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Research papers

Promoting cultural competence in healthcare through a research based intervention in the UK

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ABSTRACT

There is an urgent need to develop cultural competence among nurses and other care workers if they are to meet the needs of the diverse populations they serve, yet there is limited clarity about what this means, or how it can be measured. To date few attempts have been made to measure the effectiveness of education and training programmes which are designed to promote cultural competence. A research project commissioned by mental health service providers was undertaken to deal with the increasing need for cultural competence in a number of mental healthcare settings. It involved the delivery of a training intervention with an assessment of cultural competence before and after the intervention. The training intervention was negotiated with the participating teams and was based on the model of Papadopoulos *et al* (1998). The project included the design and development of a tool for assessing cultural competence (CCATool). The paper discusses the challenges faced by the trainers during this intervention and proposes a set of principles for the development of effective cultural competence programmes.

Keywords: awareness, cultural competence, cultural competence assessment tool, intervention, knowledge, sensitivity

Introduction

Scholarship in the field of transcultural theory has increased considerably since Madeleine Leininger first began her work in the 1950s. In recent years there has been an expansion in the number of transcultural models on offer to inform nursing practice. These have mirrored social and political shifts in attitude towards and concern for black, immigrant and aboriginal communities in the USA, Australia and New Zealand. With a few exceptions, the NHS and British nursing were somewhat late in addressing transcultural issues (Holland and Hogg, 2001). However, in the late 1990s and early 2000s a raft of cultural diversity policies emerged, recognising the changed demography of Britain and the need to address cultural issues in the wake of the Macpherson Report (1999) (see Box 1) and in an NHS undergoing modernisation.

This article describes a research based training intervention which included the development and use of a cultural competence assessment tool. It discusses the challenges of teaching cultural competence and reflects on factors that enhance or impair the success of training interventions.

Box 1 The Macpherson Inquiry (1999)

The Macpherson Inquiry was a government inquiry into the way in which the Metropolitan Police dealt with the death of the black youth Stephen Lawrence in London in the late 1990s. The inquiry headed by Sir William Macpherson of Cluny demonstrated a catalogue of negligence and poor policing which led to the failure to follow up leads and gather sufficient evidence to convict the killers of the young man. The inquiry found that the Metropolitan Police failed to take seriously the racialised nature of the fatal assault against Stephen. While there was evidence of overt racism in the police force, attitudes, organisational systems and policing practices were more a reflection of the stereotypes, ignorance and unchallenged prejudices held at all levels.

Despite increasing reference to the term 'cultural competence' in Department of Health (DoH) and NHS documents in recent years, there is limited attention to what this actually means for patients or staff. As such it is difficult to establish how it might be measured. This reflects the wider literature, in which there is limited consensus around an exact definition of what constitutes cultural competence and a particular absence of what it means for the client. In the UK, health and social care literature and policy documents are frequently unclear in their use of terminology relating to 'race', ethnicity and cultural diversity. They appear to use the terms 'cultural sensitivity' and 'cultural awareness' (and others) synonymously with that of cultural competence. However, there is little doubt about its desirability for nursing clients from all cultures in all care settings (Holland and Hogg, 2001). If cultural competence is to be operationalised and its use and effectiveness measured, it is important to have a clear definition of what it is. It is particularly salient that such a definition is not an abstract statement but is meaningful and applicable for health and social care practitioners, providers of services and those charged with the development of cultural competence training programmes.

There is significant investment in study days, short courses and more substantive training programmes by NHS trusts and public services providers. However, a trawl of UK websites using terms such as 'cultural competence', 'sensitivity' or 'awareness training' shows that these initiatives are diverse in content, duration, mode of delivery and of the skills of those who facilitate them. More surprisingly the authors of this article have been unsuccessful in their attempts to find studies that attempt to measure the impact of educational initiatives for healthcare service providers on practices or in terms of patient satisfaction, as opposed to studies of the education of minority service users.

Cultural competence is variously defined in terms of the outcomes for individual clients and groups or as the attitudes, knowledge and behaviours of practitioners and organisations or a combination of both. While there is never likely to be a single definition which is wholly acceptable to all, the following typifies the definitions found in the literature. It highlights the aims of cultural competence and the attitudes and skills that are essential for its development.

> ... the ability to maximise sensitivity and minimise insensitivity in the service of culturally diverse communities. This requires knowledge, values and skills but most of these are the basic knowledge and skills which underpin any competency training in numerous care professions. Their successful application in work with diverse people and communities will depend a great deal upon cultural awareness, attitudes and approach. The workers need not be, as is often assumed, highly knowledgeable about the cultures of the people they work with, but must approach culturally different people with openness and respect – a willingness to learn. Self awareness is the most important component in the knowledge base of culturally competent practice. (O'Hagan, 2001, p. 235)

The importance of cultural competence

As the diversity of populations continues to grow in most parts of the world, the importance of cultural competence in the caring professions has never been more acute. Health services designed to cater for relatively monocultural populations are increasingly required to review their ability to meet the needs of different ethnic groups. Government directives, legislation, consumerism, shrinking resources, economic rationalisation, and a host of other pressures demand cultural competence in organisations and practitioners. Increasingly there is a danger that organisational or government targets which rely on uptake of services or particular service outcomes will not be achieved without culturally competent provision, particularly in areas of high population diversity (Acheson, 1998).

Lack of evidence based transcultural nursing and research knowledge about cultural differences makes it difficult for providers to deliver, and for clients to experience, high-quality cost effective care. While there are many similarities between people from all parts of the world, there are also differences which arise from culture, religion, family background and individual or group 'influencing care' experiences. These differences not only impact on the values, beliefs and behaviours of clients, they underpin ideas around the provision of

care and influence the expectations that clients and practitioners have of each other.

Although there is evidence of racism in the NHS, it is less a product of the malicious intentions of individual staff or service providers, but instead reflects what the Macpherson report (1999) refers to as institutional racism (see Box 2). Failure 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 may be either intentional or unintended. Health and social care staff are constantly under pressure of time which, they argue, prevents them from looking in depth at the cultural needs of their clients. However, it is also possible that they are unwilling or fearful of the unknown, reluctant to admit lack of knowledge or understanding of health beliefs and practices that do not fit their own world view. Partial knowledge or inadequate understanding can lead to reliance on stereotypes. This leads to assumptions that all members of a group hold the same beliefs and think and behave in the same way, ignoring differences which reflect sex, class, age and experience.

Institutional racism is no less damaging than more overt forms of racism. The Race Relations (Amendment) Act 2000 places a duty on all public authorities to tackle racism in service delivery, so the onus is on authorities to bridge their knowledge gap, challenge prejudices and stereotypes and respect the needs of citizens from all cultures.

Models for developing cultural competence

While it is acknowledged that the dominant theory of transcultural nursing is that based on the pioneering work of Madeleine Leininger (1969), there now exist a number of other transcultural models providing systematic approaches to nursing practice (Campinha-Bacote, 1991; Geiger and Davidhizar, 1995; Papadopoulos *et al*, 1998; Purnell and Paulanska, 2003).

Box 2 Macpherson's definition of institutional racism

'Institutional racism consists of the 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 behaviours which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic clients.' (Macpherson, 1999, p.18)

Transcultural models, like generic nursing models, can be used in their own right to guide nursing assessment and care. In recent years they are more likely to be incorporated into the interdisciplinary documentation developed for integrated care pathways to patient care (Stead and Huckle, 1997). Nursing models such as Leininger's Sunrise Model (1995), Purnell's Cultural Competency Model (Purnell and Paulanska, 2003), and ours (Papadopoulos *et al*, 1998) for developing cultural competencies, provide detailed frameworks for the development of culturally competent nursing. The training intervention for this study was based on the latter model.

Papadopoulos (2003) defines cultural competence as:

> ... the capacity to provide effective healthcare taking into consideration people's cultural beliefs, behaviours and needs ... cultural competence is the synthesis of a lot of knowledge and skills which we acquire during our personal and professional lives and to which we are constantly adding ... transcultural health is the study of cultural diversities and similarities in health and illness as well as their underpinning societal and organisational structures, in order to understand current health care practice and to contribute to its future development in a culturally responsive way. (p. 5)

To provide this knowledge and skills with structure and to facilitate learning, the following stages were proposed (see Figure 1).

A conceptual map is provided for each stage as a guideline but can be modified to suit the type and level of students. The first stage in the model, cultural awareness, begins with an examination of one's own personal value base and beliefs. Raising of self-awareness crucially contributes towards understanding the nature and construction of cultural identity. At the same time, a person becomes more aware that cultural background is a major factor in shaping one's values and beliefs and in turn health beliefs and practices. Therefore the 'cultural awareness' stage constitutes an essential first stage in the process of achieving cultural competence.

The second stage is cultural knowledge which can be gained in a number of ways. Meaningful contact with people from different ethnic groups can enhance knowledge about health beliefs and behaviours and raise understanding of problems faced. This knowledge is required in order to understand the similarities and differences of cultural groups as well as the inequalities in health within and between groups. These may be the result of structural forces in society, such as the power of healthcare professionals. Sociological study encourages the students to consider such issues and to make links between personal position

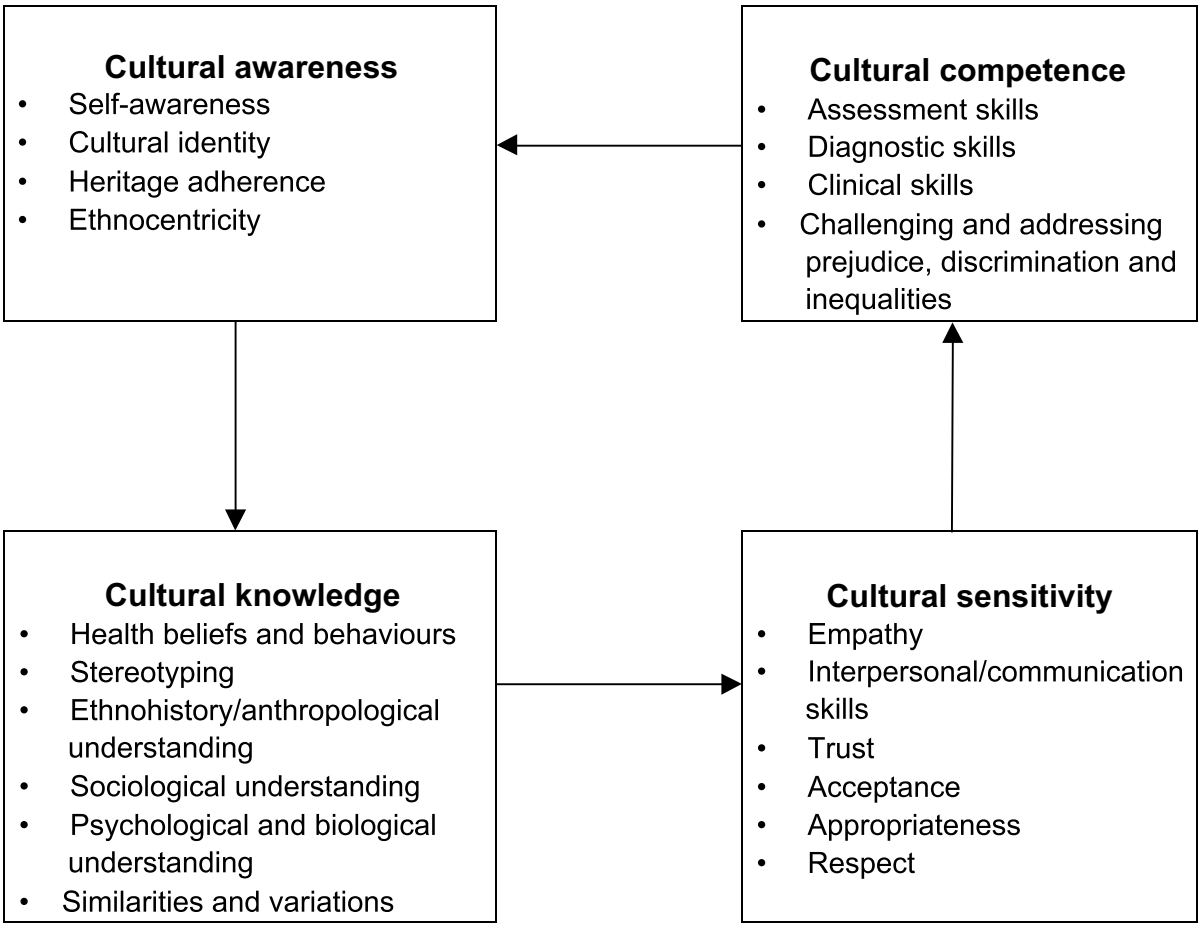

Figure 1 The Papadopoulos, Tilki and Taylor model for developing cultural competence

and structural inequalities. However, cultural knowledge can be gained from all disciplines normally used to underpin nursing curricula, such as psychology, biology, or pathology. Of particular relevance are anthropological studies, while historical understanding is increasingly being emphasised. Most importantly, evidence based transcultural nursing knowledge is expanding through research studies conducted by nurses across the world, although much nursing knowledge remains non-research evidence based (Smith, 1991).

An important element in achieving cultural sensitivity – the third stage – is how professionals view people in their care. Considering research participants as true partners is an essential component of cultural sensitivity and a crucial element in anti-oppressive practice (Dalrymple and Burke, 1995). Partnership demands that power relationships are challenged and that real choices are offered. These outcomes involve a process of facilitation, advocacy and negotiation that can only be achieved on a foundation of trust, respect and empathy. The importance of cross-cultural interpersonal communication cannot be underestimated. Ting-Toomey (1991) warns us that most of the interpersonal communication theory originates largely from individualistic, Western cultures, thus it is inevitable that terms that are widely used reflect a Western-based ideology. Therefore, although the concepts proposed under the cultural sensitivity map should be part of nursing curricula, there is no guarantee that these are taught from a transcultural perspective.

The achievement of the fourth stage, that of cultural competence requires the synthesis and application of previously gained awareness, knowledge and sensitivity. Further, focus is given to practical skills such as assessment of need, clinical diagnosis and other caring skills. A most important component of this stage of development is the ability to recognise and challenge racism and other forms of discrimination and oppressive practice.

Throughout professional life, a set of culturally generic competencies that are applicable across cultural groups are developed and used (Gerrish and Papadopoulos, 1999). These culture-generic competencies, such as the appreciation of how cultural identity mediates health, or a deeper understanding of the underpinning societal and organisational structures that promote or hinder culturally competent care, help the acquisition of culture-specific competencies. It is impossible for any health worker to

know all about the numerous cultural groups in the UK. However, using culture-generic competencies it is possible to gather the relevant culture-specific information needed to care for the patient. Figure 2 depicts the dynamic relationship between culture-generic and culture-specific competencies (Papadopoulos and Lees, 2002).

The Cultural Competence in Action Project (CCAP)

The aim of the project was to deliver a team based, practice focused model of education and training to promote cultural competence in a small number of multidisciplinary mental health teams.

CCAP project design

The project began with an assessment of cultural competence at micro-organisational level, using a tool designed by the authors. This was followed by service users' focus groups which highlighted issues important to clients and their families. These parts of the project will not be discussed in this paper. The participants undertook an assessment of their cultural competence prior to the educational intervention using a tool (CCATool) designed by the authors. The educational intervention was planned to capture the existing strengths of participants and to remedy deficiencies. Priorities were negotiated and agreed with the participants, resources identified and appropriate learning activities decided. The agreed educational programme was facilitated in the workplace over a four month period by two of the authors who are experienced trainers. It was followed by a post-intervention assessment of cultural competence using the same tool. A conventional evaluation of the training intervention was also conducted which will not be reported on here.

The cultural competence assessment tool (CCATool)

The self-assessment CCATool is based on the model of Papadopoulos *et al* (1998). It consists of four sections (awareness, knowledge, sensitivity and competent practice), with an equal number of statements in each section with which the participant can either agree or disagree**.** In addition, visual analogue scales (VAS) are included which allow the participants to self-rate their cultural awareness, knowledge, sensitivity and practice (see Figure 3 for Section one of the tool.).

Validity and reliability of CCATool

In order to establish the validity of the statements, comments were invited from a panel of experts in the field of mental health, ethnicity and culture. The tool was revised in the light of comments from the expert panel and a version with 12 statements per section was piloted with mental health professionals and students to test reliability and internal consistency. This revealed that in each of the four sections answers to 10 of the 12 statements were highly correlated (Cronbach's alpha score >7). These 40 statements formed the final tool. Statements included generic cultural items relevant to any area of healthcare practice as well as statements specific to mental healthcare.

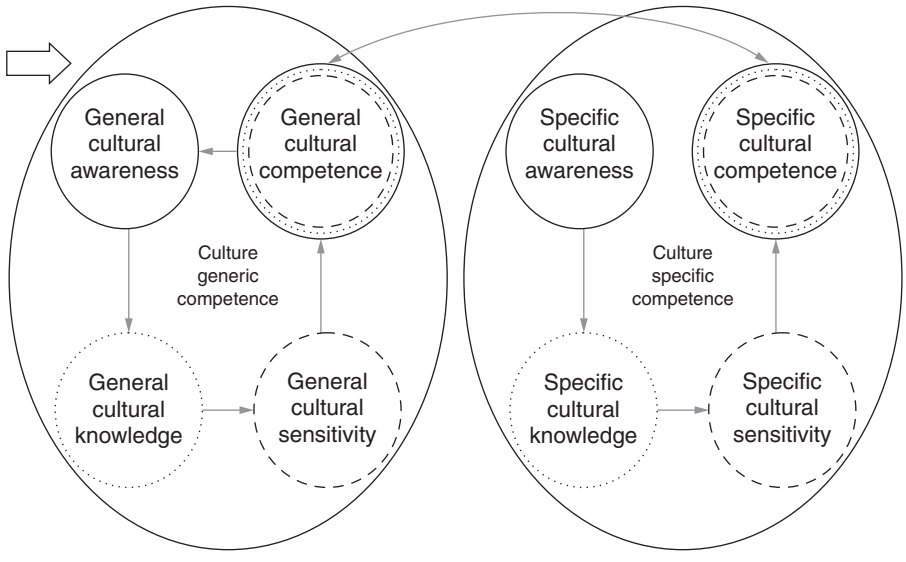

Figure 2 The culture-generic and culture-specific model

Section one: assessment of cultural awareness

	Statements	Agree	Disagree
1	Cultural upbringing impacts on the way in which individuals view other people.		
2	People from different ethnic groups share many of the same values and beliefs as people from the host community.		
3	There are many differences in values and beliefs within any single ethnic group.		
4	Gender, age, class and generation are as important as ethnicity in forming a person's identity.		
5	Ethnic identity changes with time and the influence of wider social factors.		
6	Some aspects of culture are more important to a person than others.		
7	People select the most relevant aspects of their culture in different situations.		
8	People from different ethnic groups may have the same needs but they may be expressed in different ways.		
9	To avoid imposing values on a client, practitioners should be aware of their own value and belief systems.		
10	Ethnic identity is influenced by personal, social and psychological factors.		

Visual analogue scale

I am not at all aware of my own ethnic and cultural identity

I am highly aware of my own ethnic and cultural identity

1 2 3 4 5 6 7 8 9 10

Figure 3 Section one of the CCATool

Cultural competence levels

The agree/disagree responses to statements were marked by the authors, and a level of cultural competence was assigned depending on which statements were correct. The levels were 'cultural incompetence', 'cultural awareness', 'cultural safety', or 'cultural competence'. As participants were unable to determine (objectively) their own level of cultural competence on completion of the tool the VAS provided them with an opportunity to self-assess their competency, and provided the researchers with an opportunity to compare personal perceptions of cultural competence with objective scoring. It was anticipated that the participants would achieve a higher level of cultural competence as a result of the intervention.

The CCAP intervention

Although the CCAP project was initiated by NHS mental health trust managers, the content of the programme was negotiated with the care staff who would be participating. Specific content was negotiated with them but the intervention was also tailored to address the underlying philosophies and constructs of the model. Thirty-five members of staff participated in the project, attending eight sessions, arranged in their workplace, over a four month period. Two sessions were planned for each stage of the model but adapted to meet the requirements of the different participating teams.

Cultural awareness sessions

The aim of the cultural awareness sessions was to assist participants in recognising the need to examine their own cultural values, beliefs and practices in order to reduce the risk of cultural bias, cultural clashes and the imposition of inappropriate or unethical care through ethnocentric assessments. A cultural introduction exercise focused on the culture of the participants, exploring the impact of sex, age and socio-economic and other differences, and socialisation in different communities and societies. It highlighted the culture of all peoples including those of English, Irish and other white groups, their regional identities, and the way in which individuals adhered to different aspects of their culture contextually. This was followed by a values clarification exercise emphasising the values that exist across cultures but that are shaped by time and society. Another session focused on values, beliefs and behaviours, exploring the concept of ethnocentricity, examining ways in which they inform perceptions of people and events and particularly how they impact on healthcare practice.

Cultural knowledge sessions

The cultural knowledge sessions did not aim to provide detailed information about cultures but to highlight the potential for misunderstanding due to ethnocentricity, stereotyping and the impact of the unequal distribution of power. However, one staff team requested information about the local Turkish population and were provided with information about the differing ethnohistories and experiences of the three Turkish-speaking communities in the locality. One session was provided on health beliefs and behaviours and the cultural meanings of mental illness in different minority ethnic groups. Another session was devoted to the origin of common stereotypes, examining myths and realities about particular ethnic groups and the impact on mental health and access to healthcare.

Cultural sensitivity sessions

The cultural sensitivity sessions focused on ways of avoiding insensitivity and establishing trust and rapport in order to facilitate accurate assessment, diagnosis and the delivery of holistic culturally appropriate care. One session dealt with interpersonal relationships with clients whose first language was not English, and explored differences in verbal and non-verbal communication. This session included attention to the differing ways in which distress is expressed across cultures and religious groups. The second session focused on family responsibility and its role in relation to caring in different cultures, highlighting differences in family structure, function and roles which influence mental health and healthcare.

Cultural competence in practice sessions

As cultural competence comprises of cultural awareness, knowledge and sensitivity, the focus in these sessions was on mental health practice. One session explored the principles of anti-oppressive practice in relation to black and minority ethnic clients and families, exploring their strengths and challenging racist attitudes and practices. The other session explored ways of helping clients overcome fear and mistrust, assessing mental state and working with clients' explanatory models and coping strategies. As in all the sessions, participants shared examples of good and bad practice, and drew upon their own cultural knowledge, professional practice, and perspectives from differing professional disciplines. Where possible, research based evidence was utilised but much was learned from the cultural knowledge and experience of participants.

The results of the assessment

Thirty-five members of staff completed a pretraining assessment of CCATool. Twenty-four were found to be culturally aware, 10 were culturally safe and one member of staff was culturally competent. On completion of the training, 18 staff completed the assessment tool: the majority remained culturally aware, four moved up to being culturally safe. Two members of staff moved down a level to culturally aware. Statistical tests revealed no relationship between the assessment according to the statements and the self-rated VAS.

As only half of the participants completed the post-intervention assessment, it is difficult to draw strong conclusions. Most of the participants stayed at the same level and it is of note that two of them moved down a level. This would suggest that the education intervention had not been very successful. However, the authors postulate that this may be because the impact of such training has a longer-term effect, and it may be more useful to re-assess cultural competence a number of months after an intervention and when the participants have had the time to reflect on what they have learnt and put it into practice.

Discussion

While there was much support for the project at managerial level, and several individual practitioners welcomed it, the trainers faced many challenges at all stages of the project. The teams selected for the education intervention were suspicious as to why they had been chosen to participate. Attendance varied among teams and according to the topic on the agenda. Some

participants who appeared under pressure to attend engaged reluctantly, believing they did not need training because they were a senior practitioner, had 'lived and worked with people from different cultures', or were a member of a minority ethnic group and 'knew the needs or problems' they faced. There was also a feeling that since they practised 'individualised care' they were by implication culturally competent. Staff in one of the participating organisations questioned the credibility of the white trainer believing that only a black person could understand the experience of discrimination. They also queried the extent to which somebody who was not a mental health practitioner could understand issues for people with mental health problems.

At a practical level, it was challenging to reach consensus about what to cover in the limited time available and to obtain the commitment of professionals who perceived they had undergone a similar programme of training in the recent past. There was greater willingness to identify knowledge deficits about particular cultural groups rather than examine beliefs and attitudes towards clients or to reflect on professional practice. The workload of participants influenced their ability or willingness to attend regularly and fully participate, and this impacted on group dynamics. It required considerable skill to enable participants to express honest views and attitudes in the presence of their seniors and professionals from other disciplines. There were a number of conflicting views between trainer and trainees and between trainees, and at times it was difficult to handle the prejudice, generalisations, stereotypes and thinly veiled racism that emerged in the sessions.

Conclusions and recommendations

The training intervention has highlighted a number of problems with cultural competence training and has consolidated the authors' belief that there are a number of principles for effective cultural competence training.

Principles for effective cultural competence training

- Compulsory mandates to attend cultural competence training programmes can lead to resistance or at best superficial participation, invoking sensitivities by suggesting that participants' performance is less than satisfactory. Therefore, it is more effective to adopt a whole organisation approach, involving participants in decisions about the training programme, emphasising the benefits for all patients/clients as well as the whole organisation (Kandola and Fullerton, 1998).
- Focusing only on developing the cultural competence of individual care givers will not necessarily result in a culturally competent organisation. To achieve this, the whole organisation needs to be committed and have in place the necessary structures and policies.
- It is necessary to allow adequate time out for staff to disengage from the intensity of their everyday work and to engage in cultural competence learning.
- Those involved in delivering training around cultural competence should have time to establish trust and rapport and to be aware of wider organisational factors which impact on the training or caring processes.
- It is important to have a clear framework for the delivery of cultural competence training and to recognise that while educational content is essential, the process of learning is equally significant.
- Although 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.
- Commencing training with cultural self-awareness can be non-threatening, as it highlights the cultural nature of all human beings and helps to establish rapport.
- It is necessary to include culture-generic and culture-specific input.
- It is desirable to involve service users in the planning and delivery of the training.
- Learning methods should be responsive to the different cultural backgrounds and diverse learning styles of the participants.
- The skin colour or ethnicity of the trainer is less important than his or her knowledge and skills in this area.
- It is essential that the training offers a safe environment to challenge individual racist behaviour while not attacking the individual *per se*.
- Cultural competence training invokes strong feelings and even with skilled facilitation may leave well-meaning people feeling guilty about their ethnocentricity or unwitting prejudice. There should be sufficient time for debriefing in order to allow the participants to identify how past weaknesses may become strengths.
- Pre- and post-training assessment of cultural competence is highly desirable for three reasons: to provide information about participants' existing levels of cultural competence, to give an indication of the effectiveness of the training to the trainers, and to provide the participants with a measure of their progress.
- Training programmes should be evaluated and lessons learned, and if possible shared with others.

The application of these principles will lead to effective cultural competence training which will result in better patient care for all.

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CONFLICTS OF INTEREST

None.

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