

Executive Summary



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January 2010

Towards Culturally Competent Advocacy: meeting the needs of diverse communities



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Introduction

Advocacy services can play an enabling or bridging role in facilitating access to health and social care for vulnerable groups. However, barriers exist which can prevent individuals from Black and minority ethnic communities from gaining equitable access to advocacy services, hence, also, from gaining equitable access to health and social care. An individual with a learning disability from a Black and minority ethnic (BME) community is especially vulnerable, to the extent that they face a “double discrimination” in accessing health and social care (Butt and Mirza, 1996). Begum (1995) argues that this type of layered or interlocking discrimination exerts its own particular effect on individuals and that this is greater than the sum of its parts. A new model of advocacy provision is therefore needed, one which can recognise and overcome these interlocking barriers to health and social care. Fazil *et al* assert the need “to identify models of advocacy and empowerment which are sensitive to ethnic differences and are capable of making a positive impact on the lives of the most vulnerable and powerless members of the community” (2004: 389). Towards this end, we propose the novel application of a cultural competence framework to advocacy services as a means of elucidating practice at the practitioner and service delivery levels and thereafter as a means of structuring personal and organisational development. Culturally competent advocacy can be the bridge which facilitates full and timely access to the services and entitlements to which all social groups have a right.

Cultural competence at the advocacy service provider level

Mainstream, generic health and social care services are social products in so far as they are consciously and unconsciously coloured by the cultural values, norms and aspirations of the culture which created them. In this way, “generic” health and social care services in the UK reflect and are imbued with the cultural norms of the majority culture. Advocacy services are as liable as health and social services are to unreflexively reproducing dominant societal values and praxes in their service model and failing adequately or at all to address social and cultural diversity. Advocacy services thus risk alienating and failing to support some of the most vulnerable members of society.

In applying a cultural competence framework at the advocacy service provider level, group work is undertaken towards unearthing and identifying institutional culture and the values and behaviours it embodies. Training activities illustrate the ways in which institutional and societal forces have an impact on the degree and type of support which individuals from different communities are able to access. It can happen, however, that, in pursuit of cultural competence, advocacy services place so much emphasis on the need for advocates from Black and minority ethnic (BME) communities that this is seen as a quick fix to the “minority issue” and, at the same time, majority community advocates feel disenfranchised from working with BME clients. Rather, the contribution of BME advocates should be seen as part of the process of becoming more culturally competent, not as an end in itself.

Cultural competence at the practitioner level

The cultural competence approach challenges the assumption that it is the client who must bear the “onus for change” and encourages the advocate to recognise the impact of their own culture on the advocacy relationship (O’Shaughnessy and Tilki, 2007: 71). This proactively reflexive stance is fundamental to the cultural competence model and sets it apart from other approaches to the analysis and practice of advocacy. As professionals, it is important for advocates, from both the majority and BME communities, to recognise their cultural bias and to be open to the diversity of world views as lived by their clients. It is by undertaking the work of discovering their own “cultural selves” and by striving towards a recognition of their own values, beliefs and behaviours as cultural products, rather than as universal values or ethics, that the advocate becomes more self-aware. By understanding themselves, and how their beliefs and values reflect their culture, advocates can become more comfortable and confident in working with clients with differing values and perspectives and can, moreover, develop an awareness of their own defences, projections and internalised discriminations (see Sue, 2006). By working to recognise their own biases in this way, the advocate becomes better able to predict and recognise where tensions or barriers may develop and so better able to build a successful working relationship with their client. In this way, the client’s voice is heard.

Conclusion

In light of the growing cultural and ethnic diversity at all levels of UK society, health and social care practitioners are having increasingly to interact with clients who may have limited or no English language abilities, have different care-seeking behaviours and hold different expectations of health and social care. As the need for culturally competent health and social care grows, so the need for culturally competent advocacy services grows concomitantly. At the same time, the number of adults with learning disabilities is set to increase by 11% between 2001 and 2021 (Emerson and Hatton, 2004).

Within this increase and time frame, the number of adults with learning disabilities aged over 60 is predicted to increase by 36 per cent (*ibid.*), an evolution likely to place a proportionately greater burden on advocacy services in so far as this client group are progressively less likely to have family members who can advocate on their behalf.

Despite the challenges which will undoubtedly accompany any future transition towards a culturally competent advocacy services sector, and these challenges will be considerable, the need for such a transition to take place is urgent. The publication this year of three significant documents – *Valuing people now: from progress to transformation* (the government’s consultation on the next three years of learning disability policy), the *NHS Constitution for England* and the *Six Lives* report (which investigated the deaths of six people with learning disabilities, all of whom died between 2003 and 2005 while in NHS or local authority care) – means that more attention than usual is currently focused on unequal access to public services. Experience shows that, when the spotlight of media and public attention moves on, the more durable force of inertia sets in and a reversion occurs to “business as usual”. Embracing a vision of cultural competence as a journey rather than a destination, the time may now be right for the advocacy services sector to begin taking the first steps on this journey.

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