



Social Perspectives of Race Equality and Cultural Capability (RECC)

A recent Study Day on Recovery for SPN raised several important issues around what recovery means for people from Black Minority Ethnic (BME) communities. The debates around a personally defined concept of recovery were important but what also struck me about the discussion was the central importance of a social model and holistic approach in responding to mental distress. Whether we are talking about Maori mental health services, the mental health of forced migrants or long-established groups of Asian elders in this country it became apparent that a holistic social approach was an essential ingredient of any assistance being offered.

The debate at the end of the day crystalised several key points about the medicalisation of 'recovery' and the various views of doctors, psychologists, service user activists and voluntary sector service providers highlighted the complexity of needs being responded to. However, some constant themes have begun to emerge, such as the danger of an over-individualistic approach to mental health when we know that the concept of individuality varies across cultures with some being very much about individual autonomy and personal freedom, whereas others emphasise the primacy of family and community and the roles of individuals in these social groupings. These cultural variations have to be taken into account when dealing with people from different cultural groups than the majority cultures in this country. Much of the confusion over these basic concepts in mental health derive from a simplistic understanding of culture - a superficial analysis of culture that runs the risk of stereotyping large number of people (see previous SPN article - 'Chinese people don't take milk and love to eat jelly?').

I have recently completed drafting some Race Equality and Cultural Capability materials at Advanced ESC Level (Essential Shared Capabilities) for all mental health practitioners for CSIP/NIMHE and the Delivering Race Equality programme. This material begins to address this type of confusion with practitioners and addresses the need to promote a social model approach to BME mental health. It is painfully apparent that even BME mental health service providers can sometimes fall into the trap of providing a medicalised approach to dealing with mental distress leaving the BME service user between a rock and hard place in getting appropriate help in dealing with their distress. Stigma and discrimination faced by BME service users has to be tackled in the wider community but also within BME communities themselves and BME practitioners may well need just as much training as White practitioners to provide an appropriate service despite their 'cultural understanding'. There are many other factors around power dynamics which could interfere in a positive relationship between practitioner and service user such as class, gender, sexuality issues and age. A holistic model of equality must be developed that recognises these interconnected factors but also respects the different causations of discriminations and different journeys people must make in dealing with oppression.

It is difficult to describe all of the materials here but there are some key models that begin to provide some tools for improving practice in BME mental health such as:

- A model of culture that represents its complexity and dynamic nature.
- Ways for practitioners to reflect on their own assumptions and beliefs about mental health.
- A useful discussion about the differences between the use of power and authority in communication in service settings.
- A model of cultural difference that avoids cultural stereotyping and respects the individual's 'take' on their cultural heritage.
- A model of institutional discrimination in mental health services that can help people to recognise and analyse its main features.
- Strategies for empowering BME individuals and their families/carers.
- A holistic approach to looking at people's needs leading to a social model approach to meeting needs.
- Finally, consideration of the principles for anti-discriminatory risk work.

There is also a set of useful guiding principles that underpin all of the materials.

1. Dealing with inequality and not just cultural difference

~ Valuing cultural difference without dealing with inequality and racism in mental health services will not work. Cultural capability without a strategy to address institutional and individual racism based on an analysis of power dynamics and structural inequalities will have a limited impact on discrimination in services.

2. Having a deeper understanding of culture

~ A superficial analysis of culture can lead to tokenism and cultural stereotyping – a simple understanding of culture leads to simply wrong judgements.

3. RECC is an ordinary part good practice

~ Race equality and cultural capability are not 'special' or different approaches, they are essentially about good practice and improve mental health services for everyone.

4. Services will improve only through a 'whole systems' approach

~ There must be a coherent strategy for change based on a 'whole systems' approach to achieve sustained and continuous improvement in services.

5. Greater BME service user participation leads to greater appropriateness of services

~ Genuine participation and involvement of BME service users, their families and communities is the most effective and rapid way to achieve mental health services that are more appropriate and accessible to BME people.

6. Miscommunication often leads to unnecessary conflicts

~ Everyone needs to share a common understanding of the fundamental concepts in equality and diversity work if we are to establish a constructive dialogue about difficult issues between the different groups involved in BME mental health.

7. We need to recognise institutional discrimination as a problem before we can begin to tackle it properly

~ Institutional discrimination is often covert and complex, mental health practitioners need help in recognising when and how it operates in their services.

8. Know yourself first before trying to understand others

~ You can only understand where other people are coming from in terms of culture if you understand where you are coming from first.

9. Unacknowledged prejudices grow in power and influence

~ If you don't face up to the prejudices and stereotypes you hold they will become even more powerful in shaping your practice.

10. Values are central to mental health practice

~ Value judgements come into all decisions we make in mental health service as we are dealing with people and trying to improve the quality of their lives.

The RECC materials are just one step towards achieving more appropriate and accessible mental health services. There has to be strong and committed leadership around this issue in services, properly designed systems and structures to support good practice and most importantly, effective service user and carer participation in all aspects of service design and delivery. This also means RECC training has to model this 'whole systems' approach to service improvement. Ferns Associates has a long track-record of working in genuine partnership with service users in mental health, physical disability and learning disabilities. We do not believe in having service user / survivor trainers involved in delivering training to practitioners in a tokenistic or demeaning way as happens in many areas which claim to have service user involvement in training. We view service user / survivor trainers as skilled and capable trainers first and foremost with the added expertise gained from being on the receiving end of mental health services. We would argue that this perspective of services is essential for good practice in training and leads to much more powerful challenges to practitioners and better learning outcomes. The RECC materials have been developed and designed in partnership with BME service users over many years and represent a great deal of hard and sometimes painful experiences of training practitioners as well as personal experiences of services.

If you would like to contact me to find out more about these materials please e-mail me on ferns@dsl.pipex.com

The RECC materials consist of 12 two-hour teaching sessions with accompanying pre-course readings for participants and practice development work tasks for each session to help embed learning into practice. They are in the form of three 'pdf' documents and freely available to download from my website – www.fernsassociates.co.uk

By Peter Ferns – November 2007