

Dr Serena Sharma has spent some time over the last year reviewing our curriculum from an EDI perspective, with a focus on race equality. She has compiled a list of recommendations for our lecturers, informed by her detailed audit of our first-year lectures and slide sets.

#### Theme-level Recommendations:

1. Models and theories: who created them? Acknowledge western and other biases, e.g. mainly white European and American male creators; American and Eurocentric epistemology.
2. Evidence base for all models: How diverse were the samples used? How do we know that these models are applicable to our non-white, non-European/American clients? This, and point (1) need to come early on in lectures, so that trainees can hold this critique in mind throughout. How can we use these models in a way that better suit a range of individuals; is there any evidence that this has been evaluated?
3. Diagnostic manuals DSM-V and ICD-11: these are developed within North American and European traditions of psychiatry. Acknowledge the power of Westernised medicine, psychiatry, psychology; and how the normative data is mostly white.
4. Acknowledge how the diagnostic manuals and legislation e.g the Mental Health Act (1983), The Mental Capacity Act (2005) give westernised medical professionals the power to subjugate and oppress minority individuals:
  - a) Minorities are most likely to be misunderstood and misdiagnosed;
  - b) Minorities have faced and continue to face economic, opportunistic and educational hardship due to structural racism and a favouring of "Whiteness".
5. Standardised questionnaires: what is the normative data for these? Are these questionnaires applicable to diverse populations, and cross-culturally valid?
6. Vignettes:
  - a) Remember that you are teaching trainees on a London course who are attending placements in London, which is full of diversity. Include vignettes which trainees are

likely to come across, i.e. working with clients who are very different to them. This will enable reflection about how to assess, formulate and work with a range of people, and how to respectfully and curiously learn from clients.

- b) Name the demographics in vignettes, e.g. say whether this case is a “White British homosexual man”, or a “Black Caribbean heterosexual female” or a “British Indian non-binary” rather than just saying a name and a clinical presentation. It is not possible to provide an informed and strong formulation without demographics, as these are hugely influential factors to individuals’ identities, personal experiences and positions in society.

7. Ask trainees to reflect on how their own demographics/intersectionality may influence power and dynamics with the hypothesised clients. Invite trainees to reflect on how (not if) their bias shows up, and help them to think about how they can incorporate this knowledge into formulation. This exercise also reinforces the need for direct exploration with the client about their individual context and belief systems.

8. Culture is dynamic and always changing; it is dependent on the social context of an individual. Cultural assumptions are merely assumptions, therefore the only real way to gain cultural information about a client is by *asking them*. Show trainees that this is always needed during assessments and formulation, and help them feel comfortable curiously and sensitively exploring aspects of diversity with clients, through modelling, role plays, group discussion and reflection.

9. Incorporate role plays and exercises that help trainees to work with both difference and similarity. Do not assume that cultural matching i.e. client with trainee, is helpful for the client, e.g. a client may not want someone from “their community” to know about their mental/physical health, nor easy for the trainee, e.g. the trainee may have a different interpretation of the same culture or religion. Help trainees to reflect on working with both difference and similarity.

10. Avoid using the term “culture issues” or “diversity issues” - embracing diversity is a privilege rather than an issue.

11. Very important content around aspects of diversity is often chunked together right at the end of the lecture. This appears an afterthought/add-on, and makes the content appear tokenistic rather than authentic. Integrate this material throughout the lecture. This will also

help trainees to consider diversity naturally and continuously.

12. Avoid giving out a message of white vs other:

- a) Avoid grouping together “ethnic minorities” as there is huge variation here;
- b) provide stats for all ethnicities not just White British e.g. “45% of the participants were White British”. What about the other 55%?;
- c) avoid referring to non-white clients as “culturally diverse”. All clients are culturally diverse, not just non-white British clients.

13. Describe race, ethnicity and culture together, so as not to view race in a reductionist and over simplistic way e.g. white Polish and white English are very different; Black African and Black Jamaican are very different; Asian Indian and Asian Chinese are very different.

14. There is an assumption throughout the curriculum that all trainees already know what “white British” culture is and this seems to be used as a “standard”. Be aware that the White British culture is not known by everyone who lives in the UK (and bear in mind that there are more international trainees now), so when talking about difference do not assume that *sameness* is White British and different is “other”, this is not the case.

15. When speaking about racism, specifically name Racism rather than diluting it using alternative terms. Use the words “racism”, “structural/systemic racism”, “racial trauma”, “internalised racism”. Diluting / not-naming reduces the issue of racism to something small or unimportant, which is easily considered offensive and unjust given the enormity of racism as an everyday problem.

16. Include anything related to diversity, in references or notes of slide, in the main body of the lecture. It deserves that importance.

17. For research lectures, it would be useful to see some more diverse research examples, e.g. CBT treatment satisfaction across races/cultures. Incorporating such examples would model diversity-related research to trainees, which is important.

18. Bringing in the wider context is very relevant and necessary to strengthen the message

that social and cultural context influences mental health, e.g. if an individual faces social injustice, marginalisation and discrimination and subsequently struggles with their mental health, where does the problem lie? Society, or that individual? Mental health cannot be viewed separately from this context. Using something like Bronfenbrenner's Ecological Systems Theory can help with broadening thinking.

19. You do not have to know everything about different races and cultures in order to discuss ethnic and cultural diversity. Creating a safe space and encouraging group reflection can sometimes be the most valuable, insightful and empowering part of a lecture for trainees. Providing the opportunity to learn and discuss is always better than not/staying silent.

Dr Serena Sharma, October 2022