Title page

Advocacy and people with long-term disabilities

A report of a conference held at the King's Fund Centre on 6th December 1984
June 1985
King's Fund Centre
126 Albert Street,
NW1 7NF

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Introduction

On Thursday December 6th 1984 a conference was held at the King's Fund Centre on Advocacy and people with long term disabilities. One of the aims of the conference was to discuss the issues raised in our Project Paper No. 51 - Advocacy - the UK and American experience.

This paper is an account of the conference, and participants included contributors to the Project Paper, as well as workers who are developing citizen advocacy schemes around the country, and members of self-advocacy schemes. A conference programme and list of participants are included in the Appendix.

Advocacy: setting the scene

William Bingley, Legal Director, MIND

Earlier this year Stanley Herr wrote words to the effect that "advocacy is an idea whose time has come". He was speaking in the American context but is no less true in this country.

He also raised another problem and that is the multiplicity of usages of the term “advocacy” and hence the risk of a debased concept. At its loosest level professionals refer to advocacy as "raising a fuss" or “meeting clinical needs". This confused notion of equating advocacy with satisfying service needs I think lead for instance, many social workers to define their role as advocates on behalf of their clients - when I think that although they show certain characteristics of advocacy in their job they can never be correctly classified as being primarily such.

This does bring us to the very thorny problem of what exactly is advocacy - the subject of this conference - and should we worry if it is used loosely and in many different contexts.

Mr. Herr when examining the advocacy spectrum discovered seven basic models in operation in the United States - self-advocacy, family advocacy, (citizen) friend advocacy, disability rights advocacy, human rights advocacy committees, legal advocacy and a rather painful sounding aftermath - internal advocacy.

My own view is that it is crucial to be clear about what advocacy means, and what activities fall within the definition and what do not. Primarily so that those participating in any advocacy scheme know what it is about and what it offers and secondly because it is crucial for those who come into. contact with advocacy to know what it is doing and aiming to achieve.

Having said all that does not make it any easier to suggest an adequate definition. Maybe this conference will spend a little time talking about it - perhaps not too long because there is always the danger of defining for so long that nothing else happens. I suspect there is not a comprehensive
definition. The basic Oxford dictionary definition of an advocate as "one who pleads for another", I think is not satisfactory; it is not sufficiently comprehensive or dynamic enough. For me advocacy not only entails, under its citizen advocacy hat for instance, transferring power to someone with a disability by way of speaking for them and under their instructions, but also in as many instances as possible seeking to transfer to the disabled person the ability to speak on their own behalf as well.

My own view is that we are faced with four basic models or potential models of advocacy or advocacy-characterised models.

1. Self-advocacy
   Involving people with disabilities asserting their own rights, expressing their needs and concerns and assuming the duties of citizenship to the extent of their capabilities.
2. Legal advocacy
   A term used to describe the broad range of methods and activities by which lawyers and other legally trained individuals assist persons with disabilities to exercise or defend their rights. This can include reform or creation of new laws, as well as formal or informal activities to protect a citizen's rights or interests under existing laws. Advice units like that at Springfield Hospital and,on a more national level ,my own department at MIND are engaged in this.

3. Citizen advocacy
   Working on a one-to-one basis, unpaid trained volunteers who are independent of the service-givers attempt to foster respect for the rights and dignity of persons with mental handicap and to ensure that their people get at least an opportunity to enforce and obtain their rights.
4. Guardianship
   The fourth model proposed by the International League of Societies for Persons with Mental Handicap in their recent document "Advocacy and Mental Handicap" is one that does not really exist in this country and in my view is not really a form of advocacy, and that is guardianship. For adults, apart from the limited Mental Health Act guardianship, there is no such mechanism in this country. I only mention this because one of the side-effects of the fact that the 1983 Mental Health Act lays down some rules about "consent treatment" is that it highlights the generally unsatisfactory legal position about the giving of non-urgent, primarily physical, treatments to, for instance, profoundly mentally handicapped people who are unable to consent or to elderly people who are highly mentally confused. I can foresee a call for some guardianship mechanism: a relationship that, although it calls for a display of advocacy, is essentially one of substitute judgement. If such a proposition is ever accepted it is essential that the principles of normalisation and least restrictive alternative dictate that guardianship be employed only when no less drastic abridgement of the rights and freedoms of an individual is available.

My own, no doubt deeply over-simplified, view of advocacy is that at its root lies power and the facilitation of certain groups of people with disabilities collectively or individually to exercise maximum self-autonomy. In a perfect world professionals would say that was the aim of their provision of care for people with disabilities. Obviously it is more complicated than that but instigators do face a problem in this country - there is no legal framework within which advocacy schemes can be set up.

My experience has been with Advocacy Alliance and Bob Sang in his excellent contribution to the King's Fund publication that we are launching today, quite rightly points out it would not have got off the ground without the invitation of the hospital in which the advocates are now working. One of the spin-offs of this is that many advocacy schemes are proposed by professionals themselves, with all the problems that entails in terms of meeting the independent requirements of certainly citizen advocacy projects. Self-advocacy I suspect may be in a different court. Has the time come to ask for a legal framework entitling at least people in long-stay institutions to the right to some aspect of advocacy?

The possibility of giving advocacy some loose national framework raises another question for the movement - what form should its implementation take? My own view certainly in the field of “citizen advocacy" is that projects should be as locally based as possible but balanced against this is the need for any project to be sufficiently powerful to be able to establish and maintain its independence. ‘There is also a great need for some sort of resource/support national centre to provide guidance, ideas and support. Again in the citizen advocacy field, Advocacy Alliance is doing this to a limited extent: in effect telling others of our experience, successes and failures. We hope to expand this in the future. My own view about "citizen advocacy" is that it is vital but is obviously just one arrow in the quiver of advocacy. The prime problem is recruitment - after three years we have 32 advocates. ‘Things are speeding up but it will always remain one of a number of alternatives. The great and welcome disparity in the types of advocacy schemes is one of the reasons why this conference is so very welcome to enable a stocktaking to be undertaken and ideas for the future to be generated.

If one of the problems facing the advocacy movement is the sloppy use of the word "advocacy", another potential problem is the limitation of dynamic proponents of the idea because of resources or lack of them. How advocacy proposals are to be funded, what is an acceptable source of funding and what is not, is I think another issue that needs to be addressed.

Finally, I think there is a danger that "advocacy" could take on professional characteristics of its own if it is not careful. Quite how you cope with that I find it difficult to say. Perhaps it is not a potential problem with the implementation of self-advocacy. But concern for the rights of people, of people with disabilities, should not be the monopoly of any single group or profession and maybe one of the aims of advocacy is to try and realise this state of affairs.

Advocacy is one of, if not the most, exciting developments in the field of people's rights for many years. It is essential that all involved get it right. This publication and this conference are a major contribution to ensuring this happens.

The problems of defining and implementing citizen advocacy

Bob Sang, Senior Lecturer, Brighton Polytechnic

1. Introduction

My contribution to the workshop was intended to deal with the problem of defining and understanding “advocacy" in strictly lay terms. Thus, when I look at my notes for the day I find they are a collection of words, phrases, statements, and questions which might be used in a whole variety of contexts. With one exception - the phrase "People First" occurs twice: significantly at the beginning and at the end of my notes.

So, lets start, with "People First".

One of the features of our workshop was the way we all struggled with the label "mental handicap". The new terminology, "people with learning difficulties", was more evident throughout the day's discussions and everyone seemed more comfortable with it. The trouble is I don't know anyone who does not possess learning difficulties in some shape or form; but no one makes a point of emphasising this feature of their lives. David Ward has said, and I agree with him, that "mental handicap" should be banished from use in the English language. This might cause problems, even an identity crisis, for service organisations, charities, and the like; but David's point is entirely valid. All the time we label people they find that their lives become prescribed and circumscribed by those with the power to do the labelling.

It is the process of labelling that is the problem not the labels themselves. That is why understanding the significance of "People First" is so important. Effective, innovative self-advocates like David Ward force others to recognise and respond to them as people first. A fundamental purpose of "Citizen Advocacy" is to ensure that people who cannot speak for themselves, and who experience all the disadvantages and deficits of being labelled "mentally handicapped", also have the opportunity to push back - to force the world to recognise that they are people first.

2. What does Citizen Advocacy mean?

Citizen Advocacy entails a one to one relationship between an individual who is willing to befriend and represent the interests of someone who cannot effectively speak for themselves, and who is cut off from full citizenship by the attitudes and practices of others.

The individual advocate is a volunteer who learns, through friendship, to understand and promote the interests of another by representing those interests as if they were the advocate's own. Let me illustrate this point. Put yourself in the position of someone who has to live in a hostel. How would you like to organise your day? What clothes would you want to wear? What food would you like? Who would you want to be with? - Before answering these questions assume that you know and like someone who is living in a hostel, Now ask these questions with and for them. The answers will reflect two things: your friend's choices and preferences and the kinds of choices likely to be made by any competent citizen.

There is no a-priori reason why people who live in hostels, or any other form of service provision, should not make such decisions every day of their lives. But, because they are labelled, we all know that they don't. Citizen Advocacy is an attempt to turn this situation around.

This sounds good in principle. But there is an enormous built-in problem. How can anyone be sure that the advocate won't take over the relationship? The result of this would be that all decisions and choices would reflect what the advocate wanted. There are two answers to this problem.

Firstly, this is the risk attached to any one to one relationship. Parents face it every day! The problem is people fail to recognise the problem.

Secondly, if we do recognise this problem then there is a lot that can be done about it. Advocates have to learn to listen, observe and understand. They have to be consistent and reliable so that mutual trust and confidence can develop. They must ensure that the way they behave in the relationship reflects the way they would like a good friend of their own to behave.

Would you like someone to take over all your choices, expectations, tastes, and so on?

This may suggest to you that citizen advocates have to be ‘super' people. However, if you think about it, what it means in practice is that they are people who get involved in very rewarding, worthwhile relationships which have a clear purpose.

That purpose, which is to counteract the social exclusion of others, is very positive. It is concerned with changing negative assumptions that go with labels; with pursuing rights and entitlements and not being put off; with learning all the time; with working together.

It is very positive; but achieving Citizen advocacy is fraught with difficulties and getting a scheme off the ground is a real problem.

3. Problems of Implementing Citizen Advocacy

In this section I shall list some of the key questions. How would you answer them?

Who needs advocacy? Some people think its important to establish Citizen Advocacyy in hospitals. Others prefer a community- based scheme. Even if you know where you want to start you still have to face the problem of finding the people who need/want advocates and establishing ways of deciding who has priority.

How should a scheme be run? Citizen Advocacy can only operate successfully if it is free from compromising influences. Health or social services cannot (must not!!) run such schemes. But, how is such an independent organisation to be resourced, staffed, managed? Who sets the policies and takes responsibility? Experience tells us that Citizen Advocacy programmes require a great deal of planning and preparation. Who will take that on and ensure independence?

Where, when, how do we find advocates? This is the biggest problem. Without volunteers you don't have a scheme, all you have is a lot of good intentions. Again experience tells us that this is crucial and very difficult to solve.

What about staff and the 'authorities'? It appears that, in the United Kingdom, Citizen Advocacy can only occur with the consent of those who run the service systems. To my mind this is an indictment of our Welfare State; but it is also reality. Are staff people and their managers prepared to step aside from professional self-interest and accept the consequences of advocacy. Working in a situation where conflicts of interest occur can be very rewarding; but professionals and other workers find this a hard lesson to learn.

4. Conclusion

I have deliberately raised questions rather than given answers. Citizen Advocacy is too young in this country for those of us who have been involved with it to start dishing out wisdom.

But we are clear about certain underlying principles. Citizen Advocacy will only flourish if its independence from those who run services is respected and cherished.

It must be based on relationships which are more than friendship, involvingthe pursuit of the human rights and civil liberties of people who are denied these essential elements of citizenship.

It must recruit people who are prepared to be committed and enduring friends to others who would otherwise remain the victims of the labels bestowed on them.

Finally, it is about people first.

What is “people first”

Gary Bourlet

"People First" is a self-advocacy organisation. Self-advocacy is speaking for yourself. Self-advocacy can be spoken in different ways - speaking in public, through drama, music, art and many other ways. "People First" is run by people with a disability or handicap.

“People First" began in America 105 years ago. Last year 18 of us from Britain went to Tacoma, Washington State, USA, to the American's first International Conference. We were very impressed with all we saw and learnt while we were there. We talked about it in America and decided that we wanted to start a “People First" organisation over here.

We started last October, in London, and we call ourselves "People First of London and Thames". We meet once a month at the King's Fund Centre in Camden on a Saturday afternoon. At present we have about 25 members.

Aims and Objectives

"People First" is helping people to speak up for themselves and to help one another.

"People First" is helping people to speak out for their rights.

“People First" is talking about:

- how people can get more money either through getting more benefits or through getting real jobs
- how to get help for people to improve their flats and houses
- how to get help for people who can't walk - help with transport
- how to get people to stop calling us names - to stop labelling us

We are planning ways of raising money for different things - e.g. a jumble sale.

We have been writing letters, getting the word around that we have started an organisation and we have produced our first newsletter.

Our organisation has two co-supporters or advisers. An adviser should never interrupt a meeting unless asked. Our advisers come into the last part of our meetings. Voting on any subject should be done in a good manner even if the vote does not go your way. Everybody has the right to say what they want to on any subject. You can disagree if you want to without falling out with other members.

We hope that there will be a lot of other "People st" groups in all parts of Britain before very long. But we can only get People First going if we get our friends interested and get the support needed.

If you would like to know more about our activities please write to:

Gary Bourlet, "People First", King's Fund Centre, 126 Albert Street, Camden Town, London
NWI 7NF

Advocacy Alliance

Sally Carr, Co-ordinator, Advocacy Alliance

The Advocacy Alliance was set up in 1981 by five mental health charities: One-to-One, MIND, The Leonard Cheshire Foundation, The Spastics Society, and MENCAP. It was decided that a pilot project be established in three mental handicap hospitals which differ in size and character. This stage of the project has now been achieved and advocates are working in St Ebba's, Epsom; Normansfield, Kingston; and St Lawrence's, Caterham.

Funding for the first three years came from the five charities, the DHSS, the King's Fund (for training) and the Mental Health Foundation. Money was also raised through a Thames Television appeal. The DHSS has funded the post of a full-time Recruitment Officer under the Opportunities for Volunteering Scheme and this grant has recently been approved for a third year. We have applied to the DHSS for further funds for the total project.

The Advocacy Alliance is staffed by a Co-ordinator, an Administrative Assistant and a Recruitment Officer (all full-time). The Co-ordinator is responsible for the day-to-day supervision of the other staff and is in turn supervised by the Board of Management who are representatives from the five charities.

The first year was largely spent in negotiating with Health Authorities and hospital staff to secure a working agreement which would enable advocates to effectively represent the interests of residents. Each hospital has a Project Team which consists of senior staff and members of the Alliance. The team meets once a month to discuss issues raised by advocates and to monitor the programme generally.

These Project Teams have drawn up an Ethical Code and recognised procedures. The Code recognises the right of advocates to raise issues on behalf of their residents, and makes clear to staff that resident and advocate should have free access to each other.

Since the schemes have been established, we have been recruiting and training people who live near the hospitals to act as volunteer advocates. At present there are 14 advocates at St Ebba's, 11 advocates at Normansfield and 4 at St. Lawrence's. Many more people have attended our training courses but considerable numbers drop out as they don't feel able to make a long-term commitment to one particular resident. On average, courses are attended by about ten trainee advocates and a third of those may go on to become advocates.

Recruiting people remains our major difficulty. People tend to think along the lines of hospital visiting - flowers, kind words, sympathy, etc. when asked to become advocates. The concept is simple enough - speaking up for another person, but it can be difficult for people to realise just how different advocacy is from hospital visiting, and many don't really grasp the implications until they've had their first difference of opinion with a charge nurse or ward sister.

Although we are still low in numbers, we have attracted a wide variety of people who have become advocates: e.g. a dresser from the BBC, an employee at the Royal Opera House, a long-distance lorry driver, a school cook, a woman who works in Wandsworth Prison, a member of the Territorial Army. Most of the advocates also have full or part-time jobs.

The training course consists of eight 2 hour sessions held once a week in the evenings, and a one-day workshop. The training takes place in the hospital, and staff are welcome to attend:

- two of the sessions are for staff to describe their work and what they are attempting to do for the residents;
- a speaker from MIND on legal rights;
- a speaker from MENCAP talks about helping residents gain equal access to local amenities;
- a parent who has a mentally handicapped daughter talks about her fight to ensure that her daughter lives a full life and has the same rights as other women of her age;
- members of a self-advocacy group come and talk about their lives now that they are living in the community;
- a member of the Disability Alliance talks about the benefits
- available and how to claim them.

The course is evaluated by the trainees and later courses are amended accordingly. During the course, trainees are encouraged to spend as much time as possible with the residents, and some have already matched up with someone by the end of their training. Following the training, advocates meet regularly to discuss issues and problems and I also attend these meetings to offer my help and support when it is needed.

Residents who have advocates are benefiting in a variety of ways: some have able to move to a different ward, and in one case have resisted a move with the help of their advocate who was able to explain that they didn't want to move to that particular ward. Some residents have been able to give up all or most of their medication where advocates have been able to influence the doctor concerned. Almost always, the first thing that advocates do is help their resident to choose some ordinary clothes from the local shops so that they stop looking like a hospital resident. More than one resident has had a holiday as a result of advocates asking why they have been left off the list. Three advocates took their residents off to the South Coast for a week last summer.

Advocates are now expected to attend assessments and case conferences, since the day when a Normansfield advocate surprised a number of staff by walking into a case conference uninvited and remaining there to put across his resident's point of view.

It is always difficult for residents to gain access to their own money when they live in long-stay institutions. Especially where credit systems are used for the convenience of the staff, residents often have no idea that they have any money, or that they can choose things to spend it on, or save it up if they want to, and often have no say in how it is spent. Advocates help to cut through the lengthy procedures and forms, and in some cases have decided to become the appointee which obviously eliminates the staff signatures and form fillng altogether. Advocates are able to speak up about purchases, particularly group purchases. One of our first examples of advocacy in practice was seen on a ward in St Ebba's where all the women had identical new wardrobes except the woman who had an advocate who had chosen to keep her clothing in her old, perfectly adequate wardrobe and to spend her own money in other ways.

Many residents with advocates become part of a family for the first time, and are able to make friends with people who are not mentally handicapped. Several residents are beginning to overcome their fear of animals through contact with pets. One resident, encouraged by his advocate, has begun to make sounds for the first time in his life, and she firmly believes that he will learn to speak in time.

Many residents have been able to claim for benefits which the hospital have not claimed for. Things like speech therapy, dental treatment, eye check-ups, visits to a GP for minor ailments are not freely available to residents, and advocates can help to ensure that their resident has access to specialists and particular therapies.

I think it is true to say that virtually all our advocates have as their long-term aim, to help the residents to move out of the hospital, and much of what they do is to do with encouraging independence and helping the residents to learn essential skills to be able to cope with life away from an institution.

My Life

Lloyd Page, Member, SE London Self Advocacy Group

My name is Lloyd Page. I live at 28, Rangefield Road, Bromley, Kent. I live with my mum, brother, one cat and my dog.

I get special boots from Lewisham Hospital and have to go there to get my feet measured.

I go to evening classes every Monday and Thursday at Holbeach Road School in Catford. I study English and Maths and the tutors are very helpful. I go to Leemore Centre four days a week and am a member of the intensive work group. This means that I work in the laundry for a four week period or in the print room. I find the laundry very hot for working in but I enjoy the actual work.

I spend one day a week at the Mulberry Centre (which is a Friday). This is a day spent on recreation and education.

I can use London Transport Buses every day to get to the Centre, and come home in the evening on my own.

Sometimes while on the bus, school children have called me names. This makes me feel very bitter and sad. I do not like to be called "mental" or "handicapped". I would like people to take me seriously - as an ordinary person. I feel we have something to offer to the community if it is only to make them see how lucky they are. We need their help and understanding all the time. My life has been made happier by some good friends who run voluntary clubs where we can mix with other people who understand us.

Without the help of staff and friends at the Centres my life would be very dull as they take us on holidays and we go into pubs for a shandy or coke and go to the pictures and outings to the seaside. Last week we went to Bexley Sports Stadium where we played other Centres at football. Mulberry won the shield: thanks to our Manager Terry Crew for all his hard work. I like Fridays best of all.

I would like to be an ordinary person with an ordinary job and be able to do things on my own. But I can't, I have tried; but I will keep on trying. It's hard being labelled mentally handicapped.

Citizens First – North West

Chris Gathercole, Top Grade Psychologist, Montague Health Centre

Citizen Advocacy was developed by Wolfensberger in the late 1960s in response to the question asked by parents with mentally handicapped sons and daughters: ‘What will happen when I die?'. Since services cannot be expected to meet the full range of people's needs how can ordinary concerned citizens help? Wolfensberger surveyed the work of volunteers and voluntary bodies and concluded that there are a number of features of a volunteer programme which would be desirable but no existing programme included them all in a systematic way. He arrived at the following definition:

“An unpaid, competent, citizen volunteer, with the support of an independent citizen advocacy agency, represents - as if they were his/her own – the interests of one or two impaired persons by means of several advocacy roles, some of which may last for life.”

Key features of citizen advocacy include: one to one relationships; the advocate’s loyalty is to the handicapped person, and not to the service providers, the parents or even the advocacy office; the advocate receives no financial reward; advocates receive support from the advocacy office staff, the co-ordinator and assistant; both office and advocates are independent of local service providers; a range of advocacy roles are represented in the programme including various combinations of formal and informal, friendship and task oriented, low and high intensity.

Since the very first scheme was started in 1970 there have been several hundred across North America. The lessons learned from this practical experience have been summarised in guidelines set out in a tool for evaluating citizen advocacy programmes (Standards for Citizen Advocacy Program Evaluation, O'Brien and Wolfensberger, 1979).

Workshops were held in 1982 in Blackburn and Manchester to explore citizen advocacy. In December 1983 Citizens First - North West was formed to encourage local programmes. It was registered as a charity in 1984.

At the same time a separate development was taking place in Manchester called the Blackley Leisure Integration Support Scheme (BLISS). This scheme concentrated on developing friendships through leisure activities. Although it was informed by the principles of citizen advocacy it did not focus on citizens speaking up on behalf of handicapped people.

During 1984 Citizens First - North West began to seek funds to support staff for local schemes. It is hoped that a number of local projects will be started in the north west over the next few years. We need to learn how to set schemes up and keep them going. We need to learn how to tailor our approaches to different communities. The more schemes there are, the more lessons can be learned.

A lot of decisions have to be made when starting a citizen advocacy project. What range of impairments are we concerned with? Is it to be restricted to mental handicap or should we include people with physical disabilities, and psychiatric problems and old people? What population base is reasonable for one office to cover? Should we start with friendless people in long stay hospitals?

We decided tentatively that we would focus on mentally handicapped people to begin with. Later as we get established we might broaden the range of disabilities. We have changed our minds several times about the population base. First we thought perhaps 250,000, then 100,000 would be reasonable. More recently we have wondered about neighbourhood schemes based on much smaller populations. In contrast to Advocacy Alliance, it was decided to start schemes in the community rather than in hospitals, despite the obvious need for people in hospitals to have people outside taking an interest in This was because it was felt that it would be easier to establish a scheme in the community. Once established with a clear, independent identity, it would then be possible to involve hospital residents in the scheme. There was also concern that a relationship begun while the person was resident in hospital could be broken up if that person was resettled 30 miles away. Since citizen advocacy aims to build long term relationships it was decided that the first hospital residents to be matched would be those about to be resettled. They would be matched with people from the localities to which they were being resettled. In this way the relationship could grow when the person left hospital.

Whatever the practical decisions to be taken our aim is to learn how to develop citizen advocacy in the context of British society and culture, using CAPE as a guide and adhering as closely as possible to the principles, now well established.

Bibliography

All of the following are published by and available from the National Institute on Mental Retardation, Kinsmen Building, York University Campus, 4700 Keel St., Downsview, Ontario M3J 1P3, Canada.

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Advocacy and people with long-term disabilities: event programme

The King’s Fund Centre, King Edward’s Hospital Fund for London, Thursday, 6 December, 1984

PROGRAMME

Chairperson: Alison Wertheimer, Director
Campaign for Mentally Handicapped People

10.00 Coffee
10.30 Welcome – Joan Rush, Project Officer, King’s Fund Centre

Introductory contributions

10.45 William Bingley, Legal Director, MIND
11.05 Bob Sang, Co-author of “Advocacy”, King’s Fund project paper number 51
11.30 “People First” – Gary Bourlet, Eileen Carpenter, Alice Etherington
12.00 Group work
12.45 Lunch
2.00 “Advocacy Alliance” – Malcolm Bowen, Ann Gallop, Sally Carr, Maureen Ronskley
2.20 South East London Self Advocacy Group – Lloyd Page, Pat Singfield, Tony Ward
2.40 “Citizens First – North West” – Chris Gathercole
3.00 Group work
4.00 Tea