

Practice

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Article Title

Advocacy in practice: Who Advocates for the Advocates?

Abstract

Advocacy has been defined as promoting social inclusion, equality and social justice to empower people - principles closely associated with social work's professional values. However, in-depth literature on advocacy and the current challenges it faces is sparse. Little is known about the day-to-day realities faced by advocates and the pressures they currently experience. This raises the question of who might advocate for the advocates themselves? This article reports on findings from a larger study to explore local recruitment and retention issues in adult social care from the perspective of different populations of interest in the South of England. A mixed methods approach was undertaken. One group of participants were advocates drawn from LA contracted services ($n=7$) who participated in a focus group. Comments relating to the challenges facing advocacy and knock-on impacts on advocates from the recruitment and retention issues currently being experienced in adult social care were themed together and are described. The findings highlight a number of challenges currently facing advocacy and advocates alongside an urgent need for more research to take place within this area. The authors also offer suggestions for consideration to help improve this picture.

Keywords

Advocacy, challenges, social care retention, impacts, research

Introduction

Independent Advocacy as a recognised activity and profession – supporting another person to help them express their views and wishes and stand up for their rights - can be traced back to a 1966 conference in Pennsylvania, USA for parents of children with cerebral palsy (Brandon et al., 1995). The parents began to question who would be available to support their children's needs and wishes when they were unable to do so. The conference linked to Wolfensberger's concepts of normalisation, social role valorisation and citizen advocacy (Brandon et al., 1995; Newbigging et al., 2015) and provided an approach for UK working going forward. Parents in the UK were then prompted to consider provision for their children and advocacy came to official prominence in the UK during 1981 with the establishment of the Advocacy Alliance (Sang and O'Brien, 1984; Brandon, 1995). This was established through a collaboration of five different charities (Mind, MENCAP, the Spastics Society (now known as Scope), One-to-One and the Leonard Cheshire Foundation) with the purpose of granting a redressing of the balance of power between professional and client (Sim and Mackay, 1997; Harrison and Davis, 2009). The formation of similar groups - like the Nottingham Advocacy Group in 1990 - followed, leading to the formation of the UK Advocacy Network (UKAN) (Newbigging et al., 2015). This was the first national organisation promoting Independent Advocacy. The provision of independent Advocacy is based upon a set of underpinning principles and values set out in the Advocacy Charter, developed by Action for Advocacy (the descendant of UKAN and the emerging national organisation for Independent Advocacy). This was published in 2002, with further updates by the National Development Team for Inclusion (NDTi) in 2014 and 2018. It defines advocacy as empowering people through social inclusion, equality and social justice and these principles are closely associated with social work's professional values (Forbat and Atkinson, 2005; Hardwick, 2014; Hardwick, 2016;), as highlighted within the Professional Capabilities Framework within English Social Work (BASW, 2018). Indeed, social workers should be working with and meeting advocates frequently in their role.

Since the establishment of the Advocacy Alliance, historically, advocacy has faced a number of challenges. Writing in 1997, Sim and MacKay reflected that it had proven extremely difficult at that point to secure long-term sources of funding that would be independent of service providers. The finances available for advocacy have continued to be reduced under the remit of health and social service departments (Brandon et al., 1995; Osgood 2017). In 2005, Forbat and Atkinson's review of Nottinghamshire advocacy services - looking at both the processes and outcomes for the people involved – highlighted some key themes. These were that: advocacy made a difference; there was considerable unmet need; advocates worked in what was often felt to be a hostile environment (working with or against some health/social-care staff opinions); and that advocates needed more continuing support in order to be effective.

Between 2005 and 2014, Independent Advocacy became embedded within new legislation that introduced statutory advocacy in England and gave the field a professional footing. This included Independent Mental Capacity Act Advocacy (IMCA), Independent Mental Health Advocacy (IMHA), Independent Care Act Advocacy (ICAA) and Independent Health Complaints Advocacy (IHCA). The introduction of these differing types of advocacy placed Independent Advocacy into the legislation and Codes of Practice, marking a divergence from the earlier period of grass roots citizen advocacy (Forbat and Atkinson, 2005; Hardwick, 2016). There was a mixed response, with some thinking that

advocacy was losing its independence by being legitimised professionally, whilst others felt it was gaining strength and recognition with the introduction of statutory services (Newbigging et al., 2015; Hardwick, 2016). During 2009 the Independent Advocacy Qualification was introduced as an introduction at NVQ level 2 and as a full qualification at level 3/4. In 2020, the qualification was revised to level 4 to reflect the level of responsibility held by Independent Advocates. The course is overseen by City & Guilds and is delivered by a number of specialist trainers in the UK, albeit inconsistently. As it is a practice-based qualification with written work, some are expected to complete the qualification in their own time whilst others are given a small amount of work time to complete the qualification (although rarely enough to complete it in work time). This has an impact on advocates and their ability to gain the qualification.

Current numbers of advocates in the UK, alongside the trends in numbers of people using advocacy services, are difficult to identify. As Mercer (2014) points out, the UK Department of Health database - which reported on IMCA hours spent on each 'case', the referrer, the condition and communication the person had and outcomes from IMCA involvement - ceased collecting data in 2014. Since then, there has been no data publicly accessible about how many people get help from an advocate or reflections about the quality or impact of that help. Consequently, any mirror impacts on advocacy of the similar issues which are impacting on social care recruitment and retention (Pulman and Fenge, 2024) and on service users are difficult to observe. For example, since 2012/13, adult social worker vacancy rates have risen to 11.4% in 2022/23 (Skills for Care, 2023) and a high turnover within the wider social care workforce might be negatively affecting both advocates and the people they advocate for.

There is a paucity of in-depth current literature about advocacy and compared to other professions little has been published. Indeed, most published literature has been sporadic or grey in nature, since the establishment of the Advocacy Alliance. Concerning issues that have arisen are related to the consistency of available funding; funding sources and their impact on independence; and length of contracts for service delivery (Brandon et al. 1995; Donnison, 2009; Hardwick, 2014; Hardwick, 2016; Osgood, 2017). More recent findings from a survey of $n=435$ advocates carried out during the pandemic exposed systemic flaws in health and social care (NDTi, 2020). Legislation to protect people most at risk of being marginalised or abused was not consistently embedded within LAs and health and social care providers and at times was described as ineffectual. Blanket decisions about people's daily lives at scale was witnessed, whilst over three quarters of advocates reported that people's human rights had not been upheld. As cost of living impacts continue to bite, advocacy and campaigning organisations can no longer provide the support that they used to, with 80% of advocacy workers in a Unison survey saying it was getting harder for clients to get representation and advocacy and 77% identifying specific groups losing out (Unison, 2024).

This paper adds to the limited amount of research about advocacy by exploring what day-to-day realities are faced by advocates, what pressures they are currently facing and who might be advocating for them. The paper also considers the impacts and effects on advocacy of current recruitment and retention challenges within social care.

Methods

Ethical Approval

This was a mixed methods study. Ethical approval was sought from the [anonymised] – granted February 2023 (Ref: 47759). Building on previously identified recruitment and retention themes within regional scoping work for practitioners (Pulman and Fenge, 2023a; Pulman and Fenge, 2023b), this study initiated exploratory discussions with Principal Social Workers (PSWs) for Adult Social Care (ASC) Services at two local authorities (LAs) located within the South of England to produce an outline for a collaboratively agreed project. The purpose was to explore local recruitment and retention issues in ASC from the perspective of four populations of interest:

- Social care practitioners currently working in ASC at two local LAs.
- Social care staff with responsibility for performing exit interviews with LA staff currently working at the two LAs.
- Students currently enrolled in social work undergraduate and postgraduate programmes within the region.
- Service users with lived experience of receiving services at the two local LAs/advocates drawn from LA contracted services.

Our broad research questions concerned:

- What could be learnt from each population of interest concerning recruitment and retention issues in relation to ASC?

Our article focuses on data collected from part of the fourth population of interest - advocates drawn from LA contracted services. Advocates represent or support people to represent themselves and are professionals who social workers will refer people to. Advocates should be a regular presence in the delivery of social work.

Recruitment

For recruitment, representatives drawn from localised Region LA contracted services were approached to help identify participants. Managers were asked to nominate up to two advocates from regional advocacy providers and a focus group of $n=7$ was identified.

Focus Group

A semi-structured focus group schedule was constructed to collect reflections on care received, the impact of staff shortages or changes in staffing on care received and on advocates, and suggestions for improvements. It offered view on how advocates representing and supporting service users might be affected by recruitment and retention issues in ASC and a possible lack of consistency within the social care workforce. The main areas of discussion were around social care staff recruitment and retention in line with the research question. As a result, there was more of an emphasis on ICAA and IMCA, the role of social workers, carers and the legislation they used. Comments were also made in the context of other statutory advocacy such as IMHA as well as on informal community advocacy. The focus group was held in an accessible local venue and was led by an experienced facilitator. The duration was two sessions of fifty minutes with a twenty-minute break. To minimise participant burden, we obtained written informed consent via a participant agreement form on the day.

Data Analysis

A generic qualitative approach to thematic analysis was used (Caelli et al., 2016) with inter-researcher interpretation. Following familiarisation with the focus group transcript, a member of the team charted themes. Subsequently, to minimise possible bias, a second researcher familiarised themselves with the transcript and the matrix of initial themes. We developed an agreed coding scheme using an analytical framework that combined a priori issues from the original topic guide and emerging themes (Braun and Clarke, 2006). Themes were identified and coded and then agreed between the two researchers.

Limitations of study

This study may have been affected by respondent selection and bias. Participation was on a voluntary basis and respondents were drawn from regional advocacy services selected by managers and also through advocacy training programmes. The small number of participants in the focus group and their focused geographical area might not be representative of the national picture in England. Furthermore, we acknowledge that advocacy services vary internationally due to differences in governance and legislation but our findings will hopefully be of interest to others concerned with these same issues.

Results

Comments relating to the challenges facing advocacy and the knock-on impacts on advocates from recruitment and retention issues currently being experienced in social care were themed together and are described.

Demographics

In total, $n=7$ advocates participated in the focus group.

Working (under the radar)

Visibility

In terms of visibility, advocates considered themselves as a hidden or forgotten profession. Sometimes thought of as an add-on or afterthought until suddenly called into action at key moments. Participants considered that social workers and other professionals had a lack of understanding about what the role of an advocate entailed:

...they really don't seem to understand what your role is. Because quite often I'll be asked, can you give me your view. Not what's the view of the client, what is your view? [P414]

This could feed into negative thoughts about themselves and not feeling valued as a professional in their own right:

Hopeless. I think we are completely hidden and that's why people don't understand when you become... Especially with an older person, going to the care home. They look at you blankly. Well, I've got an LPA [Lasting Power of Attorney], why are you here? [P414]

Visibility to social work students was also described as being low with limited coverage on qualifying programmes concerning the role and remit of advocacy services. Sessions on programmes provided

by advocates were not mandatory for students and poorly timed lectures and/or scheduled sessions being removed at short notice limited access to role learning. In other cases, training on advocacy was included. For example, a management level NVQ within health and social care mentioned by one participant had an entire module on advocacy. However, there appears to be a lack of a consistent approach to including sessions on the role of advocates within the wider social work curriculum.

Training of health and social care professionals was thought to be disorganised as each individual provider delivers awareness training separately. Training could be improved if it came from a central point rather than on an ad hoc basis with no structure. It was also considered that some training on advocacy would be beneficial within both hospitals and LAs, so that staff at all levels were aware of what advocacy was and how it might impact on roles.

Outside, looking inside

Participants often thought that others considered them as professionals making their own professional judgement, rather than as someone advocating on behalf of another person:

Almost as a decisionmaker and you often have to explain at the best interest decision meeting... you're not there to be involved in the decision-making process, you're there to give the client view... [P410]

However, their position could be isolating, which was acknowledged as being part of the role. Professionals need to remember that advocates are outside of the social care network and are there to challenge decisions on behalf of the client. This tension - between being asked to be a decisionmaker and representing the client's views - might contribute to attrition as advocates grapple with professional isolation, stress and the adversarial aspects of their role. Advocates therefore face challenges related to advocating for their clients within a system of service cutbacks and workforce challenges.

Representation and recognition

Participants noted that there was little representation for advocacy on integrated care boards, safeguarding boards and other related committees. A lack of peer support or a representative body was noted before and during the pandemic:

...it was managers of all the different services who came together and shared their...experiences of COVID. But it was top-down. So, when I said, "Can we come along to those meetings", 'Oh, no, no, it's managers only' [P416]

A lack of professional body for advocates was thought to compound a lack of recognition and visibility and was mirrored in the lack of knowledge and understanding of advocacy amongst the community. This contributed to a feeling of a lack of a strong collective voice. The need for platforms for advocates to discuss issues with other advocates outside of their own organisations was also commented on and the lack of a regulatory body that supports advocates was also noted.

Staff turnover in social care

The social care workforce was described as increasingly transient and it proved challenging to maintain advocacy awareness within a system where there was high turnover of workforce:

...coming back to agency staff, those agencies have been moving around different settings and if they were taking that advocacy awareness with them, it's going to embed in each setting that that professional...that can only be helpful but I just get a sense that actually it's, well, I'm agency, therefore...it's not my job. [P410]

High staff turnover post-pandemic at all levels had helped reduce knowledge about advocacy and had led to difficulties in building consistent relationships with allocated social workers due to higher numbers of agency workers.

Training, recruitment and retention

Participants felt that more streamlined, less rushed training for advocates was also required:

...as opposed to finding an hour within your week to do a bit of studying and set them up... I'm not saying it needs to be at degree level, but having a proper course or a proper time that people can dedicate to it, as opposed to fitting it in, on the side of your job. [P411]

Participants suggested that there was a need to provide better training concerning assertiveness and resilience skills in light of the current demands of the job - particularly for those advocates who were not naturally assertive and required additional support to develop these skills.

Ongoing legal training - including crossovers between legislations - was also thought of as inadequate and needing enhancement. Although it was acknowledged that some recent positive changes had been made in some locations. Finally, participants considered that making delivery more consistent across the board and improving quality assurance, would make the situation much clearer.

The demographics of the profession were discussed as being quite confined - a relatively high average age coupled with concerns about diversity and inclusivity. Participants also felt that there was limited career progression when discussing the longevity of the role:

I think unless you want to go into management, there's not really anywhere for advocacy to go. You kind of reach a ceiling and unfortunately that goes for the pay as well. [P411]

It was acknowledged that if advocates wanted to work on more complex projects they might need to look elsewhere. Similarly, attracting new advocates was viewed as challenging, with implications for the future sustainability of the role.

Demand and increased caseloading

Population and community reasons

Caseloads involving safeguarding has increased for advocates. People were reaching a crisis point because there was not enough early intervention. After hospital discharge there was no pick-up or continuity in the community for people, due to cases not being assigned to advocates, social workers or unqualified social care practitioners and some cases were being closed as they were perceived as being 'not in crisis'. Increased caseloads now had a much greater level of complexity:

...I'm looking at the end of November [two months away] to see some clients, because I have such a huge caseload...but I'm getting a lot of the complex cases but they're taking up so much time. [P410]

There were more Section 21A (Mental Capacity Act, 2005) challenges – a challenge of living arrangements under a Deprivation of Liberty Safeguards (DoLS) authorisation - as people were being placed because there were no other options for them and they were unable to get a package of care in the community. An increased complexity in cases was also causing settled cases to be visited with less regularity.

Community advocacy - which might prevent crisis in many cases - had been reduced as statutory work always came first. Nowadays community advocacy was usually delivered by volunteers even though the casework can be complex. This proactive work is not easy to document and prove worthwhile to employers under personal work outcomes. Key Performance Indicators (KPIs) are set by the funding commissioners and are not focused on the improvement of quality of life for service users. Service users need to be in receipt of an LA commissioned service or NHS secondary care before they can obtain issues-based advocacy.

Social work / NHS overflow

Social work appeared to be moving away from relationship-based practice to procedurally driven form-filling, with advocates picking up some of this work instead. Although realising this was not part of their role, advocates were now finding themselves doing part of the social worker's job to uphold a person-centred approach:

But because you want that for that person and it's not being considered by the social worker or professional, you do do that, because you're driven by the, you know, the... It's the right motive, isn't it, but you do end up slipping into the role that isn't for us to do. [P413]

There was deemed to be less time for IMHA within hospitals as advocates now had little time to do it. Finally, participants noted that social workers did not actually have to visit the person and monitor the conditions as the Best Interests Assessor (BIA). This was the responsibility of advocates and there was subsequently a greater lack of face-to-face contact.

A more hostile environment

Social care today

At the time of this study, social care was considered as focusing on 'best value' as opposed to what was in the client's best interest. Participants felt that the Care Act (2014), and the principles enshrined within it, were not thought to be deliverable due to resource constraints. The use of agency staff at all levels was considered a challenge, as there was a perceived lack of understanding of IMCA and IMHA along with the rights of patients by many agency staff:

...they do have a Mental Health Act Admin but the staff don't understand their role, because there is such a reliance on agency staff. I don't think they're bothered. They're turning up, they're doing their shift, they're getting their pay and those bits in between that are really fundamental to patients' rights are not happening. [P410]

Participants described a greater lack of knowledge and awareness in newly qualified social workers regarding legislative work - particularly around the Mental Capacity Act (2005). This was compounded by a lack of professional curiosity. Newly qualified social workers were perceived to be entering the workplace with a more adversarial attitude (in addition to approaching issues from a more financial standpoint):

...the minute you do say something, that their back's up, because, you're challenging them. And it's really hard when you first qualify and you've got your cases... [P414]

Participants believed that these changes within frontline social care practice resulted in advocacy being seen more as a box ticking exercise. This could also be due to a lack of understanding and visibility of the role and no visibility of advocacy within some programmes.

Communication

A greater lack of communication than before the pandemic and due to decreased resources over the last decade was perceived between advocates and social workers:

I felt that you were part of a team...there was an understanding that you might sometimes challenge. But that in the end we all have the same goal and that was the client, the service user. It doesn't feel like that anymore and, as a consequence, it's a lot harder to be an advocate, because people are more oppositional. [P416]

There were sometimes difficulties finding a social worker to talk with in person and social worker contacts changed more regularly than previously. There were more tensions between social workers and advocates. Pre-pandemic, advocates were always directed to the duty social worker rather than to a named contact – seen by some as depersonalisation of the services - and subsequently during the pandemic it was almost impossible to contact someone. This was particularly difficult for advocates, because they wanted to help, but were prevented from doing so. There was more of a strain on the relationship between the service user, the advocate and the social worker, with everybody working in different silos. This often resulted in a 'can't do' culture.

A need for more support

Hybridisation and isolation

Hybrid working patterns and office restructures, hastened by the pandemic, has increased lone working and feelings of isolation in some cases:

We've got...Not a big team but bigger than it used to be but [colleague name] said to me a few weeks ago, in her first couple of weeks, you're the first person to phone me this week... [P416]

There was acknowledgement that hub office space had been lost since the pandemic, which some perceived as detrimental. Promised office space had in some cases not been forthcoming, leading to more desktop advocacy - similar to what had happened during the pandemic. Difficulties described when discussing hybrid working included feelings of isolation and lack of support, and this was seen as a particular risk for new advocates. A lack of team culture - where team structures were breaking down for advocates in a post-COVID-19 world - led to isolation and more pressure to deal with things in isolation.

Burnout and attrition

Burnout was mentioned by most participants. Anecdotally this included middle management burnout, with managers going off on long-term sickness. There was a perception that every case was now heavy and complex which contributed to burnout:

...and it can get quite difficult. It's actually quite stressful for you and the client because you're sitting with the client and they're seeing you being barraged by the clinical staff and that they don't understand why. [P414]

Attrition from the advocacy workforce over a period of time due to increased pressures was also discussed. Stress could be caused by the ethical challenges of working within the confines of the system which some viewed as being apposite to some of their values as an advocate and an inability to provide required support. Being unable to achieve desired outcomes for clients was disheartening:

...everything they shared with you, even though you have tried to take that forward, has been completely disregarded. And they aren't able to make that link that it's not you know, our fault, but they end up feeling that actually even despite having an advocate, what difference does it make? [P413]

Management and supervision

Some managers were described as lacking knowledge of the legislation that advocates were dealing with. Some had no actual practice experience as advocates so that their hands-on experience of advocacy or their understanding was completely different to the actual experience of an advocate. A lack of peer mentoring was also described, whilst a lack of supervision was mentioned by some. One participant noted that they could go two months without seeing someone. Others described supervision as being more case focused rather than reflective, depending on the perspectives and demands put upon the supervisor. Some of the supervisory forms were felt to be awkward and long-winded, rather than supporting reflective conversations. This also prevented advocates having the support of critical reflection on cases within a supportive supervision relationship.

Power dynamics

Participants also discussed how independent advocates might be at risk of losing their independence as they became more entangled in LA processes with tender outcomes based upon ticking all the boxes of the LA commissioner. As funding for advocates is provided by LAs, some questioned the limits of their independence and felt there was a tension in challenging the organisation that paid their wages:

We're funded by the local authority. We're not independent. And we've actually had that drilled down by the Head of DoLS in our LA, who said, 'Remember who pays your wages'. [P410]

Discussion

Our findings highlight some new insights about the changing context of advocacy as a result of austerity and funding constraints and the wider workforce challenges across social care (Skills for Care, 2023) - resulting in increased agency staff usage and inconsistent training about advocacy on qualifying social work programmes. The changes mean that advocates now operate in a much tougher and more stressful position than previously (Forbat and Atkinson, 2005). Much like the wider adult social care workforce (Pulman and Fenge, 2024), advocates have been affected by a tumultuous wave of challenges over the last few years. This has included an extended period of governmental policy-led austerity - impacting upon funding for essential public services (Murphy, 2023) - alongside the additional impacts of Brexit (Perkins and Repper, 2021), the COVID-19

pandemic (NDTi, 2020) and a cost of living crisis – making it increasingly hard for clients to get representation and advocacy (Unison, 2024). Research suggests that in the last ten years it has become a lot harder to be an advocate, because people across health and social care - including relationships with NHS staff - had become more oppositional. Perhaps due to a lack of understanding about the role and its visibility and status. Participants felt they now had less time to build a relationship with a client to find out their views' and this impacted on their ability to provide the advocacy service they wished. The role of advocacy has gradually evolved into something akin to a legal troubleshooter, with more difficulty in getting people to listen to client views.

Forbat and Atkinson (2005) described the differences and contact points between acts of advocacy and the social worker. This led them to a discussion of the dilemmas in advocacy around support, independence and 'silent accounts' of negative experiences from advocacy partners. Provision of support they believed should be mindful of the troubled position that advocates held. Outside and independent of mainstream health and social care services and having to challenge professionals and speak up for those who were oppressed or disempowered - often through or because of those same organisational systems. They suggested there was a need for greater awareness and that practitioners, including social workers, should have greater clarity about what independent advocates aimed to do and to understand their difficulties in questioning established systems and organisations from an outsider position. Our data highlights the continued invisibility of advocacy and lack of understanding about the role in supporting clients in an independent way. Although the professionalisation of advocacy has gradually occurred – with IMHA, IMCA, ICAA and IHCA being introduced – over the past 20 years, little has changed around the perception of advocacy. With societal challenges resulting from the impact of COVID-19, alongside pre-existing austerity measures, undermining the role further.

In 2014, Hardwick (2014) noted that advocacy services did not need to be registered with the Care Quality Commission and advocates were not required to have any qualifications, although many did and commissioners often made qualifications a funding requirement. The Advocacy Code of Practice and the Quality Performance Mark (QPM) - a certificate stating that a service upholds the standards of the Code of Practice - are both features of the Advocacy Charter (NDTi, 2018) and point a possible pathway towards formal regulation. However, the QPM is not officially recognised outside of the advocacy sector and by some commissioners, whilst the NDTi is yet to be legally recognised as a regulatory body. Consequently, these regulatory gaps and a lack of professional standing and knowledge base affects the ability of advocacy services to challenge injustices and to have a recognised national voice or professional representation.

Training could be improved to increase the standing of advocacy within health and social care, which alongside professional registration might help to improve recognition of the profession. However, some see this as debatable, as by regulating the profession it loses its grass roots community approach. These schools of thought having been outlined previously in research literature (Newbigging et al., 2015; Hardwick, 2016). Regulation in turn might exert a positive impact upon the recruitment and retention of advocates provided the initial values that come from citizen advocacy are upheld.

Implications for practice/policy

Alongside an urgent need for more research to understand the role that advocacy plays within key health and care legislation (for example, IMCA, IMHA, ICAA and IHCA) and the issues and tensions faced nationally, our findings highlight a number of challenges currently facing the profession. Advocacy is a vital role considering the difficult funding climate within social care which can result in wider power imbalances. Participants made a number of suggestions to help improve Independent Advocacy to ensure that advocates are able to continue to empower people and which may create tangible improvements in advocacy practice:

- Enhancing training on legislation, assertiveness and resilience.
- Heightening representation and recognition of advocacy.
- Raising awareness of the profession in social care and publicly by providing co-ordinated training opportunities.
- Revisiting the Independent Advocacy Qualification to enhance it and strengthening quality assurance processes.
- Working to address and break down the increasing divides between advocates and health professionals and social care teams.
- Ensuring there are adequate fully embedded support mechanisms considering the changes to the profession.
- Working on providing a stronger collective voice for the profession.
- Securing funding processes and policy to ensure that Independent Advocacy is completely independent and properly represented.

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Disclosure statement

The authors report there are no competing interests to declare.

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