring organisations’ work, regarding advocacy provision and training respectively. It provides useful commentary on potential for reform in this area and how contentious issues such as where the balance should be between national vs local commissioning may impinge on future changes. However the evidence base for these recommendations is not made clear.
Watts (2017)	Scholarly	Policy review about advocacy services for autistic people, which makes the case for specialised provision for this service user group.	Discusses Government policy via reference to various sources, including official documents, and scholarly and journalistic works.	Presents a strong argument and engages with issues concerning specialisation in advocacy services. No review methodology is given so it is unclear how the argument was constructed in relation to the literature cited.

Winter (2019)	Official	Safeguarding Adults Review (SAR) into the death of a woman with learning disabilities (‘Jo-Jo’), who died in a state of severe neglect. The SAR’s remit included ascertaining the circumstances around her death, whether local and national policy was followed by practitioners, and what lessons should be learnt.	Review of information provided by statutory health and social care agencies.	A detailed case study of a tragic loss of life that underscores the importance of practitioners complying with key statutory stipulations around ensuring access to independent advocacy, albeit this was only one part of the shortcomings in professional practice identified in respect of care for Jo-Jo.

Additional works cited

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Lonbay, S. P. (2015) *Bridges and barriers: exploring the involvement of older people in adult safeguarding*. Ph.D. Northumbria University. [Online] [Accessed on 9th December 2019] http://nrl.northumbria.ac.uk/33327/

Newbigging, K., Ridley, J. and Sadd, J. (2017) *Commissioning Care Act advocacy: a work in progress research report*. Birmingham: University of Birmingham, HSMC. [Online] [Accessed on 20th November 2019] https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/HSMC/publications/2016/CA-advocacy-commissioning-research-report.pdf

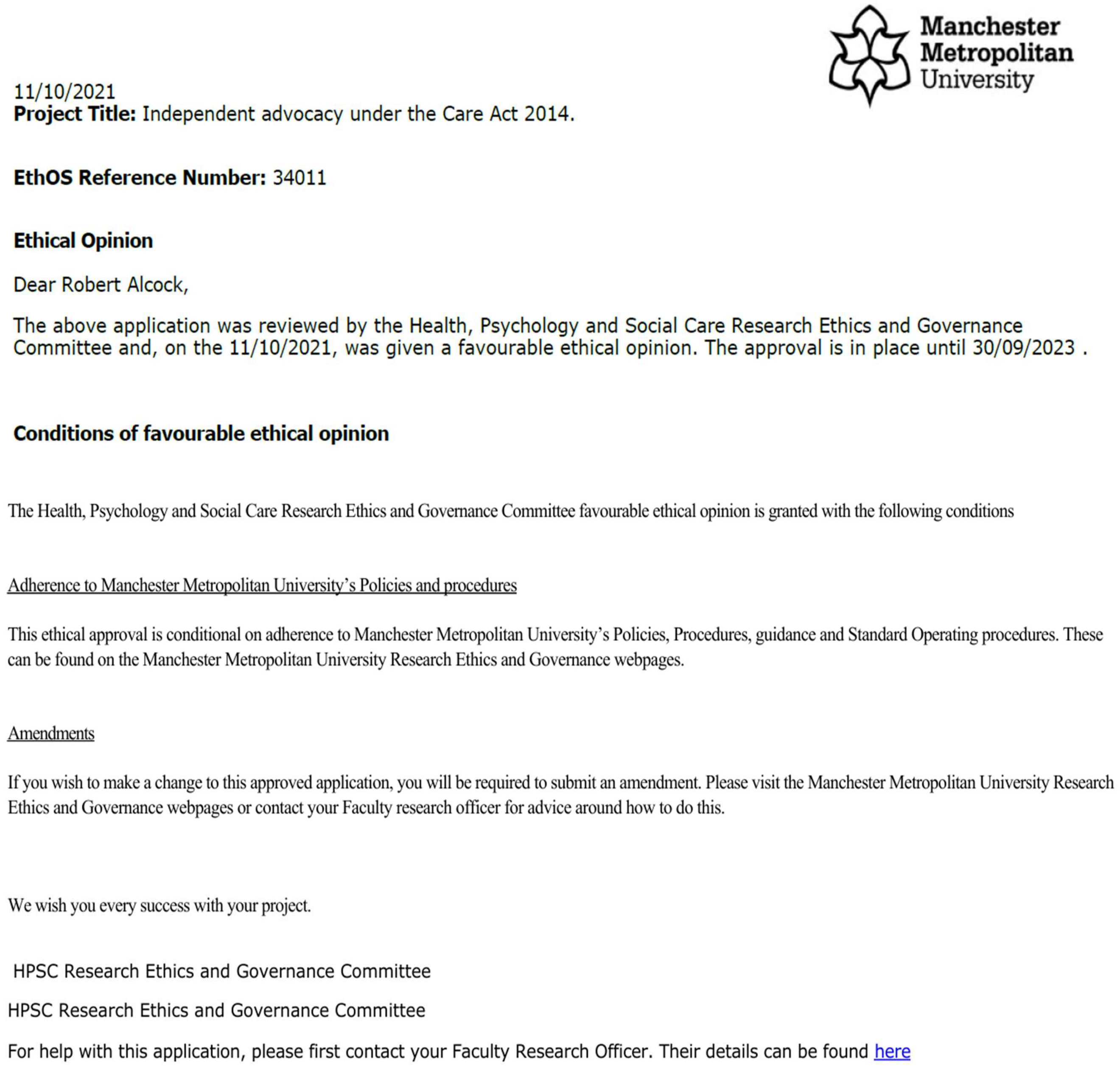
Ridley, J., Newbigging, K., McKeown, M., Sadd, J., Machin, K., Cruse, K., De La Haye, S., Able, L. and Poursanidou, K. (2015) *Independent mental health advocacy-the right to be heard: context, values and good practice*. London: Jessica Kingsley Publishers.

Southall, C. (2017) Social workers' experience of assessing capacity and 'best interest' decision making under the Mental Capacity Act 2005. Ph.D. Northumbria University.

Social Care Institute for Excellence. (2018) *Named Social Worker pilot: Programme evaluation – final report.* London: Social Care Institute for Excellence. [Online] [Accessed on 27th January 2025] https://www.scie.org.uk/social-work/named-social-worker/final-report/

Appendix D: Ethical approval

The following are excerpts from the notifications received from Manchester Metropolitan University's Health and Education Research Ethics and Governance Committee, showing approval to conduct the research. The updated approval received in March 2022 was due to changes to my method of recruiting service user participants.



Manchester Metropolitan University

11/10/2021
Project Title: Independent advocacy under the Care Act 2014.

EthOS Reference Number: 34011

Ethical Opinion

Dear Robert Alcock,

The above application was reviewed by the Health, Psychology and Social Care Research Ethics and Governance Committee and, on the 11/10/2021, was given a favourable ethical opinion. The approval is in place until 30/09/2023 .

Conditions of favourable ethical opinion

The Health, Psychology and Social Care Research Ethics and Governance Committee favourable ethical opinion is granted with the following conditions

Adherence to Manchester Metropolitan University's Policies and procedures

This ethical approval is conditional on adherence to Manchester Metropolitan University's Policies, Procedures, guidance and Standard Operating procedures. These can be found on the Manchester Metropolitan University Research Ethics and Governance webpages.

Amendments

If you wish to make a change to this approved application, you will be required to submit an amendment. Please visit the Manchester Metropolitan University Research Ethics and Governance webpages or contact your Faculty research officer for advice around how to do this.

We wish you every success with your project.

HPSC Research Ethics and Governance Committee

HPSC Research Ethics and Governance Committee

For help with this application, please first contact your Faculty Research Officer. Their details can be found here

Manchester
Metropolitan
University

17/03/2022
Project Title: Independent advocacy under the Care Act 2014.

EthOS Reference Number: 34011

Ethical Opinion

Dear Robert Alcock,

The above amendment was reviewed by the Health and Education Research Ethics and Governance Committee and, on the 17/03/2022, was given a favourable ethical opinion. The approval is in place until 30/09/2023.

Please remove my telephone number from the PIS. Contact is through the FOHE-ethics@mmu.ac.uk email address. I'm not in the office very often and any messages would be missed.

Conditions of favourable ethical opinion

Application Documents

Document Type	File Name	Date	Version
Additional Documentation	34011 Robert-Alcock Recruitment-flyer v1.0	17/02/2022	1.0
Additional Documentation	34011 Robert-Alcock Guide-to-providers v1.0	17/02/2022	1.0
Additional Documentation	34011 Robert-Alcock Protocol v1.3	17/02/2022	1.3
Additional Documentation	34011 Robert-Alcock Participant-Information-Sheet-Easy-Read v1.3	16/03/2022	1.3

The Health and Education Research Ethics and Governance Committee favourable ethical opinion is granted with the following conditions

Adherence to Manchester Metropolitan University's Policies and procedures

This ethical approval is conditional on adherence to Manchester Metropolitan University's Policies, Procedures, guidance and Standard Operating procedures. These can be found on the Manchester Metropolitan University Research Ethics and Governance webpages.

Amendments

If you wish to make further changes to this approved application, you will be required to submit an amendment. Please visit the Manchester Metropolitan University Research Ethics and Governance webpages or contact your Faculty research officer for advice around how to do this.

We wish you every success with your project.

Health and Education Research Ethics and Governance Committee

Health and Education Research Ethics and Governance Committee

For help with this application, please first contact your Faculty Research Officer. Their details can be found here

Appendix E: Criteria for participant recruitment

The following sets of inclusion and exclusion criteria for participants are based upon version 1.3. of the research protocol, dated 16th February 2022, which was submitted with my application for amended ethical authorisation.

Inclusion Criteria

The following are the inclusion criteria for each of the participant cohorts. Across all cohorts, there will be no additional inclusion or exclusion criteria other than those cited. Hence, recruitment will be of individuals of any gender identity, ethnicity, or age (provided they are 18 years or older). All participants must be willing to comment upon CAA, based upon their own knowledge, experiences, and perceptions.

National contributors

Individuals with expertise about CAA on a regional/ national scale:

- Possessing an advanced level of knowledge about policy and/or practice aspects of CAA, on a national or regional scale.
- Recruitment across the four individual participants will seek to provide for some variety of perspectives upon CAA.

Case studies

Local authority commissioning officer:

- An officer based within the adult social care department of a participating local authority.

Senior manager within a CAA provider:

- A senior manager within a CAA provider organisation that is participating in the project.
- Having responsibility for aspects of CAA services in one of the case study local authorities.

Manager of a team providing CAA services:

- In a team manager or equivalent role within an CAA provider organisation that is participating in the project.
- Having responsibility for aspects of CAA services in one of the case study local authorities.

CAAs:

- Employed in a role that requires them to act as an ICCA, as at least part of their responsibilities. This may be full or part-time. The role may or may not require them to additionally provide other forms of advocacy, such as Independent Mental Capacity Advocacy.
- Working as an CAA in one of the case study local authorities.
- To have provided CAA for at least three months, at the time of recruitment.

People with lived experience of receiving CAA

- To have previously received a CAA service from at least one of the participating provider organisations.
- For the most recent episode of advocacy involvement to have concluded in the last three months. This timescale will be extended, to up to six months since the advocacy episode concluded, if the CAA provider believes this is necessary to ensure adequate recruitment.
- To have mental capacity, as defined by the Mental Capacity Act 2005, to give informed consent to participate in the study.

- To be able to communicate, during the research interview, about their experiences of receiving CAA. This will comprise both receptive and expressive communication, but the person's participation needs not necessarily be confined to verbal communication. However, if the person's primary form of communication is non-verbal, further inclusion criteria must apply.
- If the person's primary form of communication is non-verbal, *either* of the following inclusion criteria must *also* apply:
    i) I will be able to appropriately engage with the person regarding the subject of the research via non-verbal means; *OR*
    ii) I will be able to access appropriate support from a suitably qualified third person in order to facilitate such communication.

- If the participant is non-English speaking, an appropriate interpreter service (also translation of any written materials) must be accessible to the study.
- The participant must agree to receiving any third-party communication support that is necessary for the interview to take place.
- The participant must be aged over 18 years.

Social workers (as focus group participants):

- To hold a current professional registration as a social worker, with Social Work England.
- To be employed, on a full or part-time basis, as a social worker in the adult services department of a participating local authority.
- To have experienced working on cases with CAA involvement.
- To have been employed in a social work role for at least six months at the time of the focus group session.
- To be willing to discuss their experiences and perceptions of CAA in a focus group setting.

Exclusion Criteria

For the recruitment of people with lived experience *only*, the following exclusion criteria apply in addition to the inclusion criteria.

Experts by experience:

The person will be unable to participate in the research if any one of the following apply:

- If the person lacks capacity, as defined by the Mental Capacity Act 2005, to give informed consent to participate in the research.
- If an identifiable risk of any distress or other form of psychological harm would arise from the person's involvement in the study. This may, for example, relate to the reasons for them receiving a CAA service, such as due to an adult safeguarding enquiry.
- If an identifiable risk to the researcher or any third party would arise from the person's involvement in the project. This is not confined to physical risks.

Appendix F: Topic guides for interviews

The following are example guides to the semi-structured interviews that were conducted. The included guides are those for interviews with:

1) A Care Act Advocate

2) The local authority commissioner

3) The manager of a Care Act Advocacy provider

4) Focus group guide—social workers. This was used to guide the joint interviews with social workers, which took the place of the originally intended focus groups. I had intended to personally moderate the focus groups and was available to perform this role for the joint interviews; however these were largely self-moderating.

5) People with lived experience of receiving a CAA service

Where interviews were conducted with multiple individuals from a stakeholder cohort—e.g. with CAAs—the interview guides were adjusted iteratively as progress with the interviews proceeded. This was to account for what worked relatively well or badly in the preceding interviews and to attempt to fill gaps in knowledge that became apparent over time.

Although an interview guide was prepared for interviewing people with lived experience of receiving a CAA service, these were utilised flexibly as these interviews were relatively unstructured. This was because I had received very little prior information about these individuals, their use of CAA services and any support needs they had in respect of participating in the interviews. I therefore wanted to have maximum scope to tailor my approach within these interviews. For the national commentators, a dedicated guide was prepared for each, which are not reproduced here. Moreover, the guide for the interview with the team leader from Fencross Advocacy is not included. This comprised a mixture of questions drawn from the interview guides pertaining to CAAs and to CAA managers.

Independent advocacy under the Care Act 2014

Interview guide—Independent Care Act Advocates

1. What motivated you to become an independent Care Act advocate?

2. In your experience, how effectively are Care Act advocates able to support the involvement of service users in social care processes, so they can make their own decisions wherever possible?

3. How effectively are Care Act advocates able to provide a source of challenge to professionals and the local authority, if necessary?

4. How well do you feel you are able to advocate for people from diverse backgrounds, including through ‘culturally appropriate’ advocacy?

5. Is it challenging to work across the diverse range of social care needs that people have and the conditions related to these? E.g. learning disabilities, autism, and dementia, as well as various communication needs.

6. Does the Care Act advocate role provide opportunity to work with people in a sufficiently in-depth, long-term and preventative way?

7. How has Covid-19 affected your work?

8. How would you characterise working relationships with professionals such as social workers?

9. Do Care Act advocates have access to enough support in their role?

Version: 1.3. **Date:** 10th February 2022

10. Independent advocacy has been described as becoming increasingly professionalised. Do you agree, and is this a good thing?

11. How well does Care Act advocacy join up with other types of advocacy? E.g. IMHA, IMCA, also non-statutory advocacy e.g. citizen advocacy.

12. Are there any other challenges you face in your role that we haven't discussed? Is there any good practice you'd like to highlight, or other points you would like to make?

Independent advocacy under the Care Act 2014

Interview guide—Local authority commissioners

1) At what stage in the commissioning process is the current contract for Care Act Advocacy?

2) Have there been any developments over time in how the local authority monitors and evaluates the Care Act Advocacy service it commissions?

3) How do you approach resourcing decisions about Care Act Advocacy? For example regarding the ‘financial envelope’ for the service?

4) How do you seek to ensure that Care Act Advocacy ‘joins up’ as well as possible with other types of statutory advocacy, principally IMHA and IMCA?

5) How does Care Act Advocacy fit into a wider service ‘offer’ provided by the council and local community? Does this include non-statutory advocacy?

6) How, through the commissioning process, do you seek to promote Care Act Advocacy services that are responsive to the diversity of the communities they serve?

7) How has Covid-19 affected the commissioning of Care Act Advocacy? Do you see any of the changes brought about by the pandemic becoming long-term?

8) How do the local authority and Care Act Advocacy provider work together to promote ongoing development of service quality?

9) From the local authority’s perspective, what are some of the priorities for the future development of the Care Act Advocacy service?

10) How is awareness and understanding of Care Act Advocacy promoted within the local authority’s Adult Social Care Department?

11) To what extent is learning about the commissioning of Care Act Advocacy shared between local authorities?

Version: 1.2. **Date:** 20th April 2022

12) When statutory advocacy was first being developed in the 2000s, there was some debate about the merits of national vs local commissioning. Do you have any reflections on this now, from your experience regarding Care Act Advocacy?

13) Are there any further challenges facing the commissioning of Care Act Advocacy? Do you have any recommendations for future policy/ practice regarding Care Act Advocacy?

Independent advocacy under the Care Act 2014

Interview guide—Manager of a Care Act Advocacy provider

1) Please provide an overview of your role, regarding managing the Care Act advocacy service.

2) How well is the system for receiving referrals working? Do you have any way of knowing whether people who are eligible for Care Act advocacy are actually receiving it?

3) What are some of the important considerations, and challenges, when allocating cases to individual Care Act advocates?

4) What impact is Covid-19 having on the Care Act Advocacy service at present?

5) Would you agree that independent advocacy has become increasingly professionalised? Is this a good thing?

6) How, as a manager, are you able to support the Care Act Advocates who work for your organisation?

7) How well is Care Act advocacy able to support people to become involved in social care processes?

8) How well is Care Act advocacy able to provide a source of challenge to the local authority, when this is needed?

Version: 1.2. **Date:** 14th February 2022

9) How well is your organisation’s Care Act advocacy service able to respond to diversity across the people it serves? Here, I’m considering diversity in terms of:

i) Social diversity within the broader community, e.g. the notion of ‘culturally appropriate advocacy’

ii) Diversity across different social care needs and related conditions, e.g. dementia, autism, learning disabilities.

10) How well, in practice, does Care Act Advocacy join up with other forms of advocacy, both statutory and non-statutory?

11) Are there any other significant challenges affecting the practice of Care Act advocacy by your organisation at present?

Independent advocacy under the Care Act 2014

Focus group guide—Social workers

These questions are designed to initiate discussion among the focus group.

1. How have your experiences of referring people for an independent Care Act advocate been?

Is it easy to tell when someone meets the criteria for having a Care Act advocate?

2. How well does the system for referring for a Care Act advocate, and having one allocated, work in your local authority?

3. In your experience, how well are Care Act advocates able to promote people's involvement in social care processes?

4. How effective do you think Care Act advocates are at providing a source of challenge—either directly to professionals, or to local authority decisions more generally?

5. Based on your professional experience, how would you characterise working relationships between Care Act advocates and social workers?

6. How well equipped do you think Care Act advocates are to carry out the role given to them in law and statutory guidance?

7. What have your experiences been of advocacy for carers, as delivered under the Care Act 2014?

Version: 1.2. **Date:** 22nd November 2021
Ethical approval number (EthOS): 34011

8. How well is Care Act advocacy able to respond to diversity? *'Diversity' here is wide-ranging, including a) different conditions and circumstances that can shape individuals' social care needs, e.g. dementia, learning disability, autism; and b) forms of diversity across wider society, e.g. relating to ethnicity, gender, religion and more.*

9. How significant have the changes brought about by Covid-19 been for Care Act advocacy?

10. To what extent should advocacy be seen as part of the social work role?

11. How well do you think Care Act advocacy complements other forms of advocacy that are available in the local authority that you work in?

12. From your perspectives as social workers, do you have any recommendations for policy and practice regarding Care Act advocacy?

Independent advocacy under the Care Act 2014

Interview guide— People with lived experience

Introduction

- Thank the interviewee for their involvement. Remind them of the expected length of the interview, however they can end it—or take a break—at any time they wish.
- Ensure the person has read and understood the PIS (which was supplied in easy read format), has understood it, and has no issues with its contents. Invite any questions about this.
- Then, ensure the interviewee signs the consent form.
- Check again that the person consents to audio recording and if so, start recording.
- *Adjustments will be made to the above procedures as necessary, e.g., it may be necessary to take verbal (recorded) consent, or a support worker may assist with these processes.*

Questions

1) Demographic information

During introductory conversation, ask the interviewee to confirm their:

> i) Ethnicity (where possible, use the format for recording this that is contained in guidance from the Office for National Statistics https://www.ons.gov.uk/methodology/classificationsandstandards/measuringequality/ethnicgroupnationalidentityandreligion]
>
> ii) Gender identity and use of pronouns.

2) Can you tell me about why you recently had support from a CAA?

How came to have a CAA

> ***Prompt:*** Try to focus on the most recent advocacy experience but can bring in other experiences.
>
> What was happening at the time? E.g., safeguarding, assessment etc.?

3) What did the CAA do to help you?

Prompt: Met the person alone?

Accompanied them in meetings?

4) Did having a CAA help you to understand what was happening regarding your assessment, care/support plan, safeguarding etc?

Follow-up: If yes, how did they do this?

5) Did having an CAA help you to get what you wanted (regarding assessment, care/support plan, safeguarding etc)?

What did it achieve?

Follow-up: If yes, how did they do this?

Prompt: Communication with professionals?

Innovative methods?

6) Do you think that the CAA understood your situation and was on your side?

Follow-up: Probe why the person thought this.

7) Did you think the CAA was more on your side than the other professionals you were dealing with, such as social workers?

Follow-up: Probe why the person thought this.

8) Before you recently had a CAA, did you know much about advocacy?

Prompt: If yes, what was the previous understanding of advocacy?

How was advocacy explained to the person, by the social worker or the advocate themself?

9) Did coronavirus (Covid-19) affect the help you received from your advocate?

Prompt: Social distancing?
Hygiene/ PPE?
Meeting online rather than in-person?

10) a) Have you ever experienced other types of advocacy?

Prompt: Either statutory advocacy (if eligible) or non-statutory advocacy, e.g., participation in a self-advocacy group.

b) If yes, how did this compare to CAA?

11) Overall, how important was it for you to have had an CAA during your recent assessment/ review/care and support planning/ safeguarding?

12) Do you have any advice for other people who may in future have support from a CAA?

13) Do you have any advice for the people who make rules about independent advocacy and who provide independent advocacy services? Is there anything that you would like to see change?

Conclusion

Ask if there is anything the interviewee would like to add or clarify.

Remind the interviewee they will receive a copy of the interview transcript once this has been prepared [check arrangements for sending this], and they can request amendments for up to 14 days after receipt [again, ensure conversation is tailored to the needs and circumstances of the individual].

Thank the interviewee for their participation.

Version: 1.0. **Date:** 1st August 2021

Appendix G: Participant information sheets

Separate participant information sheets were prepared for each participant cohort. Two of these are reproduced below by way of illustration. These are the participant information sheets for:

i) CAAs (Version 1.3.; dated 9th February 2022)

ii) Service users. This is in easy-read format (Version 1.2; dated 17th February 2022).

Participant Information Sheet

Independent advocacy under the Care Act 2014

1. Invitation to research

- I wish to invite you to take part in a research project about independent advocacy under the Care Act 2014 (Independent Care Act Advocacy). My name is Robert Alcock and I am a PhD student in the Department of Social Care and Social Work at Manchester Metropolitan University (MMU). The research project will seek to answer questions about how effective Independent Care Act Advocacy (ICAA) is, what about it is working well and what is working less well, and why.

2. Why have I been invited?

- You have been invited to take part as your work involves providing ICAA, and you are based in one of two local authorities that are participating in the research as case study sites. Each case study will consider how ICAA is being provided in a particular local authority. I will be interviewing six Independent Care Act Advocates in total (three in each local authority). It is important for the study to get frontline perspectives from those who work as independent advocates.
- I will also be interviewing people from a range of other stakeholder groups. These are local authority commissioning managers; managers of organisations that provide ICAA; and experts by experience, who have recently used an ICAA service. I will also be interviewing people with expertise about how ICAA is being delivered on a regional or national basis, and holding focus groups with social workers.

3. Do I have to take part?

- No—it is up to you to decide. There will be no negative consequences for you if you decide not to participate. I will describe the study and go through this Participant Information Sheet with you, which you can keep. I will then ask you to sign a consent form to show you agreed to take part. You are free to withdraw at any time, without giving a reason—again, there will be no negative consequences for you if you do this.

4. What will I be asked to do?

- If you choose to take part, I will interview you about your experience of working as an ICAA. I will only interview you once. The interview should last about an hour and it can be paused or ended at any point you wish. The final PhD thesis is due to be submitted by September 2023. Before the interview takes place, I will ask you to sign a consent form. This will show that you agree with the terms of your involvement in the research, as set out in this Participant Information Sheet.

- I will arrange the interview with you, so it can take place at your convenience. If regulations and guidance at the time of the interview allow us to meet in person, you will be able to choose whether this happens or whether the interview will be held online instead, using Microsoft Teams. If you want to hold the interview in person, this could be done at a private meeting space where you work, or at another place if you prefer. It has already been agreed with your employer that the interview can take place during your work time.

- During the interview, I will ask you about your experiences of working as an ICAA, and what your views are about different aspects of your role. You will have a lot of flexibility to choose how to answer the questions and there will be opportunity for you to add in any further points you wish to make. Some of the main topic areas that I will ask you about are as follows: how effective do you think ICAA is? What factors make ICAA more effective or less effective? How do you see your role and identity when you are at work? How well do you feel you are able to challenge other organisations and professionals on behalf of service users? How well does ICAA fit with other types of advocacy, such as Independent Mental Capacity Advocacy? Also, I will be keen to hear of any recommendations that you have for how ICAA can be improved.

- You do not need to prepare for the interview. However, if you wish, you may want to think in advance about the topics listed above. During the interview, if you draw on any case examples from your practice, please ensure that these are anonymised, so the confidentiality of service users is maintained.

- If conducted in-person, the interview will be audio recorded. If conducted on Microsoft Teams, it will be recorded using the function within this platform. This will only be to ensure that what is said is captured accurately, so it can be transcribed into written form. The recordings themselves will not be made public in any form.

- When the findings of the research are reported, things you say in the interview may be included in the report. This will include direct quotes of your own speech, if you consent to this. When the research is reported, you will remain anonymous throughout the study and your real name will be replaced with a pseudonym (made-up name). If you wish, you can choose your own pseudonym, otherwise I will assign one to you. The local authorities and organisations that take part in the research will also remain anonymous in all reports and other public outputs from the research. They will also be referred to using made-up names. Also, when I report the findings of the research, I will try to reduce any risk that you could be indirectly identifiable. Therefore, I may omit or even change some details that could help someone to work out who may have participated in the study, even without the person's name being reported. Furthermore, although your employer shared the initial invitation to be involved in the research, the identities of the Independent Care Act Advocates who agree to participate will be known only to myself and my academic supervisors.

- Once I have transcribed the interview, you will be emailed a copy of the transcript. You will then have 14 days to review the transcript and request via email any amendments to the transcript, such as if you said something in the interview and later felt this to be incorrect. Only one set of amendments can be accommodated.

5. Are there any risks if I participate?

- During the interview I will only ask you questions relating to your professional role. However, some of the questions may be about times when you have encountered tensions whilst working as an Independent Care Act Advocate, such as regarding your relationships with other health and social care professionals. I might also ask whether you have faced any ethical conflicts in your role, such as whether you have ever found it personally difficult to advocate for a service user's choices—which you may yourself have felt to be morally questionable or harmful to the person's wellbeing. There is a possibility that discussing such matters could cause participants upset or distress.

- Although, as described above, participants will remain anonymous in all research outputs, there may be practical limitations to maintaining your anonymity in all circumstances. Given the number of Independent Care Act Advocates that your organisation employs, it is highly likely that others within your organisation will be able to infer, with a reasonable degree of likelihood, whether you have participated. Furthermore, during the interview, comments that you make, such as references to particular case examples, could help others with knowledge of both yourself and the study to conclude that it might be you who is making the comments. Other people who have knowledge of both your professional role and which local authorities are case study sites—for example, participants in the research who work for the local authority—may similarly be able to work out the identities of Independent Care Act Advocates who are taking part.

- The research will seek to learn from the experiences of practitioners. This may involve reflecting on difficult situations that have arisen in practice. However, if a participant said anything during an interview that seriously called into question their ability to practice in a safe and competent manner, or did likewise for another professional, there would be a legal and ethical responsibility for this to be appropriately reported. Similarly, if anything were disclosed during the study that indicated a safeguarding concern relating to an adult at risk, or a child, and appropriate steps were not already being taken to address this matter, there would again be a legal and ethical responsibility to ensure that this is reported to appropriate authorities.

6. Are there any advantages if I participate?

- There will be no direct advantage to you from participating in the research. However, there is currently a shortage of research about ICAA and the project will contribute to filling this gap. This knowledge will be beneficial for developing the role of Independent Care Act Advocate. It will promote wider understanding of the role of Independent Advocacy, which is important so that other professionals give due regard and respect to it and those who provide it. Such knowledge will also contribute to ongoing development of the training and support arrangements for Independent Advocates. Improved understanding about ICAA will also benefit service users by helping to better support them to have their 'voice heard' within social care processes.

7. What will happen with the data I provide?

- When you agree to participate in this research, we will collect from you personally identifiable information.
- Manchester Metropolitan University ('the University') is the Data Controller in respect of this research and any personal data that you provide as a research participant.
- The University is registered with the Information Commissioner's Office (ICO) and manages personal data in accordance with the General Data Protection Regulation (GDPR) and the University's Data Protection Policy.
- We collect personal data as part of this research (such as name, job title and email address). As a public authority acting in the public interest, we rely upon the 'public task' lawful basis. When we collect special category data (such as ethnicity) we rely upon the research and archiving purposes in the public interest lawful basis.
- Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. You can withdraw from the study at any time and once you withdraw, we will cease to collect any further information from you. However, please note that you will only be able to withdraw information that you have already provided to us if you notify us of this within 14 days of the interview for the study taking place.
- If your data is shared this will be under the terms of a Research Collaboration Agreement which defines use, and agrees confidentiality and information security provisions. It is the University's policy to only publish anonymised data unless you have given your explicit written consent to be identified in the research. **The University never sells personal data to third parties.**
- We will only retain your personal data for as long as is necessary to achieve the research purpose.
- During the study I will collect the following data from you: 1) Name; 2) Job title; 3)Time spent working as an Independent Care Act Advocate; 4) Time in current role; 5) Ethnicity; 6) Gender; 7) Your views and experiences relating to ICAA.
- I will ask you to confirm your data in categories 1 to 6, via email. Data in category 7 will be gathered through participation in an interview.
- From the audio recording of the interview, I will produce a written transcript in MS Word. NVivo, a software application, will also be used to help analyse the data you provide. All your data will be stored in pseudo-anonymised form on the University's secure and backed-

up cloud storage service. Pseudo-anonymisation means that all your personal data will be stored without reference to yourself by name; instead, your pseudonym will be used. A list linking people's real identities and their pseudonyms will be stored as a separate document, subject to an additional layer of password-protection.

- In all reports and other outputs from the research, you will only be referred to by the pseudonym that is given to you, not your real name. Furthermore, information that could lead to a significantly increased risk of you being personally identifiable as a participant in the research will either not be included in the reports or will be altered, although any alterations must not make any material difference to the integrity of the research and its findings.
- After the study is completed, all material related to it, including the interview data, will be stored securely in the University's e-space digital archive. The material will be securely disposed of 10 years after it is last accessed.
- For further information about use of your personal data and your data protection rights please see the University's Data Protection Pages (https://www2.mmu.ac.uk/data-protection/).

What will happen to the results of the research study?

- The results of the research study will be written up and presented in my PhD thesis, which is due to be completed by September 2023. Once approved, the thesis will be publicly available through an online academic repository.
- There are also other ways in which I plan to share my findings. Findings from the research will be written up as articles that will be submitted for publication in academic journals. I will also try to share my research findings beyond academia, to bring them to the attention of policymakers and practitioners where they can have a positive impact. I will therefore submit articles to print and online titles that are read widely within the health and social care sector, alongside producing briefing papers for the benefit of busy practitioners and policymakers. I will also seek to work with organisations around sharing my findings, for example as part of training for Independent Advocates and social workers.
- If you give permission on the consent form, I will get in touch with you to provide feedback about the outcome of the research, providing you with a relevant briefing paper.

Who has reviewed this research project?

- This research project has been reviewed by my academic supervisors. These are Dr Caroline Leah and Dr Robert Hagan, both Senior Lecturers in Social Work (c.leah@mmu.ac.uk and r.hagan@mmu.ac.uk) and Prof Sara Ryan (sara.ryan@mmu.ac.uk), Professor of Social Work. All are based at Manchester Metropolitan University.
- The research project has also been reviewed and approved by MMU's Research Ethics Review process, number 34011.

Who do I contact if I have concerns about this study or I wish to complain?

• If you have any concerns or queries about the research, I can be contacted as follows: Robert Alcock, PhD student, Manchester Metropolitan University, Brooks Building, 53 Bonsall Street, England, M15 6GX; email robert.alcock3@stu.mmu.ac.uk; or by telephone on 0161 247 2050.
• If you have any concerns or complaints about the research, you can also get in touch with the following.
Supervisory Team

• Dr Caroline Leah, Senior Lecturer in Social Work, c.leah@mmu.ac.uk; Dr Robert Hagan, Senior Lecturer in Social Work, r.hagan@mmu.ac.uk; Prof Sara Ryan, Professor of Social Work, sara.ryan@mmu.ac.uk. All are based within the Department of Social Care and Social Care, Manchester Metropolitan University, Brooks Building, 53 Bonsall Street, Manchester, M15 6GX, tel. 0161 247 2264.
Faculty Ethics Contact

• Professor Khatidja Chantler, Head of Research Ethics and Governance, Faculty of Health, Psychology and Social Care (k.chantler@mmu.ac.uk), School of Nursing, Brooks Building, 53 Bonsall Street, Manchester, M15 6GX, 0161 247 2000.
Data Protection Officer

If you have any concerns regarding the personal data collected from you, our Data Protection Officer can be contacted using the legal@mmu.ac.uk e-mail address, by calling 0161 247 3331 or in writing to: Data Protection Officer, Legal Services, All Saints Building, Manchester Metropolitan University, Manchester, M15 6BH. You also have a right to lodge a complaint in respect of the processing of your personal data with the Information Commissioner's Office as the supervisory authority. Please see: https://ico.org.uk/global/contact-us/

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Information Sheet

Independent advocacy under the Care Act 2014

What is this information about?

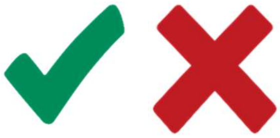
This information is about a research study. The information is to help you to choose if you want to take part in the study.

The researcher's name is Robert Alcock. He is a student who is doing research for a university.

Research is when we try to find things out.

The study will be finding out about a type of advocacy called Independent Care Act Advocacy. Some people have this type of advocacy when they get help from social services.

Advocacy is about helping people to have their say.



The study will try to find out about Independent Care Act Advocacy. It will ask questions about how good it is.

Why Me?

You have been asked if you want to take part in the study because:

- You recently had support from an Independent Care Act Advocate.
- You are aged over 18.

Do I have to take part?

No. You do not have to take part in this study. It is your choice.

You will be asked if you consent to taking part. **Consent** is being asked if you agree to something. This means saying yes or no.

Take time to decide if you want to take part. Ask Robert any questions you have.

If you take part, it will not change any of your support, rights or benefits. If you choose not to take part, it will also not change any of your support, rights or benefits.

What will I do if I take part?

Robert will speak to you on two different days.

First, he will talk to you about the study and will answer any questions. This will take around 15 minutes.

Second, he will talk to you about what it was like having an Independent Care Act Advocate. This is a research interview.

The interview will take between 30 minutes and an hour.

Robert will ask you again if you want to take part before you start.

You will help to choose when the interview happens and where it happens. It is important that you are happy with this. It could be at your home or somewhere else where you feel happy with meeting.

If you want, Robert can find other ways to speak to you for the interview. This could be because of Coronavirus (Covid-19) or just because you prefer to do this.

Other ways Robert could speak to you are:

Telephone

Microsoft Teams

Microsoft Teams is an app for speaking to people online, which you can use on a smartphone or laptop.

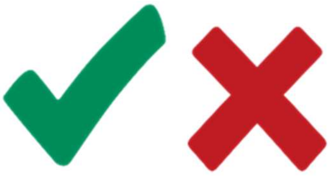
Ask Robert if there is another way you prefer.

Robert would like to record what you say so he can write about it later. Usually, only Robert will listen to the recording. Sometimes, someone else from the University might have to listen to it. People from outside the University will not be able to listen to it.

What will I be asked about?

Some of the things Robert might ask you about are:

- Did your advocate do a good job of telling you what they were helping you with?
- Did you feel able to tell your advocate what you wanted?
- Did having an advocate help others to know what you wanted?
- Did having an advocate help you to get what you wanted?



What will happen to the results of the research study?

What you talk about in the interview is confidential.

That means Robert will keep it private.

He will not use your name when he writes about the research. Instead, he will use a made-up name so other people can't tell it is you. You can choose your made-up name if you want.

Robert will use different ways to tell people about what he found out.

What you tell him will be used in a thesis. A thesis is a type of report for a university degree. Other people will be able to read the thesis. Words that you say may be printed in the thesis, if you say this is OK. Robert will not use your real name.

What you say may also go into reports and it may go on the internet. Robert may speak about what he has found out to people such as advocates, social workers and people who make decisions about the services people get.

If you want, Robert can talk to you again to let you know about what he has written. He can send a copy to you too.

Can I change my mind? Yes. You can change your mind at any time when you talk to Robert. The talking will stop. You do not have to tell him why you want to stop.

If you don’t want us to have your answers anymore, Robert will take them out. But after 2 weeks he might not be able to take them out because he may have already started writing about them.

Robert will ask you if you want to see your answers when they have been written down.

You can ask for things that have been written down to be changed. If you want to make a change you need to tell Robert within 2 weeks of the interview.

Are there any good things about taking part?

Doing research about advocacy can help make it better.

You will get a £15 voucher at the end.

We hope you will enjoy taking part in the interview and it will be interesting.

Are there any risks if I take part?

When universities do research projects we have to think about whether there are any risks to taking part.

Talking about why you had an advocate might make you feel sad or upset.

If you do not like answering the questions we can stop.

If you feel unhappy after you have finished speaking to Robert, or you need any help, please let him know.

Some people may be able to work out that you took part in the research, even though your real name is not used.

If Robert is worried about your safety or the safety of other people, then he will need to tell someone. This could be a person such as a member of staff or a social worker. Robert will try to talk to you about this, if he can.

Keeping your information safe

If you take part in the research, we will collect information about you. The University has to follow laws to make sure it keeps this information safe.

There is more information about these laws at the end of this sheet. You might want to ask someone to look at this with you.

Your information will be stored in a safe place, on computers at the University. It will be stored with a made-up name instead of your real name.

Your real name will be also kept on a computer but will be kept apart from the other information about you.

We will not share your information with anyone outside of the University, unless we think you or someone else might be in danger. We will only keep your information for as long as we need to. At the end of the research, the University will keep your information in a safe place on computers.

We will change it so nobody can work out it is you. If no one has looked at it for 10 years, it will be destroyed.

Who can I ask about this?

If you have any questions or concerns about the research, please contact Robert.

Robert Alcock, PhD student

Write: Robert Alcock, c/o Dr Caroline Leah, Manchester Metropolitan University, Room 2.22, Brooks Building, 53 Bonsall Street, England, M15 6GX

Email robert.alcock3@stu.mmu.ac.uk

Telephone on XXXXXXXXX.

If you are unhappy about the research, you can also get in touch with Robert’s supervisors, who are checking on the research. They are:

Dr Caroline Leah, Senior Lecturer in Social Work

Email: c.leah@mmu.ac.uk

Dr Robert Hagan, Senior Lecturer in Social Work

Email: r.hagan@mmu.ac.uk

Professor Sara Ryan, Professor of Social Care

Email: sara.ryan@mmu.ac.uk

Caroline, Robert and Sara are based within the Department of Social Care and Social Work, Manchester Metropolitan University, Brooks Building, 53 Bonsall Street, Manchester, M15 6GX. You can telephone them on XXXXXXX.

If you are unhappy about the research you could also tell Professor Khatidja Chantler, by emailing her at xxxxxxx, or leaving a message for her on this number: XXXXX

If you are not happy about how we managed information about you, you can tell the Data Protection Officer legal@mmu.ac.uk or call them on XXXXXXXX

Data Protection Information

When you agree to participate in this research, we will collect from you personally identifiable information.

The University (as a 'Controller' for your personal information) will look after your personal information, by making sure it is safe, used only for the reasons we tell you, and not shared with anyone else. The way we look after your information is ruled by UK law. Under UK law, we need to have a very good reason for using your information (this is called a 'lawful basis'). Sometimes, we might also want to use sensitive information about you, like information about your health, religion and ethnic background. This is called 'special category information'. Where we use this type of special information, we need to have another lawful basis. In this case, the reason we want to use your information is to do research which aims to benefit everyone (this means that it is in the 'public interest' and in the 'substantial public interest').

You have the right to make choices about your information under UK law. For example, you can ask for us to give you a copy of the information we collect about you, or you can ask us to delete it. You can do this by contacting dataprotection@mmu.ac.uk, or by asking the researcher to do this for you. For more information about this and for information on how to speak to a data protection expert, you can visit https://www.mmu.ac.uk/data-protection/data-subject-rights. If you have any questions, you can ask the researcher or anyone listed in the contact details above.

What if I change my mind?

You can stop being a part of the study at any time, without giving a reason. You can ask us to delete your personal information (also called 'data') at any time, but it might not always be possible. If you ask us to delete information within 14 days of the interview, we will make sure this is done. If you ask us to delete information after this point, we might not be able to. If your information is anonymised, we will not be able to withdraw it, because we will not know which information is yours.

Collecting information about you

During the study I will collect the following information about you:

1) Your name
2) Your age (within a range)
3) Your gender
4) Your ethnicity
5) Some basic information about your social care needs
6) Information about how you communicate and if you have any extra communication needs
7) Some basic information about how and why you received support from an Independent Care Act Advocate.
8) Your views and experiences regarding Independent Care Act Advocacy.

Information in categories 1 to 7 will be given to me by the Independent Care Act Advocacy provider. I will collect information in category 8 by speaking to you in an interview.

If you agree, I will make an audio recording of the interview. This means that only the sound will be recorded and there will be no video. I can still interview you if you do not want to be recorded. Instead, I will write down things that you say. I will use the audio recording to write down what you say on a computer. Computer programmes will be used to help me 'analyse' what you said—this means to look at it in detail.

Storing your information

All of your information will be kept in pseudo-anonymised form on the University's secure cloud storage service. Pseudo-anonymisation means that all your information will be kept without your real name attached to it. Instead, your pseudonym (or made-up name) will be used. A list linking people's real names and their pseudonyms (made-up names) will be kept separately and securely on the University's cloud computer system.

In all reports from the research, you will only be referred to by the pseudonym (made-up name) that is given to you, not your real name. Also, if there is information that could lead to a much bigger risk of someone else working out that you took part in the research, this will either not be included in the reports or will be changed. However, any changes must not stop people from being able to trust the research or find it useful.

As soon as possible after the research is finished, further changes will be made to the information that is kept about you. Any information that could be used to work out if you have taken part in the research will be destroyed. This means your information will be anonymised. The anonymised information will then be kept in the University's e-space repository, which is another safe computer system. The information will be destroyed 10 years after someone last looked at it.

Acknowledgement:

This Participant Information Sheet adapts some ideas, including layout, expressions and use of Photosymbols from the Participant Information Sheets from the '200 Lives Project' (IRAS Reference Number: 288650) and the 'Coronavirus and People with Learning Disabilities project' (EthOS ID 25565). Thanks are extended to Francesca Ribenfors and Dr Sue Caton, of the respective projects. Both are of the Department of Social Care and Social Work at Manchester Metropolitan University.

Appendix H: Recruitment notices

i) Recruitment email to social workers

This was sent to managers at the participating local authorities, who disseminated it within their organisations in order to recruit social workers to the focus groups. Due to poor levels of recruitment, the focus groups were instead conducted as joint interviews.

ii) Recruitment email to CAAs

This was sent to managers at the participating CAA providers, who disseminated it within their organisations in order to recruit individual CAAs for interview.

iii) Recruitment flyer for service users

This flyer was provided to CAA providers to assist with recruitment of service user participants, as set out in appendix D. The providers agreed to use alternative means of contacting service users, such as via telephone, if this was more suitable for individuals.

Recruitment email to social workers

1st December 2021; v.1.3 (sent to local authority managers in December 2021 and January 2022)

Hello,

I am a PhD student in the Department of Social Care and Social Work at Manchester Metropolitan University. I would like to invite social workers, who have at least six months' post-qualification experience, to take part in my research about Independent Care Act Advocacy, through participation in a focus group.

The study is exploring how independent advocacy is being delivered under the Care Act, responding to a shortage of academic research about this important topic. It is also seeking to evaluate how well different aspects of Independent Care Act Advocacy are working, so that practical recommendations can be made.

The main part of the research will consist of case studies of Independent Care Act Advocacy in two local authority areas. XXXXXX is one of the case study sites.

Participation in the study is entirely voluntary. If you do choose to take part, you will remain anonymous in the reporting of the research. Please find attached a Participant Information Sheet that gives further details about the study and what will be involved if you decide to participate. You will be asked to attend one focus group session, lasting up to 90 minutes. This will take place over Microsoft Teams on Thursday, 20th January, 2.00-3.30pm. The focus group will consist of between six and eight social workers, drawn from different adult social work teams within XXXXX. Please note that if more than eight social workers express interest in participating, priority will be given to selecting people from a range of different teams.

I can be contacted at robert.alcock3@stu.mmu.ac.uk to answer any questions that you may have about the study and your potential involvement in it.

Many thanks

Robert

Robert Alcock
PhD student
Department of Social Care and Social Work
Manchester Metropolitan University

Recruitment email to Independent Advocates

12th June 2021; v.1.1 (sent to Fencross Advocacy and Martborough Voices in November 2021)

Hello,

I am a PhD student in the Department of Social Care and Social Work at Manchester Metropolitan University. I would like to invite you to take part in a doctoral research study about Independent Care Act Advocacy.

The study is titled *To have their voices heard'? A realist study of independent advocacy under the Care Act 2014*. It is exploring how independent advocacy is being delivered under the Care Act, responding to a shortage of academic research about this important topic. It is also seeking to evaluate how well different aspects of Independent Care Act Advocacy are working, so that practical recommendations can be made, where these are needed.

The main part of the research will consist of case studies of ICAA in two local authorities. [*Insert local authority*] is one of the case study sites, and your employer, [*Insert advocacy provider*] is participating in the research. They have given me the opportunity to write to members of their team of Independent Care Act Advocates, to invite your individual participation.

Taking part in the study is entirely voluntary. If you do choose to participate, you will remain anonymous in the reporting of the research. Please find attached a Participant Information Sheet that gives further details about the study and what will be involved if you decide to participate. Essentially, I would conduct a single interview with you, in which we would discuss your role and your experiences of providing Independent Care Act Advocacy. The interview would last about an hour. I would arrange to meet with you at your convenience—either online or in person—during work time.

If you are interested in participating, please could you let me know by emailing me at robert.alcock3@stu.mmu.ac.uk. I will also be very happy to answer questions that you may have about the study and your potential involvement in it.

With thanks and best wishes

Robert

Robert Alcock
PhD student
Department of Social Care and Social Work
Manchester Metropolitan University

Would you like to take part in research about advocacy?

Hi, I'm Robert, a PhD student at Manchester Metropolitan University. I'm doing research about **Care Act Advocacy**. I want to find out about Care Act Advocacy in your local area.

I'm getting in touch as you recently had support from a Care Act Advocate from **Martborough Voices**. I'd like to invite you to take part in a research interview about how you found this. You only have to do this if you want to—it is up to you!

If you would like to speak to me, you can choose where and when the interview happens. If you would prefer not to speak in-person, we can talk over the phone or online.

If you are interested in taking part, please get in touch to find out more.

You can contact me:

- By email at: robert.alcock3@stu.mmu.ac.uk
- By post to: Robert Alcock, c/o Dr Caroline Leah, Department of Social Care and Social Work, Manchester Metropolitan University, Room 2.22, Brooks Building, Manchester, M15 6GX
- By phone call, text or WhatsApp, on XXXXXXXXX

Or you can let Martborough Voices know. They will then pass your contact details on to me. Contact them:

- By email at: XXXXXXXXXXXXX
- By phone: XXXXXXXXX

Thank you for reading this!

Robert Alcock

Appendix I: Requests for participants' information

The below form was emailed to all non-service user participants in the period before the interview was conducted, for the purpose of collecting some additional information about them. The form was adjusted to individual participant cohorts. For example, only CAAs were asked about their ethnicity. A decision was taken to collect this data from this participant cohort because of its relevance to considerations about 'cultural appropriateness' in advocacy services. The national contributors were also asked to state at this stage whether they wished to participate on a real-named or pseudonymised basis. This was subsequently confirmed on the day of the interview and formally recorded via the taking of informed consent. For service user participants, necessary information was gathered on the day of the interview, via verbal discussion.

Written request for participant information

Thank you for agreeing to be interviewed for my research regarding independent advocacy under the Care Act 2014.

I would be grateful if you could please provide the following additional information about yourself to me by email. The legal basis for the collection of this personal information is discussed in the Participant Information Sheet that has been provided.

Job title:

Gender:

Please state your gender identity:

Please also state your pronouns, e.g., she/her, he/him or they/them. These will also be used in the reporting of the research.

Pseudonym:

In all reporting of the research, you will be referred to using a pseudonym (made-up name). You can choose your own pseudonym, but if you do not wish to do this, I will assign one to you. If you wish to choose your pseudonym, you can advise me of this here, or on the day of the interview, or via separate email up to 14 days after the interview. This question will be adjusted if a national contributor chooses to participate on the basis of being personally identifiable.

Additional – the following sections will only be included in emails sent to certain participant cohorts:

What is your ethnic group?

This question is for Independent Care Act Advocates only. The format of the question and possible responses follows guidance from the Office for National Statistics *https://www.ons.gov.uk/methodology/classificationsandstandards/measuringequality/ethnicgroupnationalidentityandreligion]*

Please choose one option that best describes your ethnic group or background:

White

1. English/Welsh/Scottish/Northern Irish/British
2. Irish
3. Gypsy or Irish Traveller
4. Any other White background, please describe

Mixed/Multiple ethnic groups

5. White and Black Caribbean
6. White and Black African
7. White and Asian
8. Any other Mixed/Multiple ethnic background, please describe

Asian/Asian British

9. Indian
10. Pakistani
11. Bangladeshi
12. Chinese
13. Any other Asian background, please describe

Black/ African/Caribbean/Black British

14. African
15. Caribbean
16. Any other Black/African/Caribbean background, please describe

Other ethnic group

17. Arab

18. Any other ethnic group, please describe

Social workers participating in the focus groups will also be asked the following questions:

Team:

Please state which team you currently belong to:

Time spent as a practising social worker:

Please state how long it has been since you started practising as a registered social worker:

Appendix J: Procedure for recruiting people with lived experience

The method for recruiting people with lived experience of using CAA services was altered while the project was underway. The method for which I gained initial ethical approval involved a two-stage recruitment process. Thereby, CAA provider organisations would supply me with an initial 'longlist' of service users they had worked with over a recent period. The main criterion for inclusion on this longlist was that staff from the provider organisation understood individuals would have mental capacity to consent to participate in the research. The longlist, which would have been pseudonymised, would have contained some basic details about the nature of the individual's involvement with a CAA. From this longlist, I would select a shortlist of individuals, whom the CAA provider would then approach on my behalf. This arrangement was proposed after a CAA provider said they were concerned there may be a perceived conflict of interest if they had final determination over which service users would participate, as they did not want to be seen to put forward service users on the basis they would speak positively about their service. However, this recruitment method proved overly complex to implement. The main reason was that it necessitated a formal data transfer agreement with the CAA providers, under data protection protocols. This proved difficult to arrange, especially amid the acute pressure on services that was being experienced due to the Covid-19 pandemic.

In response to these implementation difficulties, I developed an alternative arrangement for recruiting service user participants, again in collaboration with participating CAA providers. This involved the advocacy organisation identifying up to 10 prospective participants, which they would approach to invite their participation. This would include via distributing a recruitment flyer that I had designed (see appendix F). Approval for this amended recruitment method was obtained from the Faculty Research Ethics and Governance Committee. Below I reproduce an extract from version 1.3. of the research protocol, which was submitted with my application for amended ethical authorisation. These sections of the protocol set out in detail the arrangements for recruiting people with lived experience of receiving a CAA service. The protocol used the term ‘experts by experience’ to refer to service user participants.

Within these updated arrangements for service user recruitment, the CAA providers again agreed to contact only individuals whom they deemed would have capacity to give consent to participate in the research. Nevertheless, I took ultimate responsibility for ensuring that participating individuals had such capacity. If, during interaction with a service user participant, there was any reason to question whether they had mental capacity to give informed consent to participate, I would assess their capacity in this regard according to the MCA2005, s.3. However no need to formally assess capacity was identified in respect of the prospective participants who were identified through this process.

The participants with lived experience received a gift voucher as a token of appreciation for contributing their time and expertise to the project.

Extract from version 1.3. of the research protocol, dated 16th February 2022:

“6. STUDY PROCEDURES

6.1. Participant Recruitment

The recruitment of experts by experience will proceed with particular care. This recognises that if someone is statutorily eligible for CAA, they need additional support to properly engage with processes under the CA2014, also that these support needs cannot be met from within the person’s informal social network (DHSC, 2021a). Within statutory guidance (DHSC, 2021a:7.10-7.16), the criteria for determining whether someone would have ‘substantial difficulty’ in engaging are similar to the criteria in the functional test of capacity under the Mental Capacity Act 2005 (Department for Constitutional Affairs, 2007). However, the ‘substantial difficulty’ threshold to receive CAA is a lower one than the threshold for determining mental incapacity. Moreover, assessment of ‘substantial difficulty’ is more generalised than the decision-specific determination of capacity. Therefore, a person who has capacity to make decisions about their care and support may still be eligible for CAA.

The CAA providers will act as gatekeepers for the recruitment of experts by experience. They will be asked to purposively select, for initial approach, a target of 10 experts by experience whose suitability as potential participants is indicated by the inclusion and exclusion criteria. Participants must be able to take part in a research interview about their experiences of CAA, without any reasonably foreseeable risk that this will cause them any form of harm, such as distress or anxiety. The CAA provider will make initial contact with the selected experts by experience. This will be via the most appropriate means for the individual, based on the CAA provider's recent experience of working with them. The person may be telephoned, or contacted by email or post. A recruitment flyer that introduces the research in clear and simple terms will be used. The expert by experience will then have various options by which they can express interest in participating, or ask further questions. They can contact me directly, via one of three means: emailing my student account; writing to me via a University address; or contacting my personal mobile phone number via call, text or WhatsApp message. Or they can contact the advocacy provider, via email address or phone call. If the person contacts the CAA provider in response to the flyer, the latter will pass on the person's name and contact details to me, with their permission. This will similarly happen if the ICCA provider telephones the person, and they express a wish to either participate or find out more.

When experts by experience respond to the initial recruitment contact, I will engage with them using the most appropriate means of communication. I will discuss further with them what participation entails and answer any questions. At this point, I will send the Participant Information Sheet (PIS) to the person. This is in easy read format and uses PhotoSymbols. Once the person has had opportunity to read the PIS, further contact will be made to see if they wish to proceed with arranging an interview. The number of experts by experience that will be interviewed per case study is therefore dependent on the success of the recruitment process and is difficult to predict. If more than three experts by experience from a case study local authority wish to participate, I will interview them all unless there are strong reasons to the contrary. The CAA providers will not be requested to keep repeating these recruitment efforts until three successful responses are received, as this would be burdensome.

During initial discussions about the expert by experience's potential involvement, personal and sensitive personal data relevant to the project may be disclosed to me by the person themselves. Such disclosure may include further information about the person's needs and the nature of CAA involvement in their case.

Consent

Experts by experience will receive a PIS and a consent form in an 'easy read' format. If they require this in an alternative accessible format, or in another language, this will be fulfilled so far as this is possible, such as by engaging a translation service. However, the ability to access necessary support and resources may impose a limitation regarding this.

An important exclusion criterion is if a person does not have mental capacity, according to the Mental Capacity Act 2005, to give informed consent to participate in the research. This criterion will be applied by the CAA provider. Following the Mental Capacity Act 2005, capacity will be initially presumed; however, throughout the recruitment process, I will ensure that the inclusion and exclusion criteria continue to be properly applied. If, during contact with an expert by experience regarding the research, there are reasons to question whether they have mental capacity to give informed consent to participate, this will be assessed according to the criteria of s.3 of the Mental Capacity Act 2005.

Hence, it will be determined whether the person:

- Understands the purpose and nature of the research;
- Understands what the research involves, including its benefits, risks and burdens, as set out in this Protocol;

- Retains the information long enough to make an effective decision;
- Understands that they are under no obligation to participate and can withdraw from the study at any time.

If necessary, I will assess the expert by experience's capacity to give informed consent to be interviewed for the project. This will be done during contacts with them preceding the interview proper. In doing so, I will be able to draw upon experience of conducting such assessments whilst practising as a social worker in adult social care, and I remain registered as a social worker with Social Work England (registration number SW95387). If there are indications that the person may have fluctuating capacity, it will be assessed whether they are able to make the decision about giving informed consent at the time it needs to be made. Therefore, it will be necessary to ensure that the expert by experience has capacity to give informed consent at the point immediately prior to the interview commencing, when final consent to participate is given.

In addition to ensuring that experts by experience have capacity to give informed consent, I will seek to establish that their participation arises from their own free will, and not due to any sense of pressure or coercion. Assessment of this will proceed via steps such as asking the person why they are interested in being interviewed for the project.

For experts by experience, consent will be recorded using a method that is suitable for the individual. This will be explored with them during initial discussions and the CAA provider will also be consulted as needed, with the person's permission. An 'easy read' consent form will be available for experts by experience. It may be appropriate to use an alternative form of consent gathering, such as taking an audio recording of someone giving verbal consent if they are unable to sign their name. Experts by experience will also be offered the opportunity to have a third-party present during the interview to provide any support they may require. In discussing this, there will be cognisance that the expert by experience will not have previously been able to access support from a person identified as an 'appropriate individual' under the CA2014, and will accordingly have had an CAA appointed to assist them. However, it may be the case that the expert by experience wishes to have someone such as a professional carer or support worker present for their interview.[14] If a third party is present for the interview, they may be able to assist with the process of recording consent, if the expert by experience agrees to this. For example, if a person has difficulties with reading or writing, a support worker could assist them to sign the consent form, such as by writing in the date for them."

REFERENCES

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[14] Under the CA2014, someone who is paid to provide care and support to a service user is precluded from also being considered an 'appropriate individual' to informally advocate for that service user (DHSC, 2021a:7.33).

Appendix K: Consent forms

Reproduced below are the main variations on the consent form that were used. For interviews conducted online, the participant received a copy of the consent form in advance. Then, immediately prior to the interview, consent was taken verbally according to each point on the form. This was audio recorded, along with the ensuing interview.

The different consent forms are as follows:

i) For national contributors

This consent form includes an option for the participant to waive their right to anonymity.

ii) Participants with lived experience

This consent form was in easy read format.

iii) Case study participants (non-service user)

CONSENT FORM: NATIONAL CONTRIBUTORS

Independent advocacy under the Care Act 2014

Participant Identification Number:

	Please tick your chosen answer	YES	NO
1.	I confirm that I have read the participant information sheet version 1.0., date 30th April 2021 for the above study.	☐	☐
2	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
3	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.	☐	☐
4	I agree to participate in the project to the extent of the activities described to me in the above participant information sheet.	☐	☐
5	I agree to my participation being audio recorded for analysis. No audio clips will be published without my express consent.	☐	☐
6	I understand and agree that my words may be quoted anonymously in research outputs.	☐	☐
OPTIONAL			
7	I wish to chose my own pseudonym (first name only), which I will be known as in all research outputs. If you have already chosen a pseudonym, please state it here: ______________________. You can contact the researcher to inform him of your choice of pseudonym up to 14 days after the interview takes place. Otherwise, the researcher will assign a pseudonym to me.	☐	☐
8	I wish to be informed of the outcomes of this research. I can be contacted at: ____	☐	☐
9	I give permission for the researchers named in the participant information sheet to contact me in the future about this research or other research opportunities.	☐	☐
10	I wish to waive my right to anonymity as a participant in the research. I understand that I will be referred to by my real name in the resulting PhD thesis and all other published outputs based upon the research, and that these outputs will be publicly accessible. My organisational affiliation will also be named in all such research outputs.	☐	☐

______________________ ______________________ ______________________

Name of participant Date Signature

______________________ ______________________ ______________________

Name of person Date Signature
taking consent

Version: 1.2 **Date:** 17th February 2022

CONSENT FORM: CASE STUDY PARTICIPANTS (Professional)

Independent advocacy under the Care Act 2014

Participant Identification Number:

	Please tick your chosen answer	YES	NO
1.	I confirm that I have read the participant information sheet version .... , date .... for the above study.	☐	☐
2	I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	☐	☐
3	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.	☐	☐
4	I agree to participate in the project to the extent of the activities described to me in the above participant information sheet.	☐	☐
5	I agree to my participation being audio recorded for analysis. No audio clips will be published without my express consent.	☐	☐
6	I understand and agree that my words may be quoted anonymously in research outputs.	☐	☐
OPTIONAL			
7	I wish to chose my own pseudonym (first name only), which I will be known as in all research outputs. If you have already chosen a pseudonym, please state it here: _______________________. You can contact the researcher to inform him of your choice of pseudonym up to 14 days after the interview takes place. Otherwise, the researcher will assign a pseudonym to me.	☐	☐
8	I wish to be informed of the outcomes of this research. I can be contacted at: ____	☐	☐
9	I give permission for the researchers named in the participant information sheet to contact me in the future about this research or other research opportunities.	☐	☐

_______________________ _______________________ _______________________

Name of participant Date Signature

_______________________ _______________________ _______________________

Name of person taking consent Date Signature

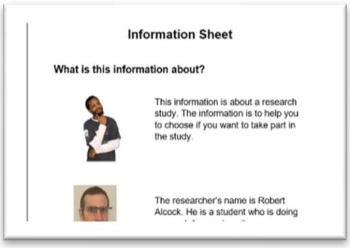
Version: 1.2 **Date:** 17th February 2022

Manchester Metropolitan University

Consent Form (People with lived experience)

Independent advocacy under the Care Act 2014

A **researcher** is someone who tries to find out new things.



Information Sheet

What is this information about?

This information is about a research study. The information is to help you to choose if you want to take part in the study.

The researcher's name is Robert Alcock. He is a student who is doing

I have read the information sheet. (Dated 12th June 2021, version 1.1)

yes	no
✓	✗
☐	☐

I have been able to ask any questions I have about the research.

yes	no
✓	✗
☐	☐

I understand that I do not have to take part.

yes	no
✓	✗
☐	☐

I understand that I can stop taking part at any time. I do not have to say why I want to stop and there will be no problems for me if I stop.

yes	no
✓	✗
☐	☐

Version: 1.0. Date: 1st August 2021

I agree to take part in the study as described on the information sheet. This means I am happy to talk to the researcher about having an advocate.

yes ✓ ☐ no ✗ ☐

I agree for things I say to be recorded. I understand I can say no to this and still take part in the research.

yes ✓ ☐ no ✗ ☐

I understand what I say will be private. The researchers will not use my real name in anything they write.

yes ✓ ☐ no ✗ ☐

I understand that if I tell the researcher somethings that makes them worried about me or someone else, they may have to tell someone.

yes ✓ ☐ no ✗ ☐

I agree for the researchers to write down and share words I have said. I understand my name will not be used.

yes ✓ ☐ no ✗ ☐

I would like the researcher to send me a copy of the report.

yes ✓ ☐ no ✗ ☐

Name………………………………………………… Date………………………

Signature…………………………………………………………………

If the person is unable to sign their name was verbal consent recorded? Yes/No

Researcher name…………………Researcher Signature…………………………

Acknowledgement: *This consent form adapts some ideas, including layout, expressions and use of Photosymbols from the 200 Lives Project easy-read consent form (IRAS Reference Number: 288650). Particular thanks are extended to Francesca Ribenfors, Research Associate, Department of Social Care and Social Work at Manchester Metropolitan University.*

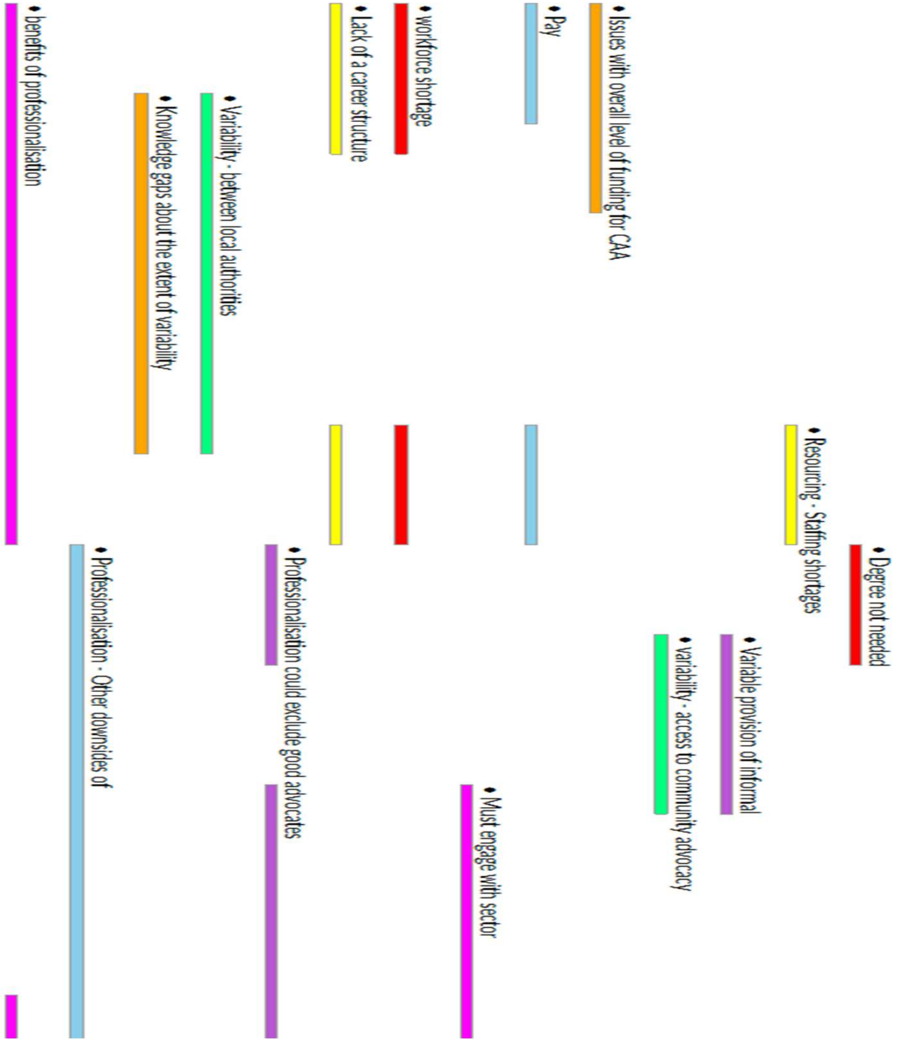
Version: 1.0. Date: 1st August 2021

Appendix L: Extracts of coded transcripts

The following are extracts from coded transcripts—one from each case study. The first is from the interview with Rachel (M, FA); the second is from that with Helen (CAA, MV). Alongside each transcript excerpt are the relevant coding stripes from NVivo, showing which portions of the text have been assigned to which code (some sections are assigned to multiple codes). For clarity, beneath each extract I have included a key, listing the codes used and the corresponding colours of coding stripes.

Robert Alcock: There's been a lot of commentary that independent advocacy has become increasingly professionalised over recent decades. I wonder what your views are as to whether this is a good thing?

Rachel: I think…I could talk about this for a very long time. But what I'd say succinctly is I'd say there are definitely positive elements around this. So if you professionalize an industry, either through registration, accreditation, you introduce a framework in terms of wages, a clear recruitment path and I think also, if you regulate an industry and formalize it, then there'll be much clearer guidance nationally in terms of how much advocacy resource is needed to meet the needs of communities. Because at the moment it does vary a lot. And it varies between local authorities significantly. There is no standardized approach. So for example, I'm an advocate for, in terms of IMHA, and I know we're talking about Care Act Advocacy, but for me it's all bit connected because we deliver all statutory advocacy and all of the advocates sort of, you know, do a mix. So for IMHA, you know, I really think there's a very strong case that the local authorities know how many psychiatric beds there are per local authority and there should be IMHAs correspondingly attached to that. So I think there's benefits in terms of that. And I think there's a lot of very skilled people working in health and social care that would be great advocates and in the charity sector in general. But there's just not a defined career path and you know, perhaps it could alleviate some of the downward pressure on wages. However, some of the drawbacks of the professionalization are, of course, it could be an access barrier to people as well; because there's some, you know—social workers have to have a degree—I don't necessarily think you need a degree to be a really good advocate. And I do wonder as well, in terms of the impact it will have on community advocacy, though that's not even funded in Fencross. And that's another thing as well, some local authorities have a community advocacy pot. Our local authority hasn't had that for about 10 years now. So there's also differences in terms of general community advocacy provision across different local authorities. So I would tend to say, that professionalization is generally a better thing, but we need to make sure that sort of advocates have input and advocacy leaders have an input into how this is done, because you know we want to make sure that we are able to engage with people that—you know people can come into the industry



Codes used

Degree not needed	🟥
Variable provision of informal advocacy	🟪
Variability – access to community advocacy	🟩
Issues with level of overall funding for CAA	🟧
Pay	🟦
Must engage with the sector	🟪
Workforce shortage	🟥
Lack of a career structure	🟨
Professionalisation could exclude good advocates	🟪
Variability between local authorities	🟩
Knowledge gaps about the extent of variability	🟧
Benefits of professionalisation	🟪
Other downsides of professionalisation	🟦

Robert Alcock: You mentioned about the need to take an individualized approach, and about communication. We talked about interpreters already. Is there anything in terms of working, you know, with people with alternative communication styles? Is there anything that you use in particular with people [affected by this]?

Helen: Yeah. So I've worked with somebody who has been deaf and just got, because of his age, declining eyesight. So it's, you know, preparing things in advance in large print, so that they can look and answer the questions and take in more. It took more time with that person, but being able to allocate the time that they needed to find out, you know, what was important, to them; what they thought their needs were; and how to meet their outcomes, really. I've also worked with somebody who uses Makaton. And whilst I'm sad to say that I don't actually use that myself, I have worked with somebody who does use Makaton to find out, you know, to be able to communicate effectively with them.

- Communication within conduct of processes
- Time resource to spend with service users
- Specialisation - communication

Robert Alcock: The next question is: does the Care Act advocate role provide opportunity to work with people in a sufficiently in-depth long-term and preventative way?

Helen: So I was reading this and I've made a few notes, so let me just refer back to them. So I'd say it depends on the size of your caseload and the demand at that current time, in terms of how many referrals we've had and how they've been spread amongst the team. Like I said before, I think we often have the opportunity to spend longer with individuals than a social worker would. But we don't work with them over a long period of time. It's more time specific, so for however long that process takes—so if it's an assessment, until the assessment's complete and we know that the individual is happy with the assessment, we would then close the case. Similarly with support planning or, you know, a safeguarding once it's concluded and the individual is aware of the outcome, we tend to close the case. There are times when we come across people, through our Care Act work and we see that there's a need for advocacy, but it might not be related to Care Act. In some cases, we are able to keep those people open and work with them for a little longer, but again it very much depends on our capacity, because we have to prioritize, unfortunately, the Care Act work, because that's where our funding comes from, or the majority of our funding. And so it would depend on what we're able to do for that individual, but often we do keep people open for longer.

- Processes - Process driven
- Remit - CAA provides opportunity for long-term advocacy
- Remit-preventative approach
- Resources determine tightness of remit
- Resourcing determines if can keep open beyond process

Codes used

Specialisation - communication	🟪
Resourcing determines whether can keep open beyond CA2014 processes	🟥
Resources determine tightness of remit	🟨
Remit - preventative approach	🟪
Remit—CAA provides opportunity for long-term advocacy	🟩
Time resource to spend with service users	🟧
Processes: process-driven	🟦
Communication within conduct of processes	🟪

Appendix M: Code list

The following tables comprise the full project code list, exported from NVivo. As coding progressed, the early stages of theme generation were embarked upon, as I began to assemble the codes into groups that were reflective of topics. This was done via the functionality of creating ‘a parent and child’ coding hierarchy in NVivo.

The topics are as follows:

- Accessibility
- Processes
- Working relationships
- Legal
- Training
- Participants’ work history
- Commissioning
- ‘Advocacy Plus’
- Effectiveness
- Integration
- Representation—policy
- Variability
- Referral
- Remit
- Challenge
- Occupational role and identity
- Support
- Advocacy ethos
- Organisational
- Resourcing outcomes
- Specialisation
- Equity, diversity, inclusion (EDI)
- Covid-19
- Structural factors in adult social care

In appendix M, I show the initial stages of refining the themes.

ACCESSIBILITY	
Accessibility - Carers advocacy	Unsure what to do to promote CAA
Groups facing particular exclusion	Broad eligibility criteria
Multiple exclusion homelessness	Cannot quantify referral shortfall
Accessibility - Health processes	Change in referral levels over time
More providers can do to promote	Clarity of eligibility criteria
Accessibility - statutory requirement not being met	Eligibility criteria are too strict
Accessibility - Transition children to adult	Insufficient resources for promoting access
Advocates promoting access in individual cases	Interprofessional relationships can affect accessibility
Awareness among professionals	Lack of awareness of need for CA2014 assessment
Awareness less embedded than IMCA and IMHA	Need to audit social work practice regarding referrals
Staff turnover affects awareness	Organisational dynamics affect referral rates
Awareness among service users & carers	Professionals must be aware of benefit not just statutory requirement
Providers promoting referrals	

REFERRAL	
Appropriate individual - difficult to gauge	Referral - err on side of caution
Busyness of Social workers as a barrier	Referral - family requesting
Confusion between statutory remits	Referral - knowledge gap
Cross-referral	Referral - Other eligibility grounds
Determining ‘appropriate individual’ status	Referral - service user consent
Difficulties in assessing substantial difficulty	Referral - service user requesting
Ease of determining eligibility	Referral - Strict vs loose referral criteria
Ease of referral varies between areas	Referral due to 'family dynamics'
Family not acting in best interest	Referral routes
Family resistant to advocacy referral	Referral- Under-referral
CAAs push back re: tokenistic referrals	Referrals - timeliness
IMHA - recently getting more referrals	Referrals as a way to resolve 'disputes'
Improve system prompts	Referrals guidance from CAA provider
Issue with referral coming from LA	Referrals need checking before allocation
Local authority wants advocate to mediate	Service users preferring family support
Managers spurring referrals	Self-referral in some local authorities
Misunderstanding of eligibility	Some decline CAA input
Perceived high volume of referrals	Variability in accessibility
Prioritising referrals for statutory advocacy	Waiting lists an issue
Quality of the referral	Waiting lists not an issue
Referral - Automatic trigger	Referral - Clarity and ease of process

PROCESSES	
Ability to explain processes	Processes - Positive practice
Accessibility of advocate to the s/user	Processes - Process driven
Advocate is proactive	Supporting service user involvement
Advocate not proactive in meetings	Processes matter - not just outcomes
Affecting pacing of processes	Providers and ex-providers keen to help
Alert when person is totally unbefriended	Feedback to the practitioner in writing
Aligning with family wishes	Writing of reports
Attending meetings with the person	Relationship-building with service users
CAA acting in best interests	Relationships with family
CAA insufficiently involved by the practitioner	Consulting family
CAA involved in support planning	Don't need to engage much with family
CAAs' desire for minimal involvement	Family can be confused about CAA role
Challenge of promoting self-advocacy	Family may resist and block access
Aiding communication within conduct of processes	Resistance to involvement (process)
Some prefer remote communication	Risk of process not person led
Consulting case records	Safeguarding can add extra time pressures
Consulting others	Seeing person one to one
Continuity of advocate for repeat referrals	Service users' recognition of Advocacy role
Creative advocacy practice	Showing understanding & empathy
Cross-border issues	Support with funding processes
Ensuring proper conduct of processes	Time pressures can affect CAA quality
Finding out what the person wants	Time resource to spend with service users
Following up re: need for referrals etc.	Using appropriate language
Gaining service users' trust	Using other laws e.g. Equality Act 2010
Getting family onside	Wishes not best interest
Health-led processes	Working with natural support networks
Helping the person voice choices	Workload management - must be organised and structured
IMHA offers relational opportunities due to close proximity	Person may be unwilling to engage with processes
Instructed v non-instructed	Personal qualities affect effectiveness
Variability in levels of cognitive and communication impairment	Personalisation e.g. Direct Payments
Majority of cases person lacks capacity about some decisions	Practitioner supports person's involvement
Making processes person-centred	Pressures relating to safeguarding and hospital discharge
Risk of focusing on needs not outcomes	Process - Negative culture
Non-instructed - watching approach	Processes - Advocates' proximity to SUs
Not getting informed about case closure	Benefits of specialisation
Organic advocacy methods	Ensuring reasonable adjustments are made
Perception of CAAs' independence	Processes - Knowledge of person

REMIT	
Advocacy as a service in its own right	Remit - Difference between general and statutory advocacy backgrounds
Advocates not involved when should be	Remit - Issue-based advocacy
Being assertive about maintaining limits of role	Remit - Issues outside statutory advocacy
CAA practice can be too oriented around processes	Remit - Length of involvement
Ending - can be grey area	Remit - Powers are sufficient
Ending - processes that can be more open-ended	Remit - Proactive safeguarding
Ending - processes with clarity	Remit - some service users don't want ongoing support
Links between remit and challenge	Remit- support with practical tasks
Prepare service users for limited involvement	Remit too narrow
Prevention - virtuous circle	Remit-preventative approach
Pros and cons of different approach to remit	Resources determine tightness of remit
Re-allocated back to same worker	Some CAAs unsure of role
Remit - availability of alternative support	Ways to expand remit
Remit - CAA provides opportunity for long-term advocacy	Advocacy regarding forced marriages etc
Remit - Consistency of involvement	Advocacy regarding parenting role
Remit - contract insufficiently flexible	peer advocacy
When long term can have a preventative element	Support for close ones to act as advocates
Would like to work with outside remit	

WORKING RELATIONSHIPS	
Advocates as true to social work values	Social worker and CAA - positive working relationship
Annoyance to social workers	Social worker facilitates CAA involvement
CAA may know law better than social worker	Social worker raising issues with advocates' conduct
CAA providers' outreach to practitioners	Social workers and advocates acting in agreement
CAA responding to deficiencies in professional social work	Social workers as advocates - challenge to independent advocacy
CAA valued by social workers	Social workers challenging funding panel
CAAs having more time for relational work	Social workers constrained in their practice
CAAs' relationship with health staff	Social workers expecting advocate to step outside remit
Challenges not personalised	Social Workers expecting CAAs to act as support workers
Communication with social worker	Social workers feel advocates acting outside remit
Co-operation in holding care providers to account	Social workers feel advocates not understanding current system
Co-operative working with social workers- negative views	Social workers not involving advocates
Involvement in MDTs	Social workers trained to be advocates
Involvement stops - social worker doesn't know how to proceed	Social workers valuing advocates
Limits to social work advocacy	SWs need to practice in way that respects advocacy
MDTs must be aware of advocacy	Student social workers as bridge
Mutual understanding of roles & pressures	SW seeking what is best for the service user
Partnership working with social workers	SW-CAA difference - wants and needs
Practitioners' knowledge about advocacy	Tension in working relationship
Practitioner knowledge in CMHTs	Tokenistic engagement with advocacy
Takes time to embed awareness	University gave social workers an insufficient understanding of advocacy
Professional awareness - training and culture	Variability in working relationships
Relationships impact on referral levels	Working relationship-Differential between teams
Rest of system is not promoting involvement	Risks of taking social workers' assurances in good faith
Social work - Best interest vs wishes of the service user	

CHALLENGE	
Barriers to pursuing Judicial Review	Instructed advocacy - work with the person regarding challenges
CAA - social worker relationships are not adversarial	Judicial review can get things moving
Care costs cap policy might encourage appeals	Lack of legal requirement for social care complaints advocacy
Challenge - upholding wishes rather than best interest	Making representations to local authority funding panel
Challenge can prolong needs going unmet	Mechanisms of challenge
Challenge in Court of Protection	Mental capacity affects routes for challenges
Challenges not personalised	More robust challenges needed
Challenging service providers	Not needed to seek judicial review
Commissioning relationship can affect challenge	Ombudsman decision
Commitment to making challenges	Prefer negotiation before overt challenge
Difficult to get Legal Aid	Putting concerns in writing
Difficulty of using complaints system	Raise concerns with the social worker
Disappointment over lack of appeals process	Referring concerns to local authority quality team
Escalate to social work manager	Regret if challenge is insufficiently robust
Focus of challenge can be wider than individual	Service users seeking challenge
Framing challenges via Human Rights	Skills, knowledge and confidence to challenge
Frequency of challenge	Social worker and CAA often in agreement
Hospital discharge - different perspectives and timeframes	Successful challenges
IMCA skillset more pronounced regarding legal challenge	Successful use of complaints system
Importance of challenge recognised	Supporting the service user to make their own challenges
Importance of psychological independence	Tensions with making challenges as a commissioned provider
Informal challenge mechanisms are favoured	

LEGAL	
Access to legal aid	Legal route dragged out
Access to external legal support	Legal support from colleagues and managers
Extension of role as litigation friend	Dangers of seeking legal advice online
Legal - Benefits of enforceability	Local authorities don't want to pursue legal route either
Legal - Landmark cases	May know law better than social workers do
Legal literacy and support more advanced for Mental Capacity and Mental Health Advocacy	Need for legal knowledge
Legal requirements clear	Legal literacy - different types of law
Should be quicker to go down legal route	

OCCUPATIONAL ROLE AND IDENTITY	
A respected profession	Must engage with sector
A vocation	National Advocacy Qualification insufficient
A worthy role	National Qualification in Advocacy
Advocacy become more regulated and rules-based	Natural affinity for the role
Advocacy must retain relational focus	Need a thick skin
Advocacy not stressed in social work curriculum	Need more professional recognition
Advocacy sector had to change to be recognised	Need to be respected to be effective
Are there volunteer statutory advocates?	New profession finding its feet
Background in working with people with learning disabilities	New routes in - apprenticeships
Barriers to continuing as SW whilst CAA	No pre-entry training
benefits of professionalisation	Origins of professionalisation
Benefits of SW background	Pay
SW background – Anti-oppressive practice	Perception of professional as negative
Breadth of role	Personal family experience of disability
CAA employment background	Pressures equivalent to Social work
CAAs don't make decisions - differs from social work	Previous Social work experience - risk of out-dated knowledge
CAAs need a strong understanding of ASC	Previous SW experience helps relationships with professionals
CAAs should not be registered	Professional development
Can be difficult to argue for wishes not best interests	Professional status
Degree not needed	Professionalisation - Maverick occupation

OCCUPATIONAL ROLE AND IDENTITY contd.	
Developments in role over time	Professionalisation - Other downsides of
Difference based on whether started working pre-stat	Professionalisation could exclude good advocates
Different routes into advocacy	Professionalisation helps uphold service users' rights
Difficulty is underestimated	Professionalisation is a reality
Enjoy doing job	Professionalisation is a source of debate and reflection
Ensures good standards	Professionalisation not necessarily mean taken more seriously
Excluded as not seen as professionals	Professionalisation-Registration and regulation
HE needs to bolster advocacy training	Regulation and registration does not guarantee quality
Importance of confidence	Reflectivity reflexivity and recognise limits of knowledge
Independent mindset crucial	Registration demands could be unpopular
Informal demeanour	Responsibility & Accountability of role
Is a skilled role	Responsibility for own learning
Knowledge demands equivalent to SW	Retained social work registration while CAA
Knowledge gained from previous SW experience	Role is challenging or stressful
Lack of a career structure	Self-employed advocates
Lack of data about training	Sense of professional becoming removed from service users
Lack of distinctiveness from other professionals	Service users may feel they don't need another professional
Learning from new situations	Strong ethical impulse - care & compassion
Less pressure than social work	Student social worker becoming CAA
Levels of staff turnover	Other professionals becoming advocates e.g. nurses
Lonely position	Training opportunities in line with Social work
Maintain distinctive role while professional	Use professional judgement
Moral component compatible with professionalisation	Volunteer advocates
Motivation - Disenchantment with statutory social work	workforce shortage
Motivation - justice and rights	LPS will increase need for advocates

TRAINING	
Manager impacts training availability	Tighter qualification requirements needed
More training in specialist communication skills needed	Training is issue-focused
Opportunities to identify own training needs	Variations in training between organisations
Sufficient and high-quality training available	

SUPPORT	
CAAs feel well supported	Importance of team spirit
CAAs get opportunities to source own training resources	Informal support undermined by COVID
Cases are held individually by CAAs	Providers sought to enable remote support during COVID
Good training opportunities for CAAs	Statutory advocates receive enhanced training and support
Importance of peer support among CAAs	Supervision is readily available
Importance of supervision	Support from team leaders
Importance of team meetings	Trusted to manage own diary

PARTICIPANTS' WORK HISTORY	
Work history - CAAs	Work history - Social workers

ADVOCACY ETHOS	
Advocacy is unique	Possibility of returning to group advocacy
CAA ambivalent relationship with traditional ethos	Traditional ethos - Departure from idealism, radicalism, traditions & values
Continuity with pre-CA2014 practice	Political component to advocacy
Fought to make advocacy statutory - now disappointed	Roots in citizen advocacy
Try to reconcile tensions	

COMMISSIONING	
Commissioners - recognise value of CAA	Learning within commissioning process
Commissioners - respect independence of CAA	Limits on commissioned advocacy hours
Commissioners' focus has been on volumes of work	Merits of central commissioning
Commissioning - More accountability needed	Merits of local commissioning
Commissioning - One or multiple CAA providers	Move to integrated commissioning of stat advocacy
Commissioning and 'service culture'	Need to review commissioning model
Commissioning group advocacy	No adult social care complaints advocacy commissioned in some areas
Commissioning inclusive services	Process of commissioning advocacy hub
Gaps in commissioners' knowledge	Process of re-commissioning
Importance of Advocacy QPM	Provider subsidising cost of service
Lack of data about what is commissioned	Providers telling commissioners about issues
Variability of commissioning between areas	Still in first round of commissioning

ORGANISATIONAL	
Advocate caseloads	Organisational history
CAA manager as a practitioner also	Organisational size and means of evaluation
Co-production within CAA services	Organisational size and trust among team
Importance of teamwork to the organisation	Organisational size inhibits specialisation
Consistency of team	Organisational stability
Individual role descriptions	Pilot of culturally appropriate advocacy
Local knowledge as organisational Unique Selling Point	Providing services in addition to advocacy
Maintaining organisational independence	Quality important to organisational ethos
Moving offices	Relationships between local authority and CAA provider
Organisation - Hybrid provider organisations	Size more management layers
Organisation - Nature of the adult social care dept	Size of provider organisation - big v small
Organisation - Scaling up advocacy providers	Organisation - Ethos of small organisation
Organisation invests in staff	Strong self-regulation already exists
Organisation within the informal advocacy sector	Team leader role
Variety of CAAs' previous work experiences	

'ADVOCACY PLUS'	
Advice and information	Diverse advocacy provision
Advocacy Plus - notion of a 'spectrum'	Lack of links between statutory and informal advocacy
Difficulty of replicating community model	

RESOURCING	
Allocation can be challenging	Resources - Cost pressures encouraging home working
Cases are all complex	Resources insufficient for improved accessibility
Challenge of balancing resourcing with referrals	Resourcing - Funding of adult social care
Difficulty of 'bearing down on demand'	Resourcing - more time than social worker for relational work
Difficulty of 'weighting' caseload	Resourcing - Staffing shortages
Evidence of underfunding	Resourcing affects person-centredness
Flexibility - block and spot contracting arrangements	Resourcing affects scope for equity, diversity, inclusion
Hard to predict referral levels	Resourcing affects speed of allocation
Imbalance - expected to be quick to open but may be long to close	Resourcing can make worker consistency difficult
Imbalance between SW and CAA numbers and resourcing	Resourcing creates quandary - quality v quantity
Increased resourcing for the CAA provider during contract period	Resourcing determines if can keep open beyond process
Issues with overall funding level for CAA	Resourcing makes it hard to have specialisms
Lack of ring-fenced budget	Resourcing problematic when CAA so wide-ranging
National commissioning may secure more resources	Short staffing
Need a pool of sessional advocates	Size of caseload
Pessimism about resourcing prospects	Time with service user can vary due to resourcing
Referral rates vary over time - reasons unclear	Timescales for allocation
Variability in resourcing between local authorities	Variability between organisations in how resourcing shortfalls are dealt with

OUTCOMES	
Benefits - Access to health services	Benefits- 'Watchful eye'
Benefits - Empowerment, choice, control	Counters epistemic injustice
Improves professionals’ behaviour	Creating false expectations
Benefits - Person-centred	Decisions in line with chosen outcomes
Benefits - Promoting dignity	Negative - Going against service users' wishes
Benefits - Upholding rights	Promoting involvement
Benefits - welfare rights	Promoting wellbeing
Benefits- community development	Securing resources

EFFECTIVENESS	
CAA is effective	Organisational agency and culture
Capturing social impact	Effectiveness - Outcomes not just process
CAAs successfully unpicking situations	Effectiveness - Visibility of results

SPECIALISATION	
Advocates' preferences for types of work	Social workers also find genericism challenging
Background in working with people with learning disabilities	Social workers support advocate specialisation
Benefits of a mix of backgrounds	Some evidence of specialisation within teams
CAAs enjoy the variety of their work	Some specialism too far e.g. child protection
Composition of social work teams	Adaptability and transferable skills
Dilemma regarding merits of specialisation	Specialisation - communication
Diversity includes social issues	Specialisation - everyone is individual
Each area of advocacy as specialism	Specialisation - genericism has diluted
Experience improves ability to undertake wide-ranging work	Specialisation - use appropriate language
Familiarity of specialism infrastructure	Specialisation - working with people with learning disabilities
Identified areas of specialisation	Specialisation can hamper advocate efficacy
Jack of All Trades quote	Specialisation- knowledge
Need broad knowledge base	Specialist knowledge – learning disability and autism
No specialisation within advocacy training	Size of staff teams limits specialisation
Pilot projects provide additional resource	Success at meeting specialist needs
Risk of communicating inappropriately to group	Training regarding specialist areas of practice
Similarity of arguments regarding specialisation across service user groups and advocacy types	Universal advocacy principles
Wide scope is challenging	Variability of knowledge levels

INTEGRATION	
Advocacy planning in a locality needs to be integrated	Integration is accepted in the sector
Becoming more integrated	Integration may dilute advocacy specialisms
Boundary issues	Integration more resource efficient & effective
CAA - overlap with IMHA	Integration not thought through from outset
CAA broadest type of statutory advocacy	Keep practising across specialisms to ensure skills maintained
CAAs also acting as paid RPR	Mid-sized organisations moving to try to deliver all themselves
Clarity of statutory advocacy roles	Martborough - do RPR if out of area
Continued differences between advocacy types	Mix done by individual CAAs
Disjuncture between Ordinary Residence requirements	Move to staying with CAA rather than going to IMCA
How IMCA-CAA split is managed	Need to raise knowledge about MCA
IMCA seen as having elevated status	Overlap may be done informally
IMHA integration issue - is ward based	Problem if separate providers for different statutory advocacy roles
Integrating advocacy roles in Fencross	Qualification reflects need for integration
Integration - better experience for service user	Reforms to different advocacy requirements need to progress in unified way
Integration - Compatibility of different approaches	Relationship with Independent Health Complaints Advocacy
Integration - Cross-referral opportunities	Resources constraints may shape overlap
Integration - Little alignment with IMHA	Scope of other advocacy types compared with CAA
Integration - Move to multi-skilled	Social workers confused re: role boundaries
Integration - Overlap with IMCA	Social workers see need for integration
Capacity issues not just IMCA territory	Team leaders offer specific expertise
Integration - Overlapping remits	Variability in levels of integration
Integration challenging for advocates	

STRUCTURAL FACTORS IN ADULT SOCIAL CARE	
Care Act's unfulfilled promise	MHA1983 reform
Decisions above SW heads	Reform of adult social care
Growth of people lacking capacity	Resourcing shapes LA decisions
CAA only truly works when system respects it	Settling down of CA2014 processes
Impact of austerity	Structural factors can prevent the service user getting what want
Liberty Protection Safeguards	Underlying political culture

REPRESENTATION - POLICY	
Advocacy Leaders Network	More attention from DHSC
Extent of agreement in sector	Providers need to be more proactive in shaping CAA role
Importance of wider engagement	Representing the advocacy sector
Martborough Voices - historical involvement in representation	Some providers need to lobby more in their local authorities

EQUITY, DIVERSITY, INCLUSION (EDI)	
Advocacy for LGBTQ+ people	Non-statutory advocacy can be better targeted at excluded groups
Advocacy organisations historically White	Outreach by CAA providers
Advocacy with people from Eastern European backgrounds	Overlap cultural specialisation and service user group specialisation
Advocates promoting inclusive agenda	Partnering with community organisations
Availability of translators and interpreters	Exchange skills & knowledge
Aware of everyone's individuality	Culturally appropriate advocacy must be explicitly funded or no capacity to do it
Barriers to cross-cultural advocacy	Retain quality control and focus resources
Building cultural awareness among advocates	Personal experience of promoting agenda
CAAs committed to cultural appropriateness and inclusivity	Practitioners responsible for promoting diversity in access
Challenge determining when interpreter is needed	Progress with advancing equity, diversity, inclusion
Change has been slow	Providers aware of own shortcomings - EDI
Community groups can provide culturally appropriate support	Recognising differences among minoritised people
Confidentiality concerns - small cultural communities	Scope to apply culturally appropriateness to CAA
Cross-cultural advocacy can be challenging	Service users prioritising advocate effectiveness
Cultural appropriateness highlights wider access issues	Shared culture helping relationship building
Cultural appropriateness in non-instructed advocacy	Shortfall in cultural knowledge
Culturally appropriate advocacy can highlight power differentials	Should aim for services that can meet all needs
Culturally based community organisations as CAA providers	Should engage external partnerships if necessary
Demographic character of local area	Specific services in an ideal world
Diversity among staff teams – positive	Training about cultural appropriateness etc

EQUITY, DIVERSITY, INCLUSION (EDI) contd.	
Diversity should be represented in the workforce	Treating everyone fairly
Diversity—social class	Uncertainty about how to address shortfalls in cultural appropriateness
Examples of culturally sensitive practice	Unnecessary to 'match' service user and advocate
Forging links with specific services	Variability in levels of culturally appropriate advocacy
CAAs trying to gain cultural competence during casework	Wider availability of culturally specific support
Need to be flexible and adaptable	Need for a broad view of social inclusion
IMHA more diverse service user group	Limited attention during initial commissioning
Importance of organisation's external image	Limited by who is referred in
Inequality in wider society	Limits to ensuring workforce diversity
Lack of advocacy services from ethnically minoritised communities	Monitor services e.g. regarding diet
Lack of culturally appropriate advocacy	

VARIABILITY	
Diversity of service users encountered	Variability - how organisations measure advocacy
Variability in service users' ability to participate directly in processes	Variability - impact of Covid
Knowledge gaps about the extent of variability	Variability - organisational relationships (LAs and advocacy organisations)
Variable access to community advocacy	Variability - resourcing for CAA
Variability - advocates' abilities	Variability - service users' experiences of CAA
Variability - between local authorities	Variability between organisations
Variability - ease of access to CAA	Variability in ability to challenge
Variable whether adult social care complaints advocacy is commissioned	Variability of SW ability affects relationship

COVID-19	
Access to service users during Covid	Covid-online communications challenges
Advocates more stressed and isolated	Covid-reduce costs on offices etc
Benefits of online meetings	Covid-support networks down
CAA adjusted to Covid quicker than social workers did	Dealt with Covid well
CAAs as essential workers	Hard to make judgements regarding access
Changes persisting after lockdown end	CAA waived during height of Covid
Covid - alternative forms of contact	In-person interactions superior
Covid - decreased referrals	Long term effects of Covid on service users
Covid - general pressure on services	Move towards hybrid working
Covid - Impact on commissioning	Other precautions e.g. Lateral Flow Tests
Covid - IT upskilling	Overall effects of Covid
Covid - lack of access shared by SW	Remote can be beneficial for contacting some Service users
Covid - lasting excuse by providers re community access etc	Social workers' level of in-person contact during Covid
Covid - long waiting lists	Some cope with remote work better than others
Covid - long-term effects	Some social workers avoided CAA during Covid
Covid - long-term effects will be limited	Too soon to determine Covid’s long-term impact
Covid - negative impact on advocacy	Working from home is positive
Negative impact on health and social care staff	Covid creating a backlog of processes
Covid - retreat from rights and protections	Covid - CAAs reminding about referral responsibilities
Covid - returning to normality	Covid increased safeguarding demands
Covid - sense of community	Covid- PPE and masks
Covid - variability in impact level	Covid-impact on Court of Protection
Covid - visits continued	Covid-impact on Team positive
Visits depend on advocate's confidence	Covid-improved informal provision

Appendix N: Theme generation

From the codes that were clustered into broad topics, as presented in the previous appendix, I undertook theme generation as an iterative process (Braun and Clarke, 2006). I now reproduce some earlier versions of the thematic structure that I presented in the five thematic chapters. Two developing thematic structures are presented. The first, from April 2022, was an initial effort that was composed while data collection was ongoing.

The second prospective thematic structure is dated from July 2022, after all but one of the interviews had been conducted. This shows that that the previous 16 themes had been reduced to seven. This was done via merging themes and thinking differently about the coding structure. For example, I chose not to identify 'Change due to Covid-19' as a theme in its own right; instead, I re-designated codes relating to the impact of the pandemic in order to help elucidate shared meaning in respect of other themes. This meant that questions about access to CAA incorporated considerations about the effects of Covid-19 in this regard, for example. The thematic structure from July 2022 also includes sub-themes. The seven themes were reduced to five for the final thematic analysis by combining some themes relating to organisational and commissioning aspects of CAA. The sub-themes were also expanded, re-named and re-ordered for the final reporting of the themes.

During creation of the thematic structure, attention was initially given to creating a three-tiered thematic structure, with a smaller set of overarching, or superordinate themes that would be primarily analysed in the context of the six main themes, not on their own account (Braun and Clarke, 2022). However, I did not include these superordinate themes in my final thematic analysis, largely because I deemed this structure unnecessarily complex and I had difficulty retaining a clear distinctiveness between the different layers of analysis. Therefore, the five main themes are retained as the basis of the five thematic chapters. However, some overarching analysis that cuts across multiple themes was incorporated into the concluding chapter.

References

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology.' *Qualitative Research in Psychology*, 3(2) pp. 77-101.

Braun, V. and Clarke, V. (2022) *Thematic analysis: a practical guide*. London: SAGE.

Thematic structure: April 2022

1) Variability in CAA's implementation and resourcing issues [This was identified early on as a potential superordinate theme]

2) Accessing CAA: reliance upon gatekeeping professionals

3) CAA's remit: process-bound but potentially expansive

4) Challenge of staying person-centred within process constraints

5) CAA comprises many advocacy approaches

6) Working relationships with social care practitioners: the personal factor

7) Demands of legal literacy

8) Conducting challenges: persuasion before escalation

9) Taking shape: a values-based professional identity

10) Professionalisation: a threat to advocacy's traditional ethos?

11) Integration: Trending towards the integration of statutory advocacy roles

12) Informal advocacy: CAA within a range of advocacy approaches

13) Change due to Covid-19

14) Equity, diversity and inclusion: building cultural competence within broad-based services

15) Specialist advocacy for different service user 'groups': achievable within current constraints?

16) Evaluating CAA: diverse innovations within organisations

Thematic structure: July 2022

Superordinate themes

1. CAA as a microcosm of the unfulfilled promise of the CA2014
2. The inherent challenges of evaluating CAA
3. A strong advocacy ethos persists despite opposing pressures
4. Ambivalence within and towards a developing professionalised role

Main themes

1. Working with gatekeeping professionals to maximise access to CAA

i. Referral pathways and their implications for advocacy practice

ii. Evidencing sub-optimal referral and identifying its characteristics

iii. Mechanisms of professional referral

iv. CAA's response: bolstering accessibility through macro and micro-practice

2. Striving for relationship-based and person-centred advocacy practice within CAA's procedural constraints

i. Working with service users: fusing the technical and the relational

ii. The parameters of CAA practice: procedural and problematic

iii. Covid-19 as a lens for studying CAA practice

3. Professional interactions: seeking partnership where possible and challenge when necessary

i. Relationship rests on mutual understanding and respect for each other's roles

ii. Lower-level challenge: CAA provides effective channels

iii. Higher-level challenge: mental capacity as a central factor

4. Challenges of commissioning and evaluating CAA services

i. The commissioning cycle and its implications for CAA providers

ii. Challenges and prospects of developing systems of evaluation

5. Retaining a distinctive advocacy role and values-based advocate identity amid increasing professionalisation

i. Professionalisation as a source of debate and reflection

ii. Personal qualities and sources of motivation

iii. Developing a strong workforce, e.g. routes of entry into the role

iv. Support needs: role can be stressful and challenging

6. CAA and the advocacy landscape: increasing integration within statutory advocacy, a growing departure from non-statutory advocacy

i. Juxtaposing CAA and community advocacy

ii. ‘Advocacy plus’: the importance of a spectrum of advocacy

iii. Benefits of integrating statutory advocacy forms—and barriers to achieving this

7. Developing inclusive CAA services to serve the diverse needs of individuals and communities

i. Building culturally inclusive practice and services

ii. Specialisation vs ‘genericism’ within CAA services: a ‘Jack of all trades?’

Appendix O: Mapping findings to CAIMeR

Below are lists of causal factors identified from the research, allocated according to CAIMeR (Contexts, Actors, Interventions, Mechanisms and Results) (Blom and Morén, 2010, 2011).

Macro-contextual factors

Politics, society, economy	Overarching aspects of social structure, including prevailing political ideologies, e.g. neo-liberalism
	Structure of the adult social care system, e.g. devolution of responsibility to local government, market-based commissioning
	Ideology re: occupations, e.g. notions of professionalism and status
	Oppositional forces to current social configurations, including campaigns, e.g. movements against systemic racism, pressure for social care reform
Legal	International: UNCRPD, European Convention on Human Rights
	Care Act 2014: underpins care and support processes and CAA
	Care and support statutory guidance and case law
	Mental Capacity Act 2005: capacity and best-interests; interface with IMCA; Deprivation of Liberty Safeguards
	Other laws e.g. including Mental Health Act 1983, governs IMHA
	Routes to challenge social care decision-makers under different legislation, e.g. s.21a of MCA2005.
	Legal Aid, Sentencing and Punishment of Offenders Act 2012: legal aid cuts.
Policy	Resources: Funding pressures on adult social care—affects local authority practitioners, commissioned care and support services, and CAA services
	Legal/ policy interface affecting routes to challenge, e.g. availability of Legal Aid. Lack of a statutory appeals process
	Local commissioning: market mechanisms create tendency towards larger advocacy providers. New Public Management. Geographical variations across 153 local authorities.
	Policy initiatives affecting CAA provision, e.g. culturally appropriate advocacy. Consultation about further professionalisation and regulation

CAA: policy and role develop-ment	Occupational infrastructure: e.g. National Qualification in Independent Advocacy
	Quality assurance: the Advocacy Quality Performance Mark
	Pay expectations; culture/discourse re: role development. Sectoral initiative e.g. Advocacy Leaders Network
Covid-19	Pandemic threat and responses

Meso-contextual factors

Access	Referral arrangements within the local authority
	Institutional initiatives to promote access: local authority/ CAA provider, e.g. IT systems, outreach, training etc.
Commissioning	Commissioning orientation: is CAA provision commissioned as a specific statutory service?
	Level of funding for CAA services relative to need
	Availability of non-statutory advocacy and adjacent services: Do these link to CAA provision?
	Extent of joined-up commissioning with IMCA and IMHA
Organisational form and ethos	History, ethos, scale of the CAA provider; its spread of activities
	Organisational approach to defining the parameters of CAA practice
	Localised evaluation mechanisms
	Support for individual CAAs: e.g. training/supervision
Community resources	Local presence of community groups, e.g. serving cultural communities
Covid-19	Local/ organisational response to Covid-19, including among service providers

Micro-contextual factors

CA2014 processes	The nature of CA2014 processes underway and the service user's advocacy needs
Other micro-contextual pressures	E.g. safeguarding timescales, delayed hospital discharge
Practice resources	E.g. Time available for the practitioner and CAA to facilitate the service user's involvement
Micro-contextual mechanisms	Extent of partnership working between CAA and practitioner
	Practitioners' conduct of CA2014 processes—how well do they promote involvement?
	Interaction between service user and friends/relatives
	Interactions between CAA and friends/relatives
	Interactions between friends/relatives and practitioner (affects access)

Actor characteristics

Actor: Service user	Individual personhood: e.g. aspirations and outcomes sought; what they value, e.g. possessions, relationships, activities. Broader lifestyle; views of risk etc.
	Nature of impairment, especially regarding cognition/ communication. Needs for support with involvement. Decision-specific capacity
	Social environment: e.g. presence of friends/relatives
	Awareness of advocacy/ prior outlook upon it
	Ethnicity, cultural identity, language
	Other aspects of social location, e.g. gender, class, sexuality
	Nature of service use/ experiences of social marginalisation, e.g. substance misuse, homelessness
Actor: Practitioner	Legal and policy knowledge. Understanding of requirements for conducting CA2014 processes/ eligibility for a CAA
	Skills regarding communicative knowledge practices. Use of self within practice and ability to undertake relationship-based work
	Value base: commitment to ethical practice. Commitment to working with independent advocacy
Actor: CAA	Technical knowledge: law, policy, processes, service configurations
	Communicative knowledge practices: interpersonal and communication skills
	Cultural competency
	Individual social location, including cultural aspects
	Reflexivity including epistemic humility and cultural humility
	Other aspects of personal biography, e.g. own experience as a service user/carer; history of advocacy work; other previous employment
Actor(s): Friend(s)/ relative(s)	Understanding of advocacy/ outlook upon it
	Perception of self-advocacy abilities
	Relationship mechanisms between friends/relatives: e.g. between siblings

Interventions

Intervention: Practitioner	Determination of eligibility for CAA support
	Discussion of potential CAA involvement with service user/ friends/relatives
	Referral to CAA: Is one made?
Intervention: CAA	Spending time with the person: building relationships and knowledge about them
	Explaining processes to the person; preparing for meetings
	Supporting decision-making, e.g. discussing options for support plan
	Interceding with the practitioner, e.g. about the format of meetings
	Consulting with relevant others/written records to learn about the person (especially when non-instructed advocacy)
	Representing the person: conveying information about them and making the case for them
	Scrutinising processes and decisions—asking questions
	Challenge: raising concerns with the practitioner/ their managers
	Challenge: using formal procedures—raising a complaint, raising service quality issues with commissioners
	Legal challenge: Court of Protection (if applicable), judicial review
	Support with practical tasks (potential—lies outside CAAs' remit)
	Longer-term involvement with the service user (potential—CAAs' remit may not permit)

Mechanisms activated regarding CAA access and CAA practice

Mechanisms: practitioner	Recognition of needs for support with involvement and response to these
Mechanisms: CAA	Interpersonal relationships: three-way interactions involving the CAA, service user, and practitioner
	Identity-sharing mechanisms (may be present, see culturally appropriate advocacy)
	Interpretation of the person’s authentic character, based on contact and observation (non-instructed advocacy)
	Support with involvement in CA2014 processes
	Supported decision-making
	Scrutiny of conduct of CA2014 processes
	Representation of the service user: needs, wishes, understanding of individual personhood
	Challenge: negotiation with practitioners and local authority managers
	Challenge: procedural and legalist forms of challenge
	Prevention via longer-term engagement (potential may be unrealised)

Results from CAA

Results regarding access to a CAA	Access to support and representation re: CA2014 processes
Results from CAA intervention: Process-based	Emotional support and reassurance through CA2014 processes. Validation: the person’s ‘voice’ is heard
	Improved self-advocacy potential
	Conduct of CA2014 processes becomes more person-centred—more attuned to needs and wishes
Results from CAA intervention: Outcomes-based *(Dependent on interactions with the local authority)*	Exercise of choice and control
	Obtaining the care and support that is needed
	Rights and dignity are upheld, e.g. care and support is ‘least restrictive’
	Personalised safeguarding outcomes are met
	More acute needs are reduced/ delayed/ prevented
	Advancing wellbeing - broadly defined as per s.1 of the CA2014