UNIVERSITY OF WEST LONDON
The Career University

UWL REPOSITORY

repository.uwl.ac.uk

Enhancing cultural competence in staff dealing with people with drug and alcohol problems.

Luger, Lisa (2009) Enhancing cultural competence in staff dealing with people with drug and alcohol problems. Doctoral thesis, University of West London.

This is the Accepted Version of the final output.

UWL repository link: https://repository.uwl.ac.uk/id/eprint/385/

Alternative formats: If you require this document in an alternative format, please contact: open.research@uwl.ac.uk

Copyright:

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy: If you believe that this document breaches copyright, please contact us at open.research@uwl.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

Rights Retention Statement:

Contents

1. Introduction 5

1.1 Rationale 5

1.2 Aims/ Objectives 8

1.2.1 Aims 8
1.2.2 Objectives: 8
1.2.3 Limitations of this study 9

1.3 Background of this study 10

1.3.1 Professional factors that led to the study 10
1.3.2 Personal motivations for this PhD 11

1.4 Methodology 13

1.5 Overview of the thesis 16

1.6 Change in focus in this thesis 18

1.7 The UK population by ethnic group – an overview 19

2. Study Design: Action Research Framework 22

2.1 The cyclical process of action research 24

2.2 Action research is action oriented 34

2.3 Action research aims for improving practice/ social change 35

2.4 Critical reflective practice and participation 36

2.5 Action research is educational 39

2.6 Action research - research method 41

3. The Concepts of Cultural Competence and Culture 43

3.1 Cultural Competence 45

3.1.1 The drivers for cultural competence 45
3.1.2 What is cultural competence? 47
3.1.2.1 Definition 47
3.1.2.2 The concepts behind cultural competence 49
3.1.3 How to achieve cultural competence 51
3.1.3.1 Ways to make services more culturally competent 51
3.1.3.2 Cultural competence models 51
3.1.3.3 Critique of the models of cultural competence 52
3.1.4 Cultural Competence Training 58
3.1.4.1 Review of training approaches 58
3.1.4.2 Past training approaches 61

3.2 Concept of Culture 66

3.2.1 What is culture and how does it work? 66
3.2.1.1 Are we manipulated by culture or do we have a free will? 67
3.2.1.2 How do cultures regulate violations of social norms? 69
3.2.2 Cultural differences and cultural diversity 70
3.2.2.1 Cultural differences 70
3.2.2.2 Cultural diversity 72
3.2.2.3 Subcultures 74

3.2.3 The relationship of ethnicity and culture 75
3.2.3.1 Definitions and terminology 75
3.2.3.2 Ethnic categorisation for monitoring and research 76
3.2.4 Summary of the key principles of the concept of culture 78
3.2.5 Cultural differences and diversity in health beliefs and treatment expectations 79
3.2.5.1 Cultural influence on healthcare systems 80
3.2.5.2 Differences in how illness is recognised and explained 81
3.2.5.3 Different explanatory models for illness and treatment 83
3.2.5.4 Problems in the health professional-patient relationship 84

Conclusions 87

4. Drug and alcohol problems in minority ethnic groups 90

4.1 Cultural reasons for drinking alcohol and taking drugs 92

4.1.1 The meaning of drugs and alcohol 93
4.1.2 Cultural perceptions on what is normal and what is problematic? 94
4.1.3 Cultural explanations of substance using behaviour 97
4.1.3.1. Influence of religious affiliation on alcohol and drug use 97
4.1.3.2 Influence of philosophy on cultural values 99
4.1.3.3. Migration and adaptation to a different culture 100
4.1.3.4 Racism 101
4.1.3.5 Socio-economic influences 102
4.1.3.6 Socio-cultural groups 103

4.2 Trends of drug and alcohol use in minority ethnic groups 106

4.2.1 Large-scale study - The British Crime Survey 107
4.2.2 Smaller scale studies into patterns and trends of drug use amongst minority ethnic groups 109
4.2.3 Smaller scale studies into the patterns of drinking amongst minority ethnic groups 112
4.2.4 Summary of the limitations of research into the extent of drug and alcohol use 113

4.3 Service provision for people from minority ethnic backgrounds 117

4.3.1 Barriers to accessing services 117
4.3.2 Gaps in service provision 119
4.3.3 How can services be improved? 122
4.3.3.1 Mainstream versus specialist ethnic services 122
4.3.3.2 User involvement and partnership working 123
4.3.3.3 Compliance with Government legislation 124

Conclusions 127

5. Rapid Needs Assessment 130

5.1 Introduction 130

5.1.1 Background 130
5.1.2 Methodology 130
5.1.3 Limitations of this research 136

5.2 The Findings 137

5.2.1 Demographic and treatment uptake data 137
5.2.1.1 Multi-cultural Ealing 137
5.2.1.2 Treatment up-take 138
5.2.2 Findings from interview data 140
5.2.2.1 Who is using what substances? 141
5.2.2.2 Underlying factors 143
5.2.2.3 Public image and private behaviour 144
5.2.2.4 Perceptions of drug and alcohol use 144

5.2.2.5 Consequences of drug and alcohol use for the family 145
5.2.2.6 Current practice in services 146
5.2.2.7 What makes a service culturally competent? 150
5.2.3 Findings from the family anonymous focus group 151

5.3 Discussion of the findings 153

5.3.1 Treatment uptake
5.3.2 Cultural perception of drug and alcohol treatment
5.3.3 Current practice in services

Conclusions 159

6. Development of the Cultural Competence Module 160

6.1 Development of the module 160

6.1.1 General information about the module 160
6.1.2 Curriculum development 161
6.1.3 Target group 161
6.1.4 The aims of the module 163
6.1.5 The learning outcomes and content of the module 163
6.1.6 Assessment Strategy 171

6.2 Underlying Philosophy: Critical Theory and Critical Pedagogy 173

6.2.1 Application of the underlying philosophy to the module 176

6.3 Teaching and Learning Strategy 179

6.3.1 Rationale for Learning Methods and Teaching and Learning Styles 180

7. Evaluation 187

7.1 Principles and approaches to evaluation 187

7.1.1 The nature of evaluation 187
7.1.2 Evaluation is political 188

7.2 Evaluation research strategy 190

7.2.1 The purpose of the evaluation: 190
7.2.2 Evaluation design 191
7.2.3 The use of qualitative and quantitative research methods 191
7.2.4 Approaches to evaluative research 192

7.3 Models of evaluation and their application to this module evaluation 194

7.3.1 Evaluation levels and their application to the module evaluation 195
7.3.1.1 Level 1: Reaction 195
7.3.1.2 Level 2: Learning 197
7.3.1.3 Level 3: Job performance 201
7.3.1.4 Level 4: Department and organisation 203

8. Findings of the Evaluation 206

8.1 Participant's reaction to the module 207

8.1.1 Mid-term evaluation 207
8.1.2 End of term evaluation 208

8.2 Measuring Learning 213

8.2.1 Assignment 213
8.2.2 Self-rating questionnaire 214

8.3 Measuring changes in attitude 217

8.4 Job performance 223

8.4.1 Impact of the module on the individual 223
8.4.2 Impact of the module on service provision 226

8.5 Department and organisation 228

9. Discussion of the findings 233

9.1 Evaluation of participants' reaction 233

9.2 Measuring learning 239

9.2.1 Analysis of assignment results 239
9.2.2 Analysis of the self-rated questionnaires 241

9.3 Measuring attitude change 244

9.4 Job performance 248

9.5 Department and Organisation 252

9.6 Summary and conclusions of the study 255

Conclusions 258

10. Overall discussion and lessons learnt – wider implications of the study 259

10.1 Has this educational approach enhanced the effectiveness of the module? 259

10.1.1 The educational approach 259
10.1.2 Is it possible to transfer the teaching and learning approach to other areas? 266
10.1.3 Further implications for cultural competence training 268
10.1.3.1 Where should cultural competence training be delivered? 268
10.1.3.2 Training or education? 269
10.1.3.3 Cultural competence training as a compulsory element? 269

10.2 Effectiveness of action research? 271

10.3 Challenges of evaluating the effect of educational events to achieve cultural competence 276

Conclusions 282

References 284

1. Introduction

1.1 Rationale

The cultural mix of values, beliefs and behaviours of people from different social and cultural backgrounds who live together in modern multicultural societies presents many problems for those in need of health and social care, and also for the staff in these services who are trying to deal with the needs of these clients. These needs may differ widely from those of the mainstream population. In recent decades the powerful influence of culture on values and attitudes has become apparent, yet most health and social care staff, trained by an outdated monocultural curriculum, feel that they are unprepared to deal with needs which vary between cultures, ages, generations and genders. Qureshi (1994) criticised English GPs and healthcare professionals in that they tend to regard everyone as English, assuming that all patients have similar needs. He was accused of exaggerating. Since then there have been many well-meaning initiatives to change cultural perceptions and prejudices of health and social care staff, but problems still remain. Services are still criticised for being insensitive and inflexible when dealing with the needs of these population groups. Well-known examples are the reports on the Stephen Lawrence Inquiry[1] (Macpherson, 1999) and the Rocky Bennett Inquiry[2] (NIMHE, 2004a). Both inquiries accused the organisations involved of institutional racism and demanded that they employ more staff from minority ethnic backgrounds and train staff in cultural competence.

If healthcare professionals lack knowledge about cultural differences in beliefs and needs, these differences may not be recognised or be deemed insignificant. Such differences affect health beliefs and the behaviour of both patients and healthcare professionals, influencing the expectations of both. Consequently, the relationships between the patient and the healthcare professional may be affected, resulting in

[1] Macpherson's report into the killing of a black teenager in South London accused the Metropolitan Police of institutional racism.
[2] The inquiry into the circumstances of the death of 38 year old David Rocky Bennett accused the NHS of institutional racism and discrimination.

misunderstandings and misdiagnosis. This can lead to a lack of trust or inappropriate treatment, affecting the outcome for the patient. Access to services can be affected if, for example, they are only aimed at those who speak English. Clients may also feel the service is not for them if they do not take into account cultural differences or religious needs (Henley and Schott, 1999). It is often assumed that those from minority communities do not need services because of the low uptake rates from these groups. However, it is more likely that members from certain population groups do not access services because they are operated in a way that makes them unacceptable or inaccessible to them. For example, female clients may find a lack of a female healthcare practitioner unacceptable (Helman, 2007). Further barriers to treatment include poor communications, negative experiences with staff or treatments, fear of racism, or the perception that service providers do not understand their needs.

Research has highlighted that people from other cultures may not need different services to the white population. What they do need, however, are services that are organised and offered in a more flexible and responsive way (RCN, 2002). Papadopoulos *et al.* (2004) pointed out that although there is evidence of racism in the NHS, this is not because of spiteful intentions of staff or services but a reflection on the failure in recognising cultural differences and their significance. Geiger (2001) also argued against accusations of racist behaviour by healthcare staff and said that most ethnic disparities in the quality of medical care did not happen because of the racial bias of staff but because of time constraints and the complexity of the job.

The need for cultural competence in making services more responsive to the diverse needs of patients has been highlighted by many authors (NCCC, 2004b; Geiger, 2001; Philleo and Brisbane, 1997; Ehrmin, 2005). Philleo and Brisbane (1997) argued that at a time of increasing globalisation and international communication, cultural competency is as important as computer literacy. This means that to be considered a competent professional, such as a nurse, drug worker, youth worker or social worker, one needs to take into account the wider cultural context of the person who is coming for help. A cultural dialogue, where the healthcare worker is able to

communicate with people from a different cultural group, should be part of a professional approach. With regard to the treatment of substance use problems, Philleo and Brisbane (1997) pointed out that a competent professional must know more than the harm alcohol and drugs can do to the body. Substance problems call for cultural solutions and a cultural dialogue, otherwise professionals are unlikely to achieve a change in their patients' behaviour.

The need for better quality services for people from different cultural backgrounds has been recognised in a number of UK government policies, for example the Race Relations (Amendment) Act 2000 (RR(A)A 2000) (The Home Office (HO), 2000). These policies have pressurised organisations into promoting anti-racism and equal opportunities for both service users and staff, and to provide more accessible and culturally competent services.

There has been much debate since the 1980s about how to make services more culturally aware and many training initiatives have been developed. Yet, there has been much confusion about the focus of training such as, what needs to be addressed more: racism, discrimination, equal opportunity or diversity? There has been little discussion on the effectiveness of these training activities. Few have been evaluated to measure their impact, such as a change in knowledge, attitude and behaviour of those trained, or their organisation's performance towards clients (Papadopoulos *et al.*, 2004; Bhui *et al.*, 2007). Consequently there is little evidence concerning the success of these educational activities.

This PhD wants to make an original contribution to the debate surrounding cultural competence and educational practice by evaluating the effectiveness of an educational module to enhance the cultural competence of staff dealing with people with drug and alcohol problems. This study also includes an evaluation of the effectiveness of the teaching and learning strategy used.

1.2 Aims/ Objectives

1.2.1 Aims

A module was developed for professionals working with alcohol and drug users from different cultural backgrounds. The content was based on the findings of a literature review and a Rapid Needs Analysis. The module aimed to enhance the participants' knowledge and understanding of underlying factors behind drug and alcohol use and help-seeking behaviour. It also intended to develop cultural competence in assessment and treatment in order to make services more culturally competent.

The aim of this study is to evaluate the effectiveness of this module in enhancing the cultural competence of participants with the expectation of improving service provision. It also seeks to investigate if and how educational strategies can be successfully used to enhance cultural competence in practice. To meet these aims, the study involved a number of activities: a literature review, a Rapid Needs Assessment (RNA) and the development, delivery and evaluation of the module.

This study seeks to make an original contribution to knowledge by going beyond curriculum evaluation per se. Therefore, the study design is developed to the level of PhD research rather than an internal module evaluation.

1.2.2 Objectives:

The objectives of this PhD study are:

- To evaluate whether the aim of this module, to make staff in services more culturally competent, has been achieved successfully.
- To evaluate whether the approach used in the development and delivery of the module enhances the effectiveness of the educational strategy.

The evaluation of the module and its impact upon the knowledge and practice of the participants was intended to assess whether this educational strategy was successful in changing knowledge and, in particular, behaviour. The evaluation

would thereby identify whether educational strategies of this nature are appropriate and effective in enhancing cultural competence in services.

This work will highlight what lessons can be learned for staff who work with people with drug and alcohol problems. Although this study focuses primarily on the provision of services for people with substance problems, consideration will be given as to whether these concepts could be transferable to other areas, for example mental health and community care. Finally, the broader implications of this study's findings will show if lessons can be learned for other work in other educational spheres, and will add to the debate on diversity and anti-discrimination training.

1.2.3 Limitations of this study

Due to the course of events not all aims were achieved. I had been aware from the outset of the possible limitations of measuring the impact of the module on values, behaviour and job performances due to the nature of learning. This is a long-term process and is also influenced by many factors outside the control of the teacher. However, in hindsight, I admit that the underlying aims of changing service practice or organisational culture were overly ambitious.

A setback to this study was that one of the vital tools to measure the impact of the module on a change in the practice of the participants could not be used as planned. As mentioned previously, the module development was based on a literature review and a RNA. A follow-up RNA three years after the initial study was planned in order to measure whether a change in the quality of services had occurred. This study could not be undertaken because two of the four services that had taken part in the initial study had closed due to lack of funding. This only became apparent after I began preparing for the follow-up study, three years into the research. Also, a high staff turnover in the drug and alcohol field made it impossible to contact all the staff that had taken part in the initial RNA. Therefore, urgent amendments to the tools of the study had to be made. This aspect will be discussed in more detail in chapter 7: Evaluation, and chapter 10: Overall discussion.

1.3 Background of this study

1.3.1 Professional factors that led to the study

I currently work as the Principal Lecturer and Programme Leader of the undergraduate Dip(HE)/ BSc Substance Use and Misuse Studies at the Faculty of Health and Human Sciences at Thames Valley University (TVU). Our unit provides education, development and research into the area of substance use. Our programme offers university accredited training for a range of professionals that work in the drug and alcohol field, such as nurses, drug workers, youth workers, social workers, housing officers and those within the criminal justice system.

The Substance Use and Misuse Team works in close partnership with the Central North West London NHS Foundation Trust (referred to as the CNWL Trust)[3] and with the local Drug Action Team (DAT)[4]. Concerns had been raised by the CNWL Trust that the high proportion of minority ethnic populations within its catchment area was not reflected in the uptake of the Trust's drug and alcohol treatment services. Although the exact extent of substance problems within ethnic minority groups in London was not known, it was assumed that such problems were present within these population groups and that a variety of factors prevented members taking up relevant services. It was felt that cultural competence training of staff would be beneficial in order to make the services more sensitive to the needs of these population groups and, as a consequence, attract more patients from within these groups.

In 2001, the Ealing DAT responded to the Trust's concerns and commissioned TVU to develop cultural competence training for staff working in the drug and alcohol field in Ealing. This presented me with an excellent opportunity to become involved with a

[3] This partnership includes cooperation in relation to training, development and research.
[4] The Drug Action Team (DAT) is a partnership of local organisations (including health and social care, the criminal justice system, the Local Authority, education and youth). The DAT develops the local drug strategy and holds the borough's pooled drug-related budget.

subject that has fascinated me for some time, and enabled me to use this research for a PhD study.

1.3.2 Personal motivations for this PhD

Over the years I have worked as researcher, journalist and educationalist in Latin America (Luger *et al.*, 1984; Luger, 1990). This experience opened my mind to the existence of many differing cultures. Being faced with an unknown environment made me question my own culture and reflect on the things within it that I appreciated or disliked. I was confronted with the reality of poverty, lack of education and development through the consequences of an unequal world economy. I also faced racism, stereotyping and prejudiced perceptions.

In the late 1980s and early 1990s my perceptions of a cross-cultural dialogue were further challenged when I worked in a German Government funded foundation that supported projects in Africa, Asia and Latin America, the purpose of which was to empower women. This organisation was established and run predominantly by white German academics experienced in working in developing countries. The main thrust of our mission, to fight sexism, racism and imperialism, was tested when we invited women who had emigrated from these countries to work with us. The good intentions of our theoretical mission were thrown into turmoil when our immigrant colleagues demanded a share of the power and resources.

I gained much knowledge and understanding from this experience, and this helped me to successfully set up a family planning and sexual health advice service for refugee women in Berlin (Luger, 1995). My MSc dissertation at the London School of Hygiene and Tropical Medicine remained in the same area: I researched the health needs of immigrant women in Berlin and developed recommendations on how to improve their care within the health services (Luger, 1996).

The multicultural working environment at TVU, with a high percentage of students of African and Asian origin presents a challenge to both teachers and students due to

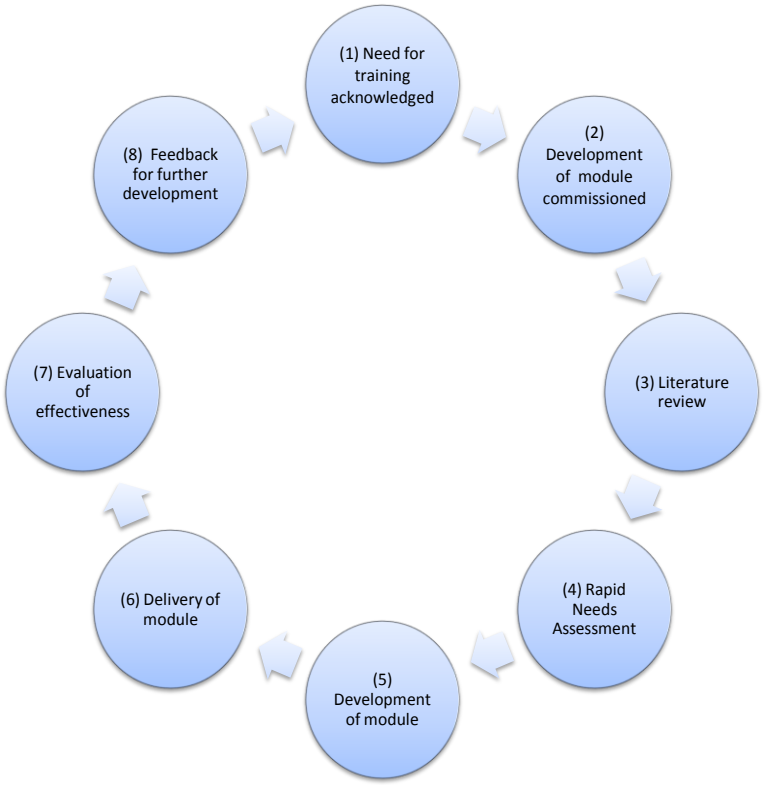
the diversity of cultures, perceptions, beliefs and values. As an educationalist I strongly believe in education as a means of enhancing people's understanding and changing their attitudes and behaviour. I accepted the challenge of developing and delivering a module in cultural competence as I strongly believe that this module could achieve a change in healthcare workers' thinking and influence their behaviour and attitude towards people who come from different cultural backgrounds.

The development of this course, and the ongoing teaching, offered an excellent opportunity to tackle my own hidden internalised perceptions and taboos and become more culturally competent myself.

1.4 Methodology

Action research was used as the methodological framework of this work. The study contains eight stages which form a cycle. The individual stages of the cycle are outlined in figure 1 below.

Figure 1: The cycle of the study



Each individual stage also represents an action research cycle. Their rationale and application within this study are outlined in more detail in chapter 2. The cycle of study started when the need for staff training to make services more culturally competent was acknowledged (stage 1). As a result the development of a module

was commissioned (2). A review of the literature (3) and the RNA (4) were carried out to guide the development of the module (5). The module was delivered (6) and evaluated (7). The findings of the individual module evaluations were fed back (8) to improve the module delivery, content and teaching approach.

A variety of research methods have been used in this PhD study:

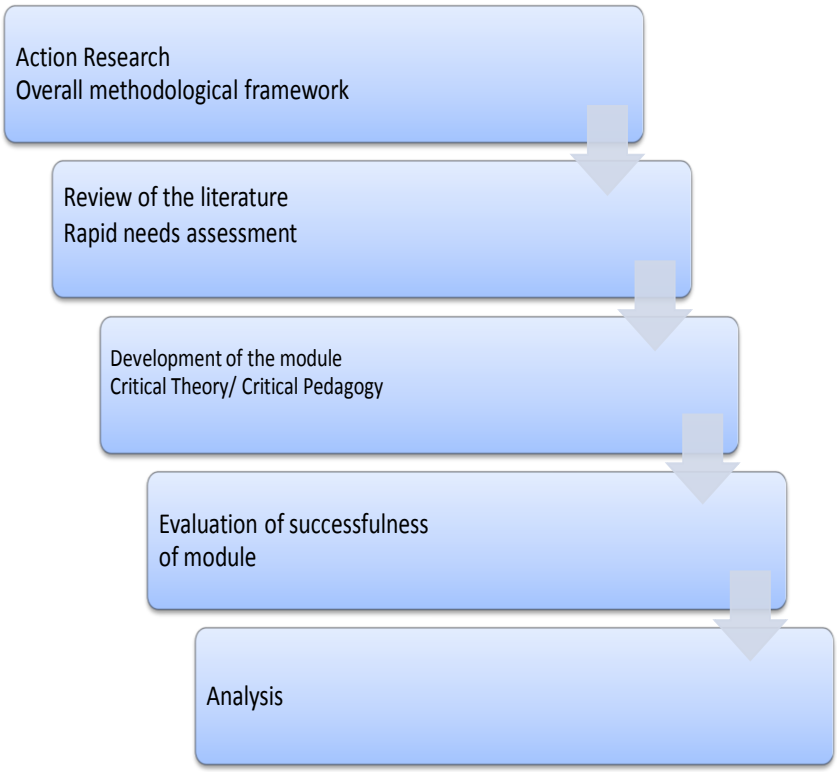
- The RNA to identify training needs and provide the basis for development of an educational module.
- A literature review to inform the RNA, content and learning outcomes of the module.
- The development of an educational module to change attitudes in staff and improve their practice.
- The evaluation of the teaching practice of this module to measure whether teaching style, method and content had enhanced cultural competence in participants.
- Continuing evaluation of the module to measure/ evaluate its success.

There will not be a specific chapter on the methods used in this PhD. Moreover, the methodology will be outlined in detail within each relevant chapter.

A multidisciplinary and multicultural steering group guided the whole process of the study. The group of nine were members of the Ealing Drug Action Team (representatives from relevant service providers, including health and social services, drug, alcohol and mental health services, the community and the Criminal Justice System). Also included were teaching colleagues from TVU.

The flowchart below indicates the process of the study and its individual stages:

Flowchart: Process of the PhD Study



1.5 Overview of the thesis

The following section will provide an overview of the study by outlining the individual chapters. Action research was chosen as a methodological framework of this work because of the nature of the study as action oriented research and my own involvement as researcher, teacher and evaluator. Chapter 2 will explain some of the key characteristics of action research techniques and demonstrate their application in the different parts of this study.

A review of the literature in chapters 3 and 4 will present the framework for the research, discuss the key concepts which informed the learning outcomes and content of the module, and give further directions for research questions.

Chapter 3 will provide a rationale of the concept of cultural competence and demonstrate its need to improve services. The concepts of culture and diversity will be explained, as will the influence culture has on people's behaviour, beliefs and values. The cultural influences on health, health beliefs and help-seeking behaviour, and the problems that can be caused in the clinical encounter when different beliefs and expectations meet, will be outlined and applied to problematic substance use. The concepts of ethnicity and ethnic categorisation will also be detailed.

In chapter 4 the literature review focuses on the specific issues of substance use. The review explores what is known about the patterns and trends of substance problems amongst minority ethnic groups. The ability of the methodology of surveys and the accuracy of data to establish the extent of substance problems are scrutinised. The study of the underlying factors of drug and alcohol problems in minority ethnic groups looks at cultural perceptions of substance use and their impact on drug using and help seeking behaviour. It also takes into account differences in social context due to gender, age and cultural issues. The review further explores what is known about the services provided for minority ethnic groups

with drug and alcohol problems. It will highlight gaps in service provision and present examples of good practice.

Chapter 5 presents and discusses how conducting the RNA identified the extent of drug and alcohol use within minority ethnic groups and recognised the training needs of staff in relevant services.

The findings of the RNA and the literature review influenced the learning outcomes of the module. Chapter 6 describes the process of module development and outlines the underlying teaching and learning strategy used for the delivery of the module. The teaching and learning strategy is based on social constructivism and fits well with the aims of the teaching and learning philosophy that is influenced by critical theory and critical pedagogy.

Chapter 7 explains the evaluation of the module. The general principles of evaluation are explained and their application for this particular module is detailed. This is followed by an outline of the evaluation strategy, together with a detailed description of the evaluation process. The findings of the evaluation are presented in chapter 8, and the analysis is presented in chapter 9, followed by a discussion in chapter 10 of the more general implications of the findings for educational research, diversity and anti-racism training, and what lessons can be learned from this study.

The definitions of concepts and terminology used in this work are attached in Appendix 1.

1.6 Change in focus in this thesis

The outline of the research proposal at the outset of the thesis was based on a thorough working knowledge and understanding of the concepts of culture and cultural competence. These evolved into a framework for the thesis and the diverse research elements therein. Naturally, through ongoing studies and increasing experience in delivering the module and testing its concepts I gained a deeper understanding of each element of the thesis. This learning process enabled me to recognise the limitations of the initial concepts and to value others that I had not previously considered as applicable.

An example is the debate on models of cultural competence. Later in my studies, during the application of various models in the classroom, I came to value the importance of a model I had previously dismissed. It addressed aspects that I felt were vital to the success of the module, such as discrimination, racism, stereotyping and a lack of equality of opportunity. This resulted over time in a change of focus in the teaching, and in the perception of models of cultural competence.

Furthermore, the initial focus of this work, as defined by the steering group, was to improve the access and treatment of services for minority ethnic groups. Through the course of the work I soon realised that purely focusing on ethnic and racial inequalities was a limited approach and that attention would have to be given to other issues of discrimination and exclusion, including gender, age and class. Therefore, the focus of teaching gradually changed. This aspect will be discussed further in sections 3.1.4, 4.3.3 and in the discussion chapter.

1.7 The UK population by ethnic group – an overview

Although, as mentioned above, the focus of this study changed over time towards diversity, the initial brief for this work was to improve the services for people from minority ethnic populations. To better understand the problem I will provide a brief overview of the UK population and its ethnic groups in this section.

The census is widely used and seen as the best tool for providing reasonably accurate information about a population. However, the census categories have been criticised for limiting ethnic identity (McKenzie *et al.*, 1996; Aspinall, 1998; Chaturvedi, 2001). For example, they do not reflect the heterogeneity of the white population and its categories are too broad to reflect the heterogeneity of ethnicities with distinct backgrounds. The limitations of ethnic categories are discussed in section 3.2.3. The ethnic categories for the 1991 and 2001 Censuses can be found in Appendix 2.

The 2001 Census revealed that the UK is more culturally diverse than ever before (ONS 2003a, b, c). Table 1 below shows the size of the minority ethnic population as 7.9% of the total population of the United Kingdom. Amongst the minority ethnic population, Indians were the largest minority group with 22.7%, followed by Pakistanis, and then those of mixed ethnic backgrounds: black Caribbeans, black Africans, Bangladeshis and others. A comparison with 1991 Census figures indicates that, between 1991 and 2001, the minority ethnic population grew by 53%, from 3 million in 1991 to 4.6 million in 2001.

The 2001 Census also showed that the non-white ethnic groups were not evenly distributed across the country. They were more likely to live in England than in Wales, Scotland or Ireland and tended to be concentrated in the large urban centres. London had the highest proportion of people from minority ethnic groups (45%). Of these, 78% of black Africans and 61% of black Caribbeans lived in London. More than half of Bangladeshis in the UK (54%) lived in London. The highest

concentration of white Irish people was in London, where they made up 3% of the population. The largest proportion of people of mixed ethnic origin was also in London.

Table 1: Population of the United Kingdom: by ethnic group, April 2001

	Total population		Minority ethnic population
	Count	%	%
White	54153898	92.1	n/a
Mixed	677117	1.2	14.6
Asian or Asian British			
Indian	1053411	1.8	22.7
Pakistani	747285	1.3	16.1
Bangladeshi	283063	0.5	6.1
Other Asian	247664	0.4	5.3
Black or Black British			
Black Caribbean	565876	1.0	12.2
Black African	485277	0.8	10.5
Black Other	97585	0.2	2.1
Chinese	247403	0.4	5.3
Other	230615	0.4	5.0
All minority ethnic population	*4635296*	*7.9*	*100*
All population	58789194	100	n/a

Source: National Statistics online. www.statistics.gov.uk/cci/nuggets.asp?id=273, accessed 03/01/2007.

For the first time, the 2001 Census collected information about religious identity[5],[6] (ONS 2003c). When combining ethnicity and religion, white Christians remained the largest single group. The majority of black people (71%) and those from mixed ethnic backgrounds (52%) classified themselves as Christians. The largest other group was the Pakistani Muslims, followed by Indian Hindus, Indian Sikhs, Bangladeshi Muslims and Jews. Some ethnic groups were more religiously diverse than others. For example, 45% of the Indians were Hindu, 29% Sikh, 13% Muslim. In

[5] The box options to tick for religion were: None; Christian; Buddhist; Hindu; Jewish; Muslim; Sikh; Any other religion, please write in.

[6] 71.6% of respondents marked their religion as Christian, 23.2% stated no religion, 2.9% as Muslim, 1.0% Hindu, 0.6% Sikh, 0.5% Jewish, 0.3% Buddhist and other.

contrast, the Pakistani and Bangladeshi groups were more homogeneous, with 92% being Muslims. Some faith communities were concentrated into particular ethnic groups. For example 97% of Jews described their ethnicity as white, and 91% of Sikhs classified themselves as Indian.

Collecting this information is useful as religion is often used as a proxy for culture. Religion greatly influences attitudes and behaviours. However, ticking a box under the heading of religious affiliation does not denote the individual's religiosity. Therefore, religion cannot be taken as an isolated category. Neither can ethnicity as it is not necessarily the same as culture. Ethnic categorisations are far too broad to be meaningful in explaining cultural beliefs. Furthermore, categorisation into broad ethnic groups implies homogeneity rather than the cultural diversity within different ethnic groups. Section 3.2.3 will discuss the concept of ethnicity and its relationship to culture in more detail.

2. Study Design: Action Research Framework

This research explores a social and professional problem, addressing it through an educational approach and evaluating the approach's effectiveness. Action research, a process that enables practitioners to reflect on their practice with the aim to improve it, was chosen as the methodological framework for this study, which seeks to improve practice by changing knowledge, attitudes and behaviour.

The underlying philosophy of the module used in this approach was based on critical theory and critical pedagogy, important elements in action research. Critical theory forms the backbone of the content and learning outcomes of the module and of the teaching and learning approach to achieve its aims. The various concepts of action research differ as to how much they are influenced by critical theory. Critical theory and action research strive for social change and critical reflection. Both aim for a society that is based on equality and democracy for all its members. Critical pedagogy, the science behind teaching, involves putting the philosophy behind critical theory into practice by emancipating participants and empowering them to question power and oppression through teaching. To achieve this, critical pedagogy uses interactive learning and dialogue, critical reflection and self-development in order to improve practice. These too are important elements of action research.

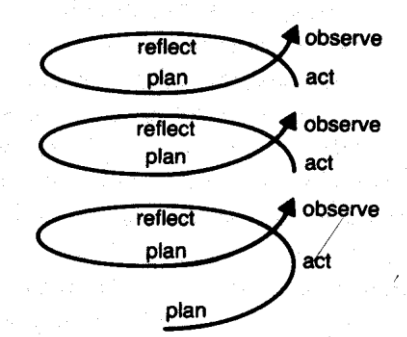
The concepts of action research have been adapted to diverse applications, including health and social care, organisational development, management and education (Kemmis and McTaggart, 1988; McNiff, 1988, 2001; Kember, 2000). The concept of action research originated in 1946, when Lewin designed a method of studying a social system, with the aim of changing it. His work was dedicated to changing the life chances of disadvantaged groups in terms of their housing, employment, prejudice, socialisation and training (Cohen *et al.*, 2007; Bowling, 2002). These aims correspond well with this PhD study, as the ultimate goal is to improve the care of disadvantaged people from different cultural and social backgrounds.

The key characteristics of action research will be analysed later in this chapter. The following section demonstrates how the cyclical process of action research has been used throughout this study.

2.1 The cyclical process of action research

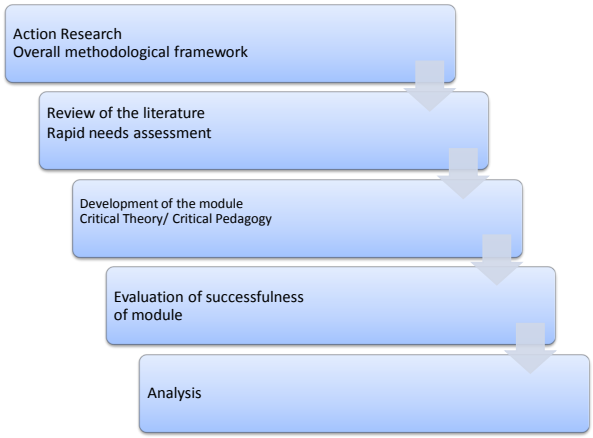
Action research is portrayed as a cyclical or spiral process that involves planning, acting, observing and reflecting. Improvement or change is brought about by a series of cycles, each incorporating the knowledge gained from the previous one (Kember, 2000; McNiff, 1988, 2001). The flowchart outlined in section 1.4 is used beside figure 2 to visualise the study process and its individual key stages, indicating how they formed action research cycles.

Figure 2: The cyclical process of action research



Source: McNiff (1988, 2001) Action Research. Principles and Practice. Routledge, p. 44

Flowchart: Process of the PhD Study



The feedback within and between each cycle is important to facilitate reflection (Ebbutt, 1985). Action research enables to reflect and act more systematically and rigorously than one usually does in everyday life (Kemmis and McTaggart, 1992).

At the beginning of the study, key research questions were set to identify the problem. The action-reflection cycle, as detailed by Whitehead (1985), was followed; this included a statement of the problem, the creation of a solution, implementation and evaluation of the solution and consequent modification of practice.

The action research cycles used in this study are outlined below. Cycles 1 to 3 run simultaneously during the stages of the module development. Cycles 4 and 5 refer to the evaluation of the module.

First cycle

Problem recognition: Only few people from minority ethnic backgrounds accessed drug and alcohol services. Action was needed to make drug and alcohol services more meaningful to people from minority ethnic populations. Is an educational module a useful means to achieve greater cultural competence?

Solution: It was suggested that more evidence-based information was needed on the extent of the problem and possible solutions.

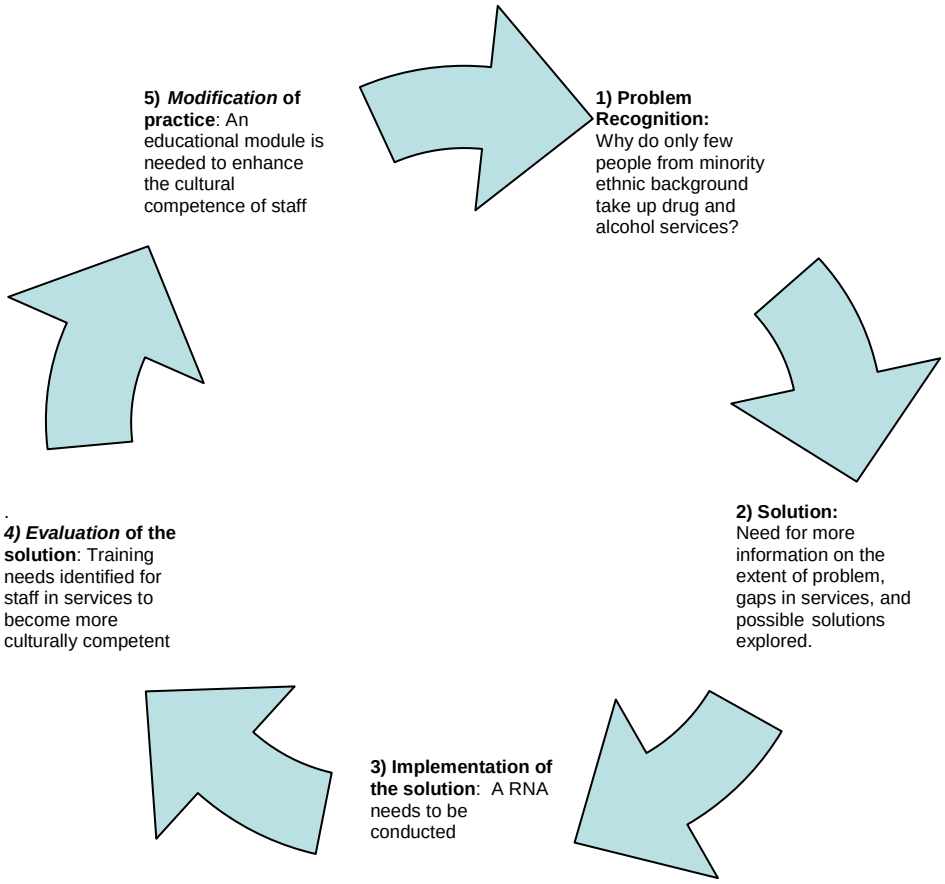
Implementation of the solution: The RNA was conducted to explore the extent of drug and alcohol problems amongst people from minority ethnic backgrounds and the underlying factors of their substance use, and to identify gaps in services and training needs of staff.

Evaluation of the solution: The RNA provided a wealth of information regarding underlying factors of drug and alcohol use in minority ethnic groups, social and cultural perceptions of substance use and help-seeking behaviour, gaps in service provision and communication problems in the clinical encounter. It identified training

needs of staff and predicted that the service would improve through cultural competence training.

Modification of practice in the light of the evaluation: From the findings it was concluded that an educational module was needed to enhance the cultural competence of staff. Consequently, I was commissioned to develop such a module.

Cycle 1:



Second cycle:

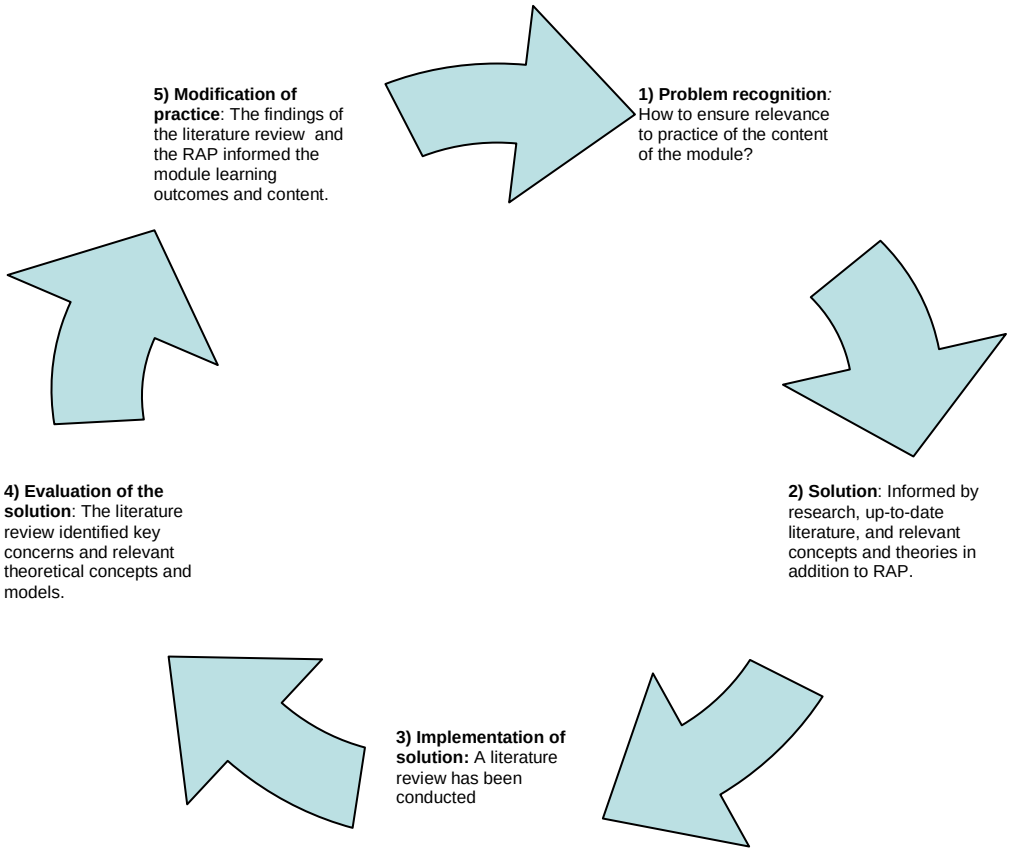
Problem recognition: How is it possible to ensure that the content of the module was relevant to practice, informed by relevant theoretical concepts and latest developments in the field?

Solution: The curriculum needed to be evidence-based on the latest research findings and theories. In addition to the RAP a review of the current literature and policy documents needed to be conducted.

Implementation of solution: A literature review was conducted into two major areas: The concepts of culture and cultural competence and substance use-specific issues.

Evaluation of the solution: The literature review identified various key concerns and a number of relevant theoretical concepts and models, (outlined in chapters 3 and 4).

Cycle 2:



Modification of practice: The literature review findings, together with the findings of the RNA, were integrated into the development of the module learning outcomes and content.

Third cycle:

Problem recognition: How best to ensure that the module is successful in achieving changes in knowledge, attitudes and behaviour?

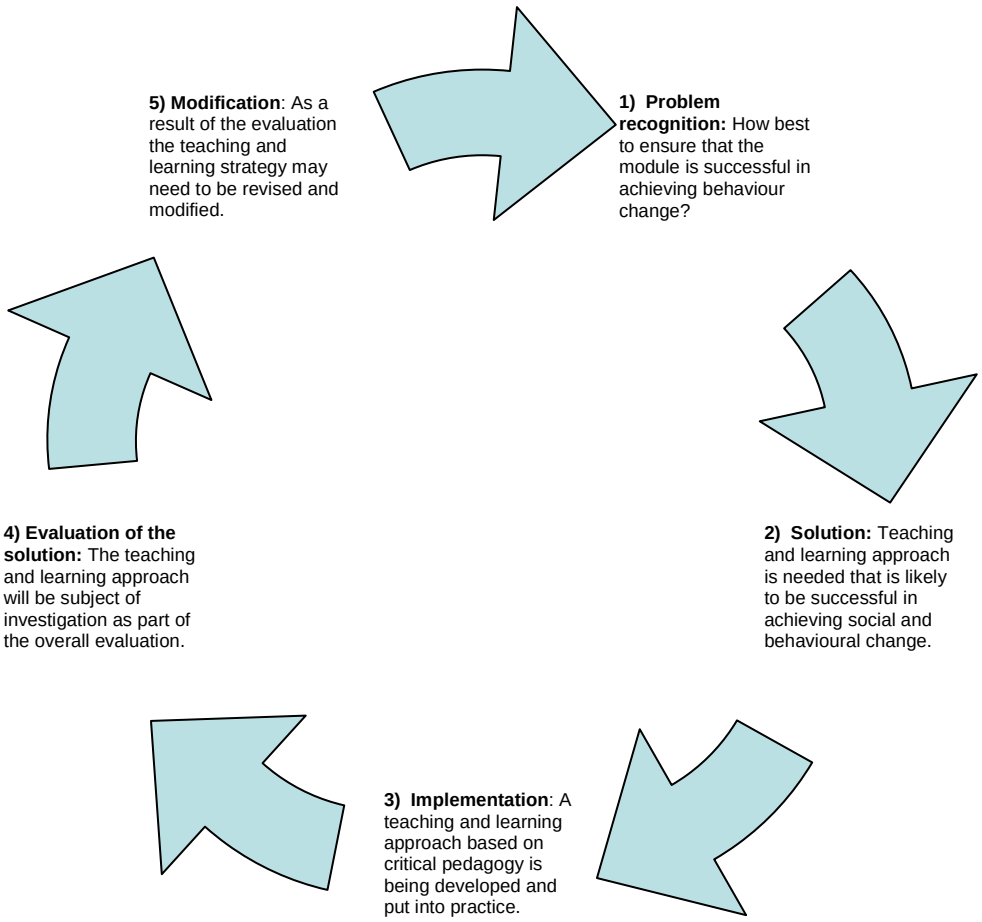
Solution: The curriculum needed to be delivered by a teaching and learning approach that would achieve social and behavioural changes.

Implementation of solution: A teaching and learning strategy was developed and put into practice based on a framework of critical pedagogy that enabled critical reflection, and social and behavioural change.

Evaluation of the solution: The teaching and learning strategy is the subject of each module's evaluation.

Modification of practice: As a result of the evaluation the teaching and learning strategy may need to be revised and modified.

Cycle 3:



Fourth cycle:

Problem recognition: How is it possible to measure whether this module was successful and achieved its aims? What criteria should be used to measure the teaching practice and learning of students?

Solution: A range of evaluation tools need to be developed to measure the progress of module delivery, student performance and teaching practices.

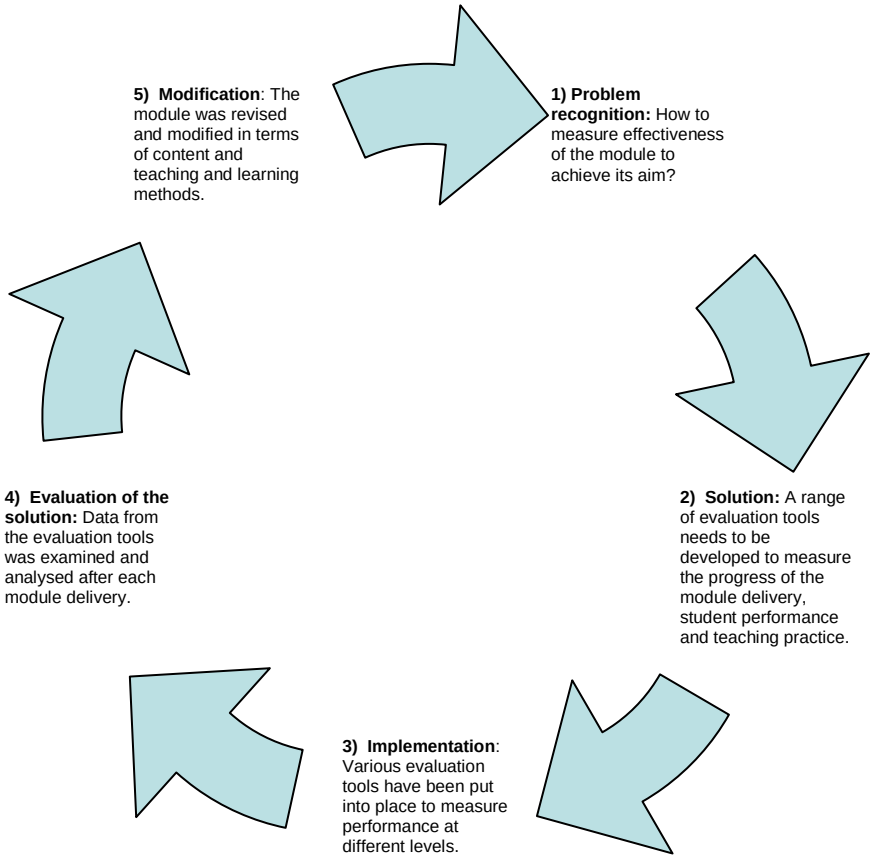
Implementation of the solution: Various evaluation tools were put into place to measure performance at different stages of module delivery.

Evaluation of the solution: The data from the evaluation tools was examined and analysed after each module delivery.

Modification of practice: As a result of the evaluation, the module was modified in terms of content and teaching and learning methods.

The revised module was subjected to continuous evaluation and the action-reflection cycle was repeated with each intake.

Cycle 4:



This action research cyclical process was also used to extend the research question to encompass a wider field beyond the individual deliveries of the module (see cycle five below).

Fifth cycle:

Problem recognition*:* How would we know whether an educational approach was effective by improving practice and enhancing the cultural competence of staff in substance misuse services?

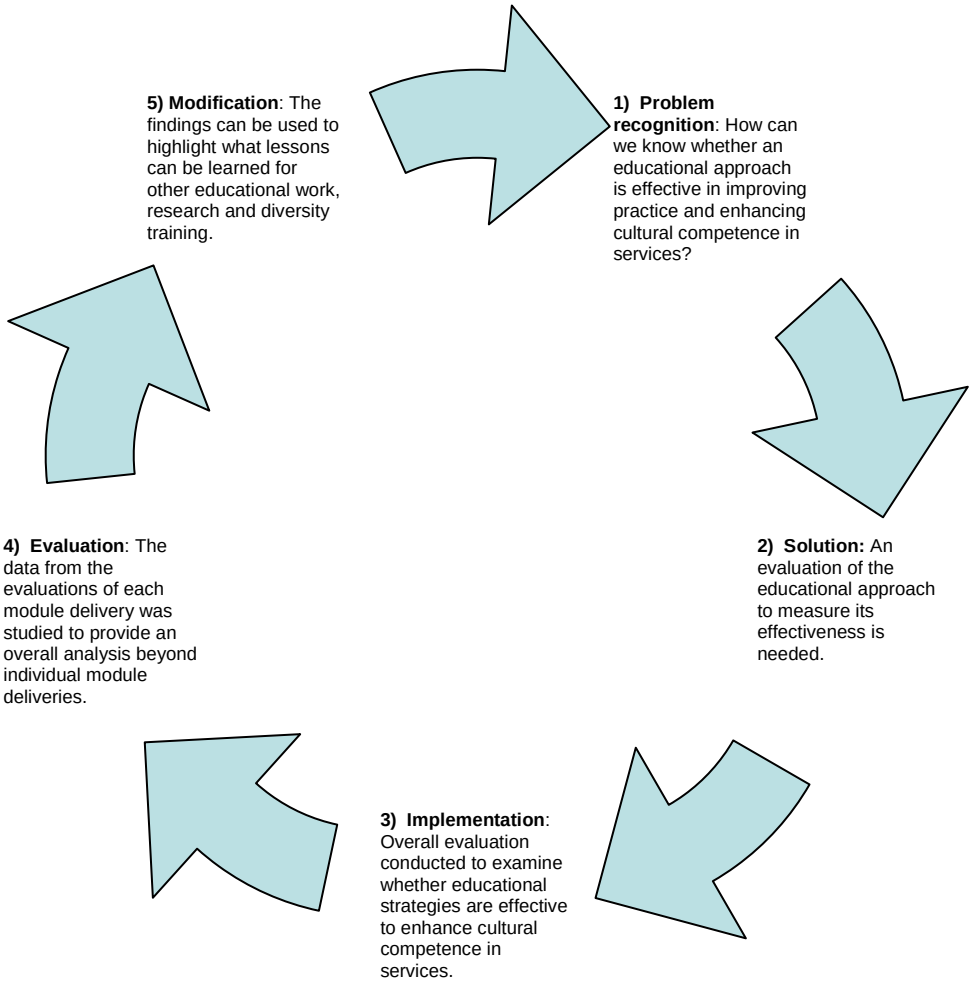
Solution: An evaluation of the educational module to assess its effectiveness was needed.

Implementation of the solution: An overall evaluation of the effectiveness of this module was conducted. This PhD could be considered a case study in addressing the wider question as to whether educational strategies were an effective tool to enhance cultural competence in drug and alcohol treatment services.

Evaluation of the solution: The data from the evaluation tools of each module delivery were studied in order to provide an overall evaluation analysis above and beyond individual module deliveries.

Modification of practice: The findings of this work could serve another purpose beyond individual module deliveries: could the lessons learned from this process be used for other educational work and research? Could they, for example, be used in the wider debate on diversity or anti-racism training?

Cycle 5:



The above illustrates how action research cycles were used in various ways during this study. The cycles operated at different but interrelated levels and some cycles operated simultaneously**.** For example, a literature review was conducted concurrently with the RNA to inform the research questions of the developing module. This literature review was later extended into a larger study to provide the evidence base for the module's content and learning outcomes. The cycles were useful for the main research questions in the overall evaluation of the research (for example, cycle 5) and also for the minor studies which focused on different aspects of the research question (for example, the RNA and literature review). They were also used to test newly introduced teaching tools or content, (for example, a new

model of cultural competence and diversity policies in addition to anti-racism policies). The use of cycles and the careful reflection at each stage encouraged constant reflection and observation in order to plan ahead for the next step. The systematic process of checking, reflecting and improving also gave weight to the validity of the findings.

2.2 Action research is action oriented

One of the key principles of action research is its commitment to action as a result of investigation (Kemmis and McTaggart, 1982). In this study, a number of research activities (see section 1.4) were used to understand and solve a problem and then to investigate whether the solution was successful.

Lewin (1948) highlighted the need for action when he proposed that research which produced nothing but books was inadequate. This resonates with Karl Marx' vision: that the task is not merely to interpret the world, but to change it (Cohen *et al.*, 2007). The need for action was also recognised by Elliott (1991) who said that action research was about improving practice rather than producing knowledge. However, action that is not informed by knowledge is insufficient. The learning process in action research, supported by critical thinking and reflection, is fundamental to the transfer of knowledge into action in order to improve practice.

The aim of this PhD goes beyond accumulating knowledge. The teaching and learning approach used for the module, influenced by critical theory and critical pedagogy (see chapter 6), seeks to improve practice by changing the knowledge and behaviour of staff. One of the measures of the success of the module was to establish whether the participants were able to transfer what they had learned from the module to their workplace, change their behaviour towards clients or initiate changes in service provision to improve practice. Without such changes, it could be concluded that the educational strategy of the module was unsuccessful.

2.3 Action research aims for improving practice/ social change

Action research has been described as ‘‘a form of collective self-reflective inquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out” (Kemmis and McTaggart, 1988, p5). Alternatively, action research can be used by practitioners to improve their professional practice. It is expected that action research, if conducted well, will enhance personal development and professional practice, be of benefit to the practitioner’s institution and to society (McNiff *et al.*, 1996).

The aim of this PhD is fourfold: to reflect upon and improve my own practice as lecturer of this module by continuous evaluation of the module and my performance; to improve the practice of participants’ work through the module and thereby achieve social change in the provision of client-centred care; to use the evaluation to reflect on what broader lessons can be learnt to improve educational practice and, finally, to see whether this approach could improve the practice of other health and social care areas.

My motivation to develop a module for practitioners exceeds simply enhancing knowledge and understanding. The module would make the participants competent by developing their skills to act on the newly acquired knowledge and understanding and as a result improve their practice. This is also in line with the concept of developing cultural competence rather than just knowledge (see chapter 3).

2.4 Critical reflective practice and participation

As mentioned above, the concepts of action research differ in the degree to which they are influenced by critical theory. Broadly, as defined by Kemmis (1997), two schools of thought exist within the confines of action research: the reflective practitioners and the critical theorists. The reflective practitioners regard action research as an improvement to professional practice at local or classroom level. The critical theorists see action research as part of a broader agenda of changing education and changing society.

An important part in the debate upon the different interpretations of critical reflection in action research is the importance given to involvement and participation. Lewin stressed the importance of democratic collaboration and participation and felt that the best way to move people forward was to engage them in their own enquiries into their own lives (McNiff, 1988; 2001). Yet, there are differing views among action researchers. Some promote the reflective practice model (Elliott, 1991) in curriculum research with the concept of the teacher-as-researcher (Stenhouse, 1975) and the reflective practitioner (Schön, 1987); others support the critical action research model, which strongly emphasises the principles of action research as a co-operative and collaborative activity (Kemmis and McTaggart, 1992; Hill and Kerber, 1967). They argue that those who are affected by the planned changes should be those who decide on interventions that lead to the changes. Critical action research has also been called 'participative action research' to emphasise its focus upon group activity and involve those affected by the subject that is being investigated.

Others found that seeing action research solely as a group activity might be too restricting (Stenhouse, 1975; Whitehead, 1985). They argued that an individualistic approach could be possible. An example is the teacher-as-researcher approach, where teachers evaluate the outcome of their teaching in order to make improvements. Kember (2000) stressed the importance of the reflective process of action research and argued that action research would also be an individual problem solving activity, or an individual reflecting on one's own practice. For example, if

individual teachers tackled issues from their courses using a cyclical, reflective approach, it would be appropriate to say that they are conducting action research.

This study combines elements of both approaches: reflection on practice and participation, and collaboration and individual activity. Reflection on practice was used as an individual activity by reflecting on my own performance as a researcher and a teacher, by assessing whether the goal to improve practice through my performance in creating the module had been met. Individual critical reflection was supported by collaborative action by the steering group, which guided the development of the module. The reflection on my performance as a teacher was complemented by collective action through the students' feedback during and after the delivery of the module.

Critical reflection on practice occurred when the students were asked to think about their own attitude and behaviour in practice. This happened either as an individual process during or after the module, or collectively during group activities and discussions. Collective and interactive learning sought to enhance their learning by listening others' views. Critical reflection is well known as powerful tool used to change deep seated beliefs (Thompson *et al.*, 2008).

In line with Morrison's (1998) statement, that those closest to the problem are in the best position to identify and work towards a solution, participation occurred at several levels. The involvement of the steering group in the research process was important for two reasons; to make sure that the module was relevant to the training needs in practice and to achieve commitment from service providers who sent their staff on the course. Likewise, participation occurred when community members, service users and service staff were invited to take part as key informants in the RNA. Involvement of students as recipients of the educational approach occurred during interaction in the classroom and in the evaluation of the module. This was vital in order to ensure that the educational module could deliver what was needed in practice.

Service users were also key informants in the RNA for the development of the module. Additionally, they were invited as guest speakers during class. A number of participants on the module were ex-substance users. They mostly identified themselves as professionals rather than as users. However, service users were not specifically targeted as participants of the training and were not involved in the evaluation of the module. In the near future it is planned to involve service users as participants of the training and in the evaluation process.

2.5 Action research is educational

Action research has become increasingly popular in small scale educational research because it helps to find practical solutions to practical problems (Bennett, 2003). Stenhouse (1975) strongly advocated the role of teachers-as-researchers in educational research in studying their own performance as teachers in the classroom and in curriculum development. McNiff *et al.* (1996) claimed that action research is clearly educational in the sense of self-development and that every action researcher needs to engage in a form of professional development. The authors used the term 'educational action research' to emphasise that change will be brought about through careful evaluation of action; not as a manipulative device but as a means of education. McNiff (1988; 2001) further argued that good teachers are supposed to be critically aware of their teaching practice and constantly try to improve this practice. Action research aids this process by using self-critical awareness and being open to a process of change and improvement of practice. However, it is the use of formal means, using research models, that ensures this reflection takes place in a systematic way, and so distinguishes action research from everyday self-reflection.

The systematic reflective research approach used in this study was not only useful in evaluating whether the individual participants had learnt from this learning experience. It also enabled reflection on the wider impact beyond individual learning and contributed to the broader debate on educational practice as to whether particular educational approaches could achieve a difference. For example, whether the educational strategy and the teaching and learning approach used in this module had been effective in achieving a change in knowledge and behaviour. It helped investigating whether the findings of this study could be transferred into other areas and to contribute to the ongoing debate about what approaches could be used in anti-racism and diversity training.

Kember (2000) emphasised the positive effects of action research on teaching and learning, as action research deals with social practice in education. It encourages the direct interaction of teachers and students and acknowledges the human element in teaching, which recognises that learners are complex rather than simply being receivers of knowledge.

This demonstrates the close link between educational action research and the concept of critical theory and critical pedagogy. The teaching and learning approach used in this thesis, based on the principles of critical theory and critical pedagogy, involved interactive learning and a dialogue between teacher and students. It emphasised continuous critical reflection, self-development and learning of all participants. This applies to the researcher/ teacher as well as the student/ participant in terms of their learning and critical reflection on practice. The principles of critical theory and critical pedagogy, and how they relate to the teaching and learning strategy of this module, are discussed in more detail in the chapter 6.

2.6 Action research - research method

Action research has frequently been criticised for lacking the validity and rigor of other research approaches. Proponents strongly defended this approach as being appropriate for their needs. For example, McNiff (1988, 2001) pointed out that the action research approach was systematic rather than an ad-hoc enquiry. The method of action research, as a continuous self-reflecting spiral of planning, acting, observing, reflecting and re-planning, enables teachers to make sense of their practice in a supportive and critical way. Kember (2000) said that one of the greatest strengths of action research was the straightforward practical approach when tackling important problems. The methodology does not require knowledge of complex research skills for complicated data collection and analysis. Therefore teachers can engage in research without relying upon outside experts. Kember (2000) concluded that action research contributed to social practice and brought theory and practice closer together.

However, the concept of the teacher researching his own practice goes against research approaches that set out to be impartial, neutral and objective. McNiff (1988, 2001) disputed this argument by pointing out the disadvantages of other educational research methods; for example, the empiricist tradition whereby data is collected by an external researcher and his interpretation of that practice provides the result of the research. McNiff admitted that action research may not be the answer to all educational research, but recommended it as a useful strategy for interpersonal issues, such as teaching styles.

Action research seemed the appropriate research approach for this PhD. Involvement in the study means that those closest to the problem should be involved in investigating it and finding solutions. This would ensure a bottom-up approach to research rather than simply passing down the findings of research by external experts. Although an external researcher could have used participatory observation to good effect, my own involvement as the closest person to the study enabled in-

depth knowledge and a degree of expertise that potentially benefited the outcomes of the study. The continuous cycle enabled me to step back, critically reflect and make changes throughout the process of the study. It also enabled me to systematically reflect on my own performance, ideas and concepts without having to depend upon an outside expert. It increased my theoretical understanding of my research and practice.

3. The Concepts of Cultural Competence and Culture

A review of the literature has been carried out as part of the action research cycles to ensure that the content of the module and its learning outcomes were relevant to practice and informed by the appropriate latest theoretical concepts and developments in the field. Chapters 3 and 4 present the findings of this literature review. Chapter 3 concentrates on the concepts of cultural competence and culture and establishes the need for cultural competence to improve services; chapter 4 focuses on issues relating to drug and alcohol problems within different cultures. A number of models will be introduced and their effectiveness in improving service provision will be discussed. Previous training approaches will be reviewed to ascertain their effectiveness, and key issues for training will be summarised.

The concept of cultural competence cannot be explained without elucidating the concept of culture adopted for this study. The complexity of culture will be explained together with its influence on behaviour, beliefs and values. The review will also consider cultural influences on health beliefs and help-seeking behaviour and will highlight the problems that can be caused in clinical encounters when different beliefs and expectations come together. Equally, the notion of ethnicity will be reviewed to demonstrate how it relates to the concept of cultural competence in this study. Links to the drug and alcohol field will be drawn throughout.

A wide range of publications have been reviewed, including Government reports and policies, books, and peer reviewed articles. The search included keyword searches, cited reference searches and hand searching of relevant academic literature. Among the databases searched were Medline, Entrez PubMed, CINAHL, Google Scholar and SLEH, the online Specialist Library for Ethnicity and Health within the National Health Service (NHS). The libraries of TVU, the King's Fund and the London School of Hygiene and Tropical Medicine were visited and the websites of relevant agencies were searched, including the Mary Seacole Centre for Nursing Practice at TVU, the Royal College for Nursing, the Commission for Racial Equality, the National Centre

for Cultural Competence in Washington, and relevant Government organisations such as the Home Office (HO), the Department of Health (DH), and the National Institute for Mental Health in England (NIMHE).

3.1 Cultural Competence

3.1.1 The drivers for cultural competence

The need for cultural competence in health and social care services has been highlighted by a number of authors (NCCC, 2004a, b; Geiger, 2001; Philleo *et al.*, 1997; Ehrmin, 2005) (see also section 1.1). They referred to problems encountered in the practitioner/ patient interaction caused by different perceptions of illness and disease. Cultural differences in health beliefs, practices, and behaviour can influence the expectations that clients and healthcare providers have of each other. A lack of awareness about cultural differences can result in miscommunication and misunderstanding between client and carer, making it difficult to achieve the most appropriate care. As a consequence, inequalities in health may increase rather than decrease.

A range of literature focused on the provision of services for people from minority ethnic backgrounds who have drug and alcohol problems. These highlighted gaps in services and problems in gaining access (Awiah *et al.*, 1990; Johnson & Carroll, 1995; Sangster *et al.*, 2001; NTA 2003; Fountain *et al.,* 2003; Fountain, 2006) and will be explored in more detail in section 4.3.1.

The need for better quality services for people from minority ethnic groups has been recognised in UK Government policies and professional guidelines (Department of Health (DH), 2000; 2004; 1998; NMC 2004)[7]. Yet, it is unclear whether this refers to a greater number of services to be provided for minority ethnic groups or simply to

[7] The NHS Plan (DH, 2000) assured that the NHS would address local inequalities, including issues such as access to services for minority ethnic communities.
The NHS Knowledge and Skills Framework (KSF) (DH, 2004) defines the knowledge and skills which NHS staff need to apply in order to deliver quality services. '*Equality and Diversity'* is one of its six core dimensions.
The Government's drug policy document 'Tackling Drugs to Build a Better Britain' (DH, 1998) promised all problem drug users irrespective of age, gender and race access to appropriate services.
The updated Nursing and Midwifery Council (NMC) Code of Professional Conduct (NMC 2004, p4) states clearly that the interests and dignity of each individual patient and client need to be respected, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs.

improve the existing services. Equally, there appears to be no shared views on what needs to be achieved and how services should be provided.

All parts of the public sector are under pressure to improve their services by training staff in cultural diversity issues. Amongst the most important drivers for the battle against racism were the Macpherson Report into the Stephen Lawrence inquiry (Macpherson, 1999) and the Race Relations (Amendment) Act 2000 (RR(A)A 2000) (HO, 2000). The RR(A)A 2000 placed a general duty on public authorities to promote race equality. The Act required authorities to ensure that they eliminate unlawful racial discrimination, and promote equality of opportunity and good relations between persons of different racial groups. Central to the Act is the belief that providing adequate training on racism awareness and cultural diversity is a step forward to prevent acts of racial discrimination.

An evaluation by the Commission for Racial Equality (CRE, 2002) on the successful implementation of public duty to promote race equality and good race relations in England and Wales identified that overall the health sector had made less progress than other public services; guidelines and action plans to achieve race equality were developed (NCLHSA, 2004; CRE, 2003) to assist public authorities in meeting their duty to promote race equality.

The recent race equality audit by the Healthcare Commission (2006a) identified shortcomings in NHS Trusts to meet their responsibilities under the RR(A)A 2000 and warned that a lack of action to meet statutory codes of practice would impact negatively on their annual performance rating. The CRE (2007) launched a formal investigation into the DH because it has not met its duty to promote race equality under the RR(A)A 2000. These failings included not carrying out Race Equality Impact Assessment Schemes on the Department's policies.

The Mental Health sector became active after the report was published on the recent inquiry into the death of David Bennett, a mental health patient who died in a secure unit at a mental healthcare trust in Norfolk (NIMHE, 2004a). This report cleared the staff of deliberate racism but accused the NHS of institutional racism and called for

managers and clinicians to receive mandatory training in all aspects of cultural competency, awareness and sensitivity. NIMHE responded with the publication of action plans, frameworks and policy documents (NIMHE 2004b, 2005) that sought to improve the health of minority ethnic communities in England.

The National Treatment Agency (NTA, 2003) offered guidance on implementing good practice in addressing racial equality in the commissioning of drugs and alcohol misuse treatment. With reference to the RR(A)A 2000, the NTA stated that tackling racial equality is relevant and should not be seen as a burden because addressing issues of race equality would improve both mainstream services and specific substance misuse treatment systems.

3.1.2 What is cultural competence?

There are many ways of referring to the provision of culturally sensitive healthcare that seeks to improve the health and well-being of minorities[8]. Few researchers referred to the concept of cultural competence in UK literature (Mulholland, 1995; O'Hagan, 2001; Papadopoulos and Lees 2002; Cortis, 2003). A vast amount of literature focused on related issues such as tackling inequalities in health (Black *et al.*, 1980; Acheson, 1998 and 2000; Bartley, 2004), cultural differences in health (Kelleher *et al.*, 1996; Hillier *et al.*, 1996), challenging discrimination and oppression (Thompson, 2003), diversity and disadvantage (Modood *et al.*, 1997), racism in medicine (Coker, 2001), institutional racism (Macpherson, 1999; NIMHE 2004a) and others. However, the idea of cultural competence goes beyond creating awareness or sensitivity.

3.1.2.1 Definition

There is no single definition of cultural competence. However, most definitions have a common element in that they require a reflection on the practitioner's own culture

[8] They include terms such as 'transcultural care', 'cross-cultural medicine or psychology', 'cultural diversity' in medicine and 'intercultural therapy'.

in order to understand the culture of a patient. As a consequence this personal awareness results in a changed attitude of the practitioner towards the client. The selected definitions below are informative:

Selected definitions:

"*Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations*." (Cross *et al.,* 1989). This definition has been adopted by the US Department of Health and Human Services Office for the development of national standards for culturally and linguistically appropriate services (CLAS) (OMHRC 2001).

"Cultural competence is 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, values and skills which underpin any competency training in numerous care professions. Their successful application in work with culturally diverse peoples and communities will depend a great deal upon cultural awareness, attitude and approach. The workers need not be (as is often claimed) highly knowledgeable about the cultures of the people they serve, but they 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)

Thus, cultural competence goes beyond awareness or sensitivity as it enables effective operating in different cultural contexts. A vital component is that cultural competence is inclusive of all cultural, ethnic and religious groups (Fortier *et al.*, 2004). Cultural competence is often defined either in terms of the outcomes for individuals and groups or in terms of attitudes, knowledge or beliefs of health and social care practitioners or their organisations (Papadopoulos *et al.*, 2004).

The following tenets governing cultural competence summarise the above discussion, and were used for this study:

Cultural competence goes beyond cultural awareness as it refers to the capacity of effectively operating in different cultural contexts.

Cultural competence is an ongoing process of self-reflection of one's own (or organisation's) values, beliefs and professional practice.

Cultural competence is the ability to maximise sensitivity and to minimise insensitivity in dealing with people from different cultural and social backgrounds.

Cultural competence is inclusive of all cultures and is not limited to particular ethnic or religious population groups.

For cultural competence to be effective, cultural knowledge and awareness need to be transferred into behaviour and action.

Cultural competence builds on the knowledge, values and skills that underpin professional competencies.

The application of knowledge, values and skills in order to work effectively with people from different cultural backgrounds requires cultural awareness and an approach that reflects openness and respect.

The most important elements of cultural competence when working with people from all cultural backgrounds are self-awareness and high motivation.

Willingness to learn is more important than knowledge alone.

Inadequate knowledge can lead to assumptions and stereotypical views about cultural groups rather than recognising the individual's beliefs and needs.

3.1.2.2 The concepts behind cultural competence

Most literature about cultural competence originated from the USA and Australia, where the debate is more advanced than in the UK and other parts of Europe. The US debate resulted in the development of national standards for culturally and linguistically appropriate services (CLAS) in healthcare (OMHRC 2001). The concept of cultural competence has become important in recent years because of increasing diverse communities and the problems that result when members of such communities approach services for help. Few professionals have been trained to deal with cultural issues that arise in the interaction with their clients. For many professionals the role that culture played in the help-seeking and treatment process

was not clear and they were unprepared to address the cultural issues of their clients (Leininger, 1991; Cross *et al.*, 1989). Mason (1998) pointed out that professionals needed to differentiate this new concept from earlier models of 'cultural awareness' and 'sensitivity'. Although many people had received training in cultural awareness in recent years, this training did not automatically result in suitable actions. Mason concluded that for cultural competence to be effective, cultural knowledge needed to be converted into behaviour and action.

In contrast, Atkinson and Hackett (1988) argued that services must be responsive to all people. Targeting population groups of colour as culturally diverse may be the most obvious, but services must also recognise and respond to the needs of groups that are not defined by their ethnicity. They differ in their needs from refugees, asylum seekers or immigrants. These include elderly people, youth, people with disabilities, women, the poor, gays, lesbians and the homeless, all of whom have distinct cultural values and needs. Mason (1998) however, warned that treating members of such diverse groups as one homogenous group would create confusion rather than improve services. Instead, it was vital to examine the utilisation rates, outcomes and client satisfaction for each cultural group in order to identify exactly which groups were not receiving the services they needed, and which groups were not making full use of the services.

This debate demonstrates an important idea within the concept of cultural competence in that ethnicity and culture are neither rigid nor particular to minority groups. The concept of 'culture' as related to ethnicity in this work will be further outlined in section 3.2.

3.1.3 How to achieve cultural competence

3.1.3.1 Ways to make services more culturally competent

Various ways have been suggested to make services more culturally competent. These include employing more staff from minority ethnic backgrounds or having ethnic specific services run by staff from within these minority ethnic groups. Both approaches have advantages and disadvantages and will be discussed in more detail in section 4.3.3.

Another approach is the use of intercultural mediators[9]. These are employees or volunteers that assist patients as the first point of contact when entering a hospital. They speak the relevant language and guide them through the bureaucracy of the healthcare system. However, if the knowledge and experience of these intercultural mediators does not feed back to educate other healthcare staff, cultural competence cannot be achieved. Such an approach may be useful to accommodate those who stay in the country for a short time, but it is not a solution when dealing with the various needs of a multicultural society.

3.1.3.2 Cultural competence models

A number of models have been developed to help health practitioners cope with the increasing diversity of their clientele and to becoming more culturally competent when working with people from minority ethnic groups (Cross *et al.*, 1989; Campinha-Bacote, 1998; Leininger, 1978; Giger and Davidhizar, 1999; Betancourt, 2002; Purnell & Paulanka, 1998; Ramsden, 1990; Papadopoulos *et al.*, 2002). The following text briefly introduces three models, followed by a critique upon their usefulness in achieving cultural competence. Their selection was based on the criteria: how well known were they to health professionals; were the concepts

[9] This approach was discussed at the International Conference on Health Promotion and Healthy Hospitals in Vienna in April 07 when representatives from hospitals in two European Cities, Barcelona (Spain) and Bologna (Italy), reported positively on their experience of using *intercultural mediators*.

transparent; and what were their differences in approach? Details of the modules can be found in the Appendix 3.

Leininger was the first to develop a theoretical concept of transcultural nursing in the 1950s (Leininger, 1978). Most of the models on cultural competence built on her theoretical concepts. Leininger's model of linking culture and care (Leininger 1997, 2002) aimed to give nurses a better understanding of the diverse components that influenced the health of individuals, families and communities. These components included religious, philosophical, educational and other factors. The model also recognised differences and similarities in the experience and practice of patient care that needed to be clarified to provide a holistic perspective of care.

Campinha-Bacote's (1998, 1999, 2002) model focused on the healthcare practitioner's process of becoming, rather than already being, culturally competent. This process involved the integration of five interdependent cultural factors: awareness, knowledge, skill, encounters and desire.

The Giger and Davidhizar's Transcultural Assessment Model (Giger and Davidhizar, 1999; 2002) assumed that each individual is unique and should be assessed with the help of a framework from which culturally sensitive care can be designed. The framework was based on six key areas of human belief and activities where cross-cultural similarities and differences can become obvious (communication, space, social organisations, time, environmental control and biological variations). These areas enabled understanding of individual as well as group characteristics without losing sight of the diversity and universality across cultural groups. They represented themes that can be understood on several levels: the individual, group, cultural or societal level.

3.1.3.3 Critique of the models of cultural competence

The above models were based on similar philosophies but differed in their emphasis and methodology. For example, Leininger and Giger & Davidhizar developed an assessment tool so that knowledge gained by conducting a comprehensive

assessment would help to guide the healthcare professional in devising treatment interventions that are meaningful to the patient. In contrast, Campinha-Bacote focused on the health practitioner's process of becoming culturally competent.

All three models recognised the importance of cultural influence on people's behaviour and beliefs, including their beliefs on the causes of illness and where they can go for help. Leininger used the term 'holistic' in her work, meaning that nurses should learn to recognise and have a better understanding of the diverse factors that influence the health and wellbeing of the individual patient, their families and community. Giger & Davidhizar argued that each individual is culturally unique and a product of past experiences, cultural beliefs and norms and needed to be understood as such. Campinha-Bacote emphasised that healthcare professionals needed to understand the client's world view and cultural interpretations of illness in order to be able to come up with an appropriate intervention.

Cultural diversity and cultural differences were also common themes. Campinha-Bacote pointed out that individuals are not a stereotypical reflection of their culture of origin, but a unique mixture of diversity within each culture. The diversity of patients, therefore, required a cultural assessment of each individual. Leininger pointed to the existing cultural diversity in the provision of care that resulted in culturally learnt behaviours of healthcare practitioners. They needed to be aware of their own bias and prejudices towards individuals who are different from them. Without awareness of the influence of one's own cultural, or professional, values there is a risk of imposing one's own beliefs and values on another's culture.

However, if cultural differences are regarded as a cultural deficit this makes culture the problem and may reinforce stereotypes and prejudices. Therefore, culturally competent care needs to go together with treating the other person as an equal instead of being dismissive or indifferent, and emphasising commonalities rather than concentrating on the differences (Coup,1996).

Awareness of the influence of culture is important, but emphasising cultural rather than individual characteristics may lead to generalisations, and even attribute blame to a particular culture. For these reasons, in the assessment process the individual must always be seen as the foreground and the context in which they live, including the culture, as the background, as suggested by MacLachlan (1997).

Linguistic and cultural misunderstandings are the cause of most problems in the interaction between practitioners and clients from a different culture. The importance of effective communication had been stressed in all three models. Giger and Davidhizar underlined that if cultural factors in communication go unrecognised or are misinterpreted, this often results in feelings of rejection and misunderstanding. For example, racism, prejudice and power can all be communicated through verbal and non-verbal actions and gestures (Robinson, 1998). Thus, for transcultural communicative competence the individual healthcare worker must learn to understand cultural values, behavioural patterns and rules of interaction in specific cultures (Gerrish *et al*., 1996).

This is also valid for the common understanding on the cause of illness and the treatment of choice between patients and health practitioners. The success of a treatment intervention is strongly related as to whether the patient feels that their beliefs are understood and accepted (Loustaunau *et al.*, 1997). Leininger explicitly stressed the importance of assessing and taking into account perspectives on health and illness that may differ between patients and healthcare professionals. An assessment that identifies the explanations that people hold about the causes and consequences of their illness (MacLachlan, 1997) is important as the explanations put forward by the client may reveal how strongly they believe in them and how willing they would be to accept other explanations.

Although the need for cultural skills in communication and assessment is highlighted, a strong emphasis on knowledge is noted throughout. The transcultural nursing model can be criticised in that it assumed that knowledge about different cultures would automatically improve care and services (Culley, 1996). On the other hand,

insufficient knowledge is a risk and busy health professionals may only acquire very superficial knowledge. This may encourage them to make assumptions based on previous experiences, thus stereotyping and judging the patient without considering the full picture. Campinha-Bacote suggested that healthcare professionals needed to engage in cross-cultural interactions in the hope that this interaction may influence the practitioner's beliefs in order to prevent stereotyping.

It is possible to be culturally competent without knowing much about a particular culture. O'Hagan (2001, p235) argued that workers do not need to be highly knowledgeable about the culture of the people they work with but they must be open and willing to learn. This is a valid point, especially as the reality is that in our globalised world populations rapidly change and service staff need to be able to quickly learn about different cultures to adapt their work to an ever changing clientele. The distinction of Papadopoulos *et al.* (2004) between culturally generic and culturally specific competencies is helpful. Thereby, culture-generic competences included the ability to recognise the impact cultural identity can have on health and to develop a deeper understanding of the underpinning societal and organisational structures.

Furthermore, knowledge about other cultures does not necessarily change the power hierarchy in the relationship between health professional and client or reduce institutional and individual racism, nor does it change people's and society's views on the perceived inferior status of members from certain cultural and social backgrounds. Some critiques described the transcultural nursing practice model as naively optimistic to assume that understanding one's own culture and the culture of others creates tolerance and respect for others and undermines the irrationality of prejudice (Mulholland, 1995).

All three models demonstrate that they include a variety of factors that impact on the individual and shape his/her beliefs and attitudes to form a wider concept of culture. Yet the authors failed to clearly articulate what their concept of culture is. Due to the increasing cultural mix of populations within the last three decades, the perception of

culture has changed dramatically, and culture, multiculturalism and anti-racism have been the subject of many debates.

Multicultural approaches, such as the transcultural nursing model, have been criticised in that they tended to reproduce what Donald and Rattansi (1992) called the 'saris, somosas and steel band syndrome', a superficial concept of culture that failed to address inequality and hierarchies of power. However, recent concepts of culture go beyond a person's cultural inheritance of values, behaviours and practices and recognise that culture is also influenced by social conflicts and power relationships (Cortis, 2003; Good, 1994).

A major criticism of the transcultural model is that it fails to recognise the political aspect of power and inequalities and to what extent they affect minority ethnic groups. It does not reflect on the hierarchy of power that impacts on healthcare provision and the relationship between the patient and healthcare professional. Further issues that are not considered are the lack of resources and time constraints that put pressure on healthcare professionals (Geiger, 2001). Both may affect their enthusiasm to work with such time intensive patients from a diverse cultural and social background. Equally, the implications of racism, both individual and institutional, within the healthcare system are not considered.

Mulholland (1994) blamed the nature of the humanistic approach in nursing for making nurses committed to an apolitical model of professional practice and education. The humanistic-informed transcultural models were developed when it became increasingly apparent that the healthcare services failed to adequately address the mono-cultural and racist aspects of healthcare in Britain. However, the multicultural approach used within the transcultural nursing frameworks was inadequate and its strategies were incapable of bringing about the required social and contextual changes. Fundamental limitations of these models were found to lie in the failure of nursing to identify and confront power as a feature of the relationship between clients and nurses and also the failure in recognising the relationship between knowledge and power.

Culley (2000) argued that the critique of multiculturalism stresses the importance of recognising the economic, social and political factors that account for inequalities and culturally unsafe practice. Mulholland (1995) claimed that the commitment of nursing to a consensus model of power would reflect assimilationist educational strategies. Central to this perspective was that cultural differences were seen as problematic and the main goal therefore was that minority ethnic groups needed to take up the host culture and as a consequence lose their own. Multicultural frameworks and strategies for nursing therefore unconsciously reflect a liberal form of assimilationist perspective.

The concept of cultural competence has also been strongly criticised by Khan (2002) who emphasised that without tackling institutional racism cultural competence is just another version of the failed policies of multiculturalism that are a diversion from social injustice. However, such criticism did not acknowledge the existence of different approaches of cultural competence. Other approaches than purely multicultural ones to address inequality may be more useful. For example, Ramsden's Cultural Safety Model (Ramsden, 1990; Royal College of Nursing (RCN), 2003), was developed in New Zealand in the late 80's by a group of Maori nurses as a means of analysing nursing practice from the perspective of indigenous people. Its concept was embedded in the redefinition of post-colonial identity, redistribution of power and resources. Ramsden and his colleagues emphasised the need for cultural safety in a bicultural situation. Culturally safe practice means taking into account the patient's values and views on treatment decisions, empowering the patients to take part. Important aspects of the cultural safety concept were the nature of cross-cultural interaction, the importance of clients' participation in the assessment of service needs and delivery. It required that the inequalities of power between groups and within systems in society were taken into account when planning services and delivering care. Discrimination, racism, lack of equality of opportunity and stereotyping are issues that the concept assists in exploring (RCN, 2003; Mary Seacole Centre, 2001).

In conclusion, all three models that were examined contained elements that are useful in achieving more culturally congruent care. However, multicultural approaches based on humanistic principles, such as those of Leininger and Giger-Davidhizar, may experience limitations as they appear to avoid conflict. Challenging discrimination and racism requires actions that staff may sometimes feel uncomfortable about. Bacote's model appeared to be less of a uniform transcultural model as it addressed the process of becoming competent without simply focusing on acquiring knowledge. It could still be criticised for ignoring power relationships and institutional racism. All three models adopt a wider concept of culture, including the social context, family and environment. However, the social division on such issues as class, race, gender, age, and disability which make up the social order of a society and that reflect inequality, discrimination and oppression were still not addressed. Multiculturalist approaches tended to ignore the complexity and diversity in ethnic groups and thereby facilitate the continuation of inequalities.

The literature review reveals that anti-discriminatory practice occurs only if issues around institutional racism and inequality in accessing services are addressed. This occurs best in a healthcare relationship characterised by dialogue and mutual respect. Important features of such an approach could be client-centred treatment and involvement in assessment and treatment decisions, in order to reduce the power hierarchy. Such a cultural competence approach is also in line with the philosophy behind this present study which seeks to address social injustice and requires action to achieve social change.

Details on how the concept and models of cultural competence are used in the educational approach will be outlined in chapter 6.

3.1.4 Cultural Competence Training

3.1.4.1 Review of training approaches

The many calls in the last decade for training to make staff and services more culturally competent resulted in a massive increase of training activities in the UK.

However, there was a lack of clarity about what constituted such issues as racism awareness and valuing diversity (Taylor *et al.*, 1998). There was no strategic approach in how to bring about real change and the organisational performance frameworks to assess the impact of training were underdeveloped (Bhui *et al.*, 2007). Many organisations did not have a clear understanding of the aim, content or philosophy of the intended training. There was also a lack of consistency; in many cases the training was patchily delivered at isolated events rather than as part of an overall strategy to address problems that surface in multicultural modern societies (IES, 2002).

For training to be successful organisations need to embed their training activities in a strategic model of cultural change and consider what they hope to achieve prior to the training. Each organisation has to find its own level of cultural progress in order to gain the best effect from training. Training should reflect a journey which is grounded in a willingness to do things differently (IES, 2002; Taylor *et al.*, 1998).

The typology which is outlined below (Wrench and Taylor, 1993) shows different training approaches to multi-cultural, anti-discrimination or diversity training based on differences in strategies (whether training is aimed at increasing knowledge, changing attitude, behaviour or organisational change, see column 1 in table 2 below) and content (whether training is focused on racism, discrimination, multicultural understanding or broader social issues such as diversity, see columns 2, 3 and 4 in table 2 below).

Table 2: Anti-discrimination training typology

Content/ Strategy	Multicultural	Anti-discriminatory	Broader issues
Information provision	Information training	Information training	
Attitude change	Cultural awareness training	Racism awareness training	
Behaviour change		Equalities training	Equalities training
Organisational change		Anti-racism training	Diversity training

Source: Wrench and Taylor (1993)

The six training approaches include information training that assumes that by providing facts and information behaviour will change; cultural awareness training

assumes that by raising awareness discrimination will reduce; racism awareness training uses awareness and confrontational techniques to result in behaviour change; equalities training seeks to achieve behavioural change by instructing individuals in legally appropriate behaviour; anti-racism training seeks to change organisational practices, including recruitment, and diversity training aims to develop a heterogeneous culture where people are treated appropriately.

When applied to the module that is the subject of this research, it can be said that this training was strategically directed at changing the knowledge, attitudes and behaviour of individual staff. However, it also aimed to go beyond the individual level and influence the assessment, treatment and care of patients within services. The training involved elements of cultural and racial awareness but focused on anti-discrimination in a wider sense. It included issues beyond that of race, such as gender, age, disability and social injustice.

A shift of focus occurred in the content of the module during the course of the study. The initial brief for the development of the module was antiracism and equality training, focusing on improving services for people from minority ethnic backgrounds. Ongoing studies and experience gained whilst delivering the module revealed the limitations of such an approach in achieving cultural competence. The decision was taken to adopt an approach of diversity training that was inclusive of people from all cultural and social backgrounds.

Luthra and Oakley's (1990) typology was similar to this concept but had an additional educational component. It assumed that change could only come about through the individual's self-driven personal development. The teaching approach used in this module, (see chapter 6) was similar as it highlighted the importance of self-reflection and that the individual must be motivated to learn and to effect behaviour change. It was also influenced by the view that expectations of outcome, as with any educational tool, need to be considered from a long-term perspective.

Four dimensions of race awareness training assist organisations in developing an overall strategy for training: philosophy, level, target and aims (IES, 2002) (see table 3).

Table 3: The four dimensions of race awareness training

Philosophy	Level	Target	Aims/Objectives
Racism Equality Diversity	Individual Group Organisation Sector	Subordinates Colleagues Clients Community	Information Awareness Attitudes Behaviour Culture

Source: IES (2002)

When mapping these four dimensions against the approach used in the cultural competence training in this study the following picture emerges:

The philosophy of the module, after initially focusing on racism and equality, clearly promotes accepting and embracing diversity. This includes discrimination in the wider sense, not only of race but also that of gender, social injustice, age, religion, sexual preference and disability. The module aimed to work at various levels: at the individual level by seeking to change the knowledge, attitude and behaviour of the individual participant, and at the organisational level because it hoped that by achieving changes at the individual level it could also influence organisational culture. The targets for change were fourfold: individual staff; clients who benefit from improved practice; colleagues who seek to improve the working relationships between staff and managers; and by enhancing the organisation's working relationship with the community and other partner organisations. Of course, and this issue will be highlighted later, changing an organisation's culture is a very ambitious task. It requires a strong and long-term commitment of the managers and their leadership and may not be achieved as an immediate goal with this module alone. The question is whether a culturally competent service can be adequately achieved by changing individual behaviour without changing the organisation's culture.

3.1.4.2 Past training approaches

Britain already has a history of anti-discrimination training, whose origins go back to the arrival of immigrants in the 1960s. A brief review of past training provision

intends to give an understanding of changes in the approach, design and philosophy of training over time.

Until the mid 1960s, the social policy assumption had been that immigrants to the UK had a responsibility to 'assimilate' themselves into the host society. The responsibility was on immigrants to learn about British society, and training was offered to teach them about British culture (Taylor *et al.*, 1998; Alibhai-Brown, 2000). After that, in the mid 1960s, a new philosophy developed with the assumption that some immigrant cultures would remain in British society and should be respected. Training was provided for professionals in services to inform them about immigrant culture. It mainly consisted of providing information about these ethnic minority population groups and creating awareness that their needs may be different from the white British population. From the late 1970s onwards such training was criticised for ignoring the reality of racism and discrimination. The 1976 Race Relations Act placed the emphasis of racial equality on the policy agenda at institutional level. As a consequence the focus of training shifted towards preventing racism and discrimination (Taylor *et al.*, 1998).

In the 1980s training was dedicated exclusively to race issues and delivered as racism awareness training for white participants. Much of the racism awareness training during that time was often confrontational and uncomfortable for the participants. It involved confronting the individual racist attitudes of white staff. This anti-racist education was criticised as an attempt to indoctrinate and also to create a new hierarchy of culture, whereby blacks and Asians were seen to have a culture that was worthy of celebration, but not white people. Blacks and Asians were regarded as blameless because racism could always be used to justify whatever they did (Alibhai-Brown, 2000). Such training approaches were frequently counterproductive. An example is a group of white young people and their families in Greenwich who after they had undergone multicultural education were convinced that black and Asian British people had received special treatment from government institutions. Their anger against non-whites had been made worse by this type of education (Hewitt, 1996)

This anti-racist approach was widely criticised as taking a rather negative, even destructive line. It led to resistance rather than addressing institutional issues with regards to racism and discrimination (Sivandandan, 1985). It was replaced in the 1990s by a broader training approach that encompassed other issues that could be subject of discrimination, such as disability, age and gender as well as race. This new approach was termed equal opportunity training and mainly focused on legislation. Still, this approach was criticised for its narrow focus on individual issues without addressing the wider structures of power and inequality. The shift from anti-racist to anti-oppressive and anti-discriminatory practice was widely welcomed as an improvement, but the new training received criticism that it differed little from the anti-racism approach (O'Hagan, 2001). Many practitioners and trainers promoted anti-racist and anti-discriminatory practices but ignored the wider concepts of culture and diversity.

It can be concluded that preoccupation with race and racism hinders rather than helps in training health and social care professionals to becoming more culturally aware. Focusing on race and racism does not take into account the many other forms of discrimination that can be just as painful for the individual, or group, for example discrimination on the grounds of gender, religion, sexuality or age which will have affected people of all walks of life. This experience may make them more likely to recognise and understand other forms of discrimination. Therefore, a wider and more inclusive educational approach could result in a common understanding of discrimination.

Consequently, the module developed in this study adopted a training approach that tried to include all population groups. It also attempted to establish a dialogue between cultures and population groups and hoped to reach an understanding of the various types of discrimination people can suffer from. Such an approach is considered to be a less emotively charged way to addressing the issue of race and is considered a more modern approach than simply focussing on racial inequalities.

3.1.4.3 Research into the impact of training approaches

Papadopoulos *et al.* (2004), who reviewed the impact of cultural competence training, reported that they were unable to find any studies that evaluated the impact of healthcare educational initiatives on their practice and patient satisfaction. Similarly, the systematic review of Bhui *et al.* (2007) criticised the lack of systematic research on the effectiveness of training approaches. Two reviews set out to provide an overview on the impact of anti-discriminatory, diversity and racism awareness training in the UK (Taylor *et al.*, 1998 and IES, 2002), but both failed to offer meaningful results into the effectiveness of such training.

Taylor *et al.*'s (1998) review looked at four key elements: the background to training; course content and methodology; responses to training activities and the evaluation of training effectiveness. This review's main focus was on the organisation's antidiscrimination policies and the drivers for purchasing training as well as the organisation's expectations of the training. When it came to measuring the outcome of the training approaches the study recognised a lack of systematic evaluation. In the few cases where evaluation had taken place it was purely initiated by the trainer to gain personal feedback on their performance but did not provide information for the purchaser on the effectiveness of the training in achieving its aims.

The Institute for Employment Studies' (IES, 2002) review of the evidence on the impact of training in racism awareness and cultural diversity in the UK public sector focused on the strategic issues of training, such as its aims, targets and process. It found a number of examples of good practice in developing effective training strategies to develop and deliver training. Without looking deeper into the effectiveness of these training events the review concluded that once the organisation established the drivers and training strategy necessary to achieve what the organisation wanted, the training would have the desired impact. Such a view underestimates the challenge of measuring the impact of training and does not take the need to provide evidence of training effectiveness seriously enough.

The lack of studies that systematically measure the impact of such training highlights the importance of new research in order to contribute to the debate into the effectiveness of training approaches in cultural competence.

3.2 Concept of Culture

The concept of cultural competence used in this work adopts a complex idea of culture. This section outlines the relevant components that underpin this concept. Firstly, this section will look at the influence culture has on its members. Secondly, it will discuss existing differences between and within cultures and the implications of this. The influence of culture on health and help seeking behaviour will be explored. Problems that arise from cultural differences within the clinical encounter will be investigated and ways will be proposed to address these through cultural competence training. Links to problematic substance use will be drawn throughout.

3.2.1 What is culture and how does it work?

'Culture' is a complex concept and encompasses a range of aspects that go beyond ethnicity and influence people's values and beliefs. It is characterised by diversity and includes gender, age, socio-economic background, faith, family status, social status in society, sexual orientation, health, political orientation and many other aspects. There is no single definition of culture, but different disciplines have different interpretations. For example:

Sociological perspective: Culture is the way of life of a society's members; the collection of ideas and habits which they learn, share and transmit from generation to generation (Haralambos, 1985).

Anthropological perspective: Culture is a set of guidelines which individuals inherit as members of a particular society. It tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment (Helman, 2007).

Through the process of socialisation people learn cultural rules and know how to behave according to their social roles and status. The shared norms and values of a society, although 'invisible', have an enormous influence on how people behave and think and what is considered to be right or wrong, and normal or abnormal

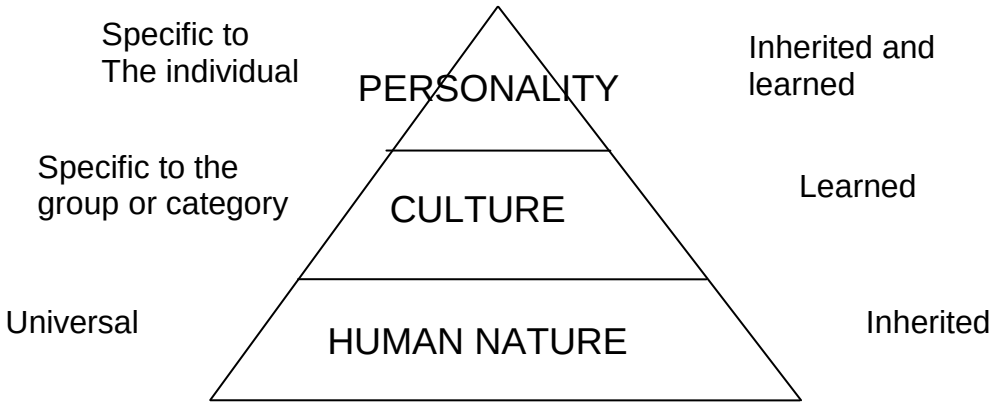
(Hofstede, 2001). Although unspoken and unwritten the norms are internalised and most people within a given culture are unaware of their existence. The rules are deep seated and difficult to change (Hall, 2003). Members of a culture often grow up unaware of their culture and have not realised that much of what is regarded as normal values and behaviours is in fact normal only to their specific culture. Only when they are confronted with a different culture that challenges their beliefs and values do they recognise that their behaviour is governed by cultural regulations (Henley and Schott, 1999). People who have lived and worked outside their own society are generally more aware of their own culture and its influence on beliefs and behaviour (Loustaunau *et al.*, 1997).

3.2.1.1 Are we manipulated by culture or do we have a free will?

If cultural norms are deeply seated and difficult to change, the question is how much of our behaviour is governed by societal rules and how much free will do we have? Relevant debates tend to fall along theoretical lines of structural versus action sociology. Culture is either seen as a constraint in which humans are being manipulated or that humans have free will and shape their identities in an interactive way (Kidd, 2002). Some commentators take the stance that whilst human beings are never totally free they do have choices, although many are not aware of them and continue to act in the way they are used to (Bourdieu, 1990). Others argue in line with postmodernist theories that lifestyles have become a matter of choices and everyone is free to act without moral standards of what is right or wrong (Kidd, 2002). However, the notion of free choice is limited in a society whose culture is governed by consumption. Given that consumption costs money, some people will have more choices than others.

Hofstede's (2001) concept of human mental programming broadened the debate as to what influences human behaviour. According to this concept, human beings are affected by many different influences, including their own personality and human nature (see figure 3 below).

Figure 3: Three levels of uniqueness in human mental programming.



Source: Hofstede G (2001, p5) amended and translated by LL.

Hofstede argued that the culture of the community in which we were brought up has an enormous influence on the way we behave and see the world, but its effect should not be overestimated.

Factors such as social status, socio-economic situation, life experiences and personality impact on whether an individual feels able to make choices or that they are powerless victims. Social context determines whether someone experiences opportunities or limitations.

In light of the above arguments, those working with clients, for example with people with drug and alcohol problems, need to be acutely aware of the social and cultural context in which their clients find themselves and how that contributes to their beliefs and behaviours. Only by understanding the underlying factors of drinking and taking drugs is it possible to understand individual perceptions on the use of substances, for example use to socialise or as coping strategy for stressful life events (see also sections 4.1.2 and 4.1.3). Therefore, critical thinking and self-reflection help to develop an understanding of the individual's social and cultural context that determines the reasons for continuous drinking and drug taking.

3.2.1.2 How do cultures regulate violations of social norms?

Each culture defines accepted ways of behaviour for its members. These differ between societies. Societal conventions and culturally defined rules prescribe how to behave (Goffman, 1978). Equally, each culture has mechanisms that serve to regulate the behaviour of its members and prevent violation of social norms. Such mechanisms are usually systems of punishment which help to achieve obedience among its members. Societal control uses positive sanctions to reward when rules are followed, and negative sanctions to punish when they have been broken (Eriksen, 2001). Societies differ in their tolerance and ability to deal with behaviours that are perceived as deviant.

An important mechanism that regulates behaviour is the power relationship within cultures. Each society is regulated by a system of social differentiation based on factors such as gender, age, class or caste, creating social inequalities between groups (Haralambos, 1985) and reproducing differences in power (Eriksen, 2001). Rather than using coercive power to control populations modern societies have developed a more indirect system of social control, where ideological conventions and imperatives are internalised by the individual (Foucault, 1977). Ideology is an important factor in shaping people's beliefs and behaviours, being used to stabilise hierarchies over time. Habermas (1981) criticised ideology because its constraints would lead to a lack of critical thinking, to inequality of power and to the passive acceptance of society.

As members of a given society and through their professional socialisation, healthcare professionals, like everybody else, are subject to ideological influence and may condemn what they perceive as deviant. Applied to the context of this study, the consumption of drugs and alcohol is influenced by cultural rules and regulations as to whether its use is regarded as normal, illegal, obsessive or deviant behaviour. These rules vary between cultures. The stigma attached to the culturally non-acceptable use of substances is likely to prevent people from accessing treatment (see also sections 4.1.2 and 4.1.3). Therefore, a non-judgemental attitude

of staff towards their clients who use drugs and alcohol is important. Healthcare professionals need to be aware of their own judgemental attitude towards clients who behave differently or are perceived to have broken society's norms and regulations. Critical thinking and self-reflection are vital to be able to recognise one's own judgemental attitudes and stereotypes and to become conscious on the effect these can have on the relationship with their clients and ultimately on treatment outcome. Only then can a change in attitude and behaviour be achieved.

3.2.2 Cultural differences and cultural diversity

3.2.2.1 Cultural differences

Embracing other cultures is often difficult, because we learn within our own culture what is acceptable (Kidd, 2002). Ethnocentrism, the tendency to perceive the world from the perspective of one's own culture, arises where judgements are made about other cultures on the basis of one's own cultural values (Marshall, 1998). Markowitz (1994) argued that this is because there are only few, if any, cultures that teach multiculturalism. People are usually raised with the dualistic thinking of the 'us/ them' dichotomy. This leads to division and may result in discrimination, or even racism, against what is seen to be strange or deviant individuals or groups of other cultures. This happens despite the fact that there are often more similarities than differences between cultures (Henley and Schott, 1999).

Efforts to avoid ethnocentrism and the political and moral problem of judging another culture as inferior or superior have led to the opposite position of not making judgements at all. This 'relativistic view' that no culture is correct, but that cultures are simply different and should be tolerated as such, has often been welcomed as a spirit of tolerance and respect for cross-cultural difference. Though, it has also raised many political and moral questions on highly controversial issues, such as the violation of human rights (Kidd, 2002; Marshall, 1998).

The influence of history on people's perceptions of cultures should not be underestimated. The internalised norms and beliefs also include the internalised

experiences of coming from a colonised or colonising culture, from cultures perceived as inferior or superior. This can lead to internalised feelings of inferiority or superiority, or internalised racism, as described by Fanon (1967) and Shaikh and Naz (2000).

Therefore in a multicultural society it is important not to judge based on one's own standards but to accept other cultures as simply being different and try to understand the values and beliefs of a culture within its context.

In the 1970s Hofstede researched international cultural differences in work-related values with the aim of developing a tool to examine and explain differences in the behavioural patterns of populations (Hofstede, 1980, 2001, 2003). His 'Concept of five dimensions of culture' covered: power distance, collectivism versus individualism, femininity versus masculinity, uncertainty avoidance and long-term versus short-term orientation. According to Hofstede, the mental programming for each of the dimensions takes place at several levels, first in the family, later at school, then at the workplace, and finally within society. He concluded that the main cultural differences between societies are in the values influenced by these five dimensions. These differences needed to be taken into account for mutual understanding.

Hofstede's analysis has been welcomed as inspiring by many researchers, yet his approach has also attracted criticism as being too simplistic and generalised and thereby reproducing stereotypical views. As the surveys were carried out only in one single company the findings cannot be representative for whole nations (Schwall, 2002; McSweeney, 2002). Furthermore, it was argued that the results were outdated and did not take into account the many political and economic changes that had influenced cultural values and hierarchies in countries worldwide since (Schwall, 2002).

Hofstede's concepts provide a framework to recognise differences between cultures and how power structures and societal philosophies influence behaviour. However,

the danger that this concept could lead to generalisation and stereotyping needs to be recognised. Hofstede's model is based on the assumption that national cultures are homogeneous and does not take into account social and cultural differences within a given culture. Many societies have become multicultural and have been influenced by many aspects of the various minority cultures they host. Equally, concepts of femininity and masculinity have changed and are constantly evolving. Hofstede's dimensions, therefore, have to be interpreted with caution.

Nevertheless, patterns of difference in values between cultures may influence help seeking behaviour, compliance, communication and the relationship between staff and clients, and may lead to many misunderstandings. Culture in the sense of collective mental programming is often difficult to change, because the values not only exist in the minds of people but also in the institutions of a society.

3.2.2.2 Cultural diversity

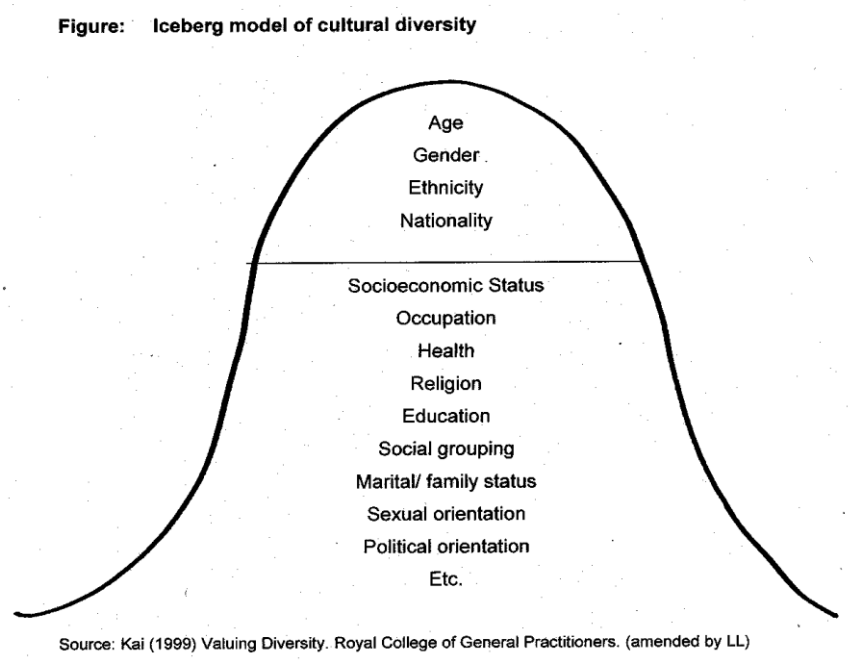
Culture is not the same for everyone, even within the same culture, but is shaped by a variety of influences and experiences. Individuals develop their own culture and experience culture in different ways, depending on their role in society and the life opportunities that go with that position. The term 'cultural diversity' includes perceived and real differences with respect to age, gender, ethnicity, disability, religion, lifestyles, family, dietary preferences, dress code, language and dialects spoken, sexual orientation, education, occupational status and other factors (Purnell & Paulanka, 1998)

Kai *et al.*'s (1999) 'iceberg model of cultural diversity'[10] (see figure 4 below), demonstrates the uniqueness of each individual, beside common features such as ethnicity and culture. The categories located above the sea level, gender, age, ethnicity and nationality, do not give detailed information on the person's background. In contrast, the categories below the sea-level, such as socio-economic status, the educational or occupational background, can give a more complex picture

[10] The iceberg model of cultural diversity (Kay *et al.*, 1999) has been developed as a tool in General Practice to understand diversity.

of the individual's social standing. They determine what opportunities someone is likely to encounter in life.

Figure 4: Iceberg model of cultural diversity



The diversity of cultures is also underlined by the fact that many Western societies include populations from ethnic and religious minorities, foreign students, migrant workers, and political refugees who all bring with them distinctive cultures. Over time, many will undergo some degree of acculturation, whereby they incorporate some of the cultural values and behaviour of the mainstream society; others will not (Helman, 2007). Shaikh and Naz (2000) point to a further aspect of diversity within cultures in that in some communities there are already three generations living in Britain. Each generation faces different challenges in the new culture.

Cultural diversity has been emphasised by Parekh (The Runnymede Trust, 2000) who argued against perceived homogeneity of cultures when he referred to the existence of 'communities within communities'. Terms such as 'African', or 'Asian' or the 'white community' wrongly imply homogeneity of a community. These

communities may differ with regards to age, migration pattern, religion, culture and many other such factors.

Diversity also extends to gender socialisation, which affects one's life chances and behaviour, and gender is evident in socially and culturally constructed roles and expectations. Some gender related issues are culture specific, others are cross-cultural and are based on fundamental differences between male and female physiology. However, there are variations between gender relations in different societies (and between them), ranging from complete equality to very limited influence of women over their own destiny (Loustaunau *et al.*, 1997).

3.2.2.3 Subcultures

The diversity of a culture is characterised by the fact that many groups have developed their own subculture. Societies involve many intellectual and political movements, such as indigenous people, immigrants, feminists, environmentalists, gay men and lesbians. Although the views of these movements are diverse, they all form part of the wider struggle for recognition of identity and difference. Each group resists the attempts of the wider society to assimilate all members of society into what it believes to be the only correct way of life (The Runnymede Trust, 2000).

A distinction has been made between subcultures that conform to the broader norms and values of the dominant culture, and deviant subcultures that reject these norms and values (Kidd, 2002). Conflicting values within a society may lead to the discrimination and disadvantage of racial, gender or ethnic groups. As a result these groups may respond by developing a deviant or counterculture (Loustaunau *et al.,* 1997). Current examples of countercultures that have been portrayed in recent media reports involve black youth gangs and also young radical Muslim groups; both are groups that feel excluded from society.

Hecht-El Minsawi (2003) drew attention to the positive side of disagreement within society. She argued that there will always be cultural standards which lose their

relevance and that people will deviate from them. Without that, no one would think differently or creatively and there would be no what she calls 'creative disobedience'. Without discussion and fresh input a culture will become stagnant, ready to adapt to the needs of its members. The current debates on the downgrading of cannabis or the smoking ban and the use of ecstasy by millions of young people in dance clubs each weekend despite its classification as a Class A drug could be seen as examples of this.

Many substance using people have developed their own subculture with their own set rules, norms and behaviours. Well known subcultures include the pub culture, the dance and clubbing culture, cannabis smokers, underage binge drinking and street drinkers. These subcultures are tolerated by societies to varying degrees depending on the society's perception on the dangerousness or deviousness of the substance (see section 4.1 for more details).

3.2.3 The relationship of ethnicity and culture

There is a strong interlinking relationship between ethnicity and culture. Ethnicity in itself is a complex concept that is separate from culture and has its own set of characteristics. The following section seeks to explore how ethnicity relates to the idea of cultural competence and how it has been used for the purpose of this work.

3.2.3.1 Definitions and terminology

> "Ethnicity defines individuals who consider themselves, or are considered by others, to share common characteristics which differentiate them from others in a society, within which they develop distinct cultural behaviour. The term was coined in contradistinction to race, since although members of an ethnic group may be identifiable in terms of racial attributes, they may also share other cultural characteristics such as religion, occupation, language or politics. Ethnic groups should also be distinguished from social classes, since membership generally cross-cuts the socio-economic stratification within society, encompassing individuals who share (or are perceived to share) common characteristics that supersede class….." (Marshall, 1998, p201)

There is often confusion between the terms 'race', and 'ethnicity', ethnic minorities and majorities and 'white' people (Bhopal, 1998, 2007; Bradby, 1995). Ethnicity is often used as a substitute for race, which has been discredited in the past by associations with racism (Senior and Bhopal, 1994). However, they are both based on different concepts. Race is thought to be determined by biological factors, while ethnicity and culture are ideas derived from social theories (McKenzie *et al.*, 1996; Pearce *et al.*, 2004).

There are strong views that even if the terminology of 'race' is not used anymore, the historical context in which the concepts have been developed and the value systems that upheld racist discrimination continue to influence the ways in which we think about human diversity. The assumption of negative attributes on the basis of race or ethnic group was found to have serious implications for the delivery of healthcare and health outcomes (Ahmad, ed.,1993; Esmail, 2004).

3.2.3.2 Ethnic categorisation for monitoring and research

The use of fixed ethnic categories to measure differences between population groups has been criticised as being too broad (Aspinall, 1997; Bradby, 1995) and encompassing heterogeneous populations with very distinct needs (Aspinall, 1998) (see also section 1.7). The categories differ between countries and refer to distinct population groups, making comparison of research results impossible (Kuramoto, 1997) [11]. Such categorisation assumes homogeneity and ignores the diversity of cultural and religious life of whole continents (e.g. Africa, Asia) by lumping together people of different cultural and health beliefs and behaviours (Chaturvedi, 2001) [12]. This can lead to false interpretations as their use is strongly confounded by factors such as social class, deprivation and educational achievement. Furthermore, prior to

[11] For example, in the UK the category 'Asian' refers mostly to South Asian populations, such as Indians, Pakistanis, Bangladeshis, but in the US the term 'Asian' incorporates Chinese, Japanese, Korean, Pacific Islanders, Filipinos and South East Asians.

[12] Chaturvedi cited as example the category 'Asian' in the UK that includes populations that have very distinct lifestyles, from the socio-economically deprived, heavy-smoking and meat eating Bangladeshi population in East London to the socio-economically affluent, vegetarian, non-smoking Punjabi Sikh population in West London.

the 2001 census the largest population group, the 'whites', remained as a single homogeneous group. This prevented identification of vulnerable groups within the white category (CRR, 2001; Aspinall, 1998).

The use of ethnic categorisation is valuable in this study to identify minority ethnic groups in need of treatment services for drug and alcohol problems. However, the categories used to gather routine statistics fail to identify certain population groups that may be vulnerable to substance use problems. Examples include: Khat taking Somalis, heroin-taking Iranians, heavy drinking Irish workers or Eastern Europeans who recently migrated to Britain. Furthermore, the use of ethnic categories is limiting as they do not distinguish by gender, age, religion or socio-economic context and assume homogeneity of ethnic groups and their needs. Such a concept is more likely to confirm stereotypical views and prejudiced attitudes of staff in services rather than to recognise the diversity of needs of individual patients. Yet, it must be recognised that classification does have its value, even if it inevitably involves some degree of over-generalisation.

Furthermore, the usefulness of ethnicity in monitoring and health related research has been debated (McKenzie *et al.*, 1996; Senior and Bhopal, 1994; Bhopal, 2007). Some authors agreed that the study of ethnicity is helpful in identifying the exposure to disease risk within particular ethnic groups. This would enable healthcare resources to be directed to those most in need. Successful examples include research into sickle cell disease and thalassaemia where the groups mostly affected are people from Africa, the Caribbean and the Mediterranean (for example works by Anionwu and Atkin, 2001). Others refer to the covert racist agenda of such research that could result in victim blaming (Chaturvedi, 2001) and warned that the perception of poor health amongst minority ethnic groups can augment the belief that immigrants and ethnic minorities are a burden (Bhopal, 1997).

Blaming the victims for their illness is a particularly relevant aspect in the treatment of drug and alcohol problems. People using drugs or drinking heavily are often accused as being morally weak, and inflicting their illness upon themselves. Often

minority ethnic groups are blamed for their lifestyle, and their perceived deviant behaviour is given as reason for their illness rather than the social conditions in which they live and work. Many staff in health and social services display a negative and discriminatory attitude towards these clients, as highlighted in sections 4.1.2 and 4.1.3. The limitations of research into the extent of drug and alcohol use amongst minority ethnic groups will be discussed in more detail in section 4.2.4.

Therefore, cultural competence training involves making healthcare professionals more knowledgeable about the diverse needs of their clients in order to understand them. They must also recognise that ethnicity cannot be used as a single variable in determining needs but that a concept of culture has to be applied that brings a wide range of factors together, including ethnicity, socio-economic status, gender, age and religion.

3.2.4 Summary of the key principles of the concept of culture

The review of the literature highlighted the following key principles which influenced the concept of culture in this work.

1) The influence of culture in shaping people's attitudes, beliefs and behaviours is significant and should not be underestimated.

2) Cultural values and beliefs are shared and internalised and may be difficult to change. However, culture is not a straightjacket but a framework incorporating a range of options for every member.

3) No culture is better than the other. Each culture has to be studied and understood on its own terms.

4) There is no such thing as a homogeneous culture. How culture is perceived depends on the person's social status within a given society.

5) Cultures differ in their tolerance to difference and their ability to deal with diversity.

6) Cultures differ in their ability to accept criticism depending on the political structures of power relations within the society.

7) Given the diversity in a society, not everybody is in agreement with all aspects of the mainstream culture and many groups have developed their own subculture.

8) Disagreements can have a positive effect as they encourage debates and enable a culture to bring about change according to the developing needs of its members.

9) Religion can have a strong impact on culture and can be more important than gender, age or class.

10) Gender, age and socio-economic status are just as important as ethnicity in influencing a person's identity.

This means that a wider concept of culture needs to be adopted that includes the individual's social and political context and life experiences. Focusing on ethnicity or country of origin alone with regards to culture is not useful. In the following passages, the key issues identified above will be applied to the practice of healthcare.

3.2.5 Cultural differences and diversity in health beliefs, help seeking behaviour and treatment expectations

As highlighted throughout this chapter, culture is present in all aspects of life and influences people's thinking and behaviour. Each society has its own culturally shaped way of dealing with beliefs about health and illness. Increasing cultural

differences and diversity in health beliefs, help seeking behaviour and treatment expectations can create many misunderstandings and communication problems, and can impact on the relationship between healthcare staff and patients. The following section aims to explain the influence of culture on people's beliefs about illness, including the causes of illness and expectations of treatment. It will also look at potential problems in the clinical encounter when clients meet practitioners who have different perceptions about disease and treatment. The section also will identify the need for changes in perception and behaviour in staff so as to better understand, and work, with patients from different cultures. Parallels to the area of drugs and alcohol will be drawn where appropriate, but section 4.1 will explore in more detail how the concepts of culture and diversity relate to cultural perception of drug and alcohol use and their impact on help seeking behaviour and treatment of drug and alcohol problems.

This area of knowledge is vital for staff to underpin cultural competence in practice. The findings of this section widely influenced the way in which the module was developed and delivered. The concepts have been used to examine their relevance in the practice of working with people with drug and alcohol problems, as detailed in chapter 4.

3.2.5.1 Cultural influence on healthcare systems

Healthcare systems are influenced by the social and cultural context of a society. Therefore, different societies produce different types of healthcare system and different attitudes to health and illness (Helman, 2007). In most societies a pluralist healthcare system (Kleinman, 1980) has been adopted, where beside the scientific medical model[13] as the official healthcare system, there are usually smaller alternative systems of healing that offer a scope for treatment approaches. These

[13] Based on the western concept of bio-medicine, a conceptual model of use that excludes psychological and social factors and includes only biological factors in an attempt to understand a person's medical illness or disorder.

range from complementary medicine to shamans and also involve treatment of illness within the family, seeking advice from friends or pharmacists and self-medication. Increasingly people also seek information on the internet or engage in self-help groups. These sectors are overlapping but each of them has their own way of explaining and treating ill-health. People seeking help commonly move between them; they decide whether, when and where to go for treatment, and whether it is effective.

People's expectations of treatment and care are influenced by their past experiences of healthcare systems. They tend to trust systems they have grown up with and mistrust those who are different (Henley *et al.,* 1999). Therefore, if confronted with an unfamiliar system, for example, in another country, people may have little faith in the diagnostic methods and treatments recommended. They may prefer to find a practitioner who understands their culture and expectations and from whom they can get the treatment that makes sense to them. They are often criticised for breaking the rules, but they simply may not know what is expected of them; or perhaps the rules may clash with their own cultural beliefs and expectations.

Therefore, healthcare professionals need to be aware of potential differences in experiences and expectations in healthcare systems in order to understand their client's behaviour. Only then will they be able to support their clients so that they can adapt to the different ways in which the healthcare system functions.

3.2.5.2 Differences in how illness is recognised and explained

Culture influences how people recognise and explain symptoms or show pain, how they respond to illness and what they expect from others when they are ill (Henley *et al.,* 1999; Fazil *et al.*, 2006). Some may think that illness is caused by external factors such as infections, by bad luck or inflicted by someone else, for example, a spell or the evil eye. Others may consider illness as a punishment for sinful behaviour, or as something brought on by family problems or even by emotional stress or sadness (Helman, 2007). Applied to the use of substances, culture

influences whether the use of drugs or excessive drinking is recognised as the causing factor of apparent health problems. The danger to someone's health may not be recognised if the use is culturally accepted as for instance with Khat (Patel *et al.*, 2005) or alcohol (Westermeyer, 1995).

Cultural and societal perceptions on the cause of illness influence views of and expectations on treatment (Henley *et al.*, 1999). For example, some may not seek treatment for drug and alcohol problems because they feel they have brought the problem upon themselves and therefore deserve to suffer. Others may not believe that treatment may help to solve their problems which they perceive as being beyond their substance use. Some, in particular family members, may have little understanding of the nature of addiction as recurring condition and may believe that detoxification is the solution to all problems rather than the beginning of a long process of recovery (see also section 5.2.2.5).

What people believe is the underlying reason for their illness depends on a number of factors. The extent to which someone believed their illness was determined by their own actions, as opposed to luck or powerful external forces, correlated with socio-economic factors. Those who had most economic control over their lives accepted more responsibility for their illness than those who saw themselves as socially and economically powerless. Those who felt powerless were more likely to believe that illness was the result of external forces over which they had no control or responsibility (Helman, 2007). A strong link between the socio-economic status and problematic use of drugs and alcohol has been established (Ramsey *et al.*, 2001; Bradley *et al.,* 1999). Therefore, patients' views of their health condition are important as they determine whether people take responsibility for their health or see the cause and cure as being outside their own control. Again, there are strong links to the use of substances. For example, the reason for using and the meaning of its use can have enormous influence as to whether the use is regarded as problematic or not and whether, when and where help is sought. Drug use or drinking can be seen as a means to relax or sleep, as a feel-good factor, a coping mechanism for difficult life situations, as self-medication or to enhance self-confidence (Fountain *et*

al., 2003; Acquire, 2003; Sangster *et al.*, 2001). The reason why someone takes drugs or drinks can have strong implications for one's motivation to engage in treatment.

3.2.5.3 Different explanatory models for illness and treatment

Miscommunication in the healthcare encounter are common if healthcare professionals and patients hold different views on the cause of an illness The definitions of health and illness differ between individuals, cultural groups and social classes, and the same disease, or symptoms, may be interpreted differently by two individuals from different cultures or social backgrounds (Helman, 2007). Healthcare practitioners and patients often hold different explanatory models (Kleinman, 1980) that explain the cause of illness, the time and onset of symptoms and the course of illness and treatment. Models are influenced by the context in which they occur and also by the social class, gender and age of the two parties involved. They can only be understood if they are examined within the specific context in which they have developed. For example, patients' analysis of how serious a health problem is, and how much it may affect their life, may only depend to some extent on the cause of the health problem; it may also depend upon whether someone can afford to take time off work and whether they have to pay for treatment. This demonstrates the strong impact the social and economic context can have on treatment choice and on when and where to go for help. With regards to drug and alcohol use the underlying factors and the social context of use need to be considered. The reasons why substances are consumed (Sangster *et al.*, 2001), the meaning given to its use (McDonald, 1994) and the social situation in which use is taking place determine as to whether use is considered a risk, a condition for which to seek help. Other factors may outweigh the risk to one's health resulting in continuing use or the decision not to seek treatment (see also section 4.1). For example the use of substances to cope with stressful life events may be justified as long as no other alternative coping mechanism is available; or the societal stigma of substance use and anxiety of negative attitude of staff may be reasons not to take up treatment.

Many health professionals have difficulties understanding their patients' explanations of ill-health (Loustaunau *et al.*, 1997). This is probably because the training of health professionals, based on the disease perspective of modern medicine ignores the psychological, moral and social aspects that characterise patients' views on illness (Helman, 2007). However, if the medical practitioner does not understand the patients' explanatory models they will be unable to respond appropriately to the culture-specific illness (Kleinman, 1980). As a result, the patient may not comply with the treatment or treatment may not be successful. Alternatively, a doctor with culturally relevant knowledge who is open to the patient's explanatory model could integrate more appropriate treatment elements. However, to respect the patient's explanatory model does not necessarily mean that the practitioner has to agree with it; it merely means that the practitioner understands the impact of a deeply held belief about the illness (Henley *et al.,* 1999). Healthcare professionals need to be aware of the existence of different explanations of illness (or the use of drugs and alcohol), and understand and accept them, in order to be able to create trust and provide care that makes sense to the client. This does not mean condoning drug use and excessive drinking, but to accept their clients' substance use as a fact, and, without prejudiced attitude, deal with the problems related to this use. There are strong parallels to the harm reduction approach in the treatment of drug use (Stimson, 1995). The primary goal of harm reduction is to prevent or treat the harm from drug use rather than adopting a moralistic view on the client's drug using behaviour. There is evidence to prove that treatment that meets the needs of the clients achieves compliance and a positive outcome (Loustaunau *et al.*, 1997). This also applies to the treatment of drug users, in that a non-judgemental and client-centred approach is more likely to be successful in engaging clients into treatment rather than a punitive approach.

3.2.5.4 Problems in the health professional-patient relationship

Another factor that greatly impacts on the relationship between doctors and patients is that of authority. The power hierarchy (Hofstede, 2001) varies between cultures and depends on a number of factors. In societies with a system of high power

hierarchies, doctors must be treated with great respect. As a result, patients might find it difficult to voice their opinions or to ask questions. In countries with a more equal relationship patients are encouraged to raise issues for clarification. Age and gender issues also play an important role in the power hierarchy of the relationship as does the social, cultural and educational background of both health professional and patient, and the health professional's attitude towards cultural diversity (Helman, 2007).

Healthcare professionals have the power to question and examine patients, to prescribe powerful treatments and to confine patients to hospitals if they are diagnosed as mentally ill or infectious (Helman, 2007). The power to prescribe or withhold treatment, such as opiate substitutes, or to carry out drug testing, can have an effect on the relationship between the healthcare professional and the user. Healthcare professionals may want to control the behaviour of population groups by withholding treatment or by medicalising what is perceived as deviant behaviour (Helman, 2007). In many cases a diagnosis is made based on cultural perceptions on what is 'normal' or accepted behaviour within a given society. This perception is widely influenced by the healthcare professional's own expectations of normal behaviour and may differ greatly from that of their patients. For example, misunderstandings and misinterpretations of behaviour have resulted in a disproportionately high number of people from African-Caribbean backgrounds being admitted to mental health institutions as described by Bhugra (1997) and Patel (2001). Equally, there is evidence of negative attitudes by healthcare professionals towards drug and alcohol users. For example, some healthcare staff in emergency departments regarded patients with alcohol related illnesses as a waste of valuable staff time and resources as these illnesses were regarded as self inflicted (Jeffery, 1979; Scambler, 2008).

Healthcare professionals need to be aware that as long as the clinical encounter continues to be characterised by a lack of understanding of the cultural and social context of the patient's life and a judgmental attitude towards people whose behaviour deviates from what is considered the norm, treatment outcomes and

patient satisfaction will remain poor. There is evidence that healthcare is likely to be more effective when the beliefs, values and norms of the patient are recognised and met (Henley *et al.,* 1999; Loustaunau *et al.*, 1997).

On the grounds of this evidence it can be concluded that in order to enhance the quality of care for patients it is vital to improve the communication between healthcare professionals and clients. To achieve this it is essential to reduce the power hierarchy and the judgemental and punitive use of authority towards patients. The relationship with the patient must be based on respect and trust. Treatment that is client centred, that involves the client in treatment decisions and takes their beliefs into account, is likely to lead to higher patient satisfaction and a better outcome. Furthermore, staff need to be aware that the patient may have a different understanding of the cause and cure of their drug and alcohol problems. Staff also need to have a sound knowledge about the context of the person's cultural and social background as these may determine the reasons for substance use. Only such an approach will enable a more culturally sensitive assessment and reduce the risk of misunderstanding or misdiagnosis.

Conclusions

The review of the literature highlighted a number of factors that are vital for the development of culturally competent services and need to be incorporated into staff training programmes.

The concept of cultural competence used in this study results from a critical analysis of different concepts and models. It is inclusive of all cultures and refers to an ongoing process of critical reflection of one's own values, beliefs and professional practice. Furthermore, cultural competence goes beyond cultural awareness as it refers to the capacity of effectively operating in different cultural contents, which requires action rather than reflection only. It believes that unequal power relationships in the clinical encounter need to be addressed and seeks to achieve patient centred care and patient involvement.

Focusing on culture presents a danger of stereotyping. However, careful use of a concept of culture in its broadest sense, like that used in this work, makes the individual the centre of attention. By doing so, the risk of stereotyping and making assumptions is greatly reduced, and culturally competent care can be achieved.

The broad concept of culture used in this study is determined by countless factors such as societal status, age, gender, ethnicity, education, religion, socio-economic situation and of being a member of the societal minority or majority. People are also influenced by the political culture of their society, including power hierarchies, industrialised or developing, coloniser or colonised culture. A key element of the concept of culture is that a perspective of culture that focuses solely on ethnicity, country of origin, or a focus that does not recognise the societal inequalities, is limited as it does not take into account the full picture of the client's cultural and social context.

In a multicultural society increasingly cultural differences and diversity in health beliefs, help seeking behaviour and treatment expectations affect the healthcare

sector. They can create misunderstandings and impact on the relationship between healthcare staff and patients. Evidence suggests that the success of a treatment intervention is strongly related to the degree of common understanding upon the cause of an illness and the most appropriate treatment for it. The successful outcome of a treatment intervention is also strongly linked to the degree of satisfaction of the patient with the service they receive. Therefore, improving communication and the relationship between the client and the healthcare professional are vital.

Cultural competence training is well placed to assist service providers to improve treatment for clients with drug and alcohol problems. This can be achieved in a number of ways: by enhancing the communication between healthcare professionals and substance using patients; increasing understanding of different perceptions on the reasons for use of substances and how these impact on health; whether treatment is sought and what expectations are on treatment; increasing knowledge and understanding of the complex context in which problematic substance use occurs and by developing the cultural skills needed to deal with diversity and difference; and lastly, by developing a non-judgemental approach towards clients that are perceived by society as deviant due to their substance using habits.

There is also an ongoing debate as to what is the best approach for cultural competence training. The approach used for cultural competence training in this study seeks to go beyond increasing knowledge by giving information as this does not automatically result in the necessary skills or bring about changes in attitudes. Enhancing skills and understanding, and changing beliefs and attitudes require a degree of critical thinking and self-reflection on one's own attitudes, values and beliefs.

Cultural competence training offers the chance to bring about a dialogue between people from different cultural and social backgrounds. In an increasingly tense climate of a multicultural city like London this dialogue is vital in order to develop a deeper understanding of the 'other', be it an individual or group. Therefore, for

training to be effective, the concept of cultural competence needs to go beyond ethnicity and country of origin and adopt a concept of culture that embraces a range of factors that influence people's beliefs and behaviours, including social and political inequality, discrimination and social exclusion. Cultural competence training needs to go beyond achieving individual behaviour change and must reach the whole organisation if it is to achieve a continuity of service.

4. Drug and alcohol problems in minority ethnic groups

The second part of the literature review seeks to explore the social and cultural factors that determine drinking and drug taking behaviour, building on concepts of cultural diversity and their impact on health and help-seeking behaviour, as previously outlined. Cultural explanations of why people use drugs and alcohol and what makes them vulnerable to problematic usage are examined. Implications for the individual and for service provision are discussed. The review will examine why there is a low uptake of services by particular population groups and will address issues of access. In an attempt to establish patterns and trends of drug and alcohol use amongst minority ethnic groups, the limitations in defining the numbers in need of treatment will be examined. The review will explore gaps in service provision and identify ways to enhance services for all clients.

The initial emphasis of this study was on minority ethnic groups. Therefore, the focus of this chapter is on ethnicity as a proxy for culture. The influence of ethnicity on drug and alcohol use has long been under-researched. Only recently, minority ethnic groups had become the focus of government policies and appeared in national surveys as a group with particular needs, just as women and young people do. There is little peer-reviewed literature on the subject and the existing research is inconsistent. Most research has been carried out at local level with only a limited impact on the national drug strategy.

For this review a wide range of publications were examined, such as national surveys, Government reports and policies, book chapters, peer reviewed articles, primary studies and reviews. Databases searched were Medline, CINAHL, Entrez PubMed, Drugscope, the HO, the DH, Google Scholar, libraries at TVU, King's Fund, and the London School of Hygiene and Tropical Medicine. I used keyword searches, cited reference searches and hand searched relevant academic journals and so-called grey literature, such as reports on local surveys or initiatives that were not published in peer-reviewed literature. In the absence of national surveys and peer

reviewed articles these reports can be of vital importance as they give an insight into the extent of problems at local level, which are frequently consistent.

4.1 Cultural reasons for drinking alcohol and taking drugs

Substances are used for many reasons: for socialising, to alter one's consciousness, to relieve tensions, to enhance confidence and sociability, or to dull feelings of despair. The widespread use of mind-altering substances is a normal part of daily life in many cultures (Claridge, 1970; Copperstock *et al.*, 1979; South, 1999; Renggly and Tanner, 1994). Substances have been welcomed by many but they have also been demonised as a form of social corrosion and of individual ruin. Many studies into the social context of drug and alcohol use have focused on the problems associated with using these substances, rather than on their positive effects and their cultural and social impact. However, evidence suggests that in the case of alcohol - although some cultures experienced problems with the drinking behaviour of its members - moderate drinking was the norm in most cultures and excessive drinking was regarded as abnormal behaviour (Helman, 2007; Wilson, 2005).

Ethnographic studies into drinking demonstrated that most cultures use alcohol for celebrating and that drinking is a social act and is a socially learned behaviour that varies between cultures (Douglas, 1987). Studies also found overwhelming cross-cultural evidence that through socialising people learns not only how to drink but also what effects to expect (Heath, 1998). Other studies indicated that drinking alcohol is an important feature within many cultures and is implicated in the behaviours, values, ideologies and histories of these cultures, rather than being a social or medical problem (Wilson, 2005).

A study into the social and cultural aspects of drinking (SIRC, 1998) explored significant cross-cultural variations in the way people behave when they drink and concluded that the effects of alcohol on behaviour are largely determined by social and cultural factors rather than the chemical effects of alcohol. Considering the many reported cases of anti-social and violent behaviour of drunken people in the UK, questions need to be raised about the social context and reasons behind such behaviour.

4.1.1 The meaning of drugs and alcohol

A number of anthropologists have commented on the importance of the symbolic meaning given to certain substances (Helman, 2007; Douglas, 1987; Mandelbaum, 1965). For example, cannabis use was a worldwide cultural symbol of youthful rebellion in Western societies against the establishment in the late 60s and 70s. The use of alcohol is known as a welcoming ritual, to celebrate or establish friendships or as a way to resolve conflicts; smoking tobacco has been used by American Indians as a ritual for establishing friendships or for peace-making. Further examples include champagne, regarded as a symbol of celebration, and ecstasy, which is seen as a dance drug. Other meanings surrounding drinking allude to proof of virility, manhood, adulthood or rebelliousness, generational transitions and social status. Cochrane (1999) found that working class Sikh men mostly believed that alcohol is a 'fortifying drink' that makes a man work harder and stronger. Hunt *et al.* (2005) linked the use of alcohol to a sense of masculinity, in that male drinking is often associated with risk-taking and aggression, but also male honour, face-saving and group loyalty.

Substance use may have a different meaning between generations. While older people may equate drug use with the stigma that would be brought upon the family or community, young people may perceive drug use as enhancing their reputation and popularity in their peer network (Bashford *et al.*, 2003). Drug use may also be a way of escaping the painful experiences of poverty and marginalisation (Sangster *et al.*, 2001).

In conclusion, the meaning given to substances not only reflects the reason for its use but also reveals deep-seated beliefs about the effect, such as whether its use is considered normal or problematic. For example, if a substance is used to cope with the challenges of daily life or to enhance self-confidence, its benefits would probably outweigh any problematic side effects. The person is either unlikely to seek

treatment or if they do, the treatment may not work unless alternative coping mechanisms are found to replace it.

4.1.2 Cultural perceptions on what is normal and what is problematic?

In order to understand abnormal substance use one needs to consider what is normal behaviour in a given society. Helman (2007) suggested that looking at the culturally defined 'normal' drinking behaviour of a group would give an understanding of the 'abnormal' forms of drinking that may be found within it. Helman defined 'normal drinking' as the everyday use of alcohol at mealtimes or for social and ritual occasions. Such moderate use is accepted; however, the type and amount of alcohol, and when, where and by whom it is consumed, is strongly controlled by cultural rules and sanctions. In 'abnormal drinking' these rules are transgressed and there is a frequent and excessive intake of alcohol which leads to uncontrolled, drunken behaviour. Helman argued that cultural groups vary in how and under what circumstances abnormal drinking is defined, and whether drunkenness is accepted.

McDonald (1994) pointed out that it is a cultural matter whether the use of a drug is perceived as problematic or not. The reality of the substance is different for users, dealers, police, patients, or doctors and is influenced by their cultural perception of illicit drugs. The perception that drug use is deviant and harmful is often based on the illegality of the drug, and behaviours associated with the drug cannot be generalised.

O'Connor (1975) classified cultures according to their drinking habits and attitudes towards drinking and drunkenness into four main groups: abstinent, ambivalent, permissive and overly-permissive. In abstinent cultures the use of alcohol is strictly prohibited and there are strong negative attitudes towards alcohol use. The author argued that while normal drinking is rare in abstinent cultures, abnormal drinking is higher than in more permissive cultures because drinking is not controlled by any drinking norms. Ambivalent cultures have two contradictory attitudes towards

alcohol, which has led to the absence of a consistent and coherent attitude towards drinking. In a permissive culture everyone is allowed to drink, but only in a controlled way and on certain occasions. There are strong sanctions against drunkenness and the rate of alcohol dependence is low. In overly-permissive cultures drinking is associated with virility, and there is widespread social acceptance of intoxication as being fashionable, humorous or at least tolerable. Alcoholism rates are much higher in such cultures.

Westermeyer (1995, 1999) argued that cultural rules have the potential to protect and that substances are rarely misused by the members of a culture because social pressure, together with social support, would ensure compliance to societal rules. According to Westermeyer (1999) the cultural rules act as protective factors for its members, yet risk occurs when individuals leave their cultural or ethnic group. Doing so may eliminate the social pressure that insisted on abstinence or made substance use safe. In the absence of clear guidelines on how to use a substance the individual may be unable to recognise potentially hazardous substance use behaviours.

All three authors argued that the notion of whether a substance is regarded as problematic or not is governed by cultural rules and regulations. In the case of drugs, common cultural perceptions on harmfulness seem to be governed mainly by a society's laws and the illegal nature of the drug. However, the current figures on drug-taking indicate that the illegality of drugs is not a deterrent for many users. O'Connor and Westermeyer regarded the cultural rules as protective factors to prevent harmful use of substances. Only when there are no rules will harmful substance use occur. Both authors ignored the fact that despite cultural rules and regulations many people continue to drink or take drugs. They also argued from a perspective of homogeneous cultures and did not take into account the many subcultures with their own norms.

In contrast, McDonald recognised the diversity of cultural perceptions towards substances within a culture. In her view, independent from the legal status of a

substance, people's cultural perception as to whether the drug is harmful is determined by the individual context in which the drug is taken and the reality of the substance. McDonald's notion that the reality of a drug depends on the social context can be applied to various examples. For example, cannabis is regarded as harmful because of its illegal status, but at the same time it is legally used to treat pain in cancer patients. Similarly, heroin is generally being portrayed as an evil and highly addictive substance. But heroin is prescribed by doctors for drug treatment purposes (Metrebian *et al.*, 2006). Most of the US soldiers who used heroin during the Vietnam war gave it up on returning home (Heyman, 2001). Also, the use of drugs, such as ecstasy, within the dance culture is a significant part of the lifestyle of many young people. This indicates a process of normalisation of a drug that is classified as a Class A drug. However, South (1999) argued that while drug use itself has not yet become the true norm, it has moved from the status of 'exception to the norm' to being part of everyday life.

McDonald stated that cultural perceptions as to whether a substance is normal or harmful have changed over time. For example, the healing effects of opium, or its derivates such as Laudanum, have been praised for centuries. Opium was widely regarded as an effective remedy for all kinds of illnesses until concerns within the medical profession regarding its harmful effects led to the introduction of the 1868 Poisons and Pharmacy Act which restricted the selling of opium (Booth, 1997; Berridge *et al*., 1987). Since then the possession, use and sale of illegal drugs have been criminalised. The current debates on the reclassification of drugs to reflect their harmfulness, for example decriminalising cannabis or making Khat use illegal, are a reflection of ambivalence towards drug laws (Nutt *et al.*, 2007).

The question, however, is how the perception of normal or problematic use influences treatment uptake and staff attitude in treatment services. The strong beliefs of O'Connor and Westermeyer as to the protective effect of societal pressure and sanctions ignore its negative consequences. Breaking societal rules may result in disapproval by society and may be reflected by the negative attitude of some staff

towards excessive drinkers. Therefore, to avoid societal stigma and sanctions, substance use remains hidden and as a result people with drug and alcohol problems may not seek treatment until they reach a crisis point. Staff in services are socialised by society's rules and regulations and may react dismissively towards clients who have broken these rules.

In conclusion, the literature analysis has raised the issue that in order to be able to judge whether substance use is considered harmful the use of these substances should be viewed against its encompassing social and cultural background. This includes knowing the social context of substance use and the meaning and expectations associated with it. The cultural perceptions tell whether the use is regarded as being within cultural (or subcultural) norms and strongly influences an individual's expectations on the substance's effects and whether this is seen as being beneficial or harmful. This perception determines whether the substance is used openly or secretly. As highlighted in section 3.2.5 this is related to the individual's willingness and ability to seek treatment and what expectations or anxieties they have about treatment services. Staff in services are also influenced by society's perceptions on substance use. Their perception, whether negative or positive, is highly influential in the relationship with the client and therefore is of utmost importance for the outcome of treatment.

4.1.3 Cultural explanations of substance using behaviour

The following section will discuss cultural explanations as to why people use drugs and drink alcohol. Possible risk factors are explored to identify what makes someone vulnerable to problematic use.

4.1.3.1. Influence of religious affiliation on alcohol and drug use

There is an intriguing relationship between religious and spiritual involvement and substance using behaviour (Morjaria, 2001; McCullough *et al.*, 1999). Some authors

suggested that religious and spiritual involvement can act as a protective factor against the development of substance using problems. It has also been documented that religions and spiritual involvement may provide a means of escaping from drug and alcohol problems.

A number of studies investigating protective factors of alcohol and drug use in adolescents identified that affiliation with more fundamentalist religions, and a strong personal commitment to living according to the faith, were inversely associated with the use and problem use of a range of substances including alcohol, cannabis and cocaine. These findings were interpreted as showing that faith can help to cope with stressful life events (Miller *et al.*, 2000). Cochrane's (1999) research into the drinking habits among white, black and Sikh men concluded that greater involvement in religions that prohibit alcohol use and socially outlaw drinking seemed to be the most likely explanation for the substantially lower levels of alcohol consumption amongst black respondents. Equally, a strong relationship between family, religious activities and substance use as highlighted by Boys *et al.* (2001) suggested that white young people seemed to use more substances, had less religious or family involvement and were more influenced by their peers. In contrast, young Bangladeshis had higher levels of family and religious involvement and lower levels of drug use.

Despite the view that religion is successful in preventing its members from using drugs and alcohol, the idea of religion as a protective factor needs to be questioned. There is ample anecdotal evidence of Moslem men and women who have drug and alcohol problems, and this suggests that religion as a protective factor does not work for everyone. Views that religious and societal rules are protective, as raised by O'Connor (1975) and Westermeyer (1999), ignore the fact that those who break the rules are more likely to be faced with strong disapproval and may even be ostracised. The possible implications on treatment uptake and attitudes of staff have been highlighted in sections 3.2.5 and 4.1.

4.1.3.2 Influence of philosophy on cultural values

Closely related to religion, and equally powerful in its influence on people's beliefs and attitudes, is the philosophy underpinning the culture of a society. Various authors commented on the clash between different philosophies and a possible link to drug and alcohol problems (Ho, 1990; James *et al.*, 1997; Amodeo *et al.*, 1998; Hofstede, 1980, 2001).

James *et al.* (1997) studied why increasing numbers of Asian American young people were turning to drugs and alcohol and pointed out that most Asian cultures were heavily influenced by Confucian and Buddhist philosophy and ethics. One of the main features of this philosophy is the unspoken obligation of reciprocity. In order to fulfil familial or societal obligations there is a strong expectation of self-negation that can result in a suppression of strong negative emotions. There are parallels to Hofstede's (1980) concept of collectivism that offers protection and in return expects loyalty and fulfilment of one's obligations.

Closely linked to 'obligation' is the concept of 'shame'. Shame re-affirms familial expectations and proper behaviour, both within and outside the family. A family member who behaves improperly loses face and brings shame to the entire family (Ho, 1990). The disparity between reported and actual rates of Asian Americans' mental illness, juvenile delinquency and substance use problems has been explained by the fact that the problems are hidden, probably due to cultural factors, such as the shame and disgrace associated with admitting to such problems. Denial of problematic substance use is, however, the primary barrier to seeking treatment (James *et al.*, 1997).

The obligation of protecting the family's honour may particularly affect minority ethnic women. It may trigger, or contribute, to a substance use problem. The shame of damaging the family's honour can also lead to excessive drinking or drug taking (Acquire, 2003; Alam, 2004).

The powerful impact of society's philosophy upon beliefs and behaviours has to be recognised when dealing with people from other cultures. The attempt to fit in with Western culture, together with an obligation to the values of a collective society, results in strong conflicts that may increase their vulnerability to drugs and alcohol. At the same time the shame brought to the family or community through such behaviour can exacerbate existing drug and alcohol related problems.

4.1.3.3. Migration and adaptation to a different culture

The literature review shows that the reasons why people from minority ethnic groups drink and take drugs are largely the same for the white population. Such reasons include boredom, curiosity, peer influence, or pleasure (Fountain *et al.*, 2003). Other reasons are an increase in self-confidence, improvement of social relationships, relaxation and feelings of well-being (Acquire, 2003). There are many specific reasons why someone from a minority ethnic background may take drugs and drink alcohol.. These include the desire to fit in with mainstream society, coping with the tensions of being an outsider, feelings of being socially excluded and the effects of migration. Other causes could be the separation from family and friends, experiences of war, and/or torture, or the insecurity surrounding the legal status of being an asylum seeker (Sangster *et al.*, 2001; Sheikh *et al.*, 2001; Shaikh *et al.*, 2000).

A report (Fountain, 2006) into the nature of illicit drug use amongst the Travelling community in Ireland established that the drug-using patterns of travellers appeared to differ little from those of the settled population. However, their social exclusion puts them at risk of becoming problematic drug users (Fountain, 2006). Likewise, recent reports by the Greater London Authority (GLADA, 2004) and McCormack *et al.* (2005) confirmed that young refugees and asylum seekers were vulnerable because of their experiences of traumatic incidents which made them leave their

home country. Their arrival in the UK at first seemed like a relief, but many subsequently encountered stressful situations.

Mokuau's (1997) concept of 'cultural conflict' referred to conflicts that arise from the experiences of immigration which could generate high-risk factors for problematic alcohol and drug misuse, such as family and generational conflicts. The different values and norms of the host country may create difficulties in adjusting to their new environment. Generational conflicts may develop between the older generation, who want to retain their cultural traditions, and younger ones who want to fit into the new culture. Additional conflicts may arise for those who are not able to fulfil traditional responsibilities. For example, if the cultural expectation of immigrants is to provide financial support to family members back home, in the face of unemployment and poverty, they may find it impossible to send money back.

It is widely acknowledged that the mental distress of migrating, displacement and efforts of acculturation, together with experiences of social exclusion, can make individuals vulnerable, leading to health and social problems, including those of drugs and alcohol (Shaikh *et al.*, 2000; Westermeyer, 1995).

4.1.3.4 Racism

Although some have argued that racism is no longer the main factor affecting the well-being of many immigrants as it was some years ago (Shaikh *et al.*, 2000) it is still a significant risk factor for substance misuse and its consequences should not be underestimated (Bashford *et al.,* 2003). Racism can take various forms, for example overt racism against individual members or groups of ethnic communities, discrimination in all areas of life (Acquire, 2003), institutionalised racism (Macpherson, 1999) or internalised racism (Shaikh *et al.*, 2000).

The effects of racism can have a lasting impact resulting in mental distress, poor relationships, self-harm, suicide and problematic substance use. The effects of racism can affect different parts of the community in different ways. Working class

people with language barriers, low-income earners, the mentally ill or the young, tend to be more vulnerable to racism than high earning middle-class second and third generations who are more likely to be accepted as British (Shaikh *et al.*, 2000).

4.1.3.5 Socio-economic influences

Amodeo and Jones (1998) argued that economic and socio-political factors, including racism and other forms of oppression, influenced a person independently of cultural backgrounds and produced either obstacles or opportunities. Those who were economically privileged, or members of the mainstream ethnic group, were more likely to receive opportunities, whilst those who were economically deprived were likely to face discrimination and oppression. As a result, alcohol-related problems often result from these obstacles.

The link between socio-economic and educational factors and problematic drug and alcohol use has been established (ACMD, 1998; Bradley *et al.*, 1999; Ramsey *et al.*, 2001). Bradley *et al.,* (1999) stressed that, contrary to common beliefs, professionals and skilled workers were more likely than poorer unskilled workers to have taken drugs at some point in their life. However, amongst regular drug users, those who had a higher level of drug use and those, for instance, who injected, tended to be unskilled workers. The authors also confirmed there was a strong link between unemployment and drug use. Similar findings are reported from analysing the link between drug use and household income, and education and social class, which showed that different types of drugs have different relationships with socio-economic factors: for example, cocaine use was highest in the richest income category while the use of heroin was highest among the poorest income group (Boys *et al.*, 2001).

Problematic drug use is mostly concentrated in deprived inner city areas that have high levels of unemployment, poverty, educational disadvantage and poor housing (Parker *et al.*, 1998). Certain population groups are more vulnerable and at risk of developing drug-related problems (Lloyd, 1998; Becker and Roe, 2005). High risk groups include young people looked after by local authorities, the homeless, young

sex workers, children excluded from school, young offenders and young people with depressive disorders (Lloyd, 1998; Evans *et al.*, 2000).

These findings verified the link between socio-economic factors and problematic drug use. It could be argued that these factors apply to the mainstream population too and are therefore not specific to minority ethnic groups. Yet, a number of publications have highlighted the particular vulnerability of minority ethnic groups to developing problems with substance use (Pearson *et al.*, 1998; Patel *et al*., 2004; Fountain, 2006; Fountain *et al*., 2007) because a higher proportion of them live in poverty, are unemployed or socially excluded.

Of course, minority ethnic groups are not a homogenous group, and not all of them are poor or marginalised. There are many differences between, and within, the various ethnic groups in terms of socio-economic status, gender, income and education. Many people from minority ethnic groups in the UK become successful business people and professionals. However, numerous publications such as the Parekh Report (The Runnymede Trust, 2000) have provided substantial evidence that some African-Caribbean, Bangladeshi, Irish, Pakistani and refugee communities are disproportionately affected by poverty. Similarly, the Acheson Inquiry into inequalities in health (Acheson, 1998; 2000) also recognised the contribution of socio-economic inequalities to inequalities in health, both within and between ethnic groups.

4.1.3.6 Socio-cultural groups

Contextual situations can be different, depending on the status of socio-cultural groups. For example, women and young people may face additional challenges, depending on their societal status. With women, problem drinking appears to be mostly correlated with a reduction in their cultural network, lack of social support (Purser *et al.*, 1999) and additional social and cultural variables, such as qualifications, employment, being single or having fewer friends from own ethnic group (Orford *et al.*, 2004). Also, as mentioned above, the anxiety of bringing shame

to the family by admitting that they have a drug or alcohol problem are the main reasons that prevent many women from minority ethnic backgrounds from accessing services. As a result, problems may not be acknowledged and services are not provided because in the eyes of the community female substance use does not exist. The notion of diversity applies here too. Not all women from minority ethnic backgrounds are poor, vulnerable or from underprivileged backgrounds. The socio-economic situation and the societal status of women differ from society to society and within societies.

Equally, the situation among youth varies widely. The diversity of the contextual situation of young minority ethnic people can be a result of differences in the acculturalisation as young people may be mainstreaming culture in different ways. Commonly assumed risk factors include experiences of conflict caused by living between different cultures, trying to fit in with the mainstream host culture of their peers (Acquire, 2003), family conflicts, arguments between young people and their parents, or family breakdown (Luger, 2002; Bashford *et al.*, 2003). Also, peer pressure and family problems are likely to lead to depression, juvenile delinquency and problematic drug and alcohol use (Kuramoto, 1997).

The stigma of drug and alcohol use may prevent someone from seeking help because of the fear of being ostracised. Problematic drug and alcohol use may not be recognised because they do not fit into the vision society has of what goes with ethnic or religious affiliation. Having accessed services they may have to face staff who have strong judgmental attitudes towards their behaviour. Staff may lack knowledge and insight into the diverse factors of problematic drug and alcohol use and may not be aware of the impact that cultural perception and the social context can have on substance use and help-seeking behaviour. Some staff may judge the client's behaviour on the grounds of their own strong religious beliefs as they do not morally agree with the use of drugs or alcohol. Others, with a more secular view, may not understand the importance religion has for some clients and find it difficult to accept the impact religion can have upon their members, or they may not understand the moral dilemma their clients face.

The lack of understanding of staff about the complexity of the underlying factors of their clients' drug and alcohol use, together with judgemental attitudes and cultural insensitivity, are bound to result in misunderstandings and conflicts in the relationship between staff and client. If these are not addressed they are likely to result in services not being accessed, drop outs or suboptimal treatment outcomes.

In conclusion, many factors, from socio-economic status, religious affiliation, philosophy of life, gender and age specific issues may impact on people's behaviour and lifestyle choices and can contribute directly or indirectly to substance use problems. Some factors can either protect or enhance vulnerability to drug and alcohol problems, depending on the contextual situation.

4.2 Trends of drug and alcohol use in minority ethnic groups

Alcohol and drug use amongst minority ethnic groups has become an increasing concern for communities and for planners and providers of health services, social services and the criminal justice system. However, little is known about the actual level of substance use or the problems related to it. Few people from minority ethnic groups come into services and this low treatment uptake has often been interpreted by service providers and funders as a reflection of low need, indicating that services do not need to change to attract more clients from minority ethnic backgrounds. However, anecdotal evidence and a number of local need assessments (for example Bashford *et al.,* 2001, 2003; Prinjha *et al.,* 2001; Sheikh *et al.,* 2001 and 2002; Luger *et al.*, 2005; Azad *et al.,* 2006) suggested that drug and alcohol problems *do* exist in minority ethnic groups.

There is an ongoing debate as to whether low attendance figures reflect the level of need, or whether the barriers in accessing services are too high to overcome. Some argue that people from minority ethnic groups may have fewer drug and alcohol problems than the indigenous white British population, because their lifestyles and cultural or religious factors are protective rather than risky (Westermeyer, 1998). Others admit they may overuse substances but do not recognise this as a problem, or they might not need treatment services as they can solve these problems effectively amongst themselves. Some have problems but do not know where to go for help, or they may not access services if they feel they are not appropriate to their needs (Fountain *et al.*, 2003; NTA, 2003).

This section seeks to critically examine the literature on whether patterns and trends of substance use among minority ethnic groups are recognisable. To achieve this, the results from large and smaller scale surveys into drug and alcohol use amongst minority ethnic groups will be analysed and their usefulness debated. The limitations of epidemiological data in providing a clear picture of the extent of drug and alcohol problems in diverse heterogeneous populations will be discussed.

4.2.1 Large-scale study - The British Crime Survey

The British Crime Survey (BCS) is the largest household crime survey in England and Wales and is regarded by experts as the most reliable evaluation of drug use in the UK. Hence, most UK drug reports are based on its data. Conducted on a bi-annual basis, the BCS targets a sample of those between the ages of 16-59 years and in particular those between the ages of 16-24 years. The survey includes questions on the use of illicit drugs[14], but not on alcohol. It provides a breakdown of information on drug use in relation to age, gender, ethnicity, socio-economic status, levels of use and drug type. The survey asks the respondents to recall their drug use according to certain periods, for example last month, last year or ever. This distinction is used for a more detailed interpretation as to the intensity of drug use[15].

Over the years the BCS had consistently shown that, irrespective of age, lifetime prevalence of drug use was greatest for white people, followed by black, then Indian and Pakistani/Bangladeshi groups. In the BCS in 2000 the category 'mixed ethnicity' was used for the first time, representing a minority group whose drug use had been long overlooked. The findings of the 2001/2[16] survey indicated that the highest rate of drug use overall was in the mixed ethnicity group, followed by white then other ethnic groups (Aust *et al.,* 2003). The authors suggested that high drug usage in people from mixed ethnic backgrounds may be a result of their socio-economic disadvantage and social exclusion as members of this population group were more likely to live in deprived areas, in rented social housing and have less disposable personal income. This is in line with the findings of the BCS 2000 survey that stressed the possible impact socio-economic factors can have on the uptake of drug use and its link to the development of problematic drug use (Ramsey *et al.*, 2001).

[14] For more detail on classification of illicit drugs see Appendix 1.
[15] For a more detailed interpretation of the intensity of drug use see Appendix 1.
[16] The data of the 2001/2 survey have been used in this study because later surveys, such as the 2003/4 and 2005/6 surveys do not show a breakdown by ethnic groups. My enquiries to the Home Office established that the data had been collected but not yet analysed.

The BCS findings are limited in their validity due to the methods of data collection (Hayes, 2000) including issues regarding the representation of those affected by drugs. Postal surveys, such as the BCS, may not reach large numbers of drug users in hard-to-reach and vulnerable populations, such as the homeless, refugees, and those living in care, with friends or extended families. Postal surveys are usually answered by the head of the household and, therefore, may not reach the person using drugs; for example, many young people from Pakistani and Bangladeshi backgrounds live with their parents and may not be the ones who complete the questionnaire. People who feel alienated from mainstream British society may not respond. A lack of English language skills or even basic literacy are further limitations. Unfamiliarity with questionnaires and a lack of understanding of the relevance of these surveys may also limit people's motivation to participate. The very nature of illicit drug use is likely to prevent people from admitting usage, for fear of the detrimental consequences, including fear of stigma and prosecution that this could have upon them and their families. Refugees and asylum seekers may fear losing their legal status or right to remain in this country if they answer truthfully. Additionally, the validity of self-reported drug use is questionable as there is much scope for incorrect answers (Cohen *et al.*, 2007). The respondents may hide truth because they fear sanctions, or they may exaggerate the extent of their use in order to seek attention or distort the data of the survey.

A vital flaw of the BCS study is that it cannot identify vulnerable population groups, which is one of the explicit aims of the survey. The limitations of research into ethnic categories have already been discussed in section 3.2.3. The aggregation of the census categories into five broad categories, together with the assumption of their homogeneity, makes the identification of particular vulnerable population groups impossible. For example, as the white group is portrayed as homogeneous it is impossible to identify vulnerable invisible minority ethnic groups, such as the Irish or Eastern Europeans. Even the newly introduced category of 'mixed ethnicity', which has the highest level of drug use, is not broken down further to establish particular population groups at risk. The newly introduced category of 'religion' gives additional

information of religious affiliation. However, their usefulness is limited because religions, such as Islam or Christianity, span various ethnicities and continents. Furthermore, affiliation does not provide information about the degree of religious devotion of the individual.

4.2.2 Smaller scale studies into patterns and trends of drug use amongst minority ethnic group*s*

Many reports have criticised the fact that drug use within minority ethnic groups is under-reported in official statistics and remains hidden (Pearson and Patel, 1998; Luger, 2002) and that refugee populations are not represented in statistical records. The lack of reliable information on the extent of drug use within minority ethnic groups has been recognised and the need for detailed research into the nature of drug use among a diverse population was stressed (GLADA, 2003). Also, the lack of acknowledgement of drug and alcohol problems within minority ethnic families and communities has been highlighted (Perrera, 1998). Possible explanations given were that community and religious leaders, anxious to protect the community's reputation as honourable citizens, often deny any alcohol or drug use amongst their community or they play down the extent of it. Yet, it is often the stigma within the community that prevents individuals and families from admitting that they have a problem and seeking treatment (Luger *et al.*, 2005).

Various studies identified differences between ethnic groups. Fountain *et al.* (2003) examined a number of local studies and concluded that in some areas drug use amongst minority ethnic groups was increasing and just as prevalent as within the white population group. Increased use of a range of drugs amongst young South Asian men was found in Calderdale (Bashford *et al.*, 2001), Bury (Prinjha *et al.*, 2001), Bedfordshire (Sheikh *et al.*, 2001) and Waltham Forest and Redbridge (Sheikh *et al.*, 2002). Concerns were expressed some time ago by communities in Bradford about drug use, in particular the use of cannabis amongst young South Asian women, and in Newham and Bradford the use of crack cocaine amongst

African-Caribbeans (Gilman, 1993). In Greater Manchester increased crack cocaine use by black Caribbeans and heroin use by South Asian males was reported (Chantler *et al.*, 1998). Fountain *et al.* (2003) concluded that the evidence from these surveys strongly indicated that drug use within minority ethnic groups was significant and increasing, and that the social and economic situation of many minority ethnic groups seemed to make them vulnerable to drug use. Although drug use may be more concentrated in young males, increasing drug use was also reported amongst young females from minority ethnic groups.

Valuable work has been carried out by the Centre of Ethnicity and Health, with the support of the DH, to engage community organisations into researching drug use within their community. This project targeted minority ethnic communities and other diverse groups and took place in two phases, in 2000/1 and 2003/6. The aim was to highlight the drug related needs of local communities and to enable these communities to articulate their needs to service providers, policy makers and funders of services. As a result a large amount of reports were produced which highlighted local patterns of drug use and gaps in services to meet their needs (for example, Rahman *et al.*, 2001; Cunningham *et al.*, 2001; Azad *et al.*, 2006, summarised by Bashford *et al.*, 2003). A summary of the reports of the 2nd phase was at the time of writing not yet available.

Patel (2001) analysed the findings of a number of local need assessments and concluded that minority ethnic groups were just as susceptible to problematic drug use as the white indigenous population, and that drug use was a significant concern within these communities. However, many of them did not access services until they reached a crisis point because the way services were provided discriminated against these drug users. Furthermore, various authors pointed out that whilst under-represented in drug services, minority ethnic communities were disproportionately over-represented within the Criminal Justice System, within in-patient psychiatric care (particularly medium and high security psychiatric care), within the care of local

authorities, and those excluded from school (Patel, 2001; NIMHE, 2003; Bhugra, 1997).

A report by the NTA (2003) that analysed local studies and anecdotal evidence found that problematic drug use amongst African-Caribbeans often centred on crack-cocaine and cannabis use, whereas problematic heroin use was more prevalent amongst South Asians (NTA, 2003; Awaih *et al.*, 1992; Sherlock *et al.*, 1997; Sangster *et al.*, 2001). The use of Khat[17] seemed to be particularly high amongst Somalis (Griffiths, 1998; Patel *et al.,* 2005). Minority ethnic drug users were found to be less likely to inject heroin than whites, but there was still evidence of injecting and sharing of injecting equipment amongst people from minority ethnic groups (Sherlock *et al.*, 1997). This concurs with the findings of a study into the provision of HIV prevention interventions for injecting drug users in Camden which highlighted that injectors from minority ethnic backgrounds were under-represented in the uptake of needle exchange schemes (Luger *et al.*, 1998).

Other studies could not confirm particular ethnic patterns of drug use. Anecdotal evidence and the findings from the RNA in section 5.2 suggest that drug use takes place within all ethnic groups, genders and ages, and that a variety of drugs are used by all of them (Luger, 2002; Luger *et al.,* 2005).

Although some studies demonstrated drug use in particular minority ethnic groups, data on drug-using patterns were difficult to obtain. Even where they were established in one local community, they could not be easily generalised because the local prevalence, social context and composition of population groups may have differed greatly. Also, generalisations of such findings may contribute to the myth of drug taking within ethnic groups and result in stereotyping particular population groups.

[17] Khat is a plant whose leaves are chewed for their stimulant effect. The plant is most commonly grown in Eastern African or Middle Eastern countries and used mostly by people from these regions.

4.2.3 Smaller scale studies into the patterns of drinking amongst minority ethnic groups

A number of studies investigated patterns of drinking in minority ethnic groups. Again, as with drugs, the findings were inconsistent and based on local research, so could not be generalised. For example, the Health Survey for England (ONS, 2001) found that men and women from all minority ethnic groups, except the Irish, were less likely to drink alcohol than the general population, and when they did they consumed less. Yet, a community survey of second and subsequent generations of minority ethnic groups in Birmingham and Leicester (Purser *et al.*, 1999) found similar rates of non-drinking behaviour but highlighted that higher proportions of men and women from each ethnic category disclosed that they drank alcohol occasionally and that heavy drinking sessions were not unusual. This concurs with the findings from Subhra and Chauhan (1999) who argued that, although certain ethnic population groups restricted the use of alcohol for religious or cultural reasons, complex patterns of alcohol use also existed within these communities (see section 4.1).

Similarly, a report by Alcohol Concern (2003) into the drinking trends amongst minority ethnic groups confirmed that the overall levels of drinking were low, but in those who did drink, consumption was relatively high. The report concluded that although the levels of alcohol consumption in minority ethnic groups appeared to be lower in general than in white people, certain members within these communities were at risk of harming themselves through alcohol consumption.

These findings are important for they can have a potentially huge impact on help-seeking behaviour. The link between societal stigma of drug and alcohol use and reluctance to take up services has been discussed in section 4.1.

Various studies reported that drinking behaviour differed by ethnic groups (Orford *et al.*, 2004; Cochrane *et al.*, 1990). Cochrane *et al.* (1990) compared patterns of

alcohol use in white UK-born, Sikh and black men in the West Midlands, and discovered differences within and between ethnic groups. They found that drinking levels differed according to lifestyle, such as if someone drank alone, in the pub, or with the family. Yet, the lifestyles of those with lower consumption levels within one ethnic group turned out to be risk factors for higher consumption levels within other groups. For example, they found that married Sikhs consumed more alcohol than unmarried Sikhs, but in the black and white groups marriage was associated with lower consumption levels.

These findings on ethnic patterns and trends of drinking need to be treated with caution. They cannot be generalised as drinking patterns differ widely according to the reasons behind drinking, and the social and cultural context. Given the diversity of ethnic groups and lifestyles of their members, drinking behaviour has to be seen in the individual and social context.

4.2.4 Summary of the limitations of research into the extent of drug and alcohol use amongst minority ethnic groups

The extent of drug and alcohol use among minority ethnic groups is difficult to establish for a variety of reasons. Communities and families may not want to acknowledge the use of drugs and alcohol for fear it may bring shame upon them. This often leads to a denial of the problem, and help will often only be sought at a crisis point. A lack of awareness that there is a problem and lack of knowledge of where to go for help may prevent people from accessing services. Furthermore, researchers, service providers and policy makers may not wish to draw attention to a problem within a certain population group for fear of being accused of racism and stigmatisation.

The methodology of surveys can also have an impact on the findings. For example, do they reach those using drugs; were there language difficulties; had the questionnaire been developed in conjunction with the communities; and could

participants be trusted when alluding to the amount of illegal drug use or levels of drinking? Due to the nature of the covert trade in illicit drugs, the exact figure of those who use them will probably never be known.

Even when prevalence data demonstrates use of drugs and alcohol by those from minority ethnic groups, these findings need to be interpreted with caution. They do not give a detailed picture of the extent of use or whether that use was problematic. There are also inconsistencies in the various studies in terms of whether they are addressing use, misuse or problematic use[18]. Furthermore, not everyone who uses drugs and drinks alcohol will develop problems, but it is important to know how many of them are in need of treatment and where to find them.

Studying ethnic differences may be helpful when it enables researchers, policy makers and service providers to identify particular population groups who are at risk and in need of services and to develop interventions targeted towards those in need. However, as outlined previously (Aspinall, 1998; Chaturvedi, 2001), research into ethnic differences and ethnic monitoring has its limitations. The data on drug and alcohol use, based on broad ethnic categorisations, is likely to provide a distorted picture of the reality because it does not reflect the diversity of population groups in terms of socio-economic background, culture, religion, gender and age differences, all of which greatly influence risk and help seeking behaviour. The danger is that the most vulnerable groups may not be identified.

The findings of local studies, such as those mentioned above, may be useful in highlighting trends in particular areas. However, their findings cannot be generalised. They depend on the particular local mix of population groups. Generalisation of such results can contribute to stereotyping of ethnic groups, thereby creating, or confirming, a myth of ethnic drug using behaviour rather than revealing the reality of substance use. For example, because of this stereotypical view excessive attention is given by the police to stop and search and to arrest young black people (Mirza *et*

[18] For a further explanation of those concepts see Appendix 1

al., 1991; London Health Observatory, 2003). Such views not only influence society's perceptions of minority ethnic groups but also that of staff in services. This may be recognised by their attitude and behaviour towards clients. The impact of stereotyping will be discussed in section 4.3.

Moreover, as discussed above in section 3.2.3 (Bhopal, 2007; Chaturvedi, 2001), a generalised uncritical picture of the extent of drug and alcohol use in minority ethnic groups may be used to portray a negative picture of antisocial behaviour and is more likely to nurture racial prejudice rather than to create an understanding of the problem. The findings on drinking or drug taking within ethnic groups may also be used to blame the victims for their health related problems because of their risky drinking and drug using behaviour. Such findings imply that the underlying explanations for drug and alcohol problems lie in their ethnicity rather than within their social context. Such a view is likely to contribute to the perception that minority ethnic groups are a burden to society because they are taking up a large portion of the healthcare budget through their irresponsible behaviour.

In conclusion, epidemiological data on ethnic differences in drug and alcohol use give an indication of substance use in particular population groups and can help services to target those in need. However, patterns of minority ethnic substance use are difficult to establish. Also, they cannot provide information on the diversity of heterogeneous populations who have a broad range of religions, languages, and lifestyles which may impact on drinking and drug using behaviour. As a result, data may lead to generalisations and encourage prejudices. These findings support the view expressed above that it is important to look beyond ethnicity and take the whole range of cultural and social factors into account that may contribute to an individual's alcohol or drug problem.

The findings also strongly suggest that it cannot be assumed that certain population groups do not have drug and alcohol problems purely on the basis that they do not access treatment services. Services need to look for potential clients from all

different cultures and backgrounds, and change their services to enable access to treatment for all population groups.

4.3 Service provision for people from minority ethnic backgrounds

Services for substance misuse have been criticised because they are unable to recognise and respond appropriately to the needs of people from minority ethnic backgrounds. The following section will review the existing literature on service provision for minority ethnic groups in the UK. The need for staff competences for treatment and care planning of drug and alcohol problems has been addressed in a number of reports (Healthcare Commission 2006b; DH 2007) and is not a subject of this study. This study concentrates on the need for culturally competent provision of services, and seeks to highlight the key barriers to services and gaps in service provision, making recommendations upon how to improve services to provide culturally competent care.

4.3.1 Barriers to accessing services

A range of literature has focused on service provision for people from minority ethnic backgrounds who have drug and alcohol problems and highlighted barriers to access (for example, Awiah *et al.*, 1990; Johnson & Carroll 1995; Kahn and Ditton, 1999; Sangster *et al.*, 2001; NTA, 2003; Fountain *et al.*, 2003, 2006; Luger *et al.,* 2005). The reasons for low uptake of services were complex. They included refusal to acknowledge that there was a problem, stigma within the family and community and a lack of knowledge about where to go to seek help. The literature also showed that overall, service provision was inconsistent and poorly co-ordinated.

It is common for people to be unaware or unwilling to accept that they had a drug or alcohol problem, regardless of their ethnic origin (Awiah *et al.*, 1992, Kahn and Ditton, 1999). If they did not consider their drug use a problem, they saw no need to access services (Abdulrahim *et al.*, 1994; Khan and Ditton, 1999). Other studies reported that South Asian drug users said they would be more likely to approach their general practitioner for help than a drug service (Chaudry *et al.*, 1997; Khan

and Ditton, 1999), although others expressed concerns about the capabilities of GPs in treating drug related problems (Sangster *et al.*, 2001).

The lack of awareness about the prevalence of drug use in their community meant that some South Asian parents were unsure about the need for services for their drug using offspring. Many were reluctant to access services because of the stigma this would bring on their families or communities. Also, some community leaders may not admit to drug and alcohol problems within their community, as these were not compatible with their idealised views of what religious norms permitted (Abdulrahim *et al.*, 1994; Luger *et al.*, 2005). The denial of drug use helped to maintain the desirable picture of a quiet and non-problematic community, but this denial became a major barrier for accessing services (Perera, 1998; Luger *et al.*, 2005).

Studies revealed that members of minority ethnic communities may be unwilling to use services associated with the HO, because of its association with immigration control and the police. Asylum seekers and refugees often feared that disclosing their problematic drug use would somehow affect their asylum application status (Flemen, 2003; Sheikh *et al.*, 2001). It was also said that distrust of 'officials' may lead to reluctance in accessing services. Many communities mistrusted services as they had become the focus of unwanted policing or interventions. Others felt that their culture had been criticised and blamed (Abdulrahim *et al.*, 1994).

A major issue preventing people from accessing services is confidentiality. For example, many young people believed that a visit to an agency or to their GP about a drug problem would result in their parents and the whole community finding out (Khan and Ditton, 1999).

The Advisory Council on the Misuse of Drugs (ACMD, 1998) noted that the low uptake of services by people from minority ethnic populations might be a consequence of the failure of agencies to make themselves accessible and

meaningful to all members of a multicultural society. For example, those with work commitments were unable to attend during normal office hours. Other barriers were lack of public transport, fears of racial attacks in certain areas, or women being unable to travel without a male family member. Furthermore, women may not want to access services that are also used by men (Johnson & Carroll, 1995).

4.3.2 Gaps in service provision

It has been argued above that increasing cultural diversity affects the healthcare sector and affects the relationship between staff and patients (Loustaunau *et al.*, 1997). Furthermore, it has been claimed that healthcare services, including drug and alcohol services, planned for the majority of the population were not always appropriate for the needs of minority ethnic groups (Smaje, 1995). There is evidence that drug services are mostly aimed at white British clients and that they failed to make their services more accessible to users from other ethnic and cultural backgrounds (Sangster *et al.*, 2001, Fountain *et al.*, 2003).

In the 1990s, drug and alcohol services were perceived by many communities and service users as lacking understanding and sympathy. Service staff was described as being ignorant of the lifestyles and cultures of minority ethnic groups and lacking an appreciation of the importance religion plays in influencing health related behaviour (Awiah *et al.*, 1990; Johnson & Carroll, 1995). Recent studies also highlighted gaps in service provision due to a lack of understanding of the needs of minority ethnic groups (Sangster *et al.*, 2001; Bashford *et al.,* 2003; NTA 2003; Fountain *et al.*, 2003; Fountain 2006). These findings could indicate that little has changed in the last decade. Equally, a study by the Alcohol Education Research Council (Johnson, 2005) confirmed that services are rarely designed to meeting the needs of people from minority ethnic backgrounds and only a few offered linguistic or culturally competent services. The study further highlighted a lack of knowledge and poverty of research about the needs of people from minority ethnic backgrounds who had alcohol problems. This is confirmed by reports about treatment in Mental Health

services that highlighted the fact that many black people were highly critical of how they were treated. Treatment was seen as being culturally insensitive. As a result black people lacked confidence in these services (DH, 1999).

There was a common perception among service users and communities that drug treatment services were run by white people for white people (Awaih *et al.*, 1992; Sangster *et al.*, 2001). Because there was a lack of ethnic minority staff, service users and communities assumed there was little empathy and understanding (Perera, 1998). Chantler *et al.* (1998), who evaluated drug service delivery to minority ethnic groups in Greater Manchester, concluded that ethnicity issues are seldom given any priority in service planning or delivery. Many participants in the study thought that the quality of services provided to minority ethnic populations was poorer than it was for white people.

A negative experience at a drug service not only deters an individual drug user from attending again, but may also prevent others from using it (Chaudry *et al.*, 1997). The findings of recent local need assessments confirmed that minority ethnic people were reluctant to access treatment services and those that did were frustrated about the lack of understanding from staff in these organisations (Bashford *et al.*, 2003).

There is a lack of understanding about the services required for minority ethnic groups because there is little information about their patterns of drug use and service needs (Fountain *et al.*, 2003). For example, the opiate focus of many statutory drug treatment services may attract opiate users for the prescription of opiates, but users of other substances, such as crack or cannabis, have limited options for treatment. Many of them access voluntary sector organisations instead. Also, the harm reduction focus of treatment services gives priority to the prevention of HIV and Hepatitis C through needle sharing and does not address the needs of non-injectors (NTA, 2003). Therefore, where people go for treatment is not a matter of choice but is related to what treatments are offered by the service.

Further limitations were found in treatment provision for female drug users and drinkers. A study for the HO (Becker and Duffy, 2002) into the service provision for female drug users noted that only few services attracted women from minority ethnic backgrounds. Most organisations who took part in this study identified this as a major flaw in their service provision. Workers argued that female drug use in minority ethnic groups was hidden, but because services were already working at full capacity little could be done to attract these women.

Other factors, such as language, impact on the initial access and ongoing treatment relationship between staff and clients from minority ethnic backgrounds. Whilst the majority of the British minority ethnic population is born and educated in Britain and speaks English reasonably well, a significant number struggle with the English language (Johnson & Carroll, 1995). Language problems are often overlooked in 'invisible' ethnic communities, such as Portuguese or Italian drug users. Their lack of knowledge of the English language contributes to their social exclusion and makes them vulnerable to exploitation; it impedes their access to seeking employment and receiving social benefit, and also impacts on the relationship with healthcare professionals (Kalunta-Crumpton, 2003). The use of interpreters can be a helpful resource in drug services. However, official interpreters may not know particular terminology and may require training. Problems can occur when family members, or their children, are asked to translate because official interpreters are not available. This can be very inappropriate if children or spouses are being asked to interpret private information about their parents' or partner's drug and alcohol problems (Patel and Sherlock, 1997; Sheikh *et al.*, 2001). Problems can also arise with translated materials because technical terms cannot easily be understood without interpretation. Employing bilingual workers has worked extremely well in many services. However, in multi-cultural boroughs where more than 100 languages are spoken (Luger, 2000), this is not feasible.

4.3.3 How can services be improved?

The continuing critique on the inappropriateness of services in meeting the needs of minority ethnic clients has called for substantial changes in how services are provided. Whilst service providers may be keen to open their service to people from minority ethnic groups, they may lack expertise and clear guidance in order to make their service more culturally appropriate to reach clients from diverse cultural backgrounds (Johnson & Carroll, 1995; NTA 2003, 2006; Fountain *et al.*, 2003).

4.3.3.1 Mainstream versus specialist ethnic services

A number of ways have been suggested to improve services. For example, it was hoped that by employing staff from minority ethnic backgrounds services would become more sensitive and responsive to the needs of people from other cultures. However, evidence from the literature (Chaudry *et al.*, 1997) and the findings of this thesis suggest that this is not enough. The NHS, the biggest employer of staff from minority ethnic groups (although not many are in management positions), has been accused of institutional racism (NIMHE, 2004a). This suggests that minority ethnic groups per se are not necessarily more culturally competent and that there can be many misconceptions between ethnic groups. Some argue that minorities, by virtue of being a minority, are often more culturally competent because they must understand how to deal with their own culture and the majority culture. But for a service to be culturally competent requires more than just having a few individuals who know different cultures. Cultural competence, as outlined in the previous chapter, must seek to address power issues and enhance knowledge and attitudes of all staff and cannot be addressed by employing one or two ethnic minority workers. Such an approach misses the opportunity to educate all staff within the service and encourage a dialogue between all cultures (Chaudry *et al.*, 1997).

One approach is to have ethnic specific services run by staff from minority ethnic backgrounds. Ethnic specific services work particularly well if healthcare staff and clients speak the same language and the clients feel culturally safe. However, such

an approach implies that ethnic groups are homogeneous, without class barriers, or gender or socio-economic differences, between people within one particular culture. Furthermore, minority ethnic services may not be the service of choice for those clients who are worried about confidentiality issues. They could be anxious that they may be seen by someone from their community or that confidential information could be given to the family or spread throughout the neighbourhood (Khan and Ditton, 1999). Services that are based on cultural beliefs may not be attractive to those who have alienated themselves from the cultural or religious norms of their community. For example, people who are deemed to have broken society's rules and regulations by using drugs and drinking alcohol, may not want to approach a service from their own culture, or may prefer anonymity, for fear of being criticised (Bakshi *et al.*, 2002).

Ethnic specific services are vulnerable to cuts or closure in times of financial constraints when they may be regarded as a luxury[19]. Due to the great number of different minority ethnic groups, it is unrealistic to cater for all of them, and some groups, that are not as vocal as others, may lose out.

The debate is still ongoing. This PhD research emphasises the need to improve mainstream services to make them more culturally competent in order to deal with clients from all cultures. Employing a mix of staff and developing a philosophy of openness to encompass all cultures are possible ways forward to achieve this goal. Cultural competence training for all staff within the service has an important role to play as it seeks to encourage learning from each other and to initiate a cultural dialogue so as to enhance the understanding of the benefits of cultural diversity.

4.3.3.2 User involvement and partnership working

Relationships between the service and client need to be based on trust and understanding rather than on power (Luger *et al.*, 2005). This can be achieved by

[19] In fact this was the case in one of the services that were interviewed for the initial Rapid Needs Assessment. SAAS, the Southall Alcohol Advisory Service run by South Asians for South Asians was closed down in 2003.

adopting a non-judgemental treatment approach that is client centred, involving the service user in treatment decisions. User involvement and partnership working is identified by the NTA (2006) as a way to ensure that clients do not feel rushed into making decisions about their treatment, that they receive clear explanations of treatment options and procedures, and have opportunities to ask questions (Boor *et al.*, 2007).

Further solutions are improved partnership working with communities (Luger *et al.*, 2005) to gain their trust and establish a relationship that enhances understanding of the needs of the community, and also explores the financial and structural limitations of the service.

The concept of cultural competence fits well in the approach of harm reduction treatment of problematic drug and alcohol use (Stimson, 1995). Both concepts require staff to be non-judgemental about their client's situation and behaviour. They need to work with the client towards an agreed and achievable goal. The approach is client centred, seeking to empower clients so that they can make active choices about their lives, and is based on a relationship of mutual respect.

4.3.3.3 Compliance with Government legislation

Services have a moral duty to deliver high quality services to all members of society. They are also legally obliged to prevent discrimination and to provide equal opportunities in the provision of services (HO, 2006). As outlined in more detail in section 3.1.1, Government policies and professional guidelines have called for the development of culturally competent services[20] and developed guidelines upon how to achieve this. Additionally, there is a range of legislation that seeks to ensure that

[20] For example the NHS Plan (DH, 2000), the RR(A)A 2000 (HO, 2000), the NHS Knowledge and Skills Framework (DH 2004) and the National Treatment Agency (NTA, 2003; 2006)

the provision of appropriate services is accessible and available to all members of the community[21].

For the practice of drug and alcohol services the RR(A)A 2000 requires that race equality is a core element in the development of new policies and that existing policies need to be reviewed in order to explore whether they have a negative impact on minority ethnic communities. The results of all assessments, consultations and monitoring exercises need to be published to be easily accessible to everyone. The act also requires organisations to ensure that all staff have equal opportunities in recruitment, career progression and staff development. Staff must be properly trained to make race equality central to their work (HO, 2003). Staff at all levels of services need to be aware of the importance of complying with antidiscrimination policies and be seen to be actively working towards this goal. The benefits would be an improved working relationship between colleagues, and between staff and clients. Cultural competence training is expected to play an important role in enabling services to comply with the directives of the RR(A)A 2000.

The RR(A)A 2000 has often been criticised because it focused on race only. It excluded many other minorities that were equally discriminated against, disadvantaged or socially excluded. The HO recently broadened its focus from race to diversity (HO, 2006). It published guidelines to assist those working in the drugs field to understand legislation to eliminate discrimination and identify and respond to the diverse needs of all communities. A further step away from race was the recent merger of various commissions[22] into the new Equality and Human Rights Commission. This new commission works towards eliminating discrimination, reducing inequality, protecting human rights and building good relations to ensure that everyone can participate in society (Equality and Human Rights Commission, 2007).

[21] Among them are the RR(A)A 2000, the Sex Discrimination Act 1975, (amended in 2003), the Disability Discrimination Act (amended in 2005), the Human Rights Act 1998 and the Equality Act 2006.
[22] The Commission for Racial Equality that is responsible to police the RR(A)A merged with the Disability Rights Commission and the Equal Opportunities Commission.

This change of focus from race to diversity can be seen as a positive move towards achieving cultural competence. The analysis of the literature, and of anecdotal experiences, led me to believe that focusing purely on ethnic groups hindered the development of a dialogue between cultures. Many people from other disadvantaged population groups felt excluded by approaches that sought to improve the services and opportunities purely for minority ethnic groups. An approach based on diversity would reach far more people, because many could understand this wider concept of discrimination, be it gender, sexuality, socio-economic, disability or race.

Conclusions

This review highlighted a number of issues that are important in order to understand the complex problems faced when working with diverse people with drug and alcohol problems. This understanding is essential to develop the skills that are needed for providing a culturally congruent service for them.

Staff must develop a critical understanding of the cultural meaning and reasons behind substance use as these determine if treatment is deemed necessary. Staff need to be aware of the many factors that impact on help-seeking behaviour and access to services. This includes issues such as whether use is hidden due to societal stigma or guilt. Staff must understand that their attitudes are equally influenced by societal perceptions on substance use and that judgemental attitudes are counterproductive. The attitude of staff needs to be driven by an understanding and respect of the diverse needs of the client.

Furthermore, staff should develop a critical understanding of the complex social context of drug and alcohol problems. Factors such as socio-economic status, religion, gender or age may engender risk or protection, depending on the social and cultural context. This context is influenced by factors such as the political system, history, and religion of a region. Lack of knowledge and understanding of the diverse causation and underlying factors behind problematic drug and alcohol use, together with a judgemental attitude and cultural insensitivity, result in misunderstandings in the relationship between professionals and clients. They may impact on treatment uptake, drop-out rates and outcome of treatment.

The review acknowledged the importance of epidemiological data on ethnic differences as this gives an indication of substance use in particular population groups and helps to target services towards population groups in need. It also highlighted the limitations of establishing patterns of drug and alcohol problems in minority ethnic groups. There is insufficient and conflicting research evidence and

the findings of the studies are difficult to compare due to the different methodologies used. The illegal nature of drug use and the socially unacceptable excessive use of alcohol, together with the fear of stigma, may hinder people from minority ethnic groups from admitting they have a problem. Hidden drug and alcohol use is therefore difficult to quantify. There is, however, evidence from local studies that drug and alcohol problems exist in minority ethnic groups, just as they do within the white indigenous population.

Furthermore, data on substance use, based on broad ethnic categories, is likely to provide a distorted picture because it does not reflect the diversity of ethnic groups. Findings have to be interpreted carefully as generalisations can lead to stereotyping. This can lead to stigmatisation of particular groups and create a negative picture of antisocial behaviour. It can also lead to problems being overlooked because of society's assumption of a population group's behaviour.

This review also explored the barriers and gaps in drug and alcohol service provision and the reasons behind low treatment uptake. These include a lack of awareness that someone has a problem with their drug or alcohol use, the negative attitudes of staff and the perception that services are for white people only. The identified gaps in services pointed to language difficulties and that staff do not fully understand the cultural context of ethnic minorities, which leads to cultural insensitivity. Recommendations included employing a cultural mix of staff, developing staff's cultural skills and empathy, increasing their knowledge and understanding and undertaking outreach work in order to network with the community and establishing trust. Future approaches should include either ethnic specific services or an improvement in the generic services. There are benefits and disadvantages in both approaches. This PhD emphasises the need for cultural competence within generic mainstream services to establish a cultural dialogue in order to achieve a culturally competent culture which will be of benefit to clients and staff.

The emphasis of this work shifted from ethnicity towards embracing a wider concept of diversity in order to include people from all cultures. Therefore, the cultural competence approach used in this study involves a person-centred approach where the individual client is in the foreground and their cultural and social context, including their ethnicity, are in the background. By using this method the risk of stereotyping is, hopefully, minimised.

Cultural competence training clearly has an important part to play in improving the knowledge and understanding of staff. Based on the findings of this research this module aims to enable staff to develop their cultural skills so that they are able to work with a diverse clientele and feel more confident and competent in the clinical encounter. It seeks to explore assumptions about specific cultural groups and to challenge stereotypical views. It also aims to develop appropriate assessment tools and interventions that are best suited to the needs of the individual and their family within the context of cultural and social factors. Particular attention will be given throughout the module to the principles of cultural competence and to the knowledge, attitudes and skills which are required to provide a culturally safe treatment and service environment. Participants will be expected to develop a non-judgemental approach and become more culturally sensitive. They will need to develop self-awareness of their attitudes towards clients from other cultures. They also need to develop skills in communication, negotiation, empathy, liaison, assessment and of specific interventions. How the findings of this literature review have been integrated into the content of the module will be described in more detail in section 6.1.

5. Rapid Needs Assessment

5.1 Introduction

5.1.1 Background

A Rapid Needs Assessment (RNA) was carried out from July to September 2001 as part of an educational development project to identify training needs and to inform the content of the module. This chapter reports upon the findings of the local RNA which explored gaps in service provision, identified training needs for staff and made recommendations on providing culturally competent services.

5.1.2 Methodology

This RNA represents the first of the action research cycles used in this study. Its purpose was to provide important knowledge for a local problem to inform the basic framework for the module content and learning outcomes.

The RNA was chosen as the methodological tool for a variety of reasons. The RNA refers to a set of tools designed to provide, quickly and at low cost, accurate and reliable population-based information about communities impacted by public health emergencies. RNAs have been used widely by organisations, such as WHO, UNHCR or CDCs (Centres for Disease Control) in emergency or post-disaster situations so that good quality information can be obtained in situations that need quick interventions (WHO, 1999; CDC, 2005).

RNAs have also been shown to be effective as a pragmatic research tool into social, cultural and economic issues, especially when only limited data exists (Ball *et al.*, 1998; Rhodes *et al.*, 1999). This is particularly an issue in the context of drug taking when use remains hidden because of its illicit nature and of the associated stigma within the community. At times, RNAs are preferable to conventional research

methods as they enable the delivery of a quick response to inform policy or decision making (Manderson *et al.*, 1992). This is of particular relevance within the ever changing field of substance use. As RNAs are undertaken with the aim of developing interventions and not simply to generate knowledge, they can be perceived as an integral part of the response and development process of an intervention (Rhodes *et al.,* 1999). Although RNAs may have limitations regarding the depth, quality and quantity of data (which a longer-term needs assessment could deliver), it offers a quick way of obtaining an initial snapshot. RNAs are also undertaken as a fast way of obtaining data to inform the development of larger and more complex studies.

Interventions developed in response to an assessment not only depend on knowledge of the local situations and practices, but also require the active participation of the targeted local communities in the assessment and the design of interventions. RNAs, therefore, have also evolved as a tool for community development (Manderson *et al.*, 1992). Community involvement is also a vital part of a similar approach that is often referred to as a rapid needs appraisal (Palmer, 1999). A good example of community engagement is the DH's black and minority ethnic drug misuse needs assessment project (Bashford *et al.,* 2003). The development of a bottom-up community response, rather than an outside-expert view, is likely to increase the community's adherence and commitment to change. It is also likely to encourage participation and collaboration, and lead to the success of the intervention. Because of its focus on action following research and its community involvement approach the RNA sits perfectly with the action research framework used in this study.

The research consisted of a literature review, analysis of annual attendance data from selected treatment centres, interviews and a focus group of key informants. The focus group involved members of a local Family Anonymous group. A further focus group, scheduled for staff from a mental health service in Acton catering for clients from a broad range of cultural backgrounds, had to be cancelled as staff had to cover for sick colleagues. Also, a focus group with service users at the Gatehouse in

Ealing failed to materialise within this time frame. Three service users from different services across London volunteered to be interviewed, but as it was logistically impossible to meet together they were interviewed individually.

A short literature review was conducted that informed the background of the study and guided the design of the questionnaire and data analysis. The data collection included documentary analysis of the annual attendance data in selected treatment centres and demographic statistics from the Local Borough of Ealing. It was intended to use the data as secondary data in order to assess whether treatment uptake in these services matched the ethnic distribution of the local population. From the four Ealing treatment centres[23] two were alcohol services and two drug services. Treatment uptake data was also selected from an alcohol treatment centre in the neighbouring borough of Hammersmith[24], a borough with a less diverse population, to compare uptake by ethnicity.

A multidisciplinary and multicultural steering group guided the study[25]. They recommended key informants for interviews from health, social, educational and community areas. The criteria for inclusion were that the participants needed to be well informed and knowledgeable about the specific areas of the study. For example, service providers were invited who had a caseload of patients with drug and alcohol problems. The recommended informants were informed about the aims of the study and were asked whether they were willing to participate. Frequently, those approached recommended other individuals or services for inclusion. They all expressed a genuine interest in the study. However, two declined to take part due to time constraints. Thirty-eight semi-structured one-to-one interviews were conducted with key informants within the borough. The distribution of the key informants was mixed in terms of their background, gender, age and ethnicity (see table 4 below).

[23] Gatehouse Alcohol Treatment Centre, Gatehouse Drug Treatment Centre, (CDT), Southall Alcohol Advice Service (SAAS), Ealing Drug Advice Service (EDAS).
[24] Wolverton Gardens Alcohol Treatment Centre.
[25] Its role and composition is outlined in section 1.4.

Table 4: Key informants by service settings and ethnic groups

Setting	n	Ethnicity	gender
Statutory alcohol treatment service	3	2 white British 1 white other	M, F M
Statutory drug treatment service	4	2 white British 1 black African Caribbean 1 white other	F, F M F
Voluntary sector alcohol service	4	1 black African other 2 South Asians 1 white British	F F, F M
Voluntary sector drug service	2	1 black African Caribbean 1 white Irish	M F
Community Mental Health Services	3	1 black African other 1 black African 1 South Asian	F M F
HIV services	1	1 South Asian	M
Generic Health service	2	2 white British	F, F
Youth services	2	1 white Irish 1 black African Caribbean	F M
Community centres	3	1 black African 2 South Asians	M F, M
Criminal Justice System	2	1 South Asian 1 white British	F M
Community and religious leaders	4	3 South Asians 1 black African	M, M, M M
Politicians	2	1 South Asian 1 white British	M M
Family members	3	2 South Asians 1 white British	M, F F
Service users	3	1 South Asian 1 white British 1 white Irish	F, M. M

In addition, a focus group using a semi-structured interview approach was conducted with parents (n=12) of drug using young people in Ealing. The focus group consisted of members of a local Family Anonymous group who attended monthly meetings in a local alcohol community treatment centre. With the assistance of the service manager the group was asked whether some members were willing to participate in the study. All group members agreed and I was invited to their monthly meeting. The focus group consisted of a mix of ethnicities, genders and ages: 5 were females, 7 were males. Ten came from various minority ethnic backgrounds, two were white British. Their ages ranged from 40-60 years.

The use of focus groups is regarded as a useful tool in action research because the group members are active participants in the research process (Bowling, 2002). The

interaction among participants during the group interview was a valuable source of data. Focus groups have advantages over individual interviews as they are more economical with time, quicker to organise and can generate a wider range of responses than individual interviews could. However, they are not appropriate for all research questions and settings, and facilitation can be challenging for the chair. The interactive nature of the focus group encourages discussions by making use of group dynamics.

There are differing views among researchers as to whether group members should know each other, how the group sample should be selected and what the optimal number of participants should be (Bowling, 2002; Cohen *et al.*, 2007; Willig, 2001). In this focus group the members (although remaining anonymous) had known each other for some time due to the common purpose of helping the problematic drug or alcohol use of their offspring. This was an advantage for this focus group because a sense of trust had already been established between members, enabling frank discussions.

As I used an existing group, I did not have any input in the sampling and size of the group. Even so, the composition of the group was diverse and balanced in terms of ethnicity, age and gender. The size of the group (12 participants) was on the upper limit of what is considered manageable for conducting a focus group. I did not have any input in setting up the room but all members were sitting around a table and were able to see me and each other.

My role was that of facilitator, asking questions and encouraging debate. The discussion of a focus group should either be taped or notes taken and ideally should have a moderator and a recorder. The group was welcoming but did not want the discussion to be taped because of confidentiality issues as part of the ground rules within their group. I did not bring an assistant to take notes for practical reasons because of the large group and the small size of the meeting room. I therefore facilitated and took notes. The interaction of the group focused more between

themselves rather than on me, which enabled me to record the meeting at the same time as chairing it.

Similarly, the interview with the key informants were recorded as written notes rather than taped. As a substantial number of participants, particularly from minority ethnic groups, had expressed their wish not to be tape recorded, I adopted this approach for all interviews. Notes taken in each interview were anonymised using a coding system, as were the notes from the focus group. Only I had access to the personal details of the participants in order to ensure the confidentiality of data.

An interview frame was developed from an understanding of the issues raised in the literature. The interview frame and key questions were discussed and approved by the steering group. The questions focused on participants' perceptions and possible explanations of the underlying factors of the cultural context of substance use within minority ethnic groups and how these impacted on help seeking behaviour. Participants were also asked what they thought of the current practice in services, to see if they identified any gaps and what they thought made a service more culturally competent.

Data analysis consisted of a thematic analysis of the notes from the one-to-one interviews, the focus group and from the initial field work. The field work involved observing the behaviour of people from the local community in shopping centres, public parks, off-licences and shops including the exploration of local geographical factors in order to gain a valuable insight into the subject area. Key themes of one-to-one interview data were identified by coding and categorising the data. This process assisted in generating themes that were in synchrony with the questions asked and transforming data into meaningful concepts, which provided the framework for the writing of the report. Analysis of the focus group data adopted the same process of coding words, phrases and sentences, deriving categories and collating them into concepts. The findings are presented as a summary or in form of quotes.

5.1.3 Limitations of this research

It is recognised that the findings of this short-term RNA cannot present a comprehensive picture on the extent of the substance abuse problem amongst ethnic minorities in Ealing. The aim was to provide a local snapshot of the problems and highlight some of the related problems for the individual, family and community, and the implications for services. Caution should be used when drawing conclusions from these local findings against the broader population of minority ethnic communities living in Britain.

Since the main minority ethnic group in Ealing is of South Asian origin, proportionally more South Asians have drug and alcohol problems. As a result there is a greater emphasis, in this study, on the drug and alcohol problems amongst this particular population group. Even though the treatment uptake data pointed to a high alcohol problem among South Asian males, most interviewees seemed to be more concerned about the consequences of drug use, particularly amongst the youth, than about problems related to the use of alcohol. For this reason, this report may seem biased towards drugs rather than alcohol use.

Unfortunately, the service user focus group could not go ahead. An interactive debate among users could possibly have added more value to the report of this study. Instead, three one-to-one interviews with clients from different services were conducted. All three service users were satisfied with the service they received, but commented that others were possibly disadvantaged in having their needs met. Although these are service users' views, they cannot represent the views of those who do not use or access the service. Therefore, one limitation of this study was the failure not to have included those with drug and alcohol problems who could not access the service.

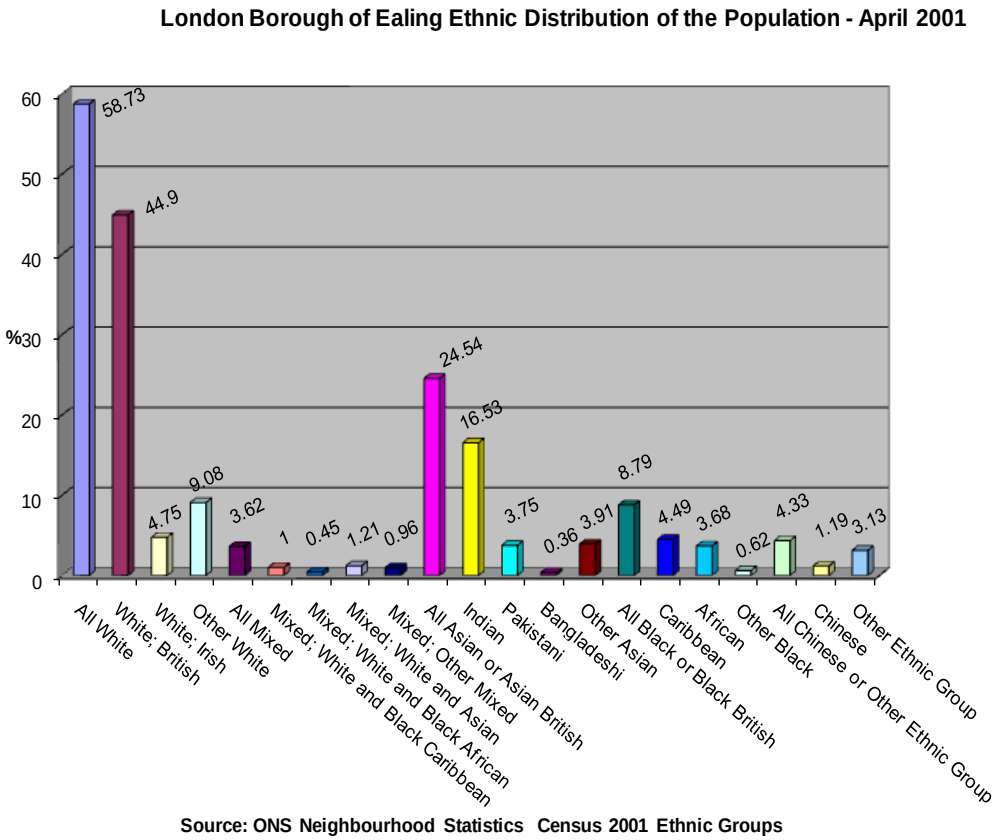
5.2 The Findings

5.2.1 Demographic and treatment uptake data

5.2.1.1 Multi-cultural Ealing

Analysis of the demography of the London Borough of Ealing showed that it has a large minority ethnic population consisting of 41.3% of the total population (compared to the average 9.1% across England and Wales) (see figure 5) and a high proportion of young people. Ealing has 19.8% of the population under the age of 16 (ONS, 2001).

Figure 5: Ethnic Distribution of the Ealing Population



Source: ONS Neighbourhood Statistics Census 2001 Ethnic Groups

According to these data the largest minority ethnic group in Ealing is of Asian origin[26] (24.6%), of which the Indian population is the largest group (16.5%). White[27] others constitute 9% and people of black origin[28] 8.8%, of which African-Caribbeans are the largest group (4.5%). According to the ONS Mid-Year Estimate (2000) the minority ethnic population in Ealing is increasing, particularly in those areas with an already high proportion of minority ethnic groups.

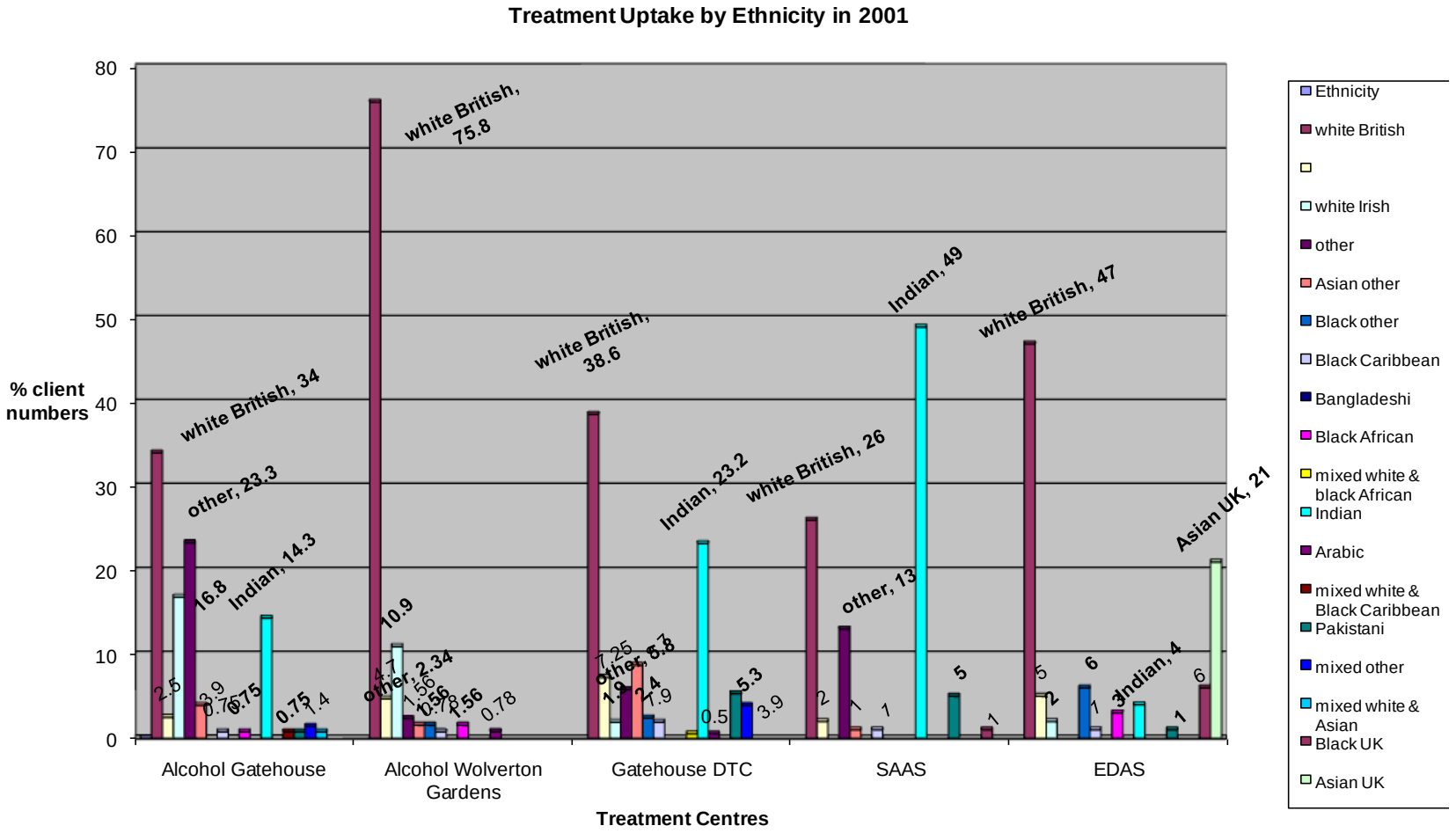
This data illustrates the huge diversity of Ealing's minority ethnic communities. This diversity is also reflected by the range of views on the use of substances, knowledge of treatment services and expectations upon these services.

5.2.1.2 Treatment up-take

The review of the treatment uptake data revealed that people from minority ethnic groups were approaching drug and alcohol services for help, but to a lower degree than the indigenous white British population. The treatment uptake data (figure 6 below) reflects the ethnicity profile of the borough. The highest proportion of clients within most of the services under study (except for SAAS) was "white British", followed by "white Irish" (Alcohol Gatehouse 16.8%), "Indian" (23.2% DTC, Gatehouse Drug Treatment Centre and 49% SAAS, Southall Alcohol Advice Service), or "Asian UK" (21% EDAS, Ealing Drug Advice Service). A look at the data from a treatment centre in the neighbouring borough of Hammersmith, an area with a predominantly white British population, confirmed that the treatment uptake seemed to reflect the ethnic profile (The Wolverton Gardens Centre: 75.8% "white British", 10.9% "white Irish" and 4.7% "white others" followed by 2.3% "others").

[26] The Census 2001 category "Asian or Asian British" consists of Indian, Pakistani, Bangladeshi and other Asian. The Ealing Census data break down of the Asian population: Indian 16.5%, other Asian 3.9%, Pakistani 3.8% and Bangladeshi 0.4%.
[27] The white category distinguishes white British (44.9%), white Irish (4.8%) and white others (9.1%).
[28] The Census 2001 category "black or black British" consists of Caribbean, African and other black. The Ealing Census data break down of the black population: Caribbean 4.5%, African 3.7%, other black 0.6%.

Figure 6:



Source: Annual treatment up-take data from selected treatment services

The local treatment data also indicated differences in the uptake of services with regard to gender and age. Drug treatment services had been used to a larger extent by young white British and declined with age (under 20 years 68%, 20-29 years 58%, 30-39 years 50%). The reverse was true for minority ethnic groups who accessed services at an older age (57% of minority ethnic clients accessed services between 40-49 years of age and 78% were over 60 years old). Analysis of the gender distribution showed a higher proportion of white British females in all services; for example the Gatehouse DTC was attended by 62% white British females, followed by 8% white other, 8% Indian, 6% mixed other.

Some services were used more than others by members from minority ethnic groups. Those services with a cultural mix of staff were more likely to be visited by members from minority ethnic groups than “white” only services. For example, the South Asian Alcohol Service (SAAS) was staffed mostly by South Asians and the Alcohol Gatehouse and Gatehouse DTC had a cultural mix of staff; whereas the Alcohol Wolverton Gardens was mainly staffed by white British.

However, the data on the uptake of treatment does not show client satisfaction, quality and success of treatment.

5.2.2 Findings from interview data

Key informants put forward explanations as to who was using drugs or alcohol, what the underlying factors within the cultural context of drug and alcohol use were and also how this impacted on help seeking behaviour. They also reported on the current practice in services, identified gaps and came up with ideas as to what made a service culturally competent.

5.2.2.1 Who is using what substances?

In relation to age and generational substance use within minority ethnic groups, in particular South Asian communities, it was often referred to as a "family of substance use". For example:

> *"The generation of older males drink more alcohol, whilst the younger generation, particularly those born in Britain, are more likely to go out and take drugs with friends. Mums are left alone, are socially isolated and take antidepressants."*
>
> (South Asian community drug worker)

Some interviewees highlighted another issue of concern that was often hidden within the family. Women often experienced domestic violence through drug and alcohol use and history often repeated itself.

> *"Even if a woman managed to throw out her drunken husband, it is particularly painful for her to see similar behaviour in her son."*
>
> (Female South Asian community alcohol worker)

There were differing views about which substance was used by which culture. Members of different communities seemed to perceive the problems as being someone else's.

> *"We Muslims don't drink. It's the Sikhs who drink heavily."*
>
> (South Asian religious leader)

Most interviewees said that alcohol was used mainly by older Asian men and by Irish men and women of all generations. Heroin was said to be largely used by young Asian males, who mostly smoked, but an increasing number had also started to inject. Cannabis and crack cocaine were perceived to be used predominantly in black African-Caribbean communities. A general view was expressed that black African-Caribbean people would not inject drugs as this was against their cultural perceptions of acceptable drug use.

Staff in one drug service reported that several Iranian Muslims were coming for treatment but could not be identified by the ethnic monitoring as they would be

categorised in either 'other' or 'white other' ethnic group. Their drug of choice seemed to be opium. It is common in Iran to use opium as a health remedy and as such is widely tolerated. In Britain, opium is not as easily obtainable unlike heroin and many switch to this as their drug of choice.

> *"Their general perception is that they are addicted because of their physical health. They use opium for self medication."*
>
> (White British drug worker in drug service)

Khat, a legal mind-altering substance, is predominantly used by members of the Somalian or Ethiopian community. Whilst alcohol and illicit drugs are not tolerated within the Somali community, Khat is widely accepted.

> *"Back home Khat is traditionally used by middle aged men after the Friday prayer for their social contact on their work free day. There is no stigma attached to Khat. The family accepts if someone is chewing Khat. As long as the person looks after his family, everything is okay."*
>
> (Female Somali Community Mental Health Worker)

Some Somali community members highlighted problems with using Khat:

> *"We have many people in our community who have problems with housing and are homeless. If they chew Khat and can't sleep, don't eat and don't get a rest, this can bring serious mental problems for them*."
>
> (Somalian Community Mental Health Worker)

Others expressed concerns that because Khat was not recognised as a drug within the wider Somali community, they were unaware that the problems they suffered from were directly related to their use of Khat.

> "*We need the evidence on the damaging effect of Khat. Only when we can explain the damage Khat does to your body and mind, we might have a chance that they agree to stop using it. Otherwise we are helpless*."
>
> (Somalian Community Mental Health Worker)

Many respondents commented that it recently became apparent that an increasing number of young women in Ealing, mainly from South Asian backgrounds, were taking crack. Many of these young women were turning to prostitution in order to finance their habit and several had become pregnant. Shame and guilt prevented

them from seeking help within their own family or community. They remained hidden and may have no-one they could turn to for help.

The general perception of most interviewees was that more young people were using drugs and drinking alcohol and had experienced problems as a result. However, the majority of the interviewees seemed to be more concerned about drug use than alcohol. This may be because drinking alcohol, even if problematic, is seen by society as more acceptable than is the use of illegal drugs.

5.2.2.2 Underlying factors

When asked about what factors they thought influenced substance use, 90% of interviewees thought that the clash between traditional and Western culture had a huge impact on the reasons behind why people drank and took drugs. It was suggested that first generation immigrants may have used drugs and alcohol to overcome their isolation and anxiety, whilst young Asian or black people born in Britain drink or use drugs to fit in with their white British peers at school or work. Some members of the South Asian community pointed out that families often suffered conflicts because of their diverging views on tradition and the influence that Western culture had on the younger generation. Young South Asians going to school or university meet other cultures, make friends and change their social values. Many Asian girls do not want to be subservient, but wish to pursue a career, choose their friends and their husbands, smoke, drink, and experiment with drugs like their British friends.

However, most South Asian interviewees stressed that even if there are conflicts and arguments within families, the support system would still be in place in a situation of crisis. For example, if a family member is found to use drugs the family would stand by them and offer support.

> *"The lad can do what he wants, take drugs, and steal the family's jewellery. The family, especially the mum, will always stay to him."*
>
> (South Asian drug prevention worker)

5.2.2.3 Public image and private behaviour

Furthermore, it emerged from the interviews that the stigma and guilt associated with drug use and the pressure of keeping up appearances within the community had a huge impact on their ability to seek professional help. For example, respondents believed that it was often difficult to live up to the public image, especially when traditional values and beliefs disintegrated with the increasing influence of Western culture.

> *"It's a shame when your husband is drinking or if the son is taking drugs. It's your fault. Blame yourself!!"*
>
> (South-Asian community worker and mother)

Few respondents (5%) from South Asian backgrounds admitted that private behaviour, be it extra-marital affairs, drinking and/or taking drugs or domestic violence, would be accepted within the family, as long as no one from outside the family got to know about it. In the event of private behaviour becoming public, the family would be overcome by shame and guilt. As a result, these problems tended to remain behind closed-doors.

5.2.2.4 Perceptions of drug and alcohol use

The majority of respondents (90%) reported that several issues were vital to a family's perception of alcohol and drug use and to their knowledge of, and attitude to, treatment. These issues included lifestyle, family structure, religion and socio-economic backgrounds, their approach to problem solving and support given from within the family and/or community. Whilst Islam and Sikhism prohibited the consumption of alcohol, Hinduism tolerated, but did not encourage it. It was also thought to be culturally acceptable for male Sikhs and Hindus to drink.

> *"Sikh and Hindu bring about macho masculine behaviour. Drink alcohol to progress to being a man, a masculine man!"*
>
> (Male South Asian sexual health worker)

A common belief by interviewees was that adherence to religious and cultural taboos were slowly being eroded. One example given suggested that young South Asian women did not seem to care about the old taboos, all they wanted was to go out and enjoy life, just like their white British friends did. Nevertheless, they expressed that the influence of religion and culture remained strong and that its impact on the individual should not be underestimated. Breaking taboos and violating the rules and social conventions of one's own community was still seen as a source of guilt and shame.

Ten percent of the respondents referred to the role that religious or community leaders played in the context of drug and alcohol consumption. They felt that while some leaders understood the problems their community members were facing, others simply ignored the existence of drug and alcohol problems:

> *"Community leaders are often defending their race and do not admit that there are drugs and alcohol problems. But they need to see the reality of their people."*
>
> (South Asian drugs worker)

5.2.2.5 Consequences of drug and alcohol use for the family

The participants in the study agreed that drug and alcohol problems can cause pain within the family and that many lacked the experience upon how to deal with these problems.

> *"They ignore the problem for a long time. Then they see things are missing in the house, jewellery, money and other valuable things. Then they realise there is a problem."*
>
> (Male South Asian drug prevention worker about South Asian families)

Service providers and community leaders emphasised that the lack of knowledge and information about drug use, together with the stigma and guilt, could generate a high level of anxiety about drugs within the family. Many South Asian families decided to fund the drugs themselves because they were afraid that the drug user would be caught committing crimes to fund their drug habit. A drug user may not receive support and treatment, because families did not know where to go for help.

In their desperation, families often took drastic measures. Examples were given of South Asian families that locked the drug user in the bedroom to keep them away from the bad influence of friends. Others tried home detoxification via 'cold turkey' treatment, whereby the drug user suffered withdrawal symptoms without the support of medical treatment. These families acted in good faith and were unaware of the dangers of withdrawal without appropriate medical supervision.

Another frequently perceived solution that was mentioned involved South Asian families sending the drug user 'back home'.

> *"They hope to get them away from western influence, from drugs and their drug using friends."*
>
> (South Asian drug prevention worker)

Drug workers commonly found that Asian families often had a limited understanding of the complexity of drug dependence and that their treatment expectations were too high.

> *"Families try to get their kids in private detox. They pay up to £ 3,000 per week and think everything is fine afterwards. But things don't go like this. As soon as the kid is back, he gets addicted again."*
>
> (South Asian drug worker)

5.2.2.6 Current practice in services

Seventy percent of staff from a white British background admitted that they often felt uncomfortable because they were aware that clients from white and from minority ethnic backgrounds had different needs. However, they were not able to identify exactly what these needs were and did not feel competent in relating to the cultural issues of their clients.

> *"I am comfortable talking about drug issues with someone from a* minority ethnic group*, but when it comes to cultural issues then I feel I am sort of stuck, because I do not know exactly what it is what they need".*
>
> *(White drug worker)*

Twenty percent of staff stated that they treated all people equally, regardless of their cultural background, and 10% of staff said that they felt comfortable in dealing with clients from other cultures. These staff mainly came from minority ethnic backgrounds and said they were socialised within a multicultural environment.

A common view was that services needed to welcome and respect everybody, independent of culture and skin colour.

> *"Of course we need to be sensitive to needs and treat people with respect and basic humanity. But this is how you should treat any client. We need to get away from stereotyping and have to listen to the individual, their relatives and friends."*
>
> (White worker in an alcohol service)

Few respondents (8%) from minority ethnic backgrounds (drug workers and community members) questioned whether white people were able to work with clients from a 'black' background as they felt that only black workers were able to understand the underlying issues behind their drug use. Most (70%) respondents recognised that the problem went beyond a black and white issue, and referred to the lack of trust that existed between cultures. Some (30%) drug workers and community members suggested that clients from minority ethnic groups preferred to access ethnic specific services as they felt that their needs would be better understood. Others (20%) argued that clients would rather see someone from a different culture because of confidentiality concerns. However, the majority (75%) thought that patients should be able to choose where to go and that all drug workers needed to be able to work with clients from all cultures and backgrounds.

The three clients who were interviewed said that they were overall satisfied with the service they had received. They also said that they did not mind who treated them, as long as the person was respectful. The female South Asian service user pointed out that some South Asian female clients preferred to be seen by a female staff member. One male white British client suggested that probably black African and

black African Caribbean clients would not want to be seen by a white worker as they might not trust them.

Staff, community members and clients came up with a number of issues that they considered should be addressed when providing a service for clients from different cultural backgrounds. Community members felt that many staff did not have enough knowledge about other cultures, for example they did not know how to pronounce names, the meaning of titles, dietary requests, lifestyles, religious rules or dress codes. They also found that there was a lack of understanding upon the importance that religion played in influencing health behaviour and of the healing process. They feared that this could lead to assumptions and stereotypes. Furthermore, a considerable proportion of community members (70%) and also some drug workers (20%) argued that people from minority ethnic cultures may be reluctant to access what was perceived as 'white' services. Possible reasons mentioned were that clients felt that they were not respected, or understood, and that they mistrusted service providers from other cultural backgrounds. Another expressed that 'white' staff, who were not aware of cultural differences, may fail to recognise the client's needs. They may also have unwittingly offended the client or made mistakes due to misunderstandings and assumptions. However, there was widespread agreement amongst the participants that clients were probably more likely to approach a service when someone from a non-white British culture worked there. Even if the client chose not to be seen by someone from their own culture, a mixed cultured service would demonstrate openness towards other cultures. There was a general agreement that more staff from minority ethnic backgrounds were needed. Staff from minority ethnic backgrounds expressed their disappointment about the lack of support from colleagues and managers when addressing anti-discriminatory practice. They also highlighted that only few minority ethnic staff were in managerial positions.

Gender differences in treatment uptake were explained by references to cultural norms and restrictions. For example, a female client mentioned that societal stigma often made it difficult for women to admit that they had an alcohol or drug problem.

Respondents from the minority ethnic communities highlighted that women may be prohibited from leaving their homes without a male companion, or that they may not feel comfortable accessing mixed gender services. Furthermore, confidentiality was highly important. It was suggested that service providers needed to assure the clients that their service was a confidential and safe environment for women.

Staff in support services stressed that in general drug and alcohol services were designed to focus on the client rather than the family. However, they found that treating a drug user from a minority ethnic background often meant treating the whole family. Problems regarding confidentiality and conflicts of interest arose when families expressed an interest in becoming involved in the care of their drug and alcohol taking offspring. Conversely, they often felt that they were on their own in situations of crisis and had little support from services.

Language related problems were identified as the main issue in the service provision for clients from minority ethnic groups. These could lead to misunderstandings, misdiagnosis and prevent people from accessing services. Whilst most young British-born people were fluent in English, it was a particular problem for the first generation immigrants, especially females, many of whom were isolated in their home environment. Using a family or community member to interpret for them may produce confidentiality problems. However, the use of official interpreters could be problematic too if they were not familiar with the terminology of drug and alcohol treatment issues.

Interviewees frequently said that communication problems went beyond language issues. A breakdown in communication between services and communities was often due to drug worker's lack of confidence when dealing with someone from a different cultural background. Time pressure and a lack of cultural awareness were also contributing issues.

Service providers claimed that a lack of resources was the main reason why their agencies could not target minority ethnic groups. Some staff admitted that minority ethnic clients were often regarded as an additional burden on their overstretched workload as they needed more support and required more time during assessment and counselling.

5.2.2.7 What makes a service culturally competent?

Interviewees suggested a number of issues to make services culturally competent. These included an awareness of the cultural mix of the potential client group and the implementation of race equality policies and non-discriminatory practices. Also the concept of a culturally competent service should become the norm for working with all clients. A cultural needs assessment should be conducted routinely in order to match the service to an individual's particular needs. A cultural mix of staff in services would signal that a service was more open and accessible to the needs of minority ethnic groups.

Interviewees felt it was important that services made contact with the communities they worked with and recommended outreach work within the community and the training of peer educators as another means of making contact. Services should also demonstrate a philosophy of open-mindedness and work in partnership with the community to ensure cultural competence.

Training needs were identified to increase the staff's cultural knowledge and understanding of the underlying factors of substance use within different cultures. Skills need to be developed so that staff could identify and meet the needs of drug and alcohol problem users, and their families, from these population groups.

However, there was a common view that the development of culturally competent services was not just an educational issue. It was felt that education must go together with a range of structural adjustments and government policies that support

the development of culturally competent organisations and services. Examples given included: increased funding for drug and alcohol treatment was needed to reduce waiting times and to increase the capabilities of staff in order to reach out to the hidden population in need of services. Also, clients should have the choice of white, mixed-culture, or ethnic-specific services. Ethnic specific services may seem to be the service of choice for many black clients; however, they may become isolated services, who would then become vulnerable to closure in times of resource constraints.

5.2.3 Findings from the family anonymous focus group

The participants in the focus group estimated that approximately 30-40% of the families in Ealing of all ethnicities faced problems with their offspring's drug use. Yet, there were few local services that young drug users and their parents could access. Working parents could not attend those that existed as they were not open in the evenings. In the opinion of parents, the waiting times for accessing drug treatment were too long; there were only a limited number of rehabilitation centres, and the times between detoxification and rehabilitation were too long to be effective. Some families tried detoxification at home, but received no advice on how to deal with the withdrawal symptoms. It was commonly felt, that staff in services did not understand young people's cultural backgrounds. In particular, parents with South Asian backgrounds criticised staff for not understanding the importance the role that families play within their culture, such as the head of the family needed to be involved in decisions regarding treatment issues. These parents admitted that they found it upsetting to be excluded from the treatment because of confidentiality issues.

All participants agreed that the parents needed to be involved in the treatment of their drug using offspring. Parents needed help because they did not know how to give support nor did they know what treatment options where available. A significant number of parents (40%) reported that they had received little understanding or help

from their GP, whilst other parents (30%) felt that their GP had been very helpful. A further 20% admitted that they had been too ashamed or frightened to ask their GP for help.

> *"I thought that it would never happen to me and that my kids would never take drugs. I was wrong. I ignored it for too long because the thought of it was too frightened".*
>
> (South Asian mother of a drug using son and daughter)

> *"Sadly, I had to realise that covering up for my son's drug use only worsened the problem".*
>
> (Black Caribbean mother)

All participants in the focus group agreed that the Family Anonymous Group had been very useful. The group helped them to accept their offspring's drug problem and to understand that family conflicts were often important causal factors. The group also helped them to change their attitudes.

> *"Being in the Families Anonymous Group changed my attitude to my son's drug taking. I needed to accept that I can't solve the problem for him. No matter, if I lecture, moralise, blame or argue with him, whether he is stoned or sober, it does not help. It may make me feel better, but it makes the situation worse. Losing the temper with my son will destroy our relationship and any possibility of me helping him."*
>
> (South Asian father)

> "*My wife does not go to the meetings, which is sad. As a consequence she does not have the same attitude towards him as I have. She does not understand him and goes on arguing. But when he is not willing to stop using drugs we need to consider what we can do to avoid standing in the way of his recovery*".
>
> (South Asian father)

Finally, all participants expressed a feeling of relief when they met others who had similar experiences and problems. Talking to others in the group helped them to find more effective ways of coping and, at the same time, gave them hope for the future.

5.3 Discussion of the findings

The findings of this RNA (Luger, 2002; Luger *et al.*, 2005) concurred with that of prior studies (for example, Johnson & Carroll, 1995; Awaih *et al.*, 1992; Patel *et al.,* 1997). More local need assessments and more complex studies have been carried out since then, which produced similar findings (for example, Bashford *et al.,* 2003; Fountain *et al.,* 2003; NTA, 2003; Fountain, 2006).

5.3.1 Treatment uptake

The interviewees in this study stressed the seriousness of drug and alcohol problems in Ealing. Limitations in establishing the extent of drug problems as explored above (Ramsey *et al.*, 2001; Bradley *et al.*, 1999) were also experienced in this study. No previous local household population or school survey in the borough had been carried out. Comparing the treatment uptake figures proved problematic because the ethnicity categories varied between individual treatment centres. The ethnic categories were not detailed enough to be able to detect certain population groups at risk of problematic drug and alcohol use. Ethnicity as a factor on its own did not seem meaningful, as it did not take into account factors such as the socio-economic situation that may impact on the vulnerability of population groups towards drug and alcohol problems. These findings confirmed issues raised in prior studies in that ethnic categorisation did not embrace the diversity within ethnic groups (Bradby, 1995; Aspinall, 1998) and that ethnicity and socio-economic groupings cannot be treated as independent variables (Bradby, 2003; Nazroo, 2003).

The impression gained from the interviews showed that the extent of drug and alcohol problems was far higher than the treatment uptake data implied. Drug and alcohol problems existed in all ethnic, gender and age groups but remained hidden. Interviewees estimated that only a minority of those who needed help were in treatment. Reasons given for the low treatment uptake by people from minority ethnic groups included that they were unaware that they had a drug or alcohol

problem (Kahn & Ditton, 1999), or lack of knowledge of where to go to seek help (Johnson & Carroll, 1995; Sangster *et al.*, 2001; Fountain *et al.*, 2003). For example, the low treatment uptake by Somalians appeared to reflect a lack of awareness of the dangers of the drug Khat (Griffiths, 1998), but also lack of services with staff experienced in treating Khat-related problems. Further reasons given included perceived negative staff attitudes and mistrust in white services. This was confirmed by later studies (Fountain *et al.*, 2003; NTA, 2003) in that mistrust can be the result of many factors, including the views that services were not suitable for them, they experienced discrimination or prejudice, or a lack of understanding by staff.

Interviewees emphasised the role of the social network and the consequences of being ostracised from one's community (Hofstede, 2001; Westermeyer, 1999). Whilst the family can be a highly supportive structure, this support is linked to the acceptance and compliance of their family's rules and norms. Breaking these rules by substance use may result in isolation and losing this family network. This in turn could lead to increased substance use. Equally, feelings of guilt and shame could lead to more drug and alcohol consumption and prevent them from seeking help.

The study explored possible reasons that may either hinder or facilitate access to services. These included the proportion of minority ethnic groups within the local population; the level of cultural awareness of staff and the degree of staff-mix in the service; if the service offered treatment in the languages spoken within the community; and if the service was known within the community or by the referring GP. The stigma associated with drug and alcohol use may prevent people from accessing services, or cause them to access services in other boroughs in order to avoid meeting someone from their own community (NTA, 2003; Fountain *et al.*, 2003; Sangster *et al.*, 2001).

5.3.2 Cultural perception of drug and alcohol treatment

The burden of drug and alcohol problems often hit families very hard, particularly if they did not know what to do or where to go to get help. The well-meant practice by South Asian families of sending their drug-using offspring back to South Asia, in the hope that once they were away from their drug-taking friends they would become drug-free, is not often successful. Sometimes this had the opposite effect and they developed a heavier drug usage, because drugs, particularly heroin, were purer, cheaper and more easily available in South Asia than in Southall (Pearson and Patel, 1998). If they did return drug free then without proper after care support they could quickly revert back to their old habits. Similarly, the expensive private detoxification units frequently used by South Asian families had a low success rate.

Such practices reflected the families' perceptions of drug use and its treatment. They often underestimated the complexity of drug dependence. They wanted a quick fix to the problems and were unaware that detoxification was only the beginning of a long road to recovery. Such perceptions did not take into account that for a successful drug treatment to work the drug user needs to be self motivated. A drug user, brought to a service by his family and not on his own initiative, is more likely to lack motivation to get off drugs. It has been well documented that treatment without the client's motivation is likely to fail (Prochaska *et al.*, 1983; Miller *et al.*, 1980). Parallels can be drawn to the concepts of explanatory models (Kleinman, 1980) and cultural perceptions on treatment (Loustaunau *et al.*, 1997) as discussed in section 3.2.5.3.

The interviews emphasised that substance use was often a way of coping with life problems and until these problems are solved drug treatment may not be successful. Therefore, the underlying causes of problematic drug and alcohol use need to be taken into account to create an understanding of the social context that determined drug taking and help seeking behaviour. This included factors such as lifestyle, family structure, religion, socio-economic situation, adaptation to and conflict between differing cultural environments, social exclusion and support systems within

the family and community. They also involved families' and communities' views regarding substance use, their knowledge and attitude to treatment, confirming previous findings (Ramsey *et al.,* 2001; Bashford *et al.,* 2003; Orford *et al.*, 2004).

Equally, the interviews revealed the importance of protecting the family's public image. Thereby private behaviour (be it extra marital affairs, alcohol, drug taking or domestic violence) was often tolerated by South Asian families, as long as their community was not aware of it. There are similarities to Hofstede's (2001) concept of collective societies when he explained that such behaviour was part of the culture of a close-knit community and extended families.

5.3.3 Current practice in services

The study revealed that more than 2/3 of staff from white British backgrounds felt uncomfortable when working with clients from minority ethnic backgrounds. One fifth adopted a colour blind approach by treating everybody the same. Only one in ten felt confident and competent when working with clients from all cultures. Reasons given as to why so many staff felt uncomfortable were that staff was concerned about unwittingly making comments or asking questions that could be interpreted as racist or culturally insensitive. This uneasiness reflected a complex conglomerate of factors that affected the staff-client relationship, including mistrust from clients and misunderstandings between staff and clients. Mistrust from clients could be the result of cultural perceptions towards services, based either on their own negative experiences or those of others. Whether justified or not, they are likely to impact on treatment uptake and success.

Questions have been raised by community members and by staff from minority ethnic backgrounds as to whether white staff are able to work with clients from minority ethnic backgrounds. The underlying suggestion that staff from minority ethnic backgrounds are better suited to work with clients from other cultures is a reflection of uncritical cultural perceptions. It indicates an assumption that people

from minority ethnic backgrounds per se are more culturally competent and that minority ethnic groups are a homogeneous group, thereby ignoring the diversity between and within cultural groups (The Runnymede Trust, 2000; Loustaunau *et al.*, 1997). Such views are reminders of the previous confrontational training approach in which minority ethnic people could do no wrong. If uncontested, they are likely to reproduce stereotypes and thereby impede the development of a cross-cultural dialogue and of cultural competence.

Some people may feel more comfortable when being treated by someone from a similar cultural background, and ideally they should have the choice of where to go for treatment. Frequently this is not possible for reasons such as resource constraints or logistics. However, in a multicultural society it should be expected that all service staff are competent and confident to provide a high quality and professional service for all clients, independent of their cultural backgrounds. This is in line with Philleo *et al.*'s (1997) argument that in a globalised world, cultural competence, like computer literacy, is a necessity. Furthermore, a cultural mix of staff in services would be attractive to clients, not only because they may wish to see staff from their own culture; it also demonstrates a philosophy of openness. This would enable staff to become more culturally competent (Campinha-Bacote, 1999).

Service providers were commonly blamed for their lack of understanding of the cultural context of clients and of their cultural insensitivity towards clients' specific needs. Whilst some service providers acknowledged they lacked cultural knowledge when working with clients from other cultures, many others blamed their overstretched working conditions, lack of resources, and time and budget constraints as the main reasons for not targeting clients from other cultures. Others admitted that they sometimes perceived these clients as burden as they took up too much time. This issue was also highlighted by Geiger (2001) who argued that insensitivity towards people from other cultures did not happen because of racist attitudes but was caused by stress due to the complexity of the job.

One third of service staff did not want to accept the sole responsibility for shortcomings in the relationship with clients from other cultures. In their view, cultural competence could only be achieved if there was a mutual dialogue between cultures. If communities did not engage but kept to themselves the gap between cultures would increase. Staff's frustration about unsuccessful communication with clients and communities from other cultures has not been widely publicised. In today's climate people are anxious that they may be accused of racism and therefore this issue remains taboo. However, this sensitive point needs to be explored further.

Recommendations upon how to provide culturally competent services for clients from different cultural backgrounds included achieving a degree of cultural awareness in staff, the culture-mix of staff and solving communication problems between staff and clients or their families, as have been lengthily discussed in the literature (Johnson & Carroll, 1995; NTA, 2003; Fountain *et al.*, 2003; Sangster *et al.,* 2001; Bashford *et al.,* 2003). Furthermore, vital elements for the successful development of a culturally competent service were the awareness of the cultural mix of their client group and the implementation of race equality policies and non-discriminating practices, and employing more key workers and managers from minority ethnic groups. Suggestions for direct improvement of treatment for clients included routinely conducting a cultural needs assessment in order to tailor the service to the individual's particular needs. Further suggestions included, working in partnership with communities and training of peer educators within these communities.

The importance of cultural competence training for staff and managers was acknowledged, but it was also emphasised that training alone was not enough. Training needed to go together with structural adjustments and government policies that would support the development of culturally competent services for clients from all cultural and social backgrounds.

Conclusions

The key implications from the findings of this study for cultural competence training and service development are as follows: understanding the underlying factors of drug and alcohol problems within minority ethnic groups, as well as their cultural perception on the use of substances and treatment is crucial for the development of meaningful services. Developing the skills of staff to identify and deal appropriately with the needs of their diverse clients are vital elements for the development of culturally competent services. In addition, more importance needs to be given to working in partnership with communities and to the training of peer educators within these communities. Resources need to be made available in order to increase the capacity of treatment services. Furthermore, more key workers and managers from minority ethnic communities need to be employed.

The RNA also showed that education needed to go together with the implementation of recent government policies aimed at minimising inequalities and social exclusion. These included race equality policies, non-discriminatory practice and complying with the anti-discrimination laws.

Multi-cultural working requires workers to learn new skills and strategies to prepare the groundwork for culturally competent services. Diversity presents opportunities, but also challenges an individual's competencies. Structural adjustments to services may be required. Developing culturally competent services offers the opportunity to access communities and to make services more responsive to the population as a whole. However, the study strongly suggested that culturally competent services can only be developed within a mutually symbiotic partnership between the different cultures, characterised by trust, openness and mutual respect.

6. Development of the Cultural Competence Module

This chapter refers to cycles three and four within this action research study. The development of the module (cycle four) involved the integration of results from the first two cycles, the literature review and the RNA, into the learning outcomes and content of the module. Cycle four also entailed the incorporation of a teaching and learning strategy, which was undertaken as part of cycle three.

Firstly, this chapter will look at the process of developing this module, its structure, target group and learning outcomes, followed by the assessment strategy. Then, the theoretical concepts of critical theory and critical pedagogy that guided my teaching and learning approach will be detailed. Finally, the teaching and learning strategy that supports this module will be discussed.

6.1 Development of the module

6.1.1 General information about the module

This undergraduate educational module is based within the Dip/BSc (Hons) Substance Use and Misuse Studies at TVU. Few universities offer educational awards in the area of drugs and alcohol. TVU, which supports widening participation in Higher Education as a contribution to achieving equality and social justice, acknowledged the gap in education within this sector and supported this module development.

The module has been designed so that it can be studied as part of the Diploma/BSc Substance Use and Misuse Studies or as a stand-alone module. It is credit-rated with 20 academic credits at either diploma or degree level[29] and consists of seven study days, delivered one day a week over seven weeks. Study days 1-6 each cover

[29] It is common procedure on the Substance Use and Misuse Programme to teach the modules simultaneously at diploma and degree level. While the content is the same, only the learning outcomes and the assessment questions differ in the depth of critical analysis expected.

a specific subject area; study day seven is dedicated to the summary of the key concepts, advice on assignment writing and evaluation of the module.

6.1.2 Curriculum development

The development of the module was based on theory and research. Critical educational theory and social constructivism inspired the theoretical framework of the teaching and learning strategy. Research suggested that an educational module could be useful and valid to increase the knowledge and change the behaviour of staff in drug and alcohol services. A literature review and RNA were conducted to ensure that the content and the learning outcomes of the module were relevant to the professional requirements in the drug and alcohol field and met the training needs of the workforce. Research also identified the target group of the module, the relevant learning material and their training needs.

A steering group[30] guided the research and the curriculum development. Their input ensured that the curriculum was targeted at the appropriate professional groups in a relevant manner. The involvement of my university colleagues was to ensure the quality of the module documentation for validation and of strategies regarding the teaching delivery, student support and assessment criteria. Whilst involvement of learners in the curriculum development was limited[31], they were able to influence the content and delivery through ongoing module evaluation.

6.1.3 Target group

The module is targeted at drug and alcohol professionals working with people from different ethnic and cultural backgrounds. Substance use related work takes place in a wide range of organisations, for example in schools, youth clubs, GP surgeries, Mental Health organisations, NHS Emergency Departments (EDs), maternity units,

[30] The composition of the steering group is outlined in more detail in section 1.4.
[31] They were only indirectly involved as representatives of service staff when interviewed for the RNA

prisons and youth offending institutions, probation services, police custodial suites, Social Services, hostels, streets, and specialist drug and alcohol services. The degree of their involvement in substance use work and their roles and responsibilities vary. Some staff may only occasionally meet a problematic drug and alcohol user. Others deal with a significant number of substance users (for example, hostel workers in a 'wet' hostel). Others are substance use specialists who offer expert advice daily, carrying out assessments or providing a full range of treatments and interventions.

The diversity of the field is reflected in the student group who attends the Substance Use and Misuse Studies programme. They are aged between 25 and 55 and come from diverse cultural and social backgrounds. The gender ratio is approximately 60:40 women to men; the ethnic ratio is 60:40 minority ethnic to white British background. The high proportion of students from minority ethnic backgrounds reflects the ethnic distribution of the workforce in the drug and alcohol sector within Greater London.

The student group was diverse. Some were highly motivated and chose to attend the course for their personal and professional development. Others had been sent by their employers and some were looking forward to a break from their daily working routine. Students also differed in their learning ability and their familiarity with the process of academic study. The fact that the participants were mature students and had come from diverse educational, professional, cultural and social backgrounds had relevance to the choice of teaching and learning approach.

The complex demands on the drug and alcohol sector require a collaborative and multidisciplinary approach to substance use problems (NTA, 2006). The module was therefore designed as a multidisciplinary course to reflect the diversity of the field and to provide multidisciplinary responses to complex problems. The teaching and learning approach was planned accordingly to ensure that participants could learn from each others' professional experiences.

6.1.4 The aims of the module

Overall, the module sought to enhance cultural competence by developing knowledge and understanding of the underlying factors behind drug and alcohol use and help-seeking behaviour amongst different cultures. Another aim was to develop culturally competent skills in assessment and intervention in order to implement culturally congruent services and to inform policy making.

6.1.5 The learning outcomes and content of the module

Learning outcomes are a statement of the knowledge, skills and understanding that students are expected to have acquired and refined for proficient practice by the end of the module. The module has six learning outcomes, taught over the course of six study days. The content of each study day was built upon the others. The learning outcomes and the content of the teaching sessions are detailed below. A copy of the module study guide can be found in Appendix 8.

1. Develop and critically reflect upon culturally competent skills in assessment and intervention.

The literature review and the RNA highlighted the need for cultural competence in order to make health and social care services accessible and meaningful to all population groups. The first study day was dedicated to a reflection on the concepts of culture and cultural competence and their implementation in practice.

Firstly, the participants were made aware of the need for cultural competence. Examples of culturally insensitive behaviour and stereotypical attitudes of staff in services were analysed. The possible reasons behind such behaviours were explored, including racism, insensitivity, indifference, or because of time and resource constraints at work (Geiger, 2001). Discussions on the impact of such behaviour on the relationship between staff and patients and on treatment uptake

and outcomes were initiated to create an understanding of the need for staff to become culturally competent.

The main drivers for cultural competence, such as the Macpherson report, the Race Relations (Amendment) Act 2000 (RR(A)A 2000) and other antidiscrimination laws, policies and professional guidelines, such as the NHS plan (DH 2000), Tackling Drugs Together (DH 1998) and the NHS Knowledge and Skills Framework (DH 2004), were introduced and their relevance to cultural competence in practice was discussed.

For a better understanding of cultural competence, the concept of culture and its relationship to ethnicity, race, religion and gender was explored. Various models (for example, Hofstede's (2001) concept of human mental programming or Kai *et al*.'s (1999) iceberg model of cultural diversity) were presented to explain the concepts of culture and cultural diversity. A reflective exercise on the participants' own cultural identity was undertaken. This was vital to be able to understand other people's cultures, and to become aware of one's own biases and prejudices. The aim was to create an understanding of the importance culture can have on individual values and behaviour, the wide variety of values, beliefs and lifestyles and the need to respect them within the context and norms of what is considered legitimate and ethical.

The purpose of this session was to create a critical understanding of the concept of culture in the widest sense that is determined by countless factors such as societal status, age, gender, ethnicity, education, socio-economic situation, cultural philosophy and power hierarchy. The understanding of cultural diversity within communities is essential in the clinical encounter to fully assess the clients' cultural and social context.

The concept of cultural competence assumes that action is required, rather than knowledge alone, to achieve a change in attitude and behaviour. Particular attention was therefore given to skills that are required to carry out a culturally competent assessment and to provide a culturally safe service environment with the aim of

achieving successful treatment outcomes. Participants were encouraged to reflect on their professional practice, to develop a non-judgemental, culturally sensitive approach to bring about a self-awareness of attitudes towards clients, to challenge attitudes and to develop skills in cross-cultural communication. The phenomena of institutional racism and internalised racism were examined and factors such as cultural adaptation, integration or assimilation and social exclusion were debated with the aim of creating an understanding of their impact on the lives of minority groups.

Various models of cultural competence were introduced (Campinha-Bacote, 1998; Giger and Davidhizar, 1999, Ramsden, 1990; Papadopoulos *et al.*, 2002) and their usefulness for practice was scrutinised.

2. Critically analyse and evaluate the patterns and trends of drug and alcohol use amongst people of different cultures and ethnic backgrounds.

The review of the literature established that epidemiological data on ethnic differences in drug and alcohol use are important to indicate problematic substance use in particular population groups and can help to target services. However, a number of limitations have been highlighted in the attempt to establish the extent of drug and alcohol problems in minority ethnic groups. Study day two was assigned to critically analyse information on patterns and trends of substance use amongst people of different cultures and ethnic backgrounds.

The findings of large scale national surveys, such as the BCS[32], peer-reviewed prevalence research and local needs assessments were presented and their methodology and data collection was scrutinised to assess whether their findings were reliable to give a realistic picture of substance use. The aim of this exercise was to develop a critical understanding towards possible methodological flaws in research and the need to be cautious when interpreting data.

[32] British Crime Survey, see also section 4.1

In order to develop an understanding of the relevance of ethnic monitoring, the participants were asked to develop a profile of their client group in terms of ethnicity, age, gender and drug of choice. These profiles were presented, discussed and mapped against the local census data to see whether treatment uptake matched the ethnic and gender distribution in the local area. The aim of this exercise was to establish the practice of ethnic monitoring in the participants' workplace and how data was put to use in service planning and delivery.

Selected studies were critically analysed (for example, Orford et al., 2004; Cochrane et al., 1990; NTA 2003) and a debate was encouraged as to whether a pattern of substance use in particular population groups, in terms of gender, age and ethnic group, could be recognised. The purpose of this activity was to establish the fact that substances were used by all ethnic groups, ages and genders and that generalisation of drug use and drinking contributed to stereotyping, rather than reproducing a true picture of use.

A group activity to identify population groups that are most vulnerable and at risk of drug use aimed to draw attention to the link between socio-economic backgrounds and problematic drug use (Ramsey *et al.*, 2001; Lloyd, 1998). Many people from minority ethnic backgrounds, due to social exclusion or their socio-economic situation, are amongst them. The purpose of this debate was to create an understanding that the risk factor was not ethnicity but social context. This led to a wider debate on the use of ethnic categorisation in monitoring and research to highlight limitations and dangers because of an assumed homogeneity (Bhopal, 2007; Chaturvedi, 2001; Aspinall, 1998).

3. Identify and discuss the underlying factors within the cultural context of the drug and alcohol use as it impacts on help-seeking behaviour.

Research identified a wide range of factors that can influence people's attitudes, behaviours and lifestyle choices (Henley *et al*., 1999; Hofstede, 2001). Equally, many factors can directly or indirectly contribute to substance misuse problems

(Parker *et al.,* 1998). Studies highlighted that staff in health and social care services lacked knowledge of other cultures and the impact that culture had on people's values and behaviour (Johnson & Carroll, 1995; Fountain *et al.,* 2003). Study day three focused on the impact of culture on health, health behaviour and health beliefs and drew links to substance use.

The underlying factors of drug and alcohol use were explored by looking at evidence from studies on a range of selected issues, including religion, philosophy, gender, age, socio-economic status or migration history. In order to create a critical understanding of the importance the social and cultural context can have on drinking and drug taking and how this could influence their help-seeking behaviour, relevant case studies were explored from a variety of view points, including anthropological, sociological and psychological disciplines.

Theories of help-seeking behaviour were critically evaluated and then applied to case studies. Factors that may inhibit help-seeking behaviour were explored with a view to enhancing participants' awareness and knowledge of the stigma of drug and alcohol use within the community and family. Also explored were stereotypical attitudes of staff and other possible barriers to services. Particular attention was paid to the possible problems in the clinical encounter due to communication problems and negative attitudes of staff. In order to enhance the participants' communication skills, videos that presented examples of poor communication practice were analysed as to what comprises culturally competent communication skills. Staff-client relationships and the attitude of staff towards difficult/non-conforming patients were examined from a culture-specific perspective. Participants were asked to critically reflect on their own working practice. Possible solutions were explored in order to improve the relationship between practitioner and client.

Research has identified the influence that cultural perceptions about the causes of health problems have on treatment uptake (MacLachlan, 1997). Literature revealed a strong relationship between cultural perception of substance use and help-seeking behaviour. The perception of use as normal or unacceptable impacts on whether the

substance is used openly or not and is directly related to an individual's willingness to seek, and their expectations of, treatment (Helman, 2007). In order to create an understanding of different cultural perceptions of the recognition of illness by clients and staff (Henley et al., 1999; Loustaunau *et al.,* 1997), theoretical concepts of health and illness (Helman, 2007; Kleinman, 1980) were analysed and applied to the practice of substance use treatment.

4. Critically evaluate theoretical models of risk and health behaviour in relation to cultural differences and social inequalities.

The literature review showed that risk perceptions varied and were influenced by social and cultural contexts. These different perceptions were likely to have had an impact on how risks are perceived and how risk assessments are conducted. On study day four theoretical concepts of risk and health behaviour were evaluated in relation to diversity, cultural differences and social and health inequalities. These included the health belief model (HBM) (Rosenstock, 1974), the problem behaviour theory (Jessor and Jessor, 1977; Newcombe, 1995) and health promotion models. The usefulness and limitations of these theoretical models were investigated to clarify what is a culturally acceptable or unacceptable risk.

In order to understand the complexity of risk behaviour and behaviour change, the participants were requested to review the social and cultural context of case studies to identify risk behaviours and protective factors for problematic substance use. Models of cultural risk or protective factors for substance use (Westermeyer, 1995; Vega *et al.,* 1998) were explored and their usefulness debated.

As cultural perception of risk is strongly related to help-seeking behaviour, participants considered factors that inhibit help-seeking behaviour. Although many of these issues may also affect the white British mainstream population, staff need to be able to recognise particular lifestyle features among minority groups that increase stress and vulnerability, leading to risky substance using behaviour.

Theoretical models of adherence and compliance were investigated with the aim of recognising cultural factors that impact on adherence and non-adherence (Barland *et al*., 2001). Participants reflected on their own practice to critically understand how adherence is greatly influenced by the quality of the relationship between staff and client. This relationship, and what may enhance it, was debated. The importance of establishing good communications with the client and of empowerment of clients was highlighted, acknowledging that the most effective care is client-centred care.

5. Explore issues with respect to stigma, psychological and mental health in relation to substance use and misuse, ethnicity and culture, and consider the implications on practice.

Research highlighted the strong link between negative cultural perceptions and societal stigma, which impact on help-seeking behaviour (NIMHE, 2003; Bughra *et al.,* 1999). Study day five explored issues regarding stigma and mental health in relation to substance use from a cultural perspective. Understanding the cultural influence on mental illness (Fernando, 2008; Bhui *et al*., 1999) is significant considering the high rate of drug and alcohol users with co-morbidities.

The concepts of previous sessions were expanded towards cultural perceptions of mental illness. The participants were encouraged to explore research evidence, and their own experiences, to see if there were cultural perception or treatment differences of the mentally ill. The focus was also on how people with a mental illness from different cultures were treated in the UK. Reflective activities were used to explore the degree to which health care professionals were influenced by negative societal perceptions on mental illness and the impact such perceptions can have on their own attitude towards the clients. The nature of stereotypes was critically explored to create a critical understanding of the influence of assumptions and prejudices. Their role in accessing services, diagnosing mental illness and communication between staff and clients were examined. Reflective group exercises encouraged participants to examine their own possible stereotypical and prejudiced attitudes.

Research evidence highlighting failures and gaps in service provision (NIMHE, 2003; Bhugra *et al.,* 1999) was critically analysed. This supported reflection on the practice of services, recognise the impact of cultural insensitivity or institutional racism on treatment outcomes and discuss the challenges that lie ahead for the NHS in providing culturally responsive mental health care.

6. Critically analyse policy development and the implementation of governmental policy at local, regional, national and international level.

The findings of this research highlighted that staff in services were either poorly informed about the relevant equality policies or that these policies were poorly implemented by organisations. On study day six the implementation of governmental policies at local, regional, national and international level was analysed and practice was scrutinised in relation to outcomes.

Reflective exercises were introduced to enable an understanding of the impact and implementation of various kinds of discrimination and institutional racism. Participants were asked to scrutinise the implementation of relevant policies (DH, 2000; DH, 1998; DH, 2004; HO, 2000) in their workplace to find out how successfully they were used.

Building on the knowledge gained on the previous study days the participants were asked to identify possible gaps and barriers in their workplace and to develop recommendations as to how to achieve cultural competence in their workplace and organisation.

Cultural competence is achieved not only by improving the staff-client relationship, but also by improving working relationships between colleagues from different cultural backgrounds. Reflection on common dilemmas when working with colleagues from another culture aimed to explore attitudes that impact on the relationship between colleagues and impede the smooth running of the service. These included different time concepts, different ways of working, cultural

misunderstandings, nepotism, group building, discriminatory jokes of colleagues and so on.

The participants were also asked to consider what barriers they may encounter in introducing changes in their workplace and how these could be overcome. They were also asked to reflect on what individuals and organisations could do to achieve a culture of equality and diversity in the workplace.

Finally, in preparation for the module assignment the participants were asked to apply a model of cultural competence to a chosen case study and to carry out a culturally competent assessment. This assignment enabled the participants to demonstrate their cultural knowledge, understanding and skills that they have gained from the course. The activity also enabled them to demonstrate critical appreciation and application of a range of culturally competent skills. These included verbal and non-verbal communication, interpersonal skills, the ability to collect culturally relevant information about the clients' risk behaviour and underlying factors, and being able to develop strategies in order to improve the service for all clients.

To summarise, the findings of the literature and RNA enabled the research-based framework for the content of the module and as such provided the key threads of the course learning outcomes and content. Ongoing evaluation and further research were undertaken to ensure that the content remained highly relevant for the participants' workplace and met their personal and professional training needs. From the beginning of the study this approach was subject to evaluation using robust methodologies, as will be shown later.

6.1.6 Assessment Strategy

The purpose of the assessment strategy for this module was to enable the participants to demonstrate their knowledge, critical reflection and cultural competence regarding the learning outcomes. The module aimed to equip them with

an analytical, reflective appreciation and problem solving skills that are essential tools in the treatment of problematic substance use in people from other cultures. As the students were adult learners an assessment was used that was more suitable to adult learning than an examination. The students had to write a 3,000 words essay in their own time with clear guidelines and tutor support.

The assignment was to design a culturally competent assessment, based on a case study, with the aim of providing recommendations for culturally congruent treatment. The students had to show cultural competence. This was achieved not only through demonstrating their knowledge on the theoretical concepts of the course, but also their skills in problem solving, communication and providing culturally sensitive care by reflecting on the practice of the case study.

The assignment was designed to provide students with the opportunity to demonstrate whether key concepts had been understood and their ability to apply them to professional practice. The assessment was intended to become a focus of learning because it was not only about demonstrating whether the learning outcomes had been fulfilled, but was also about learning through the process of writing the assessment.

The assignment questions had been mapped to the learning outcomes and guided the learner to achieving them. Although the content of teaching was the same for both study levels, the learning outcomes and assessment questions differed as a greater depth of critical analysis was expected for degree level, focusing on the macro (societal) rather than the micro level of service provision.

6.2 Underlying Philosophy: Critical Theory and Critical Pedagogy

The teaching and learning philosophy applied in developing this module was influenced by critical theory and critical pedagogy. The rationale for this is because both strive for social change, according to the methodological framework in this thesis. I chose this approach because of my own learning and work experience which had been influenced by critical pedagogy[33].

Critical theory goes back to the tradition of thought within the Frankfurt School of Philosophy and Social Theory in the late 1920s and 1930s, which was revived in the 1960s - 1970s by Jürgen Habermas. By critically revisiting Marx's idea of liberation from 'false consciousness', critical theory involved a critique of ideology and of what was being taken for granted (Blake *et al.,* 2003).

Similar to the concept of action research, which has been influenced and developed further by different schools of thought, there is no single critical theory. There are many different concepts, but some common motives and a principal theoretical interest can be identified. This entails a strong ethical concern for the individual and the rejection of injustice, humiliation or domination (Blake *et al.,* 2003). Critical theory strives for a society that is based on equality and democracy for all its members. Its purpose is not merely to understand situations and their underlying factors, but to change them. As such it seeks to emancipate the disempowered, to eradicate inequality and to promote individual freedom within a democratic society (Cohen *et al.,* 2007). The concept of critical theory refers both to a school of thought and a process of critique (Darder *et al.,* 2003).

The principles of critical theory are congruent with educational theory and the values of education for adults that have a long tradition in Germany (Olbrich, 2001). But, the

[33] This was in the 1980s when I studied Adult Education at the Free University Berlin with professors influenced by the ideas of Habermas and Horkheimer, and later while working in Central America in literacy campaigns with Salvadorian refugees and with Nicaraguan traditional midwives and health educators (Luger 1984, 1990). Our teaching practice drew on the concepts of critical pedagogy and Freire's (1972) ideas.

relevance of critical theory for education was not recognised before the 1960s. Educational theory in Germany, influenced by the moral thinking of the philosopher Kant and the era of enlightenment, informed not only progressive elements within society but also traditional education. Education has to be seen in the wider context of what the Germans call 'Bildung'. While 'Halb-Bildung' merely made people competent and fit for the existing social order, 'Bildung' meant to equip them to question that order radically (Blake *et al.,* 2003). The terms 'education' and 'learning' often refer to the transmission of knowledge and instruction, but 'Bildung' means developing the person's personality and autonomy. As such, 'Bildung' is a lifelong development process of personal and social competences, in which the person enhances his/her mental, cultural and practical abilities so as to cope with the events of life.

Habermas played a crucial role in the reinstatement of critical theory in the 1960s and 1970s by putting it into the practice of critical pedagogy (Habermas, 1972) with the aims of emancipation, self-determination, critique of ideology and analysis of communicative interaction. The goals of critical pedagogies were taken up by Freire (1972) and later by authors such as Giroux (1992) and McLaren (1991), who both looked at critical pedagogy from a post-modern perspective. Freire is considered by many to be the most influential educational philosopher in the development of critical pedagogy. His concept of emancipatory education involved questioning power, culture and oppression, and this widely influenced post-colonial theory, ethnic and cultural studies, and adult education. For Freire, the role of the educator is to challenge people's awareness of their social situation by encouraging a dialogue and critical attitude towards it. Freire also aimed to create a teacher-learner relationship that assumed equality, recognising the learner's knowledge and experience, and that the best way to enhance knowledge was to build on it.

This is in line with other concepts of critical pedagogies that challenge conventional teaching where the focus is on dissemination of predefined knowledge whereby the teacher has the knowledge and the student is the recipient of that new knowledge. In

this process the teacher upholds existing social structures and cultural/political worldviews of social groups by internalising dominant values about society that are blind to gender or other differences. Critical pedagogies believe that conventional teaching perpetuates false consciousness and hegemony which diminishes people's ability to recognise that they are being manipulated into accepting their oppression (Preece *et al.,* 2002). The subtleness and effectiveness of the system of social control, where ideological conventions and imperatives are internalised by the individual, and the role socialisation has to uphold it, have been discussed above in section 3.2, Concept of Culture (Foucault, 1977; Martin, 2003).

It has been argued that in a post-modern society the aims of critical pedagogies are changing and increasingly critical pedagogy is constructed against the background of globalisation. Preece *et al.,* (2002) pointed to a shift in focus from politics to critical consciousness or a concept of social inclusion, but argued that the issue of power and hegemony still remained an important issue of analysis. The changes also implied that the focus changed from an exclusively political or ideological position towards more critical reflection of learning, and that critical pedagogy, which once emphasised the importance of unity and common action, can be both individualistic or collective (Jarvis, 2002). This shift in focus has also taken place in action research and is reflected in the different schools of thought that distinguish between individual critical reflection and radical collective activity to empower people (Kemmis, 1997).

According to Blake *et al.* (2003), current concepts of critical theory have lost their critical potential, and critical pedagogy seems to have contributed to the immunisation of society against critique by making critique a standard component of education within the given order. McLaren (2002, 2003) claimed that the principles of critical pedagogy had been diluted by being over-psychologised, liberalised and technocratic. He found that its concept was so "post-modern" that hardly any link remained with liberation struggles. In his view, critical pedagogy has collapsed into self-satisfied relativism leading to a superficial friendliness and an insincere feel-good curriculum. Giroux (2003) highlighted the need to move beyond a purely post-

modern discourse that affirms difference without exploring the power relationships that comprise difference and domination with regards to gender, race, class and ethnicity.

These arguments raise the question whether critical theory still matters today and if an educational module based on the philosophy of critical theory and critical pedagogy is still relevant and effective in achieving social change. This question will be taken up later when the effectiveness of this module's educational approach is discussed.

6.2.1 Application of the underlying philosophy to the module

The educational approach for this module was guided by the view that critical thinking is important and can be supported by a critical educational approach. This study sought to evaluate this. My own view, from analysing the literature and from personal experience, is that critical thinking is vital for an independent individual to make informed choices in a democratic society. Without critical thinking, people are easier to manipulate, politically, economically and socially; societal and individual progression and personal growth would be limited. Furthermore, the importance of the political character of pedagogy practice has to be acknowledged, which requires analysing conflicts that arise from differences in power and influence, be it because of class, socio-economic situation, gender or ethnicity.

Guided by the literature, this thesis supports the view that critical education has an important role to play in the development of personality and of an individual's social and personal competencies that enable them to cope with the events of life. Consequently, the educator's role in this process is to challenge people's awareness of the social situation and equip them to make positive changes. Also the role of critical education is to empower students into becoming self-confident critical thinkers who not only understand situations of social injustice and inequalities, but

are also in a position to change them. Students need support in order to develop the necessary courage and skills to accomplish this.

The achievement of these underlying principles requires a supporting Teaching and Learning Strategy, which will be outlined in the following section.

During this module, the participants were encouraged to critically examine concepts and theories in order to make sense of them and to integrate this knowledge into their practice. They were asked to critically reflect on their practice and to make evidence-based recommendations to improve the provision of cultural competency in practice. The reason behind this approach was that theoretical understanding is important, but critical reflection is even more important in considering the overall picture, including the wider social and political aspects of a situation. Participants were asked to critically reflect on practice by looking beyond what is taken for granted. Such an approach enabled them to recognise overt or subtle manners of discrimination, stigmatisation, situations of inequality and social injustice, in the use of language or non-verbal communication reflecting the negative attitude of professionals, and to relate these to the moral and political context of their professional practice (Thompson *et al.,* 2008).

A further important element of the teaching approach is that participants are made aware that a non-reflective approach, such as working without considering one's own actions, or the impact of such working practices of colleagues within the organisation, may be disempowering (Thompson *et al*., 2008). They may do more harm than good and disempower by undermining someone's confidence and reinforcing stereotypes and structural inequalities.

The educational approach used in this module sought to provide participants with the skills of critical reflection in order to recognise discriminatory practice. At the same time it enables them to develop the skills of how to change situations of

discrimination and social injustice and to put these into practice. This includes challenging the attitudes and discriminatory practice of colleagues and managers and implementing changes in their own practice, or that of the organisation, that can make the service more culturally competent.

6.3 Teaching and Learning Strategy

The teaching and learning strategy underpinning this module is based on the social constructivist model of learning. Constructivism stresses the importance of existing knowledge, beliefs and skills that an individual brings to the experience of learning, because it sees the construction of new understanding as a combination of prior learning, new information and a readiness to learn (Epstein, 2002). The principles of learning in constructivist theory propose that learning is an active process in which learners construct meaning. They learn as part of a continuous process, which is seen as a social activity that forms part of the interaction with teachers, peers, family and the context in which it occurs. Learning is not possible without prior knowledge as it builds on existing knowledge. This process may take a long time and the key component to learning is motivation (Epstein, 2002).

The theory of social constructivism was developed by Lev Vygotsky. Unlike cognitive constructivism[34], in which learners are taught to construct their knowledge through experience and the role of the teacher is to stand by and encourage the process, teachers in social constructivism actively guide students as they approach problems, encourage them to work together in groups to think about possible solutions, and support them with both encouragement and advice. Students learn through interacting with their peers, their teacher and their contextual setting. The teacher facilitates the learning process by providing opportunities that encourage and support the process of understanding, by monitoring the student's progress and guiding them. The teacher must be able to motivate students and take responsibility for creating problem situations. The teacher's role is also to retrieve prior knowledge and create a social environment that enables learning. The primary focus is on the process of learning rather than the end product. Constructivist teaching is characterised by mutual respect between teacher and student. Students are encouraged to form their own opinions and ideas and teachers refrain from using

[34] Based on Piaget's theory of cognitive constructivism and cognitive development.

their power. Decision making is shared by everyone in the classroom (Kim, 2001; Atherton, 2005; Epstein, 2002).

The teaching and learning strategy based on social constructivism complements well the aims of critical theory and critical pedagogy. Both concepts seek to empower the students to autonomy and self-determination, to independent learning and to critical analysis of their social context. How far social change can be achieved by means of this teaching and learning strategy will be explored as subject of this thesis.

6.3.1 Rationale for Learning Methods and Teaching and Learning Styles as applied in this module

'Tell me and I'll forget, show me and I may remember, involve me and I'll understand.' (Chinese proverb, cited in Hart *et al.,* 1995)

It has been argued that the societal changes in a postmodernist and globalised world have impacted on the nature of knowledge, and as a result on the nature of teaching (Jarvis, 2002). The availability of multiple sources of information, for example the internet, has led to the situation that teachers can no longer assume that they are the only source of knowledge and that their learners know nothing about the subject. Also, in a time of continual change, teachers cannot continue to teach unchanging information. Instead they must constantly update their knowledge to retain their credibility. For this reason, the research-based content of the module was constantly updated to take account of the latest developments and debates in the fields of substance use and cultural competence. As adult learners bring knowledge to the course it was important to take learner's prior knowledge into account and to build on it. In addition, the students were encouraged to seek relevant information from articles, websites or books and to share them with the class. To enhance learning, the students were encouraged to critically reflect on the theoretical concepts and to relate them to the practice of their workplace. By doing so their learning was

enhanced as they had to make sense of the theoretical knowledge and apply it to their working experience (Thompson *et al.,* 2008).

As a consequence of the changes in teaching, the purpose of teaching has changed from transmitting knowledge to facilitating a process of learning and critical reflection. These changes go together with changes in the roles of both teacher and student, changes in their relationship and in the student's expectations. This requires different skills from the teacher. In particular, adult students are more likely to question the teacher if they feel they are being patronised, if the teacher is not knowledgeable, or if they feel they are wasting their time because the learning session does not meet their learning needs (Jarvis, 2002). When teaching is about helping others to learn then the teacher has an important role to play. The teacher's style, whether friendly or distant, humorous or withdrawn, has an important influence on the learning atmosphere and the process of learning. Teaching methods and teaching styles need to be adapted to the needs of the learners, to maximise their learning experience. However, while teaching methods refer to the technical process of teaching, teaching styles refer to the teacher's behaviour (Jarvis, 2002). My own teaching style aims to be friendly, approachable, flexible, committed, open-minded and sincere, motivating and encouraging. The aim was to achieve a relationship between the students and the teacher that was built upon mutual respect, trust and a caring attitude. With these attributes, I aimed to create a positive learning environment that breaks down learning barriers and stimulates the personal and professional development of the participants.

Creating a positive learning environment is important. Students need to feel they are at the right place, feel understood, supported and fairly treated by their teacher (Castling, 1996). Important ways to do that are identifying the learner's needs and creating a good working relationship with the learners. A questionnaire was used at the beginning of the module to establish the participant's prior knowledge, identifying both learning and special needs. This was followed by an exercise to explore their expectations and anxieties of the module. This exercise helped to find out about the

students' motivation and learning styles. Also, ground rules were developed at the beginning of the module to negotiate a code of conduct for the group, which were important tools to establish confidentiality and a sense of trust within the group.

An effort was made in the teaching of the module to develop a good relationship between the teacher and the students to enhance the learning process. Palmer (1998) claimed that good teachers possess a capacity for '*connectedness*'. They weave a complex web of connections between themselves, their subjects and their students. This connectedness is not made by the teachers' methods but by their hearts. Palmer also claimed that good teaching comes from the identity and integrity of the teacher. Both can only be gained through a lifelong process of self-discovery. Similarly, Goeudevert (2004) referred to a concept of '*contentedness*' when he emphasised the importance of affection in the relationship between the teacher and the student. Goeudevert argued that students who liked their teacher did better than if they disliked him or her. He claimed that the capacity of the brain was increased by affection, which could be expressed through a friendly word, an encouraging smile, praise or appreciation, and constructive criticism rather than punishment, disapproval or rejection.

The concern for others should be self-evident in the teaching methods, the teaching style adopted and the way the teacher relates to all students as people. This raises an important point as this relationship may be responsible as to whether the students identify themselves as failures or successful learners. If the teacher assumes that their student will be successful they are likely to be successful (Jarvis, 2002). This highlights the vital importance of the conduct of the teacher towards the students and the responsibility which is involved in teaching, assessing and feedback. For example, a negative critique or a sloppy remark by the teacher concerning the student's performance can be a haunting experience for life, undermining a student's self-confidence in their learning abilities. Therefore, my emphasis as the teacher was to show concern, support and fairness to all students in the class and to avoid

favouritism or carelessness in feedback. Instead, constructive feedback was given throughout that aimed to encourage and motivate learning.

A number of authors have commented on teaching and learning styles that may be suitable to cultural competence training. Concerns about previous anti-racism training that was criticised as doing more harm than good (Taylor *et al.,* 1998; Alibhai-Brown, 2000) led to a debate over which training approach was most suitable to achieve behavioural change. Some teachers believed that learning could only take place by challenging a learner's attitude and prejudices. However, as expressed by Thompson (2003), challenging racism needs to be 'elegant', tactful, and not punitive, but made in a spirit of compassion and commitment to social justice. The teaching style adopted for this module was in line with that of authors like Hewitt (1996) and Thompson (2003) who believed that a more gentle approach may be more successful in making people aware of their possible shortcomings, whereas a more aggressive approach may result in a situation whereby the learners withdraw and do not participate.

The role of the teacher is that of a facilitator to support and guide the learners in their process of learning by creating stimulating learning opportunities and encouraging debates to making learning easier (Jarvis, 2002). Therefore, a mix of teaching methods, known to suit learning by adults (such as debates, case studies, role play, experiential and enquiry methods) were used in the module to encourage critical reflection, analysis, evaluation and problem solving. Role play was used as a tool to observe skills and attitudes, which otherwise were difficult to measure (Bhui *et al*., 2007). Extensive feedback and debriefing of the participants were given to enhance learning.

Critical reflection on practice is a crucial component in action research and critical pedagogy by which deep-seated beliefs could be changed (Kember, 2000). However, this can only happen as a voluntary act and is dependent upon the motivation of the learner. Motivation to learn is a key element in the success of

learning and this motivation needs to be sustained. In order to enhance motivation, a range of stimulating teaching materials were used, such as videos, journal articles, photos, case studies, presentations by guest lecturers and initiating debates. However, as educational literature suggests, the key to motivate learners is the teacher's own enthusiasm and commitment to the subject (Kember, 2000). My own commitment to achieving cultural competence was reflected in my teaching style and the choice of resources in order to motivate the students to learning.

The role of the teacher also involves guiding the learners in the process of critical reflection and to form their own opinion (Jarvis, 2002). The importance of critical reflection as a way to enhance professional practice was endorsed. The students were encouraged to critically reflect on their working practice to identify their own stereotypical and judgemental attitudes. However, reflecting on one's practice and prejudiced attitudes may cause discomfort or conflict. Students may react by discrediting the course or by avoiding the process and retreating. Ironically this might be taken as an indicator of a successful process in that the person is being challenged effectively, as pointed out by Clements and Jones (2006). Therefore, critical reflection requires a safe and positive learning environment. Creating a relationship between the students and myself as their teacher, therefore, was a priority. The development of ground rules for the group, as mentioned above, helped to establishing a safe and confidential learning environment.

Learning is a social activity and takes place best by interacting with others, reflecting on their own and other people's experiences and interpretations (Epstein, 2002). Therefore, group activities and discussions were used to encourage interactive learning. In addition, the multidisciplinary nature of this module, bringing together professionals from a broad spectrum of services, offered an opportunity to develop collaborative working between organisations.

It has been argued that recognition of the differences between people, groups and communities is vital. If the module was to be reflective of existing differences then

others needed to be involved in its development (Clements and Jones, 2006). Involving diverse groups in the development and delivery of training would bring other world views that otherwise would not have been considered. The cultural mix of students was a learning opportunity, but also produced a challenging learning context, requiring a teaching approach that managed the diversity of the groups in terms of ethnicity, gender, age, social and cultural background, faith and world views.

As outlined above (Epstein, 2002), learning is a process rather than an end-product. Equally, becoming culturally competent is a process (Campinha Bacote, 2003). Therefore, cultural competence training is a process that takes place at a learner's individual pace and depends on a number of factors, such as motivation, engagement and their existing level of knowledge and awareness. As a result, it may be difficult to establish the success of cultural competence training and identify how much learning had taken place. Learners enter the course with a range of experiences and knowledge, and learning may take place during the course, immediately after or even some time afterwards. Teachers need to be aware that it may not be possible to establish an immediate learning effect and they may need to adjust any unrealistic expectations. This factor may also impact on the findings of the evaluation in establishing the success of this module in that the immediate outcomes may be limited.

Clements and Jones (2006) questioned where diversity training sits in relation to education and training. Indeed, there is a potentially huge difference between the teaching and learning methods used and the expected benefits to be gained from the training. Whilst training is teacher-centred, product-oriented and information-based, education is more learner-centred and initiates the process of learning. Critical pedagogy seeks to develop the person's personality and autonomy and is seen as a lifelong development process (Blake *et al.,* 2003). Consequently, people should be educated for, rather than trained in cultural competence. Enhancing cultural competence clearly goes beyond increasing knowledge by simply giving

information. Raising awareness and enhancing understanding requires a degree of self-reflection of one's own attitudes, values and beliefs and involves a learning process. Only by understanding one's own world-view it is possible to recognise and value the fact that the world view of other's may be different and equally valid (Clements and Jones, 2006; Campinha-Bacote, 1999).

Educational research supports the view that the process of critical reflection requires the trainer to have the necessary skills in order to deal with emotions, discomfort and possible conflicts that may result from the learner's reflection on their own practice and attitudes. Therefore, trainers need to be experienced in these matters, because those who do not have the appropriate skills when dealing with sensitive issues may actually cause psychological damage to the learners (Clements and Jones, 2006) and, therefore, do more harm than good (Hewitt, 1996). For that reason, it was suggested that teachers should not engage in diversity training until they have explored their own prejudices in relation to diversity issues and had their own attitudes exposed. Trainers need to have a clear concept of the subject being taught, but they also need to know how to respond personally to the issues tackled during the course. They, ideally, need to have worked through those areas that could be difficult for them (Clements and Jones, 2006).

The outcome of this module and whether its aims have been achieved is the subject of the following chapters.

7. Evaluation

Evaluation of the educational approach was carried out as part of the action research cycles 5 and 6, as described in section 2.1. Cycle 5 was used continuously to evaluate each delivery of the module, which has constantly been revised and modified as a result. A flowchart showing the progressive changes that occurred to the module throughout the process is in Appendix 4. Cycle 6 was used to consider the wider impact of the module beyond the individual. Data from the evaluations of each module delivery were analysed to provide an overall analysis on the effectiveness of the module and also to highlight what lessons can be learnt for future educational work and diversity training. The implications of using action research for the type of evaluation used in this PhD will be detailed later in this chapter.

This chapter will first expand on the theoretical debates and principles that have informed my approach to evaluation. The consequent evaluation strategy will be introduced and applied to the practice of this module evaluation. This is followed by a debate on different models of evaluation and their application to this study.

7.1 Principles and approaches to evaluation

7.1.1 The nature of evaluation

There are many similarities and differences between research and evaluation. Both use methodologies and methods of social research, and evaluators and researchers need similar skills (Cohen *et al.,* 2007; Clarke, 1999).

However, it has been argued that what distinguishes evaluation research from other forms of social research are not only the methods evaluators employ, but also the purpose for which these methods are used (Cohen *et al.,* 2007; Bennett, 2003). It is also said that researchers want to enhance knowledge in order to contribute to

theory and then make generalisations; in contrast the evaluator is less interested in contributing to theory and making generalisations but more in informing decisions (Babbie, 2004; Clarke, 1999; Bennett, 2003).

Evaluation is often portrayed as non-theoretical research oriented by its methods. Yet, the importance of theory has been stressed by a number of evaluators who have different perspectives (Patton, 1989; Chen, 1990; Clarke, 1999). Most of them found that theory performs many functions and is a vital element in the evaluation process: theory can provide evaluators with a rationale for selecting particular research methods in a specific evaluation context. Theory can also help to focus the evaluation by directing the evaluator towards certain problems.

7.1.2 Evaluation is political

Some argue that evaluative research is more political than other approaches of research because the researcher is attempting to influence policies and decisions in health and social service departments (Carnwell, 1997). Evaluation is also considered a political activity because evaluators need to negotiate what questions they address and whose interests they serve. This can result in a possible conflict between the evaluator's loyalty to the commissioner of the research and the desire to change the service or programme for the client (Cohen *et al.,* 2007).

The degree of the evaluator's involvement during and after the evaluation process varies and depends on the purpose of the evaluation and research approach. Whether or not the researcher is actively involved in the evaluation process and in initiating resulting change also has an impact on the political character of the evaluation. This influences the political character of this study. The evaluative approach of this study is underwritten by the underlying philosophy of critical theory and of action research, which puts a strong emphasis on the involvement of the teacher as a researcher in educational research (Stenhouse, 1975).

Carnwell (1997) also pointed to the benefits of a critical research approach in evaluation in that it offers the opportunity to get a better understanding of the programme through active involvement and expert experience, which assists in sound decision making. The common theme of both evaluative research and critical research methodology is that they aim to influence the decision making process. Critical research also looks for a deeper understanding. Therefore, the combination of evaluative research and critical research methodology used in this module evaluation is very appealing and highly valuable in order to establish sound results.

7.2 Evaluation research strategy

It is essential for the evaluator to develop a clear understanding of what information is required from the evaluation before developing an evaluation research strategy. A strategic way of achieving this is to look at the driving factors and purpose of the evaluation because these determine the design and methods of the study.

7.2.1 The purpose of the evaluation:

This evaluation has political aspects because the module has been developed in response to Government calls for cultural competence training in the health sector in order to fight discrimination and inequality (HO 2002; NIMHE, 2004a). There have been many training initiatives but few of them have been evaluated to measure their impact on change in the knowledge and behaviour of its participants (Papadopoulos *et al.,* 2004; Bhui *et al.,* 2007). Therefore, results of training evaluations are urgently needed to assess their impact and to inform the debate on approaches to diversity training.

The aim of this evaluation was to assess whether this module was effective in changing participants' knowledge and attitudes and therefore their behaviour towards people from different cultures. The findings should inform the debate on training approaches in order to achieve anti-discriminatory practice and equality. Furthermore, this study aims to contribute to the more general debate on the implications of educational approaches for practice. This cuts across the apparent evaluation/research or applied/basic divide and requires that the evaluation strategy has been theoretically informed to reliably contribute to the theoretical debate.

Several authors have highlighted the importance of the purpose of a study as the driving and controlling force in research because it determines the design, methods, analysis and reporting (Patton, 1990; Clarke, 1999; Castling, 1996). Patton (1990) added that the purpose of the research has implications for the role of the researcher and their involvement in the research, on the expectations of the research, the

audience and the dissemination of results. The purpose of this evaluation is to measure the effectiveness of the module to identify whether changes are required in order to improve it or whether to discontinue its delivery. The evaluation questions whether the module can be used as a model in other areas in order to bring this approach into the wider educational debate.

7.2.2 Evaluation design

Based on Scriven's (1967) distinction between *formative* and *summative* evaluations, Patton (1982) claimed that the purpose of formative evaluation is to improve an intervention, and that of a summative evaluation is to investigate the effectiveness of an intervention. Derived from my understanding of the different evaluation designs and guided by the action research approach of this study, I decided to use a combination of both formative and summative evaluations to examine the process and the outcome. Formative evaluation was used to identify the strengths and weaknesses of the individual module deliveries and to provide ongoing feedback in order to improve the programme. The summative evaluation investigated the overall effectiveness of the programme.

7.2.3 The use of qualitative and quantitative research methods

Evaluation research has no methodology of its own. The research question and the purpose of the evaluation determine the methods to be used. It has been recommended that for complex studies it is best to collect both qualitative and quantitative information to gain a more complete understanding of the study (Carnwell, 1997). This evaluation research, therefore, used a mix of quantitative and qualitative research methods to be able to provide a comprehensive picture of the process and outcomes of the module. Some critics believe that mixing methods violates the intent, purposes and philosophies of each approach as both would discover the truth from different perspectives. However, other researchers argue that the philosophical perspective is beneath the level of methods; hence, one can have

qualitative data collection within a 'positivist' perspective and quantitative data within an 'interpretive' perspective (Carnwell, 1997).

Each of the research strategies has its advantages and disadvantages. For that reason, a multi-method approach in educational evaluation has been suggested that contains formative and summative evaluations, and a range of research strategies and methods for the collection of qualitative and quantitative data (Bennett, 2003).

7.2.4 Approaches to evaluative research

Various philosophical approaches can be used for evaluative research. Again, the choice of approach depends on the subject and purpose of the evaluation and the relationship between the evaluator, decision makers and service users. Approaches that included experimental, goal-oriented, decision-focused, user-oriented and responsive approaches (Carnwell, 1997) were examined to see if they could be used for this evaluation. For example, the experimental approach is the design of choice in assessing the effectiveness of a treatment intervention by using randomly allocated control groups to compare the impact of the intervention. However, experimental approaches are often not feasible in educational research because of the complexity of the factors involved. This evaluation, therefore, does not formally test the effectiveness of the intervention but seeks to illuminate the question by gathering recipient's and commissioners' views on its effectiveness, by looking at assignment results and using a before and after questionnaire to assess its impact. The user-oriented approach requires the direct involvement of the client throughout. Such research is commonly established by service users and the researcher will only assist. The users in this research, the students, are involved in the evaluation process and their views are greatly valued. However, the research is not driven by them. Also there is no continuous student group that would take ownership of the research because the students change with each module intake.

At first sight some of the approaches seemed suitable for use in this research. However, on closer scrutiny, apart from certain elements, this evaluation research

does not clearly sit with any of them. The underlying philosophy of this study of action research and critical theory, advocates a close involvement of the teacher/researcher into the programme. On these grounds, the teacher-as-researcher model described by Stenhouse (1975) seemed the most appropriate approach. He regarded evaluation as a key element of curriculum development and recognised that teachers have an important role to play in evaluating their own teaching. However, the dual role of the teacher as teacher/researcher harbours potential bias and subjectivity in data collection and interpretation. The concern is that those involved in the development of a programme have a particular interest in gathering evidence that suggests the programme is successful. Therefore, teachers-evaluators need to acknowledge their role and interest in the programme. Possible concerns need to be addressed by careful planning of the research (Bennett, 2003).

As researcher, teacher and evaluator, I have been actively involved in the development, delivery and evaluation of the programme and, if successful, will be active in promoting the module as a tool to initiate change. My involvement harbours the danger of a subjective rather than distant or neutral view that is needed for basic and applied research. I am aware of the danger of a possible bias in data interpretation. To ensure that the evaluation process in this study is valid and reliable, and its results are comparable, standard procedures were used in a systematic way. Each module intake was evaluated individually with the same procedure and methods applied. These individual evaluation results were fed into the overall programme evaluation.

In conclusion, from the above it has become clear that it is less important what methods are used, than issues such as who is driving the research, the research question and purpose, to whom the research is accountable to and whose needs are to be addressed. These factors have direct implications on the approach used; the role of the evaluator in the research process and the methods of data collection. This evaluation study will be guided by them.

7.3 Models of evaluation and their application to this module evaluation

A number of evaluation models have been developed and tested (Forsyth *et al.,* 1999; Sanderson, 1992; Brookes, 1995). For example, the Kirkpatrick (1976) model uses both summative and formative evaluations and involves four levels of evaluation: the learner's reaction to the intervention; the learning achieved; any behavioural change brought about by the intervention; and results for the organisation. Each of these levels has different evaluation tasks to ensure the validity of the evaluation procedure. Parker's (1973) model is broader in its focus. It includes the learner's satisfaction and reaction to the intervention, the knowledge gained, the learner's job performance after the intervention, and the results of the whole group. The name of the CIRO model (Warr *et al.,* 1970) derived from its four categories of evaluation (Context, Input, Reaction, Outcome). Hamblin's (1974) model identifies five levels of evaluation: reaction, learning, job behaviour, department and organisation and ultimate value.

Four common categories can be identified from the above models: ***'reaction', 'learning', 'job performance', 'department and organisation'***. Therefore, I decided to follow the above four categories in my evaluation, bringing together elements of the above models and building on the expertise of their authors.

'Reaction evaluation' is seen as the easiest, least useful and most frequently used method. The last two categories of evaluation have been described as the most difficult, most valuable, but least used methods. They are difficult to measure because many other factors besides training can influence job performance and organisational performance (Forsyth *et al.,* 1999; Sanderson, 1992; Brookes, 1995). Warr *et al.* (1970) argued that it is sensible to focus on the easier levels of evaluation. They believed that if context, input, reaction and immediate outcome evaluation have been carried out properly, the effects on job performance and on the organisation are likely to be successful. This may not necessarily be the case, and in order to obtain sound findings of the effectiveness of the module, I decided to

concentrate on all four levels of evaluation. The authors also claimed that training should be a self-correcting system, meaning the results of reaction evaluation or immediate outcome evaluation should feed back to identify and improve weaknesses in an ongoing training programme. This corresponds well with my approach of continuous evaluation and development of the module. The results of each individual module evaluation have been used to improve the module.

7.3.1 Evaluation levels and their application to the module evaluation

In the following section, the objectives, strengths, weaknesses and usefulness are discussed and applied for each evaluation level, and the tools used are introduced. A copy of each tool can be found in Appendix 5.

7.3.1.1 Level 1: Reaction

Objectives: At this evaluation level the objectives are that the learners rate whether they found the content interesting, relevant to their working areas, enjoyable and felt motivated and supported in their learning.

Measuring the reaction to a learning event involves evaluating the learner's feelings and opinions about the materials, the content and the teaching. Although reaction to learning cannot be used to measure the effect of learning, learning theory strongly suggests that if learners are motivated and interested in the subject matter and have a positive relationship to the teacher and to the group, they are more likely to do well (Forsyth *et al.,* 1999, Jarvis, 2002). As illustrated in section 6.3, the results can be influenced by various variables, for example the student's motivation, the relationship to the teacher and the teaching style.

The strength of reaction evaluation is that it helps to uncover the learners' concerns and negative feelings and offers the opportunity for the teacher to initiate change. If these concerns are identified early on it may be possible that learners who are not satisfied with the training can still gain the maximum benefit from it. In addition, asking learners for feedback enables them to become involved in the ongoing

development of the module. This may not only lead to increased support for the learning process and feelings of ownership, but also may encourage learners to take responsibility for their own learning. This is an integral part of the teaching and learning strategy of this module.

Application for this evaluation:

Mid-term discussion

At the mid-term of each module delivery a discussion with the group was initiated by the teacher to ask for their feedback and notes were taken on a flipchart, in order to discover possible concerns and initiate necessary changes. Questions included were:

> 'How has the module gone so far for you?'
>
> 'Was anything missed which you would have liked to include?'
>
> 'Do you have any recommendations of how to improve the teaching of the module?'

Students were encouraged to give honest feedback by pointing out that their views were valued and would contribute to the continuing development of this module. Students were also made aware of the positive aspects of critical appraisal for professional development and that lip-service, in order to please the tutor, would not be useful. The results were typed, coded and the content was analysed.

Mid-term questionnaire

In addition, and to confirm the findings of the group discussion, the students were asked for their feedback via an anonymous mid-term questionnaire. This aimed to encourage students who were reluctant to openly express negative comments to articulate their concerns and critique in a safe, anonymous way. The questionnaire contained seven questions rated on a Likert scale (very good, good, okay, not satisfactory), four open-ended questions asking which sessions they liked most/least, and finally asked for comments on how to improve the learning process.

End-of-term questionnaire

On the last day of each module I asked the students to fill in the routinely used comprehensive and anonymous TVU end-of-term questionnaire. For the purpose of this evaluation I had selected seven questions that were related directly to the learning experience of the participants and could indicate how this module was perceived. Most questions were rated with yes/no. Some were open-ended, inviting additional comments. The scores were numerically coded, the additional comments were coded and the content was analysed.

End-of-term discussion

To avoid the effect of using general 'happy sheets', an additional evaluation activity was conducted. The students were asked to discuss amongst themselves, without the teacher being present, to rank their responses and agree on the positive and negative aspects of the course. Afterwards, a group representative, with the support of the group, reported their results to the teacher. The results were typed, coded and the content was analysed.

7.3.1.2 Level 2: Learning

Objective: This category considers whether, as a result of the module, learning has been achieved. The objectives at this level are to identify whether the participant's knowledge, skills and attitude with regard to the content of the module were enhanced, and to see whether the module learning outcomes had been achieved.

A number of objective and subjective methods for assessing knowledge can be used. Subjective testing includes the writing of reports and essays and responding to case studies. These tests can bring out information concerning knowledge and understanding. Objective testing is mostly used when assessing specific information and facts. These include tests such as multiple choice questions, short-answer tests, and true and false tests (Brookes, 1995). Other methods to measure changes in knowledge, attitudes and skills that can be attributed to the learning event are by means of a pre-test/post-test and control group design (Forsyth *et al.,* 1999). Some

researchers found that such rigorous experimental design is seldom possible in real teaching situations (Sanderson, 1992).

Application for this evaluation

Assignment

The assignment consisted of a written essay of 3,000 words, designed to measure whether the participants had achieved the learning outcomes of the module. The assignment involved the design of a client assessment based on a case study. This enabled the students not only to demonstrate their cultural competence in knowledge and understanding, but also in the skills that are necessary in dealing with a complex case. For more details see section 6.1.6, Assessment Strategy.

To achieve a consistent and coherent approach to assessments, generic marking grids for the diploma and degree levels were used (see Appendix 5). The marking grids were those used extensively within the Faculty. The different categories of marking they use: 'coherence', 'content', 'writing style', 'critical analysis', 'use of literature' and 'quality of referencing' are interlinked. For example, a good analysis is not possible without a sound knowledge of the content and of the literature; without sound knowledge and critical analysis the learning outcomes would not be met. The students have to achieve a mark of 40% to pass the module. The assignments were marked according to the University's marking procedure, anonymously and by two markers. The results were then analysed per module intake and for the overall picture of the programme.

Questionnaire

A self-rated knowledge questionnaire was devised and given to all students at the beginning and at the end of the module to establish their self-perceived existing knowledge before and after the event. The students were asked to rate their knowledge on a number of key concepts in the module on a scale of 'nothing', 'some', 'need to brush up', 'okay' and 'very good'. The ratings were coded and if the score at the end of the course was higher than at the beginning, an increase in self-perceived knowledge could be assumed.

Measuring change in attitude

Most of the measuring tools used in this module evaluation aimed to assess the increase in knowledge and understanding. It was also part of my aim to measure changes in attitude, but attitudes about potentially sensitive topics can be very difficult to measure accurately in practice. Nonetheless, it cannot be assumed that an increase in knowledge automatically resulted in a change in attitude. Attitude change can be measured using questionnaires, attitude surveys, interviews, informed observation and self-rating scales, but each present difficulties in ensuring respondents give honest and self-reflective responses.

A measuring tool to assess change in attitude was piloted with a cohort of 16 participants of a three day training course in cultural competence. The questionnaire (see Appendix 5) consisted of eight statements relating to cultural competence and the participants were asked to rate whether they agreed or disagreed with them. There was also space for comments. The scale ranged from strongly agree, agree, neither agree nor disagree, disagree to strongly disagree. It was assumed that if after the intervention the score for cultural competence in attitude had increased, a positive change in attitude had been achieved.

However, after completion of the questionnaire around 20% of the participants told the teacher that some statements carried a stereotypical message that was too obvious for an audience who were already highly culturally competent. Additional comments on the questionnaires demonstrated that most participants were aware of the complexity behind these issues. I concluded that the questionnaire was not suitable for people who already had a high level of understanding and cultural competence. Therefore, I decided not to continue its use as a follow-up measurement of this particular training, and not to use it for the module, but instead I looked for another, already established, tool. By this point, it was no longer possible to use such a tool for my original module evaluation, so the delivery of further training courses were used as an opportunity to test out the use of a tool to evaluate

whether changes in knowledge and understanding following an educational intervention are also followed by changes in attitude.

I chose to use the Cultural Competence Assessment Tool (CCATool) that had been developed and tested by Papadopoulos *et al.* (2004) in the Cultural Competence Action Project (CCAP), a practice-based model of training to promote cultural competence in mental health teams. The CCATool has recently been used as part of the evaluation of cultural competence training for staff in the national CAMHS[35] Support Service (HASCAS, 2007). The tool is based on the model of Papadopoulos *et al.* (1998) that distinguished four different stages of developing cultural competence: cultural awareness, cultural knowledge, cultural sensitivity and cultural practice. The authors also distinguished between culturally generic competencies that were applicable across all cultural groups and culture specific competences. The idea behind it is that while it is impossible to know about all cultures, culturally generic competences can help to acquire culturally specific information.

In line with the model, the CCATool consists of four sections: *awareness, knowledge, sensitivity and competent practice* (see Appendix 5), and so it captures each level relevant to my evaluation, from learning to attitudes and behaviour. The tool consists of 40 statements, 10 for each of the sections, with which the participants can either agree or disagree, ranging from "strongly agree" to "strongly disagree". Different levels of competence are assigned depending on the number and type of correct answers. The levels range from cultural incompetence, cultural awareness, cultural safety to cultural competence. '*Cultural incompetence'* is assumed when a score of less than five is achieved in the statements on cultural awareness. '*Cultural awareness'* is achieved with a score of five or more in the statements on cultural awareness, even when not all the generic statements are answered correctly. '*Cultural safety'* is assumed with a score of five or more in the statements on cultural awareness, plus when all the generic statements in the other stages are answered correctly. *Cultural competence* is suggested when a perfect score is achieved with a score of ten (correct answers) in all of the four stages.

[35] Children and Adolescent Mental Health Service

In addition, a visual analogue scale (VAS) is included in each section to allow participants to self-rate their cultural awareness, knowledge, sensitivity and practice (1=lowest/negative, 10=highest/positive). This allows the researcher to compare the scores obtained from the coding of statements with the self-rated scores of the visual analogue scale score. A panel of experts in the field of mental health, ethnicity and culture was asked to comment on the statements before the validity and reliability of the CCATool was tested with mental health professionals and students. After that the tool was piloted in the CCAP intervention project where 35 members of staff attended cultural competence training (Papadopoulos *et al.,* 2004).

7.3.1.3 Level 3: Job performance

Objective: This category is concerned with the changes in the learner's job performance that may have been achieved as a result of a learning event. The objectives at this level were to find out if the participants felt more self-confident in cross-cultural encounters, if their degree of cultural competence had increased and if this was recognisable in improved work performances, and enhanced relationships with colleagues and clients from other cultures.

This level of evaluation measured the extent to which the learners were able to apply their knowledge to their work place. It has been argued that this type of evaluation is particularly important because it is concerned with the impact training has on real-life situations (Forsyth *et al.,* 1999). For many jobs in health and social care, direct measurement, such as an increase in the number of customer throughput, is not possible and more indirect or subjective methods of judging performance need to be used. For instance, managers or supervisors could be asked to judge individuals on their motivation and skills. Other indirect data can be collected by interviews, questionnaires, observations or attitude surveys (Sanderson, 1992; Forsyth *et al.,* 1999).

Application for this evaluation

Questionnaire to former students

In order to measure the long-term impact of the model on the work performance of the learners I developed a questionnaire and sent it in June 2005 to former students who had attended the module. The questionnaire contained closed-ended questions (yes/no) and space for explanatory or additional comments. It sought their views about the impact that the training had on their work performance and its usefulness for their working practice. The questionnaire asked for examples as to whether they had been able to use their newly acquired knowledge, and if they had encountered barriers that inhibited the implementation of their new knowledge and skills. Unfortunately, the response rate was low (16.6%). Some of the organisations no longer existed, or contact had been lost as students had moved on to other organisations. For these reasons the findings of this questionnaire could not be included in this evaluation.

Focus groups

Instead, I decided to concentrate on staff from one particular mental health trust[36] that had attended the module. I sought support and permission from the employer to organise follow-up focus groups during working hours. I then contacted the service managers of three treatment centres and asked them to organise a focus group at a convenient date for the staff who had attended the module from October 02 to June 05 (in total, 22 staff members). This provided a good time frame to identify any impact of the module upon their work performance. Focus groups were organised in two centres. Only few staff from the third service were available so they attended one of the other focus groups. A total of 14 participants attended the two focus groups, three staff called in sick on that day, two had to attend a client in an emergency, and three were on holiday. The turnout was 63% of those invited.

[36] The CNWL NHS Foundation Trust, one of whose Deputy Directors was one of the initiators of this module development and member of the steering group.

The decision to use focus groups rather than individual interviews was made on the basis of convenience as they are more time efficient. I used the focus groups as a group interview, but encouraged the interaction amongst the participants to generate a wide range of responses. The focus groups were organised by the managers of the services. Therefore I had no input in the setting. The size of the groups with 7 participants each was small enough to be manageable. Most of the participants knew each other as they were colleagues. Nevertheless, everyone was introduced, and ground rules were established to ensure confidentiality and a safe atmosphere where participants felt able to be honest. My role was that of facilitator, asking questions and encouraging debate. In each focus group I initiated a semi-structured discussion on the effects of the module. I took notes and read the responses back to the participants to ensure that I had captured the sense of their answer correctly. The notes were typed, coded and then analysed.

In addition, I asked the participants to fill in a questionnaire and then to return it to me at the end of the focus group. The questionnaire (see Appendix 5) covered similar questions as those used in the discussion but remained anonymous. It contained close-ended questions (yes/no) and space for comments. Every participant completed one. The responses were coded and analysed. This questionnaire enabled me to compare the responses to both tools and to explore whether the anonymous responses differed from that of the focus group discussion.

7.3.1.4 Level 4: Department and organisation

Objective: This category is concerned with improvements and changes within the organisation as a result of learning. At this level the objectives were to explore whether an increase in the overall cultural competence of the organisation had been achieved. If so, had this been transferred to the practice of equal opportunities, a philosophy of cultural openness, an improved working practice between colleagues, and between staff and clients from different cultures, and an improved trust and partnership working with communities?

This type of evaluation is concerned with the effect of a learning event on an organisation and as such goes beyond the individual work performance. This evaluation is considered to be most valuable because it could be a clear indicative measurement of the outcome of a learning event. However, as mentioned above, this is also the most difficult evaluation to carry out (Forsyth *et al.,* 1999). Changes within an organisation can be the result of a number of factors not related to the learning intervention.

This level of evaluation can only take place at the workplace within the organisation. Therefore, this approach needs the full support from staff and senior management. This kind of evaluation is more practicable if the whole department is being trained (Sanderson, 1992).

Application for this evaluation

At a time of increased accountability and quality assurance this kind of evaluation is very useful in identifying the effectiveness of a learning event for organisations that send their staff on training programmes. Organisations expect value for their money in terms of enhanced work performance and positive changes within the organisation.

Follow-up RNA

At the beginning of this project, it was intended to repeat the RNA three years after the first one was carried out. The aim was to compare the findings of both studies in order to identify whether any changes in attitude had occurred and if the service has improved as a result of the module. The plan aimed to involve the same organisations and interview the same stakeholders, staff in provider services, community members and clients. By so doing it had been hoped to measure a change in performance and attitude of staff. It was expected to find out whether a change in the perception of the communities and clients towards services had occurred and if they had experienced more culturally sensitive care as a result. Unfortunately, this was not possible for a number of reasons: Two of the voluntary sector agencies who had participated in the original study no longer existed due to

funding constraints. Also, the high staff turnover within the other services made it impossible to locate and interview the same staff in order to make comparisons to their previous beliefs and attitudes. Equally, clients were difficult to trace. They probably had moved on to other services, had dropped out of treatment or no longer needed to attend the service. For these reasons I decided instead to conduct a questionnaire survey with sector managers.

A questionnaire for managers

I developed a questionnaire for managers to gather information on their views on the impact of the cultural competence training on staff performance and whether it had impacted upon organisational practice. I decided to address managers from one Trust[37] only, where I also had conducted the focus groups with former students: about 27 members of this Trust's staff had studied the module and others had attended various recent training sessions, ranging from one to three day training events and follow-up sessions. The number of staff that I had trained overall in this Trust was 110.

The questionnaire was developed in consultation with the one of the Deputy Directors of this Trust. It was then distributed to five sector managers, selected by the Deputy Director based on criteria such as if their staff had attended the training, and the likelihood of responding to the questionnaire within a short time frame. The questionnaire contained closed-ended questions (yes/no, yes, not sure, to some degree) and some space for explanatory or additional comments (see Appendix 5). All the managers responded. The responses were coded accordingly and analysed.

In summary, a range of tools have been used in this evaluation study to scrutinise the impact of the module at various levels: reaction, learning, job performance, and department and organisation. The evaluation measurements were devised as an entity to complement each other by providing evidence from different aspects to build a complex picture from which the degree of learning could be analysed.

[37] The CNWL NHS Foundation Trust.

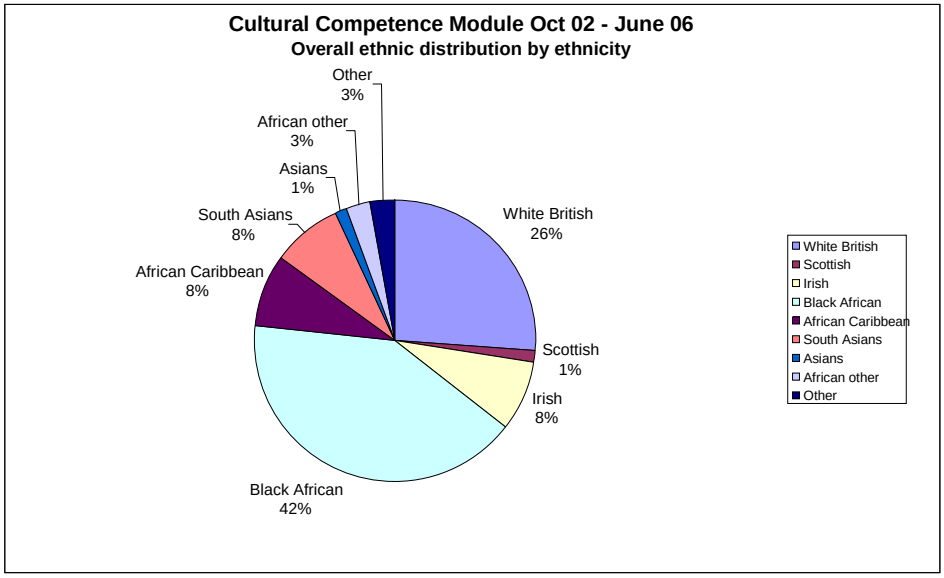
8. Findings of the Evaluation

The following chapter presents the key findings of the evaluation. The detailed results and charts of the overall evaluation and that of the individual module evaluations are attached in Appendix 6.

Six module intakes were evaluated. Seventy-three students attended the module between October 02 and June 06. 68.5% (50) of them studied the module at diploma level and 31.5% (23) at degree level. Seventy-four percent (54) of participants were current students on the Dip/BSc Substance Use and Misuse Studies. Twenty-six percent (19) were external participants who took advantage of free course places funded by the Ealing Drug Action Team.

Women accounted for 56% of the total sample. The ethnic distribution was 26% white British and 74% minority ethnic groups (see chart below). The gender and ethnic distribution was not specific to this module but reflected the target group for the Dip/BSc Substance Use and Misuse Studies, the workers in the drug and alcohol field of Greater London.

Chart 1: Overall ethnic distribution of the participants



8.1 Participant's reaction to the module

8.1.1 Mid-term evaluation

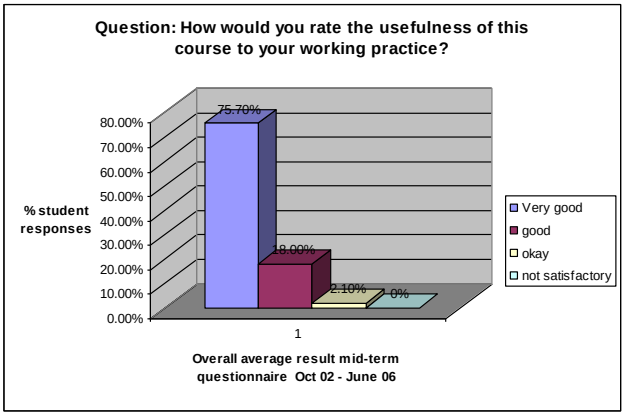
The mid-term group discussions indicated the students' positive reaction to the module. Comments showed that the learners found the module 'very useful' (Feb 03), 'interesting and challenging' (Feb 04), 'encouraging' (Oct 02), 'exciting' (Sept 04), and 'an eye-opener' (Feb 03). Positive comments on the teaching methods referred to the use of small discussion groups and the use of videos (Oct 02), the non-judgemental attitudes of the other group participants (Feb 04) and that they felt safe to express their views (June 05, June 06), the ethnic mix and the multidisciplinary composition within the group, which offered the opportunity to learn from each other (June 05 and June 06), and the teaching style which motivated them to learn more (June 06).

Negative statements referred to the learning environment within TVU, such as the quality of the food in the canteen, the broken and crowded lifts, dirty rooms, and difficulty accessing books in the library.

Concerns were raised by the participants of the Feb 03 intake in that 50% said that the assessment case studies did not relate to their particular field of work. This was especially the case for those who worked on the fringes with people with substance problems, for example in A&E departments or young people's services.

The results of the anonymous mid-term questionnaire in all of the module intakes mirrored the outcome of the group discussions. An average of 75.7% of the students found the course very useful for their working practice (see chart below).

Chart 2: Usefulness of the module



Overall, 70.7% of participants rated the teacher support highly and 61% of students found the preparation for the assignment was good; 11.5% found it very good. Regarding their own participation, 70.1% rated this as good; fewer students (54.8%) rated their own preparation for the course as good.

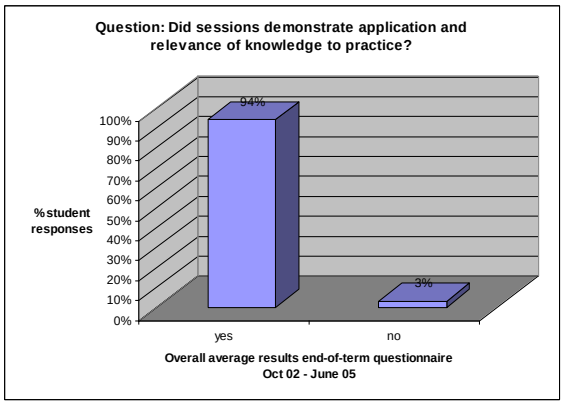
8.1.2 End of term evaluation

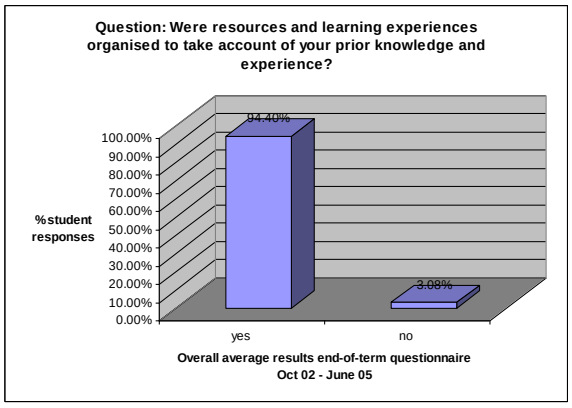
The end-of-term group discussions pointed out the students' high satisfaction with the course. Comments included the use of small group work and the multidisciplinary teaching approach (Oct 02), the good structure and delivery of the module, 'done by teachers with conviction' (Feb 03), the quality of the group discussions and the handouts, the teaching style and support given for the assignment (Sept 04), the use of videos as a learning tool and the choice of guest speakers, (Feb 04), and the teaching style (June 05, June 06). The Feb 04 group highlighted the benefits of learning in a culturally diverse group. The Sept 04 intake stated that all their expectations had been met. The June 05 group stressed the module's usefulness saying that the module should become compulsory for all staff in health and social services. The June 06 cohort appreciated the interactive teaching and the informative structure of the module.

Similar to the mid-term evaluation, negative comments mainly related to the learning environment of the University. Some students in the Feb 04 intake felt that there was too much information to take in within a short time period, but others in the same group wanted to have more content included.

The end of term TVU evaluation forms revealed the students' positive views regarding the teaching approach and their learning experience. On average, 98.5% found that the learning was designed to stimulate their curiosity and to encourage reflection on practice; 95.4% said that a questioning approach was used to stimulate their learning. Ninety-four percent agreed that the sessions were evidence based and the same number felt that the sessions were relevant to their practice (see charts below). Over 94% thought that the resources and learning experiences were organised to take account of their prior knowledge and experience, and 96.2% considered the teachers were receptive to their ideas.

Charts 3 and 4: Examples of overall results from the end-of-term questionnaire Oct 02 – June 05[38].





Some cohorts rated their experience less positively. For example, in the Feb 03 intake only 70% found that the course was relevant to their practice. A possible

[38] In the academic year 2005/06 the University's evaluation form changed and its questions were no longer applicable to the evaluation of the module. Therefore, the end-of-term evaluation form could not be used for the June 06 cohort and the analysis only includes data from Oct 02 – June 05.

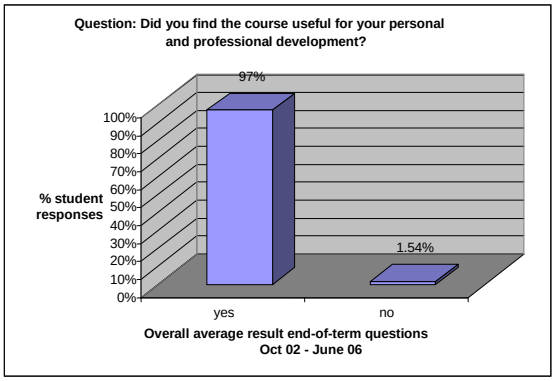
reason for the lower than average rating could be the high number of external students in this cohort that contributed to the diversity of academic and working experiences and expectations on the course. This presented a challenge for the tutor in building upon everyone's prior knowledge in a group with such a varied background.

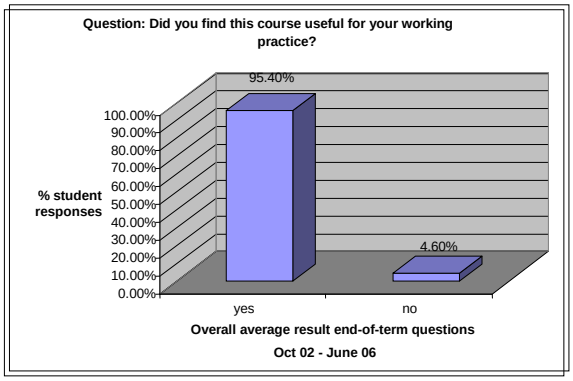
The Feb 03 cohort criticised the lack of interaction between group members. Comments included that 'the group input was not always inquiring and stimulating' and that 'the group was not able to use the opportunity offered by the tutor to ask questions to stimulate others'. This criticism referred to the fact that a significant number of students did not take part in group discussions and as a result the discussions were dominated by a few individuals.

In the Feb 04 intake, 80% (less than average) of the students felt that the teachers were receptive to their ideas. One student noted that '*teachers were very willing to listen, no-one was made feel stupid'*, another student commented '*very, sometimes too receptive'*, but another one stated that he '*felt a lack of respect...*' The background to these comments was that one participant often tried to dominate the group with his own agenda and engaged with one of the teachers in lengthy arguments. Rather than taking responsibility for their learning and reprimanding their fellow student, the group chose not to articulate their frustration. They expected the teacher to solve the problem as the following comment demonstrates: '*Often one member of the group would make the same point over and over again. I would have appreciated if the lecturer closed the discussion down...*'

At the end of each module the students were asked to rate whether they found the course useful for their own personal and professional development and for their working practice. The charts below illustrate the overall average response of all module intakes. For details of the individual module cohorts, see charts in Appendix 6.

Charts 5 and 6: Overall result of end-of-term questions Oct 02 – June 06





Ninety-seven percent of participants found the course useful for their personal and professional development and their working practice. Negative responses were only from the Feb 03 group; 7.7% of students did not find the course useful for their personal and professional development and 23% found it not useful for their practice. It was only at this point that these students expressed that their expectations on the course had not been met. Their comments included: '*As an A&E nurse I would have benefited from learning about the psychological and physical effects of drugs/ alcohol', and 'I did not understand much of the course as I felt it was related to people who work in mental health and drug and alcohol advisory services'.* In contrast, other comments from the same cohort showed that the module was useful to them. For example, '*It really has and will help me to reflect on my own practice and how to work in a culturally competent manner*'. And a similar view was found in other intakes: *'Gives me more confidence to challenge colleagues'* (Oct 02); '*It met all the criteria I had when I first came on the course'* (Feb 04); *'Yes, I feel that other staff will benefit greatly. I will include some of the exercises and handouts in my future staff training*' (Sept 04); *'I have learnt a lot from the teacher and students'; 'Yes, although I am not currently working in the drugs and alcohol field, the course has really deepened my understanding of cultural competence in all areas of my life not only work'* (June 05); *'Most definitely!'* (June 06).

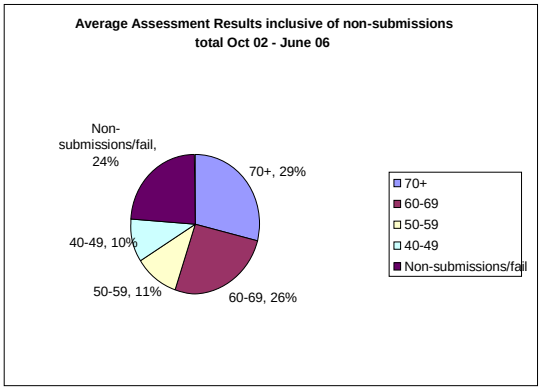
In conclusion, the evaluation revealed that 97% of the students found the module useful for their personal and professional development and 95.4% for their working practice. These findings indicate a positive reaction to the teaching of the module.

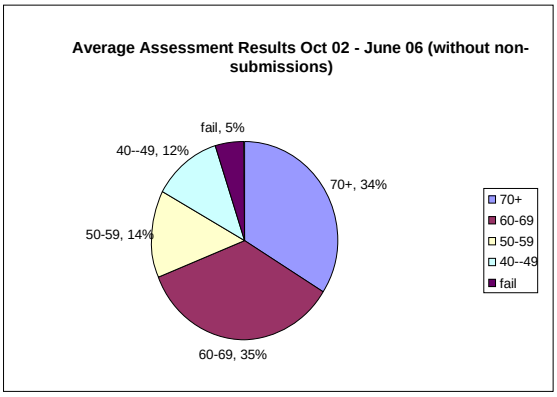
8.2 Measuring Learning

8.2.1 Assignment

The evaluation revealed overall good results for the assignments. Overall, 29% of students achieved very good marks (70+), 26% good marks (60-69), 11% satisfactory+ marks (50-59) and 10% achieved satisfactory marks (40-49). This indicated that 76% of participants achieved the module learning outcomes. However, a high number of participants (24%) did not submit their assignments and were failed. This reflected negatively upon the module result. The pie charts below indicate the overall assessment results with and without non-submissions. Only 5% of those who submitted their assignment failed.

Chart 7: Overall assessment results Oct 02 – June 05 with, and Chart 8 without, non-submissions





The non-submission rates differed between intakes. The lowest rates were in the February 04 and June 05 intakes, where all students handed in their assessment. The highest numbers of non-submissions were in October 02 and February 03, the cohort with the highest numbers of external participants[39]. In this cohort 47% did not submit their assessments. If not taking into account the non-submissions, the results would have been more positive, as 67% of those that submitted the assignment

[39] As outlined in section 6.1.2, the Ealing DAT provided funding over a two-year period for staff working in the drug and alcohol field in Ealing to attend this module.

achieved good marks (60-69). The non-submissions were mainly by external students. In contrast to those who studied the module as part of the diploma or degree, they did not need the academic credits for completing the module. Therefore, many external students did not want to undergo the strain of assignment writing. This made it difficult to establish whether they had indeed learnt something during the module.

The analysis of the results showed no significant difference between assignment results at diploma or degree levels. In some cohorts, the degree students achieved higher results, in other intakes it was the diploma students that gained better marks.

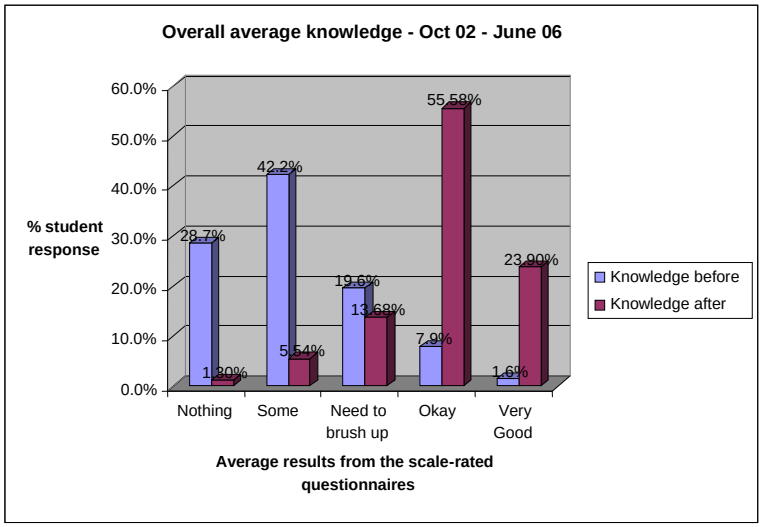
In summary, the module assignment showed that 76% of the students had met the learning outcomes, and from this a level of cultural competence can be assumed. However, assignments cannot fully indicate whether an increase in knowledge had occurred as a direct result of studying this module.

8.2.2 Self-rating questionnaire

The self-rating questionnaire suggested an increase in knowledge in all categories in all cohorts. The overall analysis showed an increase in knowledge from 28.7% having ‘no’ and 42.4% ‘some’ knowledge prior to the module, to 55.6% having ‘okay’ and 23.9% ‘very good’ knowledge afterwards (see chart below).

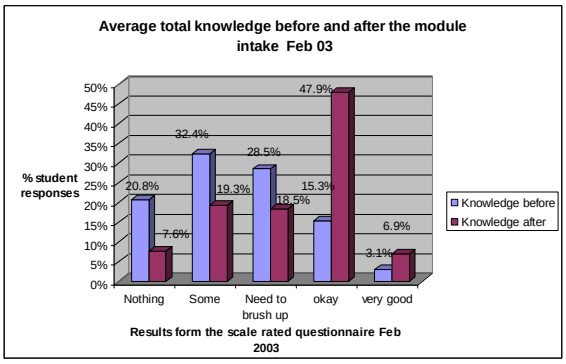
The chart shows a clear polarisation of the results with the highest scores being only some or no knowledge before the course; after the module the highest scores are **okay** and **very good**. This tendency was apparent in all the different subject areas and throughout all module intakes.

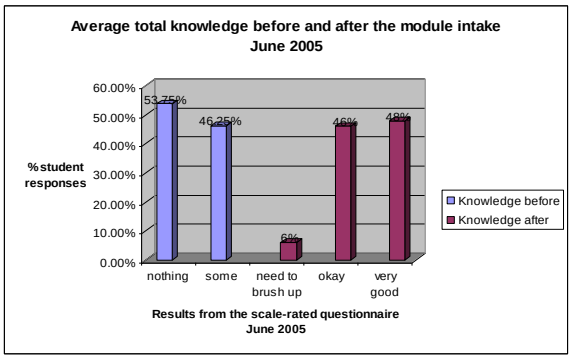
Chart 9: Overall Knowledge Oct 02 – Jun 06



Variations were found between cohorts and between categories. Some cohorts overlapped between before and after ratings (for example in the February 03 intake), in others (for example June 05) a clear polarisation of prior and after knowledge had been found (see charts below).

Charts 10 and 11: Total knowledge before and after. Examples from Feb 2003 and June 2005 intakes





Both charts indicate an increase in knowledge, but in different ways. The Feb 03 cohort, characterised by a high degree of diversity, a high number of external students and non-submission of assignments, showed the worst self-rating scores of all intakes: Only half of the course members (47.9%) felt they had '**good**' knowledge

after the course and only a few (6.9%) rated their knowledge as **very good**. In contrast the June 05 cohort consistently rated their prior knowledge as very low and after the course as good or very good.

The analysis of the scores in the further module intakes showed variations in more detail. For example, the October 02 cohort, who stated a relatively high prior knowledge concentrating in the '**some**' and '**need to brush up**' categories, consistently rated their subsequent knowledge as **high**. The June 06 cohort also rated their subsequent knowledge as **high**; however, they started from a lower baseline than the October 02 group, so their knowledge increase could be interpreted as higher.

A comparison of the 10 different subject areas explored differences between the key areas. Areas that built on existing knowledge reported higher knowledge levels before and after. For example, the category '*Patterns and trends of substance use amongst people of different cultures and ethnic backgrounds'* showed the highest degree of knowledge before and after; 55.7% had rated their prior knowledge with **some**, but after the course 67.8% said they had good ('**okay**') knowledge. In contrast, areas of new knowledge reported the most increase in knowledge. For example, the highest increase in knowledge was in the category '*Models of cultural competence*', where before the course most (62.7%) said they had **no** knowledge at all, but afterwards 57.7% said they had **good** knowledge, and 20.2% said **very good**.

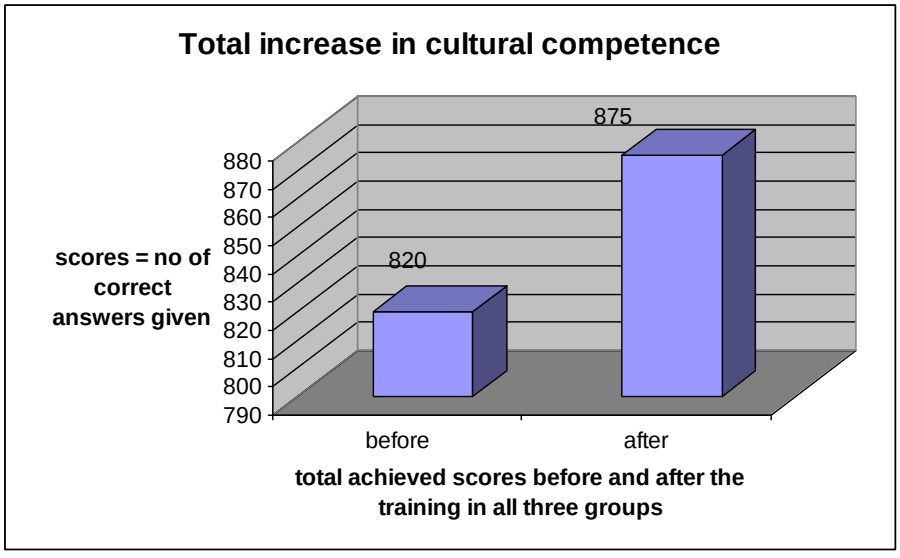
In conclusion, the self-rating questionnaire established an increase in knowledge in all categories and all cohorts to varying degrees. However, the ratings are subjective and may either over- or underestimate knowledge before or after the event.

8.3 Measuring changes in attitude

The CCATool, developed by Papadopoulos *et al.* (2004), has been used in this PhD study to establish the degree of cultural competence. For further details on the use of this tool see 7.3.1.2; for a copy of the questionnaire see Appendix 5. The participants of three groups[40] were asked to complete the questionnaire before and after the training in order to see whether a change had occurred. The tool was used in different ways: to measure an increase in cultural competence, to allocate the participants into different levels of cultural competence and to identify gaps between relative objective statements and subjective self-ratings.

An analysis of the answers in the four categories (awareness, knowledge, sensitivity and practice), showed an overall increase in all three groups in their score related to the number of correct answers given. Chart 12 demonstrates their total score for cultural competence before and after the training.

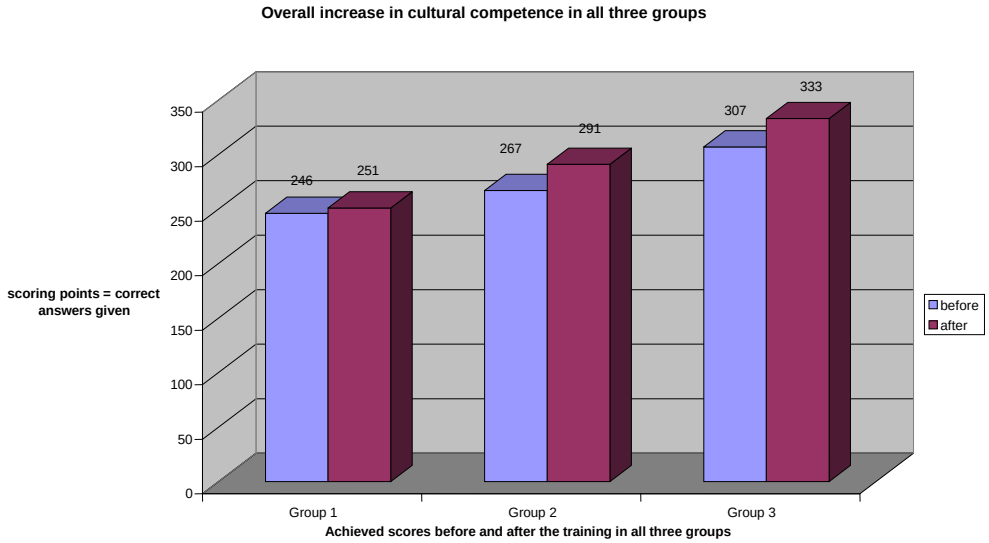
Chart 12: Total increase in cultural competence



[40] Due to time constraints for this PhD study it was not possible to use the tool in one of the module intakes. It was used on the participants of three 2 ½ Day-Training sessions within one Trust.

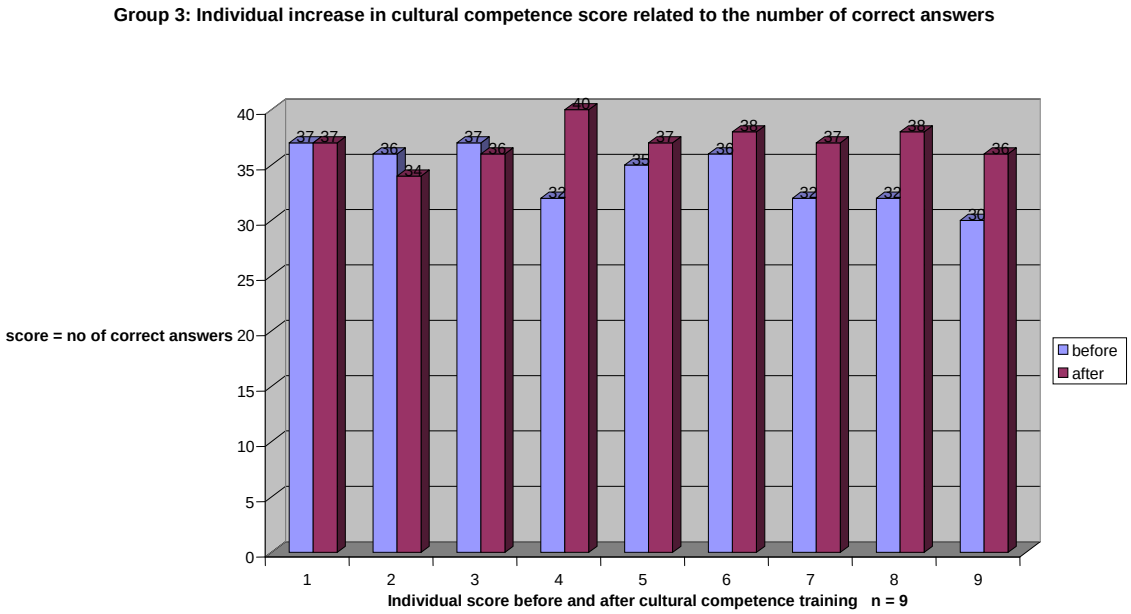
Differences between the groups and individuals were noted. Details of these can be seen in Appendix 7. Chart 13 shows the overall increase in the three groups. Group 1 entered the training with the lowest scores and achieved the least increase, whereas Group 3 entered with high scores and achieved the highest score increase.

Chart 13: Overall increase in cultural competence of the three groups:



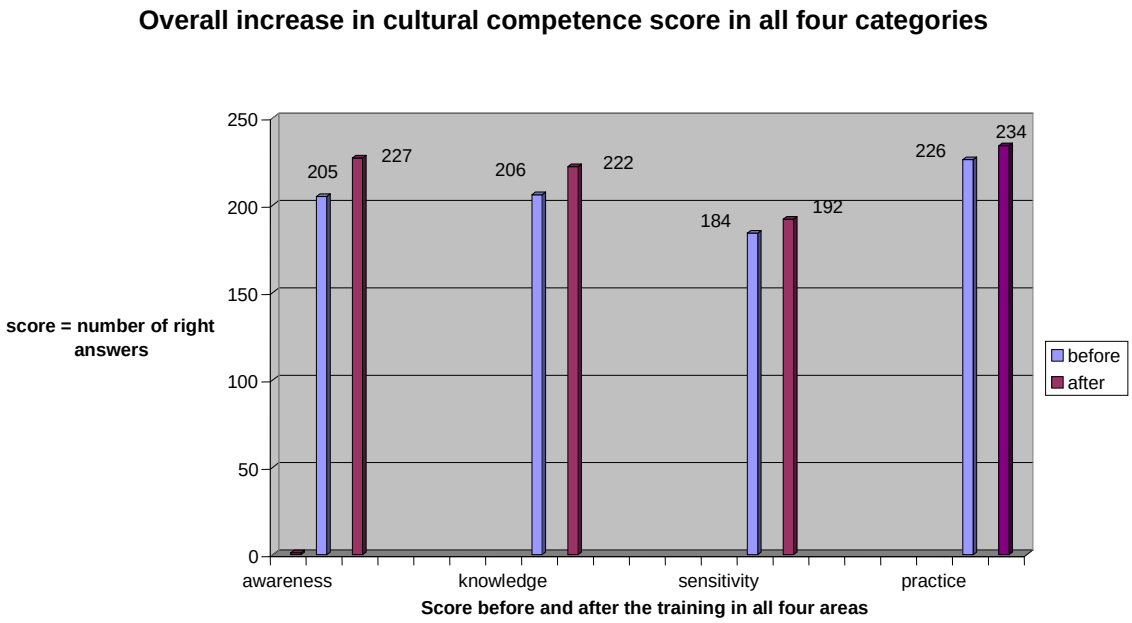
At an individual level, variations were noted in all three groups. Chart 14 below shows the individual increase in cultural competence of the participants in Group 3. In this group two people's score slightly decreased. In this group there was also the highest increase by one person from 32 to 40.

Chart 14: Individual increase in cultural competence scores of Group 3



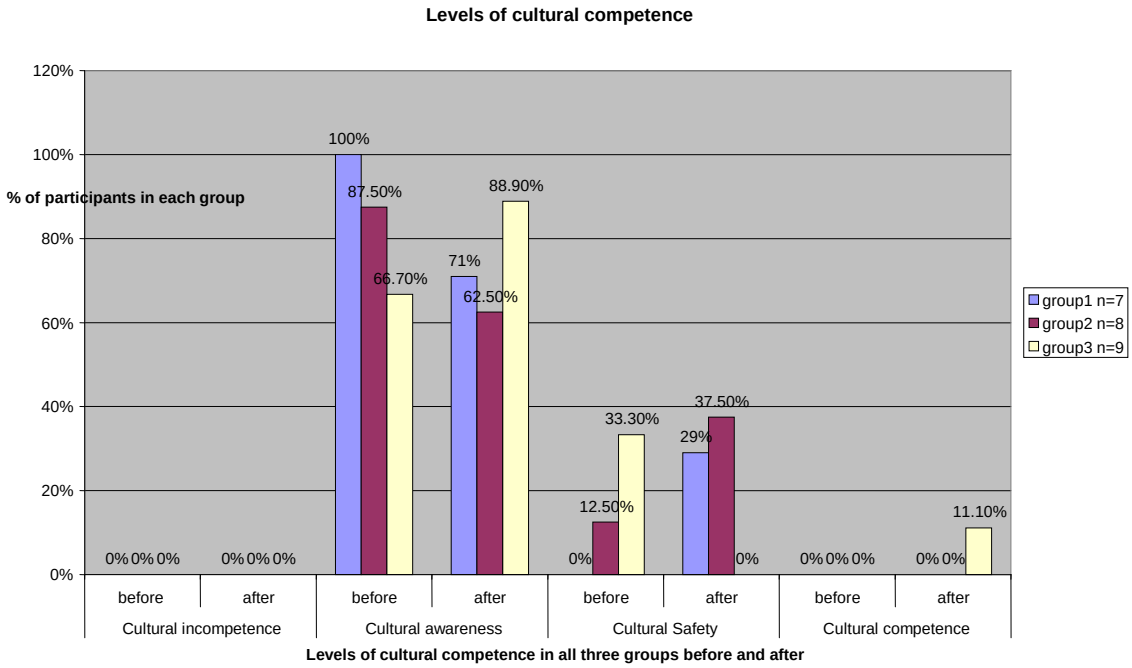
When looking at the score of the four categories (awareness, knowledge, sensitivity and practice) an increase was noted in all categories. There were also differences between the categories. The area *'sensitivity'* achieved the lowest correct answers before and after, the category '*practice*' the highest. The highest increase in correct answers occurred in the area of '*awareness'* (score 22), followed by '*knowledge'* (16), '*sensitivity'* (8) and '*practice'* (8). Chart 15 demonstrates the score in the four categories before and after the training.

Chart 15: Overall score in cultural competence in the awareness, knowledge, sensitivity and practice categories



The CCATool had also been used to establish the level of cultural competence of the participants in each group based on the scores of correctly answered questions, ranging from cultural incompetence and awareness to cultural safety and competence (see 7.3.1.2). Chart 16 demonstrates the results of the various levels of cultural competence in all three groups before and after the module. The analysis of the responses demonstrated that none of the 24 participants within the three groups was *culturally incompetent* before or after the training. The scores overall before training showed that the majority (83.3%) was *culturally aware* (100% in Group 1, 87.5% in Group 2 and 66.7% in Group 3); fewer participants (16.7%) were *culturally safe* (33.3% in Group 3 and 12.5% in Group 2). None was *culturally competent*. After training, more people were *culturally safe* (20.8%) and a few (4.2%) *culturally competent*. Cultural competence was only achieved in one group. The shift was not progressive. Some people, who before were classified as *culturally safe* reverted back to the *culturally aware* status; those who achieved a *culturally safe* status afterwards were not the same as the ones that had previously obtained this status.

Chart 16: Levels of cultural competence before and after training comparing all three groups.



Some participants, although scoring high points (38 to 39 from a maximum of 40 points) did not meet the requirements for cultural safety or cultural competence status because they failed to answer certain questions correctly[41]. The question which all groups struggled to answer correctly was question one: 'It is almost impossible to communicate with a client whose first language is not English', followed by question six: 'People from some minority ethnic groups can be very demanding'. According to the scoring tool, the training seemed not to have the desired effect of improving performance. More people answered question six incorrectly after the training than before (25% before, 50% afterwards answered incorrectly).

To summarise, the use of the CCATool established that an overall increase in awareness, knowledge and sensitivity had been achieved after the training measured by the numbers of correct answers. The degree of its increase varied

[41] All generic questions had to be answered correctly in order to achieve the status of cultural safety or cultural competence.

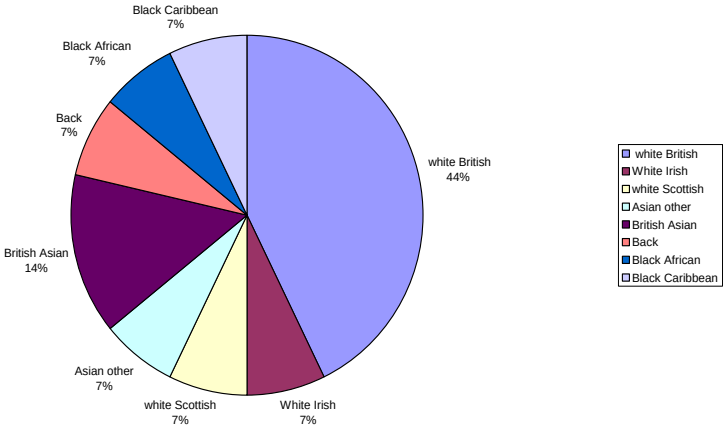
between individuals and groups. The CCATool identified a shift in the levels of cultural competence in that after the training more participants had moved from the category *culturally awareness* into the next category *cultural safety*. However, the tool did not demonstrate a progression to cultural competence for everyone. After the training, some remained within the same category and a few had to revert back to a lower level of cultural competence.

8.4 Job performance

Two focus groups were conducted with a total of 14 former students in order to evaluate the impact of the module on participants' job performance. Data were collected in form of a questionnaire and group discussion. Given the small numbers involved and the fact that there was no significant difference in the results between the two groups their results are grouped together. The key findings from the questionnaire and the group discussions are summarised and presented thematically.

The gender split of the participants was 45% women and 55% men. The overall ethnic distribution was 44% white British and 56% minority ethnic population. For details see chart 17.

Chart 17: Ethnic distribution of the focus groups



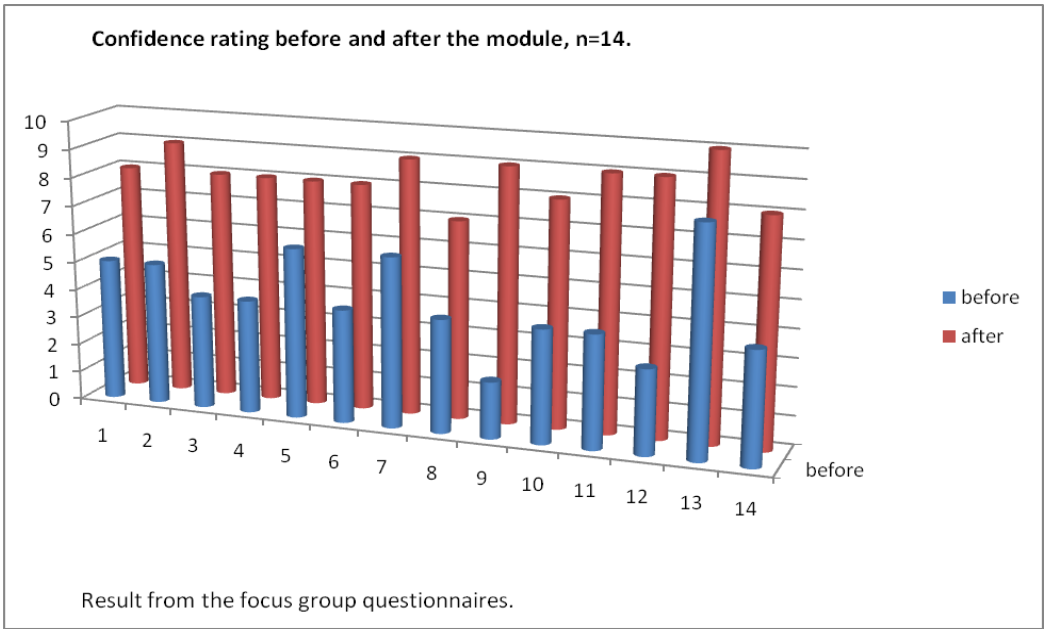
8.4.1 Impact of the module on the individual

The evaluation of the questionnaires revealed positive feedback about the impact the module had on their job performance. Twenty-nine percent rated the relevance

of the module to their working practice as 10 out of 10; 26% gave 9; 24% 8 and 21% 7 points. None rated below 7.

All (100%) said the module had increased their confidence when dealing with clients from a different cultural background. The overall rise in confidence before and after the module was rated on average from between 4.5 to 8.4 out of 10 points. See chart 18 below.

Chart 18: Confidence rating before and after the module



Their increase in confidence was demonstrated by the following example comments: *'Was able to ask questions which I did not dare to ask before'; 'Better understanding of a new group of people to our service and how to accommodate their views of our service'; 'I just became more aware of the differences not just across cultures but also within cultures. No such thing as a homogeneous group'.*

Examples from the focus group discussions confirmed that they had become more aware of the cultural differences of clients, and other matters that they never before thought about. For example, one female key worker told the group that if she had

new clients from cultures unknown to her she would now check the internet to find more information about their cultural habits and values.

Another participant stressed the point that the module had confirmed many of his views. Previously, he had felt that he had only 'woolly ideas' in his head and was unsure whether he was too liberal or perhaps mistaken. It was only after the course that he realised that his views were right and that he was now better informed and could put forward convincing arguments.

Others said they felt they were not doing too badly before the course, but now they had come to realise that they would think differently and were now more aware. Members of the focus group from minority ethnic backgrounds said they were surprised by the diversity of the clients from different cultures and that the course had made them aware of their varying needs.

When asked whether the module changed the way they worked with clients, 86% answered positively in the questionnaires. Unfortunately, those who answered negatively did not give reasons. The answers mostly referred to increased sensitivity, motivation and awareness of clients' needs. For example: *'…(the module) assisted me in treating clients with respect regardless of their culture and to accept their cultural needs and wishes', 'Including more questions in assessment about cultural issues that may impact on clients health and path through treatment', 'Improved my awareness of their needs'.*

All (100%) participants agreed that the module changed their attitude towards clients from a different cultural background. Examples given included: *'Became non-judgemental and clients became acceptable', 'I am more positive about their needs rather than seeing them as a problem'.*

One African-Caribbean drug worker admitted to the group that she had previously considered clients who had language difficulties as a burden. She felt the

communication was difficult and conducting an assessment was complicated and took a long time. After the course she came to recognise language problems not as a burden but as a legitimate need. She discussed this with her colleagues and managers and now it is common practice in their service to book an interpreter in advance if one was required and to allow more time for the appointment.

Another participant said that as a result of the course he felt that the standard assessment was inadequate and had started to include more culturally relevant questions, for example about family history.

8.4.2 Impact of the module on service provision

Eighty-six percent reported in the questionnaires that they had confronted barriers in their workplace when they tried to put elements of cultural competence into practice. Comments given about these barriers referred mostly to lack of understanding of colleagues or managers and to structural barriers.

In the discussion, the participants reported that their managers, and in particular older colleagues, were reluctant to agree to changes. Other barriers that were mentioned were lack of resources, for example finding the funding for translating leaflets or interpreters. Also, being short staffed did not allow much time for extra activities. Despite this, there was overall agreement that their organisation was supportive and had policies in place that promoted equality and equal opportunity for clients and staff. Some criticised the fact that many decisions at service level were left to the discretion of managers and it was felt that not all managers were considerate and fair to everyone.

The participants gave examples regarding the help that they would need in order to implement more culturally competent initiatives. These included: *'Colleagues need to undergo training and awareness and take responsibility', 'Helpful manager', 'Less clients, more time for individual clients'.*

When asked whether they had been able to positively influence attitudes of their colleagues or managers in treating clients from different cultural and social backgrounds in a more culturally competent way, 72% answered positively and 28% negatively. Examples given included: *'Encouraged the team to give clients more time and offer clients choices and options', 'Dissuading colleagues from making generalised statement re. clients or racist jokes'.*

Both focus groups raised the issue that it was difficult to challenge colleagues when they made racist jokes about clients or colleagues. These were often staff who were very much aware of gender discrimination but did not consider their comments as racially prejudiced. The participants disclosed that they felt it difficult to confront colleagues because it could endanger a good working relationship. This issue came also up as prime concern when asked what skills future module deliveries should include. It was strongly suggested that the module should include learning the skills on how they could diplomatically challenge colleagues who had a prejudiced attitude, without jeopardising their working relationships.

Seventy percent of participants said they had been able to implement at least one change within their working areas as a result of attending this course. Examples mostly referred to increasing colleagues' awareness, including: *'More depth introduced in existing questions that are important in gaining understanding of individuals of a culture (family, personal, health beliefs)'.*

Further comments on the module included: *'Very informative, have gained a wider understanding regarding culture in general, would benefit to have continuous or yearly updates', 'Found the course personally challenging'. 'This should be a core part of student nurse training'.*

Finally, there was general agreement that cultural competence should be part of all health services, including the training of student nurses.

8.5 Department and organisation

Five sector managers of one Trust were approached with a questionnaire to enquire about their views on the impact the module had on the service or organisation (see 7.3.1.4). Their answers were summarised and example quotes were chosen that indicate typical responses.

Two managers scored the increase in confidence of their staff as result of the module, from 7 to 8 and from 5 to 8. The others said they were not able to quantify the increase in confidence, but overall felt that their staff were already quite confident. This is confirmed by the following comment:

"In H. (name of service changed, LL) *is a high degree of clients from minority ethnic groups. Staff who work there have already to be confident in order to deal with clients. Therefore, the training probably did not add to their confidence but it added to setting standards of working and to create an understanding of what standards of working is required for the job. The training formalised what was already there."*

All but one respondent felt that the training had changed the way their staff worked with clients. One comment highlighted the difficulty of identifying with certainty that the changes were the result of the training:

"Probably not the training itself, but it formulated part of the thinking, such as equality impact assessment that assesses impact of all policies. Training certainly has created an understanding of the needs for the equality impact assessment scheme."

Other comments gave more prominence to the direct impact training had on the performance of their staff:

"Cultural competence and diversity have been promoted, now staff is reflecting what they can do. In particular they are more aware of population groups in need, for example Somalis or Polish; staff were reflecting what they can do for them and are more aware of the needs and thinking in terms of diversity."

The respondents agreed that the training had changed the way the organisation worked with clients. However, there were differing opinions whether it was the training that had impacted or whether training had built the basis on which the organisation could introduce changes:

"For example induction loops have been introduced for hard of hearing clients, the training made all staff think about diversity of needs, how to enable access, and better appreciation of the needs and the importance how to meet them."

Others commented more explicit about the impact the training had beyond the individual as a driver for change within the organisation:

"One can expect that when the individuals have been trained and become more culturally competent then this should have an impact on the overall performance and quality of the organisation. Staff have formed the equality impact assessment panel, where they take a look at local policies and guidelines to assess them with regards to ethnic, gender, and disability and see how the service is run with regards to these."

When asked whether the training had changed staff's attitudes towards clients from different cultural backgrounds, all respondents agreed. This is highlighted by the following comments:

"Staff never had bad attitudes, but training has certainly kicked off an awareness process of attitudes. Tricky because prejudices can often not be seen, but people have a greater awareness about the impact of negative attitude on clients".

"Staff's attitude was good anyway, the formation of the equality impact assessment panel can be taken as an indicator that their attitude has changed, but whether this is due to training or other activities that happened in the Trust at the same time cannot be said with certainty.

The question whether staff had confronted any barriers with putting cultural competence development work into practice was denied by all respondents and managerial support was emphasised. The respondents were keen to show that staff and managers are working together to achieve changes:

"The majority of changes come from the equality impact assessment panel where managers and staff from the service sit on as well."

"It is in all our interest to make the service more culturally competent."

When asked whether staff attending the training had been able to positively influence attitudes of their work colleagues or managers towards clients, again the answer overall was positive. 80% saw that this was definitely happening as a development process, as the following comments demonstrate.

"There is an ever increasing confidence of staff with regards to these issues, training does build confidence, staff are quite outspoken."

"Many in the organisation have attended the cultural competence course. They are helping others in improving their practice by passing on knowledge to other people and trying to advise colleagues, constantly looking at improving service."

All respondents agreed that staff who had attended the training had been able to positively influence attitudes of their colleagues towards other colleagues. For example:

"I am aware of some staff feeling that they learned new things and that this had affected their practice. One Muslim member of staff said she was able to challenge some colleagues' perception of Muslims, and this must have been a good thing!"

Managers overall were of the view that discriminatory comments between colleagues did not exist in the Trust, or at least were very rare. Yet, one comment demonstrated the discrepancy between wishful thinking and reality:

"Making racist or discriminatory comments is completely unacceptable within the service. However, sometimes discriminatory remarks are often made more subtly and difficult to tackle."

The respondents answered positively upon the degree of changes that have been made and contributed this directly or indirectly to the cultural competence training. For example, one mentioned work that had been done by staff in her service sector:

"Duty policies have been written by the team and the people brought what they learnt in the cultural competence training to the discussion for the production of the policy. The training seems to have made everyone more culturally sensitive. "

Another one commented:

"The training has certainly equipped them to do that. It may not necessarily have been as the result of the training alone, but it most possibly has contributed to a process of change within the Trust."

Another manager reported similar positive examples of initiatives being introduced by individuals or groups of staff:

"Yes. Ethnicity/diversity is standard item at the clinical governance meetings; part of what they do. Being aware of legislation, discrimination, the services display multi-faith calendars, and celebrate other religious festivals in addition to Christmas and Easter. … Also trying to offer induction loop for clients who are hard of hearing, and those who have difficulty reading small print. Also leaflets in different languages and use of interpreters are common practice. Also there are many Polish clients but no Polish speaking drugs and alcohol worker. The team recognised that they need to employ a Polish person as key worker."

When asked whether they had been able to support their staff to implement one or more changes within the working area all of them insisted that when changes occurred it was a team effort rather than initiated by the managers.

"Workers come with ideas to change services; this is discussed in team meetings. Recently the opiate team suggested conducting a diversity audit of all those clients who are prescribed methadone. The reason was that a high percentage of the clients are from Asian background and it was discussed what the implications for the service are."

"A number of activities and changes are being planned for 2008 and 2009 and with staff being trained in cultural competence there is a good basis for achieving these changes. There is a strong management support in the Trust to support staff to contribute time to perform equality impact panels."

One manager highlighted the key issue of how to transfer what had been learnt into practice:

"The training is fine, but how to get their learning into practice. How can organisations achieve this? Perhaps the training could offer more case studies to apply the learning and

skills to practice. More resources need to go into ongoing training to raise staff awareness … and to address how to deal with differences and difficulties that appear in practice."

Another one proposed continuity in training:

"Management should be investing in continuing cultural competence training as there is a big turnover of staff. Staff need to know more about the needs of different ethnic populations; also about diversity issues. There was now a merger of different equalities scheme into a single equality scheme and future training needs to cover all areas of discrimination."

Others concluded:

"The training was good and useful for staff and the organisation. It identified standards of working, made people more aware of diversity and enabled them to contribute to the development of policies and improvements in practice."

The interpretation of the key findings of the evaluation tools at all the different evaluation levels will be discussed in the following chapter.

9. Discussion of the findings

In the following section the key findings of the evaluation will be interpreted and their overall results discussed.

9.1 Evaluation of participants' reaction

The evaluation of the students' reaction in the questionnaires and group discussions revealed the students' overall positive views on the module.

The teaching and learning strategy for this module emphasised interactive learning, building on existing knowledge and experience (Epstein, 2002). The role of teachers therefore is to motivate and facilitate a process of learning and critical reflection (Jarvis, 2002). The evaluation revealed that overall the students appreciated the teaching style and felt motivated and supported in their learning. They valued the group discussions and felt safe when expressing their views. They also liked the non-judgemental attitude of group members, and felt that everyone was able to express their views and was respected with their opinion. The end-of-term evaluation confirmed that 98.5% found the learning was designed to stimulate their curiosity and reflection on practice. Overall, 95.4% said the questioning approach stimulated their learning. These findings suggest that the social constructivist model of learning that was applied to the teaching strategy of this module has, to some extent, been successful.

An important component of the teaching and learning strategy was the diversity of the group in terms of cultural and professional backgrounds. Group activities and interactive learning exercises aimed to enable the participants to learn from each others' experiences and knowledge (Epstein, 2002) and reflect on existing differences (Clements and Jones, 2006). The evaluation demonstrated that the learners appreciated the diversity of the group. The cultural and multidisciplinary mix

of the group offered multicultural learning and the opportunity to learn from each other. Others found the diversity of the group challenging, but said that it also gave them a chance of getting to know each others' culture and beliefs. The classroom encounter gave participants with different experiences and views ample opportunities for critical reflection, challenging attitudes and acceptance of differences. Reflection and managing diversity was used as part of the teaching method to enhance the process of becoming culturally competent (Clements and Jones, 2006; Campinha-Bacote, 1999). The positive learning effect of having a diverse audience in terms of gender, profession and ethnic group was also recognised by Webb *et al*.'s (2003) evaluation of antiracism training for professionals in child health.

Comments with regards to the module content were also positive. The students found the content very interesting and highly relevant to their working areas. A vital element of the teaching and learning strategy was to develop a research-based content for the module to continuously ensure that the content is up-to-date. This involved including the latest theoretical concepts and practice developments in the field to ensure that the module is relevant and suitable to the participants' diverse working practices. The students' positive views on the usefulness of the module for their personal and professional development (97%) and for their working practice (95.4%) suggest that this strategy was somewhat successful.

Concerns identified by the evaluation in relation to the module were, as far as possible, dealt with immediately by the tutor or changes were introduced for future modules. A flowchart in Appendix 4 shows the changes that occurred as a result of the module evaluation. Examples were the decision to allow students to develop their own case study for the assignment. This proved to be successful because on future courses students who used their own case studies did very well in the assignment. This can either mean that with an enhanced ownership by use of their own case study the assignment was more relevant to their working experiences (Thompson *et al.*, 2008) or that they were more motivated to begin with (Epstein,

2002). Further examples included sending out clear and detailed information on the course aims and content to the employers and funders to prevent people coming onto the course with wrong expectations (Jarvis, 2002), and gradually putting more emphasis upon reflection on practice, which helped the participants to better relate their new knowledge to their working practices (Thompson *et al.*, 2008). This also assisted the tutor in establishing and building on their existing knowledge and experience (Jarvis, 2002), so enhancing the relevance to practice for the students' diverse working environments (Freire, 1972; Thompson *et al.*, 2008). Furthermore, an increased focus on diversity rather than ethnicity, the use of more guest speakers and discussing contemporary issues that had been talked about in the media helped to keep the content relevant and up-to-date.

As demonstrated above, the strength of the evaluation is that it can help the teacher to uncover students' concerns and initiate appropriate changes (Forsyth *et al.*, 1999). In early module deliveries, some issues of concern had not been detected by the tutor on time. For example, the strong discontent of the A&E nurses in the February 03 course had not been noted until expressed in the end of term anonymous questionnaire. Therefore evaluation needs to provide robust tools to identify any issues of concerns that may have been overlooked by the teacher.

Collating participant's views by self-reporting is likely to produce 'soft' subjective rather than quantitative 'hard' data. Many factors can influence student opinions on the usefulness of the module positively or negatively. For example, students are likely to rate a module positively if they found the content of learning interesting, highly relevant to their work, if they enjoyed the teaching and learning and felt motivated and supported in their learning (Kember, 2000; Goeudevert, 2004). Negative ratings were likely to occur if the students were not motivated to do this course (Epstein, 2002), but were sent by their employer; also, if they have not had enough time to engage in the required reading and preparation and as a result could not satisfactorily participate in the discussion and felt that they were losing out (Jarvis, 2002; Epstein, 2002). Others may have found that their expectations were

not met, that the course did not take their prior knowledge and experience into account (Jarvis, 2002) and that they were wasting their time. Still more may have felt they were not able to apply the newly learnt concepts to their working practice (Clements and Jones, 2006).

Dissatisfaction may also have been caused by situations in class that had been overlooked by the teacher and were not identified, and solved, in time. For example, the high number of external students in earlier cohorts increased not only the diversity of the participants' professional and academic background, but also their expectations and motivations. Diversity became a challenge for the teacher and for the group and may have contributed to some frustration that was reflected in lower ratings. Dissatisfaction can also be the result of unmet learning needs (as in the case of the A&E nurse in the Feb 03 cohort) or unsolved conflicts within the class (as in the Feb 04 intake).

An educational module like this, aiming at behavioural change, needs to be flexible to adapt its content and teaching to the participants' learning needs. In order to maintain a convincing teaching strategy, concerns need to be identified and acted upon swiftly. Again, this requires robust evaluation tools.

The fact that in most cases the results of the anonymous questionnaires mirrored the outcome of the group discussions demonstrated that students felt free to be open and honest (Epstein, 2002). This could be interpreted as an indication that it was possible to create a relationship between teacher and students in which the participants felt safe to openly express criticism or concerns (Freire, 1972; Castling, 1996). The fact that relatively few criticisms were expressed may indicate that participants appreciated the module content and teaching style and had no reason to criticise. It is possible, however, that participants did not want to criticise because they liked the teacher, or were anxious to avoid negative consequences in class or for their assignment mark. This confirms the importance of anonymity when obtaining participants' views (Forsyth *et al*., 1999; Cohen *et al*., 2007).

An important component of critical pedagogy is to enable an equal dialogue between teacher and students in which students freely express any concerns and critique (Freire, 1972). The evaluation revealed that this has not been achieved to the desired extent. The evaluation of the anonymous evaluation sheets revealed issues of concern that had not been mentioned at any time during the module or at the mid- and end-of-term group discussions. Fortunately, the anonymous nature of the evaluation form offered the opportunity to express concerns. On reflection the tutor's expectations that the students could freely criticise the teacher (Jarvis, 2002) were overoptimistic. Similarly, the expectation that students would take responsibility for their own learning seems to have been overambitious. For example, the February 04 group, rather than confronting their dominant fellow student, they expected the tutor to intervene and solve the problem for them. The fact that these issues were only mentioned in the end-of-term evaluation form deprived the participants from the experience of engaging in a debate with the opportunity for problem-solving.

Retrospectively, to avoid that concerns and negative feelings were not identified during the module, future module evaluations should be carried out by an independent colleague rather than by the teacher herself in order to ensure anonymity and, as a result, honest feedback.

Not everyone took the opportunity to express their opinion in the group discussion and evaluation forms. If no feedback was given this made it difficult to establish their views on the usefulness of the module leaving their views open to interpretation. In later cohorts the tutor highlighted the importance of evaluation and feedback with the result that the response rate increased. Emphasising the importance of evaluation has therefore become an integral part of the teaching of the module.

The overall positive student response to the module and the teaching strategy suggested that the objectives of the evaluation at the level of '*participants' reaction*' had been achieved. However, feedback from students as to whether they liked the

module and if they found it useful for their personal and professional development is not a strong indicator to find out if the participants really had learnt something from the module. As outlined in section 7.3.1.1., evaluation of student reaction is a weak tool when it comes to establishing whether the goals of this module have been achieved (Forsyth *et al*., 1999). This kind of evaluation cannot establish whether, and to what degree, learning has taken place. However, considering the strong indications from the literature (Palmer 1998; Jarvis, 2002), that high student satisfaction is very likely to complement increased motivation and ability to learn and result in increased performance, it can be assumed that the module was likely to be successful.

9.2 Measuring learning

9.2.1 Analysis of assignment results

The purpose of the assessment strategy (section 6.1.6) for this module was to enable the students to demonstrate their knowledge, critical reflection and cultural competence with regards to the module learning outcomes (see section 6.1.5). The assignment was used to establish the degree to which the key concepts were understood and applied to practice and to see if the learning outcomes had been achieved. The understanding was that when all learning outcomes had been met then a degree of cultural competence could be assumed. The analysis of the assignment results showed that, overall, 76% of the students met the learning outcomes and passed, 29% with very good and 26% with good marks. From these findings it could be assumed that 76% of the students had achieved a degree of cultural competence.

The high number of non-submissions (see section 8.2.1) made it difficult to establish whether these students had learnt anything, and if the concepts had been understood and the learning outcomes achieved. However, positive comments in the end-of-term questionnaire gave the impression that participants felt they had learnt something. For example, in the Feb 03 cohort, the group that showed the highest non-submission rate, the end-of-term evaluation established that, apart from three local A&E staff, most of the external participants found the course useful for their personal and professional development, even though they did not submit their essay. Nonetheless, learning may be limited as much of it takes place during assignment writing by organising and analysing the learnt content (Forsyth *et al.*, 1999). The learners are often overwhelmed by the amount of information given throughout the module and most will only appreciate how much they have learnt after they have finished writing their assignments.

The assignment revealed whether the student has been able to gain an understanding of the theoretical concepts and was able to put them into practice by developing a culturally competent assessment and care plan for a case study. However, it is in the nature of academic assignments that results are greatly influenced by the learner's academic abilities (Forsyth *et al.*, 1999). Many factors can influence the quality of assignment writing. Some students are experienced learners with very good analytical and academic writing skills; others may not have had much practice in writing academic essays. For example, two of the students in the June 05 intake, who just managed to cross the pass mark of 40%, were poor in referencing, coherence and structuring the essay, critical analysis and expressing themselves in writing. This brought down their mark. However, they achieved relatively good marks for the content of their essay, which suggests a degree of understanding cultural competence.

This confirms concerns expressed by Forsyth *et al.* (1999) that in written assignments seemingly unrelated skills are assessed and influence the mark greatly. However, as this is an undergraduate Higher Education module a certain level of critical analysis and academic writing skill is expected to justify a pass and meeting the learning outcomes. Writing academic essays and using case studies are widely recognised as excellent tools to test whether concepts have been understood and applied to practice (Sanderson, 1992). This is particularly the case in cohorts like in this module where many participants do not have English as their first language and might struggle with writing.

Further factors include whether the learner was motivated (Epstein, 2002), had enough time for assignment preparation, or whether family commitments or a heavy workload reduced study time. Two students in the June 05 cohort were affected in such a way, which prevented them from having enough time for assignment writing. Their low marks did not give an indication on their understanding and whether, or how much, they have learnt. Therefore, low marks do not necessarily give an indication that little has been learnt. Similarly, good marks do not necessarily

indicate a high degree in learning but may be a reflection of the student's prior knowledge and understanding.

The assignment results may reflect general academic skills or pre-existing knowledge more than, or as much as, learning content or ideas. Therefore, there are limitations as to what a researcher can infer from assignment results.

In conclusion, the module assignment was useful in identifying if, and to what degree, the students had met the learning outcomes and whether concepts had been understood and applied to practice. However, it was not possible to indicate whether an increase in knowledge had occurred as a direct result of studying this module. In order to measure an increase in learning it may be better to collect existing levels of knowledge before and after the training event (Brookes, 1995).

9.2.2 Analysis of the self-rated questionnaires

The analysis of the pre- and post-test self-rated questionnaire in all six cohorts suggested a substantial increase in self-perceived knowledge overall in all ten categories. Variations between the module intakes and between the subject categories were identified, potentially due to many factors. For example, the participants may have built on a high level of existing knowledge (Jarvis, 2002) in order to achieve such good results; students were highly motivated (Epstein, 2002) to learn more about the subject; the teaching style (Goeudevert, 2004) or the atmosphere amongst the group members stimulated their learning (Jarvis, 2002).

The variations may also be due to the nature of the self-rating questionnaire as it depends on subjective rating (Cohen *et al.*, 2007). Many factors influence the ratings. For instance, some participants may have overestimated their prior knowledge and during the course they found that there was more to learn than they had thought. Others may have underestimated their level of knowledge. Furthermore, responses at the end of the course may have been influenced by

emotions as to how useful they had found the module. This may have been the case with the A&E nurse in the Feb 03 cohort who consistently rated her knowledge before and after the course as 'nothing'. As she did not submit her assignment, her degree of learning could not be established. Other factors included how well students were able to relate to the group or the teacher. The June 05 group was enthusiastic about the course and engaged in high quality discussions. They rated their knowledge afterwards as very high. However, this was not confirmed in the quality of the assignments for the whole group. A quarter of the group just managed to reach the pass rate of 40%.

This data was collected on the last study day, four weeks before the assignment was due. At this point, some students may have been overwhelmed by the amount of information they had received and were uncertain if they had understood the concepts. This might have been true in the Feb 03 cohort with many external participants unused to academic learning. The high non-submission rate in this group supports this. However, from the high quality of the assessments that have otherwise been submitted (11% very good and 67% good) it could be assumed that many participants underestimated their degree of knowledge. Others may have had high self-perceptions of their knowledge or failed to understand the importance of evaluation. This presumably was the case with one student in the cohort June 06 who consistently rated his knowledge prior and after the training as 'very good', but failed the assignment.

The analysis of the self-rated questionnaire demonstrated a significant rise in perceived knowledge. However, the findings raise questions about the effectiveness of measuring 'learning' by means of a self-rating exercise. In contrast to the academic assignment, the self-rating exercise offered the advantage that it allowed comparison between two sets of data, before and after the learning event (Brookes, 1995). Still, self-rating is only a crude tool. Its limitations are based on the students' subjective perception of their own knowledge and there is little possibility for the researcher to find out whether the respondents told the truth (Cohen *et al.,* 2007).

Only by using various evaluation instruments and linking their results can one get closer to the truth; for example by comparing the results of the self-rating questionnaire with that of the assignment or the anonymous evaluations sheet, and observation in class, as demonstrated in the examples above. This must be considered when interpreting findings.

Measuring knowledge is not straightforward. In new areas of knowledge it is possible to attribute any increase to the training intervention (as was the case with those participants for whom the subject of cultural competence was totally new). However, if the programme is building on existing areas of knowledge it is challenging to quantify as to what extent the knowledge, skills and attitudes shown after the event are attributable to the learning event (Brookes, 1995). Several educationalists have commented on the fact that the extent of 'learning' is generally difficult to measure as many factors influence the ability to learn over a given period (Jarvis, 2002; Forsyth et al., 1999). These include student satisfaction, teaching style, relationship between teacher and student, motivation, expectations, time available for study, relevance to the work place, and degree of prior knowledge on which to build. Furthermore, learning is a lifelong process (Epstein, 2002; Blake *et al.,* 2003). Therefore, it is difficult to ascertain when learning begins and ends, and to limit learning to a particular time frame. As discussed above, learning can take place during the module, and for a long period after the module finished. Teaching lays the foundations for learning at a later stage.

9.3 Measuring attitude change

The CCATool (Papadopoulos *et al*., 2004) demonstrated an overall increase in cultural competence in all three groups and for most individuals. The tool also established an increase in the levels of cultural awareness, cultural knowledge and cultural sensitivity. However, participants failed to achieve the 'perfect' cultural competence score because they failed to answer some questions correctly. Also, the shift in score from before and after the training was not progressive. Most participants moved up in their level of cultural competence, but a few participants' scores decreased. For example, more people answered question 6 incorrectly after the training (25% before, 50% afterwards).

This raises questions as to whether participants were in fact not culturally competent enough to achieve the status of cultural competence or if the questions were too rigid and did not allow enough flexibility in the answers. The Likert scale, as used in this attitude scaling tool, is widely used in research as it provides a range of responses allowing flexibility. It presents quantity and quality in analysis (Cohen *et al.*, 2007). However, its use in this study presented a number of limitations. Firstly, as it is self-administered there is no way of checking whether the respondents replied truthfully (Cohen *et al.*, 2007). Their answers might have been influenced by a variety of factors, including wishing to please the tutor or to be able to achieve the required result, the perfect cultural competence score. Further, the Likert scale allows a range of answers, but answering the questions may require a more complex response to consider the social and cultural context in which the situation occurs. Also, the tool does not allow enough flexibility in the interpretation of the individual cultural competence levels.

For example, a 64 year old female from Indian ethnic background, who had 13 years of service as a psychiatric nurse and spoke four different languages, answered all

other statements correctly, but failed to achieve cultural competency status because she wrongly answered three questions from the category of cultural sensitivity. For example, she agreed with statement one, that it is impossible to communicate with a client whose first language is not English, and with statement six, that people from some minority ethnic groups could be very demanding. There may be many reasons for her answers. She might have wanted to highlight a cultural issue, in that because of her Indian background she may find it difficult to communicate with someone from an African Caribbean background. The answer suggested that she was not culturally competent. Alternatively, she might have wanted to highlight that one cannot communicate effectively across a language barrier, so a professional should ensure an interpreter is available. Perhaps participants felt awkward answering these questions without having the opportunity to add additional comments. Also being able to respond creatively in communicating does not conflict with a view that there are difficulties. With regards to statement six, she might have wanted to indicate that some minority ethnic groups, because of the socio-economic context in which they live, have complex needs and meeting these needs requires more time and expertise from professionals to deal with them. In this case the answer she gave was correct, even though the score indicated it was wrong.

Furthermore, data analysis suggests that there are limitations with the use of fixed tools which define certain answers as unequivocally correct, when so much of this is subject to debate. Views on what practice is ‘right’ or ‘wrong’ are defined according to current accepted understanding of best practice, but this can change with experience and when different things are learnt.

There is no way of knowing whether the respondents felt limited in their response choice. They might have wanted to add further comments or felt that their view was not entirely expressed by the existing rating scale. Increasing the five scales to seven, giving the opportunity to chose ‘other’ as an alternative if the given choices do not apply, adding opportunities for comments, and further differentiation of the

cultural competence levels may help to create a more complex picture of the level of cultural competence.

Apprehensions about the validity of this tool have been raised by recent research (HASCAS, 2007) that tested the CCATool (Papadopoulos et al., 2004) in a two-day cultural competence training course for CAMHS (Children and Adolescent Mental Health Services) personnel. The evaluation included feedback on the training provided and completion of the self-assessment questionnaire. The feedback was positive, stating that the training was appropriate and of a satisfactory standard. The evaluation of the self-assessment questionnaire provided an indication of the level of the individual participants' cultural competence. The evaluation report recommended, however, further developing of the scoring rationale and a formula that calculates the level of cultural competence should be undertaken to enhance the sensitivity of the tool and to make it fit for practice.

The difficulty of measuring changes in attitude as a result of training has been reported by other authors (Martin *et al.,* 2002; Webb *et al.,* 2003). Martin *et al.* (2002), who attempted to assess changes in attitudes in medical students, argued that attitudes are complex mental processes that cannot be measured directly. Furthermore, the complex relationship between education, attitude and behaviour was not clear. The authors questioned the reliability of attitude scales in measuring a change in attitude in clinical practice and also indicated the potential bias of self-reported questionnaires, in particular if they were not used in an anonymous manner. The authors concluded that a single methodological approach is not suitable to provide valid results but recommended a multidimensional approach that included case studies and observation. However, both tools may also be prone to potential response bias.

The relatively small increase in the cultural competence score may be due to the fact that participants' reported a high baseline level of cultural competence. Working in a multicultural environment and serving a diverse patient population in Greater London

may result in a high level of experience without formal training. This was confirmed by the sector managers who commented in the questionnaires that their staff was already highly confident in dealing with people from different cultures.

Furthermore, a vital omission of this tool was that its concept of cultural competence focused only on minority ethnic and anti-racist issues. It did not take into account other forms of discrimination, that are, for example, based on religion, gender, socio-economic status or sexual orientation, that can equally impact negatively on the degree of cultural competence. Such a focus is limited for use in this research that is based on a wider concept of culture and cultural competence. Differences in the concept of cultural competence made comparison of the achievement of this module complicated. In order to be useful in measuring cultural competence in the wider sense of diversity and anti-discrimination, a CCATool also needs to include questions that capture discrimination and inequality on a wide range of issues not only ethnicity.

In conclusion, the CCATool identified an increase in cultural competence in all three groups. However, this increase was small and limitations have been encountered with the rigidity of the responses and the way responses were scored to establish cultural competence. Measuring attitudes is a complex exercise and questions on cultural competence often require more complex answers. Furthermore, the concept of cultural competence used in the CCATool was different to that of this research. For these reasons, caution needs to be taken when interpreting these findings.

9.4 Job performance

An important element in measuring the success of a learning event is to establish whether the participants have been able to transfer the theoretical learning to their working environment (Forsyth *et al.*, 1999). Only then can it be said that the training has truly been effective. If learning is not consolidated back in the workplace through practicing their newly learned skills or using newly acquired knowledge, the learner is more likely to forget what has been learned. An important component of the teaching and learning strategy of this module was to bridge the gap between theory and practice and not only to enable the participants to understand situations and their underlying factors, but also to change them (Cohen *et al.*, 2007). Therefore, whether this module has been effective or not depends upon the degree to which the students were able to apply what they had learnt in the module to their working area and whether a change in on-the-job performance could be attributed to the training programme.

The analysis of the findings of the focus groups with former students revealed that overall the participants felt that the module had a positive impact upon their job performance. All participants said they found the module relevant for their working practice and felt that it had increased their confidence and changed the way that they worked with clients. Participants felt they had gained an increase in knowledge, understanding and attitude. This enabled them to understand diversity better and be more positive about their clients' complex needs, less judgemental and accepting. Some felt they were better informed and more confident in arguing their point with colleagues and managers.

The limitations of self-rated questionnaires and group discussions, and their potential for responder bias, have been discussed already (Martin *et al.,* 2002). However, the fact that the anonymous questionnaires mirrored the responses of the group discussion gave some confidence in the validity of the findings. In addition, the self-

rated answers were underpinned with examples from the participants' practice, which can add support to the reliability of the responses.

The sample of the two focus groups was small and sampling was arranged by service managers within the Trust rather than by the researcher. Response bias is possible because those who volunteered to take part in this research were likely to have been highly motivated in the subject, had a positive experience with the module, had a good relationship with the teacher and passed the assessment. All of them were highly enthusiastic champions who to various degrees had taken on the task of enhancing cultural competence in their workplace. Many of them had recommended this module to fellow colleagues and managers. The positive findings, therefore, are not surprising. A more mixed focus group with individuals from various services, including those who failed the assignment, may have produced different results.

The fact that participants strongly believed that the module had a positive impact on their performance at work and on their self-confidence is valuable in itself. Bandura (1977) in his early work stressed the importance of self-efficacy beliefs, the beliefs that someone has the skills that are necessary to complete a task successfully, as indicators of someone's thinking and behaviour. Strong self-efficacy is usually reflected in motivation and self-confidence. Individuals with a strong self-efficacy belief are likely to take on complicated tasks without doubt in their abilities to succeed. Individuals who are unsuccessful are likely to fail because they lack the belief that they are able to use their skills effectively, rather than they lack the necessary skills. Following Bandura's argument that an individual's judgement of their own performance seems to be important for the development of self-efficacy and that there is a strong relationship between self-efficacy and self-confidence (Bandura, 1995), it could be concluded that the module had an impact on the students' job performance and enhanced their competence.

The findings of the focus group highlighted that participants were highly enthusiastic and committed to introducing positive changes in their area of practice. They recognised many opportunities to improve the care of the client and proposed valuable suggestions. Propositions surrounded issues that aimed at achieving client-centred care and user involvement. Participants were able to initiate some improvements in their working area and convince some of their colleagues, or managers, of the benefits of implementing culturally competent care. However, the enthusiasm of the participants to implement what they had learnt in the module was frequently obstructed. Eighty-six percent of participants admitted that they had encountered some kind of barriers in their workplace that prevented them from putting new ideas into practice that would make the service more responsive to the clients' diverse needs. The barriers ranged from time constraints, lack of resources, and reluctant and unhelpful colleagues and managers. Although the view prevailed that their organisation was supportive and had policies in place that promoted equality for clients and staff, there was a strong view that managers also needed to undergo training and take responsibility for driving cultural competence forward.

These comments highlighted the importance of managers' and colleagues' support for the implementation of new ideas. Only then can the enthusiasm and motivation of those who attended the training be utilised to implement change and improve their practice and that of the organisation (Sanderson, 1992). The importance of management support was highlighted by Thom *et al.* (2006). They evaluated cultural competence training curricula, but could not find a measurable impact of training of physicians on patient-reported and disease specific outcomes. The authors identified the brevity of the 4.5 hours training, lack of institutional based support and reinforcement of changing behaviours as study limitations. The authors concluded that in order to achieve sustained changes in behaviour, interactive training, dedicated practice time and reinforcement of behavioural changes in the practice were necessary.

Researchers have commented on the difficulty of measuring the effect of training on practice by measuring changes in a person's behaviour and job performance, because it is hard to isolate the effects of training from other influences (Forsyth *et al.*, 1999; Sanderson, 1992; Brookes, 1995). Many other factors may influence job performance and may reflect negatively on the outcome of the module. For example, senior members of staff, managers and organisations may not be open to change and do not support the learners in their effort to implement new ideas. Managers and organisations may be reluctant to agree to an evaluation because they fear blame because of possible short comings in their working practice. Furthermore, organisational culture, and also individual personality, may prevent learners from putting their new skills into practice (Forsyth et al., 1999). If participants return to their work place after successful training with new knowledge and ideas for change, but are not encouraged to implement them in their practice, the ideas and enthusiasm quickly decrease and participants will not change their behaviour (Sanderson, 1992). Activities such as action planning during the course and official follow-up visits by the trainer have proved to be effective ways of providing support and may encourage participants and managers to implement changes (Sanderson, 1992). However, to achieve this, the commitment of senior managers is needed.

Based on the findings of the evaluation and confirmed by evidence from other researchers in the field, it could be concluded that the module was likely to have had an impact on the individual's knowledge and attitude, resulting in a better understanding and improved way of working with clients. Nevertheless, the wider impact of this module on improvement in services was limited where there was a lack of support from the managers.

9.5 Department and Organisation

The key questions put to the sector managers (see 7.2.2.4) aimed to examine if they felt the training had impacted on the individual staff's performance and working practice, if the training had been able to achieve an effect beyond the individual and influenced changes within the organisation.

The analysis of the sector managers' questionnaire revealed that they saw changes in staff confidence, performance and attitude towards clients. The respondents felt that the organisation had changed for the better in how it worked with clients. Many initiatives that were introduced by individual staff members had been taken up by the team or the service. The managers were keen to show that they were supportive of staff who wanted to implement changes to the way services were delivered and that implementing cultural competence in the organisation was a team effort. This is in stark contrast to the findings from the focus groups with staff that had attended the module, where 80% of participants said that they had encountered barriers from their managers or older colleagues. However, it has to be acknowledged that the survey with the managers was conducted a year after the focus groups. During that year the organisation had gone through a comprehensive training programme which may have resulted in a change in the managers' view of the need for cultural competent practice and the importance of supporting their staff.

Overall, the respondents were positive about the training and the changes that had been introduced and attributed these directly or indirectly to the training programme. However, the respondents were divided as to the degree to which training had been able to achieve changes in the organisational culture; was training the driving factor for initiating change or did it simply provide the basis for such thinking and reflection on practice.

Some respondents strongly believed in the impact of the training. They argued that when the individuals had been trained and became more culturally competent this would have an impact on the overall performance and quality of service within the

whole organisation. They felt that those people who had attended the module were now driving forward the debate upon how best to promote equality and diversity in the workplace, helping others to improve their practice too.

Others argued that the training may not have been the decisive factor for instigating change, but added that the training set the standards for working practice that the job required. Training also provided an understanding of diversity and discrimination issues, the need for legislation and of the equality impact assessment scheme. In this sense, the training formalised what was there already and it also gave space to reflect and explore.

The proneness of self-rated and self-reported questionnaires to responder bias as identified in the previous section with ex-students applies here too (Martin *et al.,* 2002; Cohen *et al*., 2007). The sample was small and, although the sampling was not arranged by the researcher, response bias might have occurred. The small number of participants and their comments on their staff and services waived the intended anonymity of the questionnaire. The fact that some of the participating managers had attended the module may have impacted on their insight, but also on their partiality. The proponents of the training who strongly believed the impact training can have on staff's work performance and the organisational culture had formerly attended the module themselves and had become champions within their service. Others who had not attended the module tended to express the view that organisational strategies and guidelines rather than training impacted on organisational culture and behavioural change. This could be interpreted as response bias but also as a positive outcome of the training, that seemed to have motivated them and created a strong desire for cultural competence (Bhui *et al.,* 2007; Camphinha Bacote, 1998).

The key issue raised by the managers on the direct or indirect impact of the training highlights a common issue that reflects the wider debate on the impact of education on clinical practice (Sanderson, 1992; Forsyth *et al.,* 1999). It forms an integrative

part of attempts to measure the impact of learning and is in the heart of the debate as to whether cultural competence training can be successful in changing individual and organisational behaviour (Thom *et al.,* 2006; Bhui *et al.,* 2007; Webb and Sergison, 2003). The debate is ongoing but the limited research undertaken already to evaluate the impact of cultural competence training on clinical practice appears to suggest that if cultural competence is to go beyond the individual member of staff and influence a service at the organisational level, cultural competence needs to be embedded in the infrastructure and ethos of the organisation (HO, 2002; Bhui *et al.,* 2007). Service-providing organisations need to design and implement service provision to meet the needs of diverse population groups and need to work in partnership with communities and service users (Bhui *et al.,* 2007). Active support from senior management and strong leadership is needed to give a strong message and an organisational commitment (HO, 2002; Martin *et al.*, 2002). There is overall agreement that training can thereby play an important part, but the priority given to it differs.

In summary, there were different views as to the degree that changes were due to training alone or whether training was the basis on which a process of change within the Trust could be achieved. There was, however, agreement on the benefits, in that the training was useful for the individual staff and the organisation and that it should continue as an ongoing rolling programme. It had identified standards of working practice and enabled people to initiate and contribute to improvements within the organisation. The importance of assisting the trainees, so that they were able to transfer what they had learnt to their working practice, was emphasised.

9.6 Summary and conclusions of the study

The evaluation research strategy for this PhD study has been carefully designed to establish the effects of the module. A range of outcome measures were chosen to provide a comprehensive picture of the impact of the module (Forsyth *et al*., 1999; Brooks, 1995). The outcome measures were deemed to be realistic and achievable. The assessment of satisfaction was easiest to achieve, and the impact of the training beyond the individual member of staff on organisational performance was the most difficult to measure. This has also been reported from other authors (Thom *et al.,* 2006; Clemens and Jones, 2006), as attitudes are subtle, part of personal development and therefore difficult to measure.

In order to enhance the validity of the findings the evaluation did not rely on a single assessment process but chose a number of different approaches (Clements and Jones, 2006). Ten different evaluation tools were used to evaluate the outcome of the module. It is in the nature of each of the evaluation tools that there are limitations in what can be measured because of intrinsic methodological problems with each of the tools (Cohen *et al*., 2007). A comprehensive, multidimensional approach was, therefore, used to be able to minimise possible limitations of each of the tools.

The high number (97%) of participants who reported in the evaluation questionnaires that they found the module useful for their personal and professional development could suggests that the module was successful. However, the feedback on whether the students liked the module and whether they found it useful for their personal and professional development and for their working practice is not a strong indicator whether the participants really have learnt from it.

The analysis of the assignment revealed that 76% of participants (95% of those who submitted their assignment) achieved the module learning outcomes. This could be taken as indicator that they achieved a degree of cultural competence. However, although assignments can establish whether learning outcomes have been met, whether the key concepts had been understood and the ability of writing academic

essays, they cannot measure whether the knowledge and skills were acquired through the training.

The findings from the self-rating questionnaire to measure an increase in knowledge before and after the module demonstrated an overall increase in self-perceived knowledge in all ten categories. Again, this could indicate that participants' knowledge had increased after the module. However, the self-rating scores are subjective and may over- or underestimate knowledge before and after the training event.

The CCATool showed an increase in the level of cultural competence indicating a change in attitude. Yet, the tool's scoring system did not allow answers that provided more complex views. This means that the cultural competence status the individuals had been allocated may be either over or underestimated.

The findings from the focus groups with former participants brought to light an increase in self-confidence and their ability to implement some changes in their clinical practice. Also the analysis of the questionnaires from their managers established that positive changes had occurred within the organisation's service provision and culture. The benefit of the training in achieving this had been recognised. Yet, questions were raised as to the limitations of determining to what degree training had been the driving factor for initiating change or whether training simply provided the basis for reflection on practice.

Despite the limitations that each of the tools harbours, the research approaches complement each other by providing evidence from different angles. The analysis of the findings of all the tools together provides a more comprehensive picture and gives confidence into the validity of its findings.

A limitation of this evaluation research was its small scale and the relatively low number of participants. Ongoing evaluative study of this module, and similar training events, is recommended so as to be able to get a fuller picture of the implications of educational interventions of this type.

Furthermore, the research approach of teacher-as-researcher could be the source of a possible bias in data collection and interpretation (Bennett, 2003). These concerns had been addressed by careful planning of the research in all its stages, for example by bringing critical distance to what was researched, formulation of the questions, the design of the study, the ways in which data were collected and analysed and by identifying potential limitations or improvements. In critical reflection, more measures can be undertaken to increase objectivity, including the use of an independent tutor to facilitate the mid-term and end-of-term evaluations. This is to ensure anonymity and encourage participants to freely express their critique.

This evaluation intended to measure the impact of learning from the module on the individual behaviour, job performance and the cultural competence of the organisation. To some degree this has been done as part of this research by focus groups of former students and questionnaires with sector managers of one Trust. However, the scope of this PhD study was limited by what could be achieved. From the analysis of the process of the research and its findings it is suggested that future evaluations to measure the impact of learning within organisations need to extend the evaluation methods that measure the impact of the module on job performance and organisational development (Bhui *et al.,* 2007; Sanderson, 1992). Ideally, this should be done on a different scale in a survey adopting a different educational evaluation approach to that of action research. Other instruments should be included, such as using a control group that did not receive training, performance rating by managers before and after the course with regards to motivation and skills, observation or attitude surveys, evaluating the implementation of action plans and projects and by assessing job performance against occupational standards (Sanderson, 1992), such as KSF (Knowledge and Skills Framework) (DH, 2004), NVQs or DANOS (Drug and Alcohol National Occupational Standards) (Skills for Health, 2004). Such an evaluation approach requires the support and close involvement of the organisation's management.

Conclusions

The findings from this PhD research show that evaluating the impact of a learning event is not without challenges. Each of the tools used has intrinsic limitations in what it can measure. However, the analysis of the findings at each evaluation level clearly demonstrated that the learners had been able to benefit from the module and that they had been able to some extent to transfer the knowledge and skills gained in the module into their working area. A positive change in their work performance had been reported and respondents felt that this had impacted well on the performance and culture of their organisation. Despite the limitations discussed above, the analysis of the results of all the evaluation exercises suggested that the module had been effective in enhancing participants' individual cultural competence. There is, however, inconclusive evidence as to whether changes in practice have been initiated directly by the training or whether the training created the basis on which the organisation could build on.

On these grounds it may be safe to conclude that the module was able to enhance individual knowledge and attitudes, resulting in a degree of cultural competence. However, such a module can only achieve organisational change if there is structural and managerial support provided within the organisation.

10. Overall discussion and lessons learnt – wider implications of the study

This chapter reflects on the wider impact of this study on the fields of educational research and anti-discrimination training. Firstly, it will discuss whether the educational approach used for the development and delivery of the module was successful in supporting the aims of the module. Next, the research approach for this evaluation will be examined to see if the findings were robust enough to suggest whether the module was successful. This is followed by a discussion of the general implications of the findings for other educational work and for the ongoing debate on diversity and anti-discrimination training. Finally, based on the findings of this research, recommendations are being made upon how to take the learning from this study forward to achieve cultural competence in services.

10.1 Has this educational approach enhanced the effectiveness of the module?

10.1.1 The educational approach

In the debate on what educational approach is best suitable to achieve cultural competence it was suggested that providing knowledge alone is not enough, but prejudiced attitudes and behaviour need to be challenged (O'Hagan, 2001). Previous training that was confrontational and uncomfortable for participants was deemed not successful (Taylor *et al*., 1998). Also, the approach of providing information about different cultures in the hope that this would increase awareness and understanding towards people from different cultures has not proved effective (Culley, 1996). Training using the 'cookery book' approach (Webb and Sergison, 2003), where participants were provided with lists of cultural norms and descriptions of cultural differences, was not successful either. These rigid depictions of cultures were not geared to challenge racist stereotypes but allowed professionals to ignore their own prejudices and led to stereotyping and victim blaming. Lessons learnt from previous

anti-racism training (Alibhai-Brown, 2000a) have led to the view that cultural competence training should be challenging but in a gentle rather than punitive manner (Thompson, 2003). Others have called for an end of the unethical but widespread practice of 'learning by humiliation' (Martin *et al*., 2002).

This study argues that an educational approach, based on the principles of critical pedagogy and of social constructivism, is best suited to achieve cultural competence by developing personality through a process of critical reflection (Blake *et al*., 2003) rather than transmitting knowledge (Jarvis, 2002). The educational approach is strongly related to the concept of cultural competence in this module, which is inclusive of all cultures and not limited to particular ethnic or religious population groups. This wide approach was used because services need to respond to the needs of a culturally diverse population (Atkinson and Hackett, 1988). This concept of cultural competence considers that for the training to be effective, cultural knowledge needs to be converted into culturally sensitive and competent skills, behaviour and action (O'Hagan, 2001; Campinha-Bacote, 2003). This is in line with the overarching philosophy of the training approach, which recognised the importance of empowerment, critical reflection and social change (Kember, 2002).

The cultural knowledge was provided by a research-based curriculum. The theoretical concepts of cultural diversity and the need for cultural competence in health and social care services was highlighted and applied to the drug and alcohol field. Ongoing research ensured that the knowledge was up-to-date and highly relevant to the learners' working practice. A social constructivist teaching approach was used to assist in transferring this knowledge into cultural understanding, sensitivity, skills and behaviour.

Critical reflection has a crucial role in professional practice and an understanding of its advantages is vital for the personal and professional development of the individuals. A non-reflective approach may lead to getting on with the job without noticing how one's own actions may contribute to disempowerment by contributing to

low confidence, relying on stereotypes and thereby reinforcing structural inequalities. Reflective practice, however, may help to recognise where practice has become ineffective or counter-productive, or to see subtle processes at work that may lead to clients or colleagues being excluded, stigmatised or disadvantaged (Thompson and Thompson, 2008). Students were asked to reflect on their working practice and face their own possible stereotypical views and judgemental attitudes towards clients and colleagues. This was addressed by a specific constructivist learning style so that students were involved in their own self-critique in order to learn.

Whilst this approach was evaluated as beneficial there may be inherent problems when students are exposed to their own learning. Critically reflecting on one's own practice and confronting one's biased attitudes and prejudices can be challenging. This may result in uncomfortable situations or conflicts. Some teachers believe that learning can only take place by strongly challenging a learner's attitude and prejudices. Literature suggests (Hewitt, 1996; Thompson, 2003) that a more gentle approach may be more successful in making people aware of their possible shortcomings. A more aggressive approach may result in a situation where the learners withdraw from or even discredit the course (Clements and Jones, 2006). This is supported by a study that concluded that the non-threatening training approach that was used enabled a change in the participants' attitudes, behaviour and practice (Webb and Sergison, 2003).

The process of critical reflection was supported by a teaching and learning approach whose key features are to ensure interactive learning in a safe learning environment (Epstein, 2002; Jarvis, 2002). For example, the use of case studies and role play can assist in revealing hidden attitudes. Video materials and taped sessions can be used to assess attitudes, behaviour and non-verbal communication (Bhui *et al*., 2007). These methods help to detect participants' stereotypes and negative attitudes that may influence assessments and recommendations for treatment and care. The teaching and learning approach of this module believes that for critical reflection and learning to take place it is important for all participants to feel safe and supported

(Epstein, 2002). A supportive learning environment was created by generating an atmosphere of trust, respect and caring for each other. The evaluation revealed that the learners felt safe to express their views, to make mistakes and learn, assured of confidentiality because this was agreed within the group.

A critical questioning approach was used to open up the learners' minds, by encouraging them to analyse the wider context of a situation to understand the underlying factors behind someone's action. Examples include the reasons for a client's substance use as well as the background for negative staff attitudes. It also aimed to empower the participants in order to implement changes in their practice and fight against discrimination and inequality in their workplaces. To achieve this, possible barriers that may prevent them from doing so were addressed and solutions upon how to overcome these were developed collectively within the group. These included recognising the strengths of joined-up thinking, moral support and collaboration to achieve positive changes through teamwork, which are explicit aims of critical theory (Kember, 2002). The feedback from the focus groups showed that participants felt that the module had increased their confidence in working with clients, but also that they were capable to question existing ineffective or discriminatory practices and to put forward suggestions for improving services to their colleagues and managers. Participants were able to put these into practice, but these efforts to improve practice were frequently obstructed by colleagues or managers. This example shows the limitations of education. For training to be effective there needs to be more committed managers and more input from employers. If the environment is not supportive then the benefits of the training are lost.

Critics argued that current concepts of critical theory have lost their critical potential (Blake *et al.*, 2003) and that critical pedagogy had been watered down in its principles and collapsed into a self-satisfied and insincere feel-good curriculum (McLaren, 2002). A shift has occurred over the years within action research and critical theory, from radical political and ideological positions towards more critical

reflection and learning (Jarvis, 2002) to adapt to the changing times in a globalised world. This shift may also reflect the need for a different teaching and learning approach other than the previous confrontational style that may have been critical but not effective. This current version of critical pedagogy allows, and encourages, individuals to make small changes in their personal and professional environment. These small changes can be very effective in the way they work with clients or colleagues. They can also have an empowering effect instead of doing nothing and accepting unsatisfactory or unjust situations as given, only because they feel powerless and unable to initiate major changes. There is still scope for questioning power relationships in clinical practice. For example, in examining the relationship between health professionals and clients, attempts of user involvement and client centred care, and recognising the effects of social inequalities as underlying reasons for health and social problems (Acheson, 1998).

Learning was facilitated by encouraging debates, critical reflection and interactive learning activities that enabled learning from each other's knowledge and experience (Jarvis, 2002). Its effect was enhanced in a diverse group where participants had to learn how best to deal with diversity (Campinha-Bacote, 2003). The multidisciplinary and ethnic mix of the group offered abundant opportunities for inter-professional exchanges and learning from each other's experiences. The diversity of the group was frequently challenging when individuals with different life experiences and world views faced each other. However, this offered a great opportunity to practice cultural competence in the classroom and enabled the participants to learn how to deal with diversity amongst themselves. The process of using cultural competence as a method of learning in how to deal with diversity and become culturally competent (Clements and Jones, 2006) helped the learners to improve their working practices and communication skills with their clients and colleagues.

The teaching and learning approach was also guided by the view that the success of learning depends on the role the teacher plays and the teaching style used (Jarvis, 2002). The participants came with a range of knowledge and experience and

expectations on the course. They lived busy lives and did not want to waste their time or money. Meeting this expectation required a carefully developed curriculum that is research-based, up-to-date and builds on the participants' knowledge. As mentioned above, this was achieved by conducting a RNA and literature review. Literature on learning theory suggests that the success of the training depends on the degree of how relevant the participants rated the training for their personal and professional development (Epstein, 2002; Sanderson, 1992). The relevance of the content impacts on motivation to learning more and encourages developing ideas how to improve their own practice and initiate changes within their organisation. Learners that do not see any relevance to their practice are likely to feel that they are wasting their time. This was the case with the A&E workers in the Feb 03 intake, who felt they had learnt nothing and were not able to transfer the content to their practice. As a result they resented the training.

The teacher's role is to guide them in the process of learning by providing learning opportunities in a safe environment and by motivating and engaging them in relevant debates. Learning theory suggests that this requires being aware of the powerful influence that a teacher's conduct can have on students' achievements (Jarvis, 2002). Hence, particular attention was given in the module to the quality of feedback, but also to the teacher's non-verbal communication that can reveal hidden prejudices, stereotypes and negative attitudes towards students. Educational theory also highlighted the need of the teacher to be aware of their function as role model (Martin *et al*., 2002), through teaching by example, and the powerful influence they can have on student's perceptions. This applies to many situations in the classroom; for example, how to react in challenging situations, how to handle conflicts or how to deal with learners who make discriminatory remarks. Particular attention, therefore, was paid to the teaching style in this module that sought to be supportive and fair, showing concern for all participants in the course. Feedback was constructive and both encouraged and motivated students to succeed and to believe in their abilities. The feedback from the students suggested that they appreciated the teaching style and that it had motivated them to learn.

Guiding students through the process of becoming culturally competent requires a degree of self awareness about one's own stereotypical and judgemental attitudes (Clements and Jones, 2006). As mentioned above, critical self-reflection on one's own practice and attitudes may result in some discomfort and conflicts in individuals or the group. Participants may resent the training when they feel overwhelmed with the task of having to face their own stereotypical attitudes and prejudices (Clements and Jones, 2006). Teachers who are not well experienced in dealing with difficult situations may cause psychological damage to the learners (Clements and Jones, 2006). This required a constant process of self-reflection by the teacher, reflecting on-practice and in-practice (Schön, 1987) throughout the module. The feedback from the students demonstrated their satisfaction with the teaching style. In critical self-reflection it needs to be said that over time the teacher gained more experience in dealing with the challenges of a diverse group in difficult situations, but there is still much more to learn. This study strongly suggests that for the success of cultural competence training, the teacher needs to have experience in dealing with such situations and should have undergone a process of critical reflection themselves to explore their own prejudices and attitudes in relation to diversity, identifying possible difficult areas.

In summary, the findings of this study suggested that a module based on the principles of critical pedagogy and social constructivism can be effective. The feedback from the students showed that critical thinking and reflection effectively enabled them to understand situations of social injustice and exclusion, inequality and discrimination and their underlying factors. Moreover, it enabled them to initiate changes in their own individual working practice and to influence to some degree colleagues and managers, by doing so to achieve changes in the practice of the organisation.

However, there are limitations in what can be achieved by such an educational approach. If participants do not get support or reinforcement from their managers,

colleagues or organisation then the ability for creative ideas to change ineffective and discriminatory practice to enhance cultural competence may vanish quickly and together with it the motivation for engaging in critical reflection of practice, leading to disempowerment. If training was to go beyond changing the individual knowledge, behaviour and attitudes and result in a change in work performance and organisational culture, then learning needs to be supported by the management of the service and the organisation itself. This means that much more work needs to be done to ensure the support in practice in terms of employer engagement and involving managers to create an understanding of the advantages of cultural competence training for the whole organisation.

10.1.2 Is it possible to transfer the teaching and learning approach of this cultural competence module to other areas?

One respondent in the manager survey of the evaluation questioned whether cultural competence training needed to focus on drug and alcohol problems because the issues are the same whatever the nature of a client's problem. Supported by the literature (Jarvis, 2002; Epstein, 2002), the approach chosen for this module aimed to build on existing knowledge and be as near to the practice of the participants as possible to enhance outcome. This module is targeted at staff who work in a range of organisations within the wider drug and alcohol field. The content is research-based and case studies were taken from the drug and alcohol field. This approach ensured that the content was relevant and helped the trainees to apply the theoretical concepts to their working practice and reflect on their individual performance. The study argues that a less relevant focus will not engage the participants in the same way and consequently participants are less likely to apply what they have learnt to working practice.

The way the module has been designed makes it easily adaptable for other areas beyond the drug and alcohol field. The key concepts can equally be applied to other areas of health and social care. For example, knowledge on patterns and trends and

critique on data collection is just as important in other areas in order to establish the epidemiological knowledge on the extent of the problem in question. Also, it is widely acknowledged that the underlying issues of diseases are strongly influenced by the cultural context and by social inequalities (Acheson, 1998). Therefore, it is vital to establish the social and cultural context in which patients live and that may have caused, or at least contributed, to their condition. Equally, the anthropological concepts of health and help-seeking behaviour and of the influence of culture on values, beliefs and attitudes are generic issues that are also relevant in other areas of health (Helman, 2000; Henley and Schott, 1999). Likewise, in all areas of health and social care it is vital to identify gaps in services, problems in the relationship between health professionals and clients and to find ways of how to improve the quality of services for all clients. The recommendations for structural adjustments, partnership working and resources are equally relevant for other areas too. Similarly, equal opportunity and anti-discrimination policies are applicable to all areas of the health or social services.

Backed by the findings of this study and by the literature that underpinned the teaching and learning approach, it is strongly suggested that application to the participants' practice is vital in order to make the learning relevant to practice, whatever that practice is. The content of the teaching needs to be research-based and constantly updated to remain relevant to practice. The use of case studies for critical reflection and problem solving are useful means of enhancing relevance to practice. The inclusion of service user perspectives and application of relevant treatment concepts and policies, such as the harm reduction approach in the drug and alcohol field (Stimson, 1995) and the recovery approach in mental health (DH 2006), is important to enhance learning about the benefits of a client-centred approach as a central element of achieving cultural competence.

The Race Relations (Amendment) Act 2000 has called for cultural competence training in all areas of the health and social sector (HO 2000, 2003; CRE 2007). The findings of this study suggest that this module provides a useful framework that is

adaptable to all areas of health and social care, to enhance understanding and increase the skills for the treatment and care for people from all ethnicities, ages, genders and classes.

10.1.3 Further implications for cultural competence training

10.1.3.1 Where should cultural competence training be delivered – as academic or occupational training?

This module was delivered at a university embedded in a diploma and degree in Substance Use and Misuse Studies. There are advantages and disadvantages associated with this.

The advantages include the fact that the learners are away from their working environment. Learning takes place in an environment that is stimulating with facilities such as libraries, surrounded by other learners. The academic credits attached to the successful completion of the module can be used for continuous professional development and towards an academic award. Disadvantages can be its academic rather than vocational reputation and the requirement for written academic assignments.

Training events are free from such pressures, but learners miss out on the opportunity to enhance their learning by having to process what they have learnt by writing an assignment. Unless they undertake their own assessment, funders and employers may miss the opportunity to assess the effect the training had on the participants (Forsyth, 1993; Sanderson, 1992) and whether the training was value for money.

Despite the challenges of measuring the impact of a learning event, as outlined in this work, this study recommends for all training, whether academic or vocational, to develop a framework of outcome criteria against which the impact of the training can be measured. Existing frameworks, such as the KSF (DH, 2004) or DANOS (Skills

for Health, 2004), provide useful elements for assessments of skills and competences.

10.1.3.2 Training or education?

The many requests for enhancing cultural competence commonly refer to 'training' in the hope of achieving changes in knowledge, understanding and attitudes. The term 'training' is frequently used to refer to all educational events. However, the term is confusing as it encompasses different concepts, training and education. While training is usually output-orientated, task-centred and information-based, education is input-oriented, learner-centred and initiates a process of learning (Jarvis, 2002). Based on its findings, this study strongly recommends that cultural competence should be a matter of education rather than one of training (Clements and Jones, 2006). The process of becoming culturally competent requires a high degree of self-reflection on one's own attitudes and beliefs and involves a process of learning and personal development, facilitated by the teacher in a safe environment. This process may require time, and learning may happen not immediately, but at some time in the future. It is therefore questionable whether short and ad-hoc training events are able to achieve this degree of critical reflection, interactive learning and personal development.

Funding constraints may limit resources and employers may opt for short training courses rather than an educational module. Nevertheless, commissioners of training or educational events need to be aware that the success of the training event is likely to depend on the teaching and learning approach that is used, whether an emphasis is put on self-reflection and initiating a process of learning rather than seeking a "quick fix".

10.1.3.3 Cultural competence training as a compulsory element?

Some learners suggested that cultural competence training should become a compulsory element of nurses' professional development, like health and safety.

Although this is an appealing idea, there are disadvantages of such an approach. The success of critical reflection on one's own practice and confronting possible biased stereotypes and attitudes depends on the motivation and interest of the individual (Forsyth *et al*, 1999). Becoming culturally competent is an ongoing process that must happen on a voluntary basis; it cannot be compulsory. Otherwise the learner may avoid the process by disengaging with the learning, or the group, or even discrediting the course (Clements and Jones, 2006). On the other hand, stimulating and challenging discussions may set in motion a critical process of reflection.

This study suggests that the success of cultural competence training would be enhanced if the training was to be embedded within an overall organisational strategy with managerial support and became part of the organisational philosophy and culture. Further, organisations in multicultural societies need to meet the needs of a fast changing diverse population. For that reason, cultural competence training must be included in the curriculum of health and social care and in all other sectors of society, including education and criminal justice system.

10.2 Effectiveness of action research?

Action research was chosen as the methodological framework for this study because of the nature of this study as action oriented, seeking to improve practice and aiming at social change by changing knowledge, attitudes and behaviour. Action research deals with social practice in education in that it encourages the interaction of teachers and students and acknowledges that learners are complex people rather than just receivers of knowledge (Kember, 2000). Action research fits well with the philosophy of the teaching approach based on critical theory, because both critical theory and action research strive for social change and critical reflection (Kember, 2000; Kemmis, 1997).

Action research as a research strategy has become popular for small-scale research in educational settings, like that in this study, because it is concerned with finding practical solutions to practical problems (Bennett, 2003). A central feature of action research is that the practitioner evaluates their own practice with the aim of improving it.

The action research approach assisted in reflecting on and improving my own practice as a lecturer and researcher by continuously evaluating the module (McNiff, 1988, 2001). The use of formal means, e.g. through research, helped to ensure that this reflection and learning took place in a systematic way, going beyond the everyday self-reflection that teachers are expected to do. The continuous cycle of action research enabled me to step back and reflect, and as a result, to make changes throughout the process of the study. The ongoing changes enabled the constant improvement of the module based on the learners' feedback and training needs. The systematic approach of action research was not only useful to investigate the individual module deliveries and the individual learning. It also enabled me to reflect on the wider impact beyond that learning experience and to contribute to a broader debate as to whether educational approaches can achieve a difference.

There are debates amongst researchers concerning the validity of action research. Some argue that action research is not robust enough to suggest that this module had been successful and (as discussed in section 2.6) that the concept of the teacher being involved in researching their own practice goes against research approaches that set out to be impartial, neutral and objective (McNiff, 1988; 2001). The research approach, teacher-as-researcher, and the involvement of the practitioner in conducting the research can be a source of possible bias in data collection and interpretation. As a consequence, there is a strong obligation on the teacher-researcher involved in the continuing development of the programme to acknowledge and address issues related to potential bias (Bennett, 2003).

These concerns have been addressed (see section 7.2.4) by careful planning of the research in all its stages and by undertaking a number of measures to limit the risk of bias in data collection and interpretation. The evaluation was carried out on the basis of an evaluation theory (Chen, 1990) developed prior to the onset of the study. It provided a rationale for utilising particular research methods tailored to the purpose of this research (Clarke, 1999) (see section 7.2). The purpose of the research had implications for the involvement of the teacher as researcher in the study. The evaluation theory also guided the researcher towards certain issues and problems which may have been encountered during the evaluation. Particular care had been taken in the formulation of the questions, the design of the study, and the way in which data were collected and analysed (Cohen *et al*., 2007; Bennett, 2003). A wide range of tools were used to provide the probability and consistency of firm and robust findings to strengthen the case of the study (Brookes, 1995; Forsyth *et al.*, 1999). The evaluation used standardised systematic procedures to ensure valid, reliable and comparable results of the evaluation of each module intake. Critical reflection throughout the various steps of the evaluation cycles helped to bring a critical distance to what was being researched.

Whilst the involvement of the teacher-as-researcher is commonly associated with bias, the subjectivity of this approach also offered a number of advantages for the interpretation of the findings. One of the advantages was the insider knowledge of the teacher-as-researcher over the use of objective observation by an external researcher. As the one closest to the study (Morrison, 1998), the teacher-as-researcher had an in-depth knowledge and insider's expertise of collecting and interpreting data over time to an extent that an external researcher would not have been able to attain. Observations in class enabled the interpretation of comments made in the evaluation questionnaire and put them in the context in which they occurred. By knowing the context, informed action could be taken to avoid this from happening again. For example, the negative comments by one learner that she had not learnt anything could be seen in a different light once the reason was known to the researcher. Furthermore, the results of the self-rating of before and after knowledge could be interpreted differently by the person who had read and marked the assignments and who could then link the results of both tools. An outside expert could certainly undertake this work too, but they would not have the same in-depth view as the person who marked the assignment and observed the students in class. Another example is that of one student, who had rated his before and after knowledge and learning consistently as very good, but did poorly in the assignment. By knowing his contributions in the group discussions in class, which frequently consisted of discriminatory remarks, and the results of the assignment, which identified that he had failed, the teacher as researcher was able to identify that he had not done as well as he thought he had. The experience of teaching and evaluating this module led me to recognise that the success of a module can only fully be appreciated when the results of all the individual evaluation levels are brought together. The results needed to be related to each other, and this was enhanced with the insider knowledge of having taught and guided the learners through the module. This involved experiencing the atmosphere in the classroom and the quality of discussions and at the same time observing the students, their motivation and input, in the individual modules' intake and over the years. Seeing the "whole picture" helped to develop an expertise that an external researcher was not

likely to develop unless they had participated in the course as a constant observer and marked all the assignments. Such close involvement could arguably also impact on the evaluator's objectivity and independence. In addition, my involvement as teacher and researcher increased my motivation and creativity in my teaching style and as such had an important impact on the module's delivery.

Nevertheless, there are also disadvantages with the involvement of the teacher-as-researcher that should not be underestimated. The close involvement, together with the motivation to produce high quality work, can affect the ability of the teacher-as-researcher to distance themselves from the subject of the study. For example, the positive feedback from the students on the content of the module, the teaching style and the usefulness for practice was very satisfying for me as teacher. There is, however, the danger that this immediate gratifying success could, in a subtle way, cloud one's judgement regarding the importance of other less obvious measures to determine the effectiveness of the module. One must not fall into the trap of assuming that this first positive result is the final conclusion of the effect of the module. Utmost care, therefore, needs to be taken in achieving the impartiality that is necessary to objectively interpret the findings without jumping to quick conclusions.

The research approach attempted to balance the subjective insider expertise with the rigour of objective data by using a range of evaluation tools. However, in order to enhance the objectivity of the evaluation it is strongly suggested in future module deliveries to use an independent tutor as a facilitator for the evaluation sessions. By doing so, it is expected that more confidentiality will be achieved, encouraging the participants to express their concerns and critique freely without the fear of criticising the teacher who is present in class and possibly jeopardising this relationship (Cohen *et al*., 2007). Using an outside researcher is also likely to enhance the validity of the study in the perception of those commissioning the training.

From the experience of conducting this study, it can be concluded that action research is a useful approach for small-scale educational research like this PhD.

However, the action research approach may have its limitations in research outside of the educational setting. Investigating the effectiveness of this educational module on the overall practice and culture of an organisation required the focus of the research to be extended. A large-scale survey needs to be undertaken adopting a different educational evaluation approach than action research (Cohen *et al*., 2007; Bennett, 2003). Other methods could be included, such as using a control group; performance-rating by managers before and after the course with regards to motivation and skills; observation or attitude surveys; and a client satisfaction survey, evaluating the implementation of action plans and projects, and assessing the job performance against occupational standards.

10.3 Challenges of evaluating the effect of educational events to achieve cultural competence

Calls for cultural competence training (DH, 2004; HO, 2000; NIMHE 2005) are based on the belief that providing training on racism awareness and cultural diversity is a step forward to improving racial discrimination (HO, 2002). However, despite the increasing numbers of diversity and cultural competence training provisions, there is little knowledge on the effectiveness of such training. Few authors have reviewed training events and there is inconclusive evidence on their effectiveness (Bhui *et al*., 2007; Webb and Sergison, 2003; Thom *et al*., 2006; Price *et al*., 2005; Beach *et al*., 2005).

There may be many reasons why there is a lack of studies that seek to successfully and systematically evaluate the impact of cultural competence training. This may be because the importance to measure the impact of training is underestimated. As a result, expensive training may not be cost effective. Organisations also run the risk of being accused of providing lip service to Government policies only, rather than aiming for real improvements and changes in service provision for clients, if they do not provide evidence that training was effective. On the other hand, considering the wide ranging cuts in the training budget of health and social care services, the lack of evaluation feedback may be a cost issue, because in-depth evaluations make the training more expensive. Furthermore, the lack of systematic studies into the effectiveness of training events may also reflect the challenge of measuring learning and determining the degree to which training has had the desired effect.

This PhD study sought to make a contribution to the debate into the effectiveness of training approaches in cultural competence training. It aimed to add its findings to a broader debate on learning and educational practice as to whether the educational strategy and the teaching and learning approach used in this module were effective in achieving a change in knowledge, understanding and behaviour.

The study encountered a common dilemma in educational research in measuring the direct and overall impact of training/education (Sanderson, 1992; Forsyth *et al*., 1999). The fact that learning is a process rather than an end product (Epstein, 2002) makes it difficult to measure the degree of learning as it depends on many factors that may lie outside the control of the teacher. Also, measuring an increase in knowledge is easier if there has been no prior knowledge on the subject before the learning event (Forsyth *et al*., 1999). However, when working with adults, the teacher needs to build on existing knowledge, taking account that the educational event is not the only source of learning. Furthermore, with education, a long-term perspective has to be taken because results of education may only become clear after several years (Luthra and Ockley, 1990; Epstein, 2002).

There are limitations in the methods of isolating the effects of the training. Each of the various evaluation tools used in this study provided strong positive results to its objectives, indicating either learning, an increase in knowledge or a change in attitudes, behaviour and work performance. However, as discussed in more detail in section 9.6, it is in the nature of each of these instruments that they have intrinsic methodological problems, which may lead to limitations in what can be measured. For example, evaluating the students' response to the learning event gives information on the students' feelings and opinions about the module and whether they found it useful, but it does not measure whether they have learnt something. However, learning theory strongly suggests that if learners liked the event then this is likely to provide positive learning outcomes (Jarvis, 2002). A successful increase in knowledge as a result of the learning event does not necessarily ensure that this is transformed into an enhanced performance at work. Learning in the classroom cannot be deemed successful if the learning is not transferred into an enhanced performance in the work place (Forsyth *et al.*, 1999). If learning did not improve practice, a number of factors may be responsible and many of them are outside the control of the teacher. Therefore, challenges in measuring intermediate outcomes may arise because many other factors, besides learning, influence job performance

(Sanderson, 1992). This includes the organisational culture, and the influence of managers and colleagues. In addition, performance in health and social care is difficult to measure (Brookes, 1995) because it is not the quantity of client throughput but the quality of service provision that matters.

The challenges in devising appropriate tools to measure the effect of cultural competence training have been highlighted in the literature (Thom *et al*., 2006). The authors, who were unsuccessful in measuring the effect of cultural competence training on patient outcomes, concluded that the outcome measures may have been too difficult to achieve, but this should not be interpreted as indication that cultural competence training is not valuable, rather that the value of cultural competence training still needs to be established. This is also true for this research. Within the scope of this PhD research there were limitations to measure the impact of learning on the individuals' work performance and on the organisational culture. Although the feedback from the focus groups of staff and the questionnaires with managers provided some results and some interesting issues were raised, more work needs to be undertaken to establish the effect of learning on the organisation. Such evaluation requires the close cooperation from employers or managers and the establishing of different outcome measures than the ones used in this study, for example, based on job descriptions and occupational standards or the use of control groups (Forsyth *et al*., 1999).

A further common dilemma in the evaluation of educational events is that many of the evaluation tools used are subjective rather than objective measurements. This increases the likelihood of response bias (Cohen *et al*., 2007; Bennett, 2003). The difficulty of rigorously assessing whether learning has been achieved is highlighted in the literature (Sanderson, 1992; Brookes, 1995; Forsyth *et al*., 1999). Objective measures to test facts and specific information by tests, multiple choice or control groups (Brookes, 1995) are less suitable when it comes to testing the understanding of complex concepts or changes in attitudes and behaviour. Learning theory suggests that such rigorous measurements are often not feasible in real teaching

situations (Sanderson, 1992). These limitations apply also to this study. For example, when measuring cultural competence, the collection of more indirect data by means of subjective testing (Brookes, 1995), such as interviews, questionnaires and attitudes surveys may be more suitable (Forsyth *et al*., 1999; Sanderson, 1992).

In order to enhance the methodological rigor of the findings, a range of evaluation tools was used, complementing each and, although there are caveats in many of them, they enabled a complex picture to be built from which the degree of learning could be analysed. The limitations of relying on a single assessment process and the need to use a number of different approaches to validate the findings have been highlighted in the educational literature (Clemens and Jones, 2006).

Equally, the challenges of measuring and assessing competences and their relationship to self-efficacy have been reported (Lauder *et al*., 2008). Competency-based education and how best to measure and assess competence has recently become more prominent with the introduction of the NHS Knowledge and Skills Framework (KSF) (DH, 2004), a framework of the knowledge and skills NHS staff need to have, and in which competence is linked to staff development and job description. For the drug and alcohol sector, the Drug and Alcohol National Occupational Standards (DANOS) (Skills for Health, 2004) have taken on a similar role of establishing a framework of competences for staff development and achieving shared standards of working in the field. These standards of working have been welcomed as a useful way to define the existing tasks and functions of a given professional role. However, concerns have been raised that these should not be the only way to assess performance and competence. Demonstration of competence based on occupational standards may still not reveal discriminatory attitudes or racism (Clements and Jones, 2006).

The debate on how best to assess competences in educational practice, whether indirectly through self-reflection and self-reports or directly through observation is still ongoing (Mathieson *et al*., 2009). The relationship between competence and self-

reported competence as investigated by Lauder *et al*. (2008) in the area of pre-registration nursing education, and the benefits of self-assessment in identifying confidence and areas of perceived strength and weaknesses in cognitive behaviour therapy (Mathieson *et al*., 2009), are key issues in a debate that seeks to establish the reliability of self-assessment.

Self-assessment has an important role in professional development, but may be biased and unreliable (Webb *et al*., 2003). Assessment in practice is also prone to response bias because of the tendency of individuals to present themselves in the way they think is expected or favourable to them. Martin *et al*. (2002) suggested that any method to assess attitudes and performance correctly must take into account the effects of what he called 'social desirability' and other response bias.

Also, changes in attitude and behaviour often are very subtle adjustments of communication style or practice that are difficult to pick up by observation, as found by Webb *et al*. (2003), who tried to assess the impact of cultural competence training courses in child health services. The authors experienced that attitudes are difficult to assess directly and therefore relied on indirect measures of behaviour and attitude change, based on the belief that individual participants' responses to situations indicated that the training must have changed their attitudes.

A further challenge that this study faced was to establish the degree to which the teaching was the driving factor for organisational changes, or whether it solely created the basis on which the organisation could build on and introduce changes. There is no easy answer. It goes back to the dilemma in educational research of measuring the impact of learning. Although, providing a basis on which the organisation could build is valuable in its own right. It would be over-ambitious, or unrealistic, to expect that an educational course could directly change an organisation, rather than simply providing a basis on which to help build change.

The evaluation of the impact that the learning event had on work performance, and on the organisation, was carried out in one particular Trust. The feedback was positive and the training was welcomed by staff and their managers. This Trust was involved in commissioning the development of this cultural competence module and over the years had sent a significant number of their staff on this course. The Trust also developed a strong commitment and developed a Trust-wide policy and guidelines on how to develop cultural competency in the organisation. It is impossible to establish with certainty whether the cultural competence training of individual staff was able to kick off a process of cultural competence within the trust or whether the training built the basis on which the organisation was able to implement policies and changes.

Still, the evaluation showed that individual staff encountered barriers from their managers or colleagues when they wanted to implement changes in practice. This has also been reported by Thom *et al*. (2006), who did not find any measurable impact of their training. The authors acknowledged important limitations of this study in that there was a lack of institutional support and reinforcement for changing behaviours in the practice environment. This strongly suggests that cultural competence training is a long-term process and is likely to be more successful if it is supported by management. This indicates that more work needs to be carried out to ensure the support of all managers, otherwise the sustained effects of the learning will be lost quickly. Strong leadership is needed together with structural changes and the implementation of policies to address social inequalities and discrimination. Without this support, an educational module, no matter how successful it may have been in achieving changes in individual staff's knowledge, attitude and behaviour, would be limited in its ability to achieve social changes.

Conclusions

Through the use of action research and RNA, a new module was developed in the belief that a teaching and learning approach based on critical pedagogy and social constructivism engages students to learn. The purpose of the module was to enhance cultural competence in staff working in drug and alcohol services with the expectation that this would result in improved services. A critical reflection approach in a safe learning environment appears to have influenced students to adopt new forms of behaviour, which they have been able to sustain when returning to practice, leading to improved practice. The successes of the module and the teaching strategy have been shown in increased knowledge and understanding, but also in enhanced self-confidence and cultural skills in assessment and care.

Gaps have been identified in the way that students have sustained their knowledge and behaviour when returning to their working environment. Barriers in the workplace from managers or colleagues prevented some from implementing ideas to improve practice. As a consequence, the creative empowerment to improve practice achieved by the training could not be sustained.

This strongly suggests that whilst the module may have been successful in changing knowledge, behaviour and attitude in individual participants, it was not successful in achieving a change in organisational culture. This demonstrates the limitation of an educational module. Sustained behavioural change and improvements in practice require explicit and active support from management and need to be implemented together with structural changes.

This study also identified shortcomings in measuring the outcome of training on improving work performance and changing organisational culture, and limitations in measuring what an educational module can achieve. Whilst this does not necessarily mean that the module was not successful, it implies that more research needs to be

undertaken to provide evidence of the impact of an educational module on behavioural change and improved work performance.

Questions have also been raised as to the direct or indirect effect of this cultural competence training. It remained unclear whether changes in practice were the result of the training or whether the training created the basis on which the organisation could build when implementing changes.

It is the conclusion of this study that while the module was able to achieve behavioural change in individuals, cultural competence can best be achieved by an organisational commitment to a process of cultural competence within the organisation. Cultural competence training, like the module developed in this study, has an important role to play in this process.

References