

Advocacy in Practice: The Troubled Position of Advocates in Adult Services

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Summary

This paper is a review, and critical appraisal, of the theory and practice of advocacy. Advocacy is not social work, but its principles and values resonate closely to those espoused by the British Association of Social Workers (BASW, 2002). In this paper, we interrogate the assumption that advocacy is necessarily always a positive and enabling experience. Indeed, we suggest that the use of advocacy can be contested from the point of the view of the service user (the advocacy partner¹), the advocate and from professionals working with advocates (or positioning themselves as advocates).

Drawing on recent research that evaluated advocacy services in Nottinghamshire, we discuss some of the key tensions. In particular, we consider the reality of the advocate's role, including where it relates to and differs from social work, and the issue of whether advocacy can be part of what a social worker does anyway. We also review, briefly, the dilemmas arising from professionals acting as advocates, especially in relation to being independent of services.

Keywords: Advocacy, dilemmas, professional identity, supporting advocates

¹ 'Partner' is the term used throughout this paper to refer to the person on the receiving end of advocacy—the advocacy user.

Introduction

This paper is based on findings from a research project in Nottinghamshire, UK, which reviewed the effectiveness of advocacy (Atkinson and Forbat, 2003). The research was commissioned by social services and entailed reviewing advocacy in the context of its relationship with social-work managers, practitioners and clients. The focus here is on the difficulties that advocacy poses, with a particular emphasis on drawing out the implications for people who identify themselves as advocates. This is in contrast with much of the literature, which tends to make mostly positive claims about the value of advocacy.

We begin the paper by exploring those claims, in particular looking at some of the dominant definitions of advocacy alongside ideas on who uses advocacy services and how advocacy works. We then move on to outline the policy context, where advocacy can be seen to move up the political agenda. Ideas on assessing advocacy are then introduced; this provides a platform for our own evaluation of services. Finally, we present our findings pertaining to the role and status of advocates and discuss them in light of current practice.

Literature review

Defining advocacy

At its simplest, advocacy means ‘speaking up’ for oneself or others (Atkinson, 1999). However, it is rarely that simple. The literature abounds in attempts to define this elusive process. For example, Wertheimer (1998) suggests that advocacy means ‘pleading the cause, acting or speaking on behalf of another person’ (p. 9). In a more expansive definition, Dunning (1995) claims: ‘Advocacy is about stating a case, influencing decisions, ending assumptions, getting better services, being treated equally, being included, protecting from abuse, redressing the balance of power, becoming more aware of and exercising rights’ (p. 11). The lack of consensus as to its meaning, and lack of a unified identity, reflect differences in the advocacy movement as to which approach works best.

The most prolific—and passionate—writing tends to come from those who support citizen advocacy (CA). This support is based on a set of—largely uncontested—claims about advocacy. It is said, for example, to offer ‘emotional support through friendship, spokespersonship, opportunities to learn new skills and help in obtaining needed services’ (Sang and O’Brien, 1984, p. 9). CA is also said to have high ideals, aiming to empower those who are powerless; to support people who are devalued or discriminated against; and to include those who are excluded—or at risk of exclusion—from everyday life (Lee-Foster and Moorhead, 1996). In an extension of these views, Henderson and Pochin (2001) suggest that ‘advocacy is unique’ in that it centres on a ‘unique type of relationship’ (p. 82).

CA is based on a one-to-one, often long-term, relationship between an ‘ordinary person’ or citizen (unpaid) advocate and his or her advocacy partner.

In earlier manifestations, the relationship was depicted in a more contested way as being between a 'valued' citizen and a 'devalued' partner. CA is values-driven: it begins, according to Henderson and Pochin (2001), with a vision—a set of social ideals. The ideals include equity, social justice and inclusion. (Similar points are made by Dunning (1995), Brandon (1995) and Wertheimer (1998).) The drive behind this sort of advocacy is active citizenship: to include people in society who are marginalized or isolated (Monaghan, 2001). It does this through advocacy partnerships, where, it is argued, the otherwise disadvantaged person becomes a valued and respected member of the community.

Although the CA model is widespread and influential, other types of advocacy exist alongside it; there is little evidence to suggest that other models of advocacy are any less successful in delivering good outcomes to partners. This may be because, in essence, advocacy remains this simple notion of *speaking up*. This may mean speaking up for oneself (self-advocacy), though more often in conjunction with others, such as in group or collective advocacy (Brandon, 1995; Atkinson, 1999). It may mean speaking up with the help of others, such as the citizen advocate, as suggested above, in a long-term relationship. However, it may also mean an advocate who offers short-term or *issues-based* advocacy, e.g. crisis or complaints advocacy (Simons, 1995; Henderson and Pochin, 2001). It may also mean speaking up through another 'insider', or peer advocate, who has had similar experiences (Brandon, 1995; Kestenbaum, 1996; Greene, 1998). Departing from the CA model most fundamentally, advocacy may also take the form of casework from a paid advocate (Atkinson, 1999).

Although much of the literature focuses on CA, in practice, organizations offer a range of advocacy, as our Nottinghamshire study confirmed. Paid issues-based advocacy proved to be a popular alternative to the longer-term CA model. This may reflect the fact that, in practice, the availability of advocacy is 'piecemeal and patchy' (Atkinson, 1999, p. 1). As a consequence of this, it is targeted at people who are seen as 'vulnerable': disabled people, people with learning difficulties, mental-health service-users/survivors and older people. Within these groupings are, of course, people who are doubly disadvantaged, and subject to multiple levels of discrimination, including, for example, people from black and minority ethnic groups who are also disabled or have high support needs (Baxter *et al.*, 1990). Also included are those people with multiple needs (e.g. older people with mental-health difficulties).

Effectiveness of advocacy

Advocacy seems to be effective where people, for whatever reasons, lack the support of a network of friends and contacts to call upon at times of need. This includes people with learning difficulties leaving long-stay institutions or older people living alone or in residential care. Certain groups are at greater risk of exclusion and ill-treatment, not only from society, but also sometimes from the services set up to work with them (Booth and Booth, 1994; Sainsbury Centre, 2002).

Advocacy is said to be most effective when it is targeted at ‘the least visible, least vocal, most vulnerable people in our community’ (Henderson and Pochin, 2001, p. 30). Its effectiveness is usually judged by the accounts that people give about the value of their advocacy partnerships (see, e.g. *Standing By Me*, a collection of narratives compiled by Paul Williams, 1998). This captures the process of advocacy, but sheds relatively little light on the outcomes for people on the receiving end. As well as the experience of being valued, listened to and represented, the actual changes that take place in the person’s life as a result are also important (Wertheimer, 1998).

In the advocacy relationship, the partner’s views are said to predominate. This means that it is the partner’s wishes and views that are represented, not what someone else thinks is in their best interests. One of the dilemmas of advocacy is that partners may be seen to be acting against their own best interests. This distinguishes it from social work, where the social worker, acting in a client-centred way, would normally expect to take action in the best interests of the person concerned—but not so the advocate, or, at least, that is not their intended starting point:

Advocates do not work in the best interests of service users but work to their direction. Advocates listen, help service users explore options and support them to obtain information so that their decisions can be better informed (Barnes and Brandon, 2002, p. 40).

Or, as Leader and Crosby (1998) suggest, ‘partners are leaders, advocates are the followers’ (p. 128).

In CA, advocates are unpaid members of the local community—‘ordinary people’ who make a commitment to what is often a long-term, one-to-one relationship with their partner. Typically, the advocacy scheme selects advocates, matches them with partners and offers continuing support (Dunning, 1995; Brandon, 1995; Wertheimer, 1998). Other forms of advocacy use shorter-term relationships to deal with single issues, crises or specific life transitions, and, in many advocacy schemes, advocates are paid workers rather than volunteers. Nevertheless, whatever the setting, the relationship between the two key stakeholders is seen as paramount.

Advocacy works, according to its proponents, where it is independent of services. This applies to the scheme itself which, it is argued, must be *independent* of funders, commissioners and service providers so that it is free from any possible conflict of interest and can therefore represent and fight the cause of individuals (Dunning, 1995; Wertheimer, 1998; Brooke, 2002). Being independent—and being *seen* to be independent—is more difficult to achieve where advocacy schemes are part of larger voluntary organizations, such as Mencap, Age Concern and the Home Farm Trust, where other services are provided. This is because advocates may have to challenge poor practice in the voluntary sector, and it could mean confronting their own employers in certain instances.

Similarly, the literature suggests that it is not enough for advocacy schemes to be independent; advocates themselves need to be independent. Thus, it is claimed

that an advocate can only be effective when ‘free to act independently on their partner’s behalf’ (Brooke, 2002, p. 14). Only an advocate who is independent of services and independent of their partner’s family is in a position to be loyal, committed and accountable to their partner (Wertheimer, 1998; Brooke, 2002). Again, there must be no conflict of interest—if advocacy is to work, then the advocate needs to be free to act with and on behalf of their partner without fear or favour.

What makes a good advocate? The qualities identified in the literature include tenacity, patience, empathy and optimism. Useful skills include active listening, report writing, negotiation skills and a working knowledge of legislation (Brandon, 1995; Bateman, 2000). Above all, ‘the challenge is to engender in advocates a sense of *intellectual independence*, that is, a sense in which loyalty to the client/partner, a commitment to justice and empowerment, are paramount’ (Henderson and Pochin, 2001, p. 25).

Good advocates need support. The work itself can be stressful, but, added to that, advocates work in a relatively isolated position, often in a hostile environment (Barnes and Brandon, 2002). Good support comes from training, regular supervision and appraisal, team meetings, and from other advocates in pairs or groups. Peer support within schemes is important, but so too are opportunities to meet other advocates at local, regional or national events (Barnes and Brandon, 2002). We return to these issues of independence and support, in reporting on the findings from the Nottinghamshire research, and suggest that services have a long way to go in understanding how to implement these ideas.

Advocacy as policy

Advocacy used to be ‘on the fringe of things’ (Atkinson, 1999, p. 41). Now, it seems to have moved to centre stage and has become a force for change. Although advocacy has enjoyed a huge growth in the last 20 years, it has not been a steady or consistent growth. Short-term and insecure funding has seen many schemes come and go. Proponents of advocacy suggest that it has a key part to play in two areas of public life (two areas which happen to reflect current government concerns)—in promoting active citizenship and supporting social inclusion.

In this context, it is not surprising that advocacy has become a central plank in several recent policy documents. These cover the range of user groups where there is a track record of advocacy provision: people with learning difficulties, mental-health users/survivors, older people and carers. *Valuing People* (Department of Health, 2001a), for example, clearly articulates the importance of advocacy in relation to people with learning difficulties. In the mental-health field, the National Service Framework for Mental Health (Department of Health, 1999a) sets out a need for advocacy to be in place in services. The White Paper, *Reforming the Mental Health Act* (Department of Health, 2000), highlights advocacy as an important future safeguard for people subject to compulsory powers.

Advocacy has also gained recognition in policy documents relating to older people, e.g. in The National Service Framework for Older People (Department

of Health, 2001*b*). Similarly, there is recognition that carers may need advocacy too and the *National Strategy for Carers* (Department of Health, 1999*b*) points to a role for advocates in enabling carers to access benefits and services.

Evaluating advocacy

Advocacy has evolved over the last thirty years, developing and growing by and large as a grassroots movement (Dunning, 1995; Wertheimer, 1998; Atkinson, 1999). As a result, advocacy is a very diverse activity, with a lack of coherence between schemes and a lack of consistency within projects over time. Some efforts have been made over the years to standardize advocacy. Thus, there are, for example, a set of widely agreed principles devised for CA by CAIT (Citizen Advocacy Information and Training); there are Codes of Practice (CAIT, 1998; UKAN, 1994); and there are guidelines for *Good Practice in Citizen Advocacy* (Brooke, 2002). In spite of these moves, there are no agreed benchmarks for performance. This has led some health/social-care commissioners to impose their own monitoring regimes on local advocacy schemes (Henderson and Pochin, 2001).

Not surprisingly, perhaps, there is no validated, universally agreed means of conducting an independent evaluation of advocacy. However, the literature indicates three approaches to evaluation that have been—and, to some extent, still are—used in practice. One approach is the Citizen Advocacy Program Evaluation (CAPE), developed by O'Brien and Wolfensberger (1979). This relates to CA schemes and, although still used, is seen as more relevant in the North American context where it was devised. The CAIT evaluation pack is also for evaluating CA schemes. It works by comparing how a scheme operates in practice against its own aims and objectives, and against widely agreed CA principles. It is an intensive, team-based evaluation, focusing on principles rather than on outcomes for users. Finally, ANNETTE was an approach to evaluation developed by the Advocacy Network in Newcastle in response to purchasers' needing to find out whether advocacy was effective (Newcastle CVS, 1995). This approach is, according to Wertheimer (1998), cost-effective and easy to use—but its focus on measurable inputs may well be at the expense of developing a bigger and more complex picture of advocacy process and outcomes.

Typically, however, evaluations of advocacy outcomes have elicited only positive accounts of service provision (Henderson and Pochin, 2001). Any meaningful evaluation of advocacy needs a dual focus on process and outcomes. In terms of the process, it is important to look at what actually happens in the relationship between advocate and partner. However, it is also important to consider any practical outcomes for people on the receiving end (Wertheimer, 1998). Our review of Nottinghamshire advocacy services looked at both process and outcomes for the people involved. In addition, the schemes under review provided a range of types of advocacy, including issues-based as well as CA, so our approach also took into account the scope of the provision on offer. This

meant adopting a mixed-method approach to the evaluation. We also wanted to test the validity of the positive accounts that form much of the literature, and to see what advocacy means in practice.

Evaluating advocacy in Nottinghamshire

Aims and methods

The evaluation of independent advocacy services in Nottinghamshire aimed to:

- review existing advocacy projects to assess what they were achieving;
- identify shortfalls in provision and barriers to access; and
- pinpoint areas of unmet need.

As stated earlier, we wanted to look at advocacy in the round—issues-based and paid advocacy, as well as the much-vaunted CA. We wanted to explore how well it was working from the perspectives of those involved. Consequently, we used a combination of methods to evaluate the advocacy services offered by the five main providers. (These were organizations funded by Nottinghamshire County Council, who commissioned the research.)

The advocacy providers were:

- the Alzheimer's Society (advocacy for carers of people with dementia);
- Age Concern (for people aged over fifty-five, predominantly in hospital or residential settings);
- Home Farm Trust (working with people with learning difficulties);
- Nottingham and Nottinghamshire Advocacy Alliance (working with mental-health and learning difficulties); and
- Nottingham Advocacy Group (primarily serving people with mental-health problems).

The study incorporated a review of in-house documents, as well as the established advocacy literature. Visits were made to the five sites, where discussions with managers focused on recruitment, working relationships, the work environment, supervision/support and monitoring procedures. Interviews with ten advocates and five partners were also conducted. In addition, one hundred and thirty-two questionnaires were circulated to managers, advocates/volunteers (both past and present) and current partners. Accessing partners was, in fact, mostly through the questionnaires. This was done to ensure that only consenting partners would be involved in data collection, and, crucially, to maintain confidentiality of service-users. Thus, the questionnaires were sent to respondents via the organization providing advocacy, but returned anonymously to us at the university. This was to guarantee that we could not identify who the partners were—and that the organization had no knowledge of what partners had

said about the service. Organizations agreed to send out the questionnaires on the basis of a random/stratified sample to people on their records.

We used two methods to identify unmet need. One approach was a systematic telephone/e-mail consultation with a range of health/social-care managers, and the other was to conduct 'drop in' observation and informal interview sessions with members of the public in hospital and GP waiting rooms. Interviews were based on asking about people's understanding of the term 'advocacy', and thoughts on where it could be found.

Findings

The key themes that emerged across the five organizations were:

- 1 Advocacy works—it does make a difference.
- 2 It is not there for everyone who needs it; consequently, there is considerable unmet need.
- 3 Advocates work in what is often felt to be a hostile environment (alongside or against health/social-care staff).
- 4 Advocates need continuing support in order to be effective.

These points will now be considered in turn.

1. Advocacy works

We found that advocacy worked in different ways for different people, but was thought to be effective across the range of long-term CA relationships and short-term work on specific issues by paid advocates. The findings indicated that advocates gained considerable job satisfaction and sense of achievement. In addition, advocates reported a number of successes in their work, including enabling people to make choices, supporting them in moving in and out of care, and enabling partners to express their views at review meetings. Partners were predominantly positive about advocacy having made a difference to their lives. However, they suggested that 'educating others' about the importance and value of advocacy (especially health/social-services staff) was a priority if advocacy were to become more effective (and available).

2. Unmet need

We found evidence of this throughout all our interviews and questionnaire responses. In addition to existing waiting lists held by the five advocacy organizations, health/social-care managers (in telephone/e-mail discussions) and members of the public (via our hospital/GP waiting-room conversations) confirmed that

there were many more people who could benefit from having an advocate. This included some of the people whom we spoke to at random in waiting rooms, but also other people known to them—including people not currently using social-care services. Front line managers confirmed a degree of unmet need for advocacy in day and residential services for people with learning difficulties and older people. In addition, older people living at home were thought to be vulnerable, especially in the early stages of dementia.

3. A hostile environment

Our findings indicated a downside to being an advocate, in particular the stresses of working in an isolated role, sometimes in a hostile environment. Alongside the successes of advocacy, and the job satisfaction experienced by many advocates, there were many people in that role who were articulate in expressing their concerns about the process of advocacy. In addition to individual interviews and completing the structured questionnaire, many advocates wrote lengthy accounts of their experiences and ideas about how the organizations could be improved. Some of the people who completed the questionnaire had ceased working/volunteering as advocates; and one respondent provided an account of why this was and illuminated some of the difficulties in being an advocate:

I found it one of the most stressful jobs I'd ever undertaken. Advocates often experience very hostile and defensive responses from other professionals when challenged by people advocating for themselves or when advocating on behalf of a service user.

The next quote came from someone who had worked as an advocate for years, and also had an extensive business background:

After 15 years I still find it really difficult to speak within committees—what hope do other people have then?

Many of the advocates had previously worked as health/social-care professionals. Advocates highlighted the difficulties in doing this—acting as professional carers and then moving into an advocacy role. One such advocate was a retired manager, with thirty years' experience in acute mental-health services. In an interview, he noted barriers, in particular that all service-users have anxieties about not rocking the boat by wanting an advocate:

Even asking for an advocate might be interpreted as trouble-making. People might rather put up with difficulties rather than asking for their rights and potentially causing trouble.

4. Supporting advocates

Each organization in the study was asked about the support offered to advocates. This seemed particularly pertinent, given the power of the quotations

above, demonstrating the troubled position of the advocate in challenging systems and operating alongside or 'against' professionals. In response, each organization stated that they had a mentoring/informal supervision scheme. Paid and voluntary advocates held this in high esteem. Advocates were also, at times, offered meetings with managers for more formal discussion of caseloads.

One organization offered its advocates access to an independent counselling service. This was developed as a result of recognizing that working in advocacy may be stressful and may have an adverse impact on individuals' private lives. Discussion of aspects of their lives and experiences were considered better suited to a counselling environment than a management one. The counselling was funded by the advocacy organization, and had been used twice in the two years since its commencement.

Discussion

The findings confirm much of the literature, and received wisdom, that advocacy can be a helpful and beneficial strategy for many people. The people whom we contacted felt that it was a much-needed service, albeit currently under-funded and overstretched. We also uncovered unmet need, where advocacy simply wasn't there for people who needed it. There were, however, some surprises, especially the issues pertaining to the position of advocates in relation to services. This led us to question the implicit assumption in much established literature that advocacy is always positive; the study illuminated the important notions of support and independence.

Our research suggests a more complex and nuanced picture of advocacy, especially where it co-existed alongside, or in opposition to, prevailing statutory services, where advocates encountered mixed reactions from social/health-care managers and staff. In particular, we discuss, below, the advocate's role, and how it relates to the role of social workers. We consider partners' accounts, including the issue of how to get at the reality of their experiences; and we reflect on the implications of our findings for practice.

The advocate's role

Our findings revealed a number of respondents who expressed their reservations about advocacy. On one level, this connects with the difficulties inherent in the advocate's role of having to challenge systems. On another level, it relates to a much broader understanding of how difficult it is even to be asked into an organization to act as an advocate. There are implications here for developing ethical practice in supporting people in this role. We can begin to understand the intersections of ethics and practice for the advocate and the partner that come about through this.

A concern raised by several agencies was the difficulty in working with (but often against) social workers and other professionals. This was highlighted where the relationship between advocate and professional was presented as difficult. The roles of advocate and professional were often seen as being at odds—however, an additional layer of complication is added when we consider that many health/social-care practitioners, especially social workers, see themselves as advocates too. The definitions of advocacy, however, indicate that the central tenet of independence is missing from an advocacy relationship in which the advocate is also acting as a professional. Our research led us to wonder where this leaves professionals who also act as advocates.

Many people need advocacy but it is often not available at all, or not available in an accessible form. So, can social workers who already work with vulnerable adults help to fill the gap? Can they act as advocates? The CA purists say ‘No’. Only ordinary people who are independent of services can act as advocates. However, this stance means that many people consequently have no one to speak up on their behalf. This leaves an ethically dubious position for service-users.

There is a view, often quite prevalent in social work and nursing, that practitioners are in a good position to ‘advocate’ on behalf of their clients (see, e.g. Bateman, 2000; BASW’s *Code of Ethics*, 2002; Jenkins and Northway, 2002). From this perspective, social workers are seen to have an advocacy role, even if they are not advocates. Our research suggests that this role could involve:

- *referring* people to advocacy schemes;
- *whistle-blowing* on behalf of clients, speaking out about neglect/abuse;
- *supporting* people to speak up for themselves;
- *representing* the wishes and views of clients (as distinct from acting in their best interests).

The last point is the ‘true’ advocacy role and is the most controversial. There is likely to be tension for a practitioner between doing ‘what’s best’ for the person—or acting in their best interests (a professional role)—and responding to what he or she asks to be done (a representational or advocacy role)—a point made by Brandon and Brandon (2001). This difficulty is compounded by the unequal power relationship between practitioner and client, and the conflict of interest likely between practitioner and employing agency.

The partners’ experience: ‘silent’ accounts

In addition to the advocate’s experience, we were interested in the views of people who were receiving advocacy. What did they think of the service and of their relationship with their advocate? Traditionally, assessments and evaluations

have only managed to elicit positive accounts from partners. Certainly, our research confirmed this tendency. This led us to question whether there were other silent voices, and accounts which have yet to be articulated, about experiences of advocacy which have not been helpful.

Examples from our Nottinghamshire research of less-than-positive experiences were few and far between. However, we started to get a feel of what they might be when people began to express their confusion over their own rights within advocacy partnerships. When asked 'What is your understanding of your rights in this advocacy project?', people replied: 'I don't know'; 'unsure'; 'poor'; 'freedom of expression', 'don't know' and 'they haven't explained to me'.

This limited understanding of rights within advocacy may be the tip of an iceberg of what might potentially be problematic within advocacy partnerships. In particular, there may be accounts marking the tension between the pure CA approach (speaking up for) with a more focused approach that health/social-care practitioners might use in order to work towards the person's best interests.

There are, of course, ethical and practical implications for pursuing these less-than-glowing accounts, as they are potentially more revealing and carry the risk of loss of support. There are also implications for people providing advocacy or referring partners to advocacy organizations. A thorough investigation of partners' stories of what does not work well is necessary if we are ever to know whether practice is working to the best advantage of partners. Taking this as a focus can also be used as feedback for advocates regarding the effectiveness of their interventions which, in turn, will serve to support them in their role.

Implications for practice

There is a significant need to support advocates in working across professional boundaries. Indeed, this is noted in the academic literature as a potential source of tension (Hunter and Tyne, 2001; Schwartz, 2002). In the light of our study in Nottinghamshire, a core service recommendation was indicated: that professionals need more awareness of the positive role of the advocate. The hostility or defensiveness that advocates may face necessitates appreciation for the responsibilities and duties entailed in independent advocacy.

A second recommendation, stemming from the difficulties that advocates faced in working with practitioners, was in offering personal support. We questioned how service-users would be able to find the confidence to speak up for themselves when advocates (with the weighty backing of their advocacy organizations) found it difficult at times. This is particularly salient when considering that many of the advocates interviewed were former practitioners themselves (nurses, psychologists and social workers, for example), with histories of robust professional training and knowledge of how the systems operate.

Conclusion

In this article, we have set out some established ideas on what advocacy consists of and why it has become a central component to service delivery and planning. We have drawn on recent research in Nottinghamshire to explore the experience of being an advocate, and speculated on the difficulties of advocacy for partners.

In so doing, we have elucidated the differences and contact points between acts of advocacy and the role of the social worker. This led to a discussion of the dilemmas in advocacy around support, independence and ‘silent accounts’ of negative experiences from advocacy partners.

Provision of support should be mindful of the troubled position that advocates hold. They are, after all, outside and independent of mainstream health/social-care services, having to challenge professionals and speak up for those who are oppressed or disempowered, often through or because of those same organizational systems. This means there is a need for greater awareness amongst practitioners as to the difference between independent and professional-based advocacy services.

Linking these two points together, we suggest that there is a need for practitioners, including social workers, to have greater clarity about what independent advocates aim to do, and to understand the difficulties in questioning established systems and organizations from an outsider position. A more ethical and aesthetic delivery of care services is more likely to come about if these suggestions for advocacy and health/social-care services are addressed. This will oppose the feeling that advocacy is being ‘done to people’ rather than driven by service-users.

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