This paper was presented to a Conference on "Counselling and Therapy: Addressing the needs of Black and Ethnic Minority Women" at the University of Central England, Birmingham, 22 *March* 1996

Clinical Provision of Ethnosensitive Counselling: from the Margins to the Centre

Tahirah Parveen

I'm only too conscious of how little time I've got to discuss some extremely complex and pressing issues. What I would really want to do this morning is to share with you my experiences of managing what is now a "mainstream" Ethnosensitive Mental Health Unit based at Tameside General Hospital in Greater Manchester. However, what I also feel is essential is to frame what I have to say in a much wider context – both of my own personal and professional experience and of the way in which service provision for the minorities has or rather has not been developed over the last few decades.

Given that Black people have been here in Britain in substantial numbers for the best part of 40 years and that it is now at least 20 years since there was clear recognition that provision of affective services for the new minorities was posing all sorts of concerns and problems – it really is remarkable that so little progress has been made in this direction and gross uncertainty remains about how to actually deliver an effective service. Of course that doesn't mean nothing at all has happened – in fact following the disturbances of the early 80's most local authorities made a much more active commitment to equal opportunities. As a consequence there are more black people holding professional posts even if not a higher levels in the 'organisational structure'. Parallel with recruitment and selection came the substantial commitment to anti-racist training – most white professionals will have been exposed to such training.

However, beneficial or welcome such initiatives may be to our white colleagues – I am increasingly coming to the realisation that neither of these initiatives alone necessarily leads to the improvement of the quality of services that mainstream institutions are able to offer black people. In my opinion this happens for two main reasons:

Firstly anti-racism addresses an almost entirely *white* agenda. What it does not explore is the issue of how we – black people as users and providers of services have had our visions of ourselves and the way we conceptualise the world in which we live profoundly skewed by the consistent exposure to such negative and destructive attitudes. And that our mind set need not necessarily be solely determined by being "victims" of racism or "disadvantaged" at the hands of hegemony. Secondly it does not address the issue of the skills and competencies which professionals – whether white or black need to have in order to be able to offer an effective and accountable service to users drawn from a multi-ethnic/lingual/faith, etc., clientele. Hence it is my belief that we need to move well beyond the conventional agenda of anti-racism and anti-oppressive practice if we are to make any meaningful progress in this field.

Having said that, let me sketch out my own personal history so you can see where I am coming from. Having completed a degree in Psychology, I went on to gain a Post Graduate Certificate in Education but found the classroom was not a place for me, even as a requirement to moving into my final intended area of work in Educational Psychology, so I took up a job as the sole paid worker in a refuge for Asian Women fleeing violence – in Leeds – before moving onto train as a Social Worker. After four years as a generic Social Worker in an intake team (crisis and short term work) in an inner city area office in Bradford I wished to specialise as a Psychiatric Social Worker and took up a post in the Transcultural Unit in Lynfield Mount Hospital. From here I moved into Community Mental Health Centres in Bradford and Oldham before taking up my present position as Manager and Senior Practitioner at the Ethnosensitive Mental Health Unit in Tameside – which started out (3 years ago) as a Section 11 funded project, but now has been mainstreamed. Apart from myself the unit has two full time Mental Health Workers presently training in social work through the employment route.

Although the central issue I want to talk about today is our experience in seeking to develop enthnosensitive approach to service delivery, I feel I must first set the Unit in context for although we've been successful and very fortunate in surviving the abolition of Section 11 and getting mainstreamed we are now and in consequence exposed to the full force of mainstream priorities. One of these being to move resources from "talking therapies" to central government thrusts of community care for the severely mentally ill – i.e., the care programme approach towards care in the community. We find ourselves being pressed ever more firmly in the direction of Approved Social Work (ASW) and care co-ordination and if there are not enough black clients who need these kind of services then we can help out our white colleagues who are overwhelmed with such work. In other words services to the minorities find themselves sidelined once again.

But what about our own experiences in actually seeking to develop more relevant forms of service delivery? Even though we are an all black team, even though the team includes a Punjabi, Gujarati and Bengali Mental Health Workers and even though we've been allowed to set our own agenda – we've nevertheless found the task of providing an ethnosensitive service a challenging one. Partly because we've found it hard to use and develop our linguistic and cultural competencies in an effective way; but secondly, above all because we've also found that we've had to challenge conventional ways of working at almost every level.

That does not mean that minority clients encounter a radically different set of mental health problems from the majority clients – they don't. The underlying problems of schizophrenia, depression, anxiety, post puerperal psychosis and so forth have as far as we are concerned exactly the same kind of distribution in a minority population as they do amongst the majority. And if we get an over representation of clients its simply because no other part of the Health Service and I mean the entire Health Service, not just the Mental Health Service – in Tameside has been specifically charged with responding to minority needs. So we tend to have cases coming in from all sorts of different directions, if only because no other such specialist service is available.

But having got our cases, how should we respond to them? What is becoming increasingly clear is that actually delivering an effective service to a minority clientele is a deeply challenging task both intellectually and professionally. Let me highlight some of the assumptions that are all too often made and which we and I suspect many of you will have since discovered to be false and inadequate.

1. Simply being able to speak the relevant language, or being familiar with the relevant cultural conventions is not, in itself a *sufficient* basis for delivering an ethnosensitive service. It may be *necessary* to have such skills – though I want to come back to skills in a moment – but it needs more than that to deliver a service. After all English professionals don't gain a capacity to deliver a service to an English clientele simply by virtue of being English. Professional competence is also essential.

2. But *what* professional competence? Perhaps unusually in so many such projects, I am a fully qualified and experienced social worker – in the white mainstream – by contrast all my staff are still undergoing or waiting to undergo training. And of course that makes a difference. Unless one is both qualified and experienced, one doesn't understand how the system works. One can't make it work to the advantage of one's clients and one can't gain the confidence of one's white colleagues elsewhere in the system. Formal professional training rather than unqualified black staff in the hope that ethnic matching is better than nothing is no solution – on the contrary it is often a step backwards – grossly unsatisfactory to every one concerned.

3. Having insisted on formal training and formal professional qualification, the point immediately has to be made is that that too is no where near enough. One point about which we have become acutely aware is the extent to which mainline professional training is so deeply entrenched in Eurocentric assumptions that it often leaves no space for even a consideration of the prospect of ethnosensitivity.

The whole established edifice of professional practice takes a Eurocentric conceptual universe not just as given, but as the only reasonable and rational way of behaving. The existence of other cultural traditions is sometimes mentioned (after all we're all committed to anti-oppressive practice, aren't we?) but rarely, if ever, are these explored in any detail. So the way in which one might need to *alter* one's professional practice to respond to such differences is never discussed, thereby concealing the greatest inadequacy of all.

For what we have slowly begun to realise – though the point is self evident the moment one begins to think of it – it that it is *not* the case that mainline theory and practice is simply an a-cultural, scientific, and therefore in principle a universalistic outlook from which some variations might need to be made to take account of the culturally deviant practices of a few minorities. But it is *itself a cultural product* – based in, and growing out of, Eurocentric assumptions. In other words while professional qualifications and training is an essential pre-requisite for any kind of serious approach to service delivery – the first thing that one has to do having been trained is to reconsider and re-examine *all* the premises which have been taught in order to establish which of them are indeed universally applicable – even in non-European and non-Christian contexts and which need serious revision in order to make them more ethnosensitive.

In other words developing an effective service for minorities *isn't* just a matter of getting a properly staffed and mainstreamed unit (such as ours) up and running – that is only for starters. What one then has to do is to *reinvent* large parts – although by no means necessarily *every* part - of established professional practice in order to make it ethnosensitive. This is far from easy – most especially when one finds oneself in the midst of an increasingly contract based system where everything is measured (Eurocentrically, of course), and where the goal posts are constantly being changed by government directives. This is compounded yet further when white colleagues and managers fail to appreciate the enormity of the task with which we have been presented – and assume, on the one hand, that if black people are any good then ethnic matching should do the trick and on the other are just waiting for us to fail too – so reassuring them that any difficulties they were having with their minority cases weren't the outcome of their own inadequate commitment to anti-oppressive practice.

No wonder none of us is getting very far. The task we face is large and difficult and the structural context within which we find ourselves working is anything but helpful. Nevertheless, I think we have made enough progress in Tameside to begin to identify the major sources of the difficulties we face – both as black professionals seeking to deliver a more effective service *and* how the attitudes and assumptions of our white colleagues often constitute an ever greater obstacle to progress.

Discussion Points

Sources of difficulty experienced by Black practitioners in developing Ethnosensitive practice include:

1. *Lack of an adequate knowledge base:* since Mental Health professionals will rarely, if ever, have had an opportunity to explore the varied cultural character of Britain's minority populations in any detail during the course of their education and training, what knowledge they do have is almost entirely restricted to personal experience of the community to which they themselves belong.
2. *Lack of supported linguistic skills:* while those professionals who have been brought up within the midst of a South Asian community usually have some competence in their mother-tongue, this will rarely, if ever, have been supported and developed during the course of their education and training.
3. *Lack of an appropriate conceptual framework:* since their professional education and training will have. taken place within the taken for granted arena of Eurocentric assumptions, making conceptual space for – and having the personal confidence to develop – a less blinkered view of the world is a profoundly challenging task.
4. *Doubts about the legitimacy of using Ethnosensitive practice:* since minority professionals are under constant scrutiny from their white colleagues, many are uncertain about the legitimacy of deviating from Eurocentric professional conventions, most especially since this can lead to professional marginalisation.
5. *Uncertainty about the location of the boundaries of professional practice:* even if we do begin to adopt a more Ethnosensitive approach, what conventions should black professionals use to organise their practice? Where should our boundaries lie? What criteria should we use to establish them?

6. *Coping with the psychological impact of racism on our own clients:* black professionals who have not begun to appreciate the impact of exposure to racial denigration on their own psychological outlook, or to analyse how to begin to rebuild themselves in its aftermath, are most unlikely to be able to do anything more than share their clients' anger about racism.
7. *Lack of confidence in our own abilities:* no less than any other group of Black people, Black professionals' professional socialisation tends to undermine their confidence in their own analytical and expressive capacities, as well as in the legitimacy of their alternative loyalties and beliefs. Much needs to be unlearned.
8. *Difficulties in reporting back to the system at large:* even if black professionals do begin to develop Ethnosensitive practice, it is far from easy to identify the concepts and representations by means of which to use to convey the *meaning* of our own and our clients' perspectives to normatively Eurocentric white colleagues.

Difficulties experienced by White professionals in working with Black colleagues:

1. *Alarm about the prospect that they might be identified as racists:* most white professionals appear to be most concerned if they feel that it is being suggested that. they are not enthusiastically committed to pro-active anti-racism.
2. *Alarm about the prospect that their own work with minority clients might be exposed as inadequate:* if it is assumed that a pro-active commitment to anti-racist and anti--oppressive practice should resolve all problems of service delivery, anyone who actually encounters such difficulties tends to fear that this is an indication of gross moral inadequacy.
3. *Unease about establishing relationships of professional equality with black colleagues:* while white professionals seem happy enough to receive supplementary linguistic and cultural information – from Linkworkers, for example – the prospect of collaborating on a basis of professional equality with black colleagues, particularly when issues of race and ethnicity are on the agenda, appears to fill them with alarm.
4. *Jealousy:* while resources are shrinking and everyone is under pressure, the prospect that black colleagues might be allowed to follow a more open agenda in order to develop services for minorities, and that they might be given some resources (however minimal) to do so, is widely regarded as unfair.