



Advocacy in the UK

Allan J. Sim & Rob Mackay

To cite this article: Allan J. Sim & Rob Mackay (1997) Advocacy in the UK, Practice, 9:2, 5-12, DOI: [10.1080/09503159708411642](https://doi.org/10.1080/09503159708411642)

To link to this article: <https://doi.org/10.1080/09503159708411642>



Published online: 01 Feb 2008.



Submit your article to this journal [↗](#)



Article views: 99



View related articles [↗](#)

Advocacy in the UK

Allan J. Sim & Rob Mackay

Advocacy may be a popular term but what does it actually mean and how effective can an advocacy service be? This paper considers advocacy in the United Kingdom and seeks to illuminate the position currently experienced by advocates and their clients through the use of data recovered from research in the North East of Scotland.

What is Advocacy?

Advocacy is currently a fashionable term but one that still generates some confusion as to what it actually means. The general concept which informs the Advocacy movement had its origin in Scandinavia in the 1950s but the specifics can be more clearly traced to a 1966 conference in the State of Pennsylvania for parents of children with cerebral palsy (Brandon et al., 1995, p.83). Growing from this advocacy went on to become well established in the USA by the mid 1970s. In the UK advocacy really began over a decade after that Pennsylvania conference with the establishment of the Advocacy Alliance in London in 1981 (Thomason, 1987, p.5). The Alliance, which later became National Citizen Advocacy, was established by five charities: MIND, MENCAP, One to One, the Leonard Cheshire Society and the Spastic Society with the purpose of granting a redressing of the balance of power between professional and client.

But what exactly is an advocate? The dictionary defines an advocate as one who pleads, intercedes or speak for another but this definition is not specific enough for our purposes. Renshaw & Metcalf present a more useful definition. They define the advocate as an ordinary person who acts on behalf of the vulnerable individual, representing their interests and their rights independent of any service-providing agencies (Renshaw & Metcalf, 1987, p.2). The advocate then acts for and in partnership with another. Defining the advocate's role is more difficult. Attempting to find the boundaries of advocacy is not easy and this can lead to tensions both from families and from professionals. Why does my client/relative need an advocate when they have me? is a common question. The advocate is there to speak for their partner/client to act for and with them in making

sure their needs are expressed. Most commonly the advocate is an unpaid volunteer working within the framework of an Advocacy agency (Harris, 1987, p.13). Great stress has been placed on the importance of independence for these agencies both to avoid conflict with service providers and potential conflict with the client's family (Brandon, 1995, p.87). In the USA the advocate is not only recognized in law and possesses rights of information access but all states are actually required to establish independent Advocacy agencies. As yet no such situation exists in the UK. Rather advocacy projects in the UK must rely upon the support and goodwill of local authorities, hospitals and community services to both support their existence and grant them co-operation (Thomason, 1987, p.5).

The British advocate.

The British advocate then starts from a very different position of power than that of their American counterpart. This position shows no likelihood of alteration in the foreseeable future. Sections 1-3 of the Disabled Persons Act 1986 which would have granted disabled people the statutory right to an advocate while at the same time giving legal recognition to these advocates has been effectively disabled by the British government (Philpot, 1992, p.23). Currently the decision whether an advocate can be appointed rests with the health or social services authority rather than with the individual.

Further after more than 15 years since the establishment of the Advocacy Alliance it has still proven extremely difficult to secure any long-term sources of funding that would be truly independent of service providers. The finances available for advocacy still fall firmly under the remit of health and social services departments (Brandon. 1995, p.98). However, local citizen Advocacy Projects have arisen and it was with such projects that we are concerned. To illuminate the current position and problems of advocacy in the United Kingdom we will focus on research undertaken in the Grampian Region of the North East of Scotland.

Advocacy in Grampian.

The development of advocacy services in Grampian dates back to 1992, when it was recognized that there was a need for some form of Independent Advocacy service for users of health and social work services. Thus, in that year Grampian Health Board's Charter for Health was published, stating that all patients had a right to *'have someone to help you to express your*

views to the staff who work with you, and to speak on your behalf if you wish'. Later that year, Grampian Health Board and Grampian Regional Council agreed at a policy level to support advocacy in terms of Section 1 and 2 of the Disabled Persons (Services, Consultation and Representation) Act 1986.

The consequence of this has been the development of five different projects throughout Grampian. The various projects have developed at different times and in different ways with a variety of arrangements for funding and management. However, attempts have been made to co-ordinate this development work through representatives of the Health Board, Social Work Dept., and Voluntary Sector, and now through a network involving representatives of all the groups. Thus, all projects have used a common training course and have similar operational procedures and protocols.

The five projects evaluated by the research were:

Pathways:

Grampian wide. Initially for people with physical disabilities, but later generic. Full-time Co-ordinator. Line managed by Grampian Health Board (GHB). Advisory Committee of people with disabilities. Funded by NHS Management Executive and GHB.

Mental Health Advocacy Project:

Hospital based (Royal Cornhill Hospital). 1 Full-time Co-ordinator. Managed by management committee within a voluntary organization. Funded by GHB.

Amaze Advocacy Project:

Covers 3 districts of Grampian. Part-time Co-ordinator. Project of GFVO managed by its own Management Committee. Funded jointly by the Social Work Department (SWD) and GHB.

MAST:

Moray District. Two Volunteer Part-time Co-ordinators. Receives a grant from SWD. Managed through Moray Voluntary Services Organization (MVSO).

Advocacy & Representation Kincardine & Deeside:

Covers one district. Part-time Co-ordinator. Managed through the local Kincardine & Deeside VOICE. Advisory group of local people, including professional staff. Funded by SWD.

During the period of the research the Local Government Re-organization took place resulting in the establishment of three Unitary Authorities (Aberdeen City, Aberdeenshire, Moray) in what used to be known as Grampian Region. This re-organization was not without its impact on the Advocacy Projects in that a decision was made which brought the projects into alignment with the new Authorities. This led to the amalgamation of the Pathways and the Mental Health Project into what was now Aberdeen City Advocacy Project, and also the merger of Amaze and the Advocacy & Representation Kincardine and Deeside into what was now the Aberdeenshire Council. Only the MAST Advocacy Project remains as it was.

The evaluation

The purpose of the research was to examine the processes and procedures of advocacy from the perspective of the providers of the service, those who refer to the project, senior managers in areas with which the project has had contact and the users of the service. The study set out to identify the policies, problems and practices of the Advocacy Projects involved in the evaluation, their impact on users, professional staff, managers/advisors, project co-ordinators and the volunteers who experience them.

A five stage approach was utilized to obtain the necessary data,

1) Client questionnaire.

In order to cover the wide range of clients who use the advocacy projects considerable effort was expended on the construction of this questionnaire. The information sought by the questionnaire covered ease of contact, effectiveness and problems encountered.

2) Telephone questionnaire.

This was targeted at referring professionals to discover their awareness of the project and its aims, how useful the project was to them and their clients and whether they would use it in the future.

3) Management questionnaires.

Short questionnaires aimed at the management of NHS Trusts, SWD, Grampian Health Board and other significant agencies. The aim of this questionnaire was to determine levels of awareness of advocacy.

4) Client interview schedule.

A semi-structured approach to the schedule was taken to permit the expression of clients views. The interview schedule was divided into three main sections:

- A) Contacting the Project,
- B) Using the Advocate
- C) Consequences.

5) Volunteers focus group schedule.

This followed a semi-structured format and was divided into four main areas:

- A) Relevance of the Work,
- B) Training Issues,
- C) Support Arrangements
- D) Administration.

5.1) Management/Advisory focus group schedule.

Again semi-structured and divided into the following areas:

- A.) The Management/Advisory Role,
- B.) Management/Advisory Improvements
- C.) Future Development.

5.2) Project co-ordinators focus group schedule.

Structured only around three central questions:

- A) Issues Concerning the Evaluation,
- B) Issues and Problems Setting Up and Running the Projects
- C) The Future of the Projects.

The research revealed a very positive response to the use of advocates both from the projects clients and from the referring professionals. Responses to the client and professional questionnaires revealed that:

88% of the clients felt that because of the use of an Advocate that they would be better able to cope with situations that might arise in the future,

91% of clients would recommend the Advocacy Projects to others,

84% of professionals felt that advocacy had been helpful to them

96% indicated that they would refer to the projects again.

Although the research produced an overwhelmingly positive picture of the response to advocacy concerns were raised over financing, workloads and issues concerning volunteers.

In the area of funding the issue of main concern expressed by the managers/advisors, project co-ordinators and volunteers was that of the continuity of funding. This centered around the difficulties of forward planning experienced by the management/advisory groups and project co-ordinators due to the perception of a lack of a firm guarantee of funding into the foreseeable future. This problem also impacted on the volunteers who expressed concerns about project continuity and their continued involvement with advocacy due to this degree of doubt. In general terms this problem has created a level of despondency amongst those at many levels of the projects, and has created doubts about the commitment to the projects of the funding bodies.

Although the majority of the projects considered their resources to be fully committed there were those volunteers associated with the MAST project that complained that they had either had few cases or none at all. This gap between MAST and the other projects was difficult to explain especially taking into account how heavily MAST had committed itself to advertising its services.

Advertising itself has proved a paradoxical issue for the majority of the Advocacy Projects. Those within the projects were anxious to see advocacy expand and become available to everyone. Further, they recognized that advertising was necessary to explain advocacy to both the general public and professionals. At the same time, many of the projects expressed a reluctance to advertise due to the increase in demand that it would bring. For all but MAST it was indicated that increased caseloads could result in service refusals due to the lack of available volunteers to cope with these cases. This problem has resulted to an extent in a static situation for those projects which were experiencing heavy case demand. This situation was further exacerbated by the high incidence of cases of a complex nature.

The predominance of complex cases has impacted in numerous ways. To begin with, it has meant that the co-ordinators have found themselves having to take more of the cases than was ideal. The existing training of volunteers has not adequately equipped them to deal with the more complex cases. This problem exists due to advocacy being seen as an of last resort, a

place to which those problems to that have become impossible or undesirable for other agencies to handle may be referred. This use of co-ordinators' time makes it difficult for them to act as full-time support for the advocates and thus seriously undermines the time available to them for volunteer training. It also has implications for the recruitment of volunteers.

It has proven difficult within the projects to recruit the numbers of volunteers that had first been anticipated. This was in part due to awareness problems, but was frequently concerned with the suitability of volunteers. With the predominance of long-term and complex problems being presented to the projects, volunteers have to be very capable and committed. Not all of those who volunteer were suited to these tasks.

Conclusions

The research on the Grampian projects presents us with a picture that both clearly indicates that advocacy has produced a positive impact on clients and professionals alike but that the projects suffer from the nature of their construction. The fact that they have no real legal backing for their existence but rather rely on the Unitary authorities good-will in implementing measures from Section 1 and 2 of the Disabled Persons (Services, Consultation and Representation) Act 1986 on a voluntary basis weakens their position considerably. Although those who initiated the research expressed clear commitments to advocacy their commitment must be viewed within the framework of the financial difficulties currently being experienced by the new authorities. It is not a lack of will that hampers the growth of advocacy in the area but rather an inability to adequately fund the projects to an extent where expansion is possible.

Advocacy may have arrived in the UK, and it may be fashionable to talk about it but whether it can become an institution with any great influence without the same sort of backing in law enjoyed by its counterparts in the USA remains to be seen. It is clear from the research that advocacy in the UK cannot proceed on the goodwill of local authorities alone. There is a pressing need for advocacy in the United Kingdom particularly for disabled people but also for the populace at large. The research indicated that there is a very real desire to see advocacy expand to encompass all who require it but until it is granted some legislative weight it seems that it will remain for the most part a fashionable concept.

References and further reading:

Brandon, David, Brandon, Althea and Brandon, Tony (1995) *Advocacy: Power to People with Disabilities*, Birmingham, Venture Press.

Harris, Tony (1987) "Citizen Advocacy: Four Lessons from the North American Experience", *Social Work Today*, 18, (31), pp.12-13.

O'Brien, John (1981) *Learning from Citizen Advocacy Programs*, Georgia, Georgia Advocacy Office, USA.

Philpot, Robert (1992) "A Partner, Friend and Voice", *The Guardian*, 16th September, p.19.

Renshaw, Judy and Metcalf, Mike (1987) *A Friend in Need: Citizen Advocacy in Britain*, University of Kent, PSSRU.

Simons, Ken (1993) *Citizen Advocacy: the Inside View*, University of Bristol, Norah Fry Research Centre.

Thomason, Corinne (1987) *Advocacy and the Development of Community Care*, University of Kent, PSSRU.