Towards Culturally Competent Advocacy: meeting the needs of diverse communities

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Abstract

Advocacy services can play an enabling or bridging role in facilitating access for vulnerable groups to public services. This paper argues that barriers exist which can prevent individuals from Black and minority ethnic (BME) communities from gaining equitable access to advocacy services and, hence, from gaining equitable access to health and social care. When the minority ethnic individual has learning disabilities, an additional, interlocking set of barriers comes into play which further compromises access to health and social care. For people from BME communities, therefore, it may be that advocacy services are not, or not fully performing the bridging function between need and provision which they claim for themselves. This paper considers the challenges which advocacy services must confront if they are to offer full and timely advocacy support to people from BME communities. We begin by defining our terms, before going on to examine the role of advocacy in facilitating access to health and social care. Thereafter, we consider the application of a cultural competence framework to health and social care as a prelude to proposing a cultural competence framework for advocacy services. Here, we examine cultural competence at the institutional and practitioner levels, making recommendations towards its development with a focus on practitioner reflexivity, cultural knowledge and linguistic competence. Finally, we consider the critiques and the challenges of a cultural competence framework. The paper concludes by reiterating the need to commence the journey towards a culturally competent advocacy services sector, given the predicted growth in demand for its services from people who have learning disabilities and belong to BME communities.
Background

On the 21st of January 2009, the *NHS Constitution for England* was published, bringing together in one place for the first time in the history of the NHS what staff, patients and public can expect from the NHS. According to this document, the NHS is guided in all that it does by seven key principles, these in turn deriving from extensive discussions with staff, patients and the public. The first of these guiding principles states that “[t]he NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief. It has a duty to each and every individual that it serves and must respect their human rights” (DoH, 2009: 3).

Just over three months later, on the 23rd of March 2009, the Local Government Ombudsman and the Parliamentary and Health Service Ombudsman published a report entitled *Six Lives: the provision of public services to people with learning disabilities*. The six lives in question are those of six people with learning disabilities, all of whom died between 2003 and 2005 while in NHS or local authority care (see Mencap, 2007). The report relates to the investigations into these deaths, and found “significant and distressing failures in service across both health and social care, leading to situations in which people with learning disabilities experienced prolonged suffering and inappropriate care” (LGO/PHSO, 2009: 3). Referring to the *Six Lives* report, Ann Abraham, Health Service Ombudsman for England, stated that “[t]he recurrence of complaints across different agencies leads us to believe that the quality of care in the NHS and social services for people with learning disabilities is at best patchy and at worst an indictment of our society” (PHSO, 2009a). Strong words. Clearly, a gap persists between policy rhetoric and the lived experience of individuals with learning disabilities.

A striking finding in the *Six Lives* report was that none of the six families concerned had had any contact with advocacy services in the period leading up to the death of their relative. The report states that “[w]hile parents and families undoubtedly advocated strongly on behalf of their family members, it is possible that independent advocates might have provided the
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people concerned and their families with additional support, or even have affected some of the outcomes” (LGO/PHSO, 2009: 27, emphasis added). The clear implication is that advocacy intervention could potentially have saved lives. The report continues: “…the use of independent advocates could have provided an additional safeguard for the rights of a very vulnerable group of people. We cannot speculate on the reasons why they did not have this opportunity” (ibid.).

The need for advocacy services arises out of the institutional failure of mainstream public services effectively to support the needs of the most vulnerable members of our society. Until such a time as health and social care services are able to meet in full their legal obligations under the Human Rights Act, Race Relations (Amendment) Act, the Disability Discrimination Act and the Mental Capacity Act, developing the perspectives, practices and skills necessary to meet the needs of all of their vulnerable clients, advocacy remains central to redressing inequalities in health and social care provision for vulnerable groups such as those with learning disabilities.

Research findings from a range of health and social care settings indicate that people from Black and minority ethnic (BME) communities encounter disadvantage and discrimination in seeking the care to which they are entitled (see, for example, Butt and Mirza, 1996; Alexander, 1999; Mir, Nocon, Ahmad and Jones, 2001). For BME individuals with learning disabilities, such disadvantage and discrimination makes them especially vulnerable, to the extent that they face a “double discrimination” in accessing health and social care (Butt and Mirza, 1996). Indeed, Bowes and Sim refer to “the systemic exclusion of people in BME groups” (2006: 1217). Advocacy services can play an enabling or bridging role in facilitating access for vulnerable groups to health and social care. This paper argues that barriers exist which can prevent individuals from BME communities from gaining equitable access to advocacy services and, hence, from gaining equitable access to health and social care. For people from BME communities, therefore, it may be that advocacy services are not, or not fully performing the bridging function between need and provision which they claim for themselves. We consider the challenges which advocacy services must confront if they are to offer much needed advocacy support to people from BME communities. We begin by
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defining our terms, before going on to examine the role of advocacy in facilitating access to health and social care.

**Definition of Terms**

*Learning Disability*

We use here the definition employed in the government’s *Valuing People* white paper – learning disability denotes a condition which includes the presence of a significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence) with a reduced ability to cope independently (impaired social functioning). These must have started before adulthood and have a lasting effect on development. (DoH, 2001: 14). In terms of the prevalence of learning disability, no comprehensive data exist at a national level. Indeed, the government collects no data on the numbers of people who have a learning disability. Prevalence data are based on the numbers of individuals known to social services and estimates in the general population. Emerson and Hatton (2004) estimate a total of 985,000 people in England with a learning disability, giving a prevalence rate of 2% of the general population. Gill and Badger (2007) combine this with an estimate of three million people from BME communities in the UK to arrive at a figure of at least sixty thousand people from BME communities with learning disabilities. Making the case for enhanced advocacy services for people from BME communities, Gill and Badger assert that “[t]his represents a significant proportion of people who are likely to require a social care service at some point in their lives” (*ibid.*: 3).

*Black and Minority Ethnic*

We use this term to describe people from a cultural or ethnic minority in the UK. The use of umbrella terms such as BME can mask the diversity of the individuals as well as of the communities it seeks to represent. Sue and Sue (1999) make the case that it is the experience of certain distinguishing life events, rather than ethnicity or culture *per se*, which sets the ‘minority experience’ apart from that of individuals and families in the majority community. Adapting Sue and Sue (1999), the minority experience might include any or all of the following:

- the experience of racism, prejudice and discrimination
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- value systems which conflict with that of the majority culture
- bi-culturalism (the inheritance of two cultural traditions)
- minority status (memories of, for example, colonialism, slavery or ethnic cleansing; refugee and immigrant status; skin colour and obvious physical differences; names and family names)
- migration (forced or voluntary)
- language (minority families may lack English language skills, or may not possess vocabulary equivalent to standard English, for example they may lack a formal equivalent to the term “advocacy”)
- socio-economic class – aspects of wealth, occupation and status.

**Majority Community**

We use this term in preference to “white community” because, although inherent in the term “white” is acknowledgement of the legacy of white historical privilege, using the term “white community” nonetheless obscures the fact that there are white minority ethnic communities in the UK whose experience is that of the BME communities characterised above. These white minority ethnic communities, for example Irish, Portuguese, Albanian, Polish or Roma communities, are included under the umbrella term “BME community”.

**Diversity**

It is essential to recognise the heterogeneity of the BME population as well as that of the “majority culture”, not just in terms of ethnicity but in terms of lived experience. Our individual and group identities are multiple (Daniel, Roysircar, Abeles and Boyd, 2004: 764) and multi-faceted. The impacts of socio-economic status, education, employment, religious affiliation, sexuality, gender, disabilities, class, political ideologies, familial and social roles must all be acknowledged in the advocacy relationship. There is a need to recognise that diversity may be found not just amongst and within communities but also, crucially, within the families and individuals by which communities are constituted. Recognition of diversity lies at the heart of a truly person-centred approach to service provision.
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**Advocacy**

Typically, advocacy is described as a process whereby one individual (the advocate) speaks for or on behalf of another individual who has communication needs (the advocate partner) so that the advocate partner is empowered to have more choice and control in their lives. Institutional definitions coalesce around this basic conceptualisation. For example, *Valuing People*, the government’s 2001 white paper on learning disability, defines advocacy as helping people “put forward their views and play an active part in planning and designing services which are responsive to their needs” (DoH, 2001: 46). Action For Advocacy, a voluntary sector advocacy organisation, describes advocacy as “taking action to help people say what they want, secure their rights, represent their interests and obtain services they need”, going on to assert that “[a]dvocacy promotes social inclusion, equality and social justice” (Action For Advocacy, 2009). Mencap, the learning disability voluntary sector organisation, characterises advocacy simply as “the process of helping someone to express what they want to say” (Mencap, 2009).

Clearly, however, there is a set of underlying principles upon which the process of advocacy is constituted. The British Institute of Learning Disabilities, for example, sets these basic principles out thus, stating that advocacy

- supports people in expressing their views, preferences and decisions on an equal footing
- works to make things happen once decisions have been made by the people it supports
- defends equal rights against discrimination
- encourages the inclusion of the isolated and excluded
- has diverse forms which can meet many needs
- speaks up for an individual or a group on an objective basis
- does not make choices or decisions for the people who receive advocacy support
- avoids the potential conflicts which can occur when families or professionals act as advocates (British Institute of Learning Disabilities, 2009).

There are a number of different types of advocacy, for example, citizen advocacy, self-advocacy and independent advocacy (see Sheffield NHS PCT, 2007 for a comprehensive
classification), but all would seek to adhere to this set of general principles. However, whilst advocacy providers and many advocacy users may have a broadly shared understanding of the process and principles of advocacy, certain groups remain uncertain as to the term’s meaning (see, for example, DoH, 2001; Henderson and Pochin, 2001; Bowes and Sim, 2006) and hence their capacity to access advocacy services remains curtailed. For example, a recent independent inquiry into access to health care for people with learning difficulties stated that, for this client group, “[t]here is… widespread confusion about the roles of the different players in the advocacy field” (Healthcare Commission, 2008: 50). Equally, people from BME communities question the usefulness and relevance of the term, arguing that it is “too technical and alienating for people speaking languages other than English” (Joseph Rowntree Foundation, 2002: 2). In this study, one BME advocate stated that “[t]he word advocacy is not understood by our service users and we don’t try to force it on them. It is difficult to translate the word into Asian languages. We start from where the user is at…” (ibid.). Having flagged up this uncertainty regarding what advocacy is and what it can do, we now go on to examine the role of advocacy in facilitating access to health and social care.

The role of Advocacy in facilitating access to Health and Social Care

A person from the majority community with no additional needs

Most of us, without even realising it, advocate for ourselves or our family on a regular basis, for example making complaints, chasing up deliveries, querying a bill or booking a doctor’s appointment. For the majority of the UK population, accessing services and entitlements in this way – that is, using the skills of self-advocacy – is a relatively unproblematic process.

Figure 1: A person with no additional needs from the majority community successfully accessing services
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A person from the majority community with learning disabilities

However, for certain sections of the population, advocating for themselves is more problematic. If we take the example of a person from the majority community with learning disabilities, self-advocacy may not only be problematic, it may even be impossible.

Figure 2: A person from the majority community with learning disabilities failing to access services

The barriers to accessing services, information and entitlements for many groups of individuals have typically been conceptualised in terms of the individual’s own abilities or attributes, for example, their learning disability, socio-economic status, education level or cultural or ethnic background. However, with the growing recognition of a “social model of disability” and in the wake of investigations such as the Macpherson Inquiry (see below), attention has, more recently, come to focus on service-level barriers that disempower individuals and restrict their equitable access to services. The Healthcare Commission report cited above found “convincing evidence that people with learning disabilities have higher levels of unmet need and receive less effective treatment, despite the fact that the Disability Discrimination Act and Mental Capacity Act set out a clear legal framework for the delivery of equal treatment” (Healthcare Commission, 2008: 7). Mencap (2004: 11-21) provides a comprehensive account of the barriers which confront people with learning difficulties seeking access to health services:

- mainstream health services do not see people with learning disabilities as their responsibility, with the result that many health care professionals have little understanding of learning disability
- primary health practitioners feel poorly equipped to work with patients with a learning disability (this is particularly significant as nine out of ten contacts that people have with health services are with primary care)
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- doctors’ assumptions and attitudes regarding patients with a learning disability, sometimes referred to as diagnostic overshadowing, or the tendency to “dismiss changes in behaviour, personality or ability that would be taken very seriously in a person without a learning disability” (Holland AJ, 2000, cited in Mencap, 2004: 13)
- lack of training and skills in health services concerning the medical conditions known to be associated with having a learning disability and which can be prevented
- poor quality of care, with ward staff having low expectations for patients with a learning disability and being unresponsive to their needs, for example in the management of bedsores or ensuring adequate hydration and nutrition
- discrimination, potentially involving value judgements by health care staff regarding the social worth of people with learning disabilities
- failure to make life saving interventions, in its most extreme form by posting “do not resuscitate” notices. The Mencap report states that “[t]here is evidence of doctors making value judgements about the quality of life of people with profound and multiple learning difficulties, and assuming that it would be in their best interests to die” (ibid.: 20).

Echoing these findings, the Disability Rights Commission’s report *Equal Treatment: Closing the Gap* (2006), which investigated physical health inequalities experienced by people with learning disabilities and/or mental health problems, found that, in primary care, these high risk groups are less likely than other patients to receive some of the expected, evidence-based checks and treatments. In particular, people with learning disabilities who have diabetes have fewer measurements of their body mass index than others with diabetes and those with stroke have fewer blood pressure checks than others with a stroke, as well as having very low cervical and breast cancer screening rates. Moreover, the report found that “health checks identify significant unmet health needs amongst people with learning disabilities; and that when a second health check is given one year later further significant unmet need is identified, some of it serious” (ibid.: 6). How is our majority community individual with learning disabilities to overcome such barriers? Advocacy services, readily accessible and well delivered, can support our client to overcome these barriers and to access timely and appropriate health and social care. The benefits of advocacy have been promoted for many vulnerable groups, including people with mental health problems (Barnes and Brandon,
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2002), children and young people (Dalrymple, 2003), people with dementia (Cantley, Steven and Smith, 2003) as well as people with learning disabilities (Booth and Booth, 1998; Armstrong and Goodley, 2001; Preistley, 2001).

Figure 3: A person from the majority community with learning disabilities enabled by advocacy to successfully access services

The emphasis here, however, must be on readily accessible and well delivered. Too often, as the Six Lives report has detailed, advocacy services arrive too late or not at all.

A person from a BME community with learning disabilities

This person would face the double discrimination alluded to above – discriminated against because they have a learning disability and discriminated against because they are from a BME community. Indeed, were the person female, she would face triple discrimination. The 2001 report to the Department of Health, Learning Difficulties and Ethnicity, characterises this triple discrimination as follows: “[p]eople with learning difficulties from minority ethnic communities experience simultaneous disadvantage in relation to race, impairment and, for women, gender. Negative stereotypes and attitudes held by service professionals contribute to the discrimination they face” (Mir, Nocon, Ahmad and Jones, 2001: 2). These structural disadvantages (learning disability/ethnicity, or learning disability/ethnicity/gender) are not simply cumulative but are simultaneous, multiple and interlocking (see, for example, Denis, 2008, on the intersectional analysis of oppression). 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.
In light of the “substantial inequalities and discrimination” (Mir et al, 2001: 2) faced by BME communities in accessing health and social care, our person from a BME community with learning disabilities is likely either to remain cut off from public services or to receive inappropriate support. The interlocking barriers faced by minority ethnic people with learning disabilities have a number of constituent parts, principal among them:

- socio-economic status
- racist attitudes
- institutional racism
- a “colour-blind” approach to service provision, masking a failure to recognise diversity and its implications for provision
- stereotyping
- ethnicity of staff
- language (lack of professional interpreting services; lack of culturally appropriate resources and materials)
- lack of understanding of cultural knowledge (for example, cultural, religious and dietary needs)
- lack of understanding of what is meant by “equal treatment” (see, for example, Alexander, 1999; Mir et al, 2001; Joseph Rowntree Foundation, 2002; Fountain, Bashford, Winters and Patel, 2003; O’Hara, 2003; Bowes and Sim, 2006).

If it is possible for a person from the majority community with learning disabilities, via readily accessible and well delivered advocacy, to access timely and appropriate health and
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social care, what might be the experience of a person with learning disabilities from a BME community seeking such care? We could posit that, with timely and appropriate intervention from advocacy services, as in the case of their peer from the majority community, they might overcome the interlocking barriers relating to their disability/ethnicity/gender. However, discrimination against BME individuals is as likely to be encountered in advocacy as in any other public service.

“Mainstream” or “generic” advocacy services, like health and social care services, are not created in a cultural vacuum. At both service and individual advocate levels, ingrained attitudes and practices sanctioned by habitue can, for vulnerable individuals from BME communities, create barriers to accessing advocacy. Fazil et al (2004: 395) and Rai-Atkins et al (2002: 34) note that the advocacy movement has been a predominantly “white” movement predicated on “western” notions of advocacy, suggesting that the emphasis on autonomy and empowerment of the individual are not congruent with cultural contexts which have the family rather than the individual as a focus (Bowes and Sim, 2006). As Bowes and Sim summarise, “[t]he development of advocacy as a public ‘good’ enshrined in policy has not, in their view, been informed by the views and experiences of BME communities” (2006: 1211). Indeed, as indicated above, the concept of advocacy is problematic as it is not widely or fully understood by vulnerable groups such as BME communities, for whom the term may not be easily translatable, and expectations from clients and families may not match organisational aims (Quinn et al, 2003; Rai-Atkins et al, 2002; Fazil et al, 2004).

At the same time, however, Rai-Atkins et al suggest that “[a]dvocacy has the potential to secure vital redress and challenge the perpetual inequality and discrimination” which individuals from BME communities face (2002: 2). Fazil et al similarly argue 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). To support our client from a BME community with learning disabilities in accessing services, entitlements and information, this paper proposes the novel application of a cultural competence framework to advocacy services.
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Culturally competent advocacy is the bridge which enables our client to transcend the barriers they face and gain access to the services, entitlements and information they need and to which they have a right.

Figure 5: A person from a BME community with learning disabilities enabled by culturally competent advocacy to access public services

Applying a Cultural Competence framework to Health and Social Care

A cultural competence framework comprises three core elements:

- **cultural awareness and beliefs**: the practitioner’s sensitivity to their own personal values and biases and how these may influence perceptions of the client, the client’s circumstances and the service provision relationship
- **cultural knowledge**: the practitioner’s knowledge of the client’s culture, world view, and expectations of the service provision relationship
- **cultural skills**: the practitioner’s ability to intervene in a manner that is culturally sensitive and relevant (adapted from Sue, 2006).

A cultural competence framework has been applied to health care provision in the United States for some time (see, for example, Lavizzo-Mourey and Mackenzie, 1996; Institute on Ageing, 2001; Campinha-Bacote J, 2002; Betancourt, Green, Emilio Carrillo and Park, 2005) and there is now a burgeoning literature as well as a number of cultural competence toolkits and codes of practice. More recently, a cultural competence framework has been applied to health care provision in the UK (see, for example, Chandra 1996; Papadopoulos, Tilki and Lees, 2004) and in particular to palliative care (Owens and Randhawa, 2004), physiotherapy
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(O’Shaughnessy and Tilki, 2007) and community learning disabilities services (Summers and Jones, 2004). For this reason, many of our illustrative examples below are drawn from researcher and practitioner experience in the field of health care. In terms of drug service provision, a cultural competence framework informs the work of both Sangster et al (2002) and Fountain et al (2003), both of which reports focus specifically on BME communities.

Given our focus here on BME communities, a cultural competence approach is seen to be especially relevant, not least for its emphasis on inclusion. As Sangster et al note, “[a]lthough cultural competence is an inclusive notion it is especially important in relation to Black and minority ethnic communities because of their particular, rather than exclusive, needs. […] More generally, a social orientation was seen as being particularly relevant to Black and minority ethnic communities as it provided a basis for working with the realities of racism” (ibid.: 36, original emphasis). The application of a cultural competence framework has not, as far as the authors have been able to ascertain, been undertaken with regard to advocacy services in the UK. We propose that a cultural competence framework can usefully be applied to advocacy services as a means of elucidating practice at the practitioner and service delivery levels and thereafter of structuring personal and organisational development.

A Cultural Competence framework for Advocacy services

In the absence of a universally acknowledged definition of cultural competence, for the purposes of this paper we apply Sue, Ivey and Pedersen’s (1996) cultural competence framework as this is the most widely recognised. We seek here not to develop and explicate a detailed model of cultural competence and its application to advocacy services, rather to bring the ideas and tools of cultural competence into the sphere of advocacy practitioners, providers and commissioners. Nor do we seek, at all, to indulge in a finger-wagging exercise, excoriating advocacy practitioners, providers and commissioners for a lack of cultural awareness. Rather, we hope to be able to show that it is in each of us, advocacy service workers and advocacy service users alike, to consolidate and refine our capacity for empathy and reflexivity. It is our hope that future research will develop and refine the cultural competence framework and so better equip the advocacy sector to meet the needs of people from BME communities.
We propose to examine the core elements of the cultural competence framework and its applicability to advocacy services at two distinct levels:

- **institutional level** – are issues such as recruitment, new initiatives, programme evaluation, outreach services, access to and availability of service, service utilisation and service quality measured for their effectiveness for members of different cultural and ethnic groups?

- **practitioner level** – the individual advocate working directly with clients.

Investigation could also be undertaken at the sectoral level (that is, the organisation and structure of advocacy services for different BME communities and these services’ interaction with other agencies and community services). However, such a broadscale analysis lies beyond the scope of this paper.

**Cultural competence at the institutional level**

Groups at all levels – ethnic groups, social groups, communities of interest, corporations, institutions, society – typically have values that are broadly shared by their members. The values held by groups constitute the moral foundations of that which is considered “good” or “bad” and from which cultural norms – the rules for behaviours and interactions within the group – develop. These values and norms influence the way in which activities are carried out within the group as well as the way in which institutions are developed to service the group, for example the development of education and legal systems and health and social care provision. Terms such as “mainstream” or “generic” are often used when describing health and social services. However, if services are created by members of a particular community or society, can they be considered truly mainstream or generic? Mainstream, generic 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.
The UK has lagged behind the USA, Australia and New Zealand in addressing transcultural issues in the health care sector (Holland and Hogg, 2001). Cultural diversity policies did not emerge here until the late 1990s and early 2000s in recognition of the need to address cultural issues in the wake of the Macpherson Report (Papadopoulos, Tilki and Lees, 2004). This seminal report characterised the way in which the Metropolitan Police handled the death of the young black man Stephen Lawrence in the late 1990s as demonstrating “institutional racism”.

The Macpherson Report and the earlier Scarman Report (1981) were pivotal in the development and application of the notion of institutional racism, with Macpherson further refining Scarman’s definition (overt policy consciously pursued by an institution) to produce a definition much more widely applicable to the British context (Sangster et al, 2002). He distinguished between

- the racism of overtly prejudiced individuals
- racism as a conscious and deliberate policy of institutions and
- racism as unintentional or unwitting discriminatory practice in the mode of operation of organisations which are formally non-discriminatory (Lea, 2000).

The formal definition of institutional racism in Macpherson is as follows. It is “[t]he collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantages ethnic minority people. [Racism] persists because of the failure of the organisation openly and adequately to recognise and address its existence and causes by policy, example and leadership. Without recognition and action to eliminate such racism it can prevail as part of the ethos or culture of the organisation. It is a corrosive disease” (Macpherson, 1999: 28).

We reproduce it here because it captures and makes explicit the diffuse, embedded nature of the dispositions and practices which a culturally competent approach seeks to challenge at the institutional level. As Sangster et al comment, “[t]he distinction between individual and institutional racism, as defined [in Macpherson], may not always be clear because the
workings of an institution are encountered as the actions of individuals and the nature and dynamics of an institution may not be immediately obvious from the actions of individual employees” (2002: 10).

Developing a culturally competent advocacy service model: some considerations
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. O’Shaughnessy and Tilki make recommendations for service providers to assist in the development of cultural competence:

- work closely with BME communities
- provide comprehensive staff training
- audit service access and provision to all communities (ethnic monitoring of clients who use their services can be matched to the local demographic to see if the agency is in fact reaching the population it seeks to serve)
- provide clear leadership to embed and reinforce BME concerns and needs across service delivery
- provision of multilingual, culturally appropriate information
- provision of professional interpreting services
- examine policies and procedures to ensure recognition of cultural diversity
- consider ethnic profile of workforce
- work closely with other agencies
- ensure that practice is informed by relevant research and development

(adapted from O’Shaughnessy and Tilki, 2007: 70).

No quick fixes: the pitfalls of tokenism
Advocacy services, however, can place so much emphasis on the need for BME advocates that this can be seen as a quick fix to the “minority issue” and, at the same time, majority community advocates can feel disenfranchised from working with BME clients.
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As a respondent in Sangster et al comments with regard to the danger of tokenism when employing BME workers, “[t]his is the difficulty of sticking us all under one label, and even Asian all under one label, because, you know, they’re fake communities, and there’s been long intrinsic battles, so to sort of clump everybody together and assume that this one big melting pot is going to be a successful conduit I think is naïve to say the least” (2002: 33). The contribution of BME advocates should be seen as part of the process of becoming more culturally competent, rather than an end in itself (ibid.). Undoubtedly BME advocates are an invaluable resource and advocacy groups should strive to have a staff team reflecting the cultural and ethnic diversity of the clients they serve. However, it is not always possible to recruit BME advocates, for example in communities where there is proportionately a very small BME community (see, for example, North Wales Race Equality Network, 2009), it is unlikely that recruitment would be able to reflect the diversity in the BME population. Moreover, given what has been described as the ‘super-diversity’ of certain cities (Vertovec, 2007), it is unlikely that recruitment would be able to reflect the diversity in the BME population. Indeed, BME advocates for BME clients is not always the ideal. For some, “the embeddedness of the [community advocacy] groups in local community life could present problems – for example, breaches of confidentiality linked with undesirable outcomes in terms of intra-community relations” (Bowes and Sim, 2006: 1219). In addition to confidentiality, issues to do with over-identification and shared, unexamined assumptions may also qualify the intra-community advocacy relationship. Equally, for the client, “feelings of shame may be sharply felt when confronted by a worker with shared cultural understandings” (Sangster et al 2002: 34). However, despite these caveats, Sangster et al found that “while BME workers were seen to have considerable value as symbols of accessibility and trust, their value was seen to extend well beyond the symbolic. BME workers were seen to have ready access to BME social networks and were identified as an important source of authentic knowledge and experience” (2003: 34). Furthermore, it was suggested in the same study that BME workers might enhance the cultural competence of their white peers.

Bowes and Sim found that when BME advocacy service providers were asked to identify desirable features of a putative advocacy service, the top two items mentioned were having bilingual BME workers and cultural sensitivity.
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These authors report that “[e]thnicity, language and gender were the most strongly supported important factors.

However, elaborating these responses, people explained that although they had said ethnicity was important, they felt cultural sensitivity was the main issue – shared ethnicity might be one way, but not the only possible way, of ensuring this” (2006: 1217, emphasis added). This finding is significant for our promotion of a cultural competence model for advocacy services because it articulates our conviction that cultural competence is a stance, a disposition or approach that can be developed in all advocacy practitioners, regardless of ethnicity. A culturally competent advocacy practitioner is someone who has undertaken training and independent study to develop, in an iterative, reflexive manner, qualities and attributes which they already possess (see, for example, Seeleman et al, 2009). In this sense, adopting a culturally competent approach is likely to enhance the service received by all clients, not just those from BME communities. However, as indicated above, there is a need for institutional mechanisms to be in place which support, enable and facilitate the individual practitioner to work towards culturally competent service provision.

Cultural competence at the practitioner level

Applying to advocacy the principles set out in Sue (2006) in relation to clinical psychology, advocates and advocacy services must become aware of their own values, biases and stereotypes and how these might influence the advocacy product if they are to begin to work effectively with people from cultures different to their own. A cultural competence approach at the practitioner level “requires participants to identify, reflect on and challenge issues, and to explore strategies to address cultural aspects of [advocacy]” at individual, institutional and sector levels (O’Shaughnessy and Tilki, 2007: 70). For these authors, the focus of a cultural competence model is “not on providing information about different cultures, but encourages critical reflection, generates openness, explores new ideas, and challenges personal and professional ethnocentricity” (2007: 70). 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 (ibid.: 71).
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Reflexivity in service-user/practitioner interactions

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.

An example of both the extent to which we are immersed in our cultural contexts in daily life and practice, as well as of the way in which culturally competent reflexivity can produce unexpected learning, is provided by Muñoz in his research into culturally responsive caring amongst occupational therapists: “[s]o I was teaching her some one-handed or minimal bilateral kitchen skills. And thinking like a Californian I had lots of fresh vegetables and salad and all that sort of thing and I figured she could make a green salad. And she got kind of a kick out of that because she said ‘You know, where I live we don’t get that many fresh vegetables for most of the year. So I don’t mind making a salad, but this isn’t a regular part of what my diet would be.’ It was like boiiiiing! She really brought it home to me that I had been thinking in my own cultural context” (2007: 271).

Personal values and biases are developed through socialisation into family, culture and society as well as via influences from our wider socio-political environment. Personal values and understanding of cultural “norms” influence our behaviour and also our responses to interaction. Unquestioning acceptance of our cultural “norms” as being universal leads inevitably (and naturally) to a culturally biased world view.

When we encounter cultural practice which runs against our own cultural norms, a frequent response is to stereotype others and their behaviours as a means of simplifying and organising social information so as to “avoid paralysis in a complex world” (Balsa and McGuire, 2002: 104). Stereotyping is a term used by social psychologists to refer to “the process by which people use social categories (e.g. race, gender) in acquiring, processing, and recalling information about others” (Dovidio, 1999: 804). Stereotypes can arise and be sustained for different reasons. Psychological studies demonstrate that, even when groups have been arbitrarily constructed, individuals tend to claim favourable characteristics for their own group and exaggerate and attribute negative characteristics to the other group (Ashmore and Del Boca, 1981, cited in Balsa and McGuire, 2002:104).
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In the context of advocacy service provision in culturally and ethnically diverse communities, stereotyping can create significant barriers to person-centred service delivery by obscuring diversity in individuals, families and communities.

Williams and Rucker (2000) argue that negative stereotypes about minorities are an important explanation for health care disparities. At the practitioner level, negative stereotyping can lead to prejudice and discriminatory behaviour. For example, failing to offer respite care services to South Asian carers for people with learning disabilities because they are seen as “looking after their own” denies choice and potential opportunity to the carer (see Butt and Mirza, 1996). Seeleman et al assert that “[a]s a first step towards avoiding this pitfall, it is essential to be aware of one’s own prejudices and tendency to stereotype. This concerns obvious prejudices as well as subtle stereotyping, as reflected in patronising or avoiding patients” (2009: 234). An additional negative impact of stereotyping is that stereotypes can be internalised by the target group, creating negative self-belief and thus impacting on individuals’ behaviour (Loury, 2001). For example, a practitioner’s negative stereotype about a given BME community – “this group cannot be relied upon to comply with treatment” – may affect what treatment is offered by the practitioner and how they explain the treatment to the patient. This interaction may in turn influence the way the patient engages with the treatment, with the result that an assumed stereotype “can become a self-fulfilling prophecy and lead to disparities in treatment” (Balsa and McGuire, 2002:103).

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 can become 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, becoming more accommodating of difference and developing an awareness of their own defences, projections and internalised discriminations (see Sue, 2006).
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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. When advocating for clients with differing worldviews, it is essential that the advocate listen to the client’s concerns and needs and respond to them in a non-judgemental manner. In this way, the client’s voice is heard. At the same time, however, the client, like the advocate, brings their own personal and cultural biases to bear on the advocacy relationship. In addition, the client may judge the advocate in relation to their own attributes (such as age, gender or ethnicity) – “in some cultures, men may find it hard to confide in women, or older clients may believe that younger practitioners cannot have the wisdom to help” (ibid.: 240). Similarly, in Bowes and Sims’s study of advocacy for BME communities, gender was found to be important “because women might prefer a female advocate, or because women were thought generally to be more sensitive and therefore better advocates” (2006: 1221).

Seeleman et al state that “cultural background, among other factors such as religion, influences people’s perceptions of health and health care, their frames of reference, and their expectations. Awareness of how this might be of influence – instead of mere knowledge about the cultural practices or beliefs or specific ethnic groups – and an appreciation of this factor helps [practitioners] deal effectively with cultural issues” (2009: 232). A BME client may bring to the advocacy relationship current, ongoing experience of racism, the effects of previous racism, or both. It is essential for the advocate to reflect on their practice, to recognise the dynamics of the advocacy relationship and to work towards fostering rapport, trust and the client’s faith in the advocate to treat them fairly. At the same time, it is important to remember that BME communities are not at all homogeneous and that prejudice and discrimination exists within and between BME communities. Whilst BME advocates may share with BME clients elements of the minority experience described above, there can be a tendency for advocates from BME communities to be seen as the “expert” on all BME clients and issues, especially those from “their” community. This fails to acknowledge the diversity embodied in individuals, families and groups.
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**Developing “cultural knowledge”: challenges and possibilities**

Developing cultural knowledge is of fundamental importance in working effectively with individuals from BME communities. Cultural knowledge is the advocate’s knowledge of their client’s culture, world view and expectations of the advocacy relationship (Sue, 2006). An important component of developing cultural knowledge is the recognition of inequalities in power (Papadopoulos et al, 2004: 113). Culture is fluid rather than fixed – it is important to recognise that individuals adhere “to different aspects of their culture contextually” (ibid.: 112) and hence important to acknowledge the influences of variables such as migration, diaspora experience and acculturation. At a more basic level, it is simply not possible to have comprehensive knowledge of all the different groups and communities which together make up modern British society.

Developing cultural knowledge brings its own challenges. It is sometimes presented as a checklist of the cultural characteristics and practices of each BME community, with the implication that if the advocate familiarises themselves with these characteristics and practices, they are equipped to work effectively with BME clients. Such an approach, however, can end up by giving licence to stereotyping and result in the denial of individual, familial and group diversity. Developing cultural knowledge does entail learning about cultural characteristics and practices, but it requires us to understanding these in the context of diversity. An example of a cultural characteristic might be that married Hindu women wear a bindi or decorative mark on their foreheads. Indeed, many married Hindu women do wear bindis, but so too do many unmarried Hindu women, as well as married and unmarried Muslim, Sikh and Jain women. The challenge for advocates is how to develop cultural knowledge in a manner that reflects diversity and avoids over-generalisations and stereotypes. Sue refers to the skill of knowing “when to generalise and be inclusive and when to individualise and be exclusive in working with clients” as “dynamic sizing” (2006: 239) whilst Muñoz refers to the same process as being “culturally responsive” (2007: 274; see also Dyche and Zyas, 2001, on cultural empathy and Tervalon and Murray-Garcia, 1998, on cultural humility). Setting out principles for effective cultural competence training, Papadopoulos et al recommend that “[a]lthough factual knowledge about groups, habits and customs may be more acceptable to participants, training should be moved beyond the delivery of facts to challenging ethnocentric beliefs, practices and unwitting prejudice among staff” (2004: 114).
For advocacy practitioners to move beyond facts and have their unwitting prejudice challenged can be an intimidating, threatening experience, so “[i]t is essential that the training offers a safe environment to challenge individual racist behaviour while not attacking the individual per se” (ibid.).

When working and interacting with clients, it is important to have an understanding of what cultural needs or concerns the client may have which could have an impact on the advocacy relationship. Asking the client in a non-judgemental manner about cultural or religious practices or needs that are relevant to the working relationship or the particular advocacy task in hand is the best way to obtain relevant cultural knowledge about the client and their situation. To inform the questions they ask and how they ask them, advocates can draw on existing cultural knowledge of clients from that community, independent cultural knowledge study or any cultural competence training they have received. Simply by asking such a question, the advocate demonstrates both respect for and awareness of diversity. Moreover, asking in an appropriate manner can do no harm, indeed the advocate should not feel wary of asking this kind of question nor ignorant or embarrassed at the need to ask it. Similarly, if the advocate feels unable to support a particular client it is important to recognise limitations and to seek advice and support within their organisation or from a BME advocacy service. When working with a client from a BME community, as with any client, it is important to build rapport and trust. Taking time to understand your client’s cultural needs plays an important part in developing trust and credibility (Daniel et al 2004: 760). By recognising their own values and biases and by applying reasoned cultural knowledge, the advocate who is well versed in supporting vulnerable people sensitively is able to work with clients from BME communities in a culturally sensitive and relevant manner.

Once cultural awareness, knowledge and sensitivity have been developed in an advocacy practitioner, it becomes important to develop “the ability to recognise and challenge racism and other forms of discrimination and oppressive practice” (Papadopoulos et al, 2004: 110). This, too, can present a steep learning curve for the advocacy practitioner – to begin by recognising one’s own prejudices and discrimination and then to take it upon oneself to challenge prejudice and discrimination in one’s peers, in the service or across the sector.
It is necessary for the advocacy practitioner to fight the instinct to overlook prejudice or to underplay the relevance and significance of cultural difference. As O’Shaughnessy et al have it, citing Macpherson (1999), “[f]ailure to recognise cultural differences, a feeling that these differences are not significant, or that attention to individualised care will transcend them can result in discrimination, which although unintentional, potentially constitutes institutional racism” (2007: 74). In identifying and challenging prejudice and discrimination at all levels, advocacy practitioners are promoting and defending their clients’ rights. A culturally competent approach asks much of the advocacy practitioner, the advocacy service and the advocacy sector.

**Linguistic Competence**

English language knowledge and fluency level can operate as another barrier to accessing information, entitlements and services. As such, “[p]roviding appropriate interpretation services and advocacy are both mechanisms by which BME needs are articulated, therefore increasing the possibility of receiving appropriate care and participation in care decision making.” (El Ansari, Newbigging, Roth and Malik, 2009: 2).

Communicating with people in a language other than their first language can blunt our sensitivity to their feelings, attitudes and values (Shah, 1992). We think and feel in our first language, so having to communicate in a second language may have the effect of filtering or blocking thoughts and emotions (Bhugra, 2002). Similarly, an individual’s second language abilities may lead to their being perceived as flat, non-verbal, uncommunicative or lacking in insight (Sue and Sue, 1999). When BME individuals experience communication difficulties in health and social care settings, the result can be incorrect diagnoses, non-compliance with treatment or inappropriate use of health services.

Doctors experience more problems communicating with and understanding migrant patients than they do with ‘native-born’ patients (van Wieringen, Harmsen and Bruijnzeels, 2002). These difficulties may be caused by a number of factors, the most obvious being language, but cultural differences and the level of knowledge can also play a role (Seeleman et al, 2009).
Given the potential negative consequences of inadequate information, the ability to transfer information in a way the patient can understand is essential for health and social care practitioners, such as doctors. Clear communication and understanding are therefore essential for BME individuals using advocacy services.

The language needs of BME individuals who require advocacy to gain full access to public services can be considered in terms of accessibility and staff bilingualism or availability of interpretation services. Mir et al state that access to information is crucial and that, regarding printed material, “[t]ranslations that are provided in a vacuum and not linked to staff who can respond to queries are not entirely useful if language remains a barrier to applying for services” (2001: 42). Moreover, where these resources are made available is also significant, with culturally appropriate locations such as places of worship, community centres, women’s groups or GP surgeries achieving a greater impact on awareness and uptake of services. The choice of medium also plays a role, not least for those who lack literacy skills. Local press and BME community radio, television and publications, as well as video, audio-tapes and face-to-face communication, can all be effective channels. In relation to printed material it is important to recognise that there are power differentials in play in terms of who has access to gaining literacy skills, in English or in first languages, in Britain and prior to migration, for example, male privilege in terms of access to education opportunities can result in further marginalisation of women. Therefore, even access to ‘accessible information’ may be filtered through power differentials defined by, for example, gender, socio-economic status or caste.

Language barriers in face-to-face advocacy service delivery can be all but insurmountable, in which case the use of an interpreter is required. Setting aside the budgetary constraints within which many if not most advocacy service providers must operate, and the restrictions which these impose on interpretation services, the role of the interpreter is itself problematic.

Whilst it may be unethical and unprofessional to use children or other family members as interpreters, nonetheless this is often the means by which BME clients seek to overcome language difficulties. This risks children being exposed to inappropriate life experiences at too young an age and, where mature family members are used as interpreters, bias, family loyalties and power imbalances may compromise the advocacy interaction.
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In particular, using family members to interpret can result in information being filtered, downplayed or simply left untranslated. Such dilution or distortion may occur, for example, in cases involving domestic violence (whether physical, verbal, emotional, sexual, spiritual or economic), intimidation or forced marriage. Equally, the family member interpreter, whilst not consciously seeking to distort information, may unwittingly allow their own knowledge of the individual or the issue to colour their interpreted account, i.e. interpreter subjectivity may exert a distorting effect on the advocacy client's narrative.

Where language support is sought from community groups, there may be similar concerns, including concerns that confidentiality may not be maintained by the person in the interpreting role. Bilingual advocacy, where available, “functions to interpret between English and the client’s language, so that client’s needs/wishes are well understood. This broader role (than the literal translation of what is said) communicates ‘cultural, religious and social messages about clients’” (Silvera and Kapasi, 2000, cited in El Ansari et al, 2009). It has been argued by El Ansari et al (2009) and others that this is a way to achieve culturally competent advocacy. There is no doubt that bilingual advocates can improve BME clients’ experiences of advocacy and health and social care. However, we would add the caveat that, in order to work in a truly client-centred manner, bilingual advocates, like all advocates, need to be reflexive in their practice and to recognise their own biases. As with BME advocates, the recruitment of bilingual advocates can be extremely difficult and it is not possible to have bilingual advocates representing all of the linguistic needs of all clients. Therefore the role of interpreters and good practice when working with interpreters needs to be considered by advocacy groups. Ultimately, interpretation in the context of advocacy service provision must be acknowledged for what it is, a professional service with a significance and cultural and technical knowledge base which surpass mere linguistic ability: “the interpreter is the person who makes the link between two different languages and cultures… [who] makes sense of unusual questioning [and] helps contain feelings” (Raval, 1996: 36).

At the same time, professionals who work through interpreters, whether in an advocacy, health or social care setting, themselves require training in order to collaborate effectively and productively.
The Cultural Competence model: critiques, challenges and the way forward

The cultural competence model as characterised above is not without its theoretical issues, however. A recent review of the model and its application (Carpenter-Song, Schwallie and Longhofer, 2007) brought together a number of critiques, namely that cultural competence models

- often present culture as fixed
- treat culture as a variable
- conflate culture with race and ethnicity
- fail to recognise diversity within groups
- may unwittingly blame a patient’s culture
- tend to emphasise cultural differences and so obscure structural power imbalances
- fail to identify biomedicine as a cultural product itself.

On a practical level, the model is far from straightforward. Sectorally, the operationalisation of a cultural competence framework is immediately problematic for reasons of funding – the staff and management training in cultural competence and the training and provision of a culturally competent, bilingual interpretation service would place an intolerable burden on advocacy service budgets. If the transition towards cultural competence is challenging at the sectoral level, so it is also at the level of the advocacy service provider. A cultural competence framework requires that an organisation become conscious of its culture, make explicit the assumptions and understandings upon which it bases its procedures and practices and, where necessary, modify these away from a putative cultural neutrality and in favour of a culturally engaged, culturally competent footing. Cultural change of this order is notoriously difficult to bring about, precisely because institutional cultural values and practices are so unreflexive and so ingrained. Here we might usefully conceptualise cultural competence as more a journey or process of becoming than a state of being to be achieved (Muñoz, 2007).

At the advocacy practitioner level, a further set of difficulties are likely to be encountered. These revolve around the central challenge which a culturally competent approach presents to individuals – it demands of the individual a consciously modified relationship to themselves.
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and to the world. The cultural competence approach demands of the practitioner that they examine, strive to understand, and thereafter modify where necessary the ways in which they respond to the people and situations they encounter in their daily lives, both personally and professionally. One cannot be culturally competent in the workplace but not in the home. It is the comprehensiveness of the change required, its breadth and depth, its conflation of our personal and professional lives, which make the individual pursuit of cultural competence so challenging and so potentially problematic. For many advocacy practitioners, if not most, cultural competence demands a paradigm shift in the way they live their lives, away from a culturally neutral view of the self and the world and in favour of one that is culturally inflected, culturally competent.

Conclusion

In light of the growing cultural and ethnic diversity at all levels of UK society, there is a pressing need for culturally competent advocacy services as a means of ensuring that all communities are able to enjoy equal access to public services. 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 (that is, aged fifteen and over) 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. Public services operate within a legal framework and must respond in a timely and appropriate manner to their legal obligations as enshrined in UK and international law. The publication this year of three significant
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documents – *Valuing people now: from progress to transformation* (DoH, 2009a, the government’s consultation on the next three years of learning disability policy), the *NHS Constitution for England* (DoH, 2009) and the *Six Lives* report (LGO/PHSO, 2009) – 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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