Advocacy if Treated Poorly

The Science of Resilience

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Definition

When one is treated unfairly, advocacy can strongly influence the quality of their lives. To advocate is "to promote a partisan belief or stance, to embrace and advance a cause" (Greene, 1997, p.26). Forbat and Atkinson (2005) explain advocacy as "'speaking up' for oneself or others" (p. 322). Advocacy centres on representing individuals or groups and on influencing or making changes in current decisions or situations (Freddolino et al., 2004). Sosin and Caulum (1983) define advocacy as:

> An attempt, having a greater than zero probability of success, by an individual or group to influence another individual or group to make a decision that would not have been made otherwise and that concerns the welfare or interests of a third party who is in a less powerful status than the decision maker. (p. 13)

While Greene (1997) sees advocacy as "a value commitment to a particular regulative ideal (of rational decision-making, interpretive meaning, community activism)" (p. 25). Prakash and Gugerty (2010) argue that advocacy implies systematic efforts, not just sporadic events, by actors to achieve goals. Thus, advocacy refers to activities purposely done to make changes in current conditions, policies, or practices (Ezell, 2001). Freddolino et al. (2004) argue that "the purpose of advocacy within the profession is to improve the social status of individuals who may be considered vulnerable or oppressed, thereby enhancing their standing within a specific social system whether it is a community, organization, service system, societal institution, or society itself" (p. 119). The main actions of advocacy defined in this sense are referring people to programs and resources, supporting people to speak up, and representing them on behalf of their preferences (Forbat & Atkinson, 2005). Advocacy aims to protect the vulnerable by creating supports to improve their functioning, protecting and advancing claims or appeals on their behalf, and fostering identity and control (Freddolino et al., 2004).

Advocacy can be defined on two levels: *cases* (when an individual or family needs support to change) and *causes* (when an advocacy takes the form of larger structural and systematic changes in society, in order to achieve social justice) (Carlisle, 2000). The purpose of *case* advocacy is meeting individuals' needs while the purpose of *causes* advocacy encompasses relative needs, such as improving human dignity and wellbeing, equal status, social justice, and equalities over the long term (Cox et al., 2017). Advocacy can also be defined by the level from which it originates; advocacy can be grassroots or bottom-up – based on the goals and needs of the members and rooted on empowerment – or top-down – which is based on the identification of needs and goals by experts (Loue, 2006).

Advocacy is often done actively and directly, mostly on behalf of people who cannot represent themselves. In other situations, an advocate plays nondirective role and fulfilling the client's needs based on the client's specification (Freddolino et al., 2004). Sometimes the clients' preferences may be different from what is best for them and what benefits to society.

For example, Pasek et al. (2017) studied the tension caused by stigmatized individual preferences to conceal their identity (e.g., if they are lesbians, gays, bisexuals or HIV positive). Identity disclosure has some benefits, such as generating social changes to reduce the stigmas and give stigmatized persons a sense of belonging, reduce their stress and engender empowerment. When the benefits are realized, social advocacy goals are in line with individual needs. However, Pasek et al. (2017) found that some individuals have difficulties and choose to conceal their identity. When this happens, "a one-size-fits-all approach that focuses exclusively or primarily on the benefits of disclosure can be problematic" and the advocates need to tailor interventions that balance social advocacy goals with individual preferences (Pasek et al., 2017, p. 397). Therefore, advocacy needs to align with four components: empowerment, autonomy, citizenship, and inclusion (Atkinson, 1999).

Similarly, Rose (1990) explains three foundational principles in practicing advocacy:

- *Contextualization:* acknowledging the person (the client) the way they represent themselves, their problems, and how they arrived at their situation.
- *Empowerment:* defined as "a process of dialogue through which the client is continuously supported to produce the range of possibility that she/he sees appropriate to his/her needs; that the client is the center for all decisions that affect her/his life" (p. 49). Empowerment is done by externalization, critically questioning one's contextual experience, and identifying and choosing type of actions that fit in their condition. Empowerment is engendered by allowing the client to make their own choice on how to proceed.
- *Collectivity:* defined as focusing on the social networks as a way to reduce isolation and the feeling of hopelessness. Collectivity has two components: socialization of experience and transformation.

Advocacy can be found in different shapes. It can be based on the levels of the system (case or class advocacy), type of services (e.g. family service, case management), forms of advocacy (e.g. legislative advocacy, whistle blowing, rights representation), social reactions to recipients, and diagnostic categories of recipients (Freddolino et al., 2004). Most types of advocacies are done as collective efforts and involve three social actors: the advocate, the client, and the decision-maker (Sosin & Caulum, 1983). The advocate and decision-makers can work in alliance, in which they share basic agreement and view. They can also be in neutral situations, in which the decision-maker "has neither a positive nor a negative impression of the advocate or the advocacy attempt" (Sosin & Caulum, 1983, p. 13). Sometimes, advocacy happens in an adversarial situation (when there are disagreements between the advocate and decision-makers) (Sosin & Caulum, 1983).

An advocate could be from professional organisations or volunteer organisations. For example, trauma survivors' advocates may not have formal mental health training, but they have short-term specialized training in mental health, which usually focuses on crisis

intervention. These people work on behalf of a survivor's rights, providing advices, safety, care, assistance, and other resources as needed (Ullman, 2014). Advocates could also be disadvantaged individuals or group who are trying to improve their and other people's situations (Delker et al., 2019). Casa de Esperanza's *Fuerza Unida Amigos* (Strength United), in which women survivors of intimate partner violence (IPV) and collective trauma are trained as leaders and advocates in antiviolence work, is one such example of these groups (Schultz et al., 2016).

Walmsley (2002) explains that the concept of 'advocacy' came from the idea of normalisation. Normalisation aims to address social injustice and inequalities by reversing the consequences of social devaluation and establishing individuals' roles and values in society. This idea is becomes the concept of the citizen advocacy (advocacy by a person who is connected, independent, and is willing to represent the interest of other people at risk). Walmsey (2002) describes key characteristic of citizen advocacy as being a person's willingness to put their efforts and resources up for disadvantage individuals or groups, regardless of race, gender. Citizen advocates are independent, unpaid, and work in the long-term (Pochin, 2002). However, normalisation centres on conformity and denial of differences, which has received some critiques. Instead, scholars from disability field started to focus on empowerment, in the form of self-advocacy (McLaughlin, 2009). People in self-advocacy groups are better at acknowledging differences; self-advocacy shifts the balance of power and provides opportunities for people to speak up for their own rights (Atkinson, 2002).

Forbet and Atkinson (2005) classify advocacy into self-advocacy (speaking up for one-self), group or collective advocacy (speaking up with others in the form of a group) and citizen advocacy (speaking up with other people's help). Cohen (2004) classifies advocacy into individual/personal advocacy ("protecting the rights, choices and interests of an individual"), local group advocacy (a group based on shared experience, locations, or interests that selects their representatives from within to speak on behalf of them), and advocacy for groups with specific characteristics (e.g. disability, particular economic status, racial/ethnic status, etc.) (Cohen, 2004, p. 10). For Flynn (2010) advocacy can be found in the form of: formal and informal advocacy; systemic advocacy and individual advocacy; self-advocacy and representative advocacy; or best interest and empowerment as the overall aims of the practice.

Relationship to Resilience

When facing adversities receiving support can help a person to maintain their belief in humanity and reduce feelings of insecurity, vulnerability, and their sufferings (Staub & Vollhardt, 2008). The help may come from professionals (social workers, therapists, counsellors, other healthcare professionals, or legal advocates) or non-professionals (e.g., from the community). Self-advocacy, when possible, is also important to maintain one's self-efficacy and build their resilience.

Self-Advocacy

Self-advocacy, or speaking up for one-self, can build solidarity by commonality of interest. The aim of self-advocacy is to encourage self-representation, independency in making choices, standing up for one own's rights and taking responsibility (Atkinson, 2002). Self-advocacy is characterised by a new social movement which includes developing a sense of history, principles, organisation, belongings, and commitment (Walmsley, 2002). It emphasizes "the right of the service user to self-definition and control" (Fazil et al., 2004). Atkinson (2002) outlines some of the positive outcomes from self-advocating, which include enhancing personal identity and increasing self-esteem and self-determination.

Test et al. (2005) developed a contextual framework for self-advocacy for students with disability. The framework is based on literature reviews and involves four components: knowledge of self, knowledge of rights, communication, and leadership.

- *Knowledge of self*: knowing about oneself (one's interests, preferences, strengths, needs, attributes) are essential for self-advocating.
- *Knowledge of rights*: recognizing one's rights as a citizen, a student, and an individual with disability, and recognizing whether one's rights have been violated is an important step in addressing the violation.
- *Communication*: effective communication is important as a mean to promote self-advocacy
- *Leadership*: learning one's role in a group and the skills to function in the group, as well as how to navigate in the group and interact with people outside the group helps in the self-advocacy process

Advocacy plays a significant role in promoting resilience during adversity. Resilient behaviour may not always be socially acceptable; therefore, a person needs to be supported in developing self-advocacy that is socially acceptable. Grover (2005) states that "advocacy for oneself or others is itself a measure of social integration since it belies a faith in the social structure" (p. 535). Self-advocacy by children and youths, which is supported by adults, promotes their resilience. Professionals who provide service for children should organise the program in a way that improves their competency for self-advocacy and advocacy for their peers. This can be done by involving them in planning and in decision-making processes for issues related to them and their future and by recognizing their attempts at self-advocacy. Acknowledging children's and youths' ability for self-advocacy is one of the steps to respect and acknowledge them as a person (Grover, 2005).

Singh (2013) explores strategies used by transgender youths of color to face significant discrimination, prejudice, and personal and societal barriers. According to the literature, these youths are at risk of substance abuse and sexual risk-taking. Finding their place in the 2SLGBTQ+ youth community is one of their resilience strategies. Joining Gay-Straight Alliance organizations in high school or colleges gives them space to self-advocate, talk about their

identity, and make friends while also advocating for policy changes. The youth in this study found "home" where they were accepted by people with shared values and had a space to share their experience (Singh, 2013). Having a space in the community which provides them with valuation and helps them to unlearn societal norms that stigmatize them, in turn, fosters their empowerment and resilience.

Self-advocacy is also used by young Latino gay and bisexual men as one of their resilience strategies (Li et al., 2019). This population experiences microaggressions (in the form of microassaults, microinsults, and microinvalidations) in daily life which are associated with various health problems, such as depression, suicidal tendency, drug use, and sexual risk-taking (Li et al., 2019). Li et al. (2019) found that self-discovery, adaptive socialisation, and self-advocacy play significant roles in their resilience. In the process of discovering themselves, these men seek information and education, find peers and community leaders, and engage in community movements. Confronting people who were subjecting them to microaggressions was a way to take offense on behalf of their community.

Professional Advocacy

Sometimes, individuals are not capable of speaking up for themselves and/or dealing with decision-making process. In other situations, they are not taken seriously because of their status (e.g. young people). Professional advocates act as formal intermediaries on behalf of the clients (Dalrymple, 2003). Professional advocates can be individual attorneys, public interest lawyers, government attorneys, social workers, journalists, and educators (Cohen, 2004). However, the relationship between professional advocates and the people they are advocating for can range from resilience-promoting to damaging. Dalrymple (2003) explains Gomm's (1993) analysis of four different types of professional advocate-client's relationships:

1. *The oppressive relationship*, in which professionals ensure their clients function in a way that does not change the societal systems. In this relationship, clients cope within a system, thus the professionals are oppressing them.
2. *The disabling relationship*, in which professionals use their position to their own advantages, such as denying access and resources necessary for their clients' lives in order to prolong the advocates' job.
3. *The helping relationship*, in which professionals use their skills and knowledge to help clients identifying their own needs. This relationship enables and empowers clients.
4. *The brokerage relationship*, in which professionals provide clients with information about resources relevant to their skills and situations. Professionals facilitate contacts and evaluate referrals to appropriate sources or agencies for clients' empowerment. They also enable clients to access resources themselves.

Professionals, such as social workers and family therapists, can play a significant role as advocates in a person's resilience. They provide psychological supports, resources to various services, and work with clients to improving clients' ability in self-advocacy. Mumford and

Sanders (2015) explore the role of social workers for young people in care who experience adversity. These young people experience disruptions in their life which accelerate their transition into adulthood. Although they have limited access to resources, they require multiple services, such as health or psychological services. Social workers can help these youth build positive identities, provide them with safe and secure adult connections, foster their sense of agency, and provide them with a space to test out their identities. These young people may have difficulties in forming bonds with adults, such as social workers and other caregivers. When bonds are formed, this connection provides a safe space for the youths to speak freely, beyond the formal intervention. This may be the first step in these young people's positive development. Mumford and Sanders (2015) also found that social workers facilitate practical support and resources for these young people to go back to school. These young people's relationship with the social workers and engagement at school provides them with the space to experiment with their social identities, choices, and experiences. Positive supports, such as from social workers, help these young people to identify, understand, and mediate risks in their life. Working with social workers and attending classes provide them with better alternative activities. Social workers provide these youth with control and options to fosters their sense of agency.

Ungar (2010) analyses the role family therapists play as advocates for mental health resources. Family therapists provide psychological support in navigating resources and self-advocacy. Clinical practice can be a political process when therapists define what resources are provided, available, and are relevant to help their clients' coping, which sometimes requires them to speak up against social discourse. Therapists act as navigators to ensure resources are available and accessible for the client. As advocates, therapists teach individuals (the client) to self-advocate, facilitate group advocacy, and work with other professionals on behalf of clients to tackle social justice issues. Therapists also help clients negotiate by making interventions meaningful and helping clients to adapt the methods of intervention (Ungar, 2010).

Another professional that has an important role in fostering children's resilience is child advocates. Trauma can impact children on physical, neurodevelopmental, and psychosocial levels. Delinquency, violence, and criminality are strongly related to previous traumatic experiences in children. Early assessment and interventions are needed to address the history of trauma (Vandervolt et al., 2012). Vandervolt et al. (2012) look at the role of child advocates in fostering resilience. They found that child advocates foster resilience by maintaining connectedness, fostering children's affect regulation, and providing them with a space for self-development. Connectedness is important in a child's development. When children enter the foster care system, caseworkers (the agency) need to make sure that the child still has a sense of connection by maintaining their positive relationship with adults. Child advocates also provide children with the space for self-developments (through skills and education), therefore, empowering the children and mitigating a sense of helplessness and ongoing victimization. By being aware of how a traumatic experience affects a child's behaviour, child advocates can help

the child to manage their day-to-day experiences and improve the child's skills, for example by advocating for their access to psychotherapy (Vandervolt et al., 2012).

For black South African youths from poverty-stricken, rural areas, school psychologists play a significant role in advocating for their rights. Theron et al. (2014) found that school psychologists are not only responsible in school provisions, but also act as supporting caregivers who uphold children's rights. For vulnerable children and youth that are affected by adversities such as parental deaths and cruelty, school psychologists and teachers facilitate children's welfare and help to arrange police protection when needed. Therefore, school psychologists' advocacy role is fundamental in protecting and promoting a rights-based school environment.

Professional advocates also face challenges. They are very susceptible to burnout, job loss, and harassment. Relationships between professional advocates and their clients can also be challenging. For example, Fazil et al. (2004) explored an advocacy project by the East Birmingham Family Service Unit for families who have children with severe disabilities. The advocacy project involved identifying the issues, problems, and services needed to be improved, and locating appropriate resources as needed. The advocates helped the family to contact professional service providers, maximise family income by obtaining additional benefits for the families, and helped to solve various other issues. However, there was a discrepancy between the families' expectations of what the advocate could do and the advocates' actions to empower the family. Therefore, professional advocates need to clearly define the concepts and scope of their advocacy.

Collective Advocacy

Collective advocacy arises from a group of individuals pursuing collective actions to gather resources and coordinate strategies in order to achieve certain goals more efficiently. An example of collective advocacy is advocacy organisations, such as NGOs, which works on behalf of specific principals to accomplish specific goals (Prakash & Gugerty, 2007). Prakash and Gugerty (2007) note that collective advocacy can give people the opportunity to free ride on their allies' works; however, Hojnacki (1998) found that the tendency to free ride in collective advocacy activities can be minimized by good coordination and interaction with alliance partners. People are compelled to work and maintain their reputation, and therefore are motivated to contribute to the process.

For people in vulnerable groups and who are experiencing adversities, community can provide supports and resources that help them cope and foster their resilience. Examples of collective advocacy are trauma survivor groups that advocate for assault and IPV victims (Delker et al., 2019) and advocacy by Black community following Hurricane Katrina (Anderson, 2008). Anderson (2008) explains how the Black community mobilised disaster assistance (e.g. food provision, health care and housing) and advocated for political and policy actions regarding racial and class injustice following Katrina. This community came forth and discuss social,

political, and economic aspects of Katrina with various people from academic institutions, think tanks, civil rights organizations, and media.

A supportive community also provides people experiencing adversities with connections to other people or groups, from which they get strength, resources, and another sources of resilience. Community connection is one of the factors that help transgender individuals and transgender youths of colors facing oppression from society (Singh et al., 2011; Singh, 2013). These communities give encouragement when individuals are overwhelmed and provide them with a "home". Being active in the community, including collective advocacy, where they are accepted and acknowledged gives these individual strength and empowerment.

The Parliament for People with Learning Disabilities (PPLD) is an example of collective advocacy. PPLD is an organisation consisting of service users that reach out to top professionals about important issues and influence the decision-making process for issues related to their agenda. The organisation helps people who are not capable of speaking up individually to engage in discussions and be heard by people who make changes, which fosters their empowerment (Redley & Weinberg, 2007).

Community organisations can help people facing adversity locate services and resources available in the community. For example, after hurricane Katrina, a few community groups and local service providers engaged in advocating services for people impacted by the hurricane, such as for children, elderly, and people from poor neighbourhood (Green et al., 2007). Community and group support are also involved in mental health service clients' empowerment. They advocate for client's welfare and against the complexity of the systems (Mezzina et al., 1992).

Improving

Appropriate strategies are needed to achieve an advocacy goal. Sosin and Caulum (1983) explore different strategies based on typology: coercive, utilitarian, and normative. Coercive strategies are used in adversarial context, or when there is an absence of understanding between advocates and decision makers. This is beneficial for policy advocacy. Utilitarian strategies rely on negotiation and are used when parties have some similar views and bargaining is needed to find an agreement. Normative strategies rely on moral arguments and common values and are mostly used when two parties share a basic understanding about the process and clients' needs. Patton (2008) lists some interconnected factors that strengthen advocacy: a high capacity coalition, a solid knowledge and research base, a focused message and effective communications, strong national/grassroots coordination, timely and targeted lobbying and judicial engagement, and strategic funding.

McLaughlin (2009) explains various advocacy strategies based on three types of advocacy: instrumental (advocacy focuses on holding system accountable on behalf of clients),

educational advocacy (improving awareness on social justice issues for clients and public), and practical advocacy (directly working with clients to access resources). Instrumental advocacy strategies for individuals may involve lobbying on behalf of the clients, ensuring accountability, and managing connections between services. Educational advocacy strategies may involve educating individuals about their rights, options, and the systems they interact with, as well as educating others or the general public about individual rights and stigma. Strategies for practical advocacy involve assisting clients to access resources, such as by assisting them in filling out forms, accompanying them for appeals and interviews, and locating housing (McLaughlin, 2009; See Appendix A for details of advocacy strategies and dimensions).

Elpus (2007) explores ways to improve advocacy, particularly in music education. He reasons that advocacy needs a well-reasoned rational foundation. At grassroot/community levels, advocates should design good materials, attend training sessions for effective lobbying strategies, build alliances and partnerships, and connect between booster groups. At federal level, qualified practitioners needed to ensure the delivery of the program, nationwide. A national standard is needed. Rigorous lobbying and advocacy to policy makers is important to amend the law.

Interventions

East and Roll's (2014) Model of Empowerment

East and Roll (2015) describe an approach to empowering women who experience poverty, trauma, and oppressions. They built a model based on two theoretical perspectives: "(1) women's empowerment and (2) women's psychology, development, and relational-cultural theory (RCT)" (p. 280). A professional using this model needs to be aware that empowerment is: contextual, which means it depends on the situation, cultures, and identities; a developmental process; both a process and an outcome; and is based on mutual relationships that recognize differences. To integrate the RCT into theory and practice, an advocate needs to understand the concept of power, mutuality, and empathy.

The implementation of East and Roll's (2015) model involves three separate but interconnected components: (a) engagement through sharing stories, (b) developing a voice, and (c) leadership and advocacy. Engagement through sharing stories aims to build social networks and thus reduce isolation. This can be done either by one-to-one interviews or story circles. One-to-one interviews are done by volunteers, interns, or staff. The goal is to identify concerns and obstacles to attaining participants' goals. Story circles are done by sharing stories with other group members to explore commonalities and to introduce action responses. Each group consists of six to 12 participants and are led by a facilitator. The story circle format includes, "(1) an introduction and setting of guidelines, (2) focus questions directed at a particular theme, (3) a time for reflection and discussion of what participants heard, (4) a call to action, and (5) a closing" (East & Roll, 2015, p. 283). After completing an interview or story

circle, women are invited to join the agency's women's leadership program. The meetings involve workshops and discussions on various issues and topics, such as self-esteem, courage, conflict resolution, communication, goal setting, and advocacy. Then, women start to assume more leadership roles and get more involved in community forums and actions. They are given specific leadership training and can work on different programs. They also participate in advocacy effort in which they learn to speak their ideas and thoughts and begin advocating for themselves and other people (East and Roll, 2015).

The Self-Advocacy and Conflict Resolution (SACR) training

Walker and Test (2005) examined a self-advocacy intervention to improve disabled students' ability to self-advocate for their needed accommodations. The Self-Advocacy and Conflict Resolution (SACR) training consists of seven lessons with different goals for each. The structure of this training is described below:

1. First day:
    a. Lesson 1 *introduction*: taught students to introduce themselves to the instructors.
    b. Lesson 2 *disclosure:* trained students to explain about their disability, the term, what it means, and how it affects their study.
    c. Lesson 3 *solution*: taught students to explain how the previous solution has worked for them.
    d. Role-playing probe.
2. Second day:
    a. Lesson 4 *resources:* taught students to explain how the resource office is available to help them.
    b. Lesson 5 *agreement*: students practiced role-playing with their instructor on how to get an agreement and make an affirmation for the agreement.
3. Third day:
    a. Lesson 6 *summary:* taught students to review the previous conversation which led to an agreement.
    b. Lesson 7 *closure*: taught students to close the conversation with positive statements.
    c. Role-playing probe

The duration for each lesson was 15 minutes. "When the student demonstrated a criterion of 100 percent correctly demonstrated target behaviors for those two consecutive days, the intervention phase ended and a generalization probe was administered" (Walker & Test, 2005, p. 139). After passing the generalization probe, the students met with the researcher and arranged a meeting with their instructor to ask for accommodation. Students were scored by their accomplishment to get a desirable response. Maintenance training was done 1-2 weeks after the initial intervention. Walker and Test (2005) found that the SACR

intervention was effective in improving participants' self-advocacy skills and increasing their self-determination.

The Human Rights and Social Justice Scholars Program (HRSJSP)

Bakshi et al. (2015) explored a program to train medical professionals in community engagement, health inequality, and social justice. The Human Rights and Social Justice Scholars Program (HRSJSP) is an extracurricular preclinical program for first-year medical students. It aims *"*to equip the next generation of physician with the ideals, peer support, knowledge, and skills to help eliminate health inequities through system-level change" (Bakshi et al., 2015, p. 291). The program focuses on engagement with local underserved community and collaboration with community-based organisations to provide advocacy. The five components of the HRSJSP are:

- A didactic course in health and human rights;
- Faculty and student mentorship;
- A collaborative longitudinal service and advocacy project with East Harlem community partners;
- A career seminar series; and
- A research project (Bakshi et al., 2015, p. 291)

HRSJSP participants participate in an 8-week Health, Human Rights, and Advocacy course to teach them about social justice and human rights theory. The course was delivered as interactive workshop, which included formal presentations and facilitated discussions with physicians, researchers, and advocates. Students were paired with HRSJ faculty mentors and second-year peer mentors. Students could shadow their faculty mentors in a clinical setting. Each semester, students had 2 career workshops by physicians from different specialities and disciplines. Students were required to do a summer research project on social justice issue of their choice and a collaborative longitudinal service and advocacy project.

ReConnect Program

Pinto et al. (2014) examined ReConnect, a 12-session re-entry advocacy program for formerly incarcerated women. ReConnect has five goals: "(1) give participants information and tools to strengthen their ability to advocate for themselves and others; (2) strengthen participants' skills to work through the barriers they face upon returning home; (3) strengthen the participants' networks and connections to individuals who can assist them overcome barriers to re-entry; (4) engage participants in WIPP's Coalition for Women Prisoners and related policy advocacy opportunities; and (5) create an active peer network that encourages graduates to remain in contact with one another after the program*"* (Pinto et al., 2014, p. 72). ReConnect uses adult learning methods and integrates aspects of transformative learning theory. It was expected, after finishing the program, that participants would develop self-reliance and self-efficacy. Objectives and topic in each session are:

- Session 1 *Introduction/ Root causes*: exploring the goals and expectations of the program. Participants explored the root causes of their involvement in the criminal justice system.
- Session 2 *What is community?*: participants explore the concept of social supports, ways of accessing them and how to integrate into a "community". They explored the concept of power and privilege.
- Session 3 F*ilm—Trouble the Water*: example of advocacy in action.
- Session 4 *Understanding your housing options*: participants explore resources for housing, their rights of obtaining one and how to overcome potential barriers. Participants were introduced to community resources available for helping them tackle housing issues.
- Session 5 *Overcoming employment barriers*: Participants are given information about employment resources, their rights to employment, and how to overcome potential barriers. Participants were introduced to community resources available for helping them tackle employment barriers.
- Session 6 *Accessing higher education*: participants are given information about education resources, opportunities, and ways to overcome barriers to education; they were introduced to community resources regarding education.
- Session 7 *Financial justice for people with criminal records*: the session aims to increase financial literacy among participants and to introduce them to community resources available to help participants in this matter.
- Session 8 *Knowing your parental rights*: participants are given information about child custody, parental rights, and resources to help them reunite with their children.
- Session 9 *Understanding and facing your fears*: participants explore the relationship between fear and empowerment.
- Session 10 *Understanding your voting rights*: participants are informed about their voting rights and how to overcome barriers to civic participation. They were introduced to organisations that help formerly incarcerated people to gain information about their rights.
- Session 11 *How the government works-NYS Legislative Advocacy 101*: participants were introduced to the concept of legislative advocacy and grassroots lobbying.
- Session 12 *How to get involved in advocacy*: helping participants get involved in the ReConnect program.
- Graduation: participants who complete all sessions are awarded with a certificate and a gift card. Family members, friends, facilitators, and staff attend the graduation.

Participants reported some challenges upon re-entry due to the stigma around incarceration. They found it hard to find employment, housing, and reunification. Those who found employment were paid less and had higher workloads. Finding housing was hard and foster care systems required them to find permanent housing before they could reunite with their children. However, low income and lack of credit history prevented them from getting

permanent housing, which delayed their reunification. Participants of the ReConnect program could identify key resources they needed to address their problems and knew how to connect to these resources. ReConnect gave them interpersonal, interactional, and behavioural empowerment and provided them with a place to learn about acquiring information and advocating for themselves.

Assessment

Advocacy and policy change evaluation is guide by the profession's principles and standard; it is supposed to be *utilization-focused*, which means an evaluation must focus on the *intended use by intended users* (Patton, 2008). Itzhaky and York (1991) list six criteria used to measure a client's participation in a social work program/ intervention: level of participation, type and scale of activities the client is involved in, how far the client participates in a program compares to the total client system, whether the participation is voluntary or not, methods used to engage client's participation, and the client's attitude toward participation. York and Itzhaky (1991) explain that the effectiveness of an intervention can be analysed from two aspects: *goal attainment* and *system processes*. Both measurements are effective individually or in combination, depending on the purpose of the assessment. They then explain that the effectiveness of client participation can be measured from three groups of actors involved in the process:

- *Change agents*: system process is measured according to professional values and satisfaction, while goal attainment is measured by analysing leadership development, long-term independence, and better-preserved outputs.
- *Clients*: system process is measured through client satisfaction and educational achievement, while goal attainment is measured through client involvement, legitimisation, and better outputs.
- *Administration Establishment*: system process is measured by seeing participation as a political end and as a mean to build political connections; goal attainment is measured by the amount of resources they are saving and the public support and legitimization they received.

To see the effectiveness of advocacy interventions, the questions below can be used to assess a client's empowerment:

- How often do you teach yourself about your own problem and update the information/other resources needed to face the problem?
- How often do you ask other people to help when you need them?
- How confident are you to actually do [a task]?
- How comfortable are you in doing [a task] for yourself or asking for help when you need it?
- How strongly do you believe that [the intervention] is good for your improvement?

For more detailed measurement of the effectiveness of advocacy interventions, the following items based on the Youth Service Satisfaction measurement can be used (Liebenberg et al., 2016):

- Do you feel satisfied with the services provided?
- Did you help with choosing the services you received?
- Did the advocates/ staff stand by you and on your behalf?
- Were the people from the service available for you when you are in trouble?
- Were you able to ask for what you wanted?
- Did you receive the services that were right for you?
- Were the services available when you needed them?
- Were the services easy to get to?
- Did the staff respect your (and your family's) beliefs?
- Did the staff speak in a way that you understood?
- Were the staff sensitive to your cultural/ religious/ spiritual background?
- Are you able to cope when things go wrong now?
- Was this the service you needed?

Measures to Evaluate Advocacy Programs

Citizen Advocacy Program Evaluation (CAPE; O'Brien, 1987; Eliuk & Bardwell-Wheeler, 1999)

- Can be used for designing external evaluation of citizen advocacy programs or as the basis of a program self-assessment
- Consists of three categories:
    - Adherence to citizen advocacy principles: advocate independence, program independence, clarity of staff function, balanced orientation to protégé needs, and positive interpretations of handicapped people (20 ratings)
    - Citizen advocacy office effectiveness: vision and creativity of protégé recruitment, advocate recruitment, advocate orientation, advocate-protégé matching, follow-up and support for relationships, ongoing training, advocate associate emphasis, balance of key citizen advocacy activities, encouragement of advocate involvement with voluntary associations, and sufficiency of citizen advocacy staff (10 ratings)
    - program continuity and stability: community leadership involvement and funding issues (6 ratings)

Scale of Perceived Organizational Support (Eisenberger et al., 1986)

- The original is a 36-item scale; however, Worley et al. (2009) found that the 16-item version is as effective and more efficient
- Used to measure organisational readiness to meet socioemotional needs of their members and the extend to which an organisation values its members' wellbeing

- A 7-point Likert scale (1=*strongly disagree* to 7=*strongly agree*)
- Total score range of 16-112
    - Cronbach's alpha ranging from .67 to .98 (Frey et al., 2016)

Measures to Identify Recipients' Needs or Measure Their Engagement

The Pathways to Resilience Youth Measure (PRYM; Theron et al., 2014)

- Measures participants' risk, resources, experiences, and resilience processes. The PRYM can be used to identify areas where someone needs to advocate for better services
- Three subscales: individual resources, relationships with primary caregivers, contextual resources
- Items are rated on a 5-point scale (1=*does not describe me at all* to *5=describes me a lot*)

The Youth Services Satisfaction (YSS-13; Liebenberg et al., 2016; Appendix B)

- Assesses the extent to which services encourage personal agency and prioritise positive relationships with youth
- 13 questions assessing youth' satisfaction; adapted from the full length YSS (Brunk et al., 2000)
- 5-point scale (*1=strongly disagree* to *5=strongly agree*)

The Senior Empowerment and Advocacy in Patient Safety (SEAPS) survey (Elder et al., 2007; Appendix C)

- Evaluates seniors' empowerment and behaviour regarding safety tasks after self-advocacy training
- 21-item self-administered survey
- The survey consists of four subscales:
    - Outcome efficacy (OE, α: .74): believing that one's actions will benefit one's health
    - Attitudes (ATT α: .79): one's concerns and barriers to act
    - Self-efficacy (SE, α: .91): the ability to take actions
    - Behaviors (BEH, α: .91): behavioural changes after an intervention

The Second Victim Experience and Support Tool (Burlison et al., 2017)

- A survey instrument that can assist healthcare organizations to implement and track the performance of second victim support resources
- 20 items representing 7 dimensions (psychological distress, physical distress, colleague support, supervisor support, institutional support, non-work-related support, and professional self-efficacy) and 2 outcome variables (turnover intentions and absenteeism)

- Responses are measured on 5-point Likert scale (1=*strongly disagree* to 5=*strongly agree*)

Relational health indices and Relational Health Indices Youth (RHI and RHI-Y; Liang et al., 2002; Liang et al., 2010; Appendix D)

- RHI was developed to measure women' growth fostering connections. Liang et al. (2010) then adapted the measure for youth
- The RHI is 37-item scale consisting of three dimensions of relationship quality (engagement, authenticity, and empowerment) and three domains or subscales (peer: 12 items; mentor: 11 items; and community: 14 items)
- The RHI-Y consists of three domains or subscales (friend: 12 items; mentor: 16 items; and community: 14 items)
- The responses are rated using a 5-point Likert scale (1=*never*, 5=*always*) with total score of 12-60
- Higher scores represent higher relationship quality
- The RHI's Cronbach's alpha ranges from .85 to .90 (Frey et al., 2016)

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Appendix A: Advocacy Strategies and Dimensions

McLaughlin (2009)

	Individual	Marginalized Groups	Just Society
Instrumental Holding systems accountable	• lobby on behalf of ensuring accountability • liaison between services	• letter writing • demonstrations • marches • program development	• campaign for social issues e.g. living wage • professional association work
Educational Educating individuals, families, colleagues, society	• educating individuals about rights, options or choices, the system, etc. • educating others about needs/rights, stigma, etc.	• committee work • anti-poverty groups • school systems • multidisciplinary teams • public education initiatives	• public health awareness strategies (e.g., AIDS, Mental Health)
Practical Engaged in action	• assist by filling out forms • accompany to appeals or interviews • locate housing	• volunteer work for food bank, HIV network, etc. • volunteer on crisis line	• run for political office

Appendix B: The Youth Services Satisfaction

Liebenberg et al. (2016)

1=strongly disagree 5=strongly agree

1. Overall, I am satisfied with the services I received.
2. I helped choose my services.
3. The people helping me stood by me.
4. I felt I had someone to talk to from the service when I was in trouble.
5. I was able to ask for what I wanted.
6. I received services that were right for me.
7. I could get the service when I needed it.
8. The service was easy to get to.
9. Staff respected my family's beliefs.
10. Staff spoke in a way that I understood.
11. Staff were sensitive to my cultural/religious/spiritual background.
12. I am now better able to cope when things go wrong.
13. This was the service I needed.

Appendix C: The Seniors Empowerment and Advocacy in Patient Safety SEAPS Survey

Elder et al. (2007)

How often do you do the following tasks? (behaviors)	I never do this	I rarely do this	I often do this	I always do this
1. How often do you teach yourself about your own health problems and medicines?				
2. How often do you ask your doctors questions about your health problems, lab tests, and medicines?				
3. How often do you keep an updated a list of all your medicines, including those from the drug store and health food store?				
4. How often do you call the doctor's office if you haven't received the results of laboratory or X-ray tests?				
5. How often do you get a second opinion from another doctor when needed?				
6. How often do you ask a friend or family member to come with you to doctors' visits?				

How confident are you that you could actually do the following tasks? (self-efficacy)	I don't think I could	I doubt I could	I probably could	I definitely could
1. How confident are you that you could teach yourself about your own health problems and medicines?				
2. How confident are you that you could call the doctor's office if you haven't received the results of laboratory or X-ray tests?				
3. How confident are you that you could get a second opinion from another doctor if you think it is needed?				
4. How confident are you that you could give your doctors a complete and thorough story of your health problems?				
5. How confident are you that you could ask a friend or family member to come with you to doctors' visits?				

How much do you agree or disagree with each statement? (attitudes)	Strongly disagree	Disagree	Agree	Strongly agree
1. I feel comfortable changing doctors if I think my health concerns are not being met.				
2. I feel it is difficult to ask a friend or family member to come with me to doctors' visits.				
3. It would be hard to ask my doctors a lot of questions about my health problems, lab tests, and medicines.				

4. I would feel comfortable calling the doctor's office if I haven't received the results of laboratory or X-ray tests.				
5. It would be easy to keep an updated list of all my medicines, including those from the drug store and health food store.				

How strongly do you believe that doing the following will improve your health? (outcome efficacy)	Strongly do not believe	Do not believe	Believe	Strongly believe
1. How strongly do you believe that giving your doctors a complete and thorough story of your health problems and concerns will improve your health?				
2. How strongly do you believe that complaining in writing if you have problems with office staff or doctor will improve your overall health?				
3. How strongly do you believe that getting a second opinion when needed will improve your health?				
4. How strongly do you believe that asking a friend or family member to come with you to doctors' visits will improve your overall health?				
5. How strongly do you believe that teaching yourself about your own health problems and medicines will improve your overall health?				

Appendix D: Relational Health Indices (RHI)

Liang et al. (2002)

(R) indicates that the item should be reverse scored prior to calculation of a mean score.

PEER (RHI-P)
Next to each statement below, please indicate the number that best applies to your relationship with a close friend.

1 = Never; 2 = Seldom; 3 = Sometimes; 4 = Often; 5 = Always

1. Even when I have difficult things to share, I can be honest and real with my friend.
2. After a conversation with my friend, I feel uplifted.
3. The more time I spend with my friend, the closer I feel to them.
4. I feel understood by my friend.
5. It is important to us to make our friendship grow.
6. I can talk to my friend about our disagreements without feeling judged.
7. My friendship inspires me to seek other friendships like this one.
8. I am uncomfortable sharing my deepest feelings and thoughts with my friend. (R)
9. I have a greater sense of self-worth through my relationship with my friend.
10. I feel positively changed by my friend.
11. I can tell my friend when they have hurt my feelings.
12. My friendship causes me to grow in important ways.

MENTOR (RHI-M)
Next to each statement below, please indicate the number that best applies to your relationship with your most important mentor.

1 = Never; 2 = Seldom; 3 = Sometimes; 4 = Often; 5 = Always

1. I can be genuinely myself with my mentor.
2. I believe my mentor values me as a whole person (e.g., professionally/academically and personally).
3. My mentor's commitment to and involvement in our relationship exceeds that required by their social/ professional role.
4. My mentor shares stories about their own experiences with me in a way that enhances my life.
5. I feel as though I know myself better because of my mentor.
6. My mentor gives me emotional support and encouragement.
7. I try to emulate the values of my mentor (such as social, academic, religious, physical/athletic).

8. I feel uplifted and energized by interactions with my mentor.
9. My mentor tries hard to understand my feelings and goals (academic, personal, or whatever is relevant).
10. My relationship with my mentor inspires me to seek other relationships like this one.
11. I feel comfortable expressing my deepest concerns to my mentor.

COMMUNITY (RHI-C)

Next to each statement below, please indicate the number that best applies to your relationship with or involvement in this community.

1 = Never; 2 = Seldom; 3 = Sometimes; 4 = Often; 5 = Always

1. I feel a sense of belonging to this community.
2. I feel better about myself after my interactions with this community.
3. If members of this community know something is bothering me, they ask me about it.
4. Members of this community are not free to just be themselves. (R)
5. I feel understood by members of this community.
6. I feel mobilized to personal action after meetings within this community.
7. There are parts of myself I feel I must hide from this community. (R)
8. It seems as if people in this community really like me as a person.
9. There is a lot of backbiting and gossiping in this community. (R)
10. Members of this community are very competitive with each other. (R)
11. I have a greater sense of self-worth through my connection with this community.
12. My connections with this community are so inspiring that they motivate me to pursue relationships with other people outside this community.
13. This community has shaped my identity in many ways.
14. This community provides me with emotional support.

Note:

Empowerment/Zest subscales RHI-P items: 2, 7, 9, 10 RHI-M items: 5, 7, 8, 10 RHI-C items: 2, 6, 11, 12, 13

Engagement subscales RHI-P items: 3, 4, 5, 12 RHI-M items: 3, 6, 9 HI-C items: 1, 3, 5, 8, 14

Authenticity subscales RHI-P items: 1, 6, 8, 11 RHI-M items: 1, 2, 4, 11 RHI-C items: 4, 7, 9, 10

R2

For more information about R2 or to discover how you can bring the program to your organization, business or educational setting, please contact us.

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