ORIGINAL ARTICLE

Evaluation of cultural competence and antiracism training in child health services

E Webb, M Sergison

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See end of article for authors' affiliations

Correspondence to:
Dr E Webb, Department of
Child Health, University of
Wales College of
Medicine, Cardiff
CF14 4XW, UK;
webbev@cf.ac.uk

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Aims: To evaluate the acceptability and effectiveness of cultural competence and antiracism training to professionals providing services to ill or disabled children.

Methods: Immediate post-training and retrospective questionnaire survey of trainees. Main outcome measures were acceptability; perceived relevance to practice; previous training in this area; perceived impact on professionals' confidence in providing care to diverse communities; and reported changes in behaviour and practice.

Results: Cultural competence and antiracism training has been neglected in the health sector but is well received by professionals. It is a positive experience for trainees and perceived to be relevant to their practice. Appropriate and non-threatening training in cultural competence changes attitudes, behaviours, and practice, including promoting good practice in communication across linguistic and cultural differences.

Conclusions: Appropriate cultural competence and antiracism training is both effective and acceptable in child health services.

In 1992 in Cardiff a partnership between the local Race Equality Council and the Department of Child Health was formed with the aim of improving services to ill or disabled children from black or ethnic minority (BEM) communities.¹ Interviews with service providers identified a need for professional training, but available training materials adopted a "cookery book" approach with lists of cultural norms, and descriptions of cultural differences. This approach, in which the special features of "the Asian family" or "the Afro-Caribbean child" are explored, with rigid notions of culture, has done little to challenge racist stereotypes. It also allows professionals to ignore their own prejudices and leads to pigeonholing, stereotyping, and "victim blaming".²

A new training course—the Equal Rights Equal Access (EREA) pack³—was developed in response to these findings. The main learning objective of the course was the promotion of cultural competence. Cultural competence is an evolving process that depends on self reflection, self awareness, and acceptance of differences, and is based on improved understanding as opposed to an increase in cultural knowledge.^{4,5}

BACKGROUND

Training materials

The EREA pack provides a structured opportunity for trainees to:

- Explore their own attitudes
- Recognise that neither they nor their clients are culturally neutral, but a product of their own cultural conditioning
- Gain an understanding of how racism affects services.

Being provided to small groups, with strict ground rules and facilitated by professionals well versed in antidiscrimination, it enables a non-threatening and safe context in which to explore highly sensitive and emotive issues. It is delivered by a small multidisciplinary group of facilitators to a multiprofessional audience over one day. The concepts of race, culture, ethnicity, and discrimination are explored using examples from child health, either on video or within exercises using a problem based learning approach. Table 1 provides a brief

Table 1 Training plan

<i>Morning</i>	
Session 1	Introduction and ground rules
Session 2	Britain's ethnic minority population
Session 3	Stereotyping and empathy
<i>Afternoon</i>	
Session 4	Racism: What is it? How does it affect services?
Session 5	Communication
Session 6	Conclusions and ways forward to change

description of the contents of the day. The pack is currently being updated in line with the 2001 census.

Implementation

Cardiff

The training was piloted in 1995 in Cardiff, Bristol, and Birmingham, and published in 1996. A rolling programme of training was established locally, and the pack incorporated into the MSc in Child Health. It has subsequently been incorporated into other formal courses, for example, the Cardiff health visiting diploma, and the Welsh paediatric specialist registrar training programme, and is provided, on an ad hoc basis, to outside organisations including the local health authority.

Huddersfield

The programme was incorporated into the Huddersfield project to improve services to black and minority ethnic children with learning disabilities,⁶ funded by the Department of Health. In 2000, over 130 staff from health, education, and social services were invited for training; 100 booked a place and 92 attended.

Abbreviations: BEM, black or ethnic minority; CPD, continuing professional development; EREA, Equal Rights Equal Access; MDT, multidisciplinary team

Comments from the questionnaires

"Will help me to deal with patients from different ethnic groups more confidently and in a far more professional manner ..." (specialist registrar)

"... I thought I knew all this, but find that I didn't ..." (consultant paediatrician)

"... innovative session ... never attended one like this before ..." (trainee health visitor)

"... not at all threatening ..." (midwife)

"Appropriately stimulating, confrontational and thought provoking. Avoided being an exercise in political correctness" (specialist registrar)

"... This course should be compulsory on induction (rather than sitting around discussing superannuation)" (occupational therapist)

"... challenging deep-set ideas that you may not even be aware of ..." (paediatrician)

"... didn't try to give hard and fast rules but reflected the genuine dilemmas faced ..." (Health Authority employee)

"... in my training they told me I was a bastard because I was a man, and racist because I was white. After today I feel I can leave that behind me ..." (social worker)

EVALUATION

The course has been continuously evaluated in Cardiff on an informal basis, using a satisfaction questionnaire filled in anonymously on completion of training, and meetings between facilitators to allow reflective discussion. A recurring theme from these discussions, and from trainees, is the very positive effect on learning of having a diverse audience, in terms of profession, gender, and ethnic group.

Some non-randomly chosen comments from the questionnaires, which provide an insight into trainees' experiences of the day, are shown in the box. The course has been formally evaluated on two occasions.

Huddersfield project

Method

Participants

Sixty (65%) of the trainees were from health: doctors, nurses, therapists, health visitors, support workers, and managers. They were working either in community and hospital based child health or primary care, including the staff of two general practices. Education was the next largest group—24 (26%)—comprising staff from a local special school—teachers, support workers, administrative, catering, and care taking staff. Because of problems with staffing only eight trainees (9%) were from social services, all members of the disability team. The remainder were project staff. Trainees were asked to complete a baseline self assessment questionnaire before training and a satisfaction questionnaire afterwards.

Results

Of the 92 trainees who attended the training course, 86 (93%) completed a baseline self assessment questionnaire and 89 (97%) completed a satisfaction questionnaire at the end of the course.

Baseline assessment

- 20 (23%) had previously received race/culture training
- 42 (50%) said they were dissatisfied or very dissatisfied with the amount of guidance, help, and training they had received from their employer in the past in relation to working with ethnic minority clients/pupils.

Trainees were asked to rank their cultural awareness prior to training. Sixty eight (92%) said culture was an important consideration in their work. Fifty nine (78%) reported having

Table 2 Course expectations

1. *To improve knowledge and information*
 - "Raise basic knowledge of issues"
 - "More information about other cultures"
 - "What is it—institutional racism and unwitting racism?"
 - "What is equal opportunities?"
2. *To improve services*
 - "To be able to change school ethos"
 - "Raise awareness of multicultural issues that affect services"
 - "Cultural sensitivity around child protection issues"
 - "Exploring how culture affects access"
 - "Inter professional/agency working"
3. *To explore personal practice*
 - "How to avoid making assumptions and offending"
 - "Explore communication barriers"
 - "To have own attitudes challenged"
 - "Raise awareness around cultural practices"
 - "Exploring educational options"
 - "How not to offend"
 - "Increase confidence"
 - "Moving from awareness to sensitivity"
 - "To move away from ethnocentrism"
 - "Seeing something through other people's eyes"

previously reflected on their own attitudes around cultural issues and how these might affect their interactions with clients.

Course expectations

The main expectations of the course were around the three areas shown in table 2, with some examples provided.

Evaluation responses

- 87 (98%) said the course was good or excellent
- 67 (75%) said the training met most to all of their needs
- 88 (99%) said course outcomes were achieved for them
- 85 (96%) said the training helped a great deal with cultural understanding
- 85 (96%) said they were satisfied or very satisfied with the amount of practical information given
- 18(21%) said they would like further training on different cultures and beliefs.

Training provided in Cardiff to child health professionals

Method

This evaluation was retrospective, and explored the views of trainees between two and seven years after they had attended the course

Two groups were included:

- (1) Staff members of the multidisciplinary team (MDT) providing care to ill or disabled children in Cardiff. These attended the rolling programme between 1995 and 2000. (Attendance is encouraged by the directorate but is not compulsory.)
- (2) Child health professionals who have completed the multidisciplinary MSc in Child Health, into which the training is incorporated. These attended between 1996 and 2000.

In the spring of 2002 these professionals were sent an anonymised postal questionnaire, containing a total of 11 questions. It collected information on: profession; length of NHS service; previous race training; perceived relevance of the EREA training; proportion of caseload belonging to BEM groups; perceived need for further training; and impact of

Table 3 Proportion of caseload belonging to BEM communities

Proportion of caseload belonging to BEM communities	Number of trainees
<1%	9
1–5%	9
5–10%	9
10–20%	10
>20%	9
Not given	2
Total	48

training on confidence. In addition there were three questions that explored changes in behaviours or practice prompted by the training. These questions (numbers 6, 9, and 11) were:

- Did this training change the way you carry out consultations?
- In your work have you had any encounters (with clients, other professionals, your line manager, for example) in which your response has been modified or influenced by your attendance on the EREA course?
- Could you describe one or more changes you have implemented (for example, clinical, professional, managerial, CPD activities) as a result of attending this course?

Data were entered onto an Excel spreadsheet.

Results

A total of 129 questionnaires were sent out, 80 to the local MDT, and 49 to MSc graduates. Eighty replies were received (62%). Of these, 32 (40%) had not attended the training (28 MDT members and four MSc graduates). This training was not compulsory. The reasons for non-attendance were not explored, but may reflect staff prioritisation of subject areas for continuing professional development (CPD).

The remaining 48 responses were analysed. They included 15 doctors, 12 nurses, 3 health service managers, and 18 in professions allied to medicine (including therapies, dietetics, and orthoptics). They had worked in the health service for between 5 and 36 years (median 19 years).

Only nine trainees had caseloads containing over 20% of BEM clients. Despite this, 40 (83%) trainees rated the course as relevant or highly relevant, both at evaluation and at the time of attending the course. Only four found it of some or little relevance for both occasions. For 38 participants (79%) this was the first such training they had attended. Twenty five trainees (52%) felt they would now like further training, of which five stated they wanted information on other cultures.

Table 3 shows the proportion of trainees' caseloads belonging to BEM communities. For only four trainees was this information based on formal measurement. Six stated the training had no impact on how confident they felt in providing care to BEM clients, 26 felt slightly, and 12 greatly, more confident. Three did not reply. One trainee reported feeling less confident because "I have greater insight into the limitations of the services to accommodate BEM clients".

Thirty six of the 48 (75%) responded positively to one or more of the questions exploring changes in behaviours or practice, of which 27 (56%) related to communication. Of these 27, 16 related to the need to work with interpreters, for example, using appropriate interpreters, never using children to interpret. Seventeen were related to other issues in communication, either with clients or between professionals.

With clients:

- Ensuring that written materials were available in minority languages
- Including pictures of black children in illustrations used in explaining therapy

- Ensuring that health promotion messages were appropriate for all clients, not just the white ethnic majority
- Asking questions directly of a mother if the father was dominating the interview
- Never making assumptions about clients and feeling able to ask about, for example, diet and beliefs
- A change in approach when responding to complaints from BEM clients.

Between professionals:

- Changing the language used to describe ethnic minority clients
- Feeling confident to challenge misconceptions or discriminatory statements made by colleagues
- Speaking out at meetings of professional bodies if race issues were excluded.

One doctor reported "I no longer complain when BEM case notes are dumped on me in outpatient clinics".

Other changes included:

- Becoming a race awareness trainer
- Conducting an audit of services to BEM clients
- Changing the posters in the paediatric outpatient department to be more welcoming to a diverse client group
- Becoming familiar with the customs of local BEM communities
- Arranging transport more often for clinic appointments
- Offering more appropriate appointment times.

DISCUSSION

It would have been preferable methodologically, in the retrospective evaluation, to measure changes in professionals' behaviours directly, as opposed to personally reported changes. This was not possible for two reasons:

- (1) The training was not compulsory to all members of the team.
- (2) In consequence of the subject area, changes often comprise subtle, and often private, adjustments in communication style or practice that would be difficult or impossible to pick up observationally.

The response rate for the retrospective evaluation was low, at only 62%. However, the rate of positive evaluations in attending responders was high enough to provide useful information whatever the findings in the remaining 38%.

Given this, and considering both evaluations, we have shown that:

- (1) Cultural competence and antiracism training has been neglected in child health in both generic undergraduate and postgraduate training across a range of disciplines.
- (2) Such training is well received, although not always prioritised, by health professionals.
- (3) It is a positive experience for trainees and perceived to be relevant to their practice, both during the training and subsequently.
- (4) Effective training does not require cultural menus. Our work with this training programme emphasises the need for the subtler and more difficult aspect of cultural awareness as opposed to the learning by rote of, for example, dietary needs, naming systems. However, prior to training, many staff identify their training need to be for knowledge rather than understanding; a few trainees still want "menus" after training
- (5) Appropriate and non-threatening training in cultural competence changes behaviours and practice, including promoting good practice in communication across linguistic and cultural differences.

Attitudes are difficult to assess and measure directly.⁷ If one accepts that attitudes can be inferred by the responses of individuals to situations,⁸ then the reported changes in behaviours imply that this programme also changed trainees' attitudes.

The 2000 Race Relations Act⁹ requires service providers in the public, private, and voluntary sectors to ensure that all clients have equality of access to services. It now places a statutory duty on NHS Trusts to show how they will eliminate racial discrimination and promote race equality. An essential component is to ensure that members of the workforce are appropriately trained. Evidence to the Stephen Lawrence Enquiry¹⁰ emphasised the need for effective antiracism training and not just awareness sessions. The Commission for Racial Equality¹¹ has consistently recommended that training on race issues should not be conducted in isolation but as part of operational training.

Professionals may provide direct care to children, but usually their contribution is one of advice and support to the primary carers, usually the parents. Partnership with parents is thus a prerequisite if services are to be delivered effectively to ill or disabled children. Families from BEM communities may have many assets, including strong and stable extended family networks, strong spiritual/faith environments, and a well developed sense of cultural identity. Recognising and valuing these assets will lead to more effective support and empowerment of families to work in full partnership with professionals. But establishing asset based and family focused care, in line with the new assessment framework,¹² requires practitioners who are culturally competent.

We have shown that appropriate cultural competence and antiracism training is effective in changing behaviours and promoting good practice in child health professionals. It is also acceptable to a wide range of professionals working with children, with a diverse multiprofessional, multiagency, and multiethnic audience enhancing the learning experiences of both trainees and facilitators.

We believe that incorporating such training into core undergraduate and postgraduate curricula ought to be a priority both for the Royal Colleges and for universities responsible for delivering medical education and developing curricula. It should be highlighted as an important area in CPD.

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Contributors: Elspeth Webb co-produced the training materials, and is director of the Cardiff training programme. She is responsible for the implementation and evaluation of the Cardiff programme, and wrote the paper. Michelle Sergison implemented and evaluated the Huddersfield programme and co-wrote the paper.

Authors' affiliations

E Webb, Department of Child Health, University of Wales College of Medicine, Cardiff CF14 4XW, UK

M Sergison, Calderdale & Huddersfield NHS Trust, Huddersfield Royal Infirmary, Lindley, Huddersfield HD3 3EA, UK

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