

insights

evidence summaries to support
social services in Scotland

advocacy: models and effectiveness

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written by

Ailsa Stewart
Gillian MacIntyre
School of Applied Sciences, University of Strathclyde

Key points

- There is a range of models of advocacy, each with distinctive characteristics relating to type of work undertaken, length of involvement and appropriate person who should undertake the role
- There is a limited evidence base about the effectiveness of advocacy. This is primarily due to differing definitions and a lack of understanding about the role of advocacy.
- There is some evidence to suggest that the advocacy process promotes increased self-confidence and ensures the voices of people who access services are heard
- Geographically, the availability of advocacy is varied across Scotland, particularly for specialist forms of advocacy
- Advocates require a significant set of skills to undertake the role effectively; there is a need for ongoing training and regular supervision to maximise effectiveness.

Introduction

Advocacy has existed in the UK for more than 30 years and throughout this time a range of models and schemes has emerged, appropriate for different groups of people who access support (Action for Advocacy, 2006). Key features of advocacy include: independence from services, empowerment, providing people who access support with a voice, supporting people who access support to achieve active citizenship, challenging inequality, promoting social justice, and supporting people who access support to challenge inequity and unfairness (Boylan and Dalrymple, 2011). Essentially, advocacy can help individuals get the information they need, understand their rights, make their own choices and perhaps, most importantly, voice their opinions. However, it should be noted that advocacy is not about mediation, counselling, befriending, taking complaints or giving advice, although elements of these can be found to varying degrees across the different models (Patient and Client Council, Northern Ireland, 2012).

This *Insight* draws on evidence in relation to advocacy with both children and adults and on literature from the fields of health and social care. It outlines the key elements of the most prevalent models of advocacy and identifies good practice, as well as the limitations of advocacy models. The *Insight* will provide an overview of the evidence base of what works in relation to advocacy provision.

Models of advocacy

Prior to considering what works, it is important to establish the key models of advocacy identified within the literature. What follows is an overview of each model and the associated key features.

Self-advocacy: Individuals represent and speak up for themselves, with support, either individually or collectively. This support can be in a paid or unpaid capacity. Key features include:

- Outward-facing model aimed at securing services and supports for the individual
- Focus on ensuring the person's voice is heard
- Promotes confidence, skills and knowledge and protection of individual rights (Lawton, 2009).

Peer advocacy: The advocate and the person have a common background, for example, they may have shared experience of service provision, “experts by experience” (Monaghan, 2012). Peer advocacy can be conducted on an individual or collective basis and often develops spontaneously, for example in care homes or day centres. Key features include:

- Focused on common problem solving
- Lessens the imbalance of power between the advocate and their advocacy partner as they have shared experiences
- Most effectively used with specific groups, for example, people with substance misuse problems or mental health problems as they can prefer advocates with similar experiences (SIAA, 2008).

Volunteer Citizen advocacy: Volunteer Citizen advocacy involves volunteers (unpaid) who are recruited, trained and matched with an individual – generally only one at a time. It involves a one-to-one relationship over an extended period and goes beyond befriending - the volunteer represents the views of the person. The partnership is independent, supported, but not influenced by, the advocacy organisation.

Key Features:

- The relationship between the advocate and the individual (the partnership) is viewed as an outcome in and of itself
- The relationship continues regardless of any presenting ‘issue’
- Citizen advocates are supported to use their own networks, as well as community organisations to support them to develop their social networks.

Independent/professional advocacy:

A partnership between a paid advocate and a person who accesses support. The advocate provides support, information and representation, with the aim of empowering their partner and enabling them to express their needs and choices. This type of advocacy can be undertaken on a short-term or long-term basis. Long-term advocacy work may be required due to changing needs over time and the complexity of issues, for example, with parents with learning disabilities involved in the child protection system.

Key features include:

- Separation from other forms of direct service provision, eg social work
- Independent governance
- Independent funding arrangements (eg services are not directly funded by public bodies but via other indirect means, such as pooled budgets)
- Free from conflict of interest
- Individual rather than group advocacy
- Support often provided on a specialist basis, eg capacity, treatment for mental disorder, child protection issues or for specific groups, eg families and/or carers (Townesley et al, 2009).

There has been considerable debate around who should undertake the professional advocacy role and while it is clear from policy that this should be an independent role, there is some evidence to suggest that this can also be viewed as part of the social work role. Advocacy fits well with the core values of social work in terms of enabling people to achieve 'self fulfilment' (BASW, 2002 cited in Rapaport et al, 2006). Finlay and Sandall

(2009) argue that practitioners are in an ideal place to offer advocacy, having built up a relationship with a particular person, knowing their needs well and most likely having a sense of loyalty and responsiveness to their needs. However, advocacy can compromise relationships between practitioners and their colleagues and managers, and they can find themselves torn between representing the views of the person accessing support while at the same time trying to manage scarce resources on behalf of the organisation they work for (Beresford and Croft, 2004).

Independent advocacy can be particularly valuable when the relationship between the person being supported and the social worker has eroded (Featherstone et al, 2012). In such cases, the advocate can act as an important bridge between both parties and can help to repair damaged relationships.

Non-instructed advocacy: Advocacy can be provided to those who are, for reasons of capacity, unable to personally instruct their advocate. This may be because of the person's limitations in grasping concepts or because they are not able to make others understand their wishes because of significant communication barriers. Capacity to instruct or understand can be diminished for a number of reasons, for example mental health problems, dementia, acquired brain injury, or learning disabilities. However, it should be noted that having one of these conditions does not automatically mean a person lacks capacity. An advocate will observe the partner and their situation, look for alternative means of communication with the partner, gather information from significant others in the partner's life, if appropriate, and ensure the partner's rights are upheld.

Key features include:

- A focus on upholding the persons rights
- Ensuring fair and equal treatment and access to services
- Making certain that decisions are taken with consideration for the individual's unique preferences and perspectives

- Using as a last resort only when all other attempts at communicating and understanding an adults wishes have failed
- Trying out a range of methods of communication to ensure the person's wishes are clear
- Using a number of core quality of life domains, together with relevant legislation, to make comparisons and consider what quality of life or experiences would be usual and acceptable to the general population.

It should be noted that legislative obligations (e.g. within the Mental Health (Care and Treatment) (Scotland) Act (2003) or Adults with Incapacity (Scotland) Act (2000)) to provide or direct people to advocacy are not voided simply because an individual cannot instruct an advocate for any of the above reasons. Non-instructed advocacy can be utilized in these circumstances. Obligations to provide or direct to advocacy are mandated differently in Scotland than in England and Wales (SIAA, 2009).

Features of good practice

Taking these models together, it has been possible to identify a number of common features that are important for an advocate to exhibit. These include:

- A calm thoughtful and sensitive disposition
- The ability to raise relevant issues on behalf of the person in an appropriate and fair manner
- Good at building relationships with people
- Provision of support to individual when upset
- Ensure the person's views are discussed and incorporated
- The ability to be succinct, articulate, thorough and offer alternative ways of thinking
- Facilitate understanding among other professionals of the person's situation.

(Adapted from Featherstone et al, 2012)

Standards for advocacy services

In order to ensure that advocacy services are provided in a way that effectively meet the needs of people who access support and operate in a way that is underpinned by an evidence base, standards for generic advocacy services have been developed by Action for Advocacy (2006). These standards relate to:

- clarity of purpose
- independence
- putting people first
- empowerment
- equal opportunity
- accessibility and accountability
- supporting advocates
- confidentiality and complaints.

These themes are further reflected in the Scottish Independent Advocacy Alliance (SIAA) Principles and Standards for Independent Advocacy (SIAA, 2008).

The benefits of advocacy

There is a limited evidence base that explores the effectiveness of advocacy (Lawton 2009). This relates primarily to conflicting definitions and a lack of understanding about the role of advocacy (Fazal et al, 2004). It is difficult to measure the impact that advocacy has on outcomes for people who access support and their families, partly because there is such a wide range of schemes with differing aims and objectives, with shifting and often multiple or unclear outcomes (McNutt, 2011). To date, the recording of outcomes of advocacy interventions appears to be limited. However, Action for Advocacy has developed outcome measures, which have been effectively used in research (Palmer et al, 2012). In addition, SIAA has developed an evaluation framework for advocacy (SIAA, 2010), which provides tools for measuring effectiveness of advocacy services against their principles and standards (SIAA, 2008). Using the framework organisations can establish:

- The differences that have been made
- Whether these were intended differences
- If there have been any unexpected differences
- The methods that were used and which were most effective
- What works well.

Using the framework annually, a comparative picture of achievements can be developed. In addition, SIAA has considered the most effective method of gathering 'soft' outcomes data. This includes use of daily diaries by advocates as well as interviews and focus groups.

Despite the lack of evidence, it is clear that people who access support can benefit as much from the process of having an advocate as they do from the outcome (Townesley et al, 2009). Therefore, when considering what works in relation to advocacy, it is important to separate out process from outcomes (Featherstone et al, 2012). A perceived negative long-term outcome (such as the removal of a child from parental care for example,) does not necessarily mean advocacy has been ineffective (if the parent was better represented and involved in the children's hearing system).

Key benefits have emerged from the review of the literature.

Promoting empowerment

People who access support who have experienced advocacy express a high level of satisfaction with the process. This satisfaction relates primarily to the potential that advocacy has to empower people who access support by enabling them to have their voices heard (MacIntyre and Stewart, 2011). With regard to participation in formal proceedings, people who access support also reported having a greater knowledge and understanding of the processes involved and the language used, as well as their rights, leading to a greater sense of empowerment (Featherstone et al, 2012). This sense of empowerment can result in an increase in self-reported well-being, as well as increased self-efficacy and improved confidence (Palmer et al, 2012).

Practical help and support

People who access support also report high levels of satisfaction when they receive help and support. These include practical tasks such as interpretation and translation of information, help to apply for housing and benefits and to gain social support (Newbigging et al, 2011). The provision of moral support has been highlighted as being important, particularly during formal proceedings, which can be viewed as intimidating by people who access support (Featherstone et al, 2012).

Development of relationships

The relational aspect of advocacy cannot be underestimated as it appears to be a key indicator of satisfaction across different types of advocacy provision (Palmer et al, 2012). Self-advocacy, peer advocacy and citizen advocacy in particular are thought to offer great potential to promote social networks and support individuals to build relationships by offering individuals a safe and stable environment. The development of a trusting relationship between the person who accesses support and the advocate is essential and requires frequent face-to-face contact and communication, particularly in the early stages of the relationship (Palmer et al, 2012). Indeed, it is thought that higher levels of trust promotes higher levels of participation more generally (Palmer et al, 2012). Lawton, writing specifically around self-advocacy, identifies a number of good practice points for supporters of self-advocates to consider. These include:

- Not taking over but taking the initiative when required
- Making sure that people are seen in a good light
- Spending time finding out what support the person needs and how they want to be supported

What limits the effectiveness of advocacy?

Availability and recruitment

The introduction of legislatively mandated access to advocacy has the potential to create a two-tier system of support, with those subject to compulsory measures under mental health legislation being more likely than others to access advocacy (Atkinson et al, 2008). For example, a local authority in Scotland has a statutory duty to provide advocacy services for those subject to compulsory measures under the Mental Health (Care and Treatment)(Scotland) Act, 2003. There is no statutory duty under the Adults with Incapacity (Scotland) Act, 2000 or the Adult Support and Protection (Scotland) Act, 2007, although this would be considered good practice. A further unintended consequence of this may be that other important aspects of daily living such as the promotion of social inclusion and social networks are not prioritised (Rapaport et al, 2006).

A general concern, therefore, relates to the availability of advocacy across Scotland. In relation to mental health advocacy for example, the patchy availability of professionally trained advocates across Scotland has been well documented (Scottish Government, 2009), leading to concerns over the development of a 'postcode lottery'. These issues are even more prevalent when considering very specialist forms of advocacy such as for

- Supporting the adult at their own pace
- Being independent and supporting the person to challenge
- Being flexible
- Being non-judgmental and not easily shocked
- Being reliable
- Making information accessible
- Considering whether meetings are the best way to include people.

(Taken from Lawton, 2006).

“Self-advocacy, peer advocacy and citizen advocacy in particular are thought to offer great potential to promote social networks and support individuals to build relationships by offering individuals a safe and stable environment.”

those with mental health problems from BME Communities where there are serious gaps in provision (Newbigging et al, 2007).

Similar concerns exist with regard to citizen advocacy and peer advocacy. A number of difficulties in the recruitment of peer advocates has been documented in the literature (Children's Bureau, 2004). These relate to peer advocates lacking the confidence to undertake the role, as well as not wishing to be associated with others who have a similar label for fear of stigma and discrimination.

Knowledge and skills

Advocates must possess an appropriate level of skills and expertise in order to perform their role effectively and be taken seriously (Carlisle, 2000). For those operating as citizen or volunteer advocates or for those acting in the capacity of self or peer advocate, this involves a high level of commitment, alongside the availability of appropriate support and training. Providing this support on an ongoing basis can be a challenge for organisations that are often dependent on short-term funding.

There is a key tension between representing the views of an individual and empowering them to reduce the power imbalances that they are likely to face. This dilemma is particularly problematic when there has been a fundamental lack of understanding about the role and purpose of advocacy from the beginning of the process. Fazil and colleagues (2004), in their study of families from Bangladeshi and Pakistani families with severely disabled children, identified a key lack of understanding of the advocacy role. Advocates were viewed as problem solvers who could achieve what families could not.

There are also particular issues when it comes to working with people with complex support needs. SCIE (2009) found evidence of assumptions being made around the capacity and capability of people who access support to make decisions. Self-advocacy has the potential to challenge such assumptions by emphasising choice and control for people who access support (Fazil et al, 2004). However, this often leads to the isolation of self-advocates from the organisations they seek to challenge.

Funding and cost effectiveness

There is very little evidence about whether or not advocacy is cost-effective. McNutt (2011) argues that because there is little robust evidence about the effectiveness of advocacy in terms of improvement outcomes for individuals, it is not possible to ascertain whether or not it is worth the cost. However, McNutt (2011) further acknowledges that this is principally due to the fact that advocacy, in particular its costs effectiveness, can be difficult to evaluate.

The evidence indicates that effective advocacy requires long-term and preferably independent funding, otherwise, it is a challenge to deliver the key advocacy principles of independence, loyalty to the person or partner and a commitment to justice and empowerment, while at the same time balancing obligations to a funding body. Manthorpe and colleagues (2006) have recommended a number of ways in which these issues around funding and conflict of interest can be overcome:

- Funding to be administered centrally, for example by the Scottish Government
- Funding to be administered locally, for example, from a pooled budget (but not by the social work department)

- Core funding from a central body with specialist initiatives
- Services to seek multi-source funding
- Funding allocation without any strings attached.

Features of effective advocacy practice

From the evidence presented it is possible to identify the following features that are essential for good advocacy practice. Before considering these, it is important to bear in mind that the model of advocacy used and the length of the intervention will depend on a number of factors such as the presenting issue, the needs of the individual, the level of specialist knowledge required and the availability of appropriate resources.

The following features are relevant across models unless otherwise stated:

For advocates: A trusting relationship built up over time promotes increased participation. Continuity, familiarity and consistency are crucial to this (Townsend et al, 2009; Palmer et al, 2012). This has specific implications for short-term work, focusing on a single event that will require trust to be built up quickly.

Similarly, advocates will require a clearly defined role which includes a number of key components relating to specific and specialist skills, knowledge and experience (Townesley et al, 2009). To support this, training and ongoing support, which enables advocates to understand the role, develop a relevant knowledge base and develop their own skills and confidence (National Children's Bureau, 2004), is essential.

Cultural sensitivity is crucial in order to provide an understanding of and ability to begin to address some of the key issues faced by particular groups (Newbigging et al, 2007). Separating out advocacy for carers from that of people who access support is essential to ensure conflicts do not arise (DSDC, 2003).

For commissioners: Specialist provision is necessary for some service user groups with particular support or communication needs. Such provision should draw on innovative ways of working, including multi-media advocacy and storytelling group work and life-story work (SCIE, 2009). Where specialist provision is developed, specific training requirements need to be addressed, for example, legal training for those working with people experiencing dementia and children's rights training for those working with children (Boylan and Dalrymple, 2011).

Advocates must be independent and not constrained by the organisations that fund them. Independence from public services remains an important advocacy principle but many advocacy schemes are reliant on public funding. Although independence from services indicates good practice, it is important that advocates do not operate in isolation from, but in partnership with, services (Newbigging et al, 2011).

For organisations: Professionals require support to understand the role of independent advocacy and in order to feel supported not to be threatened or undermined. This is best achieved by ensuring a clear understanding of the role of advocacy (Patient and Client Council, 2012).

Whilst advocacy can be used to support anti-oppressive practice by prompting the rights of the individual, eg children's rights, there must be consideration of the stage at which advocates become involved in formal proceedings, eg adult safeguarding or child protection proceedings; too early and the advocate may be drawn into the investigation process (Patient and Client Council, 2012).

Advocacy services need to use effective mechanisms to define and record outcomes for individuals, acknowledging that these may vary from people who access support to service providers (Palmer et al, 2012).

Conclusion

This *Insight* identifies models of advocacy, explores what works well and what limits the effectiveness of advocacy. Evidence regarding the effectiveness of advocacy remains limited and while there is a reasonable amount of information relating to the process benefits of advocacy, its impact on individual outcomes remains largely unclear (Manthorpe and Martineau, 2010). A range of important process benefits has been identified relating to greater empowerment, self-efficacy and confidence, as well as a greater sense of participation and having one's voice heard.

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www.iriss.org.uk enquiries@iriss.org.uk

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