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Research Series

The Jigsaw of Advocacy

Finding a Voice

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Jigsaw of Advocacy

A Research Report

COMHAIRLE

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Foreword

In recent years advocacy has been billed as the key which will unlock entitlement to services for those who are often bewildered by the bureaucratic complexity of access to social and other state services. Advocacy in the broad sense is quite a traditional concept and is linked to the notion of civil society and of the citizen as one who takes responsibility not just for him or herself but for his / her neighbour and for the process of change. Information and advocacy have obvious links – it is not possible to make a case for oneself or someone else without accurate and up-to-date information on the topic in question. This is particularly relevant to Comhairle whose mission is to 'ensure that individuals have easy access to accurate, comprehensive, integrated and clear information on social services and to assist individuals, including those with disabilities, to identify their needs and access their entitlements to social services' (2001:3).

Over the past year Comhairle has been examining advocacy and its possible enhancement in a series of consultations and reports. This comprehensive piece of work, *Jigsaw of Advocacy* was able to draw on *Developing Advocacy Services* which reported on the deliberations of the Regional Consultative Fora. These 11 regional fora brought together voluntary and statutory groups with an interest in advocacy. A joint working group comprising both Comhairle staff and Board members and staff of Citizens Information Centres (CICs) also met during 2002 to consider advocacy services within the CICs, presenting its report and recommendations to the Board of Comhairle in June of 2003. Comhairle has also resourced a small number of advocacy projects in the community and voluntary sectors.

Advocacy comes in many models – which this report analyses – but the underlying common principle is the representation and ultimately the empowerment of vulnerable people. Social exclusion, individual problems, or low levels of literacy coupled with bureaucratic complexity can leave some people at a disadvantage in claiming their entitlements or getting the services they need.

This report did not attempt to address advocacy issues in the context of the new Disability Bill expected this year. An additional piece of work on advocacy has been commissioned by Comhairle which will be completed in 2003 and will address the particular needs of people with a disability.

This study set out to describe advocacy models and current services in Ireland and abroad, to identify the key components of such models, to discuss principles and codes of practice and to identify possible future options for Comhairle in the context of its current statutory responsibilities. Apart from the work of the Forum of People with Disabilities *Advocacy - A Rights Issue*, little has been written about advocacy in an Irish context. John Weafer in this report has provided a very thorough and comprehensive overview of advocacy policies in Ireland, an outline of advocacy elsewhere and a sketch of the embryonic services springing up in Ireland at present. He has also looked into the future, detailing the views of key players, the values and standards needed and the possible options – and challenges – for an agency like Comhairle. It is hoped that this report will contribute to an understanding of advocacy services in the Irish context and will prompt further discussion on the support and development of appropriate services.

Tom Daly
Chairman
Comhairle

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Executive Summary

Advocacy, which has always existed in human relationships is a process of empowerment and can take many forms. It is a way of enabling those who may have difficulty speaking up for themselves to do so and thus can be key to involvement in decision-making. It generally means representing the view of a person or supporting them to exercise or secure their rights.

The Information Process in Citizens Information Centres 2001. Nua Research services report

Comhairle's research and analysis into the development of advocacy has in the past year involved the production of three reports, the first on the Regional Fora, *Developing Advocacy Services*, the second on the findings of the Joint Comhairle Citizens Information Centres (CIC) Working Group on Advocacy and finally this major research report from Weafer Associates, *The Jigsaw of Advocacy*. This report analyses concepts of advocacy and the values implicit to it, brings together examples of its practice, both in services developing in Ireland and those abroad, looks at the policies supporting them, and the development possibilities open to Comhairle. It considers advocacy within Comhairle's present remit – the provision of information, advice and advocacy through the CICs – but it also examines methods and structures which might enhance Comhairle's service in the future. This will be of considerable relevance when the advocacy provisions of the new Disability Bill are known.

The underlying principle common to all models of advocacy is the representation or empowerment of vulnerable people. Advocacy is essentially a process of negotiation on behalf of an individual who is marginalised. The increasing complexity and bureaucratisation of modern life, social exclusion, literacy problems or disability can leave some people at a disadvantage in claiming entitlements and exercising their rights in society.

Information is a prerequisite to advocacy and this close link is particularly relevant to Comhairle whose mission is to 'ensure that individuals have easy access to accurate, comprehensive, integrated and clear information on social services and to assist individuals, including those with disabilities, to identify their needs and access their entitlements to social services.' One of the main ways in which Comhairle supports advocacy services is through the network of Citizens Information Centres (CICs) where

some staff advocate in relation to problems with social welfare, housing, health services or employment. Embryonic advocacy services also exist in some voluntary agencies which deal with people with disabilities, older people, Travellers and people who are homeless.

The Jigsaw of Advocacy describes advocacy models both in Ireland and abroad, identifies their distinguishing aspects, maps their development in Ireland and proposes future advocacy options for Comhairle. Its title reflects the piecemeal growth of advocacy in Ireland to date and the myriad forms that advocacy can take.

The Introduction discusses the concept of advocacy, the perceived need for advocacy services and how they are linked to information-provision. Chapter 2 looks at the policy context of advocacy, at the increasing appearance of the term in government planning documents and its links with measures to strengthen social inclusion.

Chapter 3 analyses the different types of advocacy, situating the main division between do-it-yourself type advocacy where the person or group represents themselves or those in a similar situation, and outsider advocacy where an external person takes on the representation. The first type of advocacy emphasises empowerment of the individual – although there is usually a facilitator in the background; the second type tends to emphasise the expertise or life-skills of the external advocate.

Self-advocacy can refer to any form of individual empowerment. However for people with learning disabilities it is often part of a programme to enhance their ability to assert their own choices. The spirit of self-advocacy which emphasises the autonomy of the individual is also implicit in the peer-advocacy groups which have sprung up among users of mental health services. Peer advocacy is user-led and user-run with the person advocating having once been in the position of their partner.

Citizen advocacy refers to the long-term partnership with people (usually with disabilities) who are not in a good position to assert their rights. Citizen advocates are usually unpaid and independent of service providers. In other countries this form of advocacy is most developed among people in long-stay institutions.

Professional or personal advocacy -sometimes described as crisis advocacy- employs trained workers to resolve a specific short-term problem. The work of CICs fits broadly into this category of advocacy. Offshoots of this type of advocacy are legal advocacy where professionals with legal training provide assistance to individuals through the legal system and patient advocacy where people accessing hospital services can be assisted in their dealings with hospitals.

Public policy advocacy, which is in some ways the most traditional form of advocacy, lies outside the main two strands described above but complements them. It could be defined as ‘the effort to influence public policy through various forms of persuasive communication’ and is a logical continuation of providing services on the ground.

All these forms of advocacy overlap and are not mutually exclusive: an individual could need self-advocacy or citizen advocacy over a period along with professional advocacy to deal with specific problems.

Chapter 4 puts forward the views of individuals from fifteen organisations concerned with advocacy. They emphasise the need for a well-resourced, independent advocacy service capable of addressing the different needs of disadvantaged groups. A statutory commitment to advocacy, the provision of a wide range of such services, support to agencies currently providing advocacy and a guarantee of independence are some of their recommendations.

Chapter 5 looks at key values and best practice within advocacy and at some of the philosophical and practical problems thrown up. Important values include respect for the person and his/her choices, independence and quality of service. Best Practice again emphasises independence, guaranteed statutory funding, education and training, ongoing supervision and support and accountability together with an efficient complaints procedures.

Chapter 6 deals with a Comhairle's role in the development of advocacy. Part of Comhairle's statutory brief under the Comhairle Act, 2000 relates to advocacy and Comhairle currently supports some advocacy services through its network of CICs, while resourcing advocacy projects from the community and voluntary sector through its regional grants schemes. Its social policy remit of influencing policy developments by 'highlighting the concerns of service users as to the effectiveness of social and civil services' is a form of public policy advocacy.

In developing advocacy, options for Comhairle divide along two main strands: various forms of partnership or direct involvement in the provision of services. Either option would require considerable extra staffing and funding.

Partnership possibilities include:

- a lead role for Comhairle in terms of commissioning specific advocacy services and providing support, training, monitoring and standards
- a more facilitative partnership role
- advocacy services to be provided through the network of CICs.

Advocacy services could be provided directly through the appointment by Comhairle of co-ordinators based in the Regional Offices – although this would mark a major change in Comhairle's role. A variety of structures might be needed to provide the different types of advocacy.

Advocacy services could become a personalised and effective way of standing alongside marginalized people to ensure they get equal opportunities with the more able in our society. To develop services that are respectful, effective and on a human scale in the various fields described above will be a challenge for any agency. Comhairle's information brief and its history of support for voluntary and community organisations means that it has relevant experience to bring to this demanding brief.

1 Introduction and Background

Advocacy, which has always existed in human relationships is a process of empowerment and can take many forms. It is a way of enabling those who may have difficulty speaking up for themselves to do so and thus can be key to involvement in decision-making. It generally means representing the view of a person or supporting them to exercise or secure their rights.

Nua Research Services, *The Information Process in Citizens Information Centres 2001*, P13

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1.1 Introduction

This report is based on research by Weafer and Associates, commissioned by Comhairle, to gain an overview of advocacy developments within Ireland and at European level.

The underlying principle common to most models of advocacy is the representation and ultimately empowerment[1] of vulnerable people where circumstances have taken away their capacity to speak up for their own interests. Advocacy is the process of speaking on behalf of a person or resourcing him/her to speak out, with the aim of enhancing his/her ability to be heard when he/she is claiming an entitlement or expressing a need.

Advocacy is essentially a dynamic process of negotiation conducted by, and on behalf of, an individual who is marginalised in some way. Although formal representation by a professional advisor or volunteer advocate is an important aspect of advocacy, another facet involves empowering vulnerable people to 'become advocates in their own lives through training, education and life experience' (Forum of People with Disabilities 2001:8). To do this effectively they may need back-up support. Another more traditional aspect of advocacy entails active lobbying by marginalised groups and their supporters.

Why advocacy is needed

The increasing complexity of modern life - particularly in terms of bureaucracy, social exclusion or individual problems of understanding or literacy can leave some people at a disadvantage when claiming their entitlements or getting the services that they need. Comhairle's regional consultative fora put forward the following barriers as leading to a need for advocacy. These were:

- language/literacy and cultural impediments
- approach of State bureaucracies
- lack of statutory entitlement to some services
- social inequalities.

Advocacy can be a way of overcoming these problems and is consequently a means of combating inequality.

1.2 Advocacy and Information

There is an important link between the provision of information and advocacy. For instance, in relation to patient advocacy, the Royal College of Psychiatrists (London) believes that active and informed participation is of benefit to both the patient and the clinician. They define advocacy as a process 'which involves information-gathering,

making the information accessible, discussing choices, facilitating decision-making by the individual and monitoring outcomes' (Royal College of Psychiatrists 1999:6). Chamberlin (1999) also argues that having access to information and a range of options from which to make choices are two aspects of empowerment in practice. The relationship between information and advocacy is particularly relevant to the present exploration of advocacy within Comhairle. Comhairle's primary responsibility is supporting the provision of independent information, advice and advocacy in relation to the broad range of social services. Comhairle's mission is to 'ensure that individuals have easy access to accurate, comprehensive, integrated and clear information on social services and to assist individuals, including those with disabilities, to identify their needs and access their entitlements to social services' (2001:3). Further, in its Strategic Plan 2001–2003, four principles and values that guide the work of Comhairle are identified as:

- Access to information is a basic right of all individuals
- Equality of access to state services
- Information, advice and advocacy to be of a high quality, customer focused and developed in consultation with customers
- Information, advice and advocacy services to empower people to access their rights and entitlements.

One of the main ways in which Comhairle offers advocacy services is through resourcing the network of Citizens Information Centres (CICs). The findings of a recent report[2] by Comhairle on the level of advocacy services in 38 of its key CICs suggest that all CICs are engaged in advocacy work at some level. However, the type of advocacy undertaken by CIC staff is linked to specific problems with social welfare, housing, health services or employment.

1.3 Advocacy in Ireland and Abroad

In the United Kingdom(UK) and, to a lesser extent Ireland, advocacy has grown in prominence in recent years and is moving into the mainstream of health and social care provision. However there is still ambiguity as to what advocacy is and does. Legislation to back up a right to advocacy is still rare and usually deals only with legal advocacy for those who are involuntarily committed to a psychiatric institution. In its report, *Advocacy: A Rights Issue*, the Forum of People with Disabilities describes advocacy as a claim right which should be backed up by Irish legislation in line with international instruments. The Forum backs up this argument with references to Article 40.1 of the Irish Constitution[3], the United Nations (UN) Covenants on Human Rights , the Universal Declaration of Human Rights[4] and the UN Standard Rules on the Equalisation of Opportunities (1993).

The limited number of Irish organisations or discussion documents dealing with advocacy shows that advocacy in Ireland is in an embryonic state. For example, one of the most comprehensive directories on voluntary organisations in Ireland, *the*

Directory of National Voluntary Organisations and Other Agencies, 2001–2002, produced by Comhairle, does not include advocacy in its subject index.[5] Within the Irish context, the issue of advocacy is most often associated with mental health, disability or the lobbying process. Most existing advocacy services in Ireland relate to some aspect of disability e.g. the Mental Health Advocacy Network, Irish Wheelchair Association (IWA), Schizophrenia Ireland, Brothers of Charity /Galway Citizen Advocacy. Perhaps the most frequently cited definition of advocacy in the Irish context is that of the Commission on the Status of People with Disabilities in its report, *A Strategy for Equality, 1996*, while most of the limited published work on advocacy has been compiled by disability organisations (Forum of People with Disabilities, 2001; National Disability Authority, 2003 forthcoming). The Department of Health and Children has also set out its policy on advocacy within the context of mental health in its Health Strategy, *Quality and Fairness*, 2001, while the Disability Bill 2001[6] considered the issue of advocacy services in some detail.

Given the undoubted vulnerability of many disabled people and the commitment of disability organisations, the close link between advocacy programmes and disability is not unexpected. However, the general notion of advocacy is relevant to a broader section of Irish society; people may be vulnerable and marginalised as a result of: poverty[7], old age[8], ethnicity[9], housing[10], race[11], and education[12] as well as disability. The vulnerability of such groups has also been acknowledged in recent policy documents such as the National Anti-Poverty Strategy (NAPS)[13] and equality legislation[14]. Accordingly, it is more meaningful and ultimately more useful to relate the concept of advocacy to all people who face structural disadvantage in society, whether through disability, socio-economic status or inequality. Through the network of CICs Comhairle has been more closely involved with the general form of advocacy, which assists people to access their entitlements.

1.4 Different Levels of Advocacy

The report by the Forum of People with Disabilities, Advocacy: A Rights Issue, 2001, for instance, identified 17 specific forms of advocacy[15], while a quick perusal of the Internet confirms the myriad diversity within advocacy[16]. Furthermore, while some forms of advocacy, such as citizen advocacy, are relatively well developed, 'with a clearly stated philosophy, guidelines for practice and mechanisms for review and evaluation, others, like peer advocacy[17], exist only as pragmatic, informal approaches that define who the advocates are rather than what they do or how they do it' (Henderson and Pochin 2001:143). Organisations that seek to represent the broader views of marginalised groups at national level are following the 'spirit' of advocacy, even if the specific word is not always used. The diverse models of advocacy described in Chapter Three exist within the broader political and socio-economic framework, so that policy changes at national level can have a significant impact on the effectiveness of more personal forms of advocacy. While it remains to be seen what ultimate impact the provisions of the Comhairle Act, 2000 and the new Disability Bill will have on the provision of advocacy services, significant changes are likely.

Individuals are ultimately empowered and their life opportunities enhanced through changes in national policy, particularly where this leads to the enactment of supporting legislation. Lobbying to influence public policy can be an effective form of advocacy for disempowered groups.

1.5 Context of the Research

Comhairle was established in June 2000 as a statutory body under the Department of Social and Family Affairs. Comhairle combines all aspects of the information, advice and advocacy work of the former National Social Service Board (NSSB) and the relevant information and advice functions of the former National Rehabilitation Board (NRB). Comhairle was established following publication of *A Strategy for Equality* in 1996 and the Establishment Group Report in 1998, which planned the mainstreaming of services for people with disabilities.

This report examines advocacy in terms of providing or supporting the provision of advocacy across the range of individuals or organisations, who may, at some point in their lives, need to avail of advocacy services. In relation to Comhairle's statutory responsibilities, the report looks specifically at the area of providing information, advice and advocacy in supporting people to access their rights and entitlement to civil and social services. This report also looks specifically at the provision of advocacy services through the network of Citizens Information Centres and through the support for the provision of advocacy services in the community and voluntary sector.

The concentration of this report was on the widest function of advocacy as it relates to the support of all marginalised groups and vulnerable people in relation to accessing their rights and entitlements. However much of the information gathered on developments in advocacy, both in Ireland and abroad, centres on advocacy as it relates to disability and mental health where the theory and practice of advocacy has been most clearly defined and developed.

1.6 Research Objectives

The study had four main objectives:

i. Describe the characteristics, rationale and focus of advocacy models/approaches in a number of selected jurisdictions
ii. Identify the key organisational and administrative components of each of these approaches
iii. Describe the nature and extent of current advocacy services in Ireland[18]
iv. Identify appropriate options for the development and support of advocacy services by Comhairle.

The key research questions were identified as follows:

1. Are there different approaches to advocacy that are applicable in different social settings and for different categories of people, *viz.*

    - People living in the community
    - People in residential care settings
    - People in hospitals
    - Children
    - People with disabilities
    - Older people.

2. What are the key components of the different models of advocacy?

3. What are the implications of the research for the development of advocacy services by Comhairle in relation to:

    - Volunteer advocates
    - Professional advocates
    - Issue advocates
    - Developing the role of CICs and other independent information providers
    - Joint working between voluntary and community and statutory bodies
    - Independence of advocacy process.

4. What are the limits to independent advocacy services?

1.7 Research Approach

The study involved two inter-related methods:

a. **Desk Research**: In this initial phase, a comprehensive review of literature was undertaken to provide an analysis and synthesis of the core elements of different approaches to advocacy in Ireland and in other selected jurisdictions.
b. **Consultation with Selected Agencies / Interviews with Key Informants**: 20 key informants in selected agencies were consulted regarding various aspects of the research, including their views on appropriate advocacy models for Ireland and the role of Comhairle in providing advocacy services.

The research was undertaken and the report written during the six month period, August 2002 to January 2003. The final chapter was revised in May and June 2003.

1.8 Structure of the Report

Following this introductory chapter, the policy context of advocacy in Ireland and a selection of international policies are presented in Chapter Two. Chapter Three contains an overview of the characteristics, rationale and focus of different advocacy models. Chapter Four presents the views of key informants on the current state of advocacy in Ireland and their considered views of the role of Comhairle in the provision of advocacy services. Chapter Five looks at values and the development of codes of practice within advocacy. The final chapter seeks to identify appropriate options for the development and support of advocacy services by Comhairle.

Chapter 1 Notes

1 The concepts of advocacy and empowerment are often used interchangeably. For example, the close relationship between empowerment and advocacy was highlighted, amongst others, by Thompson (2002). Chamberlin's (1999) working definition of empowerment is a 15-point description of what empowers individuals. These 15 elements of empowerment are: 1. Having decision-making power. 2. Having access to information and resources. 3. Having a range of options from which to make choices (not just yes/no, either/or). 4. Assertiveness. 5. A feeling that the individual can make a difference (being hopeful). 6. Learning to think critically; learning the conditioning; seeing things differently. 7. Learning about and expressing anger. 8. Not feeling alone; feeling part of a group. 9. Understanding that people have rights. 10. Effecting change in one's life and one's community. 11. Learning skills that the individual defines as important. 12. Changing others' perception of one's competency and capacity to act. 13. Coming out of the closet. 14. Growth and change that is never ending and self-initiated. 15. Increasing one's positive self-image and overcoming stigma.

2 The report, *Levels of Advocacy Services in Key CICs* was compiled by Comhairle in September 2002. For the purposes of the review, advocacy was defined as 'actively supporting a cause or issue; speaking in favour of; recommending; supporting or defending; arguing on behalf of oneself or on behalf of another'. (p.1)

3 Article 40.1 of the Irish Constitution states that 'All citizens shall, as human persons, be held equal before the law. This shall not be held to mean that the State shall not in its enactments have due regard to differences of capacity, physical and moral, and of social function'.

4 The general comment No.5 (1994) of the UN Covenant on Economic, Social and Cultural Rights states that the Covenant 'clearly requires Governments to do much more than merely abstain from taking measures, which might have a negative impact on persons with disabilities.... The obligation in the case of such a vulnerable and disadvantaged group is to take positive action to reduce structural disadvantage and to give preferential treatment to disabled people in order to achieve the objectives of full participation and equality'.

5 Comhairle Directory of National Voluntary Organisations, Dublin: Tenth Edition 2001-2002.

6 At the time of writing, a new Disability Bill is being prepared. It is expected that the provision of advocacy services will be included in the forthcoming Bill.

7 Information on the extent of relative poverty amongst different groups within Irish society is readily available from the research published by the Combat Poverty Agency, the Economic and Social Research Institute (ESRI) and other institutes – www.cpa.ie.

8 Just over one in ten (11.3%) or 424,000 persons living in the Republic of Ireland are 65 years of age or more. Furthermore, the Organisation for Economic Co-operation and Development (OECD) estimate that the percentage of the Irish population 65 years or more is estimated to rise significantly over the next 50 years, from 11% in 2000 to 30% in 2050 (Ageing and Transport: Mobility Needs and Safety Issues, OECD 2001). Older people are more likely to suffer from some disability and to be at greater risk of poverty.

9 A number of reports have highlighted the marginalised living conditions of Travellers in Ireland. The report of The Irish National Co-ordinating Committee for the European Year Against Racism summarised these views as follows: 'Travellers are widely acknowledged as one of the most marginalised and disadvantaged groups in Irish society. Travellers fare poorly on almost every ever indicator used to measure disadvantage: unemployment, poverty, social exclusion, health status, infant mortality, life expectancy, illiteracy, education and training levels, access to decision-making and political representation, gender equality, access to credit, accommodation and living

conditions' (1998:2). More recent reports confirm that little has changed in the interim (Weafer 2001).

10 In March 1999, 5,234 persons were recorded as homeless by the local authorities, an increase of over 100 per cent on the previous assessment in 1996. However, if the definition of homelessness was expanded to included all those on the local authority housing lists, as argued by Fahey and Watson (1995), this number would increase significantly. In October 1999, over 50,000 persons were on the local authority waiting lists. In addition to the very real difficulties associated with homelessness in itself, it is also clear that homelessness is associated with many other indicators of poverty and marginalisation, such as unemployment, alcoholism, drug addiction, a prison record, psychiatric and physical health problems (O'Sullivan 1996; McKeown 1999; Harvey 1999).

11 Over 10,900 asylum seekers arrived in Ireland during 2000. Most of these and the significant numbers of asylum seekers who had arrived in earlier years arrive without resources and are dependent on Supplementary Welfare Allowance (SWA) (Social Inclusion Strategy, Annual Report of the Inter-Departmental Policy Committee 2000/2001:48).

12 Archer (2001) observes that although considerable progress has been made in removing formal barriers to education, a number of forms of indirect discrimination are still in place, such as disability and membership of the Traveller community. Young people from poorer backgrounds are more likely to leave school without qualifications and to be under-represented in third level institutions. Research also indicates that people with no educational qualifications are less likely to be in employment and more likely to be in poverty.

13 The National Anti-Poverty Strategy (NAPS) (1997) and subsequent reviews of this strategy concluded that certain groups in Irish society tend to be at a higher risk of poverty: the unemployed, particularly the long-term unemployed; children, particularly those living in large families; single adult households and households headed by someone working in the home; lone parents; people with disabilities; older people, in particular, households headed by a retired person; members of the Traveller community; the homeless; and ethnic minorities (Social Inclusion Strategy, Annual Report of the Inter-Departmental Policy Committee 1999/2000).

14 Recently introduced equality legislation (The Employment Equality Act, 1998 and the Equal Status Act, 2000) outlaws discrimination in employment, vocational training, advertising, collective agreement, the provision of goods and services and other opportunities to which the public generally have access. Discrimination is outlawed on nine distinct grounds: gender, marital status, family status, age, disability, race, sexual orientation, religious belief, and membership of the Traveller community.

15 The models of advocacy reviewed in the Forum's report comprised: self-advocacy, group advocacy, peer advocacy, family advocacy, citizen advocacy, service system advocacy, professional advocacy, service professional advocacy, crisis advocacy, complaints advocacy, collective/class advocacy, coalition advocacy, patient advocacy, ethnic disability advocacy, Traveller advocacy, legal advocacy, and advocacy for children.

16 Conducting a general search for advocacy using the Google search engine, for instance, produced approximately 3,210,000 references to advocacy. When the search is refined to include only those sites dealing with citizen advocacy, 295,000 sites were found. Most of these sites relate to North America and the UK. It is assumed that if other languages and terminology were taken into account, the coverage of sites dealing with 'advocacy' would undoubtedly increase significantly.

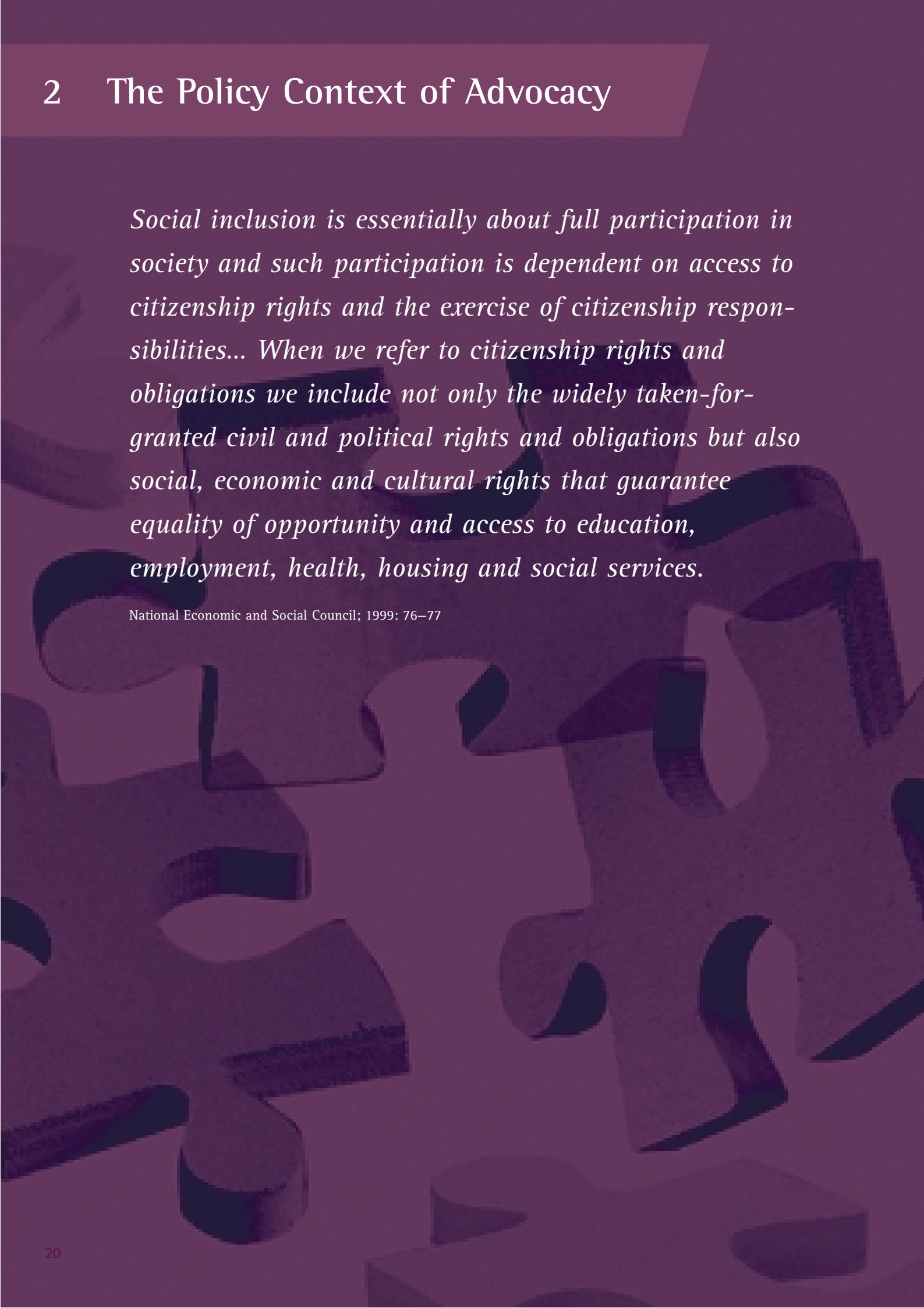
17 Some peer advocate schemes are more structured than others. For example, in Ireland, the Irish Advocacy Network (IAN) is developing quite a formalised structure and has established itself in a number of Health Board areas.

18 A survey of all voluntary organisations and statutory agencies would be required for a comprehensive picture of the extent of advocacy in Ireland. Such a survey was considered outside the scope of the present project.

2 The Policy Context of Advocacy

Social inclusion is essentially about full participation in society and such participation is dependent on access to citizenship rights and the exercise of citizenship responsibilities... When we refer to citizenship rights and obligations we include not only the widely taken-for-granted civil and political rights and obligations but also social, economic and cultural rights that guarantee equality of opportunity and access to education, employment, health, housing and social services.

National Economic and Social Council; 1999: 76–77



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2.1 Introduction

Advocacy *per se* is not a prominent feature of the Irish social or political landscape. With the exception of some preliminary policy initiatives in recent years, evidence of advocacy is scarce on the ground. *Advocacy: A Rights Issue* encapsulated the general situation very starkly: 'In 2001... there is no independent agency/ commission dedicated to promoting, assisting, monitoring and funding or developing advocacy initiatives, training, research or services in Ireland... There is no consistent investment made into advocacy provision in Ireland either on a regional or at a central level' (2001:93). The only change since is that the Department of Health and Children has provided some funding for the Irish Advocacy Network to operate a peer advocacy service in the area of mental health.

However, in another sense, advocacy has a long tradition in Ireland, with, for instance, political representatives speaking on behalf of their constituents[1]. Bax found that the majority of Irish politicians are 'predominantly concerned with local affairs and problems of individual electors' (1976:2). Similarly, Chubb who equated the role of Irish parliamentary representatives as 'going about persecuting civil servants' on behalf of their clients, noted the predominance of politicians who fulfil the 'function of adviser, contact man, expediter, and intercessor' at 'both local and central government levels' (1963:276). While the need for politicians to write letters and ask Dáil questions on behalf of constituents should have lessened due to the presence of Citizen Information Centres, public information offices in every government department, the Ombudsman and the general increase in education levels, this is not necessarily the case in practice (Brennock 2002).

The influence of voluntary organisations, community groups and campaigning organisations in speaking up for their members has increased significantly in recent years due to their improved access to decision-making structures and the emphasis within Irish social policy on social inclusion and full participation in society (Harvey 1998). Most of these bodies now make direct submissions to the Minister for Finance prior to the Budget. In addition to becoming better resourced and more professional in their approach, the voluntary and community sectors have benefited from improved contact with, and acceptance by, statutory bodies. Their participation as a social partner in the national agreement, Programme for Prosperity and Fairness (PPF), could be seen as one example of 'advocacy' in practice.

However, the considerable resources required to develop advocacy services on the ground mean that statutory involvement will be a prerequisite. Accordingly, in order to better understand the potential and actual practice of the different models of advocacy in Ireland, the policy context must be examined.

2.2 Advocacy and Irish Social Policy

The spirit of advocacy, in the sense of promoting inclusion and empowerment of marginalised groups, is a central theme underlying most of the major policy reports published by the Irish Government in recent years[2]. The *Programme for Prosperity and Fairness*, for instance, states the core objective of the Programme as to 'build a fair, inclusive society in Ireland' (Department of the Taoiseach, 2000:3), while the *National Development Plan*, 2000–2006 argues that 'if the fruits of Ireland's recent economic progress are to be more widely spread, the promotion of social inclusion as a key objective of socio-economic development must form a central part of the Plan' (Department of the Taoiseach 1999:188).

Whatever the success of these policies in practice[3], it is significant that these policy reports have moved beyond the more traditional and ultimately narrow view that economic growth and prosperity will inevitably lead to a fairer Ireland[4]. Thus, while the central focus of the National Anti-Poverty Strategy (NAPS) is on the ' 9 to 15 percent of the population... who were found to be consistently poor, that is, those who are subject to income poverty and who appear to be suffering from some form of deprivation due to lack of resources' (Government of Ireland, 1997:4), NAPS takes a broad strategic framework and acknowledges that, in addition to lack of money, poverty involves isolation, powerlessness and exclusion from participation in the normal activities of society[5]. Furthermore, policy reports tend to identify key groups of marginalised and 'at risk' sections of the population as in need of particular attention.

While much of the discussion and initiatives by State agencies focus on the structural causes of inequality, the importance of an individual's access to, and participation in, services at the local level is receiving increasing attention through the promotion of advocacy and empowerment models. For some organisations, the advocacy role is explicitly stated, while for others, the principle of advocacy is implicit but nevertheless central to the organisation's activities and strategy. The Irish Wheelchair Association, for instance, have an advocacy department whose aim is 'to ensure that members continue to have a voice and that the issue of physical disability stays on the political and social agendas until all people have equal rights and access to services' (IWA 2001:19). Conversely, although the term advocacy is not specifically mentioned in the *Social Policy Manifesto* of the Society of St. Vincent de Paul, the document's focus on the promotion of self-sufficiency and participative democracy at local level corresponds very closely with the underlying thrust of more explicit models of advocacy[6].

At a more general policy level, the notion of advocacy is beginning to surface. Major references to advocacy in official documents are listed below:

- The Report of the Commission on the Status of People with Disabilities, *A Strategy for Equality*, 1996. This was a seminal document for disabled people and contains some of the first recommendations on advocacy. These were:

- independent advocacy services to be mandatory in residential care settings (Recommendation 33)
- legislation dealing with particularly vulnerable people in residential settings to incorporate advocacy (Recommendation 48)
- education and training in self-advocacy for people with disabilities to form an integral part of the curriculum. (Ref. 4.49)
- self-advocacy to be supplemented by citizen advocacy
- the Legal Aid Board to fund people with disabilities so they can employ an advocate to access expert legal representation, where necessary (Ref. 4.49)
- the post of advocate to be established by statute, with each Health Board required to appoint at least one trained advocate on behalf of residents in long-stay services (Recommendation 382).

These recommendations have not yet come into effect with the result that some disability organisations are quite critical of the progress on advocacy to date. The Forum of People with Disabilities produced its own advocacy report in 2001 and its criticisms centred on lack of progress within the health services, a tendency to devolve responsibility for advocacy services onto voluntary organisations and user-groups and the lack of guaranteed funding for initiatives. The Forum believes that the type of advocacy recognised by the Mental Health Act 2001 - legal advocacy for those involuntarily detained - is much too narrow. (2001:42).

- *The Programme for Prosperity and Fairness* (Department of the Taoiseach, 2000)

  - Advocacy receives a specific mention in this Programme in relation to 'independent advocacy services for people who are involuntarily detained under the provisions of the new Mental Health Bill' (1999:94). In addition the underlying principles of the PPF are in keeping with the general thrust of advocacy and empowerment.

- *The Health Strategy, Quality and Fairness, A Health System for You* (Department of Health and Children 2001)

  - Within the context of mental health the Department of Health and Children calls for the strengthening of advocacy services as a priority in order 'to address the civil and human rights of the mentally ill' (2001:147).
  - The Mental Health Act, 2001 requires the Mental Health Commission to provide an independent legal representative to each person who is detained involuntarily under the Act.
  - The development within the voluntary sector of other forms of independent advocacy for mental health services users should be encouraged and supported.

Within the last year the Department of Health and Children has backed up these policies by providing funding for the following initiatives.

- Advocacy for Mental Health Service-users
  The Department of Health and Children launched a development programme for the provision of regional peer advocates through the Irish Advocacy Network, a national network of mental health advocacy user groups. Advocates are now employed in a number of Health Board areas. (11 advocates in February 2003)
- Youth Advocacy Programme
  The national pilot of the Youth Advocacy Programme was launched in 2002 in the Northern Area Health Board. This has been designed to provide support to at-risk young people and their families. It is based on a trust relationship between a skilled adult advocate from the locality and the young person.

- The Disability Bill, 2001[7]

  - The Disability Bill, 2001 (withdrawn) represented a significant development in recognising the importance of providing advocacy services to people with disabilities. The Bill proposed that Comhairle would give support and training in relation to self-advocacy, peer advocacy and group advocacy and that it would establish a Personal Advocacy Service for 'qualifying persons'. It was envisaged that the Personal Advocacy Service would provide help and support to 'qualifying persons' in applying for an assessment of needs, obtaining a health service, making a related complaint or in obtaining any other public service to which the person is entitled. Comhairle would appoint a director of the service and personal advocates to work with the director. A new Disability Bill is promised in 2003.
  - The role of the personal advocate was also outlined in the draft legislation. He/she would seek to promote the best interests of the qualifying person and help the person to understand options resulting from an assessment of need. Other areas of help would be explaining the implications of any treatment or therapy so that a person could give informed consent.
  - He or she would also have a role in liaising with service providers and would have a right of access to information, meetings and consultations needed so as to effectively represent the qualifying person.

- Department of Health and Children 2000 -*Report of the Public Consultation for The National Children's Strategy, -Our Children Their Lives.*

  - This report believes that young people's participation as active citizens can be supported by the provision of training modules for adults and professional staff and by 'independent complaints procedures, an advocacy process for children at all levels, active consumer feedback, as required in the Strategic Management Initiative, information for children about services and in particular, the advent of the Ombudsman' (2000:99).

- Homeless Agency *A Good Practice Handbook for Homeless Services, Putting People First / An Action Plan on Homelessness in Dublin 2001–2003, Shaping the Future. (1999)*

    - Advocacy is mentioned in relation to the standards organisations providing outreach services should aim to achieve if they wish to follow best practice: 'The expressed needs and aspirations of people who are homeless are accurately assessed and, either with the person or on their behalf, the case for effective and prompt delivery is effectively made to agencies...' The settlement service also aims to promote self-advocacy.
    - The twofold purpose of the support programme for people who are homeless is 'to develop ways of working with people who are homeless which are empowering and which enable them to take control of their situations and... to provide opportunities for people who are homeless to speak out about their experiences and inform the development of policy and service responses' (Homeless Agency 2001:24).

These policies have been backed up by the Speakout project for homeless people.

- Comhairle and the National Disability Authority:

The 'new institutional machinery' of disability rights (Quinn, undated) the Comhairle Act (2000) and the National Disability Authority Act, (1999) could be possible advocacy mechanisms.

- **Comhairle** was set up in June 2000 to provide information, advice and advocacy services both to the general public and to people with disabilities. It was part of the move to mainstream services for people with disabilities in response to the recommendations in the report of the Commission on the Status of People with Disabilities (1996) and the report of the Establishment Group for the Disability Authority and the Disability Support Service (*Building a Future Together*, 1998). One of its key objectives is to ensure that 'information and advice services offered are of a high quality – accurate, comprehensive, understandable, customer focused' (Comhairle 2001). The present report is part of Comhairle's response to its obligation under the legislation to support the provision or to provide directly, independent information, advice and advocacy services.
- The **National Disability Authority (NDA)** was established in June 2000 as an independent statutory body operating under the aegis of the Department of Justice, Equality and Law Reform. The NDA's first Strategic Plan, *A Matter of Rights 2001-2003* (2001) emphasises the NDA's commitment to promoting the rights of disabled people through influencing public policy and legislation. It sets out four strategic priorities:

    1. to develop policies that promote the equal status of people with disabilities
    2. to guide and monitor the implementation of the programme to make public services accessible to people with disabilities within five years

3. to influence attitudes in Irish society
4. to ensure best practice in services for people with disabilities.

This assurance of best practice in services for people with disabilities is directly related to advocacy. In the draft[8] National Standards for Disability Services published in January 2003, Standard 1.2 of the Person Centred Standards stated that service users should have access to an independent advocate. The criteria for this standard ('What people can expect') include:

- information on advocacy services
- an advocate to be available when required
- advocates to have appropriate skills
- training for the person with a disability on the role of the advocate and the effective use of advocacy.

The NDA defines the term advocate as 'family members, relatives or friends of the service user, who have the legal right or who have been chosen and authorised by the service- user to speak on his/her behalf' (NDA, Second Draft Standards in Health Services, 2003.)

- Other Agencies and Structures

- The Equality Authority has promoted advocacy through its programme for community advocates, in association with the Irish Traveller Movement. Approximately 20 advocates have received training on the procedures for taking a case under the equal status legislation. The nine grounds quoted in Equality legislation provide a useful pointer to the groups who may require advocacy.
- The Office of the Ombudsman is an independent office that investigates complaints by individuals against government departments, Health Boards and local authorities. Some of its areas of responsibility are closely related to advocacy.
- Legal aid is provided through the services of the Legal Aid Board for individuals who cannot afford to pay for legal aid themselves.

The references from policy documents and the initiatives quoted above show that although advocacy in Ireland is not yet established on an official basis, the State is aware of its potential. A considerable number of departments and public bodies see it as a tool for promoting user satisfaction and greater inclusion. The danger is that advocacy could come to be seen as a panacea for all types of complaints. In some cases people may not get the services they are entitled to because of misunderstandings or misrepresentations in their dealing with officialdom; in other cases they may not be entitled to the services they need; or the services they need may not exist in the State sector. Advocacy will only help in the first scenario. It cannot itself be a substitute for inadequate services or the absence of proper complaints and review systems.

2.3 The International Context

Advocacy is at a further stage of development abroad than in Ireland but understandings of the term still vary. In the United States of America (USA) for example, advocacy is a legal or lobbying activity whereas in the UK advocacy usually occurs in a disability context. Some of the key points to emerge from a review of 'advocacy' policy in other parts of the world are as follows:

1. Advocacy policy has developed furthest in the disability area particularly among users of mental health services. The UK, for example, currently has four major government initiatives that will create a greater role for advocates: *The Valuing People* White Paper, the Patient Advocacy and Liaison Services (PALS), Mental Health Reforms, and Quality Projects[9] . The White Paper, *Reforming the Mental Health Act 2000*', recommended that independent specialist advocacy be made available to service users in England and Wales, while the subsequent review on good practice for independent specialist advocacy proposed that the professional advocacy model, using trained, paid advocates would be most appropriate (Barnes and Brandon 2002). In Austria and the Netherlands, patient advocacy services are provided to people in mental health institutions with some degree of success (Forster, 1998). In Sweden, persons with mental health difficulties or intellectual disabilities have access to advocacy services (Brandon, 1995).

2. Legislation for advocacy is at an early stage. Where it exists, it is almost always related to mental health problems and involuntary hospitalisation (Forester, 1998). Notable exceptions to this include Australia and Canada (Forum of People with Disabilities, 2001). In the case of Australia, advocacy is formally recognised in legislation and funding is provided by the Australian Government to assist advocacy services. Under the Australian system advocacy is named within various statutes, and resourced accordingly. 'A positive feature of the Australian model is the recognition of advocacy as systemic and not just a complaints and monitoring body. It recognises that advocacy needs resources, and that it is accountable to its members' (Forum of People with Disabilities 2001:76).

   In Canada, the Ontario Advocacy Act 1992 (repealed in 1996) laid the legal foundation for a formal advocacy service in which vulnerable people could be empowered and their rights protected. Although the legislation was repealed in 1996, because it was thought 'intrusive in the lives of vulnerable people, their families and care givers', the Forum of People with Disabilities believe that an adapted advocacy act, similar to the Canadian model, is 'attractive' and should be considered in Ireland. The Australian model is more comprehensive, building advocacy into a package of other disability measures but the Canadian model allows advocacy to stand alone and may thus be easier to implement (2001:83).

3. Independence is perceived as a core value of most models of advocacy (Advocacy 2000[10]; Scottish Executive 2001). This is seen as crucial for mental health

advocates and means that 'they must not work for, or be associated with any organisation, services or people involved with or affecting the service user's life' (Barnes and Brandon 2002:23). This independence ensures an advocate is free to express the service-user's views without compromise. Independence is also a core value for general advocacy services. One of the key principles of advocacy set out by Cambridgeshire County Council, for example, is that advocates 'should not have a conflict of interest. In order to speak up for someone effectively, it is important that there are no pressures on the advocate. This is why the advocate needs to be independent of the service provider'.(Cambridgeshire County Council 2002).

4. Lack of guaranteed funding constitutes one of the biggest threats to the development and continuation of independent advocacy[11]. Where advocacy is legally recognised, statutory funding is usually provided but this is mainly confined to the area of mental health. Other advocacy projects may have to depend on voluntary contributions with their energies diverted into fund-raising. Commentators believe that advocacy services deserve the provision of reliable and coordinated grants (Scottish Executive, *Advocacy 2001*; Barnes and Brandon 2001).

5. The ultimate aim of advocacy is the empowerment of service-users either through their own efforts or through representation. Some groups set strict boundaries to advocacy; they rule out befriending or social support, advice-giving, complaint services, legal representation (Barnes and Brandon 2002); other groups would see elements of user involvement and representation in self-advocacy and a quasi-legal side to other forms of advocacy. At this early stage in the development of advocacy, it would be unwise to be too prescriptive. However, the principle that advocacy should minimise dependency and facilitate self-advocacy wherever possible remains an important one.

2.4 Concluding Comment

The philosophy of inclusion, accountability and user involvement which underlies much recent social policy would support the introduction of advocacy services in Ireland for a wide range of disadvantaged groups. The general thrust of recent policy documents appears to be in this direction. However, these policies must be supported with practical programmes and the input of resources. The Department of Health and Children's initiatives in this area are a start but they cannot, on their own, meet present needs for advocacy. If Comhairle were to become a key player in advocacy, it would require substantial extra resources to meet the demands for the type of advocacy service sought by disability groups. As well as funding, consultation with the statutory and voluntary bodies active in the areas of health, disability and homelessness, would be essential in order to set priorities. If advocacy initiatives are to prosper, the practicalities of implementation must be clearly established from the outset. These will vary according to the different types of advocacy but cross-sector

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communication is important for learning. One purpose of the present report is to provoke discussion on how Comhairle can promote the development of advocacy services in realistic ways. The following chapter presents an overview of diverse advocacy models in order to inform the subsequent discussion.

Chapter Two – Notes

1 The traditional dependence on a notable or key intermediary was carried over from the days of colonial power when the 'gombeenman' held sway to more recent decades when politicians are 'obliged' by the demands of popular political culture to spend significant time interceding with national or local bureaucracies to get grants, medical cards or other benefits for their electorate. While research does not bear out the widespread basis of political brokerage in Ireland (Komito 1989), the 'illusion of assistance' whereby politicians gain access to information before a competitor ('pull a stroke') is often sufficient to perpetuate the 'illusion of power' (Higgins 1982).

2 See the Annual Report of the Inter-Departmental Policy Committee 2000/2001 *Social Inclusion Strategy* for an overview of developments in this area.

3 The 'success' of these policy documents tends to vary according to, the nature of the policy recommendations and the implications of implementing the policies in practice. *The Progress Report on the Implementation of the Recommendations of the Commission on the Status of People with Disabilities, Towards Equal Citizenship 1999*, for instance, found that 'substantial progress' had been made in implementing the recommendations of the Commission on the Status of People with Disabilities (1996). In the case of Travellers, the publication of *The Task Force on the Travelling Community, 1995* was broadly welcomed by Traveller organisations but little progress has been made in accommodating Travellers in practice (*The First Report of the Committee to Monitor and Co-ordinate the Implementation of the Recommendations of the Task Force on the Travelling Community* 2000:8).

4 Healy and Reynolds (1998), for instance, argue that the traditionally dominant mechanistic paradigm underpinning public policy-making in Ireland is inadequate. A paradigm with indicators that took account of economic, political, cultural and social areas would be more meaningful.

5 The principles underlying NAPS are: equal access and participation for all; guaranteeing the rights of minorities especially through anti-discrimination measures; the reduction of inequalities; the development of the partnership approach; active involvement of the community and voluntary sector; encouraging self-reliance; and engaging in appropriate consultative processes (1997:3).

6 In its discussion of how policy should be developed and delivered, the document states that: 'We concur with the NAPS analysis that national structural change is necessary. Of equal importance is the effective local delivery of programmes and services. Often this is what makes the key difference to the individual living in poverty.... Policy is about improving standards of living and the quality of people's lives. People should be consulted about the improvements they feel are essential. This is crucial to designing, delivering and evaluating effective social policy. Strengthening the structures of participative democracy, from social partnership at national level to well-functioning area committees in local government, is crucial' (1999: 14–15).

7 Although this Bill has been withdrawn, it is expected that provision for advocacy services will be included in a revised Bill. The nature of these provisions is however, unknown. The promotion of a Disability Advocacy Service was also included in the lapsed Disability Commission (No.2) Bill, 2001.

8 These National Standards for Disability Services are currently under review and some changes may be expected in the final version. In particular, subsequent versions of the Standards may include more specific references to the main types of advocacy that typically assist people with disabilities i.e., self-advocacy, patient advocacy, peer advocacy, and citizen advocacy. Equally, there is a need for acceptable minimum standards across the different services. Otherwise 'advocacy services' may in one instance refer to the token activities of staff while, in another, they may be more comprehensive.

9 *The Valuing People* White Paper promises funding to develop advocacy schemes for people with learning difficulties; mental health reforms are expected to give

detained patients a statutory right to an advocate; the Patient Advocacy and Liaison Services (PALS) will form part of the NHS reforms in England and Wales; and Quality Projects guidance requires advocacy services to be developed for children in need (Valios 2002).

10 Independent advocacy - where the advocate is not concerned with carers or services - is needed, according to Advocacy 2000 because whereas 'health or social care workers will often act as advocates for their clients or patients within the system, and family members will often act as advocates for those they care for, sometimes, support is needed from somebody who doesn't have to worry about other interests.... someone who can be on one side only' (Advocacy 2000).

11 Valios states in this regard: 'Unfortunately, advocacy can be a victim of its own success. As it becomes more mainstream amd projects accept more local and health authority funding, they risk losing their independence.... Conflicts of interests are unavoidable if advocates' salaries are being funded by the organisation their client is in conflict with'. (Valios 2002)

3 Models of Advocacy

People involved in advocacy sometimes give labels to particular styles of project. In practice each project is unique and does not necessarily fit under one label... they can adapt to local circumstances and the changing needs of people they support. Three common styles of advocacy project are sometimes called independent professional advocacy, citizen advocacy and group advocacy (also known as collective advocacy or self advocacy).

Advocacy 2000, Introduction to Advocacy P.5

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3.1 Introduction

A review of the theory and practice of advocacy quickly establishes the existence of a number of different models around the world. Some use different terms for very similar activities. Apart from definitional issues the boundaries between these different models are imprecise and often quite blurred, resulting in a lack of consistency. Interviews conducted in the course of this research and a perusal of selected websites confirmed the findings of the Regional Advocacy Fora organised by Comhairle during 2002 that the practice of advocacy operates along a continuum, ranging from the provision of information on rights and entitlements at one end to actively assisting people with issues at the other. Furthermore, while some organisations did not use the term 'advocacy', a range of advocacy-related terms described their work. (Browne 2003).

If we take a broad view of all types of advocacy the main divisions seem to fall between do-it-yourself type of advocacy where the person or group represents themselves or those in a similar situation to themselves, and outsider advocacy where an external person represents the individual or group. The first type of advocacy emphasises empowerment - although there is usually a facilitator in the background; the second type of advocacy tends to emphasise the expertise or life-skills of the external advocate. These two main strands of advocacy come in many forms - *Advocacy, a Rights Issue* for example, lists at least 17 different types of advocacy.

In practice, different forms of advocacy may operate 'to principles that are not only different, but may appear contradictory.' For example, citizen advocacy schemes champion the idea of the volunteer advocate, the ordinary citizen who is uncontaminated by service perspectives; casework advocate schemes will emphasise the importance of 'knowing the system', so as to champion the user whose rights are threatened by it. (Henderson and Pochin 2001: 13). Peer advocates may emphasise the importance of the user-experience in representing others. Self-advocacy schemes underline the importance of empowering the service-user while professional advocates may point to a client's increased chance of vindicating his/her rights if he/she has an expert advocate. An individual may use two or more forms of advocacy in tandem.

In this chapter we will draw on the categorisation of advocacy in Browne's report (2003) where the major models of advocacy are taken as the following with variations grouped under these headings.

Self-advocacy covering both general self advocacy and group advocacy for people with learning disabilities

Peer advocacy covering family and community advocacy

Personal / professional advocacy covering legal advocacy, patient advocacy

Citizen advocacy

Public policy advocacy

3.2 Self-Advocacy

Self-advocacy is a term used in two distinct contexts. It can simply mean a person who having got the relevant information, speaks up for him/herself, claims his/her entitlements, or represents him/herself at a hearing or tribunal. So it can refer to a process of *individual* empowerment and is essentially what advocacy agencies seek to encourage, with the advisor, advocate or information worker having a background role. The effective self-advocate will need to possess or develop assertiveness skills, have a good understanding of rights and entitlements and be able to process information. Encouraging self-advocacy involves the development of confidence and skills that will ultimately enable the person or group to take responsibility for his/her own life (Commission on the Status of People with Disabilities, 1996[1]).

Self-advocacy and people with learning disabilities

Self-advocacy has been developed in a particular way with people with learning disabilities. Originating in Sweden in the late 1960s where people with learning disabilities were supported to form and lead their own leisure clubs, this self-advocacy movement spread to the UK[2] and Canada, eventually leading to the formation of the People First self-advocacy group in the US. Today, there are **People First** groups in Australia, Canada, Germany, Japan, the United Kingdom, the United States and elsewhere (www.peoplefirst.org.uk). The value of these self-advocacy groups, according to Shoultz (1992) is they 'typically give people with learning and other developmental disabilities their first and most consistent opportunities to develop membership and leadership skills. Within the group, members can learn about their rights and responsibilities, develop confidence about their abilities, practise the skills of speaking in public and studying an issue, learn about voting and group decision-making, exercise problem-solving techniques and develop assertiveness skills... Even group members who do not communicate verbally can and do participate and learn ways of advocating for themselves and others'. (Shoultz,1992).

Self-advocacy groups usually need a facilitator and finding a person with suitable skills is crucial when groups are beginning. It is important that the professional working in this role 'is willing to give up the authoritarian, omniscient role for one that is supportive, enabling, and consultative in nature. At the same time, disabled adults must be willing to disregard the 'patient', 'child', or 'sick' role for a role that is more adult-like, that is, one that assumes responsibilities for actions, for making decisions, and for responding to other people's needs and opinions' (Siegal and Kantor 1982:453)[3].

In Ireland self-advocacy groups have grown up in learning disability organisations and among mental health service users. The group setting can 'assist members to acquire the necessary confidence, skills and experience' (Forster 1998:158). The key-identifying characteristic of a self-advocacy group is that 'members... determine (at least theoretically they do) the direction and purpose of their activities' (Simons 1992:5). According to the Forum of People with Disabilities the benefits of self-advocacy are that 'it allows people the space to name their own world and experiences in their own way; it can lead to employment/ educational/ economic/ social and cultural opportunities; and it can lead to a greater sense of self, increased confidence and can be a prerequisite for other models of advocacy' (2001:15).

Types of self-advocacy group

Further to the work of Cooper and Hersov (1986) and Williams and Walmesly (1980), Simons (1992) lists five broad categories of self-advocacy groups for individuals with learning difficulties:

- **Discussion groups in adult education**: these groups are relatively rare.
- **Groups based in services**: these are the most common. The typical group is based at a centre, has 8-12 members and meets once a month in centre premises. Staff or independent outsiders may carry out the role of advisor.
- **Independent groups**: These groups are not usually attached to any one service. Attendance is by choice and they usually have independent advisors.
- **Divisional groups**: These are a sub-section of an existing organisation (e.g., MENCAP) and are most common in the USA.
- **Coalition groups**: these involve an alliance between people with different disabilities.

Service-based groups are the most common form of self-advocacy group in Ireland. For instance, the **Brothers of Charity** organisation was to the forefront of the self-advocacy movement in Ireland setting up the first self-advocacy group for people with learning difficulties in 1993. Since this time approximately 20 self-advocacy groups have been formally established by the Brothers of Charity throughout Ireland. Each group comprises six members and they usually meet once a week to talk about anything that affects them; to organise socials and parties; to learn about their rights as people; to have a say in things; to learn how to get on with other people; to discuss the need for physiotherapy, speech therapy and better respite care; to discuss the

programmes in the centre; and interview applicants for jobs (Wolfe 1998). In 1997, a service users council was formed, comprising two members from each of the groups. It was formed 'so that self-advocates from the different centres could meet each other; discuss their needs; speak about advocacy and any issues which are important to service users in the Brothers of Charity Services; and meet the Service Directorate' (Wolfe 1998). This Council reports directly to the director of services contributing directly to a 'bottom-up' planning of their services. Service-based groups are often closely linked to user representation.

Saint Michael's House and Saint John of God's have also initiated self-advocacy groups for their service users as has **Enable Ireland**[4]. St Michael's House produced a report for users in 1998[5]. In 1996, as part of Enable Ireland's (then Cerebral Palsy Ireland) five year strategic plan, a group of service-users and staff within adult services set up a group called **People in Action (PIA)**. The group included three service users to represent the adults who use Enable Ireland Dublin's Sandymount services. Training was considered a core element of the group's role and overall effectiveness and funding for training was provided by the NSSB through a programme called Effective Advocacy. Most of the services mentioned have developed their own self-advocacy training.

Although groups based on services probably achieve a higher level of user participation, there is a question over their independence, as advisors and facilitators are usually employees of the service. This may involve conflicts of interest or lead to certain topics being avoided. Service-based groups are 'working to a format largely determined by staff, with the aims of the group closely linked to staff conceptions of the appropriate role for users.... Self-advocates are not encouraged to question more fundamentally the nature and purpose of the service itself' (Simons 1992:7). The Forum of People with Disabilities has criticised the 'service system model' of advocacy. Often 'members reflect the more able and articulate service users, and knowledge and experience are centralised on a particular few. When members or staff leave or groups end, the knowledge and experience base is depleted' (2001: 20). However 'service-based groups are often better placed to influence directly what happens in a particular service' (Simons 1992:7) and may be better at dealing with the day-to-day issues of participants. Furthermore, self-advocacy by service-based groups represents a pragmatic and effective 'first stage' in the provision of advocacy services. At a certain stage of development some self-advocacy groups seek an external facilitator (from outside their own service) to assist them in voicing and presenting their concerns. At present this is done on an individual basis but a few services have made the first moves to initiate a network.[6]

Independent groups are free from the potential conflict of interests possible in service-based contexts, but may find it more difficult to attract a full range of users and to deal with the problems originating in different services. They may have more difficulty being accepted by services in negotiations.

Self-advocacy among other groups

The spirit of self-advocacy is implicit in many user groups, even where terms such as participation and empowerment are used instead of advocacy. It is implicit in the peer advocacy groups common among users of mental health services and is also the case with homeless persons. Self-advocacy groups operate within some hostels[7], and the Speakout model of empowerment is increasingly used to enable homeless people 'communicate with and influence people and organisations who make decisions that affect their lives' (Groundswell 2001). Speakouts are about people making and influencing decisions. Homeless people are both participants and facilitators, thereby setting the agenda and seeking solutions to their needs[8]. The essence of a Speakout is that homeless people are facilitated in speaking out and that decision-makers are present to hear and respond to their views according to an agreed format[9].

Collective Advocacy

When self-advocacy involves a group of people campaigning on behalf of themselves or others to try and change things, it is sometimes referred to as group advocacy or collective advocacy (Advocacy 2000)[10]. Self-advocacy can also refer to 'the process by which groups of people get together and give voice to their common concerns.' (Simons, 1992:5) The empowerment of the individual or group is one of the core principles underlying self-advocacy which is increasingly seen as 'a social movement with the potential to influence policy and practice.' (McNally 2002) Some of the coalitions of disability groups in Ireland in recent years – for example the groups that came together to organise the *Get Your Act Together* conference in 2001 would fit this model.

Self-advocacy in the general sense, is regarded as the most effective form of advocacy an individual can attain and practise in their daily life and where feasible it 'is or should be, the ultimate goal of all other forms of advocacy' (Atkinson, 1999:6).

3.3 Peer Advocacy

Covers family advocacy and community advocacy.

Peer advocacy has a good deal in common with self-advocacy – both insist on the autonomy of the individual. In peer advocacy the principle is that the person advocating has something in common with the person he or she is speaking for. The key characteristic of peer advocacy is that it 'is user-led and user-run only.' The person advocating works with, supports or represents someone whose difficulties are similar to those the advocate has experienced him/herself in the past. Power dynamics are more equal in peer advocacy, because both parties have experienced and struggled through similar issues and experiences, have shared similar labels. This is its greatest asset and it can be a very safe and empowering model of advocacy. 'Peer Advocates are experts by experience' (Forum of People with Disabilities, 2001:17).

Within mainstream psychiatry, the dominant early model was peer advocacy, where advocacy workers were recruited (usually on a voluntary basis) from amongst service users themselves in order to utilise the empathy of shared experience. This approach also challenged many preconceptions amongst mental health service workers as they were forced to deal with patients or ex-patients who were filling a responsible and assertive role. The value of self-help, empowerment and peer-run alternatives to the biomedical brain disease model was powerfully expressed by Bassman (2001) who was first a patient diagnosed with schizophrenia and later a psychologist[11]. Peer educational programmes, such as the Peer Education and Advocacy through Recreation and Leadership (PEARL) which is an intervention based on principles of peer helping and psychological rehabilitation in the USA, indicate positive impacts on the quality of life, empowerment, employment and educational preparedness amongst advocates (Gammonley and Luken 2001)[12]. Such outcomes resemble those of self-advocacy.

The term 'peer' refers primarily to the person doing the advocacy rather than the way of advocating. Peer advocacy is most developed among people with mental health difficulties but is also used with groups of young people who have substance abuse problems[13]. An example of peer advocacy in Ireland is the Irish Advocacy Network.

The **Irish Advocacy Network** is a network of people who have experienced, or are currently experiencing, mental health difficulties. In the words of one of its directors: *'We are providers of information and support to fellow users and survivors within mental health services to empower them to speak up and speak out and take control of their lives again. We never advise. We are totally non-judgemental and we adhere by our strict code of practice and by our confidentiality policy'.* The network was set up following a service user conference in Derry in 1999. Since this time, groups have received training in a variety of locations throughout Ireland. The training is designed and accredited through the Northern Ireland Open College Network (NIOCN)[14]. At present, the Irish Advocacy Network has a number of fulltime regional advocates working in five different Health Boards along with two administrative staff. Although the Health Boards and the Department of Health and Children provide funding, the advocates are independent of these bodies. They do observe 'proper protocol' by negotiating and agreeing with the relevant services the areas they can attend, the frequency of their visits and so forth.

Although still very much in the early stages of its development, the Irish Advocacy Network has helped in the setting up of the **Kerry Advocacy Network** and the **Cork Advocacy Network**. The first provides an independent advocacy service for individuals, both in a hospital setting and in the community using trained peer advocates and funded by the Southern Health Board.

The strength of peer advocacy ultimately depends on the support provided by advocates who have been through a similar experience to the user and their willingness to engage with authorities where necessary. This in turn is dependent on adequate funding, training, support and opportunities being provided to peer advocacy

schemes. The relatively difficult personal circumstances experienced by peer advocates may enable them to be more effective advocates but they may need suitable back-up and advisors if they are not to risk burnout. It is not always possible to find enough suitable advocates. Finally, if peer advocacy is to be effective in a health context, it is necessary that the rights of advocates are set out and that health workers accept the importance of their work. Accordingly, training for health service workers is also necessary.

Family Advocacy

Family advocacy is an independent, community-based model that usually involves family members acting on behalf of a son or daughter or sibling e.g. Down Syndrome Ireland. At a collective level, such as through the National Association for the Mentally Handicapped of Ireland (NAMHI)[15] or through Parents and Siblings Alliance, family advocacy can be most effective (Forum of People with Disabilities, 2001). Problems with family advocacy may arise if the issues for families are significantly different from those of their family member.

In the USA, state-wide family advocacy networks have gained prominence over the past two decades in supporting family members of children with serious emotional disorders. There are many international examples of family advocacy. In New South Wales, Australia. one group runs workshops or meetings which bring families together to identify and create a new vision about the life of the person with a developmental disability or they teach advocacy-related skills and strategies around different issues including accommodation support, education, work.

Community Advocacy

Community advocates typically work within the community on specific issues. In North America community advocates work in diverse areas, such as health and city planning. Community development and redevelopment is also a distinguishing feature of community advocacy (Cooper 1980).

The Equality Authority, in association with the **Irish Traveller Movement**, is currently developing a model of community advocacy to assist the Traveller community in Ireland. Approximately 20 advocates have received training on the procedures involved in taking a case under Equal Status legislation. These advocates, most of whom are from existing Traveller support groups, help Travellers to access their rights. Clondalkin Citizen Information Centre is currently involved in a pilot advocacy project funded by Comhairle which has concentrated on Travellers accessing their rights. Some projects run by Health Boards such as the Community Mothers Scheme (which gives informal support on parenting through local people) can be seen as a form of community advocacy.

The advocacy scheme used by the Union for Improved Services, Communication and Education (UISCE), a project set up by the North Inner City Taskforce in 1998, could

be seen as peer or community advocacy. Drug users are 'listened to' at meetings based on particular themes, such as homelessness and conditions in prisons. The members of UISCE represent the views of drug users on the various committees of the Taskforce.

Local community participation is one of the principal benefits in promoting community advocacy, whether this involves residents trying to stop unwanted developments or a disability group seeking improved facilities. A problem with this form of advocacy is that local groups can become frustrated if it takes too long to change a rigid system. Conversely too much involvement by a statutory agency can lead to the demise of community advocacy. In a study of community redevelopment in Los Angeles, Cooper (1980) found that in spite of independent funding, the neighbourhood council had moved from militant advocacy, with broad community participation, to community development directed largely by professionals. This seemed to be because their expertise allowed them to move the planning process forward faster than community members could keep up with.

Community advocacy operates most effectively when it results in building up the skills and confidence of individuals and groups involved. Capacity building is increasingly a key feature of statutory and voluntary initiatives e.g., the Community Development Programme; the EU Community Initiative Employment – Youthstart. Guidelines of good practice in anti-poverty and social inclusion strategies also highlight the importance of training and capacity building (Bassett and Costello, 2000)[16].

3.4 Citizen Advocacy

Citizen advocacy refers to 'the persuasive and supportive activities of trained selected volunteers and co-ordinating staff, who could also be people with disabilities, working on behalf of people with disabilities who are not in a good position to exercise or defend their rights as citizens. Citizen advocates are unpaid and independent of service providers'. (Commission on the Status of People with Disabilities, 1996: 106) Working on a one-to-one basis, citizen advocates help the person express his or her concerns and aspirations, obtain day-to-day social, recreational, health and related services and provide other practical and emotional support. Citizen advocacy is based on the idea of a 'valued citizen' (i.e., someone who does not have a problem getting heard) working with a person who is discriminated against. The relationship may develop into friendship or may expand the service user's skills or confidence to manage his/her own situation (Cambridge County Council 2002). Typically, this type of advocacy is suited to people with significant disabilities, 'with lengthy experience of living in an institution, who have no-one else to speak up for them' (Forster 1998: 158). It is particularly needed by elderly or disabled people, who are dependent on services and who have no next-of-kin.

The other objective of citizen advocacy is to encourage ordinary citizens to become more involved with the welfare of disadvantaged people and thus foster a sense of

community. 'Citizen Advocacy brings an individual together with an advocate on a long term, personal, one-to-one basis. The advocate stands with their partner to defend their rights and ...their main loyalty is to their advocacy partner not to the project' (Advocacy 2000, 2000, P.6). Having a long-term, trusting relationship with an advocate who is an ordinary member of their community can help people reintegrate into their community. Citizen advocacy should involve selected volunteers recruited, supported and trained by a co-ordinator who matches them with an individual who needs an advocate (Advocacy Across London, 2002).

Citizen advocacy originated in the USA during the 1960s, when Wolfensberger put forward the concept in order to provide a continuity of protection and advocacy for children with cerebral palsy, should anything happen to their parents or guardians. In an article written in 1995, Wolfensberger reviewed a set of 22 assumptions[17] that point to, citizen advocacy as a valid moral strategy, including the following:

- The need for advocacy and assistance is widespread among people who suffer disadvantage.
- The type of advocacy and assistance needed varies widely.
- In some cases help has to come from people with the competencies or resources the person lacks.
- All people – including disabled people – have some important needs, which can only be addressed within a freely-given, voluntary relationship.
- Many needs of people with significant disabilities are better met on a long-term basis.

The model of citizen advocacy has since spread to many other countries around the world including the UK, Canada, Australia and Ireland. Henderson and Pochin (2001) list the key features of citizen advocacy as:

- Advocates are unpaid members of the local community.
- The relationship is long-term and one-to-one.
- Schemes actively seek out individuals who may benefit.
- Schemes 'match' advocate and partner.
- Advocate is accountable principally to his/her partner.
- Schemes are independent of service agencies.

Ealing and Harrow Citizen Advocacy describe this model as 'a partnership between a person with a learning disability... The citizen advocate ... is an ordinary person from the local community with enough free time to build up a partnership of trust and understanding with a person with a learning disability.' (Ealing & Harrow Citizen Advocacy) The advocate's role has two aspects, representative and social; although the representative role is seen as more important, the social aspect is also emphasised. A freely given personal relationship is important for a person with a learning disability whose other relationships may be unequal and mainly with paid staff or other service-users.

Citizen Advocacy in Ireland

One example of a citizen's advocacy project in Northern Ireland operates out of Bryson House in Belfast and involves people with learning disabilities. Volunteer advocates are 'ordinary people who freely commit themselves to an individual... All volunteers are vetted and introduced to the aims of the project through a programme of training. Each volunteer is offered intensive support and guidance through their various roles and are invited to take part in quarterly team meetings and social events'. (Bryson House)

Within Ireland, the Brothers of Charity operate the **Galway Citizen Advocacy Project** in its West of Ireland services. In 2002, the project had five trained advocates, with a number of other individuals undergoing training. In its literature, the Project describes citizen advocacy as 'a partnership between two people;' the partner who has a learning disability and is at risk of not being heard, and the citizen advocate who has the time and the desire to represent the partner's interests as if they were their own. The citizen advocate is trained and supported to develop a long-term relationship with a person who has a learning disability and visits his or her partner once every three to four weeks. He/she may be the only 'unpaid' person in that person's life.

The benefits of citizen advocacy for vulnerable people, particularly those with learning difficulties, are clear and unambiguous. The long-term nature of citizen advocacy partnerships offers the potential for developing self-confidence and opportunities with those who may have experienced exclusion over many years. However, citizen advocacy schemes present a number of organisational difficulties. One involves the recruitment of sufficient numbers of suitable long-term advocates. This is a problem shared by many schemes, including the Galway Citizen Advocacy Project mentioned above. An interruption in the relationship can also have a traumatic impact on the user's well being if it is not handled properly. Similarly, making a good 'match' between advocate and user can be problematic. Other issues with citizen advocacy include: the need for a co-ordinator with sufficient time and resources to manage the scheme, the conflict between the relative benefits of an untrained citizen advocate and a more expert casework advocate for an individual; the tendency for some advocates to adopt a befriending rather than an advocacy role and even to take over tasks that the service should do; the lack of acceptance of volunteers by health professionals; issues of confidentiality; and whether or not advocates should receive expenses.

3.5 Personal/Professional Advocacy

Covers crisis advocacy, complaints advocacy, legal advocacy, patient advocacy.

Professional or personal advocacy employs trained workers, usually on a fairly short-term basis, to deal with specific problems and to work with an individual until that problem is resolved. It is sometimes described as crisis advocacy with one of the main examples being some of the work of CICs. The areas covered by professional advocacy

may partly overlap with those usually the domain of the legal professions, though advocates are not normally trained lawyers. Professional casework advocacy, covering a wide range of client groups, represents one of the fastest growing areas of advocacy in the UK. The reasons for this rapid growth include: 'the general decline in the number of volunteers coupled with an increase in the range of voluntary work opportunities; the crisis nature of many people's problems; and the potential for a professional casework advocacy scheme to support larger numbers of people than its citizen advocacy counterpart... 'Statutory funding agencies may also believe that a professional casework scheme can be more accountable or even more 'professional' in its approach although there is little empirical evidence to support this claim' (Henderson and Pochin 2001:9). Much of the impetus for more consistent standards, accreditation and regulation comes from this sector. However, there is a danger that 'the drive for greater accountability will lead to the imposition of traditional service measures which will value quantity over quality' (ibid, 9). Although professional advocacy emphasises expertise, the relationship with the client is also important.

The **Advocacy 2000** project in Scotland summarises the characteristics of an independent professional advocate as follows:

- The advocate aims to support people to represent their own interests where possible and in preference to acting on their behalf.
- The advocate will not offer advice on how an individual should act.
- The advocate will support a number of people, at the same time or one after the other, with different issues.
- The advocate may work with someone for a short or long time.

Professional advocacy was deemed most appropriate by Glasgow's black and minority ethnic communities according to the results of a research project conducted amongst that population (Bowes et al, 2002). Essential qualities of advocates were seen to be language and specialist knowledge, while gender and ethnicity were important for some. Advocacy development should involve the community groups in discussions about service development, and include the promotion of wider and fuller understandings of independent advocacy, and of different models of advocacy among these groups, as well as more widely in black and minority communities. Clients were seen as needing choice in advocacy and advocates needed to display ethnic sensitivity.

Crisis Advocacy

In crisis advocacy, the advocate helps with a one-off difficult situation or crisis. The advocate may be voluntary or paid but is typically professionally qualified and capable of pursuing a case through the courts. Crisis advocacy is always short term and engaged with problem solving, usually on acute or serious matters. Examples include the work of Traveller organisations and homelessness groups advocating on eviction and accommodation issues, respectively.

The work of Citizen Information Centres (CICs) is perhaps most closely associated with this form of advocacy. In addition to providing clients assistance with phone calls, letters and correct form-filling, many CICs also refer clients to other agencies when they need an advocate (Weafer and Browne 2001). Furthermore, some key CICs also advise clients on how to take a case/appeal, negotiate with decision makers on behalf of clients, help clients to build a case for appeal, and represent or support clients at a hearing. (Comhairle 2002)

The findings of a recent report[19] by Comhairle on the level of advocacy services in 38 of its key CICs, suggest that all CICs are engaged in advocacy work at some level. Approximately, one third of these key CICs reported their staff had:

- Made phone calls on behalf of clients (38%).
- Written letters on behalf of clients (32%).
- Assisted clients with writing letters on their own behalf (38%).
- Referred clients to other agencies when they needed an advocate (36%).
- Advised clients on how to take a case/appeal (32%).
- Negotiated with decision makers on behalf of clients e.g. community welfare officers, deciding officers (31%).
- Worked with a client to build a case for appeal (22%).
- Represented a client at a hearing (e.g. social welfare appeal, employment appeal etc.) within the last twelve months (22%).

A subset of this type of advocacy is complaints advocacy where an advocate is available to help a person wishing to make a formal complaint to a statutory or voluntary body. The Report of the Commission on the Status of People with Disabilities (1996) felt that availability of advocacy was essential to a fair complaints system. A group which provides short-term crisis advocacy on a limited basis is the National Parents Council Primary which offers parents the services of a skilled and experienced advocate to help them prepare effectively for the hearing of a complaint by a Board of Management.[20]

Legal Advocacy

The idea of advocacy was originally borrowed from the legal area and in some situations formal representation by a lawyer is the final route a person must take to have his/her voice heard. Legal advocacy is the most widespread form of advocacy, especially in North America[21]. Many states have their own Advocacy offices which cover disability cases[22]. These entail professionals with legal training, such as barristers and lawyers, providing assistance to individuals through the legal system. They may provide 'representation before tribunals and agencies (including criminal and civil courts) and monitor compliance with existing laws and regulations i.e. the Constitution, the Equal Status Act, 2000 and the Employment Equality Act, 1998'(Forum of People with Disabilities 2001:27). Such advocacy can shade into legal representation, the main difference often being one of cost. Legal advocacy is 'best

seen as a separate but complementary form of advocacy.' (Henderson and Pochin 2001. P10).

Legal advocacy features quite prominently in the protection of children. A **Guardian Ad Litem** (GAL)[23] is an independent person appointed by the court to represent a child's personal and legal interests. Provision was first made for the appointment of guardians ad litem under section 26 of the Child Care Act, 1991. The role of the guardian is to inform the court of what the child wishes. After consultation with the child, the child's family, the Health Board, and others, he/she also advises the court on the best interest of the child. A second form of legal advocacy for children is through a Court Appointed Special Advocate (CASA)[24] – 'a lay volunteer who is selected, trained, supervised and appointed to advocate for the best interests of the child' (CASA).

The statutory provision for legal advocacy for people with a mental disorder, which requires the Mental Health Commission to provide an independent legal representative to each person who is detained involuntarily under the terms of the Act, is further indication of official awareness of the need for this type of advocacy to safeguard the health of those whose rights have to be curtailed by involuntary detention[25]. However, this is quite a limited provision as most people with mental health difficulties are not involuntary patients, and this type of advocacy relates only to representation at the proposed tribunals. There was considerable disappointment that this was the only form of advocacy covered by the new Irish Mental Health Act, 2001 as it was felt that a more intensive advocacy service, particularly within hospitals, was required.

Patient Advocacy

Patient advocates are generally paid and are independent of the institution in which they are based. The independence of the advocate is a key feature of promoting a patient's rights. The notion of patient advocacy has gained more prominence in recent years, with the introduction of patients' charters and associations. In the UK Patient Advice and Liaison Services (PALS) are to be central to the new system of patient and public involvement. PALS will provide information and on-the-spot help for patients, their families and carers, The National Health Service (NHS) Plan envisages establishing PALS in every trust by 2002, emphasising that the public should be 'on the inside' rather than represented by some body 'on the outside.'

In the view of the Forum of People with Disabilities, to be effective a patient advocate would require statutory guarantees of access to information about the policies, procedures, and programmes in hospitals and units. With the consent of the client, he/she would also need complete access to the medical and social records of the individual, and an opportunity to participate in discussions of the individual's case, especially when decisions affecting the individual's care and treatment are to be made.

Patient Advocacy in the Netherlands and in Austria

The patient advocacy programmes in Austria and the Netherlands relate quite closely to the legal advocacy described above as they concern people who have been involuntarily detained. In the opinion of Forster, the patient advocacy programmes in Austrian and Dutch mental hospitals represent 'the two best institutionalised projects of professional advocacy[26] in European mental health' (1998:159). Both programmes started around 1980 and have developed at a similar pace since then. However, 'they also exhibit some striking differences which reflect the relevance of the specific cultural, legal and health care backgrounds' (Forster 1998:159). The key elements of both programmes, as described by Forster (1998), are summarised below.

- In the Netherlands in 1993, the National Foundation of Patient Advocates employed about 40 full-time advocates who work in 50 institutions. Patient advocates have a range of training and experience with a quarter of them coming from the legal professions. The emphasis is on their independence. All in-patients are legally entitled to patient advocacy and they control what the advocate does. The task of the patient advocate is: to inform patients about their legal position, to find solutions for their complaints (concerning the hospital) and to safeguard their legal rights. Non-legal solutions are to be preferred.

- In Austria, two private organisations employ the patient advocates with their duties regulated by law and funded by the state. All involuntarily committed patients automatically receive a patient advocate who is obliged to follow the patient's wishes provided they are not obviously detrimental to that patient. The law 'affords the patient advocates a strong position *vis-à-vis* the hospital and courts and unrestricted access to the patient.' (Forster 1998:163). In the late 1990s, approximately 35 patient advocates worked in all 13 hospitals where involuntary detention occurs. Patient advocates come from the legal and psycho-social professions. Their task is to safeguard the rights of all involuntarily committed patients.

The similarities of the models include the use of independent state-funded organisations which select, support and employ the advocates; the fact that advocates work in hospitals, within easy reach of patients. The differences between them relate to background assumptions. 'The Dutch programme views the psychiatric hospital patient as relatively powerless and therefore provides an advocate who has a very clear task -to make the client's voice heard. What the Austrian programme emphasizes in the first instance is that those psychiatric patients who have been deprived of freedom should still be treated as citizens with rights. The Dutch approach grew out of a bottom-up strategy initiated and reviewed by a movement which included patients' organisations, while the Austrian project was imposed top-down by government agencies as part of the modernization of commitment legislation' (Forster 1998:166).

The Dutch and Austrian models show what can be achieved with a relatively small number of advocates when they are independent, properly resourced and supported by

statute. Without such statutory backing and independence their negotiating powers would be weakened.

The principal benefit of all forms of professional advocacy is that it 'combines a values-driven focus on relationships, empathy and solidarity with a high level of expertise in and knowledge of local service systems and how to effect change on behalf of individuals within those systems' (Henderson and Pochin 2001: 9). What it lacks in terms of the long-term, one-to-one relationships found in citizen advocacy schemes, it makes up for by ensuring that an individual's rights and entitlements are protected. In some situations, professional advocacy can complement the ongoing work of citizen advocates, where a particular issue lies outside their experience. It can also complement the work of self-advocacy groups; part of empowerment is knowing when you need the services of an expert and how to source such a person. The only difficulties may be those of resources and the possible encouragement of dependency and reliance on experts.

3.5 Public Policy Advocacy

Public policy advocacy lies outside the main two strands of advocacy but has the longest history. It is advocacy on the macro scale and it covers the activities of many voluntary organisations which campaign to better the position of their members. Such advocacy could be defined as 'the effort to influence public policy through various forms of persuasive communication. Public policy includes statements, policies, or prevailing practices imposed by those in authority to guide or control institutional, community, and sometimes individual behaviour' (John Hopkins Centre for Communication Programmes). The John Hopkins Centre for Communication Programmes identifies six aspects of public advocacy as:

- **Analysis**: The first step to effective action is the problem and targeting possible solutions.
- **Strategy**: This involves a focus on specific goals and the means to achieve them.
- **Mobilisation**: Maximum positive impact on the policy-makers and maximum participation is the objective.
- **Action**: Keeping motivation high, all partners involved and persistence are needed.
- **Continuity**: Planning for continuity means articulating long-term goals, keeping coalitions together, and updating arguments.
- **Evaluation**: Advocacy efforts must be evaluated carefully.

These stages are important in a long-term advocacy campaign though not all groups will complete all stages.

The role of partnership and the promotion of social inclusion in recent years suggest that this type of advocacy has acquired a formal place in Irish social policy on behalf of disadvantaged groups. It is increasingly standard practice, for example, for statutory bodies to elicit the views of representative groups and consult with

individuals before policy is formulated. Equally, the work of the Community Platform which represented 22 participant community and voluntary organisations in negotiations on the National Agreement, *Programme for Prosperity and Fairness* could be seen as public policy advocacy. Voluntary groups have also started to band together in their campaigns to bring issues to government. Through their work with individuals professional advocates and self-advocacy groups become aware of issues which need a planned solution from above rather than greater activity on the ground. This process occurs between the CICs and Comhairle – the social policy records document cases which have a social policy aspect.

3.6 Appropriate Forms of Advocacy?

One of the key research questions is which type of advocacy suits different categories of people in different social settings. The practice of advocacy may entail the use of a number of models, with self-advocacy the ultimate aim. The continuum of advocacy that operates in practice (Browne 2003) is likely to remain, with service providers and individuals selecting whichever type appears appropriate – or whichever is at hand.

In another sense however, the circumstances and social settings in which individuals are based point towards particular forms of advocacy. Thus, self-advocacy has developed among people with learning disabilities, sometimes as part of a personal development programme, citizen advocacy is particularly suited to people in long-term residential care, while patient advocacy may best suit more short-term hospital situations. However such categories should not be exclusive - self-advocacy programmes could also make a real difference to the lives of excluded groups within the community, such as homeless people and drug addicts. Legal advocacy and peer advocacy are particularly relevant to people with mental health difficulties. However, many people will need crisis or professional advocacy at some point in their lives, and the person who has mental health problems and has a peer advocate to help deal with their hospitalisation may also need a professional advocate if he or she has a housing problem. Public policy advocacy should be an important part both of the democratic process and of encouraging involvement in civil society among the relatively advantaged as well as among representatives of minority groups.

For those resourcing advocacy the important thing is that diverse forms of independent advocacy should develop and be available and known to those who need them[27]. It is also vital that the various models are evaluated in practice to establish if they do in fact help people make informed decisions or get their needs, rights, opinions and hopes taken seriously.

Whichever model of advocacy is chosen, it is important that it should adhere to accepted principles of 'best practice'. Cambridgeshire County Council as part of its commitment to supporting the development of advocacy identifies the five key principles of advocacy as:

- respect for the client's view.
- as much empowerment and as little dependency for the client as possible.
- facilitation of informed choices.
- the advocate to be independent.
- choice of advocacy for the client.

These will be considered further in Chapter Five. Whether the advocacy enables the client to speak for him/herself or whether it makes a professional case for him/her, the person represented must always be at the centre of the advocacy process.

Chapter Three – Notes

1 The Commission on the Status of People with Disabilities, 1996, believes that self-advocacy 'involves the development by people with disabilities of the skills necessary to express their views to the fullest extent' (1996:106).

2 Most of the published information on self-advocacy for people with learning disabilities in Britain is derived from the work of Crawley, who carried out two postal surveys of self-advocacy groups in 1980 and 1986/7 (Crawley 1982; 1988). Crawley focused exclusively on day centres and hospitals were added in the second survey. In 1980, 22% of the responding centres had some form of self-advocacy group. By 1986/7, this proportion had risen to 60%. Hospitals were much less likely to support self-advocacy – only 27% had an active group. However, the fact that almost half of the groups or committees were formed in the two years prior to the survey seemed to indicate a 'growing professional awareness of self-advocacy during the 1980s' (McNally 2002). Evidence since Crawley's (1988) study indicates that self-advocacy groups are increasing in number in the UK (Simons 1992; McNally 2002) and the US (Longhurst 1994).

3 With the People First model in mind, two social workers started a self-advocacy group in the Bronx, New York. Members were recruited from two agency programmes that encouraged clients' self-reliance and integration within the community: a social programme for adults who have been diagnosed as moderately or mildly retarded, and an independent living programme in which the participants learned home management skills geared toward preparing them to live on their own with minimal supervision. With assistance from the authors, the group members became more confident in themselves and learned to take responsibilities for the group's functioning (Siegal and Kantor, 1982).

4 It defines its partnership role in relation to advocacy as follows: 'Enable Ireland supports service users in this (advocacy) role and will continue to assist in highlighting and lobbying on matters which will more fully assist people to live full and active lives. Partnership and consultation is the cornerstone of how Enable Ireland operates its services. Enable Ireland will further develop a diverse range of advocacy programmes leading to the representation by service users for themselves. This partnership between service users and Enable Ireland will become a potent voice, promoting and making rights for people with disability a reality' (www.enable.ireland.ie).

5 The Advocacy Research Project Report 1998.

6 IAM the Interagency Advocacy Movement held a conference in Dublin in April 2003.

7 One of the services provided by the Merchants Quay Project for people affected by homelessness, is the Fáiltiú Resource Centre. Fáiltiú runs a regular discussion forum that is attended by service users and moderated by a staff member (www.mqi.ie).

8 Speakouts were pioneered by Scottish Speakout, a group of homeless and ex-homeless people who sought to provide a platform for homeless people's voices to be heard. It became apparent however that for real change to be achieved, there had to be someone listening who was able to effect change. In 1994, the first ever conference organised by homeless people for homeless people was held and participants were offered a range of means to record their views about issues such as hostel life, inequality in health care provision, community care and housing. Two large-scale plenary sessions were held, with detailed notes taken of all the contributions. A large graffiti wall was available for comments on any subject. A video box was used for those who wished to record a message on videotape. One result of this gathering was the establishment of a steering group to formulate a *Homeless Persons Charter for Scotland.*

9 The result of one such meeting is described on the Groundswell website as follows: 'The Councillors took away a list of questions, planning to come back to the group with replies and they agreed to establish a committee to look at service provision for weekends... the GP agreed to consult with people with dependency problems to work on how to improve

their situation... The council committed to looking into the possibility of a one-stop information shop, increased access to housing for people with pets and shared accommodation for those who want to share with friends' (www.Groundswell.org.uk).

10 The value of group self-advocacy is expressed in the following definition of self-advocacy by Williams and Shoultz, 1982 quoted by Shoultz (www.soeweb.syr.edu): 'Self-advocacy means that individually or in groups (preferably both), people with mental retardation speak on behalf of themselves or others or on behalf of issues that affect people with disabilities'.

11 Bassman's experience (2001) as a patient contrasts sharply with his later experience with groups: 'My belief in fairness was severely damaged during my first few months of confinement. Foolishly, I continued to demand my rights that I believed I had, only to discover that I would pay dearly for my ignorance at playing the hospital game.. Months later I shuffled into the office, physically demonstrating the hospital's successful transformation of anger, fear, and defiance into apathetic compliance. Defeated and dejected, I was too weak to resist the psychiatrist's argument to my parents at my discharge meeting. His job was to convince us that I was an incurable 'schizophrenic'. And later as a qualified psychologist: 'Today, having earned the 'credentials' and respect of my professional colleagues and my c/s/x (consumer/survivor/ex-patient) peers, I have the opportunity to speak out and advocate for those who have lost their voices'. (Bassman 2001)

12 The research findings are based on a study of 30 peer advocates who completed training, following an initial recruitment of 40 individuals.

13 The value of using peer-to-peer techniques for drug abuse prevention was highlighted at a meeting of youth groups from 14 European states that took place in Sweden in 2001. All the participants felt that peer-to-peer work is beneficial for the 'peer-educator' and the person he or she is trying to help (www.undcp.org). One example of peer-to-peer support is the UK registered charity CASCADE which is a drug information service for young people run by young people.

14 Information available at http://www.nocn.org.uk/

15 In its Strategic Plan 2000 Plus, NAMHI lists one of its aims as encouraging member organisations to be proactive in the area of self advocacy/advocacy. Under the general aim of consumer representation and advocacy, they encourage all member organisations to be proactive in promoting advocacy for and/or by the person with a mental handicap/intellectual disability and to promote a better understanding of the concepts of, and relationship between, citizen advocacy, advocacy by a family member, self-advocacy, advocacy by member organisations; and advocacy by NAMHI.

16 Bassett M. & Costello, L. (2000) *Guidelines for Effective Involvement* Combat Poverty Agency, Dublin.

17 The practical difficulties of upholding these assumptions and of ensuring that citizen advocacy relationships are long-term and voluntary was made by Laird when he stated that 'so many 'perversions' of citizen advocacy derive from actions of citizen advocacy staff that reveal that they do not hold one or several of the above assumptions. For instance, if one does not really believe that people will help each other without compensation, one is apt to offer advocates some kind of compensation, or even switch to some form of paid advocacy. Similarly, if one does not believe that advocates will stick with an advocacy engagement over time, then one is apt to recruit people only to solve current problems but not to make a commitment to a protégé, or one may fail to interpret to advocates the ongoing needs of their protégés' (1995:21).

18 Numerous examples of citizen advocacy are readily available on the Internet, e.g., Ottawa (www.citizenadvocacy.org), Sydney, Australia (www.citadv.asn.au).

19 The report, *Levels of Advocacy Services in Key CICs* was compiled as part of the work of the Joint Comhairle/CIC Working Group on Advocacy in September 2002. It defined advocacy as 'actively

supporting a cause or issue; speaking in favour of; recommending; supporting or defending; arguing on behalf of oneself or on behalf of another'.

20 National Parents Council Primary - leaflet on Parental Advocacy Support Service 2002.

21 In a global sense, advocacy is most often associated with formal legal representation rather than with empowerment of individuals to speak out for themselves. Some of the categories covered by advocacy groups in the US, for example, include: animal rights, automotive, civil rights, communications, consumer goods, education, elder care, employment, environment, financial, food, genetic engineering, government, human rights, insurance, internet/technology, legal, medical/health, personal injury, pharmaceuticals, securities, and travel (www.worldadvocacy.com). The Office of Advocacy in the US promotes models of excellence for small business administration (www.sba.gov) (Finley 1986:3).

22 For example, the Georgia Advocacy Office (GAO)... 'a private non-profit corporation. Its mission is to work with and for oppressed and vulnerable individuals in Georgia who are labeled as disabled or mentally ill to secure their protection and advocacy. GAO's work is mandated by Congress, and GAO has been designated by Georgia as the agency to implement Protection and Advocacy within the state.' http://www.thegao.org/

23 The Guardian *At Litem* service is currently being reviewed by the government through the National Children's Office.

24 Concerned over making decisions about abused and neglected children's lives without sufficient information, a Seattle judge conceived the idea of using trained community volunteers to speak for the best interests of these children in court. So successful was this Seattle programme that soon judges across the country began utilizing citizen advocates. In 1990, the US Congress encouraged the expansion of CASA with passage of the Victims of Child Abuse Act. Today more than 900 CASA programmes are in operation, with 62,000 women and men serving as CASA volunteers. CASA is an acronym for Court Appointed Special Advocate. http://nationalcasa.org/htm/about.htm

25 One recent instance of this statutory requirement appears in the Annual Report of the Midland Health Board, 2002 when it states: 'Since the Inspector's visit the Board has supported the establishment of a peer advocacy service. .... A number of staff will work with the advocacy worker to ensure the full integration of the service and provision of an independent voice for service users. The Irish Advocacy Network and voluntary agencies have contributed fully as members of a working group established in 2002 to develop a Mental Health Strategy for the region. (Re: Report of the Inspector of Mental Hospitals for the Year Ending 31st December 2001).

26 Professional or paid advocacy is 'where skilled workers recruited and supported by an independent agency represent the interests of individuals who belong to a certain category of people, usually for a short term. Professional advocacy often provides legal and welfare rights advice and representation' (Forster 1998: 158).

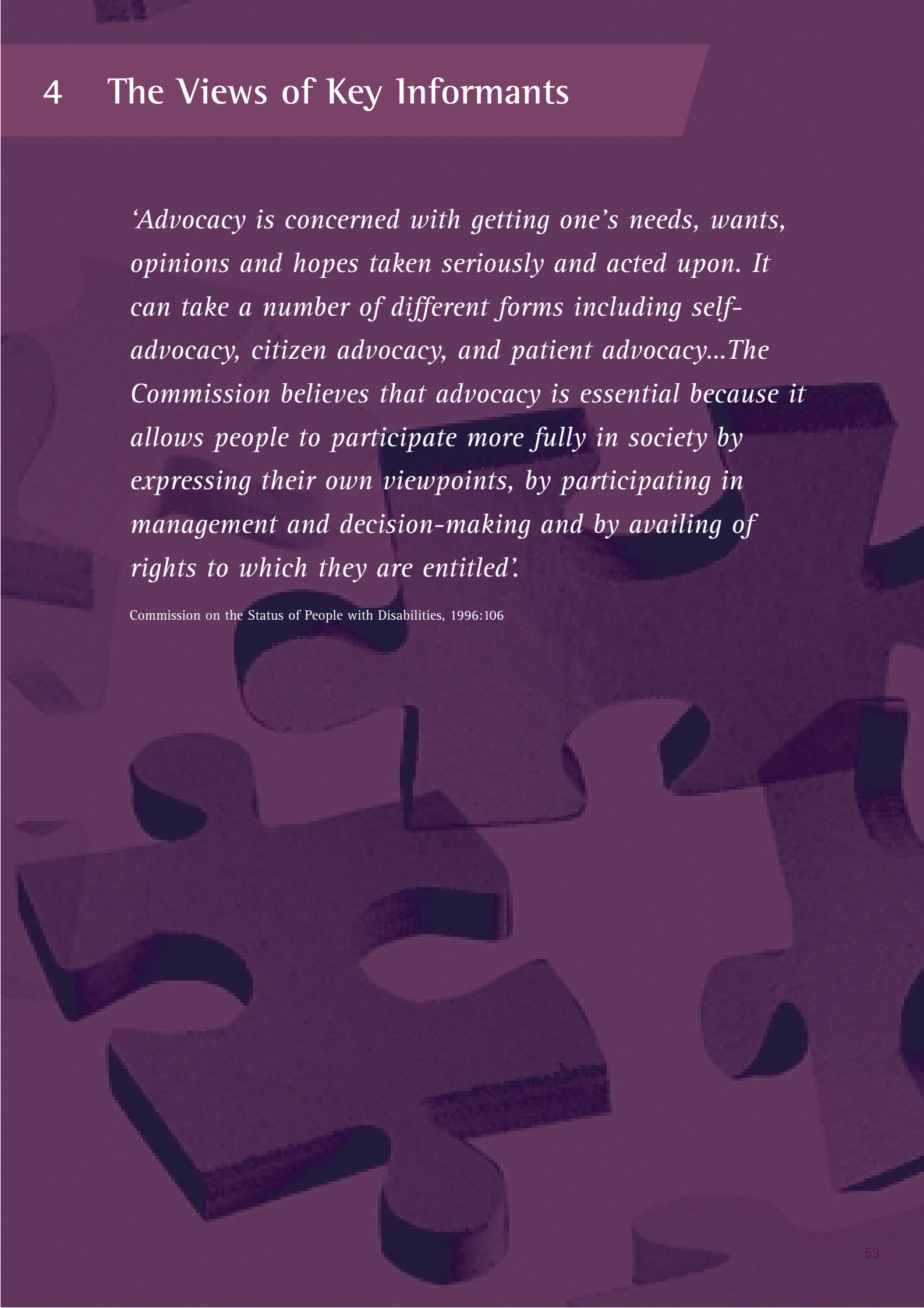
27 The Health Strategy, *Quality and Fairness*, makes this point in relation to mental health services as follows: 'The development within the voluntary sector of other forms of independent advocacy for mental health service users e.g. peer advocacy and self-advocacy, needs to be encouraged and supported' (2001:147). This principle needs to be promoted for other service users and individuals in need.

28 The relative absence of discussion amongst policy makers and academics, combined with a scarcity of objective evaluations of advocacy projects in practice is a feature of advocacy up to the present time.

4 The Views of Key Informants

'Advocacy is concerned with getting one's needs, wants, opinions and hopes taken seriously and acted upon. It can take a number of different forms including self-advocacy, citizen advocacy, and patient advocacy...The Commission believes that advocacy is essential because it allows people to participate more fully in society by expressing their own viewpoints, by participating in management and decision-making and by availing of rights to which they are entitled'.

Commission on the Status of People with Disabilities, 1996:106



4

4.1 Introduction

During the course of this project, 20 individuals from 15 organisations with an interest in, or experience of, advocacy, were consulted regarding various aspects of the research, including their views on appropriate advocacy models for Ireland generally and more specifically, the role for Comhairle in the provision of these services. Overall, these key informants were quite consistent in their views on the need for a well-resourced, independent advocacy service that would be capable of addressing the different needs of disadvantaged groups in Ireland. However, more divergent views were expressed in relation to the most effective way in which advocacy services should be delivered and particularly in relation to Comhairle's role in this process.

4.2 The Views of Key Informants on Advocacy

The main points made by the key informants on the future of advocacy services generally may be summarised as follows:

- **General Uncertainty Regarding Current Provision of Advocacy Services**: With the exception of some individuals who were familiar with specific aspects of advocacy provision in Ireland, most respondents' views of advocacy were marked by a high degree of uncertainty and a general lack of awareness concerning the current state of advocacy in Ireland. While everyone was aware of some individual developments in the promotion of advocacy in practice and in legislation, overall, most felt that nothing significant had happened since the publication of the report of the Commission on the Status of People with Disabilities, *A Strategy for Equality, 1996*. In the words of one respondent from a disability organisation: *'We are still immersed in a medical model, regardless of the rhetoric used about advocacy. ....it is more than seven years since the publication of the Commission's report, which followed three years of intensive consultation and we are still discussing what might happen. It doesn't inspire much confidence. Advocacy is the new buzzword. Most of what has happened has been developmental and superficial, with small amounts of money in some organisations being directed to advocacy'.*

- **Perceived Need for Statutory Commitment to Advocacy**: If advocacy is to flourish, it must be underpinned by appropriate legislation and resourced through a suitable state agency with the necessary resources and vision to implement an overall advocacy strategy. This agency should have the vision and commitment to lead the discussion on advocacy and not simply react to legislation or popular demands: '*The agency, which could be Comhairle I suppose, needs to know what they are trying to achieve with advocacy. Presumably, they are trying to increase participation and self-empowerment and so forth and it is possible to work through organisations or other agents. This is one way of doing it but what you don't have then is a proper kind of framework for its development. There needs to*

be some kind of strategy around advocacy and it has to be driven forward by a coherent, well thought out and well resourced strategy'.

- **Provision of Wide Range of Advocacy Services:** It is clear that advocacy can and does operate on a number of different levels, depending on the situation and the people concerned. Accordingly, a number of respondents felt that different forms of advocacy should be made available, including: self-advocacy, citizen advocacy, patient advocacy, crisis advocacy and professional advocacy. It is vital however, that any advocacy services be sufficiently resourced with trained and ideally, experienced personnel. Given the reality of limited resources within Comhairle or any similar body, some respondents felt that there is a real danger that resources could be spread too thinly and ultimately ineffectively in order to meet future legislative requirements: '*It is very important that we do not get caught up with having 500 trained advocates around the country by the end of 2003. First, we need to set up a structure and begin to employ people in a few regional centres. They can build up their expertise gradually and be a point of contact for individuals who cannot be helped by existing bodies'.*

- **Advocacy to Include All Disadvantaged Groups:** The importance of providing advocacy services for disabled persons notwithstanding, one respondent felt quite strongly that advocacy should be concerned with more than disability. Given the huge need in this area and the international focus of advocacy on people with learning difficulties, it is understandable that a similar situation would apply in Ireland. However, the notion of advocacy has importance for the broader community of disadvantaged: '*There is a strong disability and health focus at the moment but we have to remember that advocacy is more than disability. It is very important to include poverty in the discussion. There are benefits from doing this from the fact that there is a strong poverty lobby group in existence with a huge wealth of experience in empowering disadvantaged people'.*

- **Support For Existing Initiatives:** The specific notion of advocacy may be relatively new to Ireland but the general spirit of advocacy is not. Many organisations, such as the St. Vincent de Paul, have 'spoken up for the less well off in society' for many years without necessarily referring to their activities as 'advocacy'. Their members 'advocate' on a daily and weekly basis for families and individuals who are in financial difficulties or who experience difficulties in accessing services. Equally, members of other organisations 'advocate' on behalf of their specific target groups. A number of respondents felt that these organisations should be supported to continue their 'advocacy' work and to enhance this aspect of their work through the provision of training and funding.

- **Independent Advocacy Service:** Independence is perceived as a critical factor in the provision of advocacy services, particularly in relation to residential care settings where many of society's most vulnerable people are cared for. Ideally, everyone should have access to an independent advocate when required and a number of respondents felt that this access should be provided as a right and

underpinned by statute. Even in situations where the service provider has invested considerable time and resources to ensure that advocacy services are available to its users, an independent service is the preferred option. In the words of one respondent: *'Someone needs to work at local level and in many cases, such as the Brothers of Charity, it works very well. However, we need to have a formal structure for redress and complaints, which empowers the residents when conflicts of interest occur'.*

A number of respondents suggested 'cross-service' advocacy as a way that would help to overcome some of the practical problems associated with the provision of independent advocacy services: *'Some people say you can't be an advocate if you are providing a service. Certainly, you can't be an advocate to someone who is in receipt of that service and has an issue with it but you can advocate for other individuals using different services'.* To facilitate the proper working of an independent advocacy service, it is advisable that there be an independent inspectorate for all residential settings and core national standards on minimum acceptable levels of advocacy provision for all organisations providing services, including the right to speak out or have an advocate speak out on their behalf. A minimum requirement for all institutions is that everyone should know from the outset what they are entitled to from their service provider. These measures should have a statutory basis and ideally, be monitored by an independent body, such as Comhairle, the Equality Authority or a newly established advocacy agency operating through the Department of Social and Family Affairs.

4.3 A Role for Comhairle – the Views of Key Informants

Opinions on a role for Comhairle ranged from the majority of respondents who felt that Comhairle could play an important role in the development and provision of advocacy services, to those who had serious doubts about Comhairle's involvement at any level. Others, however, felt they had no real sense of what Comhairle could do in this area and accordingly, their suggestions in this regard were somewhat tentative.

The main points made by respondents who felt that Comhairle could have a positive role in the development of advocacy are summarised below:

- Comhairle should approach advocacy in a strategic way and lead from the front with a coherent plan of action and vision statement rather than reacting to existing projects or proposed initiatives. Comhairle must act proactively and aggressively to ensure that it makes a real difference to the provision and development of advocacy services: *'Resourcing existing organisations is one way to promote advocacy but doing this would not enable Comhairle to make the full impact it could have. There is a huge need to inform people of their rights and entitlements through, for example, public information campaigns. Also, if you simply support what organisations are already doing by another name, you are not adding value. You need Comhairle to lay down the parameters of what has to be*

achieved for funding etc. and to assess what is being achieved. It needs a radical shift from what is already taking place. Comhairle needs to lead proactively and aggressively. Campaigning is a very important part of advocacy'.

- Comhairle could set up a national structure with a base in the major regional areas throughout Ireland. Each of these regional centres would employ paid staff with expertise and experience in the area of advocacy who would act as a resource, particularly in the area of training, to existing voluntary organisations that currently 'advocate' on behalf of different groups: *'Given the finite level of resources, Comhairle needs to look strategically to meet the needs at national and regional levels. It needs to be mindful of the advocacy occurring at local level and to fully utilise the local structures such as the CICs, MABs, the local anti-poverty platforms etc.'*

- Comhairle should draft and implement national standards for organisations engaged in advocacy. This process should be supported by meaningful and widespread consultation with relevant organisations. Ideally, funding and other supports should only be provided to organisations that adhere to these standards or who are willing to implement them within a given timeframe.

- Comhairle should not be 'pushed' by legislation into rushing the provision of advocacy services. The number of advocates on the ground is less important than the quality of advocates, provided there is a real commitment to the development of advocacy services in the long term. Any learning that can be gained from its own experience and that of other organisations, such as the Office of Equality Investigations, would be invaluable to the successful provision of these services.

- The provision of accurate information is an essential part of advocacy for many groups: *'Ireland is such a bureaucratic country, people, especially non-nationals, don't know where to begin. Advocacy follows naturally from information and advice, such as writing a letter or helping someone when their phone is cut off'.*

- The main potential for Comhairle is to build capacity amongst volunteers and paid staff, to help them understand how to help people in different situations e.g. who are eligible for services, what can people gain from accessing services etc.

The main reservations expressed against Comhairle's involvement in the provision of advocacy services were twofold. Firstly, some respondents felt that Comhairle's focus on the provision of information and advice was likely to inhibit its progression into the more dynamic and challenging area of advocacy. Furthermore, it was felt that the necessary supports and significant shift in focus that would be required throughout Comhairle's structures to provide an advocacy service may not be forthcoming and that a new and more specialist agency would be more likely to succeed. In the words of one respondent *'It is surprising that Comhairle has been given this brief. They spent so many years providing information and advice and what we are talking about is more than information advocacy. They would have to go through a serious cultural and*

organisational change and I don't believe that they have the vision, commitment or capacity as currently set up to take on advocacy. To be fair to Comhairle, they have had quite a specific agenda in engaging with citizens and disseminating information.'

Another respondent expressed similar doubts about Comhairle's involvement in the promotion of advocacy services, as follows: *'It is difficult to think of Comhairle in this light. If you look at the history of Comhairle going back to the NSSB, I would say Comhairle have found themselves in a place they haven't wanted to be. Their understanding of advocacy would be very much within the NSSB model and they got sidetracked by the Commission on People with Disabilities report into delivering all sorts of responses that weren't within their strategic mission'.*

Secondly, some respondents were fearful that the independence of existing advocacy initiatives might be restricted in some way by a 'big brother' approach. This fear was most apparent in the area of mental health where *'a fear of control has been a major part of every person's life who has gone through mental health services. You are controlled by the system and by medication and your freedom can be taken away for long periods of time. We need Comhairle to be a friend and support to us but the service must be independent. It is nice to be under an umbrella organisation for funding and so forth but without the control'.*

4.4 Concluding Comment

The diverse views of key informants recorded *verbatim* in this chapter highlight a number of important points. First, Comhairle is most often associated with its network of CICs. Accordingly, the capacity of Comhairle to develop and support advocacy services would appear to be judged primarily by respondents' impressions, many of them anecdotal, of the capacity of CICs to undertake such a programme of work. While this view does raise valid questions about the role and capacity of CICs in the overall process, it does not appear to give full credit to the statutory, professional basis of Comhairle and the considerable resources it can bring to bear in developing and supporting advocacy services. It would appear that most respondents' perceptions of Comhairle have not changed since the enactment of the Comhairle Act, 2000. Furthermore, it does not take account of the enhanced expertise and experience in the disability sector that has undoubtedly resulted from the amalgamation of the NSSB and part of the NRB.

Secondly, it is likely that respondents understood advocacy in different ways. For those with a background in disability, advocacy is most often associated with self-advocacy, citizen advocacy, patient advocacy and peer advocacy. For others working outside disability, advocacy had a more general meaning and is more closely associated with empowerment than any specialist form of advocacy. Many, but not all, of the reservations expressed about Comhairle's role in the provision of advocacy services would appear to be grounded in the more specialist view of advocacy. Since Comhairle has traditionally been engaged in general advocacy on behalf of large

sections of the Irish population, it should continue to have a greater capacity in this regard. Conversely, the provision of more specialist forms of advocacy, such as patient or citizen advocacy services, will require significantly more investment and resources by Comhairle.

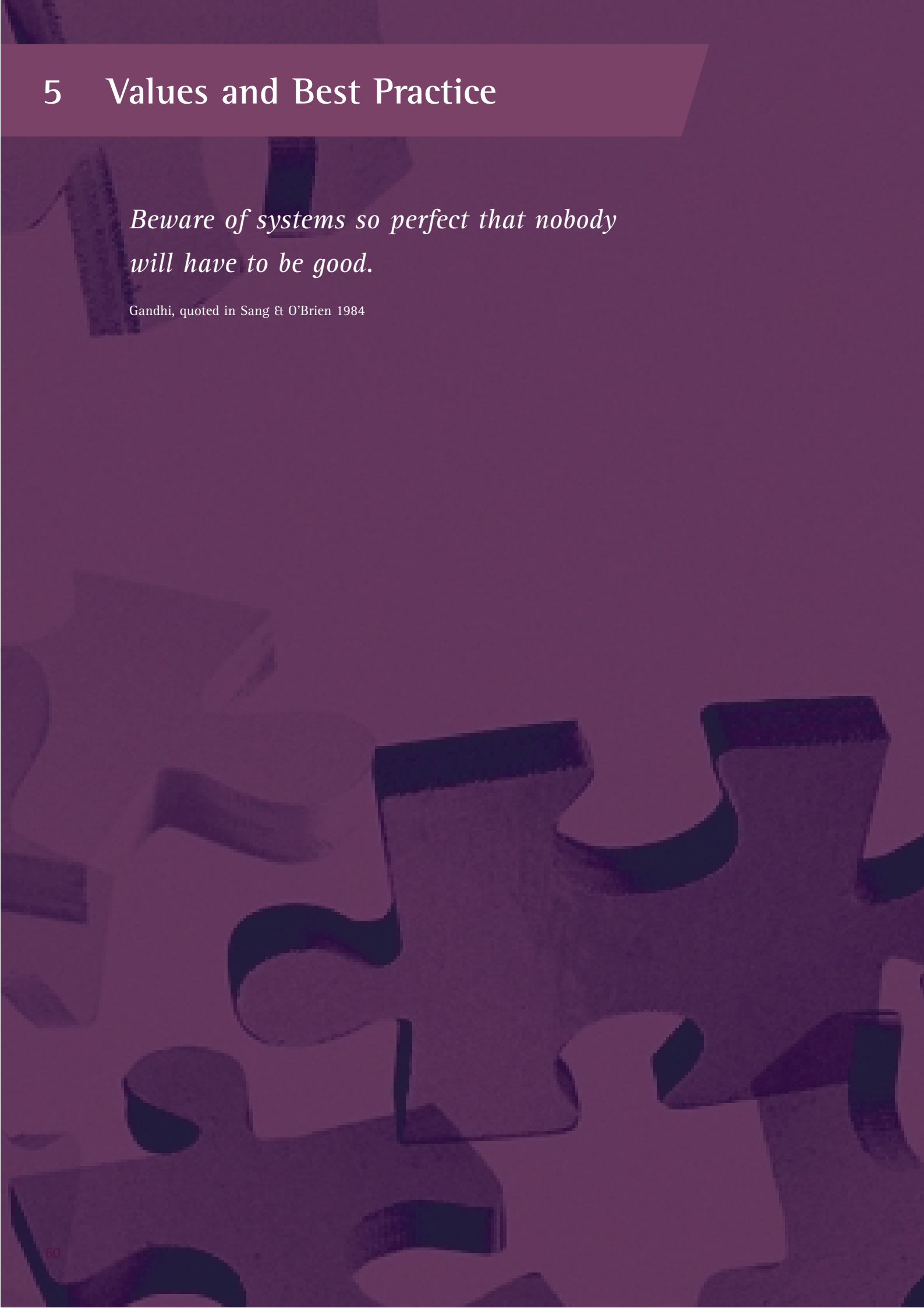
Thirdly, the importance of independence notwithstanding, the practicalities of providing funding for advocacy suggest that most funding will be provided by statutory sources, with the result that some form of accountability will be required. Accordingly, the ideal of independence will have to be tempered with the practicalities of funding and accountability.

The people interviewed in the preparation of this chapter included Jiff Stuart and Mike Timms of the NDA, John McDermott of the Refugee Information Service, Pat O'Leary of the Equality Authority, Deirdre Carroll of NAMHI, John Mark McCafferty of the Society of St. Vincent de Paul, Owen Keenan of Barnardos, Mervyn Tierney of the Irish Advocacy Network, Josephine Flaherty of the Brothers of Charity Citizen Advocacy, John Dolan and Martin Naughton of Disability Federation of Ireland(DFI), Mary Higgins of the Homeless Agency, Grainne O'Toole of the Irish Traveller Movement, Donal Toolan of the Forum of People with Disabilities, Tommy Larkin of UISCE, Julie Smith and Liz Sullivan of Combat Poverty Agency and Helen Lahert, Tony McQuinn, Máiríde Woods and Helen Brougham of Comhairle.

5 Values and Best Practice

Beware of systems so perfect that nobody will have to be good.

Gandhi, quoted in Sang & O'Brien 1984



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5.1 Key Values within advocacy

It can easily be taken for granted that advocacy is a good thing but it is important to consider the values implicit in the concept and the practice and to look at the guidelines that other advocacy organisations have developed. Advocacy depends greatly on the quality of staff chosen for the job - whether paid or volunteer - and it is important that good recruitment, training and supervision systems are in place and that those involved share an ethos of respect and empowerment.

Speaking on behalf of someone appears simple but contains a number of problems some philosophical, some practical. The philosophical ones relate to all helping professions. How can one person know what another 'really' needs? How can a partnership between an expert and a vulnerable person be truly equal? Is the advocate independent or is he/she filtering in the viewpoint of a service or a profession? Has the advocate's very skill led the person to discount his/ her own ability to represent him/herself or weakened the person's links to his/ her own informal support network? How does the advocate judge that the moment for compromise has arrived? Can the advocate be certain that intervention has led to an improved outcome for the person? Someone who speaks on behalf of another takes on a good deal of power and needs to be aware of the possibility of abusing such power. Someone who trains a vulnerable person in self-advocacy needs to be aware of the long-term consequences for that person. The implications of setting up a new type of helping profession should also be considered. The aim of advocacy is to cut through layers of bureaucracy but it could end up becoming another bureaucratic layer itself.

On a practical level questions will concern the delivery of advocacy, the most suitable type and the priority afforded to different individuals and groups. On an organisational level questions will concern the mechanisms needed to set up a service, to provide support and training to advocates, to monitor the effectiveness of a service and to protect both clients and advocates.

The advocacy movement has grown out of rights-based movements which have sought to empower marginalised groups and many of the values within advocacy are common to such groups:

- **Inclusion and Respect**: Advocates value everyone equally and believe in social inclusion.
- **Empowerment**: Advocates work with people in a way that, as much as possible, helps them develop their self-confidence, their own aspirations and opinions, and the skills to stand up for themselves in the long term.
- **Loyalty**: It is the advocate's role to be on the side of the person he/she is supporting – not to be impartial.
- **Quality**: Advocacy projects need to safeguard and monitor their own standards.
- **Independence**: Advocates should not be limited by conflicts of interest.

- **Advocacy Dilemmas**: Advocacy involves issues and problems that are not easily resolved and which may not have a 'right' answer.

Advocacy; A Rights Issue quotes principles from O'Sullivan. These reiterate some of those listed above but also emphasise accountability and the need to find non-adversarial solutions – thus edging advocacy into the negotiation arena. For him central principles of advocacy[2] are:

- Client centredness
- Independence of service providers
- Accessibility and accountability
- A co-operative rather than an adversarial basis where possible.

The last principle is interesting and emphasises the need for advocates to understand the systems of government and service provision as well as the position of clients. Negotiated solutions are usually best, but deciding where and when to compromise can be a difficult judgement call for both advocate and client.

5.2 Best Practice in Advocacy

Although advocacy is in its infancy, rules of 'best practice' are already developing.

- First, every person, particularly those who are disadvantaged by society or personal circumstances, should have the **right** to be listened to, the right to claim the services he/she is entitled to and the right to be involved in decisions affecting him/her. Ideally, these rights should be enshrined in legislation and supported by independent advocacy. However the right of an individual to health and social services should precede and be regarded as more important than the right to advocacy. There is no point in having a right to advocacy if the services are inadequate in the first instance. Transparency of entitlement and prompt delivery of services would allow more people to be their own advocates.

- Secondly, **equal access to advocacy** is important. The service should be available to all people who face a structural disadvantage in society. Statutory and voluntary groups planning services for disadvantaged groups – not just those in the disability area – should consider the need for independent advocacy. Where funding is limited, agreed criteria for focusing independent advocacy services on those most in need should be developed.

- Thirdly, the need for **guaranteed statutory funding** should be acknowledged. Advocacy is person-intensive and advocacy initiatives cannot be effective without resources. *Independent Advocacy in Scotland* believed that funding to independent advocacy organisations must respect their independence and should operate on a three-year cycle. Procedures should ensure that funding will not diminish or disappear altogether if 'differences of opinion' emerge between the statutory body

and the advocacy organisation. It is perfectly feasible to fund such schemes on the explicit understanding that the advocacy role can sometimes be adversarial even though mediated settlements are to be preferred.

- **Information** is an important prerequisite for advocacy. Without accurate and comprehensive information, self-advocacy is not feasible. Equally, an advocate must be well informed of available options. Advocacy efforts start with accurate information and in-depth understanding of the problem, the people involved, the policies, their level of implementation, the organisations, and the channels of access to decision-makers. The stronger the foundation of knowledge, the more persuasive the advocacy. The traditional role of the CICs is particularly relevant to this area as are new initiatives to make information more accessible to disadvantaged groups.

- Advocacy services should be **independent** of service providers. In an Irish context this means that advocacy should not be tied to the Health Boards, the voluntary service providers, or any other provider body. Many people who use advocacy services do so when their own efforts have failed and so are likely to be mistrustful of services. Adequate procedures need to be put in place to safeguard the independence of advocacy. One possibility is for an agency like Comhairle to act as a conduit for funding.

- **Education and training** are needed for advocates, both paid workers and volunteers. Most advocacy projects will emphasise good selection procedures and training both initial and ongoing[3]. So far training in the UK has usually been within projects (for example, Citizen Advocacy Information & Training {CAIT}) but a number of accredited courses are springing up, (for example, the University of Warwick is launching its first post-graduate programme this year). In Ireland too most training is given through individual projects. The training currently provided to CIC volunteers now incorporates specific training on advocacy in its information giver course. The Irish Advocacy Network has had its training accredited through the Open College in Northern Ireland. The possibility of a third-level accredited course is being explored with Sligo Institute of Technology (IT) and other partnerships with third level institutions may be developed. Possible areas of training are: advocacy, principles and values, role of the advocate, communication skills, disability law, equality training, social welfare and law, personal development. Different advocates may require different types of expertise.

- **Educational programmes** are also required for health service workers and policy makers. The latter need to understand the procedures to be adopted by advocates and self-advocates. Such programmes will promote an understanding of advocacy, a professional approach by advocates and should lead to the setting up of representative structures and complaints systems where these do not already exist. Statutory services need to provide good information for those seeking to advocate – for themselves or for others.

- Advocates need **ongoing supervision and support** to safeguard both themselves and the people they represent. On occasions advocacy can be stressful. Atkinson says that 'time should always be set aside on a regular basis with a project coordinator... for talking through the work in hand; to offload, to make sense of and to reflect on the advocacy partnerships.'[4] Such supervision is important in avoiding problems and retaining staff.

- People should have a **choice** about whether or not to have an advocate and about the type of advocacy they use in any given situation. However, without a significant increase in the level of resources, choice is unlikely to occur even where advocacy services exist. A person seeking assistance from a CIC, for instance, is unlikely to be able to select an advocate. Choice is particularly important in citizen advocacy schemes where the relationship is likely to be long-term. An effective network of interconnecting advocacy services would be needed to make choice possible. People who use – or are likely to need -independent advocacy should be involved in the process of planning that service.

- Advocacy projects need to have **good record management systems** which both guarantee confidentiality and allow continuity if an individual advocate leaves a service.

- A commitment to a review and evaluation of advocacy schemes is needed. Methods of measuring their effectiveness and accountability without compromising their independence are needed. At present advocacy is a fluid term which attracts a high level of interest and covers a range of activities. Added value will not be achieved if organisations simply re-label what they already do as advocacy in order to secure additional resources. The form of evaluation and monitoring used also needs careful consideration. Henderson and Pochin, for instance, believe that traditional measures of service provision are unlikely to be sufficiently sensitive to measure the impact of advocacy on the lives of disempowered people. Schemes do need to be assessed according to basic service standards but the empowering aspects of advocacy should also be considered, with a focus on outcomes as well as processes and a commitment to equality of opportunity (2001:35). A process of review should also allow new understandings of independent advocacy to emerge.

- Advocacy services need to have a **good complaints system** particularly because the lack of such a system is often a matter of reproach with other agencies. No matter how high standards are, no system can satisfy everyone all the time. Dissatisfied clients should have the possibility of recourse to an outside body where internal mechanisms fail to resolve issues. Mullins and Wood spell out the detail of this:

  'Every advocacy project should have its own complaints procedure which is clear, efficient and will act quickly, immediately someone complains about the advocacy service. The procedure should have several different layers; commencing with an

attempt to resolve the complaint informally, progressing to a more formal procedure and finally providing for independent adjudication...' [5]

- Advocacy projects need to remember the **macro-level** where policy is formulated rather than constantly evoking a 'band aid' approach. Individual advocacy cases should be fed upwards through lobbying and submissions to government so that structural change occurs at macro-level and fewer cases require advocacy.

5.3 Conclusion

Advocacy is a value driven area - its success will depend overwhelmingly on the quality of staff, their judgement, courage, expertise and negotiating skills. This is true whether they be volunteers or professional advocates. In order to maximise the chances of attracting good staff, it is important that advocacy projects are well organised and offer training and support. A significant aspect of this process will be an ongoing exchange of views between agencies, agreement on principles and development of codes of practice specific to different types of advocacy.

Chapter 5 Notes

1 Sang Bob & O'Brien John (1984) *Advocacy The UK and American experiences* King's Fund Publishing Office, London, p.33.

2 O'Sullivan Sean (1987), *You've Got a Friend*. Report on Advocacy cited in Hansard debates Ontario, Canada http://hansardindex.ontla.ca

3 Atkinson, D. (1999), *Advocacy A Review* Pavilion Publishing, Brighton, p.24.

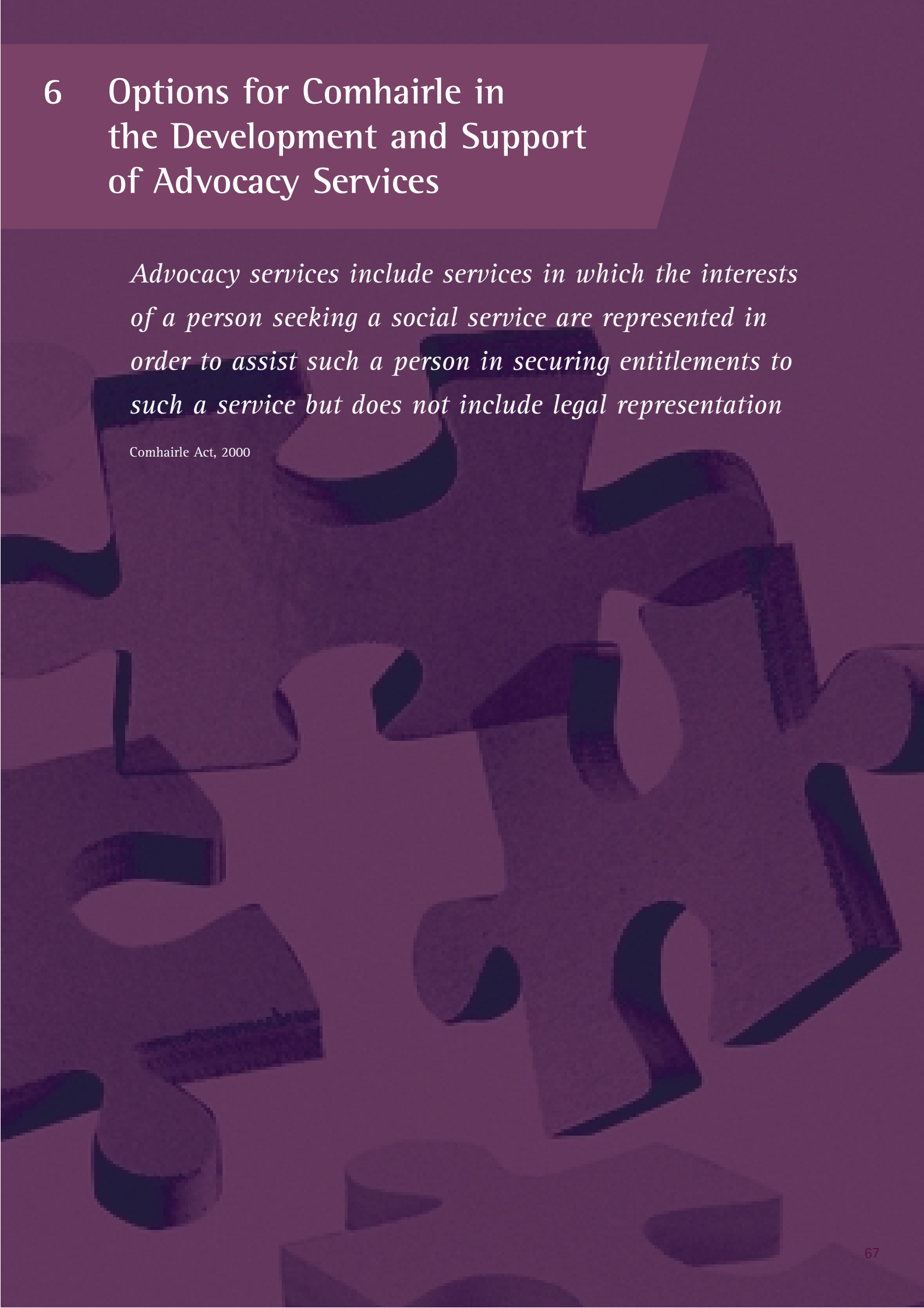
4 Atkinson, D. (1999), *Advocacy A Review* Pavilion Publishing, Brighton, P.24.

5 Mullins, G. & Wood, P. (2001), *A Clear Voice A Clear Vision: The Advocacy Reader* UKAN, Sheffield, p.70.

6 Options for Comhairle in the Development and Support of Advocacy Services

Advocacy services include services in which the interests of a person seeking a social service are represented in order to assist such a person in securing entitlements to such a service but does not include legal representation

Comhairle Act, 2000



6

6.1 Introduction

The principal aim of this final chapter is to identify appropriate options for the development and support of advocacy services by Comhairle in the context of its current statutory functions. However, it is important to recognise that any changes in national policies and legislation will influence and possibly alter Comhairle's role in this area. A crucial factor will be the availability and extent of Government funding for advocacy services.

6.2 The Present Role of Comhairle

Comhairle has a statutory brief under the Comhairle Act, 2000, part of which relates to advocacy. One of the reasons for Comhairle's formation was the decision by the Government to introduce the mainstreaming concept in services for people with disabilities[1]. Mainstreaming was designed to ensure that services for disabled people were provided by agencies that deliver services to the whole community. One of Comhairle's key functions is to support and assist individuals, in particular those with disabilities, in identifying and understanding their needs and options and in accessing their entitlement to social services. Comhairle's first Strategic Plan 2001–2003 states that, 'where necessary the information service will be supported by an advocacy service[2].'

The Disability Bill, 2001 proposed giving Comhairle responsibility for advocacy in relation to people with disabilities. This was defined as 'representing, supporting or training them (people with disabilities) for the purpose of helping them to promote their best interests in relation to matters affecting their welfare and quality of life, for that purpose, supporting or training their families, carers or other persons, or members of organisations or groups representing their interests, and representing, helping or supporting "qualifying people" to obtain access to a service provided by a statutory body or voluntary body, but does not include representation in legal proceedings.' As the Disability Bill, 2001 was withdrawn, this type of advocacy is not currently part of Comhairle's remit. However in anticipation of a new Disability Bill (expected in 2003), Comhairle has commissioned a major piece of research which will map the practical implications of providing a range of advocacy services for people with disabilities and will estimate their cost.

Under its present remit, Comhairle is committed to supporting different approaches to advocacy and to working with other organisations to develop appropriate models of advocacy[3], but its main focus has been on information-provision[4]. As mentioned in earlier chapters, Comhairle currently supports the provision of advocacy services (See 3.5) on a limited basis through its network of CICs. Activities include extra assistance with information and complaints and support with appeals. Comhairle resourced two pilot advocacy projects attached to two CICs and supports advocacy projects from the community and voluntary sector through its regional grants schemes - one example is

the Interagency Advocacy Movement (IAM), a network of self-advocacy groups for people with intellectual disabilities in the South Dublin/ North Wicklow region. In 2002, Comhairle engaged in wide consultation with voluntary groups at eleven regional fora[5] and set up a Comhairle-CIC Joint Working Group to examine advocacy within the CICs[6]. The latter group presented a report to the Comhairle Board in 2003. Comhairle's present focus is on enhancing the type of advocacy that can be provided within the CICs, commissioning research on advocacy and supporting voluntary and community groups with advocacy projects. On a macro-level, Comhairle's social policy remit is 'to influence policy developments by highlighting the concerns of service users as to the effectiveness of social and civil services.'[7] This type of public advocacy involves using case studies of the experiences of service-users as the basis of reports and submissions to Government in order to inform public policy.

6.3 Practical Issues in the Provision of Advocacy: Mainstreaming, Staffing, Training and Monitoring

If an advocacy service was to be set up, immediate issues would be the parameters of such a service, whether it would attempt to cover all types of advocacy or whether it would confine itself to one type - say, professional or crisis advocacy. Having one overall service would be in line with the ideal of mainstreaming services for people with disabilities and other minority groups; yet some types of advocacy are so specific that they may not fit easily under a mainstream programme. Attempting to streamline all advocacy under one programme might also result in another layer of bureaucracy.

A major problem in developing advocacy would be managing demand for services and prioritising those considered to have the greatest need. If all types of advocacy were provided through the CICs, it might be difficult to restrict the service to certain groups, given Comhairle's commitment to equal access. There might well be pressure for greater provision of professional advocacy given the outcomes of successful appeals in the social welfare and employment areas. The issue of choice within advocacy also requires debate. People need to be free to turn down an appointed advocate or to seek a different form of advocacy from that regularly offered to those in their situation, otherwise advocacy could be yet another domain where catchment area decides the service offered. Providing such choice could present organisational dilemmas.

Staffing and training are other issues needing detailed consideration. Disability groups sometimes call for experienced and trained advocates but at present very few of these exist in Ireland. The recruitment of suitable people is key to a successful advocacy service. Michael Kendrick describes advocacy as 'a human undertaking' and emphasises that 'quality flows quite naturally from people who embody it.' He sees quality as 'an outpouring of capacities that exist initially within people and which can respond to cultivation.'[8]

In order to attract good people to the role of advocate, thought must be given to how the job is organised. There are various possibilities. For instance, the advocacy function might be one part of a job-description; in other cases the person might work as a dedicated advocate; in still others, advocacy would be a volunteer activity. Within the CICs there has been some discussion as to whether one dedicated advocacy worker or the upskilling of experienced staff to be advocates part of the time is the most suitable way of providing professional advocacy. The role of co-ordinators is very important both in organising and monitoring citizen and professional advocacy, as the Scottish Advocacy projects demonstrate.[9]

The planning of advocacy training is at an early stage[10] and needs to be co-ordinated across different sectors allowing for both common areas and specialities. Current CIC training should be enhanced to incorporate greater input on advocacy both in terms of direct provision and knowledge of where to refer clients for more specialist assistance. This training should be linked with national standards and accreditation through an appropriate institute or institutes. Comhairle is in the process of developing such a proposal.[11] As well as enhancing existing skills, good training is to some extent a selection tool. It can also establish a better career structure for advocates as well as raising the profile of advocacy in general.

6.4 Options for the Development of Advocacy Services by Comhairle

The development of advocacy by Comhairle or any agency will not be easy. In addition to addressing organisational issues relating to the models of advocacy envisaged, the agency will face the challenge of high public expectations. There is the danger of attempting to accomplish too much too quickly with insufficient resources which could lead to disillusion among potential clients. There is also the danger that the demand for specific services sparked off by advocacy will not be met.

The following possibilities are put forward as aids to the discussion process. They divide into two main strands: various forms of partnership, with Comhairle in differing roles and direct involvement for Comhairle in providing advocacy services. The principle of partnership underlying contemporary social policy in Ireland and Comhairle's established role *vis-à-vis* other organisations would suggest a partnership route as an appropriate way to develop advocacy; three variations on how this could be done are put forward. Given Comhairle's regional structure, providing an advocacy service directly would not be impossible though it would be a new departure for Comhairle; this option is also considered.

These models refer to Comhairle's existing advocacy remit and, as set out here, do not cover the specific provision of a personal advocacy service as envisaged in the Disability Bill, 2001. All of them would require extra funding.

Partnership One – Strategic Lead Role for Comhairle

To set up a comprehensive set of advocacy services in Ireland requires the commitment and vision of a lead agency, with statutory support and funding. The primary role of this agency would be to define the type of advocacy services to be provided and to produce a blueprint for organising this provision. Such a lead agency would formulate a strategic plan within a framework of partnership and consultation both with statutory bodies and voluntary and community groups with an interest in advocacy, but it would retain ultimate responsibility for advancing the plan, setting a time-limit on the discussion process and identifying the practical implications of the vision. As advocacy is a newcomer on the social service scene, this agency would also have a review and evaluation function.

Comhairle, with its background of research in the advocacy area,[12] its recent initiatives concerning the development of advocacy training, its record of resourcing voluntary and community groups and its regional structure, is well placed to coordinate a forum of interested parties and draw up such a plan. Such a forum could tease out how the diverse forms of advocacy could best be delivered, which groups should be prioritised and how a monitoring and supervision system could operate. Comhairle would have to set out clearly the boundaries between the different forms of advocacy and determine criteria for how provision could be organised. This would have to be carried out in a transparent way that would be acceptable to the bodies involved. The embryonic advocacy projects, which some voluntary and community organisations have developed to fill perceived gaps could be supported, while new services could be set up in areas of unmet need.

Under this scenario Comhairle might be allotted advocacy funding from the Department of Social and Family Affairs, and would then take the initiative in tendering for the services it considered most necessary – that is, it might advertise for organisations to undertake to provide a particular type of advocacy to an agreed standard in a particular region for a set period. Organisations (or networks or partnerships between established organisations) could then submit plans for providing particular advocacy services, Comhairle would select the most suitable tender and would play a monitoring and review role for the duration of the tender.

Given adequate funding, Comhairle would be well placed to play this lead role. Its position under the aegis of the Department of Social and Family Affairs; the network of Citizen Information Centres around the country; the relationship with the Money Advice and Budgeting Service (MABS), and with the independent information sector together with the high regard which stems from its support of voluntary organisations are all positive factors that could assist it in such a task. However an expansion into advocacy would entail an evolution in Comhairle's background supportive role with most of these organisations (it already has a closer relationship with the CICs and the National Call Centre). A 'lead role' would involve the setting of standards, the development and implementation of

monitoring procedures, the disbursement of funds and the setting up of complaints procedures.

Such a scenario would make practical sense in that it would use the expertise and experience within community and voluntary organisations to develop advocacy and to facilitate self-advocacy. Resourcing different voluntary groups for this purpose would allow for the provision of different types of advocacy, would facilitate a certain amount of experimentation, give scope to local initiatives and encourage a bottom-up approach. Particularly in citizen advocacy, the involvement of the community is of great importance. By providing training, funding and other resources to voluntary organisations according to agreed principles of best practice Comhairle could facilitate the development of advocacy services in an effective and cost-effective manner that is in keeping with an overall partnership strategy. It would also be in a good position to monitor and review this new service. The disadvantages would be the individual and possibly time-consuming nature of developing such partnerships, possible management difficulties, the issue of independence were the larger service-providing voluntary groups to become advocacy providers. There would also be the question of Comhairle's responsibility if there were gaps in provision – for example, if no suitable tender were received for a particular type of advocacy service.

Partnership Two – Comhairle as Coordinator

Another partnership possibility would be for Comhairle to act as the coordinating body for advocacy groups; to do this it could divide the service into specific sectors: for example, disability, homelessness, Travellers, and attempt to obtain agreement on how advocacy would be provided. In this scenario Comhairle would act as facilitator rather than leader and whatever forms of advocacy emerged would depend on the decisions of the groups concerned. Such a scenario would require resources and a considerable lead-in period; it might involve supporting groups to develop training, to work out specific standards, to exchange ideas, resources and personnel and to establish contacts with local CICs. Inter-agency groups are already at an embryonic stage in the learning disability area. According to Michael Kendrick such networking is valuable:

Through these networks comes practical help in locating talent, information, good examples, best practices, problem solving, funding, allies, concepts and so forth. On top of this would be all manner of emotional and moral supports of a collegial kind.[13]

Such a co-ordinating role might also include the setting up of representative groups to develop and monitor standards of advocacy[14]. With Comhairle acting as facilitator rather than leader, the advocacy services which emerge should reflect the wishes of, and be acceptable to the voluntary and representative groups concerned. They would thus be in harmony with community development

principles. Comhairle could have responsibility for keeping a register of the different advocacy services available.

However consensus on how advocacy should be provided might not be easily or quickly established; the management of such a model would involve difficulty; conflicts could arise for Comhairle if it were to receive a mandate to develop specific forms of advocacy itself, or if it was designated as the conduit for funding. Such an approach would also favour established voluntary organisations rather than newer user-groups and might inhibit the development of advocacy in new sectors where voluntary bodies are weak. Although advocacy services in this model would be independent of the State they might be influenced by voluntary service-providers. The longer lead-in time and the more fragmented nature of provision might lead to higher costs.

Partnership Three – Delivering Advocacy through the CICs

Although the CICs are independent entities with their own Boards of Management, Comhairle, as their resourcing agency, would be better placed to negotiate with them about advocacy services, than it would be with other voluntary groups. Within the partnership model, providing advocacy through the CICs would give Comhairle the greatest degree of influence. Given extra resources, Comhairle could extend the range of services and personnel available within the network of CICs to include advocacy as an extension of the information function. Insofar as some CICs already engage in advocacy, this option is more easily achievable in practical terms.[15] These CICs, staffed by a mixture of volunteers and paid staff, could provide a solid and proven working base for an expansion into the area of professional advocacy. However it must be emphasised that extra staffing would be necessary whether advocacy was devolved on one dedicated advocate or whether the advocacy function was shared between a number of experienced information workers. The Comhairle/CIC Joint Working Group on Advocacy recommended the upskilling of experienced information workers so that each could undertake some advocacy work as the best means of providing advocacy in the CICs.[16] This would involve a considerable training programme. A case management approach to queries would also be essential and more substantial changes might be required if the CICs were to provide the more specialised advocacy services associated with disability. However organised, advocacy work takes longer than the average query dealt with in CICs and often involves return visits.[17] Staffing options could include the direct employment of advocates by key CICs or the employment of a peripatetic advocacy resource worker who would service a number of CICs. Special arrangements would be needed for advocacy in smaller CICs.

Such a model would give Comhairle considerable control over the service provided, would build on existing structures and would allow an enhanced role for both paid workers and volunteers. It would also allow Comhairle to set priorities,

to advise on how these could be achieved, to develop a panel of specialist expert advisors and to broaden access through outreach.

However, as CICs are independent entities each with their own board of management, it is possible that some might not choose to expand into advocacy, and separate arrangements would be necessary in such areas. Careful liaison with voluntary groups who already provide some types of advocacy would be needed. Another issue to consider would be how best to target advocacy at groups considered priorities. At present some of these groups make infrequent use of CICs, so targeted advertising and outreach would have to be an integral part of such a model.

Providing Advocacy Directly

Direct provision of services to the public has not so far been part of Comhairle's remit, but it would be possible to provide a direct advocacy service if sufficient staffing and funding were granted and the type(s) of advocacy to be provided were closely defined. Comhairle has five regional centres and different types of advocacy could be provided through these centres under a number of co-ordinators who would recruit advocates on a full or part time basis for different schemes. Where agreement was reached with CICs – or other public offices such as Integrated Service Centres – professional advocates could be based in these premises or could attend on a sessional basis depending on demand. It might be necessary to assign a specific number of hours per centre to particular minority groups in order to ensure equity. Consultation with voluntary groups (and, depending on the type of advocacy, with health services) would be necessary along with advisory committees to ensure the needs of different groups were met. This type of provision is probably most suited to professional advocacy but other types of advocacy – citizen advocacy, peer advocacy – could be provided under separate co-ordinators who would consult with relevant voluntary groups and establish training and support programmes. Such a service could best be developed on a phased basis.

This model would give Comhairle greatest control of the development of advocacy but success would depend on a clear remit and considerable resources from the State. As Comhairle would be setting up this service from scratch, the organisational and resource implications would probably be high. This model would also present challenges, as it would involve a move away from Comhairle's supportive role to one of service delivery. There might also be some tension between the provision of information and of advocacy services. Possible difficulties could also arise with voluntary agencies, which, because they already provide advocacy, could feel threatened by Comhairle's arrival in a field they might consider theirs. If Comhairle were itself a provider on the ground, it would also have more difficulty acting as honest broker in the development of codes of practice and reviews of advocacy services.

6.5 Conclusion

In conclusion, different options are possible for Comhairle in the development of advocacy services. These range from taking the lead role, co-ordinating advocacy in partnership with different voluntary organisations, co-ordinating advocacy services through the network of CICs or providing advocacy services directly. Whichever path is chosen, substantial funding will be required, as advocacy is staff-intensive. It is possible that choosing a different option for different forms and levels of advocacy could be the best strategy. For example, given extra funding, Comhairle might be able to provide crisis or professional advocacy without major structural change by augmenting existing services within the CICs. However, providing other forms of advocacy would require both substantial resources and a new expertise which could only be developed over time. A partnership mode might be more appropriate and more likely to succeed in the disability advocacy sector where user-involvement at the planning stage would be crucial. Encouraging self-advocacy through standardising training, developing standards for facilitators and resourcing networks for groups of advocates are also important aspects of this work.

Comhairle's primary role may well be an enabling one: to ensure that a strategic plan for advocacy is formulated and agreed with other interested parties, and that such a plan leads to a quantifiable increase in advocacy services. As the purpose of advocacy is to allow people to access their entitlements, a necessary precondition is not only good information but also greater and more transparent availability of health and social services. Advocacy needs to be seen as a mainstream option available to all citizens at different life stages rather than something solely for people with disabilities. The establishment of agreed standards and ways of monitoring and evaluating new advocacy services, together with accredited training for practitioners are areas where Comhairle could begin its involvement. Providing a forum for voluntary agencies and organisations to tease out what is meant by advocacy and what type of advocacy should take priority could be another important role – this would be particularly necessary in the disability sector. A third key area is changing the mind-set of providers – both statutory and voluntary – so that they accept it as natural that a person should claim entitlements or make complaints either through their own efforts or with the help of an advocate. Advocacy encompasses putting information at the disposal of those who are intimidated by bureaucracy, lengthy forms or procedures. The envisioning and organising of an advocacy service may well add a separate strand to Comhairle's role, but it is likely to remain closely interwoven with its overriding aim to make information more available and accessible so that all citizens can claim their entitlements.

Notes - Chapter Six

1 The policy of mainstreaming was developed in response to the recommendations in the report of the Commission on the Status of People with Disabilities, *A Strategy for Equality*, 1996 and the report of the Establishment Group for the National Disability Authority and the Disability Support Service, *Building a Future Together, 1998*.

2 *Comhairle: Strategic Plan 2001-2003* p.15.

3 Comhairle funded two pilot advocacy projects, one in Dublin and one in Sligo. Comhairle also supports advocacy through its central services in Dublin where an advocacy executive is employed and through regional funding to organisations working in this area.

4 *The Strategic Plan 2001-2003* states that 'the first priority .. (is) providing an improved quality of service to Comhairle's clients in order to meet the information needs of the public'. (p.15)

5 Browne, Michael (2002), *Developing Advocacy Services: A Report on the Deliberations of Regional Consultation Fora*, Comhairle: Dublin.

6 This Joint Working Group on Advocacy, comprising CIC and Comhairle members, met on five occasions and presented a report to the Board of Comhairle in the summer of 2003.

7 *Comhairle Act 2000*.

8 Kendrick, Michael (2001), 'Personal Leadership and its Contribution to Service to Others,' Proceedings, *Sharing the Road Conference 2001*, Brisbane Australia.

9 Advocacy 2000 website.

10 Comhairle and the Sligo IT are planning a modular accredited advocacy course. IAN provides its own training and the Centre for Disability Studies UCD has plans for training.

11 In 2003 Comhairle, Sligo IT and a range of organisations in the Sligo area are discussing the development of a flexible, modular, accredited advocacy course.

12 Browne, M. (2002) *Developing Advocacy Services: A Report on the Deliberations of Regional Consultative Fora*, also Joint Working Group Report on Advocacy (2003).

13 Kendrick, Michael J. (2001), 'Some Observations On the American Advocacy Scene' in Gray, Barry and Jackson, Robin (eds.) *Advocacy for People with Learning Disabilities*, Jessica Kingsley Publishers, London.

14 See for comparison: National Disability Authority (2003), *Draft National Standards for Disability Services*, NDA, Dublin http://www.nda.ie/CntMgmt.nsf/

15 A key measure of the general public's access to information services is the level of queries to information centres. In 2000, the total number of queries to CICs was 313,300, which represents a 31% increase on the 1999 figure.

16 Joint Comhairle/CIC Working Group Report on Advocacy (2003).

17 In a recent review of 4,744 queries from 10 CICs, the average time spent on a query was less than 10 minutes for over half (54%) and between 11 and 20 minutes for most of the remainder (Weafer and Browne 2001).

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